Luton & Dunstable University Hospital
Board of Directors

Board of Directors

COMET Lecture Hall

26 July 2017 10:00 - 26 July 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 3 May 2017 (attached) To approve 3 Minutes BoD 030517 version 1.doc 7	SL	
4	Matters Arising (Action Log) (attached) To note	SL	
5	Chairman's Report (verbal) To note	SL	
6	Executive Board Report (attached) To note 6 Executive Board Report July 2017.doc 15	DC	
7	Performance Reports (header attached) 7 Performance Reports Header.doc 45		
7.10	Quality & Performance (attached) To note 7.1 Quality and Performance Report July 17.ppt 47	CJ/SO	
7.20	Finance (attached) To note 7.2 Finance Report.docx 73	AH	
7.30	Workforce (attached) To note 7.3 Workforce Report.pptx 83	AD	

#	Description	Owner	Time
8	Clinical Outcome, Safety & Quality Committee Report (attached) To note 8 COSQ Report April May June 2017.doc 89	AC	
9	Finance, Investment & Performance Committee Report (attached) To note 9 FIP Report to the Board_Q1 FY1718.docx 95	JR	
10	Audit & Risk Committee Report (attached) To note 10 Audit and Risk Report to the Board July 17.docx 99	DH	
11	Charitable Funds Committee Report (attached) To note 11 CFC 3 May 2017 Report.doc 105	CB	
12	Hospital Re-Development Committee Report (attached) To note 12 Hospital Redevelopment Report - July 17.doc 109	DH	
13	Risk Register (attached) To approve 13 RR July 2017.doc 113	VP	
14	Board Secretary Report (attached) To ratify 14 Board Secretary Report July 2017.doc 117 14 Appendix 1 C17 Draft Conflict Declaration of Inte... 119	VP	
15	Detaisl of Next Meeting: Wednesday 1 November 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 3 May 2017	**To action**	☒
Date of Meeting	Wednesday 26 July 2017	**To note**	☐
Lead Director	David Carter	**For Information**	☐
Paper Author	David Carter	**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 3 May 2017

Present: Mr Simon Linnett, Chairman
Mr David Carter, Acting Chief Executive
Ms Cathy Jones, Deputy Chief Executive
Ms Angela Doak, Director of Human Resources
Mr Andrew Harwood, Director of Finance
Ms Sheran Oke, Acting director of Nursing & Midwifery
Ms Marion Collict, Director of Operations
Dr James Ramsay, Acting Medical Director (for Dr D Freedman)
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 Cliff Bygrave, Non-Executive Director

In attendance: Ms P Graves, Director of IT
Ms Victoria Parsons, Board Secretary
Mrs Anne Sargent, Minute 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. Apologies were recorded from M Versallion, M England and Dr Freedman.

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

The Chairman formally welcomed C Jones to her first meeting as Acting Deputy CEO and David Carter as Acting CEO.

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

3. MINUTES OF MEETING HELD ON WEDNESDAY 1 FEBRUARY 2017

C Bygrave to be deleted from list of attendees. '(m)ore' to be deleted from the Workforce Report section.

Subject to the above, the minutes were approved as an accurate record.

Proposed: J Garner **Seconded:** V Tiwari

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 referred to P Philip's secondment to the national role, with approximately one day per week to work on STP, which will be reviewed in late summer/early autumn.

He mentioned the current period of Purdah, meaning we may be unable to respond to some items.

The Chairman had recently compered a very well attended medical lecture on stroke services, which was extraordinarily well contributed to both by colleagues and the local population.

6. CHIEF EXECUTIVE'S REPORT

The Board received the Chief Executive's report, with attention drawn to the following:

L&D Stocktake – this is being undertaken to understand our risks in the strategic context.

STP – C Jones has returned from an STP secondment. D Carter explained that she is seconded into his former role, with a few changes, i.e. he retains responsibility for capital and estates. Cathy's role is very much operational with the Divisions. The aim is not to fundamentally change things but to work as a team. Cathy added that she is looking forward to working with the divisions and that we have a good strong team of GMs.

5YFV – information is awaited as to whether there will be any change to 18 weeks target.

NHS Property & Estates Review – FIP undertook a comparison of our estate for the review. The Chairman noted that R Naylor is renowned for his input into Estates. D Carter added that he has agreed the case for a significant capital injection into the NHS.

7. PERFORMANCE REPORTS

Quality & Performance Report – the Board received the report, with the following points highlighted:

D Carter noted a focus on discharge, with increased support to the discharge team and an intensive effort including an hour per day of senior management input, which is having an impact. The Red & Green initiative looks at patients that are delayed, both medically fit and those still in the medical phase.

S Oke noted continued high levels of harm free care, and that whilst falls have remained consistent, this has been a period of increased activity. Infection control has had a significant reduction on recent years. The Trust buddy system has been re-launched.

M Collict noted that 3 SIs were declared in Q4 and are under investigation. The report contains learning from 6 SIs that were closed in Q4. All incidents are monitored by COB and divisions use the learning. There was no further mortality update from Dr Foster but the number of deaths has returned to what we would expect, following the earlier increase. We are reassured there is no systemic issue in the organisation that has contributed to the increase, but are aware there will be an impact on our HSMR. A Clarke added that COSQ receives monthly updates and she attends the Mortality Board. J Ramsay noted that the mortality review process has been changed to make it more robust, with a senior colleague undertaking an early review. A Clarke added that these reviews are more effective and objective. Complaints – a process is in place to deal with the issues within Surgery and deliver on this, noting a remarkable achievement in the last 4 weeks.

D Carter reported on cleanliness, noting that in March, for the first time, the high risk category met the threshold. Issues remain, however, the overall standard has improved. A recent LBC unannounced inspection increased our food hygiene rating to 4 (5 is top of scale).

There has been no change on national target performance, urgent & emergency care remains busy. We will monitor the impact of changes to Luton Walk-in centre. The 18 weeks position is receiving significant attention with extra lists in place to give us headroom.

M Collict advised the Board that due to high numbers of requests to visit L&D, a day per month has been dedicated with an aim to accommodate a number of Trusts on one day.

D Carter finished by mentioning that the most recent stroke score is awaited, noting a definite improvement on overall scores.

Finance Report – Andrew Harwood presented the report.

A Harwood outlined that the report had been reviewed by FIP, who also reviewed the accounts (subject to audit). The reported surplus was £12.9m (NHSI required us to achieve £11.8m). The Trust secured central non-recurrent income of nearly £9m, resolved a £2m dispute with the CCG and accrued STP funding from NHS of slightly above £10m. Combined with a less than expected capital spend, the year-end cash balance was the highest for a number of years.

J Robinson pointed out that we do have an underlying deficit in performance, and there is a need to inject more vigour into the finances becoming more sustainable. A Harwood added that the underlying position would have to translate into a surplus to attract the STP fund and that we need to secure an improvement in the underlying position.

Workforce Report – Angela Doak presented the report.

A Doak noted the continuing struggle with medical recruitment in dermatology and haematology. Work is underway to understand reasons for people leaving, but more innovative ways of gathering information from leavers was required. Appraisal figures have increased and monthly reporting from divisions is now in place.

8. EXECUTIVE BOARD REPORT

D Carter highlighted the staff survey results. A Doak added that overall, these were pleasing, particularly in terms of staff engagement. Attention was drawn to bottom ranking scores, where work is being undertaken to understand this. It would appear that this may be driven by a percentage of patients with conditions that may lead to this behaviour, i.e. dementia, alcohol related, learning difficulties etc.

It was noted that the Trust monitors 'red flag' occurrences, S Oke added that the Francis Report had required Trusts to identify a number of red flags to be reported to the Board, which do show an increase since the same period last year. Measures have been introduced, such as advanced health care assistants, to undertake tasks previously undertaken by registered nurses.

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

A Clarke talked to the COSQ Report. No issues were raised.

A Clarke reported that she and A Doak are to draw up Terms of Reference for the Board to consider a new sub-committee on workforce. Excellent safety data is being reported up through COSQ indicating improvements year on year. Clinical audit – the best ever performance against plan for 2016/17 with plans in place for almost every department for 2017/18.

D Hendry referred to resource into supporting care homes as mentioned in report. M Collict responded that the pilot has been funded by NHSI and is part of a wider programme looking at care homes across the STP.

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

Jill Robinson presented the report.

J Robinson referred to backlog maintenance, noting that FIP received clarity on the plan for this year and the sequence of works. There are a large number of business cases which FIP review. In terms of the Respiratory business case (part of needs based care), FIP approved going ahead with recruitment of consultants.

11. AUDIT & RISK COMMITTEE REPORTS

David Hendry talked to the report, noting key headlines:

The external audit plan was approved. It was noted that the Trust must

ensure that proposals from BLMK are appropriately discussed and approved. In terms of internal audit, it was noted that agency staffing carries some risk due to an inconsistency in implementing controls. The Audit Committee had received assurance that this had been followed up. The 2017/18 audit plan had been approved. Presentations from IT included global digitisation exemplar. A focus on bringing cyber security measures up to date was noted.

12. HOSPITAL RE-DEVELOPMENT COMMITTEE REPORT

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

The Chairman noted that the next meeting will focus on the energy centre and overall space requirements. A Harwood informed the Board that it has been identified that there is a building on site belonging to another Trust which has benefitted from L&D's electricity supply, and which has now been invoiced.

13. RISK REGISTER

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

The Board noted the addition of 3 new Board level risks: Financial Achievement 2017/18, Mortuary Capacity and Cyber Security.

14. BOARD SECRETARY REPORT

Victoria Parsons talked to the report, noting two resignations from the Council of Governors, the Central Bedfordshire Council and Bedfordshire Public Governor. The next election process is underway.

The Board approved an amendment to the Constitution as detailed in appendix 1.

Terms of Reference for COSQ, FIP and Audit & Risk had been approved. In particular, it was noted that Audit & Risk ToRs contain a clause in relation to risk emanating from external factors. It was agreed that both COSQ and FIP should consider such a clause in their ToRs. ***AC/JR***

There is work underway and material available to support our work in relation to NHSE guidance on managing conflict of interest.

ANY OTHER BUSINESS

No further business was raised.

QUESTIONS/COMMENTS FROM NON BOARD MEMBERS

The following questions were asked by the audience:

1) Is there an impact on L&D of the 39 beds closed at St Albans and the 16 beds opened at Watford? D Carter had spoken to Hertfordshire Community Trust the previous week. One of the wards was closed on patient safety grounds. The remaining wards at St Albans remains open.

The Trust still has access to those beds and a decision on the remaining ward is yet to be made. The Trust has expressed its concern to NHSE, who have put a hold on the closure of the ward. No official response has been received. D Carter is meeting with new CO of Herts Valley next week and will discuss then.

2) Management costs are often raised and the Trust's has increased significantly. A Doak agreed to look into this in terms of how the numbers are made up and how the information is presented. ***AD***
3) Cresta House was mentioned at last Board meeting. Is there any update? D Carter responded that the deal collapsed, which is why the Arndale Centre is now being looked into.
4) Response to leaver's questionnaires was raised noting a previous suggestion that external people carry out the interviews. D Carter responded that he is happy to consider this, along with a number of other options.
5) It was noted that the appraisal rate continues to show a low average despite the new measures. A Doak responded that we did see a significant increase at time of the CQC inspection. It has been included as an objective for every manager, is discussed regularly at COSQ and also added to divisional performance meetings. It is a Board responsibility which is taken seriously. Appraisals should not be signed off if managers have not achieved objectives.
6) Governors have asked if they can carry out exit interviews. A Doak responded that she is happy to consider anything but it may be wise to use a body that has an established link with us.

SUMMARY OF ACTIONS

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

15. DETAILS OF THE NEXT SCHEDULED MEETING:

Wednesday 26 July 2017, 10.00am, COMET Lecture Hall

16. 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

BOARD OF DIRECTORS

Agenda item	6	**Category of Paper**	Tick
Paper Title	Executive Board Report	**To action**	☒
Date of Meeting	Wednesday 26 July 2017	**To note**	☒
Lead Director	D Carter	**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 – 25th April 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

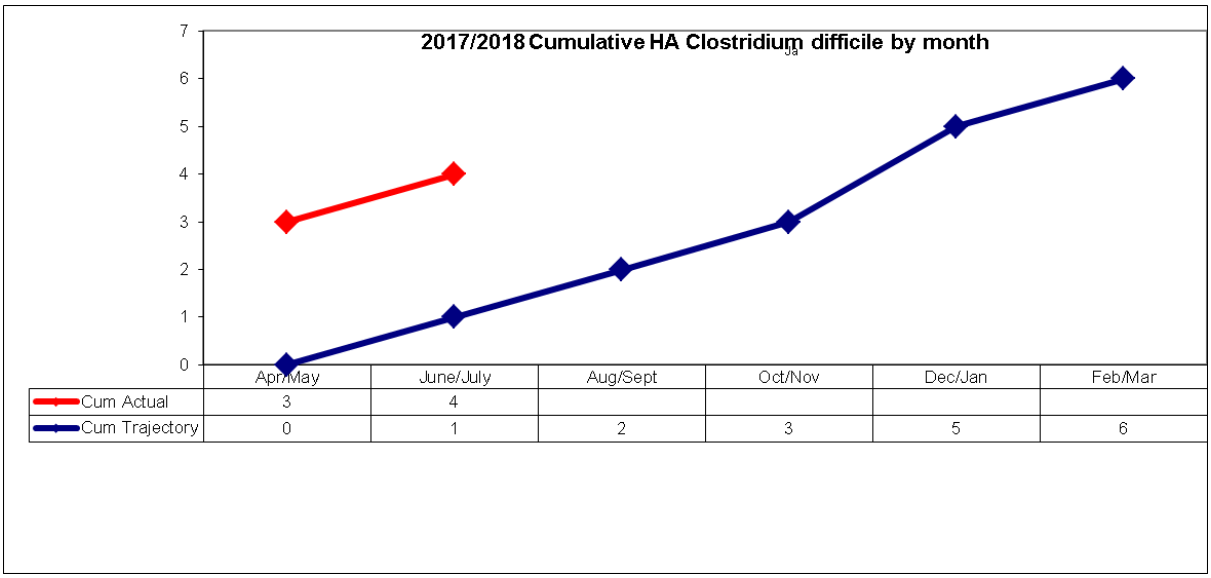
1. Infection Control Report - to note
2. Deanery Issues - to note
3. Complaints Board Update - to note
4. Mortality Board Update - to note
5. Needs Based Care - to note
6. Nursing and Midwifery Staffing - to note
7. Management of CQUIN - to note
8. Compliance Issues - to note
9. Endoscopy - to note
10. Junior Doctor Vacancies - to note
11. Medical Agency Spend - to note
12. Ultrasound - to note
13. Nasogastric Tube CAS Alert - to note
14. Trust Quality Buddy System - to note
15. Equality & Diversity Annual Reporting - to note
16. BLMK STP Central Briefing
17. Freedom to Speak Up - to note
18. Estates and Facilities Update - to note
19. Communications & Fundraising Update - to note
20. Policies and Procedures Update - to note

ACTION REQUIRED To note / consider / review / approve as specified above.	
Public Meeting ☒	Private Meeting ☐

1. INFECTION CONTROL REPORT

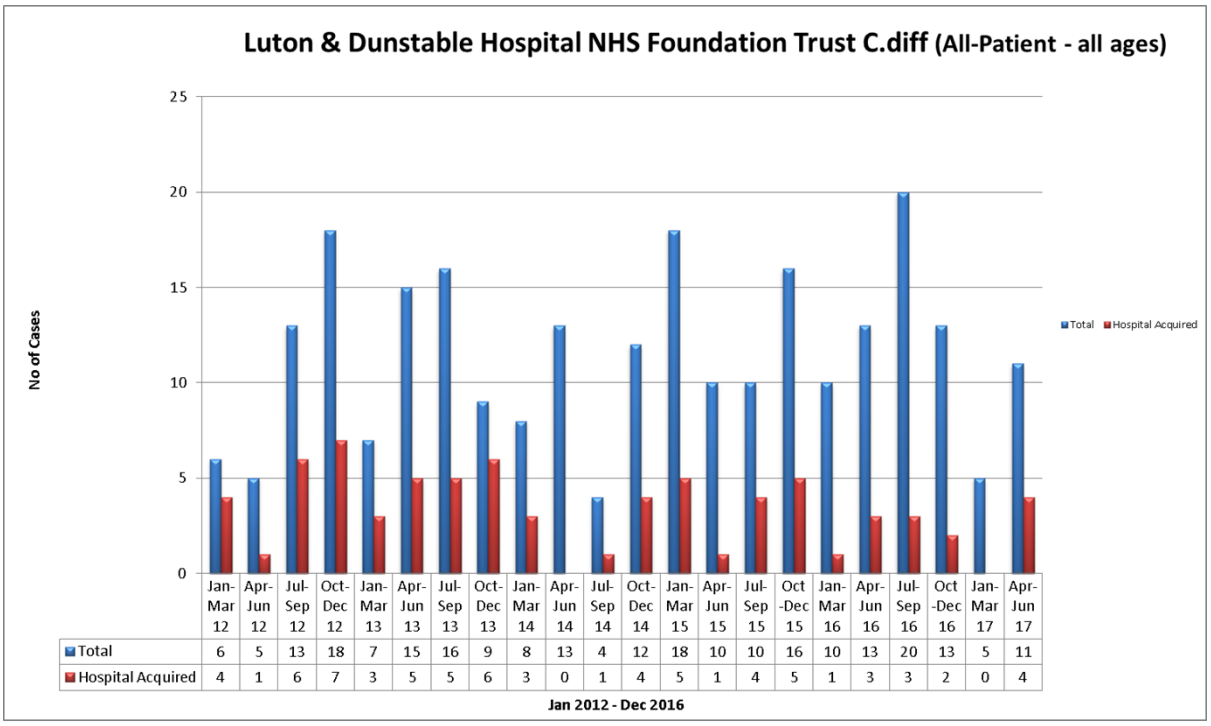
- **Clostridium difficile**

For the first quarter the Trust reported 4 cases of hospital acquired ('HA') infections (ceiling is 6 cases).



	Apr/May	June/July	Aug/Sept	Oct/Nov	Dec/Jan	Feb/Mar
Cum Actual	3	4				
Cum Trajectory	0	1	2	3	5	6

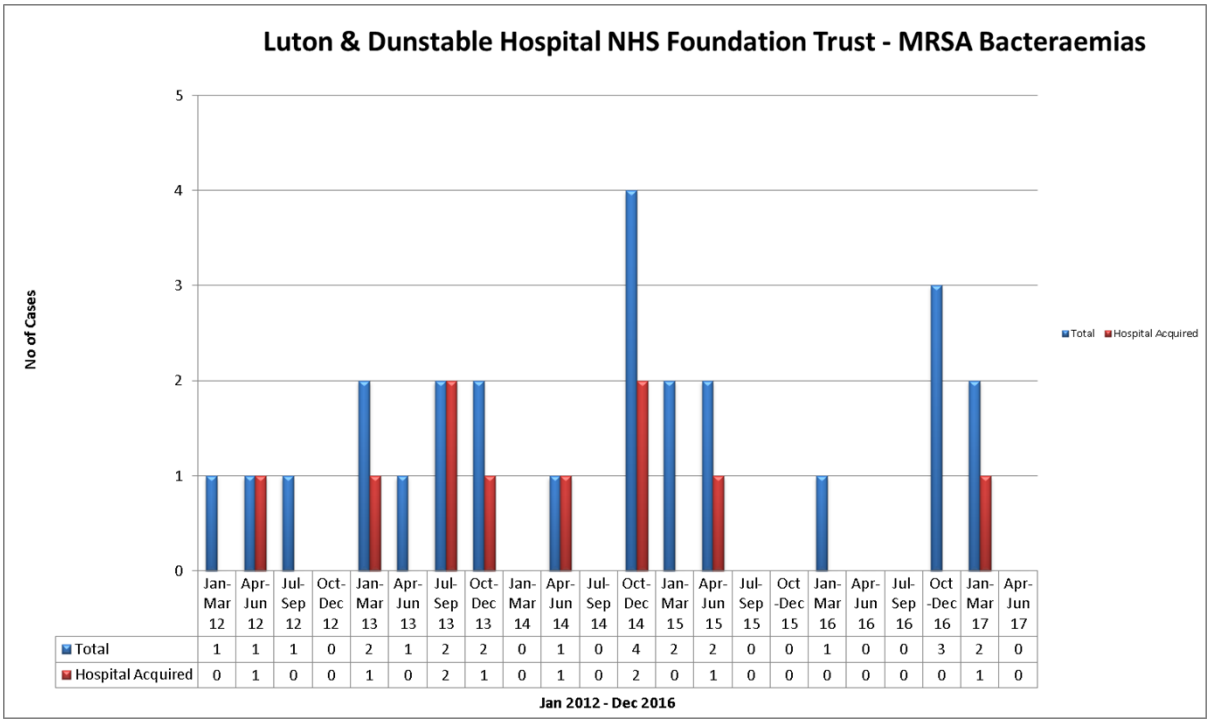
In July so far a further case of HA C.difficile has been identified. Detailed root cause analysis is undertaken on all HA cases. All isolates are also sent for typing to the reference laboratory to identify any clusters.



	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	Apr-Jun 17
Total	6	5	13	18	7	15	16	9	8	13	4	12	18	10	10	16	10	13	20	13	5	11
Hospital Acquired	4	1	6	7	3	5	5	6	3	0	1	4	5	1	4	5	1	3	3	2	0	4

- **MRSA bacteraemia**

So far this year no cases of bacteraemia due to MRSA have been identified.



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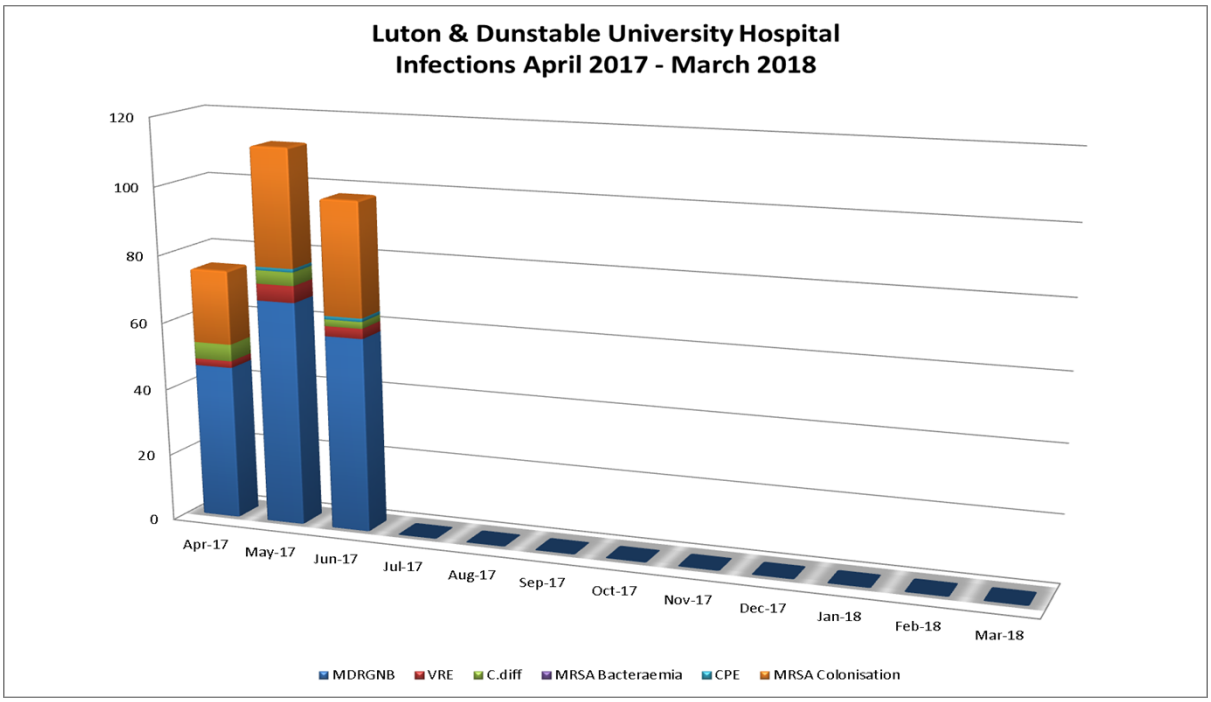
Total	1	1	1	0	2	1	2	2	0	1	0	4	2	2	0	0	1	0	0	3	2	0
Hospital Acquired	0	1	0	0	1	0	2	1	0	1	0	2	0	1	0	0	0	0	0	0	1	0

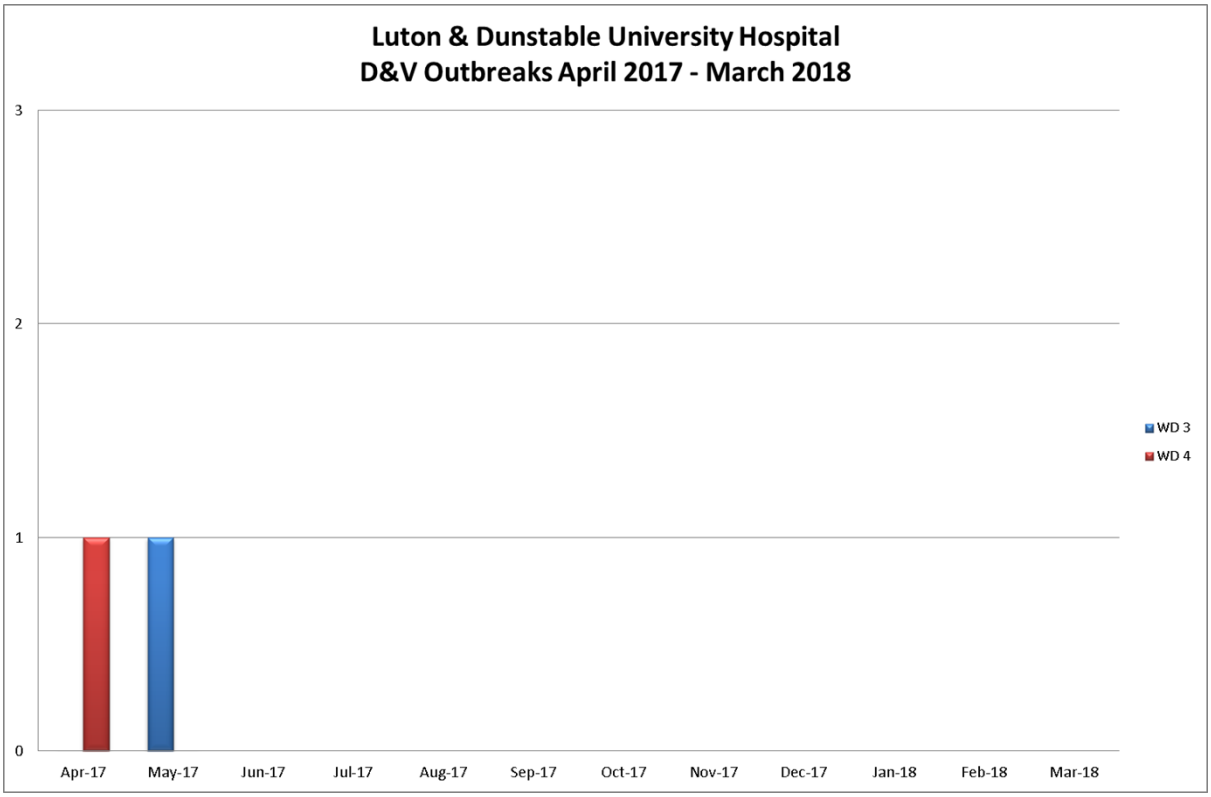
- **Multi-drug resistant organisms (MDRO)**

The number of MDRO cases remains at the same level as in previous years. The current crises with the supply issue of some antibiotics the management of patients with MDRO has become even more difficult with greater reliance on antibiotics which we were restricting in the past.



- **Diarrhoea and Vomiting Outbreaks**

In the last quarter two outbreaks of D&V have been reported.



2. DEANERY ISSUES

GMC survey

This year's GMC survey has been published and we are pleased to report it shows year on year improvement. However we recognise we have some departments that need further support. Key messages to note:

- the neonatal unit, paediatrics, and ophthalmology are recognised as "Good" areas
- gastroenterology and respiratory medicine workload pressure is identified as an issue
- trauma & orthopaedics, ENT and respiratory were identified as areas where further work is required to improve the training environment

Performance & School visits

School of Anaesthetics held an exploratory visit on 17th July 2017. This was in relation to some concerns raised by the trainees. The visit identified the need to improve the timely discussion of and learning from case reviews and SIs and the importance of providing support for trainees to escalate concerns.

Dentist - A desktop panel review took place 20th April 2017 and an action plan is due to be returned on 27th June 2017. There is nothing of significance to report.

Implementation of Junior doctors contract

All 180 trainees will be on new contract by October 2017.

3. COMPLAINTS BOARD UPDATE

The Complaints Board continues to work with the General Managers and senior nursing leads to support the improvement of timely response to complaints. Medicine, Women's and Children and DTO continue to maintain their performance. The Surgical Division continue to make improvements but continue to work with a backlog.

The Complaints Board has recently updated its Terms of Reference with an added focus on the sharing of the learning that comes from complaints. Work is ongoing to reconfigure/update the Trust's Datix Risk Management System. The reconfiguration will also enable the linking of complaints to incident reports, claims and inquests.

4. MORTALITY BOARD UPDATE

Mortality Review Strategy

Following on from the NHS Quality Board publication in March 2017, Trusts are required to develop and implement a Mortality Review strategy, supported by an operational policy, by September 2017, after which certain mortality review data will be mandatory within the Trust Quality reports and accounts.

Mortality reviews are not something that have been undertaken routinely for very long. Historically, focused mortality reviews were used to review particular small groups of patients where specific concerns existed.

In early 2017, the Mortality Board agreed to change the process. They established a rota of senior people within the organisation (a mixture of clinicians, nurses and managers) who would undertake a preliminary review of the paper. From this preliminary review, patients are identified where it was felt there may be learning to be gained from a full mortality review. The remainder of the notes are signed off as appropriate care.

An initial pilot suggested that this would reduce the burden of full mortality reviews by up to 50%. At present, every death is undergoing a preliminary mortality review by senior staff in the Bereavement Office. Current full mortality review requests are running at about 30% of deaths (these are the clinically indicated reviews). To comply with the NHS Quality Board directive, additional cases relating to categories of death triggering because of raised HSMR on Dr Foster would also need to be included, along with a number of random reviews such that approximately 50% of deaths undergo full review.

In a paper published by the National Quality Board in March 2017, the Trust has been given a clearer picture of the future of Mortality Reviews in the NHS. The paper outlines the principles behind Mortality Reviews, their methodology, and how their conduct and the learning from them will need to be reported in future. The guidance is a first draft, and is currently being updated following the 'Learning from Deaths' conference held in London on 21st March 2017, which Alison Clarke and Robin White attended on behalf of the Trust.

Cases that will require Full Mortality Review

1. Any case where concerns about the quality of care have been raised by bereaved families, carers or staff (this may mean having to ask for a full mortality review later than normal should a complaint be received from a family)
2. All cases involving the death of people with learning difficulties or severe mental illness (there is no agreed definition of severe mental illness)
3. All deaths where the procedure or illness is subject to a current HSMR Alert from Dr Foster
4. Cases where learning will be added to existing improvement work, this would include deaths with no DNACPR order, where a hospital acquired thrombosis may be involved, where DVT prophylaxis has been deficient, or where the cause of death involves sepsis or acute kidney injury)
5. All cases where death was not “expected” (e.g. following elective surgery)
6. A random sample of other deaths not required for any of the above reasons
7. Any death which may be related to an existing “Prevention of Future Deaths” order from a Coroner

The Mortality Board are currently agreeing the process for going forward with this agenda. There is a requirement for the outcomes of the Mortality Reviews to be shared quarterly through the Board Quality report from September 2017. This will be contractually enforced through changes at a national level to the Quality Accounts regulations.

5. NEEDS BASED CARE

A ‘Green Paper’ or Strategic Outline Case describing Needs Based Care was presented at a Board Seminar for discussion and consideration. The range of options described explore the opportunities around changes to the medical staffing model, nursing, therapies and pharmacy so as to enable a step change in the way we manage continuity of patient care and ensure that patients are cared for by the right specialist team.

Early pilot work within respiratory medicine to improve front door presence of respiratory specialists and deliver hot clinics has shown positive signs of better outcomes for patients. We are also trialling local improvements in therapies to enable us to better quantify the impact of more intensive therapies input.

Overall the length of stay in medicine for emergency admissions continues to reduce and the early impact of the Red to Green initiative which has been introduced on a number of medical wards has shown a significant improvement in the rate of discharge compared to admission.

6. NURSING & MIDWIFERY STAFFING

The report for April, May and June is attached as **Appendix 1**

7. MANAGEMENT OF CQUIN

The national CQUIN schemes published for 2017-2019 have been commenced in the Trust. These are as follows:

- Improving staff health and well-being;
- Reducing the impact of serious infections (antimicrobial) resistance and sepsis;
- Improving services for people with mental health needs who present to A&E;
- Offering advice and guidance;
- NHS E-referrals;
- Proactive and safe discharge;

The reports for the first quarter of the 2017/18 CQUINS were submitted to Luton CCG ahead of the deadline, and we currently await the outcome of the CCG review panel. Our understanding is that we have met the milestones for four of the five schemes which required evidence to be submitted this quarter. For the sepsis scheme, we believe that we have part met – having delivered antibiotics within the hour of decision to treat to 76% of our patients (against a target of 90%).

For 2016/17, the Trust successfully achieved five of the eight schemes. There are three schemes which were either part met, or the final outcome of all elements is yet to be known. Two Sepsis CQUINs were partially met, with delivery of antibiotics for emergency patients and inpatients having met a reduced target. It is important to note that the data analysis by PHE has yet to be published for quarter 4 of 2016/17, which will determine our achievement of the antibiotic reduction scheme for the last year.

8. COMPLIANCE ISSUES

Public Health England visited the hospital on 13th July to assess our Antenatal and Newborn Screening services. The formal report will follow in around 10 weeks, but the initial feedback was positive and the teams involved were commended on their excellent work. Improvement opportunities around ultrasound capacity, which has been constrained due to vacancies, and IT integration between systems were identified and will be identified within the reviewer's recommendations within the report.

9. ENDOSCOPY

The current capacity in endoscopy is significantly reduced due to vacancies amongst scoping staff. The unit has been struggling to fill all available sessions, and has therefore seen waiting times extend and difficulties in covering bowel cancer screening lists as part of the national programme.

Urgent attention is being given by IT and estates to support resolution to critical infrastructure issues and a recruitment drive continues for staff to improve the flexibility of cover.

10. JUNIOR DOCTOR VACANCIES

Vacancies within the FY2 and registrar levels within Surgical division (General surgery and orthopaedics rotas) remain of particular concern at the moment with high levels of unfilled shifts and resultant pressures on the corresponding teams. A recent interview round in orthopaedics identified a number of good candidates and the opportunity to over-establish to help compensate for any subsequent leavers and provide resilience to the team. General Surgery have re-designed the rota that commences in August to increase the number of posts and make this more attractive. Work continues with junior medical staff to try and identify areas of concern for them and assist in retention of this national shortage staff-group.

11. MEDICAL AGENCY SPEND

A number of core vacancies continue to drive high medical agency spend as reported in the finance papers. Divisions continue to monitor closely and are actively recruiting wherever possible into these roles, but this remains a key area of risk for the hospital. Our current trajectory is not in line with achieving the NHS improvement spend expectation for agency ceiling + 50% as a maximum, or the specific medical agency trajectory. Over the coming weeks divisions will be further assessing recovery actions to try and bring this back into balance.

12. ULTRASOUND

The ultrasound team currently have a high proportion of vacant posts - 7 wte vacant of an establishment of 16.24wte. This, combined with unprecedented demand for scans, resulted in 67 patients waiting more than 6 weeks in May 2017 and 115 patients in June 2017. The team have managed to put on an additional 800 slots during July 2017 and have significantly reduced the waiting times in order to achieve the waiting time standard from July 2017. This has required the sourcing of additional agency sonographers, which incurs a cost pressure for the DTO division, and substantive staff (sonographers and medics) have been very supportive with additional sessions.

13. NASOGASTRIC TUBE CAS ALERT

In July 2016, NHS Improvement issued a Patient Safety Alert (NHS/PSA/RE/2016/006) ‘Nasogastric Tube Misplacement: Continuing Risk of Death and Severe Harm’. This was the fifth alert relating to misplaced nasogastric and orogastric tubes issued since 2005. Introducing fluids or medication into the respiratory tract or pleura via a misplaced nasogastric or orogastric tube is a Never Event yet these incidents continue to be reported to the National Reporting and Learning System (NRLS). To date, no reports have been reported by the Trust.

A review by NHS Improvement of investigations into the reported incidents suggested problems with organisational processes for implementing previous alerts such as competency-based training, documentation formats and safe supplies of equipment.

The recent alert was therefore directed at trust boards and the processes that support clinical governance.

Trusts were required to undertake a centrally coordinated assessment of safety critical requirements for checking tube placement and share the key findings and main actions in the form of a public board paper. The appended paper **(Appendix 2)** explains the Trust's position and offers the Board assurance that the required improvement work has been addressed.

14. TRUST QUALITY BUDDY SYSTEM – DOMAIN OF EFFECTIVENESS

The CQC define effectiveness as …'people's care, treatment and support achieve good outcomes, promote good quality of life and is based on the best available evidence..;

The review took place over a 3 day period during the month of May/June 2017. Overall review response rate was 81% and the overall Trust score was 93.35% and the table below outlines how CQC determine what 'good looks like' for the domain of Effectiveness and compares it with what the staff spoken with believe.

CQC Effectiveness Domain – '..*What good looks like..'*	**L and D Staff Opinion (%)**
People's care and treatment is planned and delivered in line with current evidence based guidance, standards, best practice and legislation.	84.62%
People have comprehensive assessments of their needs, which include consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs.	98.51%
Where people are subject to the Mental Health Act (MHA), their rights are protected and staff have regard to the MHA Code of Practice	81.16%
Information about people's care and treatment, and their outcomes, is routinely collected and monitored. This information is used to improve care	93.42%
Staff are qualified and have the skills they need to carry out their roles effectively and in line with best practice	91.25%
Staff are supported to deliver effective care and treatment, including through meaningful and timely supervision and appraisal.	92.96%
Care from different staff, teams or services is coordinated	100%
Consent to care and treatment is obtained in line with legislation and guidance, including the Mental Capacity Act ('MCA') 2005 and the Children's Acts 1989 and 2004	98.59%
The process for seeking consent is appropriately monitored	34%
Deprivation of liberty is recognised and only occurs when it is in a person's best interests, is a proportionate response to the risk and seriousness of harm to the person, and there is no less restrictive option that can be used to ensure the person gets the necessary care and treatment	84.13%

Notable Areas of Practice

- Overall the trust staff had a good understanding of the MCA and/or who to seek advice from if they were unsure - staff gave examples of where the outputs of audit were used to improve service for a better experience – e.g. *MS and Parkinson's audit.*
- Staff were very confident that they worked collaboratively - *Appropriate use of the MDT. Effective use of all the care plans. Good communication in board round to ensure all patient needs are met and length of stay is optimised.*
- Generally staff were not aware how the Trust monitors the effectiveness of gaining consent although Dermatology was an example of good practice.
- Staff were readily able to give examples of how they applied learning from training to practice

Follow Up

Divisions will now follow through on any actions through their Divisional Board

15. EQUALITY & DIVERSITY ANNUAL REPORTING

The new Equality and Diversity Lead started in June. Initial priorities are the reporting areas due this month. These include Annual Equality Information Reports for Patient Services and for Staff; also the Workforce Race Equality Standard Report (WRES) and a Report showing the Trust's position in the WRES National Benchmarking 2016. Preparations are also underway for the Workforce Disability Equality Standard (WDES) and Gender Pay Gap Reporting which are new requirements for this year. The report information meets NHS, statutory and CQC requirements and is a fundamental part of the NHS Equality Delivery System (EDS2) in planning improvements to Patient and Workforce Experience. The next priorities will be to review progress on areas such as our equality objectives, the Accessible Information Standard and Equality Impact Assessment which are key to this agenda.

16. BLMK STP

The current STP Central Briefing is attached to this report as **Appendix 3**

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

During the period 1 April – 30 June 2017, there have been five concerns raised formally via 'Freedom to Speak Up'. These will all be dealt with via the appropriate channels. There have also been a small number of concerns raised informally via this route, which will be looked into appropriately.

18. ESTATES & FACILITIES UPDATE

Estates
The recent hot weather has given rise to an increase in reported incidents of overheating. Many aspects of the hospital estate do not have modern ventilation systems. Some areas do benefit from comfort cooling systems but even where these are fitted it proved difficult to maintain comfortable environmental conditions.

Difficulties have been experienced with a number of cooling systems during this period but these failures have been addressed.

Catering
Ice pops were provided for staff and patients when temperatures were exceeding 26ºC.

STP
The Trust continues to work with Bedford and Milton Keynes on a number of joint procurement initiatives. Tenders have been received and are currently being evaluated for waste management. Further joint procurement projects will include post room and linen services.

Switchboard
The ageing 'hospital bleep system' will be replaced in the second half of the year with a new system that utilises technology from the recently installed digital communications platform. The new system will go live in November 2017.

Sterile Services
In June, an external audit was conducted in Sterile Services by an auditor notified in line with EU medical devices directive. This was the first annual surveillance audit of a 3 year audit cycle under new, more stringent, auditing requirements.

The auditors commended the team on excellent quality management systems and found no significant non-conformities or corrective action required.

19. COMMUNICATIONS & FUNDRAISING UPDATE

COMMUNICATIONS:

Media Enquiries
37 media enquiries were received during the period Apr – June 2017, which is lower than usual due to the period of Purdah leading up to the general election. Themes were the: the cyber attack, L&D leadership and cladding.

Internal Communications
A new design staff newsletter was handed out at the Good, Better, Best events and will regularly be issued in line with Staff Briefings.

Intranet and Website
A scoping and analysis assessment of the current systems is underway, along with a project to improve the GP section of the website. Updates to services pages on NHS Choices have begun.

Social Media
The L&D Facebook pages have been centralised, with measures in place to close down any unofficial sites. This will enable better monitoring and response to comments.

Sustainability and Transformation Plan
The 'What we Heard' reports have been published, which summarises feedback and opinions gathered at a number of staff and engagements events held in March.

FUNDRAISING:

Donations financial year (to date) 2017: £141,873
- £66,877 from league of friends to support various equipment purchases
- £14,111 from legacies
- 245 donations made

Other Activities from charitable funds:
- We have secured a partnership with Sainsbury's Bramingham for the second year
- We have supported 25 fundraising events since April
- We have attended 11 community events to promote fundraising, membership and volunteering.
- The new Helipad appeal and Child oncology rooms appeal has been launched
- The birthing pool and blue light cystoscopy device have been purchased and are now in use

20. POLICIES & PROCEDURES UPDATE

The following Policies & Procedures were approved from May – July 2017:

P13 Maintaining High Professional Standards for Medical and Dental Staff Policy
H04 Policy and procedure for hepatitis B, hepatitis C and HIV screening for new and existing healthcare workers who undertake exposure prone procedures within a NHS setting
N01 Needlestick Policy and Guidelines
P19 Prevent Policy
C17 Conflict of Interest and Declaration of Interest Policy (Including Gifts, Hospitality, Sponsorship and Fit and Proper Persons)
A06 Annual Leave Policy - Medical and Dental
F09 Fundraising Policy
C10 Commercial Representative Policy

Appendix 1

EXECUTIVE REPORT

QUARTERLY REPORT ON NURSING AND MIDWIFERY STAFFING LEVELS

Quarter 1 – April to June 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 April through to 30th June 2017** and 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. During the reporting period fill rates were challenged by the need to open escalation (contingency) areas at short notice although this reduced in June.
- 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 recruitment due to the requirement for high pass rates in IELTs testing for both International and European recruits.

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, across the Trust the average actual level of Registered Nursing and Midwifery staff was generally within the levels planned across all shifts.

Whilst in June 2017 there were minimal contingency areas open, it was noted though that there was an increase in the amount of patients admitted requiring enhanced observations following risk assessments. The numbers of and rational for these are

reviewed and monitored daily by the Director of Nursing or her deputy and the Divisional Matrons.

We continue to explore new roles in order to address the national shortage of registered nursing staff. We will be introducing the role of Dementia Support workers, using the apprenticeship framework in September; these staff will support the delivery of quality care for Dementia patients on wards who are identified as requiring enhanced observation (specialling).

In April we have introduced to the Trust the role of 'Nursing Associates'; this new role is supported by a robust training programme which aims to develop a role that will bridge the gap between Health Care Assistants (HCA's) and Registered Nurses allowing them to deliver more hands-on care to the patient's bedside. The training programme commenced in April in association with the University of Bedfordshire as our academic lead.

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	
April	92.5	93.8	97.2	97.9	**95.35**
May	93.0	95.2	98.4	97.4	**94.90**
June	91.3	95.7	99.0	94.2	**95.05**

3.0 Staffing Management

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

Operational staffing meetings occur up to 3 times a day in order to rectify staffing challenges in a timely manner. These are chaired by the Director or Associate Director of Nursing & Midwifery. 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 unit managers, Matrons and the Director/Associate Directors of Nursing.

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.

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 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. .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. During June there was an increase in the amount of care hours per patient day. This is directly attributable to the amount of beds occupied during the month. There were decreases in bed occupancy across EAU2, EAU1, and Ward 34. On ward 11 there was often the requirement for a Registered Mental Health Nurse to provide enhanced observations. This has meant that the amount of care hours has increased for that ward. 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.

Table 2 demonstrates the CHPPD per ward over the quarter

Care Hours per Patient Day 2017

	Apr-17	May-17	Jun-17	Average
Cobham	7.2	6.7	7.4	7.1
SCBU/NICU	13.0	13.8	13.9	13.6
Paediatric Wards 25	10.6	11.7	11.7	11.3
Paediatric Wards 24	11.7	9.7	11.5	11.0
Ward 19b	5.3	5.4	5.4	5.4
Ward 19a	6.0	6.7	6.7	6.5
Ward 14	5.4	6.4	6.3	6.0
Ward 15	5.4	5.7	6.2	5.8
Ward 17	7.8	7.6	7.5	7.6
Ward 18	6.5	6.9	6.7	6.7
Ward 16	5.7	5.1	5.2	5.3
CCU	8.0	8.1	8.8	8.3
Ward 12	6.0	6.1	6.1	6.0
Respiratory Ward (Ward 10)	5.3	5.4	5.7	5.5
Ward 11	5.7	5.7	6.3	5.9
EAU 2	8.4	8.6	9.4	8.8
Ward 3	6.2	7.0	6.8	6.7
Ward 34 (Gynae)	7.2	7.1	8.1	7.5
Ward 33 (Maternity)	7.1	7.2	7.0	7.1
Ward 32 (Maternity)	7.5	7.4	7.2	7.4
ITU	30.9	30.0	37.5	32.8
HDU	17.5	19.0	20.5	19.0
Ward 23	6.3	7.0	6.7	6.7

EAU 1	10.3	11.8	13.3	11.8
Ward 22	5.9	6.3	6.1	6.1
Ward 20	5.6	5.8	5.9	5.8
Ward 21 (SAU)	7.3	7.1	7.3	7.2
Average	**8.5**	**8.7**	**9.3**	**8.8**

5.0 Vacancies and recruitment activity

In collaboration with the recruitment team, proactive recruitment activity continues with both targeted and expedient campaigns running monthly. Activities over the last month have included (but not limited to) attendance at university careers fairs, Army recruitment campaigns, use of social media, radio advertising and involvement with schools and other businesses across Bedfordshire as part of the Luton Ambassador Enterprise network.

We continue to see success from our local measures we have implemented to increase the pass rate of our international nurses sitting the OSCE examination. We currently have a 90% pass rate on first sitting of the exam. This remains well above the national average of 40%. As a result of this high pass rate, we continue to be contacted from other overseas nurses across England who wish to work with us.

We have also identified the number of Registered Nurses who trained overseas who are working with us in a Health Care Assistant capacity who could enter the nursing register following support with their English language test (IELTs). We have now commenced providing in hospital teaching to these staff members following pre-assessment. We hope to see these staff successfully pass their test and register with the NMC commencing employment with us as Registered Nurses.

The Trust Nursing and Midwifery teams note that as we move towards the winter periods, we often require higher levels of staff due to contingency areas being open and the need to continue to deliver quality care. The Assistant Director of Nursing has commenced work with the Senior Staff to plan for this period.

Vacancies

We have a number of Nursing and Midwifery students qualifying in September. They are encouraged to apply up to 12 months prior to course completion. Conditional offers are made and their place of employment negotiated. Many of our student nurses also work as bank Health Care Assistants during their training. We hope that this will go some way to address the shortages.

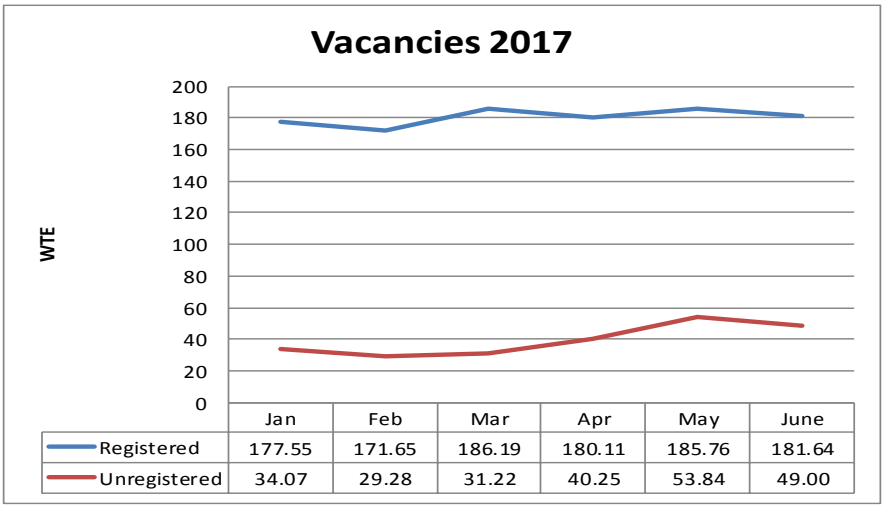
Table 3 demonstrates the existing vacancies in the units as of 30th June 2017. This reflects the vacancies as they appear without accounting for staff going through recruitment or on maternity leave, data from January 2017 to present so that trends in vacancies can be shown.

Although it appears that there has been a minimal reduction in Registered and Unregistered vacancies since May 2017 we should note that the staffing for the additional Hematology/Oncology ward which is due to open on the 10th July 2017 has been included.

Despite the high numbers of vacancies there are significant amounts of staff going through recruitment. It is anticipated that 50 WTE Registered Staff will commence in post before 2018.

In the spirit of STP working the nursing teams from Bedford and Milton Keynes Hospitals continue to share with us ideas and experiences on recruitment and retention initiatives.

Table 3 Actual Trust Registered and Unregistered Vacancies 2017 (WTE)



	Jan	Feb	Mar	Apr	May	June
Registered	177.55	171.65	186.19	180.11	185.76	181.64
Unregistered	34.07	29.28	31.22	40.25	53.84	49.00

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 wards

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)
April	**Day**		**Night**			**Comments**
Ward 18	70.0	96.5	95.8	99.2	6.5	This ward has had a high demand for HCA enhanced care. Existing HCAs on shift were redistributed to ensure this was supported.
CCU	83.0	97.1	98.9	97.0	8.0	During April 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.
Ward 12	84.9	94.0	95.0	100.9	6.0	The ward has required an increase in requirement for Registered Mental Health Nurses to provide Enhanced Observation to patients. Ward Nurses provided this support when the shifts could not be filled
May	**Day**		**Night**			**Comments**
Ward 17	80.4	97.9	100.6	99.2	7.6	Whilst the team awaits new staff joining them the thrombolysis bleep holder and Lead Nurse has worked in the numbers to support the delivery of safe care
Ward 18	74.5	94.6	100	97.6	6.9	Ward 18 currently has a higher level of vacancy. The Ward Manager and Practice Educator have been working in the numbers in order to maintain quality patient care. Staff are currently being redeployed from within the division for a fixed period while recruitment is underway.
June	**Day**		**Night**			**Comments**
Ward 14	100.2	81.8	100.0	94.5	6.3	Wards 3, 14 and 15 have been experiencing an unusually high demand for staff to undertake enhanced observations. Substantive staff have been used to fill these duties where we were unable to fill the shifts. Cohort nursing has been used where appropriate following risk assessments
Ward 15	91.9	81.4	100.0	94.3	6.2	
Ward 3	98.3	94.6	101.0	84.1	6.8	

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)
Ward 16	80.9	99.1	95.0	99.0	5.2	Ward 16 has had a reduction in bed base in order to accommodate cardiology patients. However, during June 2016 the closed beds were used intermittently for medical outliers. It was difficult to fill these duties at short notice. Staff were redeployed from CCU to ward 16 to assist with care.
Ward 33	89.5	95.4	100.5	79.5	7.0	Maternity flexes staff around their units depending on the nature of patient activities. Recently there has been an increase in the amount of MCA vacancies. These have all been recruited to during an event held in June.
Ward 32	74.2	86.1	98.9	76.9	7.2	
Ward 18	72.6	92.4	97.5	98.3	6.7	Ward 18 currently has a higher level of vacancy. The Ward Manager and Practice Educator have been working in the numbers in order to maintain quality patient care. Staff are being redeployed from within the division for a fixed period while recruitment is underway.
Ward 17	81.2	104.9	98.9	96.0	8.6	Whilst the team awaits new staff joining them on 1.7.17 the thrombolysis bleep holder and Lead Nurse has worked in the numbers to support the delivery of safe care

Appendix 2

Report to Clinical Outcomes, Safety and Quality Committee
19 July 2017

Title	Patient Safety Alert - Nasogastric tube misplacement: continuing risk of death and severe harm (NHS/PSA/RE/2016/006)
Author	Karen Radley – Head of Clinical Risk and Governance
Responsible Director	Marion Collict – Director of Operations, Risk and Governance Robin White – Medical Director – Risk and Governance
Purpose	This report informs the members of COSQ of details of the Patient Safety Alert, the key findings of the Trust's assessment and the main actions that have been taken. The paper provides assurance of the controls in place to mitigate the risk of severe harm and death from nasogastric tube misplacement.
Action required	To note the report and support the ongoing actions. To agree the content for presentation to Public Board.
LINK TO CORPORATE OBJECTIVES AND RISK	
Corporate Objectives this paper relates to	1. Deliver Excellent Clinical Outcomes (Quality) 2. Improve Patient Safety (Quality) 4. Deliver National Quality and Performance Targets
Key risks - state risk ID and risk as stated on the Risk Register	

Introduction

On 22nd July 2016 NHS Improvement issued a Patient Safety Alert 'Nasogastric Tube Misplacement: Continuing Risk of Death and Severe Harm'.

The use of misplaced nasogastric and orogastric tubes was first recognised as a patient safety issue by the National Patient Safety Agency (NPSA) in 2005 and three further alerts were issued by the NPSA and NHS England between 2011 and 2013.

Fine-bore nasogastric tubes are passed through the nasal cavity down the back of the throat and through the oesophagus to the stomach and are used to deliver medication, fluid or liquid feed. Orogastric tubes are passed through the mouth down the back of the throat and through the oesophagus to the stomach and are used to deliver medication, fluid or liquid feed.

Orogastric tubes are used primarily in newborn babies, as older infants, children and adults would tend to bite any tube sited through this route or displace it through tongue movement, but they may be used for these patients in very rare circumstances.

Introducing fluids or medication into the respiratory tract or pleura via a misplaced nasogastric or orogastric tube is a Never Event. Never Events are considered 'wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

Between September 2011 and March 2016, 95 incidents were reported to the National Reporting and Learning System (NRLS) and/or the Strategic Executive Information System (STEIS) where fluids or medication were introduced into the respiratory tract or pleura via a misplaced nasogastric or orogastric tube. While this should be considered in the context of over 3 million nasogastric or orogastric tubes being used in the NHS in that period, these incidents show that risks to patient safety persist. Checking tube placement before use via pH testing of aspirate and, when necessary, x-ray imaging, is essential in preventing harm.

A review by NHS Improvement of investigations into the incidents suggested problems with organisational processes for implementing previous alerts. Some of the implementation issues identified were:

- problems with systems to ensure staff who were checking tube placement had received competency-based training
- problems with ensuring bedside documentation formats include all safety critical checks
- problems maintaining safe supplies of equipment, particularly radio-opaque tubes and CE-marked pH test strips

The recent Patient Safety Alert was therefore directed at trust boards and the processes that support clinical governance. It was not directed at frontline staff.

The actions required were to:

1. Identify a named executive director who will take responsibility for the delivery of the actions required in this alert.
2. Using the resources supplied with this alert, undertake a centrally coordinated assessment of whether your organisation has robust systems for supporting staff to deliver safety-critical requirements for initial nasogastric and orogastric tube placement checks.
3. If the assessment identifies any concerns, use the resources supplied with this alert to develop and implement an action plan to ensure all safety-critical requirements are met.

4. Share this assessment and agree any related action plan within relevant commissioner assurance meetings.
5. Share the key findings of this assessment and the main actions that have been taken in the form of a public board paper.

Compliance and Assurance against required actions:

1. The named Executive Director from February 2017 was Ms Sheran Oke, Acting Director for Nursing and Midwifery. Prior to this date the Executive Lead was Ms Patricia Reid, former Director of Nursing and Midwifery.

2. The Head of Clinical Risk and Governance worked with the Nutritional Nurse Specialists for Adults, Paediatrics and Neonates, along with the Learning and Development Team, Imaging Team and Consultant Gastroenterologist, to produce a coordinated assessment of Trust systems. A gap analysis technique was used to compare the Trust's compliance against the safety critical requirements detailed in the resource set issued with the alert.

3. Assurance of actions to ensure all safety critical requirements have been/are being met:

Safety Critical Requirements	Action/Assurance/Compliance
Local policies and protocols need to reflect all the safety critical requirements	Adult Policy has been revised and is due for ratification on 19 July 2017
Safe Equipment: Tubes used for feeding must be radiopaque throughout their length and have externally visible length markings pH paper must be CE marked for use on human aspirate	Procurement decisions and clinical supply system would 'block' any accidental ordering of non-compliant alternatives Tubes and pH paper not meeting the safety critical requirements have been removed from all clinical areas
Competency-based training needs to reflect all of the safety critical requirements	Local training programme has been updated to incorporate all the safety critical requirements. A competency checklist has been developed. The Training and Education Department, are working with Nutrition Nurse Specialists, to develop a rolling theoretical and practical learning programme to ensure all clinical staff who confirm nasogastric tube placement have been assessed as competent.
Clinical documentation formats and checklists	The amended naso-gastric care bundle includes more thorough pre-assessment, insertion record and ongoing position check documentation. Documentation with the 4 safety criteria on anatomical position checking of x-rays is being

Safety Critical Requirements	Action/Assurance/Compliance
	introduced for medical staff to complete if x-ray required on insertion or subsequently.
Ongoing audit of compliance	Clinical audit built into Trusts audit programme.

4. Assurance is provided quarterly to the Trusts commissioners within the Quality Monitoring Report.

5. This paper will be shared at the Trust Board on 26th July 2017.

Bedfordshire, Luton and Milton Keynes Sustainability and Transformation Plan

Central Brief: June 2017

Issue date: July 2017

News

Richard Carr appointed as STP lead

The Chief Executive of Central Bedfordshire Council, Richard Carr, has been appointed the Senior Responsible Officer for the Bedfordshire, Luton and Milton Keynes (BLMK) Sustainability and Transformation Plan (STP).

Richard, who had previously acted as deputy lead for the programme, was invited by NHS England to take up the role after Pauline Philip, who has led the BLMK STP since March 2016, became the national lead for Urgent and Emergency Care in April.

Pauline will continue to be actively involved in the plans as Chair of the programme and will work closely with the leadership team.

Along with the role of Senior Responsible Officer for BLMK STP, Richard is also the Executive Lead for the multi-agency Chief Executive's Group which contains each accountable officer from all 16 of BLMK's partner organisations.

Richard's additional responsibilities for the programme will not affect his substantive role as Chief Executive of Central Bedfordshire Council and will help to ensure the continued participation of the four local authorities alongside the 12 health service providers in the development of the plans for BLMK.

Nina Pearson appointed as STP GP Lead

Dr Nina Pearson, Chair of Luton CCG, has been appointed as the GP for BLMK STP.

She will be supporting the development of resilient primary care across the region and helping to engage clinicians in General Practice in the development of plans not only in primary care but across the whole health and social care system.

In the coming weeks and months, Nina will be visiting the many different primary care forums across BLMK to meet staff and discuss ideas about improving the lives of both patients and staff.

BLMK announced as one of eight accountable care systems

Bedfordshire, Luton and Milton Keynes was been named as one of eight health and social care systems in the country to become an Accountable Care System announced by national health regulators in June 2017.

The introduction of Accountable Care Systems (ACS), announced in the NHS 'Next Steps on the Five Year Forward View', will see local health and care organisations supported by NHS England and NHS Improvement to work more closely together to provide joined up, better coordinated care.

The eight named ACSs have agreed with national leaders to deliver fast track improvements which include reducing pressures on A&E, investing in general practice to make it easier for patients to get a GP appointment, and improving access to high quality cancer and mental health services.

BLMK have drawn up outline plans for an integrated approach to commissioning for the whole population and these are being submitted to partner organisations for review, with a view to formalising arrangements in 2018/2019.

Health and Wellbeing

Diabetes

Bedfordshire, Luton and Milton Keynes is one of 13 new areas in the country to offer the NHS Diabetes Prevention Programme to patients identified at risk of developing Type 2 diabetes with the programme, rolling out across BLMK from June. Those referred by their GP to the 'Healthier You' programme will get tailored, personalised help to reduce their risk of Type 2 diabetes including education on healthy eating and lifestyle, help to lose weight and bespoke physical activity programmes, all of which have been proven to reduce the risk of developing the disease.

Engagement with the prevention programme in BLMK has been impressive with hundreds of referrals since May. The first prevention courses will run from the first week of July at various venues across the BLMK footprint.

Additionally, BLMK was successful in its bid for additional funding to support diabetes treatment and care across the region. The investment will see change and investment in four key areas:

- increasing the uptake of structured education to help people look after themselves and stay healthy. This can improve glycaemic control and psychosocial wellbeing. Structured education is designed to help both people newly diagnosed with diabetes and people with established diabetes to ensure that they are well informed and know how to look after themselves and stay healthy. The number of places offered will increase from 54,000 to 148,000.

- improving achievement of the NICE recommended treatment targets for controlling blood sugar levels, blood pressure and cholesterol. This can reduce the risk of complications such as kidney disease, blindness, limb amputation, strokes and heart attacks.
- reducing the number of amputations by improving access to multi-disciplinary foot care teams in 50 parts of the country.
- reducing lengths of hospital stays by improving access to specialist inpatient access in 60 hospitals across England.

A&E investment

Both Bedford Hospital and Milton Keynes University Hospital were allocated just under £1 million each by the Department of Health to help ease pressure on their emergency departments ahead of the busy winter period in 2017/18.

Seventy hospitals were allocated a share of £55.98million of capital funding for A&E, which was outlined in the spring Budget2017 by the Chancellor.

Bedford and Milton Keynes were awarded £850,00 and £995,000 respectively. The funding will be used by hospitals to meet the 95% standard of admitting, transferring, or discharging patients within four hours by ensuring patients are treated in the most appropriate setting.

Finance

Capital bids

The STP has been actively involved in trying to secure the maximum investment into our systems from a wide variety of sources. Building on successful bids for investments in Primary Care technology and estates development last year, BLMK has worked together to assemble a coherent and well argued case for strategic investments: to make a step-change in our digital infrastructure; and also to resolve many of the fragmented estate issues within health care settings, and make them fit to support modern models of care. This is the start of ongoing process but we are using our aggregated voice to support the approach, believing that together we can achieve more.

Collaborative Investment and Savings Programme (CISP)

Six of Bedfordshire, Luton and Milton Keynes Sustainability and Transformation Plan's (BLMK STP) partners have initiated the start of a Collaborative Investment and Savings Programme (CISP) to identify opportunities that could be adopted across the STP footprint that will improve outcomes for patients and address the savings challenge within the system in the current and next financial year.

The six partners are:

- NHS Bedfordshire CCG
- NHS Luton CCG
- NHS Milton Keynes CCG
- Bedford Hospital NHS Trust
- Luton & Dunstable University Hospital NHS Foundation Trust

- Milton Keynes University Hospital NHS Foundation Trust

The programme has now expanded to work with all 16 partners and many GP practices in the region. The Collaborative Investment and Savings Group (CISG), who oversee the work of this programme, has now also been widened to become part of the weekly meeting of BLMK's 16 chief executives to ensure full collaboration across each and every partner.

The next step of this programme is to focus on four key interventions where BLMK STP believe the biggest and quickest impact to patient experience and outcomes can happen through rapid clinical process improvements and deployment. These are: Complex Care; Transitions of Care; Primary Care Home and Paediatric Non-elective pathways.

Transitions of Care (ToC): focusing on patient flows into and out of hospital, length of stay and consistency of the discharge process and checklist across care delivery across the BLMK patch.

Complex Care (CC): starting with a focus on improving the management of care and non-elective admissions and length of stay for individuals in nursing and residential care homes.
Primary Care Home (PCH): as an enabler for organisational scale, patient access, (MDT working), and primary care alignment.

Paediatric Non-Elective Activity: investigation to understand the hotspots of inappropriate utilisation and outcomes.

Four intervention teams will lead the work in each of these four areas. Those selected will be asked to carry out this work as part of their current roles and utilise their expertise and insights to ensure the programme achieves better care, better value and better patient experience. The work will be in six-week cycles to ensure rapid progression and delivery.

Engagement

Primary Care Event

Over 120 clinician from primary, community and social care – the majority GPs – attended a interactive event in Milton Keynes in May.

The event delivered insightful presentations from local clinicians and the NAPC lead for the Primary Care Home model and offered attendees the chance to rotate around 14 different working groups, such as Mental Health, Clinical Pharmacy, Digital, Estates and Extended Access, where they were able to discuss specific innovations and interventions with a subject matter expert.

The views and opinions of attendees were captured at each of the working groups and this feedback has been taken by the Primary, Community and Social Care priority team to identity the support local clinicians require to improve and transform out-of-hospital care.

Clinical Conversation

Continuing the successful Clinical Conversation series – over 400 senior clinicians have attended four previous events – the next conference takes place on Thursday 3 August at Wyboston Lakes in Bedford.

Invitations have been sent to all GPs, senior clinicians and health and social care leaders across all 16 BLMK organisations to see presentations from Sam Everington, chair of Tower Hamlets CCG, about his award-winning work in Primary Care and Dr Navina Evans, Chief Executive of ELFT, discussing the role mental health has to play in the BLMK STP.

What we've heard so far

A report detailing over 1000 views gathered at a variety of staff and public engagement events and an online questionnaire was published on the BLMK website at the beginning of July. These views were gathered following the publications of the secondary care 'Discussion Paper' in March.

The 'What we've heard so far' document was shared with all event attendees and staff across BLMK's 16 partner organisations to ensure an open and transparent feedback process.

All of the feedback recorded in the document was also shared with the team of clinicians working on the STP's sustainable secondary care priority and will inform further thinking on hospital services in BLMK. This team are now working on a 'Case for Change' which will set out why a transformation of these services of needed and some ideas as to how this could happen.

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

BOARD OF DIRECTORS

Agenda item	7	**Category of Paper**	Tick
Paper Title	Performance Reports	**To action**	☐
Date of Meeting	26 July 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	COSQ 19th July 2017, FIP 12th July 2017, 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

April, May & June 2017 data

Medical Directors

Director of Nursing and Midwifery

Director of Operations, Risk & Governance

Deputy Chief Executive

Safety Thermometer

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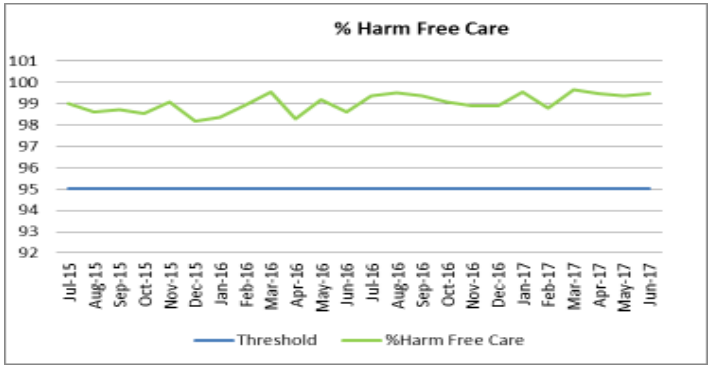

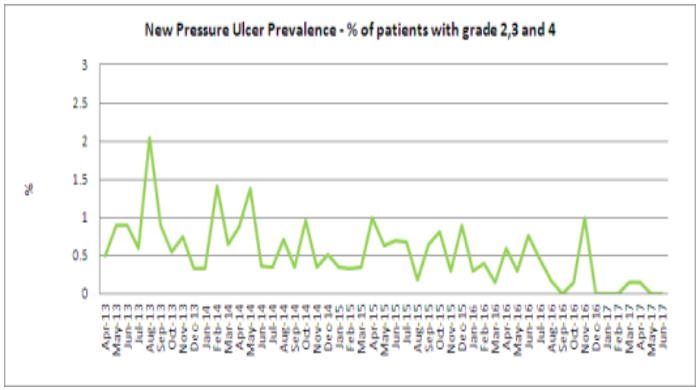

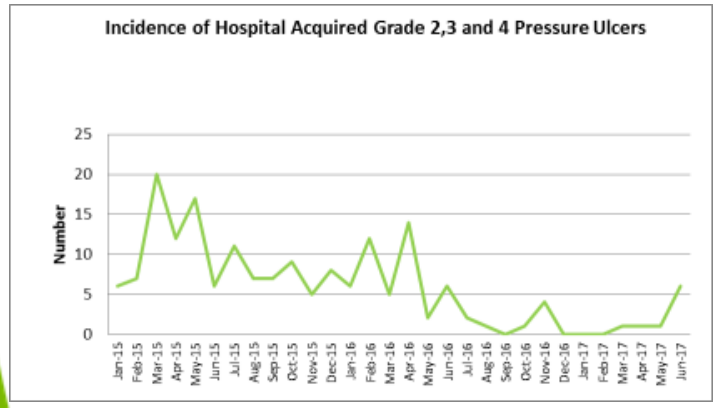

New Harm Free Care

The Trust has continued to deliver high levels of care free from new harm to our patients reporting 99.5% in April, 99.38% in May and 99.49% in June. We have had four consecutive months at more than 99%, with nine months in the past year at this high rate.

Pressure Ulcers

There was one avoidable category 2 hospital acquired pressure ulcer in April and no category 2 damage in May. A category 3 pressure ulcer was reported in May but found to be unavoidable.

June saw an increase in hospital acquired Category 2 pressure ulcers. Five pressure ulcers on 4 patients were confirmed as category 2 damage. Following root cause analysis 4 pressure ulcers were deemed unavoidable and 1 was assessed as avoidable.

The Tissue Viability Service continues to provide increased visibility and educational support to ward areas and continues to review and monitor all hospital acquired pressure damage. 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. The Trust is also actively engaged with a county wide Pressure Ulcer Ambition Group set up by Luton community services to identify and reduce the severity and incidence of pressure ulcers across the health economy which includes the development of a new 'pressure ulcer passport'.

Safety Thermometer

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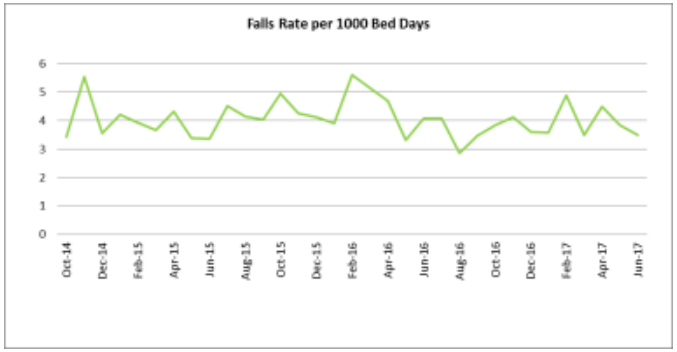
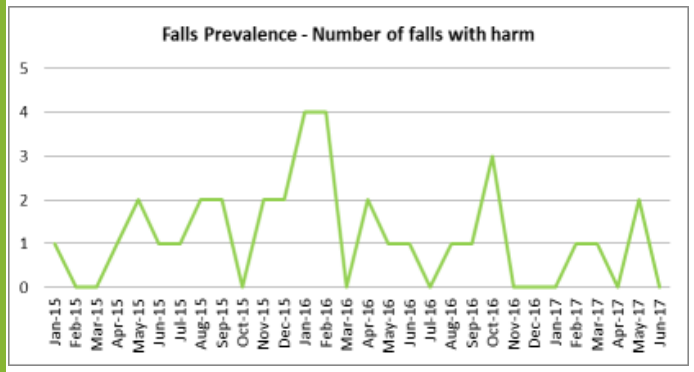
Falls





Patient Falls (incidence)

In **April, May** and **June (2017)** there were **87, 76** and **64 (227 in total)** inpatient falls respectively. The quarterly rate was 3.96 per 1000 bed days.

During **Q1** there were **6** falls that resulted in moderate and above harm, 2 of which are undergoing serious incident investigations. In both incidents the patients required surgery for hip fractures. Three other cases of harm were managed conservatively. One patient fall that resulted in a hip fracture was deemed to be unavoidable. All these incidents are being reviewed using root cause analysis and the learning will be shared across the Trust.

The new patient information leaflet on *Falls Prevention in Hospital* has been 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 data collection has been completed for an audit of "Appropriate assessment and use of bedrails". Analysis and final report is in progress. A future plan is for a bedrail audit to be completed on a monthly basis as part of the wards documentation audit on Meridian.

Actions from recent RCA investigations include:

*Focus on early identification of patients at high risk of falls and the appropriate interventions/risk reduction strategies.

*Monthly "Drop in" sessions led by multi-specialty Specialist Nurses have been launched and the first in May was well attended by DME nursing staff.

*Matron for Medicine is working with BLMK acute Trusts in the development of behaviour charts for patients who require enhanced observation. This will assist staff in responsive and appropriate care management.

*The patient information leaflet "Falls Prevention in Hospital" is to be included in the "Welcome Pack" pilot on EAU and SAU.

*The RCP National Inpatient Falls Audit data has been submitted. RCP report expected to be published in November 2017.

* Head of Patient Safety to revisit the nursing risk assessment documentation as part of the review of the new documentation.

*To develop a post fall proforma for both nurses and doctors to complete to ensure patients are managed appropriately after they have fallen. This will include guidance on patient examination , investigations required and actions to be taken.

Safety Thermometer

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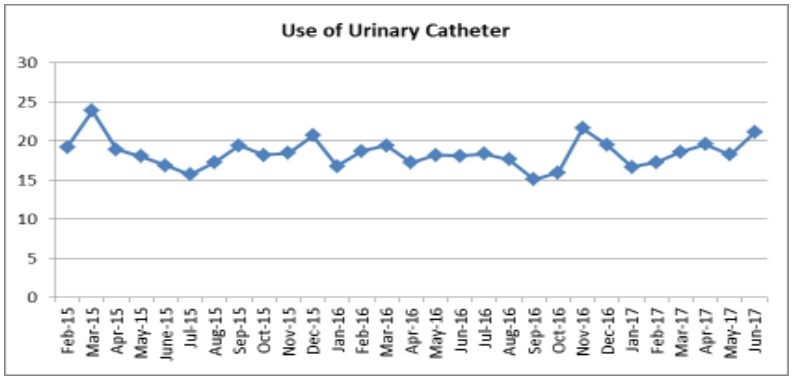
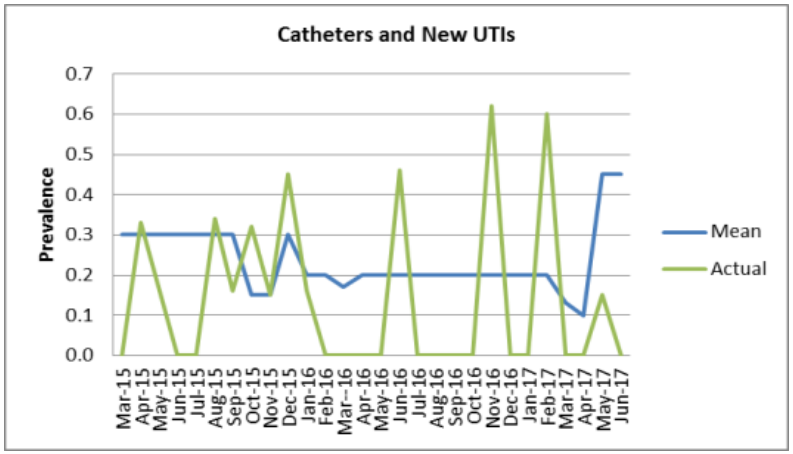
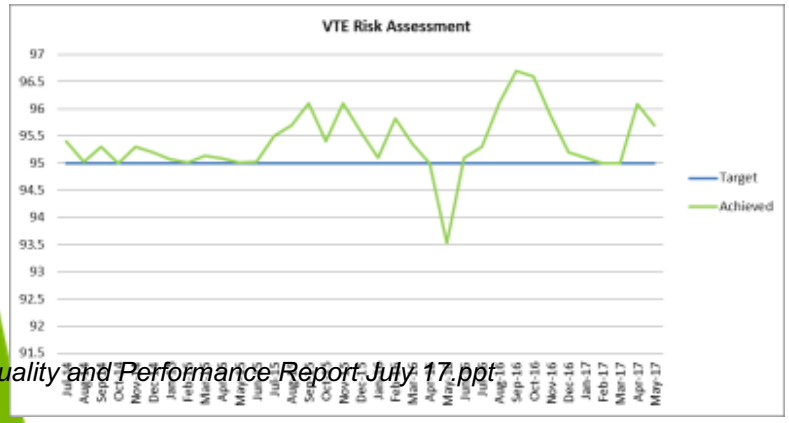
Catheter Acquired UTI





VTE



Use of Urinary Catheters:

The most common reasons for catheter usage continues to be accurate management of fluid balance and the management of urinary retention.

April has again seen a rise in catheter usage to 19.56%, which then reduced in May to 18.56% despite the admission rate being higher. In June there was rise to 21.06% attributed to on-going high acuity of patients and a number of maternity patients who required a short term catheter during childbirth (six). There has also been an increase in the number of patients admitted with long term catheters.

The Continence CNS continues to ensure that ward teams are reviewing and removing catheters when they are no longer clinically needed.

In April and June there were no CAUTI's reported or identified using the ICNET computer system. In May, one CAUTI was reported and then validated by the Continence CNS . A root cause analysis has been completed and fed back to the ward team. The learning focused on documentation of both the insertion and on-going catheter management.

VTE Risk Assessment:

The compliance with VTE risk assessment was 96% for April and 95.7% for May.

Continual feedback is provided to all clinical teams regarding outstanding risk assessments on a daily basis. This has been provided at speciality level for Surgery. The focus of the improvement activity during the quarter has been to improve the process - encouraging the doctors to complete the risk assessment on admission with the admitting doctor completing the risk assessment.

The electronic VTE risk assessment will be rolled out Trust-wide, rather than piloted in Medicine as originally planned. The planned date for this has had to be moved back to ensure that appropriate discussions are held with the relevant clinicians, to ensure effective engagement, to secure a successful rollout.

Infection Control

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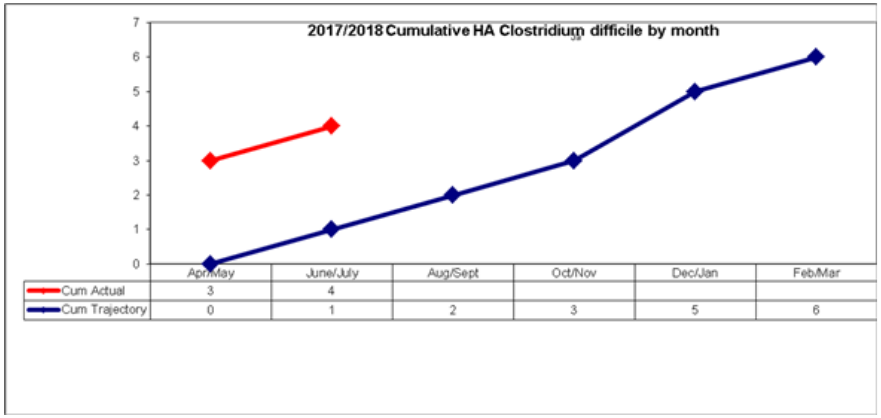
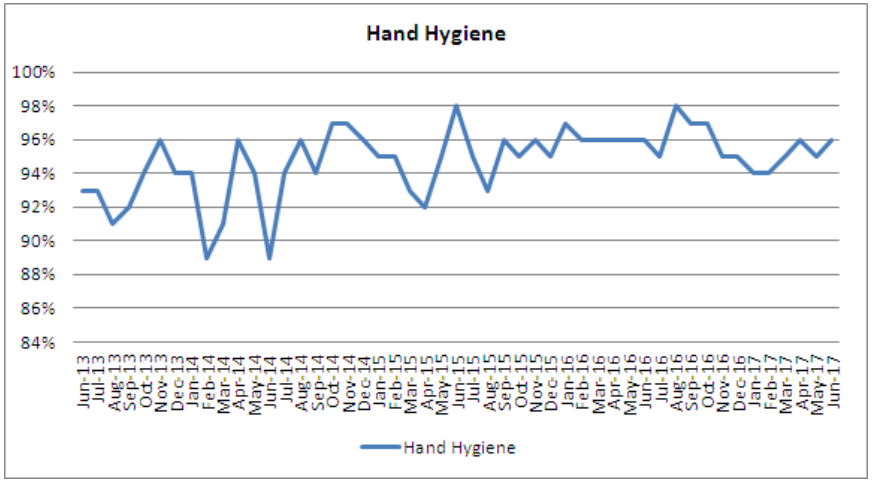
MRSA and C.Difficile

Hand Hygiene

	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	Apr-17	May-17	Jun-17
C Diff	1	0	2	1	1	1	1	3	0	0	1	1	0	2	2	0	1	0	0	2	0	0	0	1	2	1
MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0





Hand Hygiene – The updated observational hand hygiene tool and reporting via the meridian tool has been implemented and the improvement seen in the quality of data collection is encouraging. Guidance and support continues to be provided by the Infection Control Team with reminders and examples provided during observations. Learning from the e-monitoring hand hygiene project was shared at the annual ICLP day in June and at the IC Master class in May 2017.

C.difficile – The Trust ceiling for *Clostridium difficile* infection is unchanged at 6 cases (hospital acquired) for the year April 2017 to March 2018.

To date we have recorded 4 cases of hospital acquired *C.difficile* infections. Typing to date has not identified any link between cases. The ICT is appealing against 1 hospital acquired case for the last quarter, the outcome of which will be reported in the next report.

MRSA bacteraemia – There have been no instances reported during the quarter.

Cardiac Arrest Rate

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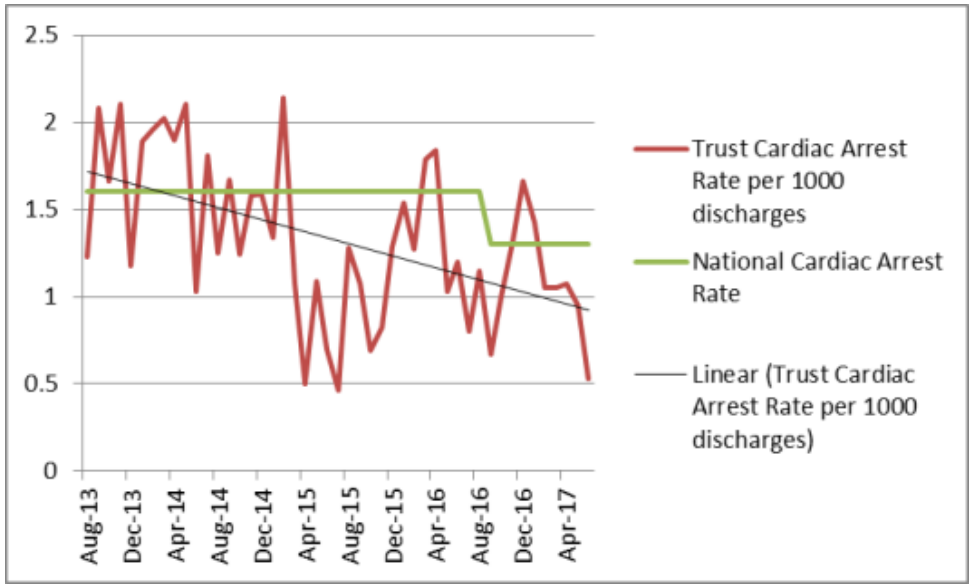

Over the last 6 months (Jan - Jun 17) the average Cardiac arrest rate has been 1.0, compared with a rate of 1.445 in the same period last year.

Improvement activities

The main improvement focus continues to be on ensuring that all wards have a comprehensive approach to monitoring all patients in order to ensure that deterioration is noticed and acted upon as soon as it occurs. The Patient Safety Team continue to monitor whether observations are being completed according to protocol, and work with wards to develop individualised improvement plans.

In addition, cardiac arrest reviews have also highlighted that there are opportunities to improve our processes around developing Treatment Escalation Plans. Potential missed opportunities are always discussed with the relevant clinicians.

Patient Experience

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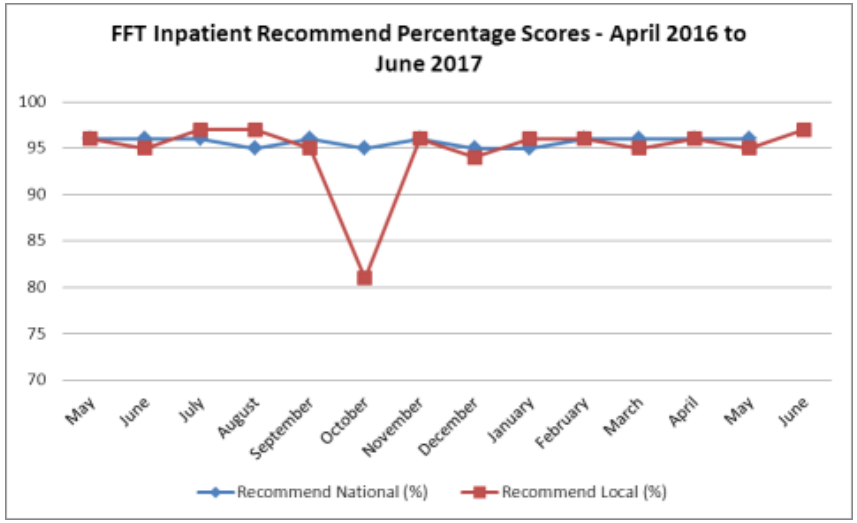
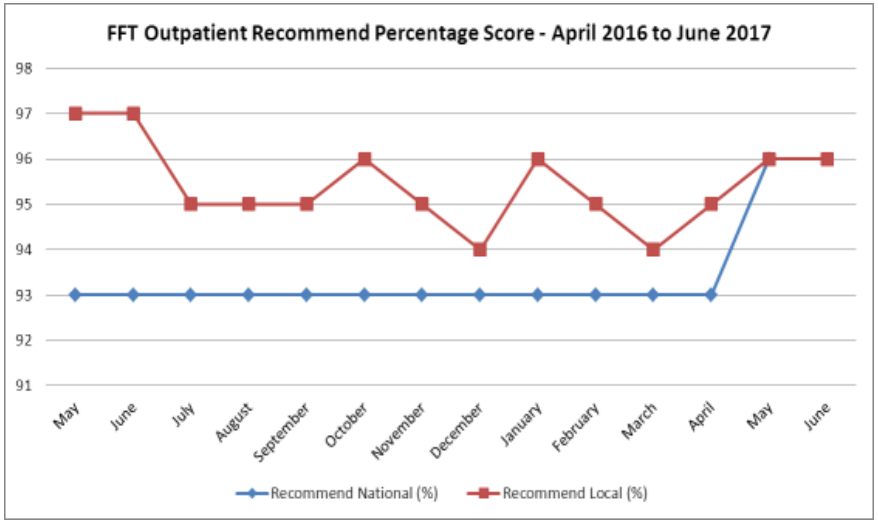
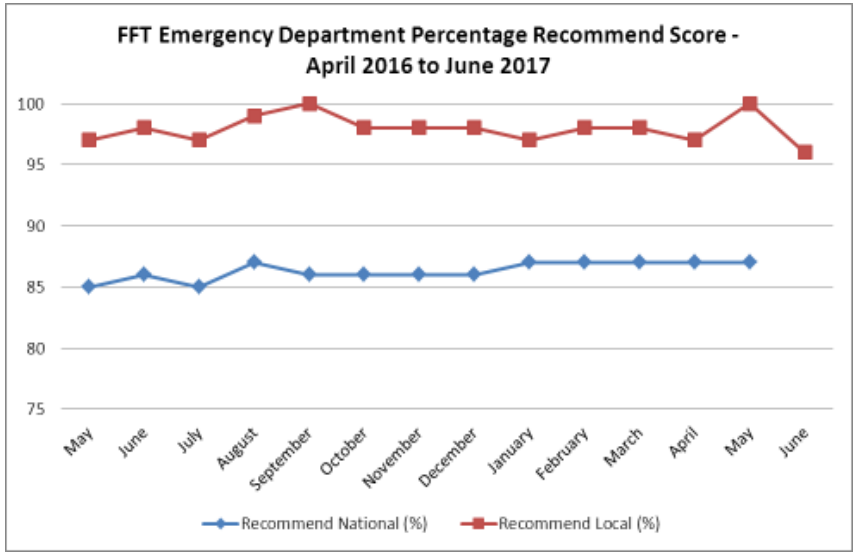
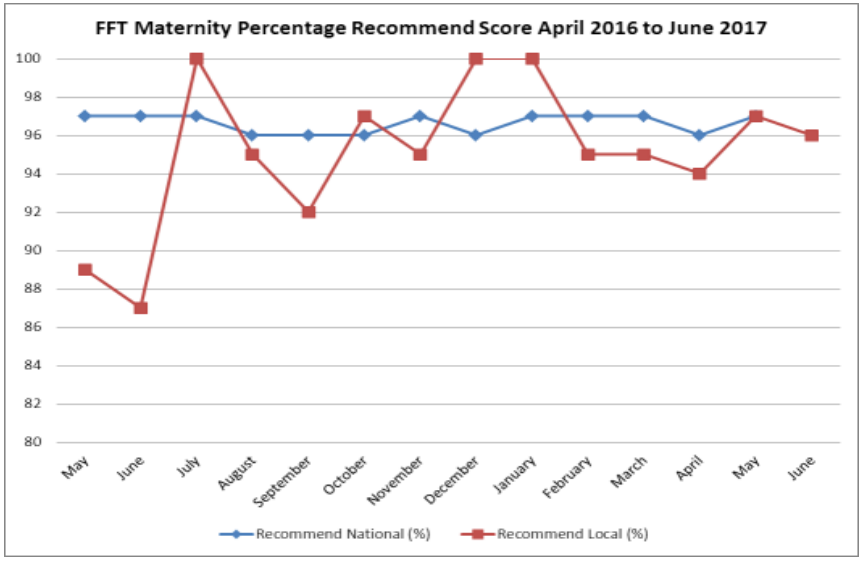
The Friends and Family Test (FFT) is a National Initiative, the scores are published each month by NHS England enabling benchmarking against other Trusts in England. The FFT asks the specific question ***'how likely are you to recommend our service / ward / birthing unit to friends and family if they need similar care and treatment'*** to every patient who has experienced a service from the Trust.









National comparison data for June will be published by NHS England in August 2017

Patient Experience

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National Patient Surveys 2016

Inpatient Survey: This has been presented to a number of forums within the Trust and will also feature as part of the Good, Better, Best Event 2017. Posters are being prepared for display around the Trust so that staff, patients and the public can view the results and get involved in quality improvements.

A&E Survey: The full management report has been received and is undergoing analysis and action planning.

Children and Young People's Survey: Initial Survey results received. They cannot be easily compared with the previous survey completed in 2014, as the number of questions has increased and the age groups have changed. The team will undertake a thematic review and triangulate the information with the previous actions plan and feedback received from the monthly FFT results. Full management report due mid July

Maternity Survey: Initial Survey results due 5th September 2017
Full management report early October.

Patient Experience Improvement Activity

- Service user involvement in the development of the quality improvement strategy and in the interviews of PALS officer.
- Results from the enhanced inpatient survey have been shared with Nursing and Midwifery Board. Sisters to attend QPM with their actions to improve based on real time patient feedback.
- Patient and Public Participation Group will have their own Event in the Tent, where they will review the Patient Welcome Booklet, as well as have awareness sessions about the Carers Lounge and Patient Ambassador post
- Development of 'Hello My Name Is' initiative to help address communication issues. Early adopters identified within the Trust.
- Increasing use of patient stories as they are a powerful catalyst for change and help to contextualise, inform and energise improvement activity. Stories are a valuable addition to quantitative measures of patient experience.

PALS (Patient Advisory and Liaison Service)

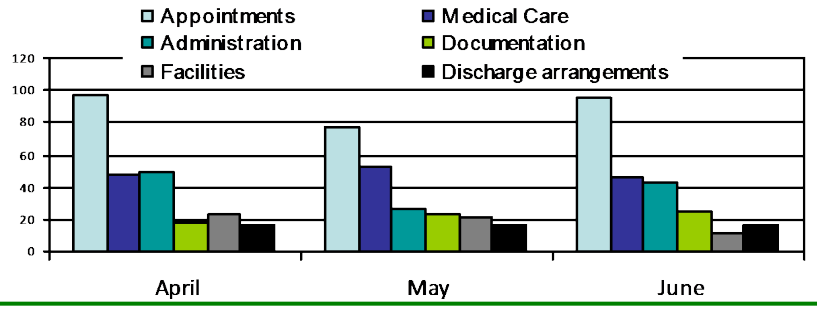
Method of Contact (Reported on Datix)

	Face to face	Emails	Telephone calls	Other calls not recorded on datix
April 2017	121	120	81	93
May 2017	82	149	75	151
June 2017	107	120	92	110

The data above shows that telephone calls continue to be the most common method for contacting PALS and issues with appointments (various issues)are the most common reason (see graph below)

PALS **resolved 864** queries in Q1; **56** were **pending resolution**; **30 complaints** were redirected to Patient Affairs at the patient's request.

Reason for contacting PALS Q1 2017



Interpreting Services

Polish interpreting continues be the language most commonly requested

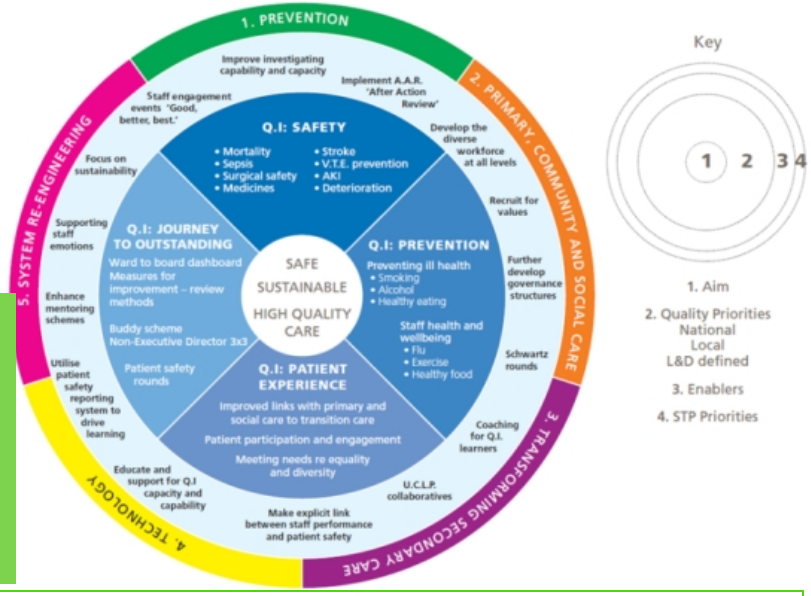
The plan is to use telephone interpreting as the default for all appointments. Technical issues with telephones in Outpatients are a challenge which needs resolution. Work is in progress to address this

Type of Appointment

	April	May	June
Face to face	428	521	511
Tele-Phone	61	50	47

CQC

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



Development of a Quality Improvement Strategy and Support Network:
Engagement events have been held to progress our ambition to create a vision and strategy for Quality Improvement. A wider stakeholder event took place on 27th June including a wide range of staff and service user representatives. The patients' perspective will be firmly embedded in the Trust approach to QI.

The Good, Better, Best staff engagement event in the Tent was used as a platform to share the plans to deliver a more cohesive approach to QI and set this in the context of the journey that the Trust is on following our CQC and IHI feedback.

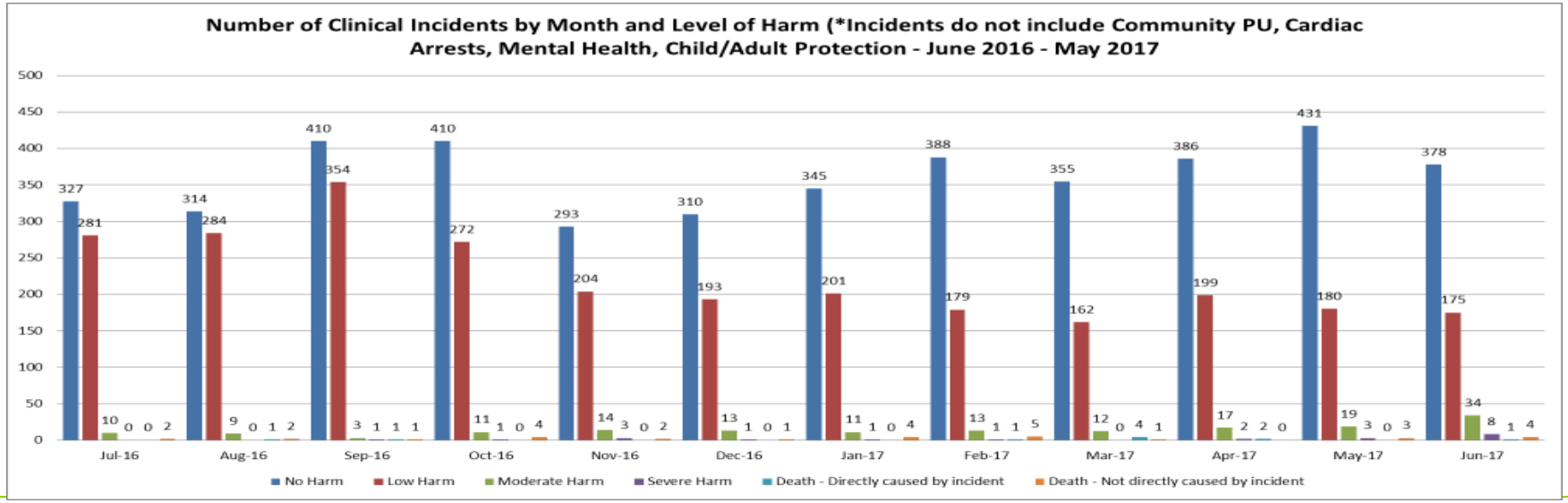
Staff and patient representatives, were invited to sign up to join a number of initiatives:
A review of the Trust values in order to further build a culture of improvement which values the experiences of our patients and staff;
To become the Trust's early adopters of the "hello my name is" campaign to improve communication and the development of our relationships with patients;
To join the team to provide education, coaching and mentoring to those who need support for QI;
All staff were asked to identify how they could make a difference in their own area of work and to seek guidance to take those ideas forward.

- 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.

- The focus of recent Back to the Floor Fridays has been very much on patient experience

A number of initiatives are underway to ensure that the Trust continues to be responsive over time. These include:
- The launch of an enhanced real time patient experience survey in June 2017.
- The development of a new Nursing and Midwifery Strategy 2018-2021 to be launched in May next year.
- The Patient Ambassador role to be implemented by September 2017.
- The first event to celebrate QI across the trust is being planned.
- A QI email address and twitter hashtag to promote wider modes of communication to enable easier staff involvement.

Incidents



Incident reporting: In Q1 a total of 3526 incidents were reported via the Datix Incident reporting system of which 1842 were clinical related.

The top clinical incidents in Q1 were medication errors, inpatient falls and hospital acquired skin damage (moisture lesions/pressure ulcers). These are consistently the top 3 reported incidents.

The graph above provides details of the number of clinical incidents reported per month by level of patient harm.

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 investigations (71.69% overdue at 04/07/17). This data 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 or 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, and including April 2017. The Trust has declared 100% compliance across each of the reporting months.

Serious Incidents

Safe | Effective | Caring | Responsive

In Q1, **11** Serious Incidents, including **2** Never Events, were declared by the Trust:

	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*
2017/18	4	7	0										11

- Inpatient fall resulting in cerebral bleed (patient death)
- Inpatient fall resulting in cerebral bleed and hip fracture (patient death)
- Inpatient fall resulting in hip fracture (severe harm)
- Grade 4 pressure ulcer under splint (severe harm)
- Delayed diagnosis of cord compression (severe harm)
- Breech delivery with fetal head entrapment (severe harm)
- CTG monitoring delay - neonatal resuscitation (severe harm)
- Never Event - Insulin overdose – use of incorrect device (moderate harm)
- MRSA Bacteraemia (low harm)
- Never Event - Wrong site anaesthetic block (no harm)
- Information Governance Breach – Level 2 (no harm)

---

1 Serious Incident investigation report was submitted to Luton CCG in the reporting quarter. The deadline for submission was met.

The investigation looked into an anaesthetic complication when a bilateral tension pneumothorax occurred during jet ventilation, resulting in hypoxic brain damage to a 38 year old female.

The learning from the investigation includes:

•If a key member of staff is unavailable for a difficult procedure, a replacement with an appropriate level of skill should be found, or the procedure postponed;

•The results of relevant investigations, such as the CT scan on this occasion, should be easily available to anaesthetists at the time of pre-operative assessment;

•Whenever possible an interpreter should be obtained for patients who cannot speak English. There should not be a reliance on relatives to interpret;

•All team members should be present at the pre-operative 'theatre huddle';

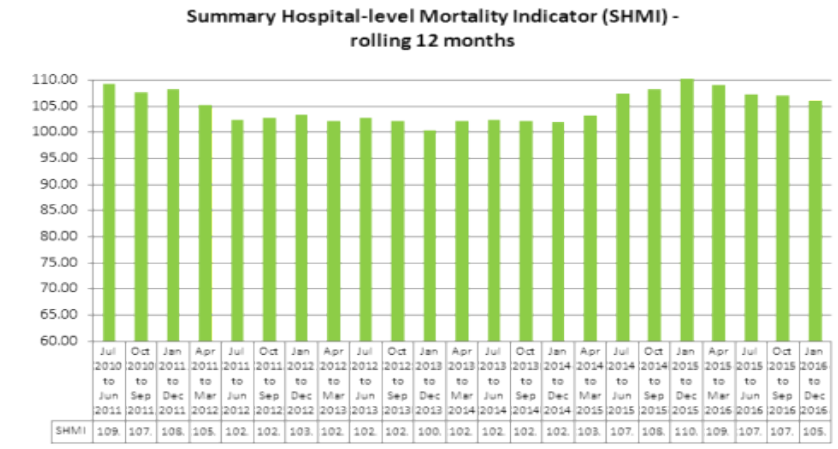
•When a critical incident occurs in the operating theatre, the relevant data must always be downloaded from the anaesthetic monitor.

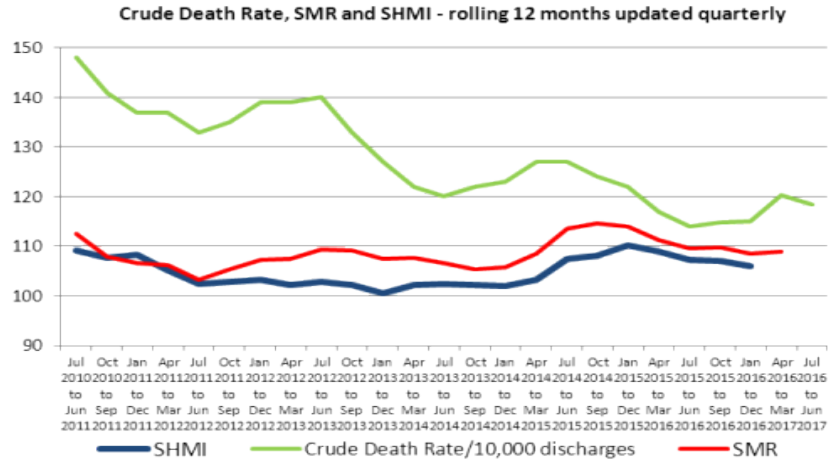
Mortality

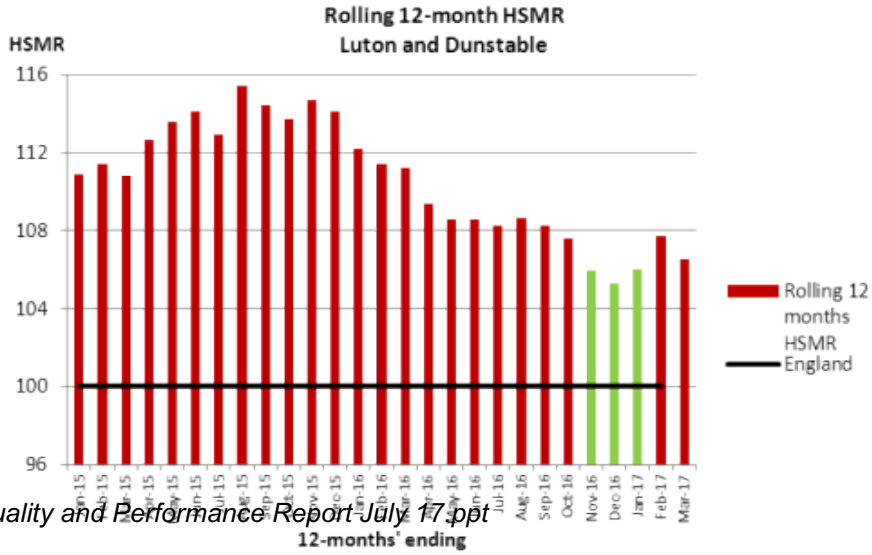
Safe | Effective | Caring | Responsive

HSMR/SHMI

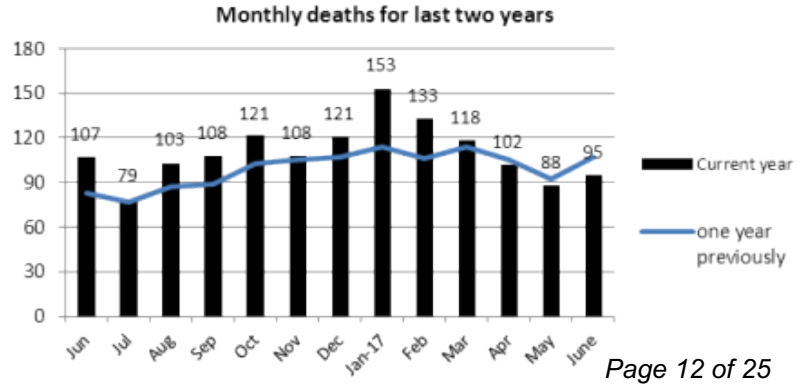
The rolling 12-months HSMR for March 2017 reduced to 106.54 but remains statistically significantly high. The SMR for the same period remains red at 109.04. The rolling 12-month SHMI (which includes deaths in the first month after discharge from hospital), fell to 105.95 for the year ending December 2016. The crude mortality rate is also reducing, following the sharp increase seen in the first two months of the calendar year. It now stands at 118.4 for the year ending June 2017.







Since January 2017 (153 deaths) and February (132 deaths), recent months have seen deaths return to more normal levels. Each of the last three months have seen lower mortality than for the same months in 2016 despite the number of inpatients being nearly 3% higher.



Patient Experience

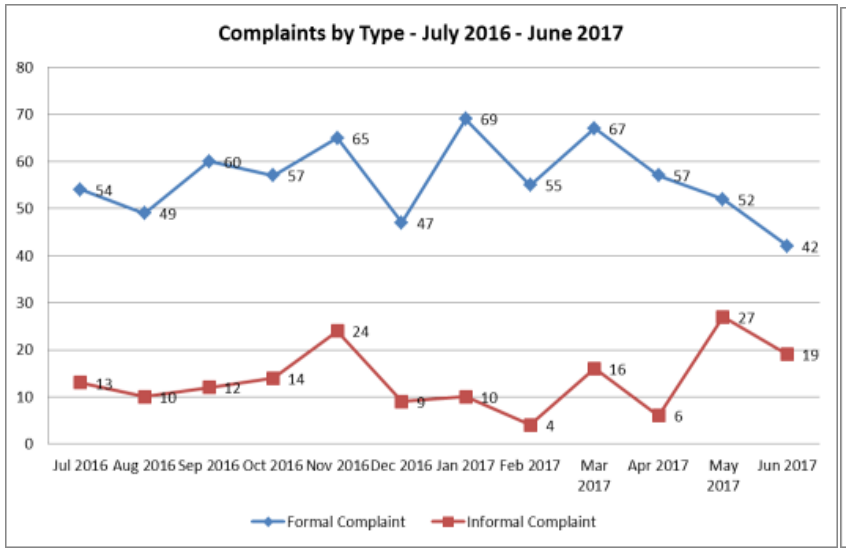
Safe | Effective | Caring | Responsive

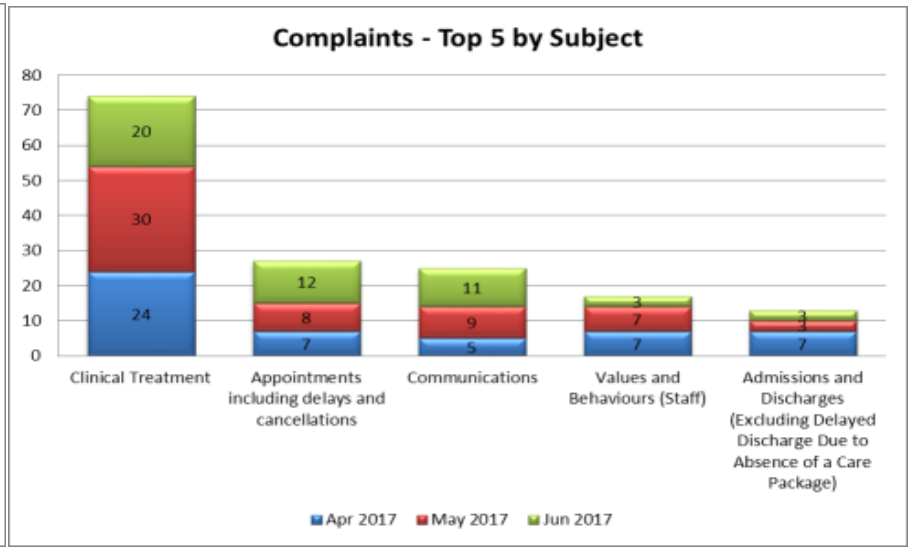
Complaints

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	55	98.65%	49.09%
Mar-17	67	96.20%	39.58%
Apr-17	57	100.00%	57.14%
May-17	54	100.00%	67.14%
Jun-17	42	98.15%	69.86%

The percentage of complaints responded to within the 35 day timescale continues to improve and saw compliance of 69.86% in June 2017, a 12% improvement across the quarter and a 24% improvement over the last 2 quarters.



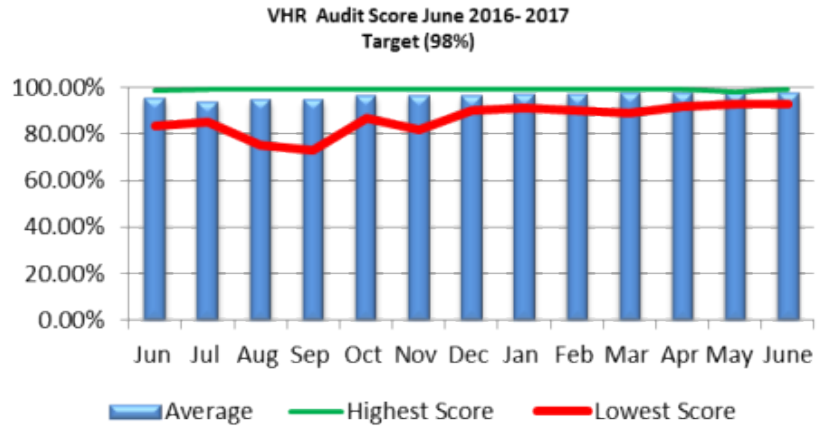


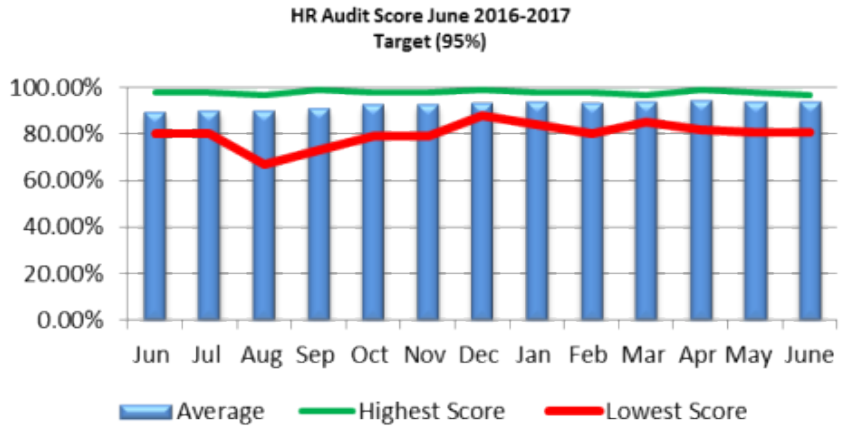
The reconfiguration of the complaints module in Datix is complete. This ensures that data reported since April 2017 internally, and externally to NHS Digital (previously HSCIC), is accurate. Examples of complaints regarding clinical treatment include inadequate pain relief or sedation, missed or delayed diagnosis and delays in treatment or procedures.

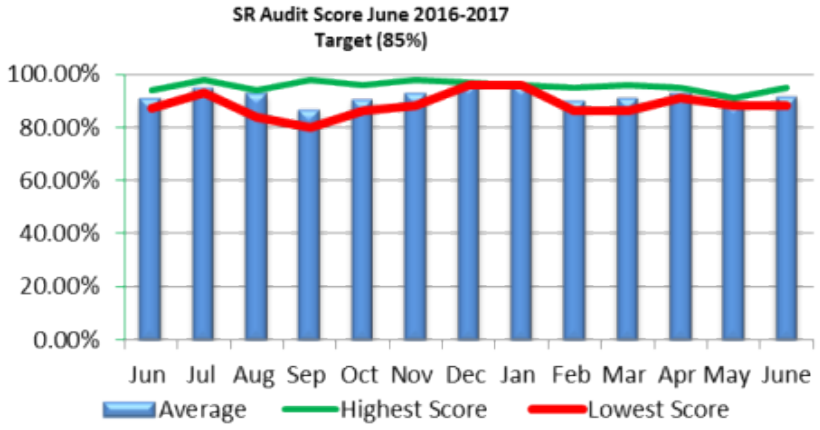
Cleanliness

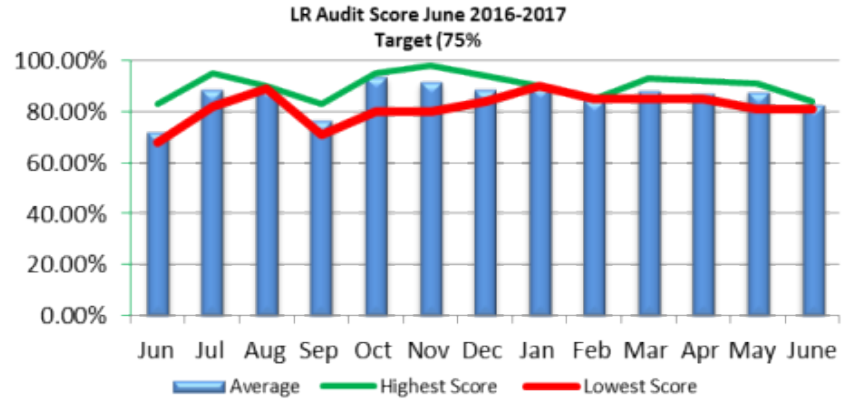
Safe | Effective | Caring | Responsive

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.









Cancer Long Waits

Safe | Effective | Caring | Responsive

Quality Review & Public Reporting of Cancer Long Waits - April

Function	LCCG - Commissioner	L&D - Provider	BCCG - Commissioner
Review numbers and reasons for 62 day breaches and >104 day long waiters via RAG long waiters tracker and agree action plan.	**Joint Commissioner/Provider Group** Luton Cancer Action Group *(1st Weds month)*		**Joint Commissioner/Provider Group** Bedfordshire Cancer Improvement Group *(2nd Tues month)*
a) Report numbers & outcomes/learning themes from 62 day breaches. b)Report numbers, outcomes/learning from RCAs and harm reviews for >104 day long waiters.	**Local commissioner quality group:** Patient Safety & Quality Group *(last Weds month)* Integrated Quality & Performance Report (IQPR)	**Local provider quality group:** Clinical Outcomes, Safety & Quality Committee *(3rd Weds month)* Quality Performance Report	**Joint Commissioner/Provider Group** Bedfordshire Cancer Improvement Group *(2nd Tues month)*
	LCCG Board (Public Board, alternate months)	**L&D Board** (shared with Governing Board)	**BCCG Board** (Governing Body - monthly via Integrated Quality, Safety & Performance Report)
Commissioner led escalation of issues related to cancer long waits.	**Regional Quality Surveillence Group**		

62 day breaches - 5 patients (5.0)

Number of days from referral to treatment	CCG	Breach	Tumour Site	Reason for Delay Post RCA
74	Herts Valley	1.0	Haem	Complex diagnostic pathway across two tumour sites identified low grade cancer for active surveillance
79	Beds	1.0	Urology	Diagnostics across two tumour sites prior to surgery
77	Beds	1.0	Lung	Extensive diagnostics to consider curative treatment prior to referral to Specialist Palliative Care team.
85	Luton	1.0	Lung	Complex diagnostic pathway across two tumour sites prior to referral to Harefield for consideration for surgery & returned for treatment at L&D
86	Beds	1.0	LGI	Patient dated for surgery on day 57 but developed coomorbidities that required further diagnostics prior to treatment

104+ Days Breaches - 3 patients (2.0)

Number of days from referral to treatment	CCG	Breach	Tumour Site	Reason for Delay Post RCA
135	Beds	0.5	Urology	Supplementary histology opinion required from external Trust prior to confirmation of
111	Beds	0.5	Urology	62 day delay for brachytherapy at MVCC (referred day 49)
105	Luton	1.0	Haem	Complex pathway across two tumour sites and patient unsure if to proceed with treatment.

* An RCA with clinical harm review by respective MDT Lead has been undertaken and reviewed by respective local Commissioner group

National Targets

Safe | Effective | Caring | Responsive

Cancer

	Threshol	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	Qtr 3 2016/17	Qtr 4 2016/17	Apr-17	May-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%
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%
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
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%	96.7%	96.8%	94.9%	94.9%
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%	98.3%	96.6%	95.1%	98.5%
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%	99.7%	100.0%	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%	88.3%	89.7%	88.3%	87.5%
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%	97.4%	96.4%	98.2%	95.7%

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 for the first two months of the year.

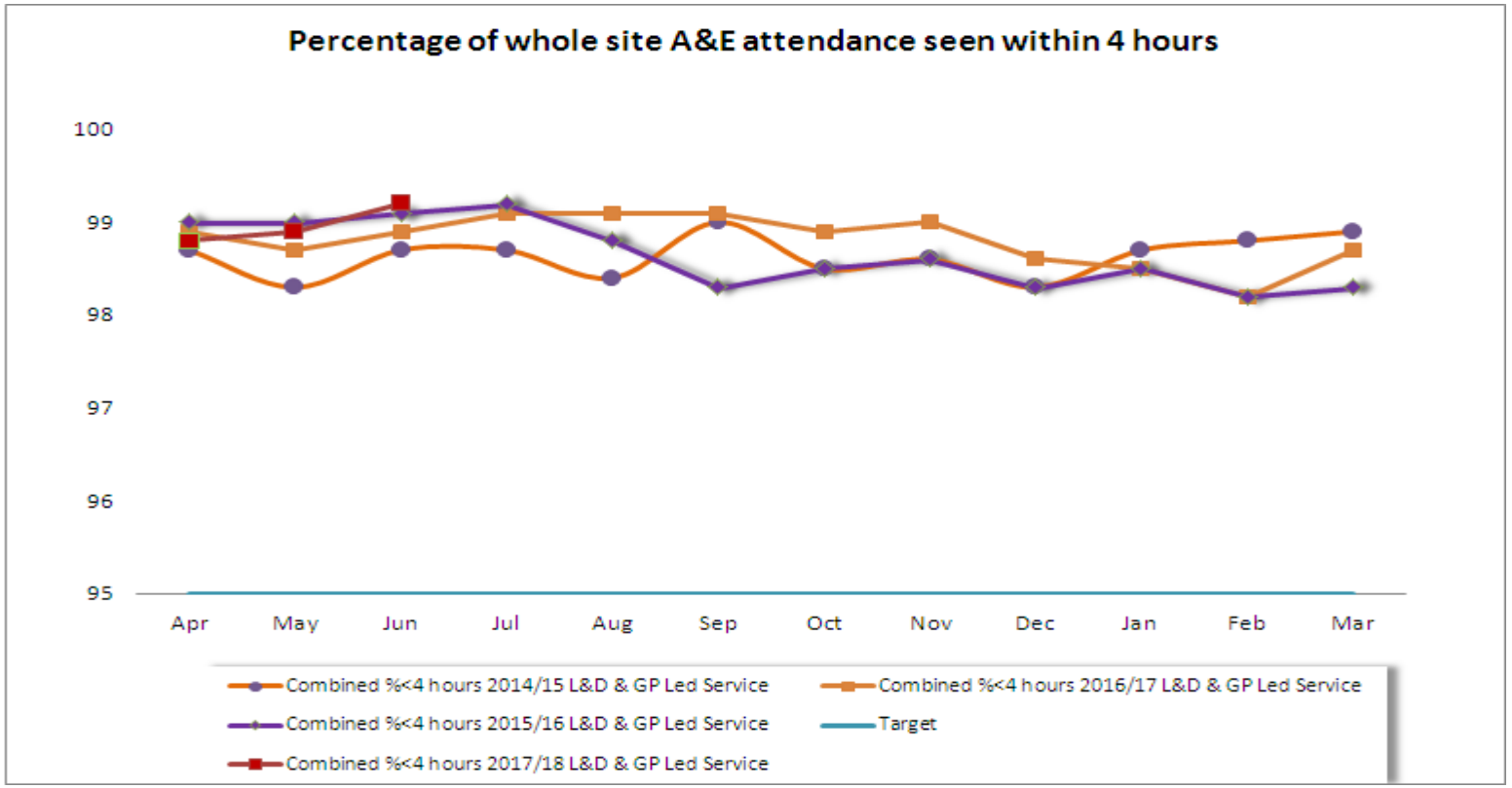
National Targets

Cancer Plan 62 Day Standard by Tumour Site

	Accountable Total Treated		Accountable Breaches		% Meeting Standard	
	Apr-17	May-17	Apr-17	May-17	Apr-17	May-17
Breast	11	9.5	0	0	100.0%	100.0%
Gynaecology	3	2	0	0	100.0%	100.0%
Haematology	3	5	2	1	33.3%	80.0%
Head & Neck	4	1.5	0	0.5	100.0%	66.7%
LGI	7	4	1	0	85.7%	100.0%
Lung	3.5	5	2	1.5	42.9%	70.0%
Skin	10	8	0	0	100.0%	100.0%
Urology	15	17	2	2	86.7%	88.2%
UGI	2.5	1.5	0	1.5	100.0%	0.0%
Sarcoma	n/a	0.5	n/a	0.5	n/a	0.0%
Other	1	2	0	0	100.0%	100.0%

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



The ED performance improved in June 2017 to 99.2% of patients presenting to the hospital site being seen within 4 hours.

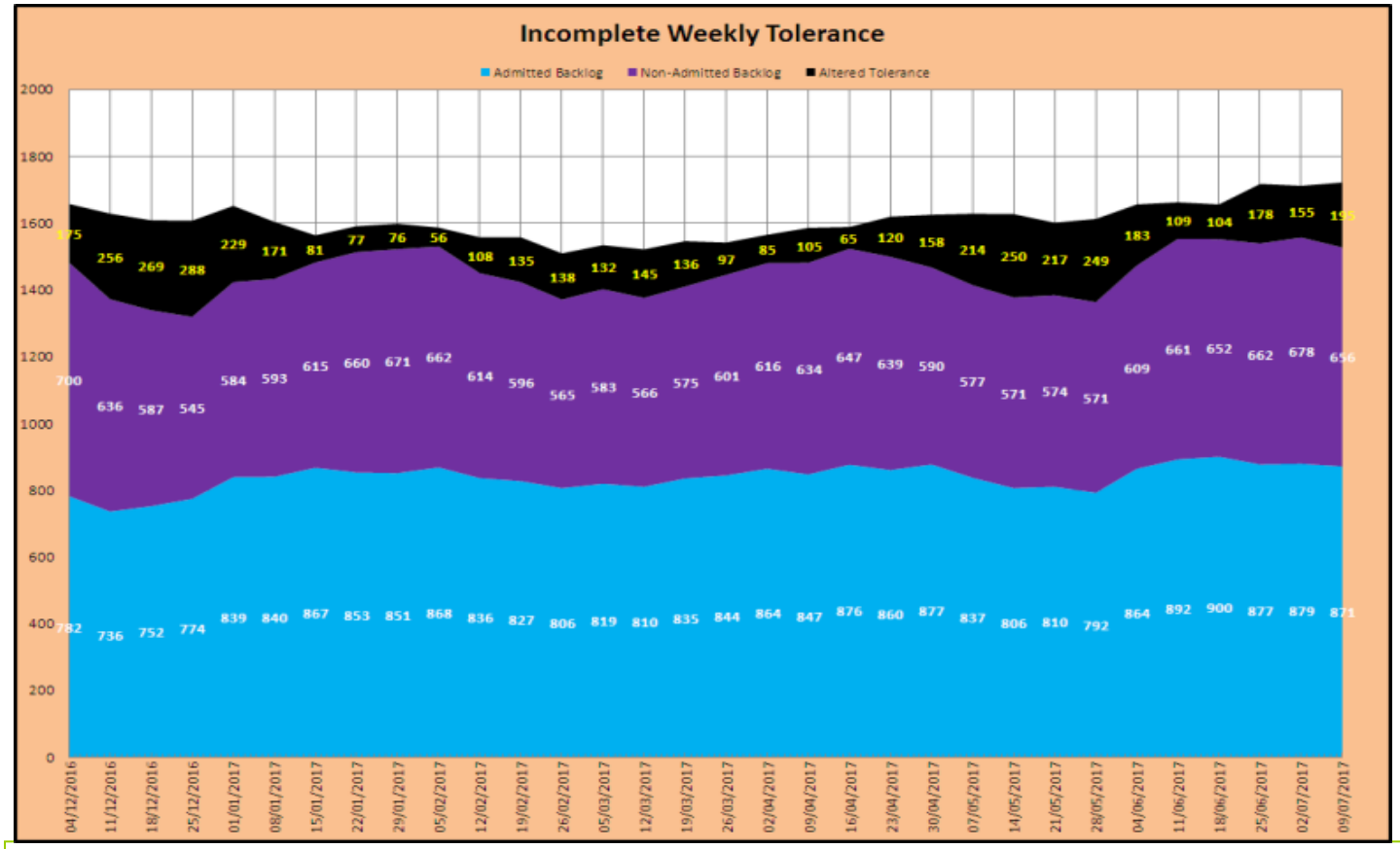
A&E

National Targets

18 Weeks

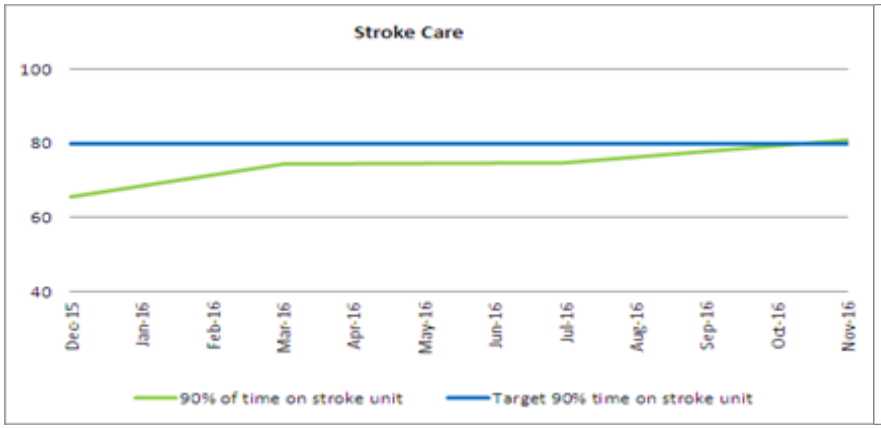
Treated Within 18 Weeks

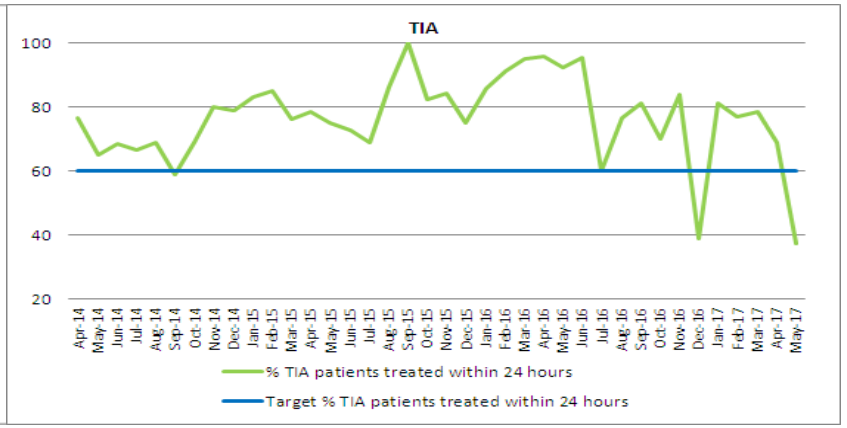
Incomplete	Targets	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	92%	96.9%	96.8%	97.0%	96.9%	97.1%	97.1%	97.1%	96.9%	96.7%	96.6%	96.8%	97.2%
2015/16	92%	97.9%	97.8%	97.6%	97.7%	97.3%	97.0%	96.4%	96.5%	95.3%	94.6%	94.2%	94.2%
2016/17	92%	94.2%	94.5%	94.8%	93.7%	92.9%	92.6%	92.2%	92.7%	93.1%	92.5%	92.9%	92.6%
2017/18	92%	92.8%	93.2%	92.7%									



The overall Trust 18 week performance remains over the 92 threshold, although we have seen a slight deterioration in the position during June 2017. Specialties are working to local targets on backlog reduction to try and increase the tolerance on this target to the levels achieved in Q3 2016, although it is necessary to balance this against the CCG aims for elective activity reductions.

National Targets





The expected date for publication for the next stroke audit report (SSNAP) is July 2017. 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.

National Targets

Safe | Effective | Caring | Responsive

Stroke

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

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	Mar-17
Over 6 weeks		35	15	39	39	40	29	15	10	33	32	27	22
% 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	0.4
Total Waiting		4290	4378	4,200	4,256	4,081	4,427	4,168	4,146	3,700	4112	4759	4987

	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Over 6 weeks		17	80										
% over 6 weeks	<1%	0.37	1.67										
Total Waiting		4603	4781										

The Trust did not achieve the diagnostic target in May 2017 due to significant capacity issues in Ultrasound which lead to 67 breaches of the 6 week diagnostic target in month. A recovery plan is in place and additional capacity identified.

National Targets

Safe | Effective | Caring | Responsive

Last Minute Cancellations

Last minute Cancelled Operations

	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Clinical reasons		42	44	59	31	43	39	45	60	51	59	52	39
Non-clinical reasons		38	48	60	28	32	27	40	28	47	57	76	48
Patients not-dated in 28 days	0	0	0	0	0	0	0	0	0	2	0	1	0
Elective activity*		3517	3339	3624	3468	3495	3625	3552	3546	3391	3499	3364	3763
% Cancelled operations	<0.8%	1.08%	1.44%	1.66%	0.81%	0.92%	0.74%	1.13%	0.79%	1.39%	1.63%	2.26%	1.28%

* Elective activity defined according to the performance assessment guidance (G&A ordinary and daycase first FCEs)

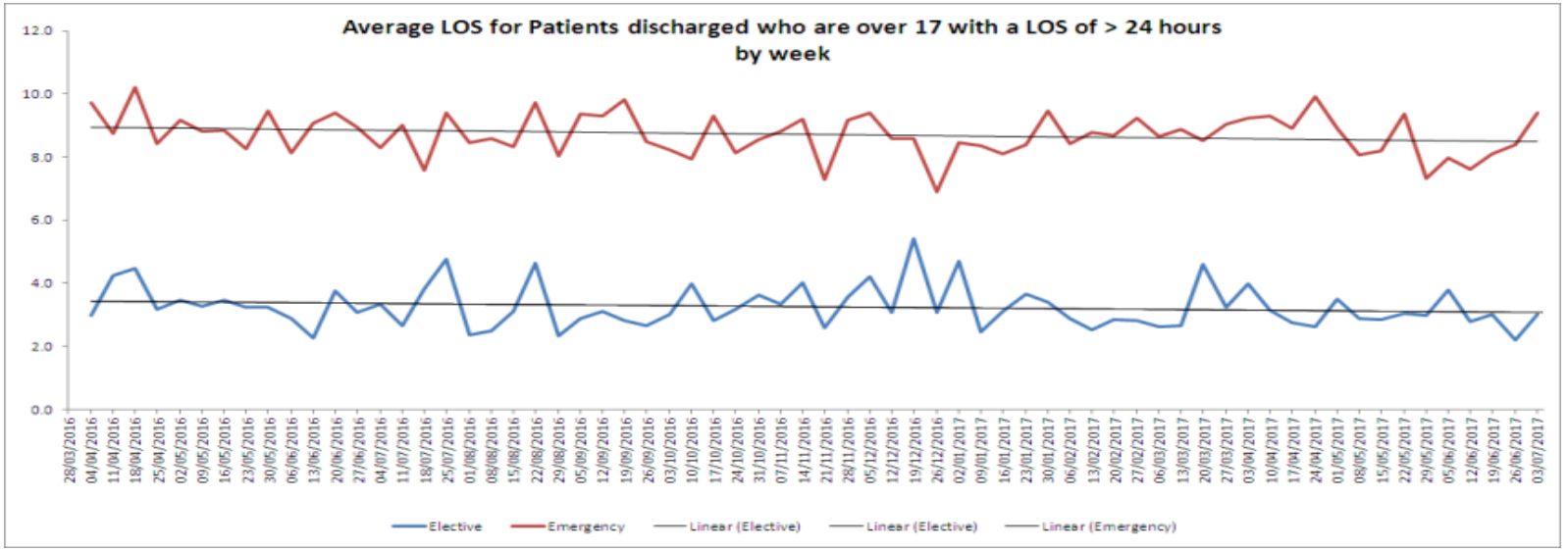
	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Clinical reasons		38	32										
Non-clinical reasons		43	24										
Patients not-dated in 28 days	0	0	1										
Elective activity*		3,060	3557										
% Cancelled operations	<0.8%	1.41%	0.67%										

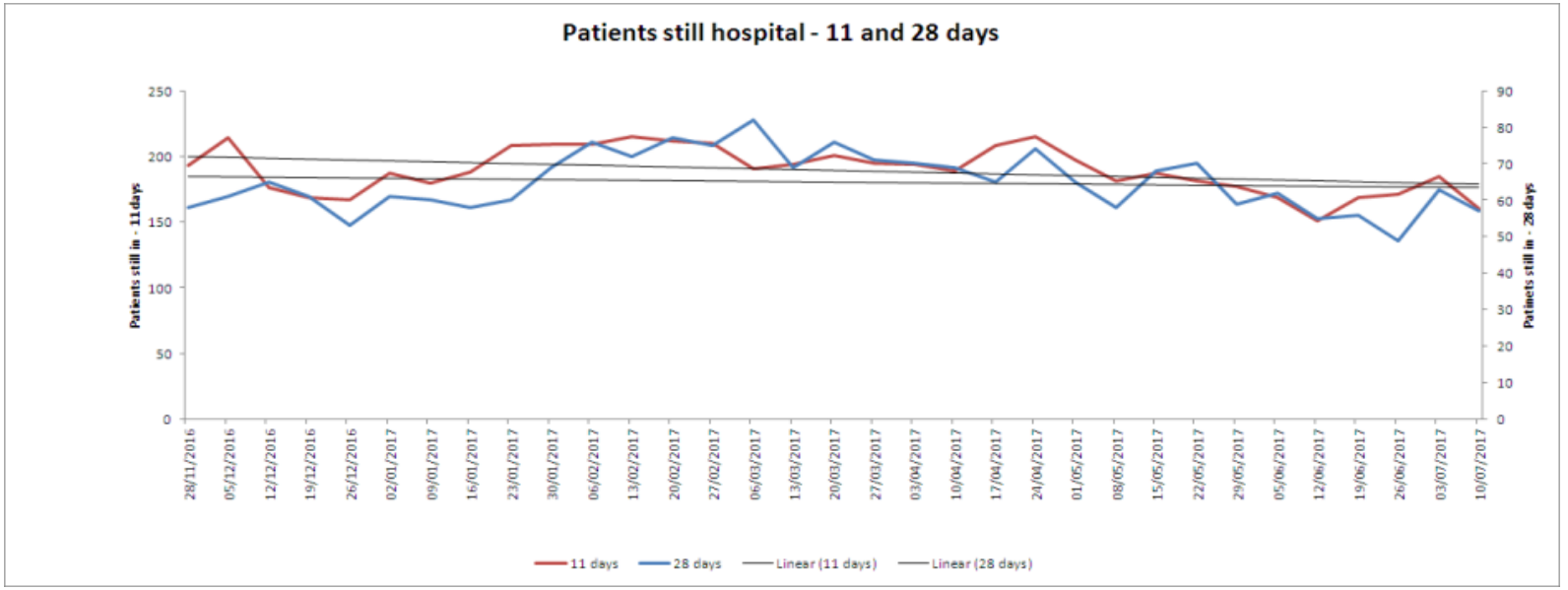
One patient was recorded for May 2017 as having not been re-listed for surgery within 28 days of a previous cancellation on the day of admission. This was an Oral and Maxillo-Facial Surgery Patient (specialist commissioning).

National Targets

Safe | Effective | Caring | Responsive

LOS





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	Qtr 1 2017/18
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%	99.0%
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	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%	92.9%
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	4
MRSA – meeting the MRSA objective of no more than 1 cases/year	0	1.0	1	0	0	0	0	0	0	1	0

Finance Report

Report for Month 3

Executive Summary

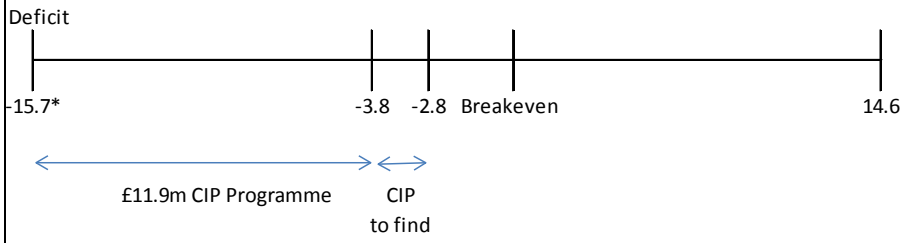
Trust ahead of plan at Month 3, albeit a plan that is heavily front-ended (i.e. easier in M1-6).

Pay growth a challenge, a significant driver of this is medical locum expenditure and the Trust is, without remedial action, on course to fail the Agency Ceiling (+50%) and the specific target around Medical locum spend

2017-18 Plan	Divisions presented recovery plans identifying £2.8m deficit	Amendments proposed to plan

MARCH PLAN

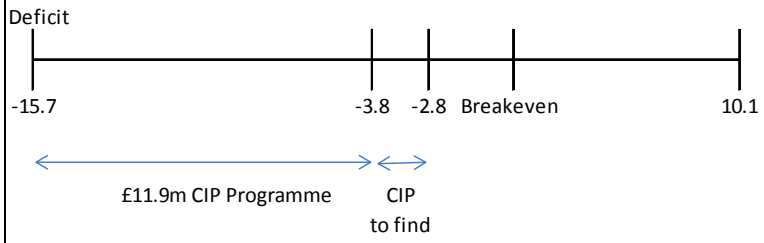
POSITION AGAINST £14.6M CONTROL TOTAL. FIP AGREED POSITION OF £2.8M DEFICIT



* Position excludes £11m of possible risks that FT will need to manage

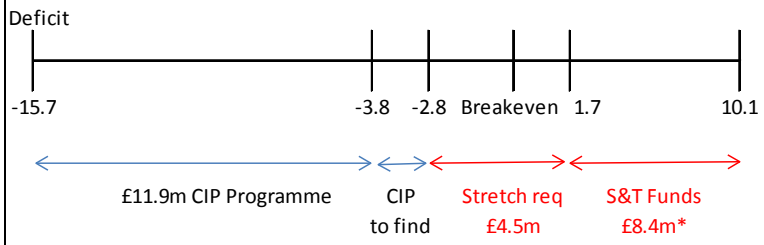
APRIL PLAN

OFFER OF REVISED CONTROL TOTAL £10.1M. INITIALLY DECLINED.



APRIL REVISION

After discussion Control Total accepted. Additional CIP beyond March levels not viable, therefore dialogue with DH/NHSI required to support stretch target



* Requires FT to post £1.7m surplus to access S&T fund

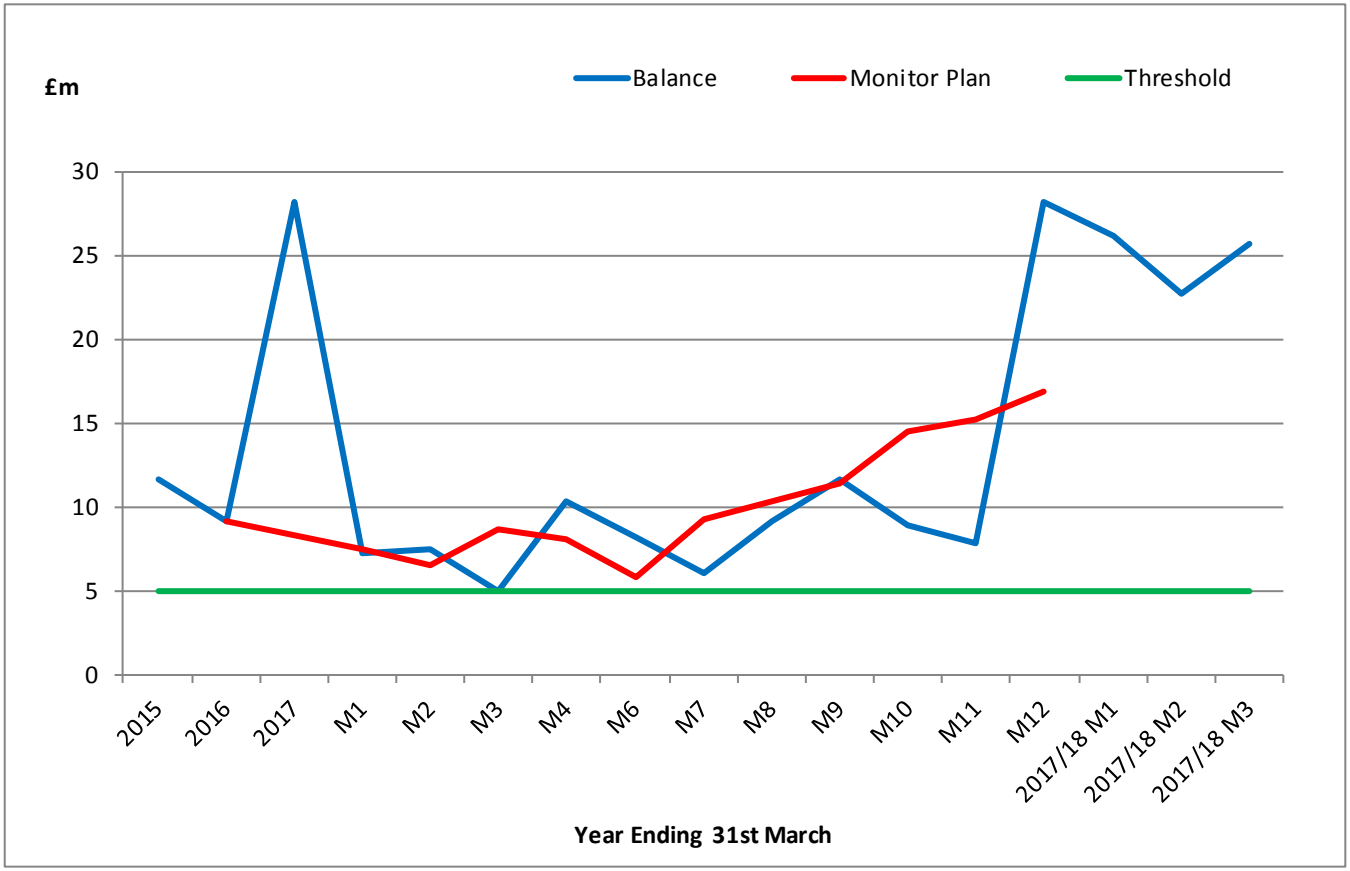
I&E Phasing figures £m					
	In Month Core	YTD Core	In Month S&T*	In Month Stretch	YTD All
April	-1.6	-1.6	0.4		-1.1
May	-0.6	-2.1	0.4		-1.3
June	-0.3	-2.5	0.4		-1.2
July	-0.1	-2.6	0.6		-0.8
August	0.2	-2.4	0.6		0.0
September	-0.5	-2.8	0.6		0.1
October	0.6	-2.2	0.8		1.6
November	0.3	-2.0	0.8		2.7
December	-0.3	-2.2	0.8		3.3
January	0.6	-1.6	1.0	1.5	6.3
February	-1.4	-3.0	1.0	1.5	7.4
March	0.2	-2.8	1.0	1.5	10.1

Securing the stretch improvement resource of £4.5m represents a massive challenge. Options for consideration include:

- Securing external resource (as per FY16/17)
- Seek (via STP leadership) a re-distribution of STP acute Control Total within BLMK (MKGH has CT before STF of -£26.1m compared to LDH position of +£1.7m)
- Undertaken a substantial cost cutting exercise

INCOME & EXPENDITURE ACCOUNT	Fin Year 2015/16 Actual Full Year £000s	Fin Year 2016/17 Actual Full Year £000s	Fin Year 2017/18 Budget Full Year £000s	Fin Year 2017/18 Budget YTD £000s	Fin Year 2017/18 Actual YTD £000s	Fin Year 2017/18 Variance YTD £000s
NHS Clinical Income - Contract	243,844	262,577	277,339	67,874	68,493	-619
Other Income	24,485	24,920	21,794	5,449	5,713	-264
Total Income	**268,329**	**287,496**	**299,134**	**73,322**	**74,206**	**-884**
Consultants	32,477	35,629	36,055	9,066	9,584	518
Other Medical	28,890	30,255	29,765	7,452	7,998	546
Nurses	68,485	72,972	75,670	19,000	18,781	-219
S&T	20,114	21,177	22,171	5,543	5,492	-51
A&C (Including Managers)	20,854	22,589	24,621	6,155	6,076	-79
Other Pay	7,132	5,526	5,500	1,375	1,433	58
Total Pay	**177,952**	**188,147**	**193,782**	**48,591**	**49,364**	**773**
Drug costs	26,003	27,558	28,064	7,016	6,590	-426
Clinical supplies and services	22,492	24,993	25,235	6,346	6,168	-178
Other Costs	38,820	42,159	44,042	11,136	11,540	404
Non-Recurrent		0	0	0	0	0
Total Non-Pay	**87,315**	**94,710**	**97,342**	**24,498**	**24,298**	**-200**
EBITDA	**3,062**	**4,639**	**8,010**	**233**	**544**	**-310**
Non Operational	12,009	13,014	13,242	3,328	3,247	-81
Deficit	**-8,947**	**-8,374**	**-5,232**	**-3,094**	**-2,703**	**391**
Non SLA Income		2,516	2,500	625	250	-375
Trading Position	**-8,947**	**-5,858**	**-2,732**	**-2,469**	**-2,453**	**16**
S&T Funding		10,078	8,418	1,263	1,263	0
Revenue Allocation		8,700	4,515	0	0	0
Non-Recurrent	9,000	0	0	0	0	0
Total Operating Surplus/Deficit (-)	**53**	**12,920**	**10,201**	**-1,206**	**-1,190**	**16**

Cash	Plan to be finalised when Capital plan agreed

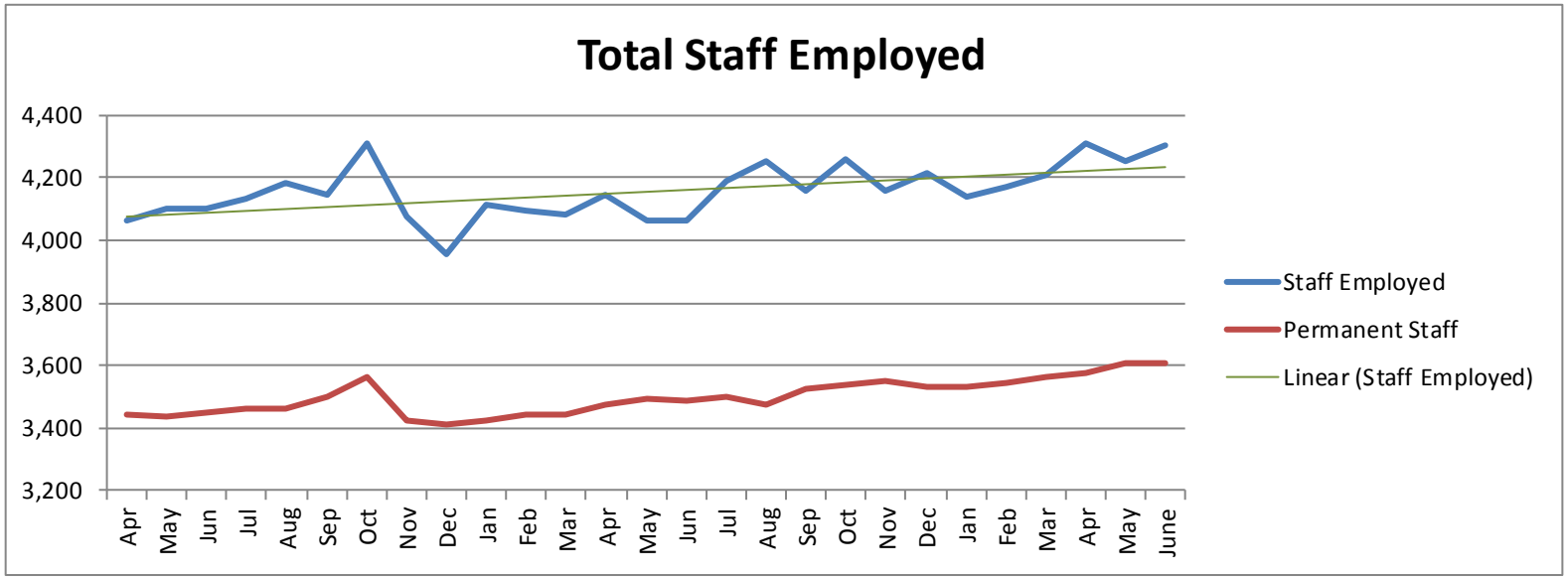


Statement of Financial Position

Statement of Financial Position For the period ended 30 June 2017	Opening 31 Mar 2017 £000s	Closing 30 Jun 2017 £000s
Non-Current Assets		
Property, plant and equipment	113,730	113,402
Trade and other receivables	1,917	2,122
Other assets	2,574	2,678
Total non-current assets	**118,221**	**118,201**
Current assets		
Inventories	3,291	3,155
Trade and other receivables	23,665	26,292
Cash and cash equivalents	28,176	25,820
Total current assets	**55,133**	**55,266**
Current liabilities		
Trade and other payables	-24,133	-25,083
Borrowings	-1,423	-1,423
Provisions	-407	-407
Other liabilities	-1,651	-2,169
Total current liabilities	**-27,614**	**-29,083**
Total assets less current liabilities	**145,740**	**144,385**
Non-current liabilities		
Borrowings	-29,612	-29,463
Provisions	-733	-717
Total non-current liabilities	**-30,345**	**-30,180**
Total assets employed	**115,395**	**114,205**
Financed by (taxpayers' equity)		
Public Dividend Capital	61,512	61,512
Revaluation reserve	8,316	8,316
Income and expenditure reserve	45,568	44,378
Total taxpayers' equity	**115,395**	**114,205**

Staff in Post

	2015												2016									2017					
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**
Admin/Estates	696	705	704	713	719	709	722	709	695	724	712	706	753	733	746	763	767	740	760	709	742	743	753	751	774	768	771
WD Clk/Support	391	398	401	409	431	426	426	244	194	218	207	206	212	196	211	216	214	212	222	214	225	212	221	226	238	228	229
HCA	513	514	529	527	554	534	601	574	548	595	566	578	593	546	535	581	642	559	593	550	571	545	558	564	604	557	559
Consultant	224	221	227	228	239	236	240	244	230	247	247	253	246	252	254	258	263	258	259	263	266	263	254	255	262	269	281
Medical non-Cons	353	365	372	373	391	386	381	392	367	364	366	368	362	374	365	373	399	418	402	417	401	400	408	405	384	396	436
N&M	1,346	1,365	1,331	1,317	1,317	1,307	1,394	1,382	1,373	1,420	1,442	1,420	1,418	1,414	1,414	1,443	1,419	1,403	1,437	1,429	1,438	1,414	1,417	1,438	1,477	1,452	1,439
Learner	6	6	4	3	3	4	4	5	8	8	7	7	7	7	6	3	3	2	2	2	6	6	6	6	6	6	5
Therapy/Technical	340	339	339	345	351	357	364	362	365	363	359	360	361	352	343	350	342	348	362	358	358	362	371	371	366	373	374
Healthcare Scientists	192	188	192	210	178	179	178	165	170	172	184	184	187	185	183	202	204	215	219	212	203	190	177	189	197	198	204
Other	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Staff Employed	**4,063**	**4,103**	**4,102**	**4,129**	**4,185**	**4,142**	**4,312**	**4,078**	**3,952**	**4,113**	**4,093**	**4,084**	**4,142**	**4,061**	**4,060**	**4,190**	**4,255**	**4,160**	**4,259**	**4,156**	**4,213**	**4,139**	**4,167**	**4,208**	**4,312**	**4,249**	**4,302**
Made up of:																											
Permanent Staff	3,444	3,434	3,450	3,465	3,464	3,503	3,561	3,424	3,413	3,425	3,443	3,440	3,477	3,494	3,488	3,501	3,474	3,525	3,540	3,550	3,534	3,534	3,547	3,562	3,574	3,607	3,604
Locum / Bank	449	501	496	494	578	486	588	500	395	556	482	507	524	416	429	526	632	453	547	481	530	469	498	530	627	522	571
Agency	169	168	156	170	143	153	163	154	144	131	169	136	140	151	142	164	149	182	172	125	149	135	122	117	111	121	127



Agency Spend	Worse than forecast	Plan requires improvements in future periods

£000s	15/16	16/17	17/18 Plan	17/18 Act
Apr	1,241	1,217	1,159	1,161
May	2,486	2,544	2,315	2,394
Jun	3,621	3,745	3,460	3,693
Jul	4,781	5,097	4,556	
Aug	6,022	6,267	5,610	
Sep	7,280	7,664	6,479	
Oct	8,562	8,957	7,330	
Nov	9,839	10,031	8,170	
Dec	11,043	11,183	9,030	
Jan	12,135	12,306	9,862	
Feb	13,510	13,414	10,689	
Mar	14,660	14,394	11,511	

The Trust received notification from NHSI of an additional **"Medical Locum (agency) reduction target"**.

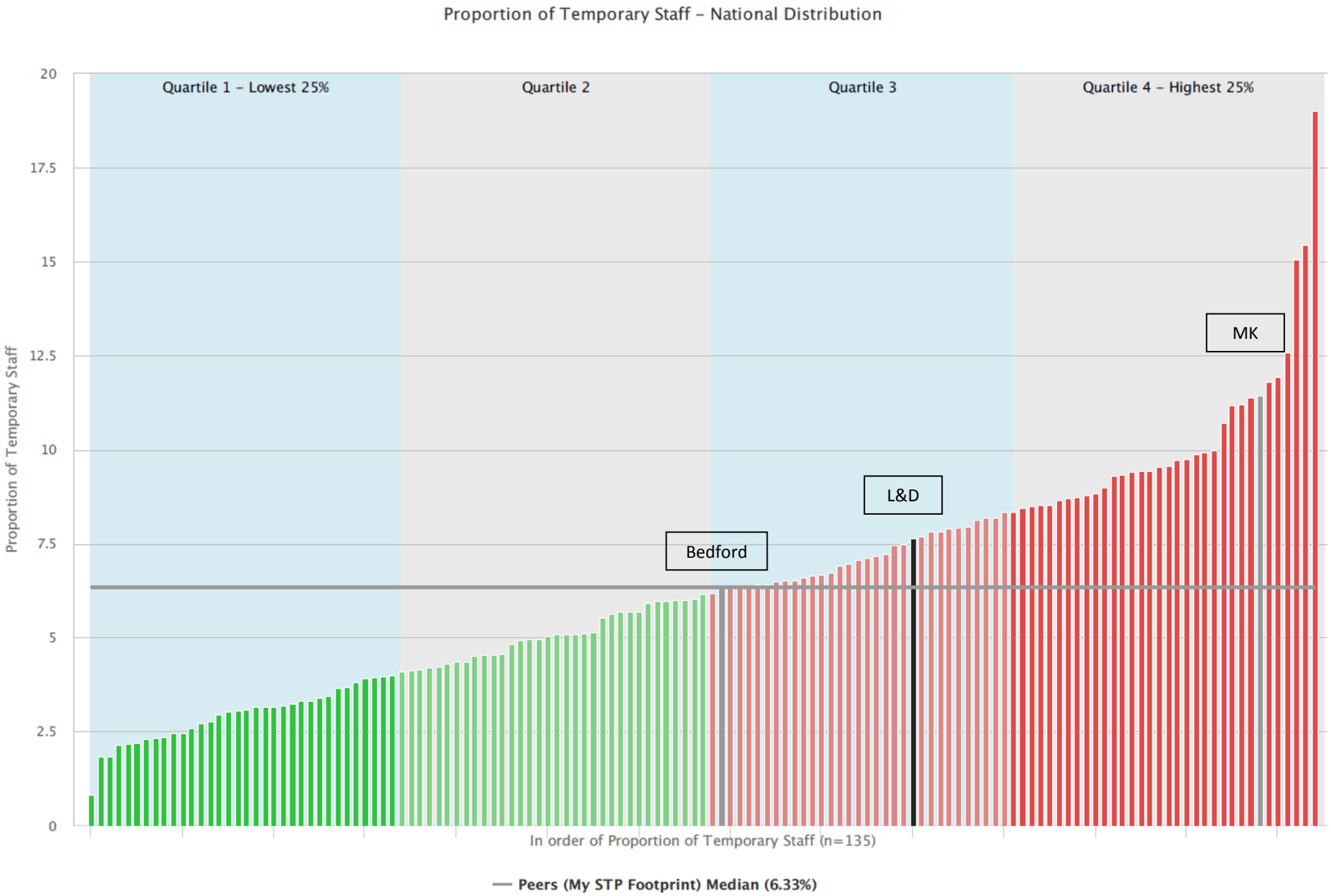
The communication set out that "The Medical Locum reduction target does not change the overall agency ceiling for your trust. The Medical Locum target aims to reduce the locum spend in 2017/18 compared to 2016/17 outturn position by the amount stated above." **The L&D's reduction target is £506k, which effectively equates to a Medical Locum (agency(ceiling of £5,654k**

Trust plans for 17/18 would deliver Medical locum (agency) spend of £4,887k, the ceiling in the table below has been phased by pro-rating the overall ceiling against the phasing in the Trust plan. **The Trust is currently on course to breach the Medical Locum (agency) ceiling.**

	Forecast				
	Medics	**Nursing**	**Other Clin**	**A&C**	**Total**
Apr-17	503	531	108	17	1,159
May-17	502	516	125	13	1,156
Jun-17	489	513	134	9	1,145
Jul-17	469	508	114	5	1,095
Aug-17	466	483	101	5	1,055
Sep-17	358	456	50	5	869
Oct-17	359	440	47	5	851
Nov-17	359	436	40	5	840
Dec-17	359	455	40	5	860
Jan-18	342	448	36	5	832
Feb-18	341	448	34	5	828
Mar-18	340	443	34	5	822

	Ceiling	Actual				
	Medics	**Medics**	**Nursing**	**Other Clin**	**A&C**	**Total**
Apr-17	582	599	471	83	9	1,161
May-17	581	617	496	101	19	1,232
Jun-17	566	698	443	151	6	1,299
Jul-17	542					
Aug-17	539					
Sep-17	415					
Oct-17	415					
Nov-17	415					
Dec-17	415					
Jan-18	396					
Feb-18	394					
Mar-18	393					

Agency Spend	16/17 Performance	Above national average



Carter Update

- NHSI Pathology Return **submitted to NHSI on 30th June**

- Recently joined the first wave of NHSI Imaging programme
  Imaging Data Collection from 49 Carter Cohort Trusts
  Submission date to NHSI 21st July

- Acute Therapies Benchmarking – This return includes a comprehensive analysis of four AHP disciplines: Physiotherapy Occupational Therapy, Dietetics and Speech & Language Therapy
  Submission date 21st July 2017

- Pharmacy & Medicines Optimisation Benchmarking Return
  This return covers a range of topics including; workforce, finance, policies & procedures, hours of availability, equipment and stock, clinical pharmacy and good practice
  Submission date 4th August 2017

- Seeking benchmarking information from NHSI on newly collected information re pharmacists and A&E.

- Latest release showing far more data with Cancer, Procurement, Corporate Services and Commercial Income live. There is also new data on non-consultant doctor productivity, top ten medicines, workforce analysis and new "peering options"

- Future releases will include an "opportunity scanner", compartments on agency and theatre productivity and a new "in-year cost-per-WAU" metric

- Some metrics hindered by source data (i.e. when they drive off ESR, this excludes agency expenditure)

Workforce
July 2017

(Reporting May/June 2017 Data)

WORKFORCE BALANCED SCORECARD **Reporting Period: May / June 2017**

Workforce	Trust Target	May-17 Trust Actual	May-17 Corporate	May-17 Diagnostics	May-17 Medicine	May-17 Surgery	May-17 Women' and Children's	Jun-17 Trust Actual	Jun-17 Corporate	Jun-17 Diagnostics	Jun-17 Medicine	Jun-17 Surgery	Jun-17 Women' and Children's	Jun-16 Trust Actual
Workforce Statistics														
Staff in post (Assignment Headcount)	-	4027	491	712	1120	922	782	4021	493	709	1119	919	781	3899
Budgeted WTE	-	4145	480	653	1285	1007	719	4145	480	653	1285	1007	719	4014.0
Staff in Post (WTE)	-	3607	452	618	1016	864	656	3604	454	617	1018	861	655	3488
Vacancy Rates (%)	10%	12.98	5.97	5.38	20.92	14.17	8.68	13.04	5.61	5.52	20.82	14.46	8.88	13.10
Nurses & Midwives Budgeted WTE		1438	33.7	28.0	543.5	420.4	411.9	1438	33.7	28.0	543.5	420.4	411.9	1352.5
Nurses & Midwives in Post (WTE)	-	1185.0	35.5	25.9	408.9	344.2	370.5	1179.1	35.5	25.7	407.5	341.4	368.9	1194.5
Nursing & Midwives Vacancy Rates (%)	10%	17.56	-5.30	7.58	24.77	18.13	10.04	17.98	-5.30	8.15	25.03	18.78	10.43	11.68
Nursing Vacancy Rates (%)	10%	23.12	-5.30	7.58	24.77	18.13	10.21	24.01	-5.30	8.15	25.03	18.78	11.57	12.25
Midwives Vacancy Rates (%)	10%	9.86	-	-	-	-	9.86	9.13	-	-	-	-	9.13	8.11
Sickness FTE Days Lost	-	3301	373	582	1036	634	675	-	-	-	-	-	-	3312
Sickness Rates (%)	3.32%	2.96	2.67	3.04	3.30	2.39	3.32	-	-	-	-	-	-	2.85
Estimated Sickness Cost (£)	-	255658	18601	53292	71240	53330	59195	-	-	-	-	-	-	263331
Maternity Absence Rates (%)	-	2.73	2.02	3.07	2.62	1.65	4.50	2.68	1.84	2.86	2.77	1.55	4.46	3.06
Other Absence Rates (%)	-	0.27	0.27	0.50	0.07	0.23	0.41	0.21	0.15	0.39	0.02	0.13	0.41	0.41
Turnover %	10%	16.13	13.76	16.96	18.89	16.36	12.70	16.22	14.67	17.52	18.68	16.74	11.94	15.91
Appraisal Rate %	90%	74	70	78	73	77	73	78	76	85	76	81	72	74
Core Statutory Training %	80%	81	78	82	79	84	79	80	77	80	79	82	77	86

RECRUITMENT COMMENTARY

Nursing Recruitment - 32 nurses started in post between April and the end of June with a further 85 within the recruitment process. Since May the Trust has been working with our recruitment agencies to source nurses from overseas that have already passed their IELTS or those that already have their NMC registration. Nursing recruitment events undertaken in the last period include: University of Hertfordshire and the University West of Scotland. Events planned for the next period include:, Midwifery open days and a campaign targeting Southern Ireland.

General recruitment events also undertaken for the last period were: Harlington Upper School, Luton Mall, Cardinal Newman High School and All Saints Academy. Events planned for the next period include Leighton Buzzard Market Place and Challney Boys High School.

European Recruitment - Between February and April 10 Italian nurses arrived at the Trust; A further 7 Italian nurses will arrive in July; 2 of these already have their NMC PIN and the remaining 5 have completed the 6 week residential course and will take their IELTS exam during July.

International Recruitment –4 Indian nurses started in post at the beginning of March. A further 3 nurses, 2 from the Philippines and 1 from India, arrived at the Trust at the end of May.. A further 2 nurses, 1 from Philippines and 1 from India, are scheduled to arrive in July. We have recently applied to the UK Visa and Immigration authority for permission to bring another 16 International nurses to the UK and these nurses will be arriving throughout August and September.

HCA Recruitment - The Trust continues regular HCA Division led recruitment campaigns for both permanent and bank positions to keep vacancies to a minimum and maintain effective numbers registered on the bank. There have been 27 substantive HCA starters throughout April to June and 22 were recruited for the bank

STAFF IN POST WTE BY DIVISION

DIVISION	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	% Growth From April 2017	Average % Growth per month	% Growth over last 12 months
Corporate	420.1	430.2	434.5	432.9	431.2	433.4	431.9	438.2	446.5	445.986	451.8	453.5	1.69%	0.72%	7.96%
Diagnostics, Therapeutics and Outpatients	592.7	585.2	596.1	607.3	606.8	603.2	609.2	615.9	610.9	609.771	618.2	617.3	1.24%	0.38%	4.15%
Medicine	1017.9	1021.7	1027.6	1030.0	1039.1	1022.4	1017.0	1008.5	1004.4	1018.21	1016.5	1017.7	-0.05%	0.00%	-0.02%
Surgery	818.1	806.0	813.8	815.3	818.8	817.2	819.9	829.8	842.4	845.574	864.1	860.9	1.82%	0.48%	5.24%
Women's & Children's	651.8	632.0	652.6	654.1	654.9	657.9	656.4	654.9	658.0	654.184	656.2	654.8	0.10%	0.04%	0.47%
TOTAL	**3500.5**	**3475.0**	**3524.6**	**3539.7**	**3550.8**	**3534.1**	**3534.4**	**3547.3**	**3562.2**	**3573.7**	**3562.2**	**3604.3**	**0.86%**	**0.27%**	**2.97%**

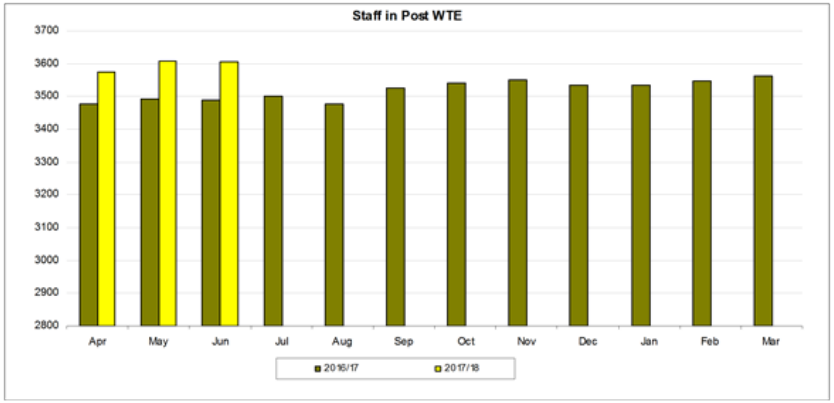
WTE COMMENTARY

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 2.97% since July 2016 mainly attributed to recruitment to vacancies and recruitment to fixed term contracts in place of Contracts for Service/agency.

- There are currently 107 band 5 Nursing / Midwifery vacancies across the Trust. There are 85 band 5 Nurses currently going through the recruitment process, which includes our recently interviewed (non-campaign) European and International nurses that already have their IELTS or NMC pin.

- Currently there are 25 vacancies for band 2 Healthcare Assistants with 19 currently going through the recruitment process and due to commence between July and September 2017.



Medical Recruitment

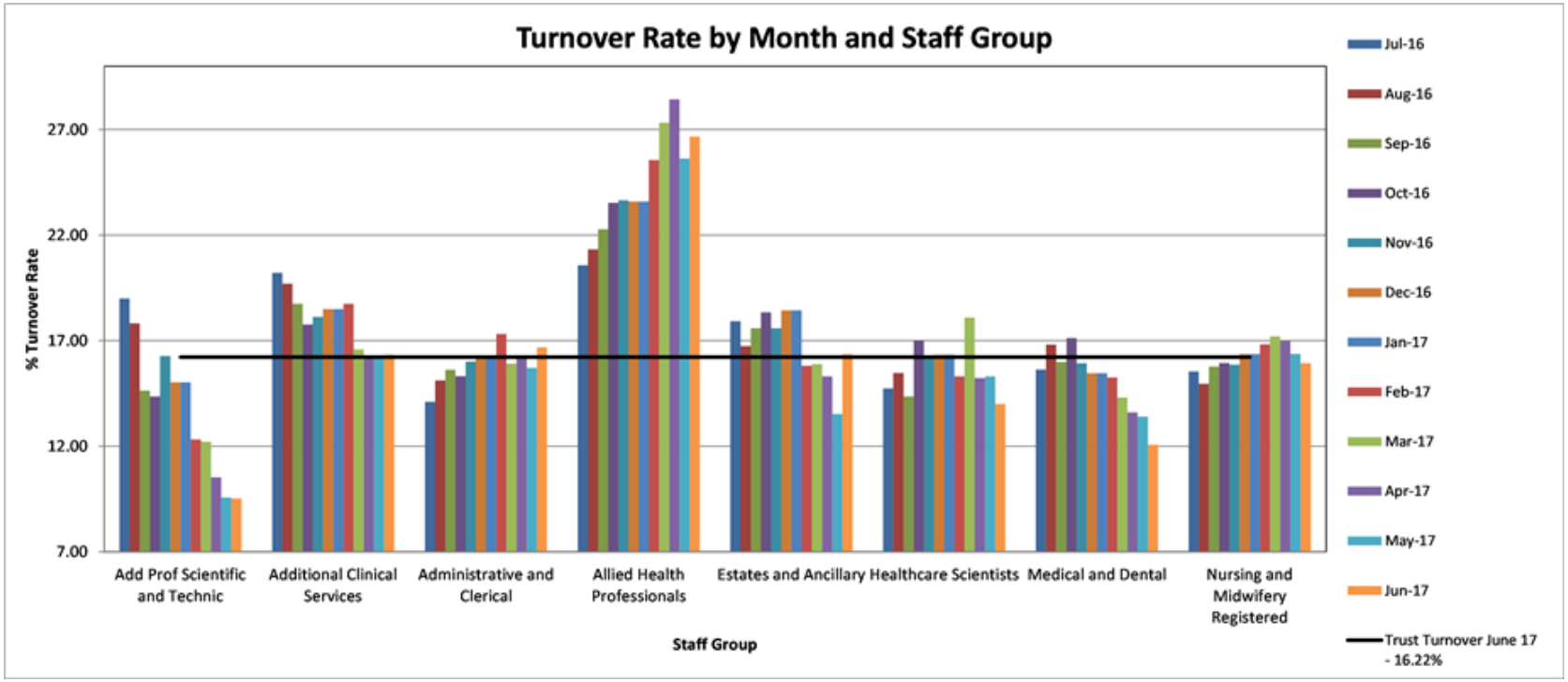
From April – June 2017 6 AACs were held to recruit Consultants in the following specialities: Acute Medicine (1 Post), Neurology (1 post), Haematology (1 post), Respiratory (1 post) , Cellular Pathology (1 post), and Diabetes (1 post). Further AAC's are planned for July 2017 in General Surgery with interest in Paediatric surgery (1 post), and August for Elderly Medicine (3 posts).

The new Junior Doctors contract (2016) continues to be rolled out in line with NHS employers timeline for Deanery Trainees and is on target to transition all posts to the new contract for the August rotation (a total of 115 Doctors). The Trusts expect to have all trainees transferred to the new terms and conditions by October 2017.

New Starters

Between April – June 2017 3 new substantive Consultants started in post in the following specialities: ENT, Haematology, and Radiology. There is one consultant scheduled to start in July for Neurology.

TURNOVER

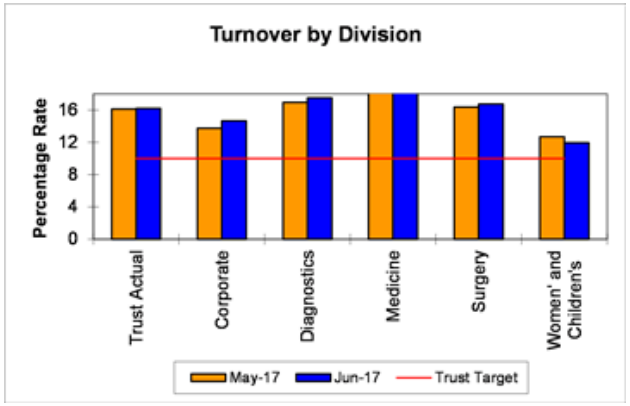


TURNOVER COMMENTARY

The Trust's overall turnover rate is 16.22% for the reporting year ending 30th June 2017. This is a reduction from the previous period (16.96%) and is just below the regional average (16.5%)

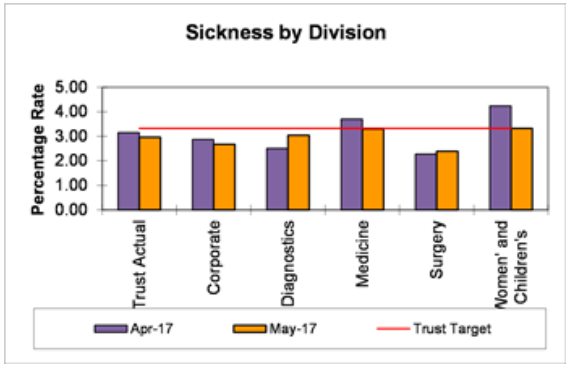
There were a total of 94 leavers in May and June with the top 3 reasons for leaving were 22.34% due to voluntary resignation reasons, 8.51% retired and 5.3% were dismissed due to capability.

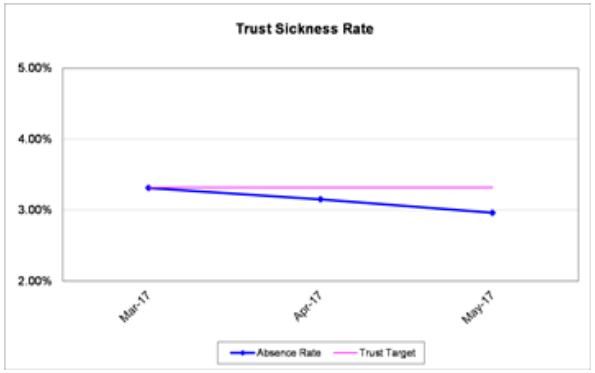
During May a facilitated Nursing and Midwifery retention workshop was held reviewing retention /stability data and the underlying factors driving turnover. The output from this workshop established phase 1 of a retention programmed which will be overseen by a retention Steering Committee. Phase 1 will focus on Nursing and Midwifery as the Trust's largest staff group facing resourcing challenges. Future phases will focus on other staff groups and build on the learning from work undertaken in earlier stages. The work streams identified as part of phase 1 can be grouped into 6 broad areas of focus: culture, leadership, intelligence, reward, training & development and financial challenge.

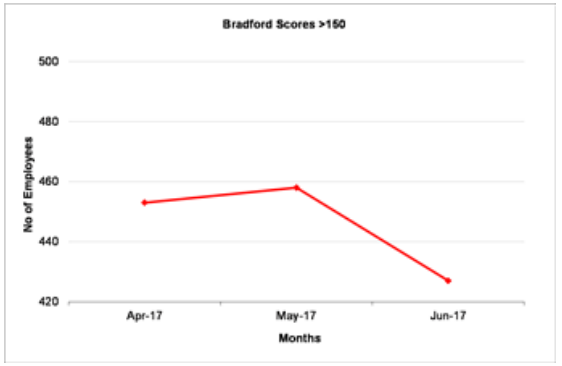


* Turnover figures above do not include Junior Doctors.

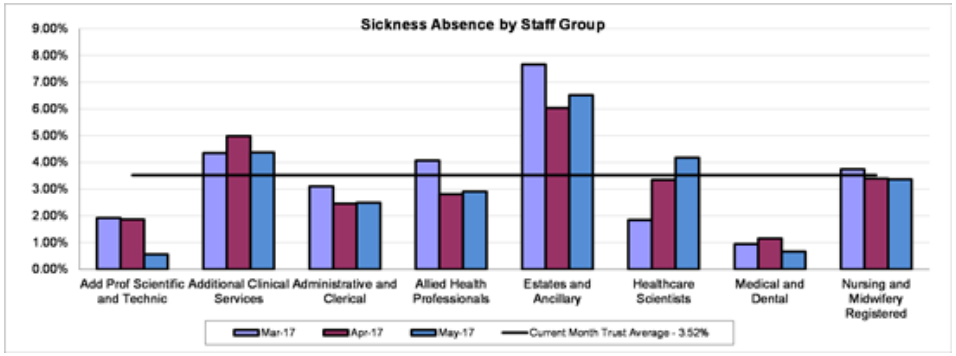
SICKNESS ABSENCE







Sickness Absence by Staff Group	Mar-17	Apr-17	May-17	Last 12 Months Average
Add Prof Scientific and Technic	1.92%	1.87%	0.56%	2.75%
Additional Clinical Services	4.34%	4.98%	4.37%	5.29%
Administrative and Clerical	3.10%	2.45%	2.49%	3.41%
Allied Health Professionals	4.06%	2.81%	2.91%	3.36%
Estates and Ancillary	7.66%	6.03%	6.51%	7.62%
Healthcare Scientists	1.84%	3.35%	4.17%	2.56%
Medical and Dental	0.94%	1.15%	0.66%	0.86%
Nursing and Midwifery Registered	3.74%	3.39%	3.36%	3.66%
Trust total	3.31%	3.15%	2.96%	3.52%



SICKNESS ABSENCE COMMENTARY

The monthly average for May 2017 (2.96%) is less than for April 2017 (3.15%) and is below the Trust target of 3.32%. The Trust's overall average for the year ending 31st May 2017 is 3.52%. This is above the Trust target and slightly higher than the same period last year (3.34%).

The number of employees with a Bradford score over 150 has reduced from 458 in May to 427 in June. Of these, 64% have had a formal Stage 2 sickness absence meeting within the last 12 months - same as last month but continues an upward trend.

There have been reductions in the number of employees with a Bradford score over 150 in all areas of the Trust, with the exception of Cancer Services and Speciality Medicine, who have shown increases in numbers this month.

TRAINING COMPLIANCE BY DIVISION

June 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	76%	100%	83%	76%	83%	68%	80%	77%	85%
Diagnostics, Therapeutics and Outpatients	85%	100%	84%	81%	89%	80%	80%	82%	82%
Medicine	76%	96%	80%	79%	82%	82%	78%	81%	92%
Surgery	81%	75%	83%	82%	85%	87%	80%	81%	88%
Women's & Children's	72%	83%	79%	77%	81%	83%	77%	77%	92%
TRUST TOTAL	**78%**	**92%**	**82%**	**79%**	**84%**	**83%**	**79%**	**80%**	**88%**
Change from last month	4%	0%	1%	0%	0%	3%	0%	0%	1%

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

Compliance for most statutory training topics remains steady this month, with Safe Moving Practical, Fire and Safeguarding Children increasing slightly.

Appraisals

The Trust-wide compliance figure has increased by 4% this month, with an increase of 8% for Allied Health Professionals, Healthcare Scientists and ancillary staff. We have made contact with a number of line managers who have then been able to improve compliance due to a concerted effort to undertake the appraisals that were overdue.

This month, we are going to focus on reminding managers in the areas that are below 65% compliance, particularly where there are smaller staff groups.

Following release of the detailed reports to cost centre managers, we will scrutinise any queries carefully as the discrepancies are most often because appraisals have not been reported in a timely way with the information we require despite monthly reminders of the deadline.

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

BOARD OF DIRECTORS

Agenda item	8	**Category of Paper**	Tick
Paper Title	Clinical Outcome, Safety & Quality Report	**To action**	☐
Date of Meeting	26 April, 17 May and 21 June 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 26 April, 17 May and 21 June 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 26 April, 17 May and 21 June 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 26 April, 17 May and 21 June 2017.

2. **Patient Story –** A patient story has been re-introduced onto the agenda from June 2017 and patients or relatives/carers will be invited to attend to share their story on occasion.

3. Governance

Terms of Reference – The terms of reference for COSQ were agreed following a revision to include an addition to the objectives and amendment to job titles.

Quality Report and Performance Report - COSQ received and reviewed the Quality and Performance Report at each 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. Data for cancelled operations was also contained within the report and discussed in detail.

Duty of Candour regarding readmission to theatre was discussed and further clarity was requested.

Quality Improvement Strategy - COSQ discussed the development of a Quality Improvement Strategy, noting that this focuses on empowering staff to resolve issues within their own areas. The committee acknowledged the large number of quality topics to be pulled together, including a number of developments and initiatives that are already underway. Stakeholder discussions have been held to develop the Trust's ambition to create a Faculty for Quality Improvement. Actions from the IHI report will be incorporated into the Strategy as one of the sources of information to feed in.

Medicine Division – The Clinical Chair for the Medical Division was in attendance in April and confirmed that clinical governance processes are working well within the Medicine Division. The committee discussed mortality reviews and noted the proposals for continuing the reviews with a triage of 100% followed by consultants carrying out a full review on 50% of the deaths. The Associate Director of Nursing (Quality) highlighted one of the national HQIPPs (a priority chosen by NHS England) relating to patients with learning disabilities.

Surgery Division – The new Clinical Chair for the Surgery Division and the Associate Director for Surgery attended COSQ in June and gave an overview of the governance structure and processes within the Division. Discussion took place with regard to ensuring that clinical outcomes are discussed at clinical governance meetings. COSQ acknowledged the challenges faced by the Surgery Division to drive improvement.

Quality Account – COSQ received the Quality Account for comment. The committee discussed the resources available to achieve the quality priorities and the COSQ

workplan was updated to ensure that the quality priorities are monitored.

CQC Trust Buddy Scheme – The committee received the update report on the CQC buddy visits.

4. Quality Dashboard

Nursing Dashboard – The Acting 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, particularly in Women's and Children's Division.

5. Clinical Outcome & Patient Safety

Mortality – Assurance was given that following a peak in deaths in January and February, the Dr Foster HSMR data has now been published and the L&D has not been identified as an outlier. This indicates that there was a national trend in deaths in January and February. The Medical Adviser noted that all deaths have been audited and nothing unexpected or unexplained was identified.

Trauma and Orthopaedic Visit - The Acting Deputy Chief Executive informed the committee of a Trauma and Orthopaedics GiRFT visit from Professor Briggs on 5 May 2017. It was noted that the main area of discussion and concern was the recruitment and retention of junior medical staff as there has been a decline in substantive FY2 staff. An urgent review of the medical model is being undertaken, with a proposal for implementation of a hot week system. Other areas of improvement identified included: the necessity for a designated clean joint ward; an audit to be undertaken relating to re-admission rates within 30 days for hip and knee replacements; and network arrangements should be sought with other local hospitals for some procedures that are carried out in low volume.

Serious Incidents – COSQ received the reports giving an update on Serious Incidents and Never Events. Completed serious incidents and the learnings are being actioned through Divisions and monitored by the Clinical Operational Board.

COSQ received other reports and noted updates for the following:

- Needs Based Care
- Hospital Acquired Thrombosis
- Infection Control Quarter 4 2016/17
- Managing Patients with Severe Sepsis

6. Patient Experience

Inpatient Survey – The Associate Director of Nursing (Quality) presented a summary of the inpatient survey results and the Trust's comparisons with other Trusts surveyed by Quality Health (35 in total). The Executive Team held two 'deep dive' sessions and reported back to COSQ. COSQ noted the importance of the Trust's Vision and Values.

COSQ received and noted the inpatient survey report, together with a presentation which highlighted the areas where the Trust scored in the worst 20%. It was reported that an in-depth discussion had been held at the Executive meeting and agreed that time would be dedicated during the staff engagement events to focus some work, particularly

around discharge and communication, with the wider workforce. The committee discussed the merits of ward/department teams taking ownership of issues and doing small things which make a difference. Alongside the development of a new Quality Improvement Strategy, all staff will be supported, motivated and encouraged to work with patient ambassadors to hold conversations with patients to resolve some of the issues. An updated survey has been launched on iPads to give some better intelligence.

Patient Experience Annual Report – The Patient Experience Report for the year 2016/17 was received and noted.

Legal Claims – The committee had previously noted the increase in claims and the Head of Litigation attended to brief the committee on the themes of claims which related to incidents which occurred over a timescale of 3 years. The themes involve A&E and Orthopaedics ie missed fractures, and new processes are already in place to mitigate future incidences. Currently there is no dataset to compare claims against other Trusts.

End of Life Care Report – The Acting Director of Nursing and Midwifery confirmed that the End of Life Care Strategy Group continues to meet quarterly and agreed to share a workplan with clear deliverables at a future meeting.

7. Quality Priority 1 – Clinical Outcome and CQUINs

A new reporting format was presented to COSQ in June. The committee noted the progress and commented on the following clinical outcomes and CQUINs:

- Improve our approach to mortality surveillance, identifying and reducing avoidable deaths;
- Reduce the impact of serious infections (Antimicrobial Resistance and Sepsis) (also CQUIN);
- Improve services for people with mental health needs who present to A&E (also CQUIN);
- Provide services to patients experiencing frailty in line with best practice;
- CQUIN – Offering Advice and Guidance;
- CQUIN – NHS e-referrals.

8. Report from Clinical Operational Board

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

9. Workforce Update

Statutory Training and Appraisals – The Training and Development Reports covering activity up to 31 May 2017 were received and noted. The committee discussed overseas nurses and working with the agency to support individuals through the recruitment process. The Director of HR highlighted that the poor performing areas regarding appraisal compliance are working to improvement plans. With regard to conflict resolution training, it was confirmed that bespoke sessions are being delivered to some areas.

Nursing Workforce - COSQ reviewed the nursing workforce reports and noted the content. The Acting Director of Nursing and Midwifery re-iterated the challenges to maintain good levels of staffing in all areas and the difficulties around retention of some

nurses due to competitive salaries offered at neighbouring Trusts. Therefore there has been a focus on retention and a workshop has been held with Matrons and Human Resource staff.

Staff Survey Feedback – The committee received a summary of the results of the staff survey and acknowledged the positive feedback.

10. CQUIN 2016/2017

COSQ were informed that CQUINs for 2016/17 were achieved in full with the exception of the CQUIN relating to sepsis where the Trust achieved the part of CQUIN relating to screening but only partly achieved regarding IV antibiotics within an hour, due to a number of issues relating to prescribing and delays in administration.

11. Risk Register

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

12. Safeguarding

Adult Safeguarding – COSQ received an update on Adult Safeguarding and noted the main themes of referrals against the Trust which were not upheld. Delivery of Adult Safeguarding Level 3 training to FY2 doctors was recognised as a concern and a plan has been instigated to ensure compliance. The Trust has advertised for a lead consultant for adult safeguarding.

Safeguarding Children and Midwifery – The Safeguarding Leads were in attendance and presented an update on safeguarding children and midwifery, highlighting current serious case reviews.

13. Maternity

The committee received and noted the maternity action plan overview report.

14. Clinical Audit

The draft report for the Medical Devices Audit was received which highlighted issues with regard to planning for replacement of equipment, and training of medical devices and competencies. The Executive Team agreed to undertake an urgent review.

15. Papers Received for Information:

- Minutes of the Nursing and Midwifery Board meetings
- National Quality Publications of Interest

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

BOARD OF DIRECTORS

Agenda item	9	**Category of Paper**	Tick
Paper Title	Finance, Investment & Performance Committee	**To action**	☐
Date of Meeting	26 July 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: 26 April, 17 May, 21 June & 12 July 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 26 April, 17 May, 21 June & 12 July 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 26 April, 17 May, 21 June & 12 July 2017.

Public Meeting ☒ Private Meeting ☐

FINANCE INVESTMENT & PERFORMANCE COMMITTEE REPORT TO THE TRUST BOARD

This summary report covers meetings held on 26th April, 17th May, 21st June & 12th July 2017.

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

Committee Member	26/04/2017	17/05/2017	21/06/2017	12/07/2017
Jill Robinson (Chair)	✓	✓	✓	✓
Simon Linnett	✓	✓	✓	✓
David Hendry	✓	✓	✓	✓
Mark Versallion	✓	×	✓	×
John Garner	✓	✓	✓	✓
Clifford Bygrave	×	×	×	✓
Pauline Philip	✓	-	-	-
Andrew Harwood	✓	✓	✓	✓
David Carter	✓	✓	✓	✓
Danielle Freedman	✓	×	×	×
Mark England	✓	✓	-	-
Angela Doak	✓	✓	✓	✓
Cathy Jones	✓	✓	✓	✓
Sheran Oke	✓	✓	✓	✓

Matt Gibbons and Tim Hughes are regular attendees and were present for all the meetings above. Other attendees between April & July were Victoria Parsons, Jenny Pigott, Jim Machon, David Hartshorne, Louise Young, Sally Gitkin, Philippa Graves, Ricky Shah, Alison Clarke, Vimal Tiwari, Caroline Roberts, Jenny Cadman, Rebecca Pheby and the full management team from the Surgical Division.

During the first 4 months of 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 final FY16/17 financial position, including recognition of significant non-recurrent income that contributed to a surplus of £12.9m. It was reported that KPMG completed their audit of the year end accounts and there were no unadjusted differences arising.
- Considered the initial FY17/18 financial position, including issues associated with achieving the FT Control Total and actions required to mitigate the substantial financial risks faced by the FT. It was reported that Divisional improvement plans are managed through monthly business planning meetings and with Deputy Chief Executive oversight
- It was noted that agency expenditure (particularly in relation to medical locums) remains an area of concern
- 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 and developed the FT approach to the FY17/18 Control Total

- Ratified the year-end forecast submission after due consideration of the Divisional improvement plans (CIPs), MRET & Readmissions, and securing further stretch improvements
- Received feedback from the FT Audit Committee
- Received an Internal Audit Report on financial governance.
- The Trust's backlog maintenance was considered in the context of site redevelopment and the Trust's capital plan for FY17/18.
- Received notification that GDE funding had been released to the Department of Health but the election had delayed its release to the FT
- Received and supported a case to increase Dermatology nursing to facilitate phototherapy and mitigate the continuing short supply of specialist doctors
- Received and supported a case for investing in mortuary service capacity and resilience
- Cases for substantive service development in Respiratory and Rheumatology were moved for consideration alongside the full Needs Based Care proposal
- The capital cost summary of the site re-development was considered under the headings of STP, Trust funded, phase 2, external and completed, with an agreement that the hot block proposition was relevant to the STP.
- Considered key HR matters (including recruitment issues, the new junior doctors' contract, IR35 changes, junior doctors' rostering 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
- Supported the plan to relocate Luton Sexual Health Services to Arndale House with agreement to consider which other services might be relocated alongside LSHS through a business case to come back to FIP in September.
- Considered Divisional reports from Surgery and Medicine. These reports were overviews of FY16/17 performance alongside forward views of FY17/18 in terms of deliverables, opportunities & risks
- Considered and approved an additional General Surgery consultant (locum).
- Advanced plans for the helipad development, including agreeing seeking Libor funding and reconciling the impact on backlog issues
- Considered the plan with increasing and enhancing imaging capacity in MR and SPECT
- Received a report on the progress with the apprenticeship schemes which are on target
- It was agreed that post implementation reviews should include tests of resilience and functionality as much as finances and quality.
- Received various STP updates.

Recommendation
The Board is asked to note this report.

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

BOARD OF DIRECTORS

Agenda item	10	**Category of Paper**	Tick
Paper Title	Audit and Risk Committee	**To action**	☐
Date of Meeting	26 July 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 17 May 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 Committee held **17 May 2017.**

SUMMARY/CURRENT ISSUES AND ACTION

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

- External Audit - ISA 260 Audit Memorandum and Audit Opinions/FY 16/17 Annual Report & Accounts
- Internal Audit – Progress Reports/ Financial Governance & Delivery of the Financial Plan Final Report/ Medical Devices Final Report/ Internal Audit Plan 2017/18
- Counter Fraud – Progress Report and Self Review Tool
- Assurance from Sub Committees
- Board Secretary Report
- Sub Committees' Updates

ACTION REQUIRED

To note the **17 May 2017** Audit and Risk Committee Report.

Public Meeting ☒ Private Meeting ☐

REPORT of 17 MAY 2017 AUDIT and RISK COMMITTEEMEETING

Please find attached the Report from the 17 May 2017 Audit and Risk Committee.

For governance and auditing purposes:-

- The Committee members present were:
  David Hendry, Alison Clarke, Vimal Tiwari, 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: Cliff Bygrave, Mark Versallion, and Danielle Freedman

- Conflicts of Interest & Changes:
  None identified.

- The minutes/report of the previous meeting held on 22 March 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 17 May 2017.

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

2. Minutes of Last Meeting – 22 March 2017

The minutes of the meeting on 22 March 2017 were approved.

3. Matters Arising/ Action Log

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

- Adult Safeguarding - Board Seminar plan to be shared
- Estates – business plan from Director of Estates received late, not yet reviewed
- Backlog maintenance – risk register to be updated to include separate risk
- Cyber security – given recent national focus on this - Board Seminar to be organised
- Fraud Self Review Toolkit non employed individuals – still unclear on the rationale for them being treated differently and what assurance is available from third parties.
- Costing Assurance Report – also on FIP agenda where executive input can be provided. Noted it was a very positive report
- Internal Audit recommendations – assessing responses before being transferred to the risk register as appropriate
- Counter fraud Case – call held between chair and LCFS to understand delay. Some of the delay is attributable to counter fraud where specialist input was required to be co-ordinated with input from the Trust. COSQ taking the matter forward
- Management stretch – ongoing assessment of risk before being formally added to the risk register
- HR Strategy – Terms of Reference being drafted for consideration of an HR Sub Committee.
- Overseas Visitors and training on identification and recruitment actions to be carried forward

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

4. KPMG External Audit

ISA 260 Audit Memorandum and Audit Opinions –

No issues were identified over the course of the audit; the risks identified in the audit plan were specifically assessed concluding that the processes and assumptions were sound. An unqualified opinion on the financial statements is anticipated along with a clean opinion on the Quality Accounts.

No concerns noted in respect of the value for money conclusion although it was noted that the environment is challenging. A recommendation was made to formalise/ standardise STP reporting to the Board. The Committee requested that this recommendation be revised for such reporting to be monthly rather than bi-monthly. The Committee expressed concern over risks associated with the STP including the financial exposure, delegated authority over spend, lack of clarity as to the outcomes of STP work, difficulties monitoring the Trust's performance arising from STP transactions due to the FT 'banker

arrangements', and management stretch as a result of Trust staff being seconded to STP. External Audit reiterated that regular reporting will enable the Board to monitor and challenge such risks.

Subject to final checks the work on the quality indicators is likely to result in external audit being able to issue the required limited assurance opinion.

Thanks were noted to the Finance Team and the Board Secretary for the timeliness and quality of the accounts production and underlying records.

Post Committee Update – Opinions issued in advance of deadline on 26 May 2017.

The Committee agreed that External Audit recommendations should follow the same process as internal audit. Update to be provided at October meeting

It was agreed that the Management Representation letter for the financial statements would be signed by the Director of Finance, Andrew Harwood and the equivalent letter for the quality accounts be signed by the Acting Chief Executive, David Carter.

5. Financial Year 2016/17 Annual Report and Accounts

Review of Financial Performance (Extract from Annual Report) – A few changes were requested to avoid inconsistencies with disclosures by other STP partners and provide clarity on the underlying cause of the cash balance being higher than expected.

Annual Governance Statement – Minor changes requested. Committee confirmed that as the Accountable Officer as at 31 March 2017 it was appropriate for Pauline Philip to sign this statement.

Financial Statements – the Committee requested regular reporting to FIP in a similar format to the financial statements for receivables.

6. 2016/17 Compliance

Waivers – Ongoing issue in respect of timeliness of identification of potential waivers resulting in limited opportunity to influence the decision making process. Procurement are aiming to cover 40% of contracts on the Contract Register which should mitigate some of the risk. The Committee requested this be added to the risk register. The Committee also questioned the appropriateness of the Trust undertaking sole responsibility for approval of waivers in respect of BLMK STP; it was requested that in future this should be a shared decision by the informed parties.

Losses & Special Payments – 2016/17 register of losses and compensation taken as read.

Payroll Bureau Audit – significant assurance conclusion noted, the Trust to confirm whether the prior year recommendation on leavers had been completed.

Declarations of Interest/ Hospitality Register/ Fit & Proper Persons Declaration – change required in respect of Jill Robinson. The Committee requested that approximate value of hospitality to be included in future and that employees be reminded of the rules regarding Hospitality as requested in the prior year.

7. PricewaterhouseCoopers Internal Audit

Internal Audit Annual Report – conclusion noted to be generally satisfactory with some improvements required in the areas of: financial governance relating to control of divisional delegated authority; agency staff; and medical devices training and replacement programme. No critical risks were identified during the year and all significant recommendations have been accepted by the Trust for implementation. It was noted by the Chair that recommendations from previous years need to be implemented as a priority.

Financial Governance & Delivery of the Financial Plan Final Report – overall concluded medium risk due to an identified gap in the scheme of delegation in respect of the mechanism/ consequences of divisional performance measures not being met.

Medical Devices Final Report – concluded to be high risk with 2 high risk findings identified. Firstly the lack of a longer term assessment of the funding requirement for a replacement equipment programme and, secondly, weaknesses in the processes for monitoring and recording training compliance in this area.

Internal Audit Plan 2017/18 – A paper was presented identifying the areas for consideration for the 2017/18 internal audit plan from COSQ, FIP and the Chair of Audit & Risk. PwC confirmed that the proposals appeared well founded and would consider these in line with their own findings and internal process in time for the Chair to propose a final plan to the Board on 7 June. In order that the programme could continue without delay it was agreed that the 3 reviews of: Financial Recovery (A4), Cyber Security (B5) and A&E review (C5) should be commenced. Other areas were discussed and mitigating actions considered including a Board Seminar on Business Continuity and a presentation on Health and Safety at the October Committee.

Outstanding 2016/17 work plan: Discharge Planning – Noted that the analysis has been undertaken and the report was being produced.

8. Counter Fraud - PricewaterhouseCoopers

Draft Counter Fraud Work Plan – was reviewed and agreed, resource input to remain the same as 2016/17 focussing on relationship with Communications which is already underway. A query was raised as to whether the Fraud Risk Group should meet more frequently. It was accepted that there are regular communications between the group if any new fraud risks are identified and therefore more frequent meetings are not necessary.

Self Review Tool (SRT) Action Plan: the action plan was noted.

NB: NHS Protect is to be decommissioned from July 2017. NHS Counter Fraud Authority to be established. The new organisation will not offer training or a regional specialist.

9. Board Secretary Reports

Risk Management & Governance – key risk noted as being backlog maintenance with management stretch to be added. A compliance review against the provider licence had been undertaken with no issues identified.

CQC Issues – CQC are seeking further assurances on 2 never event occurrences.

Draft Conflict of Interest Policy – Policy drafted based on NHS England guidance. The Committee recommended that the Executive Team advise who to exclude, if anyone, from the decision making staff listed in section 7 of the document who will be required to make an annual declaration of any interests. It

was noted that review by the Executive Team and the proposed communications plan is on the agenda for 7 June.

10. Sub Committee Updates

As the sub-committee reports had been presented to the Board recently the Committee was up to date.

11. Audit Committee Report to the Board

Noting that Appendix 2 was to be updated with the final wording of the Annual Report the report was agreed.

12. Date of Next Meeting: 11 October 2017

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

BOARD OF DIRECTORS

Agenda item	11	**Category of Paper**	Tick
Paper Title	Charitable Funds Committee Reports to Board of Directors	**To action**	☐
Date of Meeting	26 July 2017	**To note**	☒
Lead Director	Andrew Harwood – Director of Finance	**For Information**	☐
Paper Author	Andrew Harwood	**To ratify**	☐
Indicate the impact of the paper: **Financial** ☒ **Quality/Safety** ☒ **Patient Experience** ☒ **Equality** ☒ **Clinical** ☒**Governance** ☒			

History of Committee Reporting and Date	Charitable Funds Committee 3rd May 2017
Links to Strategic Board Objectives	Objective 5 – Progress Clinical and Strategic Developments Objective 6 – Develop all Staff to Maximise Their Potential Objective 7 – Optimise our Financial Position
Links to Regulations/ Outcomes/External Assessments	Links to NHS Improvement in relation to the Trust Governance Framework
Links to the Risk Register	N/A

PURPOSE OF THE PAPER/REPORT

To update the Board of Directors on the findings and approval of the Charitable Funds Committee held on 3 May 2017

SUMMARY/CURRENT ISSUES AND ACTION

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

- Chairman's Announcements
- Cheviots Investments
- Market testing of investment management
- Fundraising Update
- Management Reports
- Bids for review

Public Meeting ☒ Private Meeting

DRAFT

REPORT of 3 MAY 2017 CHARITABLE FUNDS COMMITTEE MEETING

Report from the 3 May 2017 Charitable Funds Committee.

For governance and auditing purposes:-

- The Committee members Present were:
  Clifford Bygrave, David Hendry, Simon Linnett, Alison Clarke, John Garner, Vimal Tiwari, Jill Robinson, Andrew Harwood, Sheran Oke, , and Angela Doak

- In attendance were:
  Sarah Amexheta, Sarah Newby, Victoria Parsons, Jenny Pigott and Ian Brassington (for agenda item CC326)

- Apologies were received from:
  David Carter, Danielle Freedman, Mark England, and Mark Versallion

- Conflicts of Interest & Changes:
  Other than dual interest for the committee members for the Trust and Charitable Funds, none identified

- The minutes/report of the previous meetings held on 16 November 2016 and 11 January 2017 were approved as an accurate record.

Introduction **Action**

This report updates the Board of Directors on the matters considered at the Charitable Funds Committee on 3 May 2017.

The Board of Directors is asked to note the content of the Charitable Funds Committee Report.

CC322 Chairman's Announcements
The Chair informed the Committee of agreement to contribute £500 towards the Bedfordshire branch of the NHS Retirement Fellowship.

CC323 Apologies for Absence
David Carter, Danielle Freedman, Mark England, and Mark Versallion

CC324 Minutes of Last Meetings – 16 Nov 2016 & 11 January 2017
Minutes of the previous meeting agreed

CC325 Matters Arising
Matters arising from the last meeting:

- Bid & Appeal Process – the bid and approval process as drafted was approved
- Medical Equipment Divisional Priorities – shared with Sarah Newby/ Sarah Amexheta for identification of any fundraising opportunities
- Information for volunteers, fundraising, membership is to be available for the next governors meeting
- Ophthalmology bid – confirmation received that the physical space for the equipment is available.
- Blue Light Cystoscopy Update – grant received and equipment purchased
- Helipad – Separate restricted fund created and £500k cheque deposited March 2017

CC326.1-2 Quilter Cheviot Investment Management Update
Ian Brassington presented a report showing the Q1 performance and the portfolio valuation as at 31/3/17. Clarification was received that despite a change in the team responsible for managing the portfolio the new team had been involved behind the scenes previously and therefore there was a continuation of style, strategy and service as provided in the past with a focus on growth rather than dividend yield.

CC326.3 Market Testing of Investment Management Services
The charity had received various correspondence from Quilter Cheviot in respect of the departure of a number of key individuals for the management of the Charity's investment portfolio. This led the Committee to believe this was an appropriate point to undertake a beauty parade of investment managers whilst also assessing the future of the charity with a backdrop of STP and site redevelopment. It was agreed to set up a meeting with the Chair, Vice Chair, Director of Finance and Head of Financial Control to take this forward. Cliff Bygrave, David Hendry, Andrew Harwood, Jenny Pigott

CC327 Report on General Fund
The report was presented and noted that before recognition of 2016/17 investment gains the general fund balance was £1,030k. The reserve policy is to be considered as part of the future of the charity/ investment management as discussed in agenda item CC326.3.

CC328 Fundraising Update
The report was taken as read. The power of social media was highlighted with 100 new supporters signed up as a result of a facebook page for NICU. It was requested that the NICU balance be

included in the report in future.

CC329 Future of the Charity (superceded by discussion in agenda item CC326.3)

CC330 Bids for Approval

- CC330.1 Revenue Support – £155k funding agreed for Disposable Curtains and Bioquel Pods. In respect of the patient safety post it was agreed that rather than funding the post alternative patient safety initiatives such as 'e-observations' project funding should be funded to an equivalent level (£75k) with the exact scope to be agreed outside of the meeting. Andrew Harwood
- CC330.2 Summer Engagement Event - £64k funding agreed for the summer engagement event which will expand from the previous focus on staff engagement to include a fundraising event, launch a maternity services event and recruitment.
- CC330.3 Nurse Badges – withdrawn
- CC330.4 Sepsis Film – withdrawn
- CC330.5 Patient Welcome Pack – agreed to pilot 2,500 packs and feedback to the next meeting take up and initial feedback including how the packs will be stored. Agreed to use the existing balance for Patient Information Folder Monies. Sheran Oke
- CC330.6 Employee Assistance Programme – agreed to extend the existing contract for 12 months to January 2019 at a cost of £17,185.

No other business raised.

BOARD OF DIRECTORS

Agenda item	12	**Category of Paper**	Tick
Paper Title	Hospital Redevelopment Report	**To action**	☐
Date of Meeting	26 July 2017	**To note**	☒
Lead Director	David Carter, Acting 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, 10 May 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.
Work commenced on 2 May on the extension of the Oral Maxillo-Facial facility. There have been delays to the progress of the works due largely to building issues exposed following demolition. The project will be completed in September.
Design work for the Sexual Health Services clinic at Arndale House is complete. The works will be tendered at the end of July. Negotiations on the lease documents have commenced.
A new cost plan for the proposed helipad has been completed following additional design work instructed in April. This is under review.

ACTION REQUIRED
The Board is requested to note the report.

Public Meeting ☒ Private Meeting ☐

REDEVELOPMENT PROGRAMME BOARD REPORT
11 July 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 10 May 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). An application for funding for the new Services Block from the STP transformation fund was submitted at the end of May.

The next stage of design for the proposed helipad has been completed. A new cost plan has been issued which has highlighted an increase in cost due to the scope of the enabling works required, together with a reassessment of the construction costs associated with building the new liftshaft in the centre of the site. The current state of the project is being reviewed by FIP on 12 July.

An update on the projected cost of the scheme was presented to FIP on 17 May.

3. Enabling schemes

Work to refurbish the first floor of the Nurses home annexe (Block 38) was completed at Easter.

The contract for the extension of the OMFS area commenced on 2 May after the removal of asbestos products within the area. Progress by the contractor has been impacted by a delay in the production of design information for the M&E services. This has led to a 4 week delay on the project. There have also been a number of service variations requested by the operations team.

The design of the new Sexual Health Services clinic at Arndale House is complete. Tenders for the contract will be issued in July. Access to start construction is linked to completion of the strip out work by the landlord. This has been delayed as a consequence of delays by Luton Borough Council in committing to the scheme. This has now been resolved. Discussions on the legal provisions have commenced.

FIP have also approved the proposal to take the balance of the first floor at Arndale House. This space is intended to be used to support the transfer of services from the main site. This will allow a number of key patient experience, as well as operational issues, to be addressed. Proposals will be subject to approval of separate business cases by FIP. The intention is to add the scope of works to those for the Sexual Health Services clinic to achieve best value from the contractor.

The redevelopment team are supporting the major schemes to deliver new equipment for the Imaging department.

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. Arrangements for these discussions are in hand.

5. Programme Risk Register

The risk register has been updated and was reviewed by the Programme Board at the meeting in March. The register will be reviewed again in Q3.

6. Future activity

The redevelopment team are supporting the development of projects which address short-term capacity constraints within the Trust.

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

BOARD OF DIRECTORS

Agenda item	13	**Category of Paper**	Tick
Paper Title	Risk Register	**To action**	☐
Date of Meeting	26th July 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 17th May 2017 and 21st June 2017. Finance, Investment and Performance Committee 21st June. 2017Executive Board 25th July 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

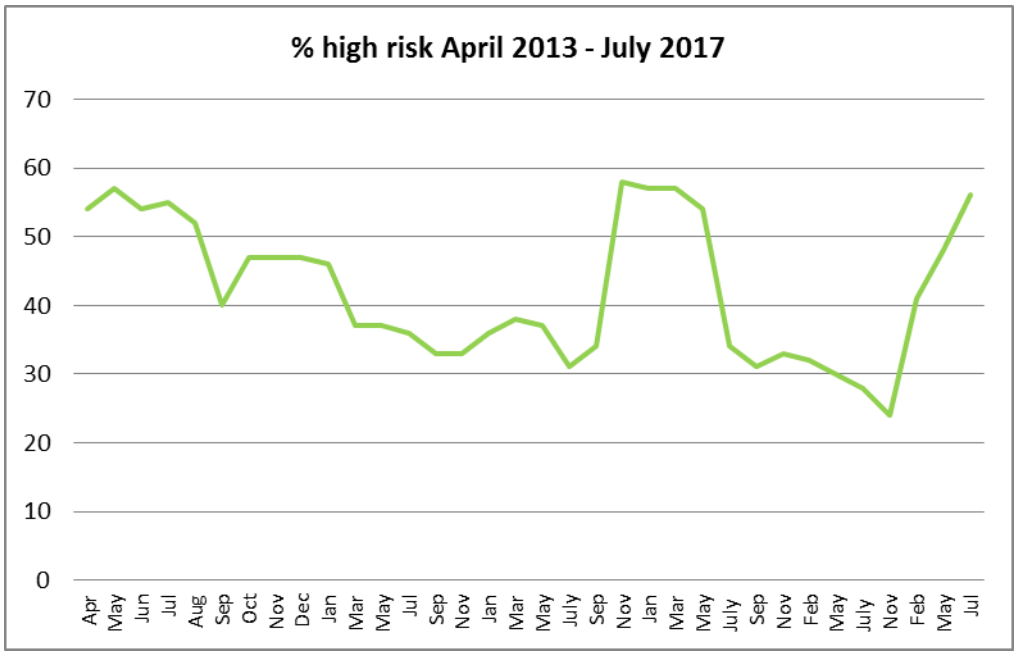
ACTION REQUIRED

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 23 Board Level Risks on the Risk Register (25 in May 2017). 53% are currently high risk (15+).



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

Board of Directors Review
The Board reviewed the risks on the 3rd May 2017.

Risk ref	Risk Description	Agreed conclusion
1175	Agency Risk 2016/17	Close risk and review for 2017/18
650	Bed Pressures	Maintain risk
669	Appraisal rate	Maintain risk
1018	HSMR	Maintain risk

Emerging risk of national availability of antibiotics.

Clinical Outcome, Safety and Quality Committee (COSQ)
COSQ reviewed clinical board level risks on the 17th May 2017 and 21st June 2017.

Risk ref	Risk Description	Agreed conclusion
796	Inpatient Experience	Review risk following inpatient survey
669	Appraisal Rates	Maintain risk

Finance Investment and Performance Committee (FIP)
FIP reviewed finance and performance board level risks on the 21st June 2017.

Risk ref	Risk Description	Agreed conclusion
1117	CCG verification	Maintain risk
1200	Cyber security	Maintain risk

Noted new risks.

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

Risk Review

12 new risks were reviewed and approved between 19th April and 17th July 2017. Four risks allocated as Board Level:

- 1212 – Agency costs 2017/18
- 1210 – Vacancy rates 2017/18
- 1213 – Management Time and Capacity
- 1211 – Backlog Maintenance
- 1226 – National Availability of Antibiotics

4 risks were closed, none at Board level:

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

- 604 – Ward environments
- 641 – Electrical infrastructure
- 619 – Lack of gas resilience
- 830 – Building Management System

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

BOARD OF DIRECTORS

Agenda item	14	**Category of Paper**	Tick
Paper Title	Board Secretary Report	**To action**	☐
Date of Meeting	26th July 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
- Policies and Procedures

ACTION REQUIRED

Board are asked to:

- Approve the Conflict of Interest Policy

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 Brian Spurr, Central Bedfordshire Council, has taken up the appointed governor position from May 2017.

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

2. Members

The next Medical Lecture is on the 11th October 2017 and is on Colorectal Surgery and Stoma Care.

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

3. Conflicts of Interest Policy

At the last Board the new Conflicts of Interest guidance had been issued. The Trust has since developed its own policy document based on the national guidance and this has been reviewed by the Audit and Risk Committee and the Policy Approval Group. It is one of the policies that the Board are asked to approve and the policy is appendix 1.

The Board of Directors are asked to approve the Conflict of Interest Policy.

State if the document is a Trust Policy/Procedure or a Clinical Guideline	Policy

Document Title:	Conflict of Interest and Declaration of Interest Policy (Including Gifts, Hospitality, Sponsorship and Fit and Proper Persons)
Document Number	**C17**
Version Number	**4**
Name and date and version number of previous document (if applicable):	C17 Conflict of Interest and Declaration of Interest Policy (Including Gifts, Hospitality, Sponsorship and Fit and Proper Persons) ver 3 BC02 - Conflict of Interest Policy (Including Gifts and Hospitality and Sponsorship) ver 2 (September 2011) Conflict of Interest Policy ver 1 (May 2009)
Document author(s):	Company Secretary
Document developed in consultation with:	Company Secretary Finance Department HR Department Board of Directors Head of Procurement Senior Independent Director
Staff with overall responsibility for development, implementation and review:	Board Company Secretary
Development / this review period:	April 2017

Date approved by the Policy Approval Group/Clinical Guidelines Committee on behalf of the Trust Board:	**June 2017**
Chief Executive / Chair Clinical Guidelines Signature:	**David Carter**
Date for next review:	**June 2020**
Date document was Equality Impact Assessed:	**June 2017**

Target Audience:	All Trust Staff
Key Words:	Conflict of interest, gifts, personal gain, private interests, register of declared interests, sponsorship, bribery, declaration, fit and proper persons, annual declarations
Associated Trust Documents:	Standing Orders Scheme of Delegation Anti-Bribery Policy Trust Procurement Strategy Standing Financial Instructions Counter Fraud Policy Recruitment and Retention Policy Raising Concerns Policy Commercial Representative Policy Fundraising Policy

Contents

1 Policy Summary

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

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

2 Introduction

Luton and Dunstable University Hospital NHS Foundation Trust (the 'organisation'), and the people who work with and for us, collaborate closely with other organisations, delivering high quality care for our patients. Adhering to this policy will help to ensure that we use both charitable and NHS money wisely, providing best value for taxpayers and donor and accountability to our patients for the decisions we make.

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

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

3 Purpose

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

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

This policy should be considered alongside these other organisational policies identified on the front page.

4 Key terms

A 'conflict of interest' is:

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

A conflict of interest may be:

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

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

5 Interests

Interests fall into the following categories:

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

6 Staff

At Luton and Dunstable University Hospital NHS Foundation Trust we use the skills of many different people, all of whom are vital to our work. This includes people on differing employment terms, who for the purposes of this policy we refer to as 'staff' and are listed below:

- All salaried employees
- All prospective employees – who are part-way through recruitment
- Contractors and sub-contractors
- Agency staff; and
- Committee, sub-committee and advisory group members (who may not be directly employed or engaged by the organisation)

Further guidance is available at www.england.nhs/ourwork/coi and on the Trust intranet.

7 Decision Making Staff

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

Decision making staff in this organisation are:

- Executive Directors (voting), Non-Executive Directors and other non-voting Directors
- Those at Agenda for Change band 8a and above

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

- Medical Consultants
- Administrative and Clerical staff who have the power to enter into contracts on behalf of their organisation
- Administrative and Clerical staff involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment and formulary decisions

Decision making by the Charitable Funds Trustees where they have a conflict of loyalty arising from their role and responsibilities as executive directors.[*]

8 Identification, declaration and review of interests

8.1 Identification & declaration of interests (including gifts and hospitality)

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

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

A declaration of interest(s) form is available at: on the intranet under policies and procedures/c/conflict of interest

The following information is captured:

- The returnee's name and their role within the organisation
- A description of the interest declared (reflecting section 5)
- Relevant dates relating to the interest
- Space for comments (e.g. action taken to mitigate conflict)

Declarations of gifts and hospitality and sponsorship should be made to the Company Secretary using appendix 2.

Declarations of interest should be made to the Company Secretary. The Company Secretary will review the interest and approve the log onto the register of interests using appendix 2.

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

[*] With the latter the conflict should be raised at the Charitable Funds Committee, considered by the Committee, formally agree whether or not this precludes the individual from decision making in the specific instance and note this in the minutes.

8.2 Proactive review of interests

8.2.1 We will prompt decision making staff annually to review declarations they have made and, as appropriate, update them or make a nil return. The following staff will be requested to complete an annual declaration:

- Executive Directors
- Non-Executive Directors
- Other Directors
- Council of Governors
- Medical Consultants
- 8a and above

This process will be overseen by the Company Secretary annually and appendix 3 will be used to gather the information.

8.2.2 Staff who fall in the below categories will be subject to training and declarations on induction into their post or starting in a new role:

- Administrative and Clerical staff who have the power to enter into contracts on behalf of their organisation
- Administrative and Clerical staff involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment and formulary decisions

This process will be overseen by the Head of Procurement.

9 Records and publication

9.1 Maintenance

The Company Secretary will maintain the gifts, hospitality and sponsorship log. Materiality of this will be reviewed by the Audit and Risk Committee annually.

The Company Secretary will review the interest and approve the log onto the register of interests. If there are any concerns about materiality, this will be escalated to the Chair of the Audit and Risk Committee for oversight and approval. Annually a report is made to the Audit and Risk Committee.

9.2 Publication

We will:

- Publish the interests declared by decision making staff on the Trust's website (www.ldh.nhs.uk) annually.

If decision making staff have substantial grounds for believing that publication of their interests should not take place then they should contact the Company Secretary to explain why. In exceptional circumstances, for instance where publication of information might put a member of staff at risk of harm, information may be withheld

or redacted on public registers. However, this would be the exception and information will not be withheld or redacted merely because of a personal preference.

9.3 Wider transparency initiatives

The organisation fully supports wider transparency initiatives in healthcare, and we encourage staff to engage actively with these.

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

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

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

10 Management of interests – general

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

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

Each case will be different and context-specific, and the Company Secretary will always clarify the circumstances and issues with the individuals involved. Staff should maintain a written audit trail of information considered and actions taken.

Staff who declare interests should make their line manager or the person(s) they are working to aware of their existence.

11 Management of interests – common situations

This section sets out the principles and rules to be adopted by staff in common situations, and what information should be declared.

11.1 Gifts

Staff in the NHS offer support during significant events in people's lives. For this work they may sometimes receive gifts as a legitimate expression of gratitude. We should be proud that our services are so valued. But situations where the acceptance of gifts could give rise to conflicts of interest should be avoided. Staff and organisations should be mindful that even gifts of a small value may give rise to perceptions of impropriety and might influence behaviour if not handled in an appropriate way.

A gift means any item of cash or goods, or any service, which is provided for personal benefit, free of charge, or at less than its commercial value.

- Staff should not accept gifts that may affect, or be seen to affect, their professional judgement.

Gifts from suppliers or contractors:

- Gifts from suppliers or contractors doing business (or likely to do business) with the organisation should be declined, whatever their value.
- Low cost branded promotional aids such as pens or post-it notes may, however, be accepted where they are under the value of £6* in total, and need not be declared.

Gifts from other sources (e.g. patients, families, service users):

- Gifts of cash and vouchers to individuals should always be declined.
- Staff should not ask for any gifts.
- Gifts valued at over £50 should be treated with caution and only be accepted on behalf of the organisation not in a personal capacity. These should be declared by staff.
- Modest gifts accepted under a value of £50 do not need to be declared.
- A common sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).
- Multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50.

All gifts should be reported to the Company Secretary using appendix 2.

11.1.1 What should be declared

- Staff name and their role with the organisation.
- A description of the nature and value of the gift, including its source.
- Date of receipt.
- Any other relevant information (e.g. circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.2 Hospitality

Delivery of services across the NHS relies on working with a wide range of partners (including industry and academia) in different places and, sometimes, outside of 'traditional' working hours. As a result, staff will sometimes appropriately receive

* The £6 value has been selected with reference to existing industry guidance issued by the ABPI: http://www.pmcpa.org.uk/thecode/Pages/default.aspx

hospitality. Staff receiving hospitality should always be prepared to justify why it has been accepted, and be mindful that even hospitality of a small value may give rise to perceptions of impropriety and might influence behaviour.

Hospitality means offers of meals, refreshments, travel, accommodation, and other expenses in relation to attendance at meetings, conferences, education and training events, etc.

- Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement.
- Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event.
- Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. This can be accepted, and must be declared, if modest and reasonable. Senior approval must be obtained.

Meals and refreshments:

- Under a value of £25 - may be accepted and need not be declared.
- Of a value between £25 and £75* - may be accepted and must be declared.
- Over a value of £75 - should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept.
- A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or a reasonable estimate).

Travel and accommodation:

- Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared.
- Offers which go beyond modest, or are of a type that the organisation itself might not usually offer, need approval by senior staff, should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept travel and accommodation of this type. A non-exhaustive list of examples includes:
  - offers of business class or first class travel and accommodation (including domestic travel)
  - offers of foreign travel and accommodation.

All gifts should be reported to the Company Secretary using appendix 2.

11.2.1 What should be declared

- Staff name and their role with the organisation.
- The nature and value of the hospitality including the circumstances.
- Date of receipt.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.3 Outside Employment

* The £75 value has been selected with reference to existing industry guidance issued by the ABPI http://www.pmcpa.org.uk/thecode/Pages/default.aspx

The NHS relies on staff with good skills, broad knowledge and diverse experience. Many staff bring expertise from sectors outside the NHS, such as industry, business, education, government and beyond. The involvement of staff in these outside roles alongside their NHS role can therefore be of benefit, but the existence of these should be well known so that conflicts can be either managed or avoided.

Outside employment means employment and other engagements, outside of formal employment arrangements. This can include directorships, non-executive roles, self-employment, consultancy work, charitable trustee roles, political roles and roles within not-for-profit organisations, paid advisory positions and paid honorariums which relate to bodies likely to do business with an organisation. (Clinical private practice is considered in a separate section).

- Staff should declare any existing outside employment on appointment and any new outside employment when it arises.
- Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks.
- Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from the organisation to engage in outside employment.

The organisation may also have legitimate reasons within employment law for knowing about outside employment of staff, even when this does not give rise to risk of a conflict. This is documented within the Standard Contract issued to staff on employment.

11.3.1 What should be declared

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

11.4 Shareholdings and other ownership issues

Holding shares or other ownership interests can be a common way for staff to invest their personal time and money to seek a return on investment. However, conflicts of interest can arise when staff personally benefit from this investment because of their role with an organisation. For instance, if they are involved in their organisation's procurement of products or services which are offered by a company they have shares in then this could give rise to a conflict of interest. In these cases, the existence of such interests should be well known so that they can be effectively managed.

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

- Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.
- There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

11.4.1 What should be declared

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

11.5 Patents

The development and holding of patents and other intellectual property rights allows staff to protect something that they create, preventing unauthorised use of products or the copying of protected ideas. Staff are encouraged to be innovative in their practice and therefore this activity is welcomed.

However, conflicts of interest can arise when staff who hold patents and other intellectual property rights are involved in decision making and procurement. In addition, where product development involves use of time, equipment or resources from their organisation, then this too could create risks of conflicts of interest, and it is important that the organisation is aware of this and it can be managed appropriately.

- Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the organisation.
- Staff should seek prior permission from the organisation before entering into any agreement with bodies regarding product development, research, work on pathways etc, where this impacts on the organisation's own time, or uses its equipment, resources or intellectual property.
- Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

11.5.1 What should be declared

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

11.6 Loyalty interests

As part of their jobs staff need to build strong relationships with colleagues across the NHS and in other sectors. These relationships can be hard to define as they may often fall in the category of indirect interests. They are unlikely to be directed by any formal process or managed via any contractual means - it can be as simple as having informal access to people in senior positions. However, loyalty interests can influence decision making.

Conflicts of interest can arise when decision making is influenced subjectively through association with colleagues or organisations out of loyalty to the relationship they have, rather than through an objective process. The scope of loyalty interests is potentially huge, so judgement is required for making declarations.

Loyalty interests should be declared by staff involved in decision making where they:

- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.
- Sit on advisory groups or other paid or unpaid decision making forums that can influence how an organisation spends taxpayers' money.
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.
- Are aware that their organisation does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

11.6.1 What should be declared

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

11.7 Donations

A donation is a charitable financial payment, which can be in the form of direct cash payment or through the application of a will or similar directive. Charitable giving and other donations are often used to support the provision of health and care services. As a major public sector employer the NHS holds formal and informal partnerships with national and local charities. Staff will, in their private lives, undertake voluntary work or fundraising activities for charity. A supportive environment across the NHS and charitable sector should be promoted. However, conflicts of interest can arise.

- Donations made by suppliers or bodies seeking to do business with the organisation should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.
- Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the organisation, or is being pursued on

behalf of the organisation's own registered charity or other charitable body and is not for their own personal gain.
- Staff must obtain permission from the organisation if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the organisation's own.
- Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued.
- Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

11.7.1 What should be declared

- The organisation will maintain records in line with the above principles and rules and relevant obligations under charity law.
- All donations should be reported to the Fundraising Team.

Refer to the Fundraising Policy for more information.

11.8 Sponsored events

Sponsorship of NHS events by external parties is valued. Offers to meet some or part of the costs of running an event secures their ability to take place, benefiting NHS staff and patients. Without this funding there may be fewer opportunities for learning, development and partnership working. However, there is potential for conflicts of interest between the organiser and the sponsor, particularly regarding the ability to market commercial products or services. As a result there should be proper safeguards in place to prevent conflicts occurring.

- Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit the organisations and the NHS.
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.
- No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.
- At the organisation's discretion, sponsors or their representatives may attend or take part in the event but they should not have a dominant influence over the content or the main purpose of the event.
- The involvement of a sponsor in an event should always be clearly identified.
- Staff within the organisation involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.
- Staff arranging sponsored events must declare this to the organisation.

11.8.1 What should be declared

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

- All sponsorship should be reported to the Company Secretary who will discuss this with the Head of Procurement.

11.9 Sponsored research

Research is vital in helping the NHS to transform services and improve outcomes. Without sponsorship of research some beneficial projects might not happen. More broadly, partnerships between the NHS and external bodies on research are important for driving innovation and sharing best practice. However, there is potential for conflicts of interest to occur, particularly when research funding by external bodies does or could lead to a real or perceived commercial advantage. There needs to be transparency and any conflicts of interest should be well managed.

- Funding sources for research purposes must be transparent.
- Any proposed research must go through the relevant health research authority or other approvals process.
- There must be a written protocol and written contract between staff, the organisation, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services.
- The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service.
- Staff should declare involvement with sponsored research to the organisation.

11.9.1 What should be declared

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

11.10 Sponsored posts

Sponsored posts are positions with an organisation that are funded, in whole or in part, by organisations external to the NHS. Sponsored posts can offer benefits to the delivery of care, providing expertise, extra capacity and capability that might not otherwise exist if funding was required to be used from the NHS budget. However, safeguards are required to ensure that the deployment of sponsored posts does not cause a conflict of interest between the aims of the sponsor and the aims of the organisation, particularly in relation to procurement and competition.

- External sponsorship of a post requires prior approval from the organisation.
- Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and withdraw if appropriate.
- Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or

prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise.
- Sponsored post holders must not promote or favour the sponsor's products, and information about alternative products and suppliers should be provided.
- Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

11.10.1 What should be declared

- The organisation will retain written records of sponsorship of posts, in line with the above principles and rules.
- Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this policy.
- All sponsored posts should be reported to the Company Secretary who will discuss this with the Head of Procurement.

11.11 Clinical private practice

Service delivery in the NHS is done by a mix of public, private and not-for-profit organisations. The expertise of clinicians in the NHS is in high demand across all sectors and the NHS relies on the flexibility that the public, private and not-for-profit sectors can provide. It is therefore not uncommon for clinical staff to provide NHS funded care and undertake private practice work either for an external company, or through a corporate vehicle established by themselves.
Existing provisions in contractual arrangements make allowances for this to happen and professional conduct rules apply. However, these arrangements do create the possibility for conflicts of interest arising. Therefore, these provisions are designed to ensure the existence of private practice is known so that potential conflicts of interest can be managed. These provisions around declarations of activities are equivalent to what is asked of all staff in the section on Outside Employment.

Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises* including:
- Where they practise (name of private facility).
- What they practise (specialty, major procedures).
- When they practise (identified sessions/time commitment).

Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):
- Seek prior approval of their organisation before taking up private practice.
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.†

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

† These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch. 9 of the

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

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

11.11.1 What should be declared

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

11.12 Fit and Proper Persons Test

From 1st November 2014, all Executive Directors, Non-Executive Directors and Director equivalent posts (including contracted Directors) are subject to the Fit and Proper Persons Regulations. To this end, on appointment (see Recruitment Policy) and annually, the Board Secretary ensures a declaration is signed and reported to the Audit and Risk Committee annually. Declarations will also be sought if an existing employee moves into a Director position. If an existing Director changes their role, they will not be required to complete a further declaration but will form part of the annual review. The Declaration Forms are in appendix 1.

12 Management of interests – advice in specific contexts

12.1 Strategic decision making groups

In common with other NHS bodies the organisation uses a variety of different groups to make key strategic decisions about things such as:

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

The interests of those who are involved in these groups should be well known so that they can be managed effectively. For this organisation these groups are:

- Board of Directors
- Clinical Outcome, Safety and Quality Committee
- Finance, Investment and Performance Committee

Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf)

- Charitable Funds Committee
- Hospital Re-Development Board
- Remuneration and Nomination Committee

These groups should adopt the following principles:

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

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

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

The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. Good judgement is required to ensure proportionate management of risk.

12.2 Procurement

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

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

The Trust has in place a Trust Procurement Strategy and any queries should be directed to the Head of Procurement.

13 Dealing with breaches

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

13.1 Identifying and reporting breaches

Staff who are aware about actual breaches of this policy, or who are concerned that there has been, or may be, a breach, should report these concerns to the Company Secretary or the Local Counter Fraud Team.

To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Ever individual has a responsibility to do this. For further information about how concerns should be raised review the Counter Fraud Policy, Anti-Bribery Policy or the Raising Concerns Policy.

The organisation will investigate each reported breach according to its own specific facts and merits, and give relevant parties the opportunity to explain and clarify any relevant circumstances.

7.4. Following investigation the organisation will:

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

13.2 Taking action in response to breaches

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

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

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

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

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

- Employment law action against staff, which might include

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

13.3 Learning and transparency concerning breaches

Reports on breaches, the impact of these, and action taken will be considered by the Audit and Risk Committee twice a year. The Company Secretary is responsible for collating and reporting the breaches to the Audit and Risk Committee.

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

14 Review and Monitoring

What is the standard/audit criteria	Time frame/ Format /how often	How/Method	Reviewed and action plan development by who/which group	Action Plans monitored by and how often
Review of Declarations of Interest	Annual	Report to the Audit and Risk Committee	Audit and Risk Committee	Company Secretary Annually and as required
Review of gifts, hospitality and sponsorship	Annual	Report to the Audit and Risk Committee	Audit and Risk Committee	Company Secretary Annually and as required
Review of Fit and Proper Persons Declarations	Annual	Report to the Audit and Risk Committee	Audit and Risk Committee	Company Secretary Annually and as required
Reporting of breaches of the Conflict of Interest Policy	Twice a year	Report to the Audit and Risk Committee	Audit and Risk Committee	Company Secretary twice a year and as required

15 Communication

This policy will be communicated via:

- Communication of each section once a week via email and through the team brief on an Annual basis.
- The policy will be available on the Intranet.

- Annually, the relevant staff will be asked to complete the Declaration of Interest form.

16 Associated documentation

Freedom of Information Act 2000
ABPI: The Code of Practice for the Pharmaceutical Industry (2014)
ABHI Code of Business Practice
NHS Code of Conduct and Accountability (July 2004)
APPENDIX 1

Pre-employment and Annual Declaration for Executive Director, Non-Executive Director and Director-Equivalent Posts

LUTON AND DUNSTABLE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST ("the Trust")

"FIT AND PROPER PERSON" DECLARATION

1. It is a condition of employment that those holding director and director-equivalent posts provide confirmation in writing, on appointment and thereafter on demand, of their fitness to hold such posts. Your post has been designated as being such a post. Fitness to hold such a post is determined in a number of ways, including (but not exclusively) by the Trust's provider licence, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008 ("the Regulated Activities Regulations") and the Trust's constitution.

2. By signing the declaration below, you are confirming that you do not fall within the definition of an "unfit person" or any other criteria set out below, and that you are not aware of any pending proceedings or matters which may call such a declaration into question.

Provider licence

3. Condition G4(2) of Luton and Dunstable University Hospital NHS Foundation Trust's Provider Licence ("the Licence") provides that the Licensee shall not appoint as a director any person who is an unfit person, except with the approval in writing of Monitor.

4. Licence Condition G4(3) requires the Licensee to ensure that its contracts of service with its directors contain a provision permitting summary termination in the event of a director being or becoming an unfit person. The Licence also requires the Licensee to enforce that provision promptly upon discovering any director to be an unfit person, except with the approval in writing of Monitor.

5. An "unfit person" is defined at condition G4(5) of the Licence as:

   (a) an individual:

      (i) who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; or

      (ii) who has made a composition or arrangement with, or granted a trust deed for, his/her creditors and has not been discharged in respect of it; or

      (iii) who within the preceding five years has been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not)

for a period of not less than three months (without the option of a fine) was imposed on him/her; or

(iv) who is subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986; or

(b) a body corporate, or a body corporate with a parent body corporate:

(i) where one or more of the Directors of the body corporate or of its parent body corporate is an unfit person under the provisions of sub-paragraph (a) of this paragraph, or

(ii) in relation to which a voluntary arrangement is proposed under section 1 of the Insolvency Act 1986, or

(iii) which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking, or

(iv) which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act, or

(v) which passes any resolution for winding up, or

(vi) which becomes subject to an order of a Court for winding up.

Regulated Activities Regulations

6. Regulation 5 of the Regulated Activities Regulations states that the Trust must not appoint or have in place an individual as a director, or performing the functions of or equivalent or similar to the functions of, such a director, if they do not satisfy all the requirements set out in paragraph 3 of that Regulation.

7. The requirements of paragraph 3 of Regulation 5 of the Regulated Activities Regulations are that:

(a) the individual is of good character;

(b) the individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed;

(c) the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed;

(d) the individual has not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity; and

(e) none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.

8. The grounds of unfitness specified in Part 1 of Schedule 4 to the Regulated Activities Regulations are:

(a) the person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged;

(b) the person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;

(c) the person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986;

(d) the person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;

(e) the person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;

(f) the person is prohibited from holding the relevant office or position, or in the case of an individual for carrying on the regulated activity, by or under any enactment.

Trust's constitution

9. The Trust's constitution places a number of restrictions on an individual's ability to become or continue as a director. A person may not become or continue as a director of the Trust if:

(a) they are a member of the Council of Governors, or a governor or director of another health service body;

(b) they are a member of the Foundation Trust's Patients' Forum;

(c) they are the spouse, partner, parent or child of a member of the Board of Directors of the Foundation Trust;

(d) they are a member of a Scrutiny Committee covering health matters of a local authority in the Trust's catchment area.

(e) they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;

(f) they have made a composition or arrangement with, or granted a Trust deed for, their creditors and have not been discharged in respect of it;

(g) they have within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed;

(h) they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

(i) in the case of a non-executive Director, they are no longer a member of one of the public constituencies (with the Exception of the Chair);

(j) they are a person whose tenure of office as a Chair or as a member or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non attendance at meetings, or for non-disclosure of a pecuniary interest;

(k) they have had their name removed, by a direction under section 46 of the 1977 Act from any list prepared under Part II of that Act, and have not subsequently had their name included on such a list;

(l) they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

(m) in the case of a non-executive Director they have refused without reasonable cause to fulfil any training requirement established by the Board of Directors; or

(n) they have refused to sign and deliver to the Secretary a statement in the form required by the Board of Directors confirming acceptance of the code of conduct for Directors.

I acknowledge the extracts from the provider licence, Regulated Activities Regulations and the Trust's constitution above. I confirm that I do not fit within the definition of an "unfit person" as listed above and that there are no other grounds under which I would be ineligible to continue in post. I undertake to notify the Trust immediately if I no longer satisfy the criteria to be a "fit and proper person" or other grounds under which I would be ineligible to continue in post come to my attention.

Name: _____ Signed: _____

Position:_____ Date: _____

APPENDIX 2 - TEMPLATE INTERESTS DECLARATION FORM

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Mr John Smith	*Senior Policy Manager, Commissioning Directorate, Organisation A*	*Hospitality received - £95 from Organisation Z to pay for travel to speak at conference on Managing Conflicts of Interest on 21/12/16*	*21/12/2016*	*21/12/2016*	*Approval to attend event and accept hospitality given by Mary Baker, Head of Unit*

Please see below for information on how to populate the above boxes

The information submitted will be held by **Luton and Dunstable Universirty Hospital NHS Foundation Trust (L&D)**for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that L&D holds.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to **L&D**as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, internal disciplinary, or professional regulatory action may result.

I **do / do not [delete as applicable]** give my consent for this information to published on registers that **L&D** holds.

If consent is NOT given please give reasons:

Signed:		**Date:**	

Please return this form to **<INSERT CONTACT DETAILS OF INDIVIDUAL/TEAM>**

GUIDANCE NOTES FOR COMPLETION OF SPECIMEN INTERESTS DECLARATION FORM

Name and Role:	Insert your name and your position/role in relation to the Organisation you are making the return to
Description of Interest:	Provide a description of the interest that is being declared. This should contain enough information to be meaningful (e.g. detailing the supplier of any gifts, hospitality, sponsorship, etc). That is, the informaiton provided should enable a reasonable person with no prior knowledge should be able to read this and understand the nature of the interest.
	Types of interest:
	Financial interests - This is where an individual may get direct financial benefits from the consequences of a decision they are involved in making
	Non-financial professional interests - This is where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or status or promoting their professional career
	Non-financial personal interests - This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career
	Indirect interests - This is where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making
	A benefit may arise from both a gain or avoidance of a loss.
Relevant Dates:	Detail here when the interest arose and, if relevant, when it ceased
Comments:	This field should detail any action taken to manage an actual or potential conflict of interest. It might also detail any approvals or permissions to adopt certain course of action