Luton & Dunstable University Hospital
Board of Directors

Board of Directors

COMET Lecture Theatre

31 July 2019 10:00 - 31 July 2019 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 1 May 2019 (attached) To approve 3 Minutes Public Board meeting 010519 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 Proposed Merger Update 010519.docx 15	D Carter	10.25
7	Executive Board Report (attached) To note 7 Executive Board Report July 2019.doc 17	D Carter	10.30
8	Performance Reports To note 8 Performance Reports Header.doc 65		
8.1	Quality & Performance 8.1a Q and P Exec Summary.doc 67 8.1b Quality Performance Report Q1 Apr May June... 71	L Lees/C Jones/C Thorne	10.45
8.2	Finance 8.2 Finance Report.doc 103	M Gibbons	10.55

#	Description	Owner	Time
8.3	Workforce 8.3 Workforce Boardreport_July 2019_v3.pptx 115	A Doak	11.05
9	Clinical Outcome, Safety & Quality Report To note 9 COSQ Report Apr May Jun.doc 121	A Gamell	11.15
10	Finance, Investment & Performance Committee Reports (to follow) To note 10 FIP Report to July 2019 Trust Board v2.docx 127	I Mackie	11.25
11	Hospital Re-Development Committee Reports (attached) To note 11 Hospital Redevelopment Report - July 19.doc 135	M Prior	11.35
12	Charitable Funds Committee Reports (attached) To note 12 Charitable Fund Board Report July 2019.doc 139	S Linnett	11.40
13	Audit & Risk Committee Report (attached) To note 13 Audit and Risk Committee Report May 2019.doc... 143	S Barton	11.45
14	Risk Register (attached) To approve 14 RR July 2019.doc 147	V Parsons	11.50
15	Board Secretary Report (attached) To ratify 15 Board Secretary Report - July 2019.doc 151 15.1 COSQ Terms of Reference reviewed March 2... 155 15.2 FIP Terms of Reference reviewed March 2019... 159 15.3 HRD Terms of Reference - updated February... 163 15.4 Audit and Risk ToR reviewed February 2019.d... 167	V Parsons	11.55

#	Description	Owner	Time
16	Details of Next Meeting: Wednesday 6th November, 10.00am in COMET Lecture Hall		
17	Close		

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LUTON & DUNSTABLE UNIVERSITY HOSPITAL

BOARD OF DIRECTORS

Agenda item	3	**Category of Paper**	Tick
Paper Title	Minutes of the Meeting held on Wednesday 1 May 2019	**To action**	☒
Date of Meeting	31 July 2019	**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 1 May 2019

Present:
Mr Simon Linnett, Chairman
Mr David Carter, Chief Executive
Ms Cathy Jones, Deputy Chief Executive
Ms Angela Doak, Director of Human Resources
Mr Matthew Gibbons, Acting Director of Finance
Ms Liz Lees, Chief Nurse
Ms Catherine Thorne, Director of Quality
Mr David Kirby, Associate Medical Director (for Dr D Freedman)
Ms Alison Clarke, Non-Executive Director
Dr Vimal Tiwari, Non-Executive Director
Mr Mark Versallion, Non-Executive Director
Mr Simon Barton, Non-Executive Director
Mr Denis Mellon, Non-Executive Director
Mr Mark Prior, Non-Executive Director

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

1. CHAIRMAN'S WELCOME & NOTE OF APOLOGIES

The Chairman opened the meeting, noting it was a meeting in public and that questions (other than points of clarity), would be taken at the conclusion of the agenda. The Chairman welcomed D Kirby, attending on behalf of D Freedman.

Apologies were noted from D Freedman.

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 6 FEBRUARY 2019

Changes/errors were identified as follows:

Pg 6, Q 1 – 'governor' should read 'member of the public'

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

Proposed: VT **Seconded: AC**

4. MATTERS ARISING (ACTION LOG)

There were no matters arising.

5. CHAIRMAN'S REPORT

The Chairman recorded congratulations for an overall outstanding performance, particularly over the winter. He stated his keenness for L&D to become even more embedded in the community, noting good responses to the helipad appeal and the works completed by local tradesmen on the new accommodation. The Chairman reported that the Trust is considering the introduction of a new sub-committee of the Board, a Workforce Committee.

6. MERGER UPDATE

D Carter reported little change since the last report. Other funding options are being explored and dialogue is underway with DoH. The Trust continues its work to bring together Pathology services across L&D and Bedford Hospital with an MD appointed to run that work and the joint service. M Versallion voiced that the L&D not being granted capital to begin the merger probably reflects the state of the NHS in other areas.

7. EXECUTIVE BOARD REPORT

D Carter presented the report, highlighting the following:

NHS Access standards – the most significant change is the indication to move away from the 4 hour emergency care target. The national steering committee has good representation from L&D, we are assured that our voice will be heard and the new measures will be piloted in 2 waves of 6 week blocks with a gap between to enable review and refining. The aim of the Trust is to provide safe and accessible services, whatever the target is and however it is measured. V Tiwari observed that some Trusts take the 4 hour target as a 4 hour wait, noting that a lot of patients are in and out a lot quicker at L&D and do not wait. D Kirby added that in cases where children wait above 4 hours, it is largely due to a wait for a bed at a tertiary facility. D Kirby summarised that the first pilot would be within weeks or months, the second pilot later in the summer/autumn and envisaged that the revised standards are adopted, with all Trusts expected to work to them, by the end of the calendar year.

Medical Education – the project manager appointed to the surgical division is making good progress in shaping the way that L&D move forward, which is critical to ensure that the experience of trainees is good. There is a lot of work to promote anaesthetic training at the Trust and use of a real time app has been introduced to understand the mood rather than await survey results. C Jones and A Doak are taking a keen interest in Improving Surgical Training (IST) and Internal Medicine Training (IMT) in terms of doctors in post and the impact on the ability to deliver services.

Mortality – in response to a comment on the marked improvement, C Thorne felt that this was likely to be multi factorial. D Carter also felt that a number of actions are likely to have contributed. A Clarke added that there has been

more ownership of the actions and that the winter had not been so bad in terms of peaks in mortality. D Kirby added that activity is broadly the same as last year but use of contingency and overflow beds is significantly less, with senior medical staff seeing patients much earlier in their journey, along with slightly milder weather conditions.

Winter pressures and 'Super Stranded' Patients – C Jones outlined that the Trust's improved performance is due to an overall reduction in length of stay that that the Trust moves patients on much quicker, enabling contingency areas to be vacated within days this winter rather than in weeks or months. Needs based care is now established in Respiratory, is just underway in Cardiology and will be rolled out to Stroke, which will then cover approximately 75% of the daily take.

Nursing & Midwifery Staffing – L Lees outlined that this reflects the daily challenges the Trust has to respond to and the continued work on recruitment and retention. Fill rates are included in the report as L&D feel this is a useful indicator, although no longer reported to NHSI.

Management of CQUIN – C Thorne explained that CQUINs for next year are altered to be more relevant to the organisation and to give a good indicator of the service given to patients. A lot has been learned from the process and the intention is to have less 'reds' next year.

Compliance Issues – evidence was uploaded over the previous weekend in advance of the JAG visit in July. It was noted that this remains a risk for L&D.

GDE – P Graves reported that a supplier has been appointed for the Inpatient Care Co-ordination workstream. The Chairman voiced concern re the speed of systems currently. P Graves responded that there is 18 months to the end of the programme but that improvements should be seen by the end of the year. The Chairman reported that the MSC had raised the question of training in the use of these platforms. P Graves assured him that investment will be made in sufficient training for users, noting that data collection will become much easier once all systems are connected.

Information Governance Quarterly Report – P Graves advised that this is contractually reviewed since GDPR, with no concerns raised and using external reviewers and experts to ensure validity of the report.

Cancer Reallocation Rules – C Jones outlined the new cancer diagnosis standard and changes in the way breaches are allocated on 'two provider' and 'three provider' pathways, with the latter being more complex. She noted that this year will also be a year of shadow monitoring the 28 day standard which will have a big impact on L&D's histopathology service.

Infection Control – L Lees explained the change in the way C.diff numbers will be counted and that the target for every organisation has gone up. The rationale is to have a system-wide approach. The guidance has changed and the process with community partners will need to be much more advanced.

Estates – attention was drawn to the deterioration in cleaning performance, where audits have been increased. It is hoped that with some effort from

them and with the new manager on site, they can get back to green and avoid penalties.

8. PERFORMANCE REPORTS

Quality & Performance Report – the Board acknowledged the report, highlights on the Quality section were presented by L Lees as follows:

L Lees outlined the change in the way the pressure ulcers are reported this year, with more being identified as 'device related'. In relation to falls, the new bed stock means that all patients have access to a low rise bed. There has been a focus on reducing falls but the Trust remains under the trajectory it has set itself. The cardiac arrest rate increased slightly during March which will be monitored, but analysis has shown nothing alarming. In relation to complaints, L Lees explained that Patient Affairs and Patient Experience have amalgamated into one team. There has been a focus on using PALS and clinical staff for resolution at the time issues are raised.

C Thorne highlighted the rise in incidents in March, which may be attributed to our encouragement to report these. Concentration is currently on incidents that remain open, with support being given to those involved. The Trust continues to meet its Duty of Candour compliance.

A Clarke added that the Trust continues to see an improvement in Fractured Neck of Femur and that COSQ would receive a full report in May.

C Jones commented on the Performance section:

The Trust is disappointed that the 18 week 92% standard was not met at the end of March although additional activity has had a good impact on those patients waiting between 14-18 weeks (the rising backlog). There is concern that outpatient waiting times have risen during March and April, but awareness that this is also the case in neighbouring Trusts. It is disappointing that the Stroke national audit rating dropped to 'C' due to bed pressures preventing patients getting to stroke beds within 4 hours. The model is being re-designed and whilst performance has improved, it is unclear whether we will achieve 'B' for the final quarter of 2018/19. Attention was drawn to the lowest level for 2 years of diagnostic breaches.

Finance Report – M Gibbons introduced the report, highlighting:

The Trust delivered the control total for 2018/19 allow access to £10.6m of sustainability funding and subsequent bonus monies amounting to £7.7m which is to be spent on capital, not revenue. It was acknowledge that all staff contributed to this achievement, but it does reflect an increased use of interim staff, where the Trust is above the NHSI plan. D Mellon mentioned the large projects that have been achieved and the good cash position at year end. M Gibbons clarified that end of year figures are subject to audit review.

Workforce Report – A Doak presented the report, highlighting:

With reference to nurse staffing, the Trust is aware of the need to focus on retention. In terms of medical recruitment, the Trust is moving towards a

better position with much more robust and proactive working and turnaround times reducing. Turnaround time for AHPs is much improved. In terms of sickness, the Trust is in the lower quartile in 'Model Hospital' measuring. There is a robust action plan in place to address mandatory training, with COSQ looking at the data on a monthly basis.

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

A Clarke took the report as read, noting that the focus going forward will be fractured neck of femur, statutory and mandatory training, bare below elbows and quality academy.

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

D Mellon took the report as read, acknowledging that this truly is the start of a difficult year.

11. HOSPITAL RE-DEVELOPMENT COMMITTEE REPORTS

M Prior presented the report, noting a lot of activity over the coming months, including completion of Theatres G & H on schedule, electrical infrastructure, which has encountered some non-critical delays, along with the evaluation of tenders for Lewsey Road car park.

12. CHARITABLE FUNDS COMMITTEE REPORT

S Linnett took the report as read, noting that there is a lot of work underway, notably the helipad appeal and most visible, the gala dinner on 18 May. He also highlighted the work of local tradespeople on the newly purchased parent's accommodation.

13. AUDIT & RISK COMMITTEE REPORT

S Barton presented the report, noting that whilst KPMG undertake the external audit work, the internal audit work assures the Trust that relevant controls are in place, noting that some business continuity work has been deferred.

14. RISK REGISTER

V Parsons drew attention to the 4 new Board level risks: Pathology Integration, Assessment of Ligature Points, 7 Day Services Audit and Fractured Neck of Femur, which were duly ratified by the Board.

15. BOARD SECRETARY REPORT

The Board Secretary took this as read, noting no areas for escalation.

ANY OTHER BUSINESS

No further business was raised.

S Linnett mentioned that a process is underway to recruit 3 NEDs to cover those approaching the end of terms, which may result in the Trust expanding its number of NEDs, as governors have identified 4 to replace the talents of those finishing. Thanks were recorded to D Mellon who had agreed to stay until the end of May. Thanks were also recorded to A Clarke who would be on annual leave in July. S Linnett noted the immense support he has had from Alison, from whom he has learned a lot, mentioning her discipline and ability to deal with anything.

QUESTIONS/COMMENTS FROM NON BOARD MEMBERS

The following questions/comments were raised by the audience:

1. Will there be multiple routes out of the site in terms of cloud computing in view of the reliance on external communications? P Graves responded that this is a relevant challenge and reassured the audience that we have had a review; our links are diverse and moving though different directions.

SUMMARY OF ACTIONS

To be made available after the meeting.

15. DETAILS OF THE NEXT SCHEDULED MEETING:

Wednesday 31 July 2019, 10.00am, COMET Lecture Hall

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	Proposed Merger Update	**To action**	☐
Date of Meeting	31 July 2019	**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

Following the announcement in September 2017 of the proposal to merge Bedford Hospital and Luton & Dunstable University Hospital (L&D) to create a single Foundation Trust, significant work has taken place to develop plans and review the Full Business Case (FBC) submitted to national regulators (NHS England / Improvement).

Alongside the submission of the FBC, the Trusts submitted a separate business case for capital investment, outlining the means by which the full benefits of the merger would be realised. Although there has been a delay in obtaining approval for this investment and no firm date yet proposed to create a single Foundation NHS Trust, the partnership approach established by the two hospitals continues with real progress made in exploring the opportunities this will bring such as developing collaborative working within Pathology and Information Management Technology (IMT) services.

Bedford Hospital published its Three Year Plan in July reaffirming its commitment to the merger as a strategic objective.

BOARD OF DIRECTORS

Agenda item	7	**Category of Paper**	Tick
Paper Title	Executive Board Report	**To action**	☒
Date of Meeting	Wednesday 31 July 2019	**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 – 23 July 2019		
Links to Strategic Board Objectives	All Objectives		
Links to Regulations/ Outcomes/External Assessments	CQC NHS Improvement 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.	Medical Education Update	- to note
2.	Complaints Board Update	- to note
3.	Mortality Board Update	- to note
4.	Nursing & Midwifery Staffing	- to note
5.	Management of CQUIN	- to note
6.	Equality, Diversity and Human Rights (EDHR) Annual Reports	- to note
7.	Winter Pressures and Super Stranded Patients	- to note
8.	18 Weeks	- to note
9.	Cancer Reallocation Rules and 28 Day Faster Diagnosis	
10.	Impact of Changes to Pensions Tax for Consultants	
11.	GDE Update	- to note
12.	Information Governance Quarterly Report	- to note
13.	Infection Control Report	- to note
14.	BLMK STP	- to note
15.	Freedom to Speak Up	- to note
16.	Interim NHS People Plan	- to note
17.	Estates & Facilities Update	- to note
18.	Communications & Fundraising Update	- to note
19.	7 Day Services	- to note
20.	Inpatient Experience Survey & Maternity Patient Experience Survey	- to note
21.	Policies & Procedures Update	- to note

ACTION REQUIRED

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

Public Meeting ☒ Private Meeting ☐

1. MEDICAL EDUCATION UPDATE

Performance and School visits:

GMC Survey 2019 – This was published at the beginning of July 2019. The Trust has some programmes and departments that need development but on the whole the survey report demonstrated that trainees rated the trust well on the question of overall satisfaction. Over the next few weeks I will be working with departments, training programmes where issues have been raised to responded to the survey with an action plan of the changes that need to be made.

School of surgery – Following the appointment of Heather Taylor as project manage the department have put in place changes outlined in the action plan and those needed for the transition into the Improved surgical training (IST) programme in August 2019. There is improvement in the departmental understanding of trainee/junior allocation, the establishment, rotas and educational needs. A phased approach is being used to gradually increase the number of juniors on the rota to meet all the requirement of changes and requirements for the introduction of IST. This realistically will not be in place until August 2020. The feedback from trainees currently is positive and they feel empowered in being involved in rota designs and future planning.

An updated action plan from the exploratory visit will be sent to the Head of Scholl/Deanery by 16/8/19 and will incorporate the actions that stemmed from the 2019 GMC trainee survey.

School of Anaesthetics – Higher anaesthetic trainees have been placed at the trust from August 2019. The department is working collaboratively with the Head of school (HoS), current trainees and the Deanery to promote anaesthetics training at the trust. The 2019 GMC survey was disappointing for the department but helps in identifying where there is still potential of improving the environment for trainee.

IMPORTANT: National changes planned in training from August 2019, the Exec and Board need awareness of these as there will be an impact on trainee numbers, rota design and educational elements:

Improving surgical training (IST) and Internal Medicine training (IMT). The Trust has set up working groups to establish National changes needed to trainee/junior doctor numbers and rota in readiness for the introduction of IST and IMT from August 2019. As outlined in previous reports these changes will impact on the number of juniors/trainees needed on the rotas to be compliant with IMT and IST.

2. COMPLAINTS BOARD UPDATE

The Complaints Board met on 19 June 2019 and received an update following the external review which was undertaken in January 2019. The Patient Affairs department has been rebranded to “Complaints Department”. Specialist complaints and PALS training has been developed and the Complaints Team are delivering this

training throughout the Trust. This will enhance the ability of staff to manage and resolve issues locally and prevent the current culture of defaulting to PALs.

The decision has been made that Complaints leads remain within Divisions. A standard operating procedure (SOP) is being developed with the aim of being in place by September 2019.

The Trust Complaints Policy has been approved. One of the key changes in the revised policy is reinvigorated timelines for complaints.

The Divisions presented thematic reviews, which mainly focussed on communication issues. All Divisions are being urged to be proactive in offering telephone or face to face conversations to address complaints wherever possible. The Chief Nurse set all Divisions a target to reach an overall 90% response rate by the end of August 2019 data.

3. MORTALITY BOARD UPDATE

As part of the on-going work of the Mortality Board, templates for divisional reports have now been completed to ensure consistent reporting. Additionally there has been a small reduction of deaths in the community which is the first ever decrease in population for Luton and the Mortality Board Chair and Quality Lead for the CCG are meeting to discuss further.

4. NURSING & MIDWIFERY STAFFING

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

5. MANAGEMENT OF CQUIN

The Trust is working to implement the National 2019/20 CQUINs *(please see table overleaf).* NHS England has prioritised quality improvements for this year's CQUINs which are aimed at fully embedding best practice (identified in NICE Guidance) to ensure long term sustainability across the NHS. The Trust has established a CQUIN programme board for oversight of the scheme.

The data for the first quarter will be uploaded to NHS England by the due dates which fall on 31st July (Antimicrobial scheme) and 16th August (remaining schemes). (Flu data will be due in March 2020.)

No	Scheme sub-part title	Key outcomes
1a	AMR - Lower Urinary Tract infection in older people	90% of antibiotic prescriptions for lower UTI in older people, meets NICE guidance NG109 and PHE diagnosis guidance (60-90%)
1b	AMR - antibiotic prophylaxis in colorectal surgery	90% antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose prescribed in accordance to local antibiotic guidelines - using NICE CG74 (60-90%)
2	Staff Flu Vaccinations	80% uptake of flu vaccine by frontline clinical staff between 1st Sept-28th Feb 2020 (60-80-%)
3a	Alcohol and Tobacco Screening	80% of inpatients (age 18+) admitted for at least 1 night who are screened for BOTH alcohol and tobacco (40-80%)
3b	Tobacco Brief Advice	90% smokers given brief advice including offer of NRT (50-90%)
3c	Alcohol Brief Advice	90% pts identified as drinking above low risk levels, given brief advice or specialist referral (50-90%)
4	Three high impact actions to prevent Hospital Falls	80% of inpatients (age 65+, admitted for 48hrs+) receiving key falls prevention actions: Lying and standing BP at least once; no hypnotics/antipsychotics/anxiolytics OR documented rationale; mobility assessment within 24hrs of admission to inpatient unit which states aid not required or the walking aid is provided within 24hrs of admission (25%-80%)
5a	Same Day Emergency Care - Pulmonary Embolism (PE)	75% patients with confirmed PE are managed in same day setting where clinically appropriate - NICE CG144 (50-75%)
5b	Same Day Emergency Care - Tachycardia with Atrial Fibrillation (AF)	75% patients with confirmed AF are managed in same day setting where clinically appropriate - NICE CG180 (50-75%)
5c	Same Day Emergency Care - Community Acquired Pneumonia (CAP)	75% patients with confirmed CAP are managed in same day setting where clinically appropriate - NICE CG191 (50-75%)

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

The Trust's Annual Equality Reports for year ending March 2019 will be considered by the Executive for approval prior to publication on the Trust website August 15th 2019. These include Annual Equality Information Reports for (1) Patients and (2) the Workforce and also (3) the Workforce Race Equality Standard (WRES) and (4) the new Workforce Disability Equality Standard 2019, along with a Supplementary WRES Report for the Trust with Local and National Results comparison which shows the Trust's position.

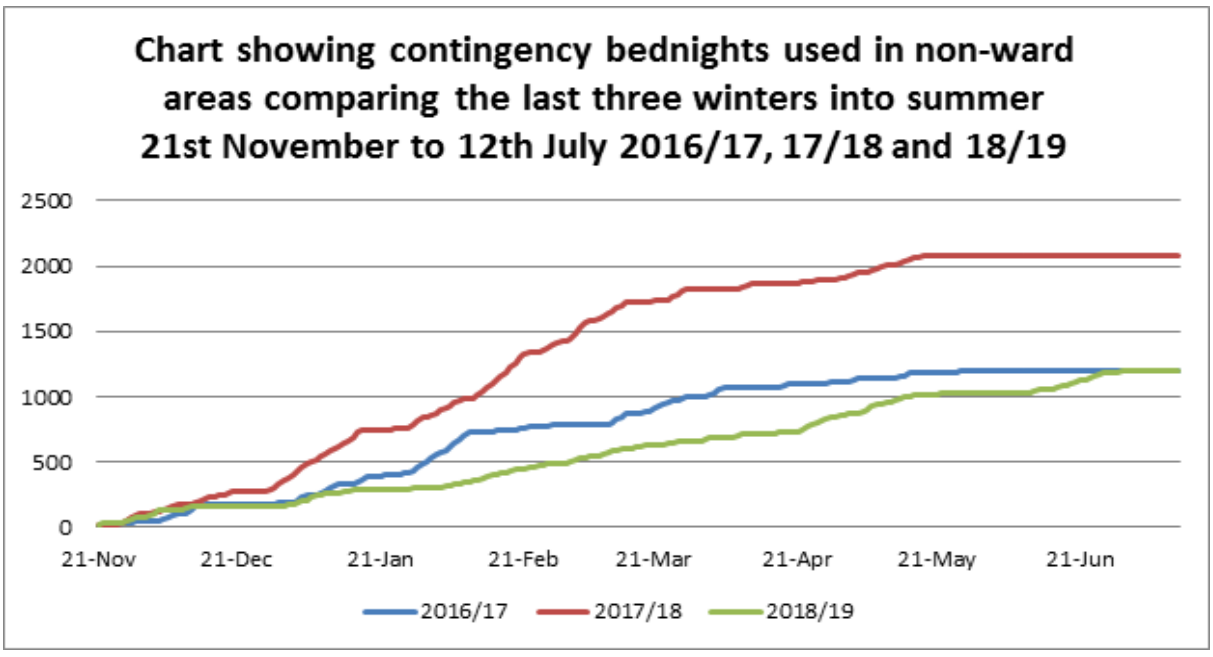
The Trust's 2nd Gender Pay Gap Report (for data year ending March 31st 2018 and published March 30th 2019 in line with statutory requirements) is available via the following link: https://www.ldh.nhs.uk/wp-content/uploads/2019/03/190321-Final-Gender-Pay-Gap-Report-2019-on-March-2018-data-V2.pdf

Preparations are underway early for the 3rd Gender Pay Gap Report for data year ending March 2019 so that any concerns can be shared and addressed before the publication deadline of March 30th 2020.

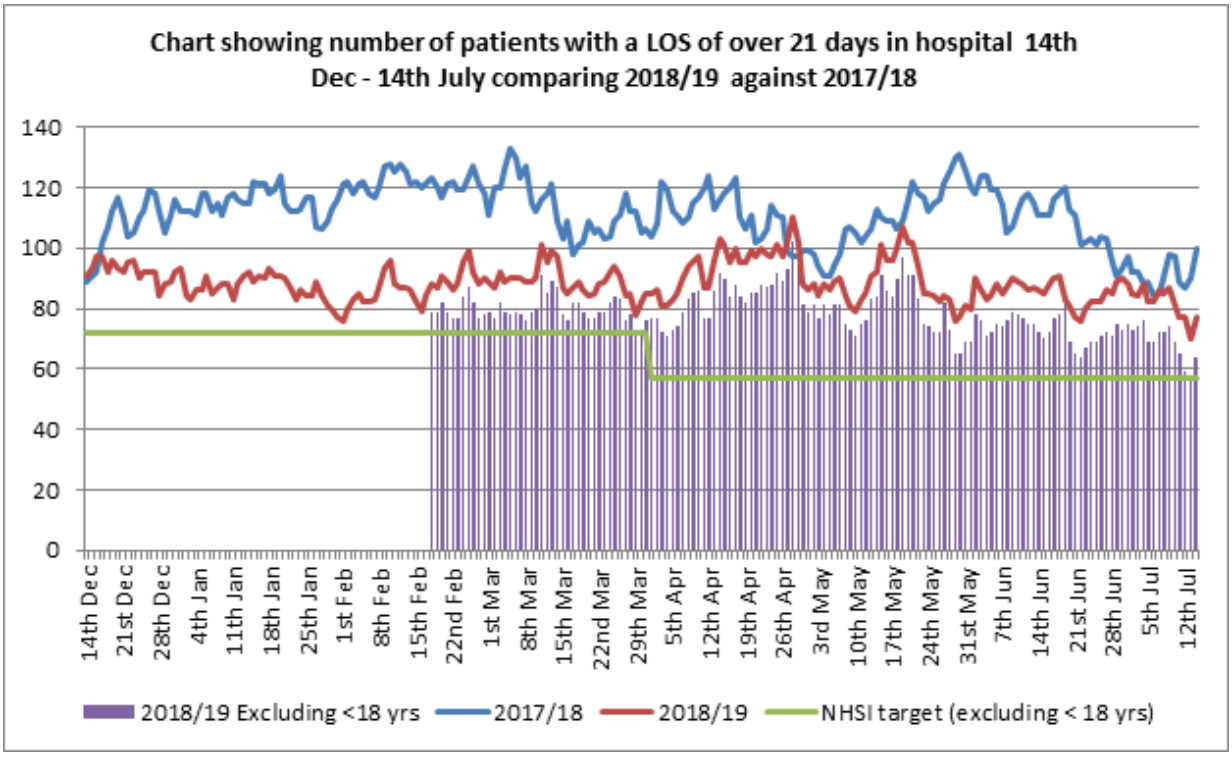
7. WINTER PRESSURES AND SUPER STRANDED PATIENTS

The first quarter's emergency activity has been high for the time of year, with non-elective discharges 8.6% higher than in Q1 2018/19 (based on initial month end count). This is significantly above the plan we have set with commissioners and is causing continued pressure on contingency beds with Ward 5, the winter ward, remaining open past the expected closure date in May, and contingency bed usage throughout June and into July.

Compared to winter 2017/18 the Trust has continued to perform well on outlier bed use, although the gap has reduced somewhat. However when comparing to the winter of 16/17 we can see that there has not been much change in the cumulative July position; whereas the recent winter was much better in terms of outlier bed days, May and June 2019 have seen significant contingency bed use that was not a feature of the previous two years.



The number of super stranded patients (those staying more than 21 days in hospital) has continued to reduce, and the latest data is showing that there was a strong reduction at the end of quarter 1 following some challenges around the Easter period. The purple bars in the chart below show that we met the 2019/20 set by NHSI for the first time in the 2nd week of July 2019, with the lowest ever number of super-stranded patients at 57 on the 13th.



8. 18 WEEKS

The Trust has still not been able to deliver the expected improvement in performance to above 92% for the 18 weeks referral to treatment time target at the end of June 2019, with a month end performance of 91.14%. Ongoing capacity challenges are being exacerbated by the consultant pension issues which have resulted in a reduction in extra sessions carried out in month. This is expected to worsen the position significantly over coming months (see section 10 on pensions for further detail).

9. CANCER REALLOCATION RULES AND 28 DAY FASTER DIAGNOSIS

Further to the summary provided in the previous quarter's report explaining re-allocation, April and May 2019 have seen a significant increase in the number of breaches in which we were unable to meet the required timescale for diagnosis transfer to a treating provider, but treatment was delivered within the allocated window, thereby resulting in re-allocation of a whole breach to the L&D which would previously have been shared with another provider. The Trust was able to achieve the 62 day treatment target in May 2019 delivering performance at 85.2% against a target of 85%. The June position is not yet finalised, but is likely to be equally challenging in performance terms.

The 28 day diagnosis standard performance in May 2019 was 62.6%, with 320 patients out of 855 waiting longer than 28 days to receive their diagnosis. There is not currently comparable data from other trusts available to review, but we anticipate this performance to be above average. This standard is in shadow-monitoring for this financial year, and we expect to be advised of the target performance threshold for 2020/21 towards the end of this year.

10. IMPACT OF CHANGES TO PENSIONS TAX FOR CONSULTANTS

See attached paper submitted to the Board in June 2019 at **Appendix 2**.

11. GDE Update

Following the NHS Digital Health Check visit, there is more detailed work scheduled this month to confirm on the HIMSS Gap analysis and provide further assurances to NHS Digital on the gaps identified and approach of completing them on time by December 2020. There are workshops organised to agree the plan to execute these.

Bedford Fast Follower relationship will be strengthened in the coming months through shared senior resources between Luton and Bedford through regular workshops ensuring information and lessons learnt are shared by both sides and best practice encouraged.

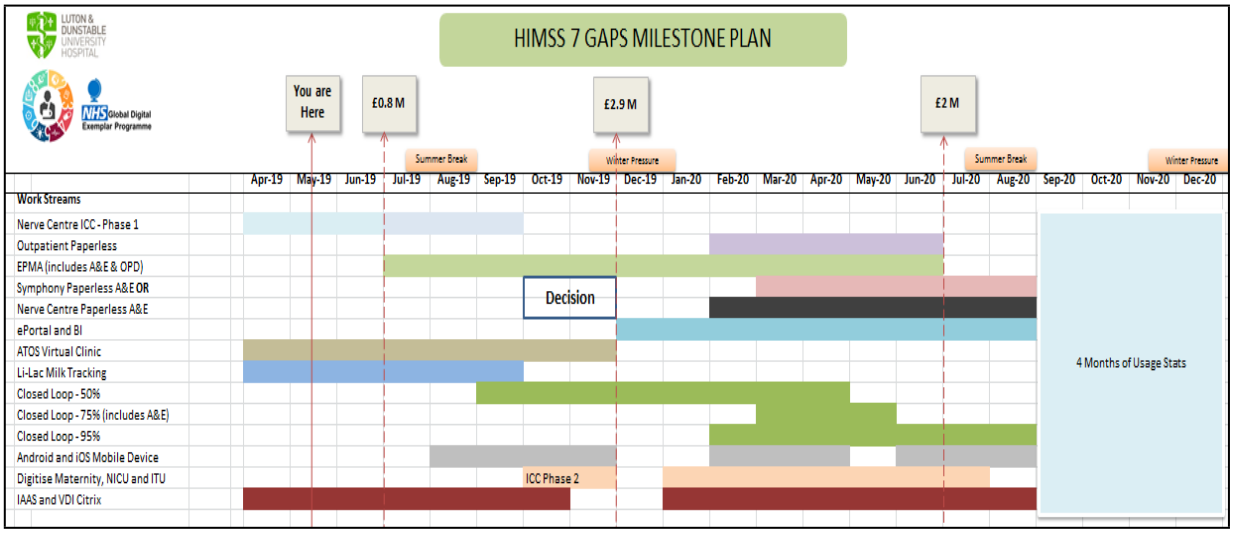
The GDE Programme is in implementation phase with multiple projects scheduled to Go Live in the next 6 months which include Refer to Pharmacy, Milk Tracking, Switchboard Upgrade, Virtual Clinic, and Inpatient Care Coordination (ICC), e-Forms, e-Referrals and IAAS Migration.

The ICC contract with NerveCentre was signed off in June and there has been back to back workshops organised to make progress in the implementation of ICC to the existing areas and currently the team are on track to deliver ICC in October 2019. Switchboard Upgrade is scheduled for 25th September Go Live. E-Forms and e-Referrals will be going live through a rolled out phased approach. IAAS Migration is scheduled to complete in October and Virtual Clinic, Milk Tracking and Refer to Pharmacy in September this year. The e-Portal and Business Intelligence tender was submitted in June and currently this is going through a procurement phase with implement plan scheduled from early next year.

Cranfield Innovation Centre reflects the innovative and creative nature of the GDE Programme which showcases the clinical environment such as Nursing Bay which is getting busier with more staff members and suppliers using the state of art facility with 7 pods now ready for suppliers. There are approximately 35 staff members that use Cranfield as its office site, and all supplier planning sessions are being conducted there.

As a GDE site the Trust is required to submit 6 Blueprints for technological change projects they have undertaken. We have successfully submitted 3; these are the Emergency Department process, Electronic Referral management and IAAS. The team are currently working on Virtual Ward and Milk Tracking for Blueprinting.

The GDE Programme Benefits RAG status is Green and currently benefits of Unified Communications, EDRMS, e-Pharmacy and DevOps are baselined and being monitored. There is further work to be carried out in benefits of ICC, e-Portal and Milk Tracking and also putting benefits governance in place.



12. INFORMATION GOVERNANCE QUARTERLY REPORT

This is attached at **Appendix 3.**

13. INFECTION CONTROL REPORT

Clostridium Difficile - The reporting criteria for diarrhoeal disease due to *Clostridium difficile* have changed from this financial year. The changes to the CDI reporting algorithm for financial year 2019/20 are:

a) Adding a prior healthcare exposure element for community onset cases.
b) Reducing the number of days to apportion hospital-onset healthcare associated cases from three or more (day 4 onwards) to two or more (day 3 onwards) days following admission.

For 2019/20 cases reported to the healthcare associated infection data capture system will be assigned as follows:

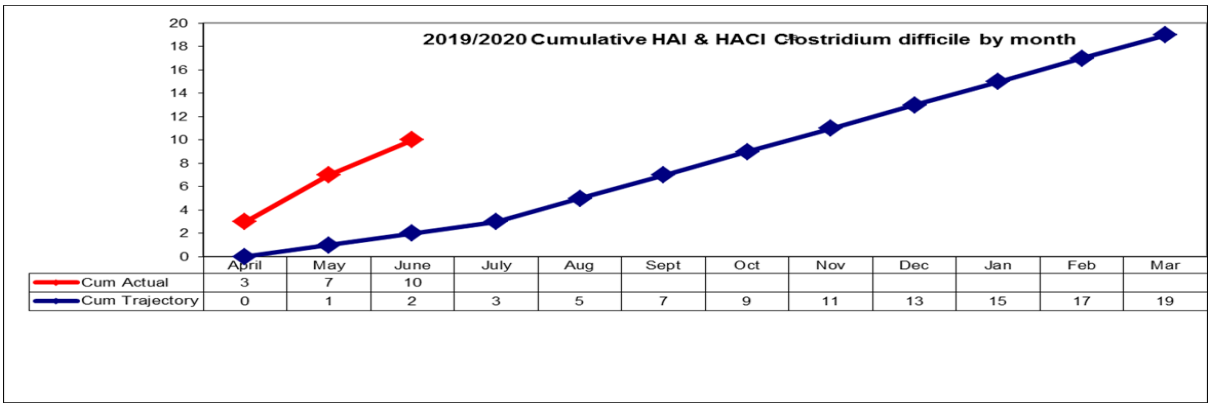
1) *Hospital onset healthcare associated*: cases that are detected in the hospital two or more days after admission.
2) *Community onset healthcare associated*: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.
3) *Community onset indeterminate association*: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks.
4) *Community onset community associated*: cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks.

The new apportioned ceiling for C.difficile is 19 cases. In 2019-20 the Health care associated or hospital acquired cases (HA) i.e. Trust apportioned cases will include the first 2 categories (HOHA & COHA).

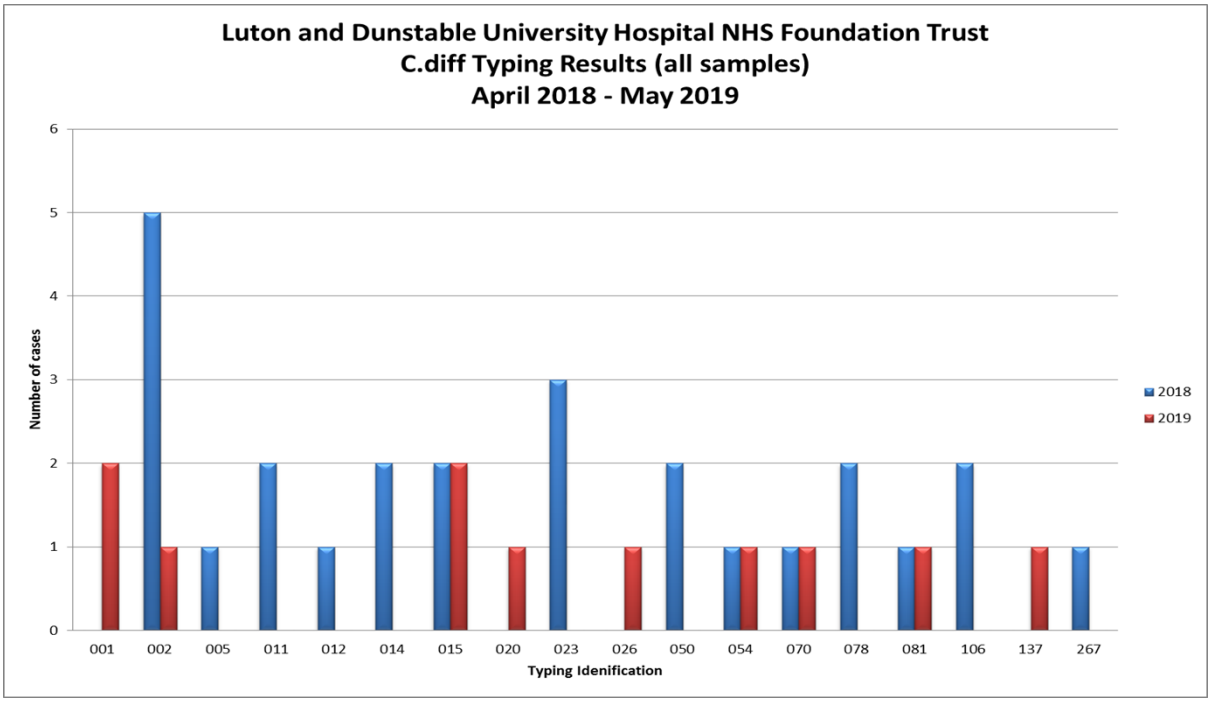
There has been one case in July with the total for the year to date of eleven cases.

- HOHA – 6
- COHA – 5

If the current trend continues the Trust is at risk of exceeding the allocated ceiling by the next quarter.



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Cum Actual	3	7	10									
Cum Trajectory	0	1	2	3	5	7	9	11	13	15	17	19

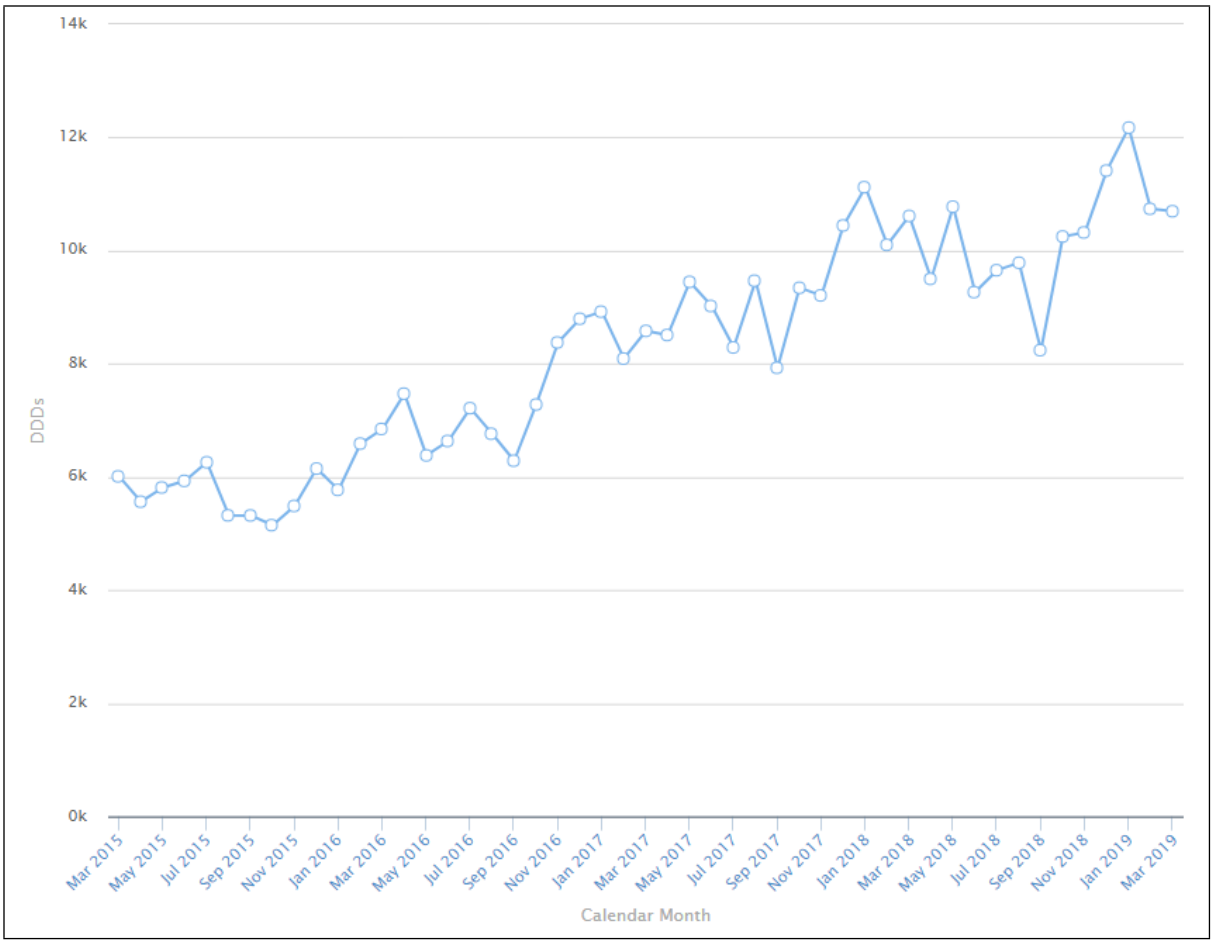


Root cause analysis (RCA) themes:

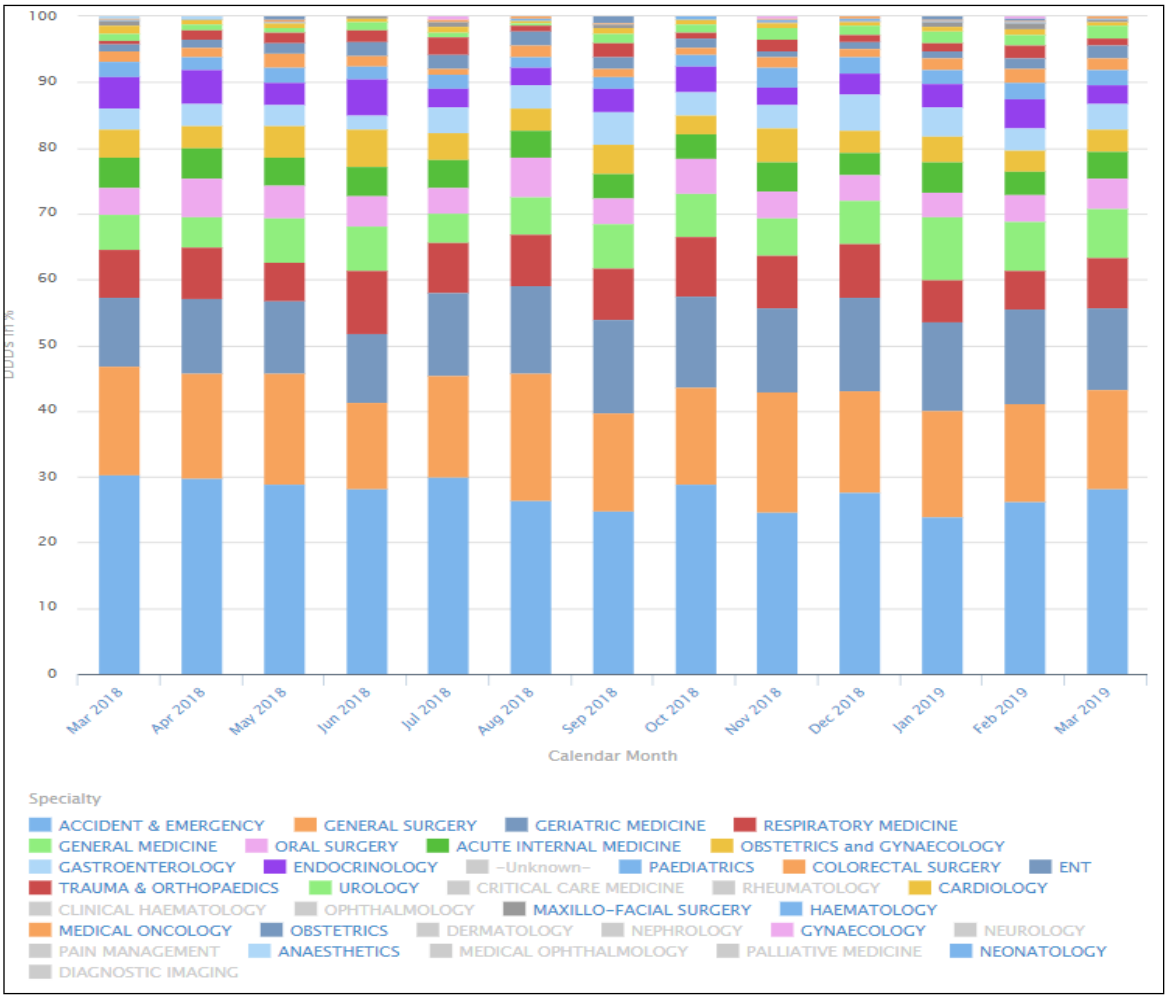
- Time to isolation: 2/7 in-patients who were symptomatic were NOT isolated. A positive CDT result was the prompt.
- On time sampling: Only 1 sample was not collected and tested in a timely fashion
- Probiotics: A significant number of patients did not have probiotics prior to the positive result 5/11
- PPI use: A significant number of cases were treated with PPIs.

- Antibiotics: All of the patients had a history of one or more antibiotics; there has been an increase in the use of co-amoxiclav and it is possible that the tazocin shortage last year influenced increased use of ciprofloxacin and Ceftazidime.
- Delayed sampling in patients with known or suspected inflammatory bowel disease history.
- Compliance with infection control and hand hygiene practice needs to improve. There is inappropriate use of gloves and application of the “Five moments of Hand Hygiene” is variable. Compliance with the Trust “Bare Below the Elbow” guidance needs to be improved and robustly implemented. The use of nail varnish and jewellery by staff is an on-going problem. Senior Medical staff should set an example and ensure their juniors comply.
- All the patients identified have been managed medically with a favourable outcome.

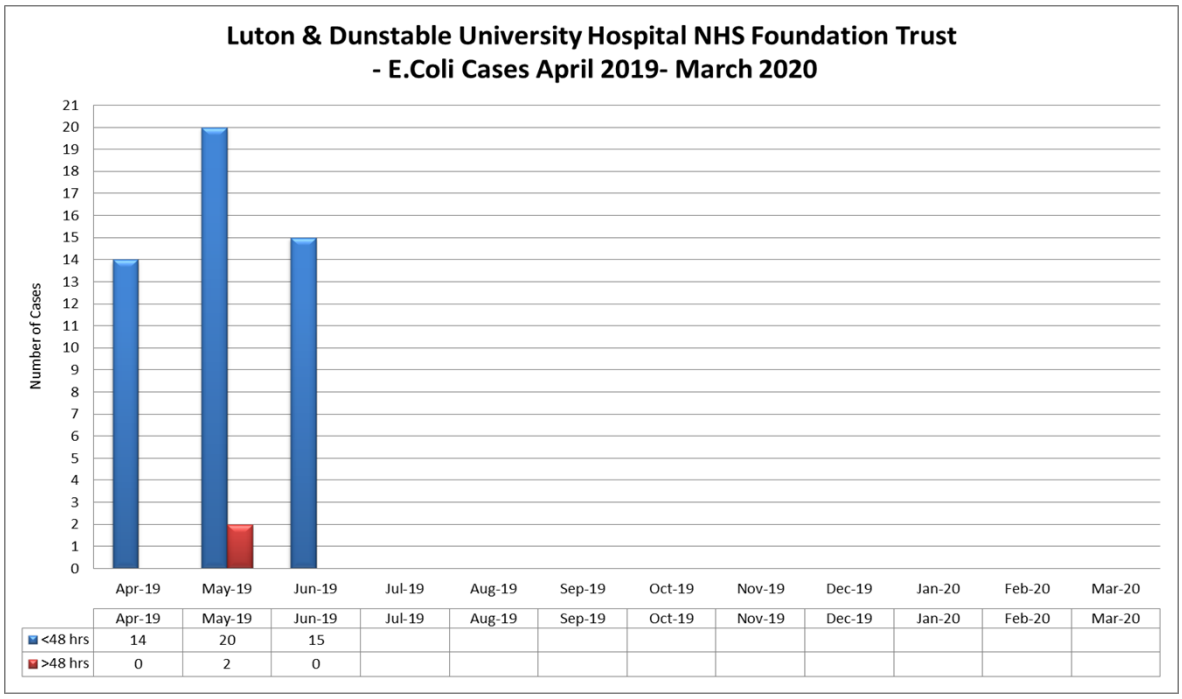
Total co-amoxiclav usage



Co-amoxiclav usage by specialty



E.coli bacteraemia - E.coli is the commonest cause of bloodstream infections. The majority of these infections are secondary to urinary tract infections.



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
<48 hrs	14	20	15									
>48 hrs	0	2	0									

RSV & INFLUENZA - The 2018 -19 RSV and influenza season is now over and the Trust is planning for the next winter season. Our trust has been set a target to vaccinate 80 % of staff against influenza. Following the success of the POC testing for Influenza and RSV in paediatrics the Trust is considering the implementation of this PCR based rapid testing in other areas e.g. Accident and Emergency department or the Emergency assement unit. This test is very rapid and has very good sensitivity and specificity

Infection Control Focus on Hand Hygiene and Glove use - The Trust continues to stress the importance of compliance with Hand Hygiene policy and following the "WHO Five Moments". In the week beginning the 15th of July the Trust is focusing staff attention on our "Bare below the Elbow" policy. We are also working to reduce the unnecessary use of gloves by staff.

14. BLMK STP

The current STP Central Briefing is **attached to this report as Appendix 4.**

STP Digital Strategy

In August 2018 NHS England released a prospectus to the 44 Sustainability Transformation Programmes (STPs) for three years funding under the Health Lead Service Improvement programme. The initial funding was allocated money in three phases with approximately 25% capital in 2018/19, the second capital allocation of 25% given in 2019/20 and then the final 50% revenue due in 2020/21. STPs had between September 1st and October 5th to submit bids, supported by outline business cases for their system programme.

BLMK allocated 100% for the provision of an integrated shared care record to improve health and wellbeing across the population of circa 900K residents. L&D offered to host the funding on behalf of the BLMK STP/ICS (System) as long as the Trust was not solely exposed for the financial liability.

Since the application, the Milton Keynes system has progressed in how it intends to operate going forward with links into the Thames Valley Longitudinal Health and Care Record exemplar through Milton Keynes University Hospitals. This has resulted in agreement to partition the HLSI funding to allow MK and Bedfordshire and Luton to receive HLSI funding to progress separately within the ICS vision of an integrated shared care record.

The year one funding of £1.671 capital has been made available for application and draw down. However, at this moment there is no commitment to years two and three. The funding has been allocated as follows:

1. Interoperability architecture phase 1 - £ 571,000
2. Enhance the development of data sets to support risk stratification - £200,000
3. Develop the first phase of a Citizen facing information portal - £ 150,000
4. Development of systems and reporting mechanisms to facilitate coded data collection - £200,000

5. Continued development of interoperability functionality between mental, community, GP and hospital systems - £300,000
6. Enhanced rollout and configuration of community systems for example Systmone and RiO - £ 250,000

The current proposal is that MK focus on 2, 4 and 6 and Bedfordshire on 1, 3 and 5 and the funding is apportioned in this way. The Trust now needs to consider with other ICS partners what can be achieved through this funding in the absence of commitments to future years allocation.

15. FREEDOM TO SPEAK UP

Three newly appointed Freedom To Speak Up Champions were announced on the 7 May 2019.

- Phil Spencer, Estates, speakuptophil@ldh.nhs.uk
- Mellisa Damodaram, Obs and Gynae, speakuptomellisa@ldh.nhs.uk
- Clive Underwood, Theatres, speakuptoclive@ldh.nhs.uk

Phil, Mellisa and Clive will work alongside the Freedom to Speak Up (FTSU) Guardian and will support the L&D's Vision for Raising Concerns- ***To build a culture of speaking up and ensure that all staff feel able and supported to raise their concerns to help make the hospital a safer place for patients and a better place for staff to work.***

Staff are often the first to identify problems within the hospital so we encourage and empower our staff to come forward and raise their concerns so that every ward and department is operating safely and in the best interests of patients, their family or carers and our staff.

The Champions have been appointed to offer staff a choice about who they speak to and the hope is that more staff will now come forward if they have a concern. The Champions will then escalate concerns raised in the most effective way to ensure they can be investigated thoroughly and appropriately to improve patient safety, quality and experience.

The FTSU Guardian continues to meet regularly with the Chief Executive, Director of HR and the Non-Executive lead for FTSU.

16. INTERIM NHS PEOPLE PLAN

The interim People Plan is structured by the following themes:

1. **Making the NHS the best place to work**
   Making the NHS an employer of excellence – valuing, supporting, developing and investing in our people

2. **Improving our leadership culture**
   Positive, compassionate and improvement focussed leadership creates the culture that delivers better care. We need to improve our leadership culture nationally and locally.

3. **Addressing urgent workforce shortages in nursing**
   There are shortages across a wide range of NHS staff groups. However, the most urgent challenge is the current shortage of nurses.

4. **Delivering 21st century care**
   We will need to grow our overall workforce, but growth alone will not be enough. We need a transformed workforce with a more varied and richer skill mix, new types of roles and different ways of working, ready to exploit the opportunities offered by technology and scientific innovation to transform care and release more time to care.

5. **A new operating model for workforce**
   We need to continue to work collaboratively and to be clear what needs to be done locally, regionally and nationally, with more people planning activities undertaken by local integrated care systems (ICSs)

The workstreams are led by medical, allied healthcare professionals, healthcare scientists, pharmacy and dental heads of professions. They are working alongside the NHS Long Term Plan national service programmes to involve partners and stakeholders to develop the actions detailed in the interim NHS People Plan.

Locally we will consider the interim NHS People Plan at the newly created Workforce Committee which is a sub-committee of the Trust Board.

17. ESTATES & FACILITIES UPDATE

Hard FM Services

Site wide water legionella testing: Evolution, our water safety contractor, has been engaged to carry out site wide legionella testing for 2019/20. A formal tender for a water safety contractor will be let by August 2019.

Tap replacement: Tap replacement has taken place on an ad hoc basis when older taps have failed or been identified as a possible source of infection.

Silver copper ionisation unit: The Silver copper ionisation unit has been installed and connected; silver copper ionisation levels are being monitored and reported back to the Water Safety group.

Lifts: Dilapidation surveys have been completed on all lifts and considered by Trust's external consultants. Works are progressing on lift 15 in the surgical block which will be back in service by the end of August. A programme of upgrade works will then follow on the remaining three lifts. Lifts 2 and 4 (Maxfax/OPD) have been identified first as requiring major upgrade as part of a rolling programme. Consultants have been appointed to develop specifications and tender documentation.

Electrical: Electrical infrastructure (EI) project is progressing. Superstructure on Substation H is complete and St Mary's Wing and Ward 18 electrical services were migrated across to the new infrastructure on 18th and 19th June. Works to reinstate the car park and finishes around substation H will be completed at the end of August.

The superstructure on Substation G is complete and the new HV and LV equipment is currently being installed. The new electrical services in the substation are scheduled to be tested and live by the end of the month. Following this, works will concentrate on installing new electrical mains from the substation to the existing estate. Once complete an extensive period of service migrations will take place to complete the works.

Ventilation: All critical air plant verification reports have been reviewed and action plans have been put in place to carry out all remedial AHU works required for these areas. The Trust has completed and awarded a contract to refurbish / upgrade plant serving theatres A to D and theatre 5. These works will commence in August.

Asbestos: Tenders have been returned for asbestos clearance in the Hospital ducts. These have been reviewed and the contract is shortly to be awarded which will see works commence on site in August.

Fire: Fire compartmentation remedial works tenders have been returned and have been reviewed. There is a wide variance in the tender returns that requires the procurement exercise to be repeated. The specification and scope is currently being reviewed and the new procurement exercise will commence in August.

Soft FM Service

Cleaning Standards: Cleaning standards over the last two months have improved and Engie are on track for passing all KPI's in July

Key Cleaning KPI's:

	Target Score	Engie Reported Scores - April	Engie Reported Scores – May	Engie Reported Scored – June
Very High Risk	98%	97.39%	98.01%	98.05%
High Risk	95%	93.96%	94.20%	94.40%
Significant Risk	85%	89.84%	92.55%	87.55%
Low Risk	75%	83.08%	78.05%	86.73%

The contract monitoring team are continuing to closely monitor the position / performance.

Food Safety / Patient Services: Engie have appointed a new Catering Manager, Darren Langdon, who commenced on 1st April. Along with the improvement plan it is hoped that this will result in improvements over the coming months. The new Catering Team structure is in place.

Key Catering KPI's:

Catering KPI's passed for March and April and there are clarifications required to determine May's scores as temperature checks and correct meals for special diets need to be agreed.

Engie have commenced an ongoing kitchen deep cleaning programme. This ensures all ward kitchens are cleaned weekly, in addition to daily Housekeeper cleans.

Engie have completed over 60% of staff for food hygiene training and have been given to mid August to complete due to additional training required further to

agreement on annual refresher training. All Engie staff will be up to date on food hygiene training to NHS standards by then.

New trolleys for dirty tray collection in Restaurant are now in place.

PLACE: Mini PLACE inspections continue to be carried out monthly. However June assessment had to be cancelled due to annual leave. Our next PLACE is schedule for next Wednesday 24th July. Following a review of National PLACE collections by NHS Improvements some changes to the collection process are expected. As a result of this, the 2019 collection will run later in the year and is expected to launch around September. Where access to areas is available maintenance and refurbishment work is being carried out to rectify findings.

18. COMMUNICATIONS & FUNDRAISING UPDATE

COMMUNICATIONS:

External Communications and Media attention- we received 10 media enquiries over this period and have generated numerous positive news stories for local press, including the NICU Big Build, Blood Donation week (introduced a donor to a recipients who was one of our NICU patients) and Helipad Appeal.

There was a very positive response to Community Engagement event and Mamma (maternity open day) and suggestions have been made/received for improving them in the future.

Social Media impact- The L&D now has 5000 followers and has recently introduced a weekly job advert as part of the schedule. A meeting has been held with Resolutions and Terrence Higgins Trusts to discuss expanding health promotion messages to include alcohol awareness and sexual health messages.

Internal Communications and Events – Staff briefing sessions and monthly staff awards have continued to be well received and beneficial for staff. A proposal has been submitted for a new intranet to be more user friendly, and alternative options have been researched for consideration.

CHARITY:

- Current financial year 19/20 the charity has received £122,956.
- Volunteer numbers have increased by 47 in line with 25% projected growth. Aim to have 400 active volunteers by end of year.
- First Youth Volunteering programme completed. Out of the 15 youth volunteers 4 have stayed on as youth volunteers, 3 have asked to become substantive volunteers and one has gained a role within the Trust.
- **Accounts:** Work has started on the Charity annual accounts, auditors are due in end of July. Report and outcomes to be presented at September Charitable Funds meeting.
- **Chair:** Clifford Bygrave will be stepping down as Charity Chair at the end of July. Simon Linnett will become Charity Chair in line with a traditional Corporate Trustee framework.
- **Helipad:** The team has been successfully working across the community to drive involvement and support. Throughout Ramadan and continuing on; Discover

Islam, local mosques, Inspire FM, Bartham Press and Community Awards are aiming to raise £100k towards the appeal. The Bedfordshire Police Crime Commissioner, Luton Rotary North, Someries Rotary, Dominos, Luton and Harpenden Mayors are supporting through the year. As are various schools around the area. MAGPAS will receive a grant from the department of Health and Social Care, we will receive a portion of this, awaiting breakdown and allocation amounts.

- **NICU accommodation appeal**: Steel Charitable Trust have agreed to contribute £10k per annum over next 4 years for running costs. Project due to be completed end of July. All works and materials have been donated, with outstanding items pledged. Over 80 trades and suppliers have come forward to date.
- **Mag seed treatment and scanner** – application for funding submitted to international Rotary, awaiting outcome.
- **Strategy** – We have been progressing the plan submitted to the Board of Directors last September. The team merged at the start of April and we have been recruiting into the new posts. Office location and space need to be rectified to realise strategy and also to accommodate new starters. Hospital lottery will be launched at engagement event.

19. 7 DAY SERVICES

The 7 Day Hospital Services Programme aims to deliver improvements for patients by supporting high quality care seven days a week. Ten clinical standards were developed in 2013 and with the support of the Academy of Medical Royal Colleges, four of these clinical standards were prioritised for delivery to ensure that patients admitted in an emergency receive the same high quality initial consultant review, access to diagnostics and interventions and ongoing consultant directed care at any time on any day of the week.

These 4 priority standards against which we must deliver for 90% of patients 7 days per week are:

- Standard 2: Time to consultant review
- Standard 5: Diagnostics
- Standard 6: Consultant directed interventions
- Standard 8: Ongoing daily consultant-directed review

In addition to compliance with the 4 key standards, the Trust is required to provide a progress report towards achieving the remaining 6 standards:

- Standard 1 Provision of patient information
- Standard 3 MDT assessment of emergency patients within 14 hours of admission
- Standard 4 Handovers
- Standard 7 Access to mental health services
- Standard 9 Access to support services in hospital, primary, community and mental health settings

At the end of June 2019, the Trust submitted the 7 day services board assurance framework confirming current compliance with the 4 priority standards and progress against the other 6 standards. The key risk highlighted by detailed audits of inpatients carried out by service teams in April 2019 is that we are not delivering 90%

of consultant reviews within 14 hours of emergency admission; the current compliance has improved from 70% in Spring 2018 to 76% in spring 2019, but still falls some way short of the 90% requirement. The trust was able to confirm compliance with the other 3 priority standards.

Each service will now need to identify the actions that will be taken to improve compliance to above 90% prior to a re-audit in the autumn 2019.

20. INPATIENT EXPERIENCE SURVEY AND MATERNITY PATIENT EXPERIENCE SURVEY

The national patient surveys have been published for 2018 and show a largely unchanged position from the 2017 survey results. Due to the significant time between collection and publishing, the surveys are somewhat limited in their usefulness; however they are used by CQC and provide an additional set of indicators about the quality of services delivered. Discharge and medication delays continue to be the main survey areas in which we do not benchmark well compared to other organisations in the inpatient survey. The maternity survey suggested we have improved in in terms of the help offered to women contacting a midwife during pregnancy, and in the offer for partners to stay in hospital as much as the woman wanted. We did not benchmark as well as others on the advice offered about emotional changes that may occur after birth.

Full copies of the reports are available on the CQC website.

21. POLICIES & PROCEDURES UPDATE

The following Policies & Procedures were approved during May, June and July 2019:

L07 - Learning Disabilities Strategy
M08 - MCA/DOLS
S05 - Safeguarding Adults
New - Delirium SOP
H05 - Honorary Contract
I01 - Immunisation of healthcare workers against and management of exposure to measles, mumps, rubella, and varicella zoster, seasonal influenza and tuberculosis.
S21 - Policy on Support Arrangements for Employees involved in Potentially Traumatic/Stressful Work Related Situations
E08 - Emergency Blood - red cells and platelets
R15 - Radiation Safety Policy
New – NICU Admission and Escalation Policy
New – Individual Rights and Subject Access Policy
New – Patient Information Sharing Opt out procedure
New - Abduction Policy
S07 - Safeguarding Children Policy
HR Policies – Extension Agreement

MONTHLY REPORT ON NURSING AND MIDWIFERY STAFFING LEVELS

1.0 Introduction

The Luton and Dunstable Hospital workforce is assessed using the guidelines within the NHS improvement 'Developing Workforce Safeguards' Report 2018. Benchmarks are set against their compliance with recommendations set out in the Report to support a consistent approach to workforce decision making by delivering high quality care through safe and effective staffing.

The recommendations are as follows:

- To deploy sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively
- To have a systematic approach to determining the number of staff and range of skills required meeting the needs of people using the service and to keep them safe at all times
- To use an approach that reflects current legislation and guidance, where it is available.

1.1 Summary of Report:

Both fill rate and CHPPD have improved in June compared to a dip in May, the increase did not impact on agency spend.

There is a higher level of sickness among healthcare assistants compared to registered nurses which has led to lower fill rates for HCAs in quarter 1.

Data from Model Hospital indicates the Trust CHPPD is above average compared to recommended peers. There is the need however to consider the fill rate includes NICU level 3, the split service of HDU and ITU that drives the fill rate up.

There is a continued focus on the recruitment and retention of Registered Nurses. The HR Team actively explores all avenues and strategies to combat recruitment and retention challenges. As part of the retention work with NHSI we are currently reviewing our recruitment of registered nurses to ensure we have a more flexible approach. Keeping this in mind we have relaunched the registered nurse pool with a focus on hard to fill day shifts.

2.0 Safe Staffing Process

The Trust has robust processes in place to ensure safe staffing across inpatient areas. Outlined below are the standard actions that are followed:

- Continued daily monitoring and ward RAG rating of staffing levels across inpatient wards
- Active management by the Operational Matron and support from Divisional Matrons to review staffing requirements twice a day
- Working with agencies to identify long line of rostered duties to support areas with high vacancies
- Controlled release of unfilled shifts to agencies
- Additional support provided by e-Roster and Bank

- Matrons, Specialist Nurses and the Education Team working clinically where needed
- The provision of the Clinical Site Nurse Service in the evenings to cover the handover of the night shift and support staffing across the Trust.

2.1 Average Shift Fill Rates for the Trust

The Trust's average fill rate for April was 94% (RNs - 92.9% and HCAs - 83%). May's fill rate was significantly impacted by sickness among Healthcare Assistants (an average of 6.48%, nearly twice the Trust target of 3.32%). The average fill rate for May dropped by 9.8% (from 94% in April to 84.2% in May). Not unique to May the day shifts were most difficult to fill. Generally night shifts fill better than day shifts mainly to enhanced pay. Average fill rate for day staff dropped by 8.5% (from 92.7% in April to 84.2% in May) and average night staff dropped by 5.7% (from 95.3% in April to 91.9% in May). The ward that was most affected by the low fill rate for HCAs was ward 25 (paediatrics) with a fill rate of 78.16% for HCA shifts.

The fill rates for June rose back to figures considered to be normal for the Trust. The average fill rate for day staff rose to 92 % in June (7.8% increase compared to May). The average night fill rate in June was 95.3% (3.4% increase compared to May). There are seven wards (wards 3, 10, 11, 14, 15, 24, & 33 - see Appendix 1) with fill rates below 85% in either registered staff or care staff. There are multifactorial reasons of sickness, vacancy and enhanced care needs that impacted their fill rates.

It is worth noting the increase in fill rate for June did not impact on spend for Bank and agency (see Chart 6).

Table 1 – Average Unify Return fill rate by staff group

	Day		Night	
Trust Average Fill Rates	Registered Nurses	Care Staff (HCA)	Registered Nurses	Care Staff (HCA)
June	92.5%	91.4%	96.5%	90.7%
May	89.1%	79.3%	96.6%	87.2%
April	93.4%	92%	97.7%	93%

- *See Appendix 1 for full UNIFY return rate for June*
- *See Appendix 2 for a full list of CHPPD by ward for June*

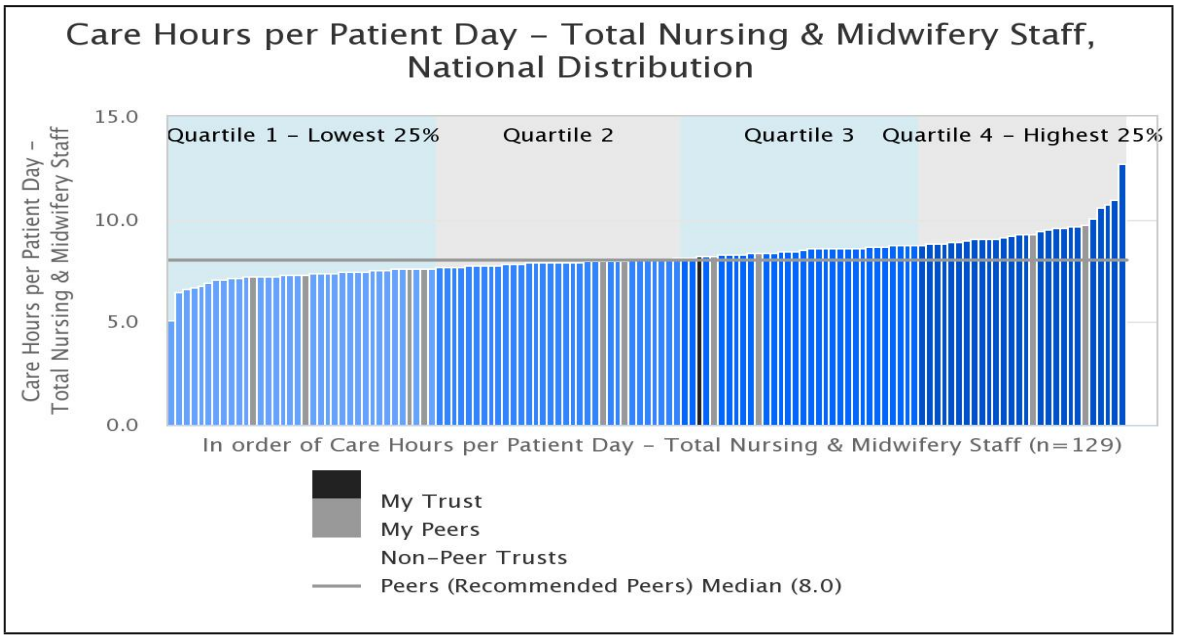
2.2 Care Hours per Patient day (CHPPD)

CHPPD measures the total care hours received by each patient over a 24 hour period. The standard calculation uses hours worked by staff divided by the number of patients on the ward in the 24 hour period. The table below (Table 2) displays CHPPD for April, May and June. Given the low fill rate for HCAs in May the CHPPD in May was the lowest in this quarter. Chart 1 is the latest available data sourced from model hospital dashboard (variation chart). That chart shows comparison of the L&D CHPPD data for all nursing staff (nurses, midwives and HCAs) to peer Trusts as well as other Trusts.

Table 2- Average CHPPD

			Average 24 Hour		
Trust Average			Registered	Care Staff	All Staff
June			6.4	3.1	9.5
May			6.3	3.0	9.3
April	7.8	4.1	11.9		

Chart 1: Care Hours per Patient Day (CHPPD): Data source Model Hospital Dashboard

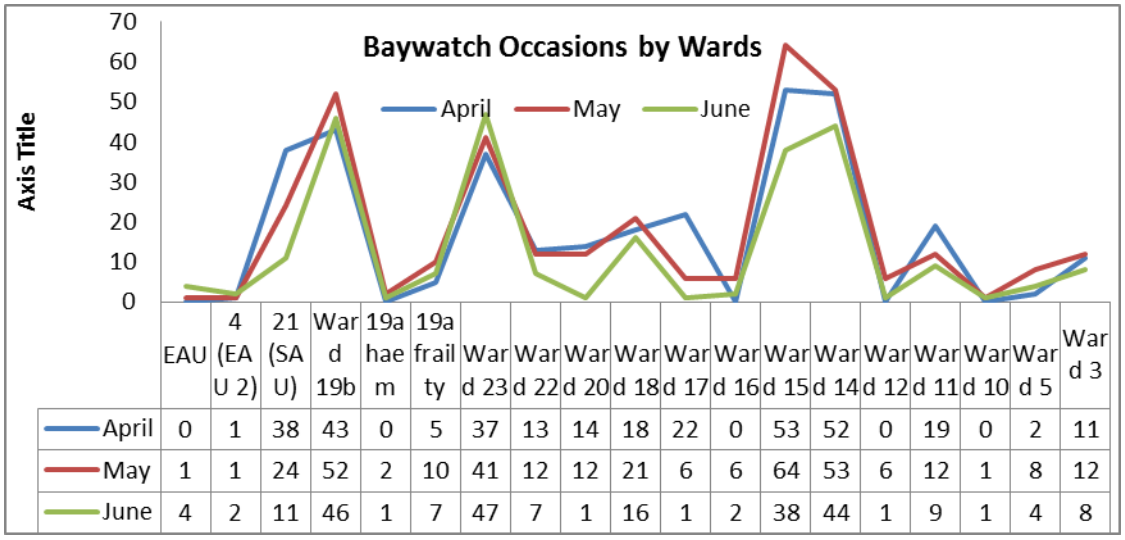


3.0 Enhanced Care

There remains a requirement for enhanced care provision for our highest risk patients. In the first two months of Q1 there had been an increased demand for patients needing RMNs (Registered Mental Health Nurses). In April we required 185 RMNs, this figure rose significantly to 239 in May of which only 203 of those shifts were filled. The shortfall was managed by the wards undertaking risk assessments and using HCAs to provide 1:1 care (see charts 2 & 3).

In June the overall usage of cohort bays and 1:1 care was the second lowest so far for this year. There was total of 250 occasions, which is a significant drop compared to 344 occasions in May. The reduced usage is not attributed to unfilled shifts, the requirement was lower. However as previously stated there was a significant increase in RMN use. This can be attributed to the complex needs of the patients. There is no change of trend in wards that use enhanced care. This predominately remains the Complex Medicine wards 14 and 15; Rehabilitation 19b and Trauma Orthopaedics, ward 23.

Chart 2: Baywatch

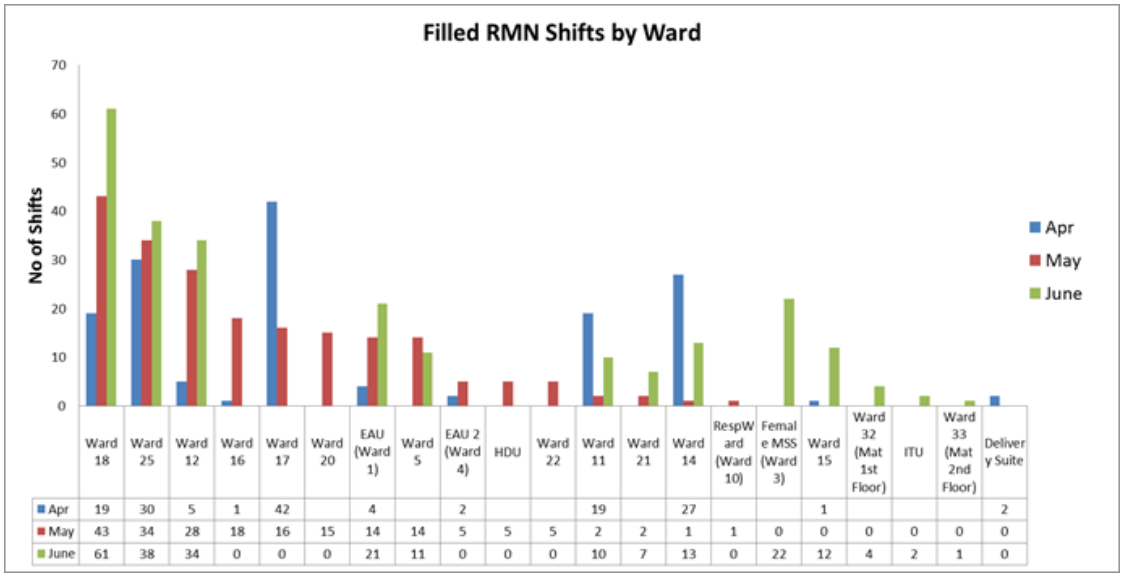


	EAU	4 (EAU 2)	21 (SAU)	Ward 19b	19a haem	19a frailty	Ward 23	Ward 22	Ward 20	Ward 18	Ward 17	Ward 16	Ward 15	Ward 14	Ward 12	Ward 11	Ward 10	Ward 5	Ward 3
April	0	1	38	43	0	5	37	13	14	18	22	0	53	52	0	19	0	2	11
May	1	1	24	52	2	10	41	12	12	21	6	6	64	53	6	12	1	8	12
June	4	2	11	46	1	7	47	7	1	16	1	2	38	44	1	9	1	4	8

3.1 RMN

RMN requests for June were 321 out of which 236 of were filled. Shifts that are not filled the wards risk assessment and use HCAs to provide 1:1 care or change to minimise risks. (See chart 3)

Chart 3 – RMN usage by ward



	Ward 18	Ward 25	Ward 12	Ward 16	Ward 17	Ward 20	EAU (Ward 1)	Ward 5	EAU 2 (Ward 4)	HDU	Ward 22	Ward 11	Ward 21	Ward 14	RespWard (Ward 10)	Female MSS (Ward 3)	Ward 15	Ward 32 (Mat 1st Floor)	ITU	Ward 33 (Mat 2nd Floor)	Delivery Suite
Apr	19	30	5	1	42		4		2			19		27			1				2
May	43	34	28	18	16	15	14	14	5	5	5	2	2	1	1	0	0	0	0	0	0
June	61	38	34	0	0	0	21	11	0	0	0	10	7	13	0	22	12	4	2	1	0

Table 3 - filled & Unfilled RMN shifts

	Apr-19		May-19		Jun-19	
	Filled	Unfilled	Filled	Unfilled	Filled	Unfilled
RMN Shifts	152	33	203	36	236	85
Filled percentage	82.16%	17.84%	84.94%	15.06%	73.52%	26.48%

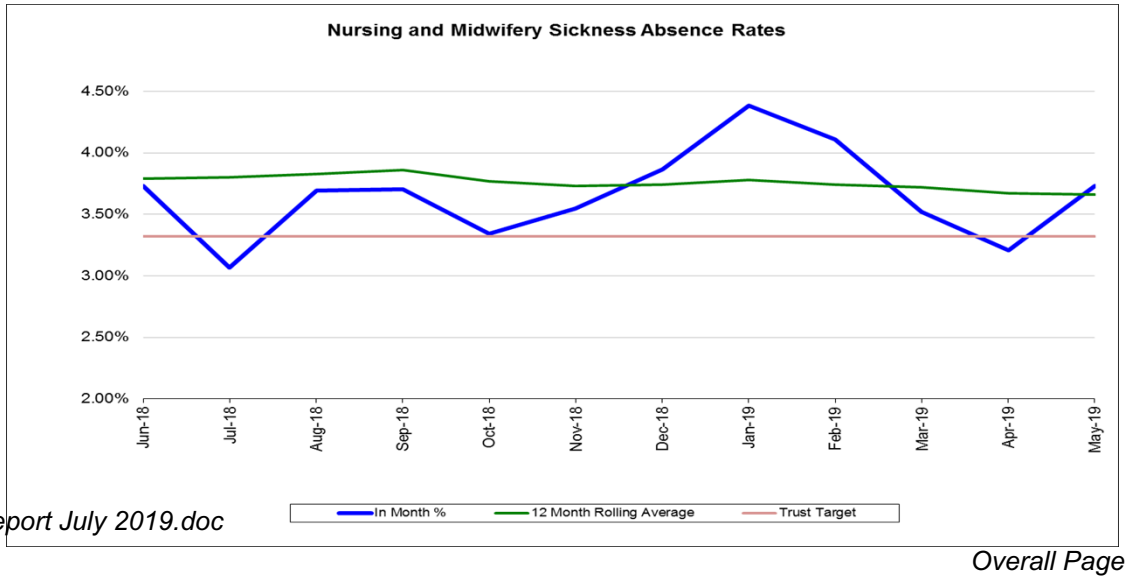
4.0 Sickness

The monthly average target of sickness absence of the Trust is 3.32%. Tables and charts below display monthly rates and trends of sickness absences of registered nurses & midwifes, and healthcare assistants. HCAs have the highest sickness rates with May being the highest (6.48%) for this financial year. ESR system runs a month behind the annual calendar therefore we do not have sickness data for June in order to understand how that would have impacted on staff fill rate and CHPPD. Months where Trusts target were missed are highlighted in yellow. According to the available data for the year HCAs have higher sick rates than RGNs. HCA rates are mostly above 5% (see table 5). It is in correlation with the fill rates for the last 3 months: RN fill rates have been consistently higher than HCAs.

Table 4 – Nursing and Midwifery Sickness Rates

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
In Month %	3.73%	3.07%	3.69%	3.71%	3.34%	3.55%	3.86%	4.39%	4.11%	3.52%	3.21%	3.73%
12Month Rolling Average	3.79%	3.80%	3.83%	3.86%	3.77%	3.73%	3.74%	3.78%	3.74%	3.72%	3.67%	3.66%

Chart 4 – Nursing and Midwifery Sickness Trend

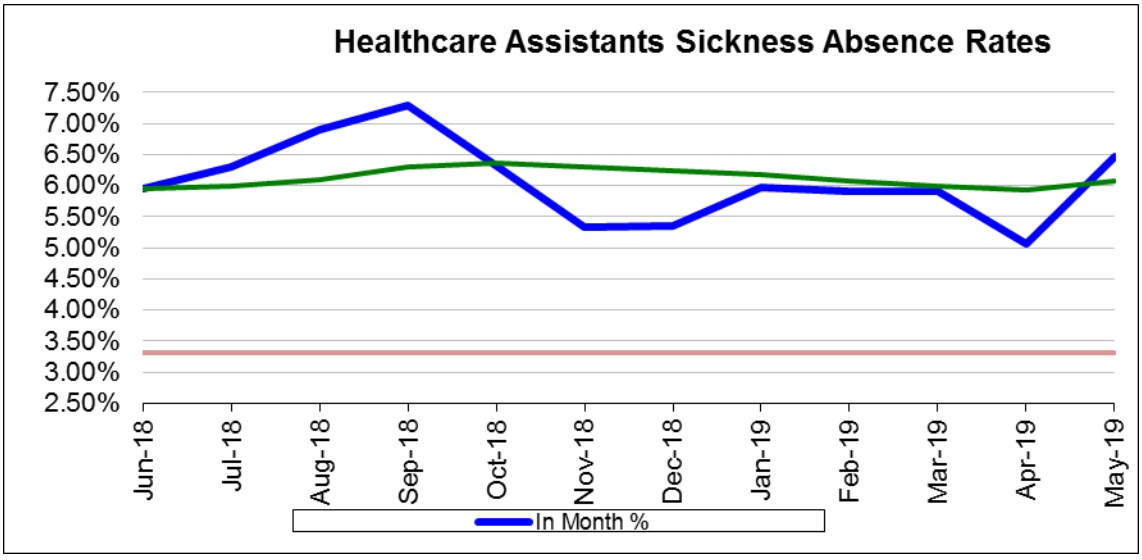


Sickness rate for HCAs remains challenging. Following some improvement in April there has been deterioration in May. Managers are being asked to focus their attention with support from Human Resources to avoid delay and cancellation of stage 2 sickness meeting.

Table 5 – Health Care Assistants Sickness Rates

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
In Month %	5.94 %	6.30 %	6.89 %	7.28 %	6.32 %	5.34 %	5.35 %	5.98 %	5.91 %	5.92 %	5.06 %	6.48 %
12Month Rolling Average	5.95 %	5.99 %	6.10 %	6.31 %	6.36 %	6.31 %	6.23 %	6.17 %	6.07 %	5.99 %	5.93 %	6.07 %

Chart 5 – Healthcare Assistant Sickness Trend

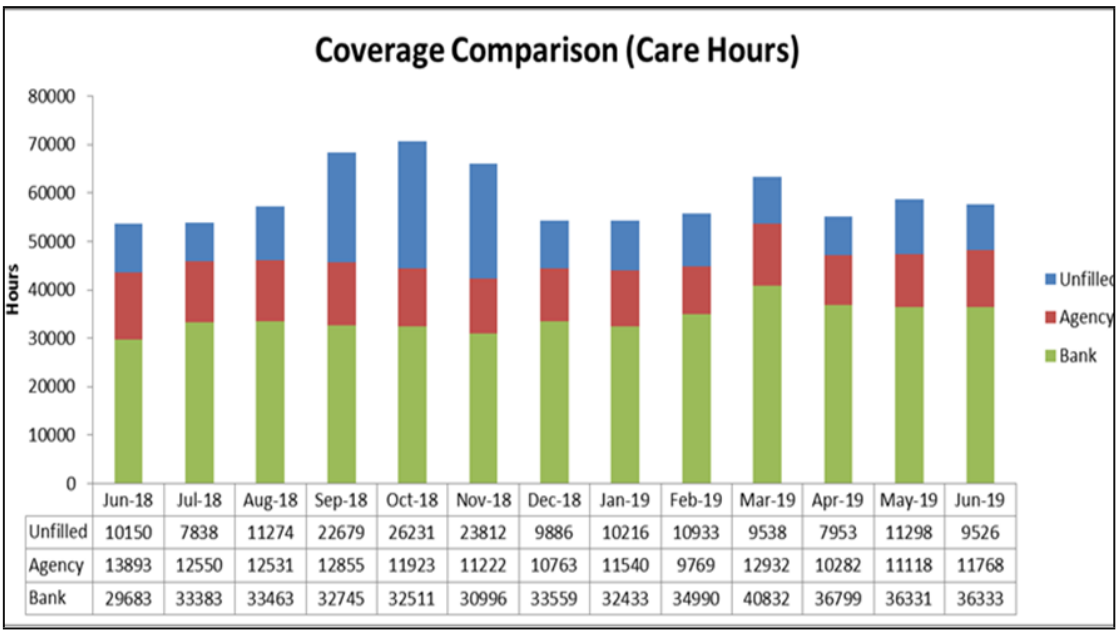


5.0 Coverage comparisons of Bank/Agency and unfilled shifts

There are a number of contributory factors which affects fill rates and use of bank and agency use. Vacancy, sickness absence and opening of escalation areas (Cath lab, endoscopy, Paeds ED, SSSU, theatre A- E and theatre 1-6) are 3 of the major

contributory factors. Contingency areas were opened 16 days with 2 areas opened at the same time on 11 occasions. The most challenging times are when there are more escalated areas opened at the same time that happened once in June where 4 areas were opened at the same time. There were 4 occasions where only 1 area was opened. In total contingency was opened 27 times compared to May when it was opened 57 times over 15 days. Acute medicine was the division that was most impacted by the escalation areas, on 19 occasions they had to supply a registered nurse or swap one for an agency nurse to support the contingency plan.

Chart 6 - Bank and Agency Usage



	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Unfilled	10150	7838	11274	22679	26231	23812	9886	10216	10933	9538	7953	11298	9526
Agency	13893	12550	12531	12855	11923	11222	10763	11540	9769	12932	10282	11118	11768
Bank	29683	33383	33463	32745	32511	30996	33559	32433	34990	40832	36799	36331	36333

Table 6- Bank and Agency Usage

Filled/Unfilled	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Grand Total
Unfilled	10150	7838	11274	22679	26231	23812	9886	10216	10933	9538	7953	11298	9526	171335
Agency	13893	12550	12531	12855	11923	11222	10763	11540	9769	12932	10282	11118	11768	153146
Bank	29683	33383	33463	32745	32511	30996	33559	32433	34990	40832	36799	36331	36333	444059

5.1 eRostering

Table below shows Healthroster KPIs of the various divisions. Net hours refer to unused hours that could be utilised to fill shifts. Divisions falling below the Trust target are highlighted in yellow. All division met the target for annual leave allocation. Roster approval targets were met by both mangers and matrons. The only KPI requiring improvement is net hours balance. Some the challenges revolve around on boarding of overseas nurses and new starters. That requires a manual intervention of the Health roster team to initialise individual rosters. Others are in relation to the need to

wait for excess hours for any individual to accumulate to 12 hours before allocated (most wards work 11.5 hour shifts) [see table 7 overleaf].

Table 7 – eRostering KPIs (averages by division)

	Trust Target	Trust Average	Emergency Medicine	Acute Medicine	Critical Care	Complex Medicine	Specialty Medicine	Cardiology	Surgical	Hospital at Home	Childrens	Womens
Net Hours Balance	<75 hours	487.621	150.32	172.38	95.46	713.24	1164.65	168.97	886.46	100.69	1407.18	16.86
Annual Leave	13% - 15%	12.79%	13.10%	12.22%	13.65%	11.98%	11.68%	14.33%	13.84%	11.80%	12.79%	12.44%
Roster Approval (Partial Lead Time)	63 days	59	51	60	64	62	63	58	60	60	43	58
Roster Approval (Full Lead Time)	56 Days	43	38	57	46	59	58	54	52	57	42	51

5.2 Vacancies and Recruitment Activity

Registered nurse vacancies remain a challenge both locally and nationally, there is continued focus on Skype interviews for EU and Non-EU nurses which yields an average of 15 nurses a month. The focus for the year ahead is retention of staff with some engagement sessions planned with band 5 RN's to understand what support might increase staff satisfaction. Band 5 nurse vacancies have increased by 8 from 100 WTE in May to 108 in June. The data does not take into consideration the 12 overseas nurses who arrived in June. They are classified as band 4 until they pass the OSCE which takes approximately 3 months.

The HCA vacancy in May was 84 and we recruited 32, the June campaign yielded 27 with 12 of them joining the bank and the rest (15) are substantive.

Registered Nurses	
Local recruitment	20 nurses recruited externally (4 bank 16 substantive)
Overseas Nurses	12 nurses arrived in June
Vacancy (band 5)	108

Appendix A June Fill Rate

Ward Name	Day	Night		
	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate: registered nurses/ midwives (%)	Average fill rate - care staff (%)
418 F05 Haem Onc Unit	94.0%	86.2%	98.4%	93.7%
418 N19 Cobham Clinic	85.5%	96.1%	98.4%	100.0%
418 H30 SCBU/NICU	99.7%	99.7%	99.8%	100.0%
418 H25 Paediatric Wards 25	100.0%	99.2%	87.9%	94.0%
418 H25 Paediatric Wards 24	100.5%	82.3%	81.5%	92.4%
418 G10 Ward 19b - Rehab	91.3%	86.2%	100.0%	100.0%
418 G20 Ward 19a	88.6%	90.1%	100.0%	100.0%
418 G16 Ward 14	92.3%	82.7%	100.0%	96.7%
418 G15 Ward 15	101.0%	80.4%	98.9%	96.3%
418 G06 Ward 17	98.3%	86.4%	100.8%	90.6%
418 G05 Ward 18	85.3%	102.9%	94.4%	83.3%
418 G02 Ward 16	90.2%	106.1%	99.0%	92.5%
418 F40 CCU (Ward 4a)	99.0%	104.8%	100.0%	86.4%
418 F12 Ward 12	89.6%	94.6%	99.5%	99.7%
418 F11 Respiratory Ward (Ward 10)	83.5%	81.8%	97.9%	87.3%
418 F04 Ward 11	84.7%	84.0%	87.9%	97.7%
418 F03 EAU 2	91.8%	87.5%	94.0%	110.4%
418 F02 Female MSS (Ward 3)	93.9%	82.2%	95.9%	92.0%
418 E34 Ward 34 (Gynae 3rd Floor)	100.6%	85.4%	100.0%	100.1%
418 E33 Ward 33 (Mat 2nd Floor)	80.3%	101.2%	86.0%	92.1%
418 E32 Ward 32 (Mat 1st Floor)	92.6%	86.2%	108.0%	101.2%
418 D60 ITU	84.4%	108.9%	92.7%	-
418 D20 Theatres - HDU	99.8%	88.0%	98.0%	89.9%
418 B23 Ward 23	94.9%	93.7%	97.5%	80.4%
418 B01 EAU (Ward 1)	88.1%	84.4%	96.6%	90.2%
418 A22 Ward 22	92.0%	102.0%	94.5%	92.9%
418 A21 Head & Neck Unit (Ward 20)	97.1%	89.5%	99.4%	90.1%
418 A20 Short Stay Unit (Ward 21)	92.0%	87.0%	96.9%	90.7%

Appendix B - June CHPPD

Ward Name	Registered midwives/ nurses	Care Staff	Overall
418 F05 Haem Onc Unit	4.6	2.9	7.5
418 N19 Cobham Clinic	4.7	2.7	7.4
418 H30 SCBU/NICU	11.9	0.7	12.6
418 H25 Paediatric Wards 25	10.6	3.6	14.2
418 H25 Paediatric Wards 24	6.9	3.8	10.7
418 G10 Ward 19b - Rehab	2.9	3.9	6.8
418 G20 Ward 19a	3.8	4.3	8.1
418 G16 Ward 14	2.7	4.6	7.3
418 G15 Ward 15	2.4	4.1	6.5
418 G06 Ward 17	4.5	3.4	8.0
418 G05 Ward 18	4.3	3.8	8.1
418 G02 Ward 16	3.0	2.7	5.8
418 F40 CCU (Ward 4a)	6.1	2.1	8.2
418 F12 Ward 12	3.6	2.6	6.1
418 F11 Respiratory Ward (Ward 10)	3.0	2.3	5.3
418 F04 Ward 11	2.9	3.5	6.4
418 F03 EAU 2	6.0	2.8	8.8
418 F02 Female MSS (Ward 3)	3.9	2.5	6.4
418 E34 Ward 34 (Gynae 3rd Floor)	5.9	3.3	9.2
418 E33 Ward 33 (Mat 2nd Floor)	3.8	3.5	7.2
418 E32 Ward 32 (Mat 1st Floor)	3.9	2.0	6.0
418 D60 ITU	32.8	0.9	33.7
418 D20 Theatres - HDU	22.9	3.6	26.4
418 B23 Ward 23	3.4	3.8	7.2
418 B01 EAU (Ward 1)	6.9	3.2	10.1
418 A22 Ward 22	3.5	2.9	6.5
418 A21 Head & Neck Unit (Ward 20)	4.0	2.9	6.9
418 A20 Short Stay Unit (Ward 21)	4.6	3.4	8.0

Impact of the tapering of the tax free pension growth allowance for senior medical staff

Briefing for the Board of Directors June 2019

1. Executive summary

The following paper and appendix 1 explore the significant risk to financial performance and delivery of access targets as a result of the changes to the tax free annual allowance.

With the current level of known mitigation, the Trust has identified a financial risk of around £350k over the next three months. Key performance indicators for cancer 62 day wait and diagnostic waits are significantly affected from July 2019 with a longer term risk to maintaining zero 52 week waits.

This is a significant risk, and services are prioritising the work needed to mitigate the sudden and unexpected change in the senior workforce capacity as a result.

2. Background to the problem

The tapered annual allowance was introduced from 6 April 2016. This means that from the 2016-17 tax year, a reduced annual allowance may apply to an individual's pension savings depending on the level of taxable income within the tax year. It applies to individuals with a threshold income of more than £110,000 and an adjusted income of more than £150,000. For every £2 that an individual's adjusted income goes over £150,000, their annual allowance for that year reduces by £1. The minimum reduced annual allowance someone can have is £10,000.

Because the NHS pension scheme is a defined benefits scheme rather than a defined contribution scheme, senior medical and dental staff are very likely to find themselves in excess of the adjusted income threshold, particularly in years where their pension growth has been high e.g. where they have received an incremental uplift in pay[1] or received a Clinical Excellence Award. It is also nearly impossible for an individual to forecast the growth, and there are not the same opportunities as with a defined contribution pension to manage the growth and so mitigate the impact of the tapered allowance.

The tapering over the three years means that a growing number of senior staff are now receiving tax bills of tens of thousands of pounds. This means that additional responsibilities and extra sessions which all contribute to the threshold income calculation look like particularly poor value for staff if it makes the difference between being over or under threshold. The choices that senior staff are faced with are to try to reduce earnings by reducing the amount of work carried out for the NHS, to withdraw from the pension scheme and risk loss of associated benefits such as death in service and ill health retirement, or to take early retirement.

3. Impact on the Trust performance and financial position in Q1 and Q2 2019/20

A paper was submitted to NHSI/E in May (Appendix 1) setting out the likely impact on performance at that time as a result of sudden withdrawal of consultants from any additional sessions. The paper set out that in the first instance outpatient clinics and endoscopy sessions would see a significant volume impact, with elective lists carried out on Saturdays outside of job plan would also reduce. The paper highlighted that the expectation was

[1] Consultants on the 2003 contract are eligible for an incremental uplift every year in the first 4 years as a consultant, and then every 5 years to their 19 year as a consultant when they reach top of scale. The 5 year increments are worth circa £5,750.

that18 week performance would deteriorate significantly over the 5 months, June to October 2019 (from 91% to around 75%) with accrual of a backlog of over 4,500 patients to treat. The diagnostic target was forecast to be missed from June 2019 and the cancer 62 day target will be affected from July, although the expectation is that this will not be an ongoing deterioration, but rather a step-change downwards in performance as we lose the flexibility from staff which has historically enabled us to avoid patients breaching by just a few days. The Trust carries significant risk of 52 week breaches in a number of specialist pathways where performance has been maintained through additional operating lists on Saturdays.

The Trust has acted to offer consultants flexibility in continuing to deliver extras in the short term, with the offer of time off in lieu later in the financial year if subsequent independent financial advice is for them to stop carrying out additional work. Our non-consultant staff have also been supportive in offering additional sessions where possible for example in endoscopy, although these staff do not offer the same level of flexibility as consultants. This has mitigated the original risk of cancellations of large numbers of patients who already had appointments booked in May and June.

It is not possible to easily track forward book bookings at a trust-wide level and make estimates as to the likely activity for the month, due to the high proportion of work which is booked at relatively short notice (2 weeks). However, service managers in medicine, DTO and Women's and Children's divisions have confirmed that they are not yet seeing an impact of consultants withdrawing from additional outpatient clinic sessions. Clinics do not make a large contribution to the bottom line when running as extras as the income is largely offset by premium pay costs, therefore the financial risk of any reduction is marginal in the short term. Covering annual leave sessions during the holiday period of July and August is however a largely untested risk at this point in the year and if it is necessary to bring agency staff in to cover sessions or outsource work to the private sector this will have a negative impact on the Trust's financial performance.

The surgical division is seeing an immediate reduction in activity in June around Saturday operating. It is expected that around 70 fewer elective operations will be carried out on Saturday in June compared to previous months with 5 Saturdays.

Generally additional elective lists make only a small contribution due to the high expense of additional theatres staff out of hours. Poorly utilised lists or those with high risk, low volume surgery such as complex cancer cases are more likely to make a loss. However these lists keep sufficient capacity in the system to enable the high volume routine work to take place, which tends to be more profitable. As waiting lists pressures increase, cases have to be prioritised on the basis of clinical need, and therefore the low risk work gets pushed back. This means that our average contribution per case is likely to reduce over the coming months.

The theatre timetable for the week commencing 22nd July currently has 7 uncovered all-day sessions across general surgery, gynaecology, ENT and OMFS and 7 uncovered ophthalmology lists (half days). Where consultants have indicated that they will not carry out additional sessions, the likelihood of covering these is now much lower. Theatres staff and anaesthetic staff however are rostered, and so there is a burden of stranded costs. Assuming an average income of £6,000 per half session and a conservative 25% contribution from these lists, this represents a £21k risk to the financial bottom line for that week. Therefore the financial risk to the trust from lost operating could be in the region of £250k over the next three months if alternative ways of covering lists are not identified. A further financial risk is presented if we are not able to adjust staffing accordingly and end up with stranded costs. Clearly this number is susceptible to volume and case mix change, which are difficult to forecast and may be significantly higher or lower.

Endoscopy sessions are the other significant risk, and since the changes in rostering of nursing staff to cover weekends within establishment, make a significant contribution of around £3.5 to £4k per session. The unit has capacity for around 200 sessions per month, and around 20 to 25% of these are currently covered by staff as extras pending the recruitment of 2 substantive consultants to Gastroenterology and return to full establishment in Upper GI. An agency consultant contract has been extended from April to July at a cost of circa £22k per month to support cover of clinics and free up substantive staff for endoscopy. Whilst this protects some activity and the financial position as the hourly rate is broadly equivalent to a consultant premium session, this will contribute to the ongoing problems with agency spend. The service has also reduced training lists in June and July as fewer patients are booked for these lists. Whilst a sensible short term decision to protect against the immediate risk, this is clearly not sustainable in the longer term, as training staff to scope independently is one of the key resolutions of this risk.

The most likely outcome based on current intelligence is that the service will lose around 10 sessions per month for the next three months. This represents a total financial risk of £105k to £120k. In order to try and limit the impact on waiting times, work is underway with outsource providers to understand alternatives for provision of this work.

In order to try and mitigate the short-term impact, a letter has been sent to all consultants with a variety of options for them to share with their financial advisor as to ways in which the Trust might be able to support them with requests for pension flexibility etc. However it is not anticipated that this will help significantly apart from for those consultants who are very close to the earnings threshold, and therefore the overall strategy needs to be to replace consultant extras with substantive sessions (likely to be through additional workforce given the disincentive to increase NHS work as a result of the taper) or through alternative methods such as skillmix change, outsourcing, or a rationalisation of service developments to ensure protection of core business.

4. Impact on department job plans

The Trust has prioritised consultant productivity in job planning and service objectives, and has been historically supported by consultant staff being willing to have relatively high job plans[2] with smaller teams of committed individuals covering a lot of clinical work. A large proportion of consultants are on 10 – 12 PAs, with job plans of 13+ PAs not being unusual in teams with a high proportion of out of hours demand. Other Trusts conversely have taken a very different approach to consultant job plans and have set a limit for job plans at 10 PAs. As a result of the incentive to reduce NHS earnings introduced by the tapering, the Trust is seeing increasing numbers of consultants asking to reduce their job plans to 10 PAs. This will require re-working of department job plans and either a reduction in activity, or an increase in the number of consultant posts.

As an example (see below), one consultant on a 13.3 PA job plan would wish to reduce at least to 11 PAs. This means removing 2.38 PAs worth of activity. Without changing the level of on-call cover for emergency admissions and theatres, the only way that this can be achieved is through a reduction in theatres, clinics and endoscopy. This is calculated at a high level to be a 36% reduction in contribution to elective sessions from this consultant. All 6 consultants in the team have made similar requests, and so the likely impact will be the need to recruit an additional 2 consultants, at pace. This is likely to be extremely challenging in some specialties where there have been unfilled consultant vacancies for a number of years, but is also a fundamental shift in the culture of our senior workforce and our strategy for consultant team growth.

[2] A standard consultant job plan is 10 PAs (with each PA being 4 hours) which represents 40 hours of work Monday to Friday (out of hours work is at 3 hours per PA). Consultants undertaking private work are expected to offer 11 PAs to the NHS before carrying out fee-based activities outside the NHS

JOB PLAN EXAMPLE - FOR ILLUSTRATION ONLY

Summary of Programmed Activities

	Category	Activity	Total PAs
-	DCC		10.874
		Endoscopy	1.619
		MDT	0.304
		O/P Clinic	1.548
		On-Call Consultant (Daytime)	2.361
		On-site, at home, on the telephone and travelling to and from site	0.619
		Patient Admin	1.108
		Predictable Emergency Work	0.000
		Theatre General Surgery	2.315
		Ward round	1.000
+	SPA		1.500
+	MS		1.009
		Grand Totals:	13.382

Annualised plan:

Endoscopy: 68 lists = 1.619 PAs

Theatre: 73 half day sessions = 2.315 PAs

Clinic: 65 sessions: 1.548 PAs

Total: 5.482 plus related admin 1.09 = 6.57

To lose 2.38 PAs from the elective activity ie if everything else were left exactly as is

So: 68 sessions would become 43
73 would become 47
65 would become 42

This is a 36% loss in elective sessions.

The services are currently working with consultants to scope out the likely extent of the requested reductions and agree an approach to team job planning to deliver this. This is being done with support from the Trust's external job planning expert, and concurrently with a refresh to job planning principles to reflect the increasing tendency for consultants to request less than full time hours or job shares.

Whilst this is being seen first in the surgical specialties, it is expected that job plan reductions will shortly be requested in other divisions, and early thinking has commenced with teams who are already considering team job plan changes to ensure that proposals align with the likely direction of travel in the future.

5. Summary and Conclusion

The impact of the tapering of the tax free pension growth allowance is widespread across the services, both with an immediate impact through loss of additional consultant sessions and the commensurate reduction in capacity, income and flexibility to enable sustainable delivery against targets.

Over the coming months, services will develop local trajectories and strategies for covering the work, and the Trust will need to be agile in its approach to recruitment of additional resource where this is the optimal solution to the issue. For month 3, services will be asked to re-profile income forecast based on a worst case scenario for session fill and then explore the corresponding cost reduction.

Impact of the tapering of the tax free pension growth allowance on additional duties carried out by senior medical staff
Briefing paper 22nd May 2019

1. Background

1.1. Over the last two weeks we have seen an exponential increase in the number of consultant staff who have indicated that they will withdraw from carrying out additional clinical sessions and extra responsibilities. This is as a direct result of the lack of clarity around the impact of the tapering of the tax free allowance depending on individual circumstances. Consultants are assessing the risk that they will give their time on days not usually worked, and find themselves having incurred a significant tax bill and effectively having worked for free. Faced with this uncertainty, the majority decision has been to withdraw from offering additional sessions.

1.2. The L&D has a long track record of strong performance, and has been well supported by our clinical staff offering flexible additional sessions to ensure that surge or growth in specialist areas can be delivered to a high quality standard. Although additional clinics, theatre lists and diagnostic sessions are paid at a premium rate[3], this has not changed over the last 8 years, and represents much better value than agency staff because of the high productivity of the additional sessions and the continuity it affords for the patient.

1.3. We are advised by consultants who have tried to gain independent financial advice that the NHSBA has a significant waiting time for requests for the individual pension information that is required by a specialist to provide forecasts. On that basis, the withholding of additional sessions is likely to last several months. In any case it is likely that once individuals do get financial advice it is likely that for the majority of consultants the advice will endorse their decision to reduce their commitments.

1.4. The following sets out our current impact assessment of the loss of additional sessions relating to each of the key performance areas. Our planning assumption is that clinically urgent and cancer work will be prioritised over routine work in all instances. We have not assumed any additional agency staffing to mitigate the lost sessions as this is currently an area in which we are doing everything possible to reduce our exposure. This may help to mitigate in the medium term but with a corresponding financial burden. No expectation of additional locum medical staff has been made due to the difficulties we already experience in obtaining staff via this route and the current vacancy level.

2. 18 weeks

2.1 The following table describes the different types of capacity affected and the relevance to the 18 week delivery plan.

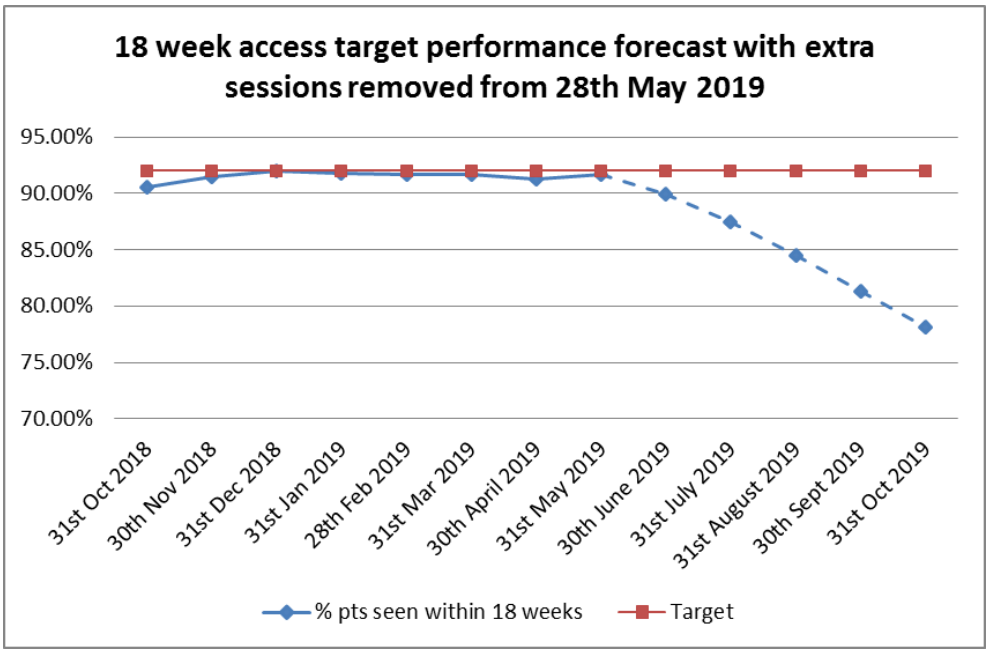
Elective lists run on Saturdays	292 operations carried out Jan – April 2019 outside of Super Saturdays [4] i.e. outside of job planned activity. Forecast for the year is 876 patients that would be added to 18 week backlog (996 patients are currently over 18 weeks).

[3] The rates offered are £750 for an elective session at the weekend or £700 for a midweek session (half day). £500 for a clinic or diagnostic list which is a fixed rate which includes all additional administrative work.

[4] Super Saturdays run the 2nd Saturday of every month and are fully job planned as a 6th full elective theatre day for that week.

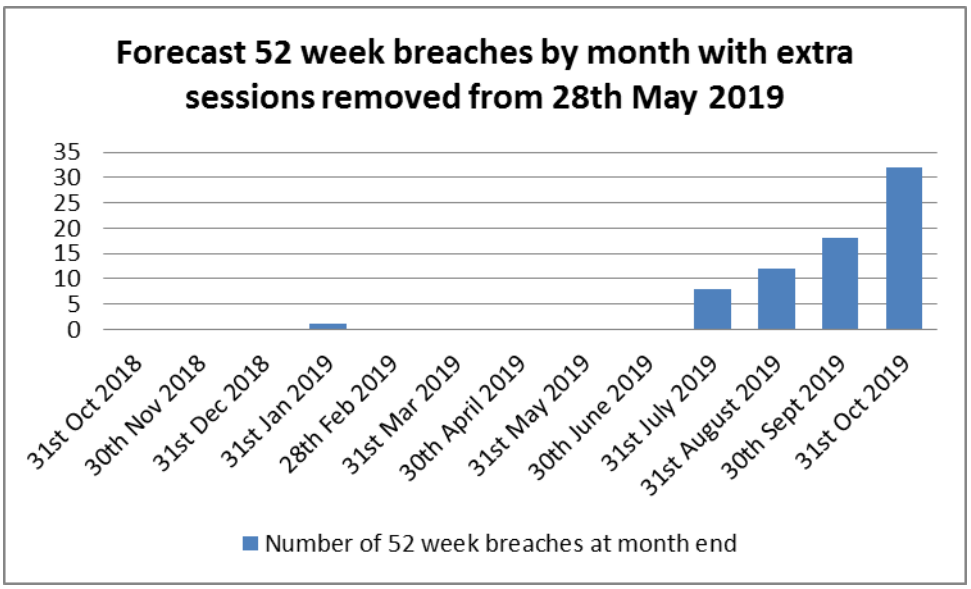
Specialist surgery	Specific risks around procedures such as silo-endoscopy, spinal surgery, paediatric orthopaedic surgery which are single handed or small numbers of operators and are being managed as extras. As an example there are currently 19 patients waiting for over 40 weeks for procedures from single handed practitioners who are routinely providing extras to keep their waiting list under control.
Outpatient extra sessions	98 adhoc clinics were run last week which at an average of 10 patients per clinic is 980 patients. This reflects the average run rate since the beginning of 2019 and has not yet been quite sufficient to reduce the non-admitted backlog to target level. If we assume that 30% of these clinics are agency and the remainder are extras, then losing sessions will result in adding 650 patients per week to the waiting list

Using this information to project the 18 week performance results in the following trajectory:



Although it is difficult to model the precise impact, under this scenario by the 31st October 2019 the accumulated backlog of patients to treat over and above business as usual to recover the performance is 4,732 and the total waiting list growth for the period is 12.4%. This would take many, many months to recover.

The expected impact on 52 weeks is predominantly linked to the specialist surgical capacity, where only one individual or a small team with significant capacity pressures are able to complete a particular procedure and are currently avoiding 52 week breaches by running additional sessions. The following trajectory assumes that we are able to displace routine activity for the first tranche of patients that reach 52 weeks, but that this becomes increasingly difficult.



3. Diagnostic Target

3.1 The most significant impact is on endoscopy with an average 10 sessions per week currently completed by consultants working extras to backfill annual leave etc. Only the colorectal team are currently delivering 52 week cover within the team job plan, due to consultant vacancies in Gastroenterology and Upper GI surgery. Around 98 patients per week capacity would be lost, resulting in pathway delays for 18 weeks and clinical risks from surveillance and routine diagnostics being deprioritised to support delivery of 2WW pathways.

3.2 The following table demonstrates the impact of losing the additional sessions and not being able to source alternative provision. With very few middle grade staff available to scope, and no nurse endoscopists, the only viable alternative would be to outsource significant activity to the private sector.

	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	43	35	40	38	38	48	43	48	18	13
% over 6 we	<1%	0.9	0.93	0.81	0.75	0.84	0.83	0.76	0.95	0.98	0.99	0.34	0.22
Total Waiting		4864	5138	5,324	4,654	4,740	4,533	4,987	5,031	4,378	4,871	5,267	5,659

	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Over 6 weeks		32	30	126	322	616	1008	1400					
% over 6 we	<1%	0.6%	0.6%	2.3%	5.6%	9.7%	13.7%	16.0%					
Total Waiting		5227	5,267	5,393	5,715	6,331	7,339	8,739					

4. Cancer Targets

4.1. For Bowel cancer screening, 2 lists per week are covered by a locum carrying out extras who has advised withdrawal of services. It is not possible to achieve the bowel cancer screening targets without this capacity (50% of total weekly lists).

4.2. The endoscopy delays described above will have a significant impact on Upper GI and Lower GI pathways within one month.

4.3. Breast one-stop clinics – currently 1 to 2 extra sessions per month are delivered by the breast surgeons and consultant radiologists, which are critical to meeting the 2 week cancer target

4.4. Cancer operations required at short notice are frequently listed as extras (around 3 lists per week) and not having the flexibility to call on consultants to do extra will mean that routine work is displaced or patients may miss the 62 day target by a few days. Whilst it is likely to be possible to mitigate the impact in June 2019 by displacing routine work, the delivery of the 62 day target will not be possible from July 2019 if the flexibility currently offered by consultants reduces.

	Threshold	Qtr1 18/19	Qtr2 18/19	Qtr3 18/19	Qtr 4 18/19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Cancer: two week wait from referral to date first seen (7), comprising either:												
all cancers	93%	96.4%	96.0%	95.8%	95.4%	93.7%	95.4%	93.2%	91.0%	89.0%	87.0%	85.0%
for symptomatic breast patients (cancer not initially suspected)	93%	93.8%	97.8%	93.4%	92.5%	93.2%	93.3%	91.0%	86.7%	86.7%	86.7%	86.7%
All cancers: 62-day wait for first treatment (4), comprising either:												
from urgent GP referral to treatment	85%	89.4%	86.4%	86.8%	88.4%	85.2%	86.5%	85.1%	77.3%	77.3%	77.3%	77.3%
from consultant screening service referral	90%	95.7%	93.5%	93.3%	90.8%	92.9%	93.5%	91.0%	90.1%	85.0%	85.0%	85.0%

5. Urgent operating sessions and Emergency Care

5.1 Weekend trauma list cover is currently 50% managed through extras and as a result services would have to pull anaesthetists from weekday sessions to cover which will further impact on the elective performance beyond the direct impact of lost cover shown above.

5.2 Currently 10 -15 additional sessions per month are delivered in the Emergency Department as shifts for enhanced consultant cover during the evening and night sessions. These sessions would be at risk, which reduces the senior decision making at the front door, and risks additional admissions.

5.3 The Evening Responsible Physician duty (providing a 2nd A-rota consultant physician at the front door) is delivered through 5 additional shifts per week in winter months. Ambulatory care cover for around 3 sessions per week is also delivered through extra consultant sessions due to the vacancies in acute physician posts.

5.4 NICU resident consultant cover for registrar gaps that are paid as extras currently will convert to agency spend. This equates to an average of two 11-hour shifts per week.

6. Summary

The effect of the pensions issue has been both rapid and dramatic and will lead to a sharp deterioration in performance. Unless a solution is found quickly, performance will continue to fall and, together with the withdrawal of senior clinicians from positions of responsibility, will have a devastating impact on this, and indeed all Trusts.

Information Governance (IG) Quarterly Board Report
July 2019

Purpose of this report:	• Update, information & awareness
Report by:	• Heidi Walker IG Manager/Data Protection Officer

Data Security & Protection Toolkit (DSPT)

Luton and Dunstable University Hospital NHS Foundation Trust published the assessment on the 31st March 19 as **Standards NOT met with improvement plan.**

The 6 month improvement plan was approved by NHS Digital and the department is on target to meet the 6 month deadline.

Following on from The Trusts submission on the 31st March the DSPT now has sixteen extra requirements and the Trust's current position is:

52 of 116 mandatory evidence items provided
0 of 40 assertions confirmed

A baseline DSPT will be submitted to NHS Digital on or before 1st October 2019. The figures above will increase significantly and be reported in the next quarterly report.

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.

There has been one reported incident (using this tool) for the last quarter.

1. Complaint full response sent to patient's previous address.

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:

Data Privacy Impact Assessment (DPIA)

The DSPT requires organisations to publish their DPIA's as part of the organisations transparency materials. A register of approved DPIA's is now published on The Trust website and updated on a monthly basis.

Data Flow Mapping & Departmental Information Assets

As part of the DSPT improvement plan, further engagement and departmental reviews within each area is being undertaken with a gap analysis on existing flow maps/assets.

The Information Governance department have recruited a deputy IG manager to support this business function.

This a legal requirement and failure to have detailed information mapping of all the Trusts personally identifiable data flows could leave the Trust open enforcement action/fines from the Information Commissioners Office.

Shared folders/access controls

To comply with GDPR, The Trust needs to have strict data access control and a full awareness of:

- what data they hold;
- why they are holding it and;
- what permissions they have to use it.

PID is stored within folders on the share drive and it's necessary for workflow, however; if staffs are saving PID onto departmental folders (within the share drive) they must ensure that only the relevant staff members have access to that information.

It is advised that all heads of department review which staff members have access to their departmental folders/drive. This action needs to be prioritised and awareness raised to ensure that staff access' to PID within folders/drives are legitimate and not excessive.

Without a clear option to audit the share drive user access and the controls surrounding it leaves The Trust extremely vulnerable.

Subject access requests (SAR)

Under the Data Protection Act 2018/GDPR we have 30 days to respond to a SAR; however we aim to comply with the Caldicott recommendation of 21 days.

The Trust continues to see an increase in requests for medical records and is currently receiving in the region of 800 a quarter from Solicitors and patients, Police, Courts, Council and other professional bodies.

The information governance department recently agreed to trial the processing of all Legal disclosures. It has been reviewed and decided that the department will continue to process the clinical negligence SARS but all other legal requests will be facilitated by the legal team.

The team are overstretched and are seeing compliance figures fall. It has been agreed that an extra resource will join the team for 2 days a week to support this function.

Compliance for responses within the legal 30 day deadline has dropped to 74% from 97.5% last quarter.

Year 2019/20		No of requests
Q1	April-June	**633**
Q2	July – September	
Q3	October – December	
Q4	January – March (to date)	

Total Received	

Requests received from	Number of Requests				
	Q1	Q2	Q3	Q4	Total
Patient	201				
Court Order/Social Services	12				
Solicitors	244				
Health Organisations	59				
Police	11				
Coroner	8				
Government	16				
Insurance	27				
Legal	47				
Other pending requests for June	179				

Freedom of Information (FOI)

Under the Freedom of Information Act public authorities are required to respond to requests no later than 20 working days.

The Act makes this clear:

"a public authority must comply with section 1(1) promptly and in any event not later than the twentieth working day following the date of receipt."

The compliance for The Trust Freedom of information requests is improving. The departmental process has been streamlined and deadlines closely monitored which is highlighted in the figures below:

Compliance for FOI responses this quarter has raised to 72.8% which is a huge improvement compared with the last quarter (43.8%)

Year 2019/20	No of requests	Breached Legal deadline of 20 working days
April-June	**198**	**54**
July – September		
October – December		
January – March		
Total Received		

Part of transparent processing is about being clear, open and honest the IG department are preparing to publish all FOI responses within its publication scheme. This will allow the trust to conform to guidance and hopefully reduce the amount of duplicate requests whilst raising compliance figures

Mandatory IG Training

The Trust must adhere to national guidance which requires Information Governance training to be completed annually.

As part of the DSPT improvement the development learning team are moving towards asking staff to complete Information Governance Training on a yearly basis. This update ensures that our staff are kept up to date with data security, and that they are equipped with the knowledge of how to spot potential online security threats as well as using data in line with legal requirements.

They plan to make this revision as part of a phased approach, continuing to report the current, two-yearly refresher via the monthly reports, but with the yearly requirement also highlighted to staff via the ESR Portal – Learner Homepage. This will give employees time to update their training if required, without making them immediately non-compliant through the move to annual updates.

This is one of the areas included within the DSPT improvement plan and the Information Governance department is awaiting an update from the development learning team.

<u>Current position</u>

Percentage of staff completing Information Governance training is 83 % every 2 years.

Percentage of board members completing IG training is 67%.

National Data Opt Out

The national data opt out is a service that allows patients to opt out of their confidential patient information being used for research or planning eg..

- for research purposes such as to identify the effectiveness of a new drug
- to provide information to support the safe and effective delivery of health and care services

- for a patient who has died, where they had previously set a national data opt-out

It was introduced on 25 May 2018 enabling patients to opt out from the use of their data for research and planning purposes, in line with the recommendations of the Nation Data Guardian in her review of Data Security, Consent and Opt-outs.

All health and care organisations in England must comply with the national data opt-out policy by March 2020

The Trust must:

- Implement a technical solution to enable staff to check lists of NHS numbers against those with national data opt-outs registered.
- Have a process in place to ensure only the filtered data is used or disclosed

The check for National Data opt-outs service uses the messaging exchange for social care and health (MESH)

The Trust does not currently comply with the National Opt-outs (as noted in the privacy notice) and Information Governance will be managing it locally until IT implements the relevant technical solution.

It is advised that The Trust view this as a high priority due to the fines associated with processing data unlawfully.

Bedfordshire, Luton and Milton Keynes

Integrated Care System

Central Brief: July 2019

Issue date: July 2019

News

Engaging communities to develop a plan for health and care transformation

A campaign to understand what is important to local communities about the future of health and care services across Bedfordshire, Luton and Milton Keynes (BLMK) has started with local health and care organisation's capturing the views of local people at events across the region.

The campaign, which will run until mid-September under the title #BLMKfutureNHS, will provide BLMK residents and communities with an opportunity to share their views about existing services and what is important to them for the future.

#BLMKfutureNHS will build upon the work that local organisations have done to involve and engage local people to shape the services that they use. Most recently Healthwatch in BLMK undertook a two month engagement programme to understand people's general views, as well as specific experiences of cancer and mental health care, and what they would like to see available in the future.

Over the next two months, teams will be talking to people and staff working in health and care services at public and staff events across BLMK. As part of this campaign, a dedicated stand will be in shopping centres or large supermarkets in Bedford, Luton, Milton Keynes and Central Bedfordshire (Dunstable, Biggleswade and Leighton Buzzard) during July, August and September. People will be able to take part in a short questionnaire and talk to members of the team about health and care services.

The main dates and locations are as follows:

- Tesco Dunstable, Saturday 27 July
- The Mall, Luton, 1-3 August (Thursday to Saturday)
- Harpur Centre, Bedford, 8-10 August (Thursday to Saturday)
- Centre MK, Milton Keynes, 12-14 September (Thursday to Saturday)

The engagement team will be out and about at local community events encouraging people and communities to share their views. A full calendar of events and meetings that the team will be attending is available on the BLMK ICS website – www.blmkpartnership.co.uk. In addition, a survey will be uploaded to the ICS website and this will go live from Monday 29 July

The campaign will support the development of a five year plan for health and wellbeing for our area, based on feedback from local people and communities and developed by the 15 partners of the BLMK ICS*. This is partly in response to the NHS Long-term Plan which was published earlier this year and sets out the priorities and ambitions for the NHS to meet the changing needs of the country's growing population.

PCN Shared Learning Event

In May, the ICS hosted a Primary Care Network Shared Learning Event for over 140 colleagues across BLMK, NHSE and other systems hoping to learn from BLMK.

The event provided an opportunity for established PCNs to share practical examples of the things they've done and what they've learnt along the way. Attendees were invited to test and challenge approaches and help shape and adapt methodology to ensure it works for different populations and partner organisations across BLMK and beyond.

Attendees also learnt more about the Primary Care Home approach to population health management and integration, team-based working and how it can be applied to local communities, network, organisation and teams.

BLMK formally introduced the Primary Care Home (PCH) model in 2018/19, a type of PCN, to provide clear underpinning principles and methodology for all those responsible for developing PCNs across the ICS. Since April 2018 BLMK has been working with the National Association of Primary Care to co-design, develop and test bespoke approaches and BLMK-specific methodology to build and embed PCNs and PCN ways of working

If you have any queries following the event or are seeking some support with developing your PCN, do get in touch with Sarah.Forster@mkuh.nhs.uk.

Milton Keynes High Intensity User Scheme – Parliamentary Awards 2019
Earlier this month a scheme to help some of the most vulnerable and lonely people in society won a prestigious regional Parliamentary Award. The High Intensity User team delivered by P3 at NHS Milton Keynes Clinical Commissioning Group have taken a new approach to helping some of the most vulnerable and lonely people in our society to flourish, whilst saving NHS resources through sustainable reductions of in A&E attendances; 999 calls and non-elective admissions.

The High Intensity User programme that is being delivered through Milton Keynes CCG uses the core principles of a de-medicalised, de-criminalised and humanised approach, providing a personalised response to each individual's circumstances. Results shows that 999 Ambulance calls and hospital admissions drop by about 90% among the group. The impact was not just felt by the health community as calls to the police 999 and 101 numbers from this group also reduced by 52%.

The individuals classified as high intensity users have been stuck in the 'revolving door' of unscheduled care for years and have clearly benefited from a different approach. Quite often it is thought that this is a problem with the elderly who feel isolated and have complex health needs. However, the cohort usually consists of a large proportion of people in the 35-45 age groups covering several professional groups, not just the unemployed.

The model used by Milton Keynes CCG forms part of the NHS RightCare High Intensity User Programme. The programme is being scaled up and spread across the country by NHS RightCare. NHS RightCare is a national programme of NHS England and NHS Improvement.

We are considering how the High Intensity programme might apply in the others places within BLMK.

What is stepping into my shoes?
The initiative has been developed to support local leaders to work together, learn and share knowledge from across the system to create public services that are more integrated based on the needs of the local population.

It is an informal staff development opportunity that involves creating an 'interchange' of learning experiences and is a simple concept of matching learners and sharers together with the intention of a mutual learning opportunity. The Learner shares what they are looking for in terms of experience in another organisation while the Sharer reveals their skills and knowledge and in what capacity.

Some organisations already have similar schemes within their own organisation, however, this expands the range of opportunities to include organisations from health and social care and across different sectors e.g. hospital, general practice, community health, mental health and council.

Developed to support local staff to work together, learn and share knowledge from across the system to create public services that are more integrated based on the needs of the local population. The scheme would therefore benefit those staff, clinical and non-clinical, that have identified leadership development within their

personal development plans, and particularly those staff that are supporting integrated ways of working across organisations and health and social care sectors.

The initiative is running across all Bedford, Luton and Milton Keynes locations. More information is available on the right hand side of this page.

To find out more click here.

Events

The Child and Adolescent Mental Health Service Stakeholder Meeting

When: 9 September 2019

Where: tbc

If you are interested in discussing Child and Adolescent Mental Health Services in Bedfordshire or wish to share feedback, then please come along and meet us at our Stakeholder Forum.

Children and Young People Personalised Care Workshop

When: Wednesday 18 September, 2019

Where: Rufus Centre, Steppingley Road, Flitwick, Bedfordshire, MK45 1AH

Time: 10.00 – 4.00pm

BLMK ICS will be hosting to a special workshop focussed on **children and young people's personalised care.** The aim of the event is to jointly review and develop the children's Personalised Care agenda going forward. The session will be supported by CYP Leads from the Personalised Care Group within NHS England.

BLMK are a demonstrator site for Personalised Care and we are working to embed the Personalised Care approach across our health and care system. We are now keen to support additional progress with personalisation for children and young people; learning together from what has been achieved so far in order to understand what needs to happen next.

Objectives for the workshop include:

- Recap on our personalised care objectives as service areas that are part of a health and care system for children and families, to include person centred care and support planning, personal health budgets etc.
- Review current position, using the self-assessment tool, and consider best ways to take the agenda forward
- Outline the progress made to-date and highlight the support on offer from NHSE as part of the Personalised Care Programme and identify where we can benefit from support going forward
- Review workforce and development, including training, that will be required
- Consider how the approach is co-produced within BLMK and how we communicate with families/service users
- Agree next steps and actions to move the Personalised Care agenda forward for CYP.

Food and refreshments will be provided at the event.

To register for this event please click here.
To keep up to date with latest news

Follow us at: @BLMKPartnership
www.blmkpartnership.co.uk

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

BOARD OF DIRECTORS

Agenda item	8	**Category of Paper**	Tick
Paper Title	Performance Reports	**To action**	☐
Date of Meeting	31 July 2019	**To note**	☒
Lead Director	1. Liz Lees, Chief Nurse / Cathy Jones, Deputy CEO / Catherine Thorne, Director of Quality and Safety Governance 2. Matt Gibbons, Interim 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 May-July 2019, FIP May –June 2019, Executive Board July 2019	
Links to Strategic Board Objectives	Objective 1 – Deliver Quality Priorities (patient experience, patient safety and clinical outcomes) Objective 2 – Deliver National Quality and Performance Targets Objective 3 – Implement our New Strategic Plan Objective 4 – Develop all Staff to Maximise Their Potential Objective 5 – Optimise our Financial Position	
Links to Regulations/ Outcomes/External Assessments	CQC Internal Audit HSE External Auditors	
Links to the Risk Register	Agency Costs HSMR Vacancy rate	Bed pressures Appraisal Finance costs 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 – Apr – June 2019

RAG Key:

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

	Topic	Page No.	Internal threshold – in month RAG
1	**Pressure ulcers** Following changes in national reporting the number of HAPUs remains higher than in the previous quarter. June had the lowest number of HAPU in Q1. There has been a change in the profile of categories with an increase in category 1 and a decrease in categories 3 and 4. This provides assurance that skin integrity check compliance has occurred.	**2&3**	
2	**Falls** There was a total of 218 falls in Quarter 1. This is a 9% decrease from the same quarter last year. The number of falls per 1000 bed days remains at the external falls review recommendation of 4.8 and below. There were 6 moderate harm and 2 severe harm incidents. The Trust is currently implementing the National CQUIN for Falls prevention for all patients over 65.	**4**	
3	**CAUTI & VTE** Catheter usage rose in April and May but dropped again in June. 2 CAUTIs were reported in May. VTE risk assessment remains consistently good.	**6**	
4	**Infection Prevention and Control and Cleanliness** New criteria for allocation of Clostridium difficile infections came into force from 1 April 2019. The revised ceiling for our Trust is 19 cases. In the first 3 months we have recorded 11 cases that will be allocated to the Trust. Excessive use of broad spectrum antibiotics, compliance with hand hygiene, inconsistent use of probiotics and excessive reliance on glove use are some of the emerging themes.	**7**	
	The High Risk category areas continue to fail to achieve the required standard for cleaning.	**8**	
5	**Cardiac Arrest Rate** Over the last 6 months the average cardiac arrest rate has compared favourably to last year. There were 7 cardiac arrests in May but no concerns regarding monitoring and escalation in these requests.	**9**	
6	**Incidents and serious Incidents** A piece of work to address the numbers of incidents that have not received final approval. However, all of the open incidents have been subject to review and are under investigation.	**10, 11**	
7	**Patient Experience / Complaints** Friends and Family Test response rates – our FFT remains above the national average for response and recommender rates for both inpatients and the Emergency Department. Maternity and Outpatients are above the national average for recommend, however	**12, 13, 14, 15, 16**	

	both areas struggle with response rates. The national Inpatient and Maternity CQC survey results are about the same as previous years.		
	There were 30 formal complaints declared in June which is the lowest is has been since January. The percentage of complaints responded to within 35 working days was 69.81% in June. The Chief Nurse has asked Divisions to endeavour to raise the response rate to 90% by August 2019.		
8	**Mortality** Crude death rate, SMR and SHMI continue on a downwards trajectory **Fractured Neck of Femur** The HSMR for fractured neck of femur has remained consistent for the months January to March 2019 and is lower than the same period last year at 123 (compared to 144 Apr 17 to Mar 18). The proportion of patients being admitted directly to the #NOF ward is consistently better since Nov 2018.	**17,18**	
	Learning from Deaths There were no deaths identified in Quarter 4 for which the SJR outcome was 'likelihood of avoidability'.	**19**	
9	**Cancer** Achievement against all cancer standards in March 2019**.** Quarterly performance was green across the board apart from symptomatic breast patients which was due to patient choice. There has been a significant peak in the number of urology breaches as a result of the new national re-allocation guidance. Where the L&D has not been able to complete the diagnostic phase of the pathway within 32 days, historically E&NH Trust has had long delays so the whole breach has been shared. In May, the treatment times at E&HT have reduced and so the whole breach was reallocated to the L&D.	**20, 21, 22**	
10	**Emergency Department performance** The Trust has been selected as one of 14 sites to field test the proposed new clinical access standards and so is not publishing 4 hour access standard data during the pilot period.	**23, 24**	
11	**18 Weeks** The Trust did not deliver the 18 week target for April, May or June 2019.	**25**	
12	**Stroke** The Jan - Mar SSNAP report has been published and our overall performance has returned to a B rating. The challenges with the number of patients arriving on the stroke ward within 4 hours continue, with performance significantly under the 80% quality target.	**26, 27**	
14	**Diagnostics** The number of patients waiting over 6 weeks was within the target although the number of breaches rose reflecting the significant capacity challenges the Trust is experiencing currently.	**28**	
15	**Late Cancellations** All patients whose surgery was cancelled on the day had their procedure rebooked within 28 days during June 2019 and there was a drop in the percentage on the day cancellations.	**29**	

16	**Length of stay** The Trust has a target to reduce the number of 'super stranded' patients (those staying over 21 days) to an average of 57 beds occupied by patients with a length of stay of over 21 days. The Trust achieved this number for the first time in July 2019.	**30**	
17	**Dementia** In April and May 2019 the trust achieved the screening and referral standards but has not consistently documented delirium assessments in the cases audited. This will improve with deployment of the Nervecentre ICC in the autumn.	**31**	

Quality & Performance Report

April, May & June 2019 data

Chief Medical Adviser

Chief Nurse

Deputy Chief Executive

Director of Quality

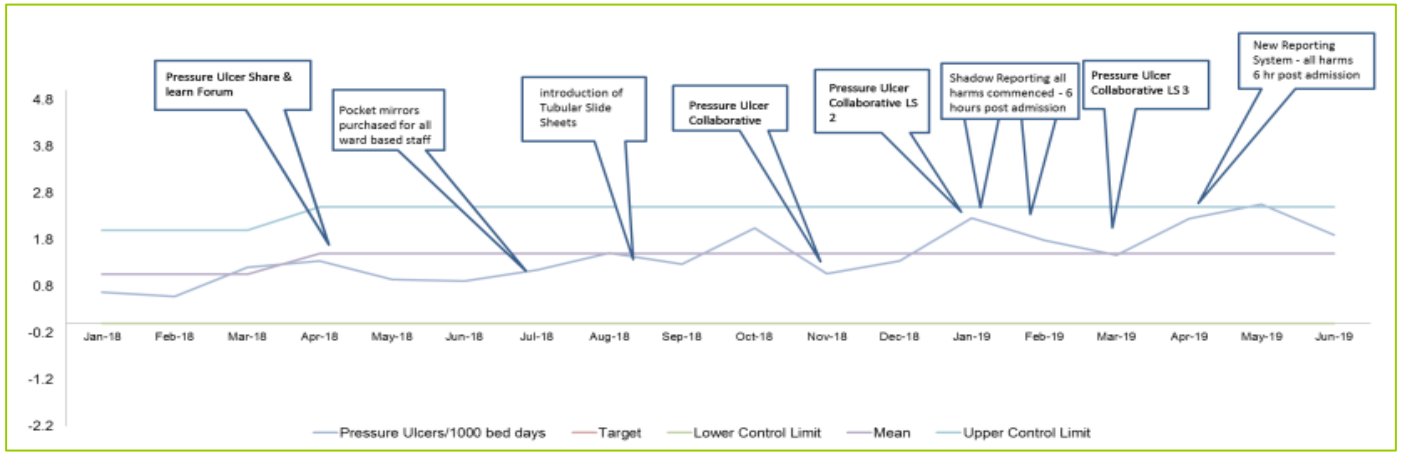
Harm Free Care

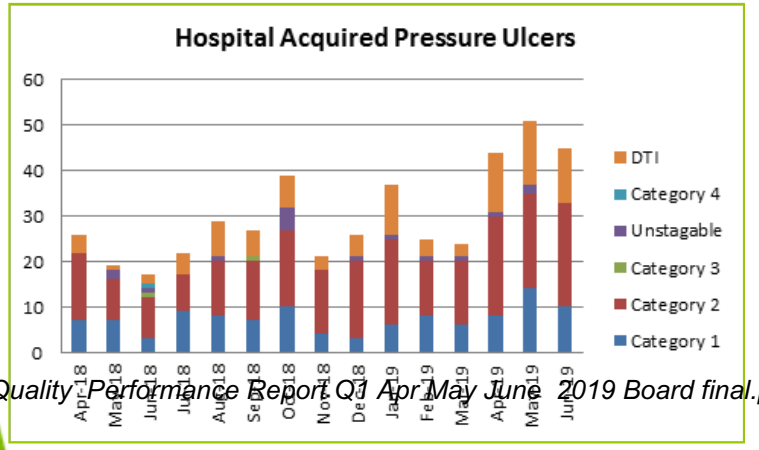
Safe | Effective | Caring | Responsive

Pressure Ulcers

From April 1st in line with NHS Improvement recommendations (June 2018), new reporting of hospital acquired pressure ulcers (HAPU) came into effect. In accordance with the new guidance this report will include all categories of pressure ulceration, identified after 6 hours of admission. This will include Categories (Grade) 1 to 4, Deep Tissue Injuries (DTI) and unstagable pressure ulcers where depth cannot be determined (previously referred to as Unclassified Category 3). Pressure ulcers caused by medical devices, i.e. Anti-Embolitic Stockings, Oxygen Delivery devices, Plaster of Paris, will be reported as Device Related (DR).

In the reporting period (April – June 2019) there was a total of 133 HAPU's. The table below illustrates the breakdown by category. Of the 133 pressure ulcers 17% (n=23) were caused by medical devices, 4 Category 1, 15 Category 2, 2 DTIs and 2 unstageable.



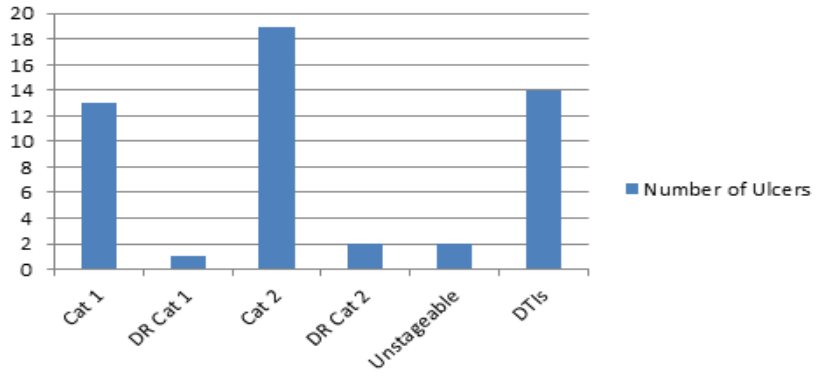


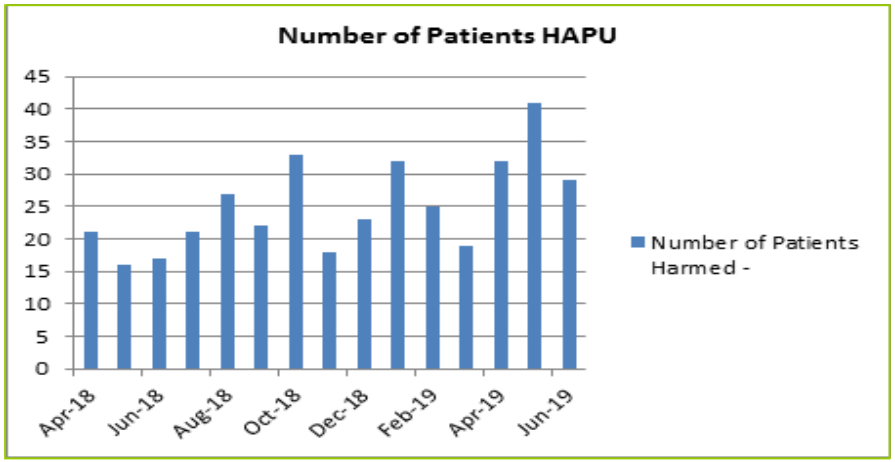
The chart opposite illustrates the total number of HAPU by category that have occurred by month since April 2019. This includes all categories 1-4, DTIs and unstagable pressure ulcers.

Harm Free Care

Safe | Effective | Caring | Responsive

Pressure Ulcers





Pressure Ulcer Prevention update

Although the overall number of HAPU remains high the increase in the number of incident reports (1485) provides assurances that staff are completing skin checks, and are much more aware of device associated skin damage. The changes to guidance on the identification of pressure damage on admission from 72 hours to 6 hours has proved extremely challenging, however 86% of pressure ulcers/moisture lesions are identified within 6 hours at the front door. We have seen significant skin and pressure ulcer risk in EAU. Overall the pattern of reporting has changed over Q1. There were no Category 3 or 4 pressure ulcers reported during Quarter 1 and no unstageable pressure ulcers in June. There was an increase of category 1 pressure ulcers by 40%, this would indicate that staff are identifying damage at an earlier stage.

Total number of patients with HAPUs – the graph above shows the number of patients who developed pressure damage whilst in the care of the Trust; again this has been adjusted to reflect NHS Improvement guidance. In the reporting period 104 patients developed 133 pressure ulcers, 32 patients in April, 43 patients in May and 29 patients in June.

Of the 43 patients in May, 17 of the HAPUs occurred on 7 patients. Two patients in this group were palliative, one patient with 3 DTIs, a subsequent RCA indicated no lapses in care were found. A gentleman who was being nursed in a prone position restricting the options for repositioning also incurred 3 areas of pressure damage.

Next Steps – Many of the RCA outcomes of pressure damage has identified the timeliness of assessments and time to equipment use as being a theme. A focused piece of work has commenced to explore the impact multiple ward moves has on documentation and interventions taken.

The Tissue Viability team is working with Operational Contracts Service Delivery Team and Ward Managers from EAU 1, 2, Ward 3 and A&E to explore options for alternative approaches to meeting our patient and dynamic mattress service needs. One pilot being trialled in EAU and MSS is using the Repose Mattress before patients are moved to a base ward where they receive a full assessment. It is anticipated that the repose does not need to change. The clinical areas involved are committed to early identification and interventions to reduce the risk of pressure damage occurring within the first few days of admission.

Harm Free Care

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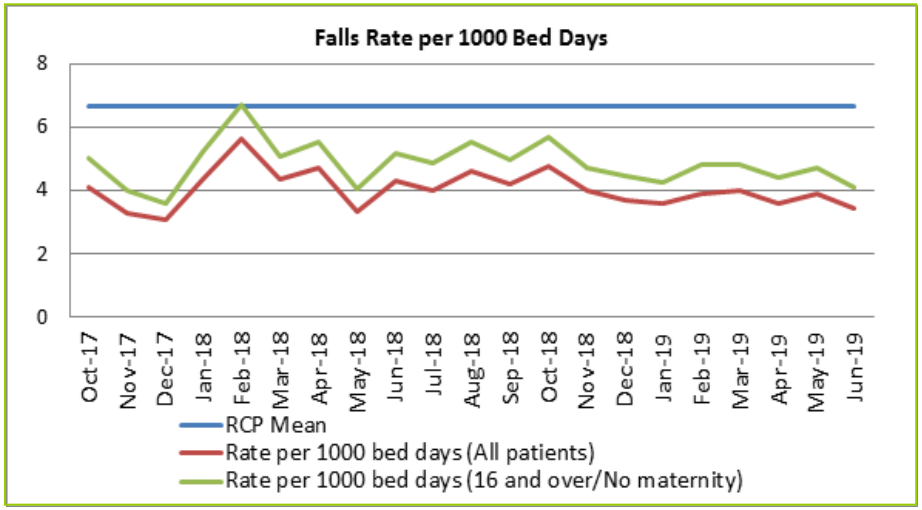
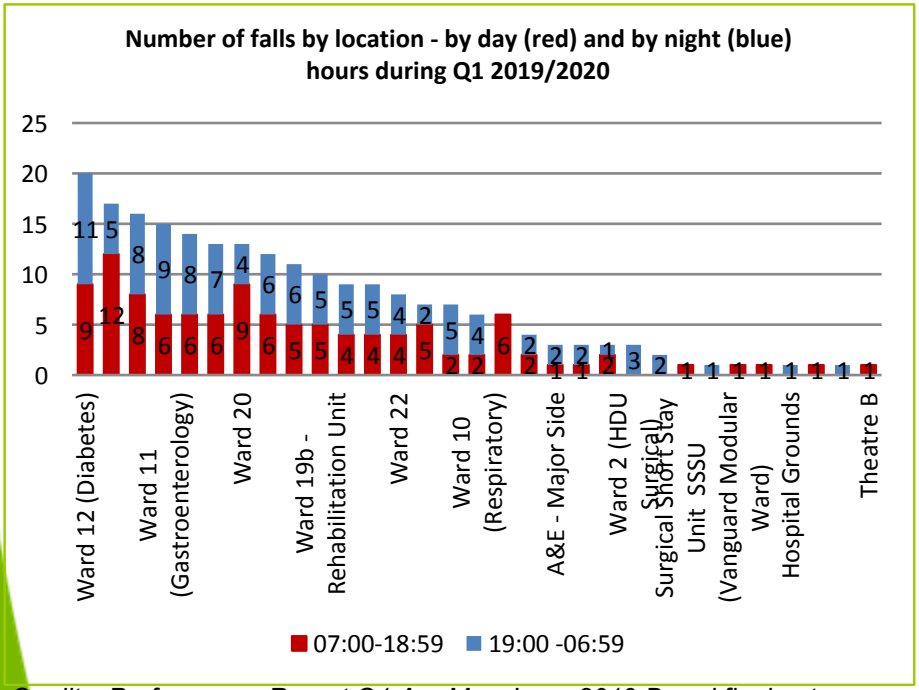
Falls





Inpatient falls

In April, May and June there were 72, 79, and 67 falls respectively (218) in total. This is a decrease of 9% from the same quarter last year. In Q1 the number of falls per 1000 bed days was 3.4 for whole Trust and 4.1 for the RCP rate. The rate continues to remain below external review recommendation of 4.8.

Complex Medicine had 28% of the falls, Medicine 23%, Surgery 19% and Emergency Medicine 17% with the remainder between Stroke, Contingency and Women & Children Divisions.

There has been noted an improvement in the number of falls on wards 14 and 15 where the Baywatch initiative was initially piloted. The system is now embedded in "day to day" activity with Ward 15 having reduced the number of falls by half in the first 6 months of this year in comparison to 2018 (52 to 26).

Following increased falls activity on Ward 19a, the Falls Clinical Nurse Specialist attended their "Team Day" to promote falls awareness and risk reduction strategies.

Injurious falls

There were 6 moderate harm falls reported over the quarter and 2 severe harm fall incidents.

The severe harms were both #NoF that required surgery. 1 of these has been reported to the CCG due to potential omissions in care. The number of injurious falls equates to the same number as Q1 last year.

There were 4 falls with low harm reported on the Safety Thermometer.

Harm Free Care

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Falls

Falls Prevention initiatives

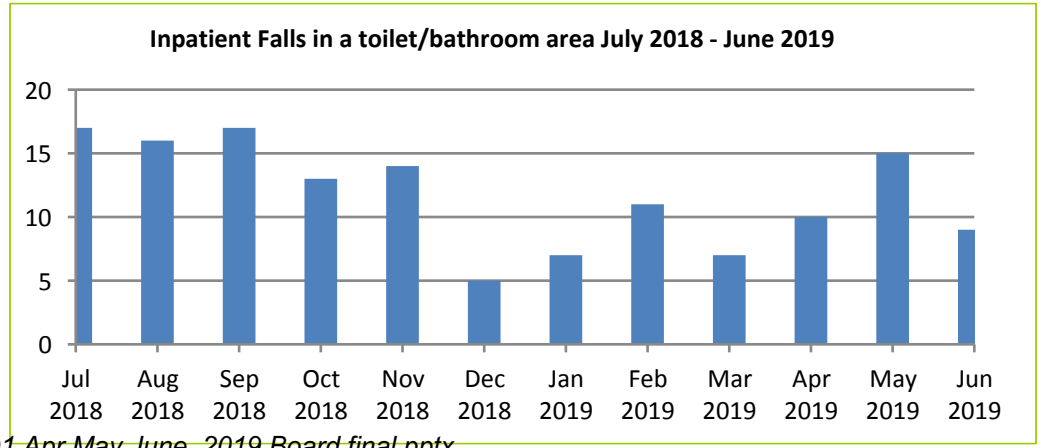
The improvement work in the toilet and bathrooms continues. The grab rails have now been installed and work is ongoing looking at call bell placement and review of toilet seats. There has been an increase in falls in toilets with 34 reported (there were 25 in the previous quarter). Falls in these areas were across the Trust and deemed to be as a result of human factors as opposed to issues with equipment. The need to reinvigorate the importance of patient assessment and safety when using the bathrooms and toilets has been highlighted to Matrons and Ward Managers for dissemination to staff.

The "Get up, Get Moving" campaign was launched in June. The initiative supports patients to get up and out of bed and to keep as active as able whilst an inpatient. Getting patients up and moving has been shown to reduce falls, improve patient experience and reduce length of stay.

The Trust is currently participating in the 2019/20 National CQUIN on Patient Safety - "Three high impact actions to prevent Hospital Falls". The focus is on three key falls prevention actions for all patients aged 65 and over.

1. Lying and Standing blood pressure recording
2. Review of the use of hypnotics, antipsychotics or anxiolytics. If given clear rationale documented.
3. Mobility assessment within 24 hours of admission and if needed walking aid provided.

The initiative is currently being rolled out across the Trust with the first set of data (Q1) due to be audited by the end of July.



Harm Free Care

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Catheter Acquired UTI

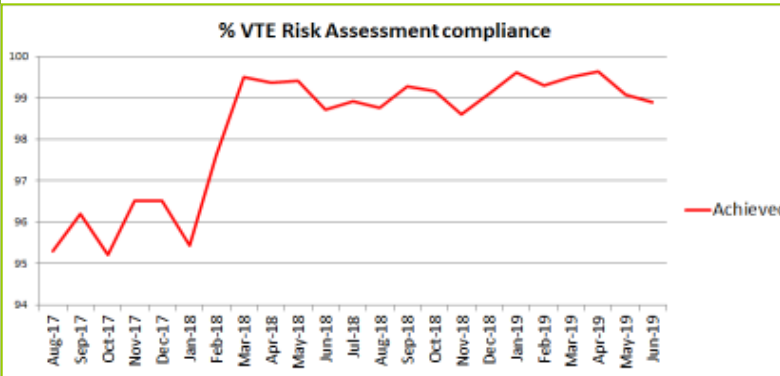
Use of Urinary Catheters:
Between March and May catheter usage rose from 16.34% to 17.18%. June saw a drop to 14.76%, a 3% decrease. (Mean for the last 24 months is 17.34%)

The safety thermometer data recorded no CAUTIs in March or April, 2 were reported in May 2019. RCAs were completed and highlighted 2 key areas on which to focus improvements: communication and documentation. The managers have agreed to make this part of their daily safety briefs reminding staff of the importance of documenting the reason for catheter insertion.

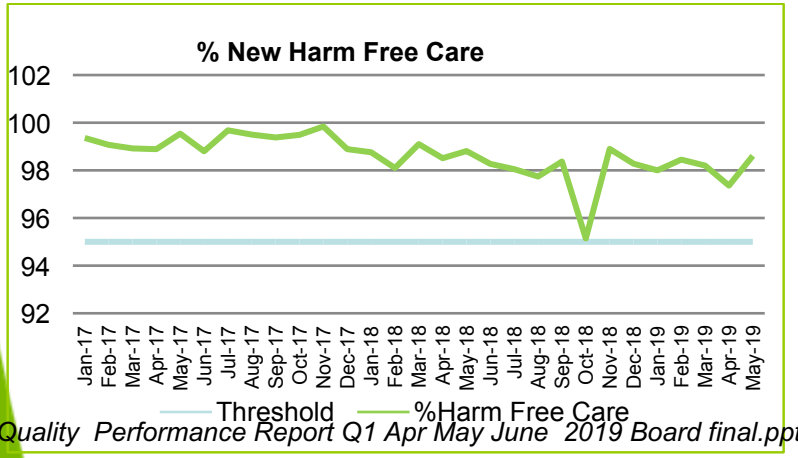
Awareness of bowel management for spinal patients has improved and there are now 23 members of staff trained in bowel care. The continence nurse commenced a new clinic once a month for urology patients. The urology/oncology and the urology team consider the service provides a better pathway and support for patients with continence problems after treatment.

To ensure staff are bladder scanning correctly, a new phantom bladder has been purchased and 3 training dates arranged. Also, with a supplier, the CNS conducted a product evaluation of a new pad. The results demonstrated better consistency between the community and acute setting. The number of products in use was reduced from 38 to 8 products with a cost saving of £20,000 over 9 months.

VTE



VTE Risk Assessment:
In June 98.90% of patients were VTE risk assessed on admission.
The Thrombosis committee continues to strive to support appropriate and complete risk assessments. The overall aim is to reduce incidence of avoidable hospital acquired thrombosis by also ensuring provision of prophylaxis to appropriate patients.



New Harm Free Care
The Harm Free Care data is sourced through a one day snapshot audit. The Trust has delivered harm free care well above the national expected threshold of 95% for the quarter. The overall decrease in the last year correlates with an increase in pressure damage reporting.

Infection Control

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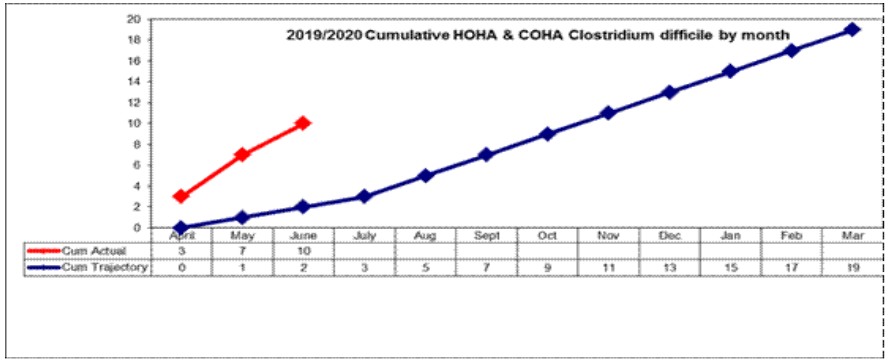
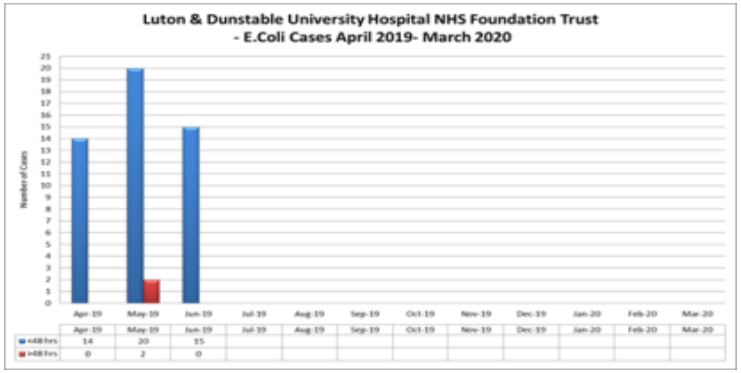
MRSA/C.Difficile/E.Coli

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
C Diff	0	1	0	0	0	0	1	0	1	0	0	1
MRSA	0	0	0	0	1	0	0	0	0	0	0	0
E.Coli	2	5	3	1	6	2	2	4	1	4	1	5

New reporting from 1st April 2019

	Apr-19	May-19	Jun-19
C Diff	3	4	3
MRSA	0	1	1
E.Coli	0	2	0





C. difficile – There were 3 Community Onset Healthcare Associated (COHA) cases in June with a total 10 cases for the year to date. The outcomes of the RCA performed by the clinical teams are shared with the CCG infection control team (ICT) and will be used for learning within the hospital and wider community.

MRSA bacteraemia –There has been one hospital acquired MRSA bacteraemia in June; the post infection review (PIR) is in progress.

E. coli bacteraemia – The largest number of cases continue to be identified on admission.

The changes to the CDI reporting algorithm for the financial year 2019/20 are:

- Reducing the number of days to identify hospital onset healthcare associated cases from >3 to >2 days following admission
- Community of healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the Trust reporting the case in the previous 4 weeks
- Community onset indeterminate association: cases that occur in the community (or within 2 days of admission) when the patient has been an inpatient in the Trust reporting the case in the previous 12 weeks but not the most recent 4 weeks.

Month	Returns	Before patient contact	Before clean/aseptic	After body fluid exposure	After patient contact	After contact with patient surroundings
April 2019	1982	90%	92%	93%	93%	88%
May 2019	1843	91%	91%	95%	95%	90%
June 2019	2194	88%	94%	94%	92%	88%

Hand Hygiene - In June, 25 out of 42 wards recorded more than 50 hand hygiene opportunities observed with the rest recording between 2 and 49 over the month.

Cleanliness

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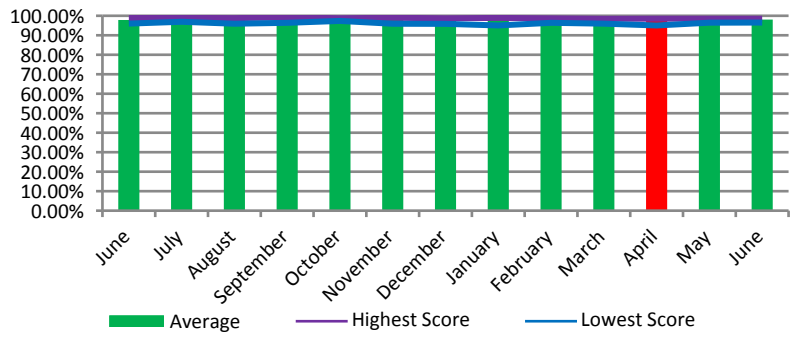
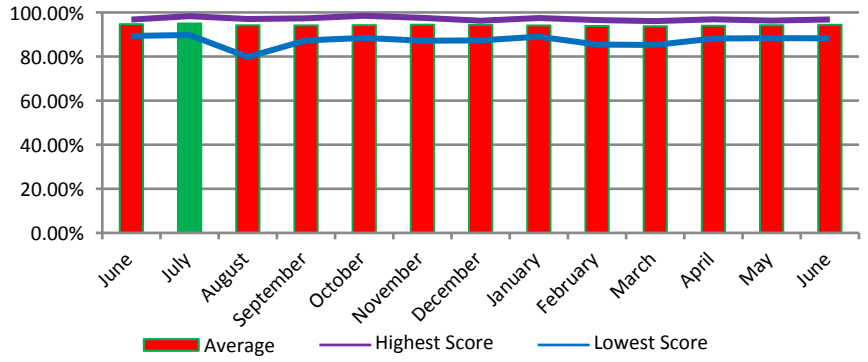
The graphs below show the average audit scores in respect of the cleaning service. Although the High risk areas have failed to achieve the target score for the 11th month in a row, the June score was an improvement for the third month and the early signs are that the areas continue to improve into July. With the introduction of a Deep Clean Team for ward kitchens and patient bedside tables this has a positive impact on the overall scores to date, therefore there is an expectation for all areas to achieve the target score in July.

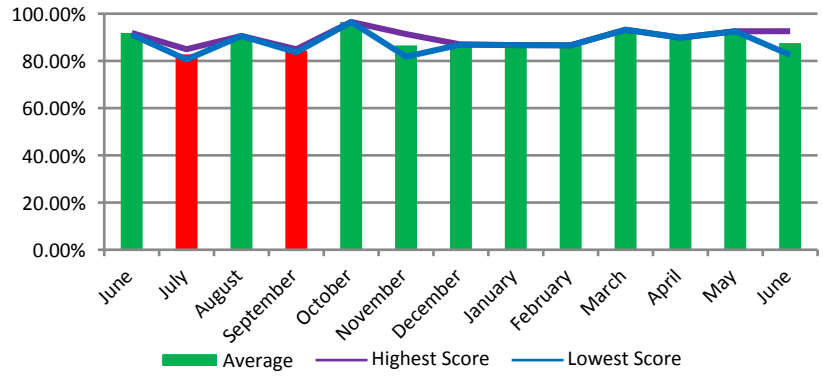
VHR Audit Score June 2018-2019
Target (98%)



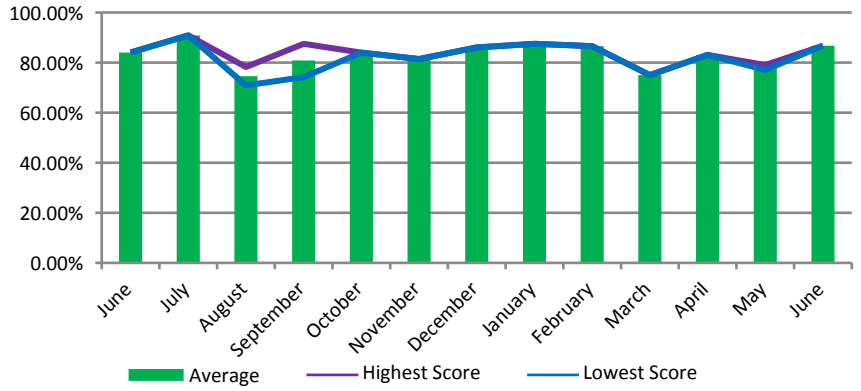
HR Audit Score June 2018-2019
Target (95%)



SR Audit Score June 2018-2019
Target (85%)

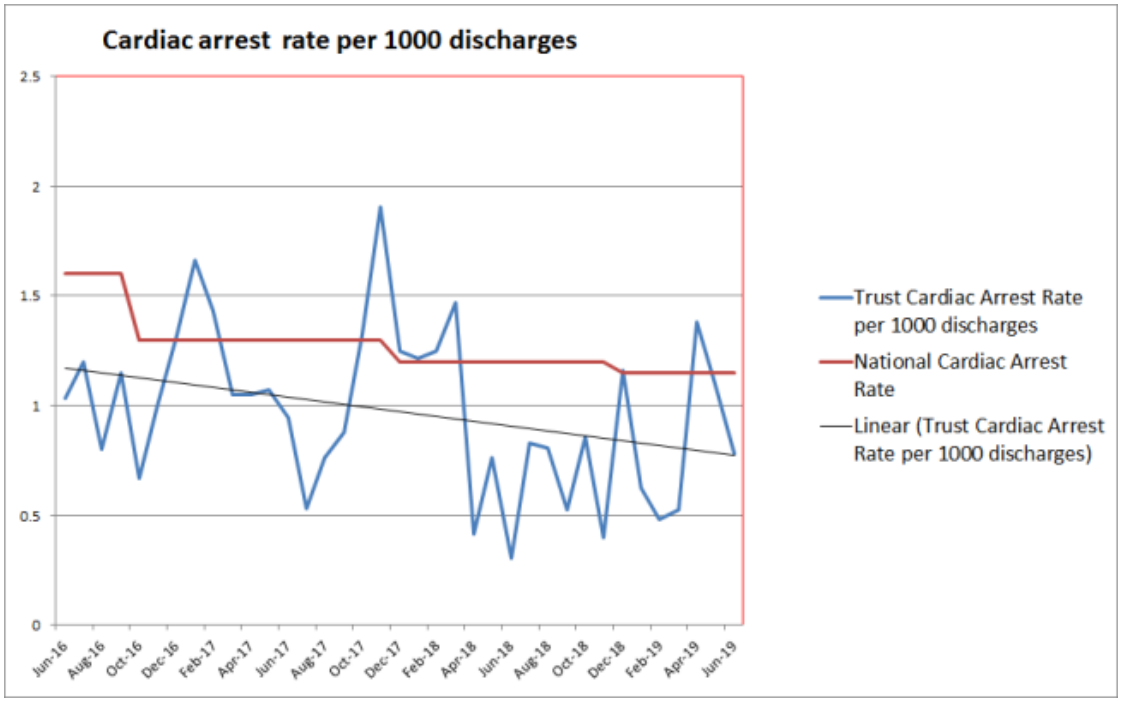


LR Audit Score June 2018-2019
Target (75%)



Cardiac Arrest Rate

Safe | Effective | Caring | Responsive



Improving the Management of the Deteriorating Patient

Over the last 6 months (Dec to May) the average cardiac arrest rate has been 0.81 which compares favourably to last year where the rate was 0.9 for the same period.

There were 7 cardiac arrests in May – there were no concerns regarding monitoring and escalation in these arrests.

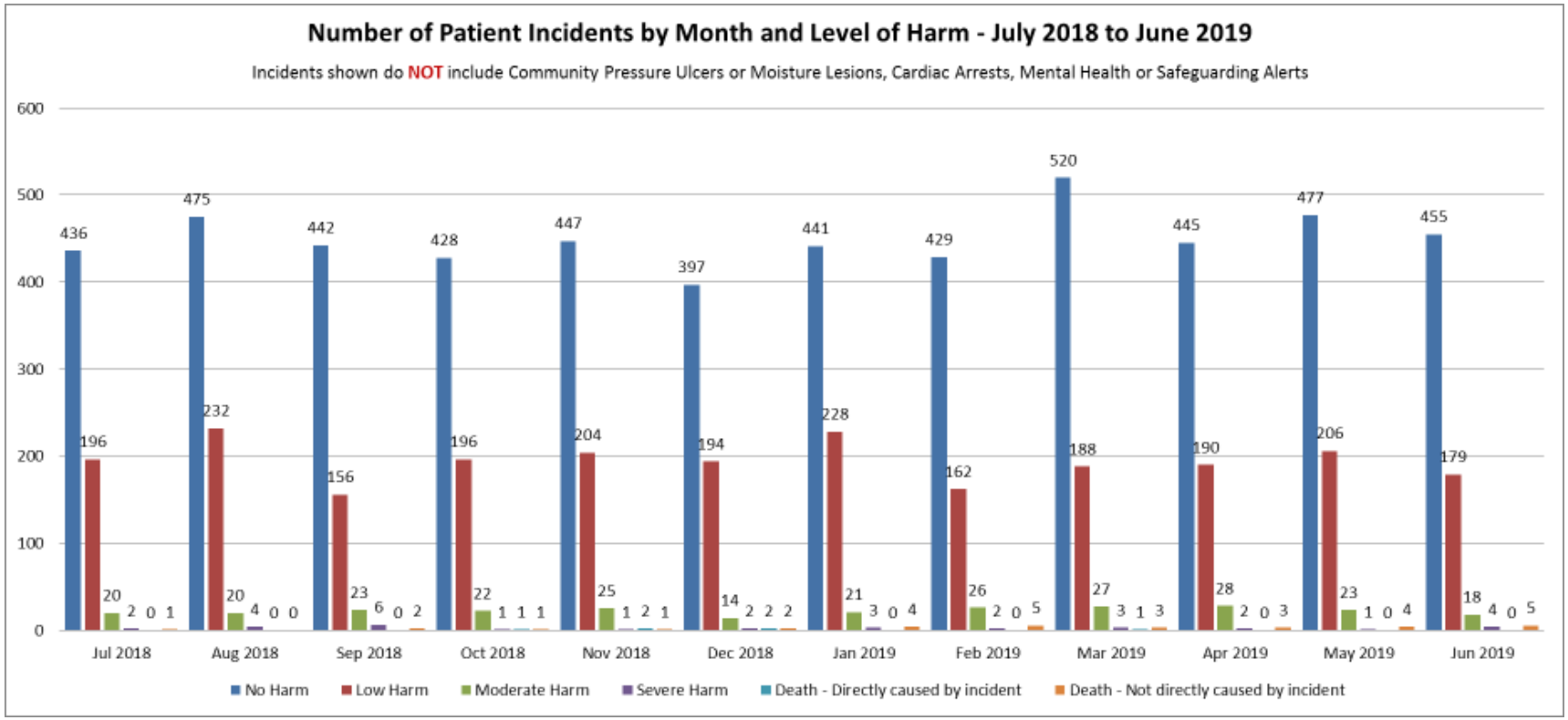
Improvement activities

Staff in all areas are in the process of undertaking the Royal College Physicians e-learning training package as part of the planned transition to NEWS2. This package not only outlines the differences between NEWS1 and 2, but reminds staff what action to be taken when a patient is deteriorating.

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 and overdue incidents. This report is sent to divisional management and clinical leads. The number of overdue incidents is reducing every month. A focussed piece of work has been undertaken to reduce the number of incidents by supporting the teams to develop sustainable processes for the management of incidents.

Incidents Awaiting Review			Incidents Being Reviewed			Awaiting Final Approval			Total		
Open	Total Overdue	% Overdue	Open	Total Overdue	% Overdue	Open	Total Overdue	% Overdue	Open	Total Overdue	% Overdue
36	0	0.0%	1580	1104	69.9%	388	257	66.2%	2004	1361	67.9%

Incidents

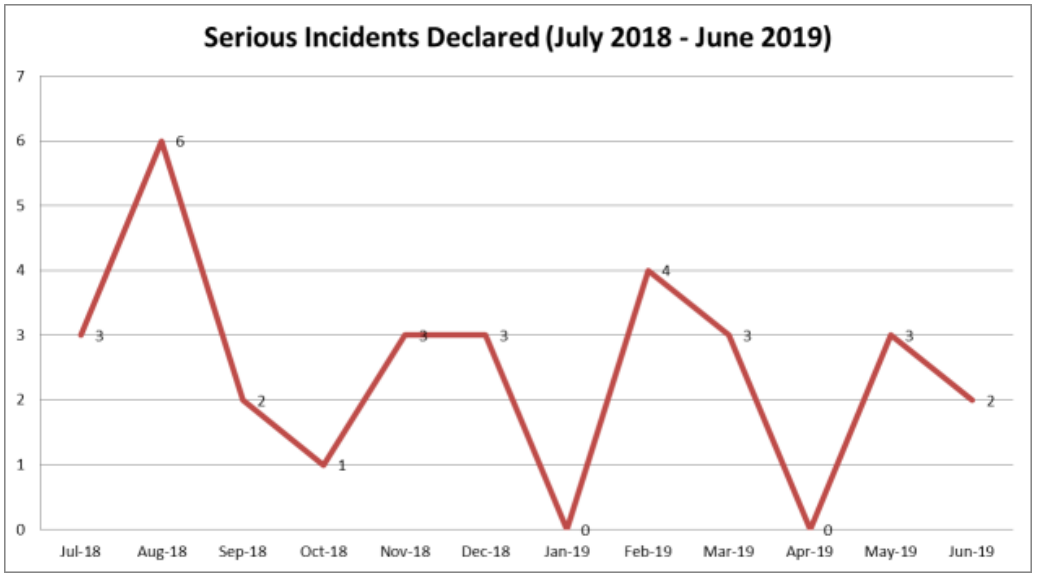
Safe | Effective | Caring | Responsive

Never events , serious incidents and clinical incidents

Duty of Candour Compliance:
A statutory Duty of Candour applies to all patient safety incidents where there has been an act or omission in care or treatment resulting in moderate harm, severe harm or death
Data is reported in arrears and lists **verified** incidents

	March-19	April 19	May 19
Number	5	1	TBC
Compliance %	5	1	TBC

	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
2018/19	4	3	3	3	6	2	1	3	3	0	4	3	35
2019/20	0	3	2										5



Serious Incidents – 2 serious incidents were declared in June 2019

- Baby born in poor condition requiring cooling
- Patient fall from trolley sustaining a fractured neck of femur

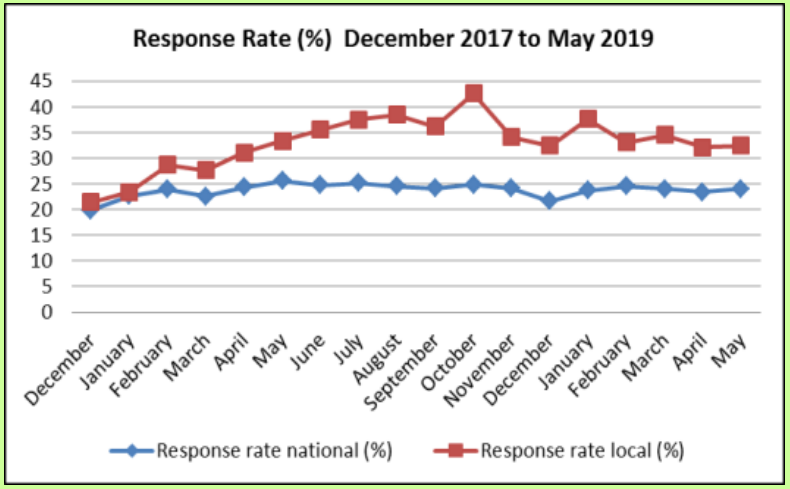
At the end of June the Trust had a total of 28 open Serious Incidents:

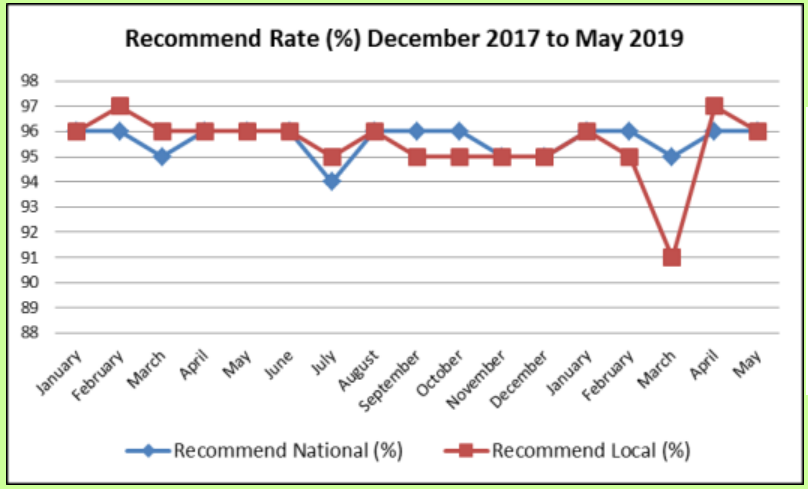
- 6 incidents under investigation
- 22 incident was awaiting comment/closure from Luton CCG

Patient Experience

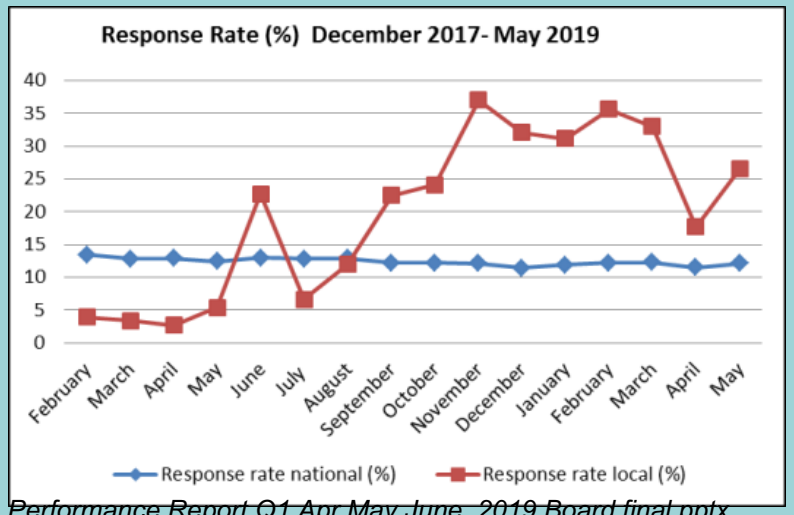
The Friends and Family Test (FFT) scores are published each month by NHS England enabling benchmarking against other Trusts in England. The FFT asks the question ***'how likely are you to recommend our service / ward / birthing unit to friends and family if they need similar care and treatment'.*** *The graphs below show comparison response rates for the four areas of Inpatients, Emergency Department, Maternity and Outpatients.*

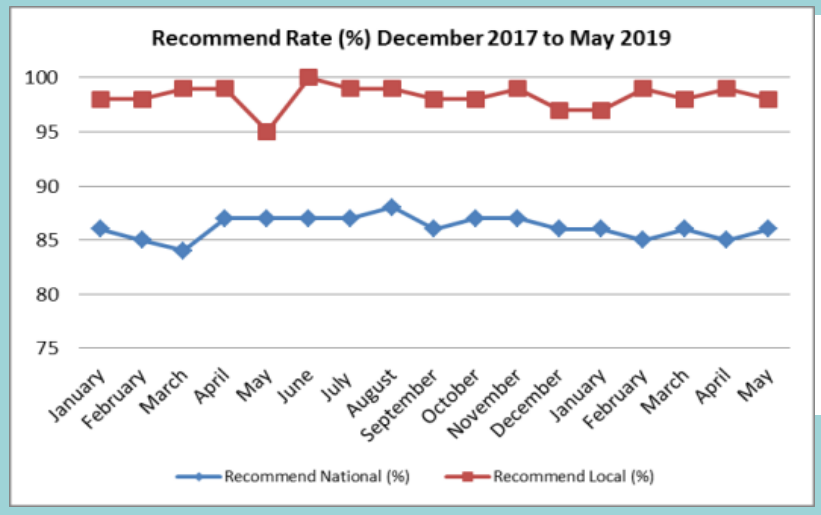
Inpatients





Emergency Department





Patient Experience

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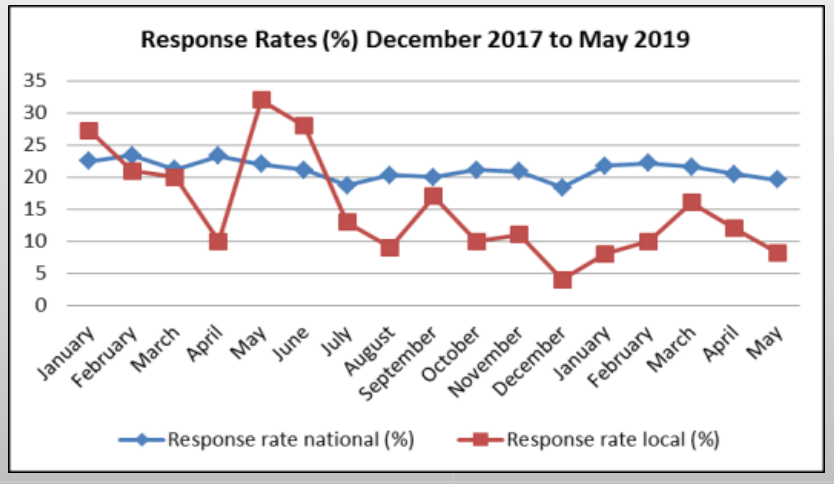
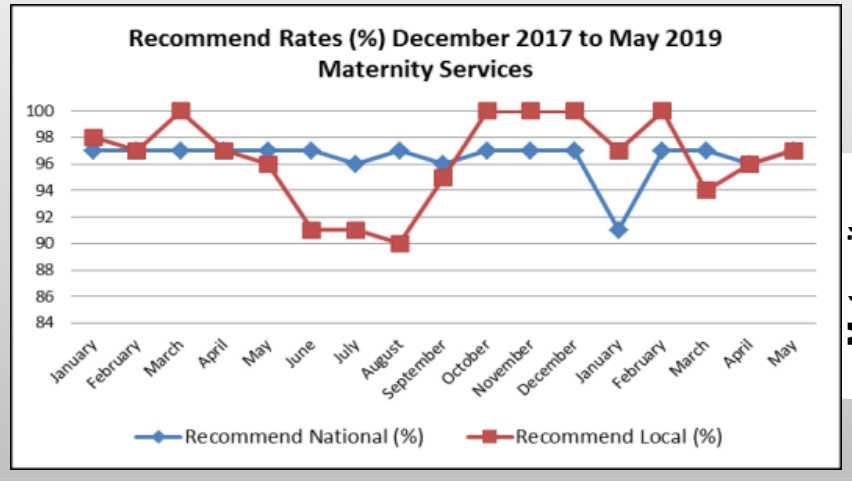
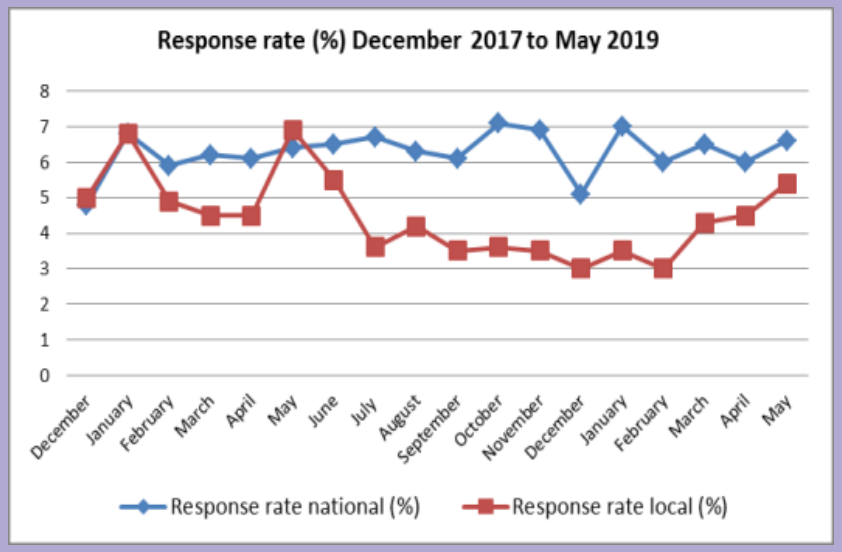
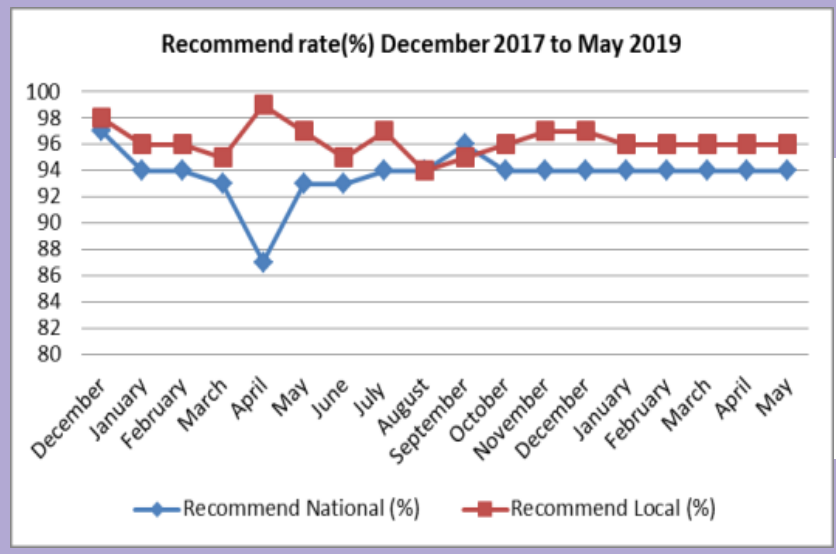




Maternity





Outpatients

National comparison data for April will be published by NHS England in June 2019. Inpatients and ED continue to score consistently higher than national scores

Patient Experience

Safe | Effective | Caring | Responsive

Patient Experience

National Patient Surveys 2018 and 2019

Final results have been released by CQC, which benchmarks us against all other NHS Trusts (better than/about the same/worse than)

2018 Adult Inpatient Survey

•Response rate:	**Trust 39%**	**National 45%**
The Emergency Department	8.5/10	About the same
Waiting lists & planned admissions	8.4/10	About the same
Waiting to get a bed on a ward	6.9/10	About the same
The hospital and ward	7.7/10	About the same
Doctors	8.2/10	About the same
Nurses	7.8/10	About the same
Care and Treatment	7.8/10	About the same
Operations and procedures	8.2/10	About the same
Leaving Hospital	6.6/10	About the same
Overall view of care and services	3.4/10	About the same
Overall experience	7.9/10	About the same

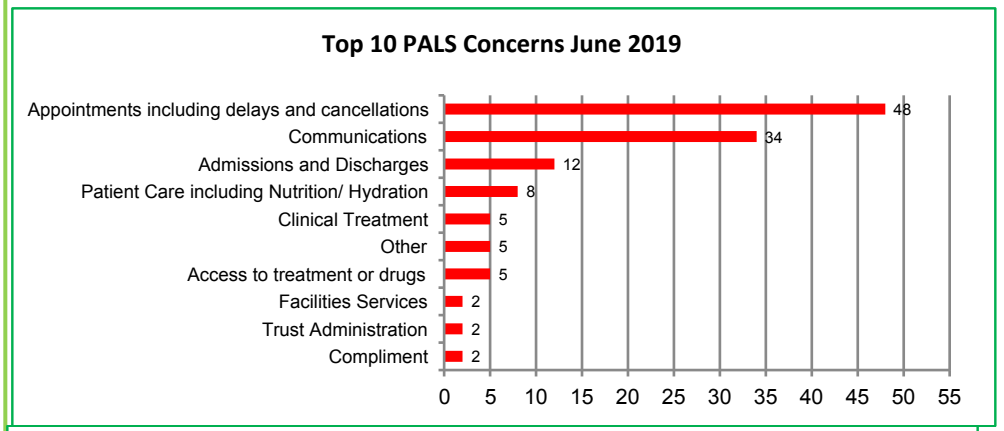
2018 Maternity Survey

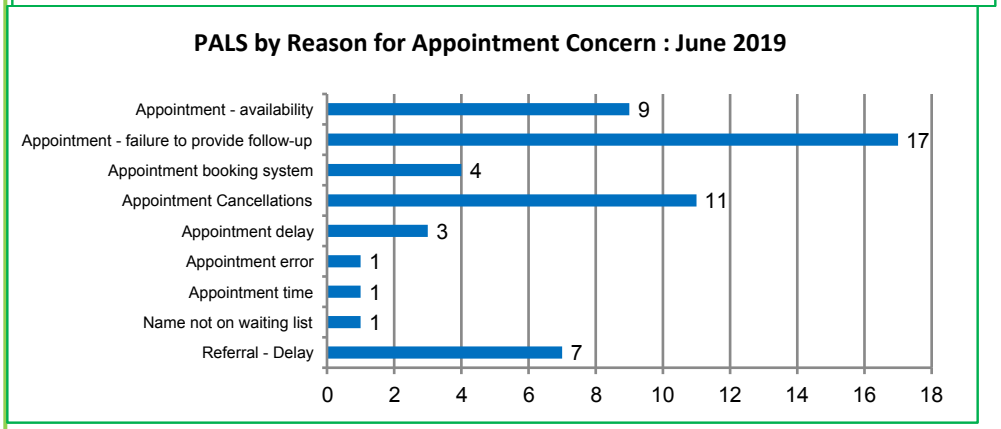
•Response rate:	**Trust 32.45%**	**National 36.8%**
Labour and birth	8.8/10	About the same
Staff	8.8/10	About the same
Care in hospital after the birth	7.4/10	About the same

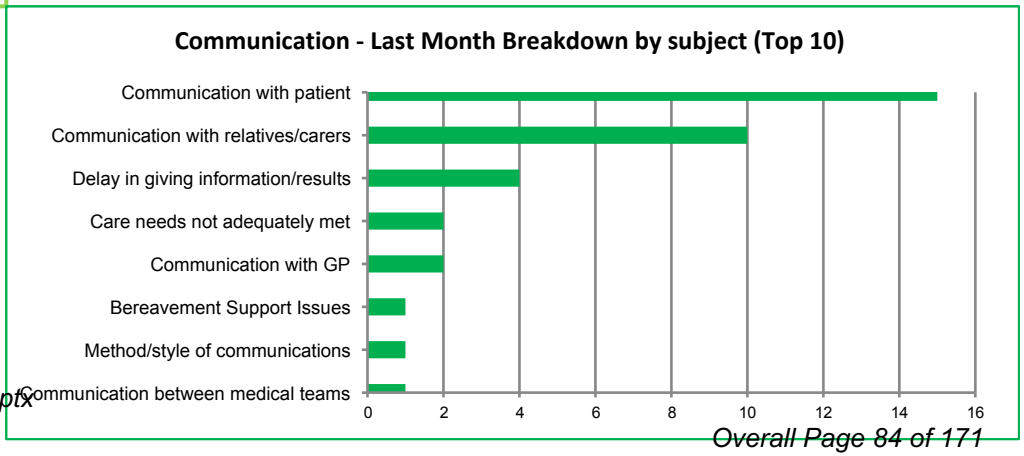
PALS (Patient Advisory and Liaison Service)- from datix

	Face to face	Emails	Telephone calls	Other contacts not recorded on datix*
April	66	54	41	757
May	31	57	26	810
June	53	58	67	759

	April 2019	May	June
Escalated to complaints (patient choice)	0	1	2



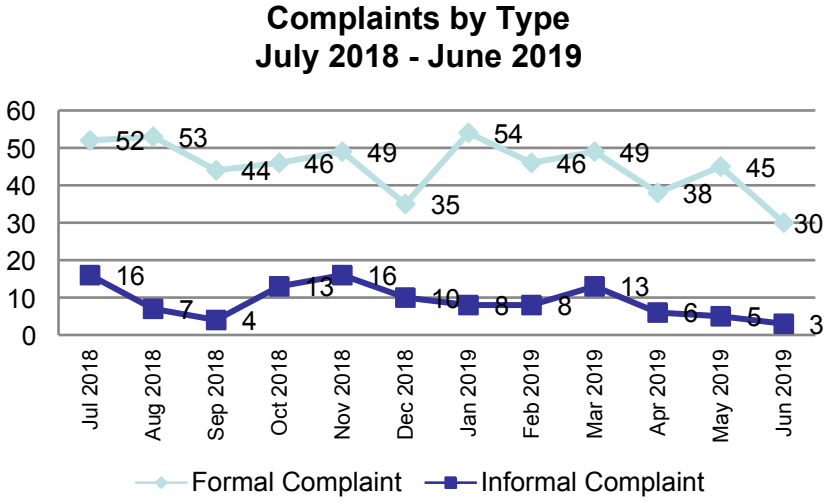


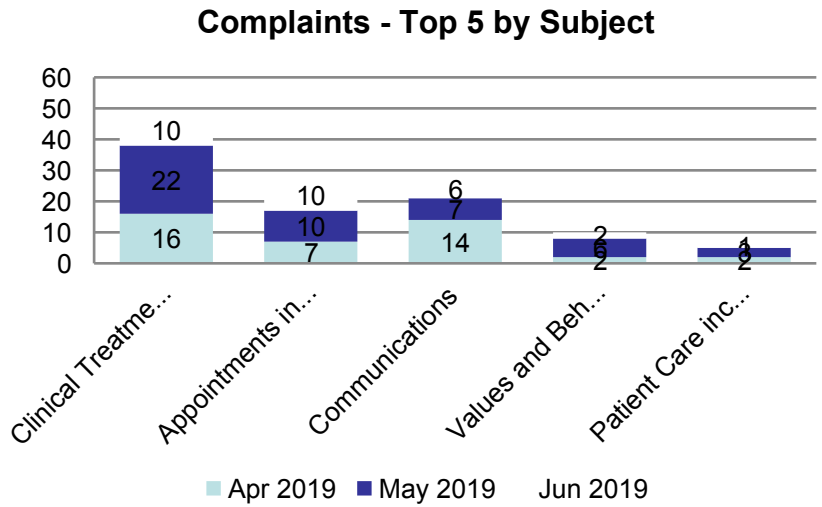


Patient Experience

Safe | Effective | Caring | Responsive

Complaints





There were 30 formal complaints declared in June which is the lowest it has been since January. The Complaints Team are working closely with the PALS team to endeavour to resolve complaints informally. A training package has been designed for staff to resolve concerns/complaints at source which will be delivered by the Complaints Manager and the Patient Experience Manager. It is hoped this will reduce the number of issues sent to PALS and Complaints. Complaints are also included in staff induction as part of the Patient Experience presentation. Service Managers continue to help with resolving concerns in real time to prevent formal complaints. This appears to have a positive effect in reducing the overall number. The most prevalent subjects raised continue to be around Clinical Treatment, Appointments and Communications. The Trust is in the process of putting together the Standard Operating Procedure (SOP) to underpin the recently approved Complaints, Concerns and Compliments Policy. This will be submitted to the Complaints Board in September.

COSQ03: Closed Complaints by Division and Outcome Code (Closed date)

	Not Uphe	Partially	Upheld	Total
Diagnostics, Therapeutics and Outpatients (DTO)	4	6	6	16
Medicine: Acute and Emergency Medicine	20	6	1	27
Medicine: Medical Inpatients	14	21	3	38
Medicine: Medical Specialties	5	6	1	12
Support Division	0	1	0	1
Surgery	21	12	12	45
Women and Childrens Health Unit	6	11	7	24
Total	70	63	30	163

The table to the left shows outcomes for Complaints closed. Shown for the last 3 months.

April - June 2019

Patient Experience

Safe | Effective | Caring | Responsive

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-18	34	95.74%	53.73%
Jul-18	45	100.00%	71.19%
Aug-18	50	100.00%	63.04%
Sep-18	43	100.00%	52.63%
Oct-18	45	100.00%	57.89%
Nov-18	46	98.21%	68.52%
Dec-18	34	100.00%	43.18%
Jan-19	49	100.00%	52.94%
Feb-19	41	98.46%	75.00%
Mar-19	43	85.71%	69.81%
Apr-19	36	90.91%	69.57%
May-19	42	94.55%	57.38%
Jun-19	30	84.44%	69.81%

The Complaints Team endeavour to log complaints and acknowledge on the same day if complaints are received via email and within 3 working days if received by post or via the CEO's office. At present a complaints officer is on maternity leave and therefore the team are short staffed. A replacement staff member will commence with the team on 8th of July and therefore we are hopeful to improve the acknowledgment response rate to over 95% by end of August.

The response rate has improved in June from last month. The Divisions are actively working to maintain their complaint response times. The complaints tracker is sent to Divisions weekly whereby the progress of complaints is shared with Divisions on a weekly basis and is monitored by the Complaints Manager and the Chief Nurse. The Divisions have been working hard to close off overdue complaints and this is evident from the improved figures for June. The Chief Nurse discussed with Divisions to endeavour to raise the response rate to 90% by August, 2019.

Mortality

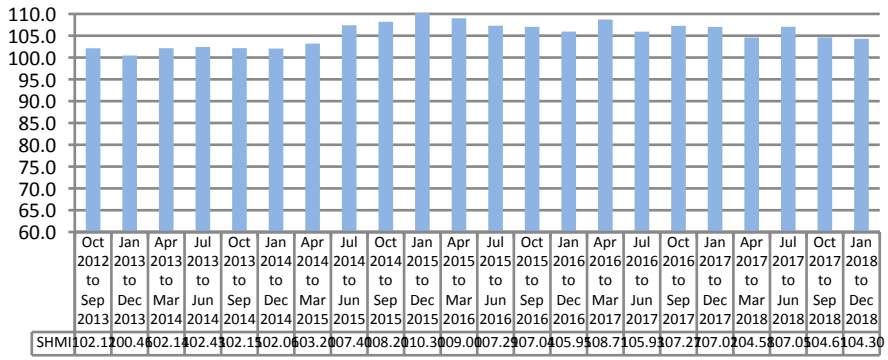
Safe | Effective | Caring | Responsive

HSMR/SHMI

Comparative Mortality Rates

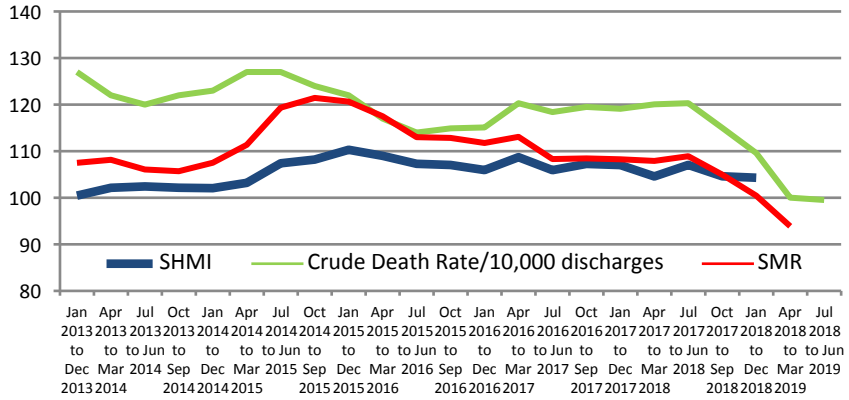
There are several different ways of measuring mortality and it is best practice to look at, and compare, all these different mortality indicators rather than relying on any one measure. The latest mortality indicators are all showing a positive trend. The exceptionally good performance during 2018 for crude death rates has now begun to manifest in the standardised mortality indicators too. The Standardised Mortality Ratio (SMR) for the year ending in March 2019 was 94 (6% better than the national average) whilst the HSMR was very similar at 93.9. The Risk Adjusted Mortality Index (RAMI), which not only adjusts for age, gender and casemix but also factors in the length of stay for some chronic conditions , was also slightly better than the national average at 99.1 for the year ending March 2019. SHMI always lags behind the other mortality indicators as it includes deaths within 30 days of discharge and is only issued quarterly. For the year ending December 2018 it improved to 104.30 (about 4% above the national average) . Crude mortality is discussed in further detail below.

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

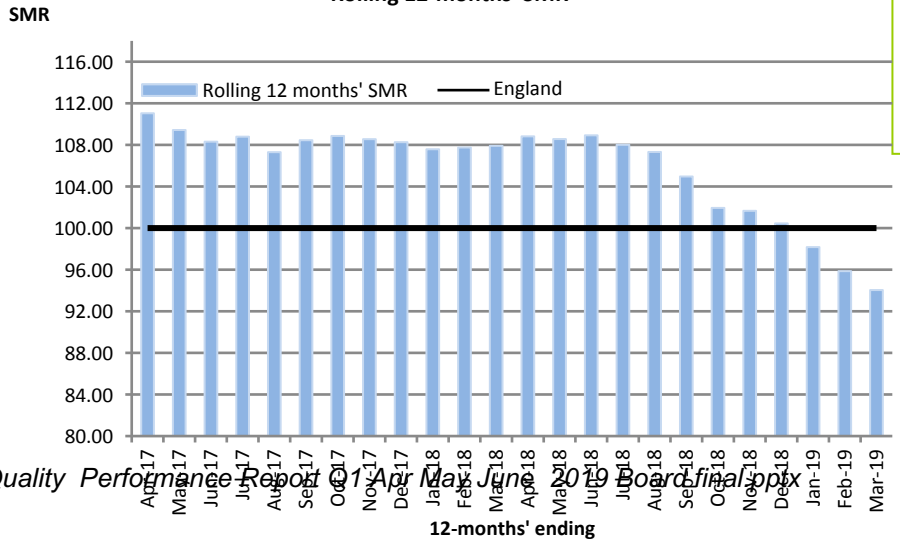


	Oct 2012 to Sep 2013	Jan 2013 to Dec 2013	Apr 2013 to Mar 2014	Jul 2013 to Jun 2014	Oct 2013 to Sep 2014	Jan 2014 to Dec 2014	Apr 2014 to Mar 2015	Jul 2014 to Jun 2015	Oct 2014 to Sep 2015	Jan 2015 to Dec 2015	Apr 2015 to Mar 2016	Jul 2015 to Jun 2016	Oct 2015 to Sep 2016	Jan 2016 to Dec 2016	Apr 2016 to Mar 2017	Jul 2016 to Jun 2017	Oct 2016 to Sep 2017	Jan 2017 to Dec 2017	Apr 2017 to Mar 2018	Jul 2017 to Jun 2018	Oct 2017 to Sep 2018	Jan 2018 to Dec 2018
SHMI	102.12	100.46	102.14	102.43	102.15	102.06	103.20	107.40	108.20	110.30	109.00	107.29	107.04	105.95	108.71	105.95	107.27	107.02	104.58	107.05	104.61	104.30

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



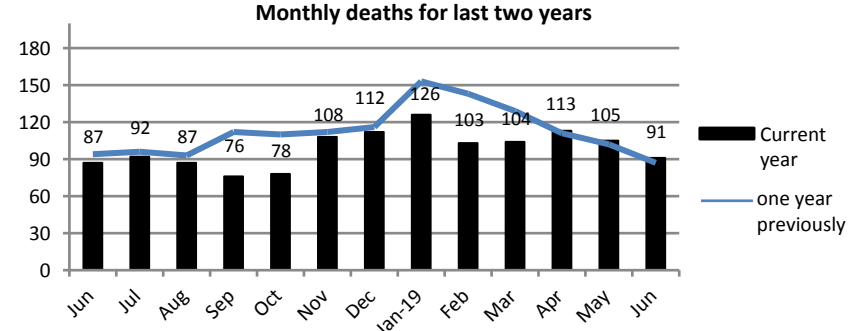
Rolling 12-months' SMR



Actual Deaths

In the year to June 2019 there were 1195 deaths and stillbirths at the hospital compared to 1364 in the previous 12-month period. This was despite an increase in admissions of nearly 6%. The crude mortality rate of 10.0 (deaths per 1000 discharges and deaths) continues to be extremely low . In the month of June 2019 itself there were 91 deaths, four more than the number in June 2018 .

Monthly deaths for last two years



Fractured Neck of Femur

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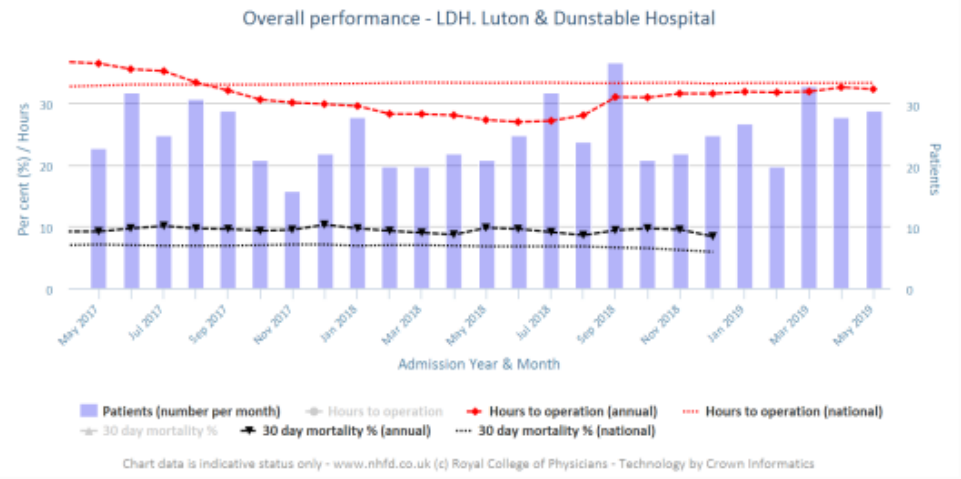
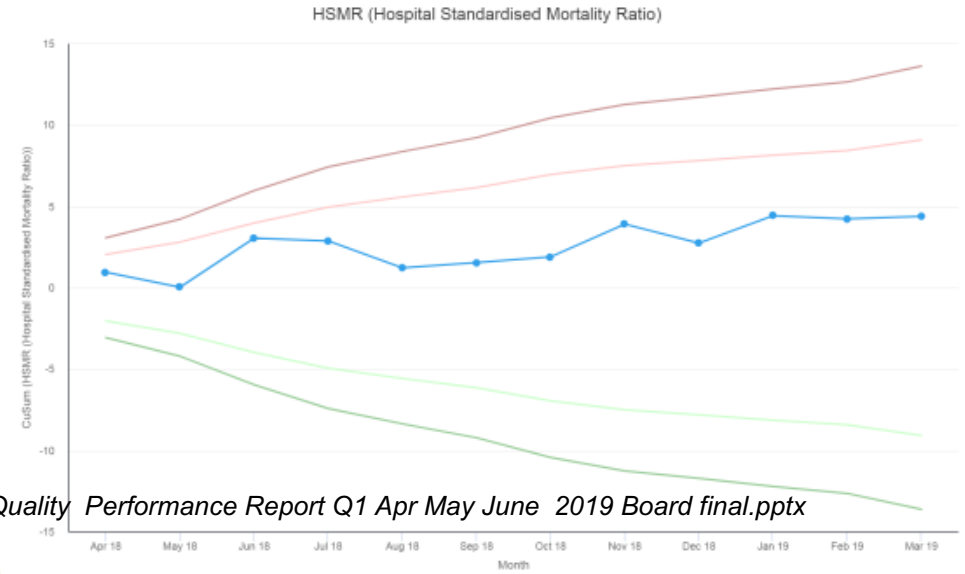


Description	Local Numerator	Apr 17 - Mar 18	Apr 18 - Mar 19	Peer Value	Performance	Alert
HSMR (Hospital Standardised Mortality Ratio)	3/4	25	144.92	121.28	104.82	



Following a Dr Foster alert in April 2017 and a formal notification from the national hip fracture database in August 2018 (relating to 2017 mortality) a number of improvements have been made to hip fracture processes, structures and governance. HSMR has improved from 166 to 126 over this period however there are still a number of challenges facing the service. Unfortunately a letter has been received relating to potential alert status for 2018 adjusted mortality (10.4%), however we are exploring whether this is a data quality issue as:

- NHFD report our crude mortality for 2018 to be 8.4% - this is a substantial upwards adjustment indicating our patients are substantially less morbid than the national average. This is not the case
- Crude mortality has significantly improved from 2017 (10.3%)
- HSMR for same period is well within 2SD of national average, which was not the case in 2017

The Hip fracture quality improvement programme is underway, Dr Ramsey appointed as chair, subgroups have commenced and the first programme board meeting is scheduled for 9th August

Key concerns

- Repeated failed recruitment episodes to the 2nd ortho-geriatrician and 2x ortho-geriatric specialty dr posts
- Difficulties getting full representation to subgroup meetings due to clinical commitments

Learning from Deaths

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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

	2018/19			
	Q1 Total	Q2 Total	Q3 Total	Q4 Total
Total Number of Deaths in Scope	282	241	284	312
Primary Mortality Reviews Completed	275	238	134	68
Full Mortality Reviews Requested	77	66	40	18
Full Mortality (Structured Judgement) Reviews Completed	58	39	28	15
% Full Mortality Reviews Requested that have been Completed	75%	59%	70%	83%

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.

Quarterly Structured Judgement Review findings:

	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
1 - Definitely Avoidable* 2 – Strong evidence of avoidability 3 – Would be probably avoidable (>50:50)	1	0	0	0
4 - Would be possibly avoidable (<50:50)	8	4	2	0
5 - Slight Suggestion of avoidability	7	7	3	3
6 - Definitely not avoidable	42	28	26	12

*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.

Key findings from the SJRs:

- Review of newly identified AF post-operatively should include a Troponin assay, even in the absence of classic cardiac chest pain, as this is a common presentation of silent myocardial infarction.
- End of life care pathway implementation should not be delayed awaiting palliative care team review once the decision for it has been made and communicated to patients or next of kin, unless there are genuine, documented reasons for doing so.
- A number of patients were either admitted inappropriately, or should have had the opportunity to die in a non-acute setting, but community services were unable to provide the necessary support in a timely enough fashion.

Key objectives for the Learning from Deaths agenda:

- Recruitment of Medical Examiners has commenced, and it is hoped these will be in post by September 2019.
- Complete final configuration of the Datix Cloud IQ Mortality module.

Cancer Long Waits

Quality Review & Public Reporting of Cancer Long Waits - March

62 day breaches - 7 patients (5.0 breaches)

Number of days from referral to treatment	CCG	Breach	Tumour Site	Reason for Delay Post RCA
74	Luton	1.0	Urology	Diagnosis delayed due to medical reasons
101	Luton	0.5	Urology	Dealyed diagnostics at L&D, repeat diagnostics required to obtain histological diagnosis
96	Luton	0.5	Urology	Delayed diagnostics at L&D (MRI and Biopsy)
73	Luton	0.5	Gynaecology	Delayed diagnostics at L&D (pateint declined initial TV US and cancelled OPA)
85	Luton	1.0	LGI	Delayed diagnostics at L&D (Patient delayed initial diagnostics)
102	Luton	0.5	Urology / LGI	Complex diagnostic pathway
92	Luton	1.0	Urology	Complex treatment pathway

104+ Days Breaches - 2 patients (1.0 breach)

Number of days from referral to treatment	CCG	Breach	Tumour Site	Reason for Delay Post RCA
152	Luton	0.5	Urology	Delayed diagnostics and treatment decision at L&D, Elective capacity inadequate at Lister, patient declined two dates.
129	Luton	0.5	Lung	Delayed diagnostics at L&D due to concerns about patients capacity to consent

National Targets

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Cancer

	Threshold	Apr-18	May-18	Jun-18	Qtr1 18/19	Jul-18	Aug-18	Sep-18	Qtr2 18/19	Oct-18	Nov-18	Dec-18	Qtr3 18/19	Jan-19	Feb-19	Mar-19	Qtr 4 18/19	Apr-19	May-19
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%	97.2%	96.5%	95.5%	96.4%	96.4%	96.0%	95.5%	96.0%	95.3%	95.8%	96.2%	95.8%	93.7%	95.4%	96.8%	95.4%	93.8%	93.3%
for symptomatic breast patients (cancer not initially suspected)	93%	92.4%	94.0%	94.9%	93.8%	98.6%	96.6%	98.1%	97.8%	90.5%	96.2%	94.3%	93.4%	88.1%	95.6%	93.8%	92.50%	91.90%	96.8%
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%	90.2%	88.7%	90.4%	89.4%	86.8%	86.8%	85.4%	86.4%	86.6%	85.7%	88.5%	86.8%	88.1%	87.2%	89.5%	88.4%	87.2%	85.2%
from consultant screening service referral	90%	100.0%	95.5%	91.7%	95.7%	90.6%	95.7%	94.1%	93.5%	92.4%	95.4%	91.1%	93.3%	87.2%	92.9%	96.9%	90.8%	93.8%	100.0%

The Trust achieved all of the cancer targets in May 2019. Quarterly performance was green across the board apart from symptomatic breast patients which, as previously documented, was due to patient choice.

From April 2019 the national shadow monitoring against the 28 day faster diagnosis standard commences, and new rules come into effect around reallocation of breaches to try and ensure that where a number of providers have been involved in a patient's pathway, that any breach is incurred by the provider who has caused the greatest delay in the pathway. This will make in-month monitoring more complex, and the cancer services team are embedding new processes to support the new way of reporting.

National Targets

Safe | Effective | Caring | Responsive

Cancer

Cancer Plan 62 Day Standard by Tumour Site

	Accountable Total Treated												
	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Breast	11	15	14	16	9	9	17	8.5	9	7	8	15	15
Gynaecology	2	2.5	2.5	6.5	1.5	3	1	4	3	2	2.5	1.5	2.5
Haematology	5	4	6	7.5	5	2	8	2	8	1	5	2	2
Head & Neck	3	1.5	4.5	5.5	5	1.5	1	2	5.5	4	0.5	2.5	3
LGI	5	8	5	6	5	7	6	5.5	4.5	4	8.5	7	3
Lung	6.5	2.5	2.5	5.5	3	2	2	3	4	2.5	6	n/a	6
Skin	10	5	22	12	13	11	18	5	9	4.5	10	10	15
Urology	24	19.5	13.5	29	17	18.5	15.5	14	15	15.5	16	13	21
UGI	3.5	1.5	3.5	5	2	3	3	4	4	2.5	3.5	3	6
Sarcoma	n/a	n/a	1	n/a	1	0.5	n/a	n/a	n/a	n/a	n/a	0.5	1
Testes								2	n/a	n/a	n/a	n/a	n/a
Other	1	2	n/a	n/a	n/a	2	1	2	1	n/a	1	n/a	n/a

	Accountable Breaches												
	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Breast	0	0	1	1	0	0	0	0	0	0	0	0	0
Gynaecology	1	1.5	1.5	2.5	0	0	0	0	1	0.5	0.5	1	0
Haematology	0	0	0	0	3	0	2	1	0	0	0	1	1
Head & Neck	0	1.5	1.5	1	1	0	0	0.5	0.5	0.5	0.5	0.5	0
LGI	2	0	2	0	1	2	3	1.5	1	0	1.5	1	0
Lung	0	0.5	1.5	1.5	1	0.5	0	0	2	1	1	n/a	1
Skin	0	0	0	0	1	0	0	0	0	0	0	0	0
Urology	3	1	2.5	6	2	3	2.5	2	3	3.5	3	3	9
UGI	1.5	1.5	0	0.5	0	2	2	1	0	0	0	0	0
Sarcoma	n/a	n/a	0	n/a	0	0.5	n/a	n/a	n/a	n/a	n/a	0.5	0
Testes								0	n/a	n/a	n/a	n/a	n/a
Other	1	0	n/a	n/a	n/a	0	1	0	0	n/a	0	n/a	n/a

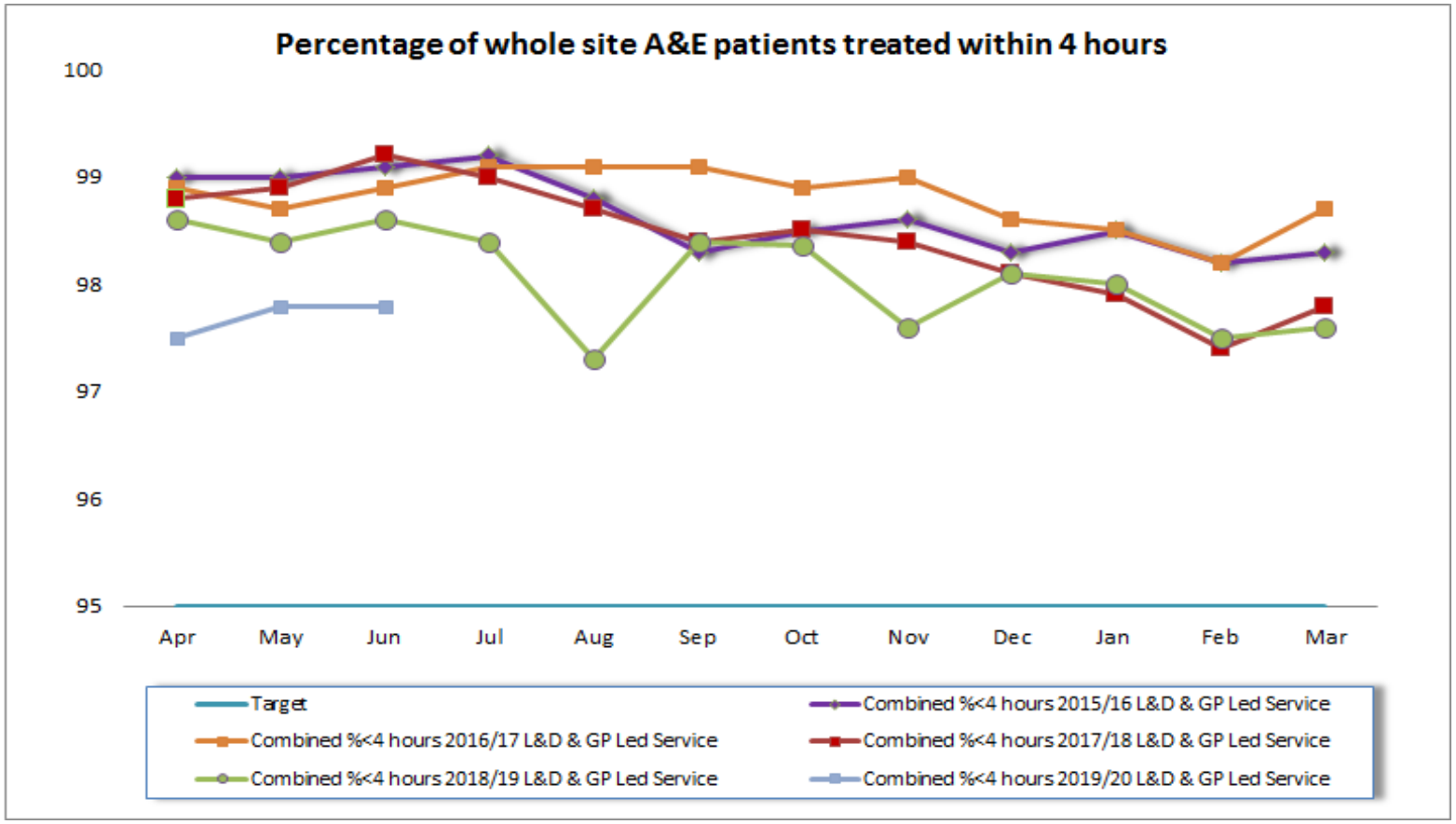
	% Meeting Standard												
	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Breast	100.0%	100.0%	92.9%	93.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.00%	100.0%	100.0%
Gynaecology	50.0%	40.0%	40.0%	61.5%	100.0%	100.0%	100.0%	100.0%	66.7%	75.0%	80.00%	33.3%	100.0%
Haematology	100.0%	100.0%	100.0%	100.0%	40.0%	100.0%	75.0%	50.0%	100.0%	100.0%	100.00%	50.0%	50.0%
Head & Neck	100.0%	0.0%	66.7%	81.8%	80.0%	100.0%	100.0%	75.0%	90.9%	87.5%	0.00%	80.0%	100.0%
LGI	60.0%	100.0%	60.0%	100.0%	80.0%	71.4%	50.0%	72.7%	77.8%	100.0%	82.40%	85.7%	100.0%
Lung	100.0%	80.0%	40.0%	72.7%	66.7%	75.0%	100.0%	100.0%	50.0%	60.0%	83.30%	n/a	83.3%
Skin	100.0%	100.0%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.00%	100.0%	100.0%
Urology	87.5%	84.9%	81.5%	79.3%	88.2%	83.8%	83.9%	85.7%	80.0%	77.4%	81.30%	76.9%	57.1%
UGI	57.1%	0.0%	100.0%	90.0%	100.0%	33.3%	33.3%	75.0%	100.0%	100.0%	100.00%	100.0%	100.0%
Sarcoma	n/a	n/a	100.0%	n/a	100.0%	0.0%	n/a	n/a	n/a	n/a	n/a	0.0%	100.0%
Testes								100.0%		n/a	100.00%	n/a	n/a
Other	0.0%	100.0%	n/a	n/a	n/a	100.0%	0.0%	100.0%	100.0%	n/a	100.00%	n/a	n/a

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 has been a significant peak in the number of urology breaches as a result of the new national re-allocation guidance. Where the L&D has not been able to complete the diagnostic phase of the pathway within 32 days, historically East and North Herts NHS Trust has had long delays to treatment and so the breach has been shared. However in May 2019 the treatment times at E&NHT have reduced, and so the whole breach has been reallocated to the L&D. This is an ongoing risk, although the urology team are re-reviewing the biopsy pathway to identify any further opportunities to reduce the time taken in the diagnostic phase.

National Targets



A&E

The Trust delivered above the 95% performance threshold every week in 2018/19. Following a challenging April due to a number of days of extreme surge and pressure on the medical teams admitting emergency patients, May's performance improved, although still not to same performance standard as previous years.

From 20th May 2019 the Trust will not be reporting performance against the 4 hour standard during the pilot period for the new Emergency Care Access standards.

National Targets

A&E Clinical Access Standards

The Trust has been selected as one of 14 sites to field test the proposed new clinical access standards. This currently consists of two 6 week periods of testing, the first of which commenced on 22 May 2019.

The new standards that are now being measured are:

- time to initial assessment,
- mean time in ED for all patients who have been discharged home or admitted into the wider hospital,
- numbers of patient who wait longer than 12 hours from arrival.

It is expected that during the second phase of testing there will also be metrics around treatment within the first hour for critically ill and injured patients, and increased same day emergency care admissions. We are working closely with NHSE and NHSI and providing daily and weekly reports so that they can assess the impact of the new standards. As a Trust we are working to understand what changes to systems and processes might be needed in the future to ensure that we are able to meet the new standards as successfully as we have been able to maintain the 4 hour stand whilst ensuring good patient experience and outcomes.

National Targets

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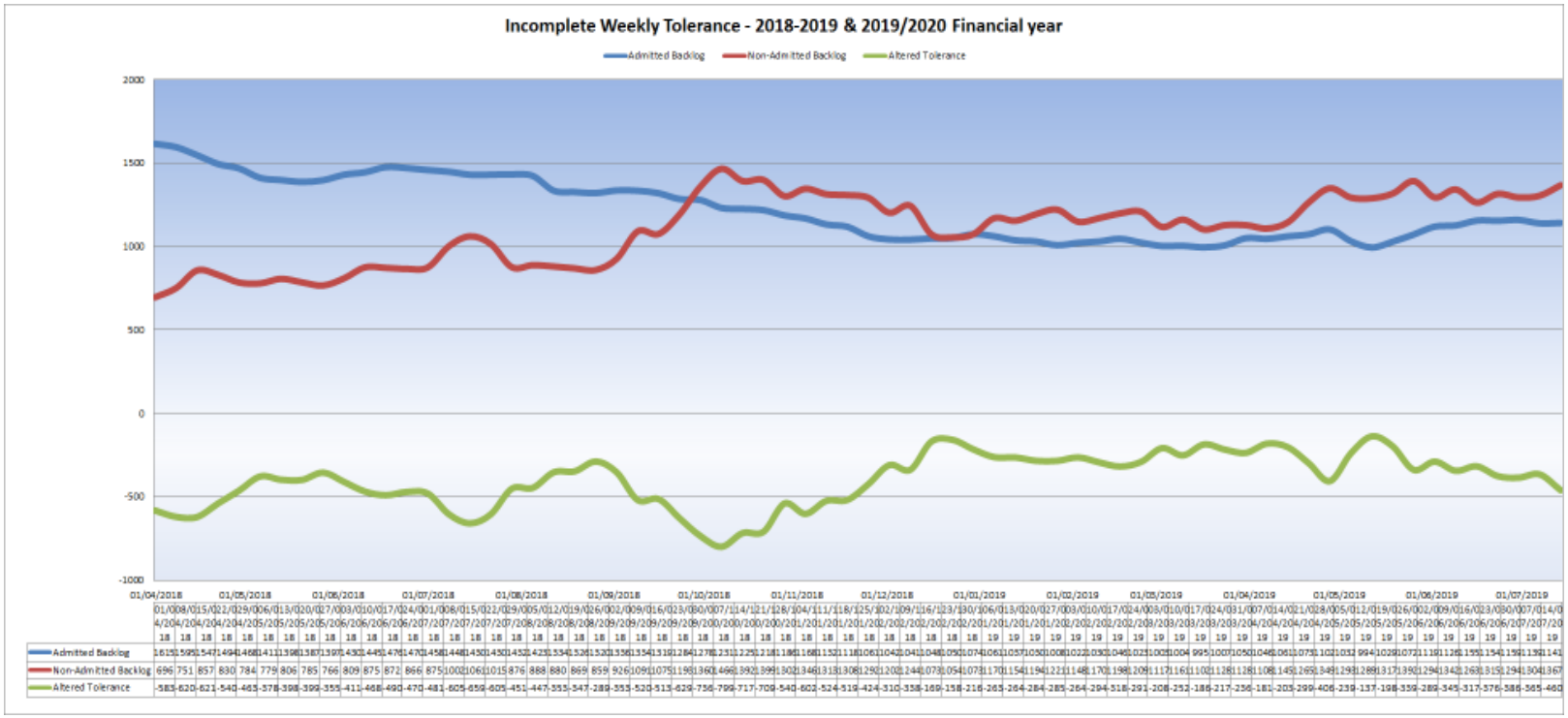
18 Weeks

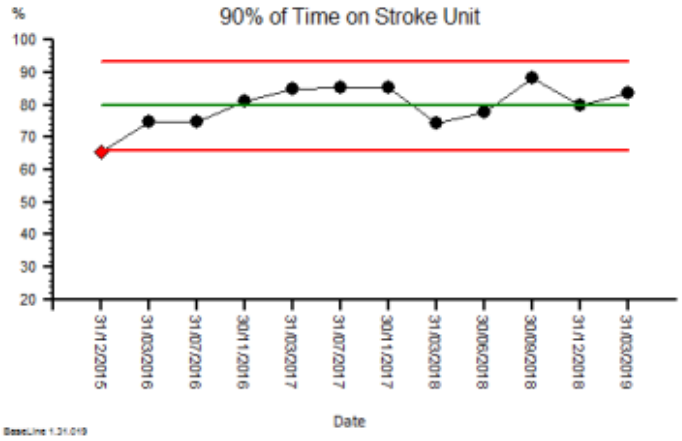
Treated Within 18 Weeks

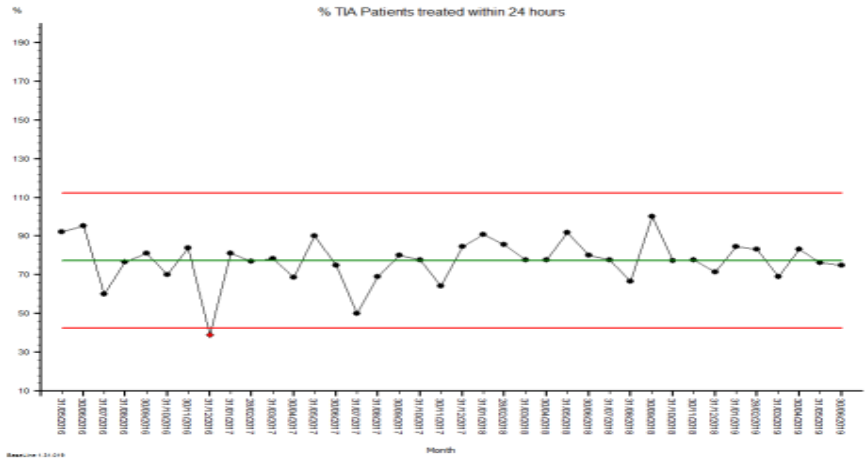
Incomplete	Targets	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	92%	96.9%	96.8%	97.0%	96.9%	97.1%	97.1%	97.1%	96.9%	96.7%	96.6%	96.8%	97.2%
2015/16	92%	97.9%	97.8%	97.6%	97.7%	97.3%	97.0%	96.4%	96.5%	95.3%	94.6%	94.2%	94.2%
2016/17	92%	94.2%	94.5%	94.8%	93.7%	92.9%	92.6%	92.2%	92.7%	93.1%	92.5%	92.9%	92.6%
2017/18	92%	92.8%	93.2%	92.7%	92.8%	92.6%	92.0%	92.2%	92.2%	90.9%	91.0%	90.2%	90.0%
2018/19	92%	90.7%	90.9%	90.4%	90.8%	91.1%	89.6%	90.5%	91.5%	92.0%	91.8%	91.7%	91.7%
2019/20	92%	91.2%	91.6%	91.1%									

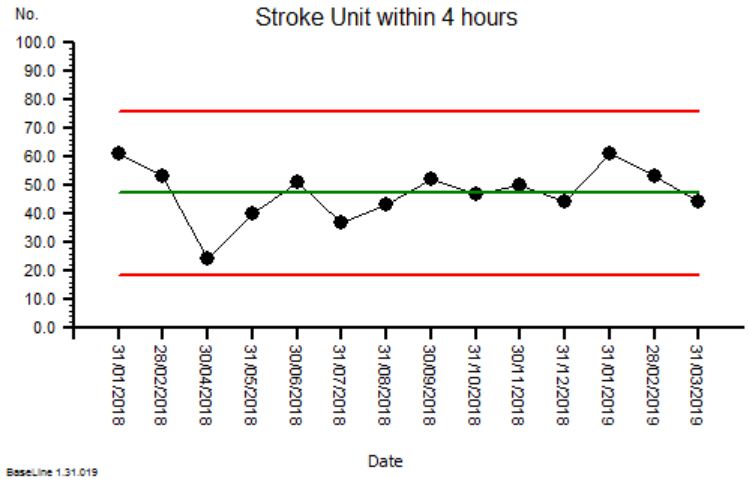


The Trust achieved 91.14 % against the 18 week standard in June 2019, which is a slight deterioration from May. There is significant to maintaining this level of performance with the loss of consultant extra sessions due to the pensions changes, and also the closure of theatres in August for urgent refurbishment of the air handling equipment.

National Targets







SSNAP data has now been published for Jan – Mar 2019. In each month, the % of patients achieving 90% of their time on the stroke ward was above the 80% target, however the December performance was clearly challenged as a result of bed pressures across the trust.

The challenges with the number of patients arriving on the stroke ward within 4 hours continue, with performance significantly under the 80% quality target. This is one of the areas of focus for the stroke team review of their model of care, which needs to ensure equality of access for patients who are thrombolysed and those who are not.

TIA performance (patients being treated for TIA within 24 hours) has continued above the 60% target threshold since Autumn 2017.

National Targets

Overall SSNAP Performance (Jan - Mar 19 SSNAP Report)

Reporting Period	Apr-Jul 16	Aug-Nov 16	Dec - Mar 17	Apr-Jul 17	Aug-Nov 17	Dec - Mar 18	Apr-Jun 18	Jul-Sep 18	Oct - Dec 18	Jan-Mar 19
SSNAP level	D	C	C	B	B	D	B	B	C	B
SSNAP score	59.8	66	67	74	76	58	72	74	64.6	
1) Scanning	B	B	A	A	A	A	A	B	A	A
2) Stroke Unit	D	D	D	D	D	E	E	D	D	D
3) Thrombolysis	B	B	C	B	B	D	C	B	B	B
4) Specialist Assessments	B	B	B	B	B	B	B	B	B	B
5) Occupational Therapy	A	A	A	A	A	C	A	A	C	B
6) Physiotherapy	B	B	B	B	B	C	B	C	D	B
7) Speech and Language Therapy	E	E	E	C	C	E	C	B	C	C
8) MDT working	E	C	C	C	D	E	D	D	D	C
9) Standards by discharge	B	B	B	B	B	B	B	B	B	B
10) Discharge processes	D	D	C	C	B	A	A	A	A	A

The SSNAP data for Jan – Mar 19 demonstrates a return to a B rating in our overall score. This reflects a significant improvement in the Occupational Therapy and Physiotherapy domain indicators, and a corresponding improvement in the MDT working compliance.

Time to stroke unit remains the biggest risk to continued achievement of a SSNAP rating of B or above.

National Targets

Safe | Effective | Caring | Responsive

Diagnostic Test Access

	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	43	35	40	38	38	48	43	48	18	13
% over 6 weeks	<1%	0.9	0.93	0.81	0.75	0.84	0.83	0.76	0.95	0.98	0.99	0.34	0.22
Total Waiting		4864	5138	5,324	4,654	4,740	4,533	4,987	5,031	4,378	4,871	5,267	5,659

	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Over 6 weeks		32	30	41									
% over 6 weeks	<1%	0.6%	0.59	0.8									
Total Waiting		5227	5115	5,095									

The June 2019 performance against the 6 week diagnostic target was maintained above the target threshold of 99%, however the number of breaches rose again in month reflecting the significant capacity challenges the Trust is experiencing currently. Whilst everything possible is being done to mitigate the loss of consultant extras, the likelihood of the Trust continuing to maintain this performance in July and August is low.

National Targets

Safe | Effective | Caring | Responsive

Last Minute Cancellations

Last minute Cancelled Operations

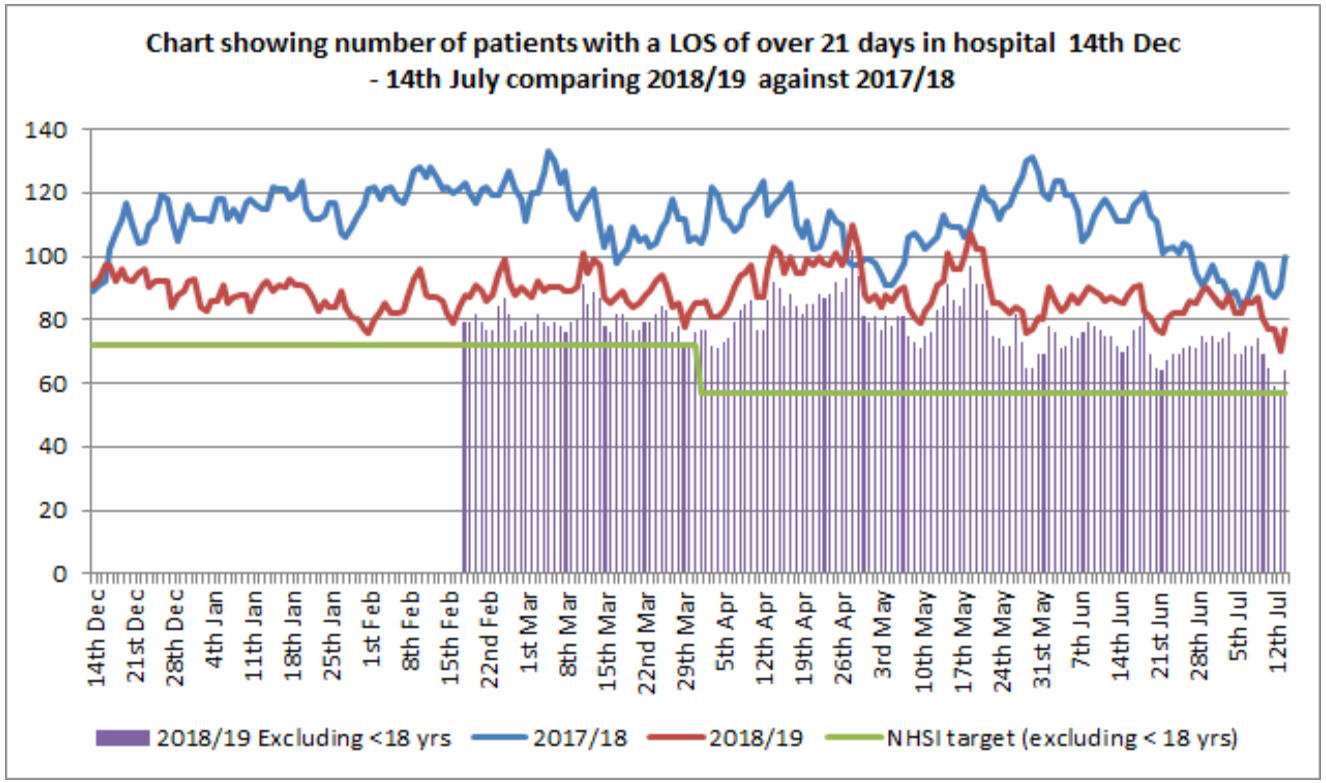
	Target	30/04/2018	31/05/2018	30/06/2018	31/07/2018	31/08/2018	30/09/2018	31/10/2018	30/11/2018	31/12/2018	31/01/2019	28/02/2019	31/03/2019
Clinical reasons		49	55	46	40	43	43	48	45	48	52	52	45
Non-clinical reasons		34	42	56	51	51	39	88	61	48	81	38	40
Patients not-dated in 28 days	0	0	0	1	0	0	1	0	0	3	3	0	1
Elective activity*		3,499	3658	3824	3791	3573	3473	3,888	3,974	3447	3909	3672	3766
% Cancelled operations	<0.8%	0.97%	1.15%	1.46%	1.35%	1.43%	1.12%	2.26%	1.53%	1.39%	2.07%	1.03%	1.06%

	Target	30/04/19	31/05/19	30/06/19	01/07/19	01/08/19	01/09/19	01/10/19	01/11/19	01/12/19	01/01/20	01/02/20	01/03/20
Clinical reasons		32	48	55									
Non-clinical reasons		32	40	26									
Patients not-dated in 28 days	0	0	1	0									
Elective activity*		3,694	3774	3635									
% Cancelled operations	<0.8%	0.87%	1.06%	0.72%									

All patients whose surgery was cancelled on the day had their procedure rebooked within 28 days during June 2019, and there was a drop in the % of on the day cancellations. This is a positive early reflection of the additional work the pre-assessment team are doing to proactively telephone every patient two weeks to 10 days before surgery to check the patient is still fit, understands their fasting instructions and know the time and date of their surgery. The team will continue to monitor the impact this is having on avoidable cancellations.

Performance

LOS



The Trust has a target to reduce the number of 'super-stranded' patients (those staying over 21 days) by 25% during 2018/19 and by a further 15% in 2019/20, to an average of 57 beds occupied by patients with a length of stay of over 21 days.

The purple bars on the chart track performance against this year's target of 57, and the Trust achieved this number for the first time in July 2019, despite an extremely busy time for emergency admissions. Further scrutiny of these patients will continue through the long length of stay ward rounds and Executive Sitreps to ensure that clinical teams are supported with escalation of particularly complex cases. This will further drive down the number of super stranded patients to help sustainable achievement of an average that is below the target 57.

Performance

Safe | Effective | Caring | Responsive

Dementia Assessment and Referral

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	368	408	422	373	386	398	388	377	407	448	1090	1203	1172	1232
	Total eligible 75+ emergency admissions	378	360	371	419	445	393	402	431	404	407	419	462	1109	1257	1237	1288
	% Screened	97.6	98.1	99.2	97.4	94.8	94.9	96.0	92.3	96.0	92.6	97.1	97.0	98.3	95.7	94.7	95.7
Q2	Assessments carried out	55	31	24	35	33	18	14	15	9	15	36	39	110	86	38	90
	Total assessments required	60	36	26	38	36	26	15	18	10	19	38	43	122	100	43	100
	% Assessed	91.7	86.1	92.3	92.1	91.7	69.2	93.3	83.3	90.0	78.9	94.7	90.7	90.2	86.0	88.4	90.0
Q3	Referrals from those assessed	30	16	16	13	14	8	8	8	2	3	13	13	62	35	18	29
	Total requiring referral	33	16	17	14	15	8	8	8	3	3	14	13	66	37	19	30
	% Referred	90.9	100.0	94.1	92.9	93.3	100.0	100.0	100.0	66.7	100.0	92.9	100.0	93.9	94.6	94.7	96.7

2019/20

		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	QTR1	QTR2	QTR3	QTR4
Q1	Eligible 75+ emergency patients screened	424	387											811			
	Total eligible 75+ emergency admissions	441	418											859			
	% Screened	96.1	92.6											94.4			
Q2	Assessments carried out	15	30											45			
	Total assessments required	20	36											56			
	% Assessed	75.0	83.3											80.4			
Q3	Referrals from those assessed	5	11											16			
	Total requiring referral	5	11											16			
	% Referred	100.0	100.0											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.

The Trust continues to struggle with formal documentation of delirium assessment in diagnosed cases , despite dementia assessment and referral being strong. The Nervecentre ICC due for launch in the autumn will automatically prompt staff for this assessment and will significantly improve the auditability of compliance, which will improve performance against this indicator.

Finance Presentation
FY19-20

Draft Report for Month 3

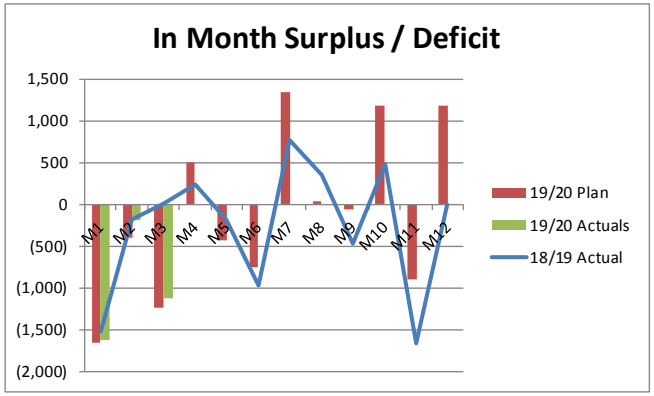
Executive Summary

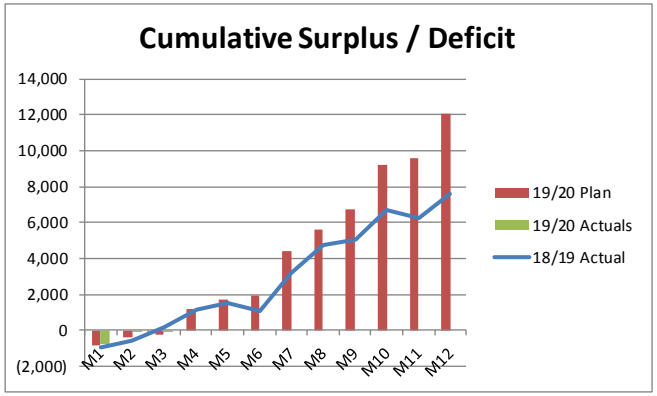
This paper focuses on the Trust level performance. Divisional / Service Line performance is covered in the SLR Report.

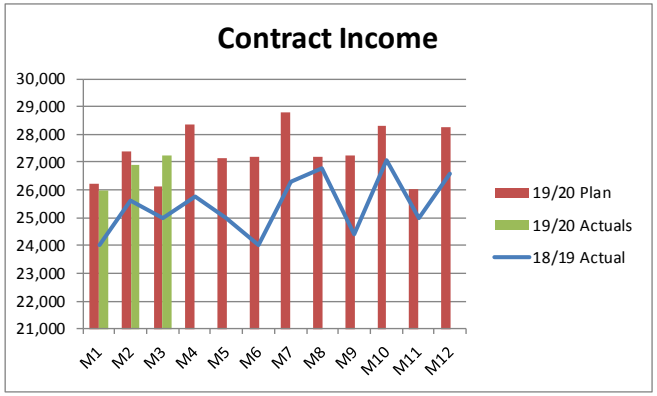
The Trust delivered the Control Total for Month 3 2019/20 and therefore gained access to the Provider Sustainability Funding (PSF). The phasing of the plan (see slide 3) has many of the stretch CIPs delivering in Q3/Q4 and therefore the Trust should be delivering (or preferably exceeding) plan in Q1/Q2

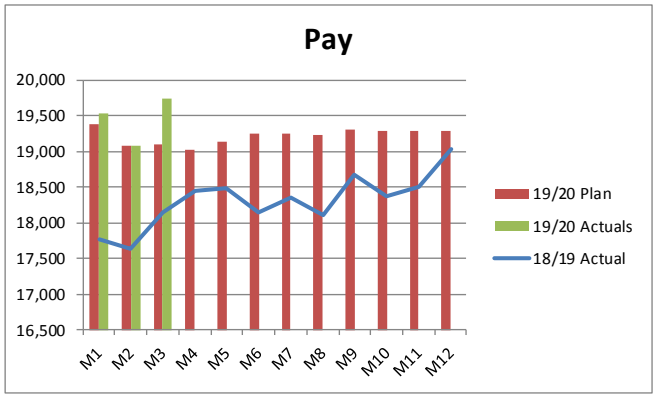
Significant overperformance on non-elective activity, driving high costs.
Medical agency is driving a significant medical pay pressure (offset in part by vacancies in other pay groups).

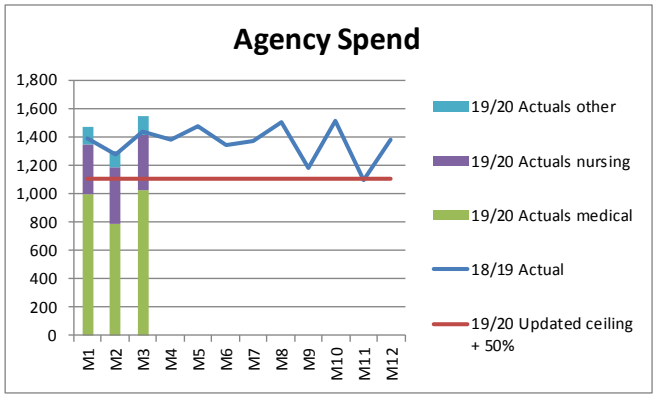
Run rate charts (excludes DH Revenue Grant for 2018/19) **£000s**

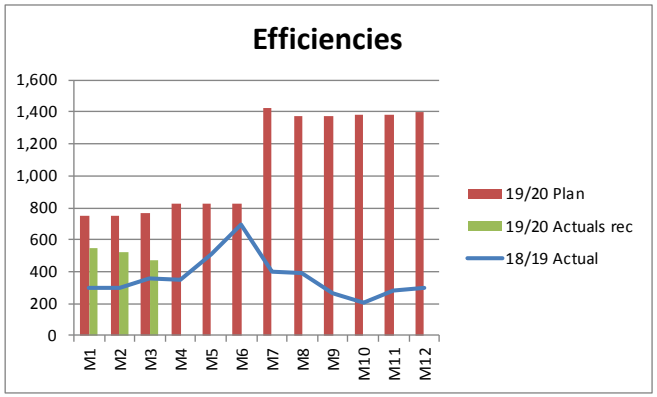


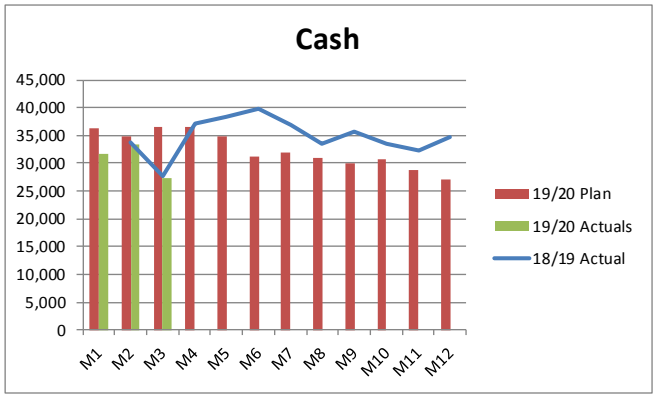


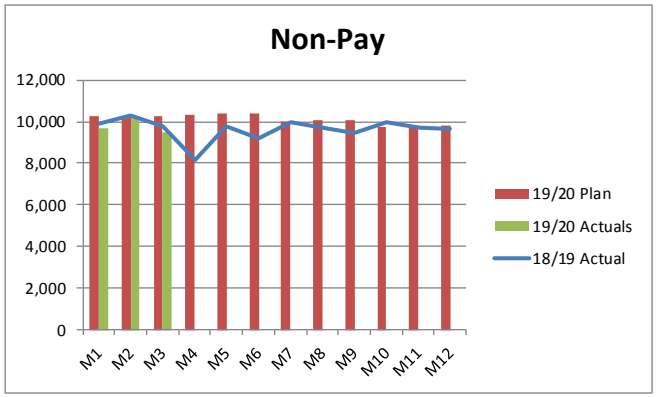


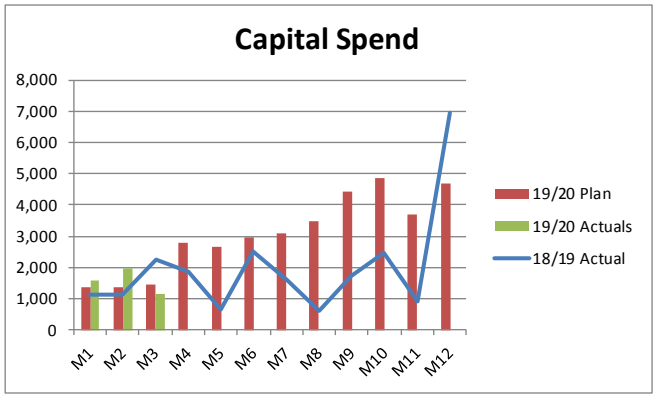








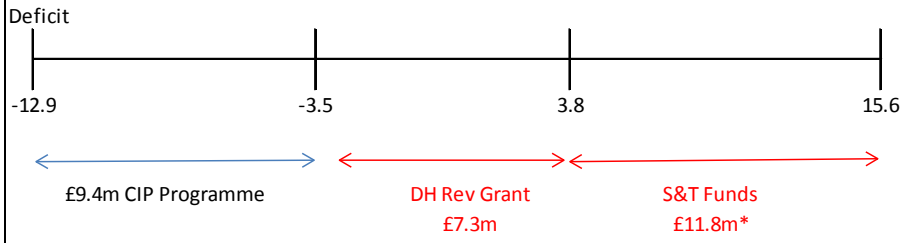




18-19 Plan

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 £1.7m (from a £17.3m surplus to a £15.6m surplus)



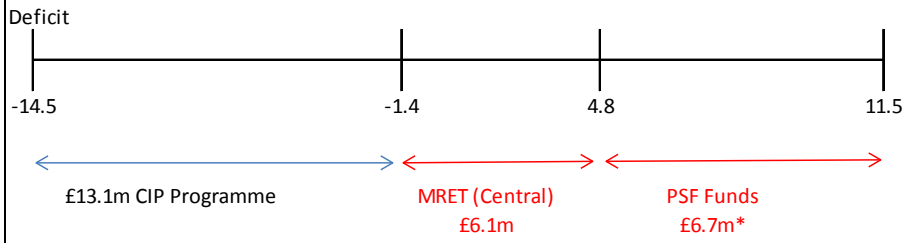
* Comprised of £8.4m for Trust delivery and £3.4m for STP delivery

I&E Phasing £000s	In Month Core	Ytd Core	In Month PSF	Ytd PSF	YTD Plan
April	-1,162	-1,162	337	337	-825
May	103	-1,060	337	674	-386
June	-746	-1,806	337	1,011	-795
July	1,002	-804	449	1,460	656
August	64	-740	449	1,909	1,169
September	-261	-1,002	450	2,359	1,358
October	1,845	843	674	3,033	3,876
November	526	1,369	674	3,707	5,076
December	444	1,813	673	4,380	6,193
January	1,679	3,492	786	5,166	8,658
February	-408	3,083	786	5,952	9,035
March	1,673	**4,756**	786	**6,738**	**11,494**

19-20 Plan

MAY POSITION

The Trust has a significant CIP programme, but by signing up to CT has gained access to MRET (guaranteed) and PSF (contingent on performance).



* Split between Trust & STP delivery under discussion, c£1.4m may be dependent on STP

The Trust has now received confirmation (and amended financial forms) of the reduction in the Control Total from £19.2m to £11.1m. As part of the change, the Trust has agreed to overperform by £0.4m in 2019/20.

The phasing of the plan (see above) gives the Trust time to embed CIP changes, but with £10m of the £11.5m surplus being delivered in the last six months, it will be important for the Trust to maintain focus on existing and forthcoming CIP delivery in the "easier" first six months

Subsequent to the submission of the plan, the Trust has been notified of an additional £0.548m PSF relating to 18/19. Due to the late notification, this needs to be recognised in 2019/20. The Trust's surplus target has been adjusted accordingly to £12.042m

Plan & Control Total delivered

	Fin Year	Fin Year	Fin Year	Fin Year	Fin Year	Fin Year	In Month	In Month	In Month
INCOME & EXPENDITURE ACCOUNT	**2017/18**	**2018/19**	**2019/20**	**2019/20**	**2019/20**	**2019/20**	**2019/20**	**2019/20**	**2019/20**
	Actual	**Actual**	**Budget**	**Budget**	**Actual**	**Variance**	**Budget**	**Actual**	**Variance**
	Full Year	**Full Year**	**Full Year**	**YTD**	**YTD**	**YTD**	**£000s**	**£000s**	**£000s**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**			
NHS Clinical Income - Contract	283,064	297,593	333,796	81,004	80,873	132	26,550	27,273	-723
Pay Award Funding		2,833							
Other Income (T&E, Secondment, RTA)	24,052	26,001	23,384	5,638	5,684	-46	1,876	1,972	-96
Total Income	**307,116**	**326,427**	**357,180**	**86,643**	**86,557**	**86**	**28,427**	**29,245**	**-818**
Consultants	40,151	42,215	43,814	11,021	11,171	150	3,683	3,674	-9
Other Medical	33,866	36,832	36,024	8,893	9,998	1,106	2,966	3,517	551
Nurses	77,152	82,892	87,164	21,771	22,011	240	7,158	7,518	360
S&T	21,844	24,634	27,384	6,790	6,570	-220	2,271	2,212	-58
A&C (Including Managers)	24,171	27,002	29,213	7,311	6,962	-349	2,428	2,236	-192
Other Pay	5,839	5,987	7,031	1,767	1,635	-132	582	581	-1
Total Pay	**203,024**	**219,563**	**230,630**	**57,553**	**58,347**	**794**	**19,088**	**19,739**	**651**
Drug costs	27,476	29,295	32,697	8,173	7,003	-1,170	2,724	2,119	-605
Clinical supplies and services	25,307	26,814	26,334	6,599	6,374	-225	2,182	2,196	14
Other Costs	47,563	51,067	52,245	13,540	13,803	264	3,887	4,645	758
Non-Recurrent	0	0	0	0	0	0	0	0	0
Total Non-Pay	**100,345**	**107,176**	**111,276**	**28,311**	**27,180**	**-1,132**	**8,792**	**8,959**	**167**
EBITDA	**3,747**	**-312**	**15,274**	**778**	**1,030**	**-251**	**547**	**547**	**0**
Non Operational	13,101	13,260	15,294	3,777	3,601	-176	1,242	1,027	-214
Trading Position	**-9,354**	**-13,572**	**-20**	**-2,999**	**-2,571**	**-428**	**-695**	**-480**	**-215**
MRET / Readmissions Gainshare	4,555	6,343	4,776	1,194	1,188	6	398	392	-6
PSF Funding	13,313	18,363	7,286	1,559	1,377	-182	436	254	-182
Revenue Allocation	4,500	7,300							
Non-Recurrent	2,355	3,390					0	0	0
PSF STP Funding	0	808					0	0	0
Total Operating Surplus/Deficit (-)	**15,369**	**22,631**	**12,042**	**-246**	**-7**	**-239**	**139**	**165**	**-26**

Key Activity Metrics – Trust activity (per day) appears relatively strong

Category	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
ELECTIVE INPATIENTS	**3,499**	**3,658**	**3,824**	**3,791**	**3,573**	**3,473**	**3,888**	**3,974**	**3,447**	**3,909**	**3,672**	**3,766**	**3,694**	**3,774**	**3,635**
All Elective Surgery (excl Gynaecology)	2,234	2,340	2,392	2,382	2,228	2,228	2,375	2,500	2,122	2,379	2,346	2,342	2,233	2,249	2,178
All Elective Medicine	769	785	908	845	789	746	963	935	835	972	826	905	919	984	1,001
All Elective Womens & Children	216	228	214	224	230	219	230	201	223	218	195	214	225	207	205
All Elective Clinical Support Services	280	305	310	340	326	280	320	338	267	340	305	305	317	334	251
NON-ELECTIVE INPATIENTS (excl well babies)	**5,487**	**5,914**	**5,543**	**6,374**	**5,735**	**5,689**	**6,438**	**6,214**	**6,011**	**6,790**	**5,709**	**6,649**	**6,177**	**6,313**	**5,968**
All Non-Elective Surgery	818	888	824	912	888	862	950	844	834	900	805	915	862	935	906
All Non-Elective Medicine	2,168	2,202	2,128	2,184	2,219	2,148	2,296	2,384	2,298	2,550	2,300	2,480	2,469	2,518	2,356
All Non-Elective Womens & Children (excl *)	2,499	2,823	2,589	3,275	2,628	2,675	3,189	2,984	2,875	3,339	2,604	3,254	2,846	2,860	2,706
All Non-Elective Clinical Support Services	2	1	2	3	0	4	3	2	4	1	0	0	1	6	4
Number of Births*	382	480	433	459	475	0	445	0	427	414	374	432	422	440	0
Consultant First Outpatient Attendances	**9,418**	**10,296**	**9,433**	**10,005**	**9,244**	**9,116**	**11,193**	**11,212**	**9,346**	**11,101**	**10,297**	**10,767**	**10,082**	**10,955**	**10,082**
Consultant Subsequent Outpatient Attendances	**17,830**	**18,481**	**17,371**	**18,062**	**17,529**	**16,604**	**19,449**	**19,255**	**15,684**	**19,469**	**18,227**	**18,659**	**18,368**	**18,387**	**18,366**
A&E Attendances	**8,477**	**9,241**	**9,178**	**9,665**	**8,605**	**8,815**	**8,868**	**9,323**	**8,933**	**9,177**	**8,290**	**9,491**	**9,051**	**9,127**	**9,083**
Elective Inpatient per Working Day	**175**	**174**	**182**	**172**	**162**	**174**	**169**	**181**	**181**	**178**	**184**	**179**	**185**	**180**	**182**
All Elective Surgery (excl Gynaecology)	112	111	114	108	101	111	103	114	112	108	117	112	112	107	109
All Elective Medicine	38	37	43	38	36	37	42	43	44	44	41	43	46	47	50
All Elective Womens & Children	11	11	10	10	10	11	10	9	12	10	10	10	11	10	10
All Elective Clinical Support Services	14	15	15	15	15	14	14	15	14	15	15	15	16	16	13
Non-Elective Inpatient per Calendar Day	**183**	**191**	**185**	**206**	**185**	**190**	**208**	**207**	**194**	**219**	**204**	**214**	**206**	**204**	**199**
All Non-Elective Surgery	27	29	27	29	29	29	31	28	27	29	29	30	29	30	30
All Non-Elective Medicine	72	71	71	70	72	72	74	79	74	82	82	80	82	81	79
All Non-Elective Womens & Children (excl *)	83	91	86	106	85	89	103	99	93	108	93	105	95	92	90
All Non-Elective Clinical Support Services	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultant First Outpatient Attendances per WD	**471**	**490**	**449**	**455**	**420**	**456**	**487**	**510**	**492**	**505**	**515**	**513**	**504**	**522**	**504**
Consultant FU Outpatient Attendances per WD	**892**	**880**	**827**	**821**	**797**	**830**	**846**	**875**	**825**	**885**	**911**	**889**	**918**	**876**	**918**
A&E Attendances per Calendar Day	**283**	**298**	**306**	**312**	**278**	**294**	**286**	**311**	**288**	**296**	**296**	**306**	**302**	**294**	**303**

Source: Summary Activity Count produced by Information Department
Note: This slide does not account for casemix (i.e. the tariff for a Surgical elective inpatient can range from £189 to £25,319)

Contract Income | **POD Breakdown** | **Discussions re CQUIN block ongoing**

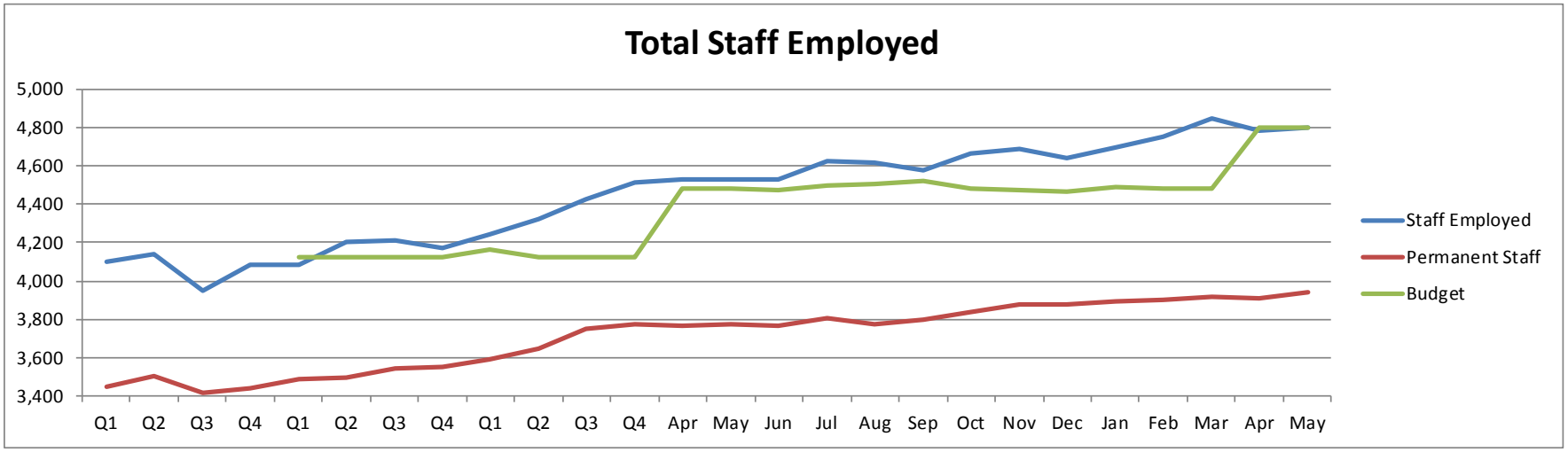
Category £000s	Annual Plan	Ytd Plan	Ytd Actual	Variance	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
Admitted Patients - Elective	22,187	5,035	4,906	-130	1,674	1,761	1,601	1,863	1,688	1,908	2,101	1,926	1,820	2,013	1,820	2,013	**22,187**
Admitted Patients - DC	24,292	5,622	5,912	291	1,860	1,955	1,807	2,093	1,902	2,062	2,266	2,075	1,966	2,170	1,966	2,170	**24,292**
Admitted Patients - Non PbR - Elective	1,013	227	142	-85	76	80	72	84	76	88	97	89	84	93	84	93	**1,013**
Admitted Patients - Non PbR - DC	108	26	7	-19	9	9	9	10	9	9	10	9	9	9	9	9	**108**
Emergency EMRET/READ	-9,455	-2,364	-2,340	24	-788	-788	-788	-788	-788	-788	-788	-788	-788	-788	-788	-788	**-9,455**
Maternity Payment Pathway	11,706	2,910	2,914	3	959	991	959	991	991	959	991	959	991	991	928	991	**11,706**
Outpatients - First	12,727	3,056	3,253	196	1,002	1,052	1,002	1,152	1,052	1,052	1,152	1,052	1,002	1,102	1,002	1,102	**12,727**
Outpatients - Follow Ups	13,956	3,352	3,285	-67	1,099	1,154	1,099	1,264	1,154	1,154	1,264	1,154	1,099	1,209	1,099	1,209	**13,956**
Outpatient - Multi-professional 1sts	808	194	368	174	64	67	64	73	67	67	73	67	64	70	64	70	**808**
Outpatient - Multi-professional FU	1,036	249	327	79	82	86	82	94	86	86	94	86	82	90	82	90	**1,036**
Outpatient Procedures	12,199	2,930	2,743	-187	961	1,009	961	1,105	1,009	1,009	1,105	1,009	961	1,057	961	1,057	**12,199**
A&E	18,419	4,580	5,146	567	1,510	1,560	1,510	1,560	1,560	1,510	1,560	1,510	1,560	1,560	1,459	1,560	**18,419**
UB IMAGING	3,976	955	1,131	176	313	329	313	360	329	329	360	329	313	344	313	344	**3,976**
Direct Access (PbR)	2,204	529	478	-51	174	182	174	200	182	182	200	182	174	191	174	191	**2,204**
Same Day Chemo	1,073	258	324	66	84	89	84	97	89	89	97	89	84	93	84	93	**1,073**
Breast Screening	3,969	953	1,073	120	313	328	313	359	328	328	359	328	313	344	313	344	**3,969**
Critical Care	17,063	4,123	4,268	145	1,331	1,436	1,356	1,407	1,351	1,475	1,422	1,411	1,568	1,493	1,336	1,477	**17,063**
Admitted Patients - Non Elective 0LOS	14,139	3,515	3,486	-30	1,159	1,198	1,159	1,198	1,198	1,159	1,198	1,159	1,198	1,198	1,120	1,198	**14,139**
Admitted Patients - Non Elective 1+LOS	111,509	27,725	28,931	1,207	9,140	9,445	9,140	9,445	9,445	9,140	9,445	9,140	9,445	9,445	8,835	9,445	**111,509**
Admitted Patients - Non PbR - Non-Elective 0LOS[1]	1,618	390	336	-53	128	134	128	146	134	134	146	134	128	140	127	140	**1,618**
Admitted Patients - Non PbR - Non-Elective 1+LOS[2]	1,647	400	247	-153	131	137	131	146	137	136	146	136	133	142	130	142	**1,647**
Direct Access	5,175	1,243	1,239	-4	408	428	408	469	428	428	469	428	408	448	408	448	**5,175**
Non-Prebooked outpatients	56	13	17	3	4	5	4	5	5	5	5	5	4	5	4	5	**56**
Outpatients - Non PbR	4,413	1,060	1,033	-27	348	365	348	400	365	365	400	365	348	382	348	382	**4,413**
Outpatients - Telephone	336	81	103	22	26	28	26	30	28	28	30	28	26	29	26	29	**336**
Pre-assessment	1,478	355	356	1	116	122	116	134	122	122	134	122	116	128	116	128	**1,478**
Onestop	2,414	580	387	-193	190	200	190	219	200	200	219	200	190	209	190	209	**2,414**
Other Services	20,924	5,187	4,201	-986	1,709	1,768	1,709	1,783	1,768	1,717	1,783	1,717	1,761	1,776	1,658	1,776	**20,924**
DRUGS	23,713	5,696	4,953	-743	1,868	1,961	1,868	2,147	1,961	1,960	2,147	1,960	1,868	2,054	1,867	2,054	**23,713**
CQUIN	3,507	877	900	23	292	292	292	292	292	292	292	292	292	292	292	292	**3,507**
Other	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**2**
MRET / Readmissions Central	6,183	1,546	1,546	0	515	515	515	515	515	515	515	515	515	515	515	515	**6,183**
Contract Income Provision	-600	-298	-800	-502	-100	-100	-100	-100	-100	-100	0	0	0	0	0	0	**-600**
Total	**333,796**	**81,004**	**80,873**	**-132**	**26,656**	**27,797**	**26,550**	**28,751**	**27,582**	**27,617**	**29,290**	**27,686**	**27,733**	**28,804**	**26,542**	**28,788**	**333,796**

1 Predominantly short stay activity in EAU, which has a local price where less than 2 hours

2 Various, largest items Paediatric HRGs without a national price (Cystic Fibrosis, Behavioural Disorders,

Staff in Post – Broadly stable, agency numbers a concern

	2015				2016				2017				2018									2019					
	Q1	**Q2**	**Q3**	**Q4**	**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	764	777	791	800	815	810	797	831	842	831	833	851	852	844	856	865	860	860	848
WD Clk/Support	401	426	194	206	206	214	220	220	227	220	224	228	230	228	220	238	240	235	234	244	243	242	241	243	249	258	257
HCA	529	534	548	578	558	594	571	555	560	569	551	572	567	559	578	621	621	621	611	610	614	603	626	632	637	623	637
Consultant	227	236	230	253	251	260	263	257	270	272	281	289	286	288	285	292	291	287	291	297	290	300	293	300	309	299	302
Medical non-Cons	372	386	367	368	367	396	407	404	402	440	444	447	452	445	459	469	447	419	471	434	422	458	469	502	476	466	491
N&M	1,331	1,307	1,373	1,420	1,416	1,422	1,435	1,423	1,446	1,456	1,541	1,571	1,561	1,565	1,562	1,531	1,546	1,546	1,577	1,608	1,582	1,609	1,625	1,650	1,606	1,632	1,623
Learner	4	4	8	7	7	3	3	6	6	4	7	10	10	10	10	10	5	5	5	5	4	7	7	7	7	7	5
Therapy/Technical	339	357	365	360	352	347	359	368	370	376	385	392	391	397	396	400	406	413	423	423	421	430	425	430	435	440	432
Healthcare Scientists	192	179	170	184	185	207	211	185	198	204	202	199	215	226	221	227	216	214	215	217	208	200	202	211	203	208	205
Other	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	2	3	3	3	3	3	3	2
Staff Employed	**4,102**	**4,142**	**3,952**	**4,084**	**4,088**	**4,202**	**4,210**	**4,171**	**4,246**	**4,321**	**4,429**	**4,511**	**4,529**	**4,530**	**4,532**	**4,621**	**4,616**	**4,575**	**4,665**	**4,690**	**4,638**	**4,695**	**4,747**	**4,844**	**4,784**	**4,796**	**4,803**
Made up of:																											
Permanent Staff	3,450	3,503	3,413	3,440	3,486	3,500	3,541	3,548	3,595	3,650	3,750	3,772	3,764	3,772	3,763	3,806	3,774	3,797	3,835	3,878	3,877	3,895	3,903	3,916	3,908	3,942	3,932
Locum / Bank	496	486	395	507	456	537	520	499	531	552	550	614	623	617	614	670	690	640	678	663	515	529	584	619	594	586	587
Agency	156	153	144	136	145	165	149	124	120	119	129	124	142	141	154	145	152	138	153	149	118	138	114	154	133	121	137
Budget					4,127	4,127	4,127	4,127	4,164	4,127	4,127	4,127	4,482	4,483	4,476	4,495	4,501	4,520	4,482	4,473	4,466	4,485	4,485	4,483	4,799	4,799	4,799



*Q3 Drop in 2015 is Engie

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

Agency Spend **Deterioration in month, see agency paper for further narrative and action plan**

£000s	17/18	18/19	19/20	19/20	19/20
	Actual	Actual	Actual	Cum Plan	Mthly Plan
Apr	1,161	1,384	1,440	1,118	1,118
May	2,394	2,655	1,292	2,172	1,054
Jun	3,693	4,090	1,548	3,248	1,077
Jul	4,953	5,472		4,288	1,040
Aug	6,185	6,946		5,455	1,167
Sep	7,354	8,290		6,461	1,006
Oct	8,580	9,661		7,435	973
Nov	10,059	11,160		8,447	1,013
Dec	11,137	12,341		9,198	751
Jan	12,339	13,852		10,337	1,138
Feb	13,408	14,946		11,245	908
Mar	14,831	16,322		12,250	1,006

19/20	Medical Agency	£000s
Division	Service Line	Spend
Surgery	Anaesthetics	112
Surgery	Other	119
Medicine	General Medicine	1,182
Medicine	ED	226
Medicine	Cardiology	179
Medicine	Dermatology	147
Medicine	Respiratory	114
Medicine	Other	265
W&C	Total	148
DTO	Pathology	251
Other	Other	0
Total		**2,743**

	Plan				
	Medics	Nursing	Other Clin	A&C	Total
Apr-19	566	446	93	12	1,118
May-19	513	440	99	2	1,054
Jun-19	542	450	82	2	1,077
Jul-19	594	359	85	2	1,040
Aug-19	695	388	81	2	1,167
Sep-19	557	374	74	2	1,006
Oct-19	571	344	56	2	973
Nov-19	602	352	56	2	1,013
Dec-19	376	317	56	2	751
Jan-20	680	400	56	2	1,138
Feb-20	508	342	56	2	908
Mar-20	576	371	56	2	1,006
Total	**6,780**	**4,582**	**852**	**36**	**12,250**

	Actual				
	Medics	Nursing	Other Clin	A&C	Total
Apr-19	964	350	117	10	1,440
May-19	753	393	137	9	1,292
Jun-19	1,025	384	137	2	1,548
Jul-19					0
Aug-19					0
Sep-19					0
Oct-19					0
Nov-19					0
Dec-19					0
Jan-20					0
Feb-20					0
Mar-20					0
Total	**2,743**	**1,127**	**391**	**21**	**4,281**

Statement of Financial Position – Significant cash payments expected in Q2

Statement of Financial Position For the period ended 31 May 2019	Closing 31 Mar 2019 £000s	Closing 30 June 2019 £000s
Non-Current Assets		
Property, plant and equipment	136,504	139,380
Trade and other receivables	2,927	2,777
Other assets	2,287	2,251
Total non-current assets	**141,718**	**144,408**
Current assets		
Inventories	3,733	3,757
Trade and other receivables	44,957	51,326
Cash and cash equivalents	34,766	27,285
Total current assets	**83,456**	**82,368**
Current liabilities		
Trade and other payables	-30,802	-32,012
Borrowings	-1,668	-1,665
Provisions	-407	-375
Other liabilities	-597	-604
Total current liabilities	**-33,474**	**-34,656**
Total assets less current liabilities	**191,700**	**192,120**
Non-current liabilities		
Borrowings	-27,198	-27,459
Provisions	-404	-388
Total non-current liabilities	**-27,602**	**-27,847**
Total assets employed	**164,098**	**164,273**
Financed by (taxpayers' equity)		
Public Dividend Capital	68,616	68,616
Revaluation reserve	11,913	11,913
Income and expenditure reserve	83,569	83,744
Total taxpayers' equity	**164,098**	**164,273**

CAPITAL PLAN

Report for Month 3

The Trust agreed a reduction of £10.9m from the original NHSI April submission. Much of the slippage is on the Energy Centre. There has been modest spend of £4.7m year to date against a revised £37.1m plan.

Capital

CapEx £m Simplified	Actual FY17/18	Actual M12 FY18/19	*'Indicative'* FY19/20	Actual FY19/20	FY20/21	FY21/22	FY22/23	FY23/24	Project Total
BAU									
Medical Equipment	2.1	2.9	3.0	0.1	3.0	3.0	3.0	3.0	
BAU Estate (*incl backlog*)	2.4	1.8	5.4	0.0	5.0	5.0	5.0	5.0	
BAU IT	2.8	0.7	1.0	0.1	1.0	1.0	1.0	1.0	
BAU CapEx	**7.3**	**5.4**	**9.4**	**0.2**	**9.0**	**9.0**	**9.0**	**9.0**	
Schemes									
MRI	0.6	3.8	0.2	0.0					4.5
Imaging Corridor Works			1.9	0.0					1.9
Electrical Infrastructure	0.1	1.5	6.4	0.8	0.9				8.9
Decontamination & Endoscopy Rooms	0.4	2.0	0.5	0.211					2.9
Acute Services Block (*locally funded*)	0.3	0.0	0.1	0.0					
Lifts / Helipad Enabling					1.0				1.0
Ground floor imaging / switch room/ 3rd CT*			0.1	0.0	1.0				
Ward 10/11/12									
Ward Block									
Energy Centre Building		0.0	2.5	0.0	4.7				7.2
Energy Conservation Measures		0.0	1.4	0.01	4.6	3.0			9.0
Anticipated slippage			-0.6	0.0	0.6				
Car Park Deck - Lewsey Road		0.0	0.0	0.0	2.5				2.5
Pathology Joint Venture		0.6	3.6	0.2					4.2
PAS		0.0	0.1	0.0	2.5				2.6
CT SPECT		0.9	0.1	0.0					1.0
NHS Winter Scheme (inc Theatre G & H)		3.0	4.5	1.3					7.5
CEO Patient Management App		0.1	0.2	0.0					0.3
Slippage on FY18/19 plan			1.8	0.4					
Dunstable Road House		0.3	0.1	0.0					0.3
Beds Contract		0.8	0.5	0.5					1.3
Other	2.4	3.9	0.3	0.2					
Main Schemes	**3.8**	**17.0**	**23.6**	**3.6**	**17.8**	**3.0**	**0.0**	**0.0**	
GDE	**0.4**	**2.8**	**4.1**	**0.9**	**3.0**				10.3
Total	11.5	25.1	37.1	4.7	29.8	12.0	9.0	9.0	
Less Transfer to Deferred Asset		-1.3							
Total Capital Spend		**23.8**	**37.1**	**4.7**	**29.8**	**12.0**	**9.0**	**9.0**	

Workforce
July 2019

(Reporting May / June 2019 Data)

WORKFORCE BALANCED SCORECARD

Reporting Period: May / June 2019

Workforce	Trust Target	May-19 Trust Actual	May-19 Corporate	May-19 Diagnostics	May-19 Medicine	May-19 Surgery	May-19 Women' and Children's	Jun-19 Trust Actual	Jun-19 Corporate	Jun-19 Diagnostics	Jun-19 Medicine	Jun-19 Surgery	Jun-19 Women' and Children's	Jun-18 Trust Actual
Workforce Statistics														
Staff in post (Assignment Headcount)	-	4381	574	790	1211	995	811	4369	566	791	1215	994	803	4187
Budgeted WTE	-	4528	559	767	1334	1107	760	4528	559	767	1334	1107	760	4397
Staff in Post (WTE)	-	3942	528	694	1102	934	684	3932	520	694	1107	933	677	3763
* Vacancy Rates (%)	10%	12.93	5.56	9.57	17.41	15.63	9.96	13.17	6.99	9.55	17.00	15.68	10.97	14.41
Nurses & Midwives Budgeted WTE		1502	49	28	565	428	432	1502	49	28	565	428	432	1456.0
Nurses & Midwives in Post (WTE)	-	1291.6	43.0	26.6	474.0	361.2	386.7	1287	42.0	27.1	468.5	369.4	380.0	1272.0
Nursing & Midwives Vacancy Rates (%)	10%	13.99	12.44	5.65	16.08	15.57	10.41	14.30	14.48	4.07	17.05	13.67	11.98	12.68
Nursing Vacancy Rates (%)	10%	14.42	12.44	5.65	16.08	15.57	9.74	14.49	14.48	4.07	17.05	13.67	11.05	13.47
Midwives Vacancy Rates (%)	10%	11.31	-	-	-	-	11.31	13.13	-	-	-	-	13.13	4.40
Sickness FTE Days Lost	-	4054	455	531	1329	785	954	-	-	-	-	-	-	4210
Sickness Rates (%)	3.32%	3.34	2.78	2.48	3.94	2.74	4.49	-	-	-	-	-	-	3.56
Estimated Sickness Cost (£)	-	358878	39381	51357	102288	73383	92469	-	-	-	-	-	-	299112
Maternity Absence Rates (%)	-	2.65	1.91	2.43	2.96	2.17	3.61	2.65	1.72	2.58	3.03	2.19	3.47	2.64
Other Absence Rates (%)	-	0.37	0.54	0.36	0.41	0.26	0.32	0.38	0.28	0.45	0.39	0.27	0.53	0.41
Turnover %	10%	15.19	18.60	15.65	16.26	13.14	13.01	15.11	18.19	15.42	16.75	12.16	13.55	16.01
Appraisal Rate %	90%	80	72	89	79	81	75	79	73	86	79	81	72	80
Core Statutory Training %	80%	89	87	91	89	89	89	90	87	91	90	90	89	79

RECRUITMENT COMMENTARY

Nurse Recruitment - 48 nurses started in post between April and June of which 9 were registered with the NMC and 39 with registration pending. 9 bank nurses also started in post during this period with 29 band 5 nurses leaving the Trust.

The Trust continues with both local recruitment as well as overseas recruitment for registered nurses. Recruitment campaigns undertaken in this period include attendance at Central Bedfordshire College and Luton Mall recruitment stand. Events planned over the next few months include a recruitment stand at the Trusts Community Engagement event in July and attendance at the Luton Employment, Training & Skills Fair in September 2019.

International Recruitment – The Trust is continuing with regular Skype interview campaigns for Non-EU qualified nurses. There are currently 196 overseas nurses in the pipeline who have passed their IELTS/OET and are now progressing through the various stages of the NMC process. Throughout this period 39 overseas nurses have arrived at the Trust. These 39 nurses will sit their OSCE exam during the next two months. Dates for OSCE exams are limited due to high volume of overseas candidates throughout the country. Further Skype interviews are planned throughout July and August. Between April and June 6 overseas nurses passed their OSCE exam and gained their NMC registration.

European Recruitment - The Trust attended a facilitated recruitment event in Portugal in May. The event did not have the forecast attendance and as a result much fewer interviews were held resulting in only1 job offer.

HCA Recruitment - The Trust continues with regular recruitment campaigns for both permanent and bank positions to keep vacancies to a minimum and provide an effective bank resource. There have been 28 substantive HCA starters and a further 12 HCA's joined the bank during the period. 17 substantive HCA's have left the Trust during this period. The next two planned HCA Open Days have been scheduled for 6th July 2019 and 14th August 2019.

* Please note the 2019/20 budget establishment is reflected in the figures. The overall establishment increased by 131 which included an increase of 46 WTE to Nursing and Midwifery resulting increased vacancy rates.

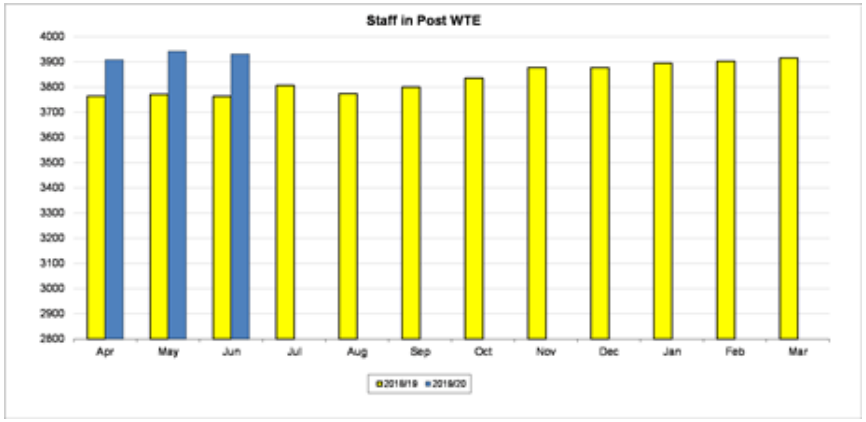
STAFF IN POST WTE BY DIVISION

DIVISION	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	% Growth From April 2018	Average % Growth per month	% Growth over last 12 months
Corporate	514.0	519.6	519.9	525.3	536.1	538.3	530.9	527.5	530.7	528.0	528.0	530.7	0.52%	0.29%	3.24%
Diagnostics, Therapeutics and Outpatients	642.2	640.3	652.7	658.9	664.6	666.3	675.7	678.3	685.6	685.9	694.0	685.6	-0.04%	0.61%	6.76%
Medicine	1072.8	1063.3	1070.8	1071.3	1087.9	1087.0	1100.4	1097.1	1095.6	1084.5	1102.0	1095.6	1.02%	0.19%	2.12%
Surgery	892.9	876.7	883.0	891.3	891.2	898.0	901.8	907.0	912.6	918.1	934.0	912.6	-0.60%	0.20%	2.21%
Women's & Children's	684.4	674.1	673.6	688.6	698.1	687.4	686.6	693.6	691.9	691.8	684.2	691.9	0.02%	0.10%	1.09%
TOTAL	**3806.4**	**3773.9**	**3800.0**	**3835.3**	**3878.0**	**3877.0**	**3895.4**	**3903.5**	**3916.5**	**3908.3**	**3942.2**	**3916.5**	**0.21%**	**0.26%**	**2.89%**

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) continues to increase. With an increase of 0.21% since April 2019 and 2.89% over the past 12 months. Increases since April result from additional Typist/Medical Secretary appointments, Nurses, HCA's and filling medical vacancies in A&E.
- There are currently 108 band 5 Nursing vacancies across the Trust. There are 221 band 5 Nurses currently going through the recruitment process, which includes 25 applicants recruited through our local recruitment campaigns and 196 IELTS/OET passed applicants recruited through our overseas recruitment campaigns.
- Currently there are 84 vacancies for band 2 Healthcare Assistants (HCA) with 38 currently going through the recruitment process due to commence between June and August 2019. The new budgeted establishment increased vacancy rates from April 2019. However, the number of new starters have increased and ,coupled with no HCA leavers in May, this has resulted in a forecast reduction in vacancies over the next two months to circa 66 by the end of August 2019.



Medical Recruitment

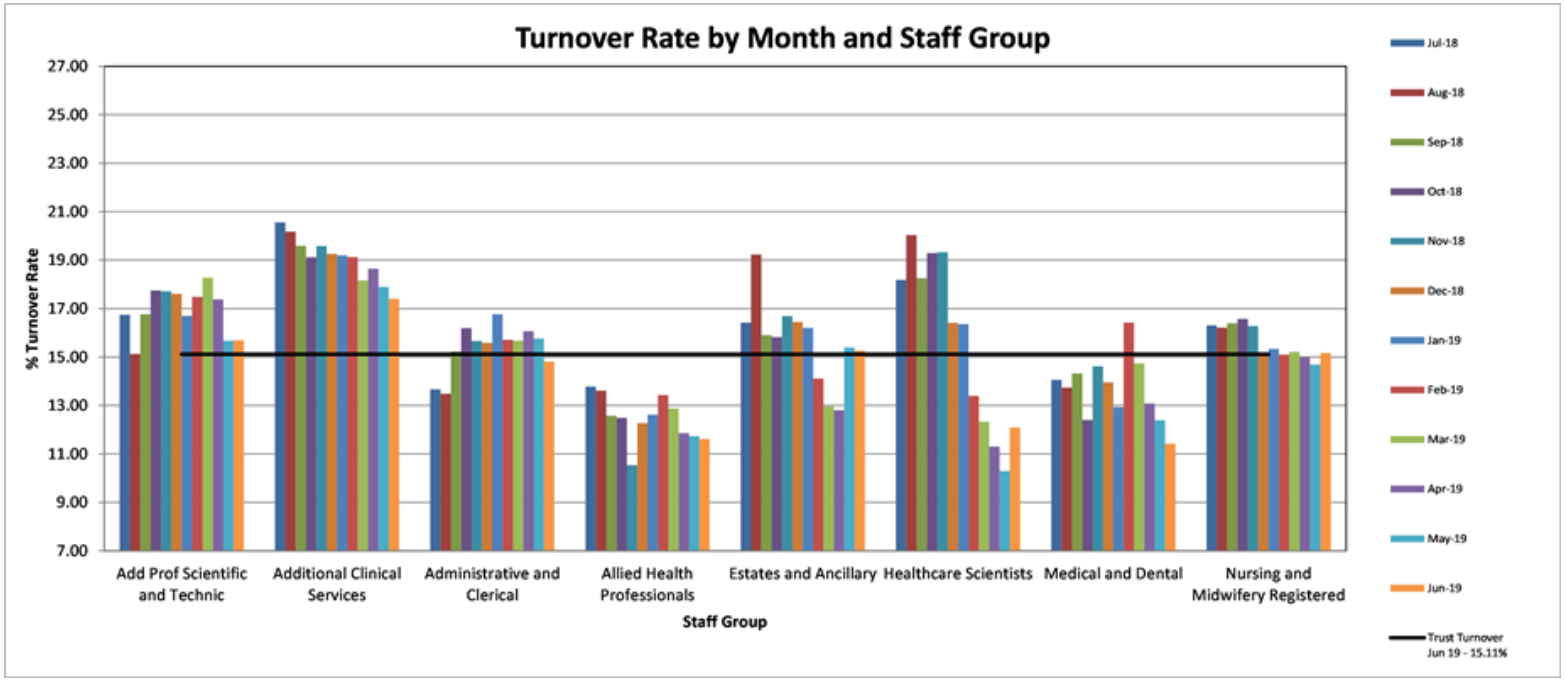
Between April and June 2019 four AACs took place and ten Consultant appointments have been made (2- Gastroenterology, 1- Anaesthetics: Pain, 1- Anaesthetics: Head and Neck, 2 – Anaesthetics: General, 3- Anaesthetics: Pre assessment-1). Three AACs were cancelled due to no applications being received (Respiratory, Stroke and Acute Medicine).

Between July and September 2019 13 AAC's are scheduled for the following specialties: NICU, Haematology, Anaesthetics – Intensive Medicine, Urogynaecology, Elderly Medicine, Orthogeriatrician, Stroke, Emergency Medicine, Neurology, Radiology, ENT – Bariatrics, Diabetes and Trauma and Orthopaedics- Spinal.

New Starters

Between April and June 2019 one new substantive Consultant started in post in Diabetes.

TURNOVER



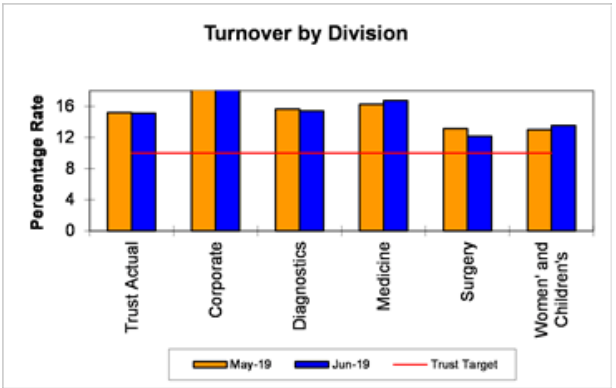
TURNOVER COMMENTARY

The Trust's overall turnover rate is 15.11% for the reporting year ending 30th June 2019. This is a decrease in month from May 2019 (15.19%) and when compared to June 2018 (16.01%). Overall turnover is below the EoE Q4 average of 16.04%.

Most staff groups are now showing a downward trend in turnover with the exception of two smaller staff groups. Estates and Ancillary have of only 101 WTE employees in post and 17 leavers over the year, and Healthcare Scientists have only 98WTE employees in post with 13 leavers over the year.

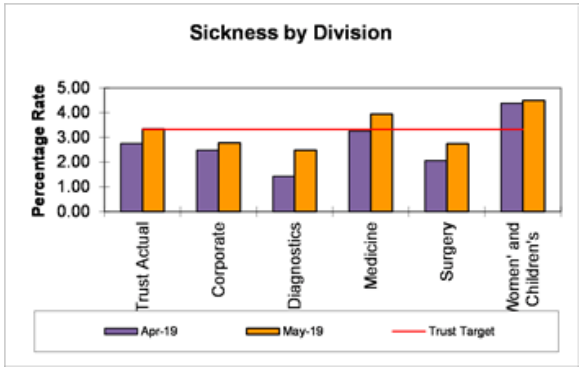
Nursing and Midwifery turnover for June 2019 is 15.17 % which is a marginal decrease of 0.2% when compared to June 2018. However, this remains a decrease of 1.12% from the highpoint in October 2018. Turnover can be attributed to Relocation 39%, Promotion 16%, Work life balance 13%. The remaining 32% relates to 6 leavers that all left for different reasons. The Retention Matters Project attended an NHSI event reviewing work undertaken across the NHS to improve retention and as a result the project are undertaking a stock take of the work to date and planning further initiatives to reduce turnover rates.

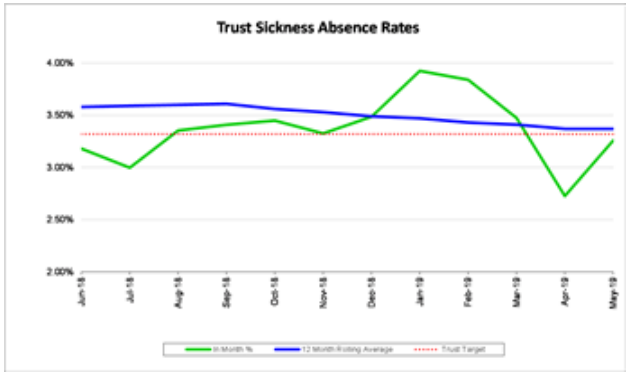
Not including Junior Doctors at end of their contract - there were a total of 141 leavers between April and June 2019 – top reasons for leaving were: Relocation – 19.85%, Work Life Balance – 17.73%, Retirement – 9.92%, Health - 6.38% and Promotion - 5.67%.

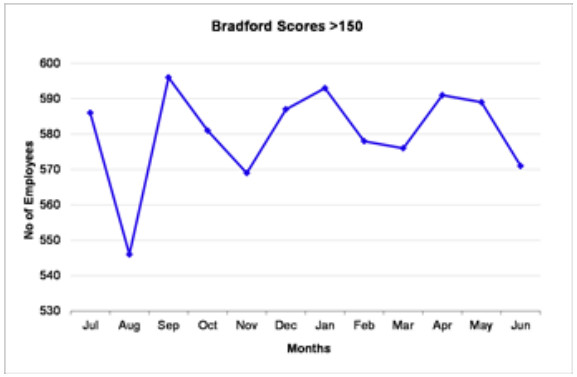


* Turnover figures above do not include Junior Doctors.

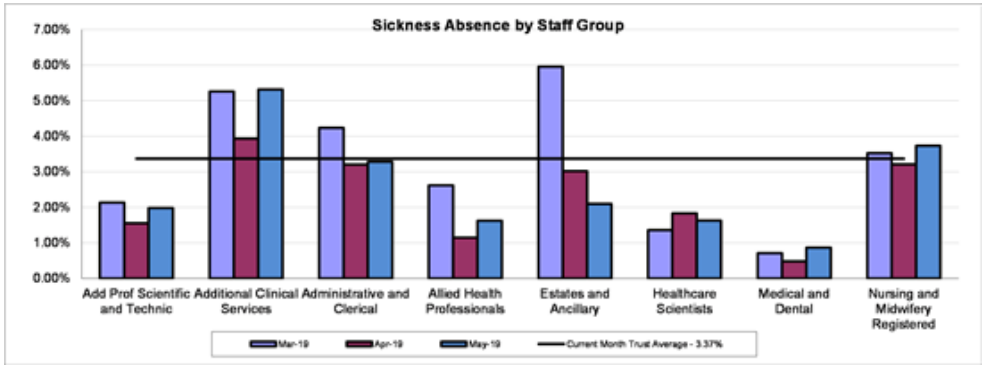
SICKNESS ABSENCE







Sickness Absence by Staff Group	Mar-19	Apr-19	May-19	Last 12 Months Average
Add Prof Scientific and Technic	2.13%	1.55%	1.98%	2.75%
Additional Clinical Services	5.25%	3.93%	5.31%	5.38%
Administrative and Clerical	4.23%	3.20%	3.28%	3.47%
Allied Health Professionals	2.62%	1.15%	1.62%	2.13%
Estates and Ancillary	5.95%	3.01%	2.10%	4.04%
Healthcare Scientists	1.36%	1.83%	1.62%	1.46%
Medical and Dental	0.71%	0.48%	0.86%	0.86%
Nursing and Midwifery Registered	3.52%	3.21%	3.73%	3.66%
Trust total	3.47%	2.73%	3.26%	3.37%



SICKNESS ABSENCE COMMENTARY

The monthly average for May 2019 (3.26%) is higher than for April 2019 (2.73%) but is below the Trust target of 3.32%. The Trust's overall average for the year ending 31st May 2019 is 3.37%. This is slightly above the Trust target but is lower than the same period last year (3.56%) and lower than EOE Q4 Average of 3.90% and the NHS National median of 4.5%, which places the Trust in the lowest quartile for absence rates.

There were 571 employees with a BS over 150 at the end of June 2019, which was a decrease from the previous month (589). The breakdown of sickness categories was 63.5% short term sickness; 26.5% short term due to underlying health issues; 8.5% long term sickness; 1.5% pregnancy related sickness.

Formal Stage 2 meetings were held with 397 of these employees (i.e. 70%) – an increase from 68% in the previous month and the second time this level of stage 2 meetings has been achieved over the past 5 years.

A further 25 Stage 2 meetings were cancelled in June 2019 (compared to 27 in May 2019). The primary reason for cancelled Stage 2 meetings in the month was due to the employee being off sick, with the next highest reason due to the Line Manager being on leave or unavailable. Cancellation information is escalated to General Managers and Matrons on a monthly basis to enable them take steps to address any avoidable cancellations. Divisions are devising local plans to reduce the cancellations and are addressing issues with individual managers who have multiple avoidable cancellations. Consideration is being given to add timely completion of stage 2 meetings and a KPI for avoidable cancellations as an appraisal objective.

TRAINING COMPLIANCE BY DIVISION

June 2019	APPRAISALS	INDUCTION	STATUTORY TRAINING											
			Fire	Infection Control	Safe Moving - Theory	Safe Moving - Practical	Information Governance	Safeguarding Adults	Safeguarding Children	Core Safeguarding Child Level 3 ***	Specialist Safeguarding Child Level 3 ***	Conflict Resolution	Basic Life Support	Immediate Life Support
TRUST TARGET	90%	100%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Corporate	73%	80%	82%	89%	88%	92%	84%	90%	86%	100%*	N/A **	74%	57%	100%
Diagnostics, Therapeutics and Outpatients	86%	70%	91%	91%	93%	94%	88%	92%	86%	92%	100%	86%	69%	0% *
Medicine	79%	85%	88%	91%	91%	96%	86%	88%	87%	67%	57%	69%	74%	32%
Surgery	81%	82%	87%	91%	91%	95%	85%	89%	86%	100%	N/A **	77%	70%	47%
Women's & Children's	72%	N/A	86%	89%	89%	94%	86%	90%	91%	86%	81%	56%	68%	54%
TRUST TOTAL	79%	81%	87%	90%	91%	95%	86%	90%	87%	82%	77%	71%	71%	40%
Change from last month	-1%	6%	0%	0%	1%	1%	0%	0%	0%	1%	3%	1%	-1%	1%

Compliance Thresholds

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

* This figure relates to less than 2 people
** Training not required

*** Please note Core requires 2 hours training per year and Specialist requires 4 hours per year.

TRAINING COMMENTARY

Statutory / Mandatory Training

Compliance for core mandatory training increased to 90% during the June period. However, the underlying compliance for all topics remained at 87%. We continue to assess the uptake of training sessions, scheduling in additional training when possible to meet demand. Progress has been made with the CQC Action Plan which has contributed to the steady progress that has been made in the majority of areas. We continue to work with more challenging areas such as Resuscitation Training.

There are over 727 future bookings for BLS in addition to any direct bookings as part of the Resuscitation Team drop-in days. There are also over 117 future bookings for ILS. However, compliance is not improving at an acceptable rate. The Training Administration Team follow up each non-attendance in order to better understand why staff are do not attend their training and resulting data will be used to improve attendance and make any necessary changes to procedures. Early indications are there are four themes; sickness, staffing levels, shift conflicts and employment changes (changing dept.) Addressing these themes through improved communication will be picked up at the Matron's meetings.

Conflict Resolution training compliance has increased by 1% during the June period. Divisional Leads have been instrumental to this upturn in compliance. Diagnostics, Therapeutics and Outpatients currently sits at an impressive 86%. Low compliance for the Women's and Children's Division will be discussed at our next review meeting, ensuring that improvements are made over the coming months.

A list of staff who have been non-compliant for all of their mandatory training for three months are being contacted directly asking them to complete the outstanding training as soon as possible. This is followed up with Divisional Leads and at the monthly meetings with Training and Development will be asked to support this approach, with the expectation that there is improvement by the following month. The list is updated each month, with a fresh list being produced quarterly.

Appraisals

The overall appraisals' compliance rate for the Trust has dropped by 1% during the June period. This is due to a number of appraisal completions expiring within the DTO and W&C's divisions.

Monthly lists of staff who have not had an appraisal in the last 12 months is sent to Divisional Leads. This makes it clear as to which areas need to be contacted in order to improve compliance. Dates of upcoming appraisal training sessions are distributed alongside the Divisional and Cost Centre level reports, to raise awareness of the classes to those who are new to the appraisal process.

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	31 July 2019	**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 24 April, 22 May and 26 June 2019	
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

SUMMARY/CURRENT ISSUES AND ACTION

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

- Report on progress with the Quality Priorities 2019/20
- 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 24 April, 22 May and 26 June 2019.

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, complaints and national performance targets.

The Chief Nurse noted that the increase in numbers of pressure ulcers was expected due to a change in the criteria of data collection. She gave the committee assurance that staff are alert to skin damage and ensuring that plans are put in place as early as possible.

With regard to falls, an external review was undertaken and there has been an invigorated focus on reducing falls. Interventions have been progressed including improved bathroom facilities. The Therapy Lead Manager was in attendance at the May meeting and presented the proposal for the End PJ Paralysis project (Get up, get moving) which is being piloted on a few wards. COSQ gave support for progressing the initiative and discussed how this is launched and the sustainability of the project.

COSQ noted that the target for C.Diff has changed and the numbers of C.Diff for the first quarter are higher than anticipated. Root cause analysis has not identified any particular themes and this work is ongoing.

Following an external review of the Trust's complaints process, improvements are underway. The Complaints Board met on 19 June 2019 and Divisions have been set a trajectory to achieve 90% of response time within 35 days by the end of August 2019 (it was noted that the national guidance is 40 days).

The Chief Medical Adviser reported that the standard mortality rate has improved dramatically with the Trust currently well below the average. She noted that SHIMI looks at mortality after the patient is discharged from the hospital and this remains on the same level. Much work has taken place including focus on end of life care, ward rounds at weekends, and coding of those patients who had co-morbidity. However, it was noted that there are certain areas where the mortality rate is high, particularly fractured neck of femur (see update in item 3 below).

The Deputy Chief Executive briefed the committee on the pilot for new clinical access standards from 22 May 2019. The new standards being measured are: time to initial assessment; mean time in ED for all patients who have been discharged home or admitted into the wider hospital; and numbers of patients who wait longer than 12 hours from arrival. The Trust is working closely with NHSE and NHSI.

Assurance was given that avoidable cancelled operations are decreasing and any unavoidable cancellations are very complex.

COSQ received monthly reports regarding the 18 week referral to treatment target, noting that the Trust has achieved just below the 92% target level for the quarter. The concern around the consultant pension tax free allowances continues to present the risk that activity will drop and the rate will not be sustained. In terms of quality, cancer and emergency patients are prioritised against the 18 week patients.

Nursing Quality Dashboard – The first draft of the new nursing dashboard was shared with the committee. The Chief Nurse noted that more detail around individual wards/departments is available to Matrons and the corporate nursing team to monitor performance. Work is taking place to provide a more triangulated approach looking in depth at workforce and quality.

Quality Account – The draft Quality Account 2018/19 was received and approved by COSQ.

3. Clinical Outcome and Patient Safety

Serious Incidents – COSQ received reports giving an update on Serious Incidents (SI) and Never Events. The Director of Quality and Safety Governance highlighted that when any incident is reported via Datix and assigned to a handler they are also reviewed by the clinical risk team to ensure that nothing gets missed should there be a time lag in the handler picking up the incident. It was noted that although 75% of the incidents are open, the majority of these will be either under investigation or will just be waiting for final sign off. The clinical risk team are looking at measures that may speed up this process. The committee noted that the Post Event Action Review for Learning (PEARL) process is where events are considered for escalation as reportable serious incidents.

The Chief Nurse continued to report that there has been a cluster of incidents in Maternity over the past few months and therefore a review is being undertaken for assurance purposes. The committee discussed staff cultures and near miss transparency.

Fractured Neck of Femur Mortality – The General Manager for Trauma and Orthopaedics presented an update on the Fractured Neck of Femur position. The committee noted the programme structure with 6 task and finish groups. Assurance was given on the actions due for completion by the end of June although the 7-day senior medical review has not progressed.

GIRFT (Getting It Right First Time) - The Deputy CEO reported that the Trust has approximately 3 GiRFT visits every two months. Recent visits have been Diabetes, Endoscopy and Imaging. Action plans from the first tranche of GiRFT visits are predominantly complete. Some revisits are just starting to commence. A key message coming from GiRFT nationally is that the NHS needs to standardise data as there are inconsistencies in the way that data is reported. GiRFT are also keen to incorporate litigation into their workstreams.

Stroke – The GM for Medicine and Service Manager for Stroke were in attendance at

the June meeting and explained that the previous SSNAP score had disappointingly dropped from a B to C rating but focussed work had helped to bring the latest published score back to an overall B rating. The domains relating to therapies were noted and discussion took place with regard to recommendations for therapies resource. The committee were briefed that GiRFT had made a recent visit to the Trust in relation to stroke and offered support. With regard to patient outcomes, COSQ were informed that SSNAP is an outcome measure and there are varying scales of mobility and assurance was given that the Trust has a score of 3 which is a moderate level of mobility.

Pre-Assessment – A presentation was made giving an overview of the improvements in pre-assessment project, noting its success and post implementation outcomes.

7 Day Services – A report was presented informing COSQ of the progress toward compliance with the 7 day services standards.

Infection Control – The Director of Infection Prevention and Control was in attendance at the April meeting and updated the committee on work to date to invigorate the drive for no avoidable infection. He noted that the Infection Control policy has been revised and the strategy will be renamed to "Infection Prevention and Control Code of Practice' and will build on the previous 'No Avoidable Infection Strategy'. Discussion took place with regard to hand hygiene and 'Bare Below the Elbows'.

Quality Impact Assessments on CIPs – A paper was received giving an overview of the Quality Impact Assessment tool and outlining the cost improvement and income generation plans for 2019-20. There is a process that any medium negative impact on quality will be presented to COSQ. The finance team undertook an initial assessment and assured the committee that no adverse impact had been identified. Further scrutiny and sign off is underway by the Deputy Chief Executive and the Chief Nurse.

4. Patient Experience

The annual Patient Experience report was received. The committee noted feedback was flagging "would not recommend" due to noise at night. Steps have been taken to address this by replacing/repairing 'noisy' bins and doors.

5. Quality Priority and CQUIN

The committee received the Quality Priority and CQUIN reports each month.

6. Report from Clinical Operational Board

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

7. Workforce Update

Statutory Training and Appraisals – The Training and Development reports covering activity to 31 May 2019 were received and noted, together with detailed reports showing mandatory training and appraisal compliance by Division. The Director of HR highlighted a mandatory training position comparison from January to May 2019 and

noted the improvement, particularly with regard to conflict resolution training. It was confirmed that performance of both mandatory training and appraisals is reported at Executive Performance meetings with the specialties.

The formation of a new Workforce Committee was noted.

Nursing and Midwifery Workforce - COSQ reviewed the monthly nursing workforce reports. The increased use of mental health nurses, particularly for Paediatrics, was noted.

8. Risk Register

The risks assigned to COSQ which were due for review were discussed and updated. The committee was alerted to an emerging risk with regard to consultant pensions which will have the impact of consultants discontinuing to do additional sessions.

9. CQC

The committee received the CQC action plan update report and were given assurance that both the regulatory 'must do' actions and the 'should do' actions were either completed or in progress to meet the deadlines.

10. Nurse Accreditation Proposal

The Deputy Director of Nursing presented a paper outlining the concept of a nursing accreditation scheme which includes ward accreditation, shared governance, and staff recognition. The suggestion is to introduce the scheme in stages. The first phase would include the base wards all using similar key performance indicators but, at the same time, making the dashboard relevant to individual areas, and senior teams using an assessment tool to observe care, the environment, reviewing the documentation and outcome data for the area and speaking to staff and patients about their experience. The ward would then be required to create an improvement plan which will be reviewed at the quality and performance meetings. COSQ supported the proposal.

11. Safeguarding – Adults and Children

COSQ received and noted the Joint Adult and Children Safeguarding Report for Quarter 4. The Chief Nurse highlighted that processes are good but challenges are around staff training.

12. Audit

Internal Audit
Clinical Coding report - The Acting Manager Clinical Coding, and Director of IM&T, attended the meeting in May and gave an update on the recommendations from the PWC report. It was noted that presentations had been made to junior doctors to focus on co-morbidity capture. COSQ noted the findings.

COSQ received the audit report for the Urgent GP Clinic and noted that Altrumed have accepted all recommendations.

A paper outlining outstanding actions from internal audit reports was received by the committee. It was confirmed that COSQ submits a report to each Audit Committee.

Clinical Audit Forward Plans
A briefing paper was provided outlining the numbers and levels of audits that have been put forward on Divisional forward audit plans for 2019/20.

13. Papers Received for Information

- Summary Report on Saving Babies Lives Care Bundle Audit
- Medicine Nursing Consultation
- Maternity Dashboard
- Complaints Board minutes

FINANCE, INVESTMENT & PERFORMANCE COMMITTEE REPORT TO THE BOARD

This report reflects the matters considered at the Finance, Investment and Performance (FIP) Committee meetings on 22nd May, 26th June and 24th July 2019.

The key focus of the FIP Committee is to conduct Board level review of financial and investment policy. The Committee reviews financial performance issues and oversees overall performance against national and local targets.

This report highlights the issues and themes presented to FIP in May, June & July[1] 2019:

1) Trust and Divisional financial performance against the plan for the year to date 2019/20

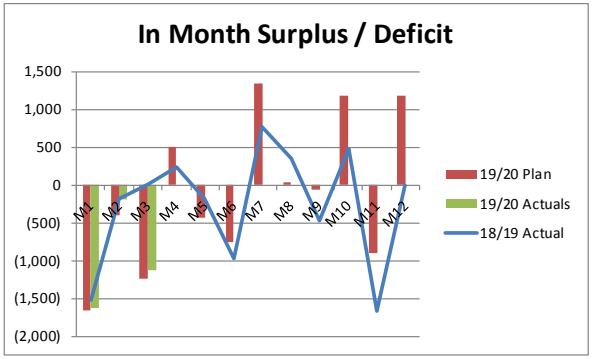
2) Associated cost improvements, contracting issues, capital expenditure during 2019/20, cash-flow and associated FIP actions;

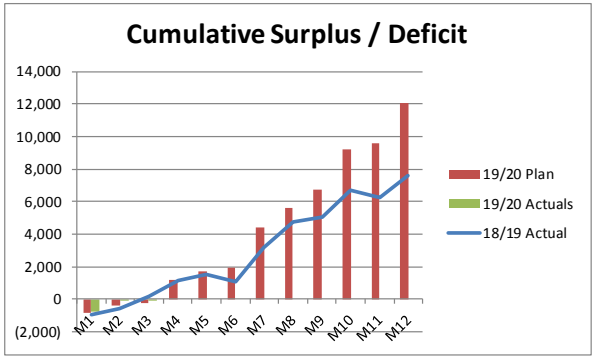
3) Investment decisions and review;

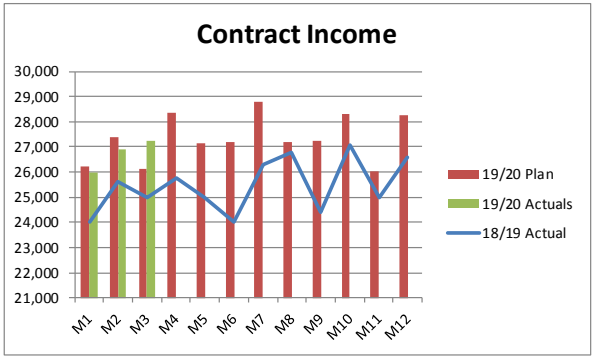
4) Other FIP matters.

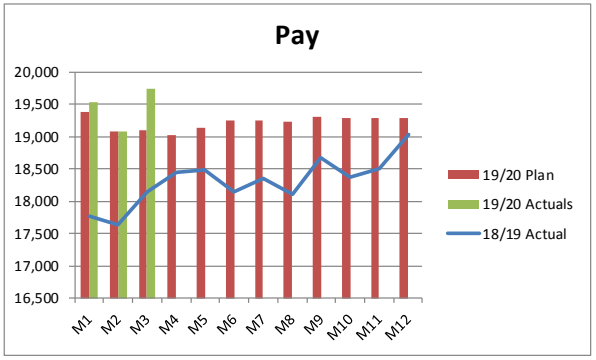
[1] July minutes have not yet been approved by the Committee

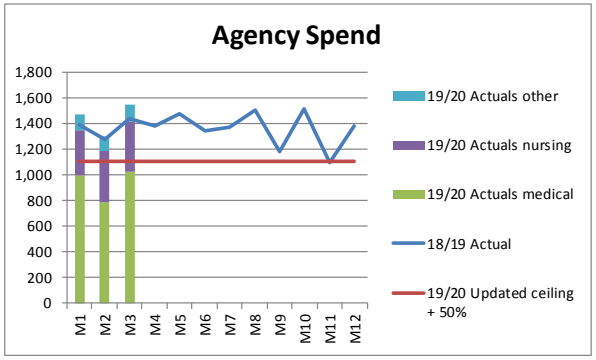
1. Key Finance Issues – 2019/20 Performance

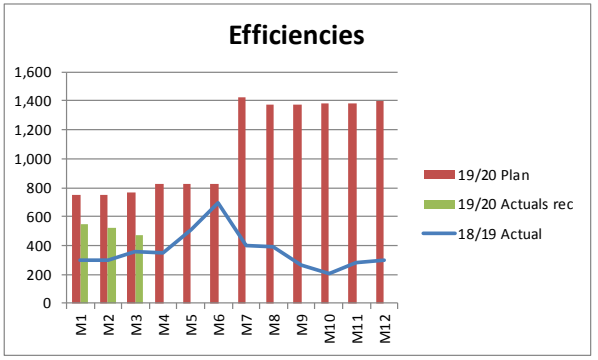


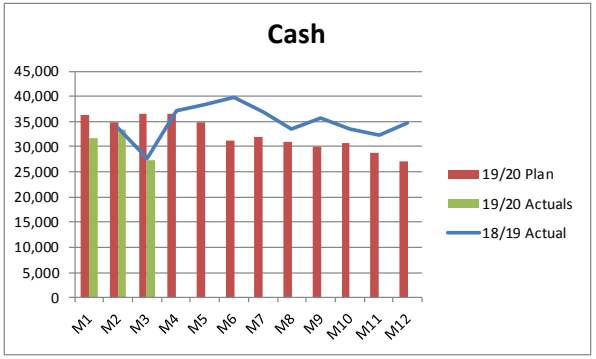


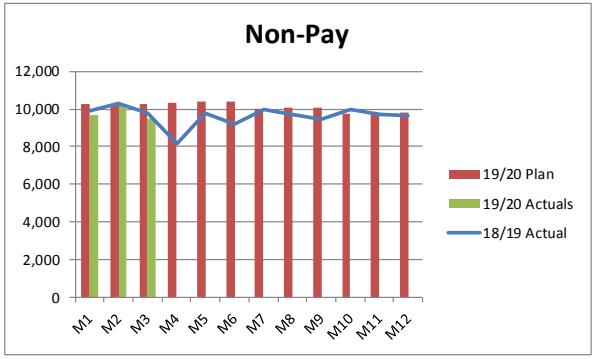


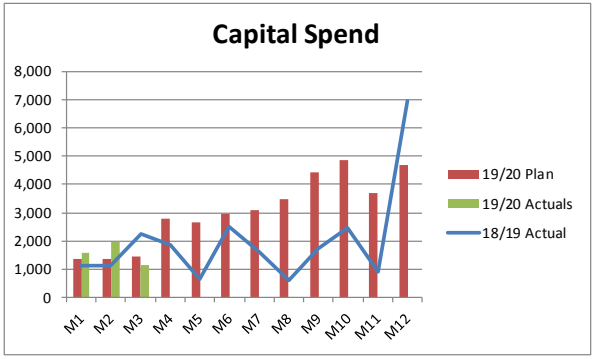












Area	Commentary	FIP Actions Noted
Income	The Trust reported income of £86.6m for Q1 FY19/20 which is £0.09m behind plan (noting that the under-recovery on High Cost Drugs income is offset by an equivalent underspend on HCD expenditure). This value does not include £1.2m of MRET/Readmissions gainshare nor the £1.4m of PSF that the Trust has accessed for delivering its Control Total in Q1. FIP recognise that this income is significant in contributing to the planned cumulative surplus for FY19/20 that would otherwise be a small deficit. At July's FIP meeting it was noted that over the full year the Trust might expect to lose over £1m of elective income (compared to plan) due to the impact of the pension scheme taxation issue. It was also noted that CQUIN had been blocked at 90% with Luton and Bedfordshire CCGs.	None not otherwise noted
Expenditure	For Q1 FY19/20, spend was £0.3m ahead of plan. FIP have noted this with caution as a significant proportion of the favourable variance relates to an underspend on High Cost Drugs that is offset by equivalent under-recovery of income. The main source of concern is that pay is overspent by £0.8m with a £1.3m overspend on medical pay being offset by underspending in other pay categories. While this is driven by continuing high demand for non-elective services, a significant number of vacancies within Medicine's junior doctor establishment work is continuing to ensure all booking processes are robust and controlled. This issue was explored further as part of the Service Line Reports pack that is now presented regularly to FIP. The overview position is described on the following page. The Month 4 reports will form the basis of a reforecast with mitigating recovery plan actions to be considered by the Executive Team in advance of September's FIP meeting.	Medical pay continues to be subject to a number of different actions. These include a concerted and concentrated effort on recruitment, improved process control, revising agency engagement models and ensuring Executive sign off of all significant transactions. Nursing pay also remains under continuous review with an enhanced patient care model business case to be considered at September's FIP meeting.
Surplus/ Deficit	At Q1 the Trust reported a £0.007m deficit position compared to a planned deficit of £0.25m. This was after accessing £1.4m of PSF.	None not otherwise noted
CIPs	With CIPs behind plan, the reforecast and initiation of a recovery plan will be reported from September.	Fast track and medium term opportunities were explored through FIP and formed the basis of the Trust's recovery planning
Cash	The Trust reported a cash balance of £27.3m at 30th June 2019.	None not otherwise noted
Capital	The capital expenditure plan for FY19/20 is now £37.1m with £10.9m having been removed (or slipped) in order to contribute to the NHSEI request to reduce capital plans by 20%. At the end of Month 3 actual spend was £4.7m.	None not otherwise noted

Service Line Report – Headline Summary

Based on the month 2 estimated position, 4 services were selected for this month's deep dives (theses are highlighted in orange).

The key areas of concern are:

1. Medical pay spend in medicine (circa £200k over per calendar month, £2.4m without intervention)
2. Medical pay spend in A&E (£182k variance on pay in month) - Some late claims for bank shifts (circa £30k)
3. Rehab income down £50k per calendar month due to the opening of community beds (£600 risk FYE)
4. Paediatrics HDU activity £80k behind plan, this is anticipated to pick up in the latter part of 19/20
5. Operational services multi-various, but in the main relating to HSDU (£107k) car parking (£51k), maintenance contracts (£48k) and Portering (£33k). The current trend on Portering would suggest a FOT overspend of £120k a year.
6. Restorative Dentistry is £66k behind as they are operating at 50% capacity due to environmental and water supply issues.

Su			Me						Op Services, Med-E		
	Orthopaedics	16		Respiratory	17		Br Scr	180		Director of Nursing	-15
	Br Surgery	24		Diabetic & Endocrine	-35		Imaging	-26		Managing Director	-19
	Vasc Surgery	4		Nephrology	-14					Director of IT	-16
	Plastic Surgery	15		Rheum	178					Renal Unit	0
	Theatres	127		Neurology	252						
	Critical Care	264		Derm	83					Non-Directorate	115
	Surgical Support Services	28		Sexual Health	96						
	Pain	23		Limbs	-13						
	Cancer Services	164		Orthotics	-22						
	Cobham	-53		Specialty Medicine Central	44						

2. Investment Decisions & Review in 2019/20

Business Case	Summary of Proposal	FIP Actions Noted
Electrical Infrastructure	Building work was completed in June. FIP acknowledged a number of changes in the scope of works, largely driven by the need to accommodate defects in the current cable network, and the decision to upgrade switchboards. In addition, a cost plan was completed on the proposed work to sub-station D within the Surgical Block. Following some discussion FIP approved the revised plan value (£0.9m more than original plan), with an expectation that it should ultimately be less following negotiations.	None
Energy Centre	Following the presentation of the Energy Centre Business Case at June's FIP, the Redevelopment team presented a revised business case to FIP in July. The revised business case included greater detail on how the savings will work, and assurance from both external advisors. Following due and careful consideration the Committee recommended the case to the Trust Board for approval with a proposal agreed to bring forward the lighting upgrade plan.	None
Pathology Joint Venture	The terms of the "Contractual Agreement" between the L&D and BHT, a refined target operating model and final draft of the proposed financial arrangements were considered by FIP in advance of the Trust Board. Following due and careful consideration the Committee recommended the case to the Trust Board for approval with the future proportionality of the contract to be considered in more depth.	None

Business Case	Summary of Proposal	FIP Actions Noted
Endoscopy Decontamination Unit	The Committee were informed that the EDU was completed and handed over by the end of June.	None
Car Park Expansion	The Hospital Redevelopment team to continue to pursue all available options and report progress back to Hospital Redevelopment Board (and subsequently FIP). Current plans include the implementation of a scheme to allow visitors to share staff parking facilities (after 3pm), mitigating parking issues in advance of any capital development.	None
Imaging Department Upgrade	In June the Imaging Department presented the case upgrading the Imaging Department environment and equipment. Following lengthy and detailed discussion, and an acceptance by the GM for DTO that there is still work to be done on pathway management, the scheme was approved to proceed.	None
Senior Nursing Structure (Medicine)	The Chief Nurse presented a paper in June outlining proposed changes to the Senior Nursing structure within Medicine. Following extensive discussion the revised structure was approved for the Chief Nurse to take out to consultation with work on benefits realisation to be concluded to support future review.	None

3. Other Matters

Numerous topics have been covered by the FIP Committee between May and July. These have included confirmation of the correction in the Trust's Control Total, GDE developments and progress, the nursing workforce review, agency expenditure, contract updates, briefings on the junior doctors' contract and detailed discussion on the impact of the pensions tax issue.

Service Line Reporting continues to develop, with detailed service positions being presented alongside "deep dive" reviews where particular issues warrant it. It has been noted that detailed recharge mappings will result in an SLR rebasing in future months.

The Committee continues to regularly review the risk register items to which it is aligned and has also contributed feedback on the 2019/20 Operational Plan as well as the Annual Report for 2018/19.

It should be specifically noted that in relation to the 2019/20 national costing exercise FIP approved the following on behalf of the Trust Board:

- That the plan is sufficient to meet the requirements to produce the required costing submission by the deadline date including:
    - Senior Review and sign off to ensure the return has been prepared in accordance with the Approved Costing Guidance;
    - Processes to validate the activity and costing data with services;
    - Completion of the information gap analysis and costing standards gap analysis, with any issues to be addressed as part of the planning process.
- That the costing and other teams involved in the submission are sufficiently resourced to produce and validate the submissions with the planned timeline.
- Actions from any previous NHSI/Ernst & Young audit have been reviewed and addressed.

FIP also recorded thanks to Denis Mellon for his time and commitment to the Committee and in July welcomed Ian Mackie as the new Chair.

4. Conclusion

The Trust Board is asked to note this summary of the FIP Committee deliberations from May to July 2019. The date of the next meeting of the FIP Committee is September 25th 2019.

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

BOARD OF DIRECTORS

Agenda item		**Category of Paper**	Tick
Paper Title	Hospital Redevelopment Report	**To action**	☐
Date of Meeting	31 July 2019	**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, 15 May 2019 Redevelopment Programme Board, 19 June 2019 Redevelopment Programme Board, 17 July 2019	
Links to Strategic Board Objectives	Objective 1 – Improve patient experience Objective 2 – Implement our New Strategic Plan Objective 3 – Optimise our Financial Plan	
Links to Regulations/ Outcomes/External Assessments	NHSI HSE CQC	
Links to the Risk Register	All estate and facilities risks	

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

SUMMARY/CURRENT ISSUES AND ACTION
A report on the progress of the redevelopment programme is attached.
Construction of the first phase of the electrical infrastructure upgrade works is underway. The new sub-stations are complete, and one of these is now live and operational.
Construction of Theatres G & H and the new Day Surgery Unit will be completed at the end of August.
Construction of the new endoscope decontamination facility was completed in July. The scheme is now operational.
The Business Case for the Energy Centre has been issued to FIP for approval. It will need to be passed on to the Trust Board and the Governors for final approval in August.
The planning pre-application submission, outlining the proposed details of the new energy centre, has been accepted by the planning team at the Council. A full submission will be made in August following completion of public consultation.
The Managed Services Agreement for the scheme is now substantially complete.

ACTION REQUIRED
The Board is requested to note the report.

Public Meeting ☒ Private Meeting ☐

REDEVELOPMENT PROGRAMME BOARD REPORT
1 May 2019

TO BOARD OF DIRECTORS

1. Introduction

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

2. Governance

The Programme Board met on 15 May 2019, 19 June 2019 and 17 July 2019.

3. Main scheme

The Trust has now recognised that funding for the construction of the Acute Services Block will not be considered by the DHSC until the Comprehensive Spending Review takes place in the autumn.

4. Enabling schemes

Construction is continuing on the critical upgrades to the High Voltage electrical infrastructure. The construction of two new sub-stations alongside the Dunstable Road is complete. The feeds to St Marys and ward 18 have now been transferred to the new sub-station H. The migrations to sub-station G have been deferred until the autumn to coincide with other electrical works on the site. A completion programme for the project, which will include the upgrade to the existing sub-station within the Surgical Block is being developed.

Construction of the new theatres and Day Surgery Unit is progressing. There has, however, been a slippage on completion. The works will now be completed on 22 August. Activity within the new theatres will commence as scheduled on 2 September. The critical activity is the upgrade of the theatre E/F second stage recovery area to provide additional first stage recovery space.

Commissioning of the endoscope decontamination unit was completed in July. The unit is now operational. The old unit within the Endoscopy Unit has been de-commissioned. The further delay to the project was driven by the requirement to address air leakage from critical rooms within the department.

Construction of the deck on the Lewsey Road car park will not proceed over the summer. None of the tenders received provided a satisfactory basis for award of a contract. The team are now pursuing a number of further options which would support delivery of the scheme.

5. Energy Centre

The business case for the new Energy Centre was discussed by the Redevelopment Board and FIP at the respective meetings in June and July. The final draft has now been submitted to FIP with a recommendation that this should be submitted to the Trust Board and to the Council of Governors for final approval.

The Council Planning Team has supported the proposed scheme subject to satisfaction of technical conditions following conclusion of the Pre-Application process. This now clears the way for submission of a full application. This is now ready, but needs to await completion of consultation with local residents. The current programme is to submit the full application in August.

Detailed design of the new building is underway. The Trust has issued an instruction to proceed with the design of the Centrica plant installation to support development of the proposals. It has also agreed that the lighting upgrade, which is one of the main energy saving measures, should proceed.

Discussions on the form of the Managed Services Agreement have made good progress. The document is now largely in final form, and should be ready for signature in September. Implementation of the MSA is conditional on satisfaction of a number of Conditions Precedent, principally in connection with satisfactory grant of planning.

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

The decision on funding for the Acute Services block will determine the future activity of the redevelopment team.

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	31 July 2019	**To note**	☒
Lead Director	Matthew Gibbons – Director of Finance	**For Information**	☐
Paper Author	Sarah Amexheta	**To ratify**	☐
Indicate the impact of the paper: **Financial** ☒ **Quality/Safety** ☒ **Patient Experience** ☒ **Equality** ☒ **Clinical** ☒**Governance** ☒			

History of Committee Reporting and Date	Charitable Funds Full Committee 15th May 2019
Links to Strategic Board Objectives	Objective 5 – Progress Clinical and Strategic Developments Objective 6 – Develop all Staff to Maximise Their Potential Objective 7 – Optimise our Financial Position
Links to Regulations/ Outcomes/External Assessments	Links to NHS Improvement in relation to the Trust Governance Framework
Links to the Risk Register	N/A

PURPOSE OF THE REPORT

To update the Board of Directors on the findings and approval of the Charitable Funds Committee held on 15th May 2019.

SUMMARY/CURRENT ISSUES AND ACTION

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

- Update on NICU parent's accommodation
- Open spaces
- Update on engagement event and funding available
- Investment portfolio update
- Update on governance and risk management
- Update on new Charity strategy
- Fundraising update
    - Lottery
    - Mini PCNL
    - Legacies
- Finance update
- Bids for Approval of funding

ACTION REQUIRED

The Committee are asked to note the report

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 held on 15th May 2019.

2. Conflicts of interest:

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

3. Matters arising

- Update on NICU parent's accommodation
- Open spaces
- Update on engagement event and funding available
- Investment portfolio update
- Update on governance and risk management
- Update on new Charity strategy
- Fundraising update
    - Lottery
    - Mini PCNL
    - Legacies
- Finance update
- Bids for Approval of funding

NICU Parent's Accommodation

4. A revision of the application submitted at 28 November Charitable Funds Committee on parent's accommodation, in response to updated information for the appeal. Where we had presumed the conversion costs to be around £72k, we have been amazed by the response of local tradespeople which has meant that the majority of this is likely to be covered by such local charity; this was not explicitly sought – it erupted from a simple request on a social media post in February.

   Given the success of the request a revision of the charitable commitment has been considered. Due to the funding requirement being significantly lower than originally sought, sufficient funds exist within LDF5 to cover any charitable component. Other costs: Car parking and purchase costs are covered by the Trust and are assets of the Trust.

Open spaces

5. No further update given at time of meeting, Simon Linnett and Jenny Pigott to review progression and spend, to follow up at next meeting.

Update on engagement event and funding available

6. A brief verbal update given by Victoria Parsons. The committee were advised that the event was already budgeted at the lowest possible rate. Finance confirmed funding was now available within LD1A. The Committee agreed to fund the proposition, £80k, CC417.1

Investment management update

7. The **Market perspective portfolio** was shared and highlights investments made under LD1A and LDF3. Quarterly performance summarised by Clifford Bygrave.

Fundraising team and Voluntary Services amalgamation

8. An update was given on the progression of the new charity strategy, it was highlighted that lack of office space is currently stopping progression and also affecting potential income generation from footfall location and team morale.

   The team need to be sited together to add resilience and also to support an integrated Function. The spot suggested in main reception will also support the large amounts of donation of gift in kind or cash donations brought into reception. The growing scale of this poses an issue when the team is located away from the main area, it also poses a potential security risk with cash being transported across the site. The reason to have a manned hatch as opposed to an open office to insure security with cash and high value items donated, it also creates a separation for those in the team working on higher end more detailed propositions and reporting.

   In other Trusts charities with a centralised footfall position have seen a significant increase in regular giving, individual donations and lottery supporters. This move will benefit the Trust by creating a more dynamic, engaged presence and with good branding, reinforced positive messaging and will also uplift the visual dynamic of the area creating a strong presence.

Update on governance and new risk policy.

Noted:

9. The Charity Chair asked that the Trustee representatives to review and include any risks they perceive and report back. It was requested that this is updated and reviewed at each charitable funds meeting.

Charitable funds finance update

An update was given on the amount of money available in the general fund, which is very close to the reserve limit. The Committee were made aware that the exercise to contact designated fund holders for their spending plans had taken place, with plans on most funds recognised, as part of the dormant funds process.

New Charity strategy approval

Sarah Amexheta introduced a strategy proposal which the Committee then discussed. It was agreed to the suggestions and proposals indicated, including financial commitments for the amalgamated team.

Fundraising team update

A report was given to the Committee updating them about different fundraising activities, legacy notifications and progress on specific fundraising projects.

- The committee agreed to the recommended proposal for the Trust Charity Lottery scheme, including supporting the start-up costs for the scheme: £1561.40 plus VAT

Bids for approval of funding

The Committee agreed to fund:

- £80,000 Engagement Event - Committee noted that the free funds were not sufficient to support this from LD1A, but agreed to fund once funds were available, as they recognised the value to staff.

- £9,300 for Carers packs – not supported by the committee.
- £108,000 for the CT Beam cone scanner, funding secured from a grant giving Trust, agreed.
- £17,000 Mini PCNL, the committee would wish to support the bid, but due to insufficient funds being available, they requested the department works with the fundraising team to raise the outstanding balance needed, and to include charitable funds already held in that department towards the cost.

Date of next meeting: 15 May 2019.

BOARD OF DIRECTORS

Agenda item	13	**Category of Paper**	Tick
Paper Title	Audit and Risk Committee Report to Board of Directors	**To action**	☐
Date of Meeting	31 July 2019	**To note**	☒
Lead Director	Matthew Gibbons – Director of Finance	**For Information**	☐
Paper Author	Jenny Pigott	**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 15th May 2019
Links to Strategic Board Objectives	Objective 5 – Progress Clinical and Strategic Developments Objective 6 – Develop all Staff to Maximise Their Potential Objective 7 – Optimise our Financial Position
Links to Regulations/ Outcomes/External Assessments	Links to NHS Improvement in relation to the Trust Governance Framework
Links to the Risk Register	N/A

PURPOSE OF THE REPORT
To update the Board of Directors on the findings and approval of the Audit and Risk Committee held on 15th May 2019.

SUMMARY/CURRENT ISSUES AND ACTION
The Report gives an overview of the matters addressed including the following:

- External Audit Reports 2018/19
- Internal Audit Annual Report 2018/19
- Internal Audit Annual Plan 2019/20
- Annual Report and Accounts
- Internal Audit Management Reports
- Counter Fraud Annual Plan
- Board Secretary Report
- Sub-Committee Updates
- Audit and Risk Committee Report to the Board

ACTION REQUIRED
The Board are asked to note the report.

Public Meeting ☒ Private Meeting ☐

THE LUTON & DUNSTABLE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST

REPORT FROM THE AUDIT AND RISK COMMITTEE

1. This Report updates the Board of Directors regarding the matters discussed at the Audit and Risk Committee held on 15th May 2019.

2 External Audit

Draft ISA260
KPMG presented their draft ISA260. The audit was substantially complete and they anticipated an unqualified opinion on the financial statements, value for money conclusion and quality accounts. The final version of the ISA260 would be presented to the Board on 22 May.

As in previous years the work on the quality accounts encountered difficulties in corroborating Symphony data but nothing contradictory was found. The Trust compares favourably with other organisations in KPMG's ability to issue a clean opinion across the quality indicator work.

The agreement of balances work was ongoing and the variances in the initial outcome report were discussed and understood.

Letters of Representation
It was agreed that the letters of representation would go to the Board the following week. The Chief Executive would sign the quality accounts letter and the Director of Finance the financial statements letter.

3. 2018/19 Annual Report and Accounts

Financial Performance – Annual Report Extract
The draft financial performance extract was discussed and agreed.

Annual Governance Statement
The draft annual governance statement was presented for comment. The Committee agreed that workforce and the trust estate continued to be high risk and that the divisional risk management/ governance processes being aligned should be specifically mentioned. The statement was agreed subject to minor narrative changes.

Financial Statements
The draft accounts were presented for comment. The Committee thanked both audit and the finance team for their efforts.

Post Committee Note – The audited financial statements, annual report and quality accounts and related documentation were uploaded in advance of the NHS Improvement deadline.

3 2018/19 Compliance

Waivers
A report of the waivers raised in the period October 2018 to March 2019 was presented.

Queries in respect of specific waivers were to be investigated and fed back to the relevant Non Executive Directors.

It was noted that NHS Digital have negotiated a discounted contract for Microsoft licences.
Post meeting note – the Trust procurement department had negotiated a price for the Microsoft licence below the NHS digital contract price.

Schedule of Losses
The annual report of losses and special payments was presented. A query was raised in respect of the digital plate detector claim where no financial outlay was recorded. It was confirmed that this was replaced under the Trust insurance policy.

Payroll Bureau Audit
The report from the payroll bureau auditors was presented confirming that there is reasonable but not absolute assurance that controls are operating effectively.

Declaration of Interests/ Hospitality Register
The Board Secretary confirmed that this was an ongoing exercise with 169 out of 400 individuals responding at the time of compiling the report. New disclosed interests were reported to the Committee. The hospitality register was also reported.

4 Internal Audit

Draft Annual Report
Internal audit reported their draft annual report which concluded that they were in a position to conclude 'generally satisfactory with some improvements required'.

Finalised Report: Scheme of Delegation Phase 1
This report highlighted it was difficult to identify decisions made above thresholds set in the scheme of delegation.

2019/20 Draft Annual Plan
The proposed plan gives breadth of assurance for next year's opinion. Risks are flagged in the document which are not covered by the plan, for example Health & Safety. Concern was raised over the dilution of the Health & Safety sub-committee reporting to COB for the Board and whether this is a risk that requires additional assurance. The Committee recommended that the Board approve the internal audit plan.

5. Counter Fraud

Annual Plan
PwC presented their annual plan which includes continuation of the engagement with the Communications department to embed fraud awareness, preparation and attendance at Fraud Risk Group, liaison with internal audit, and responding to fraud alerts and emerging issues. Juliette Meek is the lead for investigative work. The plan was agreed.

6. Board Secretary Report

Risk Management and Assurance Framework
The Board Secretary provided an overview of the current risks rated 15 or over and

review of compliance with the NHS Provider Licence. It was noted that the CQC inspection gives assurance over the processes in place.

7. Sub Committee Updates

Updates were received from all sub committee chairs providing assurance on issues relating to internal control, governance and risk management.

8. Draft Annual Audit & Risk Committee to the Board

The draft annual report to the Board was presented and agreed.

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

BOARD OF DIRECTORS

Agenda item	14	**Category of Paper**	Tick
Paper Title	Risk Register	**To action**	☐
Date of Meeting	31st July 2019	**To note**	☐
Lead Director	All Directors	**For Information**	☒
Paper Author	Victoria Parsons – Board Secretary	**To ratify**	☒
Indicate the impact of the paper: **Financial** ☒ **Quality/Safety** ☒ **Patient Experience** ☒ **Equality** ☐ **Clinical** ☒ **Governance** ☒			

History of Committee Reporting and Date	Clinical Outcome, Safety and Quality Committee 22nd May, 26th June and 24th July 2019 Finance, Investment and Performance Committee 24th July 2019 Executive Board 23rd July 2019
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

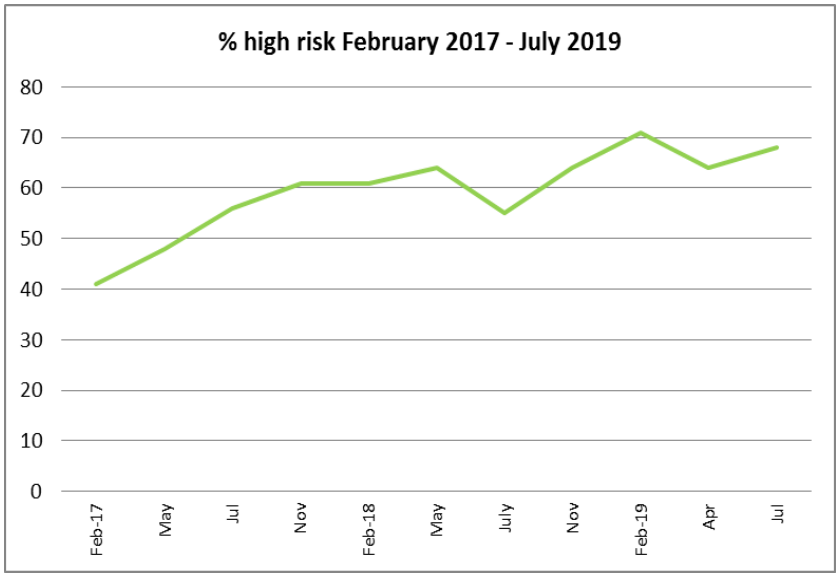
ACTION REQUIRED

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 31 (reduced from 33) Board Level Risks on the Risk Register. 68% are currently high risk (15+).



Board of Directors Review

The Board reviewed the risks on the 1st May 2019.

Risk ref	Risk Description	Agreed conclusion
1410	Brexit - medicines	Maintain risk
644	18 weeks	Maintain risk
1421	Bleep System	Maintain risk
669	Appraisal	Maintain risk
1423	CQC Mandatory Training	Maintain risk
1422	CQC Infection Control	Maintain risk
1435	Pathology Integration	Maintain risk
1278	Acquisition of Bedford Hospital	Review risk

Emerging risks in relation to 28 day cancer diagnostics

Clinical Outcome, Safety and Quality Committee (COSQ)

COSQ reviewed clinical board level risks on the 22nd May, 26th June and 24th July 2019.

Risk ref	Risk Description	Agreed conclusion
1463	Impact of the national pension scheme	Maintain risk
650	Bed pressures	Maintain risk
1410	Medicines shortage post Brexit	Maintain risk
1442	NEWs 2 Implementation	Maintain risk
644	18 weeks	Increase risk
669	Appraisal rate	Maintain risk
1210	Vacancy rate	Maintain risk
1423	CQC Mandatory Training	Maintain risk
1433	Ligature Points	Maintain risk
1200	Cyber Security	Maintain risk
796	Patient Experience	Maintain risk
1259	JAG Accreditation	Maintain risk

Risk ref	Risk Description	Agreed conclusion
1422	CQC Infection Control Practices	Maintain risk
1431	Fractured Neck of Femur	Maintain risk
1018	HSMR	Maintain risk

Emerging risks in relation to CQUIN Attainment 2019/20 and University of Bedfordshire

Finance, Investment and Performance Committee (FIP)
FIP reviewed their board level risks on the 24th July 2019.

Risk ref	Risk Description	Agreed conclusion
1465	Agency 2019/20	Increase risk
1466	Finance 2019/20	Increase risk
1211	Backlog maintenance	Maintain risk and review
1435	Pathology Integration	Maintain risk
644	18 Weeks	Increase risk
1210	Vacancy	Maintain risk
1278	Acquisition of Bedford Hospital	Close risk and open new risk regarding paused acquisition
1117	CCG verification processes	Maintain risk
1165, 1166 1163, 1164	Hospital Re-Development Risks	Review requested at Hospital Re-Development Committee
890	Rolling programme of medical devices replacement	Maintain risk

Executive Board Review
The Executive Board reviewed all Board Level Risks on the 23rd April 2019.

Risk ref	Risk Description	Agreed conclusion
1465	Agency 2019/20	Review risk
1466	Finance 2019/20	Review risk
1423	CQC Mandatory Training	Maintain risk
1422	CQC Infection Control Practices	Maintain risk
644	18 Weeks	Increase risk
1463	Impact of the national pension scheme	Maintain risk
650	Bed pressures	Maintain risk
1210	Vacancy	Maintain risk

Risk Review

21 new risks were reviewed and approved between 19th April and 22nd July 2019 three were allocated as Board Level:

- 1463 - Pension Scheme
- 1465 - Agency Costs 2019/20
- 1466 - Financial Target 2019/20

21 risks were closed, four at Board level:

- 1356 – Agency Costs 2018/19
- 1357 – Financial Target 2018/19
- 1421 – Bleep System
- 1355 – Patient Transport

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

BOARD OF DIRECTORS

Agenda item	15	**Category of Paper**	Tick
Paper Title	Board Secretary Report	**To action**	☐
Date of Meeting	31st July 2019	**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 updates
- Use of the Trust Seal
- Committee Structure Changes

ACTION REQUIRED

Board are asked to:

- Note the progress
- Ratify the terms of reference

Public Meeting ☒ Private Meeting ☐

1. Council of Governors

There are currently five vacancies on the Council of Governors

1) Bedfordshire CCG
2) Hertfordshire Valley CCG
3) University College of London
4) Staff – Ancillary and Maintenance – review the constitution that may merge this class with another
5) Staff – Admin and Clerical – recruitment to be taken forward in next election.

The elections for 2019 are currently underway.

Public Seats:
6 Luton
1 Bedfordshire

Staff Seats:
1 Nursing and Midwifery
2 Admin and Clerical
1 Professional and Technical

Despite a targeted approach, we were unsuccessful in obtaining any candidates for the Ancillary and Maintenance seat. The Constitutional Working Group will meet to discuss plans for 2020.

2. Members

The next Ambassador magazine will be issued to members in August 2019.

The Annual Members Meeting is the 11th September 2019.

The next medical lecture on the 9th October 2019 is Orthopaedics – Hips and Knees and will be led by Mr Jim Gray and his team.

3. Non-Executive Directors

Four new Non-Executive Directors started in June 2019:

- Ian Mackie
- Annet Gamell
- Richard Mintern
- Gill Lungley

4. Use of the Trust Seal

Date used	Seal number	Subject	Supporting information
17/5/19	139	○ Collateral Warranty for the Electrical Infrastructure Upgrade	Refers to seal 138

5. Terms of Reference

In the last 12 months the sub-committee Terms of Reference were approved by the committees – the Board are asked to ratify the Terms of Reference in 15.1-4:

- COSQ
- FIP
- Hospital Re-Development
- Audit and Risk

6. Changes to the Sub-Committee Structure

From July 2019, the Hospital Re-Development Board will report to the Finance, Investment and Performance Committee.

Two new sub-committees of the Board have also been agreed:

- Workforce Committee
- IT Strategy Committee

The Terms of Reference of these committees will be approved by the Board in November 2019.

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

CLINICAL EXCELLENCE, QUALITY & SAFETY

TERMS OF REFERENCE

CLINICAL OUTCOME SAFETY AND QUALITY (COSQ)

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

Accountability:

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

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

Reporting:

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

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

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

Objectives:

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

2. ***To review and quality assure:***
    a. on all aspects of quality and risk and ensure that Trust policies reflect latest guidance and legislation
    b. on behalf of the Board of Directors, the Trust compliance in relation to Health & Safety act.
    c. on behalf of the Board of Directors the Trust's compliance with the Health Act 2006 on reducing HCAI's
    d. the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

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

4. ***To receive***:
    a. information on trends & themes from claims, incident reporting and complaints and to initiate measures to reduce risk. Where appropriate, to ensure that identified risks are considered and included in risk registers
    b. a report from the Clinical Operational Board
    c. reports on progress & oversee the outcome of

improvement plans arising from CQC reviews or investigations, on behalf of the Board of Directors or Chief Executive

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

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

Programme Board Members Responsibilities:

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

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

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

Workplan:

Each meeting:

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

Quarterly

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

Every four months

- Review against the Trust Objectives related to hospital redevelopment

Annually

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

As required

- CQC Insight Report
- CQC Inspections
- Internal Audits
- Deanery Report
- External Reports

Agreed in March 2019

To be reviewed March 2020

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

CLINICAL EXCELLENCE, QUALITY & SAFETY

TERMS OF REFERENCE

FINANCE INVESTMENT AND PERFORMANCE COMMITTEE (FIP)

Status:	Sub-committee of the Board of Directors
Chair:	Non-Executive Director
Membership:	Non-Executive Director (Chair) Chief Executive Deputy Chief Executive Director of Finance Chief Nurse Director of Human Resources Chairman 2 additional Non-Executive Directors *Chief Medical Advisor/Medical Director (to attend on request in line with the agenda) All other members of the Board of Directors shall be entitled to attend and receive papers to be considered by the Committee. In the absence of the Chair, any NED present will take the Chair.
In Attendance:	Divisional Representation (by invite) Board Secretary for Governance agenda items Deputy Director of Finance Associate Director of Contracts and Performance Re-Development Programme Director
Meeting Frequency:	Monthly (with the exception of August and December)
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:	FIP is a formal sub-committee of the FT Board of Directors and complies with the Standing Orders and the Scheme of Delegation.
Authority and Chairs Action:	The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other professional advice and secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

The Non-Executive Chair, as Chair of FIP is, on an exceptional needs basis, granted delegated authority to make decisions on time critical issues arising between planned meetings of FIP. 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 FIP meeting.

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

Accountability: The Chair of the FIP, along with the Director of Finance and the Deputy Chief Executive will maintain a direct link from FIP to the FT Board of Directors providing a report and assurance of the effectiveness of finance and performance.

The Director of Finance and the Deputy Chief Executive will report to the Chief Executive and report progress to the formal Executive meetings on a monthly basis and to any other formal Committee as required.

Reporting: The minutes of FIP meetings shall be formally recorded and submitted to the Board of Directors.

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

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

Objectives: **Objectives:**

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

Financial Policy, Management & Reporting:

- To consider the Trust's medium term financial strategy, in relation to both revenue and capital**.**
- To consider the Trust's annual financial targets.
- To review the annual budget, before submission to the Board of Directors.
- To consider the Trust's financial performance, in terms of the relationship between underlying activity, income and expenditure, and the respective budgets.
- Initial review of annual financial statements
- To review proposals for business cases (>£0.25m) and their respective funding sources
- To commission and receive the results of in-depth reviews of key financial issues affecting the Trust.
- To maintain an oversight of, and receive assurances on, the

robustness of the Trust's key income sources and contractual safeguards and efficiency improvement programmes.
- To review and agree the annual financial plan, including the plan for delivery of cost improvements and productivity and efficiency improvements resulting from the Re-engineering programme.
- To review progress of the Re-engineering programme monthly and recommend any additional action as necessary.
- To receive and consider, as appropriate, reports on 'commercial' activities of the Trust.
- To approve the detailed Capital Expenditure Plan for the Trust (within the overall resource approved within the Annual Plan
- To review delivery of Capital Projects.

Operational Performance:

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

Investment Policy, Management and Reporting:

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

Procurement Strategy:

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

Operational Strategy:

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

Risk:

- To receive assurance reports in accordance with the Risk Management Strategy
- To receive information on trends & themes from Finance and Performance reports to initiate measures to reduce risk. Where appropriate, to ensure that identified risks are

considered and included in risk registers
- To review Board Level Risks assigned to the Committee monthly and assure the Board of Directors that controls and actions taken are adequate

Other Duties:

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

Programme Board Members Responsibilities:

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

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

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

Workplan:

Each meeting:
- Finance position
- Business Cases
- Contract updates
- Agency expenditure
- GDE update
- Hospital Re-Development
- Business Cases post implementation reviews

Quarterly
- Risk Register
- Assurance Framework

Annually
- Budget Setting
- Annual Accounts
- Annual Report
- Operational Plan
- Review of the Terms of Reference

As required
- External Reports

Agreed in March 2019 updated June 2019

To be reviewed March 2020

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

CLINICAL EXCELLENCE, QUALITY & SAFETY

TERMS OF REFERENCE

HOSPITAL REDEVELOPMENT PROGRAMME BOARD

Status:	Sub-committee of the Board of Directors
Chair:	Non-Executive Director
Membership:	Chief Executive Non-Executive Director x 3 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 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

Approved at the meeting on 20th February 2019

To be reviewed February 2020

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

CLINICAL EXCELLENCE, QUALITY & SAFETY

TERMS OF REFERENCE

AUDIT AND RISK COMMITTEE

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

action was taken, is to be made to the next quorate meeting.

Quorum: 3 members.

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

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

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

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

Objectives:

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

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

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

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

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

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

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

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

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

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

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

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

2.2 Unadjusted mis-statements in the financial statements.

2.3 Major judgmental areas.
2.4 Significant adjustments resulting from the audit.
2.5 Compliance with accounting standards.
2.6 The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee.
2.7 The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.
2.8 To examine the circumstances when Standing Orders are waived and tenders where the lowest value tender is not awarded.
2.9 To review schedules of losses and compensation payments and make recommendations to the Board.
2.10 Review compliance with Internal Financial Controls
2.11 Review proposed changes to the Tendering Process, Standing Orders, Standing Financial Instructions and Scheme of Delegation.
2.12 Compliance with relevant legal requirements.
2.13 Monitor formal announcements relating to the Trust's financial performance.
2.14 Review conflict of interests and the hospitality register on an annual basis.
2.15 To review all equivalent matters relating to Charitable Funds.

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

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

5. Counter Fraud - The Committee will:
5.1 Appoint an appropriate counter fraud provider, agree the fee and as appropriate, the termination of the contract.
5.2 Review the annual counter fraud programme and ensure that it is adequately resourced.
5.3 Receive periodic reports of progress in investigations undertaken and an

annual report of work undertaken.
5.4 Review policies and procedures for all work relating to fraud and anti-bribery (including the bribery act).
5.5 Review the arrangements by which staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters ensuring that arrangements are in place for the proportionate and independent investigation of such matters.

Programme Board Members Responsibilities:

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

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

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

Workplan:

Each meeting:

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

Twice a year:

- Waivers

Annually:

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

Agreed on 6 February 2019

To be reviewed by end March 2020

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

* as and when required.

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