Luton & Dunstable University Hospital

Board of Directors

Board of Directors

COMET Lecture Hall

03 May 2017 10:00 - 03 May 2017 12:00

AGENDA

#	Description	Owner	Time
1	Chairman's Welcome & Note of Apologies	SL	
2	Any Urgent Items of Any Other Business and Declaration of Interest on items on the Agenda and/or the Register of Directors Interests	SL	
3	Minutes of the Previous Meeting: Wednesday 1 February 2017 (attached) To approve 3 Minutes BoD 010217 version 1 (3).doc 5	SL	
4	Matters Arising ((action Log) (no actions) To note	SL	
5	Chairman's Report (verbal) To note	SL	
6	Chief Executive's Report (attached) To note 6 CEO Report May 2017.docx 11	DC	
7	Performance Reports Header (attached) 7 Performance Reports Header.doc 15		
7.10	Quality & Performance (attached) To note 7.1 Quality and Performance Report for Board, CO... 17	SO/DC/CJ	
7.20	Finance (attached) To note 7.2 Finance Board Report May 17.docx 39	AH	
7.30	Workforce (attached) To note 7.3 Workforce Report April 2017 v5.pptx 49	AD	

#	Description	Owner	Time
8	Executive Board Report (attached) To note 8 Executive Board Report May 2017.doc 55	DC	
9	Clinical Outcomes, Safety & Quality Report (attached) To note 9 COSQ Report Jan and March 2017.doc 81	AC	
10	Finance, Investment & Performance Committee Report (attached) To note 10 FIP Report to the Board_Q4.docx 87	JR	
11	Audit & Risk Committee Report (attached) To note 11 AUDIT and RISK 8 FEB and 22 MARCH 17 COM... 91	DH	
12	Hospital Re-Development Committee Report (attached) To note 12 Hospital Redevelopment Report.doc 103	DH	
13	Risk Register (attached) To approve 13 RR May 2017.doc 107	VP	
14	Board Secretary Report (attached) To ratify 14 Board Secretary Report May 17.pdf 111	VP	
15	Details of Next Meeting: Wednesday 26 July 2017, 10.00am, COMET Lecture Hall		
16	Close		

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LUTON & DUNSTABLE UNIVERSITY HOSPITAL

BOARD OF DIRECTORS

Agenda item	3	**Category of Paper**	Tick
Paper Title	Minutes of the Meeting held on Wednesday 1 February 2017	**To action**	☒
Date of Meeting	Wednesday 3 May 2017	**To note**	☐
Lead Director	Pauline Philip	**For Information**	☐
Paper Author	Pauline Philip	**To ratify**	☒
Indicate the impact of the paper: **Financial** ☒ **Quality/Safety** ☒ **Patient Experience** ☒ **Equality** ☒ **Clinical** ☒ **Governance** ☐			

History of Committee Reporting and Date	N/A
Links to Strategic Board Objectives	All objectives
Links to Regulations/ Outcomes/External Assessments	CQC Monitor
Links to the Risk Register	All Board Level Risks rated High Risk (15+)

PURPOSE OF THE PAPER/REPORT

To provide an accurate record of the meeting.

SUMMARY/CURRENT ISSUES AND ACTION

Matters arising to be addressed through the action log.

ACTION REQUIRED

To approve the Minutes.

Public Meeting ☒ Private Meeting ☐

THE LUTON & DUNSTABLE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST
BOARD OF DIRECTORS

Minutes of the meeting held on Wednesday 1 February 2017

Present:
Mr Simon Linnett, Chairman
Mrs Pauline Philip, CEO
Mr David Carter, Managing Director
Ms Angela Doak, Director of Human Resources
Mr Andrew Harwood, Director of Finance
Ms Sheran Oke, Acting director of Nursing & Midwifery
Mr Mark England, Director of Re-Engineering
Dr Danielle Freedman, Chief Medical Adviser
Ms Alison Clarke, Non-Executive Director
Ms Jill Robinson, Non-Executive Director
Mr John Garner, Non-Executive Director
Dr Vimal Tiwari, Non-Executive Director
Mr David Hendry, Non-Executive Director
Mr Mark Versallion, Non-Executive Director
Mr Cliff Bygrave, Non-Executive Director

In attendance:
Ms Marion Collict, Director of Operations
Ms Cathy Jones, Director of Service Development
Mr Ian Allen, Director of Estates and Facilities
Ms Gwen Collins, Senior Adviser to the Board
Ms Victoria Parsons, Board Secretary
14 non Board members, including governors

1. CHAIRMAN'S WELCOME & NOTE OF APOLOGIES

The Chairman opened the meeting, welcoming governors & members of the public. With the exception of public & governors, papers would be assumed to have been read. Questions would be taken at the end of the meeting, other than points of clarity. Actions would be summarised by the Board Secretary following the meeting. The audience were reminded that this was a meeting in public, as opposed to a public meeting.

2. ANY URGENT ITEMS OF ANY OTHER BUSINESS TO BE DECLARED AND ANY DELARATIONS OF INTEREST?

No items of any other business were raised. No declarations of interest were made.

3. MINUTES OF MEETING HELD ON WEDNESDAY 2 NOVEMBER 2016

Food Standards Agency Rating – in response to a question from the chairman, David Carter reported that the Food Standards Agency had re-visited in January and re-assessed the service to be Grade 3.

Workforce – in response to a question from the Chairman relating to

appraisals, Angela Doak reported that the issue was dealt with in the Workforce Report.

COSQ – in response to a question from the Chairman, Marion Collict updated the Board on the position in relation to the proposed centralisation of complaints.

The minutes were approved as an accurate record.

Proposed: J Garner **Seconded**: A Clarke

4. MATTERS ARISING (ACTION LOG)

There we no actions recorded.

5. CHAIRMAN'S REPORT

The Board received the Chairman's report as follows:

The chairman reported on the event held to acknowledge the work of volunteers. He asked the Board to express their thanks, which was fully supported. He also asked David Carter to confirm that the car parking issues for volunteers had been resolved. David Carter confirmed that this was the case.

The Chairman then asked David Carter to update the Board on the improvements being made with regards to car parking.

6. CHIEF EXECUTIVE'S REPORT

The Board received the Chief Executive's report.

The CEO drew the Board's attention to a number of areas where she believed that they would wish to acknowledge the work of our staff, with particular reference to our excellent performance across the hospital during the winter period.

7. PERFORMANCE REPORTS

Quality & Performance Report – the Board received the report.

Sheran Oke talked to the Quality Report highlighting a number of areas of excellent performance in relation to the quality of care being provided. She asked to Board to note the performance which was delivered despite the hospital being extremely busy.

Marion Collict spoke to the risk management part of the report, highlighting the work on incident reporting and our good compliance with the Duty of Candour. She informed the Board that we have seen some improvement in our HSMR but stressed that the comprehensive programme of work in relation to understanding mortality issues continues.

The Board also discussed the work being done to understand the spike in patient deaths during January, to understand if there were any issues. The Medical Adviser to the Board confirmed that the review had indicated no concerns. Alison Clarke felt the organisation should be congratulated on this prompt response. Finally, Marion gave a comprehensive update in relation to improving complaint response times.

David Carter updated the Board on the Trust's good performance in relation to ED, Cancer and 18 weeks and our ongoing efforts to further improve 18 week performance. Mark Versallion asked David Carter to comment on the balance between facilities (space) and staff in trying to improve the matter. Finally, the Board's attention was drawn to the work being done to improve stroke performance.

Finance Report – Andrew Harwood presented the report.

He updated the Board on our financial position. He highlighted the work being done with NHSI in relation to our 'Control Total' and the case that had been presented to them concerning the methodology that had been used in the setting of the same. Finally, he alerted the Board to the work being done with regards to agency expenditure and the challenges that we continue to face in the management of medical agency staff. He informed that Board that 9 of the 20 'high cost' agency positions have been resolved during December. Vimal Tiwari suggested the NEDs might be involved. Alison Clark raised the issue of staff turnover and whether greater efforts were needed to understand the reasons that staff leave the organisation.

Workforce Report – Angela Doak discussed the work that is being done in relation to overseas recruitment and the problems that we are trying to resolve. She highlighted some of the success that the Trust have had in relation to ore local recruitment, in particular, HCAs and a number of medical posts.

With regards to agency staffing, the Board was informed that weekly agency staffing meetings are taking place.

8. EXECUTIVE BOARD REPORT

The CEO drew the Board's attention to a number of items and the Board discussed the issues in relation to catering at greater length.

9. CLINICAL OUTCOME, SAFETY & QUALITY (COSQ) COMMITTEE REPORT

A Clarke talked to the COSQ Report, no issues were raised.

10. FINANCE, INVESTMENT & PERFORMANCE (FIP) COMMITTEE REPORTS

Jill Robinson highlighted a number of issues, including challenges in relation to agency costs and capital planning. She reminded the Board that 2017/18 would be very difficult in light of the national financial position and ongoing demand. Finally, she acknowledged the opportunity with regard to IT innovation.

11. CHARITABLE FUNDS COMMITTEE REPORTS

David Hendry talked to the report and highlighted some significant donations.

12. HOSPITAL RE-DEVELOPMENT COMMITTEE REPORT

The Board noted the report, which was taken as read.

David Hendry updated the Board on the work that is proceeding despite the overall hospital re-development programme being suspended until we are able to confirm that it is in line with the work of the STP. The Chairman reinforced that a significant amount of work is taking place and that it is important that this is communicated across the organisations.

13. SUSTAINABILITY & TRANSFORMATION PLAN FOR BEDFORDSHIRE, LUTON & MILTON KEYNES, OCTOBER 2016 SUBMISSION

Mark England updated the Board on the work of the STP and in particular, the collaborative savings programme across the 3 acute hospitals and the 3 CCGs. The CEO informed the meeting that the STP was now engaged in a series of meetings with NHSE and NHSI, she believed these discussions would be very supportive.

14. RISK REGISTER

Victoria Parsons highlighted a number of issues and the work that had taken place to review the same.

15. BOARD SECRETARY REPORT

Victoria Parsons talked to the report. Mark Versallion highlighted the lack of progress in Bedfordshire CCG and Herts Valley CCG in identifying a governor.

ANY OTHER BUSINESS

No further business was raised.

QUESTIONS/COMMENTS FROM NON BOARD MEMBERS

The following questions were asked by the audience:

1) In response to a point raised in relation to equality and diversity of our workforce, the Chairman and CEO reassured the meeting that this issue is always taken seriously by this Board, and is part of an ongoing programme of work. The CEO confirmed that when senor positions are filled in the future, we will continue to meet the highest standards in relation to this issue.

2) In relation to a question regarding the STP and consultation, the CEO confirmed that if any clinical service changes are proposed at the end of March that meet the standard of requiring 'formal public consultation' as

opposed to informal, then the required consultation process will be undertaken.

SUMMARY OF ACTIONS

To be made available after the meeting. ***VP***

16. DETAILS OF THE NEXT SCHEDULED MEETING:

Wednesday 3 May 2017, 10.00am, COMET Lecture Hall

17. CLOSE

These minutes may be subject to disclosure under the Freedom of Information Act 2000, subject to the specified exemptions, including the Data Protection Act 1998 and Caldicott Guardian principles

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

BOARD OF DIRECTORS

Agenda item	6	**Category of Paper**	Tick
Paper Title	Chief Executive's Report	**To action**	☐
Date of Meeting	Wednesday 3 May 2017	**To note**	☒
Lead Director	P Philip	**For Information**	☒
Paper Author	P Philip	**To ratify**	☐
Indicate the impact of the paper: **Financial** ☐ **Quality/Safety** ☒ **Patient Experience** ☒ **Equality** ☐ **Clinical** ☒ **Governance** ☒			

History of Committee Reporting and Date	N/A
Links to Strategic Board Objectives	Objective 1 – Deliver Excellent Clinical Outcomes Objective 2 – Improve Patient Safety Objective 3 - Improve Patient Experience Objective 5 – Implement our New Strategic Plan Objective 6 – Secure and Develop a Workforce to meet the needs of patients
Links to Regulations/ Outcomes/External Assessments	Monitor CQC
Links to the Risk Register	None

PURPOSE OF THE PAPER/REPORT

To update the Board on current issues.

SUMMARY/CURRENT ISSUES AND ACTION

The report provides updates on current issues.

ACTION REQUIRED

To note the content of the report.

Public Meeting ☒ Private Meeting ☐

LUTON AND DUNSTABLE HOSPITAL NHS FOUNDATION TRUST

CHIEF EXECUTIVE'S REPORT

MAY 2017

1. GOOD, BETTER, BEST – SUMMER 2017

We are currently planning our Summer staff engagement event which will take place from 10th to 14th July 2017. The event will focus on two topics: how we re-design care to ensure greater 'continuity' of clinical input; how as an organisation, we promote a culture that supports and motivates our staff. This will be the 5th such event which have become very popular with our staff.

2. ANNUAL REPORT AND QUALITY ACCOUNT

In line with national timescales, FIP has approved the text of the Annual Report to be submitted to our External Auditors. COSQ has approved the text of the Quality Account to be submitted to the External Auditors and external stakeholders (CCG, Healthwatch and Overview Scrutiny Committees) at their meetings on the 26th April 2017.

The final version of the Annual Report and Quality Account will be approved by the private board on the 24th May 2017 before it is submitted to NHS Improvement and then to parliament before the end of June 2017. The annual report will be publically available in early July and will be communicated at the Annual Members Meeting on the 13th September 2017.

3. 2017 L&D STOCKTAKE

During recent weeks, as we have worked across the organisation to prepare our Annual Report (including our Quality Account), it has become clear to me that it would be helpful for the Executive Directors and Divisional Directors to undertake an L&D 'Stocktake' exercise. The exercise will consider our strengths, weaknesses, risks and opportunities as a Trust in delivering the objectives set out in our Operational Plan for 2017/18 and our Quality Account. Importantly, the exercise will include plans to address any weaknesses or deficiencies identified. It is our intention to present the stocktake to the Chairman and Non-Executive Directors at a Board Seminar towards the end of May.

4. SUSTAINABILITY AND TRANFORMATION PLAN (STP)

The Trust continues its active support and involvement in the Sustainability and Transformation Plan for Bedfordshire, Luton and Milton Keynes. As detailed in the publicly available plan (www.blmkstp.org) work is ongoing, and the Trust is collaborating with other system partners to design and deliver improved health and care services for our population, in line with the priorities set out in the plan.

5. COMMUNICATIONS FROM NHS ENGLAND / NHS IMPROVEMENT

Five Year Forward View Next Steps
On the 31st March 2017 the Five Year Forward View Next Steps was published. The Five Year Forward View Next Steps has been drafted by both NHS Improvement (NHSI) and NHS England (NHSE). It outlines progress on the ambitions set out in the Five year forward view since its original publication in October 2014, defines what still needs to be achieved over the next two years, and how this will be achieved. It also outlines priorities for the service specifically in 2017/18 as follows:

- Deliver financial balance across the NHS
- Improve A&E performance
- Strengthen access to GP & primary care services
- Improve cancer and mental health services

6. MANAGING CONFLICT OF INTEREST

On the 7th February NHSE published guidance on Managing Conflicts of Interest in the NHS. This guidance provides guidance for the management of conflicts of interest in the NHS. It is intended to protect patients, taxpayers and staff covering health services in which there is a direct state interest. It comes into force on 1 June 2017. A conflict of interest is defined as ***'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.'***

The guidance:

- Introduces consistent principles and rules for managing conflicts of interest
- Provides simple advice to staff and organisations about what to do in common situations
- Supports good judgement about how interests should be approached and managed

7. NHS PROPERTY AND ESTATES: NAYLOR REVIEW

On the 31st March 2017 the NHS Property and Estates: Naylor Review was published by the Department of Health. This is an independent review undertaken by Sir Robert Naylor for the Department of Health. The review assesses national estate strategy, local delivery of estate management and capital requirements for NHS estate and provides a view on what actions need to be taken across these areas.

PAULINE PHILIP

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

BOARD OF DIRECTORS

Agenda item	7	**Category of Paper**	Tick
Paper Title	Performance Reports	**To action**	☐
Date of Meeting	3 May 2017	**To note**	☒
Lead Director	1. Sheran Oke, Acting Director of Nursing / David Carter, Managing Director 2. Andrew Harwood, Director of Finance 3. Angela Doak, Director of Human Resources	**For Information**	☐
Paper Author	As above	**To ratify**	☐
Indicate the impact of the paper: **Financial ☒ Quality/Safety ☒ Patient Experience ☒ Equality ☒ Clinical ☒ Governance ☒**			

History of Committee Reporting & Date	Executive Board 25 April 2017	
Links to Strategic Board Objectives	Objective 1 – Deliver Excellent Clinical Outcomes Objective 2 - Improve Patient Safety Objective 3 - Improve Patient Experience Objective 4 – Deliver National Quality and Performance Targets Objective 5 – Implement our New Strategic Plan Objective 6 – Develop all Staff to Maximise Their Potential Objective 7 – Optimise our Financial Position	
Links to Regulations/ Outcomes/External Assessments	CQC Internal Audit HSE External Auditors	
Links to the Risk Register	1175 – Agency Costs 1018 – HSMR	650 – Bed pressures 669 – Appraisal

PURPOSE OF THE PAPER/REPORT

To give an overview of the quality, activity, compliance and workforce performance of the Trust.

To provide a summary of the financial performance of the Trust

SUMMARY/CURRENT ISSUES AND ACTION

The report gives an update on:
1. Quality & Performance
2. Finance
3. Workforce

ACTION REQUIRED

To note the content of the reports.

Public Meeting ☒ Private Meeting ☐

Quality & Performance Report

January, February & March 2017 data

Medical Directors

Director of Nursing and Midwifery

Director of Operations, Risk & Governance

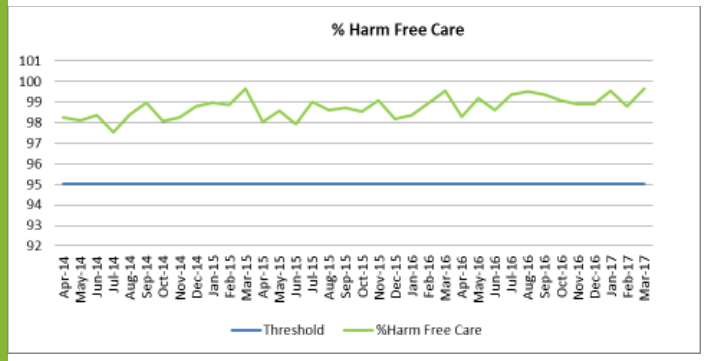
Managing Director

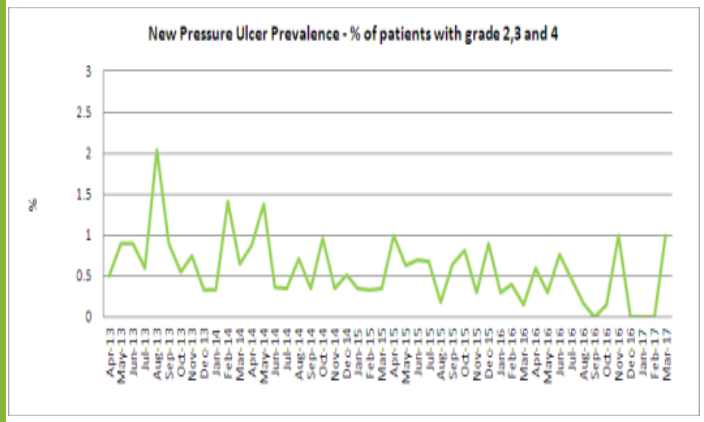
Safety Thermometer

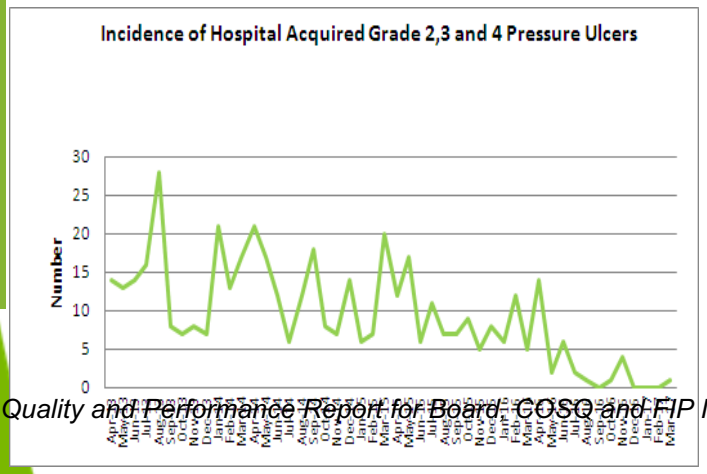
Safe | Effective | Caring | Responsive

Patient Safety Thermometer

Pressure Ulcers







Harm Free Care

The Trust has continued to deliver high levels of Harm Free Care to our patients reporting 99.54% in January, 98.8% in February and 99.68% in March. The most recent score is the highest achieved for the Trust since the Safety Thermometer began. This is an achievement at a time when activity was exceptionally high across the Trust.

Pressure Ulcers

There were no Hospital Acquired pressure ulcers grades 2-4 in January. One grade 4 pressure ulcer is currently under investigation which was located under a long term splint worn by a patient admitted in February. Due to insufficient evidence within the documentation as to where the damage originated (community or hospital), the decision has been taken to investigate and treat this as a hospital acquired category 4 pressure ulcer. There was one reported incidence of Hospital Acquired pressure damage category 2 in March 2017, deemed unavoidable due to End of Life skin failure.

During the quarter (Jan-March) there have been 25 incidences of Hospital Acquired pressure damage all of which were classified as Suspected Deep Tissue Injury (SDTI), and were deemed as unavoidable. 17 of these resolved with SSKIN bundle care; 5 were due to End of Life skin failure and the other 3 are currently being monitored by the 3 ward teams and the Tissue Viability team.

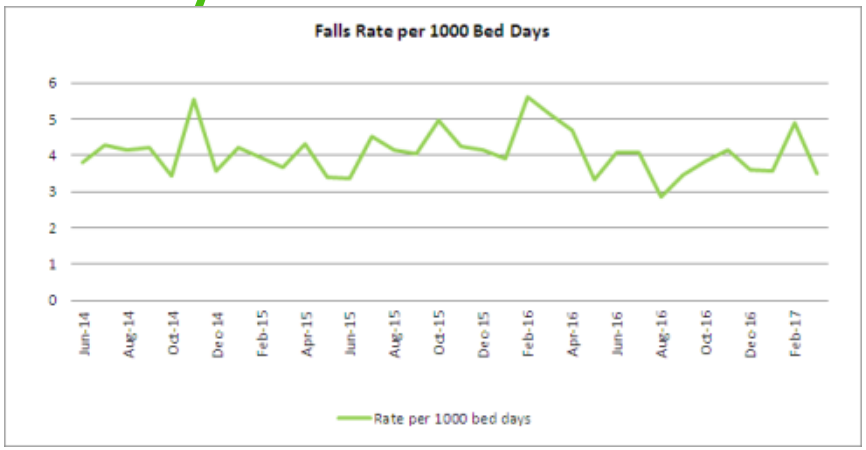
A SDTI is defined as "a localised discoloured area of intact skin or a blood-filled blister". There are a number of reasons why SDTIs develop, including pressure and shear; they are often seen in patients who have been acutely unwell. Once identified, SDTIs are closely observed for signs of further deterioration over a two week period.

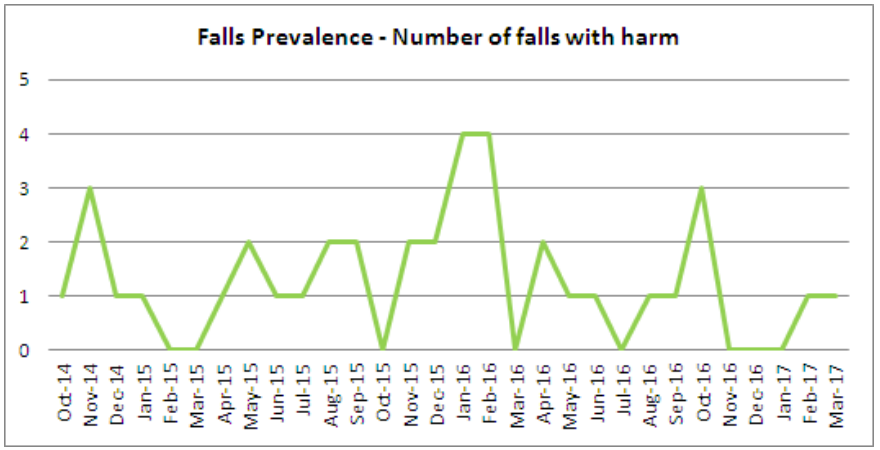
The Tissue Viability Service has also increased visibility and educational support to ward areas and has been reviewing all hospital acquired pressure damage on a daily basis from Monday to Friday. Their focus has been on the prevention and management of heel ulcers, changing the heel protection product to a simpler product and by adding the new SSKIN care planning bundle into the patient admission booklet and educating staff at the bedside on its use.

The focus on ensuring the early identification and correct management of pressure ulcers continues with several initiatives in place to support a reduction. Pressure ulcer training is given in 'Stop the Pressure' study days, in statutory training and opportunistically on the wards, taking every opportunity to improve care.

Safety Thermometer

Safe | Effective | Caring | Responsive





Falls

Patient Falls (incidence)

In January, February and March (2017) there were 73, 89 and 70 inpatient falls respectively. This is an 18% decrease from the same quarter last year with a decrease in 1000 bed day rate from 4.8 to 3.95.

The number of falls reported as "moderate and above" harm has also reduced with 3 over the quarter. One fall occurred in January when the patient sustained fracture to shoulder and hip. These injuries were managed conservatively and, following internal investigation, the fall was deemed unavoidable. There have been two falls in March which are currently undergoing root cause analysis investigation.

The new patient information leaflet on *Falls Prevention in Hospital* is now available and is currently being distributed across the Trust.

The multifactorial falls risk assessment tool in the new nursing proforma aids staff in identifying patients at risk of falling and the strategies available for their safe management.

The Falls Clinical Nurse Specialist continues to support staff on the wards with focus on contingency areas and those wards with a higher number of incidents.

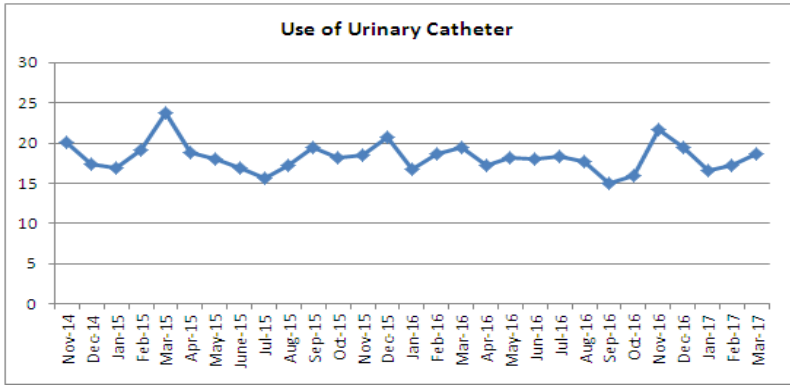
Weekly falls data continues to be disseminated to the Matrons to provide "real time" information on themes and trends that can then be promptly addressed and appropriate actions put in place.

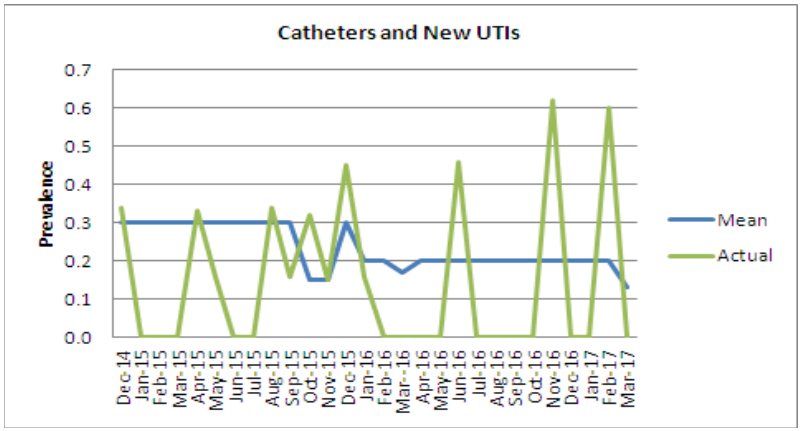
The Trust has recently carried out an audit of "Appropriate assessment and use of bedrails" results of which will be available at the end of April.

Safety Thermometer

Safe | Effective | Caring | Responsive

Catheter Acquired UTI



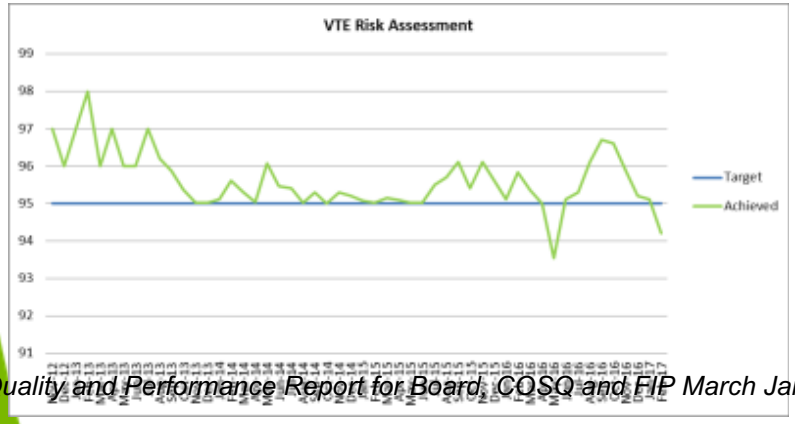


Use of Urinary Catheters:

The most common reasons for catheter insertion continues to be for either accurate management of fluid balance or the management of urinary retention. In January 16.64 % had an indwelling urinary catheter inserted with no patients developing an infection. In February, this increased slightly to 17.27% and again in March to 18.58%, partly attributed to the higher acuity of patients.

The Clinical Nurse Specialist (CNS) is working collaboratively to monitor the use of catheters and provide support to areas of high usage to ensure that all areas have a robust system of assessment of the need for catheters to remain in situ. In February, with the aid of the ICNET system, the Continence CNS was more readily able to identify that 3 catheterised patients had developed a urinary infection. Root Cause Analysis investigations have been completed leading to action plans and sharing of learning. The CNS Continence will continue to use of the ICNET system for enhanced identification of CAUTI'S , so that training can be targeted to areas where problems are being identified.

VTE



VTE Risk Assessment:

The methodology for calculating compliance rates is under review and provisional data shows a drop in compliance with risk assessment to 95.1% in January and 94.2% in February. A number of initiatives are in place to ensure that all appropriate patients receive timely VTE risk assessment.

Continual feedback is provided to clinical teams regarding VTE compliance rates, this will be also be provided to the general managers thus giving the opportunity to focus on the initiative within the Departmental Governance meetings and for teams to review how they may improve performance. Certificates are awarded to teams and individuals with 100% compliance rates for the month and to recognise the role of VTE champions. A new VTE risk assessment form (compliant with CG92 NICE guidelines) is being piloted to evaluate whether a re-designed risk assessment format will be easier to complete.

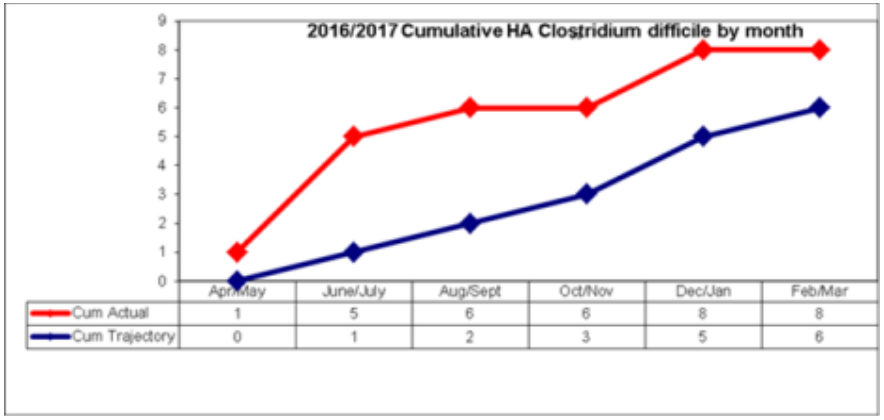
Activities are still underway to support the implementation of the electronic version of the risk assessment in ePMA in pilot form with the projected date of roll out in the pilot wards forecast for the end of May.

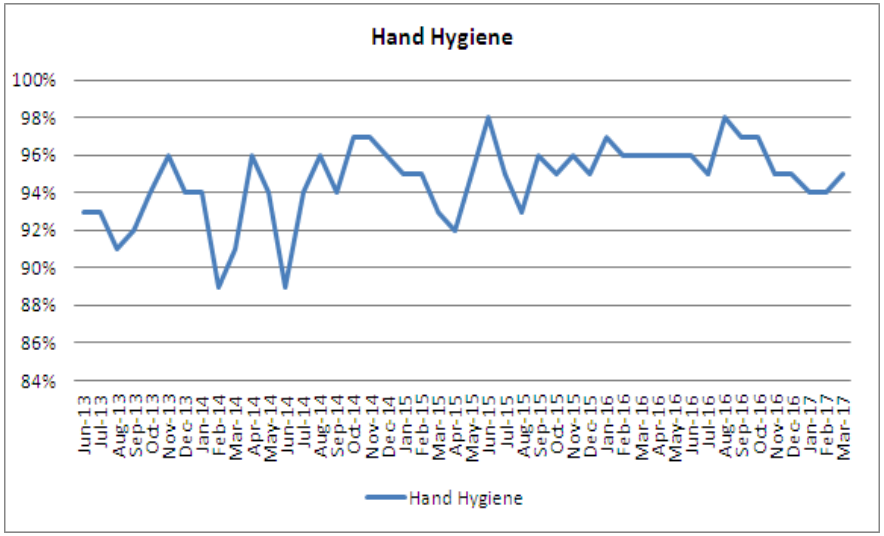
Infection Control

Safe | Effective | Caring | Responsive

MRSA and C.Difficile

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
C Diff	0	1	0	2	1	1	1	1	3	0	0	1	1	0	2	2	0	1	0	0	2	0	0	0
MRSA	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1





Hand Hygiene

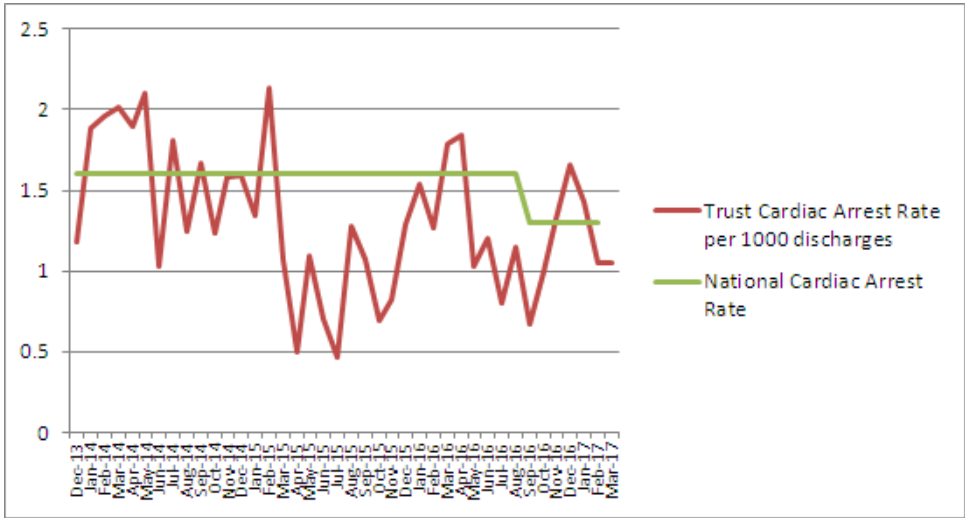
The Pilot Programme for Electronic Hand Hygiene Monitoring – In the Trust's four pilot areas, "traditional" observational audits with ward staff have been carried out in order to triangulate the data with the electronic monitoring data. Feedback has enabled staff to have an improved understanding about the 5 moments of hand hygiene through continual review of the results. In the pilot wards there has been a complete replacement of batteries to make sure all the dispensers are updated and working. Compliance against the denominator has improved but is still below target. A hand hygiene audit workshop is planned for April 2017 and the learning from the pilot wards will be used to inform the content.

C.difficile – At the end of March 2017 we had recorded a total of 8 cases of hospital acquired C.difficile infections, with no cases reported in this quarter. No particular type strain is dominant and no outbreaks / clusters have been reported. In the last quarter the Infection Control Team appealed against 4 hospital acquired cases, three of which were successfully upheld. The ceiling (trajectory) for 2017-2018 is the same as last year ie 6 cases.

MRSA bacteraemia – There has been one case of hospital acquired MRSA bacteraemia reported in March and this is being investigated using Root Cause Analysis.

Cardiac Arrest Rate

Safe | **Effective** | Caring | Responsive



Over the last 6 months (October 2016 – March 2017) the average Cardiac Arrest rate has been 1.2 (per 1000 discharges), equal to the rate during the same period last year. This is in keeping with the rise in the Cardiac Arrest rate in the winter months of the previous 3 years.

Learning from Cardiac Arrest reviews

A thorough review of every cardiac arrest continues to take place. Additional Consultant time is now being devoted to the work - enabling the reviews to take place more promptly thus supporting more timely investigations in collaboration with the clinical teams. Weekly cardiac arrest status reports are being set up to enable greater transparency of any outstanding cardiac arrests which require review, and to share key learning themes.

The purpose of the cardiac arrest reviews is to highlight learning at any point in the patient pathway, the main areas of learning and focus for quality improvements have been:

1. Further improving the timely, appropriate monitoring of deteriorating patients,
2. Further improving the timely, appropriate medical decision making.

In February, the Trust rolled out the use of Treatment Escalation Plans (TEPs) for all non-elective admissions. It is anticipated that this will help to ensure that all patients have timely, appropriate decisions made by the responsible clinicians. Each patient will then have a clear plan in place to support clinical decision making should the patient deteriorate. This will be especially helpful out of hours when it is less likely that the clinical team will be familiar with the patient. Audit has been carried out of use of the TEPs. A number of recommendations have been made to support improved compliance rates this includes incorporating the TEP form in the admission proforma to facilitate easier completion.

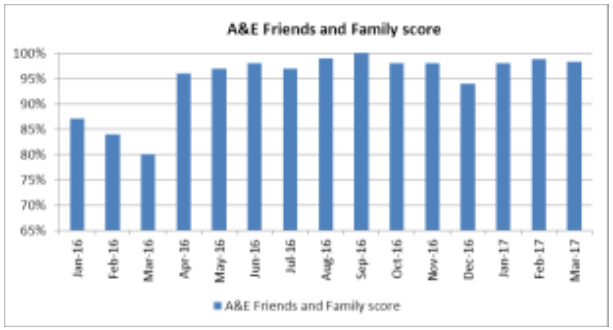
Patient Experience

Safe | Effective | Caring | Responsive

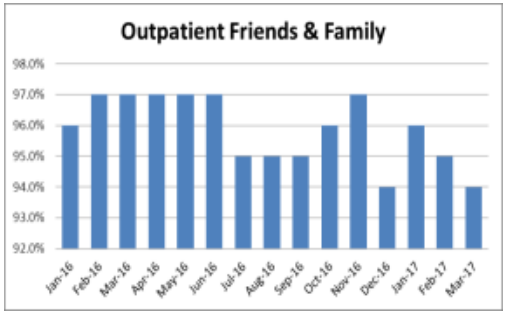
Friends and Family

The Friends and Family Test (FFT) is a National Initiative, the scores are published each month by NHS England enabling benchmarking against other Trusts both regionally and nationally. Although NHS England only use data from inpatients, A&E and Maternity services, as a Trust we also monitor responses from all our outpatient areas. The FFT asks the specific question ***'how likely are you to recommend our service / ward / birthing unit to friends and family if they need similar care and treatment'*** to every patient who has experienced a service from the Trust. It also encourages patients to leave both positive and negative comments about their experience, allowing specific wards or departments to take action and drive improvements and in some cases respond directly to the patient. This process is a key element to effectively monitor and learn from the patient experience in the Trust. In January the response rate was 3645 and 3348 in February and 3957 in March. We continue to promote the use of the iPAD which enables staff to obtain and manage real time feedback and we are working with our IT provider to implement a texting service to seek feedback from patients who used our ED, OPD and maternity services. The inpatient survey has been developed in order to elicit more useful information to underpin the FFT to help drive quality improvements in the wards.

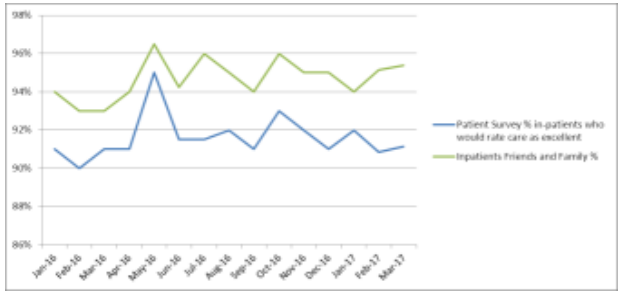
The overall Trust recommend score for January 2017 was **93.68%, 95%** in February and **95%** in March**.**



The overall recommend score for **A&E** in January 2017 was **98%, 99%** in February and **98%** in March**.** The Trust has continued to maintain a score of more than 96% - since April 2016, consistently achieving above the latest national average score of **86%** (December 2016).



The overall recommend score for **Outpatients** in January 2017 was **96%, 95%** in February and **94%** in March. This also remains above the latest national average score of **93%.**



The overall recommend score for **Inpatients** in January 2017 was **94% and 95%** in both February and March. The national average recommend score is **96%** (figures from Dec 2016).

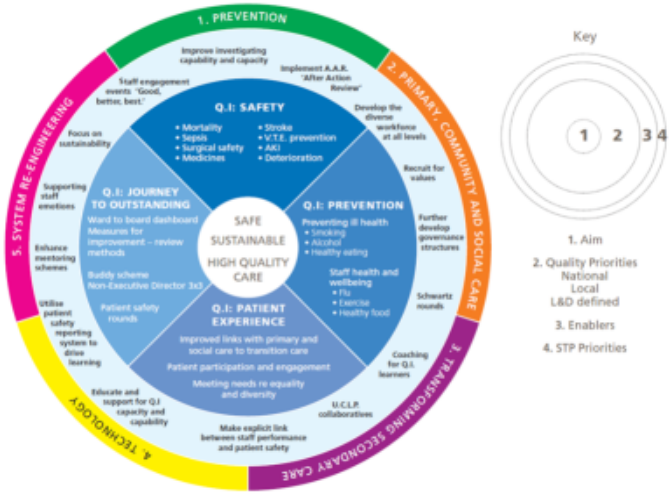
We have added some questions to our inpatient surveys to better help identify areas for improvement.

The **Maternity** score is only linked to question 2 of the FFT ***'how likely are you to recommend our Labour ward, birthing unit or homebirth service to friends and family if they needed similar care or treatment?'***

During January Maternity have continued to work to increase the response rate, and the Patient Experience team continue to make themselves available to support this work further. **364** responses were received in January, **432** in February and **403** in March. The recommend score was **96%** in January with a slight reduction to **95%** for February and **94%** in March. The national average score was 97% in February.

CQC

The Trust's Quality Framework "Quality Wheel" was first introduced to staff at the Good, Better, Best event in December 2016



Development of a Quality Improvement Faculty:

The first steering group meeting has been held to consider our ambition to create a 'Faculty for Quality Improvement'. The key aims of the Faculty were agreed and include for example:

- The development of groups of skilled individuals to undertake improvement projects
- Provide a coordinated approach to Service Improvement
- Processes that will enable Divisional Governance Structures to support the Quality Improvement progress
- Prioritisation of improvement activity with a focus on delivering the corporate objectives
- The alignment of quality improvement work to key themes such as reduction in mortality and harm; improving the patient and staff experience; building a safety culture
- The use of recognised QI methodology to help staff deliver tangible outcomes
- The development of systems that provide support to those undertaking quality improvement, to include Improvement buddies, mentoring, coaching and celebrations of success

The Faculty will enable the realisation of the following enablers from the Quality Wheel:

- **Focus on sustainability**
- **Coaching for QI learners**
- **Enhanced mentoring schemes**
- **Educate and Support for QI capability and capacity**

- Monthly nursing audits and Harm Free Care data collection which feeds into the Quality Management process. Ward Sisters and Matrons meet with the Corporate Nursing Team bi-monthly to scrutinise the data and to provide action plans and assurance on progress against actions.

- Staff development and appraisals are on-going and reported on, in more detail through the HR report.

- The senior nurses / midwives "Back to the Floor" Fridays recommenced in February, having been interrupted to allow the team to focus on safe staffing in January whilst there was pressure in the clinical areas. Three domains of the CQC framework were assessed along with an audit into our provision for the care of dying patients, and an audit of fluid balance charts.

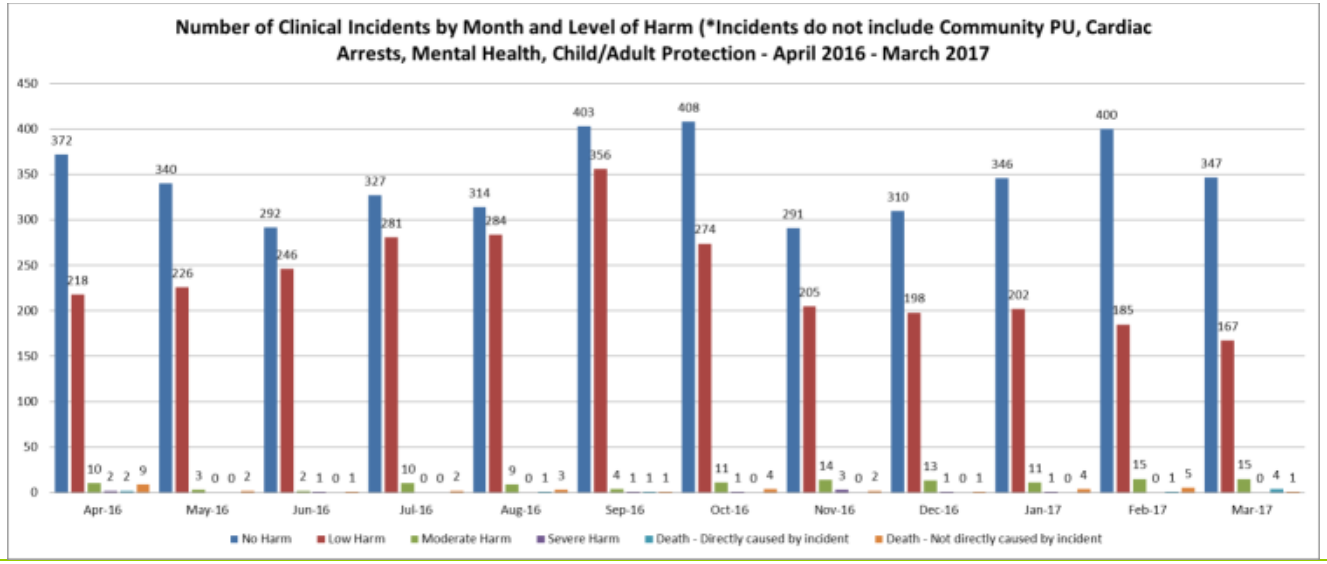
A number of initiatives are underway to ensure that the Trust continues to be responsive over time. These include:

- A review of the nursing and midwifery care audits;
- A review of the Back to the Floor Fridays;
- A review of our strategy and approach to seeking feedback from patients and strengthening the application of learning to the delivery of quality improvements in the clinical areas.

Incidents

Safe | Effective | Caring | Responsive

Never events , serious incidents and clinical incidents



Incident reporting: In Q4 a total of 3416 incidents were reported via the Datix Incident Reporting System. The above graph provides details of the number of clinical incidents reported per month and by level of patient harm. The top 3 incidents reported in Q4 relate to medication errors, patient falls and hospital acquired skin damage.

Work continues to reconfigure the Datix risk management system to ensure the Trust can be confident of extracting meaningful and accurate information. In February 2017 categorisation was aligned for the first time, which has improved the accuracy of reporting. Further changes will be made early in the upcoming financial year.

Incident investigations: The Risk and Governance Team continuously monitor the status of incidents within Datix including the timeliness of investigations. The Team are supporting the Divisions in monitoring the number of open investigations by producing a fortnightly report along with a 'handlers' list and this is sent to divisional management and clinical leads. There is continued concern with the length of time it is taking to complete these investigations. This is monitored through COB. The Risk and Governance Team are delivering additional training and support sessions to address this.

Duty of Candour Compliance

The Risk and Governance Team review all incidents reported as resulting in moderate harm, severe harm and death, and confirm with the clinical team whether they were 'unintended and unexpected'. If so the statutory Duty of Candour process is triggered. Due to the reporting in arrears for Duty of Candour compliance, the latest validated data of notifiable patient safety incidents is available up to January 2017 (7/7 – 100%). The Trust has been 100% compliant across all previous months.

Serious Incidents

Safe | Effective | Caring | Responsive

Never events , serious incidents and clinical incidents

Serious Incident (SI) Investigations: In Q4, 19 cases were discussed at an Executive Led Panel to determine whether Serious Incident criteria was met. 16 of the 19 cases discussed did not meet the criteria due to either level of harm or avoidability. Three incidents were declared in the quarter:

- Unexpected death – Diverticulae perforation with faecal peritonitis
- Unexpected death – Cerebral bleed
- Unexpected death - Maternal

Incidents Reported	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2016/17	5	4	1	2*	2	1	2	2	0	0	0	3	22*

*Later downgraded by the CCG as no acts or omissions in care led to the death of the patient

The investigation process was completed for 6 Serious Incidents in Q4 2016/17. Learning from these incidents has included:

- Ensuring clear and accountable ownership of patients under joint consultant care;
- Ensuring optimal theatre usage/performance;
- Ensuring clear and unambiguous documentation which must fully comply with national and Trust policies. Data entries must use the 24 hour clock;
- The need for close monitoring of skin checks by Senior Nursing Staff confirming they are completed in accordance with Trust Policy
- Ensuring that any pressure damage is consistently checked on a daily basis to allow for early recognition of deterioration in skin integrity
- Ensuring that pressure relieving equipment is checked that it is working correctly on 'essence of care' rounds
- Ensuring that pressure damage is reported on Datix and escalated to Senior Nurse/Tissue Viability Team at the earliest opportunity
- Ensuring that patients undergoing surgery have their temperature recorded every 30 minutes in accordance with NICE CG65
- Ensuring that all staff have an understanding of how to recognise and manage sepsis, and the importance of timely administration of antibiotics
- Ensuring that all ward rounds include an overview of blood results, observations, fluid management and physical examination of each patient, with findings clearly documented

Action plans are in place for all incidents to ensure the learning informs quality improvement

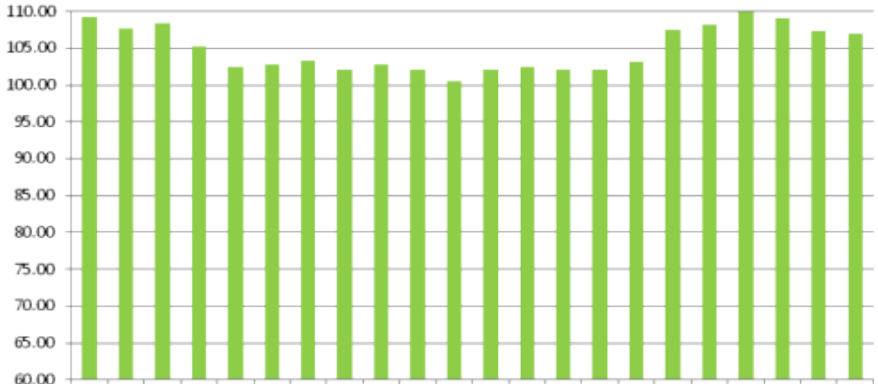
Mortality

Safe | Effective | Caring | Responsive

HSMR/SHMI

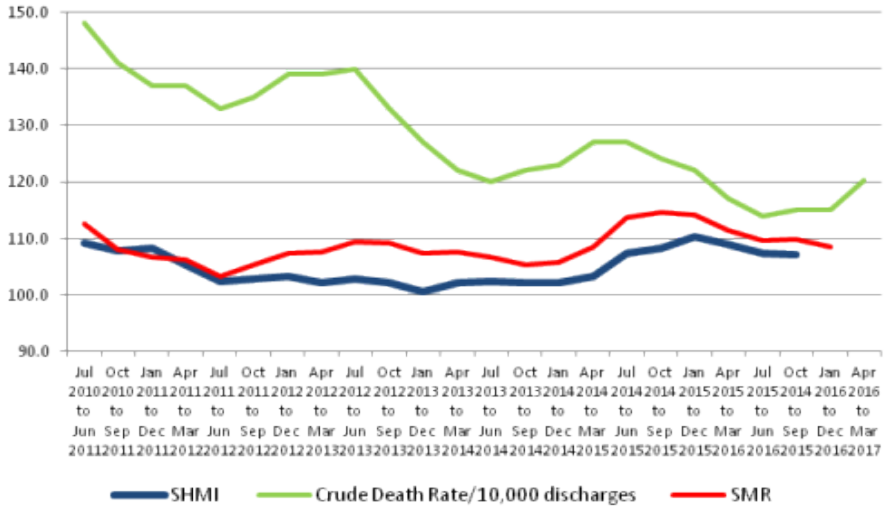
The HSMR fell to 105.27 for the 12 months ending December 2016. This value has now not been statistically significantly high (red), for the last 3 months. The SMR for the same period has also reduced but remains red at 108.55. The rolling 12-month SHMI is only produced quarterly: the latest value is 107.04 for the year ending September 2016.. The crude mortality rate however increased due to high numbers of deaths in January and early February. For the 12 months ending in March 2017 the crude mortality rate was 120.5 per 10,000 discharges, the highest rate seen since December 2015.

Summary Hospital-level Mortality Indicator (SHMI) - rolling 12 months

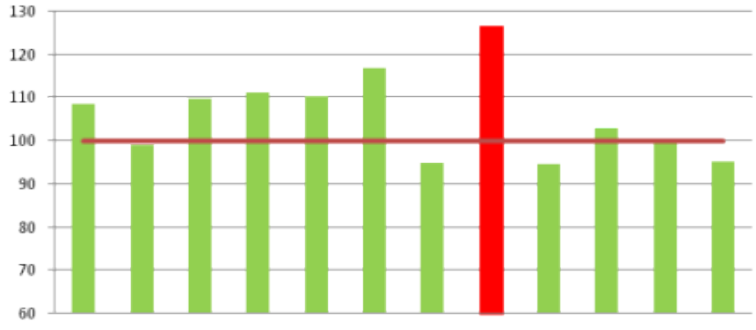


	Jul 2010 to Jun 2011	Oct 2010 to Sep 2011	Jan 2011 to Dec 2011	Apr 2011 to Mar 2012	Jul 2011 to Jun 2012	Oct 2011 to Sep 2012	Jan 2012 to Dec 2012	Apr 2012 to Mar 2013	Jul 2012 to Jun 2013	Oct 2012 to Sep 2013	Jan 2013 to Dec 2013	Apr 2013 to Mar 2014	Jul 2013 to Jun 2014	Oct 2013 to Sep 2014	Jan 2014 to Dec 2014	Apr 2014 to Mar 2015	Jul 2014 to Jun 2015	Oct 2014 to Sep 2015	Jan 2015 to Dec 2015	Apr 2015 to Mar 2016	Jul 2015 to Jun 2016	Oct 2014 to Sep 2015
SHMI	109.	107.	108.	105.	102.	102.	103.	102.	102.	102.	100.	102.	102.	102.	102.	103.	107.	108.	110.	109.	107.	107.

Crude Death Rate, SMR and SHMI – rolling 12 months updated quarterly



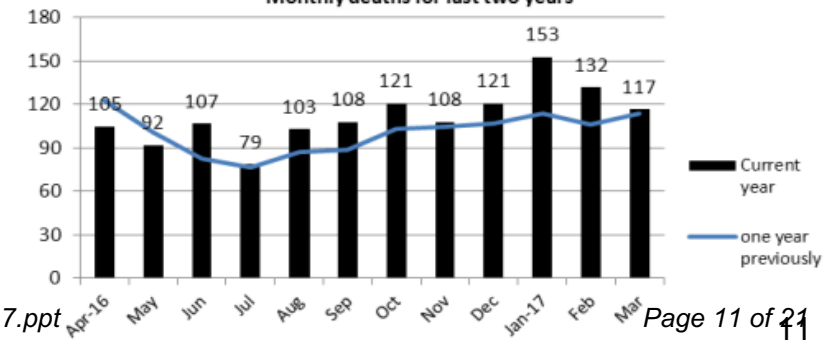
Hospital Standardised Mortality Ratio (HSMR) - monthly



	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
HSMR	108.5	98.95	109.67	111.3	110.27	116.69	94.85	126.69	94.59	102.86	99.6	95.15

January 2017 saw 153 deaths, the highest month since 2008 and February saw 132 (equivalent to 146 in a 31-day month). Audits of these recent deaths suggest that they were not unexplained or unexpected. In March, deaths reverted to more expected levels

Monthly deaths for last two years



Patient Experience

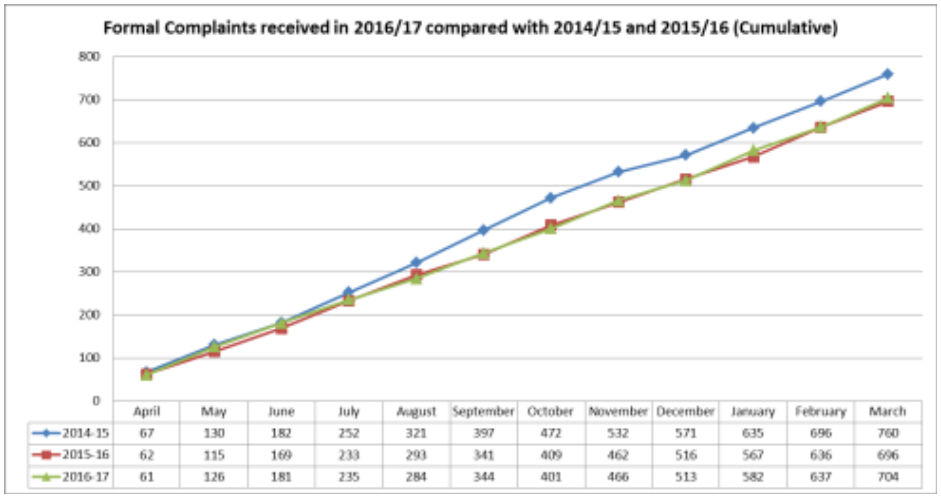
Safe | Effective | Caring | Responsive

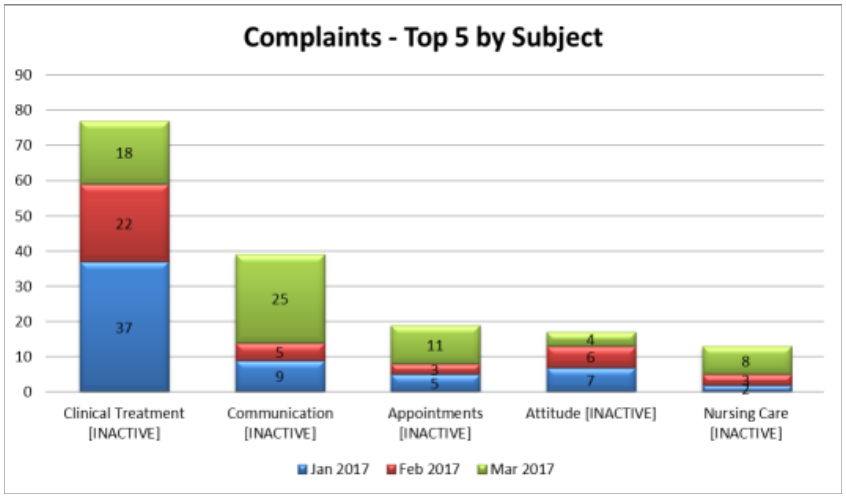
Complaints

New Formal Complaints Including Re-Opened Complaints

Month	Total Number of Formal Complaints Received	Patient Complaints: % of complaints acknowledged within 3 days of receipt	Patient complaints: % of complaints responded to within the agreed target (i.e. 35 working days)
Jan-17	69	98.41%	45.31%
Feb-17	56	98.65%	49.09%
Mar-17	67	96.20%	39.58%

The percentage of Complaints that were due for acknowledgement in Q4 shows a compliance of >96%. It is not always possible to formally acknowledge a complaint within 3 days if the complaint has been raised via the hospital's website and not all relevant details are available. Responding to complaints within 35 days has been difficult to achieve, often because of reasons outside of the investigators control. The Patient Affairs Team currently sends out a weekly report of breached responses to the divisions. To help us meet the target in 2017/18 we are developing a tracking system to monitor complaints through each stage of the complaints process. In 2017/18 the weekly report will include the status of all open complaints. The Surgical Division have the highest number of outstanding Complaints.



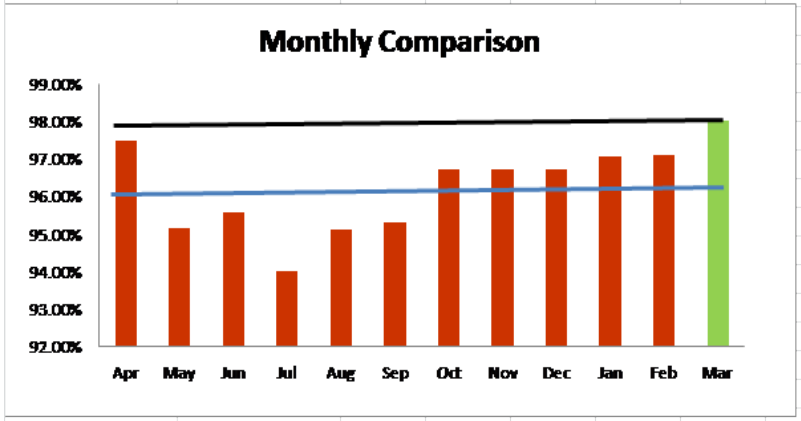


In Q4, 9 complaints were re-opened. Our aim for 2017/18 is to reduce the number of re-opened complaints by ensuring 'first time right' responses. Work is ongoing with the Datix improvement project to allow an in-depth drill down of data to better highlight themes and trends, inform internal quality improvements as well as ensuring data exported to NHS Digital accurately reflects the Trusts Complaint's status. A further improvement to be undertaken is to combine the PALS module with the Complaints module. This will provide a comprehensive monitoring and integrated process and ensure information is managed in a more structured and effective manner.

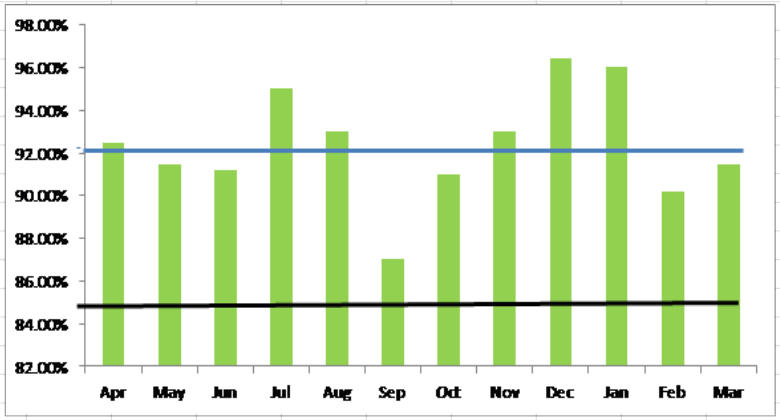
Cleanliness

The graphs below show the average audit scores in respect of the cleaning service. The audits are performed within the areas unannounced in conjunction with Trust staff. There has been another recalibration of the way in which the audit scores were recorded in by an accredited cleaning auditor to provide additional assurance regarding the accuracy of the scores. The Trust is continuing its dialogue with senior officers for the Provider regarding the implementation of the remediation plan and the timescale for the service to be delivered at the contracted level. There has been some improvement in scores but the challenge is to ensure this level is sustained at all times.

Risk Category	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Avg
Very High Risk	98%	97.49%	95.16%	95.58%	94%	95%	95%	96.70%	96.70%	96.70%	97.05%	97.11%	98.00%	96.24%
High Risk	95%	94.64%	88.73%	89.43%	90%	90%	91%	92.60%	92.60%	93.59%	94.07%	93.51%	94.20%	92.01%
Significant Risk	85%	92.45%	91.50%	91.17%	95%	93%	87%	91%	93%	96.43%	96.06%	90.18%	91.45%	92.35%
Low risk	75%	88.40%	83.19%	72.45%	89%	90%	77%	94%	92%	89.15%	89.76%	85.11%	88.53%	86.55%

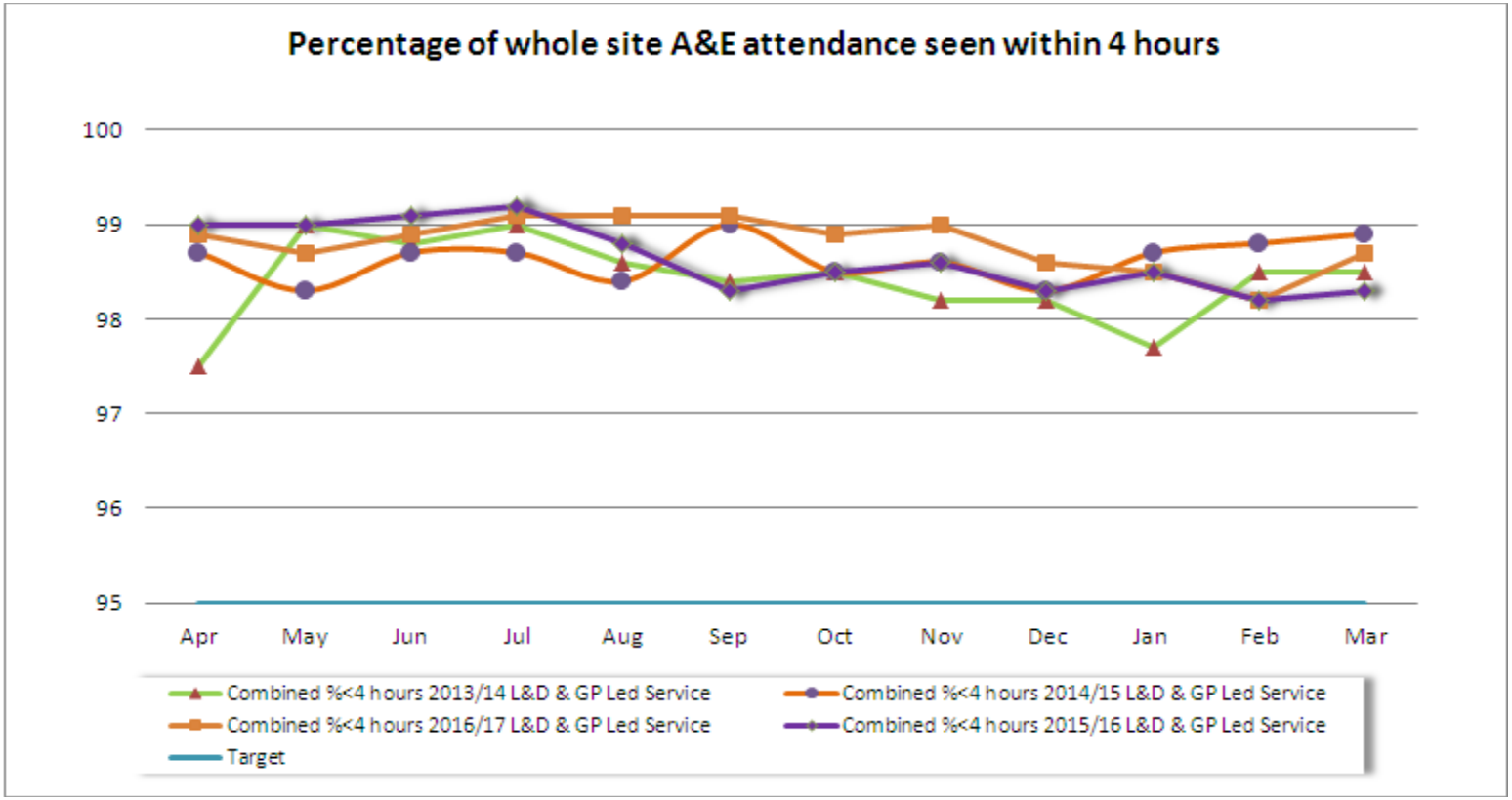


Very High Risk Areas



Significant Risk areas

National Targets



The Trust has continued to perform well against the 4-hour ED target. Over the winter period the level of attendances and admissions has remained stable.

The level of A&E attendances is at a rolling average of 283 and the 2016/17 cumulative numbers are 6.6% higher than 2015/16 with the level of admissions 6.1% higher.

A&E

National Targets

Safe | Effective | Caring | Responsive

Cancer

	Threshold	Qtr1 2014/15	Qtr2 2014/15	Qtr3 2014/15	Qtr4 2014/15	Qtr1 2015/16	Qtr2 2015/16	Qtr3 2015/16	Qtr 4 2015/16	Qtr 1 2016/17	Qtr 2 2016/17	Oct-16	Nov-16	Dec-16	Qtr 3 2016/17	Jan-17	Feb-17
All cancers: 31-day wait for second or subsequent treatment (3), comprising either:																	
Surgery	94%	98.0%	100.0%	100.0%	98.0%	96.4%	98.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
anti cancer drug treatments	98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
radiotherapy	94%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Cancer: two week wait from referral to date first seen (7), comprising either:																	
all cancers	93%	95.0%	94.6%	96.2%	96.1%	95.4%	94.1%	96.3%	97.7%	96.1%	96.3%	97.5%	97.1%	95.6%	96.7%	96.3%	97.3%
for symptomatic breast patients (cancer not initially suspected)	93%	95.9%	93.5%	96.5%	95.1%	94.5%	91.1%	98.0%	97.5%	98.0%	96.7%	99.1%	99.0%	96.4%	98.3%	93.4%	97.1%
All cancers: 31-day wait from diagnosis to first treatment (6)	96%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.7%	100.0%	99.1%	100.0%	100.0%	99.7%	100.0%	100.0%
All cancers: 62-day wait for first treatment (4), comprising either:																	
from urgent GP referral to treatment	85%	92.9%	86.8%	87.1%	90.5%	90.9%	90.2%	87.9%	86.0%	86.9%	89.4%	88.0%	87.6%	89.0%	88.3%	93.1%	85.4%
from consultant screening service referral	90%	95.7%	96.1%	96.0%	96.1%	98.5%	92.5%	95.9%	91.4%	93.0%	95.9%	97.8%	100.0%	95.8%	97.4%	97.9%	100.0%

Note : When January 16 was reported , one breach was recorded due to an administration error. This was rectified through the Qtr 4 submission to Open Exeter.

The Trust achieved all its cancer targets and is predicting to meet the quarter targets.

National Targets

Safe | Effective | Caring | Responsive

Cancer

Cancer Plan 62 Day Standard by Tumour Site

	Accountable Total Treated											Accountable Breaches										
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Breast	6.5	12	14	19	9	11	7.5	12	10.5	11	8	0	0	0	0	0	0	0	1	0	0	0
Gynaecology	2	3	4	2.5	1	2	1	0.5	2	3	1.5	0	1	0.5	0	0	0	0	0.5	0	0.5	0
Haematology	3	n/a	2	4	5	5	6	3	3	4	2	1	n/a	1	0	1	1	2	0	2	0	1
Head & Neck	2	1	3	4.5	2	2.5	2	5	5.5	2	2.5	0.5	0.5	0	1	0	0.5	1.5	1.5	0.5	0.5	1
LGI	3	11	6	10	5.5	4	5	6	6.5	9	4	0	1	2	1	0	1	0	0	0	0	0
Lung	4.5	2.5	3.5	5	4.5	3.5	3	4.5	2.5	7.5	3	0	0	1	2	1.5	1	0	1	1	0.5	0
Skin	6.5	12	9	8.5	12	9.5	11	8	4	11	11	0	0	0	0	1	0	0.5	0	0	0	1
Urology	18	15.5	13	20.5	15	11.5	9	10.5	10	14.5	12.5	5.5	3.5	3	0.5	3	3.5	2	2.5	1	2.5	3.5
UGI	2	6.5	1	1	2	4.5	4.5	3	1.5	3.5	3	0	1.5	0	0	0.5	0.5	0	0	0.5	0.5	0
Sarcoma	1	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Other	n/a	n/a	1	n/a	n/a	2	1	n/a	n/a	n/a	0.5	n/a	n/a	0	n/a	n/a	0	0	n/a	n/a	n/a	0.5

	% Meeting Standard										
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Breast	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	91.7%	100.0%	100.0%	100.0%
Gynaecology	100.0%	66.7%	87.5%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	83.3%	100.0%
Haematology	66.7%	n/a	50.0%	100.0%	80.0%	80.0%	66.7%	100.0%	33.3%	100.0%	50.0%
Head & Neck	75.0%	50.0%	100.0%	77.8%	100.0%	80.0%	25.0%	70.0%	90.9%	75.0%	60.0%
LGI	100.0%	90.9%	66.7%	90.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Lung	100.0%	100.0%	71.4%	60.0%	66.7%	71.4%	100.0%	77.8%	60.0%	93.3%	100.0%
Skin	100.0%	100.0%	100.0%	100.0%	91.7%	100.0%	95.5%	100.0%	100.0%	100.0%	90.9%
Urology	69.4%	77.4%	76.9%	97.6%	80.0%	69.6%	77.8%	76.2%	90.0%	82.8%	72.0%
UGI	100.0%	76.9%	100.0%	100.0%	75.0%	88.9%	100.0%	100.0%	66.7%	85.7%	100.0%
Sarcoma	100.0%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Other	n/a	n/a	100.0%	n/a	n/a	100.0%	100.0%	n/a	n/a	n/a	0.0%

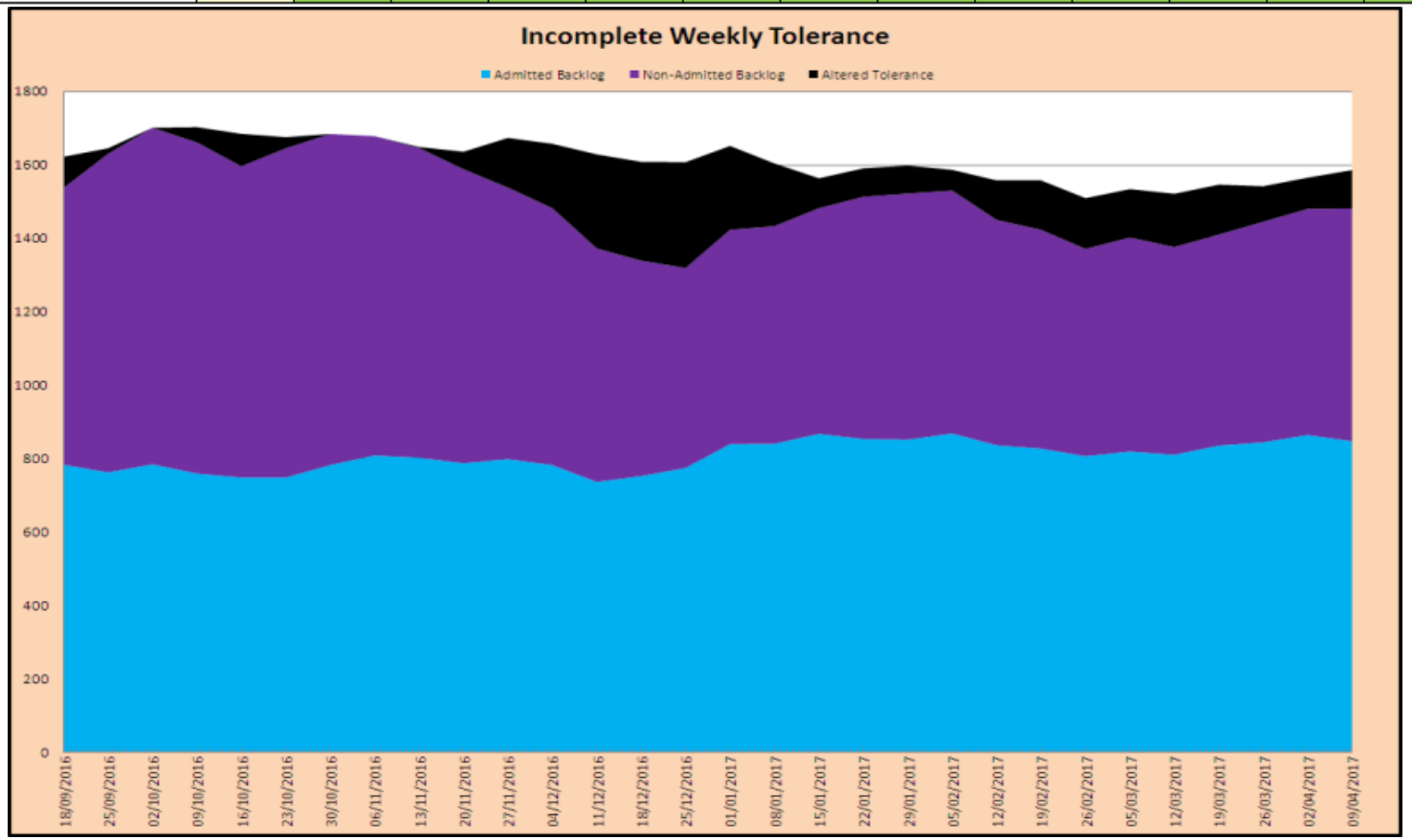
The cancer waiting time standards are set for all tumour sites taken together. Some tumour areas will exceed these standards. Others (where there are complex diagnostic pathways and treatment decisions) are likely to be below the operational standards. However, when taking a provider's casemix as a whole the operational standards are expected to be met.
(Ref: http://systems.hscic.gov.uk/ssd/cancerwaiting/cwtguide8-1.pdf page 5)

National Targets

18 Weeks

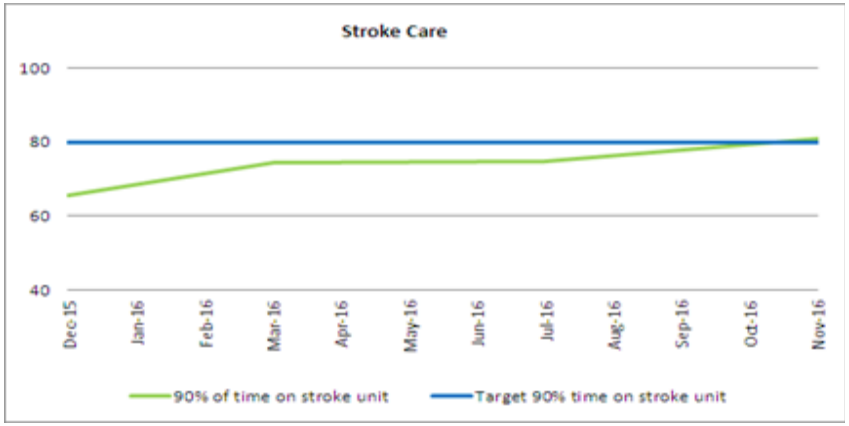
Treated Within 18 Weeks

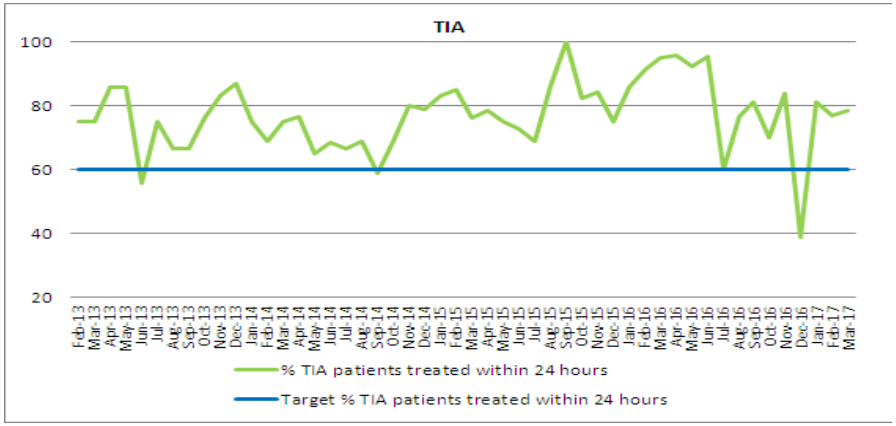
Incomplete	Targets	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	92%	96.9%	96.8%	97.0%	96.9%	97.1%	97.1%	97.1%	96.9%	96.7%	96.6%	96.8%	97.2%
2015/16	92%	97.9%	97.8%	97.6%	97.7%	97.3%	97.0%	96.4%	96.5%	95.3%	94.6%	94.2%	94.2%
2016/17	92%	94.2%	94.5%	94.8%	93.7%	92.9%	92.6%	92.2%	92.7%	93.1%	92.5%	92.9%	92.6%



The admitted and non-admitted backlog have remained stable but the reduction in the overall size of the waiting list has reduced the tolerance against the target. A plan is in place to bring the tolerance to a more stable position.

National Targets





The last published quarterly results for August through to November showed further improvement. One domain, MDT working, improved and the current compliance went from a B to an A. In addition, screening went from a B to an A.

Over the winter period the Trust has faced challenges repatriating stroke and query stroke patients back to Bedford and Milton Keynes Hospitals due to their emergency pressures. This has impacted on our ability to place stroke patients in the stroke ward although performance has improved and the Trust met the target for August – November 2016.

National Targets

SSNAP Scoring Summary:	Team type	Routinely admitting team	Routinely admitting team	Routinely admitting team	Routinely admitting team
	SCN	East of England SCN	East of England SCN	East of England SCN	East of England SCN
	Trust	Luton and Dunstable University Hospital NHS Foundation Trust	Luton and Dunstable University Hospital NHS Foundation Trust	Luton and Dunstable University Hospital NHS Foundation Trust	Luton and Dunstable University Hospital NHS Foundation Trust
	Team	Luton and Dunstable Hospital	Luton and Dunstable Hospital	Luton and Dunstable Hospital	Luton and Dunstable Hospital
	Reporting period	*Oct-Dec 2015*	*Jan-Mar 2016*	*Apr-Jul 2016*	*Aug-Nov 2016*
	SSNAP level	D	D	D	C
	SSNAP score	53.2	50.3	59.8	66
	Case ascertainment band	A	A	A	A
	Audit compliance band	B	B	B	A
	Combined Total Key Indicator level	D	D	C	C
	Combined Total Key Indicator score	56	53	63	66
Number of records completed:	*Team-centred post-72h all teams cohort*	*136*	*155*	*206*	*260*
Patient-centred KI levels:					
Patient-centred Domain levels:	1) Scanning	B	B	B	A
	2) Stroke unit	E	E	D	D
	3) Thrombolysis	C	C	B	B
	4) Specialist Assessments	E	E	B	B
	5) Occupational therapy	A	A	A	A
	6) Physiotherapy	A	B	B	B
	7) Speech and Language therapy	E	E	E	E
	8) MDT working	E	E	E	D
	9) Standards by discharge	B	C	B	B
	10) Discharge processes	C	C	C	D
Patient-centred KI level	Patient-centred Total KI level	D	D	C	C
	Patient-centred Total KI score	56	52	64	66
Patient-centred SSNAP level	Patient-centred SSNAP level (after adjustments)	D	D	C	C
	Patient-centred SSNAP score	53.2	49.4	60.8	66
Team-centred KI levels:					
Team-centred Domain levels:	1) Scanning	B	B	B	B
	2) Stroke unit	E	E	D	D
	3) Thrombolysis	C	C	B	B
	4) Specialist Assessments	E	E	B	B
	5) Occupational therapy	A	A	A	A
	6) Physiotherapy	A	B	B	B
	7) Speech and Language therapy	E	E	E	E
	8) MDT working	E	E	E	C
	9) Standards by discharge	B	B	B	B
	10) Discharge processes	C	C	D	D
Team-centred KI level	Team-centred Total KI level	D	D	C	C
	Team-centred Total KI score	56	54	62	66
Team-centred SSNAP level	Team-centred SSNAP level (after adjustments)	D	D	D	C
	Team-centred SSNAP score	53.2	51.3	58.9	66
Patients assessed at 6 months after admission					
Applicability to be assessed at 6m:	Number of patients considered applicable to be assessed at 6 months - (ref B12.1)	199	185	139	150
	Percentage of patients alive who are considered applicable to be assessed at 6 months - (ref B12.3)	*99%*	*98%*	*99%*	*98%*
Patients assessed at 6m:	Number of applicable patients assessed - (ref B13.1)	9	12	5	6
	Percentage of applicable patients assessed - (ref B13.3)	*5%*	*6%*	*4%*	*4%*

National Targets

Safe | Effective | Caring | Responsive

Diagnostic Test Access

	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Over 6 weeks		73	18	13	43	32	113	8	15	27	15	16	24
% over 6 weeks	<1%	2.04	0.48	0.31	1	0.87	2.88	0.2	0.36	0.69	0.4	0.4	1.57
Total Waiting		3578	3732	4118	4259	3697	3919	4,033	4,202	3,877	3795	4036	4291

	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Over 6 weeks		35	15	39	39	40	29	15	10	33	32	27
% over 6 weeks	<1%	0.82	0.3	0.93	0.92	0.98	0.65	0.36	0.24	0.89	0.8	0.6
Total Waiting		4290	4378	4,200	4,256	4,081	4,427	4,168	4,146	3,700	4112	4759

The Trust is compliant with the diagnostic target. This target has now been included within the Single Oversight Framework as a key indicator and one which will trigger intervention if not actioned for two consecutive months. The Trust has reinvigorated its efforts in respect of this target and reviewed its process for data collection and completion.

Monitor Compliance

Safe | Effective | Caring | Responsive

Monitor Dashboard

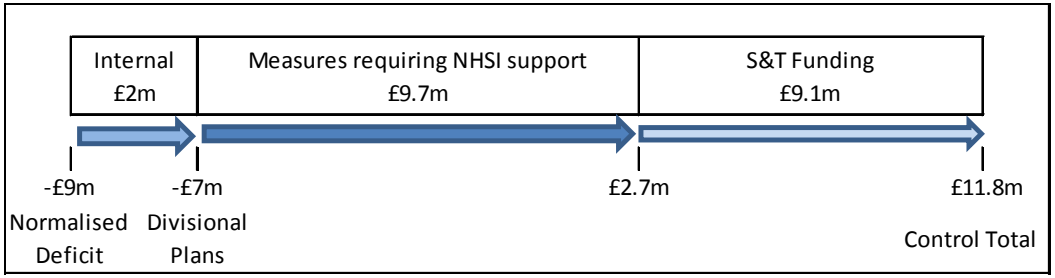
	Threshold	Weighting	Qtr 1 2015/16	Qtr 2 2015/16	Qtr 3 2015/16	Qtr 4 2015/16	Qtr 1 2016/17	Qtr 2 2016/17	Qtr 3 2016/17	Qtr 4 2016/17
Total time in A&E - ≤4 hours (Whole site %)	95%	1.0 (failing 3 or more) 0.5 (failing 2 or less)	99.0%	98.8%	98.4%	98.3%	98.8%	99.1%	98.8%	98.5%
All cancers: 31-day wait for second or subsequent treatment (3), comprising either:										
Surgery	94%	1.0								
anti cancer drug treatments	98%									
radiotherapy	94%		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Cancer: two week wait from referral to date first seen (7), comprising either:										
all cancers	93%	1.0								
for symptomatic breast patients (cancer not initially suspected)	93%									
All cancers: 31-day wait from diagnosis to first treatment (6)	96%	1.0								
All cancers: 62-day wait for first treatment (4), comprising either:										
from urgent GP referral to treatment	85%	1.0								
from consultant screening service referral	90%									
Referral to treatment waiting times – Incomplete pathways	92%	1.0	97.8%	97.3%	96.1%	94.3%	94.5%	93.0%	92.6%	92.7%
Clostridium Difficile – meeting the Clostridium Difficile objective of no more than 6 cases/year	6	1.0	1	4	5	1	3	3	2	0
MRSA – meeting the MRSA objective of no more than 1 cases/year	0	1.0	1	0	0	0	0	0	0	1

Agenda Item: 7.2

Board Report

Report for Month 12

2016-17 Plan	Divisions presented recovery plans identifying £6.5m deficit	Amendments proposed to plan

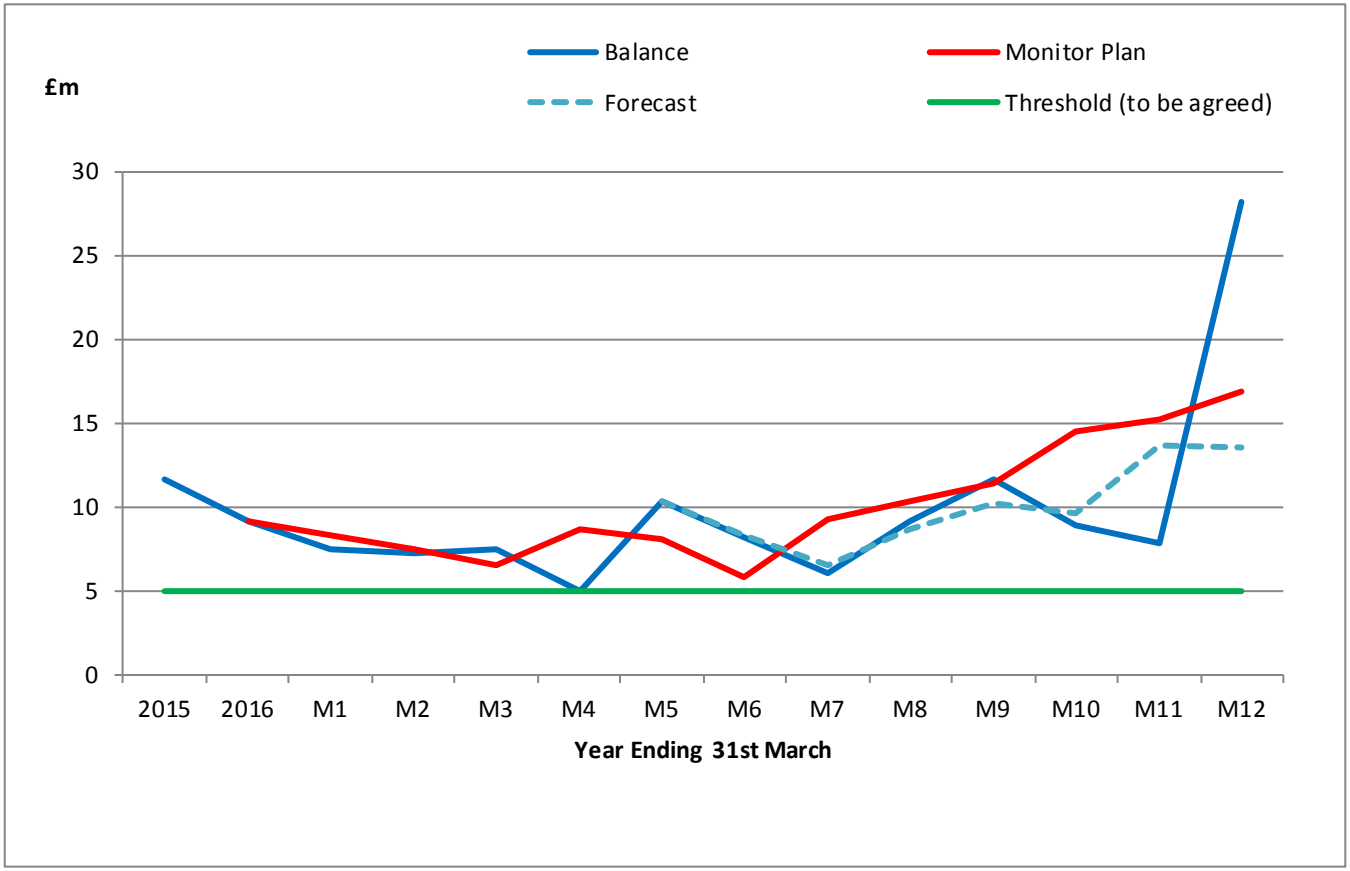


Division	Plan	Control Target Nov FIP
	£000s	£000s
Surgery	3,166	2,478
Medicine	-11,718	-10,746
Women's and Children's	2,116	1,449
DTO	770	-332
Operational Services	0	0
Corporate Services	0	373
Non-Directorate	-1,334	281
Total	**-7,000**	**-6,497**
Revenue Allocation	0	8,700
Unidentified Efficiencies	0	0
MRET / Readmissions	5,200	2,000
Winter funding	2,500	0
Long stay Pts/Medically Fit	2,000	0
S&T Funding	9,100	9,100
Revised Total	**11,800**	**13,303**
Risk Pool		-1,503
Control Total		**11,800**

Finance Report Month 12 2016-17 | **Marginally ahead of Plan** | **Includes anticipated bonus £978k S&T funding**

INCOME & EXPENDITURE ACCOUNT	Fin Year 2015/16 Actual YTD £000s	Fin Year 2016/17 Budget Full Year £000s	Fin Year 2016/17 Actual YTD £000s	Fin Year 2016/17 Variance YTD £000s	Fin Year 2015/16 2016/17 Change %	Fin Year 2016/17 Budget M12 £000s	Fin Year 2016/17 Actual M12 £000s	Fin Year 2016/17 Excl STP YTD £000s
NHS Clinical Income - Contract	243,844	260,875	262,577	-1,702	7.7%	22,865	22,572	262,577
Other Income	24,485	21,957	24,920	-2,963	1.8%	1,830	3,549	23,585
Total Income	**268,329**	**282,832**	**287,496**	**-4,665**	**7.1%**	**24,695**	**26,121**	**286,162**
Consultants	32,477	34,093	35,629	1,536	9.7%	2,846	3,013	35,629
Other Medical	28,890	29,106	30,255	1,149	4.7%	2,290	2,471	30,255
Nurses	68,485	72,754	72,972	218	6.6%	5,972	6,147	72,972
S&T	20,114	21,498	21,177	-321	5.3%	1,784	1,715	21,177
A&C (Including Managers)	20,854	22,705	22,589	-116	8.3%	1,890	1,852	22,071
Other Pay	7,132	4,961	5,526	565	-22.5%	413	606	5,526
Total Pay	**177,952**	**185,117**	**188,147**	**3,031**	**5.7%**	**15,195**	**15,804**	**187,629**
Drug costs	26,003	26,910	27,558	648	6.0%	2,242	2,688	27,558
Clinical supplies and services	22,492	23,734	24,993	1,259	11.1%	1,978	2,314	24,993
Other Costs	38,820	41,122	42,159	1,037	8.6%	3,620	3,563	41,342
Non-Recurrent		0	0	0		0	0	0
Total Non-Pay	**87,315**	**91,765**	**94,710**	**2,945**	**8.5%**	**7,841**	**8,564**	**93,893**
EBITDA	**3,062**	**5,950**	**4,639**	**1,311**	**51.5%**	**1,660**	**1,752**	**4,640**
Non Operational	12,009	12,950	13,014	64	8.4%	1,097	1,201	13,014
Deficit	**-8,947**	**-7,000**	**-8,374**	**-1,374**		**563**	**551**	**-8,374**
MRET / Readmissions		5,200	2,516	-2,684		867	293	2,516
Winter funding		2,500	0	-2,500		417	0	0
Medically Fit / Long stay Pts		2,000	0	-2,000		333	0	0
S&T Funding		9,100	10,078	978		758	1,736	10,078
Revenue Allocation		0	8,700	8,700		0	1,450	8,700
Non-Recurrent	9,000	0	0	0		0	0	0
						0	0	
Total Operating Surplus/Deficit (-)	**53**	**11,800**	**12,920**	**1,120**		**2,938**	**4,031**	**12,920**

Cash	Cash ahead of forecast at M12	Ahead of NHSI Plan



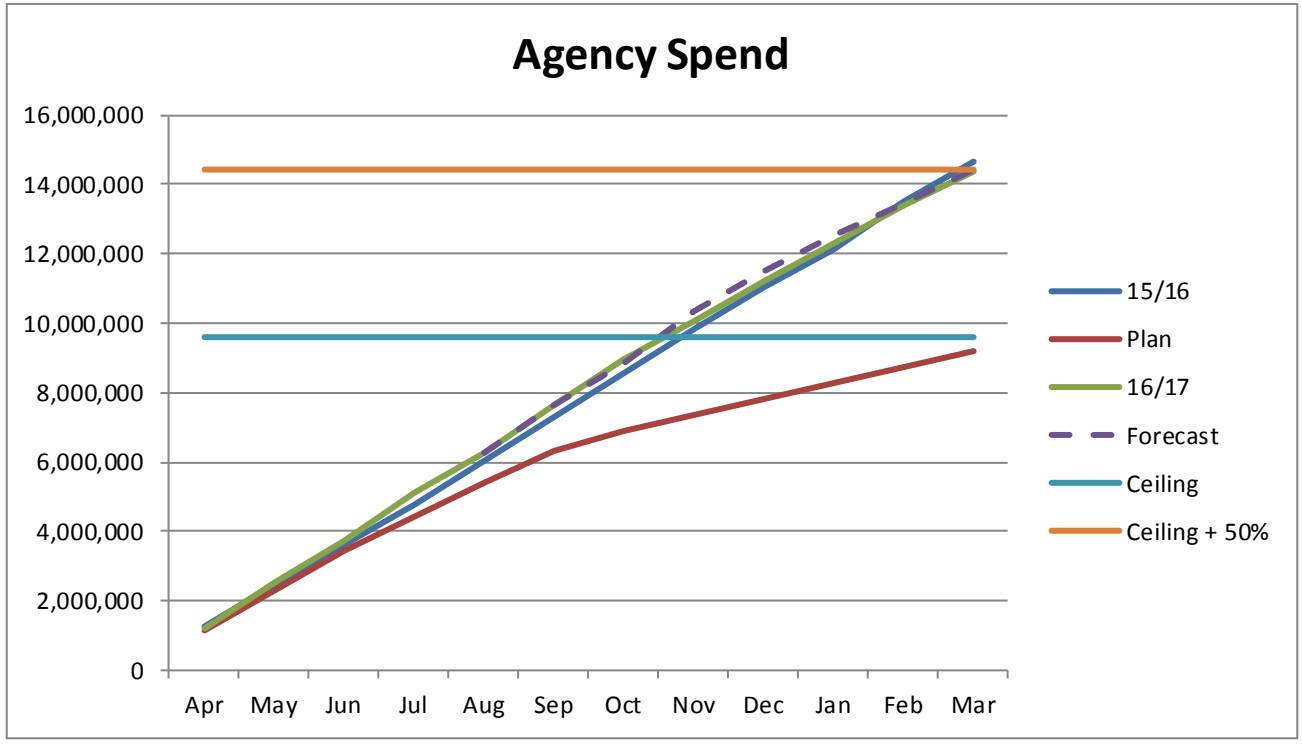
Main bridging items: £8.7m Revenue allocation received in M12 (assumed to be either Capital to Revenue or rec'd in 17/18)
£5m improvement in debtors (local CCGs). Significant overperformance paid in month (NHS Luton £5.3m, NHS Bedfordshire £2m)

Agency Spend	Just better than forecast	Just under ceiling +50%

£000s	15/16	Forecast	16/17
Apr	1,241	1,159	1,217
May	2,486	2,318	2,544
Jun	3,621	3,477	3,745
Jul	4,781	4,436	5,097
Aug	6,022	6,267	6,267
Sep	7,280	7,619	7,664
Oct	8,562	8,845	8,957
Nov	9,839	10,357	10,031
Dec	11,043	11,490	11,183
Jan	12,135	12,538	12,306
Feb	13,510	13,478	13,414
Mar	14,660	14,418	14,394

	Medics	Other Clin	A&C	Total
Apr-15	515	682	44	1,241
May-15	489	676	80	1,245
Jun-15	510	574	51	1,135
Jul-15	516	604	41	1,161
Aug-15	701	452	87	1,241
Sep-15	655	525	77	1,257
Oct-15	483	764	36	1,283
Nov-15	541	682	54	1,277
Dec-15	527	634	43	1,204
Jan-16	362	686	44	1,092
Feb-16	463	832	80	1,375
Mar-16	457	619	75	1,150

	Medics	Other Clin	A&C	Total
Apr-16	527	651	38	1,217
May-16	573	694	59	1,327
Jun-16	430	673	98	1,201
Jul-16	590	689	73	1,352
Aug-16	503	582	85	1,170
Sep-16	649	668	79	1,397
Oct-16	528	671	95	1,293
Nov-16	595	618	-138	1,074
Dec-16	433	686	32	1,152
Jan-17	484	580	59	1,123
Feb-17	494	572	42	1,108
Mar-17	354	649	-22	980



Agency	Performance by Service Line												
	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	
Service Line	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**	**Total**
Anaesthetics	152	119	141	116	177	142	137	101	212	108	122	65	**1,592**
Cancer Services	11	6	7	7	3	5	-1	3	3	2	3	3	**51**
Cobham	4	1	2	1	3	4	2	2	2	2	1	2	**27**
Critical Care	37	35	34	30	36	27	30	37	45	35	26	39	**412**
ENT	12	9	5	6	18	11	17	17	5	8	11	16	**135**
OMFS		4	6	2		0	0	0	0	-2	0	0	**10**
Ophthalmology	7	13	3	12	6	8	15	25	12	8	1	-4	**106**
Surgical Support Services	4	4	4	3		3	2	1	-1	1	0	-1	**20**
Surgical Wards	71	72	57	61	80	66	65	87	73	63	53	81	**829**
Trauma & Orthopaedics	84	71	78	101	70	140	89	130	149	144	117	95	**1,267**
Upper GI	17	1	5	8	35	43	10	27	22	3	7	-4	**174**
Surgical Division	**399**	**335**	**343**	**348**	**429**	**447**	**366**	**430**	**521**	**371**	**340**	**291**	**4,620**
Acute Medicine	49	50	53	31	47	45	49	45	43	52	59	61	**585**
Cardiology	26	44	42	-24	38	40	66	30	39	37	31	55	**423**
Dermatology	39	34	25	33	18	18	25	21	50	30	62	35	**390**
Diabetics & Endocrine			2	16	21	19	14	9	29	-22	0	-8	**79**
Elderly Medicine	73	124	103	132	65	80	66	91	62	85	71	134	**1,085**
Emergency Medicine	146	151	85	74	104	67	110	97	81	27	71	95	**1,107**
Gastroenterology	10	5	12	7	14	9	1	-2	3	1	3	5	**69**
Medicine	251	330	265	371	142	261	208	191	164	235	296	291	**3,004**
Neurological Medicine	20	1	18	13	12	4	9	10	8	3	9	13	**118**
Respiratory		9	10	5	18	9	7	1	2	2	0	0	**62**
Stroke Services	16	24	22	26	25	27	33	30	36	47	35	56	**378**
Medical Division	**629**	**772**	**638**	**685**	**504**	**579**	**589**	**521**	**515**	**496**	**637**	**736**	**7,302**

Agency	Performance by Service Line												
Service Line	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Forecast
Gynaecology	3	4	3	3	3	6	6	2	5	3	6	6	**49**
NICU	9	1	2	2	4	1	-4	5	1	1	2	2	**25**
Obstetrics	14	15	18	37	1	-4	1	1	4	8	4	2	**100**
Paediatrics	25	43	23	35	5	21	27	34	51	24	17	20	**327**
Women and Children Division	**52**	**62**	**47**	**77**	**12**	**24**	**30**	**42**	**60**	**36**	**29**	**31**	**502**
Breast Screening					6	3	-1	0	0	0	0	1	**9**
Imaging	14	13	20	30	4	37	14	8	7	0	-1	3	**147**
Outpatients	0	0				0	0	0	0	0	0	0	**0**
Pathology	74	77	45	104	80	171	133	150	144	143	45	41	**1,207**
Pharmacy		2	3	15	12	12	13	21	9	3	0	0	**89**
Therapies	29	21	28	38	35	41	60	45	16	12	11	9	**346**
Diagnostics, Therapies & Outpatients Division	**117**	**113**	**96**	**187**	**136**	**264**	**219**	**223**	**176**	**158**	**54**	**55**	**1,799**
Director of Finance	0	0	0	1	5	5	12	-23	1	1	0	0	**2**
Director of IT	14	14	41	17	33	26	69	-64	17	15	32	12	**227**
Director of Quality			20	12	22	17	-5	-6	-1	32	1	-57	**36**
Medical Education											5	0	**5**
Operational Services	6	30	17	21	26	17	12	-53	12	14	11	31	**144**
Corporate Division	**20**	**44**	**78**	**50**	**87**	**65**	**88**	**-146**	**30**	**62**	**49**	**-13**	**415**
Non-Directorate Expenditure				**5**	**2**	**18**	**1**	**3**	**-150**		**-2**	**-119**	**-242**
Trust Total	**1,217**	**1,327**	**1,201**	**1,352**	**1,170**	**1,397**	**1,293**	**1,074**	**1,152**	**1,123**	**1,108**	**980**	**14,395**
Ceiling + 50%													**14,418**

Capital	Spend YTD Slide 1/2

	Revised Plan £000s	YTD Spend £000s
Line A: Total C_Fwd Items FY15/16	**3,052**	**1,809**
Line B: Total Medical Equipment	**1,465**	**1,553**
Line C: Estates & Facilities	**1,696**	**1,168**
Line D: Sub Total Re-Development	**5,655**	**3,780**
Line E: Total IT	**1,837**	**936**
Line F: Other	**395**	**401**
Line G: Contingency £500k / Unallocated ITFF £4,620K	**0**	**0**
Line H (sum Lines A-G) Grand Total - Gross	**14,100**	**9,646**

	Revised Plan £000s	YTD Spend £000s
C_Fwd Items FY15/16		
DH Funded : E-Obs Visibility	**176**	43
DH Funded : IT E Handover	**0**	0
Estate FY15/16 : Replacement Sterile Services Washers	**120**	13
Estate FY15/16 : Oxygen VIE Upgrade	**121**	11
Estate FY15/16 : Site Wide Fire Alarm System	**205**	4
Estate FY15/16 : Nucleur Medicine Security Precautions	**76**	70
Estate FY15/16 : Corridor Redecoration	**282**	319
Estate FY15/16 : 4th Ultrasound Scan Room - Building Works	**50**	6
Med Eq - FY15/16 : Delayed Medical Equipment Purchases	**189**	205
IT FY15/16 : Infrastructure - Phase 1 & 2	**46**	45
IT FY15/16 : Infrastructure - Phase 3	**603**	297
IT FY15/16 : E Prescribing	**75**	75
IT FY15/16 : Cancer System (Chemocare)	**239**	194
IT FY15/16 : E-Rostering	**95**	95
General : Costing System	**40**	0
General : Civica SLAM (Billing)	**31**	31
ITFF Loan	**306**	214
Minor Schemes	**236**	159
Re-Development : Hot Block - AECOM Fees	**120**	5
Re-Development: Energy Centre - AECOM Fees	**43**	23
Line A: Total C_Fwd Items FY15/16	**3,052**	**1,809**

Medical Equipment		
Surgery	**660**	801
Medicine	**242**	278
DTO	**502**	234
Women's & Childrens	**300**	198
Transfer to Leasing / Slippage	**-345**	0
Corporate (Datix Project)	**106**	42
Line B: Total Medical Equipmnet	**1,465**	**1,553**

Estates & Facilities		
Backlog	**722**	415
Ward Pantries	**515**	612
Asbestos	**318**	43
Equipment Replacement	**90**	8
Clinical Service Developments	**15**	0
Offices	**36**	90
Line C: Estates & Facilities	**1,696**	**1,168**

Capital — Spend YTD Slide 1/2

Redevelopment		
Project Costs		
Internal Team	**527**	248
Transfer of Internal Team to ITFF	**-212**	-83
External Costs	**0**	26
Sub Total Main Programme	**315**	**191**
Enabling Schemes		
Ward 19 A	**2,978**	2,844
Day Unit	**0**	0
Ward 19 B (Extra 2 Beds)	**100**	0
St Mary's Additional Beds (Floor 2/3 - 8 Beds)	**300**	375
Therapies	**400**	76
Transfer of Internal Team to ITFF	**212**	83
Pathology	**100**	4
Ward 10	**200**	0
Ward 11	**200**	0
Sub Total Enabling Schemes	**4,490**	**3,381**
Keeping L&D Running		
Theatres Arrivals	**25**	0
Theatres A-F	**0**	0
Medical Gas	**25**	0
Sub Total Keeping L&D Running	**50**	**0**
Other D Hartshorne Schemes		
Cresta Hse	**200**	160
Mortuary	**0**	0
Max Fax	**600**	47
Sub Total DH Schemes	**800**	**207**
Line D: Sub Total Re-Development	**5,655**	**3,780**

IT		
ePMA Overspend (ED, Maternity, Outpatients)	**153**	138
Electronic Patient Record Project	**100**	121
LIMS (Pathology)*	**967**	187
PACS	**20**	73
Diamond	**85**	30
Unified Communications	**122**	122
WIFI	**276**	221
IT Infrastructure phase 3 - Overspend	**30**	0
NHS MAIL migration	**0**	0
Bighand Upgrade	**84**	44
Line E: Total IT	**1,837**	**936**
Other		
Off-site Beds	**0**	0
Ex SIFT - Simulation Equipment (borrowed FY15-16)	**125**	22
Ward 16 Medical Equipment	**270**	254
GDE	**0**	105
Other	**0**	20
Line F: Other	**395**	**401**
Line G: Contingency £500k / Unallocated ITFF £4,620K	**0**	**0**
Line H (sum Lines A-G) Grand Total - Gross	**14,100**	**9,646**

Key Dates

30th March	Re-submission of Operational Plan (Financials only - wording update not required) – **Submitted on time**
19th April	Key Data return (high level I&E position and Capital spend) – **Submitted on time**
24th April	Confirmation of potential bonus S&T Funding
26th April	Submission of unaudited FTCs and accounts
31st May	Submission of audited FTCs, accounts and final wording of Annual Report
26th June	Annual Report and Accounts to be laid before parliament

Governance Meetings

17th May	FIP (12-3)
	Audit (3-5)
21st June	FIP (12-3)

Workforce
May 2017

(Reporting February/March 2017 Data)

WORKFORCE BALANCED SCORECARD

Reporting Period: February / March 2017

Workforce	Trust Target	Feb-17 Trust Actual	Feb-17 Corporate	Feb-17 Diagnostics	Feb-17 Medicine	Feb-17 Surgery	Feb-17 Women' and Children's	Mar-17 Trust Actual	Mar-17 Corporate	Mar-17 Diagnostics	Mar-17 Medicine	Mar-17 Surgery	Mar-17 Women' and Children's	Mar-16 Trust Actual
Workforce Statistics														
Staff in post (Assignment Headcount)	-	3956	479	708	1107	884	778	3973	487	704	1105	898	779	3845
Budgeted WTE	-	4014	464	650	1228	981	691	4014	464	650	1228	981	691	3817.7
Staff in Post (WTE)	-	3547	438	616	1008	830	655	3562	446	611	1004	842	658	3440
Vacancy Rates (%)	10%	11.63	5.56	5.24	17.88	15.42	5.23	11.26	3.77	6.01	18.21	14.13	4.78	9.89
Nurses & Midwives Budgeted WTE		1418	34.7	26.8	529.9	419.4	407.1	1418	34.7	26.8	529.9	419.4	407.1	1352.5
Nurses & Midwives in Post (WTE)	-	1174.5	38.5	26.2	409.3	329.0	371.5	1174.4	37.5	26.3	404.2	332.6	373.8	1174.6
Nursing & Midwives Vacancy Rates (%)	10%	17.17	-10.91	2.50	22.75	21.55	8.74	17.17	-8.03	1.85	23.72	20.70	8.17	13.15
Nursing Vacancy Rates (%)	10%	18.70	-10.91	2.50	22.75	21.55	10.10	18.82	-8.03	1.85	23.72	20.70	9.68	14.50
Midwives Vacancy Rates (%)	10%	7.16	-	-	-	-	7.16	6.43	-	-	-	-	6.43	4.91
Sickness FTE Days Lost	-	0	0	0	0	0	0	-	-	-	-	-	-	3183
Sickness Rates (%)	3.32%	3.87	4.24	3.97	4.27	3.14	3.81	-	-	-	-	-	-	2.98
Estimated Sickness Cost (£)	-	304523	32781	58245	81340	66588	65569	-	-	-	-	-	-	252007
Maternity Absence Rates (%)	-	2.58	2.21	3.05	2.63	1.28	3.93	2.64	2.36	3.23	2.52	1.30	4.20	3.13
Other Absence Rates (%)	-	0.46	0.53	0.71	0.27	0.37	0.60	0.37	0.47	0.51	0.20	0.33	0.53	0.22
Turnover %	10%	17.08	15.06	18.67	19.32	17.78	12.92	16.96	14.92	19.30	19.45	16.68	12.80	15.68
Appraisal Rate %	90%	72	70	79	68	78	67	74	71	77	71	76	75	77
Core Statutory Training %	80%	82	76	84	81	82	82	81	79	82	79	83	80	84

RECRUITMENT COMMENTARY

Nurse Recruitment

European Recruitment - Seven Italian nurses commenced in post in February although currently in HCA posts pending successfully completing IELTS. A further 3 Italian nurses are due to arrive at the end of April after completing the UK based residential course. The Trust are currently working with our recruitment agency to look at ways of supporting the European nurses with IELTS training within their home county. This would result in the nurses having passed their IELTS prior to arriving in the UK.

International Recruitment – To date 9 have started in post of which four Indian nurses started in post at the beginning of March and will be sitting their OSCE exam at the end of April. We are currently applying for a further three Certificate of Sponsorships for two nurses from the Philippines and one from India with an anticipated arrival date of the end of May.

Ad-hoc advertising has continued and 44 nurses started in post between January and the end of March.

HCA/MCA Recruitment

The Trust continues with regular bi-monthly HCA recruitment campaigns for both permanent and bank positions to keep vacancies to a minimum and to continue to top up the bank. There have been 14 HCA starters throughout January to March.

Forthcoming Recruitment Campaigns

The Trust recently attended Career Fairs at several local schools and the Luton Training & Skills Fair. Planned forthcoming events include Harlington Upper School, Luton Mall Careers Stand, Armed Forces Information Day & University of Hertfordshire Careers Fair.

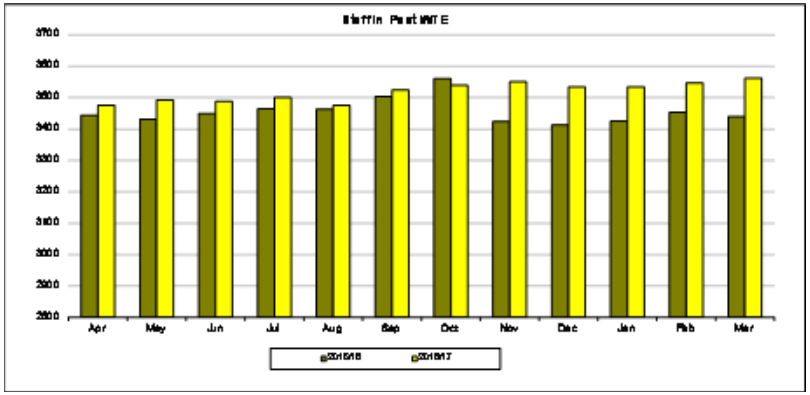
STAFF IN POST WTE BY DIVISION

DIVISION	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	% Growth From April 2016	Average % Growth per month
Corporate	401.3	407.1	419.2	420.1	430.2	434.5	432.9	431.2	433.4	431.856	438.2	446.5	11.27%	1.02%
Diagnostics, Therapeutics and Outpatients	594.7	594.1	589.0	592.7	585.2	596.1	607.3	606.8	603.2	609.207	615.9	610.9	2.72%	0.25%
Medicine	1012.8	1015.5	1006.1	1017.9	1021.7	1027.6	1030.0	1039.1	1022.4	1017.03	1008.5	1004.4	-0.83%	-0.08%
Surgery	810.8	822.2	826.0	818.1	806.0	813.8	815.3	818.8	817.2	819.922	829.8	842.4	3.90%	0.35%
Women's & Children's	657.3	655.0	647.9	651.8	632.0	652.6	654.1	654.9	657.9	656.418	654.9	658.0	0.11%	0.01%
TOTAL	3476.8	3493.9	3488.1	3500.5	3475.0	3524.6	3539.7	3550.8	3534.1	3534.4	3547.3	3562.2	2.45%	0.22%

WTE COMMENTARY

This data is based on staff in post excluding bank and honorary staff.

- The Trust's overall Staff in Post (SIP) by Whole Time Equivalent (WTE) has increased by 2.45% since April 2016. The Corporate Division has the highest increase of 11.27% this is mainly attributed to increases in IT, HR, Director of Nursing and Outsourcing cost centres.
- There are currently 100 band 5 Nursing vacancies across the Trust. There are 58 band 5 Nurses currently going through the recruitment process.
- Currently there are 10 vacancies for band 2 Healthcare Assistants with 22 currently going through the recruitment process and due to commence between April and June 2017.



Medical Recruitment

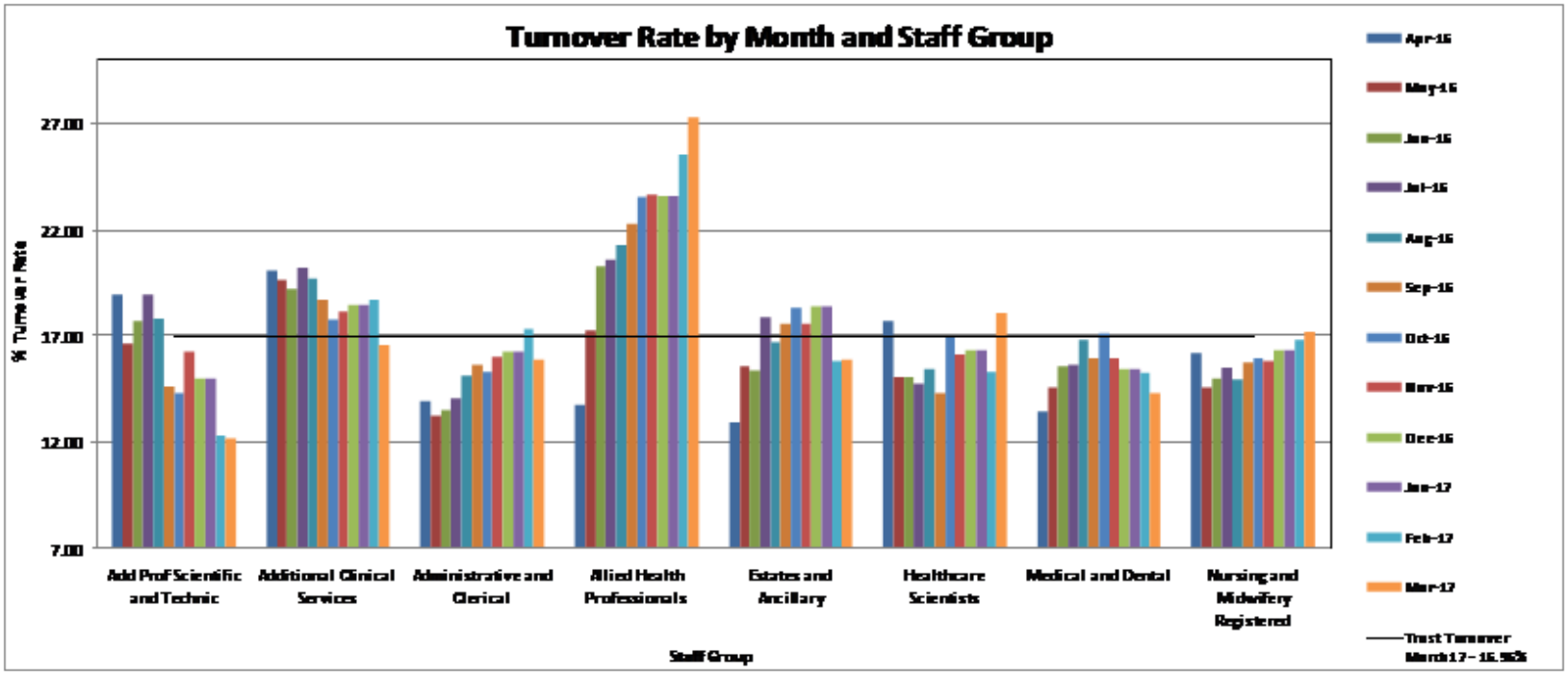
From January to March 2017 2 AACs were held to recruit Consultants in Anaesthetics (2 Posts),and Radiology (1 post)
AAC's are planned for April to fill posts in Acute Medicine (3 posts) and Neurology (1 post). A further AAC is planned in May 2017 for Dermatology (1 post) which continues to be a hard to recruit specialty.

The new Junior Doctors contract (2016) continues to be rolled out in line with NHS employers timeline for Deanery Trainees. The Trust expect to have all trainees transferred to the new terms and conditions by October 2017.

New Starters

Between January – March 2017 6 new substantive Consultants started in post, in the following specialities: Obstetrics and Gynaecology (2 posts), Gastroenterology (1 post), Anaesthetics (3 posts), 1 NHS Locum Consultant in ENT and 1 NHS Locum Consultant in T&O.

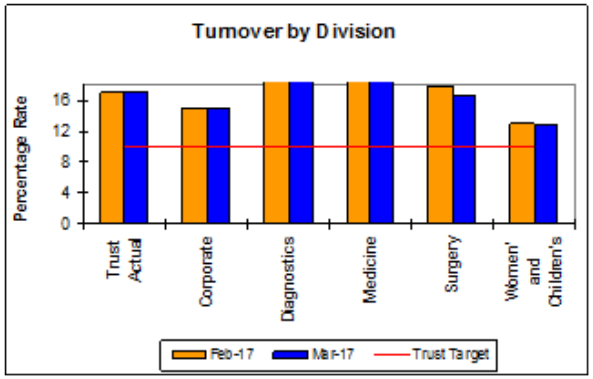
TURNOVER



TURNOVER COMMENTARY

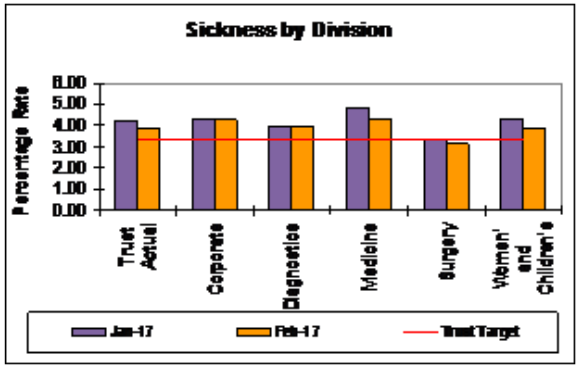
The Trust's overall turnover rate is 16.9% for the reporting year ending 31st March 2017 which is a reduction from the previous reporting period and more in line with the regional average (16.5%). Whilst there was an overall reduction in turnover for most staff groups there was increases amongst Allied Health Professionals, HealthCare Scientists and Nursing and Midwifery staff. The higher than average turnover amongst Allied Health Professionals and HealthCare scientists are linked to changes to work schedules. The top three reasons for leaving amongst nursing and midwifery were relocation (27.8%), work life balance (13.2%) and retirement (7.5%)

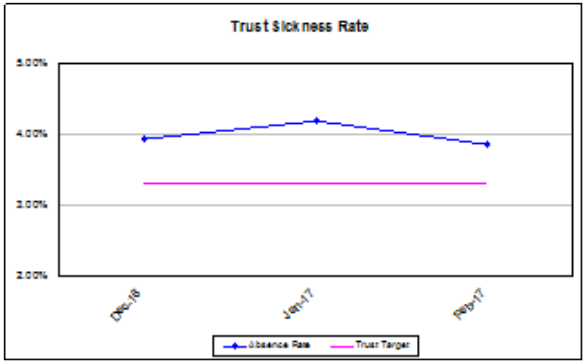
The recent audit by PricewaterhouseCoopers supported the fact that the low response rate to exit questionnaires presents a challenge to understanding underlying reasons driving turnover and the implementation of data driven targeted interventions. A focussed piece of work is underway to review retention data by staff groups and this will be completed by the end of May. This piece of work is focussed on both recruitment and retention data plus the stability of certain staff groups. The output from this review will be used to create a task and finish group focussed on the implementation of retention strategies and will report its findings to a sub-committee of the Board.

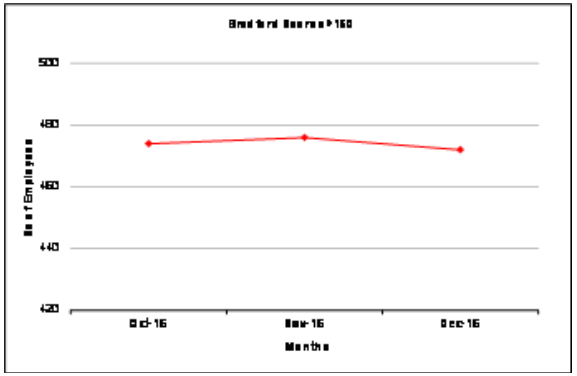


* Turnover figures above do not include Junior Doctors.

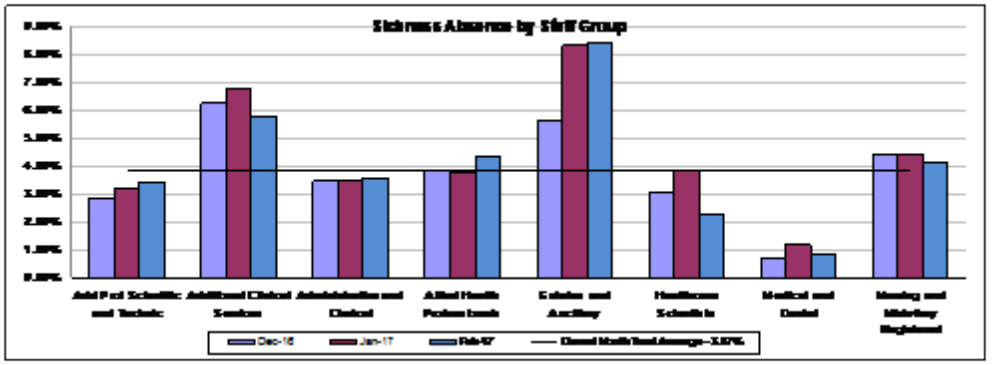
SICKNESS ABSENCE







Sickness Absence by Staff Group	Dec-16	Jan-17	Feb-17	Last 12 Months Average
Add Prof Scientific and Technic	2.86%	3.19%	3.44%	3.22%
Additional Clinical Services	6.26%	6.75%	5.80%	5.20%
Administrative and Clerical	3.45%	3.46%	3.56%	3.44%
Allied Health Professionals	3.87%	3.79%	4.35%	3.01%
Estates and Ancillary	5.62%	8.32%	8.42%	7.34%
Healthcare Scientists	3.05%	3.87%	2.29%	2.14%
Medical and Dental	0.71%	1.18%	0.83%	0.80%
Nursing and Midwifery Registered	4.43%	4.44%	4.12%	3.56%
Trust total	3.94%	4.19%	3.87%	3.45%



SICKNESS ABSENCE COMMENTARY

The overall monthly figure for February 2017 is 3.87% which is less than for January 2017 - 4.19% but it is above the Trust target of 3.32%. The Trust's overall average for the year ending 28th February 2017 is 3.45%. This is slightly higher than the same period last year (3.37%).

Overall the number of employees with a BS over 150 increased from 460 at 1st March 2017 to 470 at 1st April 2017.

The management of sickness absence remains high on the agenda for all Divisions.

There are a number of long term sickness cases within Estates, which are all being actively manage in line with the sickness policy.

TRAINING COMPLIANCE BY DIVISION

March 2017	APPRAISALS	INDUCTION	STATUTORY TRAINING						
			Fire	Infection Control	Safe Moving - Theory	Safe Moving - Practical	Information Governance	Safeguarding Adults	Safeguarding Children
TRUST TARGET	90%	100%	80%	80%	80%	80%	80%	80%	80%
Corporate	71%	86%	79%	76%	84%	80%	75%	79%	85%
Diagnostics, Therapeutics and Outpatients	77%	71%	83%	81%	88%	76%	81%	82%	81%
Medicine	71%	100%	80%	78%	81%	81%	77%	80%	90%
Surgery	76%	80%	82%	81%	85%	85%	81%	81%	87%
Women's & Children's	75%	100%	80%	78%	83%	82%	79%	79%	93%
TRUST TOTAL	74%	87%	81%	79%	84%	82%	79%	80%	88%
Change from last month	2%	-7%	0%	-1%	0%	2%	-1%	-1%	0%

Compliance Thresholds

Appraisal	Induction	Stat Training
90 - 100%	95 - 100%	80 - 100%
65 - 89%	75 - 94%	65 - 79%
0 - 64%	0 - 74%	0 - 64%

TRAINING COMMENTARY

Statutory Training
Statutory training compliance shows no major deviation since the end of February position. We continue to try and accommodate rebooking as quickly as possible for those members of clinical staff withdrawn from statutory training in the early part of the year due to staffing pressures. In addition to this, further use of e-learning for non-practical elements of mandatory training for clinical staff is being promoted as an alternative option for ward managers who are struggling to release staff for full study days

Appraisals
The Trust-wide compliance figure has increased by 2% this month, with a good increase particularly seen in the Women's and Children's division.

All Divisional performance meetings include a focus on appraisal rates. This not only provides assurance that appraisal rates are monitored on a monthly basis but also allows an opportunity for challenge in the areas where compliance is poor.

Following a recommendation from the PricewaterhouseCoopers audit of the appraisal monitoring processes, the Trust will continue to review a selection of completed appraisals for quality audit purposes each month. The review will particularly focus on the quality of objective setting and relevance of personal development planning.

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

BOARD OF DIRECTORS

Agenda item	8	**Category of Paper**	Tick
Paper Title	Executive Board Report	**To action**	☒
Date of Meeting	Wednesday 3 May 2017	**To note**	☒
Lead Director	P Philip	**For Information**	☒
Paper Author	Executive Directors	**To ratify**	☐
Indicate the impact of the paper: **Financial** ☐ **Quality/Safety** ☒ **Patient Experience** ☐ **Equality** ☐ **Clinical** ☒ **Governance** ☒			

History of Committee Reporting and Date	Executive Board – 1 February 2017	
Links to Strategic Board Objectives	All Objectives	
Links to Regulations/ Outcomes/External Assessments	CQC Monitor Information Governance Toolkit	
Links to the Risk Register	1175 – Agency Costs 1018 – HSMR Estates Risks	650 – Bed pressures 669 – Appraisal

PURPOSE OF THE PAPER/REPORT

To update the Board on items discussed / presented / approved by the Executive Board in readiness for Board awareness or approval.

SUMMARY/CURRENT ISSUES AND ACTION

1.	Infection Control Report	- to note
2.	Deanery Issues	- to note
3.	Complaints Board Update	- to note
4.	Mortality Board Update	- to note
5.	Needs Based Care	- to note
6.	Nursing and Midwifery Staffing	- to note
7.	Management of CQUIN	- to note
8.	Compliance Issues	- to note
9.	Staff Survey Update	- to note
10.	Trust Quality Buddy System	- to note
11.	NHS Staff Sickness Absence with Stress	- to note
12.	Sugary Drinks – National Press	- to note
13.	Freedom to Speak Up	- to note
14.	Estates and Facilities Update	- to note
15.	Fundraising Update	- to note
16.	Policies and Procedures Update	- to note

ACTION REQUIRED

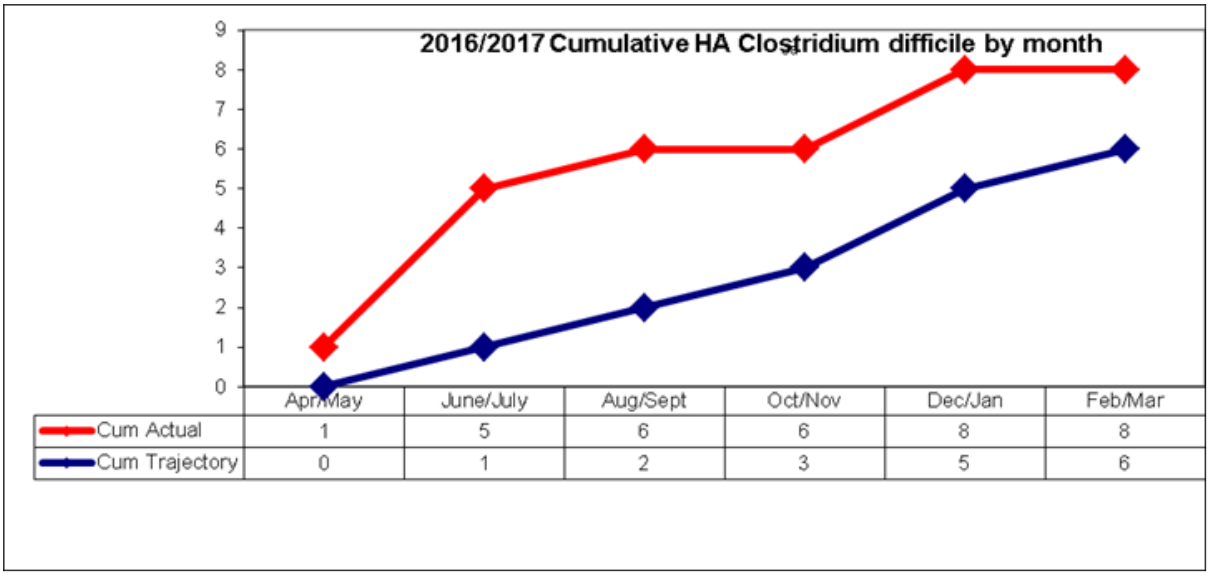
To note / consider / review / approve as specified above.

Public Meeting ☒ Private Meeting ☐

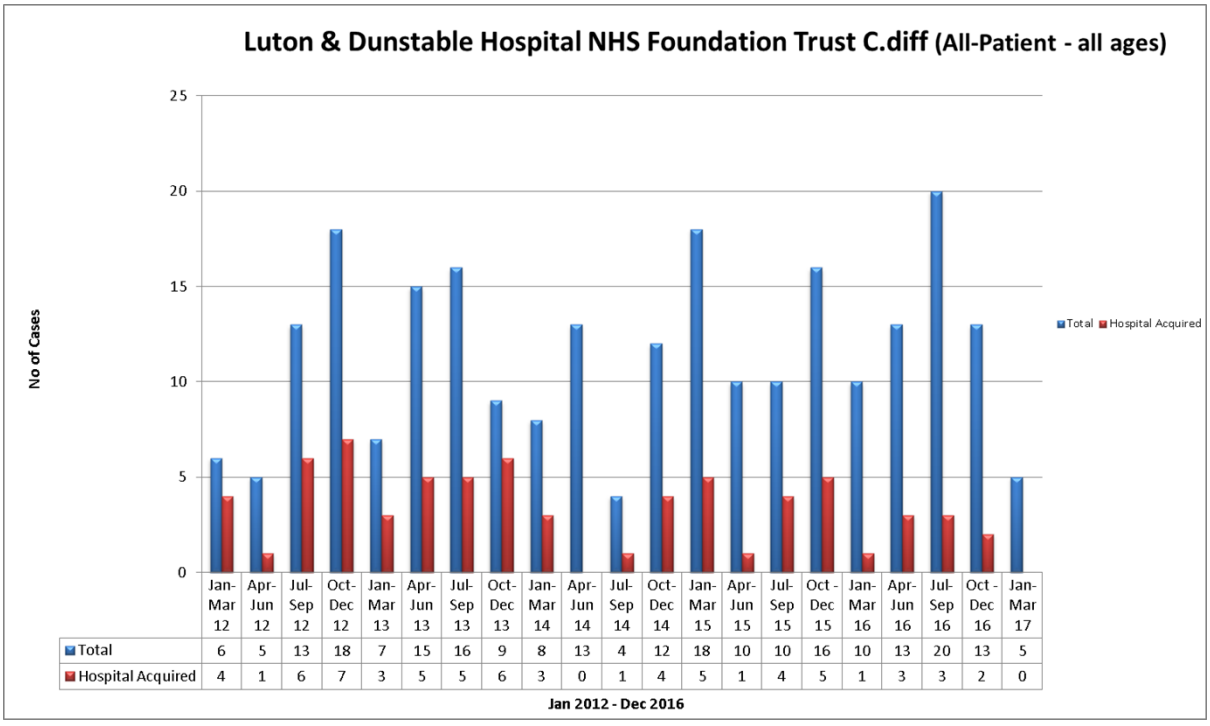
1. INFECTION CONTROL REPORT

- **Clostridium difficile**

For the year April 2016 to March 2017 the Trust reported 8 cases of hospital acquired infections (ceiling was 6 cases). The ceiling for the next financial year remains at 6 cases. So far this year we have had one case. At the end of March 2017 we had recorded a total of 8 cases of hospital acquired C.difficile infections, with no cases reported in this quarter. No particular type strain is dominant and no outbreaks / clusters have been reported. In the last quarter the Infection Control Team appealed against 4 hospital acquired cases, three of which were successfully upheld. The ceiling (trajectory) for 2017/18 is the same at last year, i.e. 6 cases.



	Apr/May	June/July	Aug/Sept	Oct/Nov	Dec/Jan	Feb/Mar
Cum Actual	1	5	6	6	8	8
Cum Trajectory	0	1	2	3	5	6

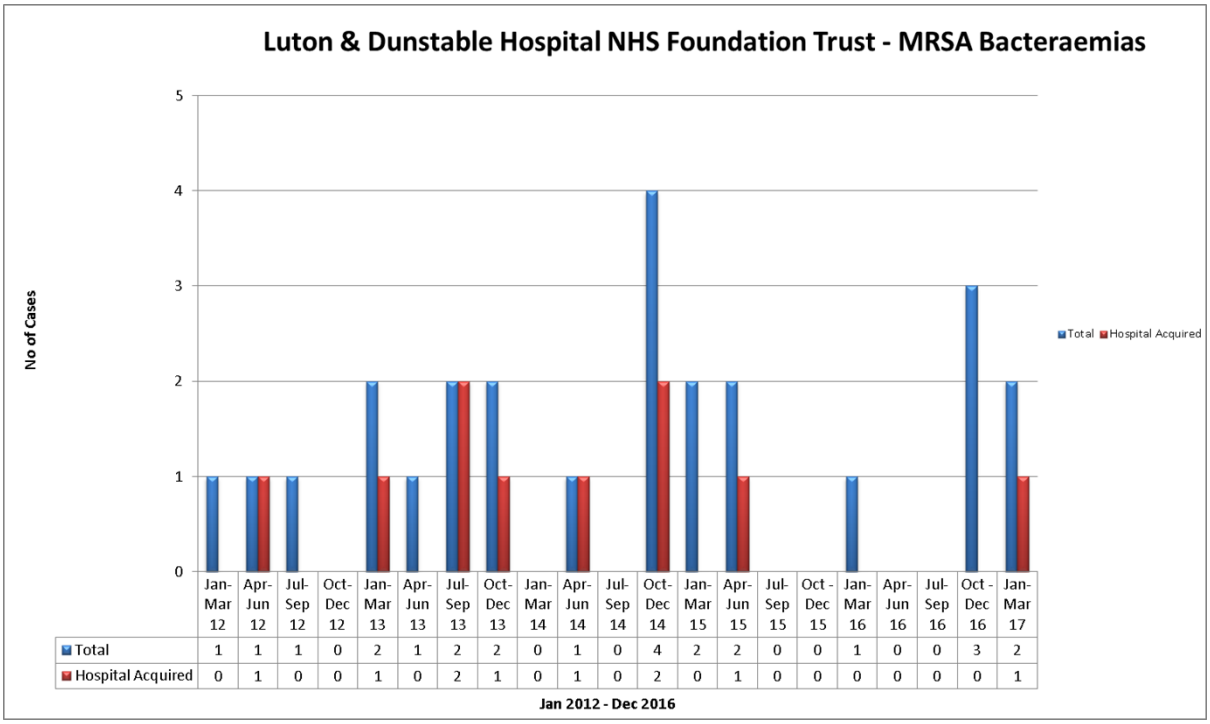


	Jan-Mar 12	Apr-Jun 12	Jul-Sep 12	Oct-Dec 12	Jan-Mar 13	Apr-Jun 13	Jul-Sep 13	Oct-Dec 13	Jan-Mar 14	Apr-Jun 14	Jul-Sep 14	Oct-Dec 14	Jan-Mar 15	Apr-Jun 15	Jul-Sep 15	Oct - Dec 15	Jan-Mar 16	Apr-Jun 16	Jul-Sep 16	Oct - Dec 16	Jan-Mar 17
Total	6	5	13	18	7	15	16	9	8	13	4	12	18	10	10	16	10	13	20	13	5
Hospital Acquired	4	1	6	7	3	5	5	6	3	0	1	4	5	1	4	5	1	3	3	2	0

- **MRSA bacteraemia**

There was one case of hospital acquired MRSA blood stream infection recorded during in 2016-17.

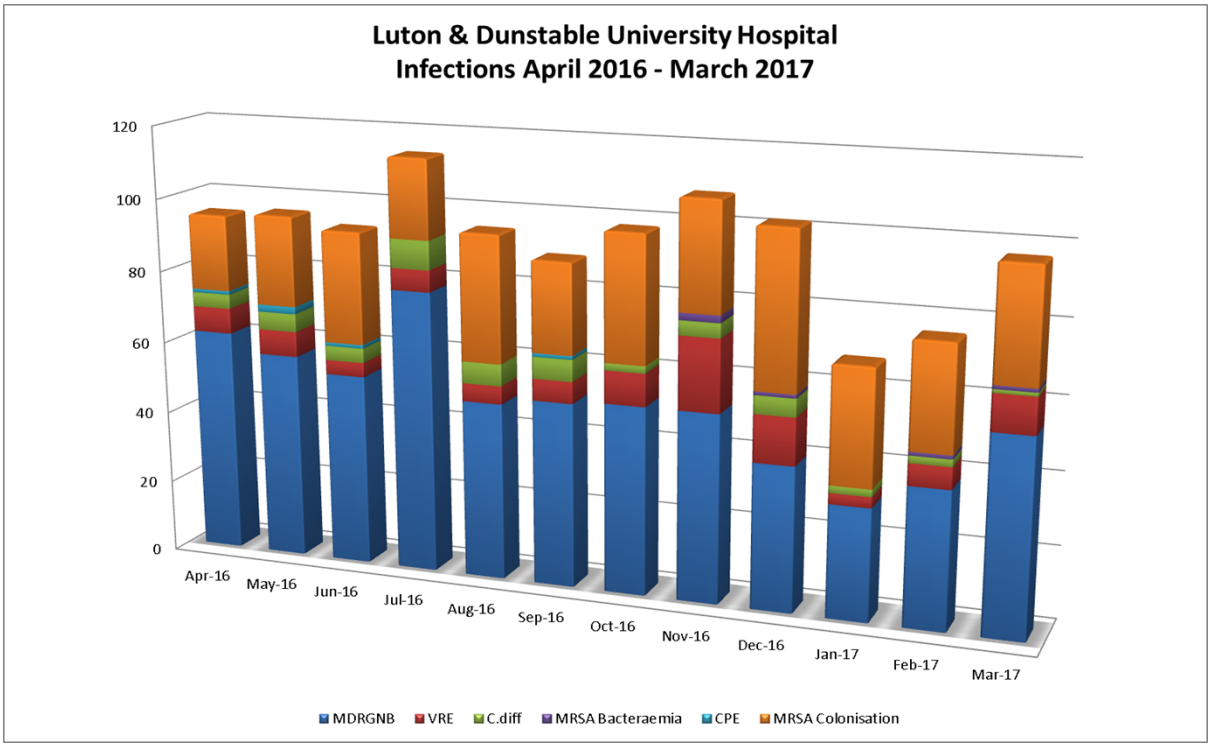
These results demonstrate consistently good performance and ensure that our patients' safety is optimised.



	Jan-Mar 12	Apr-Jun 12	Jul-Sep 12	Oct-Dec 12	Jan-Mar 13	Apr-Jun 13	Jul-Sep 13	Oct-Dec 13	Jan-Mar 14	Apr-Jun 14	Jul-Sep 14	Oct-Dec 14	Jan-Mar 15	Apr-Jun 15	Jul-Sep 15	Oct - Dec 15	Jan-Mar 16	Apr-Jun 16	Jul-Sep 16	Oct - Dec 16	Jan-Mar 17
Total	1	1	1	0	2	1	2	2	0	1	0	4	2	2	0	0	1	0	0	3	2
Hospital Acquired	0	1	0	0	1	0	2	1	0	1	0	2	0	1	0	0	0	0	0	0	1

- **Multi-drug resistant organisms (MDRO)**

The numbers of MDRO cases remain high. Management of patients with MDRO increases the need for our patients to require isolation. A number of actions to address this includes the importance of the patient receiving appropriate drug therapy, optimal management of vascular and urinary catheters and continued emphasis on good hand hygiene.

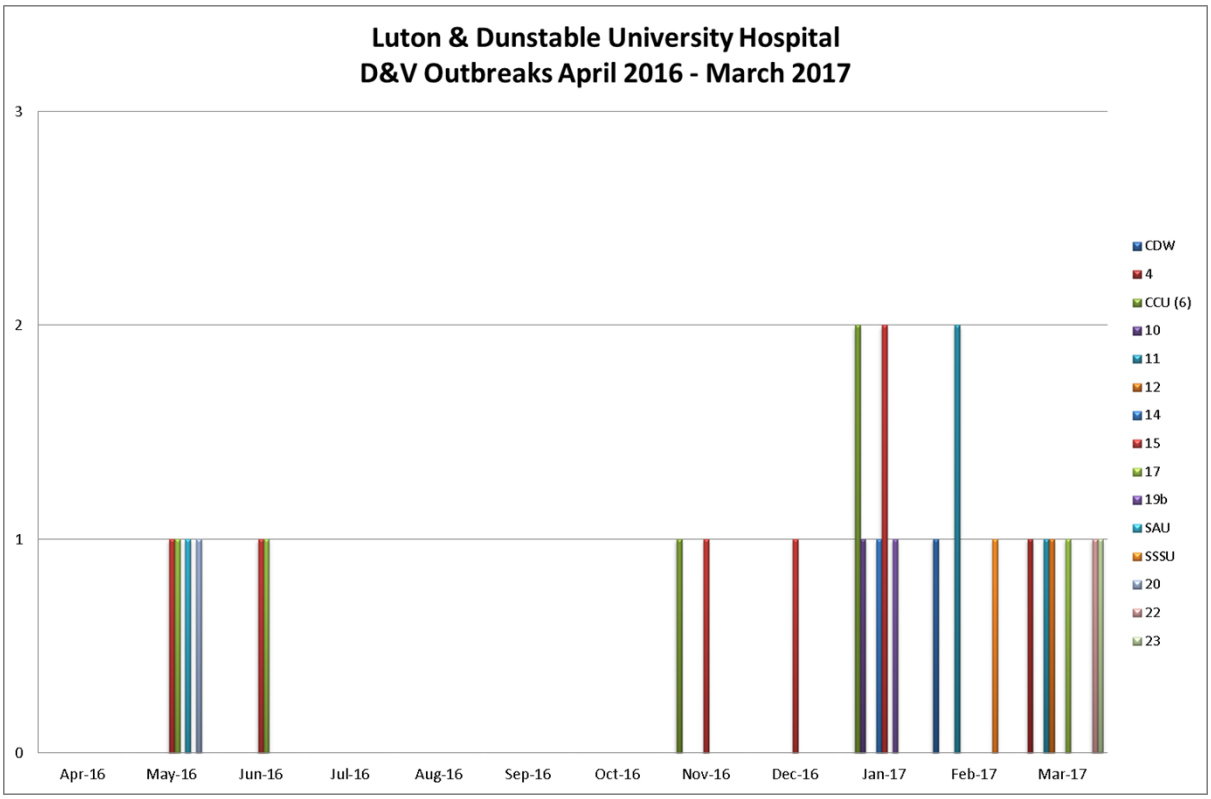


- **Winter Respiratory Viruses**

Cases of respiratory infections due to seasonal influenza are declining.

- **Diarrhoea and Vomiting Outbreaks**

During the last quarter a small number of outbreaks occurred. These were effectively escalated which ensured that the closure of beds was managed robustly with little impact on the organisation.



2. DEANERY ISSUES

No further updates.

3. COMPLAINTS BOARD UPDATE

Work is ongoing to reconfigure/update the Trust's Datix Risk Management System. The way that complaints are recorded and reported will be done differently and will provide the Trust with more meaningful and accurate data to support the learning from complaints. The reconfiguration will also enable the linking of complaints to incident reports, claims and inquests. Training on the reconfigured system will be provided by the Risk and Governance Team. A Standard Operating Procedure is being developed to ensure all complaint handlers are aware of the roles and responsibilities at Trust and Divisional level.

Surgery continues to have the largest number of open complaints. The Complaint's Board has asked the Risk and Governance Team to work with the Senior Managers

and Clinical Leads within the Surgical Division to focus on clearing the backlog. Additional resource has been introduced with immediate impact. A longer term plan to ensure complaints are responded to within the agreed timescales is being agreed within the division.

4. MORTALITY BOARD UPDATE

The latest quarterly trends show a continuing slow reduction in both the 12-month SMR and the SHMI, however, a high level of deaths in the first two months of 2017 has resulted in a sharp increase in the crude death rate.

Crude death rates for the hospital are monitored on a monthly basis within a few days of the end of the month. 2016 saw the lowest crude mortality rate for many years but the early part of 2017 has seen a sharp increase. Early indication suggests this has been a national trend but it is too early to tell if the Trust's HSMR will be affected.

The increase in deaths has been thoroughly investigated as part of our mortality governance process, to ascertain whether it is related to particular specialties, consultants, wards or conditions. Audits of the January and February deaths have been carried out and further work is planned to provide ongoing assurance.

5. NEEDS BASED CARE

The current priority within the needs based care programme has been to ensure that we are able to deliver admission for patients directly to respiratory specialists 7 days a week, and this is being incorporated into the clinical timetable currently. The business case for the lift works within the medical block as part of the Helipad business case are also a critical enabler of the full needs based care implementation.

As well as admission to the right specialty, one of the core components of the work to improving care for emergency medical patients is around improving the extent to which patients have continuity of physician. This falls into three categories; continuity within an inpatient stay in hospital, continuity between inpatients and outpatients where there is a long term condition, and continuity where a patient is readmitted for the same condition.

An immediate priority for the organisation is to improve continuity within a single episode and we are focussing on how this can be delivered within the context of seven day services. Currently it is possible for a medical patient to have 4 or 5 responsible consultants within a single stay, and we are exploring ways in which this can be reduced. We are seeking support externally from teams with expertise in logistics to assist with analysis of the models.

6. NURSING & MIDWIFERY STAFFING

The report for January, February and March is attached as **Appendix 1**

7. MANAGEMENT OF CQUIN

The reports for the final quarter of the 2016/17 CQUINS were submitted to Luton CCG ahead of the deadline, and we currently await the outcome of the CCG review panel.

It is important to note that it is not possible to ascertain whether we have achieved all the elements of the antibiotic reduction schemes as the data analysis by PHE has yet to be published for quarter 3.

The national CQUIN schemes published for 2017-2019 have been commenced in the Trust and at the present time, whilst challenging, there is no reason to believe that these schemes will not be achieved by the Trust.

8. COMPLIANCE ISSUES

CQC Inspectors conducted a short-notice announced inspection of compliance against the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000 on 15th February 2017. Compliance was assessed against all aspects of IR(ME)R. This visit is reported separately in these papers.

The Trust has received notification from JAG that the endoscopy unit has been awarded JAG accreditation following submission of the Annual Report Card 2016.

The Histopathology UKAS accreditation inspection took place in March 2017 and it was recommended that accreditation is offered under ISO15189:2012. To progress to the new standard, ISO15189, the laboratory will be required to close out a number of findings by 21/6/17.

The draft Cytology QA report was received in April 2017 with three findings to be managed.

9. STAFF SURVEY FEEDBACK

The results of the Staff Survey are included in Appendix 2

10. TRUST QUALITY BUDDY SYSTEM

In April 2017 the Trust re-launched the Trust Quality Buddy System (TQB); the approach for the system was modified to incorporate previous feedback from staff, endeavouring to make it less onerous and more inclusive. The revised approach is based around the five CQC domains and involves a nominated buddy(s) visiting a nominated area every two months to undertake a review of the selected domain for that time period.

The first domain review undertaken was the Safety Domain. Each TQB had a preloaded questionnaire, the content of which was populated based on the outputs

from the most recent report from the CQC titled **State of Care in Acute NHS Hospitals (March 2017**);aggregated findings of the CQC Inspections 2014 – 2016. In the national report it was noted that '…The safety of care is our biggest concern, with 11% of NHS acute non-specialist trusts being rated as inadequate for safety…' (CQC 2016). When assessing how safe a service is, three broad areas are considered and they include culture, staffing, and environment. In the CQC report it was identified that Trusts rated as outstanding for safety had '…an open honest culture, genuinely listening to staff about safety concerns. They are able to monitor and act on issues that are identified, and share the learning from incidents. They have an approach that is communicated and understood by all staff, and they consistently promote a culture of openness in which staff do not feel they will be blamed for problems..'

The Trust had an overwhelming response to the Safety review with a return rate of over 70%; the data is still being analysed but the initial combined result is 85.43% which is a remarkable achievement. However we still need to complete the analysis, provide everyone with feedback and prepare a more detailed report for next Trust Board.

11. NHS STAFF SICKNESS ABSENCE WITH STRESS

Our Sickness absence statistics show for (2016) that 197 staff members were absent from work due to 'stress', totalling 4,762 days absence.

Further work is currently being undertaken by our occupational Health team to examine the attendance levels to their service in order to examine if they were self referrals or management referrals, and time scales for them being seen. This will include reasons such as if it is work related, home related or a combination.

It should be recognised that not all individuals will have contact with Occupational health, and may instead be speaking with CiC our employment Advisory service, their GP, or just seek support from their colleagues, friends or managers. It is recognised that early intervention would of course be beneficial

Northumbria NHS Trust, have been classed as an exemplar Trust in managing staff with stress. They have had a system in place for 2 years, which forms part of their sickness absence management process. If a member of staff phones in sick with a mental health issue.....the manager is asked to refer that individual immediately to Occ health by using the usual s/a referral form. Within that form, there is a line that says it's for 'mental health triage'. Their Occ Health team, deal with, on average 4 - 6 cases per day. They have also now extended this to deal with absence due to MSK. (of note our self-referral (via occ health) to physiotherapy on line form has been launched. In less than 48 hrs, it has already resulted in 12 necessary referrals).

It is our intention to work with Northumbria to understand how we can improve our processes and this will be part of our next Staff Engagement Event in July.

12. SUGARY DRINKS – NATIONAL PRESS

In line with the requirement of the 2016/17 CQUIN, the Trust has been actively working with our retail partners to promote healthy eating choices over the past 12 months and this includes recent national press coverage on sugary drinks.

This is an ongoing exercise to include:

- Banning price promotions on sugary drinks
- No advertising of sugary drinks within the hospital buildings
- No placement/stacking of these products by till check outs

In 2017/18 the Trust will be looking to further extend the initiative to meet the requirement that 70% of drinks must be sugar free.

13. FREEDOM TO SPEAK UP, JANUARY – APRIL 2017 UPDATE

As previously reported to the Board, there is a framework in place to allow staff to raise concerns via 'Freedom to Speak Up' which is a national requirement.

To date there have been nine concerns raised formally from 1 January – 31 March 2017 and these have been dealt with through the appropriate channels.

14. ESTATES & FACILITIES UPDATE

Annual PLACE Inspection

The annual inspection, led by patient representatives, took place on 16th March 2017. Members of the public led the exercise and they were joined by Non-Executive Directors. Overall, the feedback from the event was very positive. The output of the exercise has been correlated into a series of scores which will then be reported into HSCIC (Health & Social Care Information Centre). The results and comparison with our peers will be published in August 2017.

Electrical Infrastructure

On 25th March, important safety works to the site's high voltage network were successfully completed. The work had the added complication of involving the adjoining Health Trust who take power supply from the hospital.

Endoscopy Decontamination

A project to replace and upgrade the existing endoscope decontamination facility has commenced. Early discussions with Luton Borough Council have taken place to understand potential planning issues.

Operation Spring Clean

The Facilities Team are organising a site wide tidy up. This is being supported by volunteer groups. Works will include:-

- Tidying external gardens
- Removing clutter from wards
- A programme of external decoration

Capital Programme

A number of infrastructure schemes have been granted outline approval for the coming year. The schemes will ensure the Trust delivers its obligation to provide a safe environment for our patients and staff. Typical works planned include the replacement of the automatic fire detection system, updating of heating controls, improving the resilience of power distribution.

Travel Zone

The new strategy for car parking is currently being rolled out. Adjustments have been made to the car parks to increase the number of spaces available for our patients and visitors.

A new exclusion zone for staff travelling to work by car will be introduced on 5th June. Alternative methods for travelling to work have been promoted; for example, substantial discounts will be available to Trust staff using Arriva bus company. Luton Borough Council are actively engaged with the Trust supporting the various initiatives to encourage staff to adopt alternatives to the car. This whole initiative is also joined up with the Occupational Health Team's promotion of healthy life styles.

Luton Borough Council Environmental Health Officer

The annual, unannounced, inspection took place in March; this is a routine inspection. Following a review of the catering management and safe systems of food management, the Environmental Health Officer upgraded the current star rating from 3 (generally satisfactory) to 4 (good).

15. FUNDRAISING UPDATE

Funds generated January – April 2017: £110,000

- £54k from one grant giving trust towards a blue light cystoscopy
- £10k from one grant giving trust towards a blue light cystoscopy
- £10k from Domino's pizza
- £10.5k from a legacy to support the diabetes centre.
- 259 donations made.
- We have three runners in the London Marathon, (NICU & Paediatrics) one of whom was the millionth runner last year.

The charity also received £500k from The County Air Ambulance Trust towards a new helipad.

Gift in kind donations not included above:
Over 300 Easter egg donated for inpatients by members of the public and local companies. We have also received Lots of knitted goods for NICU and dementia patients.

16. POLICIES & PROCEDURES UPDATE

The following Policies & Procedures were approved in February & March 2017:

F04 Fraud Policy
C25 CAS policy
L13 Policy for Adverse Incident Reporting and Investigation of incidents
W02 Control of Water Borne Contamination in Domestic Water Services including Legionella and Pseudomonas
D02 Data Quality
D08 Duty of Candour
H05 Honorary Contract

Appendix 1

EXECUTIVE REPORT

QUARTERLY REPORT ON NURSING AND MIDWIFERY STAFFING LEVELS

Quarter 4 - January to March 2017

1.0 Summary of Report

At the Trust we aim to provide safe, high quality care to our patients. Our staffing levels are continually assessed to ensure we meet this aim.

This report provides the Trust Board with information regarding staffing levels for **1st January through to 31st March 2017**. The report provides details of the actual hours of Registered Nursing, Midwifery and un-registered staff care time on the units. This is broken down between day and night shifts and includes the planned versus actual staffing levels.

Key Points:

- Although the Trust has maintained an overall staffing fill rate of above 90%, these figures continue to include higher than optimum numbers of agency nurses. Fill rates have been challenged by the need to open escalation (contingency) areas at short notice.
- The number of staff required per shift is calculated using evidence based tools, which is based on the level of dependency of the patient. This is further informed using professional judgement, taking into consideration issues such as the ward environment including size, layout, staff experience, incidence of harm and patient satisfaction plus any additional tasks that the ward staff might be required to perform. This method is in line with NICE guidance. This gives us the optimum **planned** number of staff per shift
- We continue to use care hours per patient day (CHPPD) to monitor the amount of care hours given to a patient over a 24 hour period as per Lord Carter (2016) guidance.
- There remain challenges with Registered Nurse on-boarding due to the introduction of IELTs for both International and European recruits. This has meant delays to the start date of these staff on the wards.
- A reduction in vacancies within the maternity unit in March has resulted in an increase in fill rates.

The following report details the breakdown of average shift fill rates for the Trust, staffing management, vacancies and recruitment activity.

2.0 Breakdown of average shift fill rates for the Trust

Consistent with performance in previous quarters, the average actual level of Registered Nursing and Midwifery staff was generally within the levels planned across all shifts. Exceptions included areas where Assistant Nurse Practitioners (ANPs) are employed and those areas that provided support when escalation areas opened. Although not a Registered Nurse, the ANP role is aimed at providing a

higher level of care support to our Registered Nurses to ensure the continuity and quality of patient care.

At times the average fill rate for HCA's on night duty on some wards is above 100%. This is attributable to the last minute cancellations of registered nurses. Health Care Assistants were used as they were the only staff available to work.

We continue to explore new roles in order to address the national shortage of registered staff. We hope to implement Dementia Support workers in the near future. These staff will support the delivery of quality care for patients with dementia on wards were they frequently are admitted.

Table 1 BREAKDOWN OF AVERAGE SHIFT FILL RATES FOR THE TRUST

Month	Day		Night		Overall average %
	% Average fill rate RN	% Average fill rate HCA	% Average fill rate RN	% Average fill rate HCA	
January	93.2	93.2	98.2	95.9	**95.1**
February	91.5	94.2	98.5	95.2	**94.9**
March	92.5	95.3	98.2	97.5	**95.9**

3.0 Staffing Management

Actions are taken in accordance with the Trust Safe Staffing policy (2016). This dictates the escalation process when shortfalls and red flag incidences occur. It also outlines the risk assessments and communication required.

Operational staffing meetings continue up to 3 times a day in order to rectify staffing challenges in a timely manner. These are chaired by the Operational Matron in conjunction with either the Director or Associate Director of Nursing. Matrons from each division discuss the staffing shortfalls and move staff accordingly to meet the peaks of demand and shortfalls.

At the operational staffing meetings the use of agency nursing staff is discussed and only agreed once all local staffing options have been explored. As per Lord Carter (2016) recommendations, we are actively exploring our use of staff for enhanced care (specialling) and investigating ways to address this while keeping our patients safe and well cared for. Weekly meetings between the Matrons and the Associate Director of Nursing continue to review the utilisation of staff against establishment per ward.

In line with the Lord Carter (2016) recommendations to reduce 'unwarranted variation', we have introduced a new E-Rostering dashboard. This has been piloted and is currently undergoing evaluation. This is reviewed monthly with Ward Managers, Matrons and the Director/Associate Directors of Nursing.

3.1 Red flag occurrences

The Trust continues to collect incidences of red flags on a daily basis. These are used as indicators of areas where staff composition requires intervention in order to maintain patient safety.

The amount of red flag occurrences this quarter is consistent with last quarter. This is most likely due to the on-going need for additional bed demands being placed upon the organisation requiring additional escalation capacity (see table 2). Trust staff have been redeployed to these areas to ensure safety is maintained.

We continue to see higher than optimal Registered Nurse to patient ratios on day shift. This is due to the need to redistribute nursing staff to contingency areas in order to ensure safety and continuity of care. It has been challenging to 'backfill' these shifts on the main wards.

The introduction of the Assistant Nurse Practitioner role within the organisation permits a higher level of 'non registered nursing' care to be provided to our patients within our ward areas. Quality indicators such as patient falls and pressure ulcers are monitored on a daily basis with the clinical nurse specialists flagging incidents or near misses immediately, allowing for any mitigation actions to be put in place.

Table 2 RED FLAG OCCURENCES

Month	Red flag 1: Number of shifts where more than 50% of RN on duty are agency (nights)	Red flag 2: Number of day shifts when RN to patient ratio is greater than 1:8
January	23 (3%)	111.5 (20%)
February	35 (1%)	146.5 (28%)
March	26 (1%)	162.0 (26%)

4.0 Variance report by ward/department

The Trust reports 'Hard Truth' data monthly which is uploaded to NHS Choices and the Trust website in order to promote transparency for the public. This data portrays the amount of staff needed versus the amount actually on the unit each day/night.

Appendix 1 illustrates actions taken for any wards/departments identified as having a variance of less than or greater than 15% against either the day or night staffing for either Nursing, Midwifery or Care staff over the quarter.

4.1 Overstaffing:

It is important to note that where variances are a lot higher than expected there will be contributing factors such as:

- A requirement for extra staff on an ad hoc basis to provide 'enhanced care' to high risk/vulnerable patients.

- Overseas nurses awaiting their NMC registration number so recorded as HCAs (unregistered)
- The introduction of the Band 4, Assistant Nurse Practitioner role across the hospital.
- Extra care staff on duty where unable to fill qualified requirements (following local risk assessments)

4.2 Understaffing:

During the reporting period, all areas in the Trust demonstrated an above 75% fill rate for both qualified and unqualified staff. Staff are redeployed as required following local risk assessments this can result in fill rates being reduced.

4.3 Care hours per patient day (CHPPD)

As set out in Lord Carter's final report, *Operational productivity and performance in English acute hospitals: Unwarranted variations* (February 2016) in order to have a consistent measurement of staffing levels, which enables benchmarking across hospitals and reduces variation, a new metric tool has been introduced. This is Care Hours per Patient Day (CHPPD). CHPPD describes the actual hours worked (both registered and non-registered) divided by the number of inpatients at midnight.

The Trust's CHPPD results per ward have seen little variation in the last quarter. We continue to benchmark these with our local Trusts although interpretation is difficult due to the differences in patient demographics on each ward across the sites. We have noted that per speciality our CHPPD are broadly similar. We are waiting for the NHS wide 'Model Hospital Dashboard' initiative to be in place in order to determine our position nationally.

Table 3 demonstrates the CHPPD per ward over the last quarter. Areas with high CHPPD (such as ITU and SCBU) reflect the acuity of the patients in these areas. These patients require higher levels of clinical input in a 24 hour period.

Table 3 WARD CHPPD MONTHLY COMPARISON

	Jan-17	Feb-17	Mar-17	Average
Cobham	7.0	6.2	6.4	6.5
SCBU/NICU	14.4	16.7	14.5	15.2
Paediatric Wards 25	11.1	9.9	9.0	10.0
Paediatric Wards 24	10.0	11.1	12.2	11.1
Paediatric Assessment Unit (PAU)	11.1	10.8	10.7	10.9
Ward 19b	5.8	5.6	5.2	5.5
Ward 14	5.3	5.2	5.7	5.4
Ward 15	4.9	5.4	5.4	5.2
Ward 17	6.5	7.2	7.1	6.9
Ward 18	6.9	6.5	6.6	6.7
Ward 16	5.1	5.0	5.1	5.1
CCU	7.8	7.9	7.7	7.8

Ward 12	6.5	6.1	6.4	6.3
Respiratory Ward (Ward 10)	5.3	5.5	5.6	5.5
Ward 11	5.7	5.7	5.8	5.7
Male MSS (Ward 4)	8.4	8.0	8.5	8.3
Female MSS (Ward 3)	6.0	6.3	6.2	6.2
Delivery Suite	26.1	30.6	27.8	28.2
Ward 34 (Gynae 3rd Floor)	7.2	6.8	6.6	6.9
Ward 33 (Mat 2nd Floor)	6.7	6.6	6.8	6.7
Ward 32 (Mat 1st Floor)	7.6	8.0	7.5	7.7
ITU	28.0	27.6	28.2	27.9
Theatres - HDU	16.7	18.0	16.9	17.2
Ward 23	6.0	6.2	6.1	6.1
EAU (ward 1)	8.7	9.1	10.1	9.3
Ward 22	5.6	5.6	5.9	5.7
Head & Neck Unit (Ward 20)	5.5	5.8	5.8	5.7
Short Stay Unit (Ward 21)	6.2	6.7	6.5	6.5
Overall Average	**9.0**	**9.3**	**9.2**	**9.1**

5.0 Vacancies and recruitment activity

In collaboration with the recruitment team proactive recruitment activities continue with both targeted and expedient campaigns running monthly. The Trust has both attended and is energetically pursuing local, European and International recruitment opportunities.

The Trust has had a presence at local Colleges, Academy's and the Luton Employment Fair to promote and discuss careers opportunities. Currently we have a marketing campaign underway with Diverse radio. This is in order to capture any local Nurses or Healthcare Assistants that may wish to come and work with us.

We have increased our presence at the surrounding Universities. This has included attending events at Hertfordshire, Bedfordshire and Northampton Universities. We are actively recruiting student nurses almost 12 months ahead of their qualifying date. This is with the view that they can work as bank Healthcare Assistants while they wait for their registration number.

The recruitment department continues to work through the on boarding process with the Filipino, Singaporean and Indian applicants. The standard of nurses who were appointed was high. We are starting to see these nurses commence with us however the time to recruit into post is slow due to the challenges these staff face in achieving the high pass rate required on the International English Language Test (IELTs). There are also delays with the Nursing and Midwifery Council in processing applications for registration.

We are proud to say that we have a 90% pass rate for international nurses completing their objective structure clinical examinations (OSCEs). This has been due to significant investment in the training programme led by our practice education team. Nationally the pass rate for first sitting of this exam is approximately 40%.

Recruiting to existing vacancies remains a challenge. This is consistent with the national picture. This is particularly evident in the overall amount of nursing vacancies that remain static month on month. Multiple initiatives are in place to retain staff including face to face leaver interviews and offers of rotation to other areas in the hospital.
The use of social media as a recruitment and marketing tool is recognised. The Trust has a nursing and recruitment presence on these. Regular updates are made each week. These tools are also used to communicate with our overseas nurses waiting to join us. We have increased our following and have generated over thousands of 'hits' to some adverts and events posted on these. We hope that this will direct potential candidates to our jobs posted on NHS Jobs.

We have commenced Divisional Healthcare Assistant recruitment campaigns. These are led by the Matrons and Senior nurses within the divisions and facilitated by the recruitment team. This has helped us to gain staff that are best suited to the areas where there are vacancies. It has also allowed our exiting nurses to feel engaged in the recruitment process of staff for their wards. Since January 2017 we have seen a decrease in the amount of Healthcare Assistant (band 2) vacancies. All positions have been recruited to and attrition allowed for.

Table 4 TRUST NURSING VACANCIES (WTE)

Band	Vacancies as at 1st January	Vacancies as at 1st February	Vacancies as at 1st March
Band 7	2.20	7.59	5.76
Band 6	9.59	7.42	11.58
Band 5	165.76	156.64	168.85
Band 4	4.21	Over by 2.61	Over by 1.99
Band 3	1.00	1.00	1.23
Band 2	28.86	31.89	31.98
Total	**211.62**	**201.93**	**217.41**

6.0 Action required

- The Board is asked to note the content of the report
- Be assured that there is the appropriate level of detail and assessment in reviewing the staffing across inpatient ward

Appendices

Appendix a Variance report by ward/department

Appendix a VARIANCE REPORT BY WARD/DEPARTMENT

The following wards have been identified as having a variance of greater than 15% against either the day or night staffing for Nursing, Midwifery or Care staff over the quarter. The Trust website lists the results for all inpatient wards and details whether there was a deficit or surplus between the planned and actual staffing levels.

WARDS	Average fill rate - Registered Nurse/Mid wives (%)	Average fill rate - Care staff (%)	Average fill rate - Registered Nurses/ Midwives (%)	Average fill rate - Care staff (%)	Care Hours Per Patient Day (CHPPD)	Review by Matron where 15% or more of nursing hours did not meet agreed staffing levels (highlighted in red)
January	**Day**		**Night**			**Comments**
Ward 19b	97.3	82.2	100.0	91.9	5.8	This ward has had a high demand for HCA enhanced care. Existing HCAs on shift were redistributed to ensure this was supported.
Ward 17	99.2	87.4	94.1	80.5	6.5	There have been recent changes in the establishment for ward 17. This has meant some HCA shortfalls at night. The thrombolysis bleep holder has worked in the numbers to support
CCU	82.1	84.9	98.9	96.8	7.8	During January the cardiac unit had a significantly high amount of patient escorts requiring nurse attendance off the unit at short notice. The ward manager would work in in the numbers to maintain patient safety.
Delivery Suite	96.4	80.9	96.8	95.3	n/a	In Maternity staffing is flexed throughout the unit to ensure sufficient and safe numbers dependent upon acuity (number of births). These fill rates are consistent with previous months. Maternity are actively recruiting Maternity Nurses to support the Midwives with patient care.
Ward 32	90.0	87.5	93.7	82.4	7.6	
February	**Day**		**Night**			**Comments**
Ward 19a	87.3	76.6	100.0	86.9	6.6	There have been a high number of patients on ward 19a requiring enhanced observations. The ward manager and ward staff have been reallocated to complete the enhanced observations in order to maintain the safety of these patients.
CCU	84.3	87.1	98.8	92.9	7.9	Consistent with January's fill rates Registered Nurses have been moved between CCU, Ward 16 (now cardiology) and the Cardiac Lab dependent on staff shortfalls. The ward manager has worked in the numbers to assist with maintaining patient safety
Ward 12	84.4	98.3	93.2	101.8	6.1	During February there was a high amount of Registered Mental Health Nurses required for enhanced observations on the ward.

WARDS	Average fill rate - Registered Nurse/Mid wives (%)	Average fill rate - Care staff (%)	Average fill rate - Registered Nurses/ Midwives (%)	Average fill rate - Care staff (%)	Care Hours Per Patient Day (CHPPD)	Review by Matron where 15% or more of nursing hours did not meet agreed staffing levels (highlighted in red)
						There were challenges in filling these shifts, as such the ward nurses undertook these duties
Ward 11	83.3	102.9	100.0	98.9	5.7	Ward 11 has had a number of vacancies during February. This was due to staff being seconded to other areas of the hospital to support wards with chronic shortfalls.
Ward 3	83.1	104.6	97.9	94.4	6.3	Ward 3 has significant vacancies at the moment. This has meant challenges in filling the shifts on the unit. The ward manager worked in the numbers to support the delivery of patient care. Staff were also moved from EAU1 to assist.
Ward 34	101.7	84.5	97.9	101.6	6.8	Following an assessment of ward activity, Ward 34 has been sending HCAs to other areas (including contingency) at short notice in order to help deliver patient care
Ward 32	83.5	78.4	94.2	89.5	8.0	February has continued to see challenges in meeting maternity staffing requirements. Staffing is flexed throughout the unit to ensure sufficient and safe numbers dependent upon acuity (number of births).
March	**Day**		**Night**			**Comments**
Ward 19a	85.4	89.5	100.0	91.3	6.5	Most days during March, Ward 19a has released staff to assist in the care of patients on escalation areas. The ward manager has worked in the numbers and has often worked late to help deliver care.
Ward 17	85.8	102.8	99.4	101.8	7.1	There are significant vacancies on ward 17 which has meant challenges in filling shifts despite these being sent to bank in a timely fashion. The thrombolysis holder has worked on the unit to assist with care of the patients
Although there are limited areas with low fill rates in March 2017, the specialist nursing teams have worked on the wards to maintain patient safety. This has allowed us to deploy staff to escalation areas, staff training has also been deferred to allow staff to be released back into their wards to assist in the delivery of care.						

2016 NATIONAL STAFF SURVEY SUMMARY OF RESULTS AND ACTION PLAN

1. Introduction

The thirteenth National Staff Survey was undertaken between September and December 2016. All Trusts are required to participate in the survey using a random sample of staff and the data from which is used by the CQC for the Benchmark reports across all NHS Acute Trusts.

The feedback reports produced for each organisation focus on 32 key areas (known as key findings)

The key findings are presented in the feedback reports under the following nine themes:

- Appraisals & support for development
- Equality and diversity
- Errors and Incidents
- Health and wellbeing
- Job satisfaction
- Managers
- Patient care and experience
- Violence, harassment and bullying
- Working patterns

This year the Trust opted to survey a sample survey of 1250 staff. Questionnaires were distributed in paper format only.

Completed questionnaires were sent directly to the Trusts independent survey contractor, Quality Health, for analysis by age, staff groups and work and demographic profile.

This report gives a high level overview of the survey findings. A summary report of the complete results will be made available on the Trust intranet.

The survey report provides vital feedback from staff about working in the Trust.

As in previous years, there are two types of key finding:

- Percentage scores, i.e., percentage of staff giving a particular response to one, or a series of survey questions.

- Scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these summary scores, the minimum score is always 1 (Strongly disagree) and the maximum score is 5 (Strongly agree)

2. Response Rates

2016 National NHS Staff Survey		**2015 National NHS Staff Survey**		**Trust Deterioration**
Trust	National Average*	Trust	National Average*	
43%	43%	49%	41%	6%

* Acute Trusts

The official sample size for our Trust was 1250, and we had 516 members of staff take part.

3. Staff Engagement

The survey measures overall Staff Engagement and the Trust scores are detailed as follows:

	2016 National NHS Staff Survey		2015 National NHS Staff Survey		Change since 2015 Survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
Overall Staff Engagement	3.90	3.81	3.84	3.79	No significant change	Highest (best) 20%
KF 1 Staff recommendation of the Trust as a place to work or receive treatment	3.88	3.76	3.81	3.76	No significant change	Above (better than) average
KF 4 Staff motivation at work	4.01	3.94	3.94	3.94	No significant change	Highest (best) 20%
KF 7 Staff ability to contribute towards improvements at work	75%	70%	73%	69%	No significant change	Highest (best) 20%

4. Key Findings

A summary of the key findings from the 2016 National NHS Staff Survey are outlined in the following sections:

4.1 Top Ranking Scores

Top 5 Ranking Scores	2016 National NHS Staff Survey		2015 National NHS Staff Survey		Change since 2015 survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
KF 7 % of staff able to contribute towards improvements at work	75%	70%	73%	69%	No significant change	Highest (best) 20%

KF9 Effective Team working	3.84	3.75	3.79	3.73	No significant change	Highest (best) 20%
KF 12 Quality of appraisals	3.40	3.11	3.31	3.05	No significant change	Highest (best) 20%
KF 19 Organisation and management interest in and action on health and wellbeing	3.75	3.61	3.56	3.57	Increase (better than)	Highest (best) 20%
KF 27 Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse	54%	45%	36%	37%	Increase (better than)	Highest (best) 20%

Other Key Findings that scored above or below (better than) average

- KF1 –-Staff recommendation of the Trust as a place to work or receive treatment
- KF2 - Staff satisfaction with the quality of work and care they are able to deliver
- KF3 - % agreeing that their role makes a difference to patients/service users
- KF4 - Staff motivation at work - highest (best) 20%
- KF5 - Recognition and value of staff by managers and the organisation - highest (best) 20%
- KF6 - % reporting good communication between senior management and staff
- KF8 - Staff satisfaction with the overall responsibility and involvement –highest (best) 20%
- KF10 - Support from immediate managers
- KF13 - Quality of non-mandatory training, learning or development
- KF14 - Staff satisfaction with resourcing and support
- KF24 - % reporting most recent experience of violence - highest (best) 20%

4.2 Bottom Ranking Scores

Bottom 5 Ranking Scores	2016 National NHS Staff Survey		2015 National NHS Staff Survey		Change since 2015 survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
KF 16 % of staff working extra hours***	79%	72%	75%	72%	No significant change	Highest (worst) 20%
KF 20 % of staff experiencing discrimination at work in the last 12 months	15%	11%	12%	10%	No significant change	Highest (worst) 20%
KF 22 % of staff experiencing physical violence from patients, relatives or the public in the last 12 months	18%	15%	15%	14%	No significant change	Highest (worst) 20%
KF 25 % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	33%	27%	30%	28%	No significant change	Highest (worst) 20%
KF 32 Effective use of patient/service user feedback	3.62	3.72	3.65	3.70	No significant change	Lowest (worst) 20%

*** Whilst KF 16 is an amalgamation of both paid and unpaid hrs, a further breakdown indicates the following:-

	2016 National NHS Staff Survey Trust	National Average	2015 National NHS Staff Survey Trust	National Average
% working additional paid hours	**48%**	**35%**	**43%**	**35%**
% working additional unpaid hours	**63%**	**57%**	**63%**	**58%**

Other Key Findings that scored above or below (worse than) average

- KF11 - % appraised in the last 12 months – lowest (worst) 20%
- KF18 - % attending work in the last 3 months despite feeling unwell because they felt pressure
- KF21 - % believing the organisation provides equal opportunities for career progression/promotion
- KF23 - % experiencing physical violence from staff in last 12 months
- KF26 - %experiencing harassment, bullying or abuse from staff in last 12 months

4.3 Where Staff Experience has improved (largest local changes since 2015)

Improvements	2016 National NHS Staff Survey		2015 National NHS Staff Survey		Change since 2015 survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
KF 5 Recognition and value of staff by managers and the organisation	3.55	3.45	3.41	3.42	Increase (better than)	Highest (best) 20%
KF10 Support from immediate managers	3.79	3.65	3.65	3.69	Increase (better than)	Highest (best) 20%
KF19 Organisation and management interest in and action on health and wellbeing	3.75	3.61	3.56	3.57	Increase (better than)	Highest (best) 20%
KF27 Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse	54%	45%	36%	37%	Increase (better than)	Highest (best) 20%

Of the total 32 reported key findings, all 32 can be compared to 2015 and these are as follows:

- No real statistical change = 28
- Improvements = 4
- Deteriorated = 0

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

BOARD OF DIRECTORS

Agenda item	9	**Category of Paper**	Tick
Paper Title	Clinical Outcome, Safety & Quality Report	**To action**	☐
Date of Meeting	25 January & 29 March 2017	**To note**	☐
Lead Director	Alison Clarke, NED	**For Information**	☒
Paper Author		**To ratify**	☐
Indicate the impact of the paper: **Financial** ☐ **Quality/Safety** ☒ **Patient Experience** ☒ **Equality** ☒ **Clinical** ☒ **Governance** ☒			

History of Committee Reporting and Date	Clinical Outcome, Safety and Quality Committee on January and March 2017	
Links to Strategic Board Objectives	Objective 1 – Deliver Excellent Clinical Outcomes Objective 2 - Improve Patient Safety Objective 3 - Improve Patient Experience	
Links to Regulations/ Outcomes/External Assessments	CQC Internal Audit HSE	
Links to the Risk Register	All clinical board level risks	

PURPOSE OF THE PAPER/REPORT

To update the Board on the findings and approval of the Clinical Outcome, Safety & Quality committee meetings dated 25 January and 29 March 2017.

SUMMARY/CURRENT ISSUES AND ACTION

The Report gives an overview on matters addressed, including the following:

- Report on progress with the Quality Priorities 2016/17
- Report from Clinical Operational Board
- Statutory training and appraisals
- Internal Audits
- Risk register – risks assigned to the committee

ACTION REQUIRED

To note progress to date.

Public Meeting ☒ Private Meeting ☐

CLINICAL OUTCOMES, SAFETY & QUALITY (COSQ) COMMITTEE REPORT

TO BOARD OF DIRECTORS

1. Introduction

This Report updates the Board of Directors regarding the matters discussed at the Clinical Outcome, Safety and Quality meetings held on 25 January and 29 March 2017

2. Governance

Terms of Reference – The terms of reference for COSQ and the workplan were reviewed and amended.

Quality Report and Performance Report - COSQ received and reviewed the Quality and Performance Report at the meeting and were updated with regard to the indicators including pressure ulcers, falls, mortality, cardiac arrest rates, infection control, cleaning and catering, complaints and national performance targets.

COSQ were informed that following the introduction of the quality improvement programme and the "Quality Wheel" at the Good, Better, Best event in December, an initial meeting had taken place to ensure that there is a co-ordinated and streamlined approach to quality across all clinical and non clinical areas. The importance of the Quality Framework being owned by all was re-iterated. A larger multi-disciplinary group is being established. COSQ discussed the development of a Quality Strategy.

Medicine Division – The Clinical Chair for the Medical Division was in attendance and assured the committee of the improvements relating to mortality reviews within the Medicine Division. The committee received the action log which had been developed following the Medicine Governance meeting held in December.

Discussion took place with regard to nursing homes and DNARs and the Director of Operations updated COSQ with regard to a pilot programme of providing acute urgent care to care homes with a view to improving patient experience and reducing the number of ambulance conveyances from care homes to the hospital. It will involve our clinical navigation team providing advice and responding to requests for urgent care review in the care homes. This is linked with work that Luton CCG are leading on which is aligning GPs to care homes and developing a new model of care for care homes.

CQC compliance monitoring – COSQ received and noted the Divisional CQC action plans and were informed that the Trust CQC buddy system has been re-launched, noting that 72 buddies have been aligned to key clinical departments.

3. Quality Dashboard

Nursing Dashboard – The Director of Nursing and Midwifery presented the nursing dashboards including the quality metrics, workforce and patient experience indicators for each ward and division. The committee noted the increase in sickness absence levels.

Open and Honest Care - COSQ received and noted the Open and Honest Care reports for November, December, January and February 2017.

4. Clinical Outcome

Mortality – Assurance was given that the programme of work in relation to mortality is ongoing and that mortality reviews are regularly taking place and findings are presented at the Mortality Board. The reviews have confirmed that nothing significant has contributed to the deaths.

Manage Patients with Severe Sepsis - COSQ received the Sepsis CQUIN report for quarters 2 and 3 which reported overall compliance in both quarters. The committee noted the initiatives where improvement is required. It was acknowledged that there is a high profile of sepsis on the wards, and it is raised at the safety briefings each morning. The challenge for the new sepsis and antimicrobial CQUIN which comes into effect from 1 April 2017 was noted.

5. Patient Safety

Cardiac Arrests – COSQ received feedback following a cardiac arrest review and noted that our rates are comparable with other Trusts.

Serious Incidents – COSQ received the reports giving an update on Serious Incidents and Never Events. A number of training sessions have been held relating to root cause analysis and the Head of Risk and Governance is working with the Training and Education department to provide education in report writing.

Stroke update – The Director of Clinical Services and the Lead Stroke Consultant were in attendance and presented a provider's side review of the stroke service within the STP footprint which had been undertaken by the Medical Director at Milton Keynes Hospital. COSQ were asked to discuss the scenarios to inform a response to the commissioners. The committee held a lengthy discussion, taking into consideration door to needle time, access to the service out of hours, bed base and outcome. The commissioner's decision last year (with input from the national clinical director of stroke services) that the L&D became the central HASU, was taken into consideration. It was recognised that this was the first service to be scrutinised for STP purposes and COSQ considered that there was not enough detail resulting from the review to be able to make an informed recommendation.

CQC IR(ME)R – The Imaging Manager informed COSQ that a short-notice announced inspection of compliance against the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000 took place on 15 February 2017. COSQ noted the very positive feedback from CQC. The committee received the action plan following the CQC recommendations discussed the content.

Link between Ethnicity and Patient Safety Incidents - COSQ received a paper outlining analytical findings on the information that is available in relation to 27 incidents and ethnicity between 1 January 2016 and 31 December 2016, which revealed that there were no themes or trends emerging and the ethnicity of patients involved in incidents reflects the ratio of ethnicity in admitted patients. The committee considered that although the data did not show any trends the small sample size cannot be relied upon statistically and that the data should be kept under review, especially in maternity.

6. Patient Experience

Catering Update – The Director of Estates and Facilities noted that the Luton Borough Council Environmental Health Officer re-visited the hospital to check on progress with achieving compliance with food safety management for the patient catering service in light of the previously issued low score of 1 out of 5. A new score was formally issued as 3 out of 5 "Generally Satisfactory". The Trust has its own independent EHO to undertake unannounced inspections to confirm food safety standards are being maintained.

Complaints – Following a meeting of the Complaints Board, the General Managers for Surgery were invited to the COSQ meeting in January to discuss their plans to improve response rates and to address some long outstanding complaints. The committee were informed at the March meeting that measures are in place to rectify the backlog, including extra resource from other Divisions, and separating the work of the backlog and the new complaints coming in.

Outpatient Letters – The Chair reported issued raised by Governors with regard to delays in letters following outpatient appointments. The committee noted that there is a variance in the time it takes according to specialty. In the Medicine Division, there is a delay within the transcription service who send letters to medical secretaries and await review by the Consultant. Surgery Division does not have a transcription team and rely on Medical Secretaries. However, the meeting concluded that further work needs to be done because the administrative support has not changed in line with the increase in the numbers of Consultants and this may be causing problems.

Patient Experience Report - The Patient Experience report for quarter 3 was received for information. Patient experience feedback was discussed and the committee noted that more questions will be included which are in line with some questions asked within the annual in-patient survey.

CLIP Report - The Legal Services and Complaints update for the period 1 October 2016 to 31 December 2016 was received. The significant increase in inquests and recent high profile cases in the press was noted. The committee requested more detail in relation to the increase in claims.

End of Life Care Report – COSQ received an update on the End of Life Care project and noted the issues with patient admissions from the community and nursing homes where no advanced care plan is in place. COSQ noted that the Trust was not able to access the parts of SystmOne required to support end of life patients and requested that this be urgently actioned.

7. Report from Clinical Operational Board

Highlight reports from the Clinical Operational Board meetings were received and noted.

8. Workforce Update

Statutory Training and Appraisals – The Training and Development Reports covering activity up to 28 February 2017 were received and noted. Appraisal compliance remains disappointing and appraisal data is now included within each Divisional Executive meeting.

Nursing Workforce - COSQ reviewed the nursing workforce reports and noted the content.

Nurse Revalidation – The committee received assurance that nurse revalidation stands at 100%.

Doctors Revalidation – A letter has been sent to all doctors highlighting the importance of timely appraisals. Escalation detail will be presented to Local Negotiating Committee for agreement at the end of April. Given the delays in the process, the impact will not be recognised on our next Annual Organisational Audit return which is due in May. COSQ were informed that the revalidation team have taken other steps to improve the appraisal rates and ensure that their value is understood.

9. CQUIN

The CQUIN report was received and the CQUINs for 2017/18 were noted. Notification has been received from the CCG confirming that quarter 3 CQUINs have been achieved.

10. Risk Register

The risks assigned to COSQ which were due for review were discussed and updated.

11. Maternity

The Consultant Midwife was in attendance and highlighted the following reports:

Supervisor of Midwives – new requirements - COSQ were briefed on the current function of the supervision of midwives and noted that the statutory Supervision of Midwifery Practice will be stood down in its current format from 1 April 2017. A proposed new model is being piloted in 4 areas across the country (A_EQUIP). However, in the meantime, we are developing an outline of the role for a professional midwifery advocate (PMA).

Better Births - The committee were given an update on the plan for Better Births over the next 5 years. It was noted that some pioneer sites have been set up and there are some early adopters. The importance of working with the STP footprint was emphasised and COSQ noted the challenges faced. COSQ were assured that actions are being progressed.

Safer Maternity Care – An overview was given on the Safer Maternity Care Plan published by the Department of Health in October 2016 and the 5 key drivers to achieve. The Trust's action plan was received and noted. COSQ were informed of a successful bid for funding of £50,000 through a bid for Maternity Safety Training and a midwife is now in post to support CTGs and training.

12. Clinical Audit

The terms of reference for the Medical Devices Audit were approved by COSQ. The terms of reference for Discharge Planning Internal Audit were received for information and it was noted that Chair's action had been taken to approve these terms of reference due to the timescale for commencement of the audit.

The internal audit report for HR recruitment and retention was received and the Director of HR confirmed that an action plan has been agreed. COSQ agreed with a request for the appraisal rating to be changed from low to medium.

COSQ reviewed the outstanding actions from the internal audit programme 2016/17 and discussed the internal audit plan for 2017/18.

12. Papers Received for Information:

- NED 3x3 Walkabout in Maternity
- National Quality Publications of Interest

BOARD OF DIRECTORS

Agenda item	10	**Category of Paper**	Tick
Paper Title	Finance, Investment & Performance Committee	**To action**	☐
Date of Meeting	3 May 2017	**To note**	☒
Lead Director	Andrew Harwood – Director of Finance	**For Information**	☐
Paper Author	Jill Robinson – Chair of Committee	**To ratify**	☐
Indicate the impact of the paper: **Financial** ☒ **Quality/Safety** ☒ **Patient Experience** ☒ **Equality** ☐ **Clinical** ☒ **Governance** ☒			

History of Committee Reporting and Date	Finance, Investment & Performance Committees: 20 January, 15 February & 29 March 2017.	
Links to Strategic Board Objectives	Objective 1 – Deliver Excellent Clinical Outcomes Objective 4 – Deliver National Quality and Performance Targets Objective 5 – Progress Clinical and Strategic Developments Objective 7 – Optimise our Financial Position	
Links to Regulations/ Outcomes/External Assessments	Monitor CQC Commissioners Internal Audit	
Links to the Risk Register	620 – CIP Targets 944 - Non-Achievement of Financial Target	945 – CCG verification processes 638/815 – Agency spend

PURPOSE OF THE PAPER/REPORT

To update the Board of Directors on the findings and approval from the Finance, Investment & Performance Committees held 20 January, 15 February & 29 March 2017.

SUMMARY/CURRENT ISSUES AND ACTION

The Reports give an overview of the matters addressed including the following:

- FY16/17 Financial Position
- Operating Plan 2017/18
- FT approach to the FY17/18 Control Total
- Business Cases considered
- Capital Plan FY17/18
- HR Matters:- recruitment issues/ the new junior doctors' contract/ IR35 changes/FT Agency arrangements

ACTION REQUIRED

To note the Finance, Investment & Performance Committee Report from meetings held 20 January, 15 February, 29 March 2017.

Public Meeting ☒ Private Meeting ☐

FINANCE INVESTMENT & PERFORMANCE COMMITTEE REPORT TO THE TRUST BOARD

This summary report covers meetings held on 20th January, 15th February & 29th March 2017. A verbal report of the meeting held on April 26th will be made at the meeting.

The Committee members' attendance for each of the meetings is shown below:

Committee Member	20/01/2017	15/02/2017	29/03/2017
Jill Robinson (Committee Chair)	✓	✓	✓
Simon Linnett	✓	✓	✓
David Hendry	✓	×	✓
Mark Versallion	✓	✓	✓
John Garner	✓	✓	×
Clifford Bygrave (from Feb)	n/a	✓	×
Pauline Philip	✓	✓	×
Andrew Harwood	✓	✓	✓
David Carter	✓	✓	✓
Danielle Freedman	×	✓	✓
Mark England	✓	×	✓
Angela Doak	×	✓	✓
Sheran Oke (Pat Reid in Jan)	×	✓	✓

Matt Gibbons and Tim Hughes are regular attendees and were present for all the meetings above. Other attendees during Q4 were Victoria Parsons, Jim Machon, Ian Allen, David Hartshorne, Philippa Graves, James Slaven, Elliot Tash, Wayne Keane, Denis Mellon, Ricky Shah, Nisha Nathwani, Parthi Pillai and Vimal Tiwari.

During Q4 2017/18 the FIP Committee has received items for information, considered items for action and approval, and requested a number of actions:

- Received a number of information items covering national guidance matters issued by the DH / NHS
- Considered the FY16/17 financial position, identifying issues in relation to securing the non-recurrent resource required to achieve the FT Control Total, actions being undertaken to maintain financial performance and mitigate financial risks faced by the FT.
- Considered arrangements associated with the ITFF loan
- Considered and approved aspects of the Operating Plan for FY17/18 including a request for the FT to achieve a further £4.3m of efficiency savings in addition to those identified in the Operating Plan submitted to NHSI in December 2016.
- Considered Divisional Budget propositions for FY17/18
- Considered and approved the outline capital plan for FY17/18 to a value of £21m (identifying that further work was required to refine some detail within the plan with particular reference to Electrical Infrastructure & Backlog Maintenance works)
- Considered and developed the FT approach to the FY17/18 Control Total
- Considered and supported the signing of NHS Healthcare Contracts covering FY17/18 & FY18/19
- Received feedback from the FT Audit Committee

- Received Internal Audit Reports covering cashflow forecasting, completeness of income from activities and agency & locum staff CIP scheme, and an External Report covering the FT approach to Costing.
- Received updates in relation to the PFI Contract covering the St Mary's building
- Received and supported a proposition to secure Global Digital Excellence funding – with the proviso that each of the six individual case that formed the GDE programme (when finalised) would need to be ratified by the Finance Committee
- Received and supported a case to build a Helipad on the L&D site, starting with approval to proceed to the design stage
- Received and supported a case to procure, build & equip a Decontamination Unit (together with additional Endoscopy capacity)
- Received and supported a case to expand Dental services on the L&D site
- Received a case for improving the model of care for Respiratory patients. It was agreed to proceed with recruitment of consultant physicians with a full business case to be presented to FIP in advance of substantive appointments being made.
- Considered key HR matters (including recruitment issues, the new junior doctors' contract, IR35 changes and FT agency arrangements with particular focus of high earners and long term agency staff).
- Reviewed the FT Risk Register for risks relevant to FIP
- Considered and agreed the FIP Terms of Reference *(in advance of Board ratification)*
- Considered and supported an option to take forward a town centre location for Sexual Health Services
- Requested that Divisions attend FIP on a rolling basis (one division per month)
- Requested that the FT develop a methodology and schedule for Post Project Implementation Reviews
- Received a Post Project Implementation review for the 2 new Theatres commissioned with ITFF funds
- Requested that a revised format for FT Business Cases be developed
- Received various STP updates (including various updates on the FT hosting 'banking' arrangements for the STP).

Recommendation
The Board is asked to note this report.

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

BOARD OF DIRECTORS

Agenda item	11	**Category of Paper**	Tick
Paper Title	Audit and Risk Committee	**To action**	☐
Date of Meeting	3 May 2017	**To note**	☒
Lead Director	Andrew Harwood – Director of Finance	**For Information**	☐
Paper Author	David Hendry	**To ratify**	☐
Indicate the impact of the paper: **Financial** ☒ **Quality/Safety** ☒ **Patient Experience** ☒ **Equality** ☐ **Clinical** ☒ **Governance** ☒			

History of Committee Reporting and Date	Audit and Risk Committee Reports for 8 February and 22 March 2017
Links to Strategic Board Objectives	Objective 1 – Deliver Excellent Clinical Outcomes Objective 6 – Develop all Staff to Maximise Their Potential Objective 7 – Optimise our Financial Position
Links to Regulations/ Outcomes/External Assessments	External Auditors
Links to the Risk Register	Risks 20+ reviewed

PURPOSE OF THE PAPER/REPORT

To update the Board of Directors on the findings and approval of the Audit and Risk Committees held 8 February and 22 March 2017

SUMMARY/CURRENT ISSUES AND ACTION

The Report gives an overview of the matters addressed including the following:

- External Audit - Progress Report, Technical Update, Charitable Fund and Final ISA260 Audit Memorandum
- Internal Audit – Progress Reports
- Counter Fraud – Progress Report and Self Review Tool
- Assurance from Sub Committees
- Board Secretary Report
- Compliance Policy Review – Waivers

ACTION REQUIRED

To note the 8 February and 22 March 2017 Audit and Risk Committee Reports

Public Meeting ☒ Private Meeting ☐

REPORT of 8 FEBRUARY 2017 AUDIT and RISK COMMITTEE MEETING

Please find attached the Report from the 8 February 2017 Audit and Risk Committee.

For governance and auditing purposes:-

- The Committee members Present were:
  David Hendry, Alison Clarke, Vimal Tiwari, Mark Versallion, John Garner, and Jill Robinson

- In attendance were:
  Fleur Nieboer & Ian Livingstone (KPMG – External Audit), , Paul Foreman (PwC – Internal Audit), Gina Lekh (PwC – LCFS), Andrew Harwood, Jenny Pigott, and Victoria Parsons.

- Apologies were received by: Danielle Freedman (points on papers communicated to chair)

- Conflicts of Interest & Changes:
  None identified.

- The minutes/report of the previous meeting held on 14 September 2016 were approved as an accurate record.

RECOMMENDATION

The Board is asked to note this Report.

Report from the Audit Committee

1. Introduction

This report updates the Board of Directors on the matters considered at the Audit & Risk Committee on 8 February 2017.

The Board of Directors is asked to note the content of the Audit & Risk Committee Report.

2. Minutes of Last Meeting – 14 September 2016

The minutes of the meeting on 14 September 2016 were approved.

3. Matters Arising/ Action Log

Assurance was requested to confirm post implementation reviews are now being completed. The Chair of FIP confirmed that FIP has seen some. A template is being devised to ensure a consistent approach is taken to each review. The Chair of Audit & Risk Committee requested a list of projects/ business cases with their approval date and scheduled post implementation review date be maintained. The Director of Finance will take this forward.

Concerns were raised over the outstanding actions in relation to organisation of Board Seminars. It was agreed that the Board Secretary would share a list of seminar areas/ topics with NEDs for them to agree prioritisation and determine if more dates are required.

The Board Secretary explained the rationale for the delay in reporting the outstanding internal audit recommendations to the relevant sub-committees. This was to allow the responsible officers an opportunity to demonstrate the implementation of the recommendations so that the focus of the reports to the sub-committees is on those not yet implemented. The sub-committees will receive the first reports in March.

The Chair of the Committee confirmed that the Director of Estates will provide the March Audit & Risk Committee with progress regarding his departmental business plan.

The Director of Finance advised that initial feedback from the Costing Assurance Audit was positive, the only specific issue raised was that the process would benefit from more clinical engagement. The formal report is awaited.

All other matters were completed or addressed within the remaining agenda items.

4. KPMG External Audit

Progress Report / *Technical Update* –

2017 Pulse Survey – In response to issues raised by the survey:

- The Chair of the committee asked if there was sufficient bench strength and succession planning in the Finance Department. The Director of Finance confirmed that there was resilience in the top two tiers of the finance team structure but departures of key individuals with specific knowledge and skills would inevitably be difficult to replace at that level

- The Committee noted the other issues raised from the survey, in particular the increased requirement for Audit Committees to focus on Risk Management process, reporting of non-GAPP financial measures such as Control Totals, and the new leasing standard.

External Audit Plan – The 2016/17 audit plan was approved including explicit sign off of the materiality level of £5.5m (to detect individual errors of £4.1m) and reporting threshold of £250k for individual errors identified. It was noted that where items below these levels were material "by nature" such as the criteria for receipt of the Sustainability and Transformation Funding, these will also be reported.

Key audit opinion risks, similar to previous year, were noted as: valuation of land and buildings; valuation and existence of receivables; recognition of income; and management override of controls. The Head of Financial Control confirmed that the valuer has been engaged to undertake a valuation of the St Marys block given the level of investment in the last two years. The valuers have also provided commentary to support an interim valuation for the whole site not being required this year. KPMG confirmed that they would review the detail of assets under construction as this was a significant balance.

In relation to the External Auditor's responsibilities regarding assurance on Value for Money, specifically working with partners and third parties, the auditors highlighted that they will look at the reasonableness of: assumptions made by the Trust in its STP; consider the STP governance arrangements; and how they align to those of the Trust. Discussion took place over how NEDs can obtain assurance over the STP governance arrangement, it being concluded that the STP arrangements should be formally documented by the Executive Team so that it is clear where decisions are being proposed and that governance structures exist which ensure that commitments by the individual Trust are in accordance with existing assurance processes and Standing Instructions.

External Audit agreed to re-circulate a paper on assessing going concern for public sector organisations.

The governors are to agree the local indictor for the Quality Accounts audit at their February meeting, the mandated indicators for limited assurance testing being A&E Wait Times and Return To Treatment

5. PricewaterhouseCoopers Internal Audit

Progress Report – Final report issued for Cashflow forecasting.

The Activity Recording review had been re-drafted and shared with management after the completion of additional testing.

The draft report for HR Recruitment and Retention has been issued to management with no high priority findings.

The CIPS/ Agency Staff review has also been completed with a draft report circulated in the week prior to the meeting. The initial findings in respect of this review are that the processes and controls are not as formalised or visible as they could be with an over-reliance on Rota Co-ordinators.

The Medical Devices review was underway at the time of the meeting. The Financial Governance review timing is to be agreed along with the scope and timing of the Discharge Planning review.

Cash Flow Forecasting & Cash Management – this was concluded as being low risk. However, it was noted the one medium risk recommendation required FIP to approve the level of headroom that cash is managed to. The Chair of the Committee was also keen to understand sensitivities such as the impact of additional capital requirements in excess of the plan. This is to be on the FIP agenda in March.

Health Sector Update – Of particular note was the requirement for public bodies to deduct PAYE & NI in relation to Personal Service Companies from 6 April 2017, which will impact a number of individuals who currently perform services for the Trust. The Head of Financial Control gave a verbal update on how the Trust was ensuring compliance.

6. Counter Fraud - PricewaterhouseCoopers

Progress Report – Local Counter Fraud Specialist provided an update of progress against the approved plan. There has been good progress. The fraud awareness survey is currently open with an extended deadline of the 28/2/17. To date there had been 140 responses. The results of the survey will come to the next meeting.

The 2016/17 self review kit will be shared with the Director of Finance at the end of February.

There had been 7 referrals, 2 of which are ongoing. One of the investigations had highlighted potential control weaknesses which are to be probed further by COSQ and HR.

Self Review Tool Action Plan - reviewed and progress noted by the Committee.

7. Board Secretary Reports

The report was reviewed. It was noted that the financial elements had been updated after the NHSI visit regarding agency spend and their assurance that the Trust had appropriate plans in place. There is still a significant risk linked to escalation areas and end of year settlements. The Committee requested that F3 (Cost Control Risk) be separated so that CIP delivery can be individually assessed.

8. Sub Committee Updates

COSQ – COSQ had met 3 times since the last Audit & Risk meeting.

Actions from the Culture of Learning Internal Audit review continue to be progressed in particular to ensure all opportunities identified from such areas as litigation, SIs and clinical audits are being captured.

Issues raised by the Internal Audit review of Divisional Governance had been followed up including presentations at COSQ from the Clinical Chairs of Surgery and of Medicine. However, concerns persist, particularly with regard to Surgery, and the requirement for a Board Seminar on the topic was reinforced.

More specific discussions on the implementation of internal audit recommendations would commence on receipt in March.

The Terms of Reference for the Internal Audit review of Medical Devices had been approved in January.

A helpful update on HSMR was presented by the Clinical Chair of Medicine to COSQ in January; HSMR will continue to receive close attention from COSQ until an improved trend is firmly established.

FIP – focus on the FY16/17 financial position, identifying issues in relation to securing the non-recurrent resource required to achieve the FT Control Total, actions being undertaken to maintain financial performance and mitigate financial risks faced by the FT.

Considered and approved aspects of the Operating Plan for FY17/18 including a request for the FT to achieve further efficiency savings in addition to those identified in the Operating Plan submitted to NHSI in December 2016.

Considered and approved the outline capital plan for FY17/18 (identifying that further work was required to refine some detail within the plan with particular reference to Electrical Infrastructure & Backlog Maintenance works)

Remuneration and Nomination – Nothing to report.

Executive Board – The Board had recently received a paper from the executive team therefore no further update was required.

Hospital Redevelopment – The Board had received a presentation on backlog maintenance from the Director of Estates, highlighting that there were c. £24m "Must Do" works which he was recommending to progress over the next 3 years. In addition there was a further c. £20m of backlog that would be addressed by the redevelopment. However, as the redevelopment is delayed the Board actioned Estates to provide a schedule of these issues, when they were likely to crystallise, and the required mitigation.

The Committee noted that FIP had received and supported a case to build a Helipad on the L&D site, starting with approval to proceed to the design stage.

9. Review of Terms of Reference

The committee members were requested to feedback any comments by Friday 17 February. A query was raised as to whether external audit should provide a more frequent opinion. External audit advised that this would need to be the subject of a further specific engagement and not impact on their independence. However, concerns could be raised with them at any point in the year and they would not wait for the audit opinion to raise any issues themselves. Their view was that the Trust had appropriate structures and mechanisms in place.

10. Freedom to Speak Up Guardian

The Freedom to Speak Up Guardian attended to give an overview of the new role and how it supplements existing arrangements. She also provided initial feedback on how it was working and the process issues she has encountered. She is still finding the most appropriate way to take forward some concerns raised but reiterated that she feels supported and not obstructed in any way. The committee acknowledged the significant importance of the role and its commitment to facilitating support as required.

11. Overseas Visitors

The Overseas Visitors Manager attended to both provide an update on the successful implementation of the previous internal audit review and to ensure that NEDs were familiar with the issues facing the Trust given the recent media coverage of the topic. The introduction of the additional post approximately 18 months ago has resulted in more overseas patients being identified and helps to minimise retrospective billing. Furthermore staff training and visibility of the Overseas Visitors Manager and her assistant has led to Trust staff being much more proactive.

The Overseas Manager provided the overseas visitor numbers and the values billed for the last 3 years. The Committee asked for more analysis of these numbers (Post Committee note: provided to February FIP).

When asked if there was anything else the Trust could be doing the Overseas Manager responded that having 'overseas patient awareness' as mandated training for public facing roles would be beneficial. The Audit & Risk Committee agreed to recommend to Training & Development the need to incorporate this issue into induction and mandatory training.

12. Any Other Business

None identified

13. Date of Next Meeting: 22 March 2017

REPORT of 22 MARCH 2017 AUDIT and RISK COMMITTEEMEETING

Please find attached the Report from the 22 March 2017 Audit and Risk Committee.

For governance and auditing purposes:-

- The Committee members present were:
  David Hendry, Alison Clarke, Vimal Tiwari, Mark Versallion, John Garner and Jill Robinson

- In attendance were:
  Fleur Nieboer & Ian Livingstone (KPMG – External Audit), Paul Foreman (PwC – Internal Audit), Gina Lekh (PwC – LCFS), Andrew Harwood, Jenny Pigott and Victoria Parsons.

- Apologies were received by: Danielle Freedman (joined meeting at 11am – agenda item 3.2)

- Conflicts of Interest & Changes:
  None identified.

- The minutes/report of the previous meeting held on 8 February 2017 were approved as an accurate record.

RECOMMENDATION

The Board is asked to note this Report.

Report from the Audit Committee

1. Introduction

This report updates the Board of Directors on the matters considered at the Audit & Risk Committee on 22 March 2017.

The Board of Directors is asked to note the content of the Audit & Risk Committee Report.

2. Minutes of Last Meeting – 8 February 2017

The minutes of the meeting on 8 February 2017 were approved.

3.1 Matters Arising/ Action Log

Action log taken as read with the following specific points noted:-

- FIP Committee taking responsibility for review of scheme of delegation
- Board Seminars – request to include adult safeguarding
- Hospitality – Policies refresh delayed until model policy released but will be in place for 1 June 2017
- Estates review - Director of Estates had advised that due to other pressures he has not completed his business plan. (31st March latest expectation). Chair of Committee has requested an update on the backlog maintenance prioritisation and associated risks. Concluded should be a significant risk on risk register given impact on capital programme.
- Response on checks for non-employed individuals from HR received and to be distributed for review.
- Assurance over STP governance processes – initial discussion undertaken on 15 March 2017 at Board Seminar. Committee felt that greater clarity was required on how meaningful work in progress was to be communicated
- Overseas visitors – Training had confirmed that it was not currently possible to add this into statutory training. Proposed for Deputy Director of HR and Head of Training to liaise with Overseas Visitors Manager to improve training and communications around overseas visitors.
- Counter Fraud Update – issue of delays in relation to recent investigation need further work. LCFS to provide bullet points to show the timeline. COSQ to understand this.

All other matters were completed or addressed within the remaining agenda items.

3.2 Cyber Security Update & Firewall (agenda item deferred to allow Director of IT to attend, taken between agenda item 8.1 and 8.2)

Director of IT confirmed that most of what can be done has been done. Target completion dates have been extended mainly due to roll out of VDI and the procurement process for selection of firewall replacement supplier. However, manual controls and safeguards have been put in place to mitigate the risks. The firewalls are in but the filtering software is yet to be installed due to be operational by 30/4/17.

Current processes do not allow for identification of unusual activity by individual log-ins per PC. This would require significant investment in smart card or finger print access controls. Some software has 'intelligent learning' which would flag unusual activity.

There had been a cyber- attack and ransomware attack that have been reported to the ICO. No data had been lost.

3.3 Information Governance Toolkit

This year the Trust's completed toolkit had been subject to a peer review by another NHS body to provide assurance. Nothing major identified with minor improvements made prior to submission.

4. KPMG External Audit

Progress Report/Technical Update – Completed interim audit, no issues identified. Some work on indicators started and ongoing.

Explanation of going concern for public sector provided.

5. PricewaterhouseCoopers Internal Audit

Progress Report – Financial Governance audit in progress. Discharge planning audit scheduled to commence 3 April. PwC are still expecting to complete programme in advance of the Annual Report.

Medical Devices – Draft report issued. Some Key findings – longer term funding needed for equipment remains an issue. Both COSQ and FIP Committees to review the report before the next Audit Committee meeting. (IA to action)

Summary of Follow Up Actions – still have 22 outstanding recommendations that need to be closed in FY16/17. All have been allocated to the relevant committees. This is a standing item on the COSQ & FIP agendas. It was noted that where the Trust is unable to implement recommendations these (where appropriate) should be transferred to the risk register. (VP to action)

Finalised reports

- Income from activities: additional work undertaken to validate the impact of the conclusions - any omitted activity recording has an insignificant financial value.
- Agency & Locum Staff CIPs: Overall high risk due to inconsistent application of process and lack of evidence to support decisions. Issue to be taken forward as part of enhanced performance management arrangements. Inconsistent approach to 'breaks' for medical agency still a concern due to patient safety and clinical risks.
- Recruitment - it was noted that the recruitment strategy is not linked via an implementation plan to actions on the ground. Discussion took place as to whether the sub-committee structure allows for HR strategy, performance and management to be considered in full rather than piecemeal. Committee to advise Board of their concerns. (AC to action)
  Exit questionnaires – the Committee supported the IA recommendation to adopt exit interviews rather than just questionnaires.
  Appraisals – Committee supported recommendation to strengthen appraisal review process.

2017/18 Internal Audit Plan – contractual terms are being agreed. COSQ Committee to feed into the process. FIP are to be asked for their input at their next meeting. Initial input from the Committee suggested that LDH/STP interface should be first priority followed by information governance / cyber risks from an operational performance perspective.

6. Counter Fraud - PricewaterhouseCoopers

Annual Report – Planned work completed within budget. There had been 14 referrals/investigations which are all closed.

Self Review Tool (SRT) 2016/17: The Committee reviewed the SRT. Good progress evident from previous year. The Committee noted the Director of Finance to approve prior to submission. LCFS is to provide an update of metrics shown as amber in SRT and how to move to green.

Survey Results – response rate of just under 10%. Majority would report suspected fraud. Awareness of policy is consistent from last year. However, more can be done so focus for 2017/18 is on communication with a communication plan and schedule for 2017/18 devised. Social media is the proposed way forward.

The committee debated whether there were too many options for raising concerns leading to confusion. However, on balance the Committee concluded that the issue was more one of good communication to signpost individuals to the right place.

7. Board Secretary Reports

The report was reviewed. The current Board Seminar programme was included. STP is on every agenda. Divisional governance first priority (overall governance then Surgery specifically), followed by safeguarding children, and safeguarding adults.

The Committee noted an emerging risk re leadership and management stretch against a backdrop of STP for the assurance framework. The Committee requested that backlog maintenance is added under heading S3 (gap in control).

8. Sub Committee Updates

COSQ – Both December and February meetings had been cancelled due to absence of key executives. COSQ are happy with progress for safeguarding but continue to have concerns about Divisional governance. Deep cleaning is to be raised at COSQ.

Divisional governance for Surgery is to be escalated to the Board.

FIP – focus on the FY16/17 financial position, identifying issues in relation to securing the non-recurrent resource required to achieve the FT Control Total, actions being undertaken to maintain financial performance and mitigate financial risks faced by the FT.

GDE IT funding – The FIP Chair noted that assurance was received from Director of IM&T that monies will be received in advance of spend. The Committee queried as to whether the GDE proposition requires approval by Governors – as a significant transaction. The Board Secretary confirmed that as the GDE programme contains a number of independent schemes each of which costs less than £3m the individual projects do not fall within the significant transaction category. Business cases for each individual scheme will need to demonstrate the requisite return on investment.

Remuneration and Nomination – Committee Chair gave a verbal update on the Hayes report.

Executive Board – Report noted

Hospital Redevelopment – Report noted. The Audit Chair re-iterated the backlog maintenance concern.

9. Review of Terms of Reference

Comments from Committee members had been considered in the revised terms of reference which were presented. The conflict of interest reporting was amended and specific inclusion of Freedom to Speak Up Guardian added. The Terms of Reference were approved

10. Accounting Policies

Revised accounting policies considered & accepted. Updated wording on 'going concern' (as discussed under External Audit item) would be incorporated into the year-end process.

11. 2017/18 Audit Arrangements

It was noted that the Governors had agreed to a 2 year extension for external audit.

The Committee agreed to extend internal audit and counter fraud arrangements for a further year.

12. Any Other Business

None identified

13. **Date of Next Meeting: 17 May 2017**

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

BOARD OF DIRECTORS

Agenda item	12	**Category of Paper**	Tick
Paper Title	Hospital Redevelopment Report	**To action**	☐
Date of Meeting	3 May 2017	**To note**	☒
Lead Director	Pauline Philip, Chief Executive	**For Information**	☐
Paper Author	David Hartshorne	**To ratify**	☐
Indicate the impact of the paper: **Financial** ☒ **Quality/Safety** ☒ **Patient Experience** ☒ **Equality** ☐ **Clinical** ☒ **Governance** ☒			

History of Committee Reporting and Date	Redevelopment Programme Board, 15 March 2017	
Links to Strategic Board Objectives	Objective 1 – Improve patient experience Objective 2 – Implement our New Strategic Plan Objective 3 – Optimise our Financial Plan	
Links to Regulations/ Outcomes/External Assessments	NHSI HSE CQC	
Links to the Risk Register	All estate and facilities risks	

PURPOSE OF THE PAPER/REPORT
To update the Board on the progress of the redevelopment project

SUMMARY/CURRENT ISSUES AND ACTION
A report on the progress of the redevelopment programme is attached.
Work on the redevelopment scheme has been suspended pending the outcome of the work within the STP process to establish the service delivery strategy for secondary care services across the footprint.
The works to complete the refurbishment of the ground floor of St Marys have been completed.
Work will commence at the end of April on the extension of the Oral Maxillo-Facial facility. This will be complete in August.
Heads of Terms for a lease at Arndale House in the centre of Luton to provide the Sexual Health Services clinic are under discussion.
A decision has been made to continue with the development of the design of the helipad.

ACTION REQUIRED
The Board is requested to note the report.

Public Meeting ☒ Private Meeting ☐

REDEVELOPMENT PROGRAMME BOARD REPORT
12 April 2017

TO BOARD OF DIRECTORS

1. Introduction

This report updates the Board of Directors on the progress of the Redevelopment Programme

2. Governance

The Programme Board met on 15 March 2017.

3. Main scheme

Work on the redevelopment scheme has been suspended pending the outcome of the work within the STP process to establish the service delivery strategy for secondary care services across the footprint. There has been engagement with estate leads from Bedford and Milton Keynes hospitals to support the work on the secondary care strategy within the STP (P3).

A business case on the provision of a helipad was presented to FIP on 29 March. The proposal to proceed to the next stage of design, which would underpin development of a full cost plan, was agreed.

3. Enabling schemes

The work to refurbish the ground floor of the St Marys building was completed on 16 March. The floor now supports a 28 bed ward (19B), an 18 bed ward (19A) and a 10 bed specialist ward. In addition, the work to upgrade the day unit has been completed, and a satellite pharmacy has been provided.

Work to refurbish the first floor of the Nurses home annexe (Block 38) will be completed at Easter. This will support the transfer of 60 administrative staff from the centre of the hospital. The area vacated by the outpatients team will be used to extend the Oral Maxillofacial service (OMFS), and the area vacated by the Clinical Coding team will enable completion of the new Therapies hub.

The contract for the extension of the OMFS area has been awarded to Carmelcrest Ltd following a competitive tender process. Work will start after Easter on the removal of asbestos products within the area, with permanent works commencing at the beginning of May. Work will be completed in August.

A Heads of Terms is under discussion with the Landlord of Arndale House, a disused office building above the shopping centre in Luton, to support delivery of the new sexual health services clinic. The arrangement will form part of an integrated public services hub being progressed by Luton Borough Council under the One Public Estate framework. The Landlord will refurbish the common parts, and will upgrade the mechanical and electrical systems.

4. Energy Centre

The Programme Board reviewed the status of the project. A short term plan, based around a full peer review and an assessment of the delivery of schemes by other Trusts, was agreed.

5. Programme Risk Register

The risk register has been updated and submitted for review by the Programme Board at the meeting in March.

6. Future activity

The redevelopment team are supporting the development of projects which address short-term capacity constraints within the Trust. A development plan for Imaging has been submitted. The critical issue remains the availability of accommodation to support the relocation of staff. Proposals to address this issue in the medium term are being developed.

BOARD OF DIRECTORS

Agenda item	13	**Category of Paper**	Tick
Paper Title	Risk Register	**To action**	☐
Date of Meeting	3rd May 2017	**To note**	☐
Lead Director	All Directors	**For Information**	☒
Paper Author	Victoria Parsons – Board Secretary	**To ratify**	☒
Indicate the impact of the paper: **Financial** ☒ **Quality/Safety** ☒ **Patient Experience** ☒ **Equality** ☐ **Clinical** ☒ **Governance** ☒			

History of Committee Reporting and Date	Clinical Outcome, Safety and Quality Committee 22nd February, 29th March 2017 and 26th April 2017 Finance, Investment and Performance Committee 15th February 29th March 2017 and 26th April 2017 Executive Board 25th April 2017
Links to Strategic Board Objectives	Objective 1 – Deliver Excellent Clinical Outcomes Objective 2 - Improve Patient Safety Objective 3 - Improve Patient Experience Objective 4 – Deliver National Quality and Performance Targets Objective 5 – Implement our New Strategic Plan Objective 6 – Develop all Staff to Maximise Their Potential Objective 7 – Optimise our Financial Position
Links to Regulations/ Outcomes/External Assessments	NHS I – Trust Governance Framework CQC – All regulations and outcomes MHRA
Links to the Risk Register	All Board Level Risks rated High Risk (15+)

PURPOSE OF THE PAPER/REPORT

To update the Board on action taken to mitigate against the identified Board Level High Risks

SUMMARY/CURRENT ISSUES AND ACTION

- To ratify the new board level risks identified through the risk review group

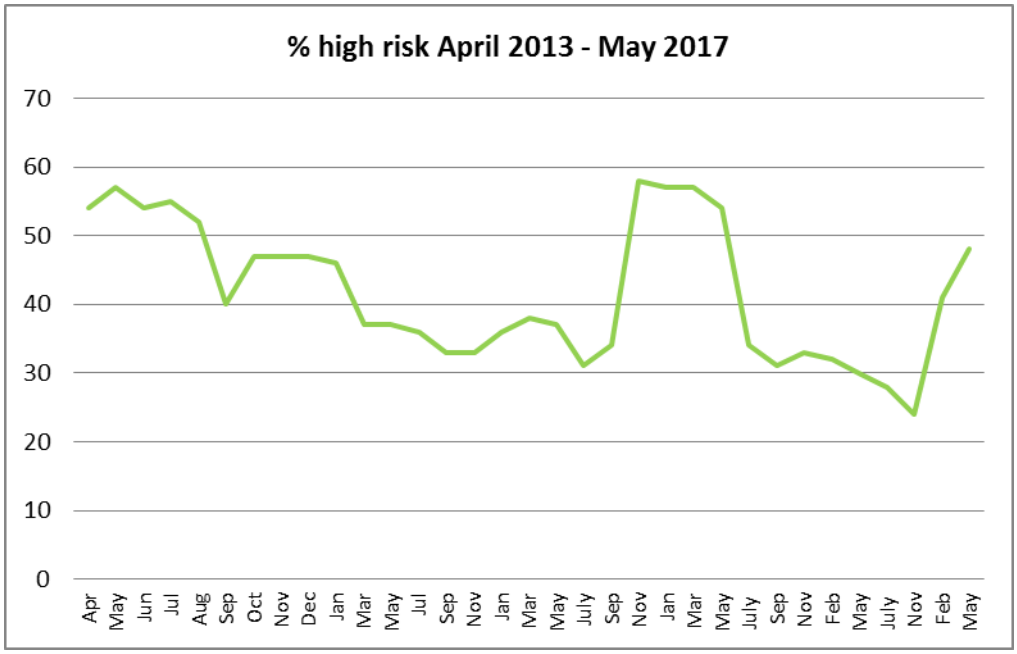
ACTION REQUIRED

To note progress to date and identify any concerns or further risks that need to be added/revised

Public Meeting ☒ Private Meeting ☐

Risk Register Governance

The are 25 Board Level Risks on the Risk Register (29 in February 2017). 48% are currently high risk (15+). The increase is mainly due to the high risks related to hospital re-development added and the closure of two board level medium risks.



All the Board Level risks are up to date with an action plan.

Board of Directors Review
The Board reviewed the risks on the 1st February 2017.

Risk ref	Risk Description	Agreed conclusion
1163	Hospital Re-Development affordability	Request review
968	Cardiac Centre	Maintain risk
1018	HSMR	Maintain risk

- Possible emerging risks of Equality and Diversity EDS2

Clinical Outcome, Safety and Quality Committee (COSQ)
COSQ reviewed clinical board level risks on the 29th March 2017 and 26th April 2017

Risk ref	Risk Description	Agreed conclusion
669	Appraisal rate	Maintain risk
791	Information Governance	Maintain risk
813	Hospital Acquired Pressure Ulcers	Close risk
650	Bed pressures	Maintain risk
968	Cardiac Centre	Revert to divisional risk
1018	HSMR	Maintain risk
776	Paeds ED	Revert to divisional risk
796	Inpatient Experience	Maintain risk

- Emerging risk related to orthopaedics noted.

Finance Investment and Performance Committee (FIP)
FIP reviewed finance and performance board level risks on the 15th February, 29th March 2017 and 26th April 2017.

Risk ref	Risk Description	Agreed conclusion
1175	Agency Costs	Maintain risk and review for 2017/18
1117	CCG verification processes	Maintain risk
1178	Financial achievement 2017/18	Agreed to review risk and maintained rating
1200	Cyber security	New risk noted

- A review of Estates Backlog risks is being undertaken by the Director of Estates and Facilities
- Emerging vacancy risk

Executive Board Review
The Executive Board reviewed all Board Level Risks on the 25th April 2017.

Risk ref	Risk Description	Agreed conclusion
1175	Agency Risks	Review risk
650	Bed pressures	Maintain risk
1178	Financial position	Maintain risk

The Executive noted emerging risks from orthopaedics that would be assessed and escalated appropriately.

Risk Review

22 new risks were reviewed and approved between 20th January – 18th April 2017. Three risks allocated as Board Level and one was assigned as a Trustwide Risk:

- 1178 – Financial achievement 2017/18
- 1182 – Mortuary Capacity
- 1200 – Cyber security

17 risks were closed, two at Board level:

- 1116 – Financial achievement 2016/17
- 813 – Hospital Acquired Pressure Ulcers

2 risks were reduced from a Board Level risks to Divisional Risks

- 968 – Use of Cath Lab for escalation
- 776 – Use of Paeds ED for escalation

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

BOARD OF DIRECTORS

Agenda item	14	**Category of Paper**	Tick
Paper Title	Board Secretary Report	**To action**	☐
Date of Meeting	3rd May 2017	**To note**	☐
Lead Director	Chief Executive	**For Information**	☒
Paper Author	Victoria Parsons – Board Secretary	**To ratify**	☒
Indicate the impact of the paper: **Financial** ☐ **Quality/Safety** ☐ **Patient Experience** ☐ **Equality** ☐ **Clinical** ☐ **Governance** ☒			

History of Committee Reporting and Date	N/A
Links to Strategic Board Objectives	All Board Objectives
Links to Regulations/ Outcomes/External Assessments	Monitor – Governance Framework
Links to the Risk Register	N/A

PURPOSE OF THE PAPER/REPORT

To report to the Board progress with amendments against the Trust Governance structures and processes.

SUMMARY/CURRENT ISSUES AND ACTION

- Council of Governors
- Membership Update
- Constitutional Changes
- Terms of Reference
- Conflict of Interest Policy

ACTION REQUIRED

Board are asked to:

- Note and approve the items as required.
- Approve the Constitution amendments and Terms of Reference

Public Meeting ☒ Private Meeting ☐

1. Council of Governors

There are currently three vacancies on the Council of Governors

1) University of Bedfordshire (actively seeking a replacement)
2) Bedfordshire CCG
3) Hertfordshire Valley CCG (Trust has never had a representative)

Cllr Maurice Jones, Central Bedfordshire Council, resigned from the CoG in February 2017. A replacement is currently being agreed. Mr Jim Thakoordin, Bedfordshire Public Governor, resigned from the CoG in March 2017. This vacancy will remain until the next election process. We would like to thanks Jim and Maurice for their support for the Council of Governors during their terms of office.

The next election process starts in May 2017 and will end July/August 2017.

2. Members

The next Medical Lecture was on the 27th April 2017 about stroke and stroke care.

The next Ambassador magazine will be issued to members in August 2017.

3. Constitution

At the Council of Governors meeting on the 15th February 2017, there were agreed amendments to the Trust Constitution. This amendment is documented in Appendix 1.

The Board of Directors are asked to approve these amendments.

4. Terms of Reference

The following Sub-Committees of the Board of Directors reviewed and approved their Terms of Reference in March 2017 (Appendix 2):

- COSQ
- FIP
- Audit and Risk

The Board of Directors are asked to approve these Terms of Reference.

5. Managing Conflicts of Interest

In February 2017 NHS England published guidance for all NHS organisations setting out expectations for the management of conflicts of interest. This will apply from June 2017 and for many NHS providers will require engagement with staff that may not have previously considered the declaration and management of their interests.
The guidance sets out the need for organisations to ensure that they:

- Have clear and well communicated processes in place to help staff understand their obligations;

- Review current policies and ensure they are in line with the new guidance;
- Have an individual or team responsible for providing advice and support to staff in managing compliance with the requirements;
- Maintain a register of interests; and
- Audit the policy and processes related to it at least every three years.

The guidance sets out minimum processes that are expected in establishing processes for collecting declarations of interests. These expect staff to encourage the declaration of interests, set a clear expectation of when they are required to be declared and determine those staff that are responsible for making declarations.

Declarations of interest should be confirmed at least annually to verify they remain appropriate and interests should be declared within 28 days of occurring. Processes should be in place to collect declarations when new staff join and when staff transfer to new roles or responsibilities.

A list of the minimum staff expected to declare interests has been established that includes Executive and Non-Executive Board members, members of advisory groups with decision making authorities, staff on Agenda for Change Band 8D and above and staff that have authority to enter into contracts.

Principles have been set out for managing interests that are identified. These set out that a range of actions may be suitable in response to declared interests, which could include not taking any action or the individual not being involved in specific committees or groups. It is not always required for them to resign from the interest. A clear audit trail should be maintained to support the identification of how each case was considered and the principles behind the decision taken and this should be periodically reviewed to ensure it remains appropriate.

A series of examples of potential interests and how they might be managed are included within the guidance. As well as other employment this includes gifts and hospitality, sponsorship, donations and private practice. The mechanisms for monitoring and assessing the response to these may be different depending on their nature.

In April 2017, NHSE published model policy that is currently being adapted for the L&D. There could be implications in relation to the increase in mandatory declarations required and the resources required to maintain this process.

Appendix 1

CoG Constitutional Working Group Recommendation

	Previous / planned change	Addition/Change	CoG
1	Page 4 Definitions. add at the end of the definitions of the 3 Acts	or any re-enactment thereof	Agreed
2	Page 4 Definitions add	DBS" Disclosure and Barring Service	Agreed
3	Page 5 Definitions add	NHSI" NHS Improvement	Agreed
4	Page 17 Elected Governors. 12.8 move to the top of the section	12.6 Elections shall be carried out in accordance with the rules set out in Annex 2. The Directors and Council of Governors will decide which of the two voting methods set out in the Election Rules is to be used.	Agreed
5	Page 17 The first part of 12.6 remove 'the Election Rule' and amend to 12.7 12.8 Public Governors are to be elected following the Election Rule by members of their public constituency, and Staff Governors are to be elected by members of their class of the staff constituency. Each class/constituency may elect any of their number to be a Governor in accordance with the provisions of this constitution.	12.7 Public Governors are to be elected by members of their public constituency, and Staff Governors are to be elected by members of their class of the staff constituency. Each class/constituency may elect any of their number to be a Governor in accordance with the provisions of this constitution.	Agreed
6	Page 20 Eligibility to be a Governor Add	12.17.13 they have failed to provide a basic DBS Certificate when requested by the Secretary to do so.	Agreed
7	Page 20 Remove 12.18.2	12.18.2 If Governors fail to attend 6/12 meetings and seminars of which 4 should be meetings. If this is not achieved, this will be subject to a review meeting with the Chairman, Lead Governor and Board Secretary and could lead to a recommendation for the termination of office.	Agreed
8	Page 20 12.18.3 change 12.18.3 If Governors fail to attend consecutive meetings of the Council of Governors the following process is undertaken: o Miss 2 consecutive meetings – Formal letter o Miss 3 consecutive meetings – Review meeting with Chairman, Lead Governor and Board Secretary o Miss 4 consecutive meetings – Termination of office	12.18.3 If Governors fail to attend formal Council of Governors meetings or Council of Governors seminars without reasonable cause the following process will be followed: o Miss 3 meetings – Review meeting with Chairman, Lead Governor and Board Secretary o Miss 4 meetings – notice of termination issued o Miss 6 meetings - Termination of office At missing 6 meetings with no reasonable grounds for missing the	Agreed

	Previous / planned change	Addition/Change	CoG
		meeting, there is no right of appeal.	
9	Page 20 12.18.7 remove all from the clause they have refused without reasonable cause to undertake any training which the Council of Governors requires all Governors to undertake;	12.18.7 they have refused without reasonable cause to undertake any training which the Council of Governors requires Governors to undertak	Agreed
10 **	Page 18 Para 12.14 Elected Governors: insert a new sub para Add a clause around extending Governors without elections when it is not in the best interest of the Trust to have inexperienced Governors or Governors who would only hold a term for less than a year.	12.14.4 The Council of Governors may under exceptional circumstances* agree to extend the term of office of all of the elected Governors for one year. 12.14.3 shall not be enforced under the terms of this paragraph, but will apply, where appropriate, at the end of the extended period.	Agreed

*Exceptional circumstances – ***'if the there is a possible merger within the next two years'***

**Item 10 is subject to review by Capsticks (Trust Solicitors) as there are links to the Health and Social Care Act that may not allow this action to be taken. The amendment would also require NHS Improvement confirmation.

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

CLINICAL EXCELLENCE, QUALITY & SAFETY

TERMS OF REFERENCE

CLINICAL OUTCOME SAFETY AND QUALITY (COSQ)

Status:	Sub-committee of the Board of Directors
Chair:	Non-Executive Director
Membership:	Non-Executive Director x 3 Chief Executive Deputy Chief Executive Director of Nursing and Midwifery Medical Director Director of Human Resources Director of Transformation and Risk Head of Quality and Patient Experience Board Secretary
In Attendance:	Divisional Representation (by invite)
Meeting Frequency:	Monthly
Meeting Management:	Agenda to be agreed by the Chair and agenda and papers to be circulated 5 days before the meeting, unless by exception and agreed with Chair of meeting in advance.
Extent of Delegation:	COSQ is a formal sub-committee of the FT Board of Directors and complies with the Standing Orders and the Scheme of Delegation.
Authority and Chairs Action:	The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other professional advice and secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. The Non-Executive Chair, as Chair of COSQ is, on an exceptional needs basis, granted delegated authority to make decisions on time critical issues arising between planned meetings of COSQ. Whenever such powers are exercised a full report explaining why such a necessity arose and exactly what action was taken, is to be made to the next quorate COSQ meeting.
Quorum:	50% of membership, to include 2 Non-Executives

Accountability:

The Chair of the COSQ, along with the Medical Director and Chief Nurse will maintain a direct link from COSQ to the FT Board of Directors providing a report and assurance of the effectiveness of clinical quality delivered by the Trust.

The Medical Director and Chief Nurse will report to the Chief Executive and report progress to the formal Executive and Clinical Operational Board meetings on a monthly basis and to any other formal Committee as required.

Reporting:

The minutes of COSQ meetings shall be formally recorded and submitted to the Board of Directors.

A report shall be made following each COSQ meeting to the next Board of Directors meeting on issues which need to be considered by the Board of Directors. The report shall give details of the action or improvement that is needed for the Board of Directors to approve.

Provide a quarterly report and update to the Audit and Risk Committee.

Objectives:

1. ***To oversee:***
    a. the promotion of a culture of openness and organisational learning from incidents, complaints and patient feedback within the trust
    b. the inclusion of the patient experience feedback

2. ***To review and quality assure:***
    a. on all aspects of quality and risk and ensure that Trust policies reflect latest guidance and legislation
    b. on behalf of the Board of Directors, the Trust compliance in relation to Health & Safety act.
    c. on behalf of the Board of Directors the Trust's compliance with the Health Act 2006 on reducing HCAI's

3. ***To ensure:***
    a. that strategic priorities are focused on those which best support delivery of Trust objectives in relation to quality and patient safety.
    b. compliance with contractual quality obligations

4. ***To receive***:
    a. information on trends & themes from claims, incident reporting and complaints and to initiate measures to reduce risk. Where appropriate, to ensure that identified risks are considered and included in risk registers
    b. a report from the Clinical Operational Board triangulating claims, complaints and incidents into a CLIP report.
    c. reports on progress & oversee the outcome of improvement plans arising from CQC reviews or investigations, on behalf of the Board of Directors or Chief Executive

5. ***To receive assurance:***
    a. from the Clinical Operational Board in accordance with the Quality Framework.
    b. on performance in relation to Trust wide patient safety projects.
    c. from the Clinical Operational Board that reports from Divisions using a quality & safety KPI data set are used to in order to identify areas of good and poor performance & inform future planning and service delivery.
    d. that decisions of NICE, NCEPOD, NSF's and other national groups are implemented.
    e. that feedback from patients, users and other stakeholders is used to inform policy and practice.
    f. on the implementation and annual review of the Trust's Risk Management Strategy.
    g. that the Trust is safeguarding adults and children.
    h. on behalf of the Board of Directors, the Trust's compliance in all CQC outcomes

6. ***To approve and monitor ongoing progress of:***
    a. The Quality Account objectives

Programme Board Members Responsibilities:

1. Individual members are expected to act as champions of COSQ within the Trust and wider health community. Members are empowered to discuss quality issues with interested Parties outside of the meeting, subject to any confidential information shared.

2. To set targets and agree control systems to ensure delivery of the stated objectives of the Quality Account.

3. To establish and maintain links with other bodies such as local CCGs, Local Council, Ambulance Service and other Trusts, Social Services etc where Services are affected by or potentially impacted by the actions agreed at COSQ.

Workplan:

Each meeting:

- Risk Register
- CQC Clinical Area Self Assessments
- CQUIN Monitoring
- Training and Education Report (including Appraisal and Statutory Training)
- Serious Incident (SI) Reporting (SI's and Action Plans)
- Quality Account Priorities

Quarterly

- Monitoring Board with commissioners
- Infection Control Report
- Mortality Report
- Patient Experience Report

Every four months

- Review against the Trust Objectives related to hospital redevelopment

Annually

- Quality Framework Review
- External Audit - Quality Account
- Staff survey
- Children's Safeguarding
- Adult Safeguarding
- Cancer Peer Review
- Research and Development
- Review of the Terms of Reference

As required

- CQC Intelligent Monitoring Report
- CQC Inspections
- Internal Audits
- Deanery Report
- External Reports

Agreed on 29 March 2017

To be reviewed March 2018

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

TERMS OF REFERENCE

Finance, Investment & Performance Committee

Objectives:

The committee will conduct objective Board level review of financial and investment policy and will review financial performance issues and oversee overall performance including CQUIN and delivery against the Cost Improvement Plans.

Financial Policy, Management & Reporting:

- To consider the Trust's medium term financial strategy, in relation to both revenue and capital**.**
- To consider the Trust's annual financial targets.
- To review the annual budget, before submission to the Board of Directors.
- To consider the Trust's financial performance, in terms of the relationship between underlying activity, income and expenditure, and the respective budgets.
- Initial review of annual financial statements
- To review proposals for business cases (>£0.25m) and their respective funding sources
- To commission and receive the results of in-depth reviews of key financial issues affecting the Trust.
- To maintain an oversight of, and receive assurances on, the robustness of the Trust's key income sources and contractual safeguards and efficiency improvement programmes.
- To review and agree the annual financial plan, including the plan for delivery of cost improvements and productivity and efficiency improvements resulting from the Re-engineering programme.
- To review progress of the Re-engineering programme monthly and recommend any additional action as necessary.
- To receive and consider, as appropriate, reports on 'commercial' activities of the Trust.
- To approve the detailed Capital Expenditure Plan for the Trust (within the overall resource approved within the Annual Plan
- To review delivery of Capital Projects.

Operational Performance:

- To receive performance reports identifying performance against national and local targets where relevant.
- Incorporate the balanced scorecard standards, when known and agreed, into a Performance Management System.
- By exception, call for the attendance of Executive Directors, the appropriate Clinical Leaders, General Managers, Divisional Lead Nurses/Midwives named as leads for targets, to account for poor or underperformance against either key financial targets or delivery of the Re-engineering programme and to agree corrective action or a revised position.

Investment Policy, Management and Reporting:

- To approve and keep under review, on behalf of the Board of Directors, the Trust's investment strategy and policy.
- To maintain an oversight of the Trust's banking arrangements and associated investment policies, ensuring compliance with the Trust's policy and Monitor's requirements.
- To approve any innovative, commercial or investment activity e.g. proposed start up companies or joint ventures.

Procurement Strategy:

- To approve and keep under review, on behalf of the Board of Directors, the Trust's procurement strategy.
- To consider and approve any significant variations to the Trust's existing procurement methodology as set out in the Trust's Standing Orders and Financial Instructions.

Operational Strategy:

- To keep under review the financial aspects of any of the Trust's departmental strategies.

Risk:

- To receive assurance reports in accordance with the Risk Management Strategy
- To receive information on trends & themes from Finance and Performance reports to initiate measures to reduce risk. Where appropriate, to ensure that identified risks are considered and included in risk registers
- To review Board Level Risks assigned to the Committee monthly and assure the Board of Directors that controls and actions taken are adequate

Other Duties:

- To monitor, and make recommendations to the Board as necessary and appropriate on the adequacy and effectiveness of the Trust's financial as well as other performance reporting.
- To make arrangements, as necessary, to ensure that all Board members are provided with necessary information for them to understand key financial performance and issues affecting the Trust.
- To examine any other matter referred to the Committee by the Board of Directors.
- To review performance indicators relevant to the remit of the Committee.

Procedural Notes:

Finance, Investment & Performance Committee reports directly to the Board of Directors. A report of any meeting of the FIP Committee will be presented to the next scheduled Board of Directors meeting. The Chair of the Committee shall draw to the attention of the Board of Directors any issues that affect the financial standing of the Trust.

- **Confidentiality -** Meetings held in private but minutes to go to the Board of Directors public Board meeting, exceptionally to Part II Private Board meeting

- **Regulation & Control -** Unless otherwise agreed, the Committee will be governed by the Standing Orders and Standing Financial Instructions of the Luton & Dunstable Hospital NHS Foundation Trust.
- **Amendments to Terms of Reference -** Amendments will only be made with approval of the membership of the Finance, Investment & Performance Committee and will be approved by Board of Directors.

Membership:

Non-Executive Director (Chair)
Chief Executive
Managing Director
Medical Director
Director of Finance
Director of Re-engineering & Informatics
Chairman
2 additional Non-Executive Directors
Director of Human Resources

All other members of the Board of Directors shall be entitled to attend and receive papers to be considered by the Committee.

In the absence of the Chair, any NED present will take the Chair.

Quorum:

Minimum of 5 members, at least 2 of whom should be Non-Executive Directors

Frequency of Meetings:

10 meetings per year, with additional meetings as deemed necessary. Meetings to be held monthly with the exception of August and December.

Review

The Terms of Reference will be reviewed annually and ratified by the Board of Directors.

March 2017

Review March 2018

TERMS OF REFERENCE

AUDIT AND RISK COMMITTEE

Status:	Sub-committee of the Board of Directors
Chair:	Non-Executive Director The Chairman of the Board of Directors will appoint the Chair of the Audit & Risk Committee
Membership:	The Committee shall be restricted to Non-Executive Directors. The Committee will comprise of all Non-Executive Directors (excluding the Chairman).
In Attendance:	Head of Internal Audit Director of Finance Financial Controller Board Secretary Clinical Representative (Medical Director) A representative of the External Auditors A representative of Counter Fraud Chairman (invite only) The Chief Executive invited to attend (at least annually) to discuss with the Audit & Risk Committee the process for assurance that supports the Annual Governance Statement. Other Executive Directors or managers may be invited to attend as necessary.
Meeting Frequency:	Meetings shall be held not less than 4 times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary. At least once a year the Committee may wish to meet with the External and Internal Auditors without any Executive Board members present.
Meeting Management:	Agenda to be agreed by the Chair and agenda and papers to be circulated 5 days before the meeting, unless by exception and agreed with Chair of meeting in advance.
Extent of Delegation:	The Audit and Risk Committee is a formal sub-committee of the FT Board of Directors and complies with the Standing Orders and the Scheme of Delegation.
Authority, Accountability and Chairs Action:	The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other professional advice and secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. The Non-Executive Chair, as Chair of Audit and Risk is, on an exceptional needs basis, granted delegated authority to make decisions on time critical issues arising between planned meetings of Audit and Risk. Whenever such powers are exercised a full report explaining why such a necessity arose and exactly what action was taken, is to be made to the next quorate meeting.

Quorum: 3 members.

In the absence of the Chair of the Audit & Risk Committee the Non-Executive Directors will nominate a replacement.

Reporting: The minutes of Audit and Risk Committee meetings shall be formally recorded.

A report shall be made following each Audit and Risk Committee meeting to the next Board of Directors meeting on issues which need to be considered by the Board of Directors. The report shall give details of the action or improvement that is needed for the Board of Directors to approve.

The Chair of the Audit and Risk Committee will make a report to the Council of Governors annually, and an annual report will be made to the Board on the work of the Audit and Risk Committee in support of its objectives.

Objectives:

1. Governance, Risk Management and Internal Control - The Committee shall review the establishment and maintenance of an effective system of integrated governance, internal control and risk management, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives. In particular, the Committee will review:

1.1 The policies and processes for preparing the Assurance Framework including review of the quality of the evidence for assurance provided by Internal and External Audit, management and other sources.

1.2 All risk and control related disclosure statements, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.

1.3 The underlying assurance processes that indicate the degree of achievement of the corporate objectives, the effectiveness of the management of principal risks (including risk & resilience review procedures and reports) and the appropriateness of the above disclosure statements.

1.4 The findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation. This will include a review of the work of other committees, including the Clinical Outcome, Safety & Quality Committee, and the work on risk of the Executive Board which can provide relevant assurance.

1.5 The policies and processes for ensuring that there is compliance with the Terms of Authorisation agreed with Monitor/NHSI, and other relevant regulatory, legal and code of conduct requirements.

1.6 The operational effectiveness of financial policies, systems and services and the financial control environment throughout the Trust, including compliance with Standing Orders and Standing Financial Instructions.

1.7 Review the policies and procedures for all work related to fraud and anti-bribery as set out in Secretary of State Directions and as required by the Directorate of Counter Fraud Services/ NHS Protect, and the operation of Trust policies for Freedom of Speech ("whistle blowing").

1.8 Review the policies, procedures and related transactions for compliance with NHS rules regarding Conflicts of Interest

1.9To monitor, on behalf of the Board, the Assurance Framework.

2. Financial Reporting - Review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

2.1 Changes in, and compliance with, accounting policies and practices.

2.2 Unadjusted mis-statements in the financial statements.

2.3 Major judgmental areas.

2.4 Significant adjustments resulting from the audit.
2.5 Compliance with accounting standards.
2.6 The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee.
2.7 The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.
2.8 To examine the circumstances when Standing Orders are waived.
2.9 To review schedules of losses and compensation payments and make recommendations to the Board.
2.10 Review compliance with Internal Financial Controls
2.11 Review proposed changes to Standing Orders, Standing Financial Instructions and Scheme of Delegation.
2.12 Compliance with relevant legal requirements.
2.13 Monitor formal announcements relating to the Trust's financial performance.
2.14 Review conflict of interests and the hospitality register on an annual basis.
2.15 To review all equivalent matters relating to Charitable Funds.

3. Internal Audit - The Committee will:
3.1 Appoint an appropriate internal audit provider, agree the fee and as appropriate, the termination of the contract.
3.2 Review and approve the internal audit strategy, operational plan, and programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework.
3.3 Annually assess and review the performance of internal audit to ensure that an effective service is provided.
3.4 Consider the major findings of internal audit investigations and management's response, and ensure co-ordination between the Internal and External Auditors.
3.5 Ensure that internal audit function is adequately resourced and has appropriate standing within the organisation.

4. External Audit - The Committee will:
4.1 Make recommendations to the Council of Governors in relation to the appointment, re-appointment, and removal of the external auditor and approve the remuneration and terms of engagement of the external auditor.
4.2 Discuss with the external auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other external auditors in the local health economy.
4.3 Review all external audit reports, including agreement of the annual audit letter before submission to the Board, and any work carried outside the annual audit plan, together with the appropriateness of management responses.
4.4 Annually assess the auditor's work, performance, and fees to ensure work is of a sufficiently high standard and the fees are reasonable.
4.5 Review the auditor's independence and objectivity and effectiveness taking into account relevant UK professional and regulatory requirements.
4.6 Review proposed engagements of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm.

5. Counter Fraud - The Committee will:
5.1 Appoint an appropriate counter fraud provider, agree the fee and as appropriate, the termination of the contract.
5.2 Review the annual counter fraud programme and ensure that it is adequately resourced.
5.3 Receive periodic reports of progress in investigations undertaken and an annual report of work undertaken.
5.4 Review policies and procedures for all work relating to fraud and anti-bribery

(including the bribery act).
5.5 Review the arrangements by which staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters ensuring that arrangements are in place for the proportionate and independent investigation of such matters.

Programme Board Members Responsibilities:

1. Individual members are expected to act as champions of Audit and Risk within the Trust and wider health community. Members are empowered to discuss issues with interested Parties outside of the meeting, subject to any confidential information shared.

2. To set targets and agree control systems to ensure delivery of the stated objectives.

3. To establish and maintain links with other bodies such as local CCGs, Local Council, Ambulance Service and other Trusts, Social Services etc where Services are affected by or potentially impacted by the actions agreed.

Workplan:

Each meeting:
- Update report from External Auditor
- Update report from Head of Internal Audit
- Update report from Head of Counter Fraud
- Update report from Director of Finance to cover matters arising
- Update reports from committees and sub boards: Finance Investment & Performance;
  Clinical Outcome, Safety & Quality; Redevelopment; Remunerations & Nominations; and Executive.
- Risk Register and Assurance Framework review
- Note of business of other committees by exception
- Review of Financial Control (as required)

Twice a year:
- Waivers

Annually:
- External Audit plan for next year
- Internal Audit plan for next year
- Counter Fraud plan for next year
- Final Accounts and ISA 260
- Terms of Authorisation
- Provider Licence Review
- Annual Governance Statement
- Head of Internal Audit's opinion on internal controls & Annual Report.
- External Auditor's audit opinion, audit certificate and findings from the audit
- Review of External Auditor's work and fees
- Counter Fraud Annual Report
- Review of governance aspects not covered above (as required)
- Losses and special payments
- Conflict of interest/ hospitality register (including Sponsorship)
- Fit and Proper Persons declarations

Agreed on 22 March 2017

To be reviewed by end March 2018

Audit & Risk Committee Work Plan	March	May	Sept	Jan
Reports/ Recommendations from Sub Committees & Assurance Processes:				
○ Assurance Framework	✓	*	✓	✓
○ Risk Management	✓	✓	✓	✓
○ CQC Regulation & Registration	*	*	*	*
○ Information governance	*	*	*	*
○ Sub Committees – Clinical Outcome, Safety & Quality Committee, Finance, Investment and Performance Committee, Executive Board	✓	✓	✓	✓
○ Chief Executive - process for assurance that supports the Annual Governance Statement		✓		
○ Review Freedom to Speak Up process & Report from Guardian	✓	*	✓	*
Compliance with and changes to Standing Orders, SFIs & Scheme of Delegation & the Financial Control Environment:				
○ Waivers		✓	✓	
○ Losses and special payments		✓		
○ Conflict of interest/ hospitality register (incl Sponsorship) Policies to be reviewed every three years or as and when required		✓		
○ Fit and Proper Persons declarations		✓		*
○ Review of Financial Control	*	*	*	
○ Terms of Authorisation		✓		
○ Provider Licence Review		✓		
Internal Audit:				
○ Consider the appointment, audit fee and termination of the contract	*	*	*	*
○ Performance monitoring				✓
○ Strategic plan	✓			
○ Progress reports & update on recommendations	✓	✓	✓	✓
○ Annual internal audit opinion/ report		✓		
External Audit:				
○ Recommend to the Council of Governors the appointment, reappointment and removal of the external auditor	*	*	*	*
○ Performance Monitoring				
○ Annual Audit Fee	✓			
○ Progress and update reports	✓	✓	✓	✓
○ Report to those charged with Governance		✓		
○ Annual Management Letter			✓	
○ Charitable Fund Reporting			✓	
○ Review proposed engagements of the external auditor to supply non-audit services	*	*	*	*
Financial Reporting:				
○ Review changes to Accounting Policies	✓	*	*	*
○ Review Annual Report & Accounts		✓		
○ Review Statement of Internal Control		✓		
○ Acknowledge formal announcements relating to the Trust's financial performance	*	*	*	*
Counter Fraud:				
○ Consider the appointment, fee and termination of the contract	✓			
○ Approval of annual work plan		✓		
○ Progress report including specific investigations	✓	✓	✓	✓
○ Annual report	✓			
○ Review of policies & procedures relating to fraud, anti-bribery and freedom of speech	*	*	*	*
Required by Terms of Reference:				
○ Reporting to the Board and Council of Governors**	*	✓	*	*
○ Review of terms of reference	✓			
○ Private discussion with internal and external audit			✓	
○ Approval of Audit Committee work plan	✓			
○ Annual Audit Committee Assessment**			✓	
Annual report to the Board		✓		

* as and when required.

** Report on assurance/ Annual Audit Committee Report to be produced for AMM / Council of Governors or next available meeting and the next Board.