Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 25TH OCTOBER 2017
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

AGENDA				Paper	Presenter
09:30	1.	Employee of the Month			Richard Fraser
		1.2	September		
		1.3	October		
09:40	2.	Apologies for Absence			Richard Fraser
	3.	Declaration of Interests			
	4.	Minutes of the previous Meeting held on 27th September 2017		Attached	
		4.1	Correct record & Matters Arising		
		4.2	Action list	Attached	
Performance Reports					
10:00	6.	Integrated Performance Report		NHST(17) 088	Nik Khashu
		6.1	Quality Indicators		Sue Redfern
		6.2	Operational indicators		Nik Khashu
		6.3	Financial indicators		Nik Khashu
		6.4	Workforce indicators		Anne-Marie Stretch
Committee Assurance Reports					
10.20	7.	Committee report – Executive		NHST(17) 089	Ann Marr
10:25	8.	Committee Report – Quality		NHST(17) 090	David Graham
10:30	9.	Committee Report – Finance & Performance		NHST(17) 091	Denis Mahony

10:35	10.	Committee Report - Audit	NHST(17) 092	Su Rai
10:40	11.	Charitable Funds – Annual account and report	NHST(17) 093	Denis Mahony
Other Board Reports				
10:45	12.	Strategic & regulatory report	NHST(17) 094	Nicola Bunce
10:55	13.	Board Assurance Framework	NHST(17) 095	Nicola Bunce
11:05	14.	COPD update	NHST(17) 096	Kevin Hardy
Closing Business				
11:15	15.	Effectiveness of meeting		Richard Fraser
	16.	Any other business		
	17.	Date of next Public Board meeting – Wednesday 29th November 2017		
BREAK				

Minutes of the St Helens and Knowsley Hospitals NHS Trust Board meeting held on Wednesday, 25th October 2017 in the Boardroom, Whiston Hospital

PUBLIC BOARD

Chair:	Mr R Fraser (RF)	Chairman
Members:	Ms A Marr (AM)	Chief Executive
	Mrs A-M Stretch (AMS)	Deputy Chief Executive/Director of HR
	Mrs C Walters (CW)	Director of Informatics
	Prof D Graham (DG)	Non-Executive Director
	Mr D Mahony (DM)	Non-Executive Director
	Mr G Marcall (GM)	Non-Executive Director
	Mr J Kozer (JK)	Non-Executive Director
	Prof K Hardy (KH)	Medical Director
	Ms N Bunce (NB)	Interim Director of Corporate Services
	Mr N Khashu (NK)	Director of Finance
	Mr P Williams (PW)	Director of Facilities Management/Estates
	Ms S Rai (SR)	Non-Executive Director
	Mrs S Redfern (SRe)	Director of Nursing, Midwifery & Governance
	Dr T Hemming (TH)	Director of Transformation
	Mrs V Davies (VD)	Non-Executive Director
Apologies:	Cllr G Philbin	Halton Council
	Mr R Cooper	Director of Operations & Performance
	Mr T Foy	St Helens CCG
In Attendance:	Mr R Little (RL)	Account Director, Liaison (observer)
	Mrs K Pryde	Executive Assistant (Minutes)

1. Employee of the Month

The award for Employee of the Month for September 2017 was presented to Lesley Carr, Assistant Practitioner, Ward 1B.

2. Apologies for Absence

2.1. Apologies were noted.

3. Declaration of Interests

3.1. None received.

4. Minutes of the previous meeting held on 27th September 2017

4.1. **Correct Record and Matters Arising**

4.1.1. Following removal of “KH confirmed that PHE had given this assurance” from paragraph 8.6, the minutes were approved as a correct record.

4.2. **Matters Arising**

4.2.1. Paragraph 8.5: Safeguarding training. KH confirmed that having written to all doctors, this is being tracked weekly, but can only be reported monthly. KH was also concerned that the ESR was not entirely accurate. AMS agreed to look into this.

4.2.2. Paragraph 8.5: Flu vaccinations. KH had sought further information regarding this year's vaccines effectiveness against new strains of flu. AMS clarified that the key message to staff regarding the importance of being vaccinated and protecting yourself, your family and patients was not changed. . SRe advised that NHSE have issued new guidance and the Trust will need to demonstrate that all staff have been offered the vaccine and record those that decide the decline.

4.3. **Action List**

4.3.1. Action 1. Minute 7.6 (31.05.17): Complaints, Claims & Incidents – context and data. Will be included in the next quarterly report to the Quality Committee. Action closed.

4.3.2. Action 2. Minute 7.8.2 (31.05.17): Relatives attendance at discussions regarding patient care plans. SRe has spoken to ward managers and matrons. Bedside handovers in the Medical Care Group are being trialled. Afternoon surgeries are also being held to discuss patient care plans, although patient consent must be obtained before such discussions take place. Action closed.

4.3.3. Action 3. Minute 7.8 (28.06.17): Board development agenda. The proposed plan has been circulated. Action closed.

4.3.4. Action 4. Minute 11.7 (26.07.17: High mortality in COPD. Agenda item. Action closed.

5. IPR – NHST(17)088

5.1. Quality Indicators

5.1.1. SRe provided an update on performance against the Quality Indicators.

5.1.2. There were no never events in September and zero cases in the year to date.

5.1.3. There were no MRSA bacteraemia cases in September. The positive sample in July has been submitted to NHSE for 3rd party appeal, with a summary of further evidence to support the appeal.

Unfortunately, there has been a case of MRSA on Ward 1A during October, which will be formally reported next month. The rapid

review has been completed and the full RCA will take place on 1st November.

5.1.4. There were 4 C.Diff positive cases in September. The total number of positive cases year to date is 19. There are two cases that will be appealed at the December panel.

5.1.5. There were no grade 3 or 4 pressure ulcers in September and 0 cases year to date (YTD).

5.1.6. The overall registered nurse/midwife Safer Staffing fill rate for August was 93.2%.

5.1.7. During the month of August there were no inpatient falls resulting in severe harm.

5.1.8. VTE performance for August was 93.57%, which remains below target. There was concern that performance was not improving and it was confirmed that KH was in the process of identifying options and would develop an action plan that would be monitored by the Executive Committee.

5.1.9. Provisional HSMR is 102.4

5.2. Operational Indicators

5.2.1. NK provided an update on the Operational Performance, in the absence of RC.

5.2.2. Performance against the 62 day cancer standard was 85.8% in August. Close monitoring of individual patient pathways continues and areas requiring improvement are being addressed through tumour specific action plans.

5.2.3. A&E performance was 82.9% (type 1) and 89.0% (type 1 & 3). The key actions for continued recovery of this position are being driven forward by the senior leaders across the organisation, focusing on both the Emergency Department and the inpatient wards.

5.2.4. RTT incomplete performance was achieved in month (92.8%). Specialty level actions to address this continue, including targeted backlog clearance plans.

5.2.5. VD enquired as to the particular issue with head and neck cancer waits. KH said there are two issues; firstly the clinical pathway is complex and secondly there is a long delay of patients being transferred and accepted by to Aintree Hospitals (the head and neck cancer centre) which resulted in the breaches. AM will escalate the Boards concerns to the CEO at Aintree Hospitals NHSFT.

5.3. Financial Indicators

5.3.1. NK provided an update of the Trust's financial position. For the month of September (month 6), the Trust is reporting an overall Income & Expenditure surplus of £3.67m, which is in line with the YTD profiled plan. Overall Trust income is £183.0m, which is also in line with plan. Clinical income is behind plan by £1.4m, which is offset by an over performance on non-clinical income by £1.3m.

5.3.2. Trust operating expenditure is £167.2m, which exceeded plan by £0.1m. Clinical supplies are £1.2m above plan which is partly offset by the additional non clinical income and pay is £3.2m higher than plan and this is offset by a £4.5m underspend against other costs. Pay control and monitoring is reviewed at the Premium Payments Scrutiny Council.

5.3.3. As discussed at the F&P Committee in some detail it was reported that the Trust is developing a recovery plan which includes productivity opportunities and robust cost control programmes for the remaining period of this year.

5.3.4. The Trust has delivered £5.8m of CIPs, and is £(0.8)m behind the YTD plan which is reflected in the Trust's overspend on expenditure.

5.3.5. The Trust's cash balance at the end of September was £3.4m, representing 4 days of operating expenses. The Trust has incurred £4.4m of capital expenditure in the six months to September.

5.3.6. Board members discussed cash reserves, pay budgets, activity and the financial risks the Trust was managing.

5.3.7. NK reported that there are signs of other NHS organisations not paying bills on time to ease their own cash positions. Payments should be received on 15th of the month, but the Trust is now seeing organisations paying anytime between 15th and the end of the month. NK has written to all debtors and if there is no improvement within the month, he will escalate the issue to NHSI, who have already been briefed.

5.3.8. AMS reiterated that from a lead employer perspective, the Post Graduate Dean has offered support with any organisations that are not paying on time.

5.4. Workforce Indicators

5.4.1. AMS provided an overview of the Workforce Indicators.

5.4.2. Absence in September has decreased to 4.9% from 4.3%. YTD absence is 4.2% which is 0.60% below the 2016-17 position of 4.8%

5.4.3. Mandatory training compliance has decreased slightly in month but continues to exceed the target by 3% at 88% compliant. Appraisal compliance is 6.9% behind target.

5.4.4. The board discussed A&E appraisals and reasons why they are not achieving target; i.e. pressures in the department.

6. Committee report - Executive – NHST(17)089

6.1. AM provided an update to the Board.

6.2. The Executive Committee approved the submission of a bid to provide Marshalls Cross Primary Care services. A business case to recruit and train advanced clinical practitioners for A&E was also approved. The business case to implement the SafeCare staffing system was approved.

6.3. The business case to create a shared care record for all St Helens patients had been reviewed.

6.4. Schematic plans for the A&E GP streaming capital scheme, funded from Department of Health allocated capital, were reviewed and agreed in principle subject to planning approval.

6.5. Other items discussed by the Executive Team included Stroke update, winter planning, and the Pseudomonas case on ward 4D

6.6. VD asked how Marshalls Cross fit into the bigger picture and the capacity of the Executive team to manage the new services. AM suggested this should be discussed at the Board time out on 1st & 2nd November.

7. Committee Report – Quality – NHST(17)080

7.1. DG provided feedback from the meeting held on 17th October. Key items discussed were:

7.2. Visit by the Secretary of State for Health, Mr Jeremy Hunt on 13th October.

7.3. Letter from Professor Ted Baker, Chief Inspector of the CQC. The letter from Professor Baker related to safety and quality of emergency care. The actions are laid out and a plan is being formulated to ensure they are implemented, which will be reported at the next meeting.

7.4. Complaints: 23 1st stage complaints were received and opened in September 2017; a decrease from 24 received in August. At the end of September, there were 59 open 1st stage complaints (an increase of 1), including 6 overdue (no change). The Trust responded to 63.6% of 1st stage complaints within agreed timeframes in September, an increased compared to August, when 58.8% were responded to within agreed timeframes. There was a 25% increase in PALS contacts compared to the previous quarter.

7.5. CQC action plan update: The committee were advised that 54 of the 57 actions had now been completed. The three overdue actions relate to

appraisals in A&E (area of particular focus over the next two months), implementation of the Maternity strategy (due to report back in January on the implementation of the low risk birth pathway) and the roll out of the amber care bundle (issues in primary and community care which were beyond Trust control).

7.6. ANNB screening update: An update was provided on the implementation of a robust action plan following a recent ANNB screening review.

7.7. Lord Carter review update: The proposal of a Cheshire & Merseyside collaborative staff bank was discussed. The project is now being supported by NSHI and used as a case study from which other regions may benefit from our learning. An STP level steering group has been established.

7.8. Francis action plan update: An executive discussion will take place regarding Freedom to Speak Up and the CQC well led assessment.

7.9. Medicines optimisation strategy: The Committee approved the updated strategy and an action plan to deliver it will be produced for next month.

7.10. HPTP strategy: A summary was provided of the current Pharmacy & Medicines Dashboard from the NHSI Model Hospital. A summary of progress on key HPTP activities was provided and important improvements (e.g. TTO's) were noted. The Committee asked S Gelder to feedback to Pharmacy staff their thanks for all improvements made.

7.11. Medicines storage and security audit update: The audit in August was unannounced and conducted by Pharmacy staff. Performance has deteriorated since the June audit, where overall Trust compliance was at 95%, compared to the August results showing 48%. The Executive team will discuss the results at their weekly meeting.

7.12. Items escalated to the Board were, CQC letter on safety and quality in ED, HPTP strategy, Medicines safety and concerns about the delivery of NIV.

8. Committee Report – Finance & Performance – NHST(17)091

8.1. GM summarised the report for the Board.

8.2. Items discussed for information:

8.2.1. A&E update. The committee reviewed progress against the performance improvement plan and were updated on the actions being taken. The issue of medically optimised patients and DTOC needs to be escalated to commissioners.

8.2.2. Finance report. The Committee had undertaken an in-depth review of the performance against the Trusts financial plan and the plans for mitigating the financial risks.

8.2.3. Key issues were e-rostering, CIP programme 2018-19, appraisals, VTE performance and the Trust financial position.

9. Committee report – Audit – NHST(17)092

9.1. SR provided an overview of the meeting.

9.2. External and internal audit, anti-fraud services and Trust governance and assurance were discussed.

9.3. SR asked for Board approval for the Business Conduct policy. There are a few minor changes from the previous version; threshold for gifts, more guidance regarding conflicts of interest.

9.4. The Board discussed in depth awareness training for staff about conflicts of interest, and should the awareness training be part of corporate induction. It was suggested that bullet points raising awareness of the policy should be given to staff as part of the Trust induction.

9.5. The Board approved the policy.

10. Charitable Funds Accounts and Annual Report – NHST(17)093

10.1. DM provided a summary to the Board.

10.2. The Charitable Funds Committee had reviewed and approved the accounts and annual report for charitable funds.

10.3. The Committee had considered two items; the development of a Charity Office and a fund raising plan for the future , both of which the committee felt needed Executive consideration.

10.4. Generalising the funds is a key issue. NK has written to all fund holders regarding this, but has not yet received a great response. AM commented that a lot of effort had gone into fundraising, but as an organisation, we needed to be forensic when reviewing what is being raised, to ensure the funds are coming in and covering the costs of the fundraising. NK will report back to the Executive Team.

10.5. AMS added that a pod in the foyer would be ideal for the Charity Manager; it would be the first thing that people see, coming into the Trust. DG said it would also be a good idea to publish what the funds are used for, "good news stories" and are staff aware of charitable funds. NK will write to Directorate Managers and widen the audience.

11. Strategic and Regulatory update report – NHST(17)094

11.1. NB provided an update.

11.2. Draft Health Service Safety Investigations Bill: In September, a Bill was laid before parliament to create a statutory Health Service Safety Investigations body. The draft bill will now be scrutinised by the Health Select Committee and if passed, will create another regulator who can come into the Trust and inspect.

11.3. CQC Regulating Health and Social Care 2016-17: Yearly publication of assessment of the quality performance, trends and themes from the provider organisations it has inspected. This detailed the operational and quality pressures being faced across health and social care

11.4. Board Development programme: Outline of the programme for the year ahead. This was approved by the Board.

11.5. Planning guidance: gave an an update on 2018-19 planning timetable and approach from NHSI.

12. Board assurance framework (BAF) – NHST(17)095

12.1. NB provided an overview of the report.

12.2. The Executive Committee review the BAF in advance of its presentation to the Trust Board and make proposed changes to ensure that the BAF remains current, that the appropriate strategic risks are captured, and that the proposed actions and additional controls are sufficient to mitigate the risks being managed by the Trust.

12.3. VD requested an update on the collaborative staff bank. AMS said that the bank is across Cheshire and Merseyside and NHSI are interested in the scheme. The issue is the rate of pay for bank work; this will need agreement. NB will add to the BAF.

12.4. The proposed amendments to the BAF were approved

13. COPD mortality – NHST(17)096

13.1. KH provided an overview of the report.

13.2. The Trust's Standardised Mortality Ratio (SMR) for COPD and Bronchiectasis diagnosis group is higher than expected for the period November 2015 – October 2016. There were 78 deaths against an expected 51.5, resulting in an SMR of 151.2. This is statistically higher than expected.

13.3. A casenote review for each of the 78 deaths took place. Each death reviewed had been attributed to one of seven groups. These groups had been agreed by the Analytical Services team, the Clinical Coding team and Dr Julie Hendry (who undertook the reviews).

13.4. The review showed that 12.8% of deaths attributed to COPD were coded inaccurately and 5.1% were inappropriately diagnosed as COPD. This alone reduces the SMR to within national confidence intervals i.e. not statistically significantly increased SMR.

13.5. In addition to the case note review, to gain further assurance, the Trust sought an external review of COPD mortality by CRAB Clinical Informatics. CRAB concluded that the apparent increased SMR in patients with COPD is related to the methodological approach used by SHMI and HSMR with regard

to the episodes of care and in fact the care of patients with COPD using trigger analysis appeared to be within the expected norms.

13.6. Both the internal and external analyses suggest that there is no clinical cause for concern for COPD patients. However, there are administrative issues that need to be addressed to ensure patients get attributed to the correct diagnosis groups.

13.7. Actions going forward:

13.7.1. Dr Hendry will work with consultants and trainees to improve diagnosis and documentation of COPD.

13.7.2. Coders will audit COPD coding quarterly for one year.

13.7.3. Dr Hendry will liaise with the Respiratory Team to discuss a COPD checklist which must include consideration of Specialty Palliative Care Team input.

14. Effectiveness of meeting

14.1. RL said that it was good to see the dynamics of the Board, very positive and lots of questions asked. There were situations that were relevant to RL that he could take away with him.

14.2. RF asked how the meeting compared to other Boards. RL said that it was a good meeting with positive culture and challenge.

15. AOB

15.1. None noted.

16. Date of next meeting

16.1. The next meeting is scheduled for Wednesday, 29th November 2017 in the Boardroom, Whiston Hospital, commencing at 9.30 am.

Chairman: ………………………………………………………………………………………

Date: ……………………………………………………………………………………………….

TRUST PUBLIC BOARD ACTION LOG – 25th OCTOBER 2017

No	Minute	Action	Lead	Date Due
1.	31.05.17 (7.6)	~~Complaints, Claims and Incidents: More context and data analysis of report is required. Agenda item.~~ AMS will meet with SRe to discuss national benchmarking and the context and data analysis	AMS	25 Oct 17
2.	31.05.17 (7.8.2)	Availability of staff to discuss patient care plans with relatives to be considered; wards to be encouraged to be more proactive. Executive Committee report back to Board. **Verbal update.**	SR	25 Oct 17
3.	31.05.17 (12)	~~Learning from deaths in the NHS – update back to Board. Agenda item. Action closed.~~		Action closed
4.	28.06.17 (7.8)	Board Development agenda – AMS will ensure that CQC guidance is included 26.07.17: AMS and NB will meet with AM and RF to discuss.	AMS	25 Oct 17
5.	26.07.17 (11.7)	High mortality in COPD – KH will provide a report for Board. **Agenda item**	KH	25 Oct 17
6.	27.09.17 (15.6)	WRES report. AMS will bring a paper to Board following the external expert input.	AMS	tbc

INTEGRATED PERFORMANCE REPORT

Paper No: V=ou
Title of Paper: Integrated Performance Report
Purpose: To summarise the Trusts performance against corporate objectives and key national & local priorities.

Summary

St Helens and Knowsley Hospitals Teaching Hospitals ("The Trust") has in place effective arrangements for the purpose of maintaining and continually improving the quality of healthcare provided to its patients.

The Trust has an unconditional CQC registration which means that overall its services are considered of a good standard and that its position against national targets and standards is relatively strong.

The Trust has in place a financial plan that will enable the key fundamentals of clinical quality, good patient experience and the delivery of national and local standards and targets to be achieved. The Trust continues to work with its main commissioners to ensure there is a robust whole systems winter plan and continued delivery of national and local performance standards whilst ensuring affordability across the whole health economy.

Patient Safety, Patient Experience and Clinical Effectiveness

England's Chief Inspector of Hospitals (CQC) awarded the Trust an overall rating of **Outstanding** for the level of care it provides across ALL services. St Helens Hospital was rated as **Outstanding.** Whiston Hospital has been rated as **Good with Outstanding Features** placing it amongst the best hospitals in the NHS. **Outpatient and Diagnostic Imaging Services** at **BOTH** hospitals have been given the highest possible rating **Outstanding** – The first Outpatient and Diagnostic service in the country to ever be awarded this rating.

There were no never events in September 2017 and zero cases year to date.

There were no MRSA bacteraemia cases in September 2017. One confirmed case year to date.

There were 5 C.Difficile (CDI) positive cases in September 2017. The total number of C diff positive cases year to date is 19. Two cases presently awaiting appeal at the December panel.

There were no grade 3 or 4 avoidable pressure ulcers in September 2017 and zero cases year to date.

The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for August 2017 was 93.2%

During the month of August 2017 there was no inpatient falls resulting in severe harm.

Performance for VTE assessment for August 2017 was 93.57%.

Provisional HSMR for 2016-17 is 102.4

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 17/18 financial outturn will have implications for the finances of the Trust
Stakeholders: Trust Board, Finance Committee , Commissioners, CQC, TDA, patients.
Recommendation: To note performance for assurance
Presenting Officer: N Khashu
Date of Meeting:

Operational Performance
Performance against the 62 day cancer standard was 85.8% in August. Close monitoring of individual patient pathways continues and areas requiring improvement are being addressed through tumour specific action plans.

A&E performance was 82.9% (type 1) and 89.0% (type 1 & 3) in month. The key actions identified for continued recovery and maintenance of this position are being driven forward by the senior leaders across the organisation, focusing on both the Emergency Department and the Inpatient wards.

Emergency Department key actions:
1. Completed the Urgent and Emergency Care 30-60-90 day Transformation Programmes Improvement with Standard Operating Procedures now in use.
2. Appropriate deployment of clinical resources to meet demand.
3. Improved use of IT to enable real time tracking of patients within 4 hours.

Inpatient areas:
1. Clinically led RED/GREEN board rounds on inpatient wards
2. KPI of expected number of discharges per ward of which 33% to be achieved by midday
3. Senior daily review and escalation for patients who no longer need care in an acute bed, supported by twice weekly discharge planning meetings and monthly executive supported system wide Multi Agency Discharge Events (MADE).

RTT incomplete performance was achieved in month (92.8%). Specialty level actions to maintain this achievement continue, including ongoing targeted backlog clearance plans.

Financial Performance
Surplus/Deficit - For the month of September 2017 (Month 6) the Trust is reporting an overall Income & Expenditure surplus of £3.67m which is in line with the YTD profiled plan. Overall Trust Income is £183.0m, which is also in line with plan; Clinical Income is behind plan by £1.4m which is offset by an over performance on Non clinical income of £1.3m.

Trust Operating expenditure is £167.2m, which exceeded plan by £0.1m. Clinical Supplies are £1.2m above plan which is partly offset by the additional non clinical income and Pay is £3.2m higher than plan and this is offset by a £4.5m underspend against Other Costs. The pay overspend relates to premium payments, agency and bank use. Pay control and monitoring is being reviewed at the Premium Payments Scrutiny Council. The financial position has been supported by the utilisation of reserves which is a risk to delivery of the FOT.

The Trust is finalising a proposed recovery plan which considers productivity opportunities and robust cost control programmes for the remaining period of this year.
The Trust has delivered £5.8m of CIPs and is £(0.8)m behind the YTD plan which is reflected in the Trust’s overspend on expenditure. The successful delivery of the £15.3m CIP target will also be aligned to the cost control programme.

The Trust is planning to deliver its planned annual surplus of £8.5m, which equates to a £(0.6)m deficit excluding STF funding of £9.1m.

The Trust's cash balance at the end of September was £3.4m, representing 4 days of operating expenses. The Trust has incurred £4.4m of capital expenditure in the six months to September.

Human Resources
Absence in September has decreased from 4.9% to 4.3%. YTD absence is 4.2% which is 0.60% below the 2016-17 position of 4.8%. Nursing sickness including HCA’s is 5.1%, a decrease of 0.70% from last month (5.8%) and below 2017/18 target of 5.3%. All qualified Nursing and Midwifery sickness excluding HCAs is 4.1% which is a 1.2% reduction from last month (5.3%) and below Q3 target (4.72%). YTD % is 4.4% which is 0.3% lower than the 2016/17 outturn at 4.7%
Mandatory Training compliance has decreased slightly in month but continues to exceed the target by 3% at 88% compliant.
Appraisal compliance is 6.9% behind target.

The following key applies to the Integrated Performance Report:

▲ = 2017-18 Contract Indicator
▲ £ = 2017-18 Contract Indicator with financial penalty
● = 2017-18 CQUIN indicator
T = Trust internal target

Sep-17

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 31-37)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Sep-17	2.6%	2.3%	No Target	2.5%		Overall SHMI and HSMR within control limits. Mortality fluctuates month-to-month, but is stable medium-term. Weekend mortality - has fallen again after 'Winter' increase (noisy metric).	Patient Safety and Clinical Effectiveness	Trust is exploring an electronic solution to improve capture of comorbidities and their coding and in the meantime we are exploring a system of emailing known co-morbidities of new admissions that we can identify from previous FCEs. Specific diagnostic groups with raised mortality are subject to intensive investigation (e.g. COPD). Major initiatives to improve management of AKI and Sepsis are well underway to improve care and reduce mortality.	KH
Mortality: SHMI (Information Centre)	Q	▲	Mar-17	1.03		1.00						
Mortality: HSMR (HED)	Q	▲	May-17	94.5	94.4	100.0	102.4					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	May-17	93.7	89.9	100.0	115.0					
Readmissions: 30 day Relative Risk Score (HED)	Q	T	Apr-17	106.3	106.3	100.0	97.7		A peak this month bucks the trend. The trust historically has a relatively high percentage of readmissions, but when adjusted for 'expected' falls within national norms.	Patient experience, operational effectiveness and financial penalty for deterioration in performance	Every effort is being made to ensure robust discharge despite extremely challenged social care and availability of packages to support independence.	KH
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	May-17	91.6	88.1	100.0	93.8		Sustained reductions in NEL LOS are assurance that medical redesign practices continue to successfully embed.	Patient experience and operational effectiveness	Drive to maintain and improve LOS across all specialties.	RC
Length of stay: Elective - Relative Risk Score (HED)	F&P	T	May-17	112.6	96.9	100.0	92.1					
% Medical Outliers	F&P	T	Sep-17	1.4%	2.2%	1.0%	1.7%		Patients not in right speciality inpatient area to receive timely, high quality care.	Clinical effectiveness, ↑ in LoS, patient experience and impact on elective programme	Robust arrangements to ensure appropriate clinical management of outlying patients are in place. Continued focused management of all patients requiring discharge support. A review of the Trust bed model has resulted in plans to reconfigure some surgical beds to medical by January, thus reducing outliers.	RC
Percentage Discharged from ICU within 4 hours	F&P	T	Sep-17	40.0%	49.4%	52.5%	48.3%		Failure to step down patients within 4 hours who no longer require ITU level care.	Quality and patient experience	Critical care step down patients discussed at all Emergency Access Meetings. Critical care rep now attending all bed meetings to agree plan and to highlight patients who will require transfer over the coming 24 hours.	RC
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients) - TOTAL	Q	▲	Aug-17	69.9%	69.6%	90.0%	75.7%		eDischarge performance poor - there is insufficient trainee doctor resource to hit this target with existing paper-based systems.		Pending ePR, we are exploring a revised, automated eDischarge solution to address the problem that there are too few trainees to reliably hit the 95% target. Medium-term plan to supplement trainee doctor numbers with advanced nurses is ongoing.	KH
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Aug-17	86.9%	88.1%	95.0%	90.0%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Aug-17	98.8%	98.9%	95.0%	99.0%					

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Aug-17	91.9%	91.0%	83.0%	94.0%		Target is being achieved. With effect from April 2017, STHK is also treating patients from the Warrington Area.	Patient Safety, Quality, Patient Experience and Clinical Effectiveness	Target achieved	RC
PATIENT SAFETY (appendices pages 39-42)												
Number of never events	Q	▲ £	Sep-17	0	0	0	2		The National safety standards for invasive procedures will provide further mitigation against future never events.	Quality and patient safety	The RCA for the first never event has been submitted and lessons learnt cascaded. Actions implemented include central line insertion check list . The January 2017 never event is being made subject of a Serious Incident Investigation.	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Sep-17	98.9%	98.8%	98.9%	98.8%		New harm free care continues to be recorded at high level	Quality and patient safety	Reducing hospital acquired harm is a key priority for the quality and risk teams, the continued development of both risk assessments and harm mitigation strategies will further reduce the risk of harm to patients	SR
Prescribing errors causing serious harm	Q	T	Sep-17	0	0	0	0		The trust continues to have no prescribing errors which cause serious harm. Trust has moved from being a low reporter of prescribing errors to a higher reporter - which is good.	Quality and patient safety	Intensive work on-going to reduce medication errors and maintain no serious harm. ePrescribing is being rolled out.	KH
Number of hospital acquired MRSA	Q F&P	▲ £	Sep-17	0	1	0	4		There was no cases of MRSA bacteraemia in September. One confirmed case to date. There were 5 C.Difficile (CDI) cases in September 2017. 2 cases are awaiting appeal at the December panel. Internal RCAs on-going with more recent cases.	Quality and patient safety	The Infection Control Team continue to support staff to maintain high standards and practices. They also monitor and undertake RCA for any hospital acquired BSI and CDI. CDI and Antibiotic wards rounds continue to be undertaken on appropriate wards.	SR
Number of confirmed hospital acquired C Diff	Q F&P	▲ £	Sep-17	5	19	41	21					
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Sep-17	2	8	No Target	17					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Sep-17	0	0	No Contract target	1		No grade 3 or 4 pressure ulcers in month	Quality and patient safety	The Trust remains compliant with tissue viability training for all nursing staff including bank staff	SR
Number of falls resulting in severe harm or death	Q	▲	Aug-17	0	6	No Contract target	22		No severe harm falls reported	Quality and patient safety	Strategic falls actions being implemented as plan .	SR
VTE: % of adult patients admitted in the month assessed for risk of VTE on admission	Q	▲ £	Aug-17	93.57%	92.25%	95.0%	93.36%		VTE performance lower than expected as data cleansing was affected by staff sickness and lower uptake by junior doctors for additional sessions. Funding for additional sessions under pressure as CIP challenges all extra spend.	Quality and patient safety	E -Prescribing solution will resolve achieving target in 2017. E-prescribing roll out now underway. As in previous years, it was not possible to secure additional trainee doctor time to support the process in August with the change-over but we are continuing to press for extra help.	KH
Number of cases of Hospital Associated Thrombosis (HAT)		T	Sep-17	4	14	No Target	28					
To achieve and maintain CQC registration	Q		Sep-17	Achieved	Achieved	Achieved	Achieved		Through the Quality Committee and governance councils the Trust continues to ensure it meets CQC standards.	Quality and patient safety		SR
Safe Staffing: Registered Nurse/Midwife Overall (combined day and night) Fill Rate	Q	T	Aug-17	92.8%	93.8%	No Target	94.9%		Shelford Patient Acuity undertaken bi-annually	Quality and patient safety	Two Shelford audits to be reported together in October 2017.	SR
Safe Staffing: Number of wards with <80% Registered Nurse/Midwife (combined day and night) Fill Rate	Q	T	Aug-17	0	0	No Target	2					

Sep-17

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (appendices pages 43-51)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Aug-17	94.7%	94.6%	93.0%	95.1%		All targets achieved.	Quality and patient experience	A Cheshire and Mersey Cancer Alliance PTL has been established is being established as part of the wider strategy to support system wide issues across patient Cancer pathways. Locally the focus is on accelerating pathway redesign and reducing variation in pathway performance by improved clinical engagement . Tumour specific dashboards are being redesigned to assist with visibility of clinical pathway performance. Increased scrutiny at patient level of open pathways and action planning at the weekly Cancer PTL review meeting. Actions arising from the reviews include working to establish improvements in booking by day 7, inter service transfers ,review of complex pathways requiring multiple MDT access and improved clinical and managerial accountability.	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Aug-17	99.5%	99.0%	96.0%	97.9%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Aug-17	85.8%	87.0%	85.0%	88.4%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Sep-17	92.8%	92.8%	92.0%	93.5%		4 specialties continue to fail the 92% incomplete target; General Surgery, ENT, T&O and Gynae. On going backlog clearance plans continue but similar issues regarding theatre and bed capacity remain. RMS and more recent MCAS primary care services also have compounded the position. However, RMS and MCAS remains unpredictable with short / no notice diverts back to secondary care	As we head into winter and there is an expectation that Surgical Beds will be handed to Medical Care Group bed availability to manage the Surgical non-elective and elective demand will potentially risk the backlog increasing causing more incomplete performance failures resulting in a failure of the target by the Trust. added to the numerator / denominator impact of RMS and MCAS the risk is RTT failure and 52 week breaches	18 weeks performance continues to be monitored daily and reported through the weekly PTL process. A backlog management plan is in place and alternatives to Whiston theatre and bed capacity are being sought to counter the significant non-elective demand. Actions to maintain and improve RTT performance reliant on theatre and bed capacity along with staff availability in collaboration with CCG's in ensuring RMS delivers in a sustainable and manageable way	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Aug-17	100.0%	100.0%	99.0%	100.00%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Sep-17	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Sep-17	0.6%	0.5%	0.8%	0.7%		The target was achieved again in September 2017. This metric continues to be directly impacted by increases in NEL demand (both surgical and medical patients).	Patient experience and operational effectiveness Poor patient experience	The planned increase in elective surgical activity in St Helens has commenced including increasing GA capacity on Saturdays. Potential to use external theatre and bed capacity continues to be progressed. Continued analysis of the referral drop and impact on RTT underway to include forecast year end position	RC
Cancelled operations: % of patients treated within 28 days after cancellation	F&P	▲ £	Aug-17	100.0%	100.0%	100.0%	100.0%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Sep-17	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Sep-17	82.9%	81.4%	95.0%	76.1%		Sept 17 Type 1 performance was 82.9% which was a slight deteriorations compared with Aug 17 of 2%.	Patient experience, quality and patient safety	The urgent and emergency care transformation plan has several interconnected work streams designed to improve overall 4 hour access performance. Emergency Department/Front Door encompassing a 90 day Improvement Programme. PDSA cycles tested a number of processes including 'walk in' streaming, Stretcher Triage streaming and internal departmental efficiencies and exit from ED. GP streaming in place as per NHSE recommendations. Flow through the Hospital Continuation of use of the SAFER Care Bundle to increase hospital discharges before midday to 33% and standardisation of daily Red to Green board rounds and afternoon huddles. Twice weekly discharge tracking meetings to manage medically optimised and DTOC escalation. Monthly Executive Multi-Agency Discharge Events (MADE) continue across the whole system to remove barriers and blocks that prevent patients with complex needs being discharged safely from hospital. Following 6a ECIP event and system resilience planning, commenced daily AMU/ED huddles and Community Matron in reach which is proving beneficial. Frailty in-reach to ED commenced. To commence 1pm Frailty/ED/SpR safety huddle from 16th October.	RC
A&E: Total time in A&E: % < 4 hours (All Types)	F&P	▲	Sep-17	89.0%	88.3%	95.0%	85.1%					
A&E: 12 hour trolley waits	F&P	▲	Sep-17	0	0	0	0					

Sep-17

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	Sep-17	0	0	0	0		Increased demand for IP capacity has a direct bearing on the ability to maintain this quality indicator.	Patient Experience	Maintained focus and awareness of this issue across 24/7.	RC
Complaints: Number of New (Stage 1) complaints received	Q	T	Sep-17	23	127	No Target	338		The number of 1st stage complaints resolved within agreed timescales in Quarter 2 is the highest it has been for 18 months at 67.8%.	Patient experience	The Complaints Team are continuing to work on reducing the small backlog of overdue complaints and to improve the timeliness of responses, which was 63.6% in September, up from 58.8% in August. Complaints training continues to be provided for staff involved in both investigating complaints and drafting responses in order to ensure comprehensive statements are provided to reduce any delays. Feedback continues to be positive.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Sep-17	22	154	No Target	293					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Sep-17	63.6%	61.0%	No Target	58.0%					
Friends and Family Test: % recommended - A&E	Q	▲	Sep-17	89.2%	88.4%	90.0%	86.6%		The YTD recommendation rates are slightly below target for A&E and for maternity (birth and post-natal ward) and outpatients, but are improving and are above target for in-patients and antenatal and community maternity services.	Patient experience & reputation	Feedback from the FFT responses is fed back to individual areas to enable actions to be taken to address negative feedback, as well as using positive feedback. The Patient Experience Manager continues to contact areas with low response rates to offer support. Reports to the Patient Experience Council now include updates on the number of areas who submit their actions to address the FFT feedback each month.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Sep-17	95.0%	95.5%	90.0%	95.5%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Sep-17	100.0%	98.6%	98.1%	98.5%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Sep-17	98.4%	98.0%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Sep-17	96.7%	94.3%	95.1%	98.7%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Sep-17	100.0%	100.0%	98.6%	93.0%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Sep-17	94.0%	94.4%	95.0%	94.4%					

Sep-17

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 53-60)												
Sickness: All Staff Sickness Rate	Q F&P	▲	Sep-17	4.3%	4.2%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	4.8%		Absence in September has decreased from 4.9% to 4.3%. It is 0.42% below Q3 target of 4.72%. YTD absence is 4.2% which is 0.60% below the 2016-17 position. Nursing sickness including HCA's is 5.1%, a decrease of 0.70% from last month (5.8%) and below 2017/18 target of 5.3%.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	Targeted action was taken in September and continues specifically towards HCA absence across the Trust. The Absence Support Team are currently focusing on ensuring reviews are undertaking prior to the 52 week expiry of stages/levels to ensure those staff are appropriately managed and action taken if absence has not improved significantly.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P	T	Sep-17	5.1%	5.2%	5.3%	5.9%					
Staffing: % Staff received appraisals	Q F&P	T	Sep-17	78.1%	78.1%	85.0%	87.4%		Mandatory Training compliance has decreased slightly in month but continues to exceed the target by 3.3%. Appraisal has reduced slightly and is 6.2% behind target.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	The Education, Training & Development team continue to work with managers of non-compliant staff to ensure continued improvement for both Mandatory Training & Appraisals.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Sep-17	88.0%	88.0%	85.0%	91.6%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q1	88.2%		No Contract Target			Whilst response rates fluctuate we remain in the top 3 acute Trusts in our region for both response and recommendation rates.	Staff engagement, recruitment and retention.	The Trust is currently undertaking the Q2 survey with results expected in October.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q1	74.3%		No Contract Target						
Staffing: Turnover rate	Q F&P	T	Sep-17	1.0%		No Target	9.8%		Staff turnover remains stable and well below the national average of 14%.		Turnover is monitored across all departments as part of the Trusts Recruitment & Retention Strategy with action plans to address areas where turnover is higher than the trust average. Further action is required by Ward Managers to provide more support to newly qualified nurses.	AMS
FINANCE & EFFICIENCY (appendices pages 61-66)												
UORR - Overall Rating	F&P	T	Sep-17	3.0	3.0	3.0	3.0		The Trust's forecast for year end performance is in line with plan. The Trust has significant contractual agreements with other NHS organisations which may impact on our ability to achieve Better Payment compliance.	Financial	Achievement against the submitted plan and delivery of CIP. Maintaining controls on Trust expenditure and delivering the planned activity while managing the variable costs. Agreeing with Commissioners and NHSE a more advantageous profile for receipt of planned income. Reducing agency expenditure in line with NHSI annual cap.	NK
Progress on delivery of CIP savings (000's)	F&P	T	Sep-17	5,800	5,800	15,315	15,248					
Reported surplus/(deficit) to plan (000's)	F&P	T	Sep-17	3,670	3,670	8,536	4,861					
Cash balances - Number of days to cover operating expenses	F&P	T	Sep-17	4	4	2	2					
Capital spend £ YTD (000's)	F&P	T	Sep-17	4,420	4,420	8,015	3,519					
Financial forecast outturn & performance against plan	F&P	T	Sep-17	8,536	8,536	8,536	4,861					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Sep-17	97.4%	97.4%	95.0%	94.3%					

APPENDIX A

			Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	2017-18 YTD	2017-18 Target	FOT	2016-17	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲£	100.0%	100.0%	100.0%	100.0%	87.5%	100.0%	96.2%	94.4%	100.0%	84.6%	100.0%	100.0%	100.0%	97.9%	85.0%		95.2%		
	Total > 62 days		0.0	0.0	0.0	0.0	1.0	0.0	0.5	0.5	0.0	1.0	0.0	0.0	0.0	1.0			6.0		
Lower GI	% Within 62 days	▲£	93.3%	81.8%	71.4%	58.3%	100.0%	91.7%	93.3%	100.0%	76.9%	100.0%	100.0%	92.3%	77.8%	89.1%	85.0%		89.3%		
	Total > 62 days		0.5	1.0	1.0	2.5	0.0	0.5	0.5	0.0	1.5	0.0	0.0	0.5	1.0	3.0			8.0		
Upper GI	% Within 62 days	▲£	100.0%	0.0%	85.7%	88.9%	100.0%	81.8%	0.0%	87.5%	100.0%	100.0%	100.0%	33.3%	88.9%	87.5%	85.0%		78.7%		
	Total > 62 days		0.0	1.5	1.0	0.5	0.0	1.0	4.0	0.5	0.0	0.0	0.0	1.0	0.5	1.5			10.0		
Urological	% Within 62 days	▲£	79.3%	76.9%	96.2%	82.6%	70.0%	95.7%	100.0%	67.6%	92.7%	59.3%	82.1%	83.3%	81.3%	81.2%	85.0%		81.4%		
	Total > 62 days		3.0	4.5	0.5	4.0	6.0	0.5	0.0	6.0	1.5	5.5	3.5	3.0	4.5	18.0			36.5		
Head & Neck	% Within 62 days	▲£	66.7%	100.0%	80.0%	33.3%	33.3%	100.0%	80.0%	80.0%	66.7%	66.7%	75.0%	75.0%	50.0%	65.0%	85.0%		67.3%		
	Total > 62 days		0.5	0.0	0.5	1.0	1.0	0.0	0.5	0.5	0.5	0.5	0.5	0.5	1.5	3.5			8.0		
Sarcoma	% Within 62 days	▲£	100.0%			100.0%	100.0%			100.0%	66.7%		100.0%		0.0%	60.0%	85.0%		93.3%		
	Total > 62 days		0.0			0.0	0.0			0.0	0.5		0.0		0.5	1.0			0.5		
Gynaecological	% Within 62 days	▲£	92.3%	33.3%	100.0%	90.9%	92.3%	100.0%	85.7%	100.0%	70.0%	83.3%	100.0%	68.8%	75.0%	76.9%	85.0%		90.1%		
	Total > 62 days		0.5	1.0	0.0	0.5	0.5	0.0	0.5	0.0	1.5	1.0	0.0	2.5	1.0	6.0			5.0		
Lung	% Within 62 days	▲£	82.6%	100.0%	80.0%	87.5%	91.7%	68.2%	77.8%	100.0%	100.0%	73.7%	85.0%	100.0%	72.7%	84.7%	85.0%		82.7%		
	Total > 62 days		2.0	0.0	1.0	0.5	0.5	3.5	1.0	0.0	0.0	2.5	1.5	0.0	1.5	5.5			13.0		RC
Haematological	% Within 62 days	▲£	50.0%	100.0%	100.0%		66.7%	66.7%	100.0%	100.0%	100.0%	66.7%	50.0%	71.4%	100.0%	76.0%	85.0%		77.6%		
	Total > 62 days		1.0	0.0	0.0		1.0	1.0	0.0	0.0	0.0	1.0	1.0	1.0	0.0	3.0			8.5		
Skin	% Within 62 days	▲£	93.7%	95.7%	92.6%	97.4%	95.7%	95.7%	100.0%	100.0%	92.5%	93.9%	98.1%	95.7%	93.0%	94.9%	85.0%		96.5%		
	Total > 62 days		2.0	1.0	2.0	0.5	1.0	1.0	0.0	0.0	1.5	1.0	0.5	1.0	1.5	5.5			9.5		
Unknown	% Within 62 days	▲£	100.0%	100.0%			100.0%	66.7%	0.0%	50.0%	0.0%	100.0%	100.0%	0.0%	100.0%	76.5%	85.0%		82.6%		
	Total > 62 days		0.0	0.0			0.0	0.5	0.5	1.0	1.0	0.0	0.0	1.0	0.0	2.0			2.0		
All Tumour Sites	% Within 62 days	▲£	89.4%	87.9%	92.0%	86.6%	85.8%	89.1%	87.6%	89.3%	88.2%	81.6%	91.4%	87.5%	85.8%	87.0%	85.0%		88.4%		
	Total > 62 days		9.5	9.0	6.0	9.5	11.0	8.0	7.5	8.5	8.0	12.5	7.0	10.5	12.0	50.0			107.0		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲£		100.0%		50.0%				100.0%					100.0%	100.0%	85.0%		83.3%		
	Total > 31 days			0.0		1.0				0.0					0.0	0.0			1.0		
Acute Leukaemia	% Within 31 days	▲£															85.0%		100.0%		
	Total > 31 days																		0.0		
Children's	% Within 31 days	▲£															85.0%				
	Total > 31 days																				

TRUST BOARD

Paper No: NHST(17)089
Title of paper: Feedback from the Executive Committee
Purpose: To feedback to the Board key issues arising from the Executive Committee meetings.
Summary: The paper covers the Executive Committee meetings that took place between 14th September 2017 and 5th October 2017. There were 4 Executive Committee meetings held during this period. The Executive Committee approved the submission of a bid to provide Marshals Cross Primary Care services. A business case to recruit and train advanced clinical practitioners for A&E was also approved. The business case to implement the SafeCare staffing system was approved. The business case to create a shared care record in St Helens was also considered. Schematic plans for the A&E GP streaming capital scheme, funded from Department of Health allocated capital, were reviewed and agreed in principle subject to planning approval.
Corporate objectives met or risks addressed: All 2017/18 corporate objectives relating to the quality of services.
Financial implications: None arising directly from this report, requiring committee approval
Stakeholders: Patients, Patients Representatives, Staff, Non-Executive Directors, Commissioners, Regulators
Recommendation(s): That the report be noted
Presenting officer: Ann Marr, Chief Executive
Date of meeting: 25th October 2017

FEEDBACK FROM THE EXECUTIVE COMMITTEE
SEPTEMBER 2017

1. Introduction

There were four Executive Committee meetings in between 14th September and 5th October, and this report provides feedback on the agenda items.

2. 14th September 2017

2.1 eRostering Implementation Update

This report detailed the progress in implementing the eRostering system across the Trust. The aim was to give nurses 50 days' notice of their rota, an increase from the current target of 28 days.

The programme was to be rolled out to Junior Doctors' rotas from November.

2.2 Assurance reports

The Integrated Performance Report (IPR), agency and bank usage report and Corporate Risk Register (CRR) for month 5 (August) were reviewed.

2.3 Marshalls Cross Medical Centre Tender

The proposed innovative service model and costs for the tender submission for the substantive contract to provide the Primary Care services at the Marshalls Cross Practice were approved.

The outcome of the bidding process would be known by mid-October and the decision would end the temporary contract that was currently in place with the Trust.

3. 21st September 2017

3.1 Surgical Care recovery plans

The plans to deliver the surgical care annual activity plan and maintain 18 week RTT performance were presented by the Care Group. It was agreed that there needed to be a focus on theatre utilisation and streamlining pre op processes before planning to deliver activity at premium cost.

Plans to develop a "Hot Gall Bladder" service were also discussed.

3.2 Advanced Clinical Practitioners

A business case was presented by the Medical Care Group to recruit three staff who could train as Advanced Clinical Practitioners with the training courses funded by Health Education England (HEE). The business case was approved as it would introduce a new type of highly skilled clinician into the A&E department (initially) to work alongside the medical workforce.

3.3 Assurance Reports

The monthly reports detailing performance against the staff appraisals and mandatory training targets and the safer staffing and vacancy dashboard for August were reviewed and areas for action agreed.

3.4 Safecare implementation business case

The financial and non-financial benefits of implementing the SafeCare system were reviewed. The qualitative benefits of the system for managing nurse staffing allocations in real time and supporting safe staffing across the organisation could be demonstrated. There were no identifiable cash releasing benefits, so the system would not be self-funding. The business case was approved in principle, subject to funding being identified.

3.5 Learning from deaths policy

The draft policy to comply with national guidance was reviewed prior to its consideration by the Trust Board at its meeting on 27th September.

3.6 Service Development Opportunities

St Helens CCG was re-tendering the Community Musculoskeletal (MSK) service and the Community Cardiac/Heart Failure services. The Trust already provides a part of the MSK service in partnership with North West Boroughs NHSFT. The bid options were discussed in the context of the wider St Helens Cares developments. An option appraisal detailing the risks and benefits was requested before determining how to respond.

4. 28th September 2017

4.1 Feedback from the CQPG Meeting on 15th August

The Executive Committee received feedback from the meeting and reviewed the issues and actions for the Trust.

It was agreed that going forward the Executive Committee would receive and review the CQPG minutes.

4.2 GP duplicate letters - update

The issue of duplicate GP correspondence being sent by the Trust had been raised by Peelhouse Medical Plaza practice. The Trust had now reviewed the current process and the cause of the problem has been identified.

Two solutions have been agreed to improve the electronic transfer of patient information and reduce duplicate information being sent to GP practices, one can be implemented immediately for “in area” GPs and the other requires agreement with Informatics Merseyside to ensure all GPs in Liverpool and Sefton can be included.

4.3 Safer Staffing Report

The monthly safer staffing assurance report was reviewed

4.4 Stroke Update

The Executive reviewed the progress in implementing the single stroke service strategy.

The implementation of phase 1 had been successful as was evidenced by the recent SSNAP results for the Trust. 30 – 40% of the stroke patients from Warrington were now being brought to Whiston.

Following the public consultation phase 2 was now being planned but the rate limiting step would be to identify 16 dedicated beds to extend the stroke unit.

Andrew Hill and the stroke team were thanked for all their hard work so far to extend the service.

4.5 Winter Planning

A further review of beds had been initiated to see if any further bed spaces could be freed up from alternative uses.

The Executive Committee also reviewed the revised A&E national capital spend plans to create a GP facility in the department and noted the need to obtain planning approval, as this was an extension to the building footprint. A meeting with the planners was taking place and it was hoped that a full planning approval process could be avoided.

5. 5th October 2017

5.1 CQPG Feedback

The Director of Nursing gave an update on the concerns raised by Halton CCG about discharge planning for an end of life patient.

The issue had been that the District Nurses had not been able to obtain the correct equipment in a timely manner. The existing communications and escalation processes had been reviewed and shared across the teams to prevent a recurrence.

5.2 Trust Board Agenda

The draft Board agenda was considered and agreed for recommendation to the Chair.

5.3 MSK Service Options Appraisal

The bid options for the St Helens MSK service were presented. A preferred option was agreed, if this was acceptable to the potential partner organisation, with an alternative option approved if agreement could not be reached.

The bid would be reviewed and approved by the Executive Committee prior to submission deadline.

The Director of Operations and Performance also reported that the Trust had submitted a bid to Knowsley Local Authority to provide sexual health services.

5.4 Secretary of State Visit

The Chief Executive reported that the Trust was likely to be visited by the Secretary of State for Health in the following week. In preparation for the visit there would be no Executive Committee meeting on 12th October.

5.5 St Helens Cares – Shared Care Record Business Case

The Director of Informatics updated the Executive Committee on the development of a business case on behalf of the St Helens Cares People's Board to create a shared care record across all health and social care services. There would be financial implications for each partner organisation to implement the preferred solution. The business case was being considered at a meeting of the St Helens Cares Executive Group and if approved would have to be considered by each organisation's Board.

5.6 ePrescribing Project Update

The Director of Informatics reported that the ePrescribing roll out had been delayed due to a problem with a supplier update. If the delay was to be substantial, an alternative strategy to address VTE recording would need to be developed to improve performance for the rest of 2017/18.

5.7 Pseudomonas cases

The Director of Nursing reported that two more cases of Pseudomonas has been detected on ward 4D and were being investigated with Public Health England. Following the previous outbreaks and work to eliminate the infection, this was very disappointing.

ENDS

TRUST BOARD

Paper No: NHST(17)090
Title of paper: Committee report – Quality Committee
Purpose: To summarise the Quality Committee meeting held on 17th October 2017 and escalate issues of concern.

Summary: Key items discussed were:

Before the items on the agenda, two important issues were raised and discussed.

1. Visit by the Secretary of State for Health, Mr Jeremy Hunt.
2. A letter from Professor Ted Baker, Chief Inspector of the CQC. The letter from Professor Baker related to safety and quality of emergency care. The actions are laid out and a plan is being formulated to ensure they are implemented.

Agenda items

1. Complaints. 23 1st stage complaints were received and opened in September 2017; a decrease from 24 received in August. At the end of September, there were 59 open 1st stage complaints (an increase of one), including 6 overdue (no change). The Trust responded to 63.6% of 1st stage complaints within agreed timeframes in September, an increase compared to August, when 58.8% were responded to within agreed timeframes.

   For Q2, 75 1st stage complaints were received and opened; an increase of 42% compared to the previous quarter. The number of open complaints increased to 59 (from 47) and the total number of overdue complaints fell to 6 (from 9). The Trust responded to 67.8% of 1st stage complaints within agreed timescales, an increase compared to 56.6% in the previous quarter. Clinical treatment was the primary cause of complaint in Q2. There was a 25% increase in PALS contacts compared to the previous quarter.

2. CQC action plan update. The Committee were advised that 54 of the 57 actions had now been completed. The three overdue actions relate to appraisals in A&E (area of particular focus over the next two months), Maternity strategy (due to report back in January) and the roll out of the amber care bundle (issues in primary and community care).

3. IPR. A&E performance, infection control, finance & HR targets were discussed. VTE performance remains below target. Quality review of community services is being developed.

4. Ante Natal New Born (ANNB) screening update. An update was provided on the implementation of a robust action plan following a recent ANNB screening review.

5. Lord Carter review update. The proposal of a Cheshire & Merseyside collaborative bank was discussed. The project is now being supported by NHSI and used as a case study from which other regions may benefit from our learning. An STP level steering group has been established.

6. Francis action plan update. An Executive discussion will take place regarding Freedom to Speak Up and the CQC well led assessment – what would this look like in an outstanding organisation. The Committee also discussed the various routes that concerns can be raised, for staff, patients and visitors.

7. Medicines Optimisation strategy. S Gelder asked the Committee for approval of the strategy, for which an action plan will follow next month. Following discussion the Committee approved the strategy.

8. Hospital Pharmacy Transformation Programme (HPTP) strategy. A summary was provided of the current Pharmacy & Medicines Dashboard from the NHSI Model Hospital. A summary of progress on key HPTP activities was provided and important improvements (e.g. TTO's) were noted. The Committee asked S Gelder to feedback to Pharmacy staff their thanks for all improvements made.

9. Medicines storage and security audit update. The audit in August was unannounced and conducted by Pharmacy staff. Performance has deteriorated since the June audit, where overall Trust compliance was at 95%, compared to the August results showing 48%. The Executive team will discuss the results at their weekly meeting.

10. Feedback from Councils:
    (a) Patient Safety Council – Patient safety thermometer data collection methodology has been changed recently, enabling ward based data entry from the previous method of centralised data upload. Some wards have encountered difficulty with data entry due to software functionality. This may influence the number and accuracy of returns submitted by the wards. A Marr requested that the software is not used until a solution is found.

    (b) Patient Experience Council – nothing to escalate.

    (c) Clinical Effectiveness Council – Impact of lack of training opportunities for nursing staff on recruitment and retention as staff are more likely to move to Trust's that are offering additional professional development.

    (d) CQPG – nothing to escalate.

    (e) Executive Committee:
        - Stroke update – this was very positive and the stroke team were thanked for all their hard work so far to extend the service.
        - Winter plan – this will be discussed at Trust Board on 25th October.
        - NIV (non invasive ventilation) – this is an area of some risk. Will be discussed by the Executive Team.

    (f) Workforce Council – nothing to escalate.

    (g) Workforce Council ToR – approved by the Committee.

AOB

Discussed at the start of the meeting.

Items to be escalated to the Board:

- CQC letter on safety and quality in emergency medicine.
- Hospital Pharmacy Transformation programme (good progress)
- Medicines safety
- NIV

Corporate objectives met or risks addressed: Five star patient care and operational performance.

Financial implications: None directly from this report.

Stakeholders: Patients, the public, staff and commissioners

Recommendation(s): It is recommended that the Board note this report.

Presenting officer: David Graham, Non Executive Director

Date of meeting: 25th October 2017

TRUST BOARD

Paper No: NHST(17)091

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the Finance and Performance Committee, 19th October 2017

Summary:

Agenda Items

For Information

- Carter Non Pay metric
  - The Committee were updated around the NHSI inclusion of impairments in the depreciation metric in Carter; the feedback from the NHSi team was that they were reviewing this methodology and it was likely that amortisation would be excluded in future reports
- E-Rostering roll-out plan for all staff groups
  - The project plan was presented to the Committee who discussed options to optimise the resource opportunities from the system. A discussion took place about the impact for the medical workforce, such as allocation of annual leave and agreement was for each Divisional Medical Directors to be involved with the project
- Surgery SLR Quarter 1 2017/18, including Activity and Backlog review and productivity
  - The report showed the placement of individual specialties on a matrix that measures financial and non-financial performance. The Committee discussed the relative theatre utilisation across both hospital sites and opportunities to recover the activity while supporting RTT performance
- Forecast Outturn 2017/18
  - The Committee discussed the changes to the risk profile during September and reviewed the mitigations, with particular reference to the STP Funding and ED performance. Other significant risks are: contracting issues, HRG4+impact, Clinical income shortfall to plan and CIPs.
- A&E Update
  - The Committee reviewed progress against the performance improvement plan and were updated on the actions being taken. The risks associated with Medically optimised patients in the Trust were discussed and we will continue to escalate to Commissioners where appropriate.
- CQUIN & Contracting Update
  - The Committee were updated on progress with the Trust's CQUIN measures and contracting performance and were informed around the consultation on 2018/19 contracts.
- CIP Council briefing was accepted.

For Assurance

- Integrated Performance Report Month 6 was reported
  - Discussion took place around operational performance with specific reference to MRSA and VTE performance and compliance with appraisals

- Finance Report Month 6 2017/18
  - Delivered year to date surplus of £3.7m, in line with planned surplus levels. In achieving this performance it was noted slippage in reserves and non-recurrent measures have been used. This will have to be replenished later in the year.
  - Specific risks in achieving outturn were discussed and included the ability to fully recover activity, exposure to tariff change, cost control / CIP risk and STF funding.
  - More robust cost control is being implemented, with specific focus on:
    - Cost Control, risk around CIP delivery, use of Premium Payments Scrutiny Council, review of discretionary spend
    -

For Approval

- **CIP Delivery Programme 2018/19**
  - The project plan was accepted.

Actions Agreed

- E:Rostering project to be presented to the Committee in February 2018
- CIP Programme 2018/19 to be presented to the Committee in January 2018

Issues to be raised at Board

- Q3 and Q4 ED performance (including all Type 3)
- Report on appraisal compliance by Care group to be presented to the Board
- VTE performance against Trust target
- Medically optimised patients and DTOCs volatility heading in to winter
- Trust Financial position, YTD and Forecast

Corporate objectives met or risks addressed: Finance and Performance duties

Financial implications: None as a direct consequence of this paper

Stakeholders: Trust Board Members, NHSI

Recommendation(s): Members are asked to note the contents of the report

Presenting officer: George Marcall, Non-Executive Director

Date of meeting: 25th October 2017

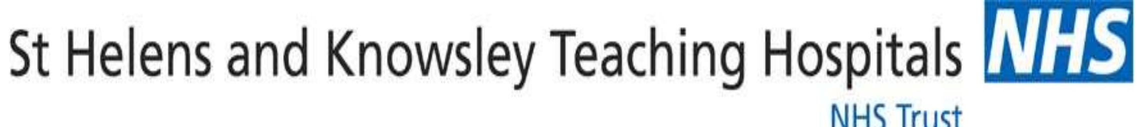
TRUST BOARD

Paper No: NHST(17)092
Title of paper: Committee Report – Audit
Purpose: To feedback to members key issues arising from the Audit Committee.
Summary: The Audit Committee met on 11th October 2017. The following matters were discussed and reviewed: External Audit : • External audit progress report including challenge questions around emerging issues and developments (GT) • The Trust's response to those challenge questions raised above (DoF) Internal Audit: • Progress/update report on Internal Audit programme (MIAA) • No issues of concern were raised. Anti-Fraud Services: • Progress/update report against the current anti-fraud plan (MIAA) • No issues of concern were raised. Trust Governance and Assurance: • The Director of Nursing update (DoN). **Standing Items**: • The audit log (report on current status of audit recommendations) (ADoF) • The losses, compensation and write-offs report for the period 1st April 2017 to 31st August 2017 (ADoF). • Aged debt analysis as at end of September 2017 (ADoF). • Tender and quotation waivers report (ADoF). **Any Other Business**: • The Trust's Standards of Business Conduct policy incorporating Managing Conflicts of Interest in the NHS policy was presented to the Committee and approved by the Audit Committee (for ratification by the Trust Board) (ADoF). See attached report and summary sheet. **Items to be escalated to the Board**: • ACTION: Update on appraisal/mandatory training compliance and feedback on staff survey results re value of appraisals (ARW) • ACTION: Share outcome of MIRTH review (DB) • ACTION: provide detail of anything significant under "damage to building/property" in the losses report (DB) • ESCALATION: Update Trust Board on debtors and associated cash risk (SRa) • ESCALATION: recommend Standards of Business Conduct Policy to the Board (SRa)

Key: Chair = Audit Committee Chair GT= Grant Thornton (external auditor) MIAA = Mersey Internal Audit Agency (internal audit and anti-fraud services) DoF = Director of Finance DoN = Director of Nursing, Midwifery & Governance ADoF = Assistant Director of Finance (Financial Services) NB. There was no meeting required of the Auditor Panel required on this occasion.
Corporate objectives met or risks addressed: Contributes to the Trust's Governance arrangements
Financial implications: None as a direct consequence of this paper
Stakeholders: The Trust, its staff and all stakeholders
Recommendation(s): For The Board to be assured on the Trust Audit programme and to accept the Audit Committee's recommendation to ratify its approval of the revised Trust Standards of Business Conduct incorporating Managing Conflicts of Interest in the NHS policy
Presenting officer: Su Rai, NED and Chair of Audit Committee
Date of meeting: 25th October 2017

AUDIT COMMITTEE PAPER

Paper No: AC(17) 057
Title of Paper: Standards of Business Conduct incorporating Managing Conflicts of Interest in the NHS
Purpose: To apprise the Audit Committee of the new policy with a view to the Committee recommending it for approval by the Trust Board.
Summary: Earlier this year a new national model policy for Managing Conflicts of Interest in the NHS was circulated to health bodies with the intention that those bodies adopt the policy either as a standalone document or incorporate within existing similar policies. The Trust has opted for the latter, incorporating it within its existing Standards of Business Conduct policy. The differences between the Trust's existing policy and the model policy are not extensive. However, where there are gaps in the existing policy these have been filled, where similar paragraphs exist between the two policies, the wording of the model policy has been selected ahead of the existing policy and where the existing policy has more detail this has been retained. Where needed the existing two declaration forms for both interests and gifts, hospitality and sponsorship have been been amended slightly as has the register for Hospitality, Sponsorship and Gifts. The new policy, however, does bring some changes of particular note, namely: - Increase in the minimum threshold for declaring gifts (from £25 to £50) - More detail on dealing with breaches and managing conflicts of interest - Greater emphasis on publication of the Register of Interests and the Register of Hospitality, Sponsorship and Gifts Register on-line to the public - More detailed advice to staff about what to do in common situations - Maintenance of an interests register in a format fit for publication (this is currently not detailed enough, being more of a simple log of declaration forms returned so has required amendment) - Anonymised information on breaches, the impact of these, and action taken to be prepared and made available for inspection by the public upon request.
Corporate objective met or risk addressed: Financial Governance
Financial implications:
Stakeholders: Audit Committee, Board
Recommendation(s): For the Audit Committee to recommend the policy to the Trust Board for approval
Presenting Officer: Mr D Brimage, Assistant Director of Finance (Financial Services)
Date of Meeting: 11th October 2017



NAME OF POLICY: Trust Standards of Business Conduct incorporating Managing Conflicts of Interest in the NHS

VERSION 04

Type of Document	Policy/Guidelines
Code	
Policy Sponsor	Director of Finance
Lead Executive	Director of Finance
Recommended by	Audit Committee
Date Recommended	October 2017
Approved by	Trust Board
Date Approved	October 2017
Author (s)	Based originally on National Standards of Business Conduct and NHS England's Managing Conflicts of Interest but local version, updated by Assistant Director of Finance (Financial Services) and the Trust's Anti-Fraud Specialist
Date Issued	October 2017
Review date	October 2020
Target Audience	All Trust staff
Document Purpose	To assist all staff within the Trust in maintaining strict ethical standards in the conduct of Trust business.
Training Requirements	None
Associated Documents and Key references	Corporate Governance Manual (inc luding SFIs, SOs, Scheme of Reservation & Delegation of Powers), Raising Concerns Policy, Anti-Fraud, Bribery and Corruption Policy, Disciplinary Policy, Gifts, Hospitality & Sponsorship, Declaration of Interests, Respect & Dignity at Work, Contract of Employment, Staff Handbook, Managing Conflicts of Interest in the NHS (Model Policy document).
Key Words	Gift, Hospitality, Sponsorship, Declaration, Conflict, Interests, Register, Fraud, Bribery, Corruption, Concerns, ACE, Behaviour, Candour

Consultation, Communication

Consultation Required	Authorised by	Date Authorised	Comments
Analysis of the effects on equality			No impact
External stakeholders			N/a
Trust staff consultation via intranet	Start date: N/a		End date:

Implementation Plan

Describe the implementation plan for the policy (and guidelines if impacts upon policy) (Considerations include: launch event, awareness sessions, communication/training via divisions and other management structures etc	Timeframe for implementation?	RAG	Who is responsible for delivery?
Communication via global e-mail and use of other communication vehicles where appropriate (eg. Team Brief, Trust Newsletter, Directorate Meetings, etc)	Immediate		Director of Finance

Performance Management of Policy KPI's (expected outcomes)

Describe Key Performance Indicators (KPIs) expected outcomes	How will the KPI be monitored?	Which committee will monitor this KPI?	Frequency of review?	Lead
KPI's not applicable				

Performance Management of minimum NHSLA process for this policy

Learning from experience

Minimum requirement to be monitored	Process for monitoring e.g. audit	Responsible individual/ group/committee	Frequency of monitoring	Performance management of minimum requirements. Responsible individual / group / committee (plus frequency of review / timescales) for:		
				Review of results	Development and update of action plan	Monitoring of action plan and implementation
Not applicable						

Who is responsible for producing action plans if deficits in KPI's and associated processes identified	Which Committee will monitor these action plans	Frequency of review
How does learning occur?	**Who is responsible for implementing and disseminating learning information?**	**Frequency**
Targeted awareness where appropriate		

Archiving including retrieval of archived document	By whom will the policy by archived and retrieved?

Document Version History

Date	Author Designation	Summary of Key changes
August 2012	Assistant Director of Finance (Financial Services) and the Trust's	Policy updated to take account of the new Bribery Act 2010, changes in management arrangements and revision and standardisation of forms and procedures.
July 2015	As above	Updated to include references to new requirements (eg. Duty of Candour) and policy generally reinforced throughout.
October 2017	As above	Updated to take into account NHS England's new model policy "Managing Conflicts of Interest in the NHS".

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EXECUTIVE SUMMARY

The Trust's local Standards of Business Conduct Policy incorporating Managing Conflicts of Interest in the NHS should be read in conjunction with the Anti-Fraud, Bribery & Corruption Policy, Disciplinary Policy and Procedure and the Raising Concerns Policy. These policies are available to view on the Trust intranet in the Policies section (under Corporate Services) and under Staff Matters (Corporate Governance). The Policy is supported and fully endorsed by senior management and the Trust Board. (For further information, staff should initially contact your line manager. The Director of Finance or a member of his senior team can also be contacted for advice).

1. SCOPE AND INTRODUCTION

1.1 St Helens and Knowsley Teaching Hospitals NHS Trust (the 'organisation'), and the people who work with and for us, collaborate closely with other organisations, delivering high quality care for our patients.

1.2 These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely. But there is a risk that conflicts of interest may arise.

1.3 Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly, are both key principles in the NHS Constitution. We are committed to maximising our resources for the benefit of the whole community. As an organisation and as individuals, we have a duty to ensure that all our dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that we are using our finite resources in the best interests of patients.

1.4 It is the responsibility of staff* to ensure that they are not placed in a position, which risks, or appears to risk, conflict between their private interests and their NHS duties. This primary responsibility applies to all NHS staff including those who commit NHS resources directly (e.g. by ordering of goods) or those who do so indirectly (e.g. by the prescribing of medicines). At St Helens and Knowsley Teaching Hospitals NHS Trust we use the skills of many different people, all of whom are vital to our work. This includes people on differing employment terms, who for the purposes of this policy we refer to as 'staff' and are listed below:

- All salaried employees, whether full or part-time
- All prospective employees – who are part-way through recruitment
- Contractors and sub-contractors
- Agency, bank and other temporary staff; and

- The Board, sub-committee and advisory group members (who may not be directly employed or engaged by the organisation)

Some staff are more likely than others to have a decision-making influence on the use of taxpayers' money, because of the requirements of their role. For the purposes of this guidance these people are referred to as '**decision-making staff**.' In this organisation these are:

- Executive and non-executive directors (including associate board directors) who have decision-making roles which involve the spending of taxpayers' money
- Clinical consultants
- Members of advisory groups or committees which contribute to direct or delegated decision making on the commissioning or provision of taxpayer funded services
- All staff at agenda for change band 8d and above
- Administrative and clinical staff who have the power to enter into contracts on behalf of their organisation
- Administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of good, medicines, medical devices or equipment, and formulary decisions

1.5 The scope of the policy includes:-
NHS funding from an external source, including funding of all or part of the costs of a member of staff, NHS research, staff, training, pharmaceuticals, equipment, meeting rooms, costs associated with meetings, meals, gifts, hospitality, hotel and transport costs (including trips abroad), provision of free services (speakers), buildings or premises. Please note that the Trust cannot spell out appropriate conduct and behaviour for every possible situation; however, staff are expected to make informed judgements about what is right and proper using the information and principles contained within the policy as a basis for their conduct and actions. Please note the scope of the Standards of Business Conduct policy incorporating Managing Conflicts of Interest in the NHS does not extend to all forms of personal conduct such as those embraced in the Trust's ACE Behavioural Standards, etc., which are covered separately.

1.6 The Trust's Standing Orders (section 5.9) includes specific reference to this policy. Since the publication of this document there have been many changes in the NHS including relevant new legislation relating to fraud and bribery and new obligations on NHS bodies and their staff. This is covered in the following paragraphs. In addition, in 2017, NHS England introduced a new model policy document called "***Managing Conflicts of Interest in the NHS***", which NHS organisations are expected to adopt as a standalone policy or incorporate within existing business conduct policies. The Trust's Standards of Business Conduct

now incorporates this.

1.7 The Bribery Act 2010 repeals the UK's previous anti–corruption legislation – the Public Bodies Corruption Practices Act 1889, The Prevention of Corruption Acts of 1906 and 1916 and the common law of bribery.

1.8 The Bribery Act 2010 came in to force on 1st July 2011. It does not apply retrospectively, which means that before that date, the repealed acts would be used to consider bribery or corruption offences.
Bribery may be considered to be: 'an inducement or reward offered, promised or provided to someone to perform their functions or activities improperly in order to gain a personal, commercial, regulatory and/or contractual advantage.

1.9 Breach of these provisions can render staff liable to dismissal and/or prosecution under the Bribery Act 2010. It is essential therefore that Directors and employees are transparent and understand the need to ensure that their actions cannot be misunderstood. All staff should follow the correct reporting channels if they receive or are offered any form of gift or hospitality and seek further clarity from the Director of Finance, the Register Administrator (see section 5.21) or a senior Human Resources Manager if they are uncertain about what is acceptable.

1.10 A bribe may be defined as "an inducement or reward offered, promised or provided to someone to perform their functions or activities improperly in order to gain a personal, commercial, regulatory and/or contractual advantage". A bribe may take the form of payment, gifts, hospitality, promise of contracts or employment, or some other form of benefit or gain. The individuals engaged in the actual bribery activity do not have to be those who instigate the offence(s), or ultimately benefit from it. All parties involved are potentially subject to prosecution. The bribe may take place prior to or after the corrupt act or improper function.

1.11 Bribery is a criminal offence. St Helens and Knowsley Teaching Hospitals NHS Trust does not, and will not pay bribes or offer improper inducements to anyone for any purpose; nor does it, or will it, accept bribes or improper inducements. This approach applies to everyone who works for the Trust, or with the Trust. To use a third party as a conduit to channel bribes to others is a criminal offence. The Trust does not, and will not, engage directly or indirectly in, or encourage bribery. This organisation, in conjunction with NHS Protect, will seek to obtain the strongest penalties, including criminal prosecution, as well as disciplinary and civil sanctions, against anyone associated with St Helens and Knowsley Teaching Hospitals NHS Trust who is found to be involved in criminal activities.

1.12 Fraud is a criminal offence. In January 2007, the Fraud Act 2006 came into force. This introduced new, specific fraud offences. Consequently, a person is found guilty of fraud if he/she is in breach of any of the following, which provide the three main ways of committing the offence:

- Fraud by false representation;
- Fraud by failing to disclose information;
- Fraud by abuse of position.

1.13 For example, failing to disclose information (such as a conflicting personal business or outside interest) when under a legal obligation to do so (as may be required by an NHS contract of employment) may constitute a fraud offence. Hence, the requirement for NHS staff to declare all relevant interests. Similarly, using commercially confidential NHS information for private gain (either by oneself or another) could also constitute a criminal abuse of position offence under the Fraud Act. Other fraud-related offences exist under the Act, specifically in respect of items (ie. false documents) used to commit a fraud. There is also a common law offence of conspiracy to commit fraud, where several individuals are involved working together.

1.14 In summary, staff should be aware that a breach of any provision of the Fraud and Bribery Acts referred to above renders them potentially liable to prosecution and may also lead to disciplinary action, as well as loss of employment and pension rights in the NHS. Professional body sanctions (where relevant) may also apply. Offences under both Acts carry sanctions including up to 10 years imprisonment and/or unlimited fines. In addition, those in the public sector should be mindful that additional sanctions are also occasionally brought under the common law offence of Misconduct in Public Office, which also carries a potential 10 year sentence. Further advice and guidance on fraud, bribery and corruption may be obtained from the Trust's Anti-Fraud Specialist and reference may also be made to the Trust's Anti-Fraud, Bribery and Corruption Policy.

1.15 The Trust's operational policies are also written in accordance with 'The Association of the British Pharmaceutical Industry's (ABPI)' code of practice.

1.16 Where collaborative partnerships involve a pharmaceutical company then the arrangements must comply fully with the Medicines (Advertising) Regulations 1994 (Section 5, Appendix B).

1.17 Failure to comply with and meet the standards and requirements contained within the policy may result in disciplinary action against the employee for breach of their employment contract. In some instances, breaches of the policy may also equate to criminal offences and the Trust's Anti-Fraud Specialist or other relevant authorities may be notified as appropriate. The Trust does not tolerate breaches

of policy and any related criminal activity.

1.18 For the avoidance of doubt, nothing contained within the policy requires or authorises an NHS employee to whom the policy applies to:

- Make, commit or knowingly allow to be made any unlawful disclosure;
- Make, permit or knowingly allow to be made any disclosure in breach of his or her duties and obligations to his or her employer, save as permitted by the law;
- Break the law.

1.19 If there is any conflict between the above duties and obligations and the policy, the former shall prevail.

1.20 The NHS has a formal constitution which establishes the principles and values for the NHS in England; it sets out rights to which patients, public and staff are entitled, and pledges that the NHS is committed to achieve. It is supported by a Handbook which explains the NHS Constitution in detail. All NHS bodies, and private and third party sector providers supplying NHS services, are required by law to take the NHS Constitution into account in their decisions and actions.

1.21 The NHS Constitution now includes the Duty of Candour. This imposes a duty on the NHS and its staff to make sure they tell patients, families, carers, and/or representatives if something goes wrong with their care. The Duty is about being honest and truthful and making sure that people are told what went wrong and why, and apologising and explaining what will be done to help stop it happening again. The Duty of Candour has been incorporated as a contractual requirement into the NHS Standard Contract of Employment. Obstructing colleagues in being candid will be a breach of professional codes. It is therefore important that the Trust and its staff are aware of and understand their responsibilities in relation to the Duty.

1.22 Staff are obliged to take an active note of the Nolan Principles which were first published in 1995 by HM Government and apply to all aspects of public life and to all those who serve the public in any way. There are seven principles, namely:

- **Selflessness** (ie. acting solely in the public interest);
- **Integrity** (ie. not to act or take decisions in order to make financial or other material benefits for themselves, their families or their friends. Hence, the need to declare and resolve any related party interests and relationships);
- **Objectivity** (ie. acting and taking decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias);

- **Accountability** (ie. being accountable for their decisions and actions);
- **Openness** (ie. acting and taking decisions in an open and transparent manner);
- **Honesty** (ie. being truthful); and
- **Leadership** (ie. actively promoting and robustly supporting the principles and be willing to challenge poor behaviour wherever it occurs).

2. STATEMENT OF INTENT

The following policy has been produced to assist all staff within the Trust in maintaining strict ethical standards in the conduct of Trust business.

Appendix A gives a synopsis of the spirit of the policy for quick reference. Appendix C gives a quick reference procedure guide.

Adhering to this policy will help to ensure that we use NHS money wisely, providing best value for taxpayers and accountability to our patients for the decisions we take.

This policy will help our staff manage conflicts of interest risks effectively. It:

- Introduces consistent principles and rules
- Provides simple advice about what to do in common situations.
- Supports good judgement about how to approach and manage interests

As a member of staff you should…	As an organisation we will…

• Familiarise yourself with this policy and follow it. Refer to the guidance for the rationale behind this policy https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf
 	
• Use your common sense and judgement to consider whether the interests you have could affect the way taxpayers' money is spent
 	
• Regularly consider what interests you have and declare these as they arise. If in doubt, declare.
 	
• **NOT** misuse your position to further your own interests or those close to you
 	
• **NOT** be influenced, or give the impression that you have been influenced by outside interests
 	
• **NOT** allow outside interests you have to inappropriately affect the decisions you make when using taxpayers' money
	• Ensure that this policy and supporting processes are clear and help staff understand what they need to do.
	
	• Identify a team or individual with responsibility for:
	  ○ Keeping this policy under review to ensure they are in line with the guidance.
	  ○ Providing advice, training and support for staff on how interests should be managed.
	  ○ Maintaining register(s) of interests.
	  ○ Auditing this policy and its associated processes and procedures at least once every three years.
	
	• **NOT** avoid managing conflicts of interest.
	
	• **NOT** interpret this policy in a way which stifles collaboration and innovation with our partners

3. DEFINITIONS

3.1 A ‘conflict of interest’ is:

“A set of circumstances by which a reasonable person would consider that an individual’s ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold.”

3.2 A conflict of interest may be:

- Actual - there is a material conflict between one or more interests
- Potential – there is the possibility of a material conflict between one or more interests in the future

3.3 Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

3.4 Interests fall into the following categories:

- **Financial interests:**
  Where an individual may get direct financial benefit[1] from the consequences of a decision they are involved in making.
- **Non-financial professional interests:**
  Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.
- **Non-financial personal interests:**
  Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.
- **Indirect interests:**
  Where an individual has a close association[2] with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

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[1] This may be a financial gain, or avoidance of a loss.
[2] A common sense approach should be applied to the term ‘close association’. Such an association might arise, depending on the circumstances, through relationships with close family members and relatives, close friends and associates, and business partners.

3.5 All other definitions where appropriate are given in the main body of the policy.

4. DUTIES, ACCOUNTABILITIES AND RESPONSIBILITIES

Director of Finance – As the lead executive and policy sponsor, the Trust's Director of Finance should ensure that the policy is periodically reviewed and appropriately distributed.

Assistant Director of Finance (Financial Services) – The Trust's Assistant Director of Finance (Financial Services) is expected to review and assist in the distribution of this policy, ensuring that it is consistent with other associated local policies, namely the Trust's Corporate Governance Manual and the Anti-Fraud, Bribery and Corruption Policy.

Anti-Fraud Specialist (AFS) – The Trust's AFS is expected to advise the Director of Finance and the Audit Committee of relevant changes in law and procedural rules associated with fraud, bribery, corruption and similar criminal activity that may impact on this policy, thereby ensuring the policy is up-to-date and relevant.

All Staff – All staff should appraise themselves of this policy and the duties/ responsibilities referred to within, noting the **principles of conduct** as outlined below:

Staff are expected to:

a) ensure that the interests of patients remain paramount at all time;
b) be impartial and honest in the conduct of their official business;
c) use the public funds entrusted to them to the best advantage of the service, always ensuring value for money.

It is also the responsibility of staff to ensure that they do not:

a) abuse their official position for personal gain or to benefit their family or friends;
b) seek to advantage or further private business or other interests, in the course of their official duties.

5. PROCESSES

5.1 Casual Gifts

Casual gifts of low intrinsic value (i.e. less than or equal to £50) from patients or relatives, such as pens, diaries etc. need not necessarily be refused; such items may allow limited resources to be concentrated directly on patient care and are unlikely to influence the recipient. Gifts in excess of £50 should normally be politely refused. Multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50. In cases of doubt, staff should consult the Director of Finance via their line manager before accepting the gift. If in exceptional circumstances it is agreed that a gift other than the above might be accepted then it requires, before acceptance, secondary formal approval by the Director of Finance or in his absence, the Deputy Director of Finance, using the official declaration form (see Appendix D). Gifts over these limits should be entered in the Trust Register (see Appendix F) whether they are accepted or not. (See also Appendix C for procedure decision matrix). Gifts from anyone other than patients or relatives (eg. suppliers and contractors) are not acceptable in any form and should be refused and the offer recorded on the gifts and hospitality register (aside from minor promotional items such as pens, diaries, etc. up to a nominal value of £6).

Breach of these provisions can render staff liable to dismissal and/or prosecution under the Bribery Act 2010. It is essential therefore that Directors and employees are transparent and understand the need to ensure that their actions cannot be misunderstood. All staff should follow the correct reporting channels if they receive any form of gift or hospitality and seek further clarity from the Director of Finance or, in his absence, the Deputy Director of Finance, if they are uncertain about what is acceptable.

The acceptance of personal *monetary* gifts is **<u>not</u>** acceptable in **<u>any</u>** circumstances as this could be seen as bribery. (Offers of money will be deemed to include vouchers of a monetary value, eg. gift vouchers.)

5.2 Hospitality

Hospitality includes meals, hotel accommodation, entertainment, invitations to sporting events etc. Modest hospitality (i.e. less than or equal to £25 per person) is acceptable provided:
(a) there is a benefit to the Trust;
(b) it is reasonable in the circumstances and commensurate with normal activity, e.g. lunches in the course of working visits or educational meetings etc. may be acceptable though it should be similar to the scale of hospitality which the Trust might offer or the person might arrange for

themselves. Such hospitality must be secondary to the purpose of the meeting.

Hospitality in excess of £25 but less than or equal to £75 per person may be accepted in line subject to the provisos in a or b shown above. The acceptance of such items must be approved beforehand by the recipient's line manager and reported to the Register Administrator (see paragraph 5.21.3) using an official declaration form (see Appendix D) for entry in the Register. No Hospitality should be accepted which is estimated to cost more than £75 per person without satisfying the provisos in a or b above and the secondary approval of the Director of Finance or in his absence, the Deputy Director of Finance, using the declaration form attached at Appendix D. Such examples should be entered in the Trust Register (Appendix F) whether they are accepted or not. If an individual is in any doubt then guidance should be sought from their line manager in the first instance. (See also Appendix C for diagram of procedure).

5.3 Commercial sponsorship for attendance at Courses, Conferences and Meetings

Acceptance by staff of commercial sponsorship for attendance at relevant conferences and courses is acceptable provided there is a clearly defined benefit to the organisation for allowing the sponsorship and full details of the sponsorship and organisational benefits are provided).

Senior medical and dental staff

The initial formal request for this will be via the senior medical and dental staff "application for professional or study leave" form which has to be signed by the appropriate medical director (see Trust policy on leave of absence for senior medical staff). Where the level has been exceeded (see thresholds below) requiring the member of staff to report the sponsorship to the Trust's Register Administrator (see paragraph 5.21.3) then a Sponsorship and Hospitality Declaration form (see Appendix D) should be completed by the member of staff, signed by the appropriate medical director and passed on to the Register Administrator for recording (or, if appropriate, seeking secondary approval of the Director of Finance).

Other staff

Where the level has been exceeded (see thresholds below) requiring the member of staff to report the sponsorship to the Trust's Register Administrator (see paragraph 5.21.3) then a Sponsorship and Hospitality Declaration form (see Appendix D) should be completed by the member of staff, signed by the appropriate line manager and passed on to the Register Administrator for recording (or, if appropriate, seeking secondary approval of the Director of Finance).

Thresholds
Commercial sponsorship up to £25 may be accepted, if in accordance with normal practice and reasonable in the circumstances, without formal approval or entry in the Trust Register.

If exceeding £25 and below or equal to £75 it can be accepted. The acceptance of such items, however, must be approved beforehand by the recipient's line manager/medical director (see paragraphs above) and reported to the Register Administrator using an official declaration form (see Section 5, Appendix D) for entry in the Register. If an individual is in any doubt then guidance should be sought from their line manager. No Commercial sponsorship should be accepted, which is estimated to cost more than £75 per person, without the secondary approval of the Director of Finance or in his absence, the Deputy Director of Finance. Such examples should be entered in the Trust Register (see Appendix F) whether they are accepted <u>or</u> not. Both the recipient's line manager/medical director and the Director of Finance should be satisfied that acceptance will not compromise purchasing decisions in any way. (See Appendix C for diagram of procedure)

Where meetings are sponsored by external sources, that fact must be disclosed in the papers relating to the meeting and in any published proceedings.

5.4 Commercial Sponsorship of Posts
External sponsorship of a post requires prior approval from the organisation.

Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and withdraw if appropriate.

Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise.

Sponsored post holders must not promote or favour the sponsor's products, and information about alternative products and suppliers should be provided.

Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

Pharmaceutical Companies, for example, may offer to sponsor wholly or partially, a post for the Trust. In the first instance it will be the responsibility of the officer arranging the sponsorship to advise the Head of Research / Clinical Audit that such sponsorship is to be received. The Trust should not enter into such arrangements, unless it has been made abundantly clear to the company concerned that the sponsorship will have no effect on purchasing decisions within the Trust. Head of Research / Clinical Audit will advise companies in writing of these requirements and where such sponsorship is accepted, monitoring arrangements will be established by the R & D Committee to ensure that purchasing decisions are not, in fact, being influenced by the sponsorship agreement. Under no circumstances should staff agree to "linked deals" whereby sponsorship is linked to the purchase, supply or promotion of a particular product from particular sources.

What should be declared:

- The organisation will retain written records of sponsorship of posts, in line with the above principles and rules.
- Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this policy.

- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf

5.5 Sponsored events

Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit the organisations and the NHS.

During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.

No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.

At the organisation's discretion, sponsors or their representatives may attend or take part in the event but they should not have a dominant influence over the content or the main purpose of the event.

The involvement of a sponsor in an event should always be clearly identified.

Staff within the organisation involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.

Staff arranging sponsored events must declare this to the organisation.

What should be declared:

- The organisation will maintain records regarding sponsored events in line with the above principles and rules.

5.6 Commercial in Confidence

Staff should be particularly careful of using or making public, internal information of a "commercial in confidence" nature particularly if its disclosure would prejudice the principle of purchasing based on fair competition. This principle applies whether private competitors or other NHS providers are concerned, and whether or not disclosure is prompted by the expectation of personal gain.

However, managers should be careful about adopting a too restrictive view on this matter. It should certainly not be a cause of excessive secrecy on matters, which are not strictly commercial per se. For example, "commercial in confidence" should not be taken to include information about service delivery and activity levels, which should be publicly available. Nor should it inhibit the free exchange of data for medical audit purposes. In all circumstances the overriding consideration must be the best interests of patients. When in doubt employees should seek guidance on what constitutes "commercial in confidence" information from the Trust's Information Governance Department.

5.7 Goods/equipment for patient care

Commercial sponsorship of, or provision of goods or equipment for patient care, is acceptable, but should be clearly documented by the person in receipt of the goods. This information should be forwarded to the Head of Purchasing and Supply who will maintain appropriate records. This officer will also confirm that the goods satisfy all legislative and regulatory requirements. If there is any doubt then the line manager should be

consulted about the need to seek Trust approval before accepting the goods.

5.8 Preferential treatment in private transactions

Individual staff must not seek to accept preferential rates or benefits in kind for private transactions carried out with companies, with which they have had, or may have, official dealings on behalf of the Trust. This does not apply to concessions negotiated with companies by NHS Management, or by recognised staff interests, on behalf of all staff, for example, NHS staff benefits schemes.

5.9 Contracts

All staff, who are in contact with suppliers and contractors (including external consultants) and in particular those who are authorised to sign purchase orders, or place contracts of goods, materials or services, are expected to adhere to professional standards of the kind set out in the ethical code of the Chartered Institute of Purchasing and Supply (CIPS) and the Trust's Standing Orders/ Standing Financial Instructions. Trust employees dealing with potential contractors should ensure those invited to tender are aware of the consequences of engaging in any corrupt practices involving employees of Public Bodies.

5.10 Favouritism in awarding contracts

Fair and open competition between prospective contractors or suppliers for Trust contracts is a requirement of Trust Standing Orders and of EC directives on public purchasing for works and supplies. This means that no private, public, or voluntary organisation, or company, which bid for Trust business, should be given any advantage over its competitors such as advance notice of Trust requirements. This applies to all potential contractors, whether or not there is a relationship between them and the Trust, such as a long running series of previous contracts.

Each new contract should be awarded solely on merit, taking into account the requirements of the Trust and the ability of the contractors to fulfil them.

The Trust should ensure that no special favour is shown to current or former employees or their close relatives or associates in awarding contracts to private or businesses run by them or employing them in a senior or relevant managerial capacity. Contracts may be awarded to such businesses where they are won in fair competition against other tenders, but scrupulous care must be taken to ensure that the selection process is conducted impartially, and that staff that are known to have a

relevant interest play no part in the selection.

5.11 Outside employment

Staff should declare any existing outside employment on appointment and any new outside employment when it arises.

Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks (see 5.22 and 5.23).

Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from the organisation to engage in outside employment.

The organisation may also have legitimate reasons within employment law for knowing about outside employment of staff, even when this does not give rise to risk of a conflict.

Trust employees should not engage in outside employment which might adversely affect their ability/judgement in performing their normal duties at the Trust. Staff are advised that they are required to report (using the official Declaration of Interests form in appendix G any other employment and that they could breach their contract of employment by working for another employer without approval. Speaking at Educational Meetings sponsored by the Pharmaceutical Industry and receiving a fee for such activity is acceptable **provided** it is during a period of annual leave or during time you are not expected to be working for the Trust, though care should be exercised not to unfairly promote one company's product over that from another company. Approval and recording should be in accordance with section 3 of Appendix C.

What should be declared:

- Staff name and their role with the organisation.
- The nature of the outside employment (e.g. who it is with, a description of duties, time commitment).
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

5.12 Clinical private practice

Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises[3] including:

- Where they practise (name of private facility).
- What they practise (specialty, major procedures).
- When they practise (identified sessions/time commitment).

Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- Seek prior approval of their organisation before taking up private practice.
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.[4]
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf

Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf.

What should be declared:

- Staff name and their role with the organisation.
- A description of the nature of the private practice (e.g. what, where and when staff practise, sessional activity, etc).
- Relevant dates.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

5.13 Shareholding and other ownership issues

Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the organisation.

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[3] Hospital Consultants are already required to provide their employer with this information by virtue of Para.3 Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf

[4] These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf)

Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks (see 5.10).

There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

What should be declared:

- Staff name and their role with the organisation.
- Nature of the shareholdings/other ownership interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

5.14 Patents

Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the organisation.

Staff should seek prior permission from the organisation before entering into any agreement with bodies regarding product development, research, work on pathways etc, where this impacts on the organisation's own time, or uses its equipment, resources or intellectual property.
Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

What should be declared:

- Staff name and their role with the organisation.
- A description of the patent.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy)

5.15 Loyalty interests

Loyalty interests should be declared by staff involved in decision-making where they:
Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.

Sit on advisory groups or other paid or unpaid decision making forums that can influence how an organisation spends taxpayers' money.

Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.

Are aware that their organisation does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

What should be declared:

- Staff name and their role with the organisation.
- Nature of the loyalty interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

5.16 Donations made by suppliers or bodies seeking to do business with the Trust

Donations made by suppliers or bodies seeking to do business with the organisation should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.

Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the organisation, or is being pursued on behalf of the organisation's own registered charity or other charitable body and is not for their own personal gain.

Staff must obtain permission from the organisation if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the organisation's own.

Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued.

Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal

responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

What should be declared:

- The organisation will maintain records in line with the above principles and rules and relevant obligations under charity law.

5.17 Rewards for initiative

Staff should ensure that they are in a position to identify potential intellectual property rights (IPR) as and when they arise, so that they can protect and exploit them properly, and thereby ensure that the Trust receives any rewards or benefits (such as royalties) in respect of the work commissioned from third parties or work carried out by employees in the course of their NHS duties. Most IPR are protected by statute; e.g. patents are protected under the Patents Act 1977 and Copyright (which includes software programmes) under the Copyright Designs & Patents Act 1988. To achieve this, the Trust should build appropriate specifications and provisions into the contractual arrangement into which they enter before the work is commissioned, or begins. They should always seek legal advice if in any doubt in specific cases.

With regard to patents and inventions, in certain defined circumstances the Patents Act gives employees a right to obtain some reward for their efforts, and employers should see that this is effected. Other rewards may be given voluntarily to employees who within the course of their employment produce innovative work of outstanding benefit to the NHS. Similar rewards should be voluntarily applied to other activities such as giving lectures and publishing books and articles.

5.18 Sponsored research (inc collaborative research and evaluative exercises)

Funding sources for research purposes must be transparent.

Any proposed research must go through the relevant health research authority or other approvals process.

There must be a written protocol and written contract between staff, the organisation, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services.

The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service.

Staff should declare involvement with sponsored research to the organisation.

In the case of collaborative research and evaluative exercises with manufacturers, the Trust should see that they obtain a fair reward for the input that they provide. If such an exercise involves additional work for an employee outside that paid for by the Trust under his or her contract of employment, arrangements should be made for some share of any rewards or benefits to be passed on to the employee(s) concerned from the collaborating parties. Care should be taken, however, that involvement in this type of arrangement with a manufacturer does not influence the purchase of other supplies from that manufacturer. It is essential that employees are transparent and seek approval for any payments offered. All employees must understand the need to ensure that their actions cannot be misunderstood.

What should be declared:

- The organisation will retain written records of sponsorship of research, in line with the above principles and rules.
- Staff should declare:
  - their name and their role with the organisation.
  - Nature of their involvement in the sponsored research.
  - relevant dates.
  - Other relevant information (e.g. what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

5.19 Inspecting equipment/systems

On occasions when the Trust considers it necessary for staff advising on the purchase of equipment to inspect such equipment in operation in other parts of the country (or exceptionally overseas), the Trust may consider meeting the costs so as to avoid putting in jeopardy the integrity of the subsequent purchasing decisions.

5.20 Taxation

It should be noted that the Trust will always be guided by Her Majesty's Revenue and Customs (HMRC) regulations in respect of potential taxable income. Therefore before embarking on any scheme staff should ensure they are aware of the likely treatment of income from whatever source. General principles are as follows:-

Under the self-assessment system, where a third party has provided benefits and expenses directly to individual employees, i.e. where the Trust has played no active part in the provision of the benefit, the tax liability is the responsibility of individual employees and should be reported to HMRC via self-assessment returns. If the money is received directly by the Trust and later reimbursed to the individual it will be paid via the payroll and taxed at source. The amount would be included on the P60 for that employee and consequently would not be taxed again. The facts should be noted by the employee on their self-assessment return to ensure HMRC are aware the transaction has taken place and avoid confusion.

Monies paid directly to the Trust's Research and Development budget with no benefit to be received by an employee will result in no income tax liability on their part. However HMRC consider that if monies are paid to a Trust Charitable Fund there is a potential for a benefit to an employee and therefore currently consider there to be a tax liability on the individual.

It should also be noted that if monies are initially paid to an employee, who subsequently pays the money to the Trust, HMRC may well still consider a tax liability is due by the employee, notwithstanding the fact that the whole amount has been passed on. This latter scenario should ideally be avoided when projects are initiated.

5.21 Declaration of interests

5.21.1 Identification and declaration of interests

All staff should identify and declare material interests at the earliest opportunity (and in any event within 28 days). If staff are in any doubt as to whether an interest is material then they should declare it, so that it can be considered.

Declarations should be made:

- On appointment with the organisation (see overleaf).
- When staff move to a new role or their responsibilities change significantly.
- At the beginning of a new project/piece of work.
- As soon as circumstances change and new interests arise (for instance, in a meeting when interests staff hold are relevant to the matters in discussion).

A declaration of interests form is illustrated in Appendix G and can also be found on the Trust's intranet under "Corporate Governance" with the section "Staff Matters". Instructions on completion of these forms and to whom the declarations should be sent are shown on the declaration forms themselves.

After expiry, an interest will remain on register(s) for a minimum of 6 months and a private record of historic interests will be retained for a minimum of 6 years.

On start of employment

The Human Resources Department will ensure that, on commencing employment with the Trust, staff are made aware that a declaration is required in the following circumstances, ie. where an employee, or his or her close relative or associate or friend, has a controlling and/or significant financial interest in a business (including a private company), or public sector organisation, other NHS employer and/or voluntary organisation, or in any other activity or pursuit, which has business dealings with the Trust or which may compete for a contract to supply either goods or services to the Trust. Declarations must be made whether the member of staff or close relatives or associates are remunerated or not.

Please note that relatives include spouses (or equivalents including partners), parents or grandparents, children or grandchildren, siblings or indeed any other family relative that may be deemed close. Any individual who fails to declare any such business relationships may be subject to an investigation by the Trust's Local Counter Fraud Specialist and potential criminal/disciplinary action where such a relationship proves to be of significance. The advice to individuals is, if in doubt, declare it. If the individual receiving the letter has any queries he may also contact the Trust's Director of Finance or, in his absence, the Deputy Director of Finance.

5.21.2 Proactive review of interests

In addition to the above, certain groups of individuals will be asked to complete a declaration of interest form **each year** (some time during the final quarter of the financial year) but this does not preclude this group of staff and other members of staff being required to make relevant declarations **as they become apparent**. The declaration will cover the whole of the financial year:

- All Board Directors including non-executive directors and associate directors
- All clinical directors, assistant directors or equivalent including heads of departments
- All procurement staff (buyers etc)
- All PFI project staff employed by the Trust involved in procurement/contracting
- All IT staff involved in procurement/contracting
- All senior Finance staff other than those included above
- All medical and dental consultants

Please also note that any individuals who do not have any interests to declare must still complete a return but clearly marked as “no interests to declare” with the form being signed and dated.

Once the declaration form is completed, signed and dated it is the responsibility of the individual concerned to appraise the Director of Finance of any change, particularly of any new “interests” arising. This can be done by the individual writing directly to/e-mailing the Trust’s Director of Finance.

In determining what needs to be declared, staff should be guided by the following principles:

DO:

- Make sure you understand the guidelines on standards of business conduct, and consult your line manager if you are not sure;
- Make sure you are not in a position where your private interests and NHS duties may conflict;
- Declare to the Trust any relevant interests. If in doubt, ask yourself:

1. Am I or might I be, in a position where I (or my family/friends) could gain from the connection between my private interests and my employment?
2. Do I have access to information, which could influence purchasing decisions?
3. Could my outside interest be in any way detrimental to the Trust or to patients' interests?
4. Do I have any other reason to think I may be risking a conflict of interest? If still unsure – declare it.
5. If I read about my private interest or my receipt of a gift or hospitality in a newspaper, would I feel embarrassed about it?

- Adhere to the ethical code of the Chartered Institute of Purchasing & Supply if you are involved in any way with the acquisition of goods and services;
- Seek your manager's permission before taking on outside work, if there is any question of it adversely affecting your NHS duties.
- Obtain Trust permission before accepting any commercial sponsorship;

DO NOT:

- Accept any gifts or inducements or inappropriate hospitality other than those specified herein;

- Abuse your past or present official position to obtain preferential rates for private deals;
- Unfairly advantage one competitor over another or show favouritism in awarding contracts;
- Misuse or make available official "commercial in confidence" information.

Accepting inappropriate donations, gifts or hospitality can be seen as bribery and it is important that staff take all steps to be transparent and eliminate any possible situation where it could be construed that they have/are receiving an inducement or reward.

5.21.3 Records and publication of interests and hospitality, sponsorship and gifts

Maintenance - A central *Register of Hospitality, Sponsorship and Casual Gifts* exists in the Executive Offices, Whiston Hospital and is maintained by the Personal Assistant to the Director of Finance (the Register Administrator). The format of the Register is shown in Appendix F to these procedures. Declaration forms should be sent to the Register Administrator, having been authorised by an approved officer/line manager*, or where the procedures merely require secondary approval by the Director of Finance in the case of senior medical and dental staff study leave which contains hospitality/sponsorship, see paragraph 5.3). The Register will be available for inspection by Senior Trust Officers and will be formally reviewed at least annually by the Trust's Audit Committee.

(* See Appendix E, paragraph 2.5.)

The Trust's Declaration of Interests Officer will also maintain a *Register of Interests* separate from the central Register of Hospitality, Sponsorship and Casual Gifts.

Publication – The Trust will publish both the Declaration of Interests register and the Hospitality, Sponsorship and Casual Gifts register annually on the Trust's website. (If decision-making staff have substantial grounds for believing that publication of their interests should not take place then they should contact the Trust's Director of Finance to explain why. In exceptional circumstances, for instance where publication of information might put a member of staff at risk of harm, information may be withheld or redacted on public registers. However, this would be the exception and information will not be withheld or redacted merely because of a personal preference.)

Wider transparency initiatives - St Helens and Knowsley Teaching Hospitals NHS Trust fully supports wider transparency initiatives in healthcare, and we encourage staff to engage actively with these.

Relevant staff are strongly encouraged to give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative. These "transfers of value" include payments relating to:

- Speaking at and chairing meetings
- Training services
- Advisory board meetings
- Fees and expenses paid to healthcare professionals
- Sponsorship of attendance at meetings, which includes registration fees and the costs of accommodation and travel, both inside and outside the UK
- Donations, grants and benefits in kind provided to healthcare organisations

Further information about the scheme can be found on the ABPI website: http:// www.abpi.org.uk/our-work/disclosure/about/Pages/default.aspx

5.22 Management of interests - general

If an interest is declared but there is no risk of a conflict arising then no action is warranted. However, if a material interest is declared then the general management actions that could be applied include:

- restricting staff involvement in associated discussions and excluding them from decision-making
- removing staff from the whole decision-making process
- removing staff responsibility for an entire area of work
- removing staff from their role altogether if they are unable to operate effectively in it because the conflict is so significant

Each case will be different and context-specific, and the Trust will always clarify the circumstances and issues with the individuals involved. Staff should maintain a written audit trail of information considered and actions taken. Staff who declare material interests should make their line manager, or the person(s) they are working to, aware of their existence.

5.23 Management of interests – advice in specific contexts

5.23.1 Strategic decision making groups

In common with other NHS bodies St Helens and Knowsley Teaching Hospitals NHS Trust uses a variety of different groups to make key strategic decisions about things such as:

- Entering into (or renewing) large scale contracts.
- Awarding grants.
- Making procurement decisions.
- Selection of medicines, equipment, and devices.

The interests of those who are involved in these groups should be well known so that they can be managed effectively. For this organisation these groups are the Board, all of its committees and steering councils and similar groups, the Executive Team and Auditor Panel.

These groups should adopt the following principles:

- Chairs should consider any known interests of members in advance, and begin each meeting by asking for declaration of relevant material interests.
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.
- Any new interests identified should be added to the organisation’s register(s).
- The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that may prejudice their judgement.

If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

- Requiring the member to not attend the meeting.
- Excluding the member from receiving meeting papers relating to their interest.
- Excluding the member from all or part of the relevant discussion and decision.
- Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate.
- Removing the member from the group or process altogether.

The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the

decision being made. Good judgement is required to ensure proportionate management of risk.

5.23.2 Procurement

Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour - which is against the interest of patients and the public.

Those involved in procurement exercises for and on behalf of the organisation should keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process.

5.24 Dealing with breaches

There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as ‘breaches’.

5.24.1 Identifying and reporting breaches

Staff who are aware about actual breaches of this policy, or who are concerned that there has been, or may be, a breach, should report these concerns to the Director of Finance or the Trust’s Anti-Fraud Specialist.

To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this. For further information about how concerns should be raised, please refer to the Trust’s Raising Concerns policy. The organisation will investigate each reported breach according to its own specific facts and merits, and give relevant parties the opportunity to explain and clarify any relevant circumstances.

Following investigation the organisation will:

- Decide if there has been or is potential for a breach and, if so, what the severity of the breach is.
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum.
- Consider who else inside and outside the organisation should be made aware

- Take appropriate action as set out in the next section.

5.24.2 Taking action in response to breaches

Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of the organisation and could involve organisational leads for staff support (e.g. Human Resources), fraud (e.g. Local Counter Fraud Specialists), members of the management or executive teams and organisational auditors.

Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures.
- Consideration as to whether HR/employment law/contractual action should be taken against staff or others.
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Protect, the Police, statutory health bodies (such as NHS England, NHS Improvement or the CQC), and/or health professional regulatory bodies.

Inappropriate or ineffective management of interests can have serious implications for the organisation and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the organisation can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes:

- Employment law action against staff, which might include
  - Informal action (such as reprimand, or signposting to training and/or guidance).
  - Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal).
- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be.
- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach.
- Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation.

Learning and transparency concerning breaches

Reports on breaches, the impact of these, and action taken will be considered by the Audit Committee at least annually. To ensure that

lessons are learnt and management of interests can continually improve, anonymised information on breaches, the impact of these, and action taken will be prepared and made available for inspection by the public upon request.

5.25 Concerns

Staff should report any suspicions or allegations of fraud, bribery or corruption to one of the following: Director of Finance, the Trust's Anti-Fraud Specialist, the Trust's designated Raising Concerns contact, NHS Fraud and Corruption reporting line on 0800 028 40 60 or the via the online fraud reporting form at www.reportnhsfraud.nhs.uk. Further guidance on reporting concerns can be found under the Anti-Fraud, Bribery & Corruption policy or the Raising Concerns policy. (Please note that all employees in the NHS have a contractual right and a duty to raise genuine concerns they have with their employer about malpractice, patient safety, financial impropriety or any other serious risks they consider to be in the public interest – Section 21 of the NHS Terms and Conditions of Service).

5.26 Monitoring, auditing and review

Monitoring and auditing of the policy is essential to ensure that required standards of behaviour and conduct are maintained. Such arrangements would include reviewing adherence to policies, identifying breaches and potential system and organisational weaknesses and making recommendations to address those weaknesses and to enhance the policy. Policies may be periodically reviewed by the Trust's internal audit and anti-fraud specialist services and also by Trust management with reports being presented to the Trust's Audit Committee alongside management responses and action plans. This policy will be reviewed in three years' time unless an earlier review is required. This will be led by the Assistant Director of Finance (Financial Services) and the Trust's Anti-Fraud Specialist.

5.27 Associated documents

Freedom of Information Act 2000
ABPI: The Code of Practice for the Pharmaceutical Industry (2014)
ABHI Code of Business Practice
NHS Code of Conduct and Accountability (July 2004)
The Trust's local Anti-Fraud, Bribery & Corruption Policy
The Trust's local Disciplinary Policy and Procedure
The Trust's local Raising Concerns Policy.
The Trust's Corporate Governance Manual

Appendix A

Staff and independent contractors working in the NHS should:

- Act impartially in their work;
- Refuse gifts, benefits, hospitality or sponsorship of any kind which might reasonably be seen to compromise their personal judgement or integrity, and to avoid seeking exert influence to obtain preferential consideration. All such gifts should be returned and hospitality refused;
- Declare and register gifts, benefits, or sponsorship of any kind, in the Trust's Gift, Hospitality and Sponsorship Register, (provided that they are worth at least £25 for hospitality and sponsorship, or £50 for gifts), whether refused or accepted. In addition, multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50. All declarations to the Register should be made as soon as it is practically possible to do so. Please note, that gifts of any value from contractors or suppliers should not be accepted (aside from minor promotional items such as pens, diaries, etc upto a value of £6);
- Declare and record financial or personal interest (eg company shares, research grant) in any organisation with which they have to deal, and be prepared to withdraw from those dealings if required, thereby ensuring that their professional judgement is not influenced by such considerations;
- Ensure that offers of sponsorship that could possibly breach the Code be reported to the Chief Executive when seeking approval to the sponsorship.
- Not misuse their official position or information acquired in the course of their official duties, to further their private interests or those of others;
- Ensure professional registration (if applicable) and/or status are not used in the promotion of commercial products or services;
- Beware of bias generated through sponsorship, where this might impinge on professional judgement or impartiality;
- Neither agrees to practise under any conditions, which compromise professional independence or judgement, nor impose such conditions on other professionals.

Appendix B

Extract from The Medicines (Advertising) Regulations 1994

Inducements and hospitality

21.

(1) Subject to paragraphs (2) and (4), where relevant medicinal products are being promoted to persons qualified to prescribe or supply relevant medicinal products, no person shall supply, offer or promise to such persons any gift, pecuniary advantage or benefit in kind, unless it is inexpensive and relevant to the practice of medicine or pharmacy. It is essential therefore that Directors, and employees are transparent and understand the need to ensure that their actions cannot be misunderstood. All staff should follow the correct reporting channels if they receive any form of gift or hospitality and seek further clarity from the Finance Director, Trust Register holder or Human Resources if they are uncertain about what is acceptable.

(2) The provisions of paragraph (1) shall not prevent any person offering hospitality (including the payment of travelling or accommodation expenses) at events for purely professional or scientific purposes to persons qualified to prescribe or supply relevant medicinal products, provided that -

(a) such hospitality is at a reasonable level,

(b) it is subordinate to the main scientific objective of the meeting, and

(c) it is offered only to health professionals.

(3) Subject to paragraph (4), no person shall offer hospitality (including the payment of travelling or accommodation expenses) at a meeting or event held for the promotion of relevant medicinal products unless -

(a) such hospitality is reasonable in level,

(b) it is subordinate to the main purpose of the meeting or event, and

(c) the person to whom it is offered is a health professional.

(4) Nothing in this regulation shall affect measures or trade practices relating to prices, margins or discounts which were in existence on 1st January 1993.

(5) No person qualified to prescribe or supply relevant medicinal products shall solicit or accept any gift, pecuniary advantage, benefit in kind, hospitality or sponsorship prohibited by this regulation.

PROCEDURE DECISION MATRIX FOR ACCEPTANCE OF HOSPITALITY, SPONSORSHIP AND CASUAL GIFTS

BENEFIT	CIRCUMSTANCES (NOTE: IF IN DOUBT SPEAK TO LINE MANAGER OR DIRECTOR OF FINANCE (For medical staff, the line manager is taken to be the relevant medical director)	DECISION	SEEK APPROVAL (Appendix D)	APPROVAL YES/NO	INCLUDE IN REGISTER? (Appendix E)
CASH OF ANY VALUE	Please also note that the acceptance of personal monetary gifts is **NOT** acceptable in **any** circumstances as this could be seen as bribery. (Offers of money will be deemed to include vouchers of a monetary value, eg. gift vouchers.) However, it may be suggested to a donor to donate the cash gift directly to the Trust's charity as an alternative.	DECLINE (NO EXCEPTIONS)	NO, BUT NEED TO REPORT	NO	YES
1. CASUAL GIFTS					
GIFT VALUE =<£50 (Low intrinsic value)	If reasonable and in appropriate circumstances as per Para 5.1 of Procedure Notes.	ACCEPT	NO	N/A	NO
GIFT VALUE>£50 (Also multiple casual gifts from same source in 12 months >£50)	Unlikely to be reasonable and appropriate except in exceptional circumstances – see below	DECLINE	NO, BUT NEED TO REPORT	NO	YES
	Exceptional circumstances – seek approval of line manager and requires further secondary approval by Director of Finance (or in his absence the Deputy Director of Finance).	DECISION MADE ONLY **FOLLOWING** FORMAL APPROVAL	REQUIRED BY LINE MANAGER AND DIRECTOR OF FINANCE	YES/NO	YES (whether approved or not)
Gift from suppliers	Gifts from suppliers or contractors doing business (or likely to do business) with the Trust should be declined, whatever their value. This form should be submitted but does not require approval. (Low cost branded promotional aids such as pens or post-it notes may, however, be accepted where they are under the value of £6 in total, and need not be declared)	DECLINE	NO	NO	YES
2. HOSPITALITY					
VALUE <=£25 per person	Commensurate with Trust provision of such services and in appropriate circumstances as per Para 5.2 of Procedure Notes.	ACCEPT	NO	N/A	NO
VALUE >£25 and <=£75 per person	Commensurate with Trust provision of such services and in appropriate circumstances as per Para 5.2 of Procedure Notes.	ACCEPT BUT REFER TO LINE MANAGER BEFOREHAND	REQUIRED BY LINE MANAGER	YES	YES
VALUE >£75 per person	Dependant on circumstances - seek approval of line manager and requires secondary approval by Director of Finance (or in his absence the Deputy Director of Finance).	DECISION MADE ONLY **FOLLOWING** FORMAL APPROVAL	REQUIRED BY LINE MANAGER AND DIRECTOR OF FINANCE	YES/NO	YES (whether approved or not)
3. COMMERCIAL SPONSORSHIP (inc fees for speaking)					
VALUE <=£25 per person	Commensurate with Trust provision of such services and in appropriate circumstances as per Para 5.3 of Procedure Notes.	ACCEPT	NO	N/A	NO
VALUE >£25 and <=£75 per person	Commensurate with Trust provision of such services and in appropriate circumstances as per Para 5.3 of Procedure Notes.	ACCEPT BUT REFER TO LINE MANAGER BEFOREHAND	REQUIRED BY LINE MANAGER	YES	YES

VALUE >£75 per person	Dependant on circumstances - seek approval of line manager and requires secondary approval by Director of Finance (or in his absence the Deputy Director of Finance).	DECISION MADE ONLY **FOLLOWING** FORMAL APPROVAL	REQUIRED BY LINE MANAGER AND DIRECTOR OF FINANCE	YES/NO	YES (whether approved or not)

St Helens and Knowsley Teaching Hospitals NHS Trust

Hospitality, Sponsorship and Gift Declaration Form

This form **must** be completed for each instance that you are offered hospitality, sponsorship or a gift from any individual or organisation. A definition of each benefit is provided on the last page; to view this now click the "Benefit Definitions" button below. To start completing the form select the Type of Benefit below and the form will guide you through the process.

Once you have completed the relevant sections as guided by the form please post your completed form to "P.A to Director Finance, Executive Offices".

Type of Benefit: Gift from other sources | Print Form | Save Form | Benefit Definitions

Please complete the details of your Gift declaration below:

Type of Gift:

Description of Gift:

Donor of Gift *(both the name of the company and person offering the Gift)*:

Value of Gift £: (If not known estimate) £85.00

Gift Value > £50 - Unlikely to be reasonable and appropriate except in exceptional circumstances. Consequently, acceptance of this gift is provisional until you have been granted approval from your line manager and the Director of Finance. If the gift is declined you should still declare by completing this form but no further approval is required.

Date Gift offered:

Decision:

Recipient Details: *Please complete and sign. If approval is required send to your line manager. If no approval is required send to: "P.A to the Director of Finance".*

Employee Name: Job Title:

Department:

Signed By Date

Line Manager Approval: *Please complete, sign and send to: "P.A to the Director of Finance".*

Manager Name: Decision: Approved ☐ Rejected ☐

Email: Telephone:

Comments:

Signed By Date

Director of Finance Approval: *Please complete and inform the recipient of the decision.*

Decision: Approved ☐ Rejected ☐

Comments:

Signed By Date

Page 1 of 2 Version 2

Hospitality, Sponsorship and Gift Declaration Form

Go to Page 1

Benefit Definitions:

The definitions below are a guide to what to include under each benefit type and must be considered in conjunction with the decision matrix for acceptance of hospitality, sponsorship or casual gifts which can be found in Appendix C of the "Standards of Business Conduct inc Managing Conflicts of Interest in the NHS" policy.

Hospitality

Hospitality includes meals, hotel accommodation, entertainment, invitations to sporting events etc. It can only be considered for acceptance if in line with the provisions in a or b below: -
(a) there is a benefit to the Trust;
(b) it is reasonable in the circumstances and commensurate with normal activity, e.g. lunches in the course of working visits or educational meetings etc. may be acceptable though it should be similar to the scale of hospitality which the Trust might offer or the person might arrange for themselves. Such hospitality must be secondary to the purpose of the meeting.

Sponsorship

Sponsorship includes commercial sponsorship for attendance at relevant conferences and courses, sponsored events, support of local research and sponsorship of or towards research/clinical posts. It should only be considered for acceptance if there is a clearly defined benefit to the organisation for allowing the sponsorship and full details of the sponsorship and organisational benefits are provided.

Gifts

Casual gifts of low intrinsic value from patients or relatives, such as pens, diaries etc. can be considered for acceptance if reasonable and in appropriate circumstances.

Cash

Cash includes money and vouchers of a monetary value, eg. gift vouchers. The acceptance of personal monetary gifts is **NOT** acceptable in any circumstances as this could be seen as bribery. However, it may be suggested to a donor to donate the cash gift directly to the Trust's charity as an alternative.

Note: When completing the donor section of the form please specify whether the donor is a current, planned or potential provider/supplier of services or goods to the Trust.

Further Information

If you are not sure if you need to make a submission please consult the "Standards of Business Conduct inc Managing Conflicts of Interest in the NHS" which includes in Appendix C a decision matrix for the acceptance of Casual Gifts, Hospitality and Sponsorship, that should be of assistance in addition to the hints in this form, a link to the document is below: -

http://www.sthk.nhs.uk/pages/LearningAndDevelopment.aspx?iPageId=3315

You may also want to read the "Anti-Fraud, Bribery and Corruption Policy" found at the link below: -

http://www.sthk.nhs.uk/pages/policies.aspx?iPageId=2707

For Office Use Only:	
Register reference number:	
Date of entry on register:	
Entered on register by: (print name)	
Entered on register by: (signature)	

Note:
This form, whether requiring secondary approval or not from the Director of Finance, should be forwarded immediately by the line manager to the Personal Assistant to the Director of Finance, Executive Offices, Whiston Hospital (contact number 0151 430 1477). Where secondary approval of the Director of Finance is required, the Personal Assistant to the Director of Finance will endeavour to contact the named line manager and, if necessary, the recipient of the gift offer with the Director of Finance's decision within a timeframe of two working days.

Codes for each benefit types:

C1	Donation of Money
G1	Gift from suppliers or contractors
G2	Gift from other sources
H1	Hospitality from suppliers or contractors
H2	Hospitality from other sources
S1	Sponsorship/Support to Attend International Meeting
S2	Sponsorship/Support to Attend National Meeting
S3	Support of Local Research
S4	Sponsorship of or Towards Research Post
S5	Sponsorship of or Towards Clinical Post
S6	Payment for Pharmaceutical Company Research ("Drug Studies")
S7	Sponsored events
S8	Other Sponsorship

"Line" Managers:
Line managers who are authorised to approve such forms are, for this purpose, those with a seniority level of at least that of an Assistant Director or equivalent. If in doubt, please refer to the Deputy Director of Finance or the Director of Finance.

For medical staff the line manager equivalent is the relevant medical director.

Guidance Notes for Completion of Hospitality, Sponsorship and Gift Declaration Form (Appendix E)

1. Introduction

1.1 All Trust employees must complete an appropriate declaration form and return to their Line Manager when there is an offer of gifts in excess of £50 or hospitality or commercial sponsorship in excess of £25 **whether you intend to accept it or not**. There is one official Trust form which covers Hospitality, Sponsorship and Casual Gift declarations (see Appendix D). The form allows for the entry in the Trust's Hospitality, Sponsorship and Casual Gifts Register (see Appendix F) which is maintained by the PA to the Director of Finance, Executive Offices, Whiston Hospital. **Note that offers of personal monetary gifts (Cash) should also be declared on the form but must not be accepted under any circumstances.**

1.2 The completion of the declaration form should be done in accordance with the Trust guidance notes specified in the Trust's Standards of Business Conduct incorporating Managing Conflicts of Interest in the NHS and in conjunction with the procedure decision matrix at Appendix C. Declaration forms also contain helpful prompts especially when completed electronically which officers are requested to do.

1.3 If several employees receive joint support, or if there is doubt about who receives support, then all relevant employees must include the item in their return.

1.4 Returns will be audited for accuracy and evidence of conflict of interest or "undue influence".

1.5 The register will be reviewed annually by the Trust's Audit Committee.

2. Information Required

2.1 The information required in either form should be self-explanatory. If in doubt, please refer to your line manager, Deputy Director or Finance or the Director of Finance.

2.2 All parts of the form need completing by the recipient of the hospitality/sponsorship/gift with exception of the section reserved for office use and the section reserved for secondary approval by the

Director of Finance. Where secondary approval is required the form should be forwarded to the PA to the Director of Finance; the reserved section will be completed by the Director of Finance and the intended recipient of the gift will be notified of approval of rejection within two working days. The section reserved for office use will be completed by the PA to the Deputy Director of Finance and details entered on the Trust's Hospitality, Sponsorship and Casual Gifts Register.

2.3 A detailed explanation of the hospitality/sponsorship/gift must be given. In addition to the space on the declaration form, staff are encouraged to append as much relevant information as possible. However, the declaration form must be completed in all cases. A code (see below) for the hospitality/sponsorship/gift type should also be stated as a help to understand the nature of the gift/sponsorship/hospitality and for use in reporting.

2.4 Codes are shown on the second page of the declaration form. They are reproduced below:

C1: Donation of Money
G1: Donation of Goods or Equipment
G2: Other Gift
H1: Hospitality
S1: Sponsorship/Support to Attend International Meeting
S2: Sponsorship/Support to Attend National Meeting
S3: Support of Local Research
S4: Sponsorship of or Towards Research Post
S5: Sponsorship of or Towards Clinical Post
S6: Payment for Pharmaceutical Company Research ("Drug Studies")
S7: Other Sponsorship

2.5 Where approval is required before acceptance of the gift, hospitality or sponsorship then the member of staff's line manager should sign the declaration form and indicate whether approved or rejected. Only line managers of a certain seniority can approve such forms; for this purpose a "line manager" is deemed to be at least at Assistant Director level or equivalent. If in doubt, please refer to the Deputy Director of Finance or the Director of Finance for guidance. For medical staff the line manager equivalent is deemed to be the relevant medical director.

Appendix F

ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST

TRUST REGISTER OF HOSPITALITY, SPONSORSHIP AND CASUAL GIFTS

Ref No	Year	Date Recorded	Date Benefit Received	Code (see below	Employee name	Position Held	Dept / Directorate	Description of Benefit	Estimated Value £	Name of Sponsor/ Benefactor	Accepted/ Declined	Authorised by	Position	Action Take?

Codes:
C1: Donation of Money
G1: Gift from suppliers or contractors
G2: Gift from other sources
H1: Hospitality from suppliers or contractors
H2: Hospitality from other sources
S1: Sponsorship/support to attend international meeting
S2: Sponsorship/support to attend national meeting
S3: Support of local research
S4: Sponsorship of or towards research post
S5: Sponsorship of or towards clinical post
S6: Payment for Pharmaceutical Company Research (Drug studies)
S7: Sponsored events
S8: Other Sponsorship (please specify)

Declaration of Interests

Purpose of the Declaration

The rules relating to Public Accountability require the Trust to confirm that all staff who are responsible for expenditure can exercise their duties and responsibilities without prejudicing the principle of accountability.

In so far as there are any circumstances or relationships which may be seen to inhibit the application of accountability it is necessary for a declaration of interests to be made in writing.

The declaration is not an attempt to infringe personal liberties and staff are entitled to determine the nature and extent of any relationships. The declaration does, however, afford Trust management the opportunity to take appropriate action to protect the interests of both staff and the Trust in the context of public accountability.

This form is about declaring relationships; the declaration of individual instances of hospitality, sponsorship and gifts should be done using the "Hospitality, Sponsorship and Gift Declaration Form" which includes a formal process for approval.

Extent of Declaration

The general advice is that all possible circumstances/relationships should be declared. This will afford the opportunity for a view to be taken as to whether the declaration is sufficient to warrant appropriate action to be taken to avoid a possible conflict. If in doubt as to whether to make a formal declaration staff should consult with their line manager or any Board Member.

Standing Financial Instructions / Standing Orders

Before making a declaration it may be helpful if reference is made to the Trust's Standing Financial Instructions (SFIs) and Standing Orders (SOs). These are contained within the Trust's Corporate Governance Manual which is available on the Trust's intranet.

Code of Conduct

Reference should also be made to the Standards of Business Conduct inc Managing Conflicts of Interest in the NHS, which reflect how staff are expected to perform their duties on behalf of the Trust. Staff making a declaration should be familiar with the code.

The purpose of this form is to provide Trust Management with information about your other interests that could influence your decisions at work. The form has four parts.

1. Relevant information about relevant financial relationships with outside organisations.

Please report all sources of revenue relevant to the submitted work that accrued either directly to you or were paid to the Trust on your behalf over the 12 months prior to submission of this declaration. If there is any question, it is usually better to disclose a relationship than not to do so. For each category list each entity on a separate line. Use as many lines as necessary to provide complete information. In addition, please disclose relationships that fall outside the 12-month window that Trust Management may want to know about and could reasonably criticise you for not disclosing (for example, long-term financial relationships that are now ended).

The goal of this section is to provide information for Trust Management about your interactions with ANY organisation (biomedical or otherwise) that could be perceived to influence, or that give the appearance of potentially influencing, your business decisions in the workplace. You should disclose interactions with ANY organisation that has or could potentially have business transactions with the Trust.

Declaration of Interests

2. Financial and non-financial relationships involving family members, close friends or other relevant acquaintances.

If monies from the types of relationships listed in Section 1 were paid to any family members, close friends or other relevant acquaintances please list the type of activity and source of the money.

3. Non-financial associations.

Please report any personal, professional, political, institutional, religious, or other associations Trust Management may want to know about and could reasonably criticise you for not disclosing.

4. Declaration.

This includes a section for signing your declaration. If you have nothing to declare please tick the box in Section 4.

Section 1. Information about relevant financial relationships with outside organisations.

Place a check in the appropriate boxes in the table to indicate whether you have financial relationships (regardless of amount of compensation) with any organisations (eg. suppliers) that have or may have any business dealings with the Trust. Use one line for each organisation; add as many lines as you need. Use the comments column to indicate any additional information that you think Trust Management would want to know about the arrangement. Report relationships that were present during the 12 months prior to submission. In addition please disclose relationships that fall outside the 12-month window that Trust Management may want to know about and could reasonably criticise you for not disclosing (for example, long-term financial relationships that are now ended).

For guidance on completion of the table below please see Appendix A "Guidance on completion of Declaration of Interests Form". Click the button below to view the guidance notes.

View Guidance Notes

If you have more than one relationship, click "Add +" to add a row. Click "Del -" to delete an extra row.

Type of Relationship	No	Money Paid to You	Money to the Trust	Organisation	Comments	
Outside Employment						Del -
						Add +
Shareholdings and other ownership issues						Del -
						Add +
Loyalty interests						Del -
						Add +
Clinical private practice						Del -
						Add +
Consultancy						Del -
						Add +
Expert testimony						Del -
						Add +
Gifts / donations						Del -
						Add +

Current version is held on the policy section of the intranet

Declaration of Interests

Type of Relationship	No	Money Paid to You	Money to the Trust	Organisation	Comments	
Research Income - all sources						Del -
						Add +
Honoraria						Del -
						Add +
Payment for manuscript preparation						Del -
						Add +
Patents (planned, pending or issued)						Del -
						Add +
Royalties						Del -
						Add +
Payment for development of educational presentations including service on speakers' bureaus						Del -
						Add +
Stock / stock options						Del -
						Add +
Travel / accomodation expenses covered or reimbursed						Del -
						Add +
Other (err on the side of full disclosure)						Del -
						Add +

Section 2. Financial and non-financial relationships involving family members, close friends or other relevant acquaintances.

Do any family members, close friends or other relevant acquaintances have financial or non-financial relationships with any organisations (eg. suppliers) that have or may have any business dealings with the Trust?

No other relationships/conditions/circumstances that present potential conflict of interest

Yes, the following relationships/conditions/circumstances are present (explain below):

Current version is held on the policy section of the intranet

Declaration of Interests

Section 3. Information about relevant non-financial (non-pecuniary) associations.

Do you have any relevant non-financial associations or interests (personal, professional, political, institutional, religious, or other) that have or may have any business connections with the Trust?

☐ No relevant nonfinancial relationships/conditions/circumstances to report.

☐ Yes, the following relevant nonfinancial relationships/conditions/circumstances are present (explain below):

Section 4. Declaration Save Print Form

☐ I have nothing to declare.

First Name: ______ Surname: ______ Date: ______

Job Title: ______ Department: ______

To the best of my knowledge the information I have provided is correct and that I will update as necessary in accordance with Trust policy. I understand that the information could be made public (for example, as a result of Freedom of Information requests, etc). I understand the potential consequences including but not limited to disciplinary action, legal action, referral to professional body, of providing misleading/false information, including by omission, on the declaration (see section 1 in particular of the Standards of Business Conduct inc Managing Conflicts of Interest in the NHS Policy).

____
Signed By

Return Options:

Option 1
You can simply save the form and send to us by email. As the form is not signed it will need to come from your NHS email account so we can validate you have sent the completed form.

Option 2
Print and sign the form, scan the form and return from any email account.

Option 3
Print and sign the form and return via post.

Completed forms should be emailed to declarationofinterests@sthk.nhs.uk or posted to the Executive Offices and marked "Declaration of Interests Officer".

Declaration of Interests

Appendix A. Guidance on completion of Declaration of Interests Form.

These guidelines are to assist you with completion of Section 1 of the Declarion of Interests Form.

Type of Relationship	Description
Outside Employment	Include any existing employment other than with the Trust on appointment and any new outside employment when it arises.
Shareholdings and other ownership issues	Include any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business partnership or consultancy which is doing or might be reasonably expected to do,business with the Trust. This section should also include work undertaken for the Trust through a personal service company, for example, or as a self-employed contractor.
Loyalty interests	Include any position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions taken in your Trust role.
Clinical private practice	Include all private practice on appointment, and/or any new private practice when it arises
Consultancy	Include all organisations or individuals from whom you have received remuneration for consultancy/professional services provided.
Expert Testimony	Include all organisations or individuals from whom you have received remuneration for Expert Testimony.
Gifts / donations	Include any gifts received from organisations or individuals. Donations made by suppliers or bodies seeking to do business with the organisation should be treated with caution and not routinely accepted. Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued.
Research Income - all sources	Include all organisations or individuals from whom you have received research income.
Honoraria	Include all organisations or individuals from whom you have received an hororarium.
Payment for manuscript preparation	Include any organisations or individuals from whom you have received remuneration for the preparation of a manuscript.
Patents (planned, pending or issued)	Include any organisation or individual from who you have received remuneration for a Patent (planned, pending or issued).
Royalties	Include all organisations or individuals from whom you have received a Royalty payment.
Payments for development of educational presentations including service on speakers' bureaus	Include any organisation or individual from whom you have received remuneration for developing educational presentations. You should also include any payments from speakers' bureaus in this section.
Stock / stock options	Include any organisation or individual from who you have received Stock or Stock options. This should include any shareholdings of companies (5% or more) in any company but particularly in the health/social care field.
Travel / accommodation expenses covered or reimbursed	Include any organisation or individual who have covered or from whom you have received reimbursement for travel /accommodation expenses.
Other (err on the side of full disclosure)	Include anything here which is not covered by any of the above but for which you could be reasonably criticised for not disclosing.

Go to Section 1

Appendix H

ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST

REGISTER OF INTERESTS

Year	Date of Entry in Register	Name	Role	Description of Interest (Drop down list)	Organisation	Relevant Dates		Comments
						From	To	

6. EQUALITY ANALYSIS

Equality Analysis Stage 1 Screening		
Title of Policy	Trust Standards of Business Conduct	
Policy Author (s)	Original policy based on National Standards of Business Conduct from which local policy produced and updated by Assistant Director of Finance (Financial Services) assisted by the Local Counter Fraud Specialist	
Lead Executive	Director of Finance	
Policy Sponsor	Director of Finance	
Target Audience	All Trust staff	
Document Purpose		
Please state how the policy is relevant to the Trusts general equality duties to: • Eliminate discrimination • Advance equality of opportunity • Foster good relations	Not relevant	
List key groups involved or to be involved in the policy development (e.g. staff side representatives, service users, partner agencies) and how these groups will be engaged	Not relevant	
Does the policy **significantly** affect one group **less** or **more** favourably than another on the basis of: answer 'yes/no' (please add any qualification or explanation to your answer particularly if you answer yes)		
	Yes/No	**Comments/Rationale**
• Race/ethnicity	No	
• Disability (includes learning disability, physical or mental disability and sensory impairment)	No	
• Gender	No	
• Religion / belief (including non belief)	No	
• Sexual orientation	No	
• Age	No	
• Gender reassignment	No	
• Pregnancy and maternity	No	
• Marriage and civil partnership	No	
• Career status	No	
Will the policy affect the human rights of any of the above protected groups?	No	
If you have identified potential discrimination, and there are any exceptions valid, legal and or justifiable?	N/a	
If you have identified a negative impact	N/a	

on any of the above protected groups, can the impact be avoided or reduced by taking different action?		
How will the effect of the policy be reviewed after implementation?	N/a	
Name of the manager completing assessment: (must be one of the authors)	David Brimage	
Job title of manager completing the assessment	Assistant Director of Finance (Financial Services)	
Date of completion	6.10.2017	

7. TRAINING

There is no formal training required to support this policy.

TRUST BOARD

Paper No: NHST(17)093
Title of paper: Charitable Funds Accounts and Annual Report
Purpose: Note the approval of the Charitable Funds Annual Accounts and Annual Report 2016-17 by the Charitable Funds Committee at their meeting held 19th October 2017.
Summary: The Charitable Funds Annual Accounts and Annual Report 2016-17 were approved by the Charitable Funds Committee on behalf of the Trustee (ie the Trust Board) after the independent examiner's report done by Grant Thornton, external auditors.
Corporate objectives met or risks addressed: Contributes to the Trust's objectives regarding Finance, Performance, Efficiency and Productivity.
Financial implications: None as a direct consequence of this paper
Stakeholders: The Trust, its staff and all stakeholders.
Recommendation(s): Ratify the approval of the Charitable Funds Annual Accounts and Annual Report 2016-17
Presenting officer: Denis Mahony, Non-Executive Director, and Committee Chair.
Date of meeting: 25th October 2016

TRUST BOARD

Paper No: NHST(17)094
Title of paper: Strategic and Regulatory Update Report
Purpose: To provide the Board with assurance that the Trust continues to take account of external strategic developments that could impact the future direction of the organisation and all regulatory requirements to comply with governance good practice.
Summary: 1. Draft Health Service Safety Investigations Bill To inform the Board of the provisions of the draft bill that was laid before parliament in September 2017. 2. Care Quality Commission (CQC) Regulating Health and Social Care 2016-17 To summarise the key points from the annual CQC Report on its regulatory activities and the state of Health and Social Care. 3. Board Development Programme To present the outline Board Development programme for the year ahead. 4. Planning guidance To provide an update on 2018/19 planning guidance from NHSI.
Corporate objectives met or risks addressed: Provide high quality sustainable services
Financial implications: This paper does not include a request for additional funding
Stakeholders: Patients, Staff, Alliance LDS Partners, C&M FYFV, Commissioners, NHSI
Recommendation(s): The Board notes the report
Presenting officer: Nicola Bunce, Interim Director of Corporate Services
Date of meeting: 25th October 2017

Strategic and Regulatory Update Report

1. Draft Health Service Safety Investigations Bill

   In September a Bill was laid before parliament to create a statutory Health Service Safety Investigations Body, to replace the Healthcare Safety Investigation Branch that has operated as part of NHS Improvement since April 2017.

   This is one of the few pieces of healthcare legislation to be included in the Queen's speech to be considered in this parliament.

   The draft Bill will enshrine in law a mandate from the Department of Health to investigate patient safety incidents. The Body will be independent from the NHS and at arms-length from government, and its purpose will be to learn lessons that can inform future patient safety policy.

   Once formed the Health Service Safety Investigation Body (HSSIB) will have
   - Clear powers to conduct independent and impartial investigations into patient safety risks in the NHS in England.
   - To create a prohibition on the disclosure of information held in connection with an investigation conducted enabling participants to be as candid as possible. (This prohibition will not apply where there is an ongoing risk to the safety of patients or evidence of criminal activity, in which case the HSSIB can inform the relevant regulator or the police.)

   There appears to be some overlap in the remits between the Care Quality Commission (CQC) and this new Body as detailed in the draft Bill; however one of the key differences between the HSSIB and CQC is the responsibility to disclose findings and reports. Whilst the CQC will continue to be obliged to publically disclose findings and reports, the HSSIB will not. The reasoning for this is to help create a culture of openness. Secretary of State for Health Jeremy Hunt said.

   "When significant errors occur it is vital that health organisations react quickly and decisively to share lessons and make improvements. To achieve this we need to create an environment where patients, public and healthcare professionals all feel able to speak out about their concerns, without fear or favour."

   The HSSIB will also be able to accredit NHS Organisations who have met the required standards for investigating and learning lessons from incidents that happen within their services.

   The draft Bill will now be scrutinised by the Health Select Committee.

2. CQC Regulating Health and Social Care 2016-17

   Each year the CQC publishes an assessment of the quality performance, trends and themes from the provider organisations it has inspected.

The CQC has now completed an inspection of all registered providers, including NHS Trusts, GPs and Care Homes (including 152 acute and specialist hospitals, 18 community health trusts, 54 mental health trusts and 10 ambulance services).

Some providers have been re-inspected and the common factors identified for those whose ratings improved were;

- Strong visible leadership
- Engaged staff
- Strong governance
- Implementing a quality improvement culture
- Clear vision and values
- Strong collaboration with local partners
- Active involvement of patients and families in care
- A strong commitment to equality

Acute trust ratings overall and by key question

Source: CQC ratings data, 31 July 2017, total 152 providers.

Key messages from the report are;

- Increasing demand and complexity means that the entire health and social care system is at "full stretch"
- NHS staff have worked hard to protect and maintain quality, but some providers have seen quality deteriorate
- Staff resilience is a concern, against the back drop of increased pressures and workforce shortages
- Adult Social Care (ASC) may be reaching a tipping point and a long term solution for the sustainable funding of these services is needed
- Fines for delayed transfers of care (DTOC) are causing tensions and impeding collaborative working

- Better care requires more joined up services and better partnership working to build care around people's needs.

Some of the key statistics contained in the report are useful context for the Board when considering how to plan services and respond to the challenges locally;

- Since 2010/11 hospital beds have reduced by 8% while the number of people admitted has risen by 16%, accommodated by reducing the average length of stay for patients
- Bed occupancy has been over 85% since 2012/13, and between January – March 2017 was the highest ever recorded at 91.4%
- Emergency admissions, elective admissions and ambulance calls have risen by 20% in four years
- There has been an increase of 18% in the number of older people who do not receive social care support – in 1 year
- Social care capacity has reduced by 2% (4000 beds) since March 2015
- GP numbers are rising but there are fewer full time and fewer per head of population
- 23% of ASC have deteriorated when re inspected
- 43 councils reported contracts being handed back

3. Board Development Programme

The draft Board Development Programme for the year ahead is attached (appendix A).

These proposals have been developed based on best practice guidance, the themes emerging from Director appraisals and identified development needs, and the initial review of the new Well led Framework.

The programme will be based around the planned schedule of Board meetings and two time out sessions, the first scheduled for early November.

The programme will maintain some flexibility to respond to events and emerging issues.

4. Planning Guidance

At the recent Quarterly Review Meeting with NHSI it was confirmed that there will be no planning submissions required before Christmas for the 2018/19 financial year. This is on the basis that last year all trusts submitted a two year financial and operational plan, and has signed a two year contract.

The priority is for Trusts to plan for winter pressures in this period.

It is expected that the when planning guidance is published the first submission of 2018/19 plans will be required in February.

ENDS

Appendix A

DRAFT

BOARD DEVELOPMENT PROGRAMME 2017/18

Purpose	Provider/Lead	Date
Corporate Law update including briefing on the new data protection regulations	Hill Dickenson	25th October 2017 Strategy Board
Briefing on the new CQC Inspection Regime and Well Led Inspections	Sue Redfern/Nicola Bunce	
Increase understanding of the 2017/18 Winter Plan and how the system is working together	Rob Cooper	
• Trust Strategy 2018 – 2023 – How we respond to the changing NHS landscape • St Helens Cares and other ACO Plans – what it means for the Trust • Shared Health Record – as a key strategic enabler for integrated care • Stakeholder mapping and Board engagement strategy • Emergency Planning – Swedish Delegation Presentation	Ann Marr Tiffany Hemming Christine Walters Anne-Marie Stretch/Nicola Bunce NewHospitals & Andy Ashton	Board Time Out 1st & 2nd Nov
Review of progress against 2017/18 objectives and implications for the 2018/19 Operational Plan changes*	Nik Khashu	29th November 2017 Board Meeting
Learning from the Halton System CQC Review	Sue Redfern	
Dementia Awareness Training	Marie Honey	31st January 2018
Planning to increase the profile, visibility and	Anne-Marie Stretch	

connection to front line services of Board Members		Strategy Board
Learning from Deaths – in depth review and understanding of Trust data prior to publication	Kevin Hardy	
CQC Relationship Manager – Board Observation and introduction to all the Board Members	Cara Taylor Hospital Inspector - Merseyside CQC(North West)	28th February 2018 Board Meeting
How technology and innovation will shape future health care – implications for the Trust	TBC	28th March 2018 Strategy Board
Approval of 2018/19 operational plan and budgets	Nik Khashu	
Approval of the 2018/19 Trust Objectives and IPR Framework	Ann Marr	25th April 2018 Board Meeting
Review of "winter" 2017/18 and lessons learnt	Rob Cooper	
• Strategic and tactical planning /responding to the changing NHS landscape. • Assurance of strategic delivery – the Trusts supporting strategies		Board Time Out April/May TBC
Feedback from Independent Well Led Review?	Nicola Bunce	29th May 2018 Strategy Board
Non-executive Directors – Mandatory Training	L&D	
Presentation of the Quality Account and review of the 2018/19 quality improvement plan	Sue Redfern	
Annual Board Effectiveness Review Feedback and development recommendations	Nicola Bunce	27th June 2018 Board Meeting
TBC		25th July 2018 Strategy Board

	Board Time Out Events
	Board Meeting
	Strategy Board

TRUST BOARD

Paper No: NHST(17)095
Title of paper: Review of the Board Assurance Framework (BAF) – September 2017
Purpose: For the Committee to review the BAF and agree proposed changes to be recommended to the Trust Board.
Summary: The BAF is the mechanism used by the Board to ensure it has sufficient controls in place and is receiving the appropriate level of assurance in relation to its strategic plans and objectives. In line with governance best practice the BAF is reviewed by the Board four times a year. The last review was in July 2017. The Executive Committee review the BAF in advance of its presentation to the Trust Board and make proposed changes to ensure that the BAF remains current, that the appropriate strategic risks are captured, and that the proposed actions and additional controls are sufficient to mitigate the risks being managed by the Trust, in accordance with the level of risk appetite acceptable to the Board. **Key to proposed changes:** ~~Score through~~ = proposed deletions Blue Text = proposed additions Red = overdue actions It is suggested that the risk score for strategic Risk 8 - Major and sustained failure of essential IT systems initial risk be increased to 20 and the residual risk be increased to16 as a result of the increased cyber security threats and recent data security incidents.
Corporate Objective met or risk addressed: To ensure that the Trust has put in place sufficient controls to assure the delivery of its strategic objectives.
Financial implications: None arising directly from this report.
Stakeholders: NHSI, CQC, Commissioners.
Recommendation(s): To review and approve the proposed changes to the BAF.
Presenting officer: Nicola Bunce, Interim Director of Corporate Services.
Date of meeting: 25th October 2017

Strategic Risks – Summary Matrix

Vision: 5 Star Patient Care

Mission: To provide high quality health services and an excellent patient experience

BAF Ref	Long term Strategic Risks	Strategic Objectives					
		We will provide services that meet the highest quality and performance standards	We will work in partnership to improve health outcomes	We will be the hospital of choice for patients	We will respond to local health needs	We will attract and develop caring highly skilled staff	We will be a sustainable and efficient organisation
1	Systemic failures in the quality of care	✓		✓	✓	✓	✓
2	Failure to agree a sustainable financial plan with commissioners	✓		✓		✓	✓
3	Sustained failure to maintain operational performance/deliver contracts	✓	✓		✓	✓	✓
4	Failure to protect the reputation of the Trust			✓			✓
5	Failure to work in partnership with stakeholders	✓	✓	✓	✓		✓
6	Failure to attract and retain staff with the skills required to deliver high quality services	✓				✓	✓
7	Major and sustained failure of essential assets, infrastructure	✓	✓	✓			✓
8	Major and sustained failure of essential IT systems	✓	✓	✓			✓

Alignment of Trust 2017/18 Objectives and Long Term Strategic Aims

2017/18 Trust Objectives	Strategic Aims					
	We will provide services that meet the highest quality and performance standards	We will work in partnership to improve health outcomes	We will be the hospital of choice for patients	We will respond to local health needs	We will attract and develop caring highly skilled staff	We will be a sustainable and efficient organisation
Five star patient care – Care						
Five star patient care – Safety						
Five star patient care – Pathways						
Five star patient care – Communication						
Five star patient care – Systems						
Organisational culture and supporting our workforce						
Operational performance						
Financial performance, efficiency and productivity						
Strategic Plans						

Risk Scoring Matrix

Impact Score	Likelihood /probability				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible (very low)	1	2	3	4	5

Likelihood – Descriptor and definition
Almost certain - More likely to occur than not, possibly daily (>50%)
Likely - Likely to occur (21-50%)
Possible - Reasonable chance of occurring, perhaps monthly (6-20%)
Unlikely - Unlikely to occur, may occur annually (1-5%)
Rare - Will only occur in exceptional circumstances, perhaps not for years (<1%)
Impact - Descriptor and definition
Catastrophic – Serious trust wide failure possibly resulting in patient deaths / Loss of registration status/ External enquiry/ Reputation of the organisation seriously damaged- National media / Actual disruption to service delivery/ Removal of Board
Major – Significant negative change in Trust performance / Significant deterioration in financial position/ Serious reputation concerns / Potential disruption to service delivery/Conditional changes to registration status/ may be trust wide or restricted to one service
Moderate – Moderate change in Trust performance/ financial standing affected/ reputational damage likely to cause on-going concern/potential change in registration status
Minor – Small or short term performance issue/ no effect of registration status/ no persistent media interest/ transient and or slight reputational concern/little financial impact.
Negligible (very low) – No impact on Trust performance/ No financial impact/ No patient harm/ little or no media interest/ No lasting reputational damage.

Risk 1 – Systemic failures in the quality of care	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause: • Failure to deliver the Clinical and Quality standards and targets • Failure to deliver CQUIN element of contracts • Patient experience indicators decline • Breach of CQC regulations • Unintended CIP impact on service quality • Availability of resources to deliver safe standards of care • Failure in operational or clinical leadership • Failure of systems or compliance with policies • Failure in the accuracy, completeness or timeliness of reporting Effects: • Poor patient experience • Poor clinical outcomes • Increase in complaints • Negative media coverage Impact: • Harm to patients • Loss of reputation • Loss of contracts/market share	5x4= 20	• Quality metrics and clinical outcomes data • Safety thermometer • Quality Ward Rounds • Complaints and claims • Incident reporting and investigation • Quality Governance structure • Risk Assurance and Escalation policy • Contract monitoring • CQPG meetings with lead CCG • NHSI Single Oversight Framework • Appraisal and revalidation processes • Clinical policies and guidelines • Mandatory Training • Lessons Learnt reviews • Clinical Audit Plan • Quality Improvement Action Plan • Clinical Outcomes Group • Ward Quality Dashboards • CIP Quality Impact Assessment Process • IG monitoring and audit • CQC Action Plan • Medicines Optimisation Strategy	To Board; • IPR • Patient Stories • Quality Board Round reports • Quality Committee and its Councils • Audit Committee • Finance and Performance Committee • Infection control, Safeguarding, H&S, complaints, claims and incidents annual reports • Staff Survey • Friends and Family scores • Nursing Strategy • Learning from Deaths Mortality Review Reports • Quality Account • Internal audit • National Inpatient Survey Other; • National clinical audits • External inspections and reviews • GIRFT Reviews • PLACE Inspections Reports • CQC CIH Inspection Report • Learning Lessons League • IG Toolkit results • Model Hospital benchmarking	5 x2 = 10	Quarterly publication of avoidable deaths data (Jan 2018)	Full Implementation of the midwifery led care pathway for women having low risk births (November 2017) Plans to achieve 30% of discharges by midday Improvement plans for Falls, Infection Control and Pressure Ulcers Recovery plan for VTE ahead of IT solution (November 2017)	Delivery of the remaining CQC (Should do) Actions (September 2017) Implementation plans the four key 7-day service standards in 2017/18 Implementation of Stroke Service integration with WHH – phase 2 planned completion in 2017/18 Improve F&F response rates (March 2017) Benefits realisation from the delivery of the St Helens community services contract by March 2018	5 x 1 = 5	KH/ SR

Risk 2 – Failure to agree a sustainable financial plan with commissioners	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to achieve the Trusts statutory breakeven duty • Failure to develop a strategy for sustainable healthcare delivery with partners and stakeholders • Failure to deliver strategic financial plans and two year operational plan, including the agreed control total • Failure to control costs • Failure to implement transformational change at sufficient pace • Failure to continue to secure national PFI support • Failure to respond to commissioner requirements • Failure to respond to emerging market conditions • Failure to respond to new models of care (FYFV) Effects; • Failure to meet statutory duties • NHSI Segmentation Status increases Impact; • Unable to deliver viable services • Loss of market share • External intervention	5 x 5 = 25	• Two year Operational Plan and STP financial Modelling • Business Planning • Budget setting • CIP plans and assurances processes • Monthly financial reporting • Service line reporting • 5 year capital programme • Productivity and efficiency benchmarking (ref costs, Carter Review) • Contract monitoring and reporting • Contract review Board and CQPG • Activity planning and profiling • IPR • NHSI monthly monitoring submissions • Creation of a PMO to support delivery of CIP and service transformation • Signed Contracts with all Commissioners • Application of agency caps • Internal audit programme	To Board; • Finance and Performance Committee • Annual financial plan • Monthly finance report • IPR • Statement of Internal Control • Annual Accounts • Audit Committee • External Audit Reports Inc. VFM assessment • SLM Reporting and commercial assessment matrix • Agency and locum spend approvals and reporting process • Benchmarking and market share reports • Annual audit programme • STF Targets and Control Total Other; • NHSI monthly reporting • Contract Monitoring Board • NHSI Review Meetings • Use of Resources reviews	5 x 4 =20	Agree a shared health economy financial and sustainability strategy/control total Develop 2017 - 19 detailed CIP plans Establish a benchmarking and reference cost group 2017/18 financial recovery plan	Develop capacity and demand modelling capability and a consistent approach to service development proposals approval Foster positive working relationships with health economy partners to help create a joint vision for the future of health services Prompt payment of lead employer invoices by other NHS organisations to maintain cash balances (October 2017)	~~PMO impact assessment and ROI -March 2017~~ Develop a detailed STP implementation plan ~~with Alliance LDS and~~ C&M partners in line with the priorities outlined in the Next Steps FYFV plan Secure maximum SFT funding 2017/8 and 2018/19. Development of clear plans for the Trusts response to ACS/O development plans in St Helens, Halton and Knowsley, including legal form and risk/benefit analysis (February 2018)	4 x3 = 12	NK

Risk 3 - Sustained failure to maintain operational performance/deliver contracts	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to deliver against national performance targets (ED, RTT, Cancer etc) • Failure to reduce LoS • Failure to meet activity targets • Failures in data recording or reporting Effects; • Reduced patient experience • Poor quality and timeliness of care leading to poorer outcomes • Failure of KPIs and self-certification returns • Increases in staff workload/stress Impact; • Potential patient harm • Loss of reputation • Loss of market share/contracts • External intervention • Loss of STF funding	4 x 4 = 16	• NHS Constitutional Standards • Care group activity profiles and work plans • Winter Plan • Care Group Performance Monitoring Meetings • Team to Team Meetings • ED RCA process for breaches • Exec Team weekly performance monitoring • Waiting list management and breach alert system • ECIST review of A&E performance • A&E Recovery Plan • Capacity and Utilisation plans • CQUIN Delivery Plans • Capacity and demand modelling • A&E Delivery Board Membership ~~Membership of CCG System Resilience Groups~~ • Internal Urgent Care Action Group (UCAG) • Data Quality Policy	To Board; • Finance and Performance Committee • IPR • System Resilience Plan • Annual Operational Plan • Data Quality audits Other; • Contract review meetings/CQPG • NHSI monitoring and escalation returns/sitreps • CCG CEO Meetings	4 x 4 = 16	Surgical Care Group activity and RTT recovery plan (November 2017) Approved winter plan for the local system (November 2017) Approval of the A&E capital scheme to create a GPAU and expansion of GP streaming (November 2017)	Long term health economy emergency access resilience and urgent care services plans re NEL admissions and DTOC	Improvement Event Action Plans and Internal Improvement strategy – on going Work with NHSI and ECIP for practical intensive support to achieve 4-hour trajectory – March 2018 ~~Review of bed usage and allocation's to achieve maximum throughput to safeguard both RTT and emergency access and throughput performance (September 2017)~~	4 x 3 = 12	RC

Risk 4 - Failure to protect the reputation of the Trust	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to respond to stakeholders e.g. Media • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements • Failure of staff engagement and involvement • Failure to maintain CQC registration/Good Rating • Failure to report correct or timely information Effect; • Loss of market share/contracts • Loss of income • Loss of patient/public confidence and community support • Inability to recruit skilled staff • Increased external scrutiny/review • Delay in FT application timetable Impact; • Reduced financial viability and sustainability • Reduced service safety and sustainability • Reduced operational performance • Increased intervention	4 x 4 = 16	• Updated Communication and Engagement Strategy • Communications and Engagement Action Plan • Workforce Strategy • Publicity and marketing activity • Patient Involvement Feedback • Patient Power Groups • Annual Board effectiveness assessment and action plan • Board development programme • Internal audit • Data Quality • Scheme of delegation for external reporting • Social Media Policy • Approval scheme for external communication/ reports and information submissions • Well Led framework self-assessment and action plan • NED internal and external engagement programme • Trust internet and social media monitoring and usage reports	To Board; • Quality Committee • Audit Committee • Charitable funds committee • Communications and Engagement Strategy • IPR • Staff Survey • Complaints reports • Friends and Family • Staff F&F Test • PLACE Survey • National Cancer Survey • Referral Analysis Reports • Market Share Reports • CQC national patient surveys • CQC Inspection ratings • Annual assessment of compliance against the CQC fundamental standards Other; • Health Watch • CQC • NHSI Segmentation Rating	4 x 3 = 12	Regular media activity reports , including social media, to the Board/Committee	Action plan to improve understanding of patients and carers' views WRES Action Plan for 2017/18 (December 2017)	~~Review of corporate reporting and scheme of delegation for approval for external reporting – October 2015~~ New Trust intranet to be developed and launched - July 2017 Achievement of 90% complaints response times target for 2017/18 – March 2018 Staff engagement and leadership strategy review (January 2018)	4 x 2 = 8	AMS

Risk 5 – Failure to work effectively with stakeholders	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Different priorities and strategic agendas of multiple commissioners • Unable to create, sustain or grow shared services (eg Payroll, HR, and Pathology & Community services. • Competition amongst providers • Complex health economy • Poor staff engagement • Poor community engagement • Poor patient and public involvement Effect; • Lack of whole system strategic planning • Loss of market share • Loss of public support and confidence • Loss of reputation • Inability to develop new ideas and respond to the needs of patients and staff Impact; • Unable to reach agreement on collaborations to secure sustainable services • Reduction in quality of care • Loss of referrals • Inability to attract and retain staff • Failure to win new contracts • Increase in complaints and claims	4 x 4 = 16	• Communications and Engagement Strategy • Membership of Health and Wellbeing Boards • Representation on Urgent Care Boards/System Resilience Groups • JNCC/ Workforce Council • Patient and Public Engagement and Involvement Strategy • CCG CEO Meetings • Staff engagement strategy and programme • Patient power groups • Involvement of Healthwatch • CCG Board to Board Meetings • St Helens Peoples Board • Involvement in Halton and Knowsley ACS development • CCG Representative attending StHK Board meetings • Membership of specialist service networks and external working groups e.g. Stroke, Frailty, Cancer • Merseyside and Cheshire Sustainability and Transformation Planning governance structure • Acute Alliance LDS Exec to Exec working • StHK Hospitals Charity annual objectives	To Board; • Quality Committee • CEO Reports • HR Performance Dashboard • Board Member feedback and reports • NHSI Review Meetings • Review of digital media trends and trust mentions • Monitoring of and responses to NHS Choices comments and ratings • Charitable funds committee • Participation in the C&M STP leadership and programme boards • Partnership working with NWB NHSFT to deliver the St Helens Community Nursing Contract	4 x 3 = 12	Annual programme of engagement events with key stakeholders to obtain feedback and inform strategic planning	C&M STP performance and accountability framework reports to Board Development of methodology and governance arrangements to provide assurance on shared services & lead contractor arrangements.	C&M STP ~~and Alliance~~ shared implementation plans and accountability structures –to meet the requirements of Next Steps for the FYFV	4 x2 = 8	AMS

Risk 6 - Failure to attract and retain staff with the skills required to deliver high quality services	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Loss of good reputation as an employer • Doubt about future organisational form or service sustainability • Failure of recruitment processes • Inadequate training and support for staff to develop • High staff turnover • Unrecognised operational pressures leading to loss of morale and commitment Effect; • Increasing vacancy levels • Increased difficulty to provide safe staffing levels • Increase in absence rates caused by stress • Increased incidents and never events • Increased use of bank and agency staff Impact; • Reduced quality of care and patient experience • Increase in safety and quality incidents • Increased difficulty in maintaining operational performance • Loss of reputation • Loss of market share	5x4 = 20	• Team Brief • Staff Newsletter • Mandatory training • Staff benefits package • H&WB Provision • Staff Survey action plan • JNCC/Workforce Council • Francis Report Action Plan • Education and Development Plan • HR Policies • Exit interviews • Staff Engagement Programme – Listening events • Involvement in Academic Research Networks • Workforce Strategy Implementation Plan • Values based recruitment • Daily nurse staffing levels monitoring and escalation process • 6 monthly Nursing establishment reviews • Workforce KPIs • Recruitment and Retention Strategy action plan • Nurse development programmes • Agency caps and usage reporting • LWEG/LETB membership • Speak out safely policy • ACE Behavioural standards	To Board; • Quality Committee • Finance and Performance Committee • Premium Payments Scrutiny Council • IPR - HR Indicators • Staff Survey • Monthly Nurse safer staffing reports • Workforce plans aligned to strategic plan • Monitoring of bank, agency and locum spending • Monthly monitoring of vacancy rates and staff turnover • Staff F&FT snapshots Other • Annual workforce plans • HR benchmarking • Nurse staffing benchmarking	5x4= 20		~~Junior Medical Cover following reduction in Deanery allocations~~ Specific strategies to overcome recruitment hotspots RMO cover for St Helens in line with strategic site development plans and changing nature of patients Plans to optimise opportunities from the apprenticeship levy to create new roles and qualifications to address skills and capacity gaps	Complete E-Rostering roll out to all Medical Staff (December 2017) Specialist nurses to dedicate time to research and training -January 2017 Departmental Development and Succession Plans - March 2017	4 x 2 = 8	AMS

Risk 7 - Major and sustained failure of essential assets or infrastructure	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Poor replacement or maintenance planning • Poor maintenance contract management • Major equipment or building failure • Failure in skills or capacity of staff or service providers • Major incident e.g. weather events/ fire Effect; • Loss of facilities that enable or support service delivery • Potential for harm as a result of defective building fabric o equipment • Increase in complaints Impact; • Inability to deliver services • Reduced quality or safety of services • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	4 x 4 = 16	• New Hospitals / Vinci Contract Monitoring • Equipment replacement programme • Equipment and Asset registers • Capital programme • Procurement Policy • PFI contract performance reports • Regular accommodation and occupancy reviews • Estates and Accommodation Strategy • H&S Committee	To Board; • Finance and Performance Committee • Finance Report • Capital Programme • Audit Committee • I.P.R. Other; • Major Incident Plan • Business Continuity Plans • ERIC Returns • PLACE Audits • Issues from meetings of the Liaison Committee escalated as necessary to Executive Committee, to capture: ▪ Strategic PFI Organisational changes ▪ Legal, Financial and Workforce issues ▪ Contract risk ▪ Design & construction ▪ FM performance ▪ MES performance	4 x 2 = 8	The estates strategy will need to be continually refreshed as the configuration of clinical, clinical support and back-office functions across a wider footprint develops. ~~At this stage it is not envisaged that major changes to the Trust estate are anticipated but maximising the use of the high-quality accommodation for clinical services will be pursued.~~ Development of strategic estate options for cancer services, urgent care and surgical care are being developed	To dovetail into the 5-year forward view programme. Maximise the potential from the GP Streaming investment to improve the A&E department flows. (Design approval by end October and scheme completion in 2017/18)	Membership of the St Helens Strategic Estates Group Membership of the NHS C&M Estates Enabling Group and Corporate Services programme Board	4 x 2 = 8	PW

Risk 8 - Major and sustained failure of essential IT systems	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Poor replacement or maintenance planning • Poor contract management • Failure in skills or capacity of staff or service providers • Major incident e.g. power outage • Lack of effective risk sharing with HIS shared service partners Effect; • Lack of appropriate or safe systems • Poor service provision with delays or low response rates • System availability resulting in delays to patient care or transfer of patient data • Inability to record activity and duplication due to reliance on back up paper or manual systems. • Loss of data or patient related information Impact; • Reduced quality or safety of services • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	~~4x4=16~~4x5=20	• HIS Management Board and Accountability Framework • Procurement Framework • Health Informatics Strategy • HIS performance framework and KPIs • HIS customer satisfaction surveys • Cyber Security Response Plan • Benchmarking • Workforce Development • Risk Register • Contract Management Framework • Major Incident Plan • Disaster Recovery Policy • Business Continuity Plans • Care Cert Response Process • Project Management Framework • Change Advisory Board	To Board; • HIS Board Reports • IM&T Strategy delivery and benefits realisation plan reports • Audit Committee • Executive committee • Risk Management Council • Information Security Assurance Group • Health Informatics Service Operations Board • Programme/Project Boards • Information Governance Steering Group Other; • Internal/External Audit Programme • Information Governance Toolkit Submissions • Information Security Dashboard • External Accreditation – CareCert, Cyber Essentials, External Penetration Test • Service Level Agreements • NHS IT Health Check (CareCert) • HIS Strategy	~~4x2=8~~ 4x4=16	Annual Financial plan agreed with all partners Cyber Security Business Case approval Infrastructure Replacement Programme to be agreed Corporate Governance Structure established Staff Development Plan Technical Development Annual Audit Assurance Report	ISO27001 Cyber Essentials Plus NHS IT Health Check (CareCert) Annual Service Delivery Assurance Report Service Improvement Plans Communications Strategy Digital Maturity Assessment	ISO27001 (09/18) Cyber Essentials Plus (09/18) CareCert Accreditation (07/18) Cyber Security Strategy (02/18) PAS Replacement programme (March 2018)	4x2=8	CW

TRUST BOARD

Paper No: NHST(17)096
Title of paper: COPD Mortality
Purpose: To provide assurance that there is no clinical cause for concern leading to increased reported Chronic Obstructive Pulmonary Disease mortality.
Summary: Chronic Obstructive Pulmonary Disease has a high standardised mortality ratio. This paper details the investigation into this and concludes that there is no clinical cause for concern.
Corporate objectives met or risks addressed: Care, Safety
Financial implications: None
Stakeholders: Trust Board, clinicians, commissioners, patients, relatives
Recommendation(s): To be assured that despite the raised SMR for COPD that there are no clinical causes for concern with this diagnosis group.
Presenting officer: Professor Kevin Hardy, Medical Director
Date of meeting: 25th Oct 2017

Introduction

1. The Trusts Standardised Mortality Ratio (SMR) for the Chronic Obstructive Pulmonary Disease and Bronchiectasis diagnosis group is higher than expected for the period Nov-15 to Oct-16. There were 78 deaths against an expected 51.5 resulting in an SMR of 151.2 (Confidence Interval 119.8 – 189.1). This is statistically higher than expected. This paper explains what the Trust has done to investigate the raised SMR and seeks to provide assurance to the Trust Board that there is no clinical cause for concern.

Context

2. According to NHS Choices, Chronic Obstructive Pulmonary Disease (COPD) is a group of lung diseases that includes chronic bronchitis (long-term inflammation of the airways) and emphysema (damage to the air sacs in the lungs) (NHS Choices). Prevalence of diagnosed COPD in England in 2015-16, using the Public Health England INHALE tool, is 1.9%, whilst prevalence in North West is 2.45%. COPD prevalence by the top 4 CCGs that contributed more than 98% of STHK COPD patient population showed St Helens, Knowsley, Halton and Liverpool have 3.0%, 3.5%, 2.6% and 2.9% COPD prevalence respectively (Public Health England, 2017). Similarly, UK datasets from 2004–12 data also highlighted that a larger proportion of people diagnosed with COPD reside in the North of UK - Scotland and the North East and North West of England (British Lung Foundation). The disease was more common in middle-aged or older adults who smoked and mortality rates were higher in North East and North West England.

Initial Analysis

3. In Apr-17 the Analytical Services team produce a detailed analytical report of COPD SMR. This report can be found in Appendix A. In an attempt to understand the raised SMR the team investigated a number of potential factors including, but not limited to: palliative care rates, comorbidity recording (the Charlson score), age, oxygen saturation levels, whether patient was seen by respiratory consultant or not, day of admission and CCG.

4. Typically in these situations detailed statistical analysis identifies confounding factors that explain a raised SMR. In this case, our preliminary analysis did not identify an underlying explanation to account for the statistically higher than expected SMR. As a result the report recommended a detailed casenote review of all 78 deaths attributed to COPD for the period Nov-15 to Oct-16.

Casenote Review

5. Appendix C has the outcome of the casenote review for each of the 78 deaths reviewed. Each death reviewed has been attributed to one of seven groups. These groups have been agreed by the Analytical Services team, the Clinical Coding team and Dr Julie Hendry (who undertook the reviews). A summary of the findings can be found in the table below.

Category	Definition	Issue Type	Total
A	Inappropriate Clinical Diagnosis	Clinical	4
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	4
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	15
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	2
E	Inaccurate Coding	Coding	10
F	Correctly attributed to COPD diagnosis group		34
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD		9
		Total	78

6. The table shows that 12.8% of deaths attributed to COPD were coded inaccurately and 5.1% were inappropriately diagnosed as COPD. This alone reduces the SMR to within national confidence intervals i.e. not statistically significantly increased SMR. More over the audit found evidence of 30 patients who were palliative but only 16 had been coded as 'palliative care' – this too would materially reduce SMR (by around 10 points).

External Review

7. In addition to the casenote review to gain further assurance the Trust sought an external review of COPD mortality by CRAB Clinical Informatics (C-CI). Copeland's Risk Adjusted Barometer (CRAB) is now used by CQC. Appendix B contains the full CRAB report. In summary CRAB concluded that the apparent increased SMR in patients with COPD is related to the methodological approach used by SHMI and HSMR with regard to the episodes of care and in fact the care of patients with COPD using trigger analysis appears to be within the expected norms.

Latest COPD SMR

8. The initial analysis undertaken by the Analytical Services team focused on the 12 month period Nov-15 to Oct-16. Since, writing this report more up to date COPD SMR is available. The latest available 12 month period is for Jun-16 to May-17. For this period there have been 67 deaths against an expected 59.1. This gives an SMR of 113.36 (C.I. 63.1 – 131.9) which is within statistically expected levels. Indeed, considering the last 6 months there have been 31 deaths against an expected of 33.4. This gives an SMR of 92.9.

Conclusion

9. In conclusion these internal and external analyses suggest that there is no clinical cause for concern for COPD patients. However, there are administrative issues that need to be addressed to ensure patients get attributed to the correct diagnosis groups.

There is also a need to involve the Specialist Palliative Care Team in appropriate patients

Actions

10. Dr Julie Hendry to work with consultants and trainees to improve diagnosis and documentation of COPD.

11. Coders will audit COPD coding quarterly for 1 year.

12. Dr Julie Hendry to liaise with the Respiratory Team to discuss a COPD checklist which must include consideration of Specialty Palliative Care Team input.

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Appendix A – Initial Analyses

CHRONIC OBSTRUCTIVE PULMONARY DISEASE AND BRONCHIECTASIS MORTALITY ANALYSIS

Chris Yates, Olufemi Olajide & Laura McNamee

Apr-17

COPD & Bronchiectasis Mortality Analysis

Previous Analysis

In December 2016 the Analytical Services Team undertook an analysis of COPD & Bronchiectasis mortality. The paper focused on the period up to Jun-16 (latest available SHMI data at time of analysis). The report looked at both SHMI and SMRs for COPD & Bronchiectasis for the same time period.

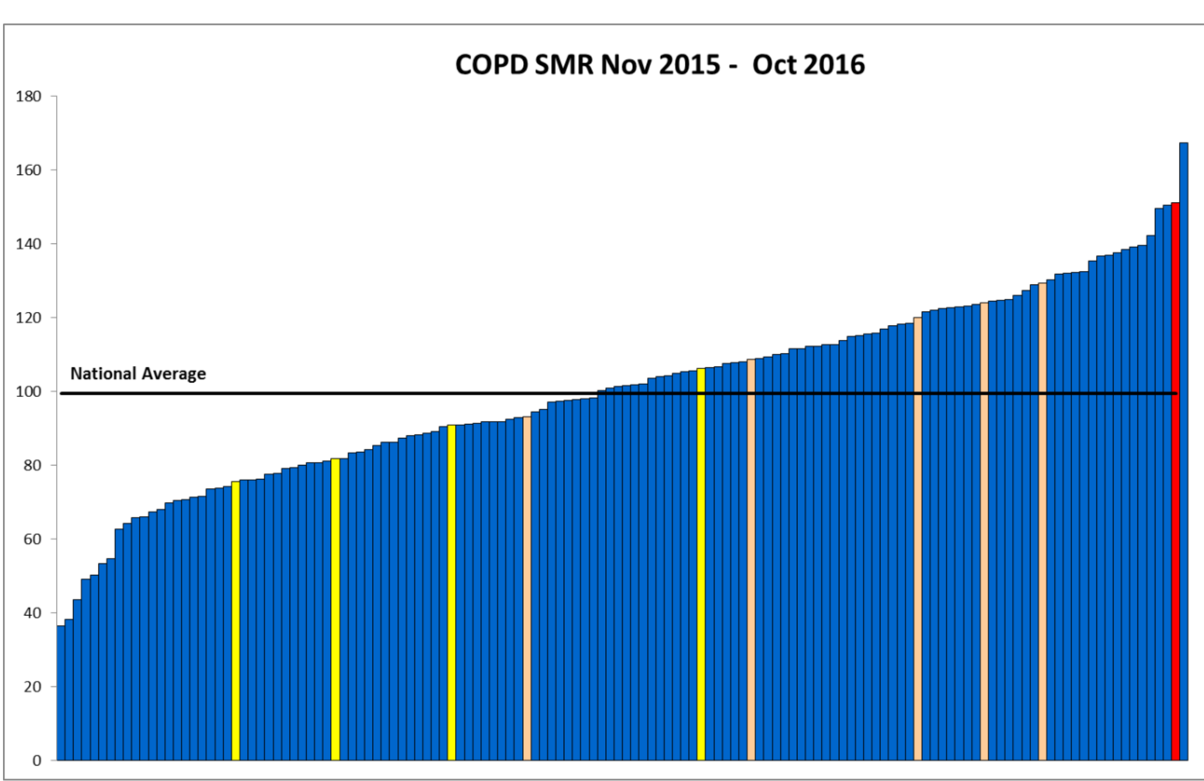
From the Dec-16 report it is clear that despite different methodologies between the 2 risk models (SHMI and SMR) that the same messages were coming out of both risk models. This paper takes those key messages and updates them for the SMR risk model. This paper also looks at issues raised by the Respiratory Medicine Team.

Unless stated otherwise, the rest of the report uses the 12 month period Nov-15 to Oct-16 (the latest available at time of starting analysis).

Standardised Mortality Ratio (SMR)

For the 12 month period patients within the COPD & Bronchiectasis diagnosis group at STHK had 78 observed deaths against an expected of 51.5. At the 95% confidence level this results in a statistically significant higher than expected SMR of 151.2 (C.I. 119.8 – 189.1). Nationally this is the 2nd highest SMR as can be seen from the figure 1 below. STHK is highlighted in red. Local peers are highlighted in brown and “similar COPD population” Trusts as advised by Dr Twite are highlighted in yellow. See appendix 1 for list of local and “similar COPD population” peers.

Figure 1. COPD & Bronchiectasis SMR by Trust Nov-15 to Oct-16



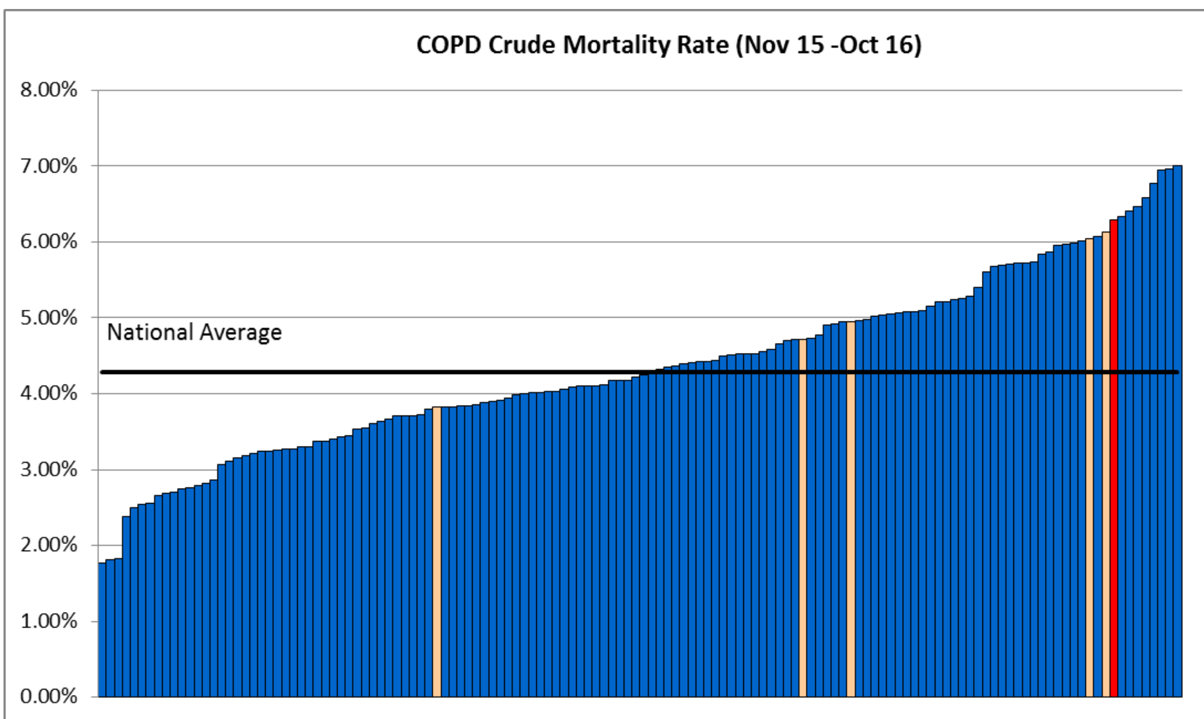
Appendix 2 shows the Trusts SMR for COPD & Bronchiectasis as a time series by financial year going back to 2011-12.

There are a number of factors that can influence the SMR. This paper addresses the major factors: the mortality rate, palliative care, comorbidities, age, diagnosis and diagnosis attribution. The paper also investigates other potential factors that do not form part of the risk model such as oxygen saturation, NIV and day of admission.

Crude Mortality Rate

The Trusts crude mortality rate for COPD & Bronchiectasis patients in the 12 month period was 6.3%.This is the 9th highest crude rate nationally and 1.9% higher than the 4.4% national average. This can be seen in figure 2 below.

Figure 2. Crude mortality rate by Trust Nov-15 to Oct-16



Taken alone this would suggest actual mortality is a large factor behind the Trusts high SMR. However, the high crude rate may be as a result of a "sicker" population, which is why it is important to investigate other potential factors.

Palliative Care

A key factor in the attribution of risk in the SMR risk model, is whether patients receive Palliative Care during their stay in hospital. Figure 3 below shows the percentage of patients in the COPD & Bronchiectasis diagnosis group that have had Palliative Care recorded during their stay in hospital. STHK has 3.6% (i.e. 36 per 1000 spells) of COPD & Bronchiectasis patients recorded as having Palliative Care compared to the national average of 2.8% (28 per 1000 spells). This suggests that the Trusts high SMR is not due to under-recording of Palliative Care relative to other Trusts in the

country. In fact using Healthcare Evaluation Data (HED) we are able to run an SMR risk model that does not factor in Palliative Care as a risk. For the period Nov-15 to Oct-16 this has the impact of increasing the Trusts SMR from 151.5 to 159.4, which ties in with the Trust having a marginal higher recording level for Palliative Care. The conclusion drawn is that Palliative Care is <u>not a factor</u> behind the Trusts raised SMR for COPD & Bronchiectasis diagnosis group.

Figure 3. COPD & Bronchiectasis Palliative Care per 1,000 Spells recorded by Trust Nov-15 to Oct-16

Palliative care per 1,000 super-spells (Nov 15 -Oct 16)

National Average

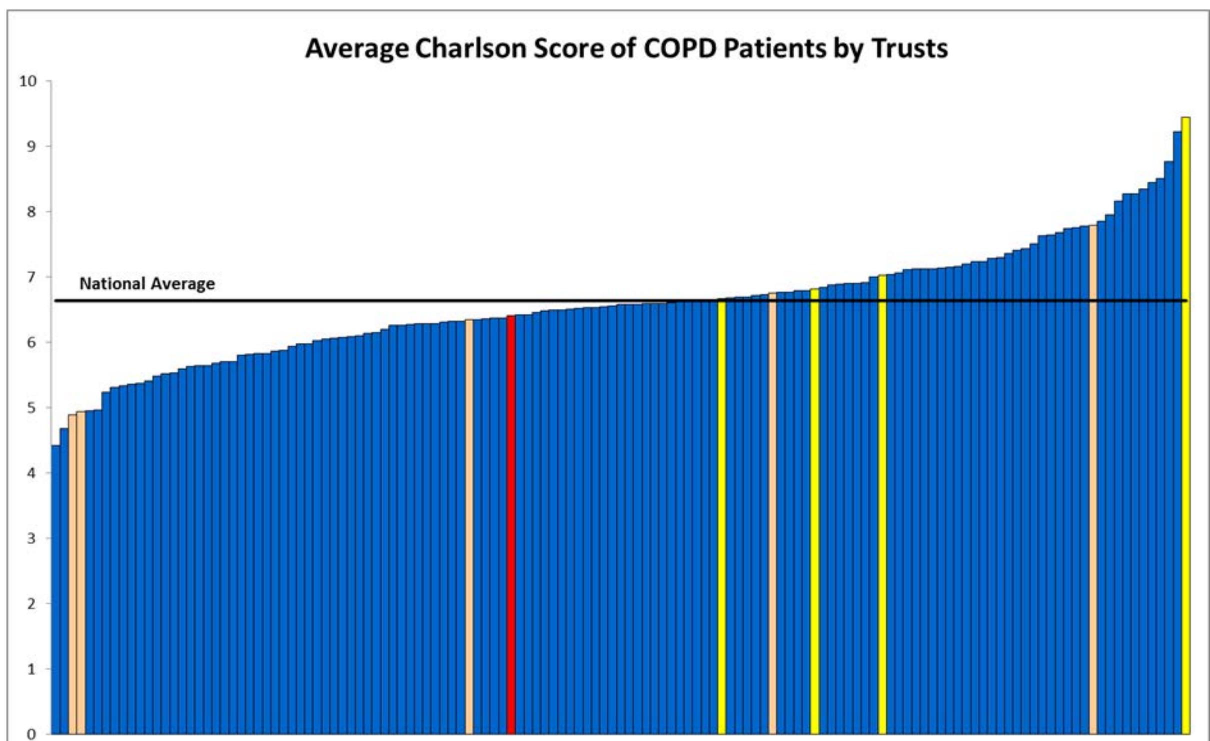
0 10 20 30 40 50 60 70 80 90

Comorbidities

Another factor on the attribution of risk of death to patients is comorbidities. Different comorbidities will result in greater associated risk of death. The Charlson score assigns a score to each comorbidity and HED (and Dr Foster) use the Charlson score as a measure of comorbidity. Figure 4 shows the Trusts average Charlson score for COPD & Bronchiectasis spells compared to other Trusts. STHK has an average Charlson score of 6.4 compared to the national average score of 6.6. Given the patient demographic that STHK patients come from, one would expect the Trust to have a Charlson score in the upper quartile. The upper quartile Charslon score is 7.1 and the 90th percentile Charlson score is 7.8

For COPD & Bronchiectasis the Trust would need an additional 10 expected deaths to fall within statistically expected levels (SMR would still be high at 127). Whilst the Trust does not have access to the risk models for deriving SMR, we have undertaken regression analysis on available national data and have found that even if we increased our average Charlson score to 9.5 (the highest nationally for COPD) then this would not result in the required additional 10 expected deaths to enable the trust to be within statistically expected levels. The conclusion drawn is the Trusts lower than average Charlson score is not the underlying explanation accounting for the Trusts significantly high SMR in the COPD & Bronchiectasis diagnosis group, however it does have a small impact.

Figure 4. Average Charlson Score for COPD & Bronchiectasis spells by Trust



Age

In the SMR risk model age is one of the contributing factors. Figure 5 below shows that the SMR for the population aged 65 and over is higher compared to the national average and local and "similar" peers.

Figure 5. COPD & Bronchiectasis SMR for patients aged 65 years and over

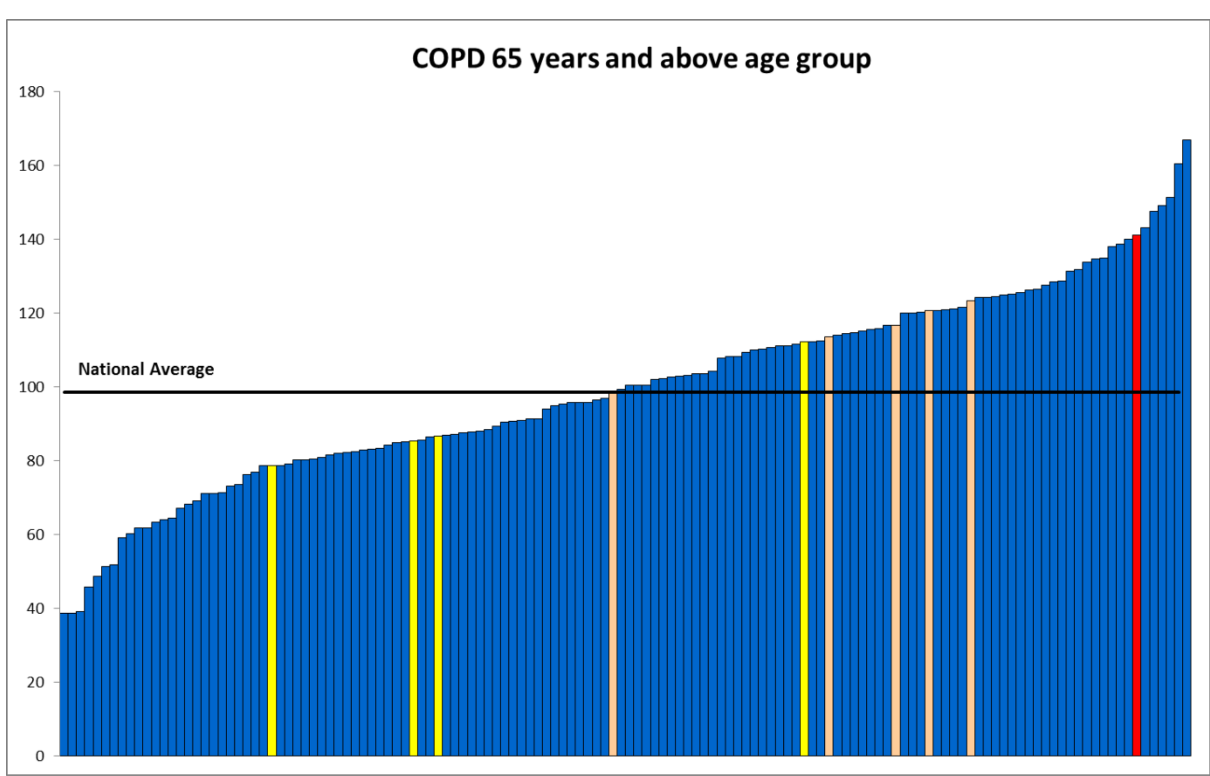


Figure 6. COPD & Bronchiectasis SMR for patients aged under 65 years

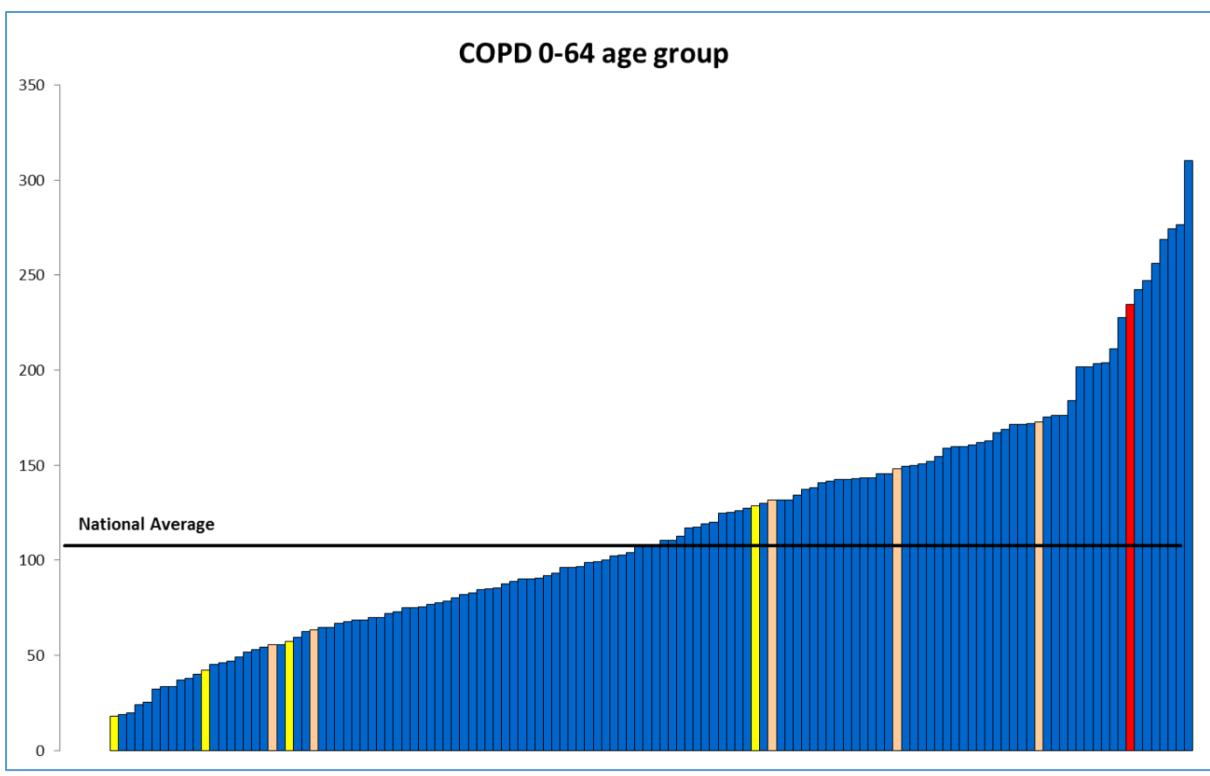


Figure 6 above shows that the Trusts SMR for patients aged under 65 is high compared to local peers and the national average.

The above demonstrates the Trusts SMR is high in both age groups, so it can be concluded that age is not the key factor accounting for the Trusts high SMR.

ICD

COPD & Bronchiectasis covers a number of different diagnoses. Figures 7 to 10 show the SMRs broken-down by the 4 ICD10 codes that account for over 98% of the spells in the diagnosis group.

Figure 7. SMR for COPD with acute lower respiratory infection (67.5% of spells in diagnosis group)

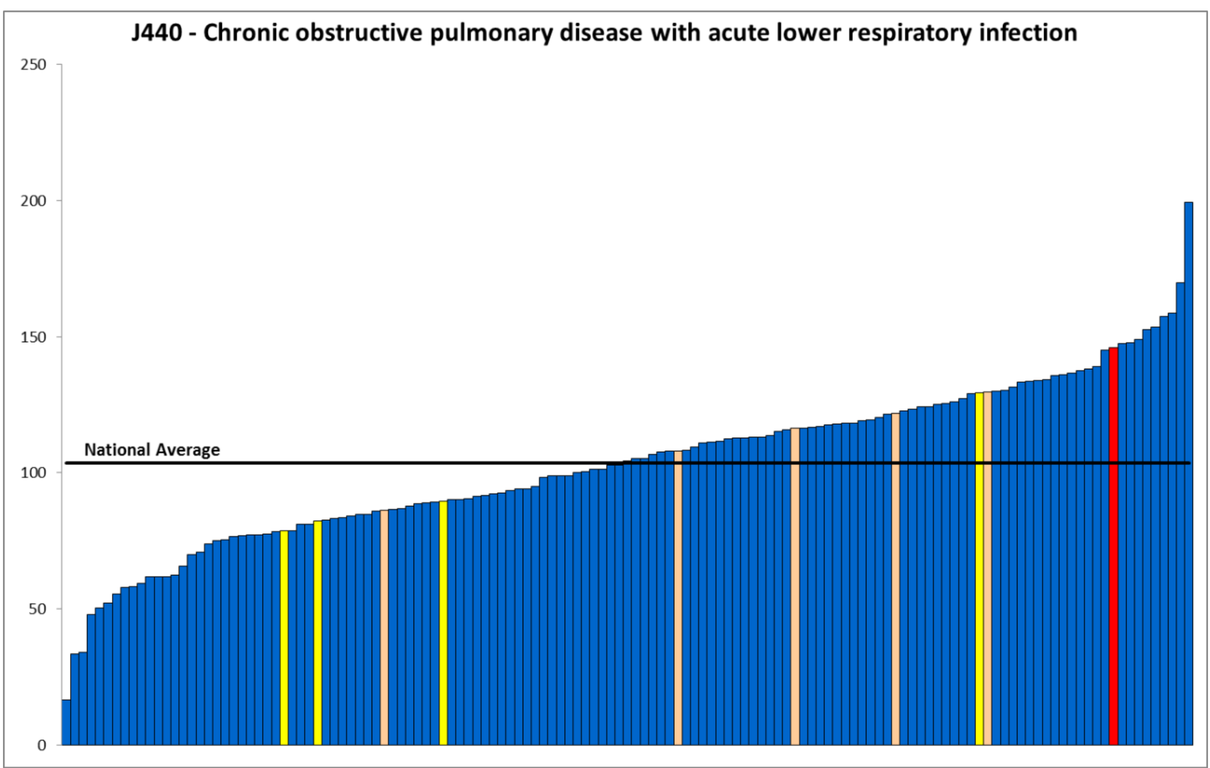


Figure 8. SMR for COPD with acute exacerbation (26.0% of spells in diagnosis group)

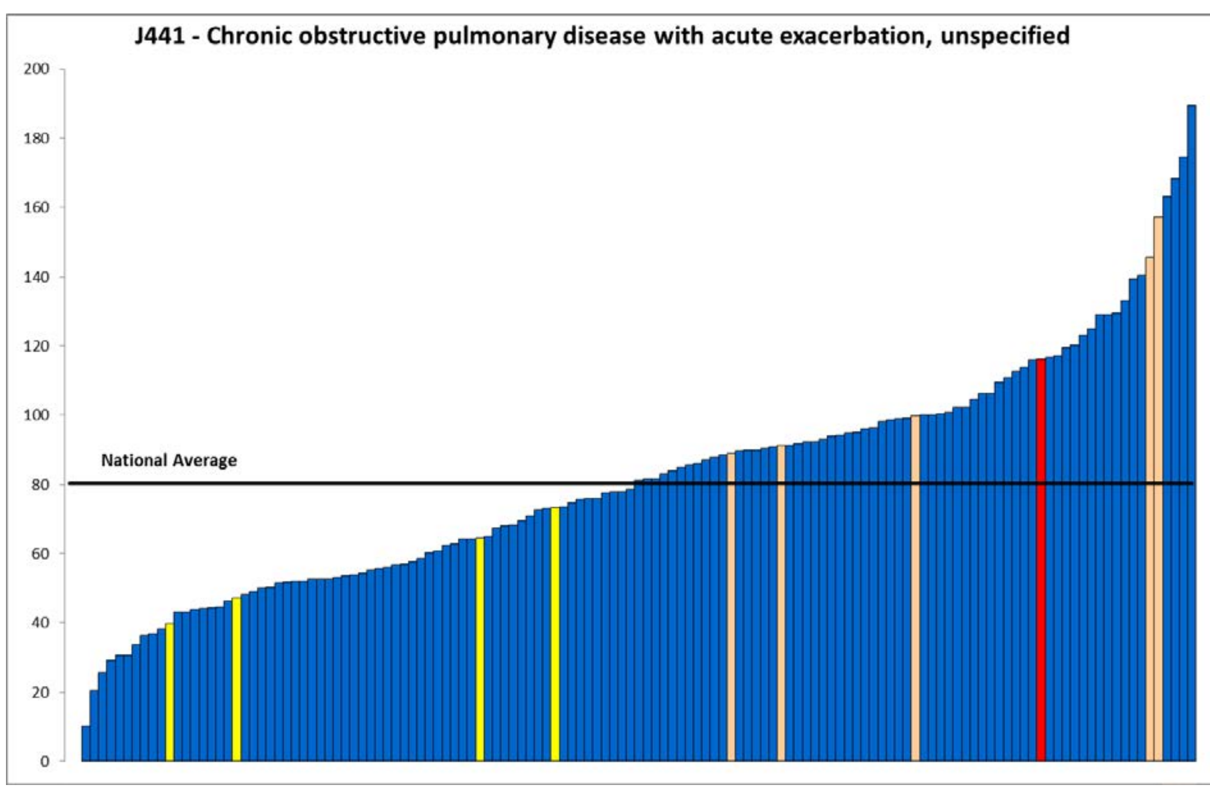


Figure 9. SMR for COPD unspecified (1.7% of spells in diagnosis group)

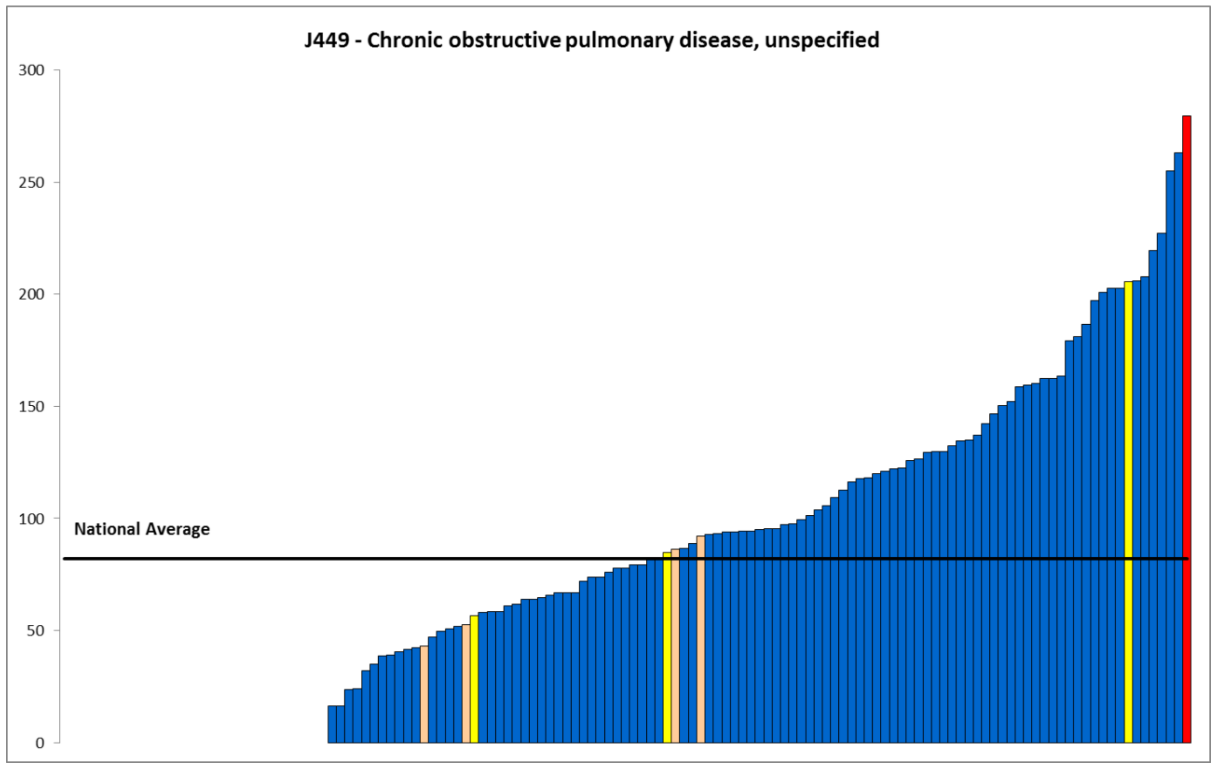
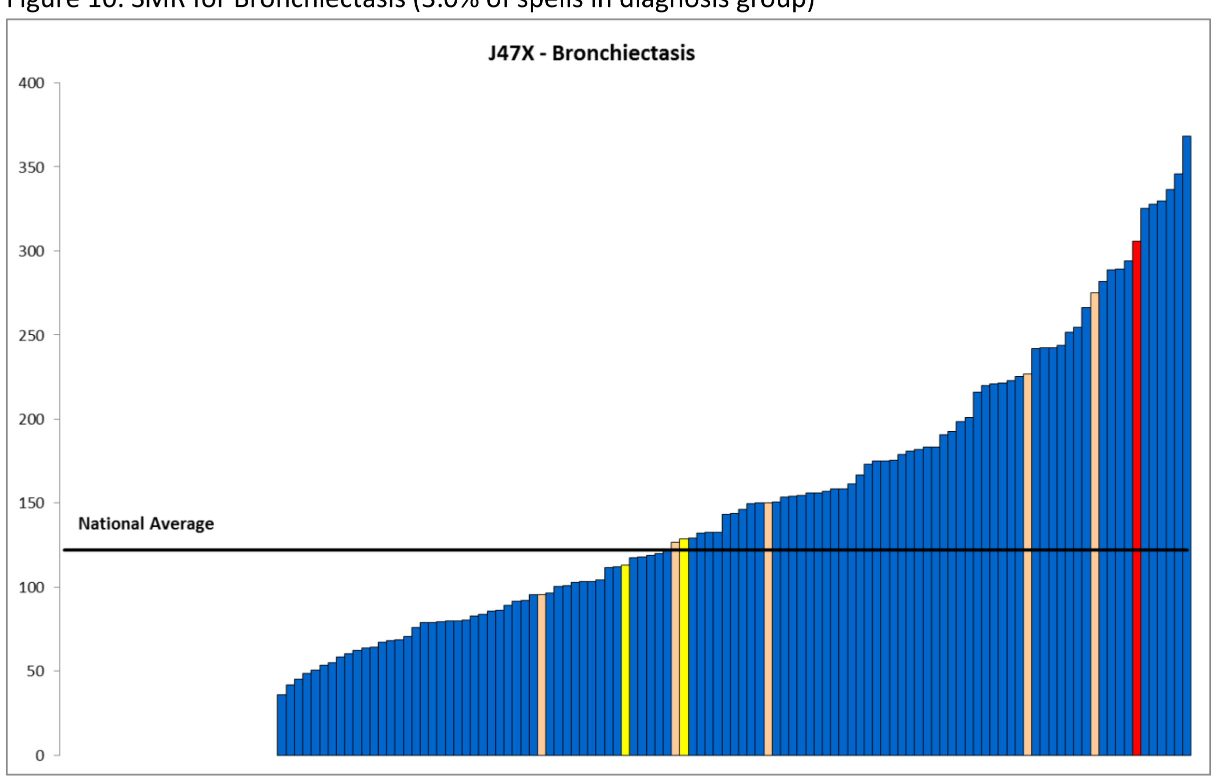


Figure 10. SMR for Bronchiectasis (3.0% of spells in diagnosis group)



All ICD codes have high SMRs compared to the national average. As a result it is difficult to attribute the Trusts high SMR to any individual ICD code.

Attribution to Diagnosis Group

Patients are assigned to diagnosis groups based on the primary diagnosis of the admitting episode of care. The only occasion where this does not apply, is if the primary diagnosis of the admitting episode is a sign or symptom (ICD10 code begins with "R"). In these cases, the primary diagnosis of the 2nd episode of care is used to assign patients to a diagnosis group. Many Clinicians and analysts believe that assigning to diagnosis group based on the 1st (or 2nd) episode rather than discharging episode is a weakness in the risk model, as the underlying primary diagnosis may not be identified until after the 1st (or 2nd) episode of care. Having said that, the methodology is consistent for all, and all Trusts will have some patients change primary diagnosis through different episodes of care.

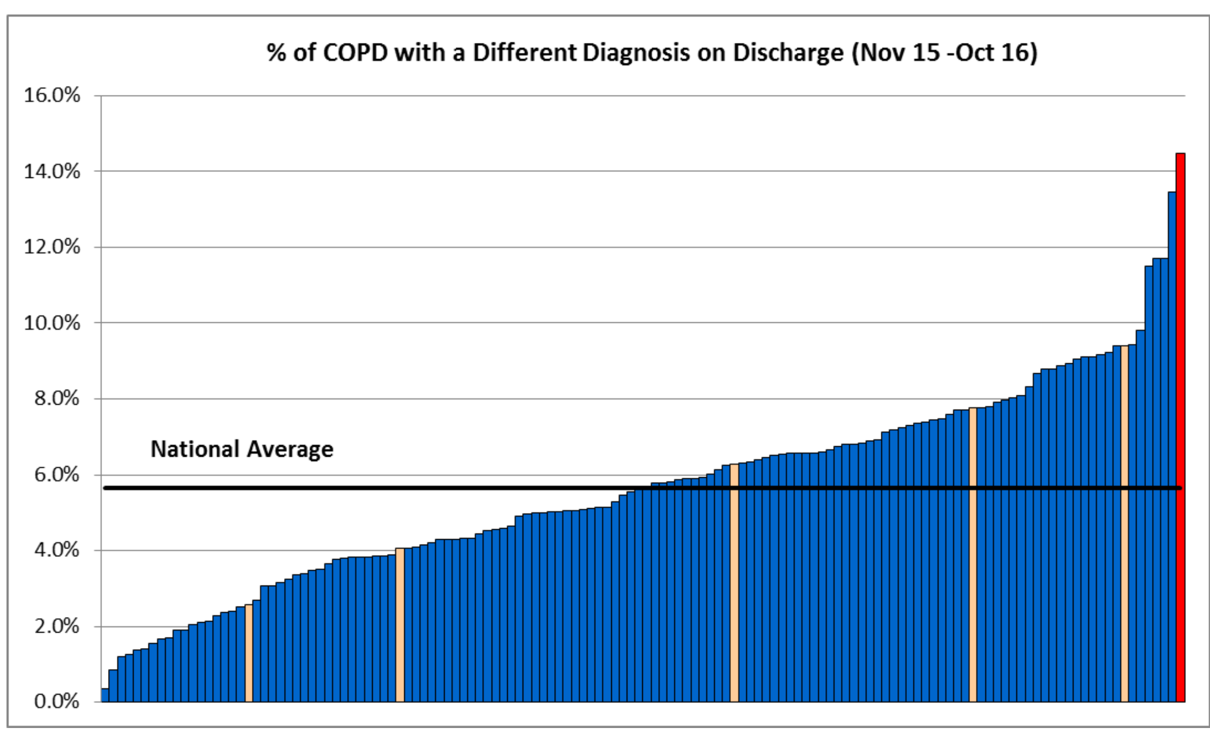
Attribution to diagnosis group issues take 2 forms. The first, as described above, is changing of diagnosis during the patients spell. The second, which is harder to analyse, relates to potentially wrongly assigning a patient to a diagnosis group throughout the patients spell.

Prof Hardy (Medical Director) has specifically asked that this report look into the diagnosis group attribution, as the Respiratory Medicine team highlighted issues concerning this.

Changing diagnosis group during an inpatient spell

This section looks at spells (regardless of patient outcome) where the diagnosis episode was attributed to COPD & Bronchiectasis and focuses on the percentage of these where the diagnosis group changed in the discharging episode. The results show STHK as having the biggest change nationally. Figure 11 shows that 14.5% of STHK patients whose diagnosis group attribution was COPD & Bronchiectasis based on 1st (or 2nd) episode have a different diagnosis group on discharging episode. This compares to the national average of 5.7%.

Figure 11. Percentage of COPD & Bronchiectasis group spells that by discharge episode have a different diagnosis group.

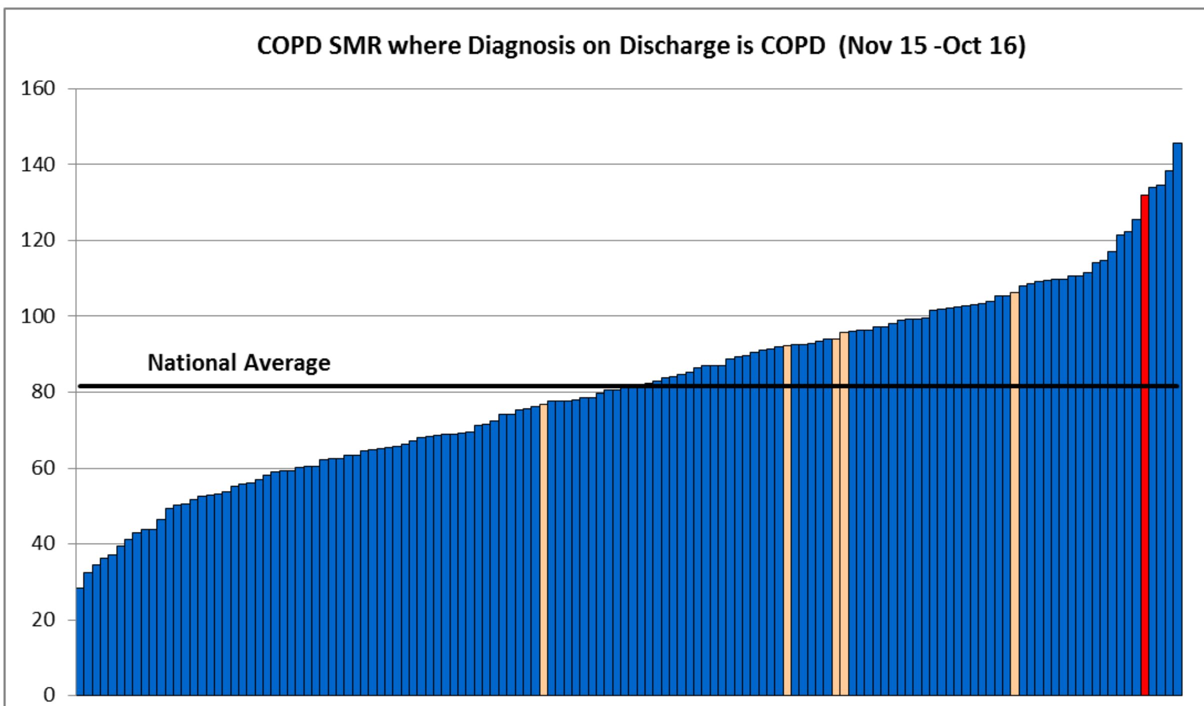


The majority of COPD patients (85.5%) do not change diagnosis group during their spell in hospital in. If we focus on this subset of the diagnosis group where the discharging episode of care also had a

diagnosis of COPD & Bronchiectasis this reduces the number of deaths to 52, reduces the crude mortality from 6.4% to 5.0% and reduces the SMR from 151.5 to 132.

Comparing STHK SMR on a like for like basis with other Trusts (using only those spells where COPD & Bronchiectasis on both admission and discharge) gives the output in figure 12. It can be seen that for this subset of patients the national average SMR has dropped to 80.9 and that the Trusts SMR of 132.0 should be compared relative to this.

Figure 12. SMR for COPD & Bronchiectasis group where same diagnosis on discharge



For the 14.5% of patients that have changed from COPD to a different CCS diagnosis group during their spell, we have recalculated these patients risk. This is not an exact science and the methodology used takes the diagnosis group on discharge and applies the average risk score for patients at the Trust where this was the diagnosis group on admission. This has the effect of reducing the Trusts SMR to 129.5 (C.I. 102.4 – 161.7).

It should also be noted that some patients may have been attributed to a different diagnosis group on admission and then subsequently ended up being discharged with a COPD diagnosis in the last episode of care – these patients are not accounted for in this analysis.

In summary the analysis within section demonstrates that the Trusts significantly high SMR is not explained by the changing attribution from COPD & Bronchiectasis on admission to another diagnosis group on discharge. It does however, highlight that the Trust does have the highest percentage of spells where initial diagnosis of COPD & Bronchiectasis changes by the discharging episode.

Wrongly assigning a patient to a diagnosis group

Clinically there is an overlap between COPD and Pneumonia patients and as a result it is sometimes difficult to assign patients to the correct diagnosis.

Figure 13. Number of Pneumonia spells

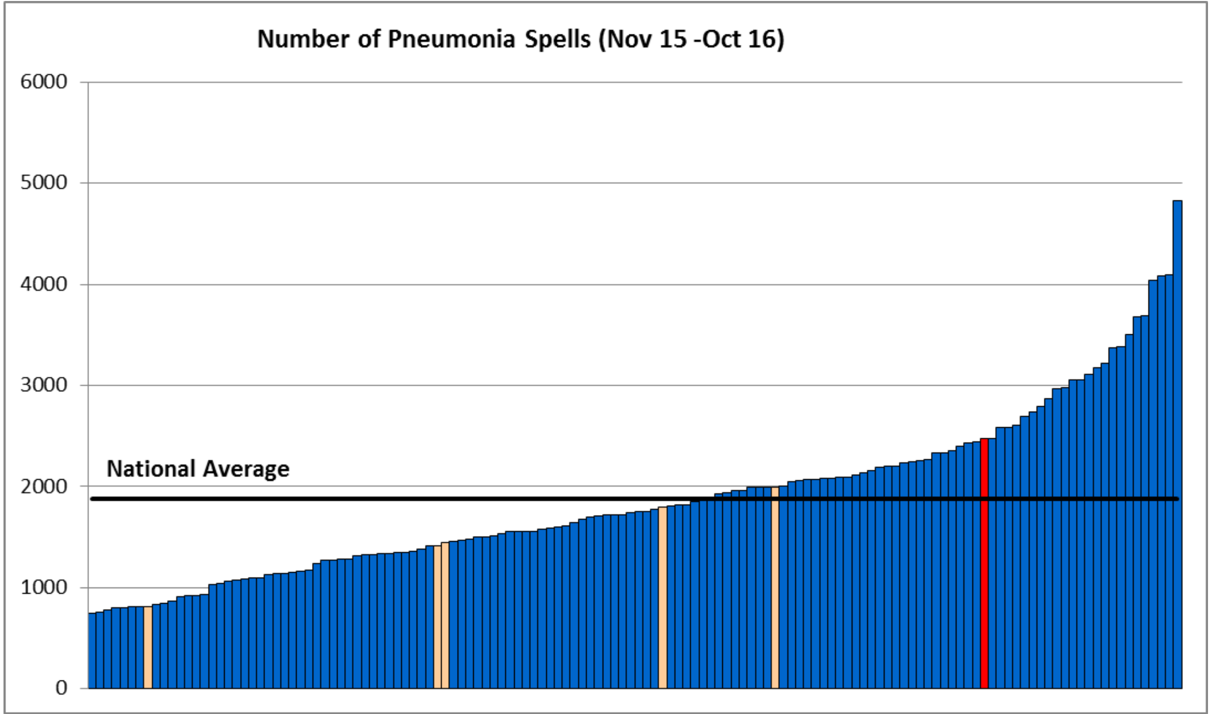


Figure 14. Number of COPD & Bronchiectasis spells

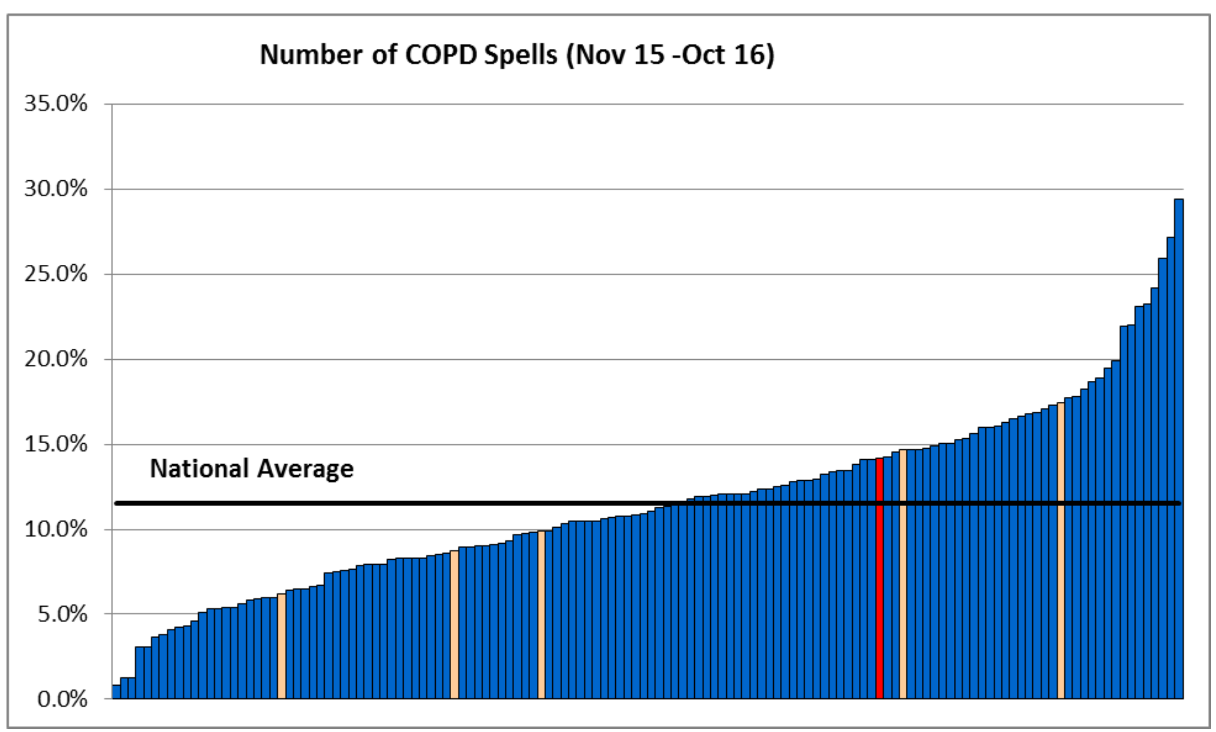
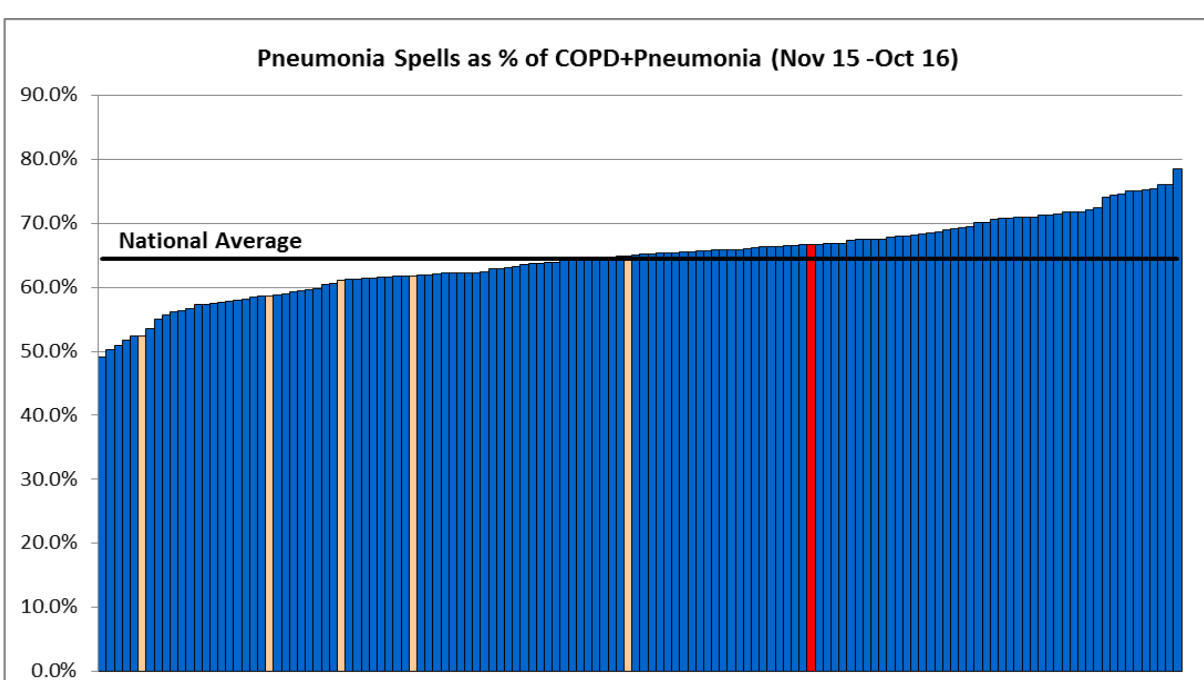


Figure 15. Pneumonia spells as a percentage of COPD and Pneumonia spells



Pneumonia patients have a higher risk associated with them compared to COPD patients. If the Trusts had a low percentage of pneumonia spells then this could indicate that the Trust was potentially recording higher risk pneumonia patients as COPD patients and as a result undercounting the expected risk associated with these patients.

Figure 15 demonstrates that the Trust has a slightly higher proportion of pneumonia spells compared to the national average and also the highest out of our local peers. This suggests that wrongly attributing patients as COPD when they should be pneumonia is not the underlying cause of the Trusts significant SMR.

Oxygen Saturation

One of the factors highlighted by the respiratory team as having an influence on the outcomes of patients was the oxygen saturation levels. We have been able to pull information from telepath and link back into the individual risk scores for patients to bring back SMRS by test result. It should be noted that we have used the first test result found from the day of admission.

Table 1: Oxygen Saturation (%) on presentation

O2 Saturation (%)	Spells	Observed deaths	Expected deaths	SMR	Lower C.I.	Upper C.I.
No Test	379	5	13.6	36.7	11.8	85.7
<=10	1	0	0.0	0.0	0.0	7790.5
>10 to <=20	13	1	1.0	101.9	1.3	567.0
>20 to <=30	23	3	1.0	306.9	61.7	896.6
>30 to <=40	26	3	1.3	230.9	46.4	674.7
>40 to <=50	36	5	1.8	280.2	90.3	653.9
>50 to <=60	43	4	1.9	205.2	55.2	525.3
>60 to <=70	56	6	2.1	279.1	101.9	607.5
>70 to <=80	59	5	2.0	252.9	81.5	590.2
>80 to <=90	238	22	10.6	207.3	129.8	313.8
>90 to <=100	352	24	16.1	149.3	95.6	222.2
Grand Total	**1226**	**78**	**51.5**	**151.5**	**119.8**	**189.1**

Table 2: PO2 (kPa) on presentation

PO2	Spells	Observed deaths	Expected deaths	SMR	Lower C.I.	Upper C.I.
No Test	381	5	13.7	36.6	11.8	85.4
>1 to <=2	5	1	0.5	190.0	2.5	1057.1
>2 to <=3	47	2	1.9	104.2	11.7	376.1
>3 to <=4	55	9	2.7	329.8	150.5	626.2
>4 to <=5	82	5	3.6	140.2	45.2	327.2
>5 to <=6	64	4	2.1	190.8	51.3	488.5
>6 to <=7	136	14	6.5	214.8	117.3	360.3
>7 to <=8	146	11	5.9	185.2	92.3	331.5
>8 to <=9	124	13	4.6	283.9	151.0	485.6
>9 to <=10	86	3	4.6	64.6	13.0	188.7
>10 to <=11	36	2	1.9	105.6	11.9	381.2
>11 to <=12	25	0	0.7	0.0	0.0	494.8
>12 to <=13	12	3	0.8	387.0	77.8	1130.8
>13 to <=14	6	2	1.1	189.5	21.3	684.2
>14 to <=15	3	0	0.0	0.0	0.0	14188.8
15+	18	4	0.8	502.3	135.1	1285.9
Grand Total	**1226**	**78**	**51.5**	**151.5**	**119.8**	**189.1**

Table 3: PCO2 (kPa) on presentation

PCO2	Spells	Observed deaths	Expected deaths	SMR	Lower C.I.	Upper C.I.
No Test	379	5	13.6	36.7	11.8	85.7
>2 to <=3	1	0	0.0	0.0	0.0	16579.3
>3 to <=4	23	2	1.4	141.1	15.8	509.4
>4 to <=5	118	4	6.2	64.7	17.4	165.8
>5 to <=6	201	15	8.5	176.5	98.7	291.1
>6 to <=7	199	11	8.4	130.5	65.1	233.5
>7 to <=8	131	13	5.5	237.7	126.4	406.5
>8 to <=9	63	8	2.5	323.2	139.2	636.8
>9 to <=10	64	7	2.1	329.8	132.1	679.5
>10 to <=11	19	3	1.4	217.8	43.8	636.3
>11 to <=12	8	3	0.5	641.9	129.0	1875.4
>12 to <=13	6	2	0.7	296.9	33.3	1072.0
>13 to <=14	8	1	0.4	247.7	3.2	1378.2
>14 to <=15	3	1	0.2	606.4	7.9	3374.1
15+	3	3	0.2	1946.0	391.1	5686.0
Grand Total	**1226**	**78**	**51.5**	**151.5**	**119.8**	**189.1**

Due to small numbers in each of the groups the confidence intervals are wide and as a result significance testing becomes very difficult.

It should be noted that as oxygen saturation does not form part of the risk model for SMR calculation, one would expect those patients with lower oxygen levels to have a higher SMR and those with normal levels to have a low SMR.

From table 1 it can be seen that those patients with oxygen saturation levels on presentation of over 90 have a high SMR (149.3), albeit not statistically significant. It can also be seen that for the vast majority of groupings for both PO2 and PCO2 that the SMR is over 100.

From table 2 there is no relationship between the PO2 levels and the SMR. In table 3 it can be seen that (as expected) the higher the PCO2 value the higher the SMR.

The conclusion drawn from this section is that oxygen saturation levels do not explain the Trusts significantly high SMR for COPD and bronchiectasis.

Non-Invasive Ventilation (NIV)

The SMR risk model does not take into account whether patients are having NIV or not. As a result one would expect NIV patients to have a higher SMR. This can be seen in the table below. When we exclude the NIV patients from the data the Non-NIV patients still have a statistically significantly high SMR. Given that other Trusts will have NIV patients within their COPD population and that non-NIV patients have a raised SMR, NIV is not the underlying explanation behind the Trusts raised SMR.

Table 4: NIV SMR summary table

NIV	Spells	Observed deaths	Expected deaths	SMR	Lower C.I.	Upper C.I.
Non NIV	1187	65	49.6	131.0	101.1	167.0
NIV	39	13	1.9	702.5	373.7	1201.4

Table 5: Comparison of NIV mortality to national picture

NIV	Spells	Observed deaths	Mortality Rate (%)	Notes
STHK NIV	39	13	33.3%	This is in-hospital mortality only.
National NIV	1508	304	20.1%	This is mortality rate ≤ 30 days (i.e. in-hospital mortality only + mortality after 30 days of discharge)

Table 5 above shows the Trusts NIV crude mortality rate for Nov-15 to Oct-16 and compares it to English data published in Feb-17 in the National COPD Audit Programme. The national data is from 2014 and looks at mortality within 30 days of discharge whereas STHK data is just in-hospital mortality.

So whilst Table 4 demonstrated that NIV was not the underlying factor behind the Trusts raised SMR, it can be seen that NIV patients do have a high SMR (this would be expected given that NIV is not part of the risk model) and that the crude rate in Table 5 compared to the national picture is high, and would be even higher if deaths within 30 days of discharge were included within STHK figures.

Consultant Team (Respiratory v Non-Respiratory)

This section utilises information on the Consultant team responsible for the patients care. It specifically splits Consultants into two groups; Respiratory and Non-Respiratory.

The table below looks at the Consultant team at diagnosis. Only 9.5% of the COPD diagnoses were made by Respiratory consultants. The SMR is high for both respiratory and non-respiratory consultants (although due to small numbers and wide confidence intervals the Respiratory team is not statistically higher than expected).

Table 6: Respiratory v Non-Respiratory Consultant at time of diagnosis

Team	Spells	Observed deaths	Expected deaths	SMR	Lower C.I.	Upper C.I.
Respiratory	117	11	5.6	195.9	97.7	350.6
Non-Respiratory	1109	67	45.9	146.1	113.2	185.6

The table below looks at the Consultant team at discharge. This shows that the SMR is statistically higher than expected for both respiratory and non-respiratory consultants.

Table 7: Respiratory v Non-Respiratory Consultant at time of discharge

Team	Spells	Observed deaths	Expected deaths	SMR	Lower C.I.	Upper C.I.
Respiratory	525	37	23.1	159.8	112.5	220.3
Non-Respiratory	701	41	28.3	144.8	103.9	196.4

The conclusion drawn from the above is that the trusts high SMR is not explained by whether the patient is treated by a respiratory consultant or not.

CCG

Breaking down the Trusts SMR by CCG gives the results in Table 8 below. St Helens and Knowsley CCGs (which together account for 75% of total COPD activity) have very similar SMRs despite varying levels of community support for COPD patients between the 2 areas. Individually both CCGs fall within statistically expected levels although combined the SMR is significantly higher than expected (SMR: 138.9, C.I. 104.6 – 180.8).

Halton CCG has no community COPD service and the SMR is higher for Halton when compared to St Helens and Knowsely CCGs, however due to large confidence intervals it falls within expected levels. Despite relatively small numbers of Liverpool CCG patients, Liverpool CCG has a statistically higher than expected SMR.

Table 8: CCG SMR summary table

CCG	Spells	Observed deaths	Expected deaths	SMR	Lower C.I.	Upper C.I.
St Helens	507	32	23.1	138.7	94.8	195.8
Knowsley	412	23	16.5	139.2	88.2	208.8
Halton	186	13	7.2	181.2	96.4	309.8
Liverpool	106	10	4.4	226.1	108.2	415.8
Other	15	0	0.3	0.0	0.0	1365.2
Grand Total	**1226**	**78**	**51.5**	**151.5**	**119.8**	**189.1**

Given that the 4 CCGs accounting for 98.8% of the activity all have high SMRs it can be concluded that CCG is not the underlying explanation that accounts for the Trusts higher than expected SMR.

Weekend v Weekday

Day of admission	Spells	Observed deaths	Expected deaths	SMR	Lower C.I.	Upper C.I.
Weekday	944	55	40.0	137.5	103.6	178.9
Weekend	282	23	11.5	200.6	127.1	301.1

Weekend admissions have a higher SMR than weekdays, however both have a statistically higher than expected mortality rate. Given both weekday and weekend admissions have a significant high SMR it can be concluded that the trusts high SMR is not explained by day of admission.

Conclusion

Having investigated a number of potential reasons behind the trusts raised SMR value for COPD & Bronchiectasis the findings are that, aside from the higher than average crude mortality rate, we can find no underlying explanation to account for the statistically significant SMR.

Recommendation

A detailed casenote review of all deaths is the required next step.

Appendix 1: Peer List

Local Peers

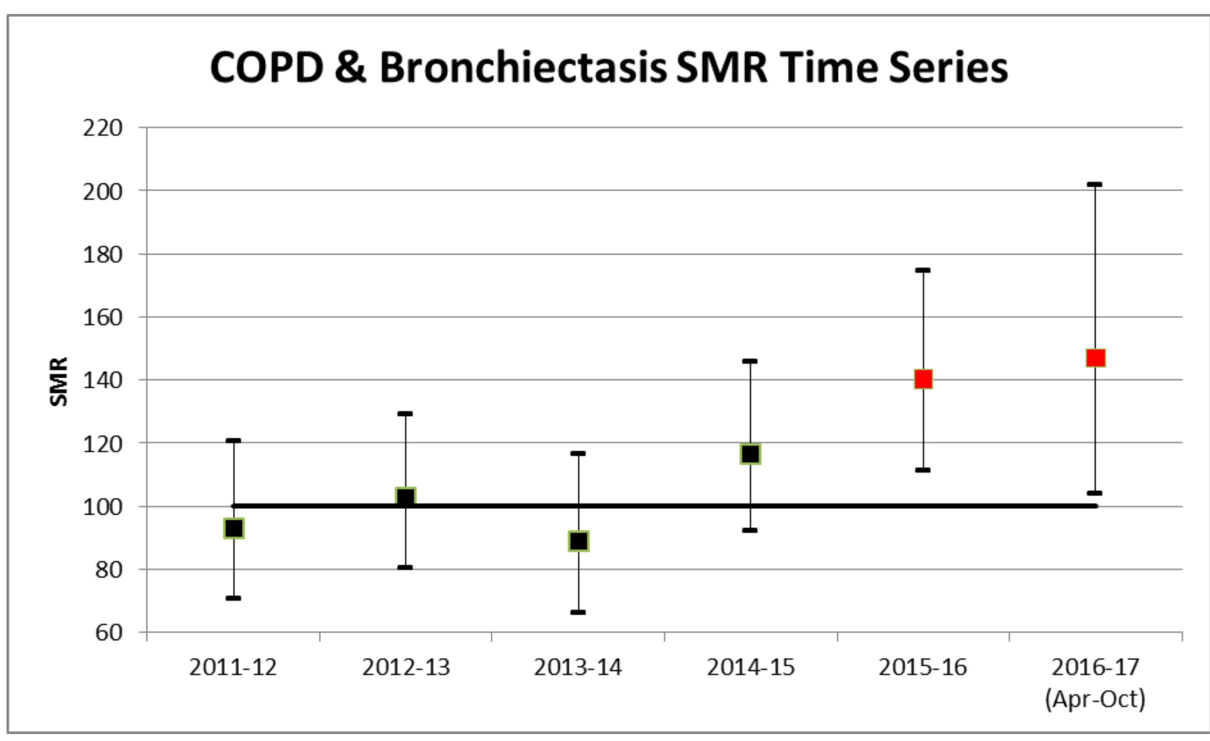
- Aintree
- Warrington
- Royal Liverpool & Broadgreen
- Southport & Ormskirk
- Wrightington, Wigan and Leigh

Similar COPD Population Peers

- Peterborough and Stamford Hospitals
- Northampton General
- Kettering General
- Hull & East Yorkshire Hospitals

Appendix 2: SMR Time Series

The chart below shows the SMR time series since 2011-12. For 15-16 and 16-17 (Apr-Oct) the SMR is statistically higher than expected.



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Appendix B – CRAB Report

CRAB

Accurate, real-time clinical quality monitoring & reporting

CRAB Review

COPD and Bronchiectasis St Helens and Knowsley NHS Trust

Introduction

1. Purpose

1.1. This report has been prepared for St Helens and Knowsley NHS Trust to examine the treatment outcome of patients with COPD and Bronchiectasis. It is designed to give a more in depth view of medical and ward-based care than may otherwise be possible with standard mortality and statistical analysis.

1.2. Taking a bulk download of standard coded HES data[1], information covering a three year period has been incorporated into a dedicated CRAB database. The resulting report has concentrated on the one year period 1st November 2015 to 1st November 2016 when the SMR for patients with COPD and bronchiectasis appeared elevated.

1.3. For ease of reference, the key methodologies and indicators applied are explained in detail in the Annex to this paper. As previously indicated, this approach has been used in a number of settings in England, including:

- the Keogh Mortality review
- quality baselining on behalf of Monitor and most recently
- for the CQC Monitoring and Inspection teams.

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Document ref.	STHK COPD Review 170712 v1.0

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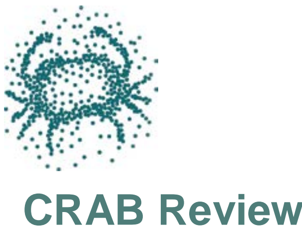

CRAB Review

COPD and Bronchiectasis St Helens and Knowsley NHS Trust

Executive Summary

1. Detailed trigger analysis has been applied to understand the quality of ward-based care and the possibility of any untoward harm in relation to patients with COPD and Bronchiectasis. This analysis suggests that care overall is good, and mortalities in this group of patients are largely unavoidable, being associated with those individuals whose disease state has deteriorated irretrievably.

2. Warning flags which have been raised SHMI and HSMR in relation to this group of patients appear to be misplaced, and are a result of a combination of:

    a. Limitations in the methodology (SHMI and HSMR focus on admission diagnosis and early episodes of care, rather than the full diagnostic profile of the patient and the final primary diagnosis); exacerbated by
    b. processes in the Trust which tend to increase the overall number of episodes before a primary diagnosis is reached.

3. Overall findings & observations

General Medicine

1. During the study period 1.11.2015 to 1.11.2016, 40,906 patients were admitted under the care of the general medical physicians. As can be seen in table 1 during this period 15,126 patients were coded as having a respiratory related diagnosis during their stay. This includes those with a primary diagnosis and those with non-primary diagnostic codes. The commonest respiratory code was Chronic Obstructive Pulmonary Disease (COPD). There are a few other minor respiratory related codes but in the main these are of an insignificant volume and have been excluded from further analysis.

Table 1: Respiratory related codes noted during study period

Diagnostic code	Diagnosis	Volume	% of total medical admissions
C34	Bronchial/lung cancer	612	1.5
C38	Pleural cancer	8	0.02
J15, J17, J18	Pneumonia	3027	7.4
J20	Acute bronchitis	15	0.04
J43	Empysema	386	0.9
J44	COPD	6080	14.9
J45	Asthma	4122	10.1
J46	Status asthmaticus	24	0.06
J47	Bronchiectasis	691	1.7
J61	Pneumoconiosis	82	0.2
J960	Acute respiratory failure	5	0.01
J961	Chronic respiratory failure	71	0.1

2. Within the pneumonia group 2,999 patients were recorded to have a J18 code which are unspecified pneumonia codes.

3. It should be noted that these volumes represent the total volumes of patients with one of these diagnoses recorded at some time during their stay rather than those patients where the respiratory related code was only recorded as a primary diagnosis. It is well recognised that that the primary diagnosis, which is often the earliest diagnosis, may differ from the actual or discharge diagnosis. It has already been noted in the report provided by the trust that the change in coding from admission to discharge was much higher in the trust than in similar organisations.

4. Reviewing those patients who had been allotted either a J43, J44 or J47 code the majority appeared to be under the care of general medical physicians (see table 2). The most important codes are J44 and J47.

5. The largest group by far who were under the care of a general medical physician appeared to be the COPD group.

Table 2: Relationship of chronic respiratory disease to specialty of physician at discharge

Diagnostic code	Total number	Number under the final care of a respiratory physician	% under the final care of a general physician	% under the final care of a respiratory physician
J43	386	82	78.8	21.2
J44	6080	485	92	8
J47	691	104	84.9	15.1

6. Using the global trigger tool it is possible to identify indicators of potential harm events. It should be noted that it is not possible from coding alone to identify whether a code was present on admission or acquired in house, with the exception of nosocomial pneumonia. However in the main some 75% of the 32 triggers which comprise the global trigger tool overall occur during the patient's stay in hospital, thus allowing their use for comparability between hospitals and indeed countries. Certain triggers have a significant correlation with death and are an excellent measure of ward based care. These include the shock/cardiac arrest, nosocomial pneumonia, sepsis and acute kidney injury triggers. The CRAB medical module is based upon the global trigger tool and assesses the incidence of each of the triggers from coded data and the chronology of episodes of care.

7. The numbers and percentages of these individual triggers have been compared between those patients who were coded with the most common chronic respiratory condition codes (J44 and J47) (Table 3 and 4) and were under the final care of either a general medical physician and a member of the respiratory team. With regard to patients with a J44 code there were 5,595 under the final care of general physicians and 485 under the final care of respiratory physicians. In patients with a J47 code there were 587 under the final care of general physicians and 104 under the final care of respiratory physicians.

8. There was no significant difference in trigger rates between those patients under the final care of a respiratory physician and those under the final care of a non-respiratory physician.

9. However the shock/cardiac arrest, nosocomial pneumonia, sepsis and acute kidney injury triggers were all elevated when compared to general medical admissions as a whole (see table 5). This is not, in itself, surprising as these triggers would be expected to be elevated in patients with COPD related diseases.

10. Patients experiencing 4 or more triggers are at a significant risk of dying and examination of these cases often reveals omissions in care. The mortality rate of patients experiencing 4 or more triggers is a very sensitive assessment of the overall quality of ward based care and we have noted in the UK that increased rates are often followed by a delayed increased in SHMI mortality ratio. These rates have been examined in section 3 in those patients with a primary diagnosis of COPD and bronchiectasis.

Table 3: Trigger rates in patients coded with J44 in general medicine during study period

Trigger	Total number	Total number in patients under the care of the respiratory team	Incidence general medical care %	Incidence respiratory care team %
Readmission	1171	103	19.1	21.2
Shock/cardiac arrest	346	24	5.4	4.9
Nosocomial pneumonia	251	26	4	5.4
Septicaemia	324	24	5.4	4.9
Acute kidney injury	766	69	12.5	14.2

Table 4: Trigger rates in patients coded with J47 in general medicine during study period

Trigger	Total number	Total number in patients under the care of the respiratory team	Incidence general medical care %	Incidence respiratory care team %
Readmission	136	21	20	20.2
Shock/cardiac arrest	38	6	5.6	5.8
Nosocomial pneumonia	27	4	3.9	3.8
Septicaemia	33	2	5.3	1.9
Acute kidney injury	85	10	12.8	9.6

Table 5: Trigger rates for key triggers in whole of general medicine during study period

Trigger	Trigger rate during study period %	95% confidence limits %	Current status
Early warning score	0.2	0.3 – 0.6	Low
Decubitus ulcer	1	0.5 – 1.5	Norm
Shock/cardiac arrest	2.5	1 - 3	Norm
DVT/PE	2.1	0.6 - 2	High
Acute kidney injury	5.1	2 - 6	Norm
Abnormal sodium levels	1.7	0.6 – 2.4	Norm
Abnormal potassium levels	1.5	0.6 – 1.8	Norm
Nosocomial pneumonia	1	0.5 – 1.5	Norm
Septicaemia	1.7	0.5 – 1.7	Norm
% Patients experiencing 4 or more triggers	1	0.25 - 3	Norm
Mortality rate in patients experiencing 4 or more triggers	16.5	12 - 35	Norm

4. *Patients with a Primary Diagnostic code of COPD and/or Bronchiectasis*

11. 1,310 patients admitted during the study period had a primary diagnosis of COPD and/or bronchiectasis at discharge. Of these 521 were under the final care of a member of the respiratory team (39.8%) and 789 were under the final care of a non-respiratory physician (61.2%).

12. Of these patients 231 (17.6%) died following admission. 97 were under the final care of a respiratory physician (18.6%) and 134 under the final care of a non-respiratory physician (17%). There was some variation in the raw mortality rate between individual respiratory physicians (see table 6) but examination of the co-morbidities in these patients suggest that these were patients with severe COPD and those with serious complications arising from their COPD.

13. There appeared to be no significant difference in demographic variables between those patients surviving and those dying (see table 7).

Table 6: Mortality rates for individual respiratory physicians (final consultant responsible)

Consultant	Total number	Total deaths	Actual mortality rate (%)
Dr Hendry	18	3	15
Dr Twite	103	16	15.5
Dr Stockton	76	11	14.5
Dr Malhotra	60	12	25
Dr Lakshman	87	18	26
Dr Alapati	21	5	23.8
Dr Koduri	96	15	17.4
Dr Naveed	70	17	24.3
Non-respiratory	789	134	17

Table 7: Demographic details

	Number	Mean age	Range	Male/female
Deaths	231	74	50 – 99	36% / 64%
Survivors	1079	71	39 - 97	38% / 62%

14. There appeared to be a higher trigger rate in those patients surviving in contrast to those dying (table 8). As can be seen from table 9 there was no difference other than acute kidney injury and abnormal potassium levels (which were higher in survivors) in individual trigger rates between those dying and those surviving.

Table 8: Trigger rates in survivors and those dying in general medicine during study period

Number of triggers	Survivors	Deaths
1 trigger event	38.4%	31.2%
2 trigger events	5.5%	3.9%
3 trigger events	2.7%	1.7%
4 or more trigger events	0.7%	0.4%
Total number	47.3%	37.2%

Table 9: Individual trigger rates in survivors and those dying in general medicine during study period

Individual trigger	Survivors	Deaths
Shock/cardiac arrest	3.9%	3.9%
Acute kidney injury	9.6%	6.5%
Readmission within 28 days	19.6%	19.9%
Septicaemia	4%	3%
Nosocomial pneumonia	2.3%	1.3%
Abnormal sodium levels	3.5%	3.5%
Abnormal potassium levels	3.3%	0.9%
Decubitus ulcer	2.4%	1.7%
DVT/PE	1.3%	1.3%

15. Trigger rates have been found nationally to correlate with the quality of ward based care and the incidence of patients with 4 or more triggers and the mortality rate of these patients with 4 or more triggers has been adopted by the Care Quality Commission (CQC) as one of its monitoring and reporting outcome measures.

16. In those patients with a primary diagnostic code of COPD and bronchiectasis the observed incidence of patients with 4 or more triggers was lower (0.7%) than would be expected in general medicine as a whole (see table 5). Additionally the mortality rate in those patients experiencing 4 or more triggers was lower (11.1%) than in general medicine as a whole (see table 5).

5. Conclusions

17. COPD related codes are common in general medical patients occurring in 17.5% of patients. However only 3.2% of patients admitted medically had a primary diagnosis of COPD or brochiectasis.

18. The primary diagnosis may differ from the admitting diagnosis and methodologies like HSMR and SHMI use only the early episodes of care for their analysis. SHMI uses the primary diagnosis from the first episode of care unless it is an R code, when it takes the primary diagnosis from the second episode of care. Whichever is the case the co-morbidities listed during these episodes will be used as the basis of calculating the Charlson Comorbidity Index. As can be seen in table 10 it is not the number of Charlson Comorbidity codes which matter it is the weighting given to individual diagnostic codes. The comorbidity index does not attempt to weight the severity of an individual disease state. SHMI and HSMR are not able to differentiate between mild and severe COAD and as can be seen in table 10 the weighting given in the mortality algorithm to the presence of COPD is low.

19. In hospitals which have a higher number of episodes of care, particularly if these occur in rapid succession, the true primary diagnostic code may not become apparent until the later episodes of care and the important Charlson Comorbidity Indicators may be missed or underestimated.

20. The current analysis does reveal a higher number of triggers in patients with COPD and in those patients admitted with a final primary diagnosis of COPD but the rates are not unexpected in these type of patients. Indeed the trigger rates were higher in survivors indicating that these patients are being treated well. The patients who die have fewer ward based trigger events suggesting that it is more likely they are dying as a result of their chronic pulmonary disease for which no further medical care was possible.

21. It is likely that the apparent increased HSMR in patients with COPD is related to the methodological approach used by SHMI and HSMR with regard to the episodes of care and in fact the care of patients with COPD using trigger analysis appears to be within the expected norms.

Table 10: Charlson Comorbidity Index

Indicator Specification: Summary Hospital-level Mortality Indicator

Appendix D.1: Charlson Comorbidity Index conditions, ICD-10 codes, new and old weights

Condition	Condition Name	ICD-10 codes	New weight	Old weight
1	Acute myocardial infarction	I21, I22, I23, I252, I258	5	1
2	Cerebral vascular accident	G450, G451, G452, G454, G458, G459, G46, I60-I69	11	1
3	Congestive heart failure	I50	13	1
4	Connective tissue disorder	M05, M060, M063, M069, M32, M332, M34, M353	4	1
5	Dementia	F00, F01, F02, F03, F051	14	1
6	Diabetes	E101, E105, E106, E108, E109, E111, E115, E116, E118, E119, E131, E136, E138, E139, E141, E145, E146, E148, E149	3	1
7	Liver disease	K702, K703, K717, K73, K74	8	1
8	Peptic ulcer	K25, K26, K27, K28	9	1
9	Peripheral vascular disease	I71, I739, I790, R02, Z958, Z959	6	1
10	Pulmonary disease	J40-J47, J60-J67	4	1
11	Cancer	C00-C76, C81-C97	8	2
12	Diabetes complications	E102, E103, E104, E107, E112, E113, E114, E117, E132, E133, E134, E137, E142, E143, E144, E147	-1	2
13	Paraplegia	G041, G81, G820, G821, G822	1	2
14	Renal disease	I12, I13, N01, N03, N052-N056, N072-N074, N18, N19, N25	10	2
15	Metastatic cancer	C77, C78, C79, C80	14	3
16	Severe liver disease	K721, K729, K766, K767	18	3
17	HIV	B20, B21, B22, B23, B24, O987	2	6

ANNEX

CRAB Methodology & data sources

1. Definitions & explanation of indices used

1.1 Surgical O/E ratio

a. The Observed/Expected ratio compares the observed rate of mortality or morbidity with that predicted (i.e. expected) from the exponential mathematical models derived from POSSUM variables. These include 18 variables, 12 physiological variables and 6 operative severity variables. These variables have been transposed into validated combinations from the HES data-set such that no additional data entry is required and are as accurate as collection of the data manually.

b. The norm O/E ratio of 1.00 can be considered as equivalent to a Standardised Mortality Ratio (SMR) of 100 but is much more accurate and sensitive to even minor variations in performance. However when analysing small volumes of operative cases or small volumes of adverse outcomes skewed results can be found. In most specialty settings this can be avoided by analysing data in 3 to 6 monthly periods or for overview investigative purpose 6 to 12 month period. Normally persisting O/E ratios over 1.25 would stimulate further enquiry.

1.2 Surgical complication assessment

a. CRAB is the only system to routinely examine all aspects of complications which are identified from direct HES code relationships and complex HES and process of episode of cares algorithms. In addition to O/E ratio CRAB utilises two other ratios:

- Chest to wound infection ratio (chest:wound infection ratio)
  Usually in the majority of trusts performing non cardio-respiratory surgery the numerical chest to wound infection ratio is 1.00 with a range between 0.85 and 1.25. In cardio-respiratory surgery this can rise to 1.45. In those units with ratios over 1.25 usually problems can be related to lack of HDU/ITU beds, deficiencies in physiotherapy, deficiencies in identifying the deteriorating patient or in early mobilisation. Use of the medical CRAB tool can usually identify the root cause.
- Deep venous thrombosis to Pulmonary embolus ratio (DVT:PE ratio)
  Usually in the majority of trusts the numerical deep venous thrombosis to pulmonary embolism ratio is 1.00 with a range between 0.80 and 1.25. Rates below this are rare and would indicate problems with chemical thromboprophylaxis in patients undergoing pelvic surgery or lower limb orthopaedics. Rates over this may indicate problems with thromboprophylaxis either attitude of surgeon, choice of mechanical or chemical thromboprophylaxis used or in risk assessment and dosage assessment.

1.3 Trigger events to assess medical and ward-based care

a. Trigger events are events during a patient's hospital stay that may have resulted from hospital based 'harm events'. The current methodology uses triggers from the UK version of the Global Trigger Tool. The CRAB medical system assesses every in-patient admission, using HES coding to identify validated surrogates which map to these trigger events. In many such cases there are direct coding relationships but in others complex combinations of HES codes with the process of episodes of care are used to identify the trigger.

b. The CRAB system has built up norms for all triggers and combinations of triggers with our knowledge of changes in these indicators with known individual clinician and institutional based anomalies it is possible to identify variations in triggers which can be associated with potential deteriorations in practice and hence outcome.

2. Data sources and use of surrogate variables

2.1 CRAB Surgical Module

a. The fully automated CRAB surgical module is based upon the POSSUM surgical scoring system which has been in use worldwide for over twenty years. There have been well over 300 papers validating its usefulness and there are publications from over 41 countries most recently extensive publications in China in all aspects of surgery.

b. The fully automated CRAB system draws on the extensive POSSUM database of manually collected data from 36 countries in various continents which have been correlated with diagnostic and operative codes both in ICD and OPCS type codes. The UK uses slightly different operative codes to the remainder of the world. In all cases the algorithms applied are reviewed at least annually, and updated where appropriate.

Physiological and operative risk scoring

c. The referential dataset allows for extrapolation of various physiological and operative variables against a standard combination of diagnostic and operative procedure codes:
Example 1: In a patient with a diagnostically coded ruptured abdominal aortic aneurysm from the international database it is possible to extrapolate the mean observed blood pressure, pulse, haemoglobin and white count and the associated operation allows for calculation of the operative severity variables, magnitude of procedure, chronology of procedure, blood loss, urgency of procedure and peritoneal soiling.
Example 2: in a patient with a diagnostically coded perforated duodenal ulcer from the international database it is possible to extrapolate the mean observed blood pressure, pulse, haemoglobin, white cell count, blood urea and electrolytes as well as the operative severity variables, magnitude of procedure, chronology of procedure, blood loss, urgency of procedure and peritoneal soiling.

d. This approach has proved to be highly accurate. Two large, separate studies have shown mortality predictions to be within 0.07% of actual, and complications predictions to be within 0.8% of actual. The respective sensitivity and specificity for individual variables are shown in table 1.

Table 1: Correlation between automated CRAB & manually collected POSSUM data

Variables	Relationship to HES data	Sensitivity (range per variable)	Specificity (range per variable)
12 Physiological variables	Multiple diagnostic and operative coded relationship	96.1 – 99.7%	95.3 – 99.8%

6 Operative severity variables	Multiple diagnostic and operative coded relationship	94.3 – 99.3%	93.8 – 99.4%
Complications (146 items)	Multiple diagnostic and operative codes with episode of care relationship	95.4 – 99.9%	95.5 – 99.9%

e. Codes for other cardiorespiratory co-morbidities and renal problems can be obtained directly from diagnostic codes or combinations of codes. Thus a patient with coronary artery disease and a past history of a myocardial infarction with a supraventricular tachycardia from the international database would score 4 for pulse and 8 for ECG changes and if on diuretics 2 for potassium changes.

f. Operative severity scores for malignancy are from direct coding relationships for primary cancer and metastatic disease.

g. For each diagnostic code the database has pre-set the mean manually observed physiological scores and in some instances as in the two examples in paragraph (c) above, complex associations between the physiological and operative severity scores.

h. In general surgery two conditions are extremely difficult to model because of their speed of evolution and the sudden deterioration in physiological status. These are total small bowel ischaemia and necrotising fasciitis. If recognised very early while the patient is fit the situation may be remedied with low risk. However delays over four hours can result in a significant deterioration in status. Fortunately these are rare problems but in the event of death the scoring may require some manual correction.

Identifying complications

i. In the main most complications have a direct coding relationship. For example wound infection is T81.4 and wound dehiscence T81.3. Some of the other primary ways of identifying complications are outlined below:

j. Some complication codes cover a range – e.g. T81.0 includes both post-operative haemorrhage and post-operative haematoma. Usually the former involves a return to theatre whereas the latter commonly are treated conservatively, and so cross-referencing with the Medical Module (below) yields the true picture.

k. Chest infection may be determined in two ways. If the patient is admitted electively and then is coded as J13X to J18.9 one may assume this was a post-operative chest infection. If any of these codes are linked to the nosocomial code Y95 or Y95X the chest infection can be assumed to be hospital acquired.

l. The K91.8 and K91.9 codes for post-procedural digestive disorders includes anastomotic leakage and bile leakage as well as some prosthetic related complications. If the patient undergoes a second procedure within 30 days the former is assumed. If the procedure is solitary and the primary procedure a bowel resection or cholecystectomy the former may also be assumed.

m. At present there is no nationally agreed “present on admission” code (POA code). In some codes such as in ‘mechanical failure of orthopaedic devices’ (T84.0 to T84.9) which includes both mechanical and infective complications of orthopaedic prosthetics, various assumptions are applied. For example: if the patient undergoes a solitary, elective procedure it is assumed that the procedure was performed to correct a long-standing problem rather than it being a complication. If however the patient has multiple procedures during a 30 day period, a complication is assumed. Similar assumptions are made for prosthetics in other sites, breast, obesity surgery and urology.

2.2 CRAB Medical Module

a. The medical CRAB module is based upon the published variables for the UK version of the Global Trigger Tool. However, instead of usual associated method of randomly sampling a small number of case notes and detecting the presence of triggers, it monitors all hospital activity and uses surrogates to assess the presence or absence of triggers. In 11 of the 32 triggers there is a direct single coding relationship (for example: T81.4, which indicates a wound infection, and A04.7, which denotes clostridium difficile).

b. In other triggers, multiple codes combined may be used as surrogates. The sensitivity and specificity for the 32 triggers is shown in Table 2 overleaf. Further examples of how triggers may be triangulated from multiple coding relationships are also given.

Table 2: Correlation between CRAB automated triggers and manually collected trigger data based on 20,000 patients

Trigger Tool Variable	Relationship to HES data	Specificity (range per trigger)	Sensitivity (range per trigger)
* Decubiti * Vitamin K administration * Naloxone * Flumazenil * Glucagon/50% dextrose * Raised troponin * MRSA bacteraemia * C difficile * Wound infection * Vancomycin resistant enterocolitis * Positive blood cultures	Single code relationship	98.7 – 100%	97.9 – 100%
* Patient fall * Change in planned procedure * Removal or damage to organ	Multiple diagnostic and operative coded relationship	92.7 – 97.8%	93.1 – 97.1%
* Shock/cardiac arrest * DVT/PE * Complication (146 in total) * Abrupt medication stop * High INR * Transfusion * Abrupt drop in haemoglobin * Raised urea/creatinine * Abnormal sodium * Abnormal potassium * Hypoglycaemia * Nosocomial pneumonia	Multiple diagnostic code relationship	90.1 – 94.1%	89.9 – 96.4%
* Lack of response to deteriorating EWS score * Unplanned transfer to ITU	Complex diagnostic and operative code with episode of care relationship	90.6 – 93.2%	87.3 – 93.2%
* Readmission * Transfer to higher level of care * Readmission to ITU * Return to theatre	Episode of care relationship	97.5 – 98.9%	96.9 – 99.0%

c. In pulmonary embolism any code from I26.0 to I26.9 indicates the presence of a pulmonary embolus. However it does not differentiate between the diagnosis present on admission or acquired in hospital.

d. Nosocomial pneumonia as noted above also requires a mapping between any code J13X to J18.9 (multiple chest infection codes) in addition to the nosocomial code Y95 or Y95X.

e. A patient fall also requires an injury code and an occurrence code which includes W01.2, W03.2, W04.2, W05.2, W06.2, W07.2, W08.2, W17.2, W18.2, W19.2, W23.2 and W25.2. Codes W01.2, W18.2 and W19.2 are the commonest.

f. The Early Warning Score trigger is the most complex to calculate and there are many surrogate combinations, combined with escalation to extrapolate this. For example, if a ward based surgical patient has a post-procedural respiratory code (any J95 code or J96.0) combined with a hypotension code (any R57 code) and the patient is escalated to ITU/HDU, in 92.8% of occasions a deteriorating EWS will have been present. This trigger has a lower specificity which means that a deteriorating score may not always be detected in every patient but in such cases alternative triggers may be present in isolation.

g. The unplanned admission to ITU trigger excludes patients admitted as an emergency from AED or directly from theatre unless the procedure OPCS code indicates that the patient would not normally expect to be admitted to ITU. It does include patients initially admitted to a general ward and then transferred to a higher level of care.

h. Readmission to ITU/HDU is based on the episodes of care and their placement.

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Appendix C – Casenote Review

Individual Patient COPD Report

Appendix

Classification of the issues found:

1. Group A = Inaccurate clinical diagnosis (Clinical Issue)
2. Group B = COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis (Clinical Issue)
3. Group C = Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease (Clinical Issue)
4. Group D = Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis (Clinical Issue)
5. Group E = Inaccurate Coding (Coding Issue)
6. Group F = Correctly attributed as COPD
7. Group U = (Poor) documentation leading to COPD diagnosis

Category	Definition	Issue Type	Total
A	Inappropriate Clinical Diagnosis	Clinical	4
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	4
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	15
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	2
E	Inaccurate Coding	Coding	10
F	Correctly attributed to COPD diagnosis group	-	34
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	9
		Total	**78**

Group A: Inappropriate Clinical Diagnosis

Category: Clinical Issue

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	✔
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		

Source	**Patient ID**	1
HED	Age	76
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	4
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**Category A (Clinical Issue)**
HED	Charlson Score	13
HED	Mortality Risk	3.70%
HED	Mortality Risk (adjusting for palliative care)	4.87%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team is: 1. ILD - complex case easily misreported 2. ?IPF	

*RTR = Respiratory Team review; HED = Healthcare Evaluation Data

Summary of issues identified

1. Respiratory team believed this should not have been a COPD patient (?Pneumonia, ?IPF), but MTR maintained original COPD diagnosis, until an addendum is provided.
2. Further comments from Respiratory team is patient had ILD
3. Respiratory team agreed this is a clinical issue and have classified under category A
4. Update: No addendum provided for this patient

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	✔
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		

Source	Patient ID	2
HED	Age	84
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	2
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**Category A (Clinical Issue)**
HED	Charlson Score	23
HED	Mortality Risk	9.21%
HED	Mortality Risk (adjusting for palliative care)	11.22%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	No
RTR	Other issues identified by Resp team is: Cancer of unknown primary, AKI	

Summary of issues identified

1. This is a clinical issue (Category A): Respiratory team believed this should not have been a COPD patient, and Respiratory Consultant provided an addendum for patient to be re-coded.
2. **Update: Patient's primary diagnosis has been appropriately re-coded to Pneumonia (J189)**

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	✔
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		

Source	Patient ID	3
HED	Age	52
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	3
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**Category A (Clinical issue)**
HED	Charlson Score	-1
HED	Mortality Risk	0.42%
HED	Mortality Risk (adjusting for palliative care)	0.50%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	No
RTR	Other issues identified by Resp team is: Multi-Organ Failure, Lymphoma, Previous Renal Transplant, Type 2 DM	

Summary of issues identified

1. This is a clinical issue (Category A): Respiratory team believed this should not have been a COPD patient, and Respiratory Consultant provided an addendum for patient to be re-coded.
2. **Update: Patient's primary diagnosis has been appropriately re-coded to Pneumonia (J189)**

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	✔
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		

Source	Patient ID	4
HED	Age	99
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	22 - Emergency: via GP
HED	Admission Day Type	Weekday
HED	Number of FCEs	5
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**Category A (Clinical issue)**
HED	Charlson Score	10
HED	Mortality Risk	9.98%
HED	Mortality Risk (adjusting for palliative care)	11.64%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	No
RTR	Other issues identified by Resp team is: Chest Infection, old age	

Summary of issues identified

1. This is a clinical issue (Category A): Respiratory team believed this should not have been a COPD patient, and Respiratory Consultant provided an addendum for patient to be re-coded.

2. **Update: Patient's primary diagnosis has been appropriately re-coded to Unspecified Acute Lower Respiratory Infection (J22X)**

Group B: COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis

Category: Clinical Issue

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	✔
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		

Source	Patient ID	5
HED	Age	78
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	3
HED	Diagnosis on discharge	**Pneumonia**
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**B**
HED	Charlson Score	0
HED	Mortality Risk	2.97%
HED	Mortality Risk (adjusting for palliative care)	3.63%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	No
RTR	Other issues identified by Resp team: Pulmonary Fibrosis, CCF, chest sepsis, pneumonia	

Summary of issues identified

1. Although Respiratory team believed this should not have been a COPD patient, the MTR maintained original COPD diagnosis
2. Respiratory team have reclassified under category B = Clinical issue

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	✔
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		✔

Source	Patient ID	6
HED	Age	80
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	3
HED	Diagnosis on discharge	**Pneumonia**
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**B**
HED	Charlson Score	8
HED	Mortality Risk	36.68%
HED	Mortality Risk (adjusting for palliative care)	5.61%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	**Yes**
HED	If yes, did Palliative team see patient?	**Yes**
RTR	DNR CPR	No
RTR	Type 1 or 2	No
RTR	Other issues identified by Resp team: Lung Cancer	

Summary of issues identified

1. Although Respiratory team believed this should not have been a COPD patient, the MTR maintained original COPD diagnosis, unless addendum provided.
2. Respiratory team have reclassified under category B = Clinical issue

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	✔
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		

Source	Patient ID	7
HED	Age	62
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	3
HED	Diagnosis on discharge	**Pneumonia**
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**B**
HED	Charlson Score	0
HED	Mortality Risk	5.74%
HED	Mortality Risk (adjusting for palliative care)	7.44%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	No
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. Although Respiratory team believed this should not have been a COPD patient, the MTR maintained original COPD diagnosis
2. Respiratory team have reclassified under category B = Clinical issue

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	✔
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		

Source	Patient ID	8
HED	Age	78
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	3
HED	Diagnosis on discharge	**Pneumonia**
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**B**
HED	Charlson Score	0
HED	Mortality Risk	2.97%
HED	Mortality Risk (adjusting for palliative care)	3.63%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: Pulmonary Fibrosis	

Summary of issues identified

1. Although Respiratory team believed this should not have been a COPD patient, the MTR maintained original COPD diagnosis
2. Respiratory team have reclassified under category B = Clinical issue

Group C: Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease

Category: Clinical Issue

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	✔
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		

Source	Patient ID	9
HED	Age	84
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	22 - Emergency: via GP
HED	Admission Day Type	Weekday
HED	Number of FCEs	2
HED	Diagnosis on discharge	**Intracranial injury**
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**C**
HED	Charlson Score	6
HED	Mortality Risk	5.17%
HED	Mortality Risk (adjusting for palliative care)	6.19%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: ?Acute Subdural Haemorrhage, Sepsis, AKI, PR Bleed	

*RTR = Respiratory Team review; HED = Healthcare Evaluation Data

Summary of issues identified

1. Although Respiratory team believed this should not have been a COPD patient, the MTR maintained original COPD diagnosis
2. Respiratory team have reclassified under category C = Clinical issue

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	✔
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		

Source	Patient ID	10
HED	Age	82
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency: via GP
HED	Admission Day Type	Weekday
HED	Number of FCEs	3
HED	Diagnosis on discharge	**Congestive Heart Failure**
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**C**
HED	Charlson Score	26
HED	Mortality Risk	7.18%
HED	Mortality Risk (adjusting for palliative care)	9.38%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: AKI + CCF	

Summary of issues identified

1. Although Respiratory team believed this should not have been a COPD patient, the MTR maintained original COPD diagnosis
2. Respiratory team have reclassified under category C = Clinical issue

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	✔
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		

Source	Patient ID	11
HED	Age	66
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	4
HED	Diagnosis on discharge	**Pneumonia**
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**C**
HED	Charlson Score	6
HED	Mortality Risk	2.30%
HED	Mortality Risk (adjusting for palliative care)	2.93%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. Although Respiratory team believed this should not have been a COPD patient, the MTR maintained original COPD diagnosis
2. Respiratory team have reclassified under category C = Clinical issue

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	✔
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		

Source	Patient ID	12
HED	Age	68
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	8
HED	Diagnosis on discharge	**Pneumonia**
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**C**
HED	Charlson Score	5
HED	Mortality Risk	3.16%
HED	Mortality Risk (adjusting for palliative care)	3.85%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	0
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. Although Respiratory team believed this should not have been a COPD patient, the MTR maintained original COPD diagnosis
2. Respiratory team have reclassified under category C = Clinical issue

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	✔
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		

Source	Patient ID	13
HED	Age	81
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekend
HED	Number of FCEs	1
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**C**
HED	Charlson Score	13
HED	Mortality Risk	7.03%
HED	Mortality Risk (adjusting for palliative care)	8.22%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: Cardiac Arrest + known moderate/severe LV impairment + failed CPR - chest pain then AF + rapid VR in ambulance - -VE Troponins	

Summary of issues identified

1. Although Respiratory team believed this should not have been a COPD patient, the MTR maintained original COPD diagnosis
2. Respiratory team have reclassified under category C = Clinical issue

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	✔
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		✔

Source	Patient ID	14
HED	Age	79
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	2
HED	Diagnosis on discharge	**Pneumonia**
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**C**
HED	Charlson Score	5
HED	Mortality Risk	31.49%
HED	Mortality Risk (adjusting for palliative care)	4.54%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	Yes
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. Although Respiratory team believed this should not have been a COPD patient, the MTR maintained original COPD diagnosis
2. Respiratory team have reclassified under category C = Clinical issue

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	✔
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		

Source	Patient ID	15
HED	Age	72
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekend
HED	Number of FCEs	3
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**C**
HED	Charlson Score	4
HED	Mortality Risk	2.56%
HED	Mortality Risk (adjusting for palliative care)	3.31%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. Although Respiratory team believed this should not have been a COPD patient, the MTR maintained original COPD diagnosis
2. Respiratory team have reclassified under category C = Clinical issue

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	✔
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		✔

Source	Patient ID	16
HED	Age	78
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	3
HED	Diagnosis on discharge	**Pneumonia**
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**C**
HED	Charlson Score	9
HED	Mortality Risk	36.23%
HED	Mortality Risk (adjusting for palliative care)	5.66%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	Yes
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: Sepsis, DVT, Anticoagulated, Illegible G7 Bleed	

Summary of issues identified

1. Although Respiratory team believed this should not have been a COPD patient, the MTR maintained original COPD diagnosis
2. Respiratory team have reclassified under category C = Clinical issue
3. Palliative patient

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	✔
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		✔

Source	Patient ID	17
HED	Age	73
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	3
HED	Diagnosis on discharge	**Influenza**
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**C**
HED	Charlson Score	13
HED	Mortality Risk	36.26%
HED	Mortality Risk (adjusting for palliative care)	5.84%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	Yes
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: Influenza Type A	

Summary of issues identified

1. Although Respiratory team believed this should not have been a COPD patient, the MTR maintained original COPD diagnosis
2. Respiratory team have reclassified under category C = Clinical issue

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	✔
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		✔

Source	Patient ID	18
HED	Age	69
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	6
HED	Diagnosis on discharge	**Pneumonia**
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**C**
HED	Charlson Score	13
HED	Mortality Risk	30.26%
HED	Mortality Risk (adjusting for palliative care)	4.53%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	Yes
HED	If yes, did Palliative team see patient?	Yes
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: Hospital Acquired Pneumonia	

Summary of issues identified

1. Although Respiratory team believed this should not have been a COPD patient, the MTR maintained original COPD diagnosis
2. Respiratory team have reclassified under category C = Clinical issue
3. Palliative patient

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	✔
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		✔

Source	Patient ID	19
HED	Age	79
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekend
HED	Number of FCEs	3
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**C**
HED	Charlson Score	0
HED	Mortality Risk	2.81%
HED	Mortality Risk (adjusting for palliative care)	3.28%
HED	NIV patient	Yes
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: Hospital Acquired Pneumonia	

Summary of issues identified

1. Although Respiratory team believed this should not have been a COPD patient, the MTR maintained original COPD diagnosis
2. Respiratory team have reclassified under category C = Clinical issue
3. NIV patient

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	✔
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		

Source	Patient ID	20
HED	Age	90
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekend
HED	Number of FCEs	2
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**C**
HED	Charlson Score	10
HED	Mortality Risk	6.36%
HED	Mortality Risk (adjusting for palliative care)	7.42%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: Complete Heart Block, Sepsis, Chronic COPD + Bradycardia + AKI + Sepsis	

Summary of issues identified

1. Respiratory team believed this should not have been a COPD patient, and they have reclassified under category C = Clinical Issue

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	✔
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		

Source	Patient ID	21
HED	Age	81
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	5
HED	Diagnosis on discharge	**Pneumonia**
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**C**
HED	Charlson Score	30
HED	Mortality Risk	10.86%
HED	Mortality Risk (adjusting for palliative care)	13.61%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: AKI	

Summary of issues identified

1. Although Respiratory team believed this should not have been a COPD patient, the MTR maintained original COPD diagnosis
2. Respiratory team have reclassified under category C = Clinical issue

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	✔
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		

Source	Patient ID	22
HED	Age	65
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	4
HED	Diagnosis on discharge	**Pulmonary Heart Disease**
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**C**
HED	Charlson Score	11
HED	Mortality Risk	3.55%
HED	Mortality Risk (adjusting for palliative care)	4.50%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	Type 2 Resp failure
RTR	Other issues identified by Resp team: Pneumonia, PE, CT identified HAP + type 2 resp failure secondary to COPD S	

Summary of issues identified

1. Although Respiratory team believed this should not have been a COPD patient, the MTR maintained original COPD diagnosis
2. Respiratory team have reclassified under category C = Clinical issue

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	✔
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		

Source	Patient ID	23
HED	Age	84
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekend
HED	Number of FCEs	5
HED	Diagnosis on discharge	**Acute myocardial infarction**
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**C**
HED	Charlson Score	4
HED	Mortality Risk	5.07%
HED	Mortality Risk (adjusting for palliative care)	6.02%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: STEM - MI	

Summary of issues identified

1. Although Respiratory team believed this should not have been a COPD patient, the MTR maintained original COPD diagnosis
2. Respiratory team have reclassified under category C = Clinical issue

Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis

Category: Clinical Issue

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	✔
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		

Source	Patient ID	24
HED	Age	85
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekend
HED	Number of FCEs	2
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**D**
HED	Charlson Score	0
HED	Mortality Risk	4.75%
HED	Mortality Risk (adjusting for palliative care)	5.67%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	No
RTR	Other issues identified by Resp team: ? Gram Negtive E Coli Septiceamia	

Summary of issues identified

1. Although Respiratory team believed this should not have been a COPD patient, the MTR maintained original COPD diagnosis
2. Respiratory team have reclassified under category D = Clinical issue (Order of diagnosis)

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	✔
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		

Source	Patient ID	25
HED	Age	84
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekend
HED	Number of FCEs	2
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**D**
HED	Charlson Score	16
HED	Mortality Risk	5.12%
HED	Mortality Risk (adjusting for palliative care)	6.62%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: Overwhelming sepsis secondary to community acquired Pneumonia + Frailty + AKI	

Summary of issues identified

1. Although Respiratory team believed this should not have been a COPD patient, the MTR maintained original COPD diagnosis
2. Respiratory team have reclassified under category D = Clinical issue (Order of Diagnosis)

Group E: Inaccurate Coding

Category: Coding Issue

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	✔
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		

Source	Patient ID	26
HED	Age	69
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	2
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**E (coding issue)**
HED	Charlson Score	25
HED	Mortality Risk	5.61%
HED	Mortality Risk (adjusting for palliative care)	7.71%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team:	None

*RTR = Respiratory Team review; HED = Healthcare Evaluation Data

Summary of issues identified

1. This is a coding issue: MTR believed this should not have been a COPD patient

2. Patient's primary diagnosis has been appropriately re-coded to Heart Failure (I509)

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	✔
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		

Source	Patient ID	27
HED	Age	67
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	1
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	**E (Coding Issue)**
HED	Charlson Score	0
HED	Mortality Risk	2.33%
HED	Mortality Risk (adjusting for palliative care)	2.97%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. This is a coding issue: MTR believed this should not have been a COPD patient
2. Patient’s primary diagnosis has been appropriately re-coded to Cardiac Arrest (I460).
3. Type 2 failure patient.

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	✔
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		✔

Source	Patient ID	28
HED	Age	74
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency: via GP
HED	Admission Day Type	Weekday
HED	Number of FCEs	3
HED	Diagnosis on discharge	**Pneumonia**
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**E (Coding)**
HED	Charlson Score	21
HED	Mortality Risk	43.53%
HED	Mortality Risk (adjusting for palliative care)	7.64%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	Yes
HED	If yes, did Palliative team see patient?	Yes
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: Admitted with anaemia	

Summary of issues identified

1. This is a coding issue: MTR believed this should not have been a COPD patient
2. Patient's primary diagnosis has been appropriately re-coded to Anaemia (D649)
3. Palliative patient

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	✔
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		

Source	Patient ID	29
HED	Age	87
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	4
HED	Diagnosis on discharge	**Pneumonia**
RTR	Diagnosis after Resp Team review	**Not COPD**
MTR	What category is patient after Multi-Team Review	**E (coding issue)**
HED	Charlson Score	0
HED	Mortality Risk	5.69%
HED	Mortality Risk (adjusting for palliative care)	6.68%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: Pneumonia and Dementia	

Summary of issues identified

1. This is a coding issue: MTR believed this should not have been a COPD patient
2. Patient's primary diagnosis has been appropriately re-coded to Pneumonia (J181)

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	✔
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		✔

Source	Patient ID	30
HED	Age	66
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	5
HED	Diagnosis on discharge	**COPD**
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**E (coding issue)**
HED	Charlson Score	18
HED	Mortality Risk	34.81%
HED	Mortality Risk (adjusting for palliative care)	5.76%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	Yes
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: Sepsis (?UTI), + AKI + Heart Failure	

Summary of issues identified

1. This is a coding issue: MTR believed this should not have been a COPD patient

2. Patient’s primary diagnosis has been appropriately re-coded to Acute Renal Failure (N179)

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	✔
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		

Source	Patient ID	31
HED	Age	59
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	22 - Emergency: via GP
HED	Admission Day Type	Weekday
HED	Number of FCEs	3
HED	Diagnosis on discharge	**Cancer of bronchus; lung**
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**E (coding issue)**
HED	Charlson Score	6
HED	Mortality Risk	1.85%
HED	Mortality Risk (adjusting for palliative care)	2.25%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: Mediastinal Mass, Lung Cancer Vs Lymphoma	

Summary of issues identified

1. This is a coding issue: MTR believed this should not have been a COPD patient
2. Patient's primary diagnosis has been appropriately re-coded to Malignant Neoplasm Bronchus or Lung, Unspecified (C349)

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	✔
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		

Source	Patient ID	32
HED	Age	80
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	1
HED	Diagnosis on discharge	**COPD**
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**E= Coding issue**
HED	Charlson Score	22
HED	Mortality Risk	7.07%
HED	Mortality Risk (adjusting for palliative care)	9.14%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: End Stage IPF + Coronary Pulmonade; ILD - died rapidly. No evidence of COPD	

Summary of issues identified

1. This is a coding issue: MTR believed this should not have been a COPD patient
2. Patient's primary diagnosis has been appropriately re-coded to Congestive Heart Failure (I500)

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	✔
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		

Source	Patient ID	33
HED	Age	77
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekend
HED	Number of FCEs	1
HED	Diagnosis on discharge	**COPD**
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**E (coding issue)**
HED	Charlson Score	3
HED	Mortality Risk	3.48%
HED	Mortality Risk (adjusting for palliative care)	4.31%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: Acute Upper Airway Obstruction; angio-oedema leading to stridor + ?arytenoid swelling secondary to infection	

Summary of issues identified

1. This is a coding issue: MTR believed this should not have been a COPD patient
2. Patient's primary diagnosis has been appropriately re-coded to Oedema of Larynx (J384)

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	✔
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		✔

Source	Patient ID	34
HED	Age	72
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	1
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	**E (coding issue)**
HED	Charlson Score	14
HED	Mortality Risk	36.63%
HED	Mortality Risk (adjusting for palliative care)	5.59%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	Yes
HED	If yes, did Palliative team see patient?	Yes
RTR	DNR CPR	Yes
RTR	Type 1 or 2	**Type 2**
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. This is a coding issue: MTR believed this should not have been a COPD patient
2. Patient's primary diagnosis has been appropriately re-coded to Pneumonia (J189)
3. Palliative patient
4. DNR CPR in place
5. Type 2 failure

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	✔
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		

Source	Patient ID	35
HED	Age	75
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	2
HED	Diagnosis on discharge	**Septicaemia**
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**E= Coding Issue**
HED	Charlson Score	5
HED	Mortality Risk	4.56%
HED	Mortality Risk (adjusting for palliative care)	5.58%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: Pneumonia Patient. 1. Death cert = Sepsis; LRTI; End Stage COPD. 2. Clerk in = Metabolic Acidosis; ? Sepsis 3. PTWR = Sepsis + Exacerbation of severe COPD 4. Radiology = Likely pneumonia as cause of sepsis	

Summary of issues identified

1. This is a coding issue: MTR believed this should not have been a COPD patient
2. Patient's primary diagnosis has been appropriately re-coded to Septicaemia (A419)

No Issue category - F

(i.e. Diagnosis remains COPD after Respiratory Team Review and Coding review)

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		**NO**
Others	**DNR CPR**		✔

Source	Patient ID	36
HED	Age	81
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	4
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD – No issue
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	6
HED	Mortality Risk	4.95%
HED	Mortality Risk (adjusting for palliative care)	5.77%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	**Yes**
HED	If yes, did Palliative team see patient?	**No**
RTR	DNR CPR	Yes
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. No Issue category - F
2. Respiratory team believed identified this patient as palliative patient but the palliative team did not see the patient.
3. Type 2 failure patient.
4. DNR CPR in place

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		✔

Source	Patient ID	37
HED	Age	74
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	4
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	8
HED	Mortality Risk	25.80%
HED	Mortality Risk (adjusting for palliative care)	3.58%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	Yes
HED	If yes, did Palliative team see patient?	Yes
RTR	DNR CPR	No
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. No Issue category - F
2. Palliative patient
3. Respiratory team review identified patient as Type 2 failure

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		**NO**
Others	**DNR CPR**		✔

Source	Patient ID	38
HED	Age	61
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	1
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	0
HED	Mortality Risk	1.58%
HED	Mortality Risk (adjusting for palliative care)	1.93%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	**Yes**
HED	If yes, did Palliative team see patient?	**No**
RTR	DNR CPR	Yes
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. No Issue category - F
2. Patient identified as palliative by respiratory team, but palliative team did not see patient
3. Respiratory team review identified patient as Type 2 failure
4. DNR CPR in place

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		✔
Others	**DNR CPR**		✔

Source	Patient ID	39
HED	Age	63
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	2D - Emergency: other admission
HED	Admission Day Type	Weekday
HED	Number of FCEs	2
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	0
HED	Mortality Risk	14.73%
HED	Mortality Risk (adjusting for palliative care)	1.72%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	Yes
HED	If yes, did Palliative team see patient?	Yes
RTR	DNR CPR	Yes
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. No Issue category - F
2. Palliative patient
3. Respiratory Team review identified patient as Type 2 failure
4. DNR CPR in place

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		**NO**
Others	**DNR CPR**		✔

Source	Patient ID	40
HED	Age	59
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	A&E
HED	Admission Day Type	Weekend
HED	Number of FCEs	1
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	0
HED	Mortality Risk	0.99%
HED	Mortality Risk (adjusting for palliative care)	1.19%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	**Yes**
HED	If yes, did Palliative team see patient?	**No**
RTR	DNR CPR	Yes
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. No Issue category - F
2. Patient recognised as being palliative, but palliative team did not see patient
3. Type-2 failure
4. Patient had DNR CPR in place

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		✔
Others	**DNR CPR**		✔

Source	Patient ID	41
HED	Age	62
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	2
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	1
HED	Mortality Risk	18.77%
HED	Mortality Risk (adjusting for palliative care)	2.37%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	Yes
HED	If yes, did Palliative team see patient?	Yes
RTR	DNR CPR	Yes
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. No Issue category - F
2. Palliative patient
3. Type 2 patient
4. DNR CPR in place

Source	Patient ID	42
HED	Age	73
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	1
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	0
HED	Mortality Risk	2.58%
HED	Mortality Risk (adjusting for palliative care)	3.11%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	**Yes**
HED	If yes, did Palliative team see patient?	**No**
RTR	DNR CPR	Yes
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. No Issue category - F
2. Patient recognised as palliative, but palliative team did not see patient
3. DNR CPR in place
4. Type 2 failure

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		**NO**
Others	**DNR CPR**		✔

Source	Patient ID	43
HED	Age	72
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	1
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	8
HED	Mortality Risk	3.20%
HED	Mortality Risk (adjusting for palliative care)	4.11%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	**Yes**
HED	If yes, did Palliative team see patient?	**No**
RTR	DNR CPR	**Yes**
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. No Issue category - F
2. Patient recognised as palliative but palliative team did not see patient
3. Type 2 respiratory failure
4. DNR CPR in place

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		**NO**
Others	**DNR CPR**		✔

Source	Patient ID	44
HED	Age	68
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	1
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	4
HED	Mortality Risk	1.98%
HED	Mortality Risk (adjusting for palliative care)	2.42%
HED	NIV patient	Yes
RTR	Is patient recognised as being palliative (by Resp Team)	**Yes**
HED	If yes, did Palliative team see patient?	**No**
RTR	DNR CPR	**Yes**
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. No Issue category - F
2. Palliative patient but palliative team did not see patient
3. Type 2 Respiratory failure
4. NIV patient

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		✔
Others	**DNR CPR**		✔

Source	Patient ID	45
HED	Age	83
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	3
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	10
HED	Mortality Risk	35.44%
HED	Mortality Risk (adjusting for palliative care)	5.03%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	Yes
HED	If yes, did Palliative team see patient?	Yes
RTR	DNR CPR	Yes
RTR	Type 1 or 2	Type 1
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. No Issue category - F
2. Patient is palliative
3. Type 1 failure
4. DNR CPR in place

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		**NO**
Others	**DNR CPR**		✔

Source	Patient ID	46
HED	Age	74
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	1
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	3
HED	Mortality Risk	2.96%
HED	Mortality Risk (adjusting for palliative care)	3.48%
HED	NIV patient	Yes
RTR	Is patient recognised as being palliative (by Resp Team)	**Yes**
HED	If yes, did Palliative team see patient?	**No**
RTR	DNR CPR	**Yes**
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. No Issue category - F
2. Respiratory team recognise patient as palliative, but Palliative team not involved
3. DNR CPR in place
4. Type 2 failure
5. NIV patients

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		
Others	**DNR CPR**		✔

Source	Patient ID	47
HED	Age	67
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekend
HED	Number of FCEs	3
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	0
HED	Mortality Risk	2.08%
HED	Mortality Risk (adjusting for palliative care)	2.42%
HED	NIV patient	Yes
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	**Yes**
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. No Issue category - F
2. NIV patients
3. DNR CPR in place
4. Type 2 Respiratory Failure

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		**NO**
Others	**DNR CPR**		✔

Source	Patient ID	48
HED	Age	67
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	1
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	0
HED	Mortality Risk	2.07%
HED	Mortality Risk (adjusting for palliative care)	2.43%
HED	NIV patient	Yes
RTR	Is patient recognised as being palliative (by Resp Team)	**Yes**
HED	If yes, did Palliative team see patient?	**No**
RTR	DNR CPR	**Yes**
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. No Issue category - F
2. Patient recognised as palliative but palliative team did not see patient
3. DNR CPR in place
4. Type 2 Respiratory Failure
5. NIV patient

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		**NO**
Others	**DNR CPR**		✔

Source	Patient ID	49
HED	Age	73
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	1
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	13
HED	Mortality Risk	4.39%
HED	Mortality Risk (adjusting for palliative care)	5.36%
HED	NIV patient	Yes
RTR	Is patient recognised as being palliative (by Resp Team)	**Yes**
HED	If yes, did Palliative team see patient?	**No**
RTR	DNR CPR	**Yes**
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: Underlying Lung Cancer + Acute MI	

Summary of issues identified

1. No Issue category - F

2. Patient recognised s palliative but Palliative team did not see patient
3. DNR CPR in place
4. NIV patient
5. Type 2 failure

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		**NO**
Others	**DNR CPR**		✔

Source	Patient ID	50
HED	Age	76
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	3
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	13
HED	Mortality Risk	5.78%
HED	Mortality Risk (adjusting for palliative care)	7.65%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	**Yes**
HED	If yes, did Palliative team see patient?	**No**
RTR	DNR CPR	**Yes**
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: Not initially managed with ABGs - palliative arena for end stage COPD	

Summary of issues identified

1. No Issue category - F
2. Patient recognised as palliative but palliative team did not see patient
3. DNR CPR in place
4. Type 2 Respiratory Failure

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		✔
Others	**DNR CPR**		✔

Source	Patient ID	51
HED	Age	76
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	3
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	0
HED	Mortality Risk	27.08%
HED	Mortality Risk (adjusting for palliative care)	3.69%
HED	NIV patient	Yes
RTR	Is patient recognised as being palliative (by Resp Team)	Yes
HED	If yes, did Palliative team see patient?	Yes
RTR	DNR CPR	Yes
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. No Issue category - F
2. Palliative patient
3. NIV patient
4. Type 2 failure

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		✔

Source	Patient ID	52
HED	Age	87
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	1
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	8
HED	Mortality Risk	50.57%
HED	Mortality Risk (adjusting for palliative care)	9.21%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	Did Palliative team see patient?	Yes
RTR	DNR CPR	No
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: Admitted with extreme frailty + AF + rapid VR - EOLC AT HOME - TYPE 2 RF on ABGS as in terminal stage - could have been secondary to severe kyphoscoliosis	

Summary of issues identified

1. No Issue category - F
2. Palliative patient
3. Type 2 patient

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		✔
Others	**DNR CPR**		✔

Source	Patient ID	53
HED	Age	73
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekend
HED	Number of FCEs	8
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	10
HED	Mortality Risk	28.45%
HED	Mortality Risk (adjusting for palliative care)	4.14%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	Yes
HED	If yes, did Palliative team see patient?	Yes
RTR	DNR CPR	Yes
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. No Issue category - F
2. Palliative patient
3. DNR CPR in place
4. Type 2

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		✔
Others	**DNR CPR**		✔

Source	Patient ID	54
HED	Age	72
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	2
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	16
HED	Mortality Risk	30.58%
HED	Mortality Risk (adjusting for palliative care)	4.67%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	Yes
HED	If yes, did Palliative team see patient?	Yes
RTR	DNR CPR	Yes
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. No Issue category - F
2. Palliative patient
3. DNR CPR in place
4. Type 2 Respiratory Failure

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		**NO**
Others	**DNR CPR**		**No**

Source	Patient ID	55
HED	Age	74
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekend
HED	Number of FCEs	2
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	13
HED	Mortality Risk	3.95%
HED	Mortality Risk (adjusting for palliative care)	4.89%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	Yes
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	Type 1
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. No Issue category - F
2. Patient recognised as palliative but palliative team did not see patient
3. Type 1 failure

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		
Others	**DNR CPR**		✔

Source	Patient ID	56
HED	Age	73
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	3
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	4
HED	Mortality Risk	2.79%
HED	Mortality Risk (adjusting for palliative care)	3.37%
HED	NIV patient	Yes
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	Yes
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. No Issue category - F
2. NIV patient
3. DNR CPR in place
4. Type 2 respiratory failure

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		**NO**
Others	**DNR CPR**		✔

Source	Patient ID	57
HED	Age	61
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekend
HED	Number of FCEs	3
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	0
HED	Mortality Risk	1.22%
HED	Mortality Risk (adjusting for palliative care)	1.55%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	**Yes**
HED	If yes, did Palliative team see patient?	**No**
RTR	DNR CPR	**Yes**
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. No Issue category - F
2. Patient recognised as palliative, but did not see palliative team
3. DNR CPR in place
4. Type 2 failure

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		**NO**
Others	**DNR CPR**		✔

Source	**Patient ID**	58
HED	Age	72
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekend
HED	Number of FCEs	3
HED	Diagnosis on discharge	123 - Influenza
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	4
HED	Mortality Risk	2.58%
HED	Mortality Risk (adjusting for palliative care)	3.09%
HED	NIV patient	Yes
RTR	Is patient recognised as being palliative (by Resp Team)	**Yes**
HED	If yes, did Palliative team see patient?	**No**
RTR	DNR CPR	**Yes**
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: Influenza Type B	

Summary of issues identified

1. No Issue category - F
2. Patient recognised as palliative but palliative team did not see patient
3. NIV patient
4. DNR CPR in place
5. Type 2

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		✔
Others	**DNR CPR**		✔

Source	**Patient ID**	59
HED	Age	82
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	22 - Emergency: via GP
HED	Admission Day Type	Weekend
HED	Number of FCEs	1
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	0
HED	Mortality Risk	33.99%
HED	Mortality Risk (adjusting for palliative care)	4.72%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	Did Palliative team see patient?	Yes
RTR	DNR CPR	Yes
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: Also had severe sepsis (no culture) + AF + delirium	

Summary of issues identified

1. No Issue category - F
2. Palliative patient
3. DNR CPR in place
4. Type 2 failure

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		
Palliative	**Seen by Palliative team**		

Source	Patient ID	60
HED	Age	80
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	22 - Emergency: via GP
HED	Admission Day Type	Weekday
HED	Number of FCEs	5
HED	Diagnosis on discharge	Pneumonia
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	21
HED	Mortality Risk	4.23%
HED	Mortality Risk (adjusting for palliative care)	5.40%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. No Issue category - F

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		**NO**
Others	**DNR CPR**		**No**

Source	Patient ID	61
HED	Age	76
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	1
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	4
HED	Mortality Risk	2.85%
HED	Mortality Risk (adjusting for palliative care)	3.41%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	**Yes**
HED	If yes, did Palliative team see patient?	**No**
RTR	DNR CPR	**No**
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. No Issue category - F
2. Patient recognised as palliative, but Palliative team did not see patient
3. Type 2 failure

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**		✔
Palliative	**Seen by Palliative team**		✔
Others	**DNR CPR**		✔

Source	Patient ID	62
HED	Age	76
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	3
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	0
HED	Mortality Risk	30.92%
HED	Mortality Risk (adjusting for palliative care)	4.37%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	Yes
HED	If yes, did Palliative team see patient?	Yes
RTR	DNR CPR	Yes
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. No Issue category - F
2. Palliative patient
3. DNR CPR in place
4. Type 2 Respiratory failure

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**	**NO**	
Palliative	**Seen by Palliative team**		✔
Others	**DNR CPR**		✔

Source	Patient ID	63
HED	Age	62
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekend
HED	Number of FCEs	1
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	0
HED	Mortality Risk	17.67%
HED	Mortality Risk (adjusting for palliative care)	2.07%
HED	NIV patient	Yes
RTR	Is patient recognised as being palliative (by Resp Team)	**No**
HED	If yes, did Palliative team see patient?	**Yes**
RTR	DNR CPR	**Yes**
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. No Issue category - F
2. Palliative patient
3. DNR CPR in place
4. Type 2 Respiratory Failure
5. NIV patient

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	**Recognised as Palliative**	**Yes**	✔
Palliative	**Seen by Palliative team**		
Others	**DNR CPR**		✔

Source	Patient ID	64
HED	Age	74
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	1
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	13
HED	Mortality Risk	3.62%
HED	Mortality Risk (adjusting for palliative care)	4.50%
HED	NIV patient	Yes
RTR	Is patient recognised as being palliative (by Resp Team)	**Yes**
HED	If yes, did Palliative team see patient?	**No**
RTR	DNR CPR	**Yes**
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. No Issue category - F
2. Patient recognised as palliative, but palliative team did not see patient
3. NIV patient
4. DNR CPR in place

5. Type 2 respiratory failure

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	Recognised as Palliative		
Palliative	Seen by Palliative team		

Source	**Patient ID**	65
HED	Age	72
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	22 - Emergency: via GP
HED	Admission Day Type	Weekday
HED	Number of FCEs	2
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	12
HED	Mortality Risk	2.65%
HED	Mortality Risk (adjusting for palliative care)	3.43%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. No Issue category - F

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	Recognised as Palliative		
Palliative	Seen by Palliative team		
Others	DNR CPR		✔

Source	**Patient ID**	66
HED	Age	50
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	4
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	0
HED	Mortality Risk	0.82%
HED	Mortality Risk (adjusting for palliative care)	0.98%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	**Yes**
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: ? opiate toxicity in common with severe COPD - known IVDU	

Summary of issues identified

1. No Issue category - F
2. DNR CPR in place
3. Type 2 respiratory failure

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	Recognised as Palliative		
Palliative	Seen by Palliative team		

Source	Patient ID	67
HED	Age	74
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	1
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	7
HED	Mortality Risk	3.12%
HED	Mortality Risk (adjusting for palliative care)	3.82%
HED	NIV patient	Yes
RTR	Is patient recognised as being palliative (by Resp Team)	Yes
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	Yes
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. No Issue category - F

2. Patient recognised as palliative, but palliative team did not see patient.
3. NIV patient
4. DNR CPR in place
5. Type 2 respiratory failure

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	Recognised as Palliative		✔
Palliative	Seen by Palliative team		✔
Others	DNR CPR		✔

Source	**Patient ID**	68
HED	Age	75
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	12 - Elective: booked
HED	Admission Day Type	Weekday
HED	Number of FCEs	1
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	0
HED	Mortality Risk	24.81%
HED	Mortality Risk (adjusting for palliative care)	3.62%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	**Yes**
HED	If yes, did Palliative team see patient?	**Yes**
RTR	DNR CPR	**Yes**
RTR	Type 1 or 2	Type 1
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. No Issue category - F
2. Palliative patient
3. Type 1 respiratory failure
4. DNR CPR in place

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	✔
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	
Palliative	Recognised as Palliative		✔
Palliative	Seen by Palliative team		✔
Others	DNR CPR		

Source	Patient ID	69
HED	Age	59
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	1
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	COPD
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	0
HED	Mortality Risk	10.60%
HED	Mortality Risk (adjusting for palliative care)	1.13%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	**Yes**
HED	If yes, did Palliative team see patient?	**Yes**
RTR	DNR CPR	No
RTR	Type 1 or 2	Type 2
RTR	Other issues identified by Resp team: None	

Summary of issues identified

1. No Issue category - F
2. Palliative patient
3. Type 2 respiratory failure

Group U – (Poor) documentation group

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	✔
Palliative	Recognised as Palliative		
Palliative	Seen by Palliative team		
Others	DNR CPR		

Source	**Patient ID**	70
HED	Age	54
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	2
HED	Diagnosis on discharge	**COPD**
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**COPD**
HED	Charlson Score	0
HED	Mortality Risk	0.82%
HED	Mortality Risk (adjusting for palliative care)	0.98%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: 1. CCF + Underlying Pulmonary Fibrosis 2. PTWR = ILD/Obesity/?Heart Failure	

Summary of issues identified

1. Respiratory team believed patient should not have been coded COPD

2. Category is undecided (Category U)

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	✔
Palliative	Recognised as Palliative		
Palliative	Seen by Palliative team		
Others	DNR CPR		

Source	**Patient ID**	71
HED	Age	70
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekend
HED	Number of FCEs	2
HED	Diagnosis on discharge	**Pneumonia**
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	**COPD**
HED	Charlson Score	14
HED	Mortality Risk	3.26%
HED	Mortality Risk (adjusting for palliative care)	4.12%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: IHD, RA, CAP - DEATH CERT, CLERK IN = SEVERE ONSET SEPSIS, COPD AS CO-MORBIDITY - DIED PRE PTWR	

Summary of issues identified

1. Respiratory team believed patient should not have been coded COPD
2. Category is undecided (Category U)

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	✔
Palliative	Recognised as Palliative		
Palliative	Seen by Palliative team		
Others	DNR CPR		

Source	**Patient ID**	72
HED	Age	84
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	2
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	Not COPD
RTR	What category is patient after Multi-Team Review	Category U
HED	Charlson Score	3
HED	Mortality Risk	5.18%
HED	Mortality Risk (adjusting for palliative care)	6.17%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: Pneumonia, Adult Respiratory Distress Syndrome Secondary To Pneumonia + Lung Abscess	

Summary of issues identified

1. Respiratory team believed patient should not have been coded COPD
2. Category is undecided (Category U)

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	✔
Palliative	Recognised as Palliative		
Palliative	Seen by Palliative team		
Others	DNR CPR		

Source	**Patient ID**	73
HED	Age	85
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	3
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	Category U
RTR	What category is patient after Multi-Team Review	COPD
HED	Charlson Score	4
HED	Mortality Risk	6.65%
HED	Mortality Risk (adjusting for palliative care)	7.76%
HED	NIV patient	Yes
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: 1. Interstitial Pulmonary Fibrosis (IPF) 2. ILD - received BIPAP in ED. 3. COPD not mentioned during admission	

Summary of issues identified

1. Respiratory team believed patient should not have been coded COPD

2. Category is undecided (Category U)

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	✔
Palliative	Recognised as Palliative		
Palliative	Seen by Palliative team		
Others	DNR CPR		

Source	**Patient ID**	74
HED	Age	65
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekend
HED	Number of FCEs	2
HED	Diagnosis on discharge	**Pneumonia**
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	Category U
HED	Charlson Score	26
HED	Mortality Risk	7.26%
HED	Mortality Risk (adjusting for palliative care)	9.70%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	No
RTR	Other issues identified by Resp team: 1. Severe Interstitial Lung Disease 2. Sepsis also noted	

Summary of issues identified

1. Respiratory team believed patient should not have been coded COPD

2. Category is undecided (Category U)

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	✔
Palliative	Recognised as Palliative		
Palliative	Seen by Palliative team		
Others	DNR CPR		

Source	**Patient ID**	75
HED	Age	75
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	4
HED	Diagnosis on discharge	**Pneumonia**
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	Category U
HED	Charlson Score	5
HED	Mortality Risk	29.47%
HED	Mortality Risk (adjusting for palliative care)	3.97%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	Yes
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: Sepsis, AKI, Metabolic Acidosis	

Summary of issues identified

1. Respiratory team believed patient should not have been coded COPD
2. Category is undecided (Category U)

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	✔
Palliative	Recognised as Palliative		
Palliative	Seen by Palliative team		✔

Source	**Patient ID**	76
HED	Age	86
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekday
HED	Number of FCEs	2
HED	Diagnosis on discharge	**Aspiration pneumonitis; food/vomitus**
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	Category U
HED	Charlson Score	19
HED	Mortality Risk	46.71%
HED	Mortality Risk (adjusting for palliative care)	7.79%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	Yes
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: 1. Pneumonia; Pneumonia Type = Aspiration 2. Parkinson's 3. A&E = Lethargy 4. CLERK IN = Worsening PD'S + LRTI 5. PTWR = LRTI + lethargy ? Drug related	

Summary of issues identified

1. Respiratory team believed patient should not have been coded COPD
2. Category is undecided (Category U)
3. Palliative patient

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	✔

Source	Patient ID	77
HED	Age	52
HED	Sex	Female
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekend
HED	Number of FCEs	4
HED	Diagnosis on discharge	**Peri-; endo-; and myocarditis; cardiomyopathy**
RTR	Diagnosis after Resp Team review	**Not COPD**
RTR	What category is patient after Multi-Team Review	Category U
HED	Charlson Score	0
HED	Mortality Risk	0.64%
HED	Mortality Risk (adjusting for palliative care)	0.75%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	No
RTR	Other issues identified by Resp team: 1. Sepsis, Large Pericardial Effusion + Evidence Of Tamponade With Pleural Effusion 2. A&E = Sepsis Chest?/UTI?, COPD as co-morbidity 3. PTWR = infective exacerbation of COPD –	

Summary of issues identified

1. Respiratory team believed patient should not have been coded COPD

2. Category is undecided (Category U)

Category	Definition	Issue Type	Tick ✔
A	Inappropriate Clinical Diagnosis	Clinical	
B	COPD documented in 1st FCE in AMU, but subsequent FCEs documented different diagnosis	Clinical	
C	Infective exacerbation of COPD mentioned in 1st FCE, but patient died from another disease	Clinical	
D	Infective exacerbation of COPD mentioned in 1st FCE, but should not have been 1st in order of diagnosis	Clinical	
E	Inaccurate Coding	Coding	
F	Correctly attributed to COPD diagnosis group	-	
U	(Poor) documentation led to COPD diagnosis where retrospective specialist respiratory review suggested not COPD	(Poor) documentation	✔

Source	Patient ID	78
HED	Age	86
HED	Sex	Male
HED	Admission date	**/**/****
HED	Discharged Date	**/**/****
HED	Admission method	Emergency via A&E
HED	Admission Day Type	Weekend
HED	Number of FCEs	2
HED	Diagnosis on discharge	COPD
RTR	Diagnosis after Resp Team review	Not COPD
RTR	What category is patient after Multi-Team Review	Category U
HED	Charlson Score	19
HED	Mortality Risk	7.33%
HED	Mortality Risk (adjusting for palliative care)	9.22%
HED	NIV patient	No
RTR	Is patient recognised as being palliative (by Resp Team)	No
HED	If yes, did Palliative team see patient?	No
RTR	DNR CPR	No
RTR	Type 1 or 2	None
RTR	Other issues identified by Resp team: Pulmonary Fibrosis, Pneumonia	

Summary of issues identified

1. Respiratory team believed patient should not have been coded COPD
2. Category is undecided (Category U)

ENDS