Luton & Dunstable University Hospital
Board of Directors

Board of Directors

Comet Lecture Hall

25 July 2018 10:00 - 25 July 2018 12:00

AGENDA

#	Description	Owner	Time
1	Chairman's Welcome & Note of Apologies	S Linnett	10.00
2	Any Urgent Items of Any Other Business and Declaration of Interest on Items on the Agenda and/or the Register of Directors Interests	S Linnett	10.05
3	Minutes of the Previous Meeting: Wednesday 2 May 2018 (attached) To approve 3 Minutes Public Board meeting 020518 final.doc 7	S Linnett	10.10
4	Matters Arising - Action Log (no actions) To note	S Linnett	10.15
5	Chairman's Report (verbal) To note	S Linnett	10.20
6	Merger Update (attached) To note 6 Merger Update 250718.docx 15	D Carter	10.25
7	Executive Board Report (attached) To note 7 Executive Board Report July 2018.doc 17	D Carter	10.30
8	Performance Reports (attached) To note 8 Performance Reports Header.doc 49		
8.1	Quality & Performance 8.1 Quality Performance Report Quarterly.ppt 53	S Oke/C Jones	10.45
8.2	Finance 8_2 Finance Paper (2).pdf 81	A Harwood	10.55

#	Description	Owner	Time
8.3	Workforce 8.3 Workforce Boardreport_July_Final.pptx 89	A Doak	11.05
9	Clinical Outcome, Safety & Quality Report (attached & verbal) To note 9 COSQ Report Apr May June.doc 95	A Clarke	11.15
10	Finance, Investment & Performance Committee Reports (attached) To note 10 FIP Report to July 2018 Trust Board v2.docx 101	A Harwood	11.20
11	Audit & Risk Committee Reports (attached) To note 11 ARC_18 05 18_Board_Report.doc 109	D Hendry	11.25
12	Charitable Funds Committee Reports (attached) To note 12 Charitable Fund Committee Report June 2018 (... 113	C Bygrave	11.30
13	Hospital Redevelopment Programme Board Report (attached) To note 13 Hospital Redevelopment Report - July 18.doc 117	D Hendry	11.35
14	Risk Register (attached) To approve 14 RR July 2018.doc 121	V Parsons	11.40
15	Board Secretary Report (attached) To ratify 15 Board Secretary Report July 2018.doc 125 15a CFC Terms of Reference reviewed June 2018.... 129 15b Hospital Re-Development Terms of Reference... 133	V Parsons	11.50

#	Description	Owner	Time
16	Details of Next Meeting: Wednesday 7 November 2018 at 10.00am in COMET Lecture Hall		
17	CLOSE		12.00

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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 2 May 2018	**To action**	☒
Date of Meeting	25 July 2018	**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 2 May 2018

Present: Mr Simon Linnett, Chairman
Mr David Carter, 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
Dr Danielle Freedman, Chief Medical Adviser
Ms Alison Clarke, Non-Executive Director
Mr Denis Mellon, Non-Executive Director
Mr David Hendry, Non-Executive Director
Mr John Garner, Non-Executive Director
Dr Vimal Tiwari, Non-Executive Director
Mr Mark Versallion, Non-Executive Director

In attendance: Ms Victoria Parsons, Board Secretary
Ms Philippa Graves, Director of IT
Ms Anne Sargent (Minute Taker)
9 Members of the Public (including Governors)

1. CHAIRMAN'S WELCOME & NOTE OF APOLOGIES

The Chairman opened the meeting, noting that it was a meeting in public and as such, questions (other than issues of clarity) would be taken at the conclusion of the agenda. Apologies were received from C Bygrave.

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

No items were declared.

3. MINUTES OF MEETING HELD ON WEDNESDAY 7 FEBRUARY 2018

Workforce Report – final line of final paragraph should read: Appraisal rate increased by 11% **'over the last 12 months'** and currently sits at 82%.

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

Proposed: M Versallion **Seconded:** V Tiwari

4. MATTERS ARISING (ACTION LOG)

There were no matters arising.

5. CHAIRMAN'S REPORT

The Chairman noted the improvement in Diagnostic performance and that recovery of RTT is ahead of where it needs to be. He voiced admiration for staff who continue to deliver over very challenging periods.

6. MERGER UPDATE

D Carter advised the Board that there were no significant changes in L&D's position, NHSI remain supportive with the pause allowing us to be more robust in our case, noting that the prime issues remain the financial issues. Submissions for the next tranche of capital are to be submitted by 18 July, with decisions due in November.

If we are successful then our 'Plan A' for the merger is 1 April 2019. Our immediate focus is to submit a refreshed capital bid and we remain confident that the STP will be supportive in their prioritising of bids. The guidance indicates a limited opportunity for capital bids above £100m (L&D's bid is currently £96m) and we are getting support and input in presenting our case. Integration work continues in Pathology and IM&T, along with clinical engagement. D Hendry added that these are both big projects which would need to have business cases signed off before proceeding. D Carter assured the Board that these will be prepared in readiness for a Board decision.

We continue to try to resolve the issue of transaction costs and have put forward a proposal for a capital to revenue transfer as a way of funding this. D Carter assured the Board that L&D will only proceed with the merger when clear of the financial support.

It was noted that the 3 local CCGs have taken a decision to appoint a single accountable officer.

7. EXECUTIVE BOARD REPORT

Infection Control Report – the issue of isolated incidences of flies in the Cath Lab has caused the Trust to cancel a significant amount of work. It was noted that recent works to eradicate the problem appear to have been effective.

School Visits – Surgery: a lot of work has been undertaken to ensure L&D has the correct environment for trainees. Anaesthetics: again, L&D are active in ensuring the right environment to make us attractive to trainees.

Mortality – The Board noted that HSMR has reduced at the Hospital and also noted the on-going work through the Mortality Board.

Needs Based Care – from a recent peer review, L&D has been put in touch with Aberdeen to look at their challenges and what has worked for them. D Mellon suggested working with Kings Fund to look at what other Trusts are doing, noting that Nuffield found this to be advantageous.

Management of CQUIN - Health & Wellbeing: C Jones gave an overview of performance against the indicators where L&D did not see step change improvements. Treatment of Sepsis did well in ED but is more difficult for inpatients where it is harder to understand where the diagnosis was made. A focus will be on having the first dose of antibiotics prescribed and administered within the golden hour. E-Referrals: the Trust no longer accepts paper referrals; if received, surgeries are asked to re-send them electronically. As a result, GPs are changing their referral pattern which is causing appointment slot difficulties as they are booking specific sessions, work will be undertaken with GPs on this. Discharge: the CQUIN penalises the short stay pathways, we have a small cohort of patients in that population which increases our difficulty in achieving. D Carter added that L&D are good at getting patients out quickly but are not so good with the mid length stay cohort. C Jones noted that 'super long' stayers have decreased.

Compliance Issues – 3 very good visits have been undertaken in Breast Screening, NICU and Urology. The importance of the merger in relation to continued improvement in NICU was stressed. V Parsons explained that departments currently maintain their own accreditation whilst she holds an overview on behalf of the Board. She will be working with the Director of Quality on the best way for this to be managed.

CQC – D Carter informed the Board of a recent information request from CQC. Preparations would be started immediately, working on the assumption that we may have a visit in the summer.

Cyber Security – P Graves updated the Board that L&D aim to be compliant with the 10 steps of cyber security, meaning that IPM and pacs servers will be patched over the coming week. Thanks were recorded to the Trust as this will result in some downtime, but will be a huge achievement with L&D being the first Trust to be fully compliant.

GDE – nationally L&D are doing well, but not so well internationally where we are required to have an international partner. D Carter highlighted the importance of any partner having similar issues to L&D. It was agreed that the enormity of this should not be overlooked.

Communications – in terms of GP Phlebotomy Services moving to Arndale House, D Carter noted that L&D are not the ideal provider of phlebotomy services. Our aim is to free up space for services that absolutely need to be at the hospital. We are close to finalising and communicating our operating model - the service will be a mixture of booked appointments and drop in.

Nursing Levels – S Oke advised the Board that Quarter 4 was challenging due to contingency areas being opened and staffed. We have an ongoing recruitment plan and are looking at a retention plan. One of the challenges is that staff are more willing to work night shifts which are more lucrative. In response to a question from M Versallion, S Oke responded that we have seen a proportion of Spanish nurses opting to return home and a reduced number of nurses wishing to come to UK, due to Brexit. A Doak added that an NHS Employers survey indicates a slow down of leavers.

Information Governance – attention was drawn to the issue of encryption and controls that are in place.

8. PERFORMANCE REPORTS

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

S Oke commented on quality aspects of the report, noting that following a difficult quarter in terms of falls and pressure ulcers, April saw a return to pre Q4 levels. VTE risk assessments are now carried out on admission. The inpatient survey results show an improvement on previous year's scores. Reports from 2 recent Healthwatch visits will be shared. Recent site visits by Luton and Bedfordshire CCGs were positive. Work continues to focus on the backlog of complaints.

CJ commented on performance aspects of the report, referring to 'learning from deaths'. L&D have not identified any deaths that would have been avoidable. We have noted some learning opportunities such as DNARs, end of life pathways etc. A Clarke expressed concern that this exercise has identified that there are only a small proportion that are reviewed within the timescale. C Jones reassured the Board that the new tool makes it much easier to comply. 18 weeks remains an area of concern, although we have not seen any deterioration from the March position, indicating that improvements so far have been sustained. She concluded by noting that re-dating cancelled operations within 28 days remains challenging.

Finance Report – A Harwood introduced the report for year ended March 2018, as submitted to NHSI. The KPMG audit started on 24 April, results of which were reported to FIP and should be signed off by auditors by 29 May. He advised the Board that L&D has delivered its plan for the year, secured on MRET and a small number of recurrent gains totalling almost £12m in aggregate. The L&D reported a surplus of £15.4m and ended the year with £36m cash. We are currently working with auditors to receive the cash in relation to incentive and bonus monies. The Board were advised that agency cap is an area of challenge, particularly in terms of the aggregate position for divisions, which is deteriorating and is likely to remain a challenge for the coming year.

Workforce Report – A Doak presented the report, noting that in recruitment of medical staff, there are national issues around sponsorship, which requires the Trust to re-apply every month to the Home Office. An open letter to the Prime Minister had been signed by Trusts the previous week. Nursing vacancy rates have reduced significantly, along with turnover rates compared to the same time last year. AHP turnover has also decreased. L&D have a constant programme of consultant recruitment and will see the handover of 200 doctors in August. Sickness is steady overall but Bradford score is increasing month on month, all individuals will be looked at in detail. Appraisal results are good, but statutory training has seen a reduction due to greater needs for staff in working areas.

A Clarke commented the staff survey showed work life balance as an area for improvement along with a lack of improvement on mental wellbeing, asking if there is anything we can do. A Doak responded that L&D has begun to put on more events based on mental health, and already do a significant amount on health & wellbeing. D Mellon asked whether we have reduced management control of employees with ill health. D Carter responded that the winter has put enormous pressures on staff and systems and has had an effect on the

ability to carry out return to work meetings etc., which in turn may have effected the sickness absence rate.

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

A Clarke took the report as read, noting the pleasing aspect of the patient stories, where relevant general managers are now invited.

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

D Mellon advised the Board the budgets are completed and have been presented to FIP. In terms of capital he advised that Arndale House will be completed by end of May and that discussions are ongoing regarding merger related capital and refurbishment.

11. AUDIT & RISK COMMITTEE REPORTS

D Hartshorne took the report as read, noting that the Scheme of Delegation is finalised.

12. HOSPITAL RE-DEVELOPMENT COMMITTEE REPORT

This was taken as read, the Chairman commented on the lack of mention of work to secure further car parking space and the potential positive impact of patients going to Arndale House.

13. RISK REGISTER

V Parsons assured the Board that this is constantly under review by the Board and sub committees. No new Board level risks had been added.

14. BOARD SECRETARY REPORT

This was received for information and to ratify 4 sets of 'Terms of Reference' which were approved by the Board.

15. ANY OTHER BUSINESS

No other business matters were raised.

QUESTIONS/COMMENTS FROM NON BOARD MEMBERS

The following questions were raised by the audience:

1. A recent meeting in the Chiltern Vale locality noted that they are unaware of the location of Arndale House, parking arrangements, disabled access etc. The Chairman responded that we will have a plan which will be communicated next week. C Jones added that the FAQs are revised regularly and can be circulated, along with information re bus services.
2. With regard to Sepsis, is it the case that we cannot get antibiotics to patients within one hour from diagnosis? C Jones explained that the

realisation of a patient becoming unwell is managed by junior doctors and is difficult to audit precisely, therefore the time taken is monitored from observations from the junior doctor. COSQ will receive a further analysis. A Clarke noted this may show variations in how much the target is missed by. Dr Freedman went on to explain the complexity of this pathway.

3. Has there been any significant rise in sickness due to people working longer in terms of changes to state pension? A Doak responded that this will be looked at for any correlation and dialogue will take place with some such staff.
4. It was noted that Cranfield was referred to in one report, but not mentioned in the Hospital Re-Development report. P Graves explained that part of the GDE plan is to have an innovation centre and that L&D have partnered with Cranfield University for this purpose.
5. It was noted that the Council have taken the remaining 5 floors of Arndale House, which along with the demolition of a multi storey car park, may mean that parking becomes worse for those patients visiting the L&D facility there. C Jones did point out that Arndale House staff had different parking arrangements which would not contribute to parking congestion.
6. It was suggested that GP patients are not necessarily aware of the changes regarding blood tests.
7. In terms of work life balance, an offer was made for a governor to discuss outcomes of a recent walkaround, which A Doak was happy to accept.

SUMMARY OF ACTIONS

To be made available after the meeting

16. DETAILS OF THE NEXT SCHEDULED MEETING:

Wednesday 25 July 2018, 10.00am, COMET Lecture Hall

17. CLOSE

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

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

BOARD OF DIRECTORS

Agenda item	6	**Category of Paper**	Tick
Paper Title	Merger Update	**To action**	☐
Date of Meeting	25 July 2018	**To note**	☒
Lead Director	David Carter –Chief Executive	**For Information**	☐
Paper Author	David Carter –Chief Executive	**To ratify**	☐
Indicate the impact of the paper: **Financial** ☒ **Quality/Safety** ☒ **Patient Experience** ☒ **Equality** ☐ **Clinical** ☒ **Governance** ☒			

History of Committee Reporting and Date	N/a	
Links to Strategic Board Objectives	Objective 1 – Deliver the Quality Priorities Objective 2 – Deliver National Quality and Performance Targets Objective 3 – Implement the Strategic Plan Objective 5 – Optimise our Financial Position	
Links to Regulations/ Outcomes/External Assessments	NHS Improvement CQC Commissioners Internal Audit	
Links to the Risk Register	Hospital Redevelopment Non-Achievement of Financial Target Vacancy rates	CCG verification processes Agency costs Backlog maintenance Management capacity

PURPOSE OF THE PAPER/REPORT
Update on proposed merger.

SUMMARY/CURRENT ISSUES AND ACTION

The paper updates the Board of Directors on the progression of the proposed merger with Bedford Hospital.

ACTION REQUIRED

To note the Merger update.

Public Meeting ☒ Private Meeting ☐

Luton and Dunstable University Hospital NHS Foundation Trust and Bedford Hospital NHS Trust

Proposed Merger Update

The STP submitted the capital bids on 16 July and the L&D Acute Services Block/merger bid was prioritised as first amongst the BLMK bids. The decision on the outcome will be communicated to the Trust in October.

The Integration continues to steer the integration process and key elements are as follows:

- Clinical integration - a 'pilot' process has commenced in T&O to establish a methodology which allows each specialty to be reviewed in order to create sufficient understanding of the existing operational models such that constructive clinician engagement can be facilitated to allow for the development of a joint service strategy. The early outcomes of this work are very positive with powerful information being identified to understand how the speciality operates on each site. The intention is that this work will be used as the model within the revised Full Business Case to demonstrate how the Trust will undertake clinical integration going forward;
- Pathology – the Trust continues to progress the pathology integration through the Joint Pathology Board. 'LMS', a specialist pathology consultancy, have been appointed and are currently working to develop the 'Target Operating Model', which will set out the way in which the merged pathology service will operate, and the financial model which underpins it;
- IM&T - the Trust continues to seek to merge the GDE and Fast Follower Programmes as a single project, allowing a co-ordinated approach which maximises the opportunities brought about by the merger.
- In addition Liz Lees has taken up the post at L&D and continues to be seconded to Bedford Hospital on a part time basis.

BOARD OF DIRECTORS

Agenda item	7	**Category of Paper**	Tick
Paper Title	Executive Board Report	**To action**	☒
Date of Meeting	Wednesday 25 July 2018	**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 & Date	Executive Board – 24 July 2018		
Links to Strategic Board Objectives	All Objectives		
Links to Regulations/ Outcomes/External Assessments	CQC Monitor Information Governance Toolkit		
Links to the Risk Register	Hospital Redevelopment Non-Achievement of Financial Target Vacancy rates	CCG verification processes Agency costs Backlog maintenance Management capacity	

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.	Medical Education Update	- to note
3.	Complaints Board Update	- to note
4.	Mortality Board Update	- to note
5.	Ward 18	
6.	Always Events	
7.	Needs Based Care	- to note
8.	Nursing & Midwifery Staffing	- to note
9.	Management of CQUIN	- to note
10.	Compliance Issues	- to note
11.	Breast Symptomatic 2 Week Wait Cancer Target	- to note
12.	CQC Update	- to note
13.	GDE Update	- to note
14.	Equality, Diversity and Human Rights (EDHR) Annual Reports	- to note
15.	Information Governance Quarterly Report	- to note
16.	BLMK STP	- to note
17.	Freedom to Speak Up	- to note
18.	Estates & Facilities Update	- to note
19.	Communications & Fundraising Update	- to note
20.	Policies & Procedures Update	- to note

ACTION REQUIRED

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

Public Meeting ☒ Private Meeting ☐

1. INFECTION CONTROL REPORT

- **Infection Control Policy**

The Trust Executive intends to focus attention on the organisational structure, policy and strategic view to inform and support infection control activity. The Trust's current policy "No Avoidable Infection Strategy" provides an overarching umbrella for this purpose. It additionally provides divisional / directorate / departmental level granularity and allows the staff responsible for the delivery of safe infection prevention & control practices and procedures to plan short, medium and long term improvements. It also provides a structure for those responsible to be held to account. However, with changes to divisional structures, the Trust's approach needs to be refreshed to ensure it remains effective. COSQ has invited Dr Mulla to attend the Committee to commence a dialogue to start this process

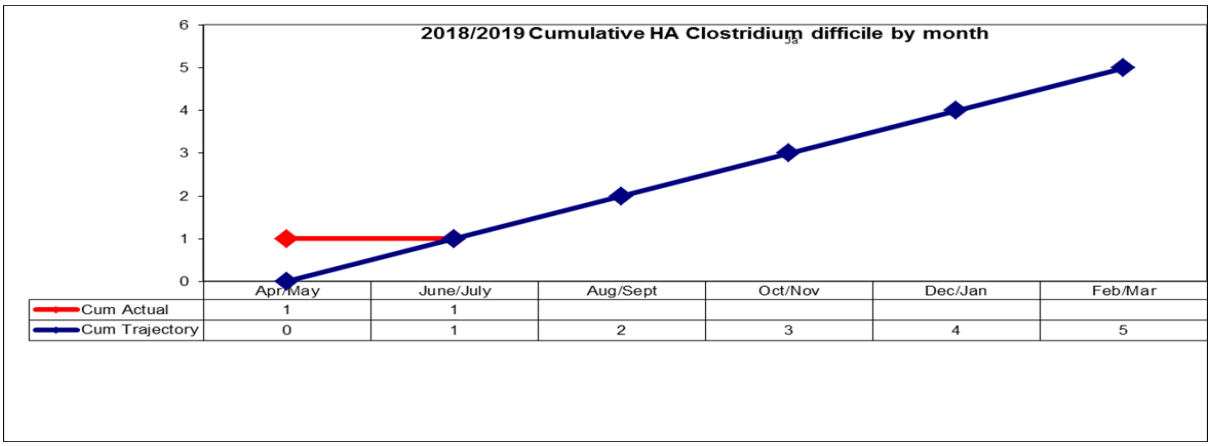
- **Cardiac Centre**

The problem with ingress of flies into the cardiac care centre has been resolved following sealing of the suspended ceiling tiles in the catheter laboratory 1. It should be noted that the catheter lab ceiling should be of operation theatre standard. It is advisable to ensure that the ceiling in catheter laboratory 2 should be sealed as well in order to prevent the ingress and breeding of flies which may find their way into the roof void.

A further problem that has been identified in the nursing area of the catheter lab is that of "rising damp". The Trust Estates department and the external contractors who built the cardiac centre are investigating the source. Preliminary investigations have failed to identify a clear source. It is currently believed that defects in the roof may have allowed rain water ingress which has made its way down and travelled below the concrete foundations and made its way up certain walls of the nursing zone.

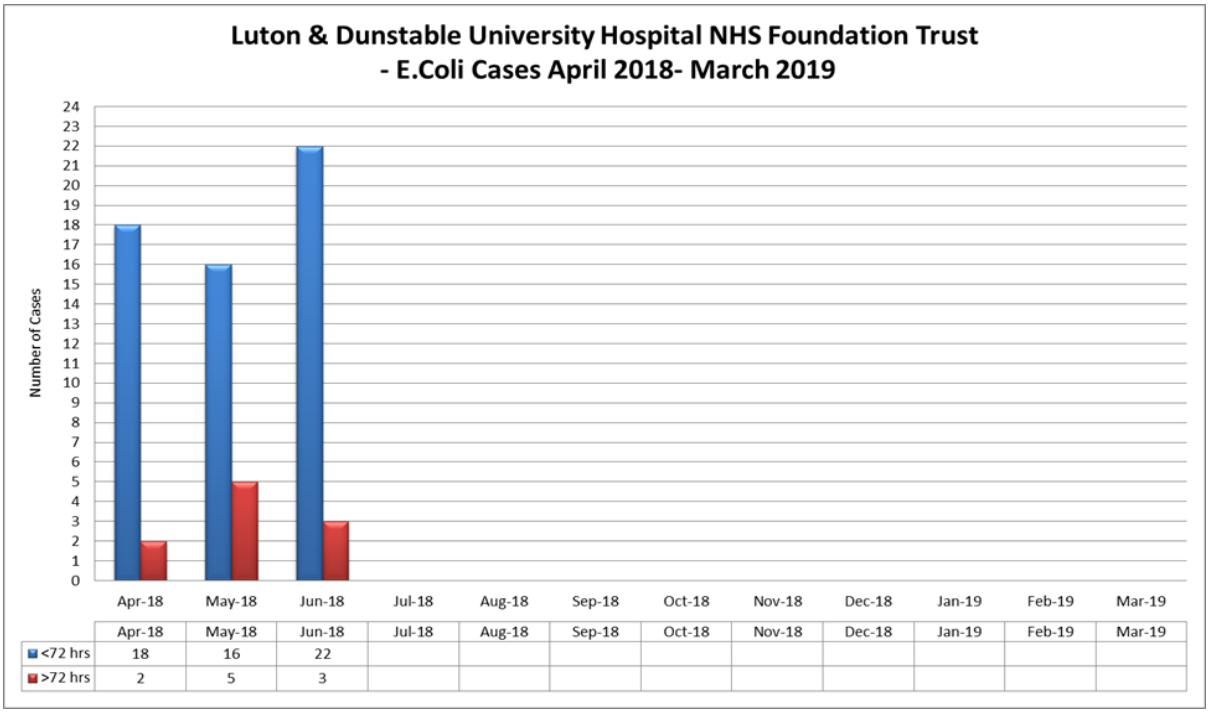
- **Clostridium Difficile**

The Trust ceiling for Clostridium difficile infection for the year April 2018 to March 2019 has been set at 5 cases (hospital acquired).

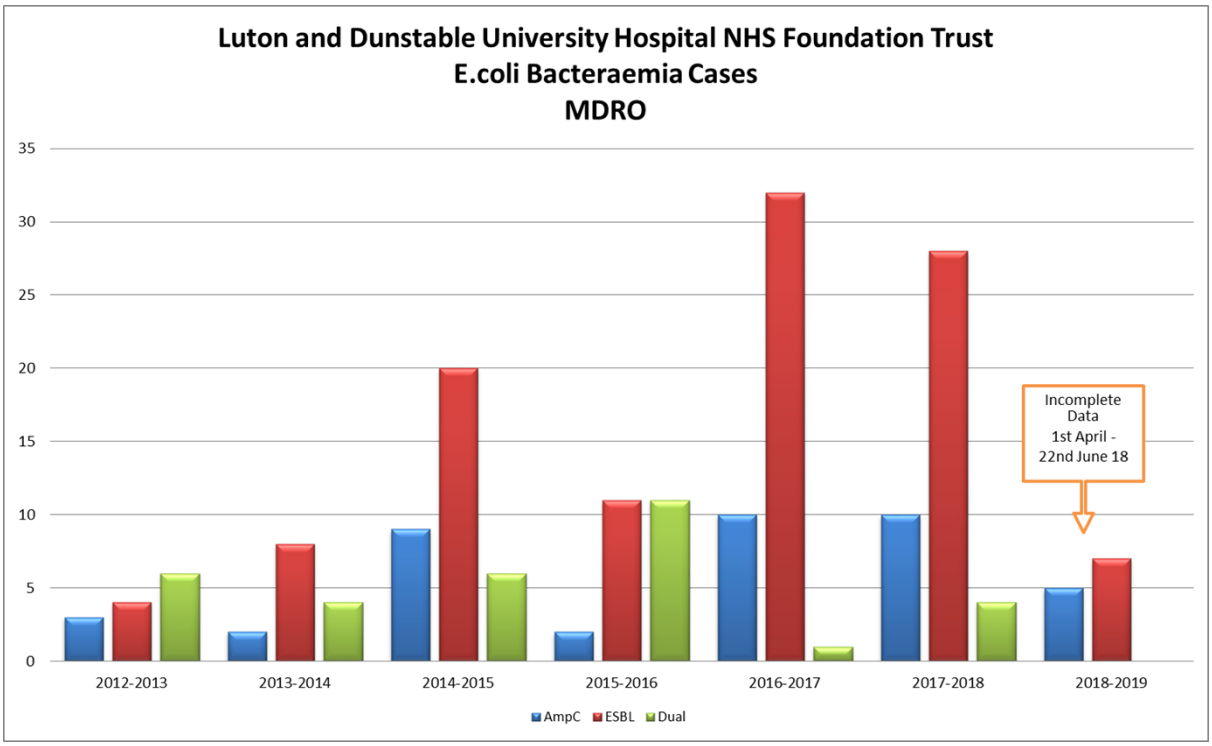


- **E.coli bacteraemia**

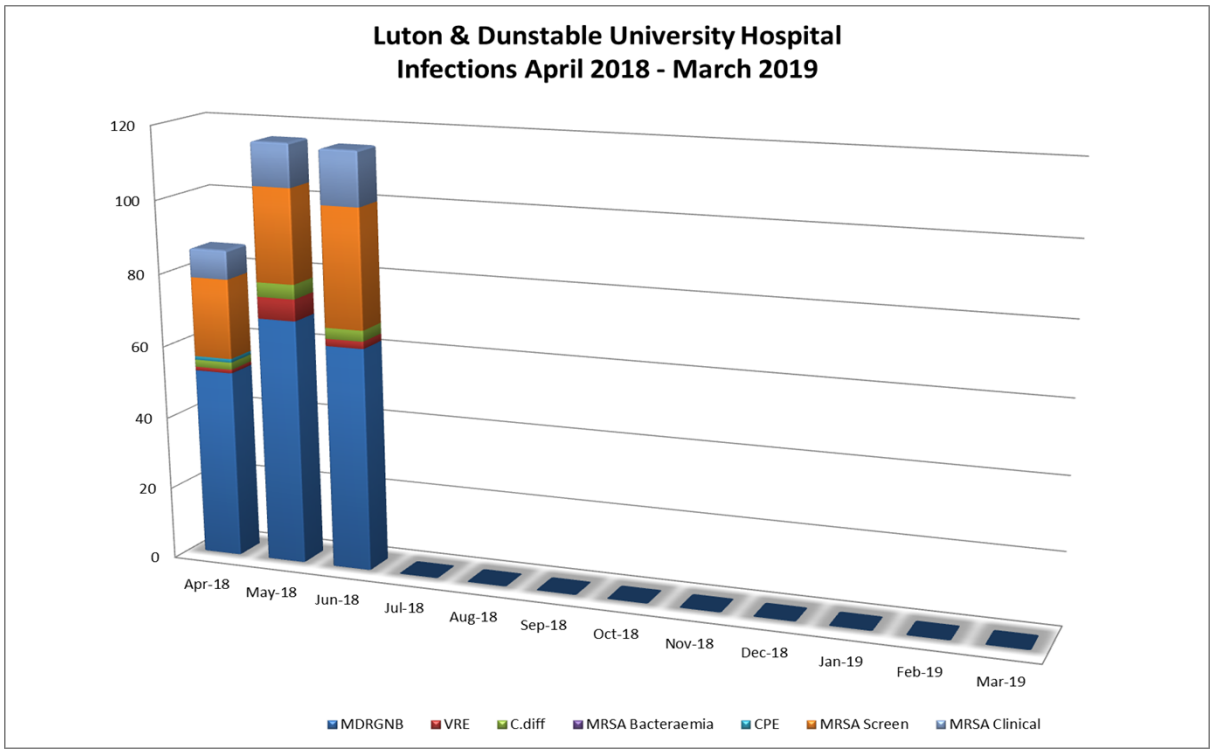
In the last quarter the Trust reported 66 cases of which 10 were isolated from blood cultures collected > 48 hours after admission to the hospital (hospital acquired).



Over the years a growing number of E.coli isolates from our patients are ESBL and AMPc producing multi-resistant E.coli (see below). The choice of empirical antibiotics in patients with sepsis is influenced by the increase in multi-resistant organisms. The high number of patients with multidrug resistant organisms places a significant burden on our isolation capacity.

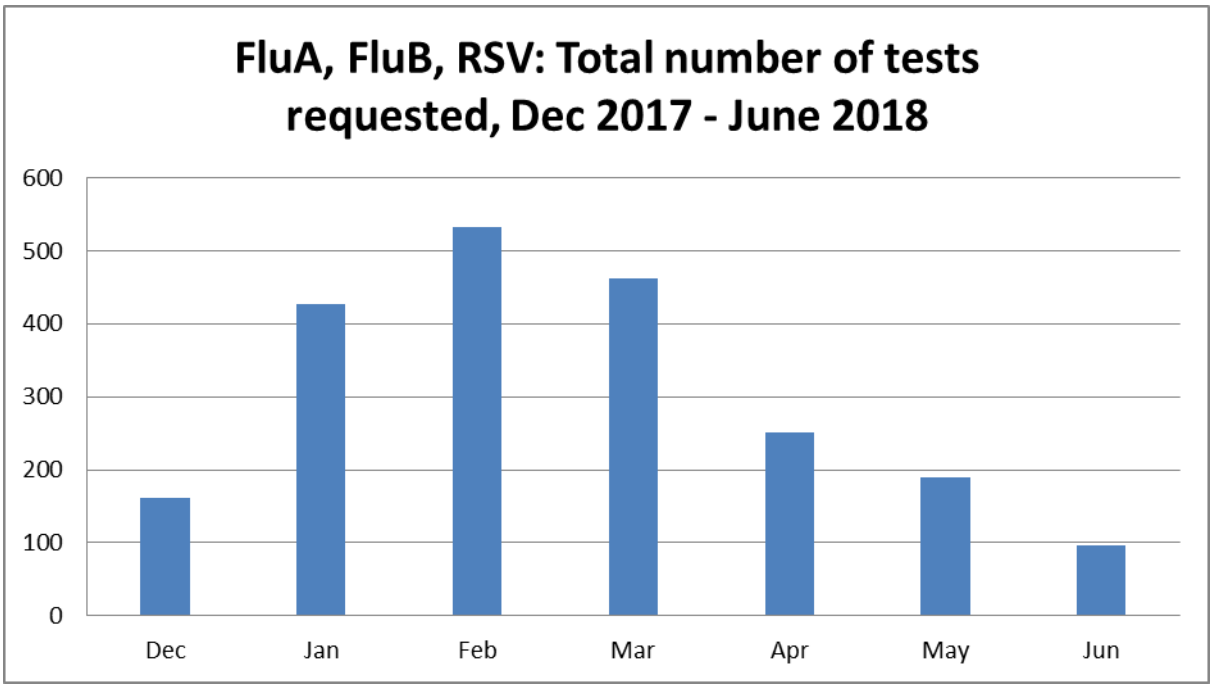


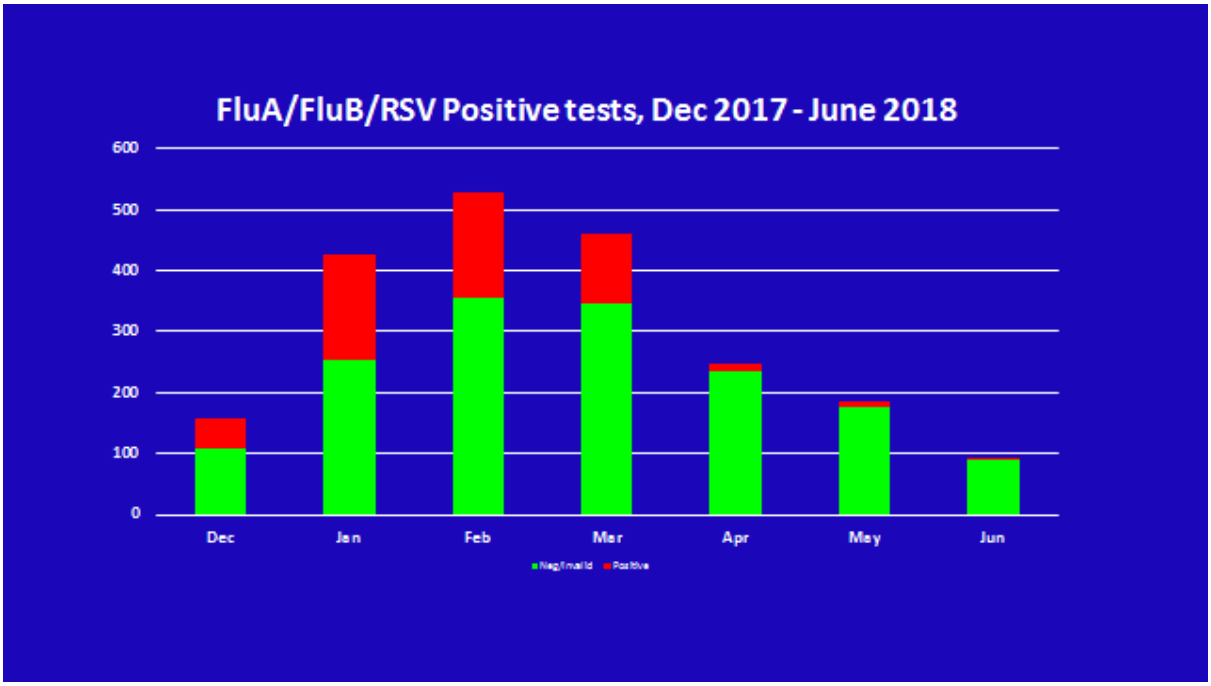
- **Patients with Multi-drug resistant organisms (MDRO)**

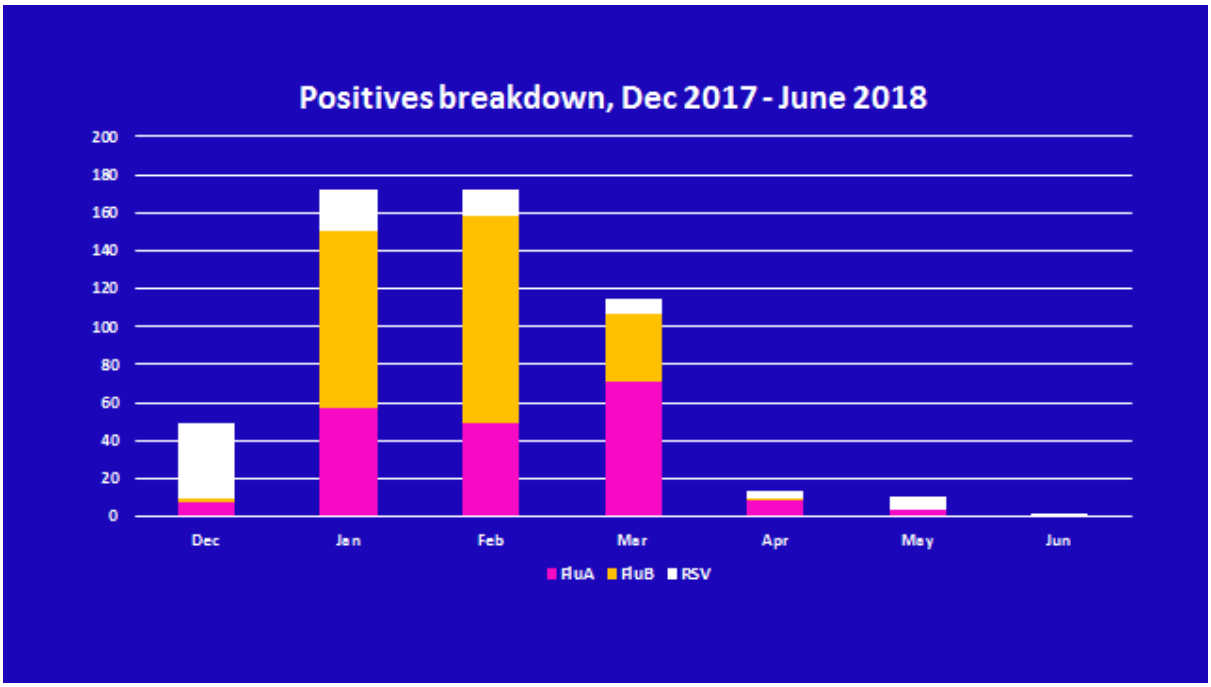


- **Influenza**

The 2017-18 flu season is now over. This season was characterised by the unusually high numbers of influenza b cases due to the failure of the tri-valent vaccine to protect against the circulating strain of the virus.







2. MEDICAL EDUCATION UPDATE

School of Surgery – Following the School exploratory visit on the 13 March 2018 the department have completed an action plan in response to the visit. The response has been reviewed by the Head of School (HoS) for Surgery. The department are working on a further response that needs to be completed by 30 July 2018. The main concerns raised included trainees rota, access to educational training and supervisors' support: these are being addressed. The department are currently reviewing the workforce skill mix and rota planning. This will include reviewing the introduction of roles to support trainees, for example - clinical administrator, advanced nurse practitioners and physicians associates.

School of Anaesthetics – The department are in discussion with the HoS for anaesthetics to pilot a live feedback process for trainees. This will help to evidence any issues day to day, but importantly will help to highlight the process on how seriously the department views trainee feedback and how this feedback is used to lead to change. This data will hopefully help the HoS to prompt the Trust in the region.

Changes planned in training from August 2019

- Improving surgical training (IST) and Internal Medicine training (IMT). The Trust has set up working groups to establish changes needed to trainee/junior doctor numbers and rota in readiness for the changes anticipated.

- Refurbishment of the COMET and the development of a trainee Rest/Common room within the COMET footprint.

Junior Doctors - The junior doctor Medical Staff Committee (MSC) remains an excellent opportunity for the Chair, CEO and representatives of the Trust Board to engage with junior medical staff and address any emerging issues. Following the July junior doctor MSC, it is apparent that some level of dissatisfaction remains around the high level of vacancies and specific challenges with publishing of the forthcoming rotas. The Director of HR is leading immediate response to provide junior medical staff with a clear update for the August rota position, and recent news that Certificates of Sponsorship (COS) have been awarded for 12 overseas doctors will significantly improve the vacancy position. The CEO and Deputy CEO are working with clinical leaders in the Surgical Division to establish what more can be done to support junior medical staff, and to ensure that proposed improvements have a positive impact on junior staff.

3. COMPLAINTS BOARD UPDATE

The Complaints Board last met in May and reviewed current Trust performance noting themes and learning. The Division of Medicine shared the significant work they undertook to improve the internal management of their complaints. This was commended and will be considered for use by other Divisions. Complaint performance will continue to be monitored through the Quality and Performance Report.

4. MORTALITY BOARD UPDATE

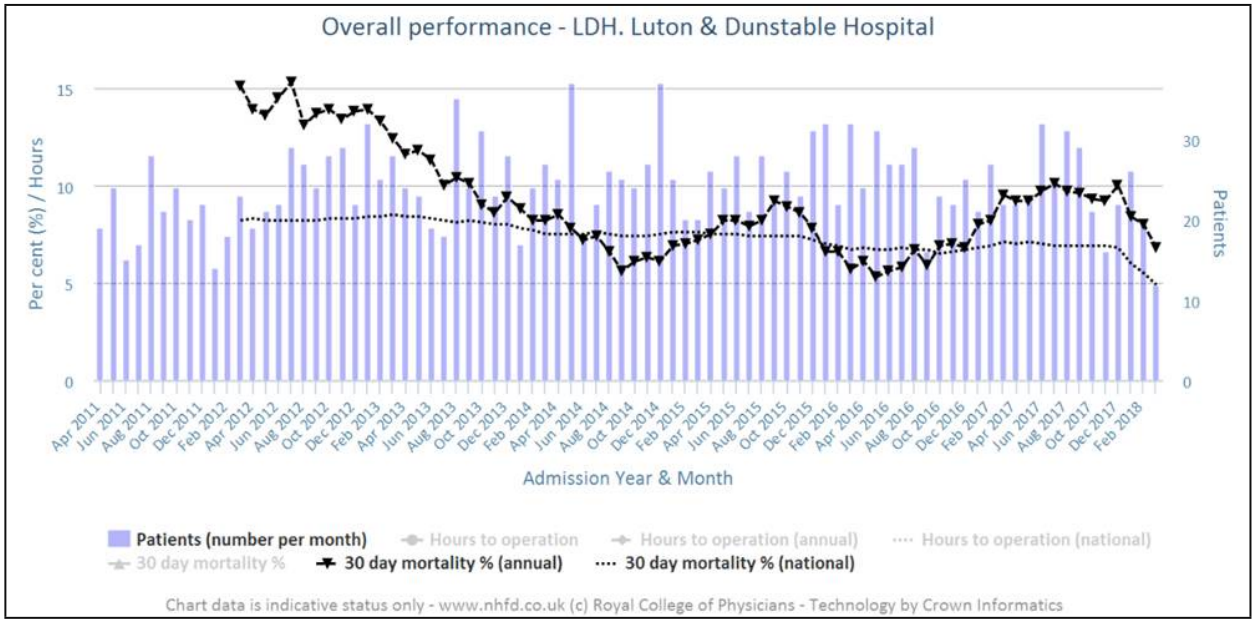
The crude mortality rate for the year to March 2018 remains the same as for the same period a year earlier.

The latest SMR and HSMR data for the individual month of January 2018 show mortality over 10% higher than the national average. The rolling 12 months ending in January 2018 shows the HSMR less than 2% above average and the SMR about 4% above average. All these mortality ratios are improved from January 2017.

SHMI which lags a little behind the other mortality indicators shows the Trust 7% higher than the national average.

Fracture Neck of Femur

Whilst overall the picture for HSMR is encouraging, the Trust did see a deterioration in 30 day mortality for patients following emergency admission for a fractured neck of femur (#NoF) during 2017. The chart below shows a steady climb from the end of 2016 to a peak in July 2017, which has not started to reverse until January 2018. Across 2017 the crude 30-day mortality was 10.0%, and the Trust's casemix adjusted figure was 10.8%. Consequently the unit was one of fourteen lying above the 2SD standard deviation threshold in the mortality funnel plot for 2017.



The reasons for the deterioration in performance have been explored by the Fractured Neck of Femur Committee and are multi-factorial. However, interventions to reduce time to theatre for patients have been effective; mornings are now protected for #NoF trauma lists, the team have extended trauma on Saturdays, a Golden Patient policy has been introduced to ensure #NoF patients get to the trauma list and the changes to the emergency model through introducing a Hot Week Rota for consultants has improved decision making.

One of the remaining issues preventing better achievement of time to theatre is around ensuring pre-operative optimisation and issues around ensuring sufficient time since the last dose for novel anticoagulants (NOACs) Dr White and Dr Pradere are working on a new guideline which should resolve this.

The direct access pathway to ward 23 has also been refreshed with the emergency department and patient flow teams to ensure patients are place under the care of the #NoF team as early as possible after admission.

The Trust will continue to monitor deaths following fractured NoF via the structured judgement reviews carried out as part of the mortality review process. Learning and themes will be highlighted, actioned and cascaded via the #NoF Committee.

5. WARD 18

Although significant improvements to medical cover for Ward 18 have been made with the establishment of a consultant and juniors for all elderly medicine patients admitted to Ward 18 (the infection control ward), it has been identified that the current model of care is still resulting in challenges for staff where patients under 78 years of age are admitted for screening or isolation. These patients are managed as outliers by the medical physician on call for the patient's date of admission and so at any one time Ward 18 may have multiple consultants under whom that care of their patients sit. A review of the options for the Ward is underway to try and ensure that the number of patients avoidably managed as outliers is reduced. This may involve changing the function of the Ward and managing isolation of infection differently in the organisation, and so it is important that this is carefully considered and full impact assessment completed before any change is made.

6. ALWAYS EVENTS

NHS England, in collaboration with the Institute for Healthcare Improvement (IHI) and Picker has developed a programme to pilot and test the implementation of Always Events® within the NHS in England. Always Events® are aspects of the patient experience that are so important to patients and family members that health care providers must aim to perform them consistently for every individual, every time. The Always Events Framework has seen significant success in improving patient centred care based on real time feedback and shared priority setting with patients and relatives, and the trust has now enrolled in the current tranche of trusts implementing Always Events. This is a really positive opportunity to ensure that we can develop consistent ways to meet the individual needs of patients to make sure that care is patient centred and delivered in partnership with them and those close to them and is an important aspect of our commitment to improving patient experience and quality of care.

7. NEEDS BASED CARE

From 4 June 2018 the Respiratory Team initiated their Needs Based Care model, with consultant staff providing dedicated support to the front door of the hospital for all respiratory patients admitted as an emergency. Early indications are that this has made a significant improvement to the length of time respiratory patients are staying in hospital, and the feedback from staff and patients has been excellent. The recruitment for therapies and pharmacy has been very successful so far, and the hope is to recruit to some of the Consultant posts during interviews which are planned for August 2018.

8. NURSING & MIDWIFERY STAFFING

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

9. MANAGEMENT OF CQUIN

The national CQUIN schemes for 2018-2019 have commenced in the Trust and 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;
- Preventing Ill Health by Risky Behaviours (tobacco and alcohol).

The reports for the first quarter are due to be submitted to Luton CCG in mid-July. Our understanding is we will have met the milestones for two of the four schemes which require evidence to be submitted this quarter. For the Serious Infections scheme and Risky Behaviours scheme, the outcomes of audit are currently awaited.

10. COMPLIANCE ISSUES

The Trust has been invited to select a date for the Breast Surgery GIRFT visit. A deep dive visit is scheduled to the Emergency Department at the end of July, and to Diabetes at the end of August. An action plan has been prepared and submitted to the National Team regarding the use of the litigation benchmarking data, and we have asked for any support from best practice sites in advising how to improve the way we cascade and use litigation data to learn from cases.

A Contract Performance Notice was issued by Commissioners in May 2018 regarding non-compliance against three of the quality indicators:

- LQR31: Provision of inpatient electronic discharge summaries within 24 hours;
- LQR40: Outpatient summary to be sent to patients GP within 7 days;
- LQR48: Friends and Family A&E Response rate.

A Contract Review meeting was held and remedial action plans agreed against each of the three areas.

The cancer peer review submissions were successfully uploaded at the end of June 2018 in line with the annual deadline. Feedback on these is usually received during quarter 3.

The endoscopy unit JAG scorecard was submitted at the end of May 2018. The Global Rating Score (GRS) resulted in an ‘Assessed improvement required’ status for six months, which was expected in light of the challenges faces earlier in the year due to capacity. The comprehensive Action Plan remains in place and the 4th endoscopy room is now in use, so the team are positive about the necessary improvements being well embedded before our full accreditation visit.

11. BREAST SYMPTOMATIC 2 WEEK WAIT CANCER TARGET

In April 2018 the Trust did not achieve the 'Breast Symptomatic pathway' target of 93% of patients to be seen within 14 days of referral. This pathway is for patients that GPs do not suspect have cancer, but are referred for specialist review of breast symptoms in case they need to transfer to a cancer pathway.

The Trust has achieved this performance threshold consistently for the last 4 years, apart from one month in June 2015 where performance dropped to 91.1% due to changes in admin staff and a surge in referrals due to capacity challenges with the Milton Keynes service.

All women are booked into the urgent breast one-stop clinic, whether referred as symptomatic or under 2 week wait. The performance is split into the two pathways, and the audit of performance is complicated as it requires clinical triage of the referrals to determine which are symptomatic and which are 2WW. In April 2018, 6 women breached the symptomatic pathway of a total 84 women referred, giving 92.8% performance (target 93%). One fewer breach would have improved performance to 94.0%.

The Trust achieved the 93% target performance in May and June (subject to validation). However, the position remains very challenging due to an increase in referral numbers and changes to the way that women book appointments electronically which have corresponded a sharp increase in the level of short notice rescheduling by patients of their appointment. Looking forward there is a greater degree of uncertainty of performance around this target every month. NHS Digital, NHSI and the CCG are aware of this issue and the potential detrimental impact on performance.

12. CQC UPDATE

Following the submission of the PIR in May the Trust has now been formally informed by the Care Quality Commission (CQC) that their Well-Led inspection will be carried out on 11, 12 and 13 September 2018.

The Use of Resources component, which is a new line of enquiry within the CQC Assurance Framework, will be carried out on 31 August 2018 by the NHSI regional team on behalf of the CQC. This will predominately be assessed against the 'Carter' metrics within the NHSI model hospital.

Although unannounced, the Trust is anticipating that the core services inspection will be at any time from the end of July onwards.

Work continues with clinical and operational teams preparing for the core services review in readiness for the inspection. Some key initiatives include the following: buddy visits with Senior Nurse / Manager / Director input; weekly decision making CQC preparedness meetings with the Executive Team; Estates and Facilities walkabout and prioritisation of key concerns; successful distribution of key messages i.e. key risks and MCA and DOLs within the staff engagement event; peer review visit with Bedford Hospital.

13. GDE Update

Following the award of Global Digital Exemplar (GDE) status by NHS England in July 2017, the approval of the individual business cases at FIP committee on 25 October 2017 and the completion of the 'NHS Digital milestone 2 assessment' process which ensured access to the second tranche of funding from central government (£3.75 million), Trust resources worked together with Bedford Hospital to secure their Fast Follower status which was confirmed in June 2018.

The Digital Exemplar programme team is now progressing with the procurement and implementation stages of the various projects as per the stage plan produced in accordance to the high level milestones plan agreed with the Department of Health. Strong clinical engagement and support has been vital to complete the procurement documentation for the Inpatient Care Coordination scheme. The aim is to send this documentation out within a few weeks and to complete this procurement exercise by October this year. This strong engagement will need to extend to support the requirements gathering exercise required for the Clinical Portal that is a shared deliverable with the STP, which has now kicked-off.

In order to manage the programme resources in the most efficient and cost-effective way, the programme team recently elevated a paper to the FIP Committee with a recommendation to create a new scheme under the GDE programme to be called 'DevOps'. This paper was formally approved by FIP in June, effectively transferring part of the budget allocated to the various projects and thus creating the capacity and flexibility required to successfully deliver the programme.

As part of the 'Global' ambition of the Digital Exemplar programme, the team recently visited Hospital de Cascais in Portugal, one of the 3 hospitals in Europe who have achieved the highest level of digital maturity with HIMSS Level 7. The aim was to have a look at their digital journey and to learn from their experience in completely eliminating paper at the point of care, and incorporating that learning into the overall vision and aims of our own programme. The hospital has also received the 'GS1 Healthcare Award' thus giving the team an unrivalled opportunity to see the use of barcodes to identify patients and products in operation. This was an extremely informative visit and has helped consolidate our GDE vision.

14. EQUALITY, DIVERSITY AND HUMAN RIGHTS (EDHR) ANNUAL REPORTS

The Trust's Annual Equality Reports for year ending March 2018 will be considered by the Executive for approval prior to publication on the Trust website August 1st 2018. These include Annual Equality Information Reports for (1) Patients and (2) the Workforce and also (3) the Workforce Race Equality Standard (WRES) with a link to the WRES National NHS Benchmarking Report 2017 /2018 which shows the Trust's position.

The Trust's 1st Gender Pay Gap Report (for data year ending March 31st 2017 and published March 30th 2018 in line with statutory requirements) is available via the following link: https://www.ldh.nhs.uk/wp-content/uploads/2018/04/Gender-Pay-Report-March-2018.pdf

Preparations are underway for the next Gender Pay Gap Report year ending March 2018 and also for the new Workforce Disability Equality Standard (WDES) Report due in 2019 which has a specific indicators to measure and benchmark local and national NHS disability equality performance.

These reports meet the terms of the NHS Contract, statutory and CQC EDHR requirements and are a fundamental part of the NHS Equality Delivery System (EDS2) in planning improvements to Patient and Workforce Experience. Next priorities will be to review progress on our Equality Objectives and other key areas such as the Accessible Information Standard and Equality Impact Assessment which are key to this agenda.

Subject to approval by the Executive, the finalised reports will be available on the website from 1 August.

15. INFORMATION GOVERNANCE QUARTERLY REPORT

The Information Governance Quarterly report is **attached as Appendix 2**

16. BLMK STP

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

17. FREEDOM TO SPEAK UP

There were eight new concerns raised from staff for the period April 1st to June 30th. Six around attitudes and behaviours, one around patient experience and one other concern.

These have all been escalated to the appropriate Board member and are being investigated.

NHSI issued a guide for Boards on Freedom to Speak Up (FTSU) in May 2018. The FTSU guardian, in collaboration with the relevant Executive and Non-Executives, has completed the self-assessment and this will be reviewed and approved by the Board.

18. ESTATES & FACILITIES UPDATE

OVERVIEW

The Interim Director of Estates & Facilities has now left the Trust. The Trust has completed the recruitment of a new Director of Estates & Facilities. Dean Goodrum, currently Director of Estates & Facilities at ENH NHS Trust, will join the Trust on 6 August. In the short-term, the role is being covered by David Hartshorne, the Redevelopment Programme Director.

Outstanding issues with Engie are gradually being resolved. Agreement on catering deductions for January to April is the main issue still for resolution.

FACILITIES

Hard FM

Medical gas: Works have now been completed to ward 5. Key tasks to be addressed in the coming quarter are the replacement of the compressor in maternity, and the works required to the MRI suite.
Water: Monthly temperature monitoring continues to highlight issues around the Trust with poor control valves and circulation. Two recent actions have resulted in loss of cold water to medical block and loss of hot water to part of surgical block. Both instances were due to unauthorised operation of valves.
Ventilation: All critical systems are being serviced and re-validated. Contract allows for quarterly maintenance and annual validation of all critical vent plant.
Electrical: New contracts for Portable Appliance Testing, fixed electrical systems testing and emergency lighting maintenance have been awarded
Boilers: All serviced and insurance inspected. Pressure systems insurance 100%. Allianz inspections are up to date
Lifts: All serviced and insurance inspected except goods lift in trust offices which requires substantial repair. Vertica producing specification to support tender for new maintenance contract.
Asbestos: Planning progressing on duct clearance. Substantial work required Q2/18 to prepare for Endoscopy Decontamination project and Electrical Infrastructure upgrade
Electrical Infrastructure: Design and management contract awarded to MACE/TB&A to develop and procure proposals to provide resilience on the HV ring main. This work will address outstanding issues within substations, and deliver full standby generation capacity on the site.

Soft FM

Cleaning: Domestic Standards overall have improved during the last 3 months. There has, however been a recent drop in standards which is being addressed.
Catering / Housekeeping: Services have improved over the last three months. The appointment of a Catering Manager at the beginning of April has been effective. There are further arrangements being put in place to improve the flow of service within the canteen.
Retail: All Retail outlets on site are compliant with the Reduction of Sugary Drinks and CQUIN requirements. The draft Lease with Engie for the retail outlets has been agreed.
Porters: The portering review is progressing. Arrangements for winter are being reviewed
Switchboard: Switchboard and Helpdesk services are still being challenged by issues with the CCG non-emergency patient transport contract with EEast.

Compliance: Work is in progress to develop a PPM schedule for use by external contractors and the in-house team.

Surveys: The 6-facet survey has been completed. This is now being used to plan a backlog maintenance programme for the site. The fire compartmentation survey of the entire site is underway and will be delivered at the end of July.

PROJECTS

Fire Alarm System: Work has commenced on updating the fire alarm system. This will be completed in October. Works are being phased to work in conjunction with other refurbishment work.

Imaging – MRI refurbishment: The new scanner has now been installed and has been commissioned. MRI2, one of the existing scanners, has now been taken out of service and will be completely refurbished.
A proposal to address some of the patient dignity issues adjacent to the X-ray rooms has been developed. This work will commence in the autumn.

Endoscope decontamination unit: Construction work has now started and will be completed before Christmas

HEALTH & SAFETY AND FIRE

Health & Safety
In the first quarter of 2018-19 there were 75 staff related DATIX Health & Safety related Incidents. This compares to 50 for the same period last year. The top 3 reported incident types were Needlestick Injuries (22), showing an increase of 12 against last year. Struck by or against (19) showing an increase of 11 and Slip Trip and Falls (17) showing an increase of 8. Only 4 incidents were rated moderate harm, 53 as low harm, 17 as no harm caused.

RIDDOR - Reporting of Injuries, Diseases & Dangerous Occurrence Regulations 2013.

The first quarter of 2018-19 showed an increase in RIDDOR Reported incidents from 2 incidents to 7 against the previous year.

There were 3 x Staff RIDDOR reports; a traffic accident, a physical assault and a parents pull down bed on the Paediatric ward fell onto a staff member causing bruising

And 4 x Patient RIDDOR reports:

- All 4 incidents caused by slip, trip or falls; 2 x resulting in facial fractures, 2 x leg fractures.

Fire

Activations - For the first quarter of 2018-19 there 21 fire alarm activations, on par with the previous year, as were the number of attendances by the fire service which was 3. There were no actual fires, all reported as False Alarms.

Training – The agreement to change Mandatory Fire Training has now been agreed and we are working with the Training department to ensure a robust monitoring and recording process is in place before rolling out the new arrangements. Fire Safety Training will be mandatory for all staff on a bi annual basis and must include a face to face session every other time. The year in between all staff must complete and record an Evacuation Walkthrough from their respected area of work

RISK REGISTER

A review of the Trust risk register shows all Estates & Facilities risks being managed and/or due for upgrade from capital expenditure. The major headlines are:

- Electrical Infrastructure – Consultants MACE appointed to compile Design for Tender
- Ventilation – Review of Critical plant – ongoing
- Gas supply – lack of resilience – to be addressed as part of Energy centre project

19. COMMUNICATIONS & FUNDRAISING UPDATE

COMMUNICATIONS:

External Communications and Media attention - a lot of interest was generated by the NHS 70th birthday celebrations and L&D features were broadcast on BBC Look East and Sky news.

Internal Communications and Events – monthly staff briefing sessions are ongoing. A new staff newsletter is being produced each month for those that are unable to attend the briefing.

Merger Communications - The two communications teams continue to work together to ensure staff and stakeholders are kept up to date as plans for the merger progress.

New staff App – A mobile app for staff has been created to give staff better access to the information they need. The app includes news alerts for staff, links to important information, access to e-roster and emails, and major incident alerts.

FUNDRAISING/ CHARITY:

Between the period of 1st April and 15th June, the charity has received 368 donations totalling £155,000.

- We held a successful legacy event on Thursday 21st June at the Old Palace Lodge, gaining new pledges of support.
- Over £1000 was raised on the NHS 70th Anniversary, with lots of activities taking place across site including visit from Mayors of Luton, Dunstable and Houghton Regis. Feedback from this event has been very positive.
- Over £13,000 was raised by Elliott Quince (former NICU Dad) selling World Cup football charts, which were even featured on TV.
- Our walk for the Child oncology project had over 40 participants including lots of staff, walking from Sainsbury's in Bramingham to the Hospital.
- We have been selected as one of the Luton Mayor charities for the year, specifically supporting the helipad.
- We have started the process of forming a helipad fundraising committee, chaired by Edward Philips, including a major donor event in line with the 80th anniversary of the opening of the L&D Hospital by Queen Mary in 1939.

20. POLICIES & PROCEDURES UPDATE

The following Policies & Procedures were approved during May & June 2018:

R15 Radiation Safety 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.
R19 Respiratory Department Access Policy
P21 SOP Criteria for Adult patient eligibility for pre-operative assessment and length of validity - new
S13 Serious Incident & Never Event Policy
C18 Consent and Capacity to Consent to Examination, Test, Treatment and Personal Care Policy
C19 Consent to Post Mortem
B02 Bank workers policy (non-medical)
R14 Risk Management Strategy

EXECUTIVE REPORT

QUARTERLY REPORT ON NURSING AND MIDWIFERY STAFFING LEVELS

Quarter 1 – April to June 2018

1.0 Summary of Report

At this Trust we aim to provide safe, high quality care to our patients. Our staffing levels are continually assessed to ensure we meet this aim. Following the investigation into Mid Staffordshire NHS Trust, the resultant Francis report NHS England (NHSE) and NHS Improvements (NHSI) requested that all Trust Boards receive reports on the levels of planned and actual nursing registered and unregistered staff. This is broken down between day and night shifts and includes the planned versus actual staffing levels.

This report provides the Trust Board with information regarding staffing levels for **1st April to 31st June 2018**.

Key Points:

- The Trust has maintained an overall staffing fill rate of above 90%. However trend analysis demonstrates difficulties in fill rates over the last 12 months, particularly on day shifts
- Continued challenges in meeting the need of enhanced care of patients particularly on wards 14 and 15
- On target to meet 0% HCA vacancies by August 2018

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

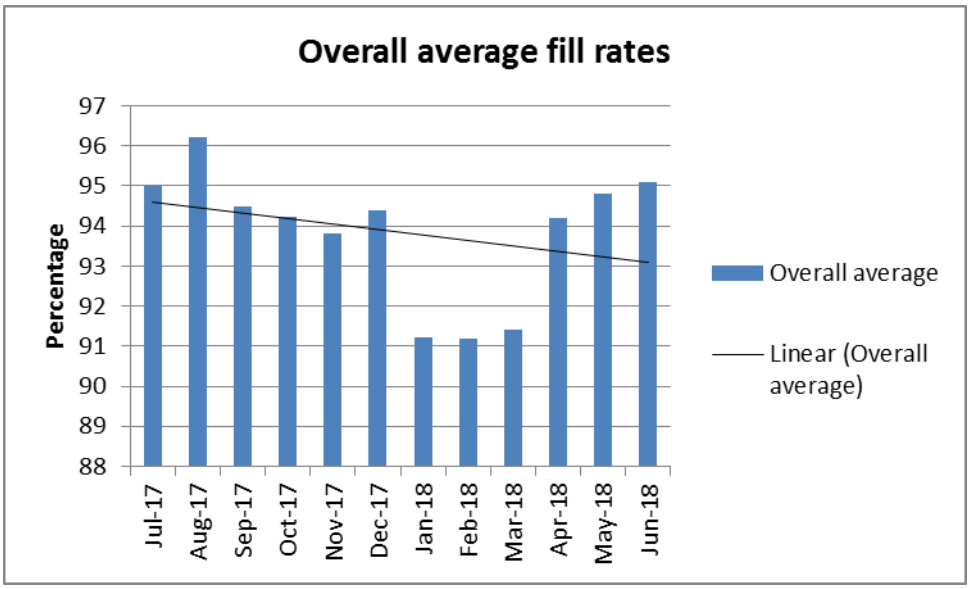
2.0 Breakdown of Average Shift Fill Rates for the Trust

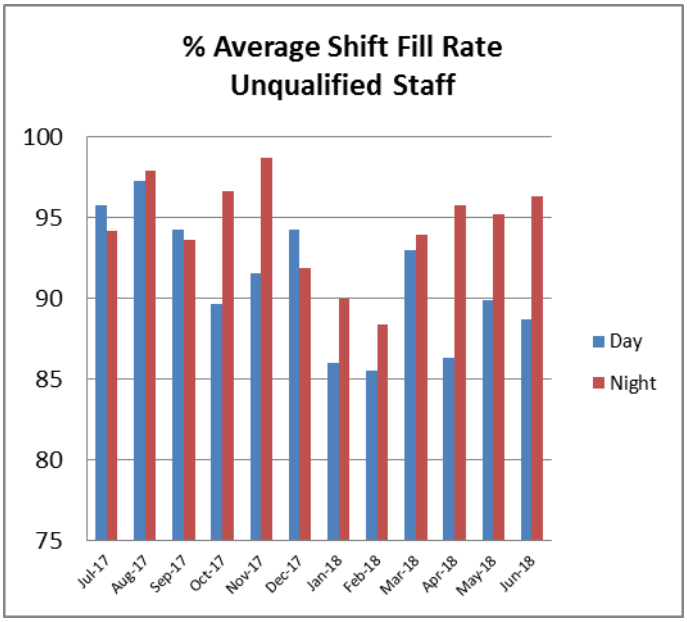
Consistent with performance in previous quarters, shift fill rates for clinical areas across the Trust demonstrate that safe staffing levels for registered and unregistered Nurses and Midwives have been maintained. Given this information areas continue to experience challenges in filling shifts particularly during the day. There has been an increase in the ability to fill shifts this quarter. This can be attributed to a reduction in the amount of contingency areas resulting in staff remaining on their base wards to deliver care.

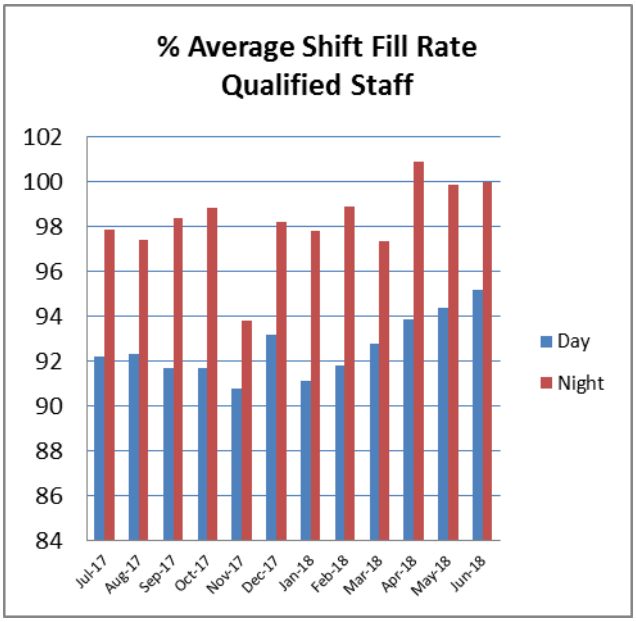
Although we met the national safe staffing requirements, we continue to see significant challenges to delivering care, particularly during the day shift. This quarter has shown some increase in the amount of Health Care Assistants on day and night shifts. However there remain difficulties in filling shifts these shifts particularly for enhanced care. Although we pre-empted these staffing requirements, filling gaps remained a constant challenge.

Table 1 AVERAGE SHIFT FILL RATES FOR THE TRUST

Month	Day %		Night %		Overall average
	Qualified	Unqualified	Qualified	Unqualified	
Jul-17	92.2	95.8	97.9	94.2	**95.0**
Aug-17	92.3	97.3	97.4	97.9	**96.2**
Sep-17	91.7	94.3	98.4	93.6	**94.5**
Oct-17	91.7	89.7	98.8	96.7	**94.2**
Nov-17	90.8	91.6	93.8	98.7	**93.8**
Dec-17	93.2	94.3	98.2	91.9	**94.4**
Jan-18	91.1	86	97.8	90	**91.2**
Feb-18	91.8	85.5	98.9	88.4	**91.2**
Mar-18	92.8	93.0	97.3	93.9	**91.4**
Apr-18	93.9	86.3	100.9	95.8	**94.2**
May-18	94.4	89.9	99.9	95.2	**94.8**
Jun-18	95.2	88.7	100.0	96.3	**95.1**







3.0 Staffing Management

The Trust has in place a number of mechanisms led by the Chief Nurse to ensure the delivery of patient care is safe. Staffing is used flexibly across the wards and clinical areas dependent of acuity of patients and staff skill mix. Multi-professional operational meetings occur throughout the day where patient requirements are reviewed and planned for. 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.

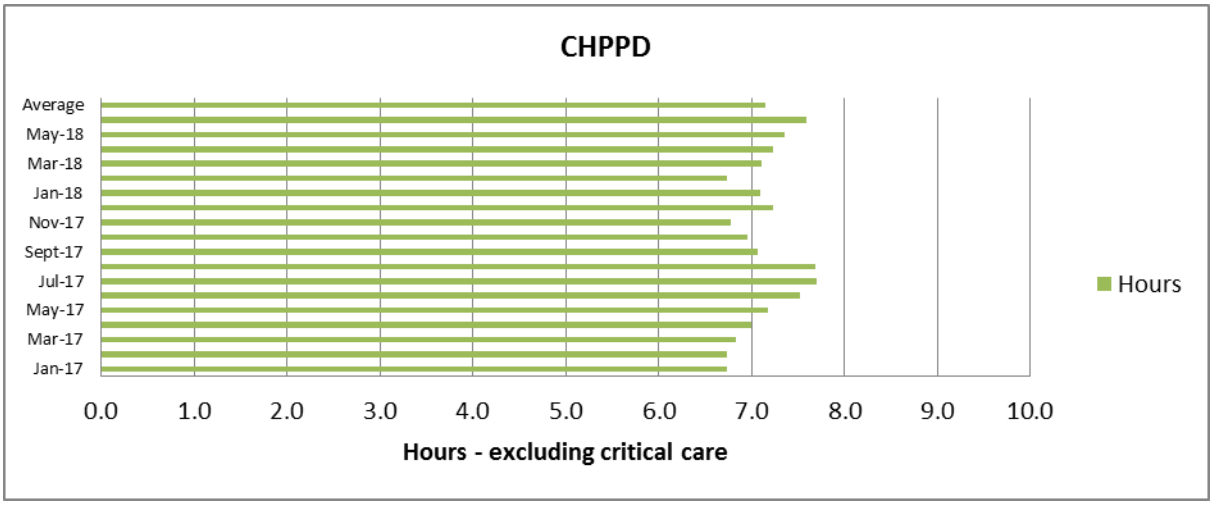
During quarter 1 there has been a reduced need to open contingency areas at short notice. This has meant that there has been an increase in the ability to staff the base wards. Consistent with the national picture, registered nurse vacancies remain a challenge.

3.0 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, Care Hours Per Patient Day (CHPPD) are recorded. CHPPD describes the actual hours worked (both registered and non-registered) divided by the number of inpatients at midnight per month.

There remains no national data for us to compare our CHPPD with. However comparisons with neighbouring Trusts demonstrate that our information is very similar. Dissimilar to the other Trusts, is that we include our maternity and acute medical units in these figures (see table 2). It is felt that this is important in order for us to monitor the CHPPD for these areas over time.

Table 2 OVERALL CHPPD MONTHLY COMPARISONS



4.0 Vacancies and Recruitment Activity

Recruitment and retention remains a focus of nursing and midwifery staff across all bands with plans for 2019 underway. (A strategic response to the challenges of retention of staff is being implemented in conjunction with the NHSI). The Trust continues to attend local schools, university job fairs, jobcentre careers days and academy events to promote the diversity that the NHS can offer in careers.

We remain challenged by the high IELTs mark requirements, but recent NMC review has now provided an alternative English exam called the Occupational English Test (OET). We have commenced a new European nurse pathway that provides in-hospital OET training to these nurses while they work as band 4 pre-registration nurses. At present we have 10 staff undertaking this programme with a further 6 due to arrive in July. The first cohort will sit their exam in July. If this pathway proves successful we anticipate continuing to pipeline these nurses into post.

At present we are averaging five international nurses arriving each month. These nurses are now undertaking an accelerated OSCE training programme delivered by our education team. This is required to prepare these staff for their OSCE examination necessary for them to register with the NMC. We are proud to state that we have an excellent pass rate of 98%.

5.0 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
- Note that there has been a consistent downward trend in the ability to fill shifts – particularly during the day and the impact this has on the delivery of patient care
- Note the continued challenges to delivery patient care due to contingency areas being open on top of existing staff vacancies on base wards
- Recognise the challenges to delivering OSCE training programmes to overseas nurses

Information Governance (IG) & IT Security – (GDPR) - Trust Board Report

July 2018

Purpose of this report:	• Update, information & awareness • Board to note message at end of report

1. Data Security & Protection (DSP) Toolkit

This new online Self-Assessment Toolkit has been published by NHS Digital and replaces the old IG Toolkit. It is made up of the Ten Data Security Standards (incorporating 40 assertions) covering:

- Requirements of the General Data Protection Regulations and Data Protection Act 2018 (which, in May 18, replaced the Data Protection Act 1998)
- Cyber Essentials
- NHS Standards & Guidance in relation to all subjects that fall under the GDPR umbrella e.g. Data Protection, IG, IT Security, Cyber Security, Data Quality, Health Records, Corporate Record, FOI & Clinical Coding.

The Trust is required to provide the requested evidence to demonstrate compliance with each Assertion. A Progress submission has to be performed by 31st October 2018 followed by final submission by 31st March 2019.

2. IG Incident Reporting Tool

The DSP Toolkit also incorporates an IG Incident Reporting Tool which the Trust is required to use for reporting IG incidents. Under GDPR serious IG breaches (defined as incidents that are highly likely, to have an impact on the '*rights and freedoms'* of the individuals concerned), MUST be reported to the ICO within 72 hours of the Trust becoming aware of the incident. Once information about an incident has been submitted through the tool the details are automatically fed to the ICO unless the tool decides from the information provided that it is not a reportable incident.

3. General Data Protection Regulation (GDPR) Progress Update

Progress towards compliance with the requirements of GDPR continues. Areas of compliance currently being or about to be worked on include:

3.1 Data Privacy Impact Assessment (DPIA) - Design and implementation of a new DPIA process. The purpose of a DPIA (to be performed at the early stages of a project which will result in the processing of personal identifiable data) is to identify and mitigate any risks that the project may have on the *'rights and freedoms of individuals'. DPIAs were* previously known as Privacy Impact Assessments (PIAs) and seen as good practice, but were not legally required.

1.2 Clinical Audit - We need to assess what level of Risk Assessment needs to be conducted for different types and Clinical Audits. Consent of patients is generally not needed for internal Clinical Audits. However, it is important we do not make this blanket assumption, so we will need to assess audits on the Trusts Clinical Audit programme. Some audits may need consent or may need additional Fair Processing requirements.

1.3 Policies - Updating current relevant policies and procedures to incorporate GDPR and Data Protection Act 2018.

3.2 Third Party Contracts - A working group has been stood up to look at how the Trust is going to update contracts it has with Third Parties who are processing personal identifiable data on behalf of the Trust. This is proving to be challenging, (unlike many other Trusts) our Third Party Contracts are not managed centrally. The ICO has provided a list of what must be included in these contracts.

3.3 Departmental Audits – Data Flow spreadsheets and Department Questionnaires were issued to departments across the Trust. Returns are being risk assessed based on who they share data with (externally), how they share it, if they hold departmental Health Records etc. We will meet with each department to discuss improvements in compliance that will reduce the risk of IG breaches occurring.

3.4 Employment Contracts – Further advice is being sought with regards the need to update Employment Contracts and how updates need to be communicated.

4. GDPR Compliance Review

A GDPR Audit Review has been conducted by Price Waterhouse Cooper (PWC). We are waiting for a report on the findings and recommendations which PWC will present to the Audit & Risk Committee in July. The Trust has formed a GDPR programme board attended by a wider group including procurement, contract management and General Management as well as the Caldecott Guardian and SIRO and has run the board alongside the established Information Governance Steering Group. The IT Security & Cyber element of GDPR has recently had a GAP analysis performed by an external security expert, as well as completed external and internal penetration testing. All elements that require improvement are currently being addressed to allow National certification for the Trust in terms of compliance. We reported in the previous update that PWC had audited the Cyber element of the Trusts security provision, and this is now compliant, with additional security layers, new policies and additional firewalls, and machine learning software and a patching regime for all servers.

5. Mandatory IG Training

A joint letter from the Department of Health and the ICO was sent out to all NHS organisations in 2009 which introduced a mandated requirement for annual IG Training for all staff. However, this has been on the Trusts Risk Register since then.

As advised by our Training and Development Department, the Trust is working to align all of the subjects that make up the mandatory training programme, with Skills for Health, who mandates the frequency of IG Training at every two years. Whilst the IG Steering Group is supportive of this, it must be highlighted to the Trust Board that this may result in non-compliance with the Data Protection & Security (DPS) Toolkit Assertion for IG Training which requires annual IG Training.

Advice has been sought from the IG Lead for NHS Midlands & East who has recommended that the Trusts Senior Information Risk Owner (SIRO) contacts NHS Digital to request an exemption from the IG Training Assertion on the DPS Toolkit which requires a yes or no answer for the following statement:

"All staff complete appropriate annual data security training and pass a mandatory test, provided linked to the revised Information Governance Toolkit.

All staff complete an annual security module, linked to 'CareCERT Assurance'. The course is followed by a test, which can be re-taken unlimited times but which must ultimately be passed. Staff are supported by their organisation in understanding data

security and in passing the test. The training includes a number of realistic and relevant case studies."

6. IG Incidents

Theft of Unencrypted Laptop (Feb 2018) - As reported to the Board in April 2018, an unencrypted laptop which held name, Hospital Number, DOB of approx. 950 babies was stolen from the Audiology Hearing Test Room in Outpatients Department. This incident was reported to the ICO who have closed the case with no further action at this stage.

Inappropriate access to patients Health Record (June 2018) – a patient contacted the Trusts IG Manager to report suspicion that a member of staff had accessed their (the patients) Health Record and disclosed highly sensitive information with members of the general public. Audit Trails confirmed the patients concern.

The member of staff has been temporarily redeployed into a role without access to personal information and a Disciplinary Investigation has commenced.

The incident has been reported to the ICO who have confirmed that they will await the outcome of the Disciplinary Investigation before conducting their own criminal investigation

7 3rd Party Contracts

The Trust has in place numerous 3rd Party contracts with data processors and under GDPR / DPA18 they must be compliant with the legislation. A Project sub group has been formed with key members of staff to review the current processes and amend where necessary. Once new processes are ready they will be communicated to Department Heads and Information asset owners.

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Message to all Trust Board members…
Is the mobile device you are using encrypted?....if it is not or if you are not sure please call IT Department on ext. 8703 or email: itservicedesk@ldh.nhs.uk asking them to check it for you!

Bedfordshire, Luton and Milton Keynes

Sustainability and Transformation Partnership

Central Brief: May 2018

Issue date: May 2018

News

BLMK Single Operating Plan

The Bedfordshire, Luton and Milton Keynes (BLMK) Sustainability and Transformation Partnership have submitted a "milestone" joint strategic plan – the Single Operating Plan – which sets out its aims for 2018/19 to NHS England. Historically health and social care organisations have developed their strategic plans in relative isolation of each of other. However, this year the whole health and care system in BLMK have worked together to create a single plan for the region, in collaboration with clinicians and wider stakeholders.

Richard Carr, Senior Responsible Officer for BLMK and Chief Executive of Central Bedfordshire Council, said: "The development of this single plan for our system for 2018/19, for all its imperfections, is a significant milestone. We have invested in our noble cause. In 2017/18 we became one of eight first wave Integrated Care Systems, with our ambition to mature from our current shadow status into a 'live' Integrated Care System during 2019/20.

"The ask for our partnership in 2018/19 is significant, with the system carrying material financial pressures, against the context of rising demand, particularly for emergency reactive services, and inequality of health and quality outcomes. These pressures are increasing and there is a requirement to future proof our services in the context of significant population growth, reinforced by the National Infrastructure Commission's proposals for the Oxford-Cambridge Corridor, to which BLMK is central.

"Our single system operating plan for 18/19 describes how we will can build on all we have achieved during 2017/18 and what our focus will be for the coming year. I would like to record my sincere thanks to all the health and council partners in BLMK for their commitment and support for our 'noble cause'. I look forward to the next year on our journey as an Integrated Care System and to us working together to deliver tangible improvements to the health and wellbeing of local people."

The full plan can be downloaded from the BLMK website by clicking here.

Transforming cancer care across BLMK

In Bedfordshire, there are over 3000 new cancer diagnosis each year, while nationally there are currently an estimated 2.5•• million people living with cancer withthis figure expected to

rise to four million by 2030[**]. It is figures like these that show that diagnosing, treating and then supporting those living with a cancer are a key area of focus for BLMK for now and into the future.

Last year, BLMK's partner the Cancer Alliance secured £1.2 million of funding to transform how, where and when certain cancers are diagnosed and changing the way people living with cancer are supported.

Catching it early

Early diagnosis is a key to improving survival rates from many of the more common cancers. In BLMK, the funding is allowing partner organisations to work together to introduce FiT testing in primary care as well as developing innovative one-stop shop diagnostics for urological cancers.

FiT stands for Faecal Immunochemical Test. It is a type of faecal occult blood test which uses antibodies that specifically recognise human haemoglobin (Hb) and is used as a diagnostic test for suspected lower gastro intestinal (GI) cancers, with a view to identifying more patients at risk of colorectal cancer with otherwise low-risk symptoms.

It is hoped that by enabling GPs access to FiT it will help patients visiting their GP with symptoms to find out much quicker if cancer can be ruled out before they go onto a cancer pathway. The initiative will be rolled out across BLMK in 2018.

Lung cancer is the third most common cancer in the UK, accounting for 13% of all new cancer cases (2015)[***]. In BLMK, the lung cancer pathways will also benefit from investment. This will involve faster access to diagnostic tests and a future plan to include actively identifying patients who are at risk of lung cancer earlier to improve our survival rates.

One-stop shop

Innovation along Cancer pathways within BLMK is an ongoing process, and there have been a number of initiatives that have been developed. In Luton, a one-stop shop for urological cancers was established in 2015 to provide, quite literally, a single appointment to run through a series of tests that are required to deliver a diagnosis on the day instead of waiting weeks for test results and further investigation. As a patient this takes away the need for a worrying wait and the frustration of separate appointments for different investigations – and ultimately delivering a better patient experience.

Living with and beyond cancer

Living with cancer is emotionally and physically challenging and day to day concerns can often lead patients to A&E. The side effect of chemotherapy treatment often leads to patients coming to A&E with concerns about infection, gastrointestinal issues and fatigue. While in some cases patients do require the services of an acute hospital, many more would benefit from services in the community, reducing hospital admissions and saving patients time in hospital.

In BLMK, specialist nurses in the community are being provided to help patients get treatment, if required, in the right setting and signposting them to other sources of support and information. The first area to benefit from specialist nurse support will be Luton and if the concept works will be phased in across BLMK in 2019. In addition, BLMK is also working with Macmillan Cancer support to offer a wide range of support for those living with cancer as well as guidance on everything from financial advice to emotional support.

Patient Advisory Board for Cancer

We are looking to establish a new patient advisory board. The new board, which will also include leading clinicians, will help us develop cancer pathways and shape plans for the future of cancer care in BLMK. If you would like more information about the board or have someone interested in getting involved contact Carol Ord, Carol.Ord@bedfordhospital.nhs.uk. Please include Patient Advisory Board in the title of emails.

****Macmillan website***

*****Statistics Factsheet. Macmillan Cancer Support. December 2017***

******Data were provided by the Office for National Statistics on request, July 2017. Similar data can be found here: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/cancerregistrationstatisticsen***

Bedford Hospital and Luton and Dunstable University Hospital Merger Update

The joint Integration Board, consisting of executive representatives from both Trusts, met in early April to discuss the plans, possible timeframes and priorities for the merger of Bedford Hospital and Luton and Dunstable University Hospital going forward. Over recent weeks, we have been reminded of the strong support that this proposal has – from clinical and non-clinical staff, our patients, the public and local politicians – and acknowledgement that our ambition to merge makes good strategic sense and will benefit patients and staff. This has been really encouraging.

Both Trust Boards have committed to reviewing progress in June this year and agreeing the most likely date for the merger to proceed. It looks like the earliest possible date would be in the autumn but that would be dependent upon us receiving confirmation in early July from NHS Improvement (NHSI) that the capital is available to support our plans. The more likely scenario is that the national funding allocation is not announced until later in the summer and in this case, we would merge at the start of the next financial year (April 2019). This is because we are aware of the impact of undertaking major organisational change during the busy winter period. In both cases integration work will continue and we will use this additional time to further develop our plans and progress key activity. We will keep you updated throughout.

Clinical engagement

We were pleased to see the spirit of collaboration and enthusiasm for working together at a recent clinical leaders' event that was well attended by clinical directors, lead nurses and senior managers from both Trusts. Both organisations acknowledge the importance of having strong leadership across clinical service lines and took the opportunity to share current work and ideas for future collaboration in areas such as endoscopy and audiology, which was well received.

Leadership update

Since our last update there have been some announcements regarding key Trust leadership posts. The L&D Trust Board confirmed the appointment of David Carter as L&D CEO in February, following the departure of Chief Executive Dame Pauline Philip from the L&D (who stepped down to focus on her role as the National Urgent and Emergency Care Director for NHS England). David was managing director since 2011 and has been acting CEO since April 2017, so this appointment provides important continuity of leadership for the L&D.

On 7 March, Cathy Jones was appointed Deputy Chief Executive at the L&D. Cathy has been acting into the role since April 2017, having held various managerial roles throughout the organisation since 2007. Working alongside Paul Tisi, Medical Director at Bedford Hospital, Cathy is leading on the clinical workstream for the merger and was previously leading the acute clinical review for the STP.

Liz Lees has been appointed Director of Nursing (DoN) at L&D. Liz, a former cancer nurse, has a wealth of experience within senior nursing leadership roles and was most recently Acting Director of Nursing at East and North Hertfordshire NHS Trust. Liz is currently the interim DoN at Bedford Hospital and will be the lead for nursing on the merger Integration Board.

These appointments will help us to finalise the membership of the Board of the merged organisation, which will be known as the Bedfordshire Hospitals NHS Foundation Trust. The final Director designates will be announced in the coming months and allow a 'shadow Board' to be in place in advance of the merger to continue the work of the Integration Board, ensuring continuity of leadership and that the interests of both Trusts and local residents are represented.

If you have any questions you can email merger@ldh.nhs.uk. A staff side forum with membership from both hospitals has also been established and met for the first time earlier this month. This committee will provide the foundation for sharing information about the TUPE process and what it means for staff at both hospitals, once a new date for the transition has been agreed.

Engagement

Primary Care Home Workshop

In April, BLMK took another step towards implementing the Primary Care Home model across the footprint.

More than 130 colleagues from primary care practices across BLMK attended the two workshops to hear from the teams at National Association of Primary Care (NAPC) and BLMK about this innovative model of care and how it can be implemented. The audience also heard from Dr Johnny Marshall OBE, Regional Primary Care Home Lead, NAPC and how his practice adopted PCH.

For those attending the workshops it was their first opportunity to hear more about BLMKs plans to implement the model across all 18 localities/clusters/neighbourhoods and to discuss with colleagues how it can be adapted to their practices.

BLMK is supporting colleagues in primary care by offering an investment scheme that allows groups of practices and clusters to receive funding for demonstrating that they are beginning to collaborate, share services, begin or enhance multi-disciplinary working for the benefit of patients.

The rollout of PCH in BLMK will see approximately £1m invested in primary care services during 2018 and into 2019.

Mental health in Primary Care Home

When: Tuesday 22 May, 2018 12.30 am – 4.00 pm

Where: Rufus Centre, Lockyer Suite, Steppingley Road, Flitwick, Bedfordshire, MK42 1AH

The event will include a range of presentations including a keynote speech from Chris Naylor from the Kings Fund.

This event is aimed at primary care clinicians and leaders, secondary care clinicians and leaders, commissioners of mental health and physical healthcare, service managers, mental health champions, public health colleagues, local authority colleagues, directors of nursing and medical directors.

Food and refreshments will be provided at the event. Places will be reserved on a first come, first served basis. A full agenda will follow in the coming weeks.

To register for the event, please confirm to Stephanie Quitaleg at Stephanie.Quitaleg@nhs.net

Opportunity

Primary Care Workforce Programme Manager

Band: 8c

Hours: 37.5 per week Secondment/Fixed Term until March 2020

Location: Flexible. Offices at the Poynt, Luton. Must be able to travel across Luton, Bedfordshire and Milton Keynes.

The post has responsibility for strategic leadership and programme management of the delivery of the BLMK GP Workforce Plan and Development Programme across the ICS/STP area of Bedfordshire, Luton and Milton Keynes

Bedfordshire, Luton and Milton Keynes (BLMK) Health and Care Partnership forms part of the first wave of Integrated Care Systems (ICS) which have evolved from STPs. They bring together NHS providers, commissioners and local authorities to work in partnership, improving health and care in their area. As part of an ICS you will have the opportunity to contribute to models that will shape future policy.

The post holder's role will be hosted by Cambridgeshire Community Services on behalf of BLMK ICS. This is an exciting new post that will work across BLMK ICS to lead on the implementation of our General Practice Workforce and Development Plan. Working with our centralised Community Education Provider Network (CEPN), which brings together the CEPNs from our three Clinical Commissioning Groups and aligned to workforce networks through the Local Workforce Action Board, the post holder will drive workforce

transformation in General Practice within a dynamic and developing workforce transformation environment.

The post holder will Programme Manage and provide senior leadership capability to the implementation of the BLMK General Practice Workforce and Development Plan, which includes innovative approaches to attraction, recruitment and retention our General Practice Workforce, including GPs (international and UK), Nurses, Practice Managers and support roles as well as new roles such as clinical pharmacists and physician's associates.

We are looking for an influential leader with a passion for driving improvement within Primary Care and General Practice. You will have senior leadership experience within the NHS and demonstrable evidence of your ability to deliver improvement and redesign. You will have the opportunity to work with a pioneering integrated care system and steer the general practice workforce development transformation in support of an integrated service offer.

For more information and an informal discussion/visit please contact Alison Lathwell, BLMK ICS Workforce Transformation Lead: Alison.lathwell@bedfordshireccg.nhs.uk Tel: 07717426900

To apply click here.

To keep up to date with all the news and information about the work of BLMK STP:

Follow us on Twitter Like us on Facebook

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

BOARD OF DIRECTORS

Agenda item	8	**Category of Paper**	Tick
Paper Title	Performance Reports	**To action**	☐
Date of Meeting	2 May 2018	**To note**	☒
Lead Director	1. Liz Lees, Chief Nurse / Cathy Jones, Deputy CEO 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 Apr, May and June 2018, FIP April, May and June 2018, Executive Board May & June 2018	
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	1212 – Agency Costs 1018 – HSMR 1210 – Vacancy rate	650 – Bed pressures 669 – Appraisal 1178 – Finance costs 796 – Inpatient Experience

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 ☐

Executive Summary and Headlines:

Quality and Performance Report – June 2018

RAG Key:

	Target attainment – no risks to escalate
	Risk to targets and/or issues identified
	Targets not achieved – issues to escalate

	Topic	Page No.	RAG
1	**Safety Thermometer Audits** The Trust continued to deliver Harm Free Care above the national expected threshold of 95%. The Safety Thermometer collection tool has now changed to web based and the Trust is awaiting final data validation for June.	2	
2	**Pressure ulcers** The Trust reported 38 pressure ulcers, grades 2-4, in Quarter 1. Only one of these was deemed unavoidable. One pressure ulcer deteriorated from a grade 2 to a grade 4. This was declared as a Serious Incident. A quality improvement plan and trajectory is being developed for the remainder of 2018/19.	2	
3	**Falls** Quarter 1 showed a reduction in falls by 16% compared to Q4. However, there were 8 falls that resulted in moderate or severe harm. A thematic review is currently underway to support the falls prevention plan. As a consequence, a falls trajectory will be set to reduce harm.	3	
4	**CAUTI** The number of CAUTI fluctuates month by month. A newly appointed Continence Nurse Specialist has been appointed with the ambition to reduce the unnecessary use of catheters.	4	
5	**Infection Prevention and Control and Cleanliness** There was one hospital acquired C.Difficile in May which is under appeal. The Trust has one of the most challenging C.Diff rates nationally and consistently. There were no MRSA bacteraemias in Quarter 1	5	
	Standards of Cleaning Performance – Engie met all cleaning targets in 2018.	6	
6	**Cardiac Arrest Rate** The rate of cardiac arrests continues to reduce. This is supported by the work of managing the deteriorating patient and treatment escalation plan use.	7	
7	**Incidents and serious Incidents** 10 serious incidents declared in Q1 (1 fewer than same period last year). There have been no never events this year.	8, 9	
8	**Patient Experience / Complaints** Friends and Family Test response rates were good in all areas with the exception of the outpatient department and ED which were below national average. The percentage of patients recommending were above or on par with average in all areas.	10,11, 12, 13	
	The percentage complaints response within 35 working days remains lower than target.		
9	**CQC** CQC date for well-led inspection confirmed 11-13 September 2018 and Use of Resources 31 August 2018. Preparation is well underway and unannounced	14	

	inspection expected imminently.		
10	**Mortality and Learning from deaths** HSMR and SMR remain within statistical limits. 73% of structured judgement mortality reviews complete for Q4, significantly better than Q3. 5 cases identified with learning themes.	**15,16**	
11	**Cancer** Achievement against all national cancer targets in May 2018.	**17, 18, 19**	
12	**Emergency Department performance** The Emergency Department 4 hour standard continues to be above 98%.	**20**	
13	**18 Weeks** The Trust achieved 90.3% against the 92% referral to treatment target in June 2018. The admitted backlog reduced however this was masked by a sharp rise in the non-admitted pathways open over 18 weeks. Specialty teams are currently validating the position and providing additional capacity to bring performance back in line with the recovery trajectory.	**21**	
14	**Stroke** Stroke performance for June is based on Quarter 4 performance. This has deteriorated to category D, due to several factors including winter bed pressures, SALT staff sickness and a deterioration in the one-hour door to needle time performance. Recovery plan in place and performance has improved.	**22, 23**	
15	**Diagnostics** The number of patients waiting over 6 weeks was within the target as of May 2018, an improving position from the April performance.	**24**	
16	**Late Cancellations** The Trust has continued to re-date all patients within 28 days of cancellation in May 2018. The percentage of operations cancelled has returned to the baseline level prior to winter pressures.	**25**	
17	**Length of stay** High level of variability since March 2018 but overall trajectory is down.	**26**	
18	**Dementia** Screening and referrals compliance remains excellent. Assessments performance appears to have dipped in May 2018. This is under investigation.	**27**	
19	**NHSI Dashboard** Green across all targets, apart from RTT quarters 3 and 4 and C.Diff and MRSA trajectories.	**28**	

Quality & Performance Report

April, May and June 2018 data

Medical Directors

Chief Nurse

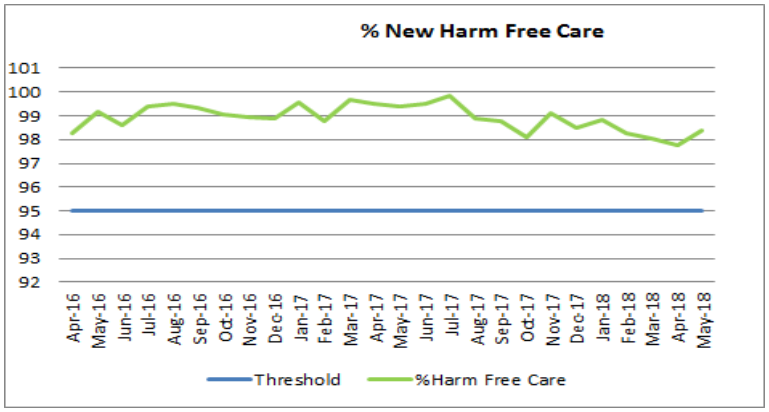
Deputy Chief Executive

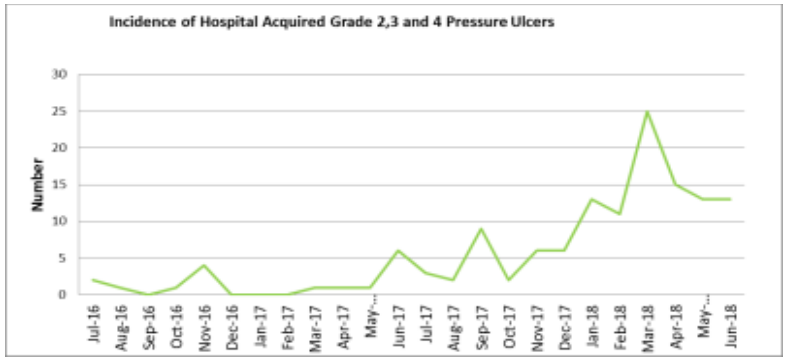
Safety Thermometer

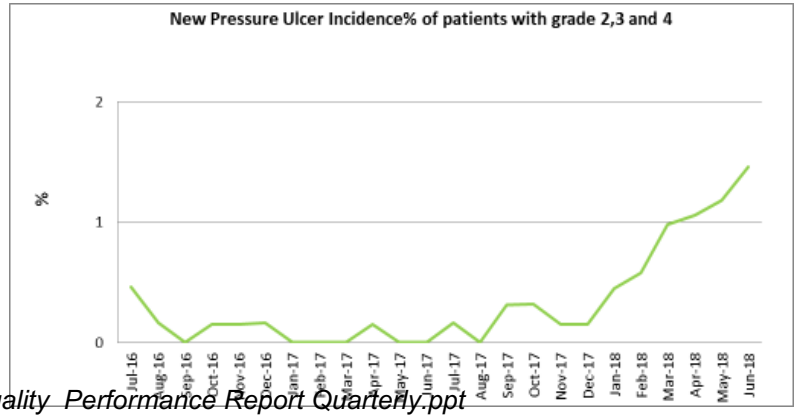
Safe | Effective | Caring | Responsive

Patient Safety Thermometer

Pressure Ulcers







New Harm Free Care

The Harm Free Care data is sourced through a one day snapshot audit. The Trust continues to deliver Harm Free Care above the national expected threshold of 95%. The Safety Thermometer collection tool has now changed to web based and the Trust is awaiting final data validation for June.

Pressure Ulcers - Incidence

The incidence of hospital acquired pressure ulcers (HAPU's) has reduced to 41 this quarter compared to the peak of 50 in Q4 17/18.

During the quarter, 41 grade 2 - 4 pressure ulcers were validated to have occurred in 38 patients of which only 1 thus far has been found to be potentially unavoidable. In May, a patient admitted with a grade 2 pressure ulcer had this deteriorate to become a Grade 4 which has been reported as a Serious Incident and is currently under investigation.

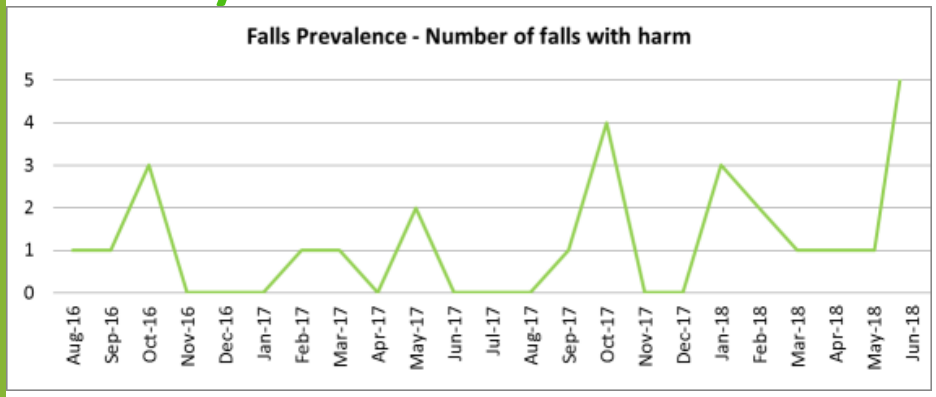
Audit carried out by the Tissue Viability (TV) Team has identified a number of areas for improvement and, along with the new recommendations from NHS Improvement (June 2018) are the focus of targeted Quality Improvement activities at present. Many of the recommendations will be in place by Dec 2018, will full implementation by March 2019.

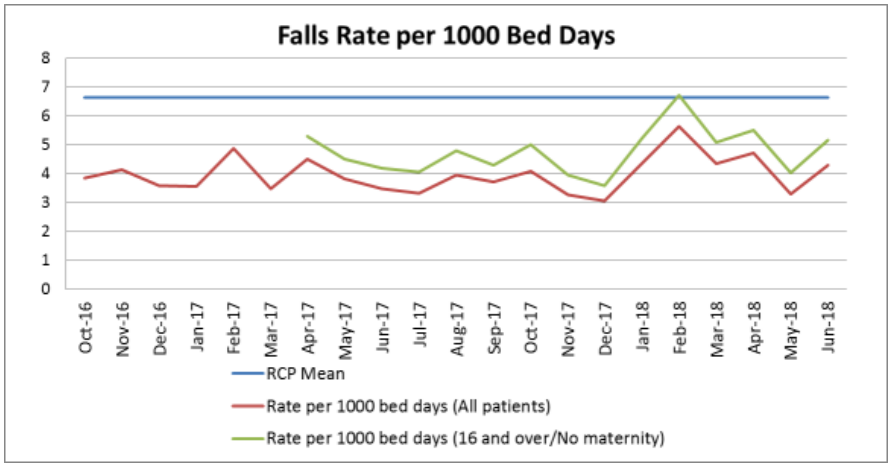
A number of initiatives have been led by the TV Team over the quarter, aimed at improving collaboration across the multidisciplinary workforce and increasing the impact of the Share and Learn review meetings. Key areas of focus are: effective documentation; an increased focus on nutrition and the impact of manual handling on skin damage; the need for robust assessment and care planning; and increasing awareness of how patients and carers can help to make a difference.

The first SSKIN Champions meeting with the new Tissue Viability team was held in May with a high turnout. The meeting focused on the barriers that prevent giving the care the patients need.

Safety Thermometer

Safe | Effective | Caring | Responsive





Falls with Harm (prevalence) (Safety Thermometer 72 hour snapshot data)
There was **1** fall reported on Safety Thermometer in both April and May. The patients sustained minor laceration.

Falls

In **April, May** and **June** there were **91, 68 and 81** inpatient falls respectively (**241** in total), a **16%** decrease from **Q4.** The falls per 1000 bed days rate also decreased from Q4 with a rate of **4.12 for** all patients and **5.18** for RCP rate.

There were **8** falls during the quarter that resulted in moderate or above harm. **3** patients sustained fractured hips requiring surgery. 2 of these falls were deemed avoidable and have been reported to CCG as Serious Incidents. The 5 other (moderation harm) falls were managed conservatively. All are being investigated using RCA methodology.

Work continues on collecting meaningful data to highlight the themes and trends around falls incidents.

- **8** patients fell in contingency areas. 1 patient fell on Ward 5 and sustained a colles # which required splinting.
- **48%** of patients fell in the daytime (07.00 - 18.59) as opposed to **52%** at night (19.00 - 06.59)
- **34** patients with a diagnosis of dementia fell. Use of the enhanced observation assessment tool continues to be promoted across the Trust this enables ward staff to make informed decisions around co-horting (Baywatch) or providing one to one care for patients at risk.
- **18% of falls were related to** toilet/bathroom use. Promotion of the Please Call don't Fall poster in all patient toilets and bathrooms and the patient information leaflet continues.

The Falls Awareness "Drop in" session was well attended in May and will now be held monthly. This gives wards opportunity to send staff for updates and enables Falls CNS to share learning from RCA investigations and discuss issues from the wards .

The Safer Handling of the Fallen Patient workshop was well received and the plan now is to run another one in September and follow up with 4 more next year. The session enables staff to work through Falls scenarios focusing on post falls management.

Safety Thermometer

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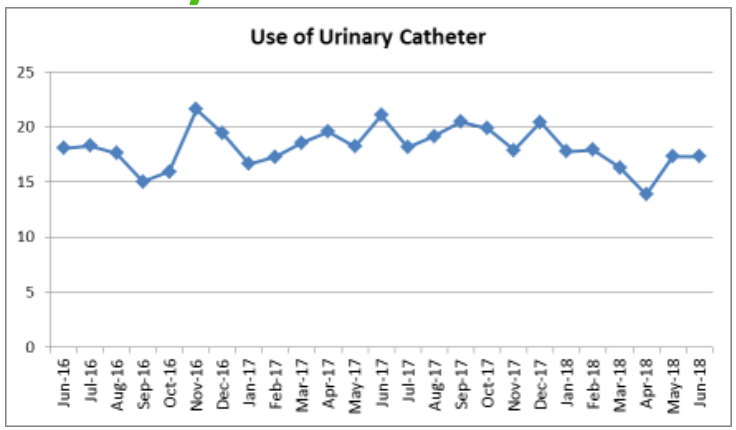
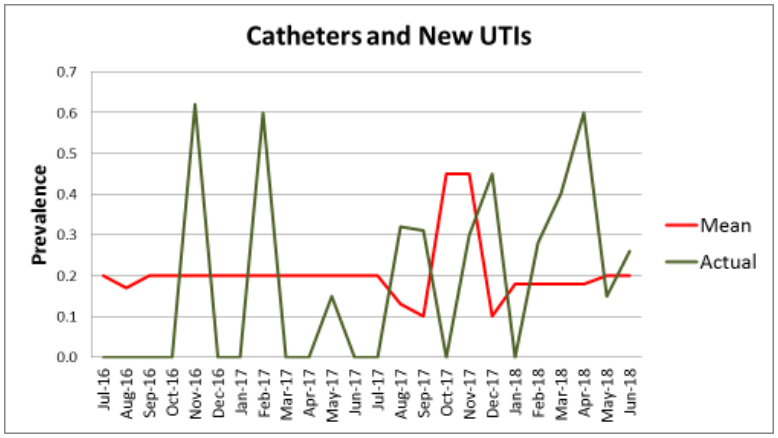
Catheter Acquired UTI





Use of Urinary Catheters:

Fewer catheters were used in April than any month since 2012. Whilst there was an increase in May, this remained static in June. The main reason for insertion is to monitor fluid output and for patients suffering acute retention.

It has been identified that high numbers of patients are being admitted with catheters already in situ.

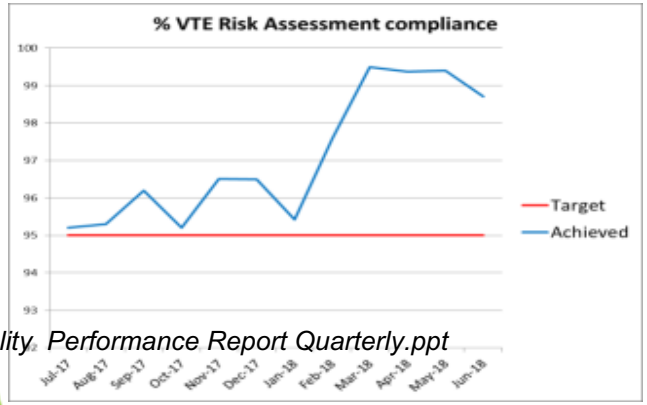
The Continence Nurse is working across the trust to promote safe use of catheters and to promote other methods of monitoring output. In June the Continence Nurse had an awareness stand to promote safe catheter care and the importance of removing catheters as soon as clinically possible. Information went out across social media and there was good attendance from patients and staff.

There were 4 CAUTIs in April, matching a previous peak, 2 of which were in patients with long term catheters.

The RCA's are providing the themes from which to learn and the Continence nurse is working closely with teams to improve catheter care.

The Continence nurse is working in partnership with the urology team to provide additional update training in the future with more in-depth training in catheter insertion and care. A number of educational posters are in development.

VTE



VTE Risk Assessment:

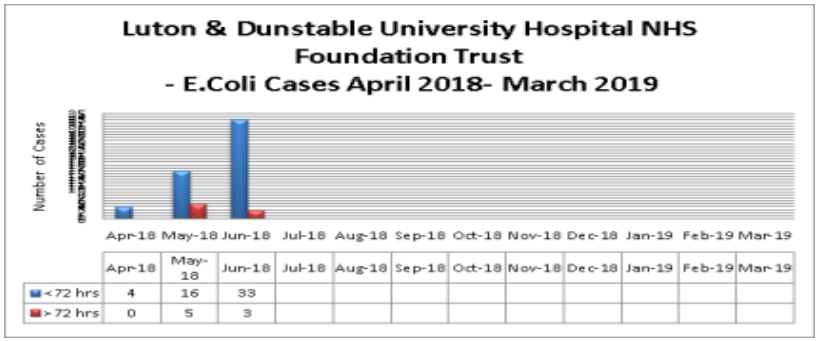
In Q1, more than 99% of patients were VTE risk assessed on admission. This continues to show that the introduction of the electronic VTE assessment is effective in ensuring that VTE risk assessments are being completed in a timely manner.

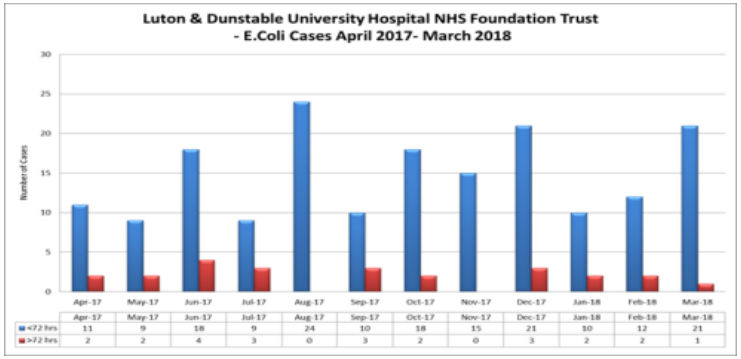
Infection Control

Safe | Effective | Caring | Responsive

MRSA/C.Difficile/E.Coli

	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
C Diff	0	0	2	0	0	0	1	2	1	1	1	1	1	0	1	0	0	0	0	1	0
MRSA	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
E.Coli							2	2	4	3	0	3	2	0	3	2	2	1	2	5	3





C.difficile – There was one hospital acquired C.difficile infection in May and this is still under appeal. There were no cases in June. The December 2017 case was successfully appealed which brings the overall total for 2017-2018 to 9 with 5 successfully appealed.

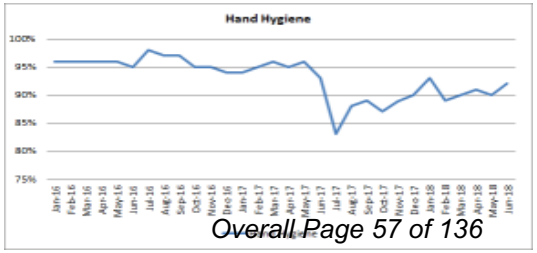
MRSA bacteraemia – There were no Hospital Acquired MRSA bacteraemia in Quarter 1.

E.Coli bacteraemia – The largest number of cases continue to be identified on admission with urinary tract thought to be the most common primary source of infection

Hand Hygiene

Hand Hygiene – Reporting of hand hygiene results via the meridian tool has continued. The number of wards observing the minimum number of hand hygiene opportunities needs to be improved. In June, 23 out of 37 wards recorded less than 20 hand hygiene opportunities with 13 recording 10 or below. The Infection Control Link Staff annual study day was used to update staff on the audit tool and compliance scores to support understanding and improvement.

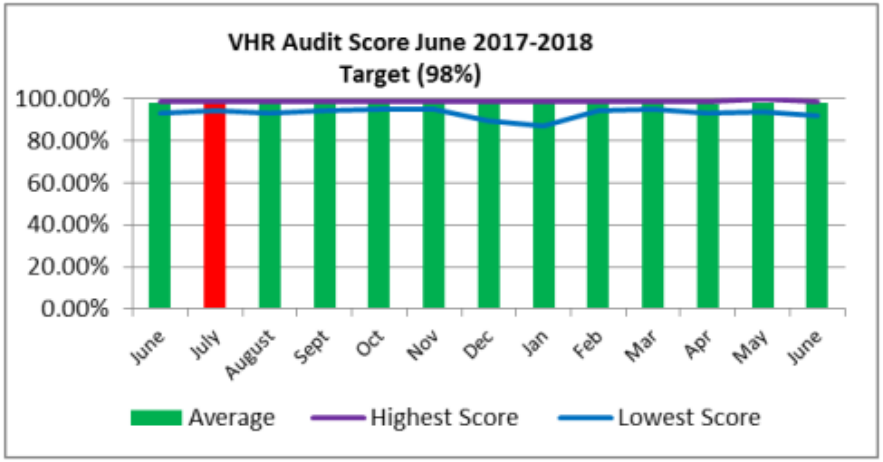
Month	Returns	Before patient contact	Before clean/aseptic	After body fluid exposure	After patient contact	After contact with patient surroundings
March 2018	490 ▲	88% ▲	94% ↔	95% ▼	91% ▲	85% ▲
April 2018	608 ▲	88% ↔	96% ▲	97% ▲	93% ▲	86% ▲
May 2018	579 ▼	86% ▼	93% ▼	98% ▲	91% ▼	87% ▲
June 2018	612 ▲	90% ▲	96% ▲	96% ▼	94% ▲	88% ▲

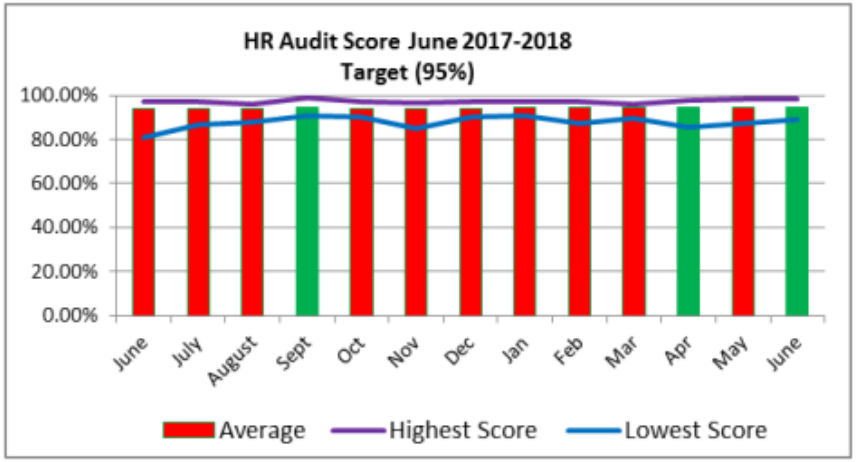


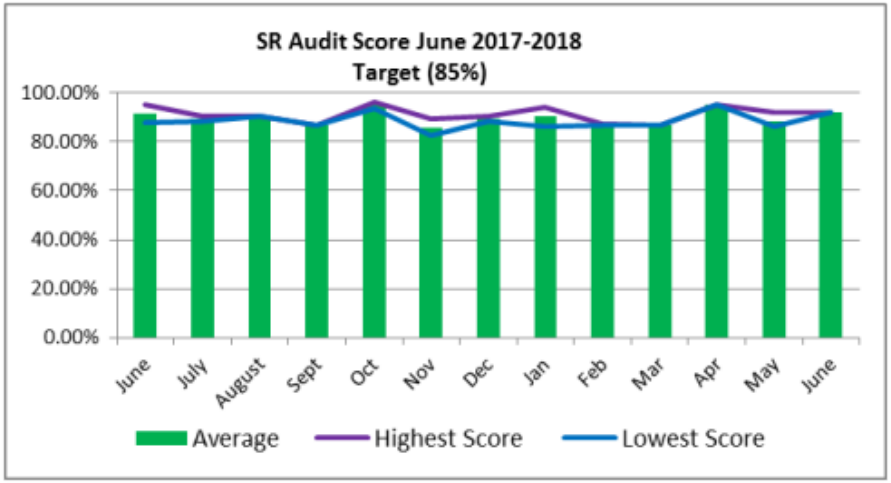
Cleanliness

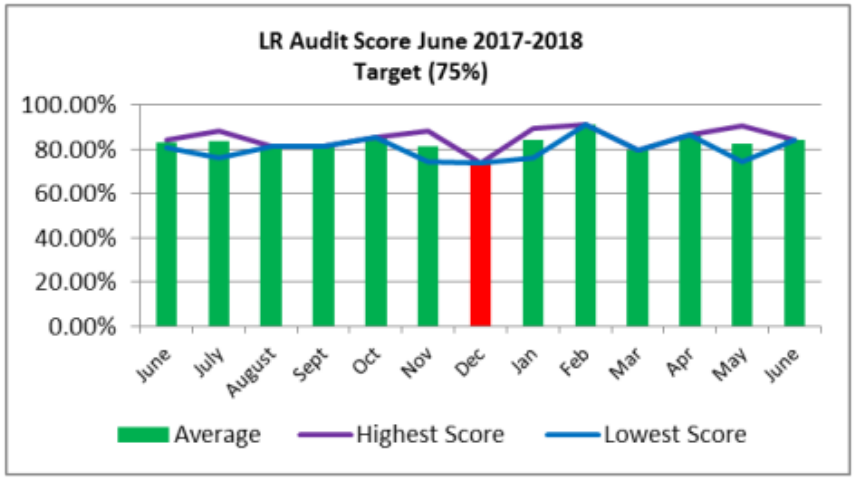
Safe | Effective | Caring | Responsive

The graphs below show the average audit scores in respect of the cleaning service. Overall the cleaning standard is consistent month on month showing steady improvement in all areas across the Trust. Therefore at the end off June we were no surprise to see all risk category from High to low all achieved the required standard. We are very please with June month achievement due to a more better working relationship between Engie and the Trust monitoring team.



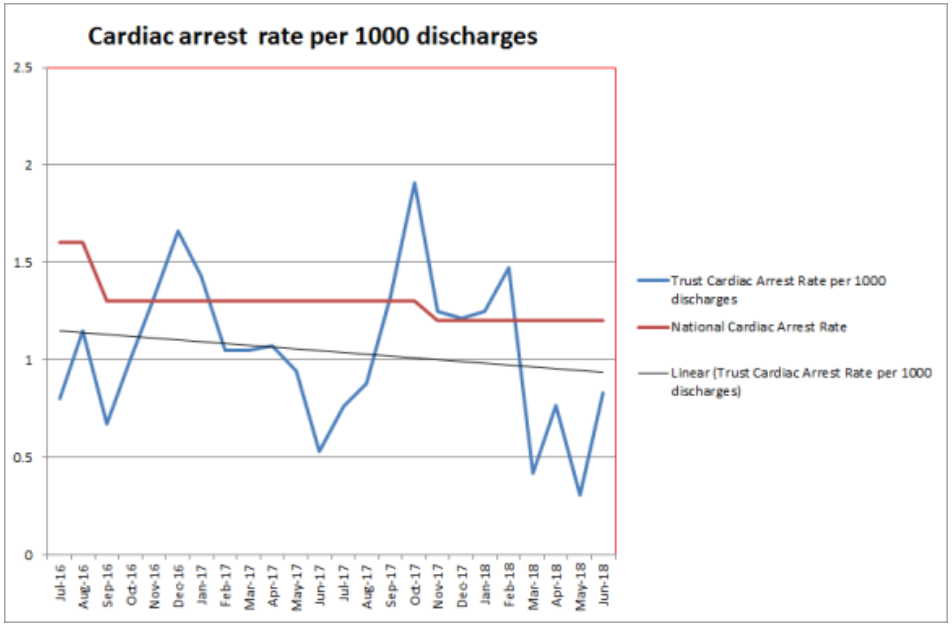






Cardiac Arrest Rate

Safe | Effective | Caring | Responsive



Improving the Management of the Deteriorating Patient

Over the last 6 months (Jan - June 18) the Cardiac arrest rate has shown a downward trajectory. The average rate is 0.83 which is a reduction on last year which was 1.1 in the same period. The Trend in arrest rate continues to follow the trend for the summer period.

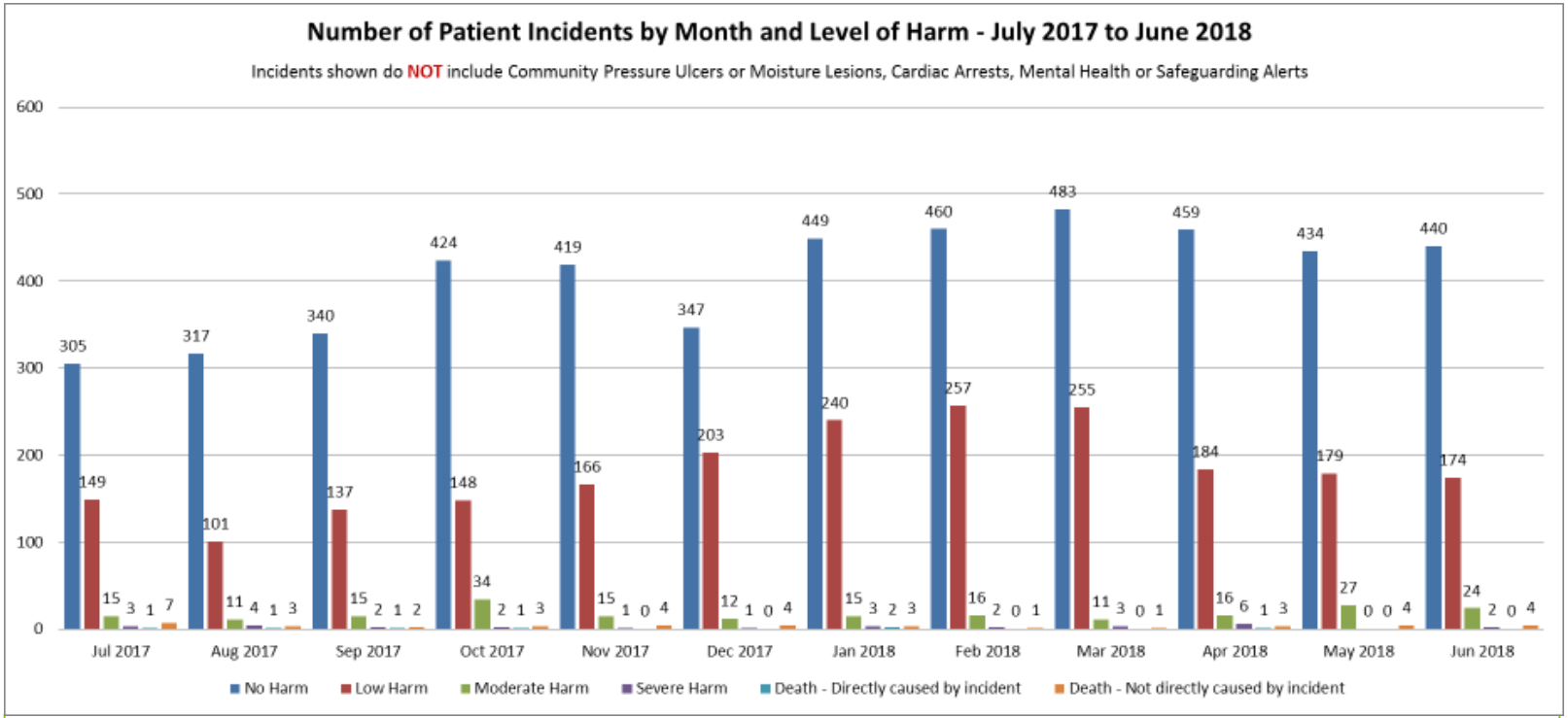
Improvement activities

The focus of improvement is on ensuring that all wards have a comprehensive approach to monitoring deteriorating patients and acting promptly following deteriorating to prevent further deterioration. In addition that appropriate Treatment Escalation Plans are made in accordance with patient needs and wishes.

Incidents

Safe | Effective | Caring | Responsive

Never events , serious incidents and clinical incidents



Incident investigations: The Risk and Governance Team continuously monitor the status of incidents within Datix including the timeliness of investigations and produce a fortnightly report of outstanding incidents along with a 'handlers' list. This report is sent to divisional management and clinical leads. The focussed piece of work being undertaken by the Risk Team to review and close incidents where there would be no meaningful benefit of an individual investigation has seen the number reduce by over 300 from the previous report. On 09/07/2018 there were 1632 open incidents of which 1197 (73%) were overdue.

Duty of Candour Compliance: A statutory Duty of Candour applies to all patient safety incidents resulting in moderate harm, severe harm or death, where there has been mistake, error or deviation in care or treatment that has resulted in the incident. Data is reported in arrears, May data is currently being validated.

Month	Apr-18	May-18	Jun-18
Number	4	TBC	TBC
%	100%	TBC	TBC

Incidents

Safe | Effective | Caring | Responsive

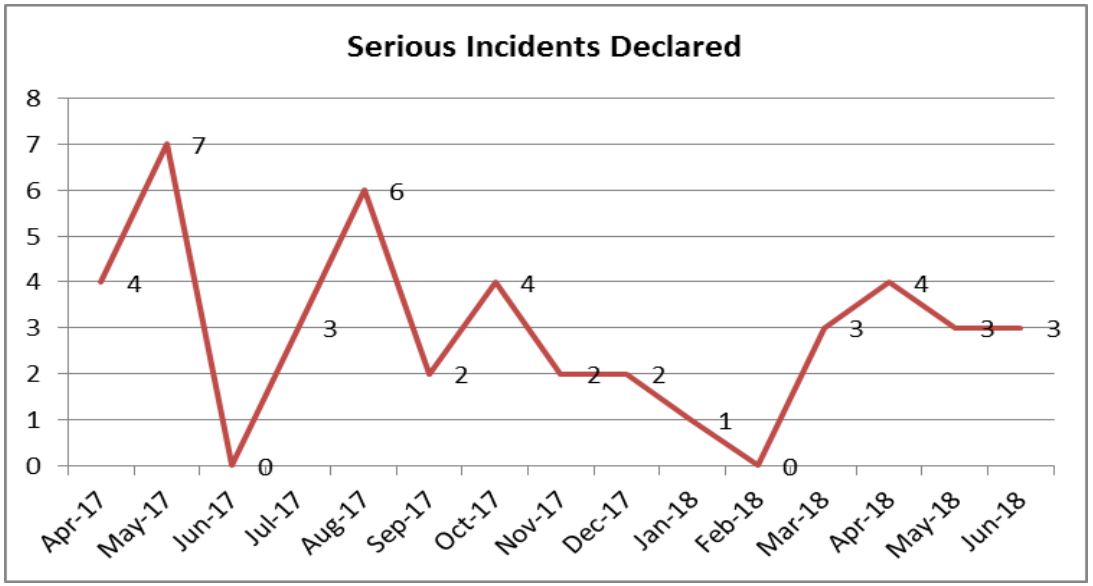
Never events , serious incidents and clinical incidents

Serious Incidents - In June 2018, 3 Serious Incidents were declared by the Trust (no Never Events):

- Grade 4 pressure ulcer – Severe Harm
- Fall from the operating table during a procedure – Severe Harm
- Inpatient fall resulting in head and facial injuries - Death

In Q1, the Trust declared a total of 10 Serious Incidents

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2017/18	4	7	0	3	6*	2	4*	2	2	1	0	3	34
2017/18	4	3	3										10



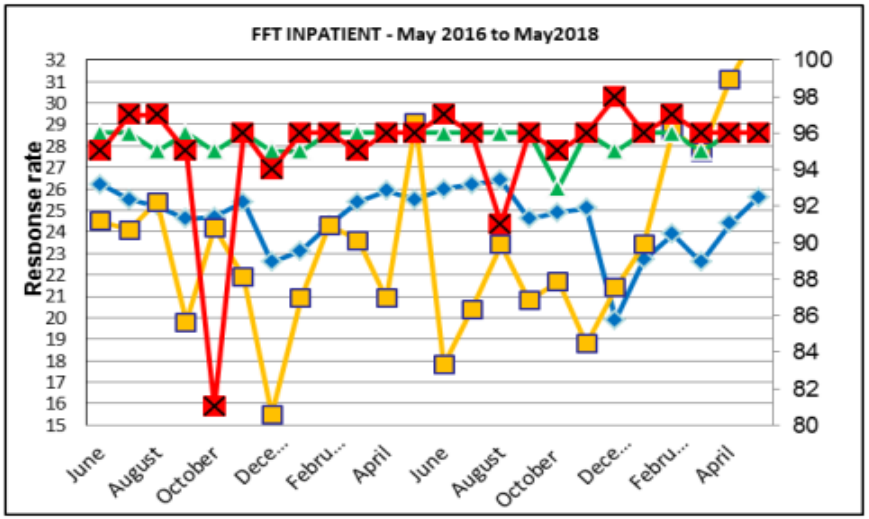
At the end of June the Trust had a total of 35 open Serious Incidents.

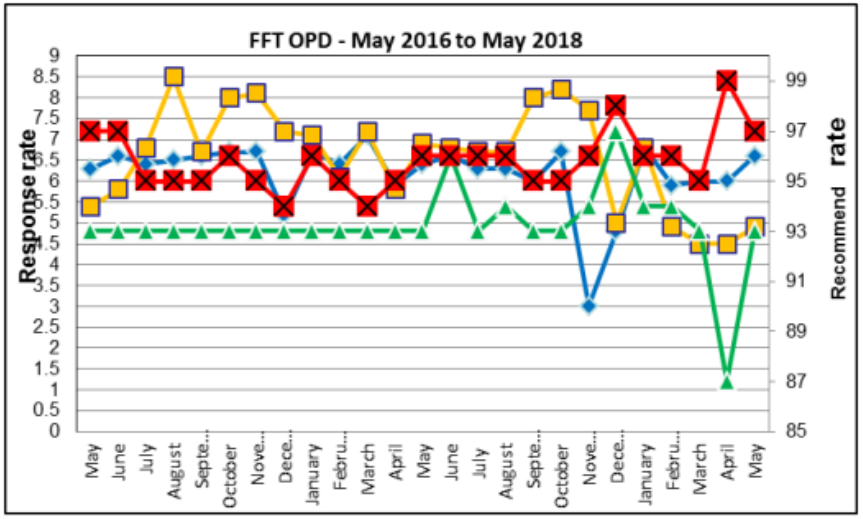
*1 incident in each reported month downgraded by the CCG

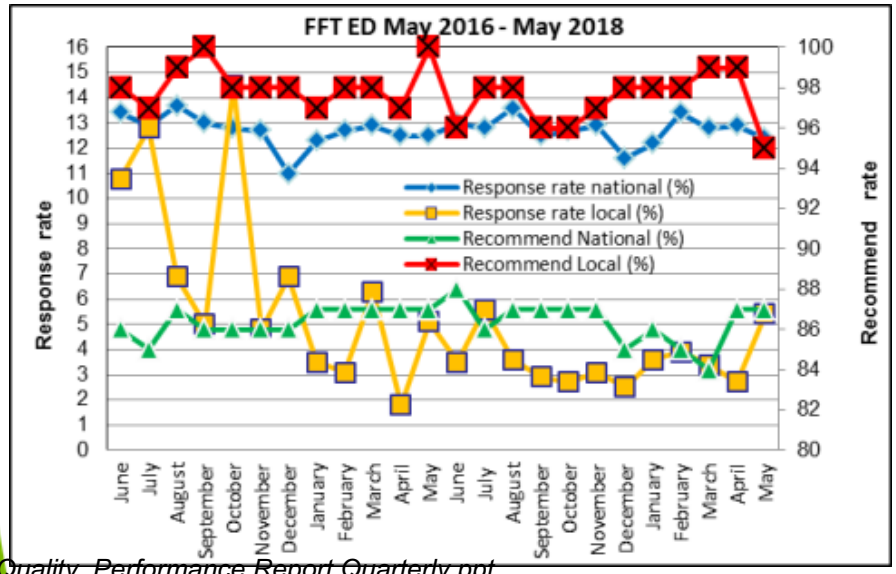
Patient Experience

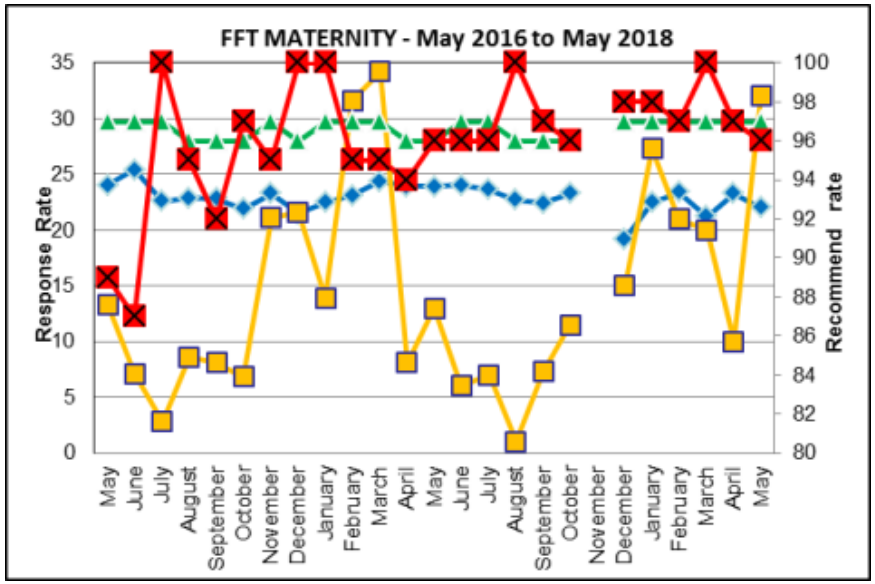
Safe | Effective | **Caring** | Responsive

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 2018 there was no national data for Maternity in November due to national technical problems.
The legend on the ED graph applies to all four.

Patient Experience

Safe | Effective | Caring | Responsive

Patient Experience

National Inpatient Survey 2017

- This continues to be widely shared around the Trust, with presentations at meetings, in newsletters/posters and staff and patient engagement events.

National Inpatient Survey 2018

- Publicity has been received and posters will be displayed in July giving patients information about the forthcoming survey and the choice to opt out.

Patient Experience Improvement Activity

Quality Improvement Project: A patient card which can be carried in a wallet is being developed as part of a QI project. It will give staff essential information about the individual.

Emergency Phrasebook: This has been printed in the top 10 languages with key emergency phrases and is available in all clinical services

Public engagement: The Patient Experience Team will have a monthly stand at Luton Culture to showcase patient feedback in the local community.

Updated COSQ reports: This report now contains more detailed reports about trends and themes reported to PALS.

Patient Packs: Packs for patients with a hearing loss will be distributed to ED and emergency admission wards in July.

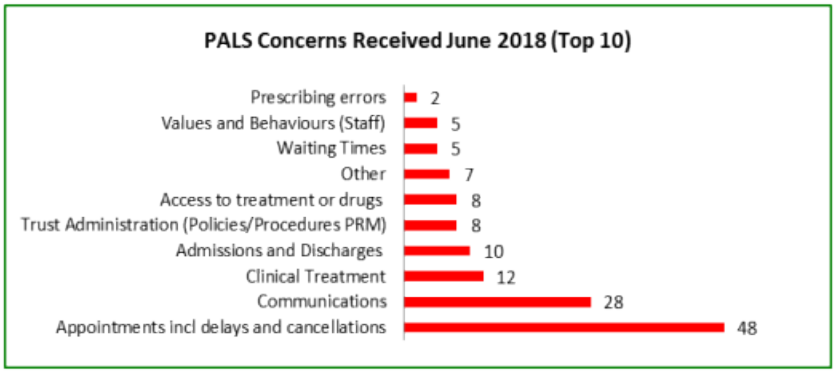
Local inpatient survey: the questions will be reviewed and republished on the Trust website in July.

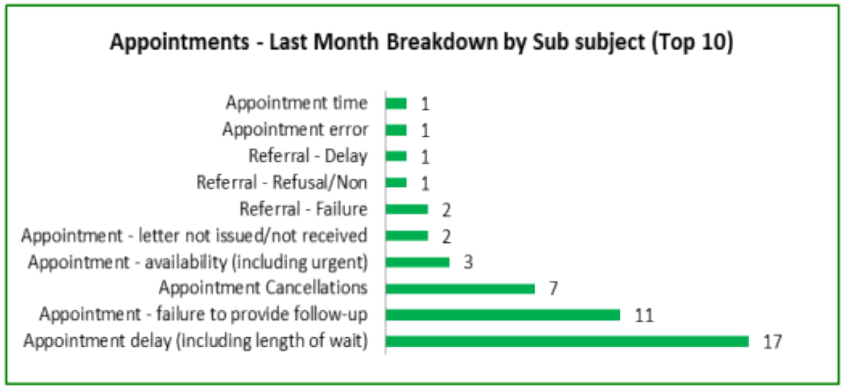
PALS (Patient Advisory and Liaison Service)

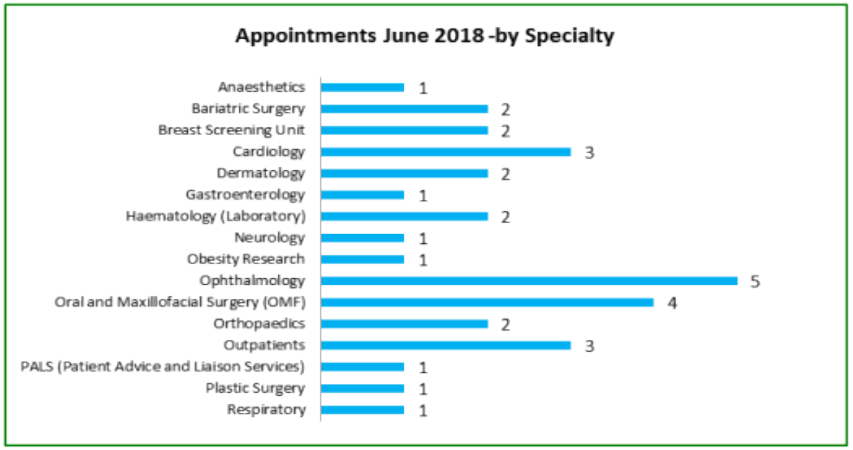
Method of Contact (Reported on Datix)

	Face to face	Emails	Telephone calls	Other calls not recorded on datix
April	66	124	66	200
May	40	80	46	234
June	29	50	56	180

PALS **resolved** 239 queries in May/June; **62** were **pending resolution**; 15 **complaints** were redirected to Patient Affairs at the patient's request.







This is a new report this month allowing more detailed breakdown of issues. This will be shared with general managers to allow actions to be taken to address concerns.

Patient Experience

Safe | Effective | Caring | Responsive

Complaints

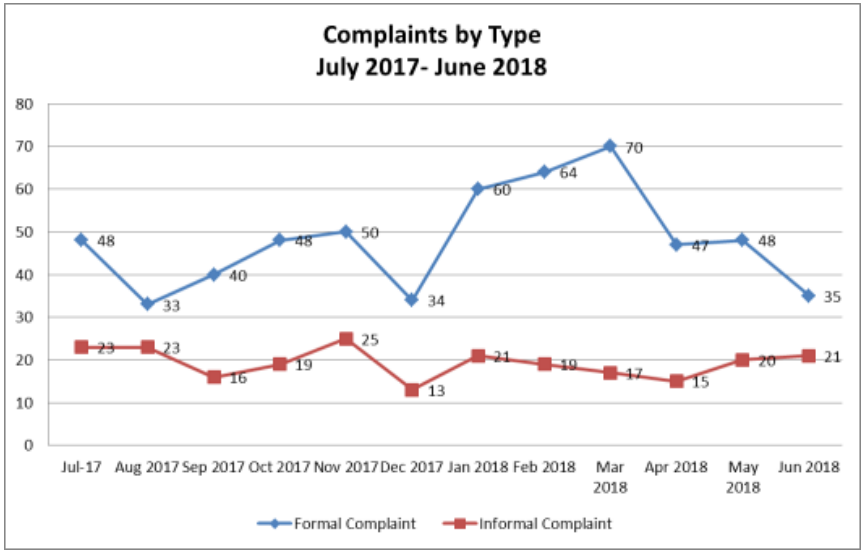
Month	Total Number of Formal Complaints Received	Patient Complaints: % of complaints acknowledged within 3 days of receipt	Patient complaints: % of complaints responded to within 35 working days
Jun-17	42	98.15%	69.86%
Jul-17	48	98.33%	66.07%
Aug-17	34	100.00%	56.60%
Sep-17	40	96.00%	45.65%
Oct-17	52	79.63%	46.81%
Nov-17	51	100.00%	52.83%
Dec-17	34	100.00%	53.70%
Jan-18	61	100.00%	48.15%
Feb-17	65	100.00%	48.00%
Mar-18	73	98.59%	48.48%
Apr-18	47	91.89%	53.66%
May-18	49	96.77%	42.47%
Jun-18	34	95.74%	53.73%

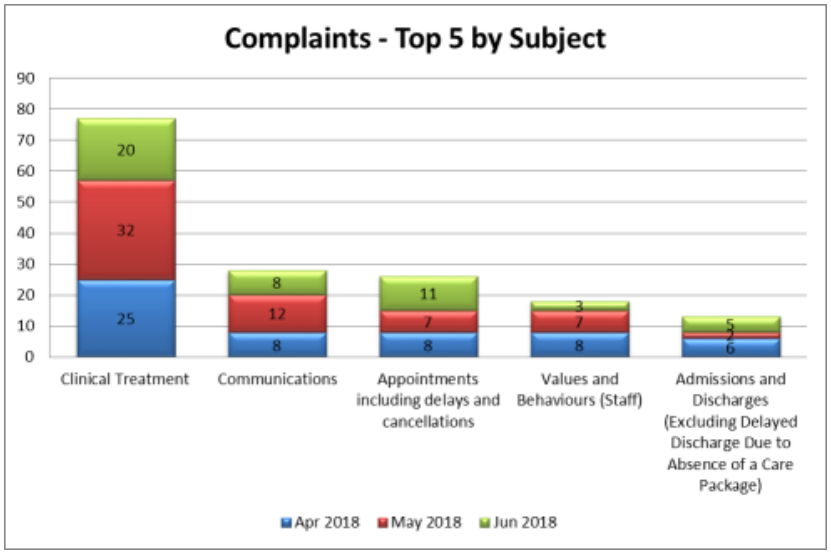
The Patient Affairs team have recently recruited into the Administrator post that had been vacant for a number of months. After training for the new member of staff has been completed, it is expected that the acknowledgement compliance will improve. There has also been some sickness absence within the team which has impacted on the team achieving the 100% acknowledgement within 3 working days.

The Patient Affairs team are currently trialling a new procedure to help improve response rates. If complainants have provided a telephone number with their complaint letter, they are contacted by the Patient Affairs Team to acknowledge their complaint and to ask for any specific questions or queries they may have. Whenever possible, the complaint will be resolved without the need for formal complaint but if this cannot be achieved, the team aim to provide the divisions with more specific information for their investigation.

A new RAG rated weekly 'complaint status report' was introduced at the beginning of July, replacing the previous weekly report of overdue complaints, this new report has already proven to be helpful to the divisions. The aim is for the divisions and senior management team to be fully appraised of all complaints, highlighting those nearing their target response dates and those which have fallen overdue. The Complaints Team are also giving consideration as to how they might 'hold' a complaint file open, without penalising the division. Such instances are whenf a response date is breached whilst waiting for a complainant to decide if they wish to accept a Local Resolution Meeting or not and not 'opening' a complaint file unless the consent to investigate is received from the patient or their representative.

Patient Experience



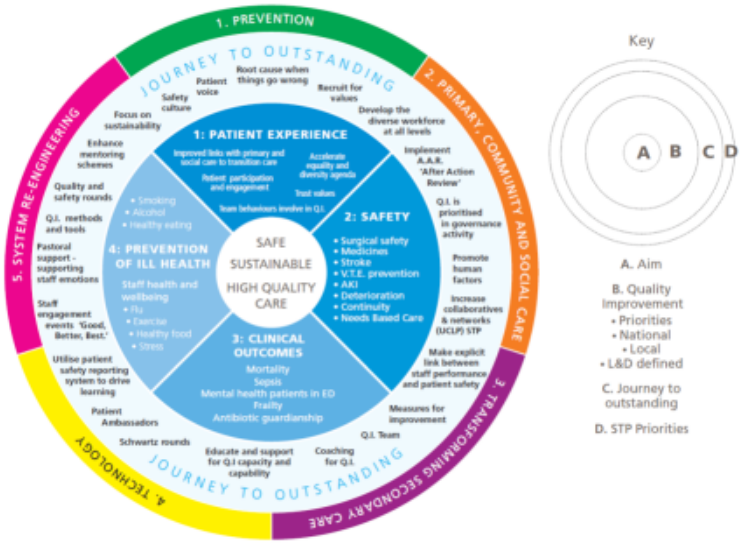


Closed in last 3 months (April-2018 - June 2018)	Not Upheld	Partially Upheld	Upheld	Total
Corporate Nursing	1	0	0	1
Diagnostics, Therapeutics and Outpatients (DTO)	19	6	0	25
Medicine: Acute and Emergency Medicine	14	12	1	27
Medicine: Medical Inpatients	11	27	8	46
Medicine: Medical Specialties	8	7	9	24
Support Division	2	3	0	5
Surgery	45	25	21	91
Women and Childrens Health Unit	10	11	8	29
Total	110	91	47	248

The table to the left shows outcomes for the 248 Complaints closed from April 2018 to June 2018

CQC

Safe | Effective | Caring | Responsive | Well Led



The Trust's "Quality Wheel" was revised following consultation with staff and service users on our QI strategy

The Trust provided the information required by the CQC ahead of visits – both announced and unannounced. The Well Led inspection is due to take place on 11th-13th September 2018. The unannounced inspection of one core service will take place before this date, with a phone call 30 minutes ahead of the arrival of the inspection team.

In preparation for the CQC visits, the Trust-wide buddy scheme has been revised and relaunched to ensure that all areas benefit from senior leadership visits on a regular basis – each area being visited at least once per week. The visits aim to support areas by bringing fresh eyes and blend challenge and supportive guidance to help deliver further quality improvements.

Luton Clinical Commissioning Group has agreed dates for their quarterly site quality visits for the year ahead, responding positively to requests to avoid the most challenging times relating to winter pressures. They have also responded positively to the Trust's request to help prepare for the impending CQC visit and, along with exchanges with Bedford Hospital leadership team, the Trust plans to use colleagues from these partner organisations to help identify areas for improvement.

Following the Trust's attendance at the London launch of the NHS England Always Events Programme, the team on Ward 20 have begun preparations to work alongside patients to co-produce improvements based on what matters most to patients. The first two of the monthly teleconference coaching sessions with the NHS England facilitators have also been held and the clinical team are very enthusiastic and engaged with the programme.

After Action Reviews (AAR) are starting to be embraced as a really supportive method of multidisciplinary team learning following an incident. The next step is to train more AAR Conductors to enable widespread use in a more timely way following any kind of incident where staff want to learn how to improve for next time. All discussions held during an AAR are confidential and stay with the team, however, there is opportunity for those involved to agree what learning or actions can be taken away and shared outside of the group and in what format so that other staff are able to benefit from learning where possible.

The QSIR programme continues to develop more quality improvement leaders from across the organisation, with cohort 4 having commenced in early June.

At the time of reporting, the Good Better Best events are underway in the tent, focusing on the Trust Values and how to de-escalate incidents which negatively impact on both staff, patient and visitor experiences.

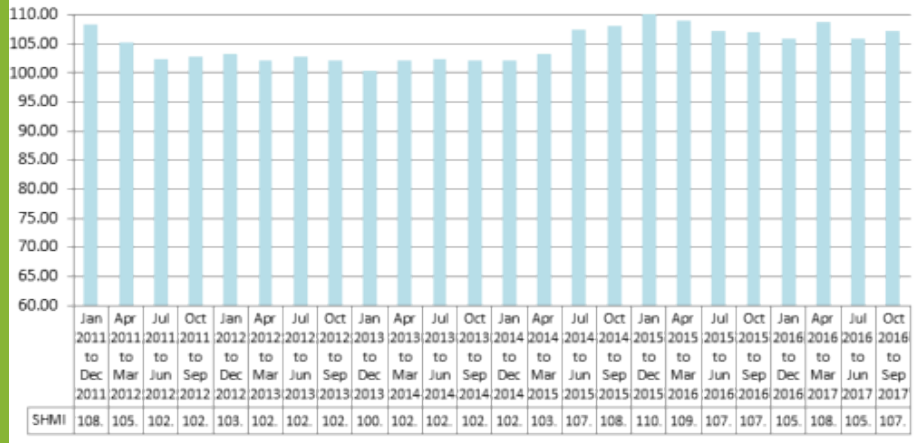
Mortality

Safe | Effective | Caring | Responsive

HSMR/SHMI

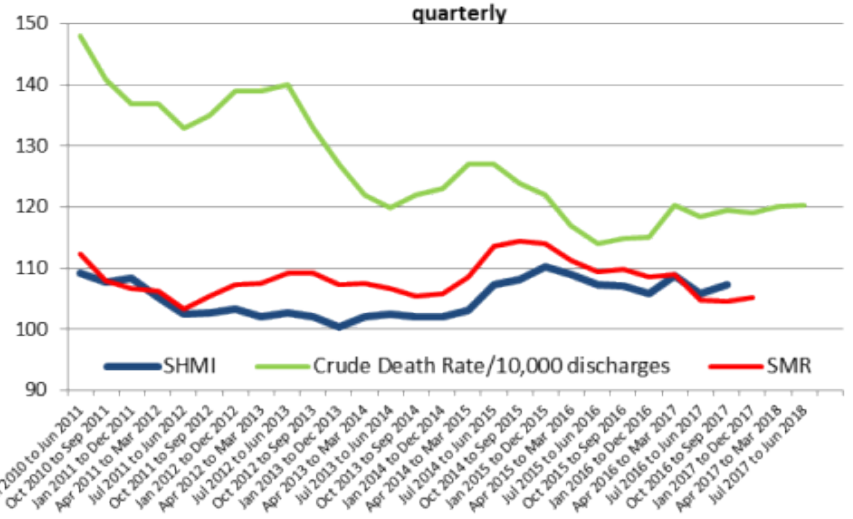
Both the SMR and HSMR figures for the year ending February 2018 continue to be within statistical limits, meaning that any variation from the national average could be just normal statistical fluctuation. The SMR for the year to February 2018 is 103.4 and the HSMR is 102.0. The national average is 100. For the HSMR this is now the 6th consecutive month of "normal" values after nearly two years of statistically significantly high figures. The latest SHMI value, covering the year to September 2017 rose to 107.27 from 105.93 for the year ending in June 2017. It remains in the "as expected" range. The SHMI includes both deaths in hospital and also those that take place in the first 30 days after a patient leaves hospital. The crude mortality rate for a full year remains steady although with significant fluctuations month by month as set out below.

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

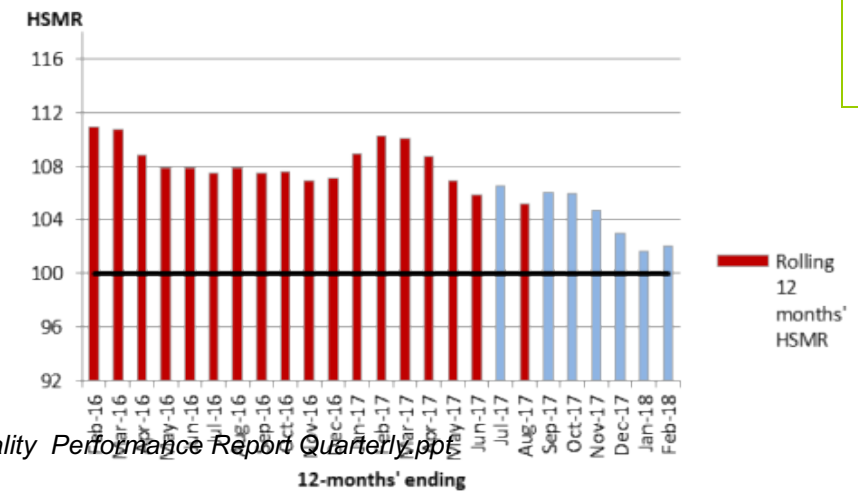


	Jan 2011 to Dec 2011	Apr 2011 to Mar 2012	Jul 2011 to Jun 2012	Oct 2011 to Sep 2012	Jan 2012 to Dec 2012	Apr 2012 to Mar 2013	Jul 2012 to Jun 2013	Oct 2012 to Sep 2013	Jan 2013 to Dec 2013	Apr 2013 to Mar 2014	Jul 2013 to Jun 2014	Oct 2013 to Sep 2014	Jan 2014 to Dec 2014	Apr 2014 to Mar 2015	Jul 2014 to Jun 2015	Oct 2014 to Sep 2015	Jan 2015 to Dec 2015	Apr 2015 to Mar 2016	Jul 2015 to Jun 2016	Oct 2015 to Sep 2016	Jan 2016 to Dec 2016	Apr 2016 to Mar 2017	Jul 2016 to Jun 2017	Oct 2016 to Sep 2017
SHMI	108.	105.	102.	102.	103.	102.	102.	102.	100.	102.	102.	102.	102.	103.	107.	108.	110.	109.	107.	107.	105.	108.	105.	107.

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

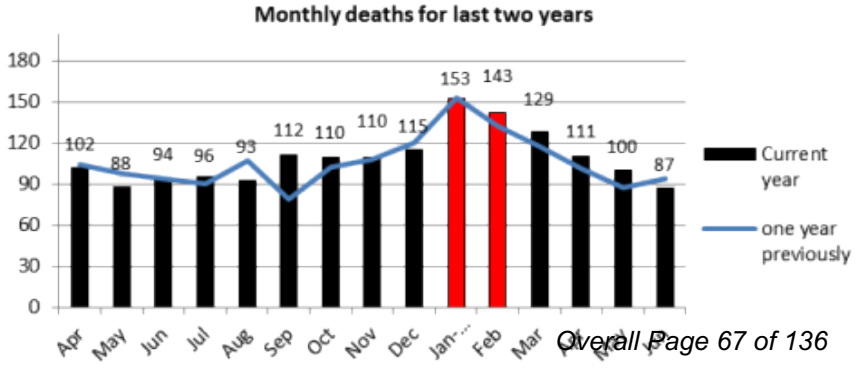


Rolling 12-months' HSMR



After very high mortality in the first two months of 2018, deaths have eased back to more normal levels for the last 4 months. The crude mortality rate for 2017 overall was 11.9 deaths per 1000 inpatients; for 2018 so far it stands at 12.6 but this includes very high values for January and February. June 2018 saw only 87 deaths, the lowest number for 3 years. The rolling 12 months crude mortality rate to June 2018 was 12.0 - very similar to the 2017 rate.

Monthly deaths for last two years



Learning from Deaths

Safe | Effective | Caring | Responsive

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable			
	Q2 Total	Q3 Total	Q4 Total
Total Number of Deaths in Scope	281	313	403
Primary Mortality Reviews Completed	246	300	389
Full Mortality Reviews Requested	48	76	105
Full Mortality Reviews Completed	34	27	77
Community Reviews Requested	n/a	17	28
% Full Mortality Reviews Requested that have been Completed	71%	36%	73%

Q3 mortality reviews were not using the structured judgement review form and so compliance was lower. The compliance was further impacted by winter pressures.

A senior team including Medical Directors have reviewed all deaths and identified any where it was felt that deficiencies in medical or nursing care may have contributed to the patients' death as part of the Trust's primary review process. Consultants then complete the full mortality review (a Structured Judgement Review) which results in an avoidability score. The findings for Q4 (to 5th March 2018) are as follows:

Quarter 4 Structured Judgement Review findings:	
	Q4 17/18
1 - Definitely Avoidable*	0
2 - Strong evidence of avoidability	0
3 - Would be probably avoidable (>50:50)	0
4 - Would be possibly avoidable (<50:50)	5
5 - Slight Suggestion of avoidability	2
6 - Definitely not avoidable	29

*Note: Where a structured judgement review score suggests some element of avoidability, this refers to the possibility that the death might have been avoided in that place, or at that time, if different actions or decisions had been taken. It does not mean that the eventual outcome for the patients would necessarily have been different.

The key learning themes from the 5 cases with a structured judgement score of 4 are:

- Frequency of observations didn't reflect risk of recurrence in a patient following a GI Bleed
- Inadequate response to hypotension in a patient with Learning Difficulties
- Failure to document a treatment escalation plan for a patient on an end of life pathway
- Delay in commencing NIV could have been avoided with a better plan following initial deterioration and escalation
- Documentation of end of life pathway and prescribing of anticipatory medicines

A number of points of good practice were also identified in each of the 5 cases

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	**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	**Local Commissioner Quality Group** Bedfordshire Cancer Improvement Group *(2nd Tues month)* Integrated Quality, Safety & Performance Report
	LCCG Board (Public Board, alternate months)	**L&D Board** (shared with Governing Board)	**BCCG Board** (shared with Governing Body)
Commissioner led escalation of issues related to cancer long waits.	**Regional Quality Surveillence Group**		

62 day breaches - 7 patients (6.0 breaches)

Number of days from referral to treatment	CCG	Breach	Tumour Site	Reason for Delay Post RCA
73	Luton	1.0	Urology	Delayed diagnostics
76	Luton	1.0	Haematology	Complex diagnostic pathway
70	Luton	1.0	Haematology	Patient initiated delays to diagnostics
101	Luton	1.0	Head & Neck	Complex diagnostic pathway
78	Herts Valleys	1.0	Urology	Complex diagnostic pathway requiring extensive outside expert opinions to obtain definitive diagnosis
76	Beds	0.5	Urology	Inufficient surgical capacity at Lister
87	Beds	0.5	Urology	Patient unavailable until 8th April due to holiday; insufficient capacity at MVH to date any earlier than date offered

104+ Days Breaches - 1 patients (0.5 breaches)

Number of days from referral to treatment	CCG	Breach	Tumour Site	Reason for Delay Post RCA
104	Beds	0.5	Urology	Patient requested thinking time to decide on preferred treatment option; patient on holiday for 14 days. 43 days from referral to treatment at MVCC.

National Targets

Safe | Effective | Caring | Responsive

Cancer

	Threshold	Apr-17	May-17	Jun-17	Qtr1 17/18	Jul-17	Aug-17	Sep-17	Qtr2 17/18	Oct-17	Nov-17	Dec-17	Qtr3 17/18	Jan-18	Feb-18	Mar-18	Qtr4 17/18	Apr-18	May-18
All cancers: 31-day wait for second or subsequent treatment (3), comprising either:																			
Surgery	94%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
anti cancer drug treatments	98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
radiotherapy	94%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Cancer: two week wait from referral to date first seen (7), comprising either:																			
all cancers	93%	94.9%	94.9%	96.2%	95.4%	95.0%	95.5%	96.4%	95.6%	97.3%	97.5%	96.7%	97.2%	97.1%	97.5%	98.3%	97.7%	97.2%	96.5%
for symptomatic breast patients (cancer not initially suspected)	93%	95.1%	98.5%	95.8%	96.7%	100.0%	94.3%	98.1%	97.7%	97.0%	100.0%	96.2%	97.8%	100.0%	97.9%	93.8%	97.4%	92.4%	94.0%
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%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
All cancers: 62-day wait for first treatment (4), comprising either:																			
from urgent GP referral to treatment	85%	88.3%	87.5%	91.9%	89.4%	89.4%	91.3%	85.5%	89.0%	90.7%	89.8%	89.7%	90.0%	87.0%	87.2%	88.9%	87.7%	90.2%	88.7%
from consultant screening service referral	90%	98.2%	95.7%	100.0%	97.9%	95.7%	93.8%	98.0%	96.2%	93.9%	94.0%	93.1%	95.2%	94.3%	100.0%	93.8%	95.6%	100.0%	95.5%

Please note the information available is preview only, as final reports are not available yet from the Cancer Waiting Times NHS Digital site

Achievement of the national standard for all cancer targets was delivered in Q4 and across the whole of financial year 2017/18
The Trust achieved full compliance with all national cancer targets in May 2018.

National Targets

Safe | Effective | Caring | Responsive

Cancer

Cancer Plan 62 Day Standard by Tumour Site

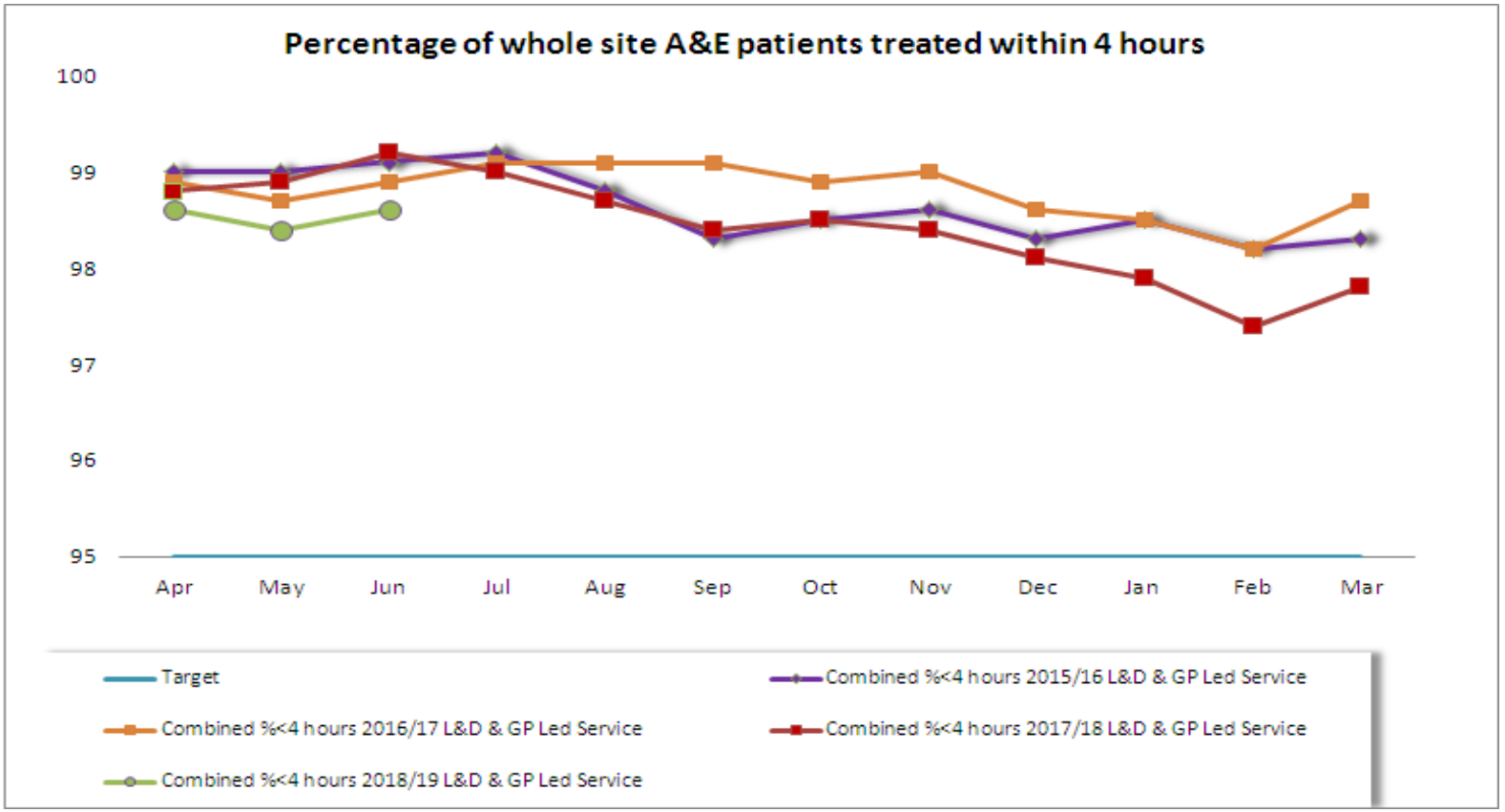
	Accountable Total Treated		Accountable Breaches		% Meeting Standard	
	Apr-18	May-18	Apr-18	May-17	Apr-18	May-18
Breast	8	11	0	0	100.0%	100.0%
Gynaecology	2	2	0	1	100.0%	50.0%
Haematology	7	5	2	0	71.4%	100.0%
Head & Neck	4	3	0.5	0	87.5%	100.0%
LGI	5	5	0	2	100.0%	60.0%
Lung	n/a	6.5	n/a	0	n/a	100.0%
Skin	12	10	0	0	100.0%	100.0%
Urology	15	24	3	3	80.0%	87.5%
UGI	2	3.5	0	1.5	100.0%	57.1%
Sarcoma	n/a	n/a	n/a	n/a	n/a	n/a
Other	1	1	0	1	100.0%	0.0%

Please note the information available is preview only, as final reports are not available yet from the Cancer Waiting Times NHS Digital site

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)

There were 8.5 accountable breaches of the cancer 62 day wait in May 2018, which reflects the current high pressure on pathways. The significant increased referrals in Urology following public health campaigns have resulted in a sharp growth in treatment numbers. The ongoing capacity pressures in head and neck are still posing a significant threat to ongoing achievement of the 62 day target.

National Targets



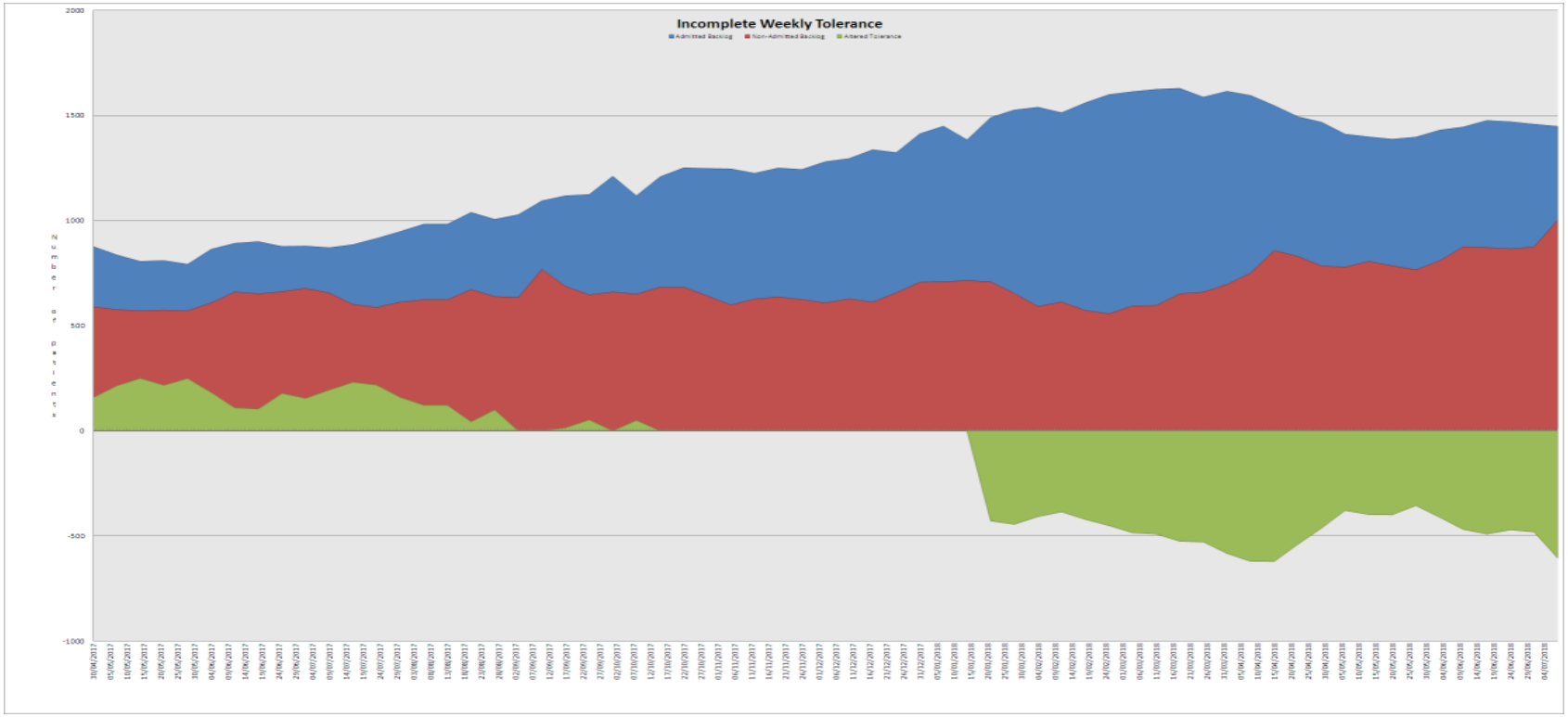
Performance against the 95% emergency access target remains well above 98% with continued improvement following the period of highest winter pressures in Jan – March 2018. In June 2018 the activity was high but performance has stepped back up to 98.6%.

A&E

National Targets

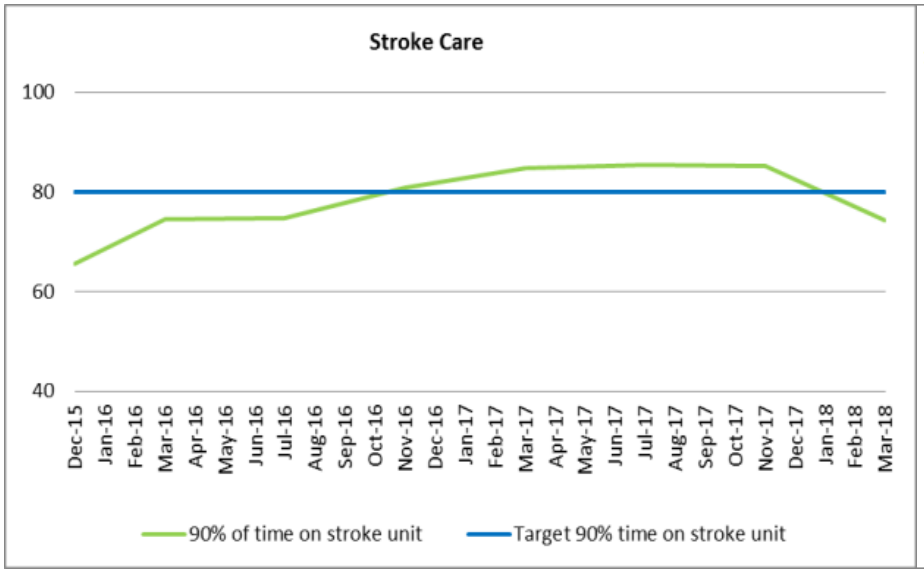
Treated Within 18 Weeks

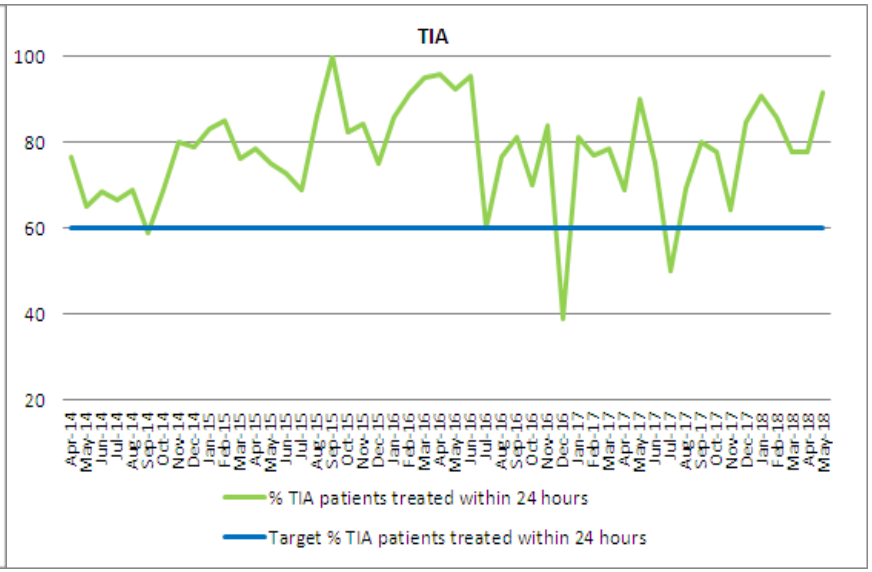
Incomplete	Targets	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	92%	96.9%	96.8%	97.0%	96.9%	97.1%	97.1%	97.1%	96.9%	96.7%	96.6%	96.8%	97.2%
2015/16	92%	97.9%	97.8%	97.6%	97.7%	97.3%	97.0%	96.4%	96.5%	95.3%	94.6%	94.2%	94.2%
2016/17	92%	94.2%	94.5%	94.8%	93.7%	92.9%	92.6%	92.2%	92.7%	93.1%	92.5%	92.9%	92.6%
2017/18	92%	92.8%	93.2%	92.7%	92.8%	92.6%	92.04%	92.2%	92.2%	90.9%	91.04%	90.23%	90.01%
2018/19	92%	90.71%	90.9%	90.38%									



The Trust achieved 90.38% against the 92% referral to treatment target in June 2018. The admitted backlog reduced however this was masked by a sharp rise in the non-admitted pathways open over 18 weeks. Specialty teams are currently validating the position and providing additional capacity to bring performance back in line with the recovery trajectory.

National Targets





The latest publication for the stroke audit report (SSNAP) shows deterioration of our target time on the stroke ward to 74.3% which is below the 80% target (SSNAP data available to March 2108 published in June 2018). An action plan is in place to improve this position, which is partly as a result of winter bed pressures.

May 2018 saw continued performance well above the 60% target for patients being treated for TIA within 24 hours.

National Targets

Overall SSNAP Performance (June 2018 SSNAP report)

Reporting Period	Apr-Jul 16	Aug-Nov 16	Dec - Mar 17	Apr-Jul 17	Aug-Nov 17	Dec - Mar 18
SSNAP level	D	C	C	B	B	D
SSNAP score	59.8	66	67	74	76	58
1) Scanning	B	B	A	A	A	A
2) Stroke Unit	D	D	D	D	D	E
3) Thrombolysis	B	B	C	B	B	D
4) Specialist Assessments	B	B	B	B	B	B
5) Occupational Therapy	A	A	A	A	A	C
6) Physiotherapy	B	B	B	B	B	C
7) Speech and Language Therapy	E	E	E	C	C	E
8) MDT working	E	C	C	C	D	E
9) Standards by discharge	B	B	B	B	B	B
10) Discharge processes	D	D	C	C	B	A

The above table now includes the Dec2017 – March 2018 SSNAP audit data, showing a deterioration of the overall score to a 'D'. This is disappointing, and reflects the challenges to delivery of the thrombolysis within one hour target that were encountered during January to March 2018. SALT performance saw an unexpected downturn due to staff absence. Time on the stroke unit also deteriorated as a result of winter bed pressures.

Performance against the thrombolysis within 1 hour indicator since April 2018 has improved significantly so the next cohort of SSNAP data should improve. A detailed report has been submitted to COSQ detailing the actions that are already in place against all domains.

National Targets

Safe | Effective | Caring | Responsive

Diagnostic Test Access

	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	146	32	119	244	218	192	242	243	151	47
% over 6 weeks	<1%	0.37	1.67	2.92	0.83	3.34	5.28	4.6	3.7	5.4	5.6	3.07	0.97
Total Waiting		4603	4781	4,998	3,862	3,567	4,617	4,760	5,155	4,473	4,319	4,921	4,839

	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Over 6 weeks		44	48										
% over 6 weeks	<1%	0.9	0.93										
Total Waiting		4864	5138										

The number of patients waiting over 6 weeks for routine diagnostics was within the 99% target as at the end of May 2018 and demonstrated further improvement from the April position.

National Targets

Safe | Effective | Caring | Responsive

Last Minute Cancellations

Last minute Cancelled Operations

	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	39	15	17	43	53	43	84	42	37	42
Non-clinical reasons		43	24	31	41	37	29	40	43	116	130	118	113
Patients not-dated in 28 days	0	0	1	0	0	0	0	0	0	5	3	13	8
Elective activity*		3,060	3557	3629	3474	3526	3439	3716	3698	3199	3610	3340	3626
% Cancelled operations	<0.8%	1.41%	0.67%	0.85%	1.18%	1.05%	0.84%	1.08%	1.16%	3.63%	3.60%	3.53%	3.12%

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

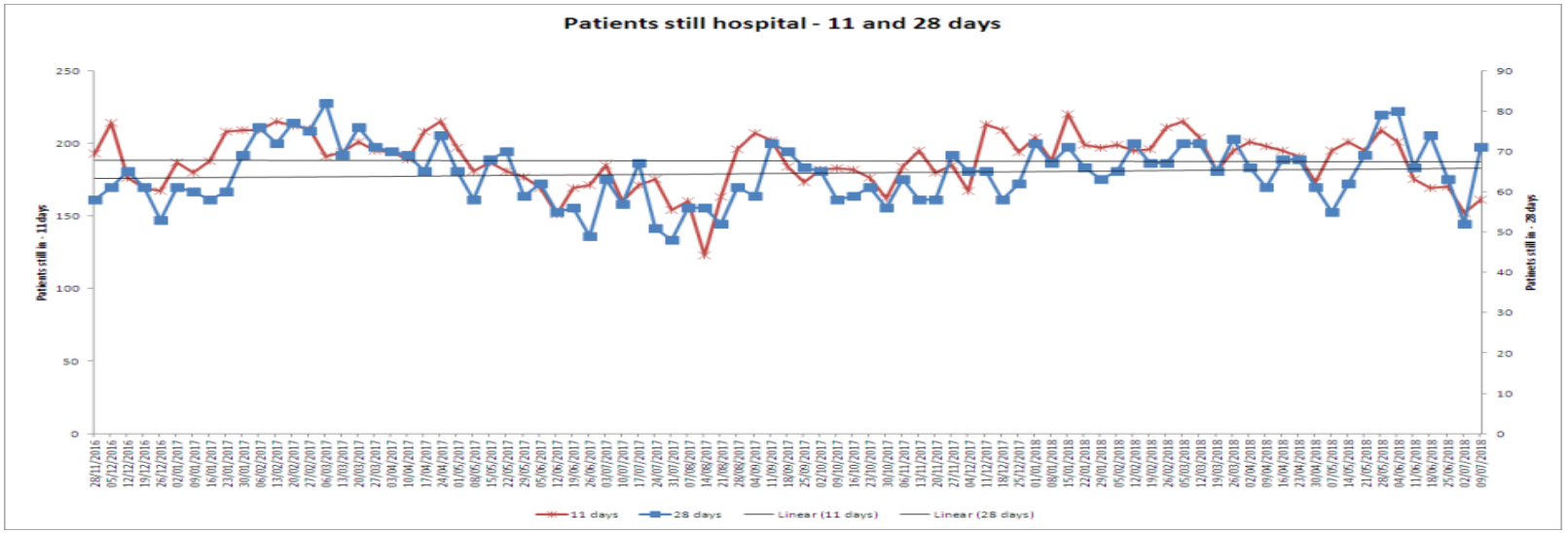
	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Clinical reasons		49	55										
Non-clinical reasons		34	42										
Patients not-dated in 28 days	0	0	0										
Elective activity*		3,499	3658										
% Cancelled operations	<0.8%	0.97%	1.15%										

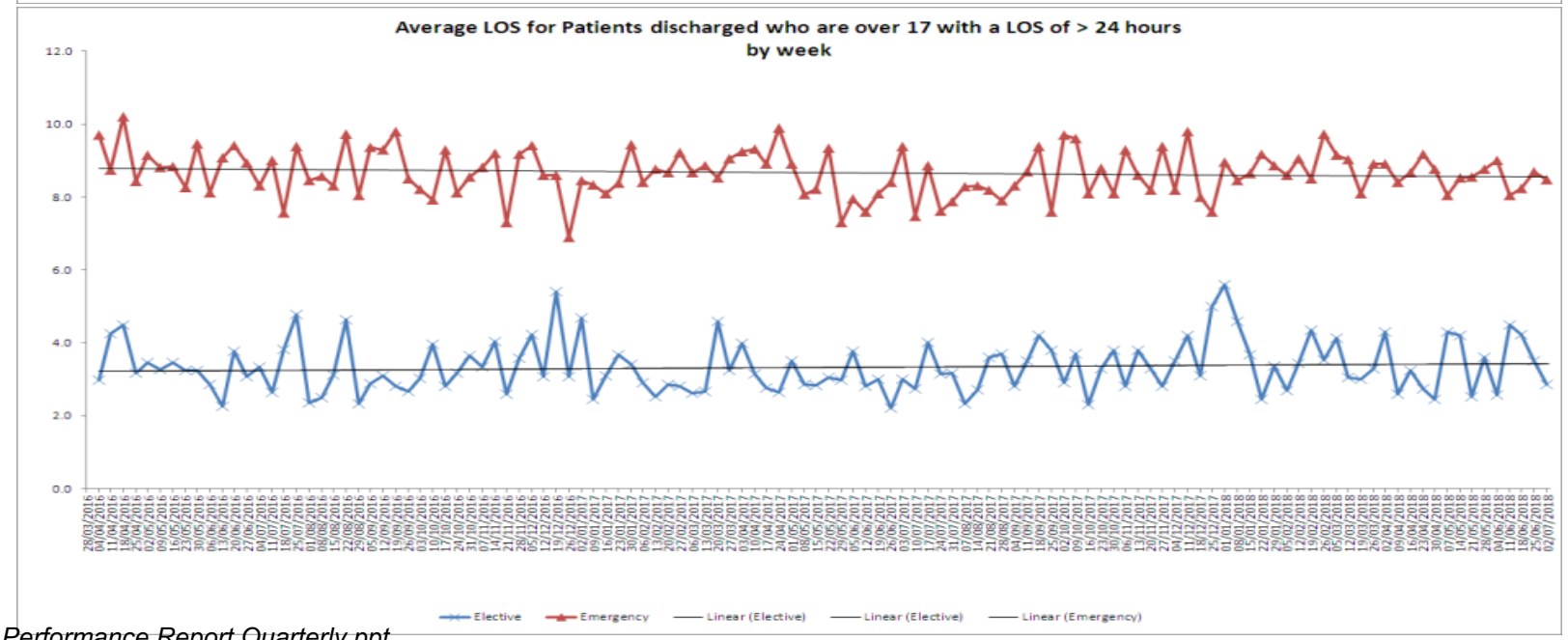
The Trust has continued to re-date all patients within 28 days of cancellation in May 2018. % of operations cancelled has returned to the baseline level prior to winter pressures.

Performance

Safe | Effective | Caring | Responsive

LOS





Performance

Safe | Effective | Caring | Responsive

Dementia Assessment and Referral

Dementia Summary																
2017/18																
		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	QTR1	QTR2	QTR3	QTR4
Q1	Eligible 75+ emergency patients screened	362	387	351	363	391	362	405	390	393	423	377	360	1100	1116	1188	1160
	Total eligible 75+ emergency admissions	397	414	368	393	395	369	418	402	415	469	398	399	1179	1157	1235	1266
	% Screened	**91.2**	**93.5**	**95.4**	**92.4**	**99.0**	**98.1**	**96.9**	**97.0**	**94.7**	**90.2**	**94.7**	**90.2**	**93.3**	**96.5**	**96.2**	**91.6**
Q2	Assessments carried out	34	34	38	54	29	42	35	30	40	43	43	43	106	125	105	129
	Total assessments required	34	37	41	58	32	46	38	32	46	46	46	46	112	136	116	138
	% Assessed	**100.0**	**91.9**	**92.7**	**93.1**	**90.6**	**91.3**	**92.1**	**93.8**	**87.0**	**93.5**	**93.5**	**93.5**	**94.6**	**91.9**	**90.5**	**93.5**
Q3	Referrals from those assessed	13	16	17	32	15	24	20	16	22	22	24	21	46	71	58	67
	Total requiring referral	14	16	17	32	15	25	20	17	24	26	24	23	47	72	61	73
	% Referred	**92.9**	**100.0**	**100.0**	**100.0**	**100.0**	**96.0**	**100.0**	**94.1**	**91.7**	**84.6**	**100.0**	**91.3**	**97.9**	**98.6**	**95.1**	**91.8**
2018/19																
		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	QTR1	QTR2	QTR3	QTR4
Q1	Eligible 75+ emergency patients screened	369	353														
	Total eligible 75+ emergency admissions	378	360														
	% Screened	**97.6**	**98.1**														
Q2	Assessments carried out	55	31														
	Total assessments required	60	36														
	% Assessed	**91.7**	**86.1**														
Q3	Referrals from those assessed	30	16														
	Total requiring referral	33	16														
	% Referred	**90.9**	**100.0**														

The November 2017 update to the Single Oversight Framework added dementia assessment to the list of operational indicators that determine a Trust's performance segment. The performance assessment by NHSI is based on quarterly performance and the performance threshold is 90% for all three indicators. The Trust achieved the 90% in all four quarters of financial year 2017/18. This detailed report is included for information and reporting against this target will be provided on a monthly basis for 2018/19. Due to the time taken to complete the audit process, data is always 1 month in arrears.

NHSI Compliance

Safe | Effective | Caring | Responsive

	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	Qtr 2 2017/18	Qtr 3 2017/18	Qtr 4 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%	98.7%	98.3%	97.7%
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	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%	92.5%	91.8%	90.4%
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	3	2	0
MRSA – meeting the MRSA objective of no more than 1 cases/year	0	1.0	1	0	0	0	0	0	0	1	0	0	1	0

Note: Qtr 4 performance for CDIF and MRSA are flagged as red despite no avoidable infections being reported, as performance in previous quarters meant that the annual threshold had already been breached

NHSI Dashboard

Finance Presentation FY18-19

Report for Month 3

Executive Summary

Although the Trust delivered the Control Total for Q1 (a plan that is phased to be easier to deliver in Quarters 1 & 2), this was only through £1m+ of non-recurrent measures.

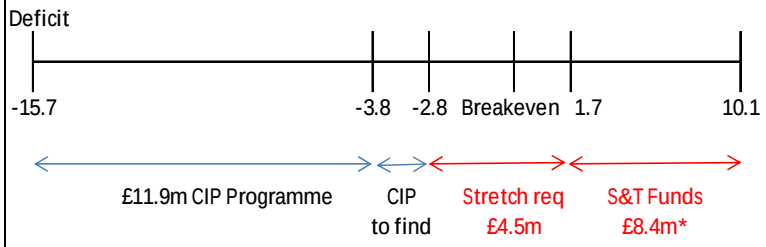
Contract income is behind plan by £521k (0.7%), hindering the RTT recovery.
CQUIN assumed to be 100%

Regulatory compliance may drive cost pressures over coming months.
Medical Pay is 5.6% overspent at Month 3, this is driving a pay overspend of £1,307k
Agency spend is ahead of plan and the current run-rate would result in an annual spend of £16.4m – against an Agency ceiling of £8.9m (+50% = £13.3m)

17-18 Plan

APRIL REVISION

The FT accepted a Control Total of £10.1m in 17-18. This included an assumed £4.5m of DH Revenue Grant

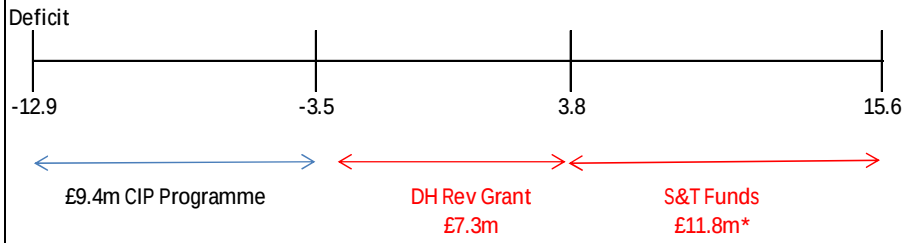


* Requires FT to post £1.7m surplus to access S&T fund

18-19 Plan

APRIL POSITION

As the Trust has delivered the Control Total in 17/18, it is permitted to reduce the Control Total requirement for 18/19 by £1.6m (from a £1.9m deficit to a £3.5m deficit)



* Comprised of £8.4m for Trust delivery and £3.4m for STP delivery

I&E Phasing £m	In Month Core	YTD Core	In Month S&T	In Month stretch	YTD Plan
April	-1.2	-1.2	0.6		-0.6
May	-0.2	-1.4	0.6		-0.2
June	-0.3	-1.7	0.6		0.0
July	0.2	-1.5	0.8		1.1
August	-0.4	-1.9	0.8		1.5
September	-1.2	-3.1	0.8		1.1
October	0.6	-2.5	1.2		2.9
November	0.5	-2.0	1.2		4.5
December	-0.7	-2.7	1.2		5.0
January	0.6	-2.1	1.4		7.0
February	-1.4	-3.5	1.4		7.0
March	-0.1	-3.5	1.4	7.3	15.6

Again the Trust is in a position where it requires external support to deliver the Control Total. As previously, securing the stretch improvement resource of £9m represents a massive challenge. The Trust has accepted an offer to amend the Control Total by £1.7m, which reduces the "ask" from DH to £7.3m.

The Trust's plan shows receipt of a £7.3m DH Revenue Grant in Q4 of 18/19 to match Control Total error.

Slippage against plan – Low income in Surgery, high spend in Doctors (Medicine and W&C) & Nursing. Agency a problem

	Fin Year	Fin Year	Fin Year	Fin Year	Fin Year	Fin Year		
INCOME & EXPENDITURE ACCOUNT	2016/17	2017/18	2018/19	2018/19	2018/19	2018/19	2017/18	2017/18
	Actual	Actual excl STP & Merger	Budget	Budget	Actual	Variance		% Change 17-18 to 18-19
	Full Year	YTD	Full Year	YTD	YTD	YTD	M3	M3
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
NHS Clinical Income - Contract	262,577	283,064	296,699	73,164	72,643	521	67,346	7.9%
Other Income	24,920	24,052	22,957	5,739	6,248	-509	5,713	9.4%
Total Income	287,496	307,116	319,656	78,903	78,891	12	73,059	8.0%
Consultants	35,629	40,151	41,108	9,968	10,301	332	9,584	7.5%
Other Medical	30,255	33,866	32,684	8,232	8,919	688	7,998	11.5%
Nurses	72,972	77,152	77,099	19,449	20,036	587	18,781	6.7%
S&T	21,177	21,844	25,241	6,139	5,995	-144	5,492	9.2%
A&C (Including Managers)	22,589	24,171	25,440	6,313	6,297	-16	6,076	3.6%
Other Pay	5,526	5,839	8,797	2,232	2,016	-215	1,433	
Total Pay	188,147	203,024	210,369	52,332	53,563	1,232	49,364	8.5%
Drug costs	27,558	27,476	29,097	7,272	7,073	-198	6,590	7.3%
Clinical supplies and services	24,993	25,307	25,902	6,411	6,561	151	6,168	6.4%
Other Costs	42,159	47,563	49,242	12,498	12,636	138	11,540	9.5%
Non-Recurrent	0	0	0	0	0	0	0	
Total Non-Pay	94,710	100,345	104,242	26,180	26,270	91	24,298	8.1%
EBITDA	4,639	3,747	5,046	392	-943	1,334	-603	
Non Operational	13,014	13,101	13,098	3,274	3,211	-64	3,247	
Trading Position	-8,374	-9,354	-8,052	-2,883	-4,153	1,271	-3,850	
MRET / Readmissions Gainshare	2,516	4,555	4,587	1,147	1,409	-262	1,147	
S&T Funding	10,078	13,313	11,838	1,776	1,776	0	1,263	
Revenue Allocation	8,700	4,500	7,276	0	0	0	0	
Non-Recurrent	0	2,355	0	0	1,095	1,095	250	
Total Operating Surplus/Deficit (-)	12,920	15,369	15,649	40	126	-86	-1,190	
Less capital donations/grants income impact					-76			
Performance against control total				40	50	-10		

£180k at risk due to System missing control total

Key Activity Metrics

Category	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
ELECTIVE INPATIENTS	3,061	3,550	3,623	3,475	3,526	3,441	3,718	3,707	3,199	3,610	3,340	3,626	3,499	3,658	3,824
All Elective Surgery (excl Gynaecology)	1,931	2,256	2,288	2,250	2,111	2,060	2,277	2,406	2,049	2,211	2,180	2,284	2,234	2,340	2,392
All Elective Medicine	614	741	775	730	872	841	890	773	697	857	699	818	769	785	908
All Elective Womens & Children	236	236	238	199	227	238	221	223	177	205	196	233	216	228	214
All Elective Clinical Support Services	280	317	322	296	316	302	330	305	276	337	265	291	280	305	310
NON-ELECTIVE INPATIENTS (excl well babies)	5,195	5,777	5,507	5,454	5,298	5,420	5,565	5,751	5,692	5,750	5,322	5,842	5,487	5,914	5,543
All Non-Elective Surgery	726	879	854	817	771	815	826	844	832	781	786	883	818	888	824
All Non-Elective Medicine	1,927	2,207	2,148	2,118	2,176	2,116	2,165	2,088	2,146	2,311	2,162	2,351	2,168	2,202	2,128
All Non-Elective Womens & Children (excl *)	2,542	2,690	2,505	2,518	2,349	2,485	2,572	2,817	2,711	2,656	2,374	2,560	2,499	2,823	2,589
All Non-Elective Clinical Support Services	0	1	0	1	2	4	2	2	3	2	0	2	2	1	2
Number of Births*	428	451	449	480	438	441	409	436	429	454	360	425	382	480	433
Consultant First Outpatient Attendances	8,742	9,874	10,004	9,661	9,940	9,270	10,453	10,747	8,341	10,332	9,542	9,904	9,418	10,296	9,433
Consultant Subsequent Outpatient Attendances	15,568	17,975	19,061	17,331	17,567	17,336	19,246	19,913	15,448	19,954	17,737	18,498	17,830	18,481	17,371
A&E Attendances	8,411	9,182	8,913	9,062	8,337	8,689	9,170	8,940	8,847	8,795	8,043	8,858	8,477	9,241	9,178

Table below shows the activity restated per working day / calendar day to remove the impact of changes in month length

Elective Inpatient per Working Day	170	169	165	165	160	164	169	169	168	164	167	173	175	174	182
All Elective Surgery (excl Gynaecology)	107	107	104	107	96	98	104	109	108	101	109	109	112	111	114
All Elective Medicine	34	35	35	35	40	40	40	35	37	39	35	39	38	37	43
All Elective Womens & Children	13	11	11	9	10	11	10	10	9	9	10	11	11	11	10
All Elective Clinical Support Services	16	15	15	14	14	14	15	14	15	15	13	14	14	15	15
Non-Elective Inpatient per Calendar Day	173	186	184	176	171	181	180	192	184	185	190	188	183	191	185
All Non-Elective Surgery	24	28	28	26	25	27	27	28	27	25	28	28	27	29	27
All Non-Elective Medicine	64	71	72	68	70	71	70	70	69	75	77	76	72	71	71
All Non-Elective Womens & Children (excl *)	85	87	84	81	76	83	83	94	87	86	85	83	83	91	86
All Non-Elective Clinical Support Services	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of Births*	14	15	15	15	14	15	13	15	14	15	13	14	13	15	14
Consultant First Outpatient Attendances per WD	486	470	455	460	452	441	475	489	439	470	477	472	471	490	449
Consultant FU Outpatient Attendances per WD	865	856	866	825	799	826	875	905	813	907	887	881	892	880	827
A&E Attendances per Calendar Day	280	296	297	292	269	290	296	298	285	284	287	286	283	298	306

Source: Summary Activity Count produced by Information Department

NHS Activity	Annual Plan	YTD Plan	YTD Actual	Variance
Admitted Patients - Elective	43,783	11,041	10,453	-589
Admitted Patients - Non Elective 30%	81,238	19,527	20,150	623
Readmissions	-3,689	-920	-878	42
30% Adjustment - Luton	-3,282	-818	-895	-76
30% Adjustment - Beds	-1,951	-486	-632	-146
30% Adjustment - Herts	-529	-132	-206	-74
Admitted Patients - Non Elective 100%	27,968	6,890	6,546	-343
Maternity Payment Pathway	11,165	2,784	2,826	43
Outpatients - First	14,043	3,441	3,095	-346
Outpatients - Follow Ups	13,508	3,310	3,187	-123
Outpatient - Multi-professional 1sts	537	132	136	4
Outpatient - Multi-professional FU	715	175	188	13
OP PROC	11,295	2,740	2,730	-11
A&E	15,963	3,980	3,969	-11
UB IMAGING	4,112	1,008	965	-42
Direct Access (PbR)	2,287	561	542	-19
Same Day Chemo	1,196	298	244	-54
Breast Screening	3,950	968	1,052	84
Critical Care	16,787	4,185	4,007	-178
Admitted Patients - Non PbR - Elective	780	195	139	-55
Admitted Patients - Non PbR - Non-Elective	2,362	589	613	25
Direct Access	4,257	1,043	1,188	144
Non-Prebooked outpatients	58	14	11	-3
Outpatients - Non PbR	3,965	938	888	-50
OPTEL	156	38	59	21
Pre-assessment	1,313	322	311	-11
Onestop	2,052	503	509	7
Other Contracted income	17,676	4,419	4,337	-82
DRUGS	19,645	4,898	5,241	343
CQUIN	6,295	1,574	1,566	-7
Other	-64	170	450	280
Challenges	-889	-222	-150	72
YTD Total	296,698	73,163	72,643	-521

Elective income is £476k behind plan in Surgery (mainly in T&O, ENT and OMFS). ENT was slightly disadvantaged by the bank holidays in May and April as they lose 2 all day lists per bank holiday. T&O expects the actuals to be better due to a higher case mix in June. Upper GI is expected to start achieving its bariatric numbers in July

Non-elective 30% income (£623k ahead of plan) is driven from the Medical Division and is representative of the continued demand on emergency and acute medicine. This is partially offset by Surgery being behind plan (mainly Upper GI, Colorectal and OMFS)

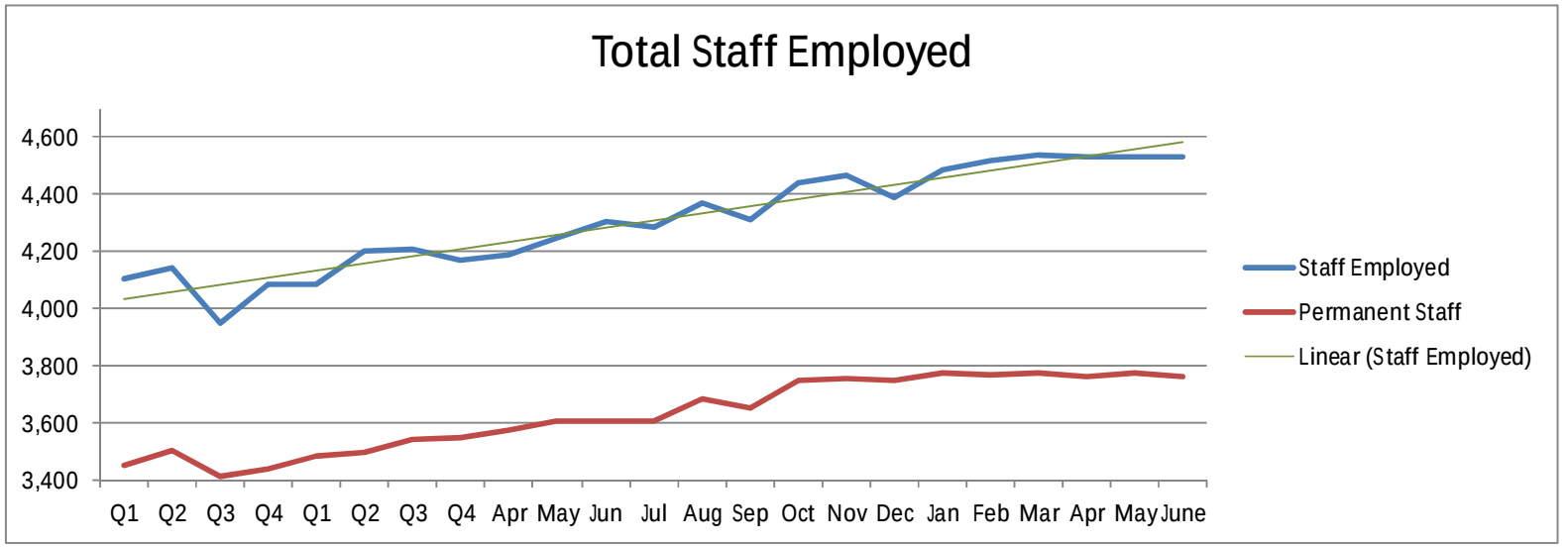
Non Elective 100% is £507k behind in W&C. This is mainly linked to Paediatric (£288k) & unwell babies' (£91k) activity, which is lower than plan. Also birth spells (£88k) below plan.

Outpatient is behind in Medicine where the transfer of Dermatology and LSH to Arndale House and the subsequent increase in space was behind plan and this has knocked on to income. The Division is reviewing ways of recovering this position during the remainder of the year, including productivity reviews in a number of key specialties. It is also behind in Surgery where the Division are in the process of allocating resource to deliver this however, recruitment will take 3-4 months. Further work with outpatients is required on DNAs/rebooking cancellations in order to mitigate some of this risk.

The "other" value is the flex to freeze impact, which has not been attributed to an individual POD

Staff in Post

	2015				2016				2017									2018					
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Admin/Estates	704	709	695	706	744	757	737	749	754	768	771	771	786	775	788	792	794	799	807	793	815	810	797
WD Clk/Support	401	426	194	206	206	214	220	220	224	228	229	228	212	221	224	226	223	226	232	226	230	228	220
HCA	529	534	548	578	558	594	571	555	564	557	559	563	580	563	549	551	553	559	572	584	567	559	578
Consultant	227	236	230	253	251	260	263	257	259	269	281	277	271	269	285	285	272	278	293	296	286	288	285
Medical non-Cons	372	386	367	368	367	396	407	404	374	396	436	415	467	437	447	459	426	458	439	445	452	445	459
N&M	1,331	1,307	1,373	1,420	1,416	1,422	1,435	1,423	1,448	1,452	1,439	1,454	1,461	1,452	1,549	1,544	1,529	1,559	1,567	1,587	1,561	1,565	1,562
Learner	4	4	8	7	7	3	3	6	6	6	5	4	4	4	7	7	7	9	10	10	10	10	10
Therapy/Technical	339	357	365	360	352	347	359	368	364	373	374	369	378	380	384	385	385	392	394	391	391	397	396
Healthcare Scientists	192	179	170	184	185	207	211	185	191	198	204	203	206	203	201	210	196	200	199	198	215	226	221
Other	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	4,102	4,142	3,952	4,084	4,088	4,202	4,210	4,171	4,186	4,249	4,302	4,286	4,369	4,308	4,437	4,462	4,388	4,483	4,516	4,533	4,529	4,530	4,532
Made up of:																							
Permanent Staff	3,450	3,503	3,413	3,440	3,486	3,500	3,541	3,548	3,574	3,607	3,604	3,610	3,685	3,655	3,750	3,753	3,747	3,773	3,771	3,772	3,764	3,772	3,763
Locum / Bank	496	486	395	507	456	537	520	499	501	522	571	559	562	534	568	567	515	586	632	623	623	617	614
Agency	156	153	144	136	145	165	149	124	111	121	127	116	121	119	119	142	127	123	113	137	142	141	154



*Q3 Drop in 2015 is Engie

** Locum / bank has been normalised for 4/5 week months to show consistency month on month

Agency Spend	Worse than plan

£000s	15/16	16/17	17/18	18/19	18/19 by Mth	18/19 Act
Apr	1,241	1,217	1,161	1,143	1,143	1,384
May	2,486	2,544	2,394	2,278	1,135	1,271
Jun	3,621	3,745	3,693	3,323	1,045	1,435
Jul	4,781	5,097	4,953	4,361	1,038	
Aug	6,022	6,267	6,185	5,329	968	
Sep	7,280	7,664	7,354	6,369	1,040	
Oct	8,562	8,957	8,580	7,491	1,122	
Nov	9,839	10,031	10,059	8,545	1,054	
Dec	11,043	11,183	11,137	9,472	927	
Jan	12,135	12,306	12,339	10,460	988	
Feb	13,510	13,414	13,408	11,457	997	
Mar	14,660	14,394	14,831	12,451	994	

The Trust's current plan breaches both the Medical Locum (agency ceiling of £5.654m and the new (tougher) Agency Ceiling target of £8.862m

Current run-rate results in Agency spend of £16.4m

If the Trust remains within 150% of the target (£13.293m) this should be sufficient to avoid NHSI scrutiny.

Failure of this target allows NHSI to apply a soft override to the Trust's Use of Resources Rating (Financial Risk Rating). It is not known whether NHSI will exercise this right.

	Plan				
	Medics	Nursing	Other Clin	A&C	Total
Apr-17	670	354	104	0	1,128
May-17	670	346	104	0	1,120
Jun-17	670	255	105	0	1,030
Jul-17	661	256	106	0	1,023
Aug-17	608	238	107	0	953
Sep-17	608	310	107	0	1,025
Oct-17	608	391	108	0	1,107
Nov-17	608	368	108	0	1,084
Dec-17	563	384	108	0	1,055
Jan-18	420	442	108	0	970
Feb-18	423	451	108	0	982
Mar-18	425	436	108	0	969

	Ceiling	Actual				
	Medics	Medics	Nursing	Other Clin	A&C	Total
Apr-17	546	695	477	184	29	1,384
May-17	546	572	475	209	15	1,271
Jun-17	546	731	495	206	4	1,435
Jul-17	539					0
Aug-17	496					0
Sep-17	496					0
Oct-17	496					0
Nov-17	496					0
Dec-17	459					0
Jan-18	343					0
Feb-18	345					0
Mar-18	347					0

Workforce
July 2018

(Reporting May/June 2018 Data)

WORKFORCE BALANCED SCORECARD **Reporting Period: May / June 2018**

Workforce	Trust Target	May-18 Trust Actual	May-18 Corporate	May-18 Diagnostics	May-18 Medicine	May-18 Surgery	May-18 Women' and Children's	Jun-18 Trust Actual	Jun-18 Corporate	Jun-18 Diagnostics	Jun-18 Medicine	Jun-18 Surgery	Jun-18 Women' and Children's	Jun-17 Trust Actual
Workforce Statistics														
Staff in post (Assignment Headcount)	-	4200	556	735	1149	944	816	4187	547	729	1153	942	816	4021
Budgeted WTE	-	4397	526	738	1340	1057	736	4397	526	738	1340	1057	736	4145
Staff in Post (WTE)	-	3772	511	638	1046	888	689	3763	503	633	1052	887	689	3604
Vacancy Rates (%)	10%	14.22	2.85	13.56	22.00	15.93	6.37	14.41	4.30	14.22	21.55	16.07	6.42	13.04
Nurses & Midwives Budgeted WTE		1456	46	28	555	411	416	1456	46	28	555	411	416	1433.7
Nurses & Midwives in Post (WTE)	-	1277.1	43.9	25.9	461.8	353.9	391.6	1272	42.9	24.7	460.5	355.6	387.8	1179.1
Nursing & Midwives Vacancy Rates (%)	10%	12.30	3.85	7.80	16.77	13.94	5.94	12.68	6.04	11.75	17.02	13.51	6.87	17.76
Nursing Vacancy Rates (%)	10%	13.97	3.85	7.80	16.77	13.94	7.62	13.47	6.04	11.75	17.02	13.51	8.79	19.24
Midwives Vacancy Rates (%)	10%	3.79	-	-	-	-	3.79	4.40	-	-	-	-	4.40	8.00
Sickness FTE Days Lost	-	3781	512	416	1159	817	877	-	-	-	-	-	-	3202
Sickness Rates (%)	3.32%	3.22	3.24	2.11	3.56	2.96	4.07	-	-	-	-	-	-	2.96
Estimated Sickness Cost (£)	-	299112	44505	34174	75673	63425	81335	-	-	-	-	-	-	242625
Maternity Absence Rates (%)	-	2.57	0.89	1.96	2.76	2.73	3.87	2.64	0.94	1.75	2.95	2.84	3.98	2.66
Other Absence Rates (%)	-	1.67	0.38	1.14	2.33	1.93	1.79	0.41	0.02	0.51	0.49	0.42	0.46	0.27
Turnover %	10%	15.74	14.66	16.33	18.58	14.35	13.67	16.01	16.30	16.03	18.26	14.97	13.85	16.22
Appraisal Rate %	90%	80	79	83	76	83	80	80	78	84	76	81	82	78
Core Statutory Training %	80%	79	77	84	77	80	77	79	74	83	79	80	76	80

RECRUITMENT COMMENTARY

Nurse Recruitment - 27 nurses started in post between April and June of which 17 were registered with the NMC and 10 with registration pending. Nurse recruitment remains a challenge and the Trust continues with ad-hoc local recruitment, open days, targeted campaigns as well as overseas recruitment. As overseas nurses now have the option of undertaking either the IELT's or OET English language test the Trust is working with a specialist English Language Training School to provide face-to-face tuition for both our EU nurses starting at the Trust and some of our in-house overseas nurses who currently work in lower banded positions.

Recruitment campaigns undertaken in this period include University West of Scotland Careers Fair, Surgery Open Day, Pharmacy Congress Event, Newly Qualified Midwifery Open and several Healthcare Assistant campaigns. Events planned over the next few months include A&E Open Day, NQ Midwifery Open Day, Luton Mall Careers Stand and further scheduled Healthcare Assistant campaigns.

International Recruitment – A small number of nurse's start at the Trust each month from our previous International campaigns to India, Philippines and Singapore. In addition, nurses from other countries who have been recruited via our Skype campaigns start each month. On-going Skype interviews continue through our agencies with campaigns planned for July and August as well as overseas nurses who apply directly to the Trust. Between April and June 2018 a total of 9 International nurses arrived in UK and 10 overseas nurses were successful in passing their OSCE to gain their NMC registration.

European Recruitment – Following a recent campaign to Italy 15 nurses were recruited and are starting at the Trust between May and July. Upon commencement they will all be undertaking classes to enhance their English language skills to support their Occupational English Test.

HCA Recruitment - The Trust continues with regular recruitment campaigns for both permanent and bank positions to keep vacancies to a minimum and an effective bank resource. There have been 21 substantive HCA starters and a further 12 joined the bank during the period. The next planned HCA Open Day is scheduled for Saturday 21st July 2018.

STAFF IN POST WTE BY DIVISION

DIVISION	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	% Growth From April 2017	Average % Growth per month	% Growth over last 12 months
Corporate	497.9	499.67	498.9	507.3	509.21	505.3	512.1	511.1	503.1	509.4	510.5	502.9	-1.27%	0.09%	1.01%
Diagnostics, Therapeutics and Outpatients	616.3	639.57	636.0	635.2	630.67	631.9	637.1	641.5	636.2	629.4	629.4	633.2	0.61%	0.25%	2.74%
Medicine	983.8	982.38	998.0	1025.1	1034	1037.1	1047.0	1043.5	1051.0	1045.1	1045.1	1051.5	0.62%	0.63%	6.89%
Surgery	860.9	866.23	869.1	886.0	883.32	882.6	887.0	886.5	898.2	894.4	894.4	886.9	-0.84%	0.27%	3.02%
Women's & Children's	651.4	667.98	680.4	696.0	695.57	689.9	690.3	688.1	683.9	686.0	686.0	688.8	0.41%	0.52%	5.74%
TOTAL	3610.3	3654.8	3682.4	3749.7	3752.7	3746.8	3773.4	3770.6	3772.4	3764.3	3765.4	3763.4	-0.02%	0.39%	4.24%

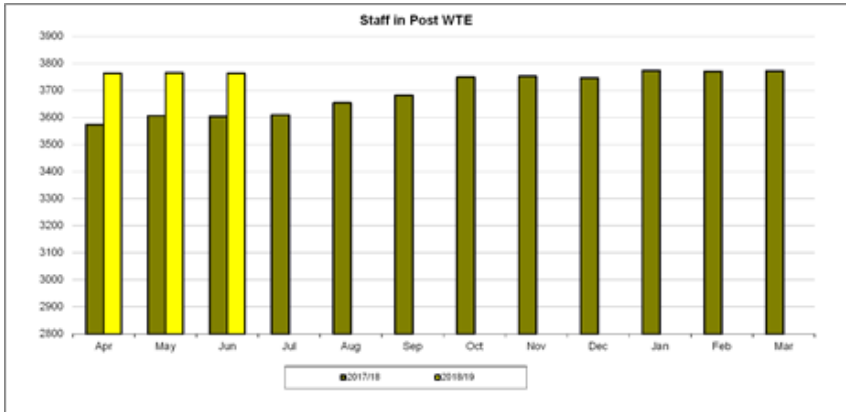
WTE COMMENTARY

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 4.24% since July 2017. This increase is attributed to increase of: Nursing and Midwifery roles 107WTE (7.84%) , Associate Nurse Practitioner 17.2 WTE, Medical posts 18.6 WTE and 6.3WTE Pharmacists. There has also been a small increase IT roles linked to recruitment to the GDE programme.

- There are currently 94 band 5 Nursing / Midwifery vacancies across the Trust. There are 61 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 57 vacancies for band 2 Healthcare Assistants with 55 currently going through the recruitment process due to commence between July and September 2018. The vacancy factor has increased since the last board report due to finalisation of the establishment for 2018/19 and revisions to establishment controls that enable real time reporting.



Medical Recruitment

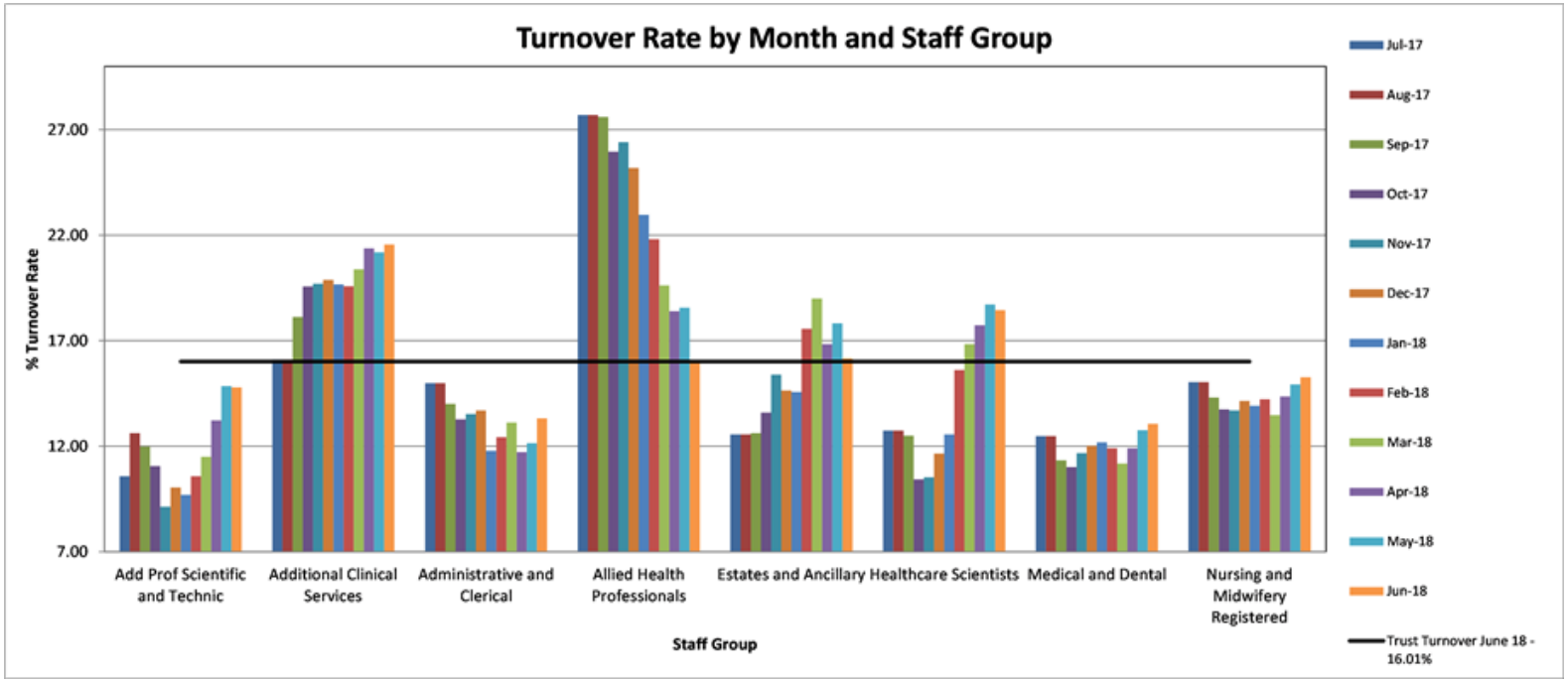
Between April and June four AAC's were planned and appointments were made for Neurophysiology (1) and Restorative Dentistry (2). Two AAC's were cancelled due to no applications received (Rheumatology and Haematology).

Between July - September AAC's are scheduled for the following specialties: Paediatrics, Anaesthetics (Paeds), Elderly Medicine, Stroke Medicine, Diabetes, Respiratory, Anaesthetics (ICM) Anaesthetics (Pain) and Obstetrics and Gynaecology .

New Starters

Between April and June four new substantive Consultants started in post: Anaesthetics (1) Urology (1) and Obstetrics and Gynaecology (2)

TURNOVER



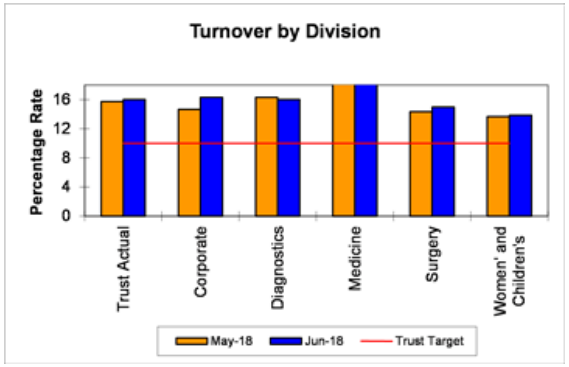
TURNOVER COMMENTARY

The Trust's overall turnover rate is 16.01% for the reporting year ending 30th June 2018. There is a marginal increase in month from May 2018 (15.74%) but it is 1.29% lower when compared to June 2017 (16.22%). Overall turnover is below the EoE Q4 average of 16.63%.

Nursing and Midwifery turnover for June 2018 is 15.27% and shows a decrease of 4.14% when compared to June 2017. Turnover for the Allied Health Professional staff group shows a 40% decrease over the same period. The NHSI Direct Support Programme which focuses on nurse and HCA turnover reduction. The Trust has established a project group, Retention Matters , with a target of reducing band 5 nurse and HCA turnover by a further 1.5% through four key work streams: improving data, transfer window/career conversations, working flexibly and retirement options.

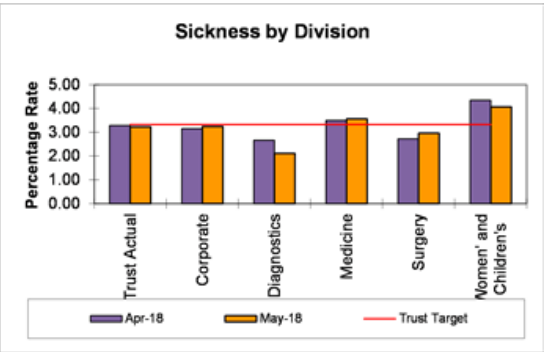
There continues to be an increase in the turnover for the other staff groups with the increase in Additional Clinical Services being attributed mainly to HCA's.

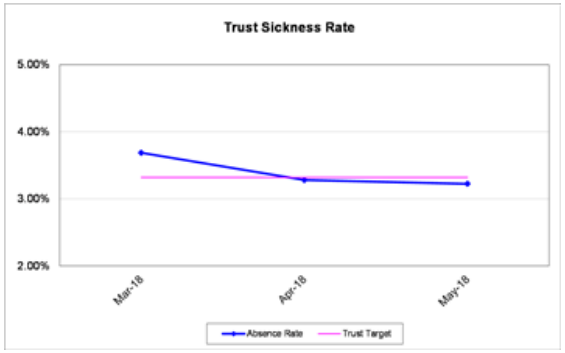
Not including Junior Doctors at the end of their contract – there were a total of 164 leavers between April and June 2018 – top reasons for leaving were: Work Life Balance – 32.93%, Relocation – 20.73%, Better Reward Package – 13.41%, Retirement 7.32% and Promotion 6.10%.

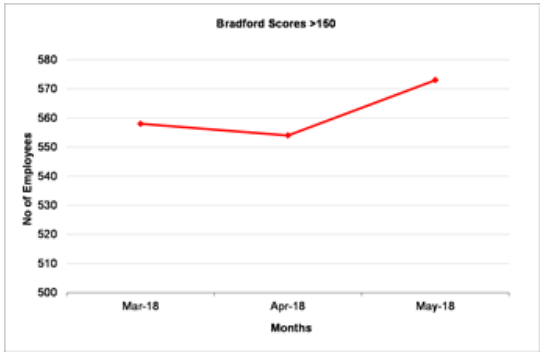


* Turnover figures above do not include Junior Doctors.

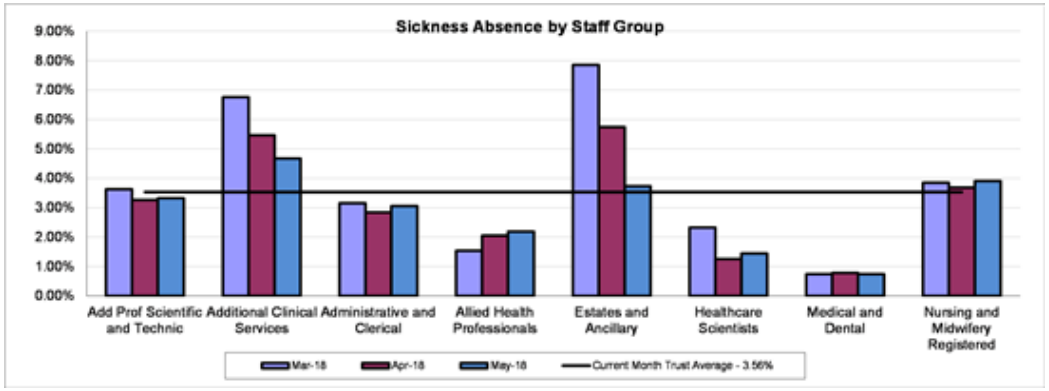
SICKNESS ABSENCE







Sickness Absence by Staff Group	Mar-18	Apr-18	May-18	Last 12 Months Average
Add Prof Scientific and Technic	3.63%	3.26%	3.32%	2.57%
Additional Clinical Services	6.76%	5.46%	4.67%	5.61%
Administrative and Clerical	3.15%	2.84%	3.06%	3.24%
Allied Health Professionals	1.54%	2.05%	2.19%	2.50%
Estates and Ancillary	7.85%	5.74%	3.73%	6.58%
Healthcare Scientists	2.32%	1.25%	1.44%	2.46%
Medical and Dental	0.74%	0.78%	0.74%	1.05%
Nursing and Midwifery Registered	3.85%	3.68%	3.90%	3.70%
Trust total	3.69%	3.28%	3.22%	3.53%



SICKNESS ABSENCE COMMENTARY

The monthly average for May 2018 (3.22%) is lower than for April 2018 (3.28%) and below the Trust target of 3.32%. The Trust's overall average for the year ending 31st May 2018 is 3.56%. This is above the Trust target and is higher than the same period last year (3.52%) but is lower than the EoE Q4 average 3.70%.

There has been an increase of 2.27% in the number of employees with a Bradford Score over 150 since last month, with 586 over the trigger point at 1st July 2018, compared to 573 at 1st June. Of the employees that have reached the trigger point 67% are short term sickness, 5% long term sickness, 26% with an underlying health reason and 3% pregnancy related. Compared to the previous reporting period this is a reduction of 3% short term sickness, long term sickness is stable, with an underlying heath condition has increased by 3% and pregnancy related sickness increased by 1%.

The percentage of Stage 2 meetings has increased from 61% last month to 65% this month – this is the fourth increase in Stage 2 meetings in a row. Estates and Facilities have continued their focus on Stage 2 meetings and have achieved the highest Stage 2 meetings for employees above the 150 trigger point 77%. The lowest percentage of Stage 2 meetings is Acute & ED (53%) however this represents an increase over the reporting period from a starting position of 22% .

The HR team continues to support divisions to manage sickness through: monthly reports circulated to managers, heads of department, matrons and general managers, a focus on sickness at monthly Divisional Board meetings, actively following up with managers to book overdue stage 2 meetings and holding targeted case review meetings with managers to put together actions plans for each person. The Trust has also implemented a new strategy to proactively manage cases with an underlying

TRAINING COMPLIANCE BY DIVISION

June 2018	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	78%	83%	77%	78%	78%	62%	74%	77%	83%
Diagnostics, Therapeutics and Outpatients	84%	75%	86%	86%	87%	76%	82%	88%	82%
Medicine	76%	100%	80%	78%	78%	80%	77%	80%	86%
Surgery	81%	77%	80%	80%	79%	82%	78%	83%	85%
Women's & Children's	82%	100%	76%	77%	77%	78%	74%	74%	91%
TRUST TOTAL	80%	88%	80%	80%	80%	79%	77%	80%	86%
Change from last month	0%	-6%	0%	1%	0%	0%	0%	0%	0%

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

TRAINING COMMENTARY

Statutory Training

We have seen a slight increase in compliance for Infection Control training. All other mandatory topics have shown no change during the June period.

To improve compliance, we have contacted Admin and Clerical staff who are non-compliant for mandatory training who have e-mail addresses registered on ESR. We have asked that they complete the required training by the end of July. This improvement method will be monitored over the coming months, changing to a different target staff group each month.

We have analysed the compliance data and the vast majority of staff who require Safe Moving and Handling Practical training are porters. The manager has been contacted and asked to ensure that the staff attend practical training as soon as possible. We have a date available in July for this training and have promoted it again.

Appraisals

The Trust-wide compliance figure remains at 80% this month. A substantial amount of appraisals were completed during the June period but this was balanced out by a number of appraisals expiring.

The Women's and Children's division has seen a 2% increase in appraisals' compliance during the June period. In addition to this, we have seen a 1% increase in appraisals' compliance for Diagnostics, Therapeutics and Outpatients.

The compliance rate for Women's and Children's – 'Others' staff group has increased from 50% to 83%. As mentioned in the previous report, only six members of staff fall under the Women's and Children's – 'Others' category, with four of those employees now having valid appraisals.

We have seen a slight decrease in compliance for the Corporate Services and Surgery divisions during the June period. We will ask divisional leads to focus their efforts on improving compliance, in addition to sending out the usual non-compliance e-mails to individual members of staff.

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

BOARD OF DIRECTORS

Agenda item	9	**Category of Paper**	Tick
Paper Title	Clinical Outcome, Safety & Quality Report	**To action**	☐
Date of Meeting	25 Apr, 23 May, 27 June 2018	**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 25 April, 23 May, 27 June 2018	
Links to Strategic Board Objectives	Objective 1 –Deliver Excellent Clinical Outcomes Objective 2 - Improve Patient Safety Objective 3 - Improve Patient Experience	
Links to Regulations/ Outcomes/External Assessments	CQC Internal Audit HSE	
Links to the Risk Register	All clinical board level risks	

PURPOSE OF THE PAPER/REPORT

To update the Board on the findings and approval of the Clinical Outcome, Safety & Quality committee meetings dated 25 April, 23 May and 27 June 2018

SUMMARY/CURRENT ISSUES AND ACTION

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

- Report on progress with the Quality Priorities 2017/18
- Report from Clinical Operational Board
- Statutory training and appraisals
- Internal Audits
- Risk register – risks assigned to the committee

ACTION REQUIRED

To note progress to date.

Public Meeting ☒ Private Meeting ☐

CLINICAL OUTCOMES, SAFETY & QUALITY (COSQ) COMMITTEE REPORT

TO BOARD OF DIRECTORS

1. Introduction

This Report updates the Board of Directors regarding the matters discussed at the Clinical Outcome, Safety and Quality meetings held on 25 April 2018, 23 May 2018 and 27 June 2018

2. Governance

Quality Report and Performance Report - COSQ received and reviewed the Quality and Performance Reports 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. The committee noted the high level of pressure ulcers in March 2018 and were given assurance that levels decreased in April and focussed improvement work was being undertaken. An increase in complaints was noted, partly due to cancellation of appointments.

The Deputy Chief Executive alerted COSQ that the Trust had failed the stroke target for thrombolysis within 1 hour during the quarter Jan-March 2018. The Stroke Team attended the June meeting and briefed the committee on the issues and noted that a localised action plan had been put in place in May 2018 to address the performance. Assurance was given that all 30 patients were reviewed and no harm was identified.

A report was received giving an update on the 18 week position and assurance was given that performance is on track to meet compliance in July 2018. COSQ was encouraged that the planned trajectory was on target but challenged plans in readiness for the next winter pressures. It was acknowledged that the current rate could not be sustained but as much tolerance as possible will be built into the plan. The committee discussed the plant issues and noted that Estates are pulling together options to undertake repair work with minimum disruption, albeit that this is likely to involve downtime. It was noted that for all last minute cancelled operations, all patients were re-dated within 28 days.

COSQ noted that Dementia Assessment and Referral was now being reported and is included in the Single Oversight Framework.

Cancer – COSQ were informed of the non achievement of the Breast Symptomatic 2 week wait target in April 2018. The committee noted the steps in place to recover the position. The Deputy Chief Executive alerted COSQ of issues being addressed with Mount Vernon regarding oncology service provision.

Quality Strategy – A scoping exercise was completed in terms of 'QI live'. Analysis shows that the organisation is not yet ready to rollout 'QI live' across the Trust. Projects are being developed or underway and the first step will be to train small cohorts to use 'QI live'. COSQ requested a more detailed project timeline to show how the Quality Strategy will be delivered to enable progress to be monitored.

3. Nursing Harm Free Care Dashboard

The Acting Director of Nursing and Midwifery presented the nursing dashboard including quality metrics, workforce and patient experience indicators for each ward and division. Focus on proactive sickness management continues.

4. Clinical Outcome & Patient Safety

Learning from Deaths – COSQ received a report and noted that national evidence shows there are between 0.5 – 3.75% avoidable deaths. The committee were given assurance with regard to the governance process to ensure that clinicians are carrying out mortality reviews.

Urology GiRFT – The outcomes of the Urology GiRFT visit and action plans were received. The report was constructive and commended a positive team.

Deteriorating Patient – The Head of Patient Safety attended COSQ in April and fed back the results of a review which had been undertaken following an increase in cardiac arrests over the previous 6 months. COSQ noted the results and acknowledged that no cardiac arrests had been recorded in contingency areas. Overall, the committee noted the good survival rate and were given assurance that deteriorating patients are being managed appropriately and the cardiac arrest rate has remained below the national average.

Outpatient letters – The Deputy Chief Executive presented the data relating to timescale of letters following an outpatient appointment and noted that performance remains disappointing. This target is now the subject of a contract performance notice from the CCG and a remedial action plan has been developed. The CCG have identified specialties the GPs consider a priority and the Trust is closely monitoring the performance for those specialties to achieve compliance and observe the process to identify the obstacles. Progress is being made to upgrade BigHand which will enable easier batch approval and speed up the process for clinicians.

Partial booking backlog – The Deputy Chief Executive gave assurance with regard to the process of tracking patients who are not already tracked through 18 weeks or cancer and shared data of the current waiting list position within specialty. It was noted that the specialties with the highest numbers of patients on follow up waiting lists are Cardiology, ENT and Respiratory who have action plans in place to reduce the backlog.

NHS Improvement Patient Safety Alerts and Never Events – COSQ received a copy of a letter from NHSI asking for Trusts to review processes for compliance and where any incomplete actions are identified, ensure that the status on the Central Alerting System is correct. The issue with regard to NG tubes was discussed and acknowledged that this is a national issue.

Serious Incidents – COSQ received reports giving an update on Serious Incidents and Never Events. The General Manager for Women's and Children's service gave assurance in April that the outstanding SI action plans have now either been closed or actions are being demonstrated. The committee discussed the requirement to have a formal process to support staff during investigations, coroners inquests etc.

5. Patient Experience

Patient Story – A patient was in attendance at the May meeting and shared her experience both as an inpatient and with regard to follow up outpatient appointments.

Healthwatch Enter and View – The Acting Director of Nursing & Midwifery briefed the committee of visits from Healthwatch and noted that feedback was generally positive.

Inpatient Survey – A summary of the results of the 2017 inpatient survey was received. The Trust performed about the same in 10 of the 11 categories. The area where the Trust performed worse than other Trusts is with regard to patient feeding. Work has already been undertaken to drive improvement and to recruit additional volunteers.

6. Quality Priority and CQUIN

The committee received a paper outlining the Quality Priorities for 2018/19, based on the 4 key areas of the Quality Strategy. The final outcome of the CQUIN schemes for 2017/18 was highlighted and the schemes for 2018/19 were outlined. The committee noted the new CQUIN with regard to risky behaviours, with the requirement to screen every inpatient and give advice and make referrals. The committee queried whether the delay of medication for sepsis on wards had an impact on mortality and were assured that no patient had been adversely affected. For the Sepsis CQUIN for 2018/19 there is much work around education of doctors regarding recording of antibiotic reviews and the shift in the way antibiotics should be prescribed.

7. Report from Clinical Operational Board

Escalation reports from the Clinical Operational Board (COB) meetings were received. The issues raised were discussed and awareness was acknowledged.

8. Workforce Update

Statutory Training and Appraisals – The Training and Development reports covering activity to 31 May 2018 were received and noted. COSQ continue to monitor statutory training and appraisal compliance and supported the proposal that all staff should be compliant at level 1 conflict resolution training. A paper was presented outlining the proposal for a revised set of mandatory training refresher sessions which will ensure full alignment to the Core Skills Training Framework.

Nursing and Midwifery Workforce - COSQ reviewed the nursing workforce reports. The Acting Director of Nursing and Midwifery brought to the attention of COSQ the local employer competition with regard to recruiting for HCAs. The Trust is participating in the NHSI retention programme and focusing on 3 workstreams: HCAs; new graduates; and those nearing retirement age.

Safe Staffing Review – COSQ received the Nursing Establishment Review for 2018/19 undertaken in line with National Quality Board (2013) and Lord Carter (2016) recommendations.

9. Risk Register

The risks assigned to COSQ which were due for review were discussed and updated; this included the risk relating to bed pressures and the opening of contingency areas,

and cyber security.

10. GDPR

The Director of IM&T and the Information Governance Manager attended the April meeting and presented the progress on GDPR. COSQ congratulated the team.

11. Maternity

The Consultant Midwife was in attendance at the April meeting and presented the Maternity Improvement Plan. Outstanding actions were noted.

CNST Incentive Scheme – The Head of Midwifery presented the Trust's position against the 10 safety actions of the CNST incentive scheme to improve safety in maternity services. The committee were impressed with the work undertaken to date and supported that the paper be presented to the Private Board meeting for approval.

The committee also discussed Birthrate Plus acknowledging that the recommendation is a ratio of 1:28 and that the Trust is an outlier in this respect. However, there was acknowledgement that there is mitigation in place, the funding is not available, and there is a shortage of midwives nationally.

Maternity Improvement Programme - It was noted that the programme is progressing and mentoring is in place for staff as required.

12. Clinical Audit / Internal Audit

COSQ continues to monitor actions arising from Internal Audit reports. A progress report was received on the Internal and External Audit Plan for A&E. COSQ received a report documenting progress on the development of Proof of Concept digital solution to the daily status report that had been developed by the Integrated Discharge team and the Medical Division.

13. CQC

CQC action plans for DTO, T&O and Medicine were received and progress was noted.

Preparations are underway for the unannounced CQC visit.

14. Needs Based Care

The Medicine Senior Team gave an update on the needs based care project. Early indications show that length of stay has reduced in Respiratory and DME as a result of introducing the frailty model. The committee were keen to see if a difference had been seen in diagnostic demand. It was acknowledged that the delay in developing the hot block is a significant issue to the project going forward. Discussion took place with regard to the continued high activity of patients.

15. Any Other Business

Clinical Leadership in Surgery:

A team on behalf of the Royal College of Surgeons visited the Trust on 17 and 18 May 2018 to review the colorectal service. Further feedback will be available on receipt of their report.

The committee acknowledged that the Clinical Chair role is vacant, however, in the interim the Clinical Directors are providing leadership at specialty level. Assurance of governance and performance is provided through the new arrangement of service line meetings with the Executive team.

14. Papers Received for Information:

- Minutes of the Nursing and Midwifery Board meeting
- National Quality Publications of Interest
- 3x3 walkabout

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

BOARD OF DIRECTORS

Agenda item	10	**Category of Paper**	Tick
Paper Title	Finance, Investment & Performance Committee	**To action**	☐
Date of Meeting	25 July 2018	**To note**	☒
Lead Director	Andrew Harwood – Director of Finance	**For Information**	☐
Paper Author	Denis Mellon – 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 held between April and June 2018	
Links to Strategic Board Objectives	Objective 1 – Deliver the Quality Priorities Objective 2 – Deliver National Quality and Performance Targets Objective 3 – Implement the Strategic Plan Objective 5 – Optimise our Financial Position	
Links to Regulations/ Outcomes/External Assessments	Monitor CQC Commissioners Internal Audit	
Links to the Risk Register	Non-Achievement of Financial Target CQUIN	CCG verification processes Agency spend STP Control Total

PURPOSE OF THE PAPER/REPORT

To update the Board of Directors on the findings and approval from the Finance, Investment & Performance Committees held between April and June 2018.

SUMMARY/CURRENT ISSUES AND ACTION

This report highlights the issues and themes presented to FIP for the end of FY17/18 and months 1 & 2 of FY18/19 including:

- Trust and Divisional operational plans for 2018/19
- In-year, Trust level performance, including income & expenditure, associated cost improvements, contracting issues, capital expenditure to the end of 2017/18 and planned capex for 2018/19, cash-flow and associated FIP actions;
- Investment decisions and review.

ACTION REQUIRED

To note the Finance, Investment & Performance Committee Report from meetings held Between April and June 2018

Public Meeting ☒ Private Meeting ☐

FINANCE, INVESTMENT & PERFORMANCE COMMITTEE REPORT TO THE BOARD

This report reflects the matters considered at the Finance, Investment and Performance (FIP) Committee meetings between 25th April and 27th June 2018.

The summary of Executive and Non-Executive Director attendance at these meetings is shown below:

Committee Member	25/04/18	23/05/18	27/06/18
Denis Mellon (Chair)	×	✓	✓
Simon Linnett	✓	✓	×
David Hendry	✓	×	✓
Mark Versallion	✓	✓	✓
John Garner	✓	✓	✓
Andrew Harwood	✓	✓	✓
David Carter	✓	✓	✓
Danielle Freedman*	×	×	×
Angela Doak	×	✓	×
Cathy Jones	✓	✓	✓
Sheran Oke	×	×	×
*attends by invite			

This report highlights the issues and themes presented to FIP for the end of FY17/18 and months 1 & 2 of FY18/19:

1) Trust and Divisional operational plans for 2018/19

2) In-year, Trust level performance, including income & expenditure, associated cost improvements, contracting issues, capital expenditure to the end of 2017/18 and planned capex for 2018/19, cash-flow and associated FIP actions;

3) Investment decisions and review;

4) Other FIP matters.

1. Key Finance Issues – 2017/18 Performance

Area	Commentary	FIP Actions Noted
Operating Income	The FT reported income of £334m for FY17/18. This was up 8% from £309m in FY16/17 driven by substantial unplanned non-elective activity, the adverse performance on elective activity being partially offset by £1m winter pressures funding, £4.5m non-recurrent support from the DH, £8.4m S&T funding, £5m of bonus funding and £4.6m of MRET/Readmissions gain share.	None not otherwise noted
Operating Expenditure	At the end of the year, expenditure was £314.4m (compared to £291.7m in FY16/17). This expenditure contained significant unplanned medical and nursing pay, both linked to the management of the activity over-preformance. Agency spend exceeded the NHSI target +50%.	None not otherwise noted
Surplus/ Deficit (after finance costs)	The Trust reported a total operating surplus of £15.4m (compared to £12.9m in FY16/17). FIP explored the underlying performance which was £4.8m deficit (i.e. before the addition of S&T funding, bonus monies, winter funding and the DH revenue grant).	None not otherwise noted
CIPs & FRP	Performance against the financial recovery plan targets was seriously compromised as a result of the winter pressures with the Surgery Division being hardest hit with elective cancellations. Whilst individual CIP targets were not delivered by any Division, the overall bottom line target was achieved due to the mitigating impact of unplanned income.	None not otherwise noted
Cash	The Trust held a cash balance of £36.4m at the end of FY17/18 which is ahead of the forecast cash position.	None not otherwise noted
Capital	The Committee noted that capital additions (including donated assets) was £12.2m (£9.9m FY16/17). This was less than planned. FIP noted that any slippage would be added to the FY18/19 plan.	

2. Key Finance Issues – 2018/19 Performance

Area	Commentary	FIP Actions Noted
Income	At the end of Month 2 reported income was £52.2m (£0.2m adverse variance) - with elective, outpatients and critical care income lines all being lower than anticipated and partially offset by smaller "other income" upsides. FIP noted that the early months position is distorted by coding challenges.	Agreement to review the contribution of good clinical records to the income position
Expenditure	At the end of Month 2, expenditure was £52.9m (£0.6m adverse variance). This is predominantly due to a significant overspend on medical pay (£0.5m) and nursing pay (£0.2m). The reasons remain under review but continue to be driven by vacancies (particularly in junior doctors), transformative care models (such as bay-watch impacting on nursing pay costs), and the initiation and safe induction of newly trained nurses on to the wards. Agency spend, and the achievement of the NHSI target, continues to present difficulties in balancing clinical performance against financial imperatives.	Medical pay is being subject to a number of different actions. These include a reduction in the hourly rate for locum shifts, revising agency engagement models and continuous review of nursing spend and controls
Surplus/ Deficit	The operating deficit at the end of Month 2 was £0.6m, £0.3m behind the plan, and after accounting for some non-recurrent items (such as the £0.5m income for the Arndale refurbishment)	Concern regarding the underlying trading position was flagged by the Finance team.
CIPs	Overall CIP targets are not being met across the Trust, with a £0.68m gap at the end of Month 2. This is, in part, being offset by some areas of income over-performance.	Fast track and medium term opportunities are being explored through FIP and will form the basis of the Trust's recovery planning
Cash	The Trust is reported a cash balance of £27.5m at 30th June 2018.	None not otherwise noted
Capital	The current capital expenditure plan for FY18/19 is £24.7m. At the end of Month 2 actual spend is £2.2m.	None not otherwise noted

3. Investment Decisions & Review

Business Case	Summary of Proposal	FIP Actions Noted
SPECT CT	The Imaging Department presented a case to replace their existing, 14 year old, Gamma Camera with a SPECT-CT scanner. It was recognised that this would improve diagnostic and reporting capabilities, expand the nuclear medicine service's clinical application for oncology, orthopaedic, parathyroid, endocrine and infection imaging, improve CT service resilience and reduce demand on other pressurised modalities. The £1m capital purchase was approved.	Post-implementation review to be conducted at a future date.
Theatres	Outline plans for the expansion and improvement of Theatres capacity were presented to FIP and it was acknowledged that detailed propositions would be considered by the Redevelopment Board following further work by the Redevelopment Team.	FIP to receive the outline business case in July 2018.
Ward Block (to incorporate improvements to Wds 10, 11 & 12)	The Committee noted that work is continuing to develop the options for inclusion in the initial Strategic Outline Case for presentation to FIP in July.	FIP to receive the SOC in July 2018.
Energy Centre	The Committee were alerted to the progress that is being made on the energy centre proposal, with an update to be presented to FIP in July.	FIP to receive the proposal in July 2018.

4. Other Matters

The Operating Plan for 2018/19 was reviewed by the Committee and ultimately approved by the Trust Board. Revised Terms of Reference for FIP were accepted and approved by the Board. A schedule of post-implementation reviews was proposed and agreed. The progress with the apprentice levy was discussed, as were opportunities to improve overseas visitor income in line with a national drive from NHSI. NHSI expectations with regards to the Trust's operating plan and NHS expectations for reducing long hospital stays were considered and discussed. It was noted that the GDE Programme Board was established as a sub-committee of FIP with reporting lines agreed accordingly.

5. Conclusion

The Trust Board is asked to note this summary of the FIP Committee deliberations from April 25th through to June 27th and the date of the next meeting FIP Committee is July 25th.

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

BOARD OF DIRECTORS

Agenda item	11	**Category of Paper**	Tick
Paper Title	Audit and Risk Committee Report	**To action**	☐
Date of Meeting	25th July 2018	**To note**	☐
Lead Director	David Hendry, 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	Audit and Risk Committee 16th May 2018
Links to Strategic Board Objectives	Objective 1 – Deliver the Quality Priorities Objective 2 – Deliver National Quality and Performance Targets Objective 4 – Develop all Staff to Maximise Their Potential Objective 5 – Optimise our Financial Position
Links to Regulations/ Outcomes/External Assessments	External Auditors
Links to the Risk Register	Risks 15+ reviewed

PURPOSE OF THE PAPER/REPORT

To update the Board of Directors on the findings and approval of the Audit and Risk Committee held on the 16th May 2018.

SUMMARY/CURRENT ISSUES AND ACTION

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

- External Audit – *End of Year Reports*
- Internal Audit – *End of Year Reports*
- Counter Fraud – *Progress Report and Annual Plan*
- Board Secretary Report
- Assurance from Sub Committees
- Audit and Risk Annual Report to Board and Governors

ACTION REQUIRED

To note progress to date.

Public Meeting ☒ Private Meeting ☐

AUDIT AND RISK COMMITTEE REPORT

TO BOARD OF DIRECTORS

1. Introduction

This Report updates the Board of Directors regarding the matters discussed at the Audit and Risk Committee on the 16th May 2018.

2. Matters Arising

The action log was reviewed and updates noted.

Arrangements for 18/19: Internal and External Audit; and Counter Fraud, were discussed, agreed and noted.

3. External Audit

Reports were received from KMPG, the Trust External Auditors:

ISA 260 Audit Memorandum for 2017/18
Was presented and discussed, noting some elements of work were outstanding, in particular final review of Land and Buildings valuation. However, the audit was substantially complete, and no issues were anticipated.

In summary:

Financial Statements Audit – Intention to issue an unqualified report.

Quality Accounts - Able to provide assurance on: the Quality Report; and the testing of three indicators.

Value for Money and Audit Certificate – Concluded Trust has adequate arrangements to secure economy, efficiency and effectiveness in its use of resources and noted KPMG work included review of papers in relation to the potential Bedford Hospital acquisition.

Recommendations – had been made for improvement in internal controls, none of a fundamental or material nature, with Management responses to be received by the 18th May.

Long Form Audit Report to Governors – evidence for unqualified opinion reviewed and discussed.

Management Letters of Representation - in relation to Quality Report and Financial statements were reviewed and discussed, the committee recommending approval at the Private Board meeting on the 23rd May 2018.

KPMG and the committee recognised the skill and commitment from the Trust, in particular Secretariat and Finance, for delivery of the 2017/18 reports to a very demanding timetable.

4. Annual Report and Accounts

Financial Performance extract of the Annual Report
Amendments were made to the text before final submission to KPMG and then NHS Improvement.

Annual Governance Statement
The AGS is linked closely to the CQC Well Led Domain and the risks identified are challenging e.g. site backlog, achievement of the control total and the merger. However, the Board are sited on these risks and the mitigations are documented. It was noted that the reference to reliance on Internal Audit needed to be updated in line with their final report in particular regarding Cyber Security to reflect the tightening of control undertaken in response to the risks identified.

Annual Accounts
Committee were assured that A&RC and FIP Chairs had reviewed in detail and that issues identified requiring ongoing review in relation to: Assets under Construction; Apprenticeship Funds; and NHS Resolution contributions will be overseen by FIP. No other issues were raised in relation to the accounts and the committee recommended approval at the Private Board on 25th May.

5. FY 2017/18 Compliance

Waivers
The waivers were noted and clarity received in relation to any challenges.

Losses and Special Payments
Losses incurred were reviewed and mitigations for preventing in the future discussed.

Payroll Bureau Audit
The audit report was received and noted. There were no material concerns.

Conflict of Interest / Hospitality Register / Fit and Proper Persons
The information was received by the committee. There were no material concerns.

6. Internal Audit

Head of Internal Audit Opinion
The committee discussed and noted the opinion of internal audit and the work on which it was based. The opinion was split into two: business areas excluding Cyber Security were assessed as generally satisfactory, with some improvements required; and Cyber Security where the healthcheck identified major improvements required.

In relation to Cyber Security good progress has since been made to address these weaknesses and the committee is monitoring progress closely.

Final IA Reports
The committee received final reports for pharmacy purchasing and inventory audit, delivery of the corporate plan and A&E Activity. There were no critical risks identified and assurance is being provided to COSQ in relation to the A&E Activity actions.

Follow up
Ongoing follow up activity is planned, including for medical devices and cyber security,

the next formal follow up update will be in September 2018.

Internal Audit Plan 2018/19
It was recommended by the committee that the Board approve the draft plan following input and review from other sub committees and the Executive team.

7. Counter Fraud

Annual Report
Progress is being made against all 4 Key Principles including by utilisation of the Fraud Risk Group.

Annual Counter Fraud Plan 2018/19
The final plan was discussed and agreed noting the Anti-Fraud standards set by NHSCFA in February 2018.

8. Board Secretary Report

Risks and Assurance Framework (AF)
The committee recommended amendments in relation to the estates review for the risk register and assurance framework.

Provider Licence Review
The annual review of the Provider Licence was presented, discussed and noted.

Standing Orders
Minor amendments were made to the Standing Orders and the removal of the full tender process was agreed, being covered by reference to the recently updated Scheme of Delegation. Agreed that FIP will lead on a more detailed review of Standing Orders with the committee to agree the output.

9. Board Sub-Committee updates

Updates were received from the sub-committees and further assurances requested in relation to:
- Improving the CQUIN reporting to be aware of any risks to achievement

10. Audit Committee report to the Board/Governors

The report was agreed.

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

BOARD OF DIRECTORS

Agenda item	12	**Category of Paper**	Tick
Paper Title	Charitable Funds Committee Reports to Board of Directors	**To action**	☐
Date of Meeting	20th June 2018	**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 20th June 2018
Links to Strategic Board Objectives	Objective 3 – Implement our Strategic Plan Objective 4 – Develop all Staff to Maximise Their Potential Objective 5 – Optimise our Financial Position
Links to Regulations/ Outcomes/External Assessments	Links to NHS Improvement in relation to the Trust Governance Framework and the Charity Commission
Links to the Risk Register	N/A

PURPOSE OF THE REPORT

To update the Board of Directors on the findings and approval of the Charitable Funds Committee held on 20th June 2018

SUMMARY/CURRENT ISSUES AND ACTION

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

- Charity Commission update for Trustees on disqualification criteria
- Minutes approval for two extraordinary meetings, held 25 April and 2 May 2018
- Feedback from previous support given by Charitable Funds to projects
- Amendment to Terms of Reference (TOR) for Independent Chair / Vice Chair
- Finance Update including report on the General Fund
- Investment Management Update
- Fundraising Team update
- Bids for Approval- *presentation of bids and decisions made*

ACTION REQUIRED

Board to ratify Mr Cliff Bygrave as the Trust Independent Chair of the Charitable Funds Committee and confirm the vice chair.

Public Meeting ☒ Private Meeting ☐

CHARITABLE FUNDS COMMITTEE REPORT

TO BOARD OF DIRECTORS

1. Introduction

This Report updates the Board of Directors regarding the matters discussed at the Charitable Funds Committee on the 20th June 2018.

2. Conflicts of Interest:

A dual interest for the committee members for the Trust and Charitable Funds

3. Matters Arising

- Charity Commission update for Trustees on disqualification criteria
- Minutes approval for two extraordinary meetings, held 25 April and 2 May 2018
- Feedback from previous support given by Charitable Funds to projects
- Amendment to Terms of Reference (TOR) for Independent Chair / Vice Chair
- Finance Update including report on the General Fund
- Investment Management Update
- Fundraising Team update
- Bids for Approval

Charity Commission update for Trustees on disqualification criteria
The Committee agreed that David Carter would be able to sign the new Charity Commission disqualification criteria on behalf of the Corporate Trustee.

Minutes approval for two extraordinary meetings, held 25 April and 2 May 2018
The Committee agreed the decisions made (in line with a quorum process) to ratify the minutes.

Feedback from previous support given by Charitable Funds to projects
The Committee received thanks for previous support from Charitable Funds for the Patient essential care packs, and maternity murals.

Amendment to Terms of Reference (TOR) for Independent Chair / Vice Chair
The committee agreed to amend the Terms of Reference to reflect an independent Chair could be nominated by board. The Chair asked the committee if they would support him continuing as Chair, it was agreed they would, however in line with the new clause this would need to be presented at a board meeting for ratification. It was also agreed that the decision of Vice Chair would need to be considered at this time.

Finance Update including report on the General Fund
A report was issued to update the Committee about the charity's general fund. Committee agreed that the Chair and Andrew would review the accounts on behalf of the Chartable Funds Committee prior to audit and distribution. It was agreed to review the reserves policy at the next meeting. The committee also agreed to recognise on-going commitments as an annual commitment within the accounts.

Investment Management Update
The Committee received an update that we are in the process of moving the investment portfolio from Quilter Cheviot to Waverton Investments. An update on current investments was given. The Committee reviewed the charity questionnaire from Waverton Investments and recommendations from Finance.

Fundraising Team update
A report was given to the Committee updating them about progress on specific fundraising projects such as the Paediatric Oncology Rooms Project and the Helipad Appeal. The report also highlighted that for the period 1st April and 15th June, the charity has received 275 donations totalling £146,000.

Bids for Approval of funding
The Committee agreed to fund:

- An allocation of up to £25,000 inclusive for the Open Spaces bid. Part of the agreement was for Simon Linnett and David Carter to meet with Kate Hayhurst from Estates to reshape the proposal around costing and plants used.

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

BOARD OF DIRECTORS

Agenda item	13	**Category of Paper**	Tick
Paper Title	Hospital Redevelopment Report	**To action**	☐
Date of Meeting	25 July 2018	**To note**	☒
Lead Director	David Carter, 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, 20 June 2018 The Redevelopment Programme Board will meet again on 18 July 2018	
Links to Strategic Board Objectives	Objective 1 – Deliver the Quality Priorities Objective 3 – Implement our New Strategic Plan Objective 5 – 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.
The capital application for the Acute Services block will be submitted through the BLMK STP in July.
Work to refurbish Arndale House to provide accommodation for the Sexual Health Services team, Dermatology and Phlebotomy has been completed.
Refurbishment of the MRI suite is in progress. The new MRI machine has been commissioned. Work on the refurbishment of the existing scanners is underway.
Design of the works to upgrade the HV supply and increase standby generation coverage has started.
A tender exercise to identify a partner to develop the proposed Energy Centre has been completed. A recommendation will be submitted to the Board in July.
Construction of the new endoscope decontamination facility is underway.
A proposal to provide two additional temporary theatres and associated recovery areas will be submitted to the Board in July.
A Strategic Outline Case for refurbishment of the Medical Block will be submitted to the Board in September.

ACTION REQUIRED

The Board is requested to note the report.

Public Meeting ☒ Private Meeting ☐

REDEVELOPMENT PROGRAMME BOARD REPORT
25 July 2018

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 20 June 2018, and is scheduled to meet on 18 July.

The Terms of Reference for the Board were reviewed at the meeting on 20 June, and will be tabled for approval on 18 July.

3. Main scheme

The Trust will submit a capital bid via the BLMK STP to enable the delivery of the Acute Services Block. This is a key part of the redevelopment plan.

4. Enabling schemes

MACE have been appointed to develop the design and manage the procurement and implementation of critical upgrades to the High Voltage electrical infrastructure on the site. This will deliver a substantially increased level of resilience on the site, and will address some of the key risks on the Trust's risk register. Work will commence at the end of 2018.

The fitout work at Arndale House in Luton to provide accommodation for the Sexual Services team, the Dermatology service and a substantial part of the Phlebotomy service is now complete. Services commenced as planned on 29 May.

Completion of the transfer to Arndale House will enable a number of key moves on the site to support delivery of additional outpatient services. A contractor has been appointed to deliver the new Pre-assessment hub, works in outpatients and the upgrade of two oncology treatment rooms in Paediatrics. The latter scheme is supported by Charitable funds. A contractor will be appointed in July to deliver the works required in COMET to support Training and Development activity.

MRI3, the new MRI scanner, has been commissioned and brought into service. The activity is now focused on the upgrade to MRI2, one of the existing scanners.

Construction of the endoscope decontamination unit is underway. Work will be completed in December.

A proposal to construct two new temporary theatres and associated recovery areas will be submitted to the Redevelopment Board in July. The aim is to complete this project by the end of the winter.

A Strategic Outline Case for the refurbishment of the Medical Block is being prepared. This will be submitted to the Board in September.

5. Energy Centre

The tender exercise to identify a partner for the delivery of the proposed Energy Centre on the site has been completed. A recommendation for the appointment of a Preferred Partner will be submitted to the Board in July.

6. Programme Risk Register

The risk register was reviewed in support of the work to provide an update of the Outline Business Case.

7. Future activity

There are a number of major schemes underway at present. These are all important projects to support the redevelopment of the site, and to address short term capacity constraints.

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

BOARD OF DIRECTORS

Agenda item	14	**Category of Paper**	Tick
Paper Title	Risk Register	**To action**	☐
Date of Meeting	25th July 2018	**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 23rd May and 27th June 2018. Executive Board 24th July 2018
Links to Strategic Board Objectives	Objective 1 – Deliver the Quality Priorities Objective 2 - Deliver National Quality and Performance Targets Objective 3 – Implement our Strategic Plan Objective 4 – Develop all Staff to Maximise Their Potential Objective 5 – 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

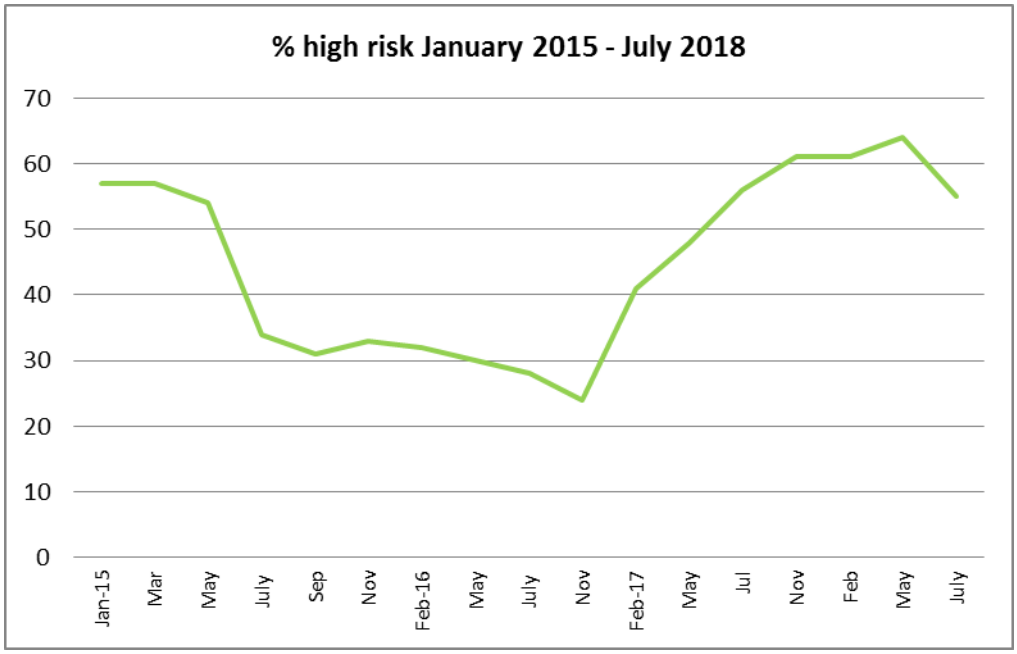
ACTION REQUIRED

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 27 Board Level Risks on the Risk Register. 55% 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 2nd May 2018.

Risk ref	Risk Description	Agreed conclusion
	Hospital Re-Development Risks	Review Risks
1211	Backlog Maintenance	Increase risk
1253	Needs Based Care	Maintain risk – review rating

Emerging risks identified – CQUIN attainment.

Clinical Outcome, Safety and Quality Committee (COSQ)
COSQ reviewed clinical board level risks on the 23rd May and 27th June 2018.

Risk ref	Risk Description	Agreed conclusion
650	Bed pressures	Maintain risk
1213	Management time and capacity	Maintain risk and review
1018	HSMR	Maintain risk
796	Patient Experience	Maintain risk
1200	Cyber security	Review risk with a view to reduce
669	Appraisal	Maintain risk

Emerging risks identified - Transport, Grow Scans and their provision, Mount Vernon capacity, Stroke SNAPP and Follow Up.

Executive Board Review
The Executive Board reviewed all Board Level Risks on the 24th July 2018.

Risk Review

38 new risks were reviewed and approved between 21st April 2018 and 16th July 2018 five were allocated as Board Level.

- 1335 - Fragility of the Head and Neck service and potential impact on 62 day cancer target
- 1337 – Service and Reputational risk of the stroke pathway attainment and SSNAP data
- 1353 – Clinic Capacity at Mount Vernon
- 1354 – Quality indicator achievement of CCG contract
- 1355 – Transport
- 1356 - Agency Costs 2018/19
- 1357 - Non-Achievement of Finance Target 2018/19
- 1358 - Achievement of the STP control total 2018/19
- 1359 - CQUIN attainment 2018/19

22 risks were closed, two at Board level:

1178 – 17/18 Finance target
1212 – 17/18 Agency Cost target

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

BOARD OF DIRECTORS

Agenda item	15	**Category of Paper**	Tick
Paper Title	Board Secretary Report	**To action**	☐
Date of Meeting	25 July 2018	**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	NHSI 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
- Non-Executive Directors
- Terms of Reference

ACTION REQUIRED

Board are asked to:

- Note the progress with Non-Executive Director recruitment
- Ratify the Terms of Reference approved by the Sub-Committees

Public Meeting ☒ Private Meeting ☐

1. Council of Governors

There are currently three vacancies on the Council of Governors

1) Bedfordshire CCG
2) Luton CCG
3) Hertfordshire Valley CCG
4) University College of London

There is currently an election for 8 public governor vacancies; (3 Luton, 3 Bedfordshire and 2 for Hertfordshire) that will be completed by August 2018.

A number of staff governor positions were elected unopposed. These are detailed below.

Name	Elected	Representing Constituency	Term of office
Belinda Chik	Re-elected Unopposed	Representing Constituency 'Nursing, HCA & Midwifery'	September 15 to September 21
Ann Williams	Re-elected Unopposed	Representing Constituency 'Nursing, HCA & Midwifery'	September 15 to September 21
Cathy O'Mahony	Re-elected Unopposed	Representing Constituency 'Professional & Technical'	September 15 to September 21
Janet R Graham MBE	Re-elected Unopposed	Representing Constituency 'Volunteers'	September 15 to September 21
Annah Saleem	Elected Unopposed	Representing Constituency 'Admin, Clerical & Management'	September 18 to September 21

No candidates came forward for Ancillary and Maintenance therefore we are currently carrying a vacancy. This will be reviewed as part of the Governor Constitutional Working Group.

2. Members

The Medical Lecture in April 2018 focused on Dementia and Dementia Care and was the most popular medical lecture the Trust has undertaken. The next medical lecture is on the 12 October 2018 and will focus on respiratory care.

The next Ambassador magazine will be issued to members in August 2018 and will invite members to the Annual Members Meeting on the 5th September 2018.

4. Non-Executive Directors

A process, managed by the Council of Governors, is in progress to recruit two Non-Executive Directors. One will have an Audit Committee/financial background and the other we are looking for capital and IT experience.

The process is currently at interview stage and will be completed by the end of July 2018.

5. Terms of Reference

The following Sub-Committees of the Board of Directors reviewed and approved their Terms of Reference in June 2018 (Appendix 2):

Charitable Funds Committee
Hospital Re-Development Committee

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

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

CLINICAL EXCELLENCE, QUALITY & SAFETY

TERMS OF REFERENCE

CHARITABLE FUNDS COMMITTEE

Status:	Sub-committee of the Board of Directors
Chair:	Board Nominated Chair If the Board Nominated Chair is unavailable, the meeting will be chaired by a Non-Executive Director elected as the vice-chair of the Charitable Funds Committee.
Membership:	All voting members of the Board of Directors Independent Chair
In Attendance:	Head of Financial Control Fundraising representative Board Secretary (as required) Representative from Investment Advisors (as required)
Meeting Frequency:	Meetings shall be held not less than 4 times a year.
Meeting Management:	Agenda to be agreed by the Chair and agenda and papers to be circulated 5 days before the meeting, unless by exception and agreed with Chair of meeting in advance.
Extent of Delegation:	The Charitable Funds Committee is a formal sub-committee of the FT Board of Directors and complies with the Standing Orders and the Scheme of Delegation. The Trustee has delegated authorities for expenditure from charitable funds, both designated and restricted, which are shown below: • Up to £5000 per request Fund Advisor • Up to £25,000 per request Chairman and Finance Director • Over £25,000 per request Charitable Funds Committee either at a regular meeting or a meeting especially called for that purpose
Authority and Chairs Action:	The Board Nominated Chair is, on an exceptional needs basis, granted delegated authority to make decisions on time critical issues arising between planned meetings of the Charitable Fund up to a threshold of £25k. Whenever such powers are exercised a full report explaining why such a necessity arose and exactly what action was taken, is to be made to the next quorate meeting.

In the Chair's absence, the Director of Finance along with the Vice-Chair of the CFC can approve bids upto the threshold of £25k.

Quorum: 3 Non-Executive Directors and 2 Executive Directors

Accountability: The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other professional advice and secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Reporting: The minutes of the Charitable Funds Committee meetings shall be formally recorded.

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

Objectives: The committee will ensure effective internal control including the management of the Charitable Trust's activities in accordance with laws and regulations, and the establishment and maintenance of controls designed to give reasonable assurance that assets are safeguarded, waste and inefficiency avoided, reliable information produced and that value for money is continuously sought.

- To manage the affairs of the charitable funds within the terms of the declaration of Trust and appropriate legislation and ensure statutory compliance with the Charity Commission regulations - including annual reporting to the Charity Commission.
- To act on behalf of the Trust in satisfying the duties and responsibilities of trustees in managing the funds.
- To ensure funding decisions are appropriate, consistent with the hospital's objectives and provide added value and benefit to the patients and staff of the Trust, above those afforded by the Exchequer funds.
- To approve the Annual Report and Accounts.
- To set investment objectives to be followed by the investment fund manager and monitor the investment performance of the funds.
- To review and monitor the activities of the Charity and receive regular reports on the performance of charitable fundraising activities.
- To ensure the implementation and adherence to appropriate, procedures and policies which ensure that accounting systems are robust, donations received and coded as instructed and that all expenditure is reasonable and clinically and ethically appropriate.

- The Committee may invite specialists to provide information or advice as required.
- To respond to the recommendations made in papers submitted to the Committee.

Members Responsibilities:

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

2. Individual members are expected to act in the interests of the Charitable Trust not necessarily in the interests of the Board.

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

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

Workplan:

Each meeting:

- Update report from Fundraising Team
- Submitted bids to the Charitable Funds Committee
- Update report from Investment Advisors (as required)
- General Fund report including review of successful bids implementation (as required)

Annually:

- Annual Report & Accounts
- External Audit report
- Overview of the Activities for the year
- Dormant Fund Review
- Terms of Reference Review
- Post investment review of the General Fund commitments

Agreed June 2018

To be reviewed by end June 2019

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

CLINICAL EXCELLENCE, QUALITY & SAFETY

TERMS OF REFERENCE

HOSPITAL REDEVELOPMENT PROGRAMME BOARD

Status:	Sub-committee of the Board of Directors
Chair:	Chairman
Membership:	Chief Executive Non-Executive Director x 2 Deputy Chief Executive Director of Finance Chief Nurse Programme Director Director of Estates and FM Deputy Programme Director Medical Director (nominated by Chief Medical Advisor)
In Attendance:	Governors x 2 Members of the Programme Team (by invitation) Professional Advisors (by invitation)
Meeting Frequency:	Monthly
Meeting Management:	Agenda to be agreed by the Chair and agenda and papers to be circulated 5 days before the meeting, unless by exception and agreed with Chair of meeting in advance.
Extent of Delegation:	The Programme Board is a formal sub-committee of the FT Board of Directors and complies with the Standing Orders and the Scheme of Delegation. Members of the Committee may nominate an alternate to act on their behalf subject to prior consent from the Chairman.
Authority and Chairs Action:	The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other professional advice and secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. The Chairman, as Chair of the Hospital Redevelopment Programme Board is, on an exceptional needs basis, granted delegated authority to make decisions on time critical issues arising between planned meetings of the Programme Board.

Whenever such powers are exercised a full report explaining why such a necessity arose and exactly what action was taken, is to be made to the next quorate Programme Board.

Quorum: 50% of membership, to include 1 Non-Executive

Accountability: The Chair of the Hospital Redevelopment Programme Board, along with the Programme Director, will maintain a direct link from the Programme Board to the FT Board of Directors providing a report and assurance of the effectiveness of the Programme Management delivered by the Trust.

The Programme Director will report to the Chief Executive and report progress to the formal Executive and FIP meetings on a monthly basis and to any other formal Committee as required

The Lead Governor will ensure the Council of Governors are kept fully appraised of the programme's progress and that opportunities for Governor participation are fully utilised.

Reporting: The minutes of the Hospital Redevelopment Programme Board meetings shall be formally recorded and approved by the Programme Board.

A report shall be made to the next Board of Directors meeting which summarises the discussions held at the Programme Board and which identifies issues which need to be considered by the Board of Directors.

The report shall give details of the action or improvement that is needed for the Board of Directors to approve.

Objectives:

1. ***To oversee:***
    a. the development of proposals for the redevelopment of the Hospital within defined parameters of time, cost and to the required quality and specification.

2. ***To review and quality assure:***
    a. the development of Business Cases for proposed schemes for submission to FIP on behalf of the Board of Directors.

3. ***To ensure:***
    a. the cost implications of redevelopment proposals are fully set out within robust financial plans and that these remain within the Trust's capital plan.
    b. development meets the highest possible standards of design in respect of clinical use, patient and staff environment and architectural merit.

4. ***To receive***:
    a. reports on existing and planned expenditure from the Programme Director.

5. ***To receive assurance:***

a. that effective project management systems and resources are in place to deliver projects successfully,
b. that there is an effective risk management system in place and regular reports on the risks and issues are submitted to the Programme Board,
c. that suitable mechanisms are in place to minimise the disruptive effects of works on the smooth running of the Trust, its staff, patients and visitors.

6. ***To approve and monitor ongoing progress of:***
   a. Project Plans which will include:
      i. Objectives
      ii. Key Milestones and Delivery Programme
      iii. Resource Plan
      iv. Process and performance monitoring arrangements and key deliverables
   b. the recommendations submitted to FIP and the Trust Board
   c. the Communications Strategy so as to ensure all stakeholders, such as patients, staff, public, Governor's and partner organisations, are kept informed and involved throughout the process.
   d. the appointment of all external project advisors and contractors.
   e. all project documentation prior to submission to the Board of Directors.
   f. all procurement documentation as required.

Programme Board Members Responsibilities:

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

2. To set targets and agree control systems to ensure delivery of the stated objectives of the Hospital Redevelopment Programme, in particular by agreeing the following at commencement of the Programme:
   a. The initial schedule of Projects forming the Hospital Redevelopment Programme
   b. Agreeing Project Management structures for each Project within the Hospital Redevelopment Programme
   c. Agree Resource Plans and budgets for all Projects forming the Hospital Redevelopment Programme. Once a Project resource plan is agreed the Project Team shall have authority to commit resources in line with the individual elements of those resource plans. Reports on resource commitment will be made at each Hospital Redevelopment Programme Board meeting by the Programme Director.
   d. Agree the key expected benefits and required deliverables for each Project within the Hospital Redevelopment Programme
   e. Agree the dependency "map" for the Hospital Redevelopment Programme
   f. Agree responsibilities and objectives for Programme

Director

g. Agree an initial Project prioritisation

3. To establish and maintain links with other bodies such as local CCGs, Local Council, Ambulance Service and other Trusts, Social Services etc where Services are affected by or potentially impacted the Hospital Redevelopment Programme or a constituent Project.

Workplan:

Each meeting:

- Highlight reports from each project
- Key project and financial milestones and progress review
- Risk register related to hospital redevelopment and items for escalation

Every four months

- Review against the Trust Objectives related to hospital redevelopment

Annually

- Review of the Terms of Reference

Agreed on 14th January 2015

Board ratification on the 22nd July 2015

To be reviewed by the end of January 2016

Reviewed at the meeting on 13th January 2016

Approved at the meeting on the 17th February 2016

Updated for meeting on 18th July 2018