Bedfordshire Hospitals
NHS Foundation Trust

Board of Directors

27 July 2022 - 10:00-12:00

MS Teams

Meeting Book - Board of Directors

10.00	1 Chairman's Welcome & Note of Apologies		Simon Linnett
10.02	2 Any urgent items of Any Other Business and Declaration of Interest on items on the Agenda and/or the Register of Directors Interests		Simon Linnett
10.03	3 Minutes of the previous meeting: Wednesday 4 May 2022	To approve	Simon Linnett
	3.1 3 Minutes of Bedfordshire Hospitals NHS Trust Public Board meeting 4 May 2022.doc		
10.05	4 Matters Arising (Action Log) (no actions)	To note	Simon Linnett
10.05	5 Chairman's Report (verbal)	To note	Simon Linnett
10.10	6 Executive Board Report	To note	David Carter
	6.1 6 Executive Board Report July 2022.doc		
	7 Performance Reports		
10.25	7.1 Operational Performance & Quality Governance	To note	Cathy/Catherine/Liz/Paul
	7.1.1 7 Performance Reports front sheet.doc		
	7.1.2 7.1 Quality and Performance Report Board July 22.pptx		
10.40	7.2 Finance	To note	Matt Gibbons
	7.2.1 7.2 Finance Board Paper.docx		
10.55	7.3 Workforce	To note	Angela Doak
	7.3.1 7.3 workforce 20220721_integrated Board Report_v3.pptx		
11.10	8 Quality Committee Report	To note	Annet Gamell
	8.1 8 Quality Committee Report July 22.doc		
11.15	9 Finance, Investment & Performance Committee Report	To note	Ian Mackie
	9.1 9 FIP Report to July 2022 Trust Board.docx		
11.20	10 Redevelopment Committee Report	To note	Mark Prior
	10.1 10 Trust Board_Redevelopment Report_May22.docx		
11.25	11 Charitable Funds Committee Report	To note	Simon Linnett
	11.1 11 CFC Committee Report May 2022.doc		
11.30	12 Workforce Committee Report	To note	Tansi Harper
	12.1 12 July 2022 12 Workforce Committee_v1.docx		
11.35	13 Audit and Risk Committee Report	To note	Simon Barton
	13.1 13 Audit and Risk Committee report to the Board.doc		
11.40	14 Sustainability Committee Report	To note	Simon Linnett
	14.1 14 Sustainability Committee Report July 2022.doc		
11.45	15 Risk Register	To approve	Victoria Parsons
	15.1 15 RR July 2022.doc		

11.50	16 Corporate Governance Report	To ratify	Victoria Parsons
	16.1 16 Corporate Governance Report July 2022.doc		
	16.2 16 Appendix 1 FIP Terms of Reference March 2022.docx		
	16.3 16 Appendix 2 Quality Committee Terms of Reference March 2022.doc		
	16.4 16 Appendix 3 Digital Strategy Committee Terms of Reference April 2022.docx		
	16.5 16 Appendix 4 Workforce Terms of Reference April 2022.doc		
	16.6 16 Appendix 5 Audit and Risk Committee Terms of Reference March 2022.docx		
	17 Details of next meeting: Wednesday 2 November 2022 @ 10am		
12.00	18 CLOSE		

Bedfordshire Hospitals NHS Foundation Trust

Board of Directors

Wednesday 27 July 2022

Report title:	Minutes of the Meeting held on: Wednesday 4 May 2022			**Agenda item: 3**
Executive Director(s):	David Carter, Chief Executive			
Report Author	Jenny Kelly, Corporate Governance Manager			
Action *(tick one box only)*	**Information** ☐	**Approval** x	**Assurance** ☐	**Decision** ☐
Recommendation	To note the contents of the report for assurance.			

Report summary	To provide an accurate record of the meeting.
Legal Implications / Regulatory requirements / Strategic objectives and Board Assurance Framework	NHS England/Improvement CQC Company Law All objectives
Jargon Buster	

BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST
BOARD OF DIRECTORS PUBLIC MEETING

Microsoft Teams Meeting 10.00am-12noon

Minutes of the meeting held on Wednesday 4 May 2022

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, Director of Finance
Ms Liz Lees, Chief Nurse
Mr Paul Tisi, Medical Director
Ms Catherine Thorne, Director of Quality and Safety Governance
Mr Steve Hone, Non-Executive Director
Dr Annet Gamell, Non-Executive Director
Mr Simon Barton, Non-Executive Director
Mr Gordon Johns. Non-Executive Director
Ms Tansi Harper, Non-Executive Director
Mr Ian Mackie, Non-Executive Director
Mr Mark Prior, Non-Executive Director

In attendance:

Ms Victoria Parsons, Associate Director of Corporate Governance
Ms Melanie Banks, Director of Strategy and Redevelopment
Ms Donna Burnett, Trust Board Secretary
Ms Helen Lucas, Lead Governor
Mr Malcolm Rainbow, member of the public
Mr Dean Goodrum, Director of Estates
Dr Michael Carter, Public Governor
Dr Jim Thakoordin, Public Governor
Ms Judi Kingham, Public Governor
Ms Anne Thevarajan, Membership and Corporate Affairs Manager
Ms Jenny Kelly, Corporate Governance Manager
Mr Patrick Hunter, member of the public
Lidia McBride, Associate Director, Grant Thornton
Ms Gill Lungley, Chief Information Officer

1. CHAIRMAN'S WELCOME, NOTE OF APOLOGIES

The Chairman opened the meeting, welcoming all members and participants.

Apologies were received from – Fiona MacDonald, Director of Culture & OD

2. ANY URGENT ITEMS OF ANY OTHER BUSINESS AND DECLARATIONS OF INTEREST ON ITEMS ON THE AGENDA

Nil

3. MINUTES OF THE PREVIOUS MEETING: 2 FEBRUARY 2022

The minutes of the previous meeting were approved as an accurate record.

4. MATTERS ARISING

There were no actions or matters arising.

5. CHAIRMAN'S REPORT

The Chairman informed the Board that since its last meeting in Public, to a certain extent COVID restrictions had lifted making the move to in person meetings once again more realistic. The Trust had demoed a hybrid meeting option and the corporate team would consider how to move forwards across the Trusts meeting structure. It was agreed that subject to the position changing the next Public Board meeting in August would take place in person at Bedford Hospital. Governor meetings would commence as hybrid meetings from the end of May 2022.

The Chairman noted that two weeks had been booked in the diary in July for staff engagement events to take place in person. Governors and Board members would be invited to attend. The first week would take place at Bedford w/c 4 July followed by Luton & Dunstable (L&D) w/c 11 July.

The Secretary of State for Health visited the L&D site on the 14 April for a ground breaking ceremony for the Acute Services Block.

Rima Makarem chair of the ICB had also visited the Bedford North Wing site on the previous Friday in order to gain a better understanding and appreciation of the challenges at the site caused by the current estate. Options were discussed regarding how ICS partners could collaborate to facilitate better use of the estate.

The Chairman informed the Board that legislation had passed through the Houses the previous week and an implementation date giving power to ICBs was on 1 July 2022. It was noted that the development of the ICB and attendant bodies and the BCA Committee beneath it would encourage partnership working across the ICS.

6. EXECUTIVE BOARD REPORT

DC introduced the report to the Board and informed members and attendees that the Trust would be holding a leadership engagement event imminently to

ensure ongoing engagement with the leadership team. It was noted that there would be significant work to do in the coming months to develop the masterplans for both hospital sites. The build for the Acute Services Block at the L&D site was proceeding at pace.

TH queried if there would be a full communications and stakeholder engagement plan and how involved patients would be in developing strategies. DC informed the Board that it was currently being debated how best to do this and when but patient engagement would certainly feature in planning.

CJ provided a COVID update to the Board. As at the date of the meeting there were 106 positive inpatients cross sites with low numbers of patients requiring critical care admission. The main focus of the Trust was to look at implications across all locations and services in changing COVID control measures. Proposals may include the reintroduction of chairs to waiting rooms, reopening areas and changing swabbing requirements. The Trust would continue to carefully monitor effects and make sure guidance is proportionate and supported by patients and staff.

PT introduced the Q3 learning from deaths section of the report and it was taken as read. It was noted that governance processes were linked and any reviews that flagged as SIs or were subject to review by the Coroner were taken to the Pearl panel. A key focus of the team was to extract and share learning from all mortality reviews both positive and negative.

LL introduced two papers included as appendices to the report re the Ockenden Review which were taken as read. It was noted that a plan had been put in place to address the several immediate and essential actions identified by the review. The national and regional teams had asked all Trusts to submit their position one year on to include a review status against the Kirkup Report too. It was noted that one year on the Trust had made huge progress in implementing all essential and immediate actions and this work would continue overseen by the regional and national maternity improvement teams until all actions were fully implemented.

The remainder of the report was taken as read. The Board noted the report.

7. PERFORMANCE REPORTS

7.1 OPERATONAL PERFORMANCE & QUALITY GOVERNANCE REPORT

The report was taken as read and discussed by exception.

LL introduced the harm free care sections of the report. It was noted that the falls rate at the Bedford site was higher than L&D for some time but the progress being made was encouraging. There had been an increase in

pressure damage across both sites reflecting the significant demand on beds in Q4 in to April. Additional capacity had been opened to manage demand.

CT presented the incidents section of the report noting that reporting levels across the organisation remained good. It was however flagged that incident reporting at Bedford appeared to have plateaued with a slight drop and no SIs had been reported at Bedford in the period. The team would go in to Bedford to make sure staff feel confident, know how and know what to report.

PT introduced the mortality section of the report and it was taken as read. It was noted that work had been commissioned with a data analyst to see what was driving the higher SHMI level on the Bedford site. This would be reported back through Leaning from Deaths Board, CQuOB and Quality Committee.

CJ informed the Board that cancer performance indicators as a whole continued to demonstrate the pressure across both sites recognising that the reporting period covers patients referred during the December and January peak of omicron when the Trust lost high numbers urgent clinics and diagnostic sessions delaying pathways. Focused work from tumour site leads was being undertaken to understand where the biggest impact is on diagnostic pathways. It was noted that 28 day performance would map through to improvement in 62 day performance.

The Board noted the report.

7.2 FINANCE REPORT

MG informed the Board that the Trust had delivered a surplus of £1.5m against a £0.6m plan for the financial year 21/22. The Trust's pay spend was £13.5m overspent year to date, £1.4m in month. Non-Pay was £28.4m overspent year to date. £4.6m related to PCR COVID testing and other out of envelope expenditure that is reimbursed by NHS England. £6m of workforce initiative expenditure which was recognised in month was offset by income.

Based on M1-9 Elective Recovery Fund performance, the Trust had recognised £7.7m. In addition to this a further £0.3m relating to independent sector income had been recognised within the position.

Capital spend was £67.8m against a revised plan of £67.4m. The Trust spent £32.3m against the revised £33m Trust CDEL. Slippage against the centrally funded schemes will put pressure on the 22/23 CDEL. The Trust would bring the 22/23 capital plan for approval at the next FIP.

It was noted that the Trust had maintained the strong financial record of 23 years financial surplus.

The Board noted the report.

7.3 WORKFORCE REPORT

AD introduced the report to the Board and highlighted the key points.

More information had been included re recruitment and retention to provide context around the amount of work being undertaken. Nursing received external funding from NHSI/E to recruit overseas nurses the Trust had met its target and received a congratulatory letter from Chief Nurse Ruth May.

A strong focus on mandatory training and appraisal recovery continued and it was recognised that the Trust needs a real shift in compliance rates. The Executive team had committed to focus on this at performance reviews for service lines.

A health and wellbeing (HWB) strategy group and working group had been convened to look at the NHS employers HWB framework to make sure that the Trust is doing everything it can for staff. There had been investment made in clinical rest areas for staff and Clinical Psychologist roles had been funded substantively.

The Board noted the report.

8. QUALITY COMMITTEE REPORT

AG introduced the report and it was taken as read.

AG particularly highlighted the special focus over recent meetings on elective recovery and maternity and safe staffing and acknowledged the sustained pressure staff and the Trust as a whole was under. Deep dives into concerning areas were takin place. For 62 day cancer waits, the Committee had been assured of the micromanagement of all patients on pathways.

The report was taken as read.

9. FINANCE, INVESTMENT & PERFORMANCE COMMITTEE REPORT

IM noted that previous discussions had covered all elements contained within the report.

The report was taken as read.

10. HOSPITAL REDEVELOPMENT COMMITTEE REPORT

MP informed the Committee that the Acute Services Block programme

remained on target. Pressures on the ED department at Luton had impacted on progress made with the redevelopment.

MP highlighted an underlying concern on behalf of the committee re pressures in the construction market on procuring labour and materials. It noted that everything that could be done to safeguard against this was being done.

SL noted that DH had retired on the previous Thursday and expressed thanks on behalf of Board for his hard work.

The Board noted the report.

11. CHARITABLE FUNDS COMMITTEE REPORT

SL introduced the report to the Board and it was taken as read.

It was noted that the helipad appeal had been paused indefinitely pending a steer from the centre.

The Board noted the report.

12 WORKFORCE COMMITTEE REPORT

TH noted that previous discussions had covered most of the report.

TH commended the enormous enthusiasm from everyone involved to embed and embrace the THIRVE values and work towards a consistent culture across both sites. Freedom to Speak Up colleagues had reported on the impressive and rapid action from management when concerns were reported.

The Board noted the report.

13. DIGITAL STRATEGY COMMITTEE REPORT

SB introduced the report to the Board and it was taken as read.

A deep dive in to the DSPT toolkit had demonstrated significant progress made and the Trust was now rated as ‘approaching standards’. In context not many Trust’s nationally had met the standards.

The Windows 10 roll out was progressing at the Luton site.

Work was being undertaken on the Digital Strategy to align with the Clinical Strategy which was also in development.

The Board noted the report.

14. SUSTAINABILITY COMMITTEE REPORT

SL introduced the report to the Board and it was taken as read.

It was noted that the Trust had commissioned a green travel consultant and moved forward to buy net zero renewable energy.

The Board noted the report.

15. AUDIT AND RISK COMMITTEE REPORT

SH introduced the report and it was taken as read.

RSM the Trust's Internal Audit provider had presented 2 reports providing reasonable assurance and positive minor suggestions.

Counter Fraud had reported too and were up to date with all investigations. The team had reported that they were very pleased with their interaction with the management team and to Corporate Governance team.

The report was taken as read.

16. RISK REGISTER

VP took the report, which outlines the governance around risk reviews, as read.

The Board noted the report.

17. CORPORATE GOVERNANCE REPORT

The report was taken as read

The Board noted the resignation of Staff Governor – Steve Morgan and thanked Steve for his contribution.

It was noted that the Governors were hosting a medical lecture in person at the Rufus Centre on the 18 May re diabetes with Trust clinicians presenting.

The Board noted the report

18. DETAILS OF THE NEXT SCHEDULED MEETING:

Wednesday 27 July 2022, 10.00 – 12.00.

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 2018, General Data Protection Regulations (GDPR) and the Caldicott Guardian principles

Bedfordshire Hospitals NHS Foundation Trust

Board of Directors

Wednesday 27 July 2022

Report title:	**Executive Board Report**			**Agenda item: 6**
Executive Director(s):	**All Executive Directors**			
Report Author	**David Carter**			
Action *(tick one box only)*	**Information** ✓	**Approval** ☐	**Assurance** ☐	**Decision** ☐
Recommendation	To note the content of the report			

Report summary		
1.	Integration Update	
2.	Covid-19 Public Inquiry	
3.	Digital Update	
4.	Infection Control Report	
5.	Learning from Deaths Board	
6.	Management of CQUINs	
7.	Medical Education Update	
8.	Nursing & Midwifery Staffing Report	
9.	Information Governance Quarterly Report	
10.	Maternity Services Update	
11.	Freedom to Speak Up	
12.	Estates and Facilities Update	
13.	Communications and Fundraising Update	
14.	Policies and Procedures Update	
Legal Implications / Regulatory requirements / Strategic objectives and Board Assurance Framework	NHS England NHS Improvement Equality Act CQC All Trust objectives	

1. INTEGRATION UPDATE

To support the organisation moving forward with a shared vision, a Clinical Strategy Framework has been developed following a period of work by Clinical Service Lines (CSLs) to identify their priorities for clinical integration. The strategy aims to challenge and assure ourselves we are maximising the opportunities that bringing our two hospitals into one Trust affords, provide a clear vision for our teams to buy into and work towards, and to guide future decision-making. Delivery of this framework is 'Phase One' of the Trust's ongoing process to describe its shared vision, which will iterate as CSLs continue to develop their detailed service-level visions and delivery plans.

A successful leadership engagement event was held in June that marked the move into 'Phase Two' of the process, which will detail plans for continued strategic development, sharing and shaping the strategy with our staff and system partners, engaging our patients and local population, and progressing our three key strategic enablers: Workforce, Digital and Estates. Phase Two will be owned by CSLs and facilitated by integration governance structures (Clinical Validation Committee and Clinical Strategy Board) and cross-cutting boards (i.e. Theatres Board) to ensure interdependencies are recognised, and that we share learning from issues and successes as the strategy is progressed.

2. COVID-19 PUBLIC INQUIRY

In response to the COVID-19 pandemic, plans for a statutory Public Inquiry to examine the response and impact of the pandemic in the United Kingdom (UK) and to support learning and preparedness for the future were announced in May 2021. The Rt Hon Baroness Heather Hallett, DBE was announced as Chair on 15 December 2021.

Following a public consultation on the draft terms of reference (TofR) ending April 2022, the final TofR were published on 28 June, highlighting the aims and scope of the Inquiry including:

- Consideration of any disparities evident in the impact of the pandemic on different categories of people
- Ensuring the experiences of bereaved families and others who have suffered hardship or loss are listened to and carefully considered
- Lessons to be learned are identified to inform preparations for future pandemics
- Relevant international comparisons are considered
- Timely sharing of interim and full report findings and recommendations

In respect to the health and care sector response, and in particular the scope of the Inquiry for the management of the pandemic in hospital, this will include:

- Infection prevention and control, triage, critical care capacity, the discharge of patients, the use of 'Do not attempt cardiopulmonary resuscitation' (DNACPR) decisions, the approach to palliative care, workforce testing, changes to inspections, and the impact on staff and staffing levels
- Antenatal and postnatal care

- The procurement and distribution of key equipment and supplies, including PPE and ventilators
- The development, delivery and impact of therapeutics and vaccines
- The consequences of the pandemic on provision for non-COVID related conditions and needs
- Provision for those experiencing long-COVID

On 21 July Baroness Hallett officially launched the UK Covid-19 Inquiry and opened its first investigation into how well prepared the UK was for a pandemic. The timetable to date details preliminary hearings starting this year, and the first witnesses to be called next spring.

Module 1 will examine the resilience and preparedness of the UK for the coronavirus pandemic.
Module 2 will examine core political and administrative governance and decision-making by the UK government
Module 3 will examine the impact of COVID-19 on healthcare systems generally andon patients, hospital and other healthcare workers and staff.
Guidance about how information will be collated by the Inquiry, and the role for individual providers has not yet been published and further information on modules specific to the care sector are expected in 2023.

On announcement of the Inquiry and in response to communication from NHSE/I in June 2021, the Trust commenced its preparations including:

- Appointing the Medical Director as Inquiry lead for the Trust.
- Issuing email communication to all staff (4 January 2022) re: the pending Inquiry and the requirement to suspend, until further notice, the routine destruction of documents relating to COVID-19. As a minimum this includes records relating to policy and decision making. This was preceded by presentation at the Medical Staffing Committee (MSC), Senior Nurses, Midwifery and AHP meeting and General Manager's Meeting.
- Ensuring all leavers' documentation is completed in full, including contact details. A workforce report is routinely run to check for completeness.
- A Trust email address was established and is monitored to support timely response to staff queries or concerns relating to document preservation.
- Entry on the Trust Risk Register in respect to preservation of documents and system-held data. IT undertook a review of 'business as usual' system backups in January 2022 to identify if there are any areas of potential risk, identifying:
    - no long term back up of email, personal shared drives (mitigation, communication to all staff to preserve relevant documents)
    - main applications, not archived so data retained

A COVID-19 Inquiry working group has been established to review and respond to the above. Membership and function is under ongoing review as the expectations are better understood. This includes informing resource requirements to manage the Trust's response in relation to identifying and managing documents and information requests, acknowledging the Inquiry has committed to minimising duplication of investigation, evidence gathering and reporting, and also in supporting our staff.

3. DIGITAL UPDATE

The Digital team have been focused on the completion of some key projects over the past quarter whilst working to improve the day to day running of digital services within the Trust. The following projects were completed in the last quarter:

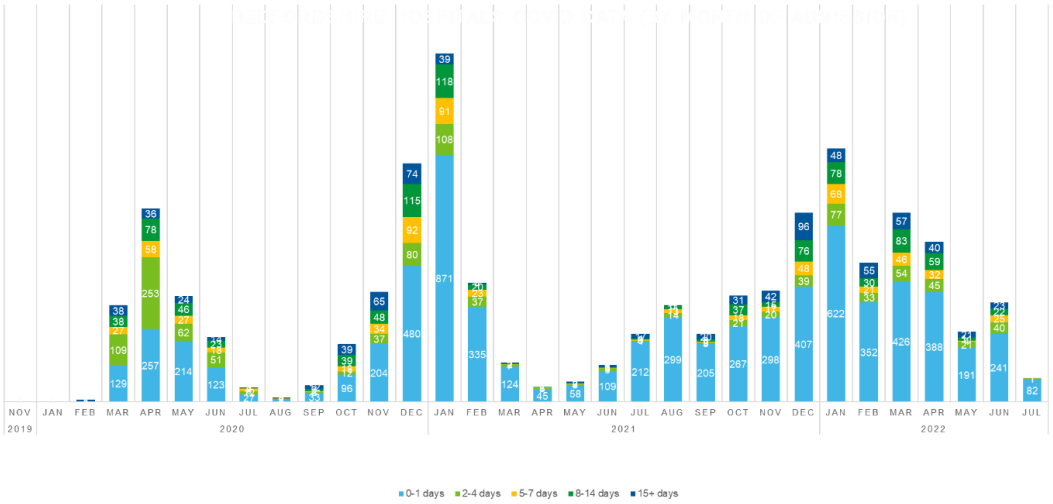
- ePMA (electronical prescriptions & medicines administration) go live on the Luton site for all inpatient wards.
- E-takelist go live in Acute Medicine and Pre-Admissions on the Luton site
- Remote Monitoring System for Cancer services on the Bedford site
- DASH Clinic go-live on the Luton site in the Orthopaedic Clinic
- Networked Respiratory Devices on the Bedford site
- Clinical Portal go-live on the Luton site
- Clinical Portal Integration with NerveCentre ePMA
- Primary Care/GP Records in the Clinical Portal
- Upgrade/replacement of Wi-Fi solution in the ward block on the Bedford site
- Technical configuration work for in preparation of the Office 365 email migration

There remains a focus on the updating of the trust's digital strategy along with plans to for the deployment of an electronic patient record to both sites. These plans are aligned with the national objectives to level of EPR capability throughout the health service in the UK. We are engaged with the regional teams in the submission of a bid to enable such plans. This is a landmark opportunity for the organisation that would deliver significant benefits in the patient care that we offer, releasing clinical time to care, increasing patient safety, and improving the digital experience of staff within our hospitals.

We are also seeking opportunities that enable us to work more seamlessly across the two hospitals through the implementation of single systems that many clinical service lines rely on e.g., a single PACS solution, a single incident & risk management system.

4. INFECTION CONTROL REPORT

COVID-19:
In recent weeks the case numbers of COVID-19 are increasing in most regions in the UK.



The Omicron BA.5 and BA.4 variants are currently the most common COVID 19 variants isolated in the UK.

Currently the pattern of disease in most patients is short lived, with mild to moderate symptoms mainly restricted to the upper respiratory tract. However, hospital admissions are increasing with increasing trend for requirement for intensive care support.

The newer COVID 19 variants continue to cause *severe disease in unvaccinated individuals* particularly if they are in a "high risk" group.

Testing for COVID – 19:
The Trust continues to support PCR based laboratory and point of care testing (POCT) in both hospitals. Staff are encouraged to use antigen tests (lateral flow assay) for asymptomatic screening twice weekly.

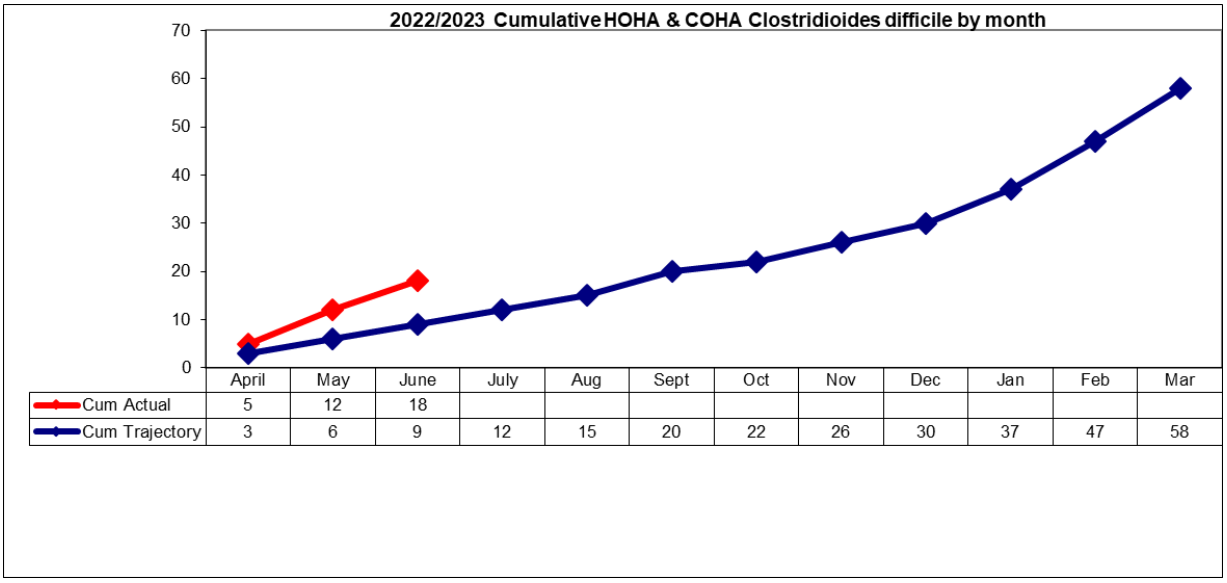
Vaccine news:
Individuals who will be eligible for a further dose will be:

- All adults aged 50 years and over
- All those aged 5 to 49 years in a clinical risk group (including pregnant women)
- Those aged 5 to 49 years who are household contacts of people with immunosuppression
- Those aged 16 to 49 years who are carers
- Residents and staff in a care home for older adults.
- Frontline health and social care workers

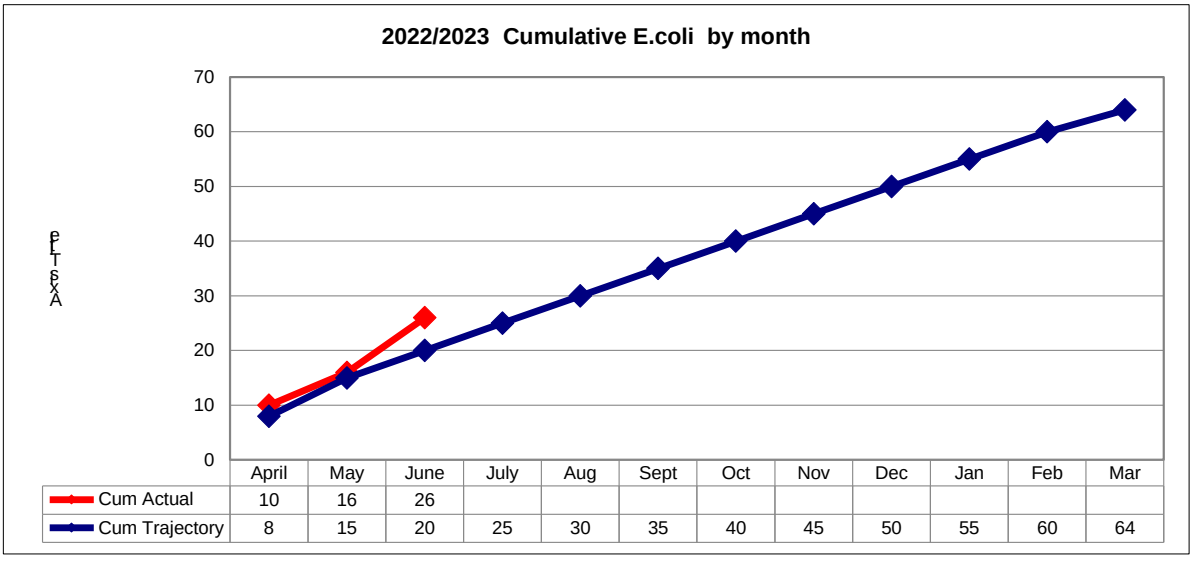
Monkey pox:
Low numbers of cases infected with Monkey pox continue to be reported. In the UK majority of the cases have been identified in London. Locally in Bedfordshire low case numbers have been confirmed with this infection. The current strain of the virus isn't highly pathogenic. Infection treatment and management of patients and contacts is evolving as we gather more intelligence of the behaviour of this virus.

Endoscope Decontamination incident:
The Decontamination lead, DIPC and ICT are investigating an incident in the endoscope decontamination unit at Bedford hospital, where the final rinse water in the unit failed sterility testing. Following initial interruption to service remedial measures put in place have seemed to resolve the current situation. A full report will be provided when all the investigations are completed.

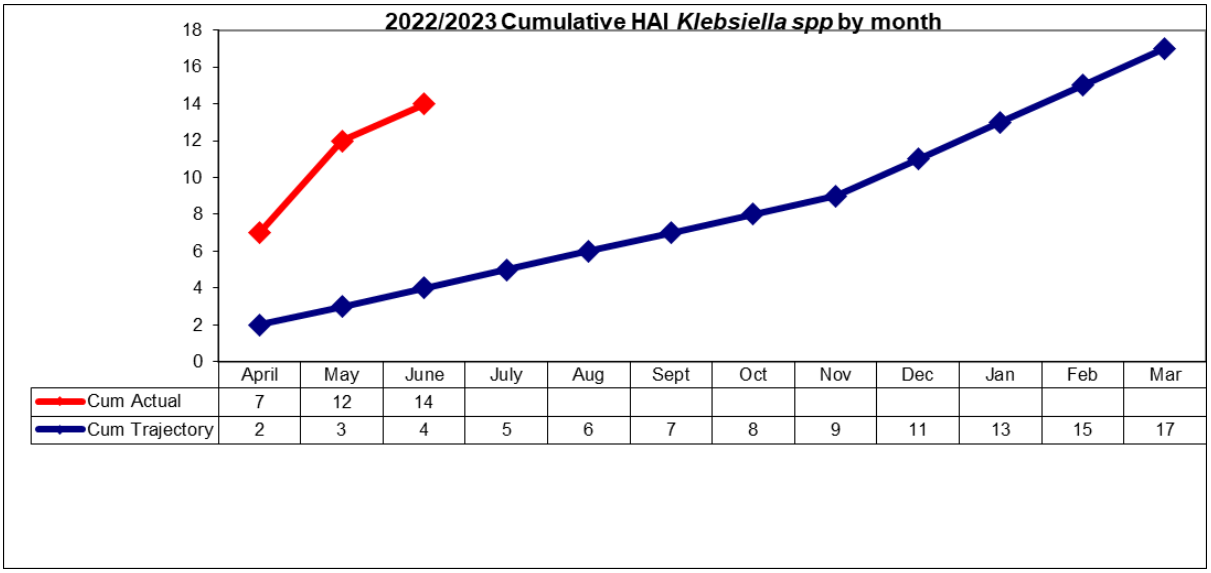
Mandatory reporting of bacteraemia due to E.coli, Klebsiella spp, Pseudomonas aeruginosa and Staphylococcus aureus and Clostridioides difficile diarrhoea

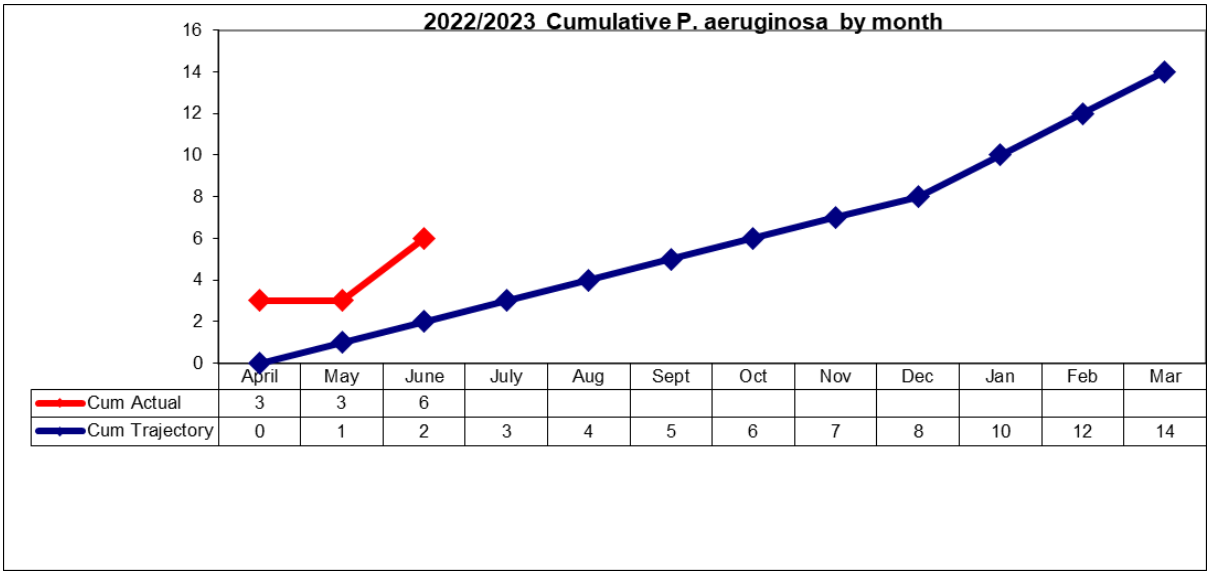


	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Cum Actual	5	12	18									
Cum Trajectory	3	6	9	12	15	20	22	26	30	37	47	58



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Cum Actual	10	16	26									
Cum Trajectory	8	15	20	25	30	35	40	45	50	55	60	64





A summary of key infections is presented below.

Bedford		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Totals (ongoing)
MRSA Bacteraemia	HOHA	0	0	0										0
	COHA	0	0	0										0
	COCA	0	0	0										0
C.diff	HOHA	2	3	1										5
	COHA	0	0	1										0
	COIA	1	1	1										2
	COCA	2	1	2										3
E.coli	HOHA	2	0	0										2
	COHA	0	2	1										3
	COCA	8	6	9										23
MSSA	HOHA	1	1	0										2
	COHA	0	0	0										0
	COCA	0	1	1										2
Pseudomonas	HOHA	0	0	1										0
	COHA	0	0	1										0
	COCA	1	1	0										2
Klebsiella	HOHA	2	1	0										3
	COHA	0	1	1										2
	COCA	1	1	0										2
MRSA Screen	HOHA	0	0	1										1
	COHA	0	0	1										1
	COCA	2	2	4										8
MRSA Clinical	HOHA	0	2	0										2
	COHA	0	0	2										0
	COCA	3	1	4										4
VRE	HOHA	2	1	0										3
	COHA	0	0	0										0
	COCA	0	0	0										0
CPE	HOHA	0	0	0										0
	COHA	0	0	0										0
	COCA	0	0	0										0
MDRGNB	HOHA		24	7										31
	COHA		7	0										7
	COCA		66	5										71
COVID	DEF													0
	PROB													0
	IND													0
	CAI													0
FLU	HOHA	5	0	1										5
	COCA	0	0	0										0
RSV	Total	2	1	4										3
Norovirus	Total	1	0	1										1
Monkey Pox	Total	0	0	0										0

Luton		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Totals (ongoing)
MRSA Bacteraemia	HOHA	1	0	0										1
	COHA	0	1	0										1
	COCA	1	1	0										2
C.diff	HOHA	2	3	4										9
	COHA	1	1	0										2
	COIA	0	0	0										0
	COCA	3	1	1										5
E.coli	HOHA	5	2	5										12
	COHA	3	2	4										9
	COCA	8	12	10										30
MSSA	HOHA	3	2	1										6
	COHA	0	0	1										1
	COCA	7	1	2										10
Pseudomonas	HOHA	2	0	1										3
	COHA	1	0	0										1
	COCA	1	1	1										3
Klebsiella	HOHA	3	2	0										5
	COHA	2	1	1										4
	COCA	4	3	1										8
MRSA Screen	HOHA	3	1	4										8
	COHA	1	3	2										0
	COCA	16	24	19										59
MRSA Clinical	HOHA	1	1	0										2
	COHA	1	2	1										0
	COCA	8	4	5										17
VRE	HOHA	1	6	2										9
	COHA	0	0	0										0
	COCA	2	2	1										5
CPE	HOHA	0	0	1										1
	COHA	0	0	0										0
	COCA	2	0	0										2
MDRGNB	HOHA	9	10	15										34
	COHA	0	0	0										0
	COCA	46	59	42										147
COVID	DEF	26	9	7										42
	PROB	45	8	4										57
	IND	32	13	5										50
	CAI	485	281	63										829
FLU	HOHA	0	0	0										0
	COCA	18	5	3										26
RSV	Total	5	5	4										14
Norovirus	Total	4	1	1										6
Monkey Pox	Total	0	1	2										3

5. LEARNING FROM DEATHS QUARTERLY REPORT 2021/22 Q4

Work continues with the clinical service lines to support learning from deaths, including identifying themes and highlighting aspects of care for quality improvement. Structured Judgement Reviews (SJRs) are shared with the service line triumvirate to inform case discussion at governance forums. The mortality and morbidity meeting toolkit is being utilised by a number of clinical service lines (CSL), and these activities are being supported by the CSL Quality Governance Leads. Further work is needed to ensure cross-cutting themes are shared across the service lines and Trust.

A quarterly forum has been established to support the work undertaken by the Trust's Structured Judgement Reviewers and to promote learning from deaths. Timely completion of SJRs is a focus for action, to support this Deputy Medical Director review of historic referrals for SJR is in progress. Case note review of outstanding 2020 and 2021 referrals and subsequent actions taken provide opportunities for individual and team feedback and will also allow reviewers to focus on more recent cases to optimise timely and meaningful learning from deaths.

Mortality review data
The following tables provide a breakdown of the deaths occurring within Q4 2021/22

Table 1 Summary of Q4 2021/22 deaths, (no.619) by age and gender

	No. deaths	Gender		Age (years)	Age (years)	Age (years)
		Male	Female	Range	Mean	Median
Bedfordshire Hospitals	**638**	**356**	**282**	19 - 102	80	83
Bedford	304 (48%)	150	154	38 - 102	80	82
L&D	334 (52%)	206	128	19 - 101	79	83

*excluding paediatric deaths (LDH, no. 2, aged 8, 16 years) and stillbirths (no.14, BH 5, LDH, 9)

Table 2 Summary of all deaths in Q4 2021/22 by month (1 January - 31 March 2022)

Month in Q4 2021/22	Bedfordshire Hospitals	Bedford	L&D
January	225 (35%)	115	110
February	208 (33%)	98	110
March	205 (32%)	91	114
Total No.	**638**	**304**	**334**

There were 266 fewer deaths in Q4 2021/22 (no. 638) compared to Q4 2020/21 (no. 904) across Bedfordshire Hospitals (BH, -147, LDH -187). This reflects the course of the COVID-19 pandemic, with January 2021 being the peak month for deaths (BH 229, LDH279).

In Q4 2021/22 for Bedford Hospital there were 46 excess deaths compared to the 5 year pre-COVID average and in comparison to 192 excess deaths in Q4 2020/21 (127/192, attributable to January 2021, marking the highest peak in excess deaths since the start of the pandemic).

In Q4 2021/22 for Luton and Dunstable Hospital there were -19 excess deaths compared to the 5 year pre-COVID average and in comparison to 162 excess deaths in Q4 2020/21 (149/162, attributable to January 2021, marking the highest peak in excess deaths since the start of the pandemic).

Table 3 Summary of all deaths in Q4 2021/22 deaths by ethnicity, hospital site

BH - Ethnicity	No. patients
Any Other Asian background	1
Any Other Black background	3
Any Other White background	15
Bangladeshi	1
Black African	1
Indian	8
Irish (White)	9
Not Given	1
Not Specified	2
Pakistani	2
White (British)	261
Total no. patients	**304**

LDH - Ethnicity	No. patients
Any Other Asian background	6
Any Other Black background	2
Any other Ethnic Group	1
Any Other White background	9
Bangladeshi	4
Black - African	3
Black - Caribbean	3
Indian	5
Mixed - White and Black Caribbean	1
Not stated - ask patient	37
Pakistani	8
Refused to give	1
White - British	242
White - Irish	12
Total no. patients	**334**

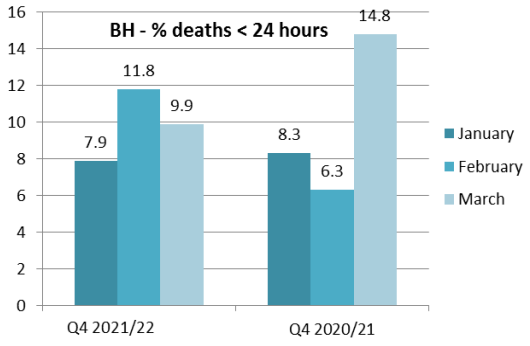
Compared to the previous quarter (Q3) the length of stay in Q4 for Bedford Hospital was unchanged with an increase of +1 day mean, + 2 days median for Luton and Dunstable Hospital (Table 4).

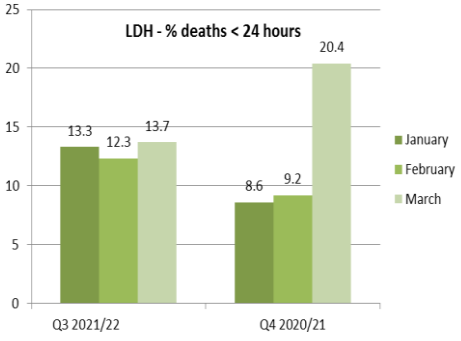
Table 4 Summary of Q4 deaths by Length of Stay (LoS) in Q4 2021/22

	LoS (days) Range	LoS (days) Mean	LoS (days) Median
Bedfordshire Hospitals	**0 - 160**	**12**	**9**
Bedford	0 - 87	13	9
L&D	0 - 142	12	8

The percentage of deaths occurring within 24 hours of admission demonstrates a consistently higher percentage at LDH compared to BH (Figure 1). All deaths occurring within 24 hours of admission are subject to review by a Deputy or Associate Medical Director, with findings presented at the monthly Learning from Deaths Board.

Figure 1 Percentage of deaths within 24 hours of admission in Q3 2020/21 and 2021/2022





From 10 November 2021 all nosocomial deaths were referred for SJR. In addition, quarterly thematic reviews for nosocomial COVID-19 are presented at the Learning from Deaths Board. Following a significant increase in referrals as a result of this change in referral criteria, and the increasing backlog of SJRs awaiting completion, the criteria was reviewed and adjusted from May 2022 to include only those deaths were Medical Examiners felt COVID-19 had contributed to the death. This will support more timely completion of SJRs and opportunities for learning from deaths. The impact of this change in referral criteria will likely be evident in Q1, 2022/23 reporting, in addition this will also be reflective of the national trends for in-hospital COVID-19 mortality.

3.0 Primary and Structured Judgement Reviews (SJRs)
SJR outcomes and impact on learning from deaths will be more fully represented on completion of all outstanding case reviews for patients who died in Q4 2021/22 (no.51/96, 53%, as of 01/06/2022), and following full reconciliation of the DMD reviews.

Table 5 reports primary review and SJR activity completed in Q4 2021/22 for Bedfordshire Hospitals Trust and by hospital site.

Table 5 Primary reviews completed and Structured Judgement Reviews (SJRs) requested and completed in Q4, 2021/22

	Total no. Deaths (Q4, 2020/21)	**Total No. Primary reviews completed***	**Total No. SJRs requested***	**Total No. SJRs completed***
Bedfordshire Hospitals	**638**	**522 (82%)**	**96** (18%)**	**45/96*** (47%)**
Bedford Hospital	304	173	44	25/44 (57%)
Luton and Dunstable Hospital	334	349*	52	20/52 (38%)

No. includes primary reviews for non-admitted patients who presented and died in ED*
Patients who died in Q4**
SJRs allocated and awaiting completion for deaths occurring in Q4***
Total no: 51, (BH, 19 and LDH, 32, as of 01/06/2022)
Data source: DCIQ

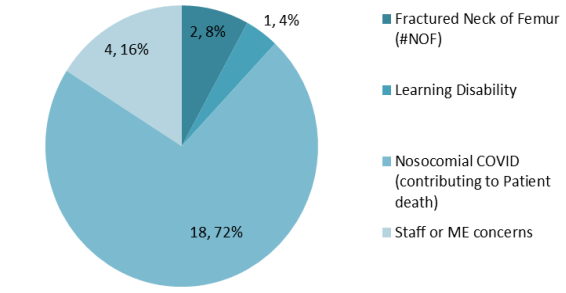
Compared to Q3 2021/22, in Q4 there is a decrease (7%) in the percentage of primary reviews completed, a broadly similar percentage of SJRs requested (18% compared to 20%), and completion of a higher percentage of SJRs at BH compared to LDH (57% and 38% respectively).

The trend for reason for referral continues as in previous quarterly reporting, with ME concerns the primary reason for referral at LDH (no.11, 55%), this may reflect the higher percentage of primary reviews undertaken compared to BH (Table 6, figures 2, b) and nosocomial COVID the primary reason for referral at BH (no. 18, 78%).

Table 6a (BH), b (LDH) All SJRs - completed for patient deaths in Q4 2021/22 (no.45) by hospital site, ward/unit and by reason for referral

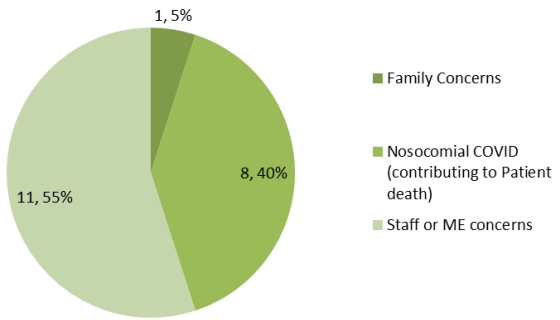
BH - Ward/Unit	Reason for referral	No. SJRs completed
Acute Assessment Unit	Learning Disability (1) Staff or ME concerns (1)	2
Arnold Whitchurch Ward	Nosocomial COVID (3)	3
Coronary Care Unit	Staff or ME concerns (1)	1
Elizabeth Ward	Nosocomial COVID (6)	6
Godber Ward	Staff or ME concerns (1)	1
Harpur Ward	Nosocomial COVID(4)	4
Reginald Hart Ward	Fractured Neck of Femur (#NOF) (1) Nosocomial COVID (1)	2
Richard Wells Ward	Fractured Neck of Femur (#NOF) (1)	1
Russell Ward Block	Nosocomial COVID (2)	2
Shand Ward	Nosocomial COVID (1)	1
Victoria Ward	Nosocomial COVID (1)	1
Whitbread Ward	Staff or ME concerns (1)	1
Total No. SJRs completed		**25**

LDH - Ward/Unit	Reason for referral	No. SJRs completed
ITU	Nosocomial COVID (1) Staff or ME concern (1)	2
EAU 2	Staff or ME concern (1)	1
Ward 3	Staff or ME concern (3)	3
Ward 5	Nosocomial COVID (1)	1
Ward 12	Staff or ME concern (1)	1
Ward 15	Staff or ME concern (1)	1
Ward 18	Nosocomial COVID (2) Staff or ME concern (2)	4
Ward 19b	Nosocomial COVID (2) Staff or ME concern (2)	4
Ward 22	Nosocomial COVID (2)	2
Surgical Short Stay Unit (SSSU)	Family concern (1)	1
Total No. SJRs completed		**20**



Bedford Hospital: Q4, 2021-22, SJR (no. 25) reasons for referral

Figure 2a Reason for referral (no., %) for SJR, Bedford Hospital in Q4 2021/22 (no. 25)



Lutona and Dunstable Hospital: Q4, 2021-22, SJR (no. 20) reasons for referral

Figure 2b Reason for referral (no., %) for SJR, Luton and Dunstable Hospital in Q4 2021/22 (no. 20)

Avoidability score assigned	No. cases (All SJRs, no. 45)	Case identifier
Score 1: Definitely avoidable	0	
Score 2: Strong evidence of avoidability	0	
Score 3: Probable avoidable (more than 50:50)	1	A
Score 4: Possibly avoidable but not very likely (less than 50:50)	12	
Score 5: Slight evidence of unavoidability	7	
Score 6: Definitely not avoidable	25	
Total no. SJRs	**45**	

Table 7 Avoidability scores assigned (no.45) for deaths occurring in Q4 2021/22 and referred for SJR

Note data is subject to change following completion of outstanding SJRs (no.51) and following outcome of DMD review of outstanding allocated SJRs

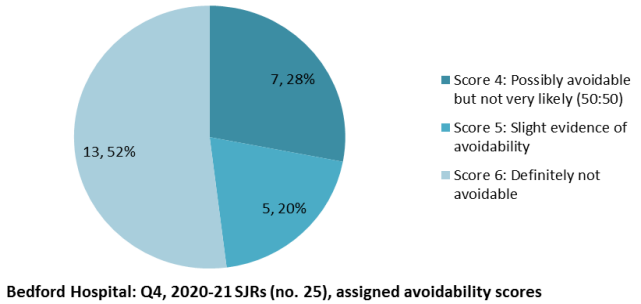


Figure 3a Assigned avoidability of death judgment score (no., %) for Bedford Hospital in Q4 2021/22 (no. 25)

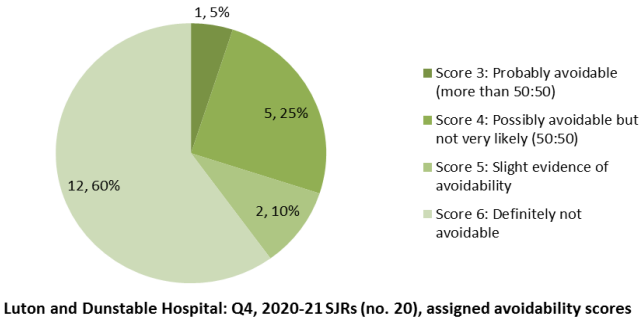


Figure 3b Assigned avoidability of death judgment score (no., %) for Luton and Dunstable Hospital in Q4 2021/22 (no. 20)

Potentially preventable deaths (avoidability score, 3) account for 2.2 % (n=1) of completed SJRs to date (no.45/96, table 7). If the 51 SJRs awaiting completion for the deaths occurring in Q4 are included, the single equates to 1.0 %. This is assuming no additional avoidability scores of 1, 2 or 3 are allocated. An update will be provided in Q1 2022/23 reporting.

Learning from deaths

For the single case assigned an avoidability score of 3 (probably avoidable, more than 50:50) in Q4, following escalation to the Medical Director and subsequent PEARL panel discussion, the outcome was the Serious Incident threshold was not met. The nosocomial infection was felt not to be a factor in the patient's death and it was determined that appropriate antibiotics had been administered on admission for possible sepsis. In terms of good practice, End of Life care highlighted good symptom control, including prescribing and administration of anticipatory medication.

In total, for all 45 SJRs completed, there was one formal complaint received relating to concerns around admission to a contingency area and failings in communication with the family, including the missed opportunity to be present at the time of death. Concerns were also highlighted relating to cancelled appointments leading up to the last admission. This case will be included for presentation at the DME mortality forum

Q3 2021/22 reconciliation

Previous reporting identified there were 56 SJRs allocated awaiting completion for patients who died in Q3 2021/22 (as of 18/03/2022). In reconciling these outstanding reviews to date (04/07/2022), 24/56 remain outstanding (BH, 10 and LDH 14), 4 cases in October, November and 10 cases in December 2021.

Of the additional SJRs completed for patients who died in Q3 not previously included in the report (no. 32, total 84/108) no further cases were assigned an avoidability score of 1, 2 or 3. Potentially preventable deaths, therefore, account for 2.3% deaths in Q3. (n=2, assigned an avoidability score of 3, detailed in Q3 reporting). If the 24 SJRs that remain outstanding for the deaths occurring in Q3 are included, this equates to 1.8%, assuming no additional avoidability scores of 1, 2 or 3 are allocated.

The breakdown of assigned avoidability scores to date for Q3 2021/22 is reported in table 8.

Table 8 Avoidability scores assigned (no.84) for deaths in Q3 2021/22 and referred for SJR

Avoidability score assigned	No. cases (All SJRs, no. 84)
Score 1: Definitely avoidable	0
Score 2: Strong evidence of avoidability	0
Score 3: Probable avoidable (more than 50:50)	2
Score 4: Possibly avoidable but not very likely (less than 50:50)	13
Score 5: Slight evidence of unavoidability	18
Score 6: Definitely not avoidable	51
Total no. SJRs	**84**

Note: data is subject to change following completion of outstanding SJRs (no.51) and following outcome of DMD review of outstanding allocated SJRs

A number of the outstanding Q3 referrals were subject to Deputy Medical Director (DMD) review in order to address the historic backlog of cases awaiting SJR. The criteria for review included all allocated but not completed referrals for SJR for deaths occurring 05/2020 to 06/2022 (No. 118). The initial focus was on historic allocations (up to 01/2022).

Key learning and actions identified included:

Following review of 30 cases a recommendation was made to close 22/30 referrals, as opportunities for additional meaningful learning and further action were judged unlikely. The DCIQ records for these cases were updated, providing an audit trail for the review outcomes, including key actions and learning identified:

- Highlight findings at Bedfordshire Care Alliance (BCA) forum with regard to system governance around anticipatory end of life care planning, impact of delayed discharges
- Case discussion at the Care of the Elderly mortality forum, with a focus on end of life care planning and the need for effective communication with families
- Case discussion at the Orthogeriatiric mortality forum, with a focus on recognition and management of gastro-intestinal bleeds, in the context of patients with multiple comorbidities
- Use of frailty scores, particularly in patients managed in outlier areas
- Benefit of inviting a 2nd opinion highlighted, to raise at cross-cutting boards and consider for inclusion in Trust draft policy for managing difference of clinical opinion

Next steps

Following completion of the outstanding SJRs for Q4 and any reconciliation following DMD review of the SJRs allocated but not completed, Q1 2022/23 reporting will provide an update for deaths occurring in this timeframe, including the avoidability of death judgements assigned and learning identified.

- DMD review findings will be shared at the next Structured Judgement Reviewers Forum and any on-going actions identified to support timely completion and learning agreed.
- In addition, to share findings with the Lead Medical Examiner and Associate Medical Director for Mortality Governance to consider the use of DCIQ email function to provide timely feedback to clinicians, including for cases where local action is required and where undertaking an SJR is unlikely to provide any additional learning.
- Work with the clinical service lines will continue to ensure learning from deaths is embedded within their quality governance activities.
  This includes:
  - ensuring mortality forums are established across the Trust as part of effective quality governance

6. MANAGEMENT OF CQUINS

The Trust is currently working towards the nine CQUIN schemes for 2022/23, engaging relevant clinical teams and key stakeholders to ensure a collaborative approach. For each of the schemes there are minimum and maximum thresholds for conformance. Four of these have been risk rated as Red; highly unlikely to achieve current milestones in Quarter 1. These include two of the incentivised CQUINs which are Cirrhosis and Fibrosis testing which requires a business case and the staff flu vaccination. Audits of each of the CQUINs for Quarter 1 are in progress and results uploaded to the national data base . The audit results will be available at the end of August and shared with the relevant working groups. Any issues will be

escalated to appropriate relevant committee's and identified areas for improvement will be considered for actions and implementation in Quarter 2.

7. MEDICAL EDUCATION UPDATE

Across the sites:
The Trust has been successful in its bid to expand its Foundation Training Programmes and with effect from this August will welcome overall an additional 33 Foundation Year One trainees; 21 at Luton and 12 at Bedford.

Alignment of policies and processes across the two sites continues and most recently has seen a review of our trainee induction plans and the introduction and expansion of Clinical Teaching Fellow roles at each site to support educational delivery.

The results of the General Medical Council National Training Survey 2022 have been released and will be discussed at various forums within the Trust following which action plans will be shared with Health Education England (HEE).

Luton site
There are currently no outstanding risk issues identified by HEE for any specialty school at the Luton site.

The recent bid to host more medical students from University College London (UCL) and become a formal 4th site for UCLMS was unsuccessful. However, the Trust continues to receive positive feedback from UCL with medical students rating the Trust as a positive learning environment which they would recommend to other students.

Bedford site
The Trust is currently working with HEE on a number of improvement plans and in order to assure themselves of progress against these plans, HEE held a series of learner and educator events in Medicine, Nursing, Midwifery, Obstetrics and Gynaecology and Paediatrics in late June 2022 The Quality Report outlining any further requirements and recommendations is expected imminently. The initial feedback was that the meetings were mostly positive and there are a number of actions that can now be closed. In order to continue the positive progression a further meeting has been scheduled for the 11th August to closely review Medicine actions and agree next steps.

The Cambridge Medical School Quality Assurance Visit took place on 11th May 2022 and the feedback from this was extremely positive and our Clinical Skills Trainers were commended for their work with the students.

Cambridge were also complimentary of the move by the trust to increase the number of Clinical Teaching Fellows to support the teaching of medical students and it was noted that Cambridge plan to appoint a Clinical Teaching Fellow Coordinator who will have oversight for the development and training of these fellows.

8. NURSING & MIDWIFERY STAFFING REPORT

The Reports are **attached as Appendices 1a and 1b**

9. INFORMATION GOVERNANCE QUARTERLY REPORT

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

10. MATERNITY SERVICES UPDATE

The quality improvement programme for our maternity services continues at pace. The group leadership team has been strengthened with the appointment of a substantive General Manager and together the triumvirate continue to lead the local teams to both meet and achieve the sustainable service developments.

An insight visit by the NHS England regional team was completed on the 20th and 23rd June, with the team visiting both of the maternity sites. The purpose of the visit was to provide assurance against the progress of the 7 immediate and essential actions from the first Ockenden report (DoH 2021). The insight visit team used an appreciative and enquiry and learning approach to foster partnership working to ensure that the actions taken to meet the Ockenden recommendations were embedded in practice. While it was an extremely busy week for our teams there were many positive developments noted by the visiting team on each of our maternity sites. With the staff describing from both sites *'a better workplace with an improved culture and the future looks good with a visible leadership team who were very accessible'.* Some recommendations have been made for the teams and many are in progress.

As a Trust providing maternity services we have been challenged due to the significant national shortage of registered midwives. While we have some way to go, our planning and investment in recruiting midwives from overseas is well underway and we currently have 22 wte midwives from overseas who are progressing through our comprehensive programme. Seven colleagues who have passed their OSCE exam and are now registering with the NMC. We have a secure pipeline of more midwives from both overseas and our newly qualified midwives who will be joining us over the coming months.

An important next step for our service is the development of our Maternity clinical strategy and vision and over the coming months the maternity leadership team are working with local champions and stakeholders in forming the strategy for the future.

11. FREEDOM TO SPEAK UP (FTSU)

Concerns raised on the Bedford site
There were seven new and three ongoing concerns carried forward from Quarter 4, 2021/22. Three were related to Patient safety including availability of patient transport and short staffing due to sickness. Seven related to Staff safety and quality issues and included concerns about a recruitment process, on-call payments, flexible working and behaviours. One related to medical treatment of a member of staff. All have been escalated and appropriate measures taken and support put in place.

Concerns raised on the L&D site
There were nine new cases for Quarter 4. Two related to Patient Safety/Quality due to staffing concerns. Seven related to Staff Safety/Quality including smoking on site, a Health and Safety concern, communication and career progression.

Feedback on the morale of the staff
The Peer listeners report to the Trust's Clinical Psychologist for support and feedback on the trends and issues raised by staff. The importance of recognition and thanks is a live issue for staff who generally feel unappreciated. The staff engagement events and recognition of long service initiatives, and the Take heART creative workshops have helped staff to feel valued and appreciated.

Support for Staff
Following the publication of the 2021 Staff Survey results, numerous departments have been engaging in focus groups with the OD team to provide confidential feedback in a safe space, particularly those departments where raising concerns emerged as a below Trust average theme. Posters publicising the service have been provided and the leadership team have been offered support by the OD team on how to promote a culture of speaking up and constructive feedback loops. The role of the FTSU Guardians and Champions and Peer Listeners have been at the centrepiece of recent staff engagement events.

Education and Training
Following the April Workforce Committee and with support from Dr Nisha Nathwani, there is now more engagement from the Guardians with junior doctors on both sites. The Guardians also attend MDT Preceptorship training and the induction training for new overseas midwives. The Guardians themselves now have to undertake refresher training before the end of October this year.

Future Plans
The National Guardian's Office has recently launched a new national policy. It is very different to the current one and we are in the process of discussing the implications of the policy and the training that accompanies it and how it will be taken forward.

12. ESTATES & FACILITIES UPDATE

Staffing
Estates and Facilities services on both sites continue to be challenged over the past period with increased activity, sickness, COVID isolations and annual leave requirements. Teams have been able to maintain a high level of service with little or

no impact on the site operations. Additional staffing / support has been secured via agencies and local contractors when required.

ERIC (Estates Return Information Collection) & Maintenance Backlog
The annual ERIC reporting cycle has been completed and submitted in advance of the deadline. This is a huge piece of data collection covering all aspects of the Estates and Facilities Services. The centre is now running through a ratification process nationally before the data is published in October. This information, once ratified, informs the national Model Hospital Data which will allow the team to benchmark its services costs and performance against other similar sized acute hospitals.

Hard FM Services - Luton & Dunstable

Ventilation:
System verifications and servicing for the period have been completed.

Asbestos:
Residual asbestos has been identified on insulated pipe work in four plant rooms on the site as part of detailed intrusive surveys. Notifications have been issued to the HSE and works are underway to remove this asbestos which is due to be completed in August.

All routine asbestos inspections have been completed for this period.

Luton and Dunstable Estates Capital Projects:

Fire Compartmentation / Fire Door Replacements:
The 2021/22 extent of fire compartmentation works is nearing completion across the site with only a few area remaining, initially delayed due to COVID restrictions.

The rolling fire door replacement programme is also progressing on site with similar restrictions due to the nature and location of the door replacements within clinical departments.

Emergency Lighting:
Works to expand the sites automated emergency lighting system infrastructure is well underway on site and nearing completion. New self-testing emergency light fittings have been installed in the Surgical Block with installation teams now working in the Medical Block. This piece of work forms part of a rolling programme which will see all emergency lights (in bedded areas) replaced and connected onto the automated system in three years' time.

Ventilation Works:
Installation of new Air Handling Units is underway on the Pathology Block (ground floor) and the Chemotherapy Department. A ventilation system rebalance will be undertaken in the Surgical block in the autumn.

Hard FM Services – Bedford Hospital

Ventilation:
Annual verifications of critical ventilation systems for 2022/23 remains on schedule.

Asbestos:
All routine asbestos inspections have been completed for this period. The department's electronic register has been updated.

Fire:
Fire compartmentations works are progressing on site, primarily in the main ward block. Detailed intrusive surveys are to be planned for the Caudwell Building in the autumn.

Electrical:
Works are nearing completion on the replacement Low Voltage (440Volt) electrical switchgear in Victoria Ward. This major piece of work has been progressed with minimal disruption to the site.

Hospital Sterile Services Department (HSSD)
The Bedford HSSD service has recently undergone a detailed external audit, a requirement for accreditation. The audit is an in-depth review of all aspects of the service. The service has successfully met all of the requirements with only one minor action which was completed during the audit.

Soft Services Updates

Cleaning Standards
The new cleaning standards expected since 2019 have finally been approved (nationally) and implemented across both sites at the beginning of May, meeting the national requirements / timelines.

Teams on both sites have worked tirelessly on the new cleaning standards over the past six months, linking with key stakeholders, communications and implementing new auditing requirements.

The team will be commencing a three-month review of performance and processes at the end of July. The new standards capture not only the performance of the domestic service but that of the estates and nursing teams. As per the new cleaning standard requirement, all-star ratings are published at the entrances of all ward and departments.

Please to report that all audit scores at Bedford have returned a five-star rating to date with a similar position at the L&D but with a handful of four star ratings. There are no scores below four star.

13. COMMUNICATIONS AND CHARITIES

COMMUNICATIONS

External Communications and Media

Media activity slightly decreased over the Apr to Jun period, with the communications team dealing with 41 media enquiries across both hospitals. This was a 21% decrease compared to the previous period.

Media enquiries were mainly themed around tackling long patient waiting lists, A&E waiting times, visiting restrictions, Platinum Jubilee Celebrations and the Health Secretary's visit to the L&D Hospital and broadcast series coverage on our obesity services provided at the L&D. Due to the nature of these media enquiries, most requests were from local and regional media representatives this period.

Positive stories reported in the local press included hospital celebration for Her Majesty's Platinum Jubilee, the Health Secretary visiting the L&D to officially mark the start of the major redevelopment project to build a new Acute Services Block and new Ward Block on the site. A further positive highlight was the BBC Look East three days series coverage on the Trust's Obesity Services provided in Luton.

The communications team received approximately eight media requests to film in the hospital and interview spokespeople during this period. These requests were mainly covering the operational pressures the COVID-19 pandemic is still having on hospitals. We were unable to accept and facilitate all requests due to the operational business of both sites, impacting the availability of Trust spokespeople.

The Communications team are organising a programme of refresher media training for key senior managers and clinicians to be completed by quarter three:

Social Media

Hospital site	Social media channel	Number of likes/followers	Increase from April 2022
Bedford	**Facebook**	**7,693**	**+148**
L&D	**Facebook**	**10,583**	**+446**
Bedford	**Twitter**	**6,812**	**+144**
L&D	**Twitter**	**6,278**	**+163**
Bedford	**Facebook Maternity Page**	**4,713**	**+105**
L&D	**Facebook Maternity Group**	**2,224**	**+112**
Bedfordshire Hospitals	**Instagram**	**1,165**	**N/A**
Bedfordshire Hospitals	**LinkedIn**	**942**	**N/A**

A few highlights from Apr to Jun on social media channels include:

- Key posts were around the Emergency Departments being extremely busy and to use alternative health services if not an emergency.
    - L&D 8 June – 72,657
    - L&D 11 July – 35,080

- Redevelopment posts continue to receive a high reach and engagement on the L&D accounts, which are now expanding to the Bedford accounts

  L&D
    - Lewsey Road closure – 11k
    - Acute Service Block/New Ward Block milestones – 4k
    - Energy Centre information as part of Greener NHS – 7k
    - Acute Service Block/New Ward Block concrete slabs – 4k
    - ED first phase handover – 5k
    - Calnwood Road diversion – 9.3k
    - ED progress – 24k
    - Sajid Javid ground breaking ceremony – 5k

  Bedford
    - Cauldwell Centre project update – 1k
    - Site tour progress – 3k
    - Second site tour progress – 4k

- Throughout this period, we have supported a variety of awareness campaigns including Estates and Facilities Day, Healthy Eating Week, National Epilepsy Week, International Day against Homophobia, Transphobia and Biphobia, OPD Day, World Fibromyalgia Da and National Walking Month.
- We held campaigns for NHS Knowledge and Library Week, Greener NHS, Bike Week, Biomedical Science Week, Volunteers Week, Nurses Day, International Day of the Midwife and Equality, Diversity and Human Rights Week with every post reaching between 3k and 11k.
- Nurses Day international nurses video was so well received reaching 52.7k on the L&D site and
- Hot weather messages
- Our long service retirement messages continue to be some of the best-received posts.

We launched our Trust Instagram account prior to our staff engagement events, with a great number of followers in place already. We had an Instagram frame at both Thank You Friday sessions with great interactive throughout the day. We look forward to seeing the account grow with followers over the coming months.

Website
During this period, we had 233K users visit our website with 518K sessions.

Aside from the staff executive log in page, the most visited pages have been:
- Job vacancies
- Blood tests
- Cancelling/change appointment (L&D)

- Visiting changes at our hospitals

Bedford
During this period, we had 37K users visit our website with 274K sessions. The most visited pages remain:

- Do it online
- Clinical hub
- COVID-19 updates
- Clinical guidelines
- Staff hub

L&D
During this period, we had 22K users visit our intranet with 175K sessions and 403K sessions. The most visited pages have been:

- Directory
- Departments and wards
- Clinical guidelines
- Do it online
- Policies

Internal Communications and Events
Staff communications and engagement remains a key focus for the communications team. We have now comfortably established our communications response to the pandemic as our Business As Usual (BAU).
The Microsoft Teams platform continues to be in frequent use to enable meetings to take place remotely and virtually and allows us to successfully facilitate and support the below forms of staff communications:

- Operational Briefings led by the COO/Deputy CEO to Senior Managers
- Monthly virtual All Staff Briefings led by the CEO with input from members of the Executive Team
- Virtual one-off live events for staff engagement events – Good, Better, Best
- Dedicated COVID-19 section on the intranet
- COVID-19 E-Briefings
- Staff recognition and award programmes (Team/Individual of the Month, DAISY awards)

The first draft of the new Communications and Engagement Strategy is now complete. This sets out clear communications objectives and ambitions for digital improvements, internal communications, stakeholder engagement and brand development for the next two years (2022 – 24). This strategy outlines some key developments and objectives for the communications department, which includes:

- Introduction of a new staff app
- Discussing options for digital screens to be placed throughout the organisation to display key messages for patients and staff
- Further development of the staff intranets
- Development of our social media channels.

CHARITIES

Voluntary Services

- 114 volunteers are now active at the L & D site, an increase of 24 since March with more scheduled to start this Month. 66 Volunteers active on Bedford site.
- There are 2 new areas for volunteers to support at Luton; Pre op assessment to help with admin and clerical tasks and liaise with patients in the waiting area and the eye day surgery unit to offer refreshments to patients post op and sit and talk to those waiting for their procedure. In Bedford a new volunteer role has just started in Radiology with a volunteer making reminder calls to patients with appointments scheduled. This role aims to assist in the reduction of DNAs
- Key areas supported (Bedford): volunteers are now placed in ED, Meet/Greet and Reception roles, Admin, Outpatient Clinics, Hospital Shop, Riverbank Ward, Tavistock Ward, IT, Primrose Unit, Microbiology, Discharge Lounge and our PAT Dogs have now returned.
- At Luton Mealtime assistants are starting to increase in numbers with 8 currently supporting across wards 14, 15 & 17. Ward 15 are now supported during 4 lunchtime sessions a week.
- In June we celebrated Volunteers' week across both sites and on 10th June, at long last, we were able to hold a Volunteer Long Service lunch at Parkside Hall in Ampthill, attended by some 80 volunteers and supported by members of the Voluntary Services and Charity Team. . HM Lord Lieutenant of Bedfordshire and, on the CEO's behalf, Gordon Johns.
- St John Ambulance support in both EDs continues but on a reduced scale owing to a significant increase in the requirement for SJA to support community events. We are aware that the SJA units are looking to recruit more volunteers to enhance their offering to the Trust. In the meantime, all support is well received in our EDs and more than 400 hours (to 31/02/22) has been given to support patients and staff across sites.
- The Blossom programme at both sites is going from strength to strength. With 10 Blossom Volunteers at Bedford and 12 at Luton. Approximately 400 End of Life and very poorly patients have been visited across both sites. Feedback from staff, patients and their families has been overwhelmingly positive.

Work Experience

- Graduation presentations completed in March / April for those students who took part In the live learning programme between September – January 2022.
- NHS classroom careers sessions have taken place to support 64 students and 2 careers fairs were attended reaching 510 high school & college age students.
- We are currently working through a new standards document produced by HEE alongside our colleagues at Bedford to submit an accreditation application later this year for our virtual and face to face education sessions.
- A summer plan is in place across both hospital sites to support work experience students who are on our waiting list over the next couple of Months.

Trust, Grants and major gifts

- In May, we received a donation from the Amateurs Trust to fund a new Central Monitoring System which was installed in early June in our newly renovated Majors Department in ED. This is already benefitting patients and clinical staff.
- We received donations from 3 charitable trusts between February and March totalling £35,000 towards our Paediatric Resuscitation and Stabilisation Room appeal to support both capital and equipment costs.
- We supported hospital's Take HeART group with funding from two charitable trusts to run a new wellbeing initiative across the two hospital sites. Six workshops have run for staff across May to July to encourage them to take time out of their busy day to be creative. This in turn has produced art work to be displayed across the hospitals for the benefit of staff, patients and visitors alike.
- We are also working across the site to start reporting on NHS Charities Together projects which we hope to submit in August.
- Funding has been secured for the 2 Pocus ultrasound scanners.
- £340k of the CT scanner money at the L&D has been received with the outstanding balance expected in shortly.

Community Fundraising

- VCreate was funded by charitable donations for 2022/2023, we had 3 main donors for this appeal.
- Amazon have made a £1000 donation towards the Children's Critical Care Room. They have donated individual sanitising and masks packs and 1,000 notebooks.
- Dunstable Town Football Club completed their fundraising for 2021/2022, they presented us with a £5000 cheque towards the cancer unit.
- We received over 1,000 Easter Eggs and Easter gifts, which were distributed to the Paediatric wards and elderly wards on both sites. The largest donation came from Kier & The Toureen Group.
- The White Company have supported with over 2,000 items donated to support patients on wards, nurse's day and to support at charity stalls.
- The charity team supported International Midwives day by sourcing items from the White Company to make gift bags, supported both International Nurses Day and Estates & Facilities Day by inviting the Rapid Relief Team in to supply free burgers for those staff.
- Spring Quiz raised over £900 to support the Children's Critical Care Room.
- An individual donor made a donation of £3,000 to support items for the early pregnancy patients.
- We received a legacy of £5,000.
- Challney High School for Boys raised £1,237 for the Children's Critical Care Room.
- Home Bargains made a donation of £2,000 from their new store opening the Children's Critical Care Room Appeal and NICU Parent's Accommodation.
- The Primrose Unit has received £15,085 in donations since the beginning of the financial year

Development

- We are working closely with clinical colleagues and the redevelopment team to shape our upcoming Acute Services Block Appeal, and to deliver upon our pledged appeals for the Children's Ward and ED.

- We are currently working on a charity development plan, including communications, unifying brand and presence across both sites.

Retail

- The Charity Hub volunteers have contributed **1223** hours since the beginning of March. We are running a campaign on social media and website to recruit more volunteers for the shop and the trolley service.
- The Hub Manager is working alongside the Volunteer Coordinator to establish a work experience scheme with the hospitality students at Luton Sixth Form College. These volunteers will be for the trolley service.
- Due to the Awesome Coffee van being outside the maternity unit from the middle of March for over two months sales on the Costa coffee machine were lower than normal. Since it has returned to its normal area sales have once again picked up. We have had **£3,661.66** paid into the account from Costa machine sales

Bedford Hospital Charity & Friends (BHC&F)

- Gifted 50 Easter eggs to the Riverbank Ward.
- Bedford Tangent Club significant fundraising for BHC&F during year April 21/22. Generous cheque presentation. All match funded.
- McDonald's bike ride to raise funds for BHC&F. All match funded.
- The appeal, '£1m for Bedford A&E', to be closed on 15th July 2022 having raised over £1m in around 18 months:
    - The Gale Family Charity Trust to match-fund the last part of the appeal up to £30,000. Achieved in full.
    - Match funding from The Harpur Trust up to £30,000 in place for events in Bedford Borough for the people of Bedford Borough.
    - Co-organised the very successful 'Music at The Mill' memorial concert for Brian Woodrow OBE DL. All profit shared between BHC&F and The Mill Theatre.
    - Concert organised by Evelyn Sunderland with Opus 18. Half of proceeds to BHC&F
    - Organised an excellent Charity Golf Day raising great funds and profile. Major fundraising dinner, The Two Charlies' organised by the Rotary Club of Bedford Castle raised significant funds for BHC&F
    - Present Laughter Theatre production for BHC&F, 50 tickets given for selling by BHC&F.
    - Received entire funds from the very successful Ball organised by the Trinacria Society.

14. POLICIES & PROCEDURES UPDATE

Trust Wide Policies Approved April – July 2022

E18T Elective Access Policy

I26T Inquest Management Policy

A09T Annual Performance & Development Review (APDR) – Non-Medical Appraisal

S28T Professional and Study Leave Policy - Senior Medical and Dental Staff

M10T Missing Adult Patient Policy

D09T Decontamination Policy
05T Business Continuity Policy

I22T Access Control Policy

I25T Patch Management Policy

V03T Volunteer Policy

W04T Work Experience Policy

F04T Counter Fraud and Bribery Policy

V04T Employee Volunteering Policy

C17T Managing Conflicts of Interest Policy

R14T Risk Management Strategy and Framework

I03T National Infection Prevention and Control Manual

Bedfordshire Hospitals NHS Foundation Trust
Corporate Nursing

NURSING STAFFING REPORT

NURSING WORKFORCE REPORT

Appendix 1a

Nursing Workforce Report
June 2022

Introduction

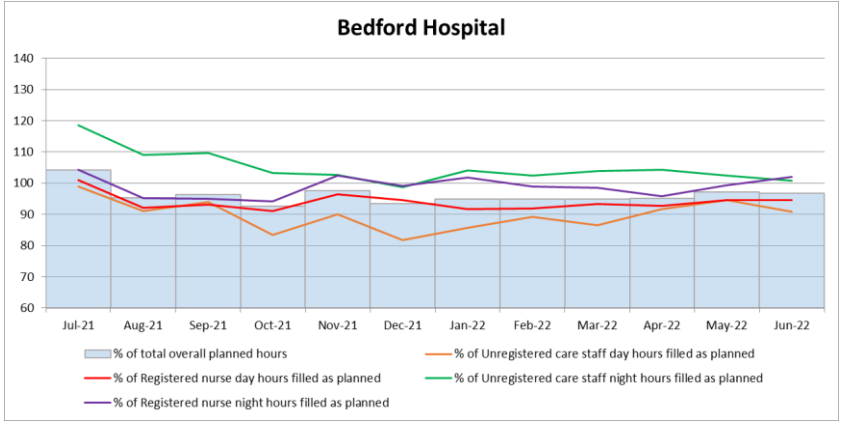
The National Quality Board (NQB) standards require that trust boards are appraised of the safety and effectiveness of nurse staffing within the organisation. This report to the trust board Quality Committee meets this requirement

The report evolves to meet the changing situations in, and priorities of the organisation. As systems and processes align across the two sites, the way information is presented will be amended.

As part of the NHS preparedness for winter a workforce assurance framework was developed and the trust has mapped our current state against this document. This has been presented to the workforce committee and some of the outputs from that document will begin to be integrated into this report going forward.

Overall Ward Fill Rate

Bedford Hospital Site				Luton and Dunstable Hospital Site			
	Apr 22	May 22	Jun-22		Apr 22	May 22	Jun-22
% of Registered nurse day hours filled as planned	92.69	94.53	94.65	**% of Registered nurse day hours filled as planned**	93.02	93.98	89.97
% of Unregistered care staff day hours filled as planned	91.67	94.64	90.91	**% of Unregistered care staff day hours filled as planned**	105.50	105.85	113.28
% of Registered nurse night hours filled as planned	95.83	99.4	101.99	**% of Registered nurse night hours filled as planned**	96.13	97.60	95.95
% of Unregistered care staff night hours filled as	104.29	102.41	100.71	**% of Unregistered care staff night hours filled as**	128.27	127.42	133.81
% of total overall planned hours	95.81	97.1	96.73	**% of total overall planned hours**	102.14	102.90	103.25

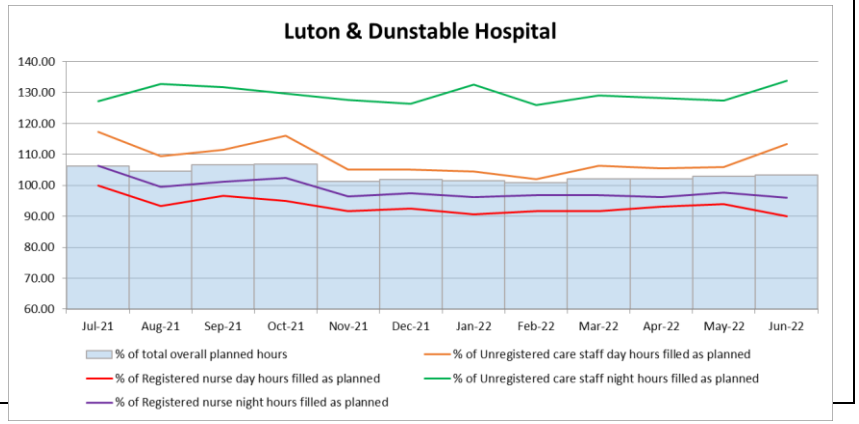


The fill rate data presented above is taken from the UNIFY workforce extract that is submitted to NHS-E. The fill rate for UNIFY is calculated by using the total number of hours actually worked on the ward in the period compared and the total number of hours required to meet the wards agreed and funded shift staffing levels (The Template). Shifts that are not required due to bed closures for example are removed to give the planned hours.

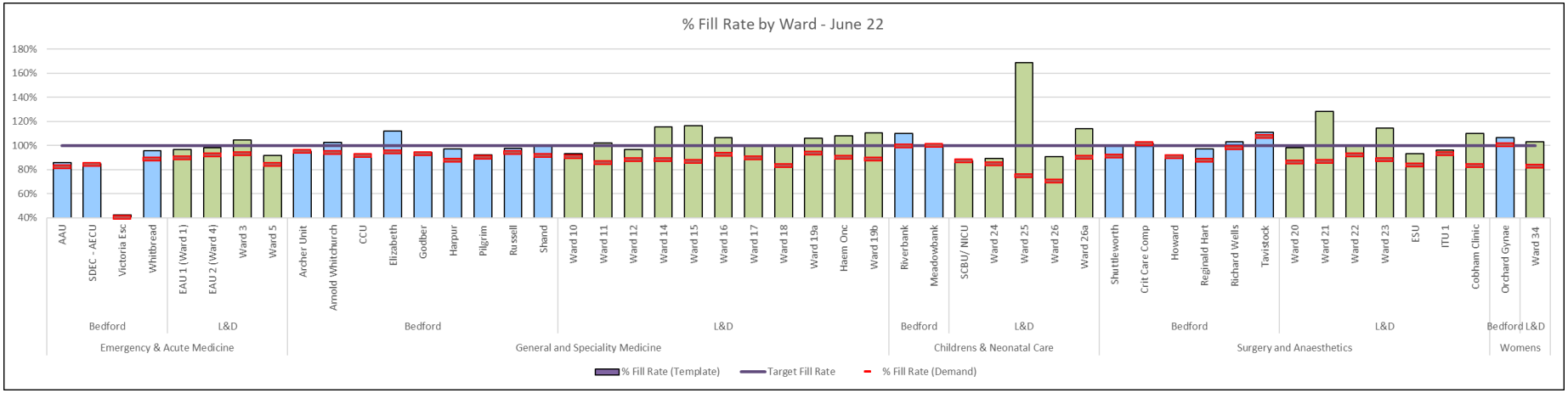
This can mean that a ward will show 100% filled despite having staff shortages due to additional shifts not being filled. If additional shifts are filled the fill rate exceed 100% even if only half of the original shifts are covered.

The alternative way to calculate fill rate is to add theTemplate and the additional required hours together to identify the Demand, this can them be used to show the fill rate compared to demand.

This is demonstrated on page 3 in relation to ward level fill rate.



Fill Rate by Ward



The chart above refers to fill rate compared to plan (blue and green bars) across the wards by site and care unit.

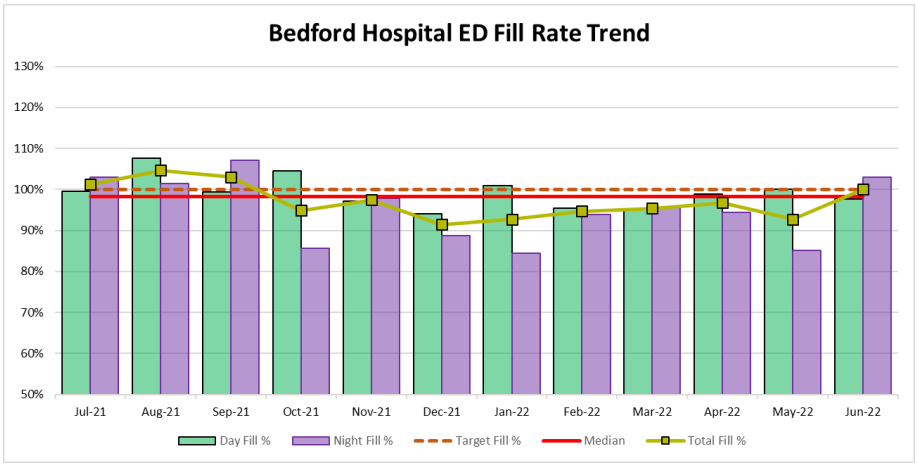
The red marks are the fill rates for each ward compared to actual demand.

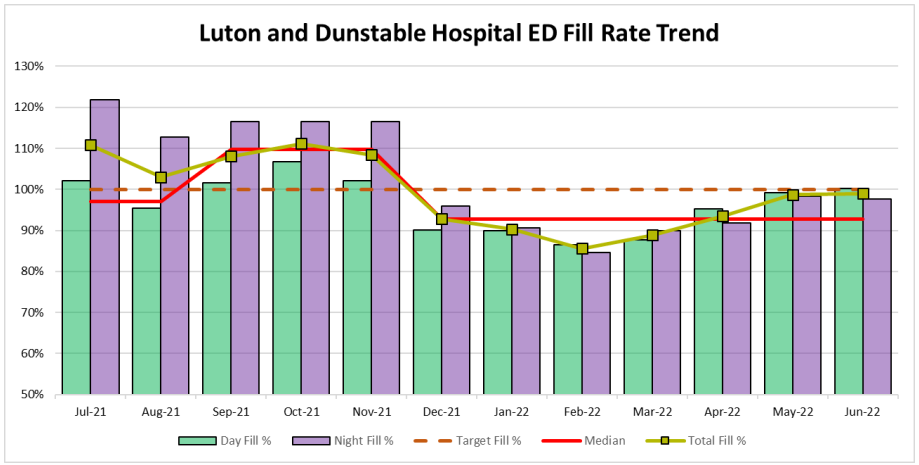
In May 50% of wards fell below 100% fill (compared to 54% in June) with 26% of wards being below 95%. SDEC at Bedford remains the ward with the lowest fill rate however; this picture is distorted by the area combining with Victoria Ward (over filled), and used as a contingency area resulting in staff demands fluctuating. AAU at Bedford is also of concern further review is required to understand the fill rate in more detail.

Ward 25 at Luton continues to show significant over fill against template, this is due to high Enhanced Patient Observation (EPO) demand, predominantly RMN's for children & young people; Ward 25 accounted for 30% of the total RMN demand on the L&D site.

The weekly roster review meetings continue on both sites, the effectiveness and function of the meetings is under constant review in a live PDSA cycle and other options to give stronger assurance are being explored. The Matrons and senior nursing team constantly monitor staffing levels across the organisation and move staff to even out the pressure and minimise risk, this includes specialist nurses and the education team assisting on the wards when available. The impact on staff when being moved is always a consideration as we try to ensure that this only happens when necessary and that all staff take their turn as far as possible to minimise the impact.

Adult ED Fill Rate

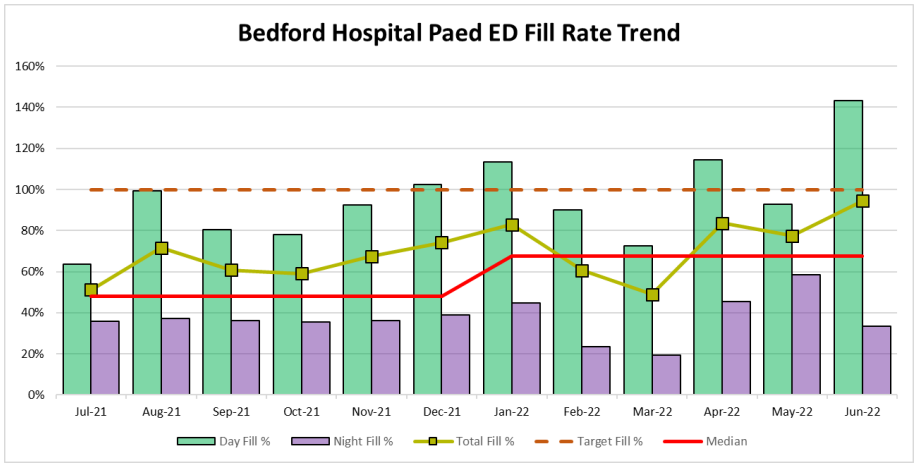


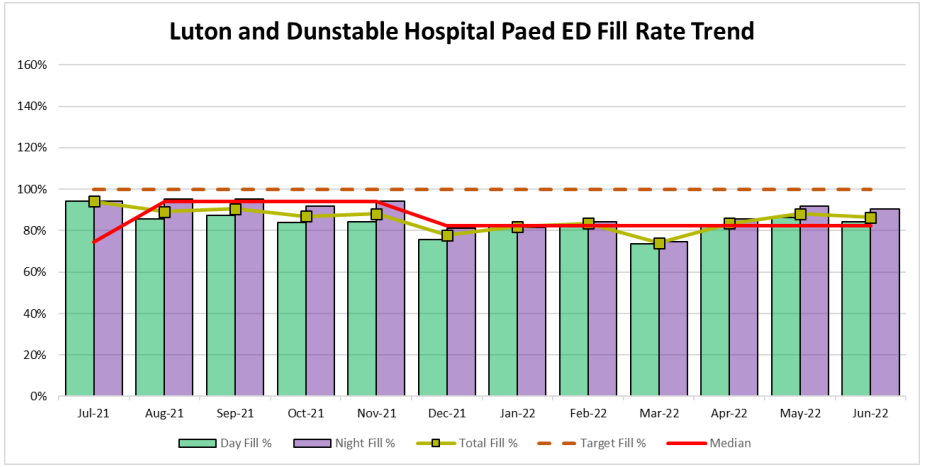


Fill rate in the adult Emergency Departments (ED) on each site remained below the respective department's median value for the sixth consecutive month, only Bedford ED meeting the demand on day shifts; however, both sites have seen significant improvement

The new ED Safer Nursing Care Tool (SNCT), developed by the Shelford Group has been released and the trust has been licensed to use the tool, four members of trust staff have completed the NHSE/I ED SNCT train the trainer course. Both departments have completed a trial audit and a formal audit took place in mid-June alongside the inpatient audit. There have been some concerns, particularly at Luton about the under collection and reliability of the data collected, as a result the data collection is being repeated w/c 25th July 2022.

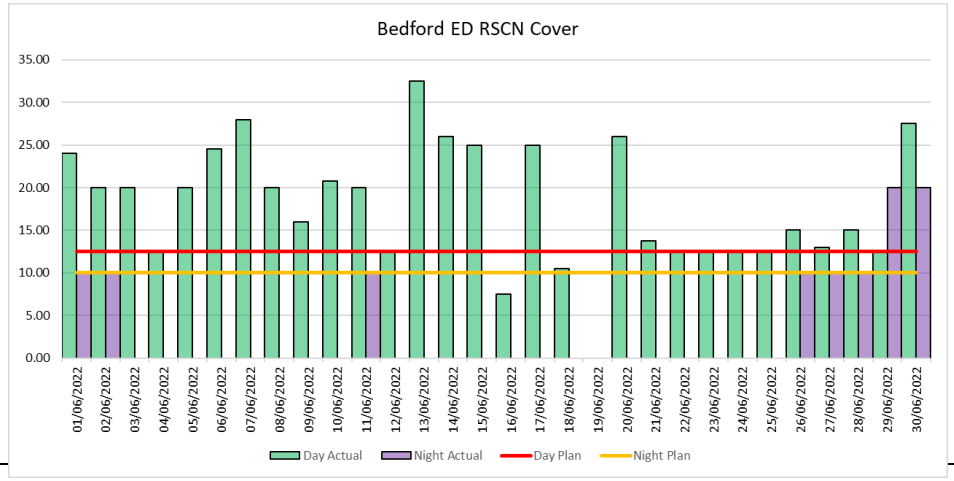
Children's ED Fill Rate





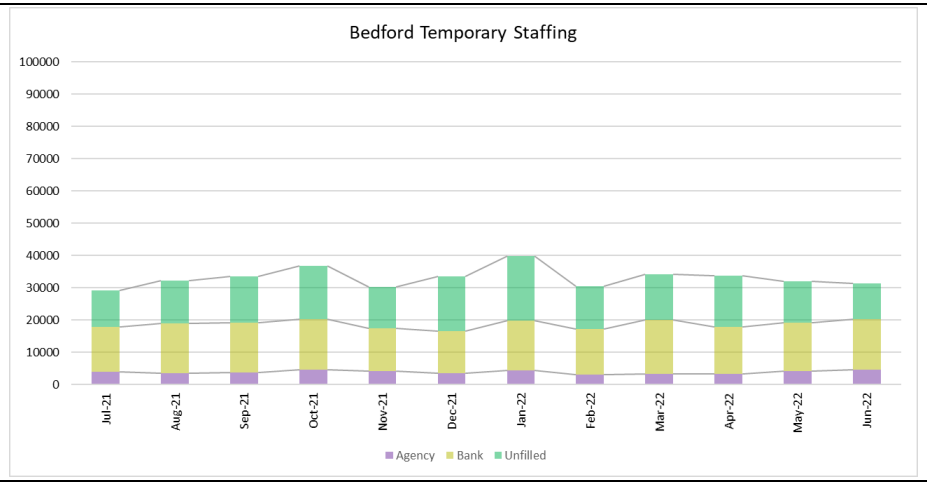
The Children's ED at Luton reflects the same issues as the adult unit with the same options being utilised to address the issues.

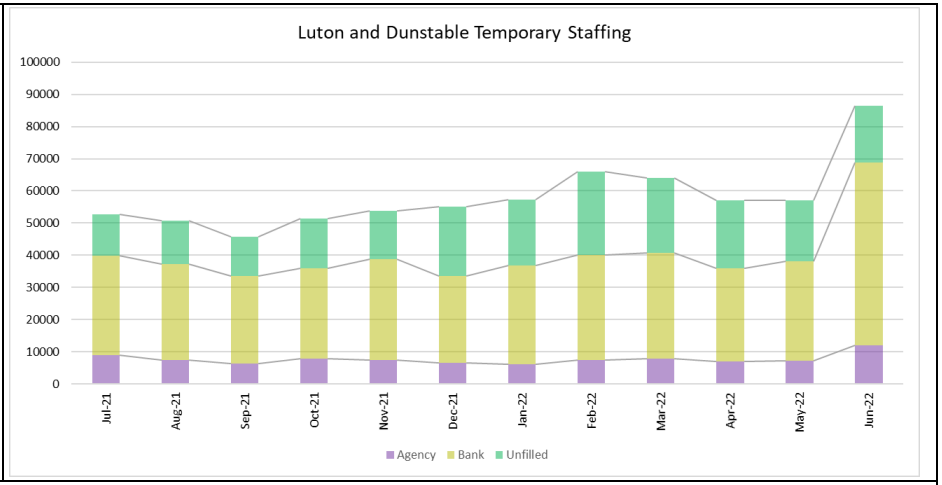
Children's ED at Bedford continues to have difficulties recruiting Registered Children's Nurses for the department, there is an active recruitment drive ongoing, new staff have been recruited and had an impact this month. Unfortunately as these staff need training and to develop ED skills they need to be supervised by experienced nurses, as a result they cannot cover night shifts at present leading to the overfill on days and under fill at night, this will be corrected as soon as it is safe to begin normal shift rotation for these staff.

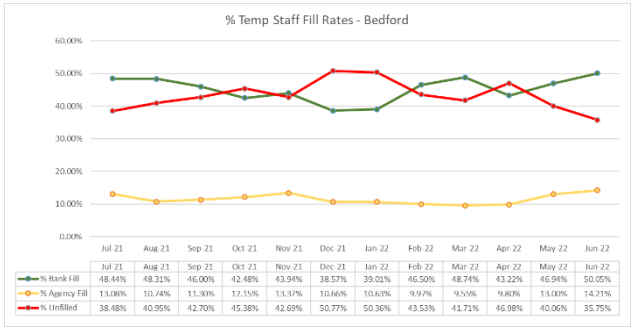


To mitigate the risk associated with insufficient numbers of Children's Nurses to fill the roster the department has a number of senior ED nurses who have undergone additional training to enhance their knowledge and skills for caring for children; there have been no incidents reported as a result of children not being cared for by Registered Children's Nurses.

Temporary Staffing Breakdown

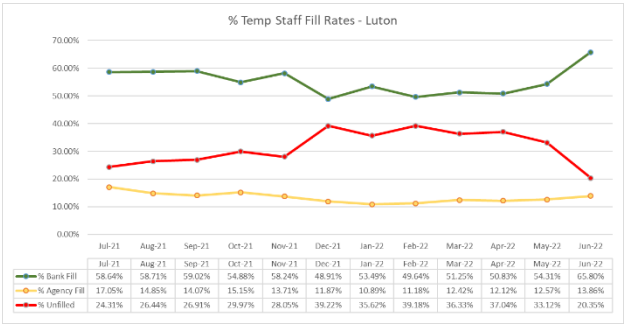




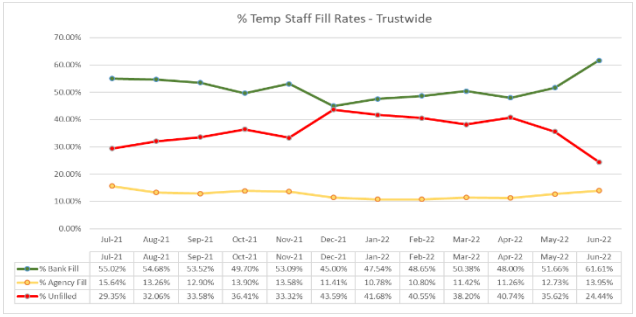


The temporary staffing profile at Bedford remains within the “normal” ranges.

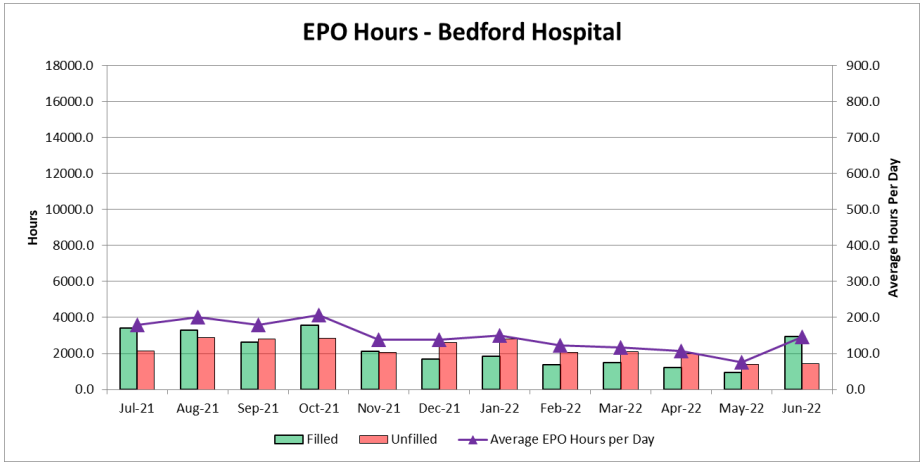
At Luton the overall demand along with bank fill have increased however agency fill remains static as it does at Bedford.

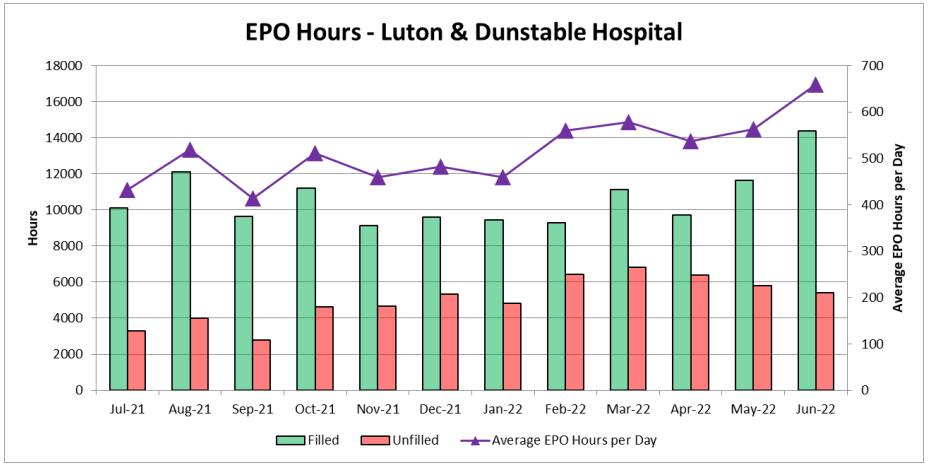


The proportion of demand that is remaining unfilled on the two sites remains significantly higher than this time last year, this may partly be due to increased demand due to increased staff absence and EPO.



Enhanced Patient Observation



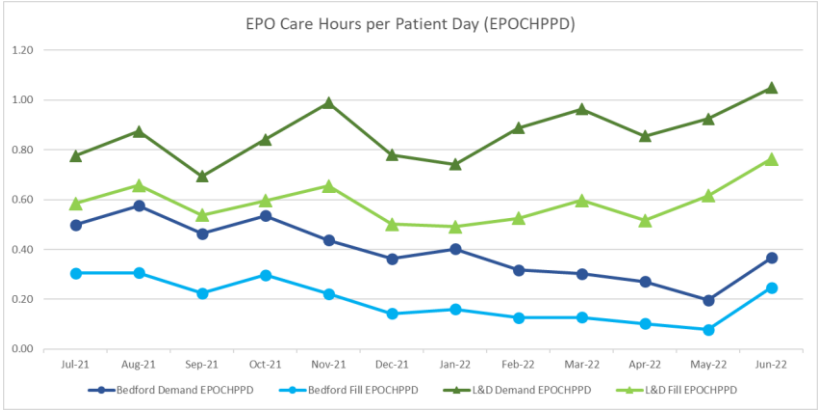


Enhanced Patient Observation (EPO) is a strategy that is implemented to support patients who have higher levels of clinical or care needs or who require close observation due to increased risk associated with cognitive impairment

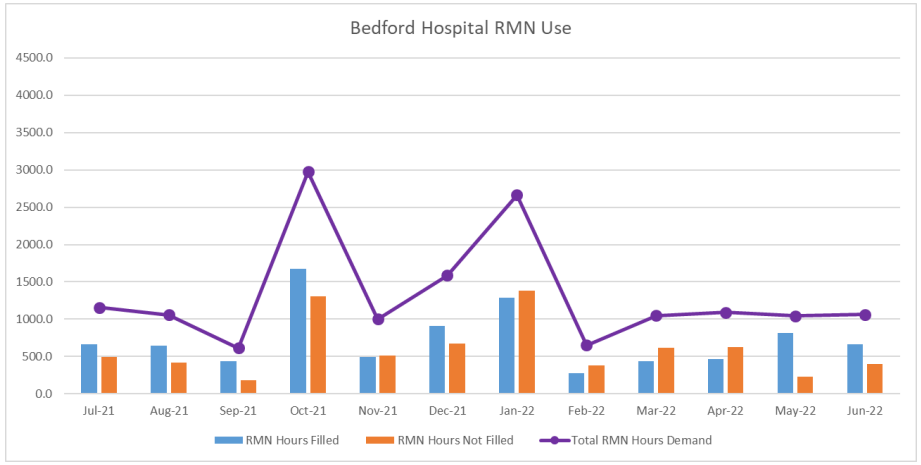
The EPO demand rate increased at Bedford for the first time in 5 months and the fill rate was greater than 50% for the first time following six consecutive months where it was below 50%, at Luton the unfilled rate remains around 30%.

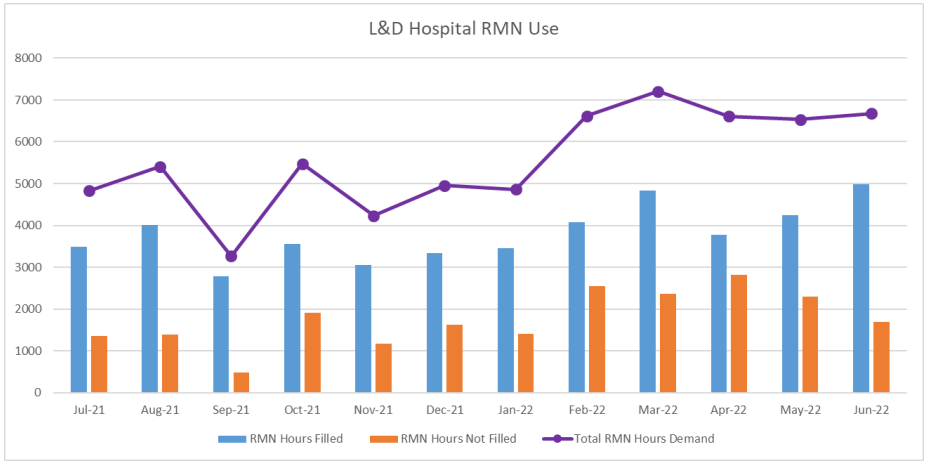
When comparing staff fill across multiple units, sites or organisations the recommended measure is Care Hours Per Patient Day (CHPPD). The chart to the left uses the CHPPD methodology to examine and compare the demand and fill rate for EPOCHPPD, demonstrating that this is significantly higher at Luton.

It is unclear why there is such a difference, possible factors could include patient demographics, working practices, environmental factors or different approaches to risk management. Further work is required to understand the reasons for this.



Enhanced Patient Observation - RMN



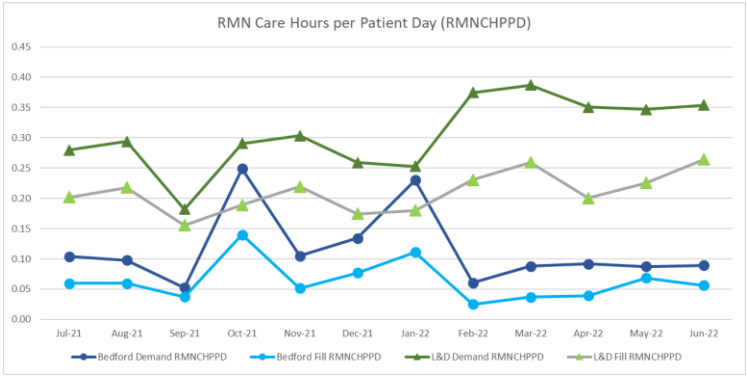


One group of patients that often require EPO are those admitted with physical health complaints but with either pre-existing mental health problems or acute mental health issues that led to the physical health problem.

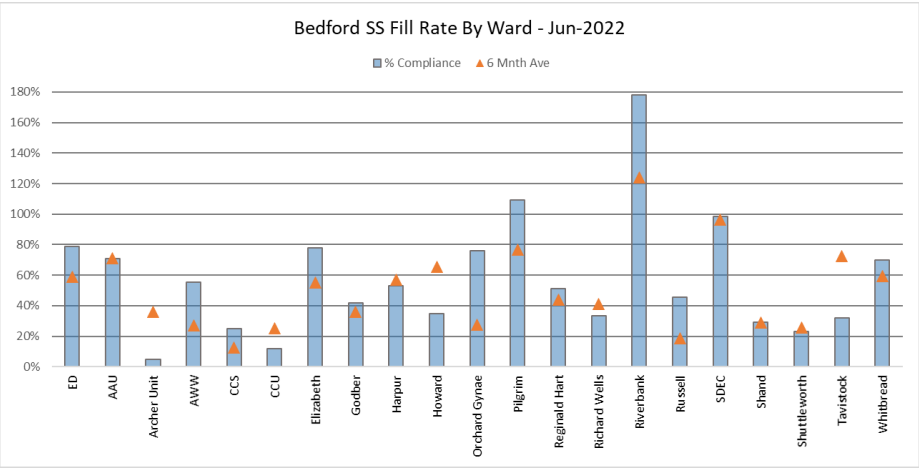
The Psychiatric Liaison Service (PLS) from ELFT, the local Mental Health Care provider, assesses these patients and develops a management / care plan, which may include a recommendation that the patient is cared for by a Registered Mental Health Nurse (RMN).

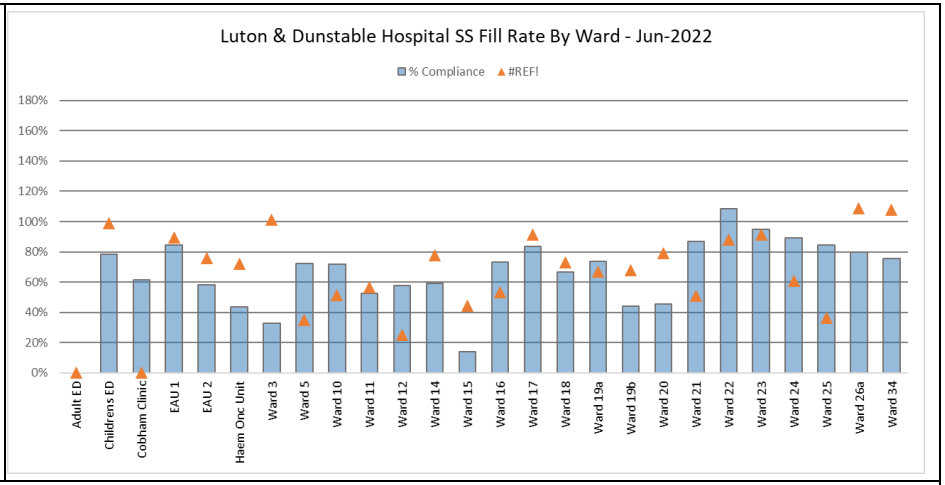
RMN hours filled and unfilled is the traditional metric shown above, however below the same data is presented using the CHPPD methodology, this shows that taking the difference in beds in to account the uses of RMN's at Luton is significantly higher than at Bedford.

Ward 25 at Luton remains a significant concern, they account for 35% of the total RMN demand at Luton in June.

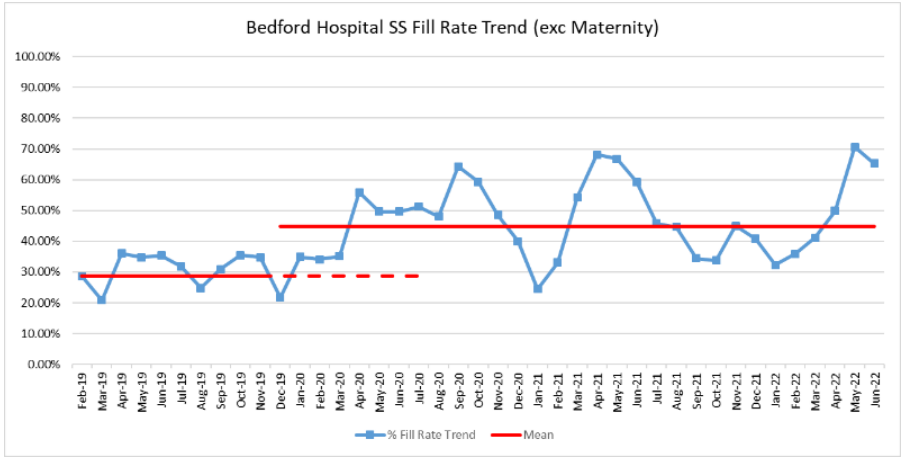


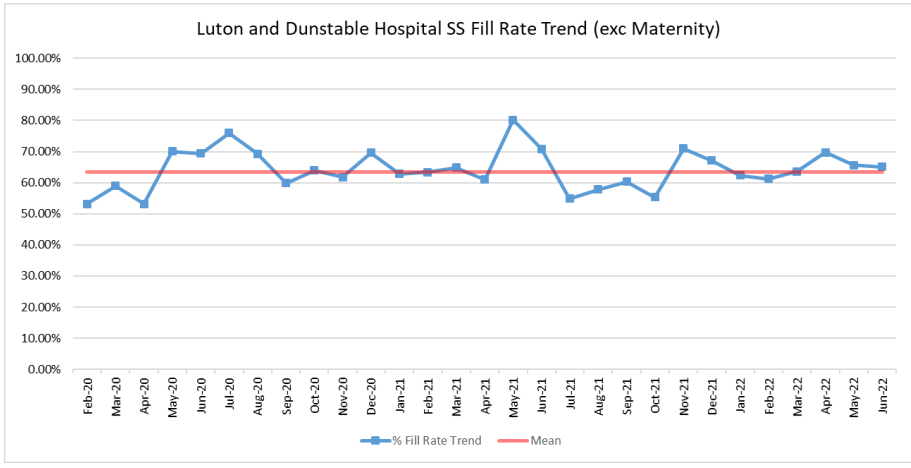
Supervisory Cover



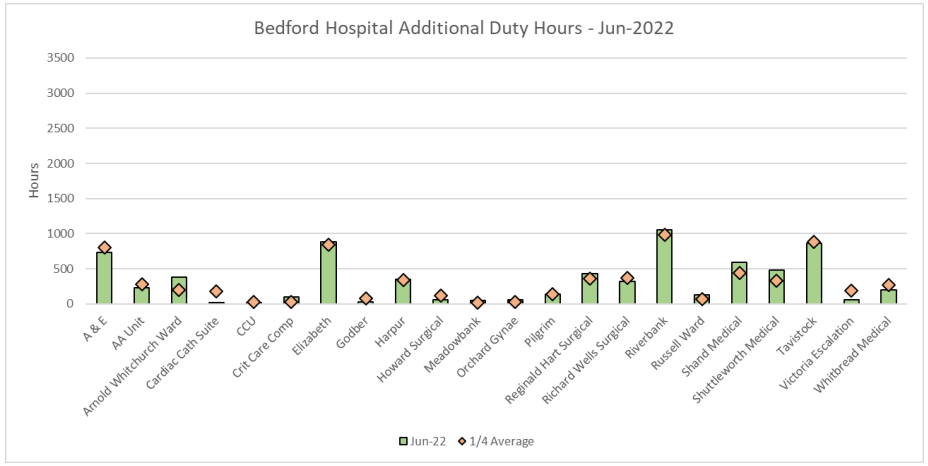


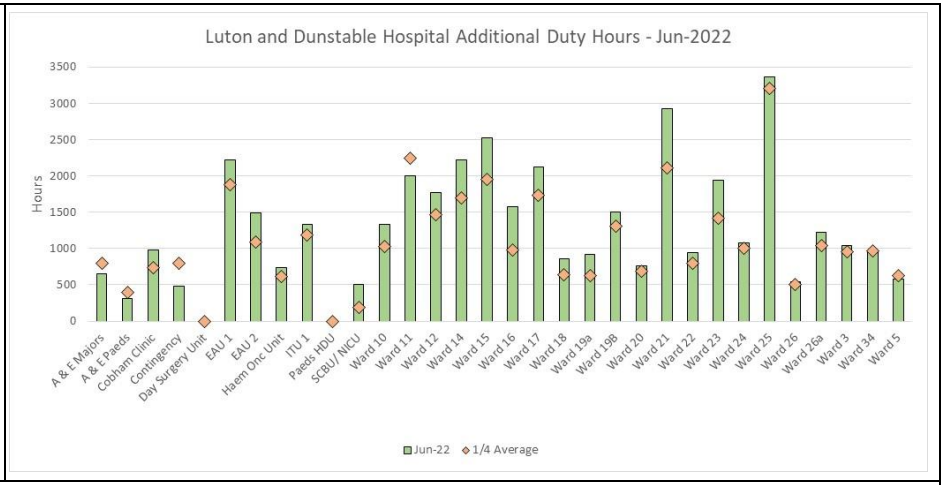
The Francis report recommended that ward managers should be rostered for 100% supervisory time (SS). The overall SS rate on both sites improved in June compared to previous months, it has exceeded mean on both sites but remains below target. This is because of ward managers filling roster gaps on the wards to maintain safety.





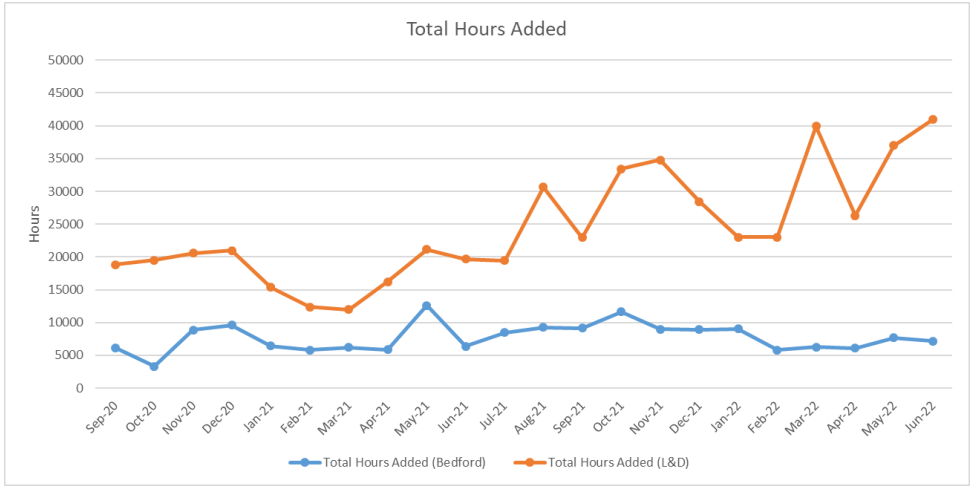
Additional Shift Use



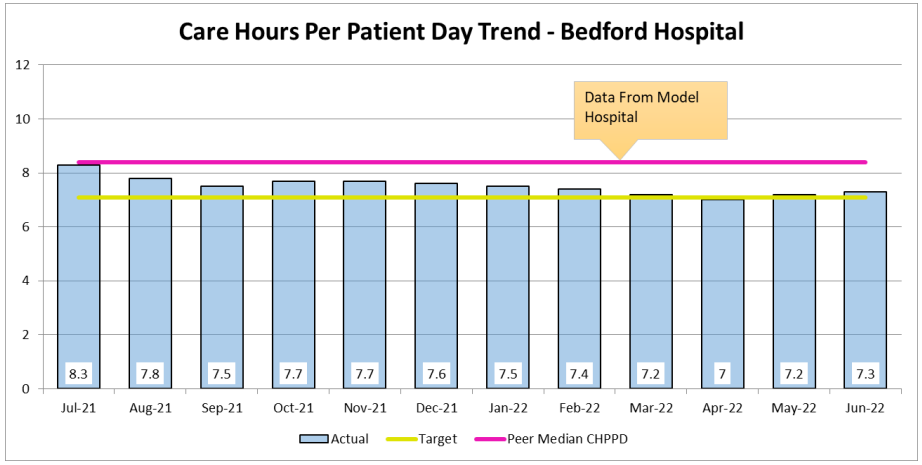


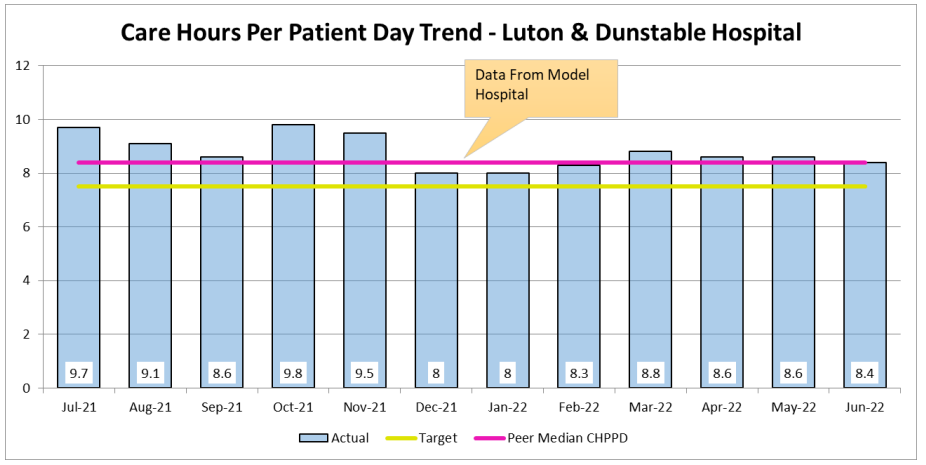
Additional duty hours demand at Bedford remains in line with or below the quarter ¼ average for all wards.

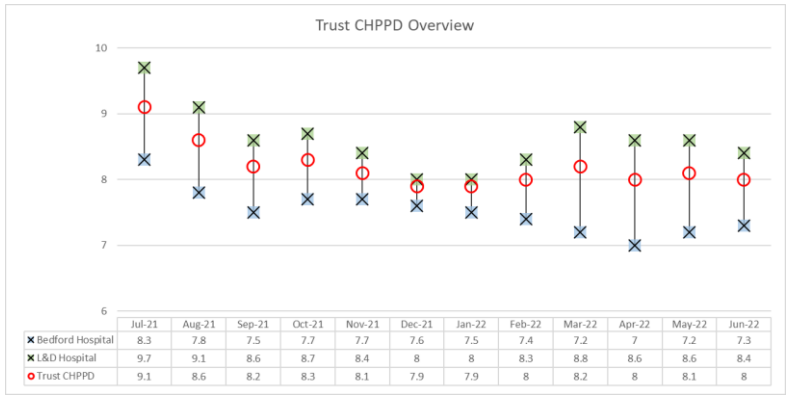
At Luton the number of hours used continues to fluctuate.



CHPPD Rate







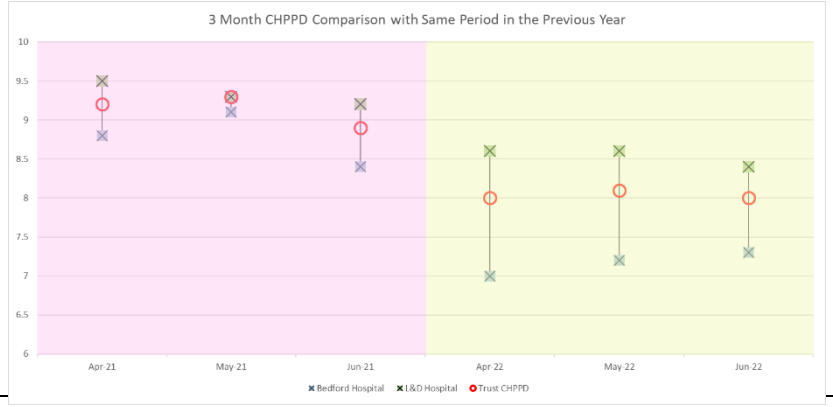
	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Bedford Hospital	8.3	7.8	7.5	7.7	7.7	7.6	7.5	7.4	7.2	7	7.2	7.3
L&D Hospital	9.7	9.1	8.6	8.7	8.4	8	8	8.3	8.8	8.6	8.6	8.4
Trust CHPPD	9.1	8.6	8.2	8.3	8.1	7.9	7.9	8	8.2	8	8.1	8

Care Hours Per Patient Day (CHPPD) is a metric promoted for use as a standardised measure of effective and safe staffing, by taking into account the number of actual hours worked in direct patient care shifts divided by the number of patients in hospital beds at midnight each day. As with all workforce analysis techniques, CHPPD is one of a number of measures that produce an overall picture rather than being used in isolation.

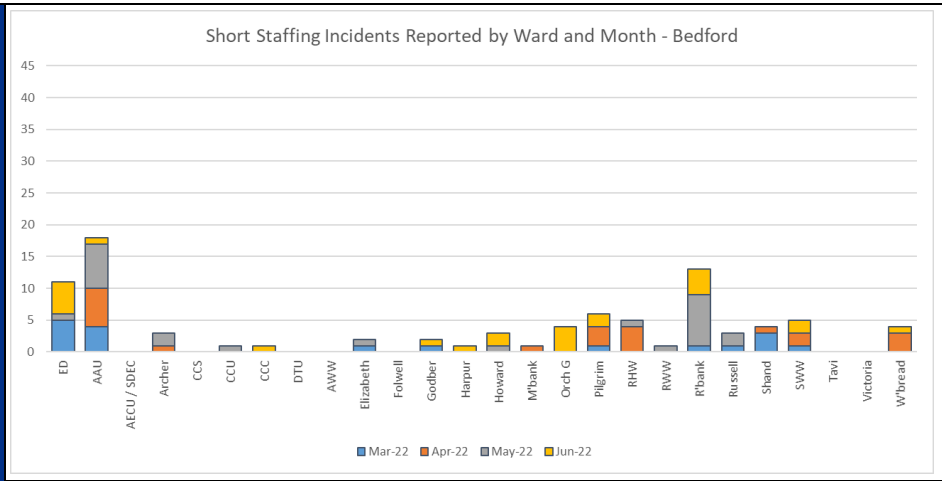
The last 10 months have seen the CHPPD on both sites fall and when comparing the last three months with the same three months last year the difference is significant, particularly at Bedford (shown to the right).

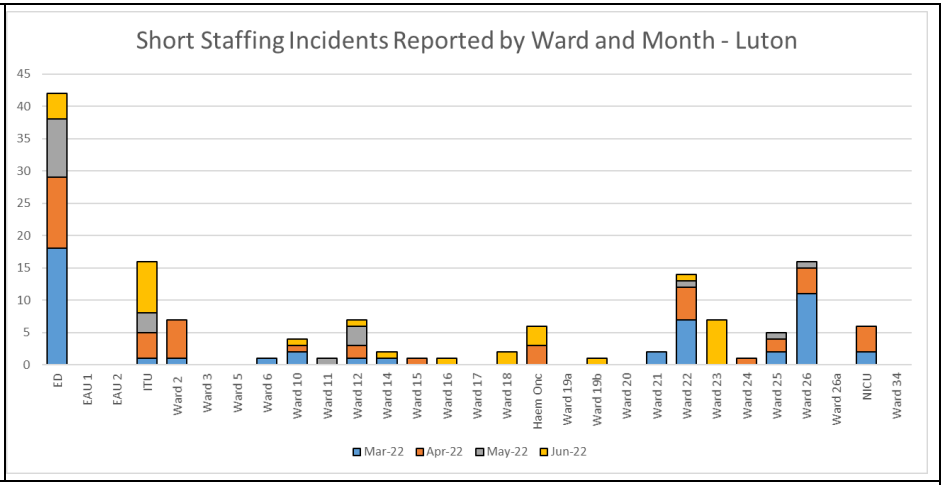
This is as a combined result of increased bed occupancy with reduced fill rates.

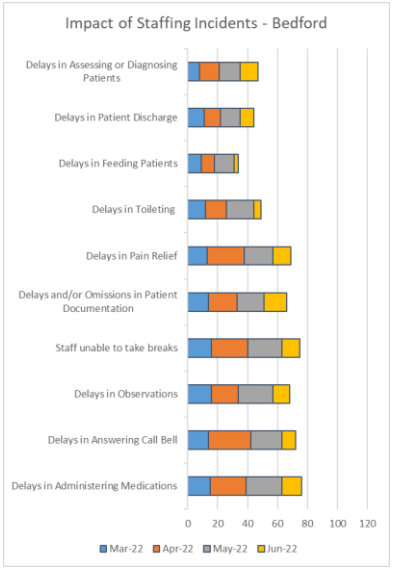
For June the overall trust CHPPD was 8.0.



Staffing Incident Reports - Nursing

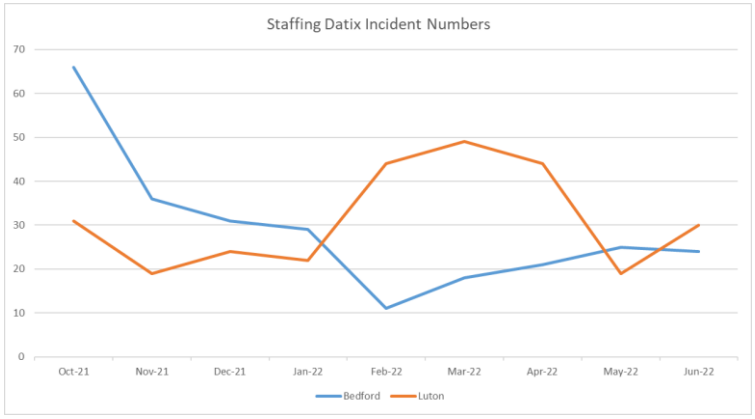


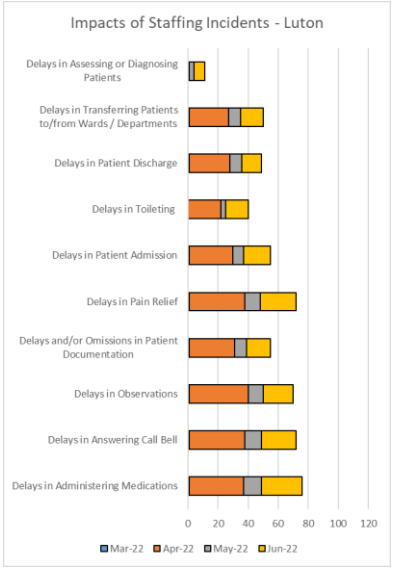




Incident reports related to staffing rebounded slightly at Luton and reduced slightly at Bedford, however it is felt that there is an element of under reporting on both sites, as the number of incidents does not correlate with the fill rate and operational feedback.

In addition to this, the number of impacts recorded related to short staffing also increased significantly at Luton.





Appendix 1b

Midwifery Workforce Report

INTRODUCTION

The requirement to ensure midwifery and support staffing levels are safe and sufficient to meet the needs of women, babies and families is clearly an imperative in the provision of a safe maternity service that meets the needs of women and their families. National Quality Board (NQB) standards require the Trust Board to be appraised of the safety and effectiveness of midwifery staffing.

PURPOSE

The purpose of this paper is to present the Quality Committee with an overview of midwifery staffing capacity for the month of June 2022. The contents of the report also ensure that the required standards for meeting compliance for year 4 of the Maternity Incentive Scheme are evidenced throughout the year.

MIDWIFERY STAFFING ASSESSMENT- EXTERNAL ASSESSMENT BY BIRTHRATE PLUS TEAM

In line with national recommendations, the Trust has a systematic process in place to set midwifery staffing establishments. This process utilises Birth-rate Plus© as the nationally recognised tool for assessing the needs of women for midwifery care throughout pregnancy, labour and the postnatal period in both hospital and community settings. From that data, it is possible to calculate the required numbers of midwives to meet all of those needs in relation to defined standards and models of care and to local workforce planning needs.

The Birth-rate Plus© review has been completed and the report has been received by the Trust. The generic casemix at both sites has increased since the previous assessments. At LDH 69.7% of women are in the 2 higher categories which is significantly higher than the 58% average for England. The generic casemix at BH is also above average at 60.7%.
There is a correlation between casemix maternity outcomes especially in relation to induction rates, delivery method, post-delivery problems and obstetric and medical complexity.

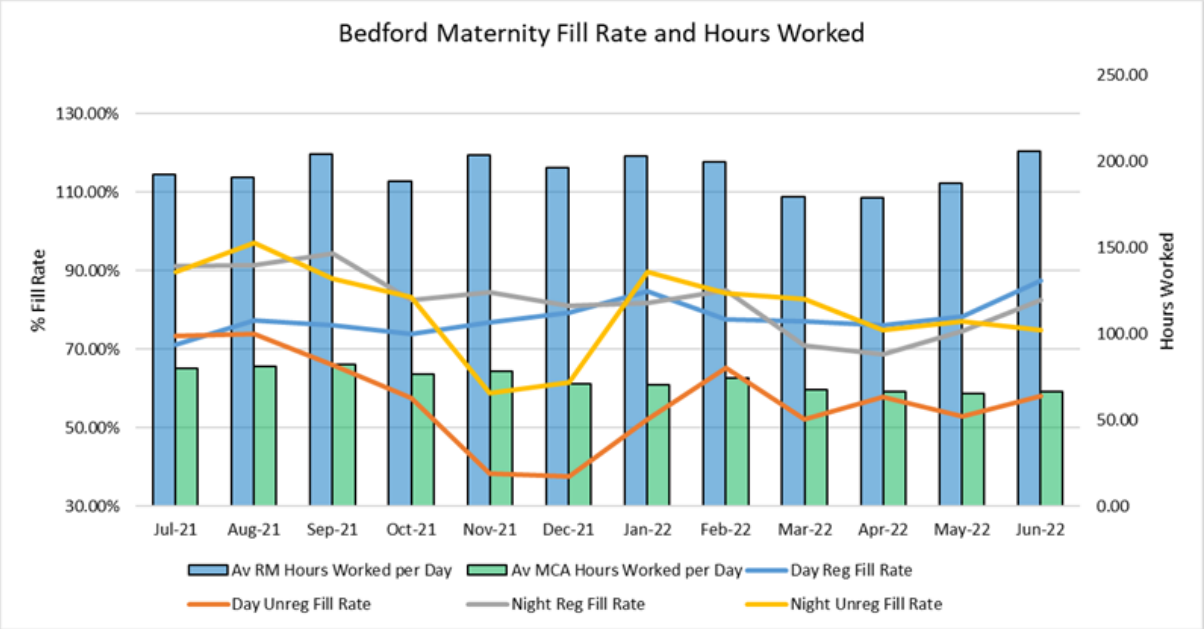
The overall birth to midwife ratios has changed to 21 births to 1 wte for LDH (1:21) and 22.8 births to 1 wte at BH (1:22.8), this is a reflection in the change in casemix on both sites. (The ratio is calculated by dividing total births by the total clinical midwives).

Following ESR and Budget alignments including the Ockenden funding, the department are reviewing the funded establishment against BR pus recommendations and the requirements for Midwifery Continuity of Care programmes to present to executive chief nurse and Trust Board.
A business case is being developed is for the additional WTE variance from current funded position.

ACTUAL AND PLANNED STAFFING REPORT FOR JUNE 2022

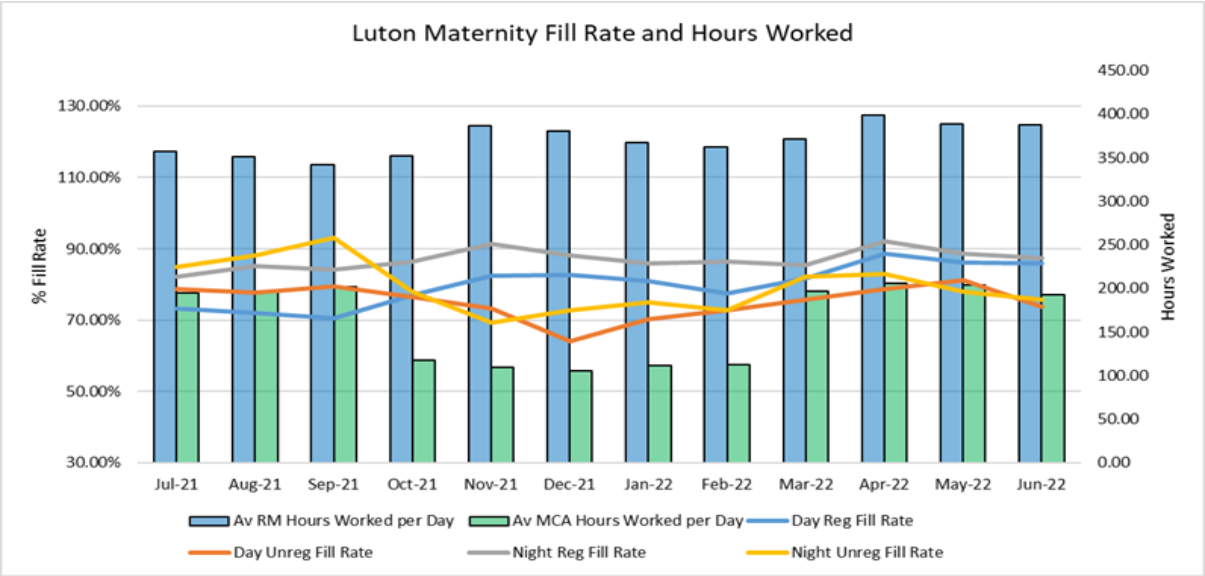
The following section gives an overview of the planned versus actual coverage in hours for each site as a trend of fill rate.

Midwifery staffing and Maternity support staff fill rates per month for each site are shown below this is based on the Unify fill rate report for the Delivery Suite and Maternity inpatient wards. The community are not included in UNIFY submissions as these are for inpatient care areas.



Bedford Maternity Fill Rate and Hours Worked	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Day Reg Fill Rate	71.17%	77.42%	76.24%	73.89%	76.75%	79.39%	84.79%	77.50%	77.15%	76.11%	78.42%	87.45%
Day Unreg Fill Rate	73.44%	73.84%	65.91%	57.65%	38.36%	37.65%	52.10%	65.32%	52.15%	57.78%	53.00%	58.00%
Night Reg Fill Rate	91.08%	91.45%	94.41%	82.66%	84.51%	81.07%	81.85%	84.95%	70.87%	68.73%	74.73%	82.63%
Night Unreg Fill Rate	89.81%	97.08%	88.07%	83.31%	58.78%	61.54%	89.80%	84.19%	82.90%	74.92%	77.20%	74.92%
Av RM Hours Worked per Day	192.08	190.20	203.97	188.05	203.35	196.18	202.66	199.39	179.31	178.57	187.02	205.53
Av MCA Hours Worked per Day	80.00	81.19	82.37	76.29	78.10	71.03	70.47	74.07	67.48	66.37	65.07	66.47

The night RM fill rate on the Bedford site increased further again during the month of June to 82.63% (second highest level this year) the day fill rate for RM also saw an increase by almost 10% to 87.45%. The Support worker day fill rate increased to 58.00% yet the night rate decreased slightly to 74.92%. Monthly staffing sickness meetings with HR remain in place as planned to resolve challenges faced from long term COVID sickness for staff unable to work in clinical roles. Staffing continues to be supported by specialists and the senior midwifery management team

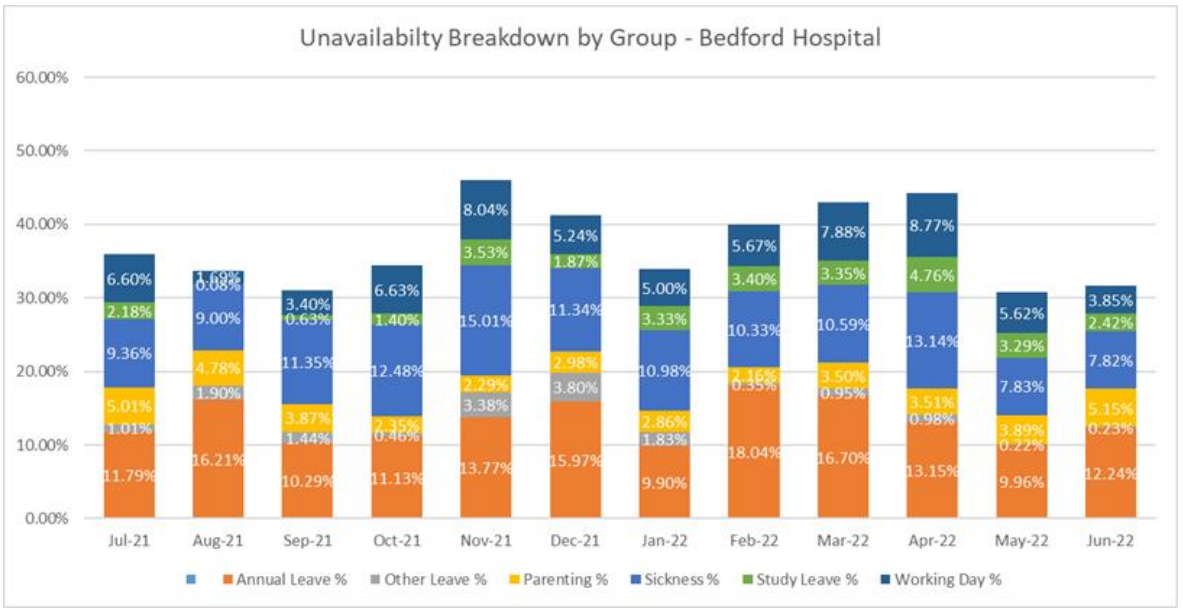


Luton Maternity Fill Rate and Hours Worked	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Day Reg Fill Rate	73.20%	72.00%	70.58%	77.11%	82.57%	82.71%	80.89%	77.52%	81.70%	88.63%	86.28%	85.82%
Day Unreg Fill Rate	78.72%	77.74%	79.50%	76.50%	73.28%	64.07%	70.30%	72.75%	75.76%	78.76%	81.22%	73.82%
Night Reg Fill Rate	82.30%	85.28%	84.18%	86.36%	91.28%	88.09%	85.83%	86.49%	85.32%	92.07%	88.71%	87.37%
Night Unreg Fill Rate	84.82%	88.11%	93.08%	78.05%	69.38%	72.82%	74.89%	72.84%	82.12%	82.93%	78.00%	75.86%
Av RM Hours Worked per Day	356.92	351.09	342.31	351.88	386.24	380.30	367.11	361.88	371.05	398.49	389.03	387.34
Av MCA Hours Worked per Day	195.28	195.48	202.28	117.39	109.99	105.85	111.40	112.25	197.24	206.20	203.99	192.27

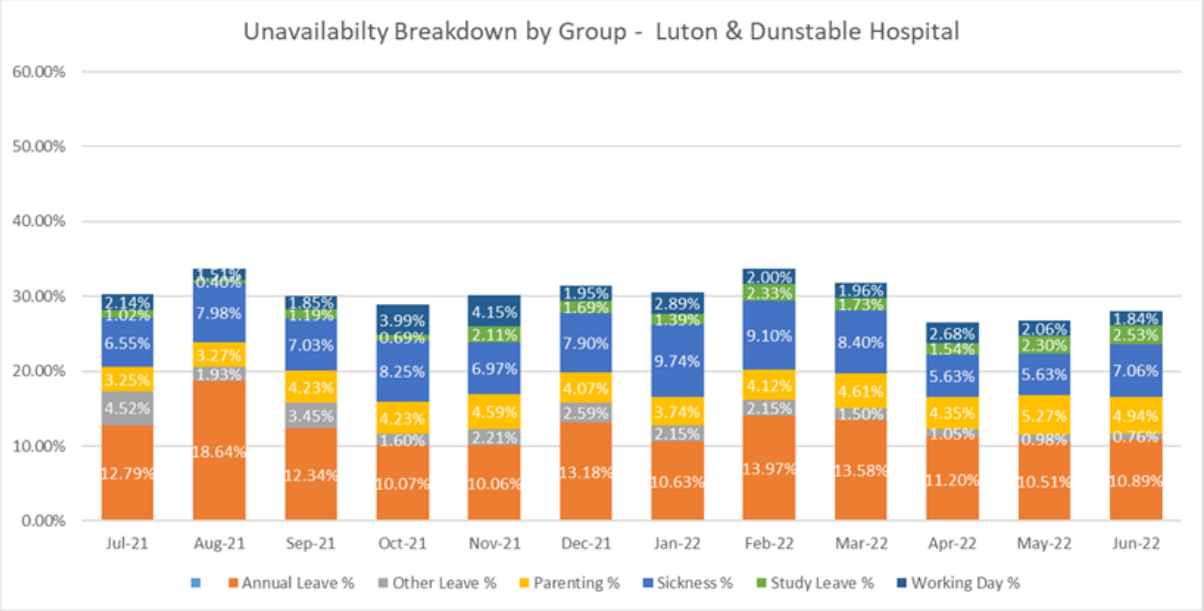
On the Luton site, there was a slight decrease in both the day and the night fill rates for both registered and unregistered staff from May 2022 to June 2022. For registered staff there was a decrease in fill rates, for the day fill rate, from 86.28% to 85.82%, and the night fill rate from 88.71% to 87.37%. The fill rates for unregistered staff decreased from 81.22% to 73.82% for the day shift, and 78% to 75.86% for the night.

UNAVAILABILITY - Vacancy, sickness, maternity leave, Covid related absence

Luton Site Vacancy RM 62.51 WTE 26.2%
Bedford Site Vacancy RM 34.87 WTE 30%
(RM establishment includes all RM band 5- 8C in clinical and specialist/ managerial roles)
This vacancy does not reflect the international/ return to practice midwives who are currently undertaking the preparation programme for OSCE.

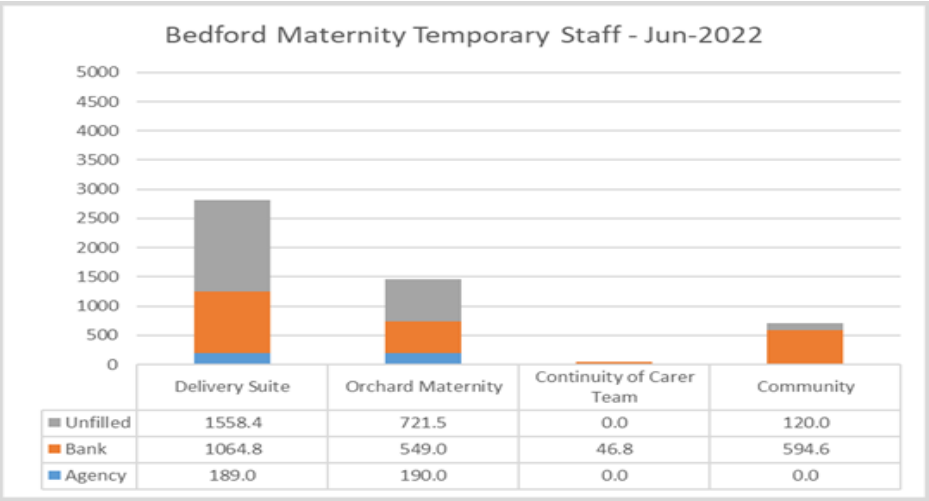


On the Bedford site, sickness has reduced to 7.82%. Annual leave allocation was within parameters at 12.24%. The number of staff working in non-clinical roles 'working days' has reduced to be better reflected within rostering.



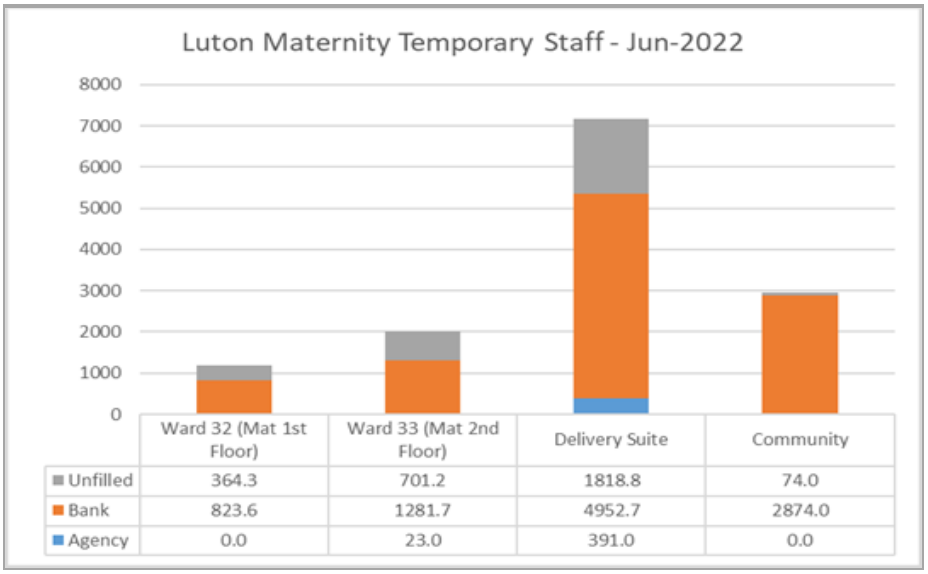
On the Luton site, sickness levels have shown a slight increase from 5.63% in May 2022 to 7.06% in June 2022. This is a new increase following a couple of months of a downward trend. The Head of Midwifery continues to work with the Occupational Health team to identify strategies to support staff in work, and support timely occupational health reviews for the staff that are currently off sick. Work continues between the midwifery management team, HR partners and Occupational Health to meet with staff and put supportive plans in place to facilitate timely return to work or to stay at work. Where possible staff on long term sick are supported to return to work on phased return using clinical and non-clinical duties. There is ongoing work with the midwifery managers and rota coordinators to ensure appropriate annual leave allocation in line with guidance.

TEMPORARY STAFFING HOURS FOR JUNE 2022



	Delivery Suite	Orchard Maternity	Continuity of Carer Team	Community
Unfilled	1558.4	721.5	0.0	120.0
Bank	1064.8	549.0	46.8	594.6
Agency	189.0	190.0	0.0	0.0

On the Bedford site, there remains a number of unfilled hours within the unit, which continues to be supported by midwifery specialists and the senior midwifery team working clinically. The main area of need remains to be Delivery Suite. This requirement though is improving and wherever possible specialists are returned to their roles if not required clinically and acuity is covered.



On the LDH site, the service has continued to rely on Bank to support staffing in the service with some shifts on Delivery suite being filled by agency midwives. The area with the highest use of temporary staff in June 2022 was Delivery suite.

BIRTHRATE PLUS RATIO

Site	No. of Births for June	BR ratio Actual for month	Actual clinical WTE	BR ratio Funded	BR recommended 2022
Bedford	227	1:28.7	78.43	1:23.8	1:22.8
Luton & Dunstable	436	1:31.6	165.76	1:25	1:21.1

(Actual clinical WTE includes RM, clinical time for specialist RM, RN,NN and Band 3 MSW)

BIRTHRATE PLUS ACUITY TOOL

The Birthrate Plus Acuity Tool supports the ‘’real time’’ assessment of workload in the Delivery Suite, Midwifery Led Birth Unit and Inpatient areas, arising from the numbers of women needing care and their condition on admission and during the process of labour and birth. Four Hourly assessments are produced demonstrating the numbers of midwives needed to meet the needs of women, based on the minimum standard of 1:1 care for all patients in labour and increased ratios of midwifery time for women in the higher need categories. The acuity system also provides a measure of classifying other women admitted to the Delivery Suite who do not give birth at the time, allocating ratios of midwifery time required.

The Ward Acuity Tool provides a prospective assessment of staffing in relation to workload and collates the data entered to produce summaries to show trends and actions taken.

LUTON AND DUNSTABLE HOSPITAL SITE ACTUITY ANALYSIS

On Delivery Suite and Triage, staffing levels met acuity 13% of the time. For 36% of the time the service was up to 3 midwives short of the number of midwives to meet the acuity of women, and 3 or more midwives short for 51% of the time. The number of midwives not consistently meeting the acuity of the women was partly due to a high number of women seen in categories III-V (Higher care needs), resulting in an increase in the requirement of midwifery time.

Staffing factors such as midwife absence due to sickness, vacancy and midwives being redeployed to other areas (Antenatal/Postnatal Ward) all affected the ability of the service to meet the patient acuity in line with the staffing levels set. The recently completed Birth-rate Plus review demonstrated the increased need for midwives on the delivery suite due to the increased number of complex women coming through the service. The acuity as demonstrated by the midwife to birth ratio has increased with the birth-rate plus recommendation being 1:21.1 against the current ratio in practise of 1:31.6.

The Team implemented measures to support staffing during periods of high escalation with Specialist midwives and Midwifery Managers working clinically, so that women were able to receive care in line with their clinical needs.

On ward 32, a high number of care hours (47%) related to safeguarding issues, and 21% of women had exceptional care needs. On ward 33, extra care hours for babies were high, (57%), compared to care hours for other episodes of care. On Ward 32 and Ward 33, there is ongoing work to improve the compliance with completing the Birthrate Plus acuity tool. The clinical midwifery manager is working with the teams to improve compliance with the recording of extra care data and exceptional care data.

The Unit went on divert on one occasion in June 2022 due to midwifery staffing and NICU unit closure:

Date	Reason for divert	No of women transferred out	Units transferred to
10/06/22	Midwifery Staffing and NICU closure	0	No Units able to help

BEDFORD SITE ACUITY ANALYSIS

On Delivery Suite, the acuity was met for 69% of the time in June 2022. Specialist Midwives are supporting across the rotas; Matrons hours are being worked flexibly to support the service, particularly for the Delivery Suite Coordinator role, due to sickness in this team. Long line agency is currently being used and recruitment to bank only working is ongoing. Both the Deputy Head of Midwifery and Head of Midwifery are working clinically at times of escalation to support the unit.

The Unit went onto divert on 4 occasions during the month:

Date	Reason for divert	No of women transferred out	Units transferred to
03.06.22	Midwifery Staffing	0	n/a
13.06.22	Midwifery Staffing	0	n/a
24.06.22	Midwifery Staffing	0	n/a
27.06.22	Midwifery Staffing	2	1 – Milton Keynes, 1 Cambridge

On Orchard Ward the extra care hours for babies remains high as in previous reports, with 82% of care being due to extra care for babies during June. The HoM is working with the Neonatal team on a pilot for staffing model changes for transitional care (TC) the definitions of TC criteria are also being reviewed.

INUTERO TRANSFERS

Site	Inutero Transfers Refused	Inutero Transfers Accepted	Transfers out
Luton	13 Refusals 3 due to Capacity 3 due to Staffing 1 due to Staffing and Workload 6 due to Capacity and Staffing	0	1 Transferred out to Lister due to NICU Closure
Bedford	0	0	3

ONE TO ONE CARE IN LABOUR

The Trust aims to ensure that women in established labour receive 1:1 care. One to One care in labour was achieved 97.2% of the time at BH and 97.2% of the time at LDH. 77 Red flags were raised at the LDH and 78 at B

For Bedford Hospital site, 97.2% of women received 1:1 care in June 2022. 177 women were identified as suitable on CMIS and 172 were recorded as achieved. There were 5 women identified on CMIS (Maternity System) who did not receive 1:1 Care in labour for the following reasons:

- 1 woman was fully dilated before 1:1 care assigned
- 3 women didn't have 1:1 care for whole intrapartum period due to staffing constraints
- 1 woman transferred from out of area, not known to be in established labour

On the Luton and Dunstable site, 1:1 care in labour compliance was 97.2% in June 2022. The total eligible for 1:1 care in labour was 355 women. There were 19 women identified on CMIS (Maternity System) who did not receive 1:1 Care in labour for the following reasons;

- 4 women gave birth before arrival to the Maternity Unit (BBA)
- 1 woman free birthed
- 2 women did not labour
- 2 woman gave birth in a midwifery setting
- 2 women gave birth on Ward 32
- 8 women didn't have care due to staffing constraints

Therefore, 10 women were included in the data used to calculate the ratio, as they were in the inpatients (Triage/ ward 32/ Delivery suite/ MLBU) and should have received 1:1 care in labour, but did not receive it. All the women had a midwife in attendance when they gave birth

1:1 Care	Goal	Red Flag	Jul 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022
Luton	100%	<95%	98%	96.7%	94.8%	98.3%	99.1%	99.6%	98.6%	99.3%	99.7%	98.0%	99.5%	97.2%
Bedford	100%	<95%	99.6%	100%	98.9%	98.9%	100%	100%	99.4%	99.3%	100%	100%	100%	97.2%

SUPERNUMERARY STATUS OF LABOUR WARD COORDINATOR

The midwife in charge of the Labour ward should not have a caseload of their own during the shift, to ensure there is an oversight and leadership of the activity within the service. Safety action 5 of year 4 of the Maternity Safety Incentive Scheme recommends that

'The Trust can report compliance with this standard is this is a one off event and the coordinator is not required to provide 1:1 care for a woman in established labour during this time'

		July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	April 2022	May 2022	June 2022
Luton	**%Shifts LWC supernumerary**	87.6%	91.4%	86.6%	83.9%	93.9%	93%	94.6%	95.8%	95.2%	93.3%	95.7%	90.6%
	Number of shifts not supernumerary	23	16	24	30	11	13	10	7	9	12	8	17
Bedford	**% Shifts LWC supernumerary**	86.6%	86.6%	76.1%	81.7%	90%	85.5%	86.5%	91.6%	73.6%	76.1%	76.9%	71.1%
	Number of shifts not supernumerary	25	25	43	34	18	27	25	14	49	43	43	52

For the month of June, on the LDH site, Supernumerary Status Band 7 dropped to 90.6% compared to 95.7% in May. There was appropriate escalation each time the Band 7 lost supernumerary status to support the Band 7 returning to supernumerary status as soon as possible. Not all schedule assessment were completed, and the midwifery manager working with the team to improve compliance with data entry

The coordinating Band 7 did not provide 1:1 care for women in established labour during the time

.

On the BH site, Supernumerary status of the Band 7 dropped from 76.9% in May 2022 to 71.1% in June 2022. Not all scheduled assessments were noted to have been recorded in June, the on call managers continue to support to help the coordinators to improve compliance with completing the Birthrate Plus Acuity Tool.

At present on the BH site the Labour Ward Coordinator (LWC) is recording a loss of SN status when providing any care activity on the unit (not necessarily when providing 1:1 care in labour). The Head of Midwifery has reviewed all sit rep reporting for the month of June. There was no care provided from LWC that was 1:1 care in labour. The sit rep is under review for ease of review for this process also.

We continue to work towards having 2 B7 on each shift for Labour ward, so there is always an additional senior midwife available should the LWC be required to support any women in established labour.

Where necessary the senior midwifery team continue to provide support to cover the Band 7 role. The current vacancy has reduced from 4.08 wte to 3.44 wte Band 7 LWC, and we have made further appointments in June/July.

RED FLAGS

A staffing red flag event is a warning sign to alert that nursing or midwifery staffing is not meeting the acuity and activity at that time. If a staffing red flag event occurs, the registered midwife in charge of the service should be notified and necessary action taken to resolve the situation. Red flags are now generated through the Birthrate Plus Acuity App.

In June 2022, 77 Red flags were raised at the Luton and Dunstable site and 78 were raised on the Bedford Hospital site.

There is some correlation in the themes of the Red flags on both sites and many of these relate to the impact that staffing levels have on the ability to either commence or continue with the process of induction of labour. We know that this has an impact on the woman's experience, not only due to understandable feelings of frustration and uncertainty during this time but also as this often prolongs the period of time spent in hospital. It can also impact on the eventual mode of delivery with women, at times, deciding to choose an elective caesarean section rather than pursuing the induction process. Red Flags table overleaf.

LUTON & DUNSTABLE SITE RED FLAGS JUNE 2022			
RF	**Definition of Red Flag**	**Number**	**Comment**
1	Delayed or cancelled time critical activity.	25	Delays in transfers of on-going inductions of labour and women presenting in early labour from Triage to Delivery Suite due to capacity and/ or staffing on delivery suite. There is on-going review of women awaiting transfer to delivery suite to continue with induction of labour Individualised monitoring plans with daily obstetric reviews for women while awaiting transfer to delivery suite Neighbouring Units contacted to facilitate transfer of women if they are able to accept. The experience of the service was that neighbouring Units were often unable to help due to being in escalation themselves
2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	.
3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	
4	Delay in providing pain relief due to midwifery staffing	0	
5	Delay between presentation and triage	2	Ongoing work to increase the number of midwives on Triage to 3 per shift
6	Full examination not carried out when presenting in labour	0	
7	Delay between admission for induction and the beginning of the process	8	Women admitted onto Triage Ward to have their induction of labour. Delays in commencing IOL are at times when there is high activity on the Triage ward. Women had timely fetal monitoring completed while awaiting to commence their induction
8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	
9	Occasions when 1 midwife is no able to provide continuous one-to-one care and support to a woman during established labour	25	Midwives were not able to provide continuous 1:1 care in labour, and this was escalated appropriately. On reviewing the CMIS system, 10 women did not have 1:1 care in labour for the duration of their labour. All women who gave birth in the Maternity Unit had a midwife in attendance at the time of the birth
10	Occasions when the Coordinator was not able to maintain supernumerary / supervisory status	17	Escalation processes implemented to support the coordinating Band 7 to return to supernumerary status as soon as possible, including the Manager on call attending on site if required out of hours. Coordinating Band 7 Midwife did not provide 1:1 care in labour during this time

BEDFORD HOSPITAL SITE RED FLAGS JUNE 2022			
RF	**Definition of Red Flag**	**Number**	**Comment**
1	Delayed or cancelled time critical activity.	3	We are working on our IOL process with a working party group in set up. Also currently reviewing our midwife provision for CS availability and creation of dedicated post under consideration. Individualised monitoring plans in place with daily obstetric reviews for women while awaiting transfer to delivery suite. Neighbouring Units were also contacted to facilitate transfer of women if they are able to accept.
2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	
3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	
4	Delay in providing pain relief due to midwifery staffing	0	
5	Delay between presentation and triage	5	Appropriate escalation to try and redeploy staff and facilitate timely reviews as best as able to
6	Full examination not carried out when presenting in labour	0	
7	Delay between admission for induction and the beginning of the process	14	Unable to commence IOL due to staffing levels, individualised care plans developed with obstetric team
8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	
9	Occasions when 1 midwife is no able to provide continuous one-to-one care and support to a woman during established labour	4	
10	Occasions when the Coordinator was not able to maintain supernumerary / supervisory status	52	Escalation processes implemented to support the coordinating Band 7 to return to supernumerary status as soon as possible, including the Manager on call attending on site if required out of hours.

WORKFORCE AND RECRUITMENT

. In Start date	Candidates - Arrival dates	L&D	Bedford
31/01/2022	0	0	0
28/02/2022	3	1	2
28/03/2022	5	3	2
25/04/2022	5	2	3
30/05/2022	6	3	3
27/06/2022	3	1	2
		10	**12**

Our cohort of international midwives pipeline continues as planned. We now have 12 RMs at Bedford 10 RMs at Luton, with a further 19 expected to arrive between now and October.

Two dedicated posts for a 12-month period have been created from external funding and recruited into, for supporting the on boarding of the internationally recruited midwives, across both sites. The maternity team are working jointly with recruitment and the nursing team to best develop the recruitment programme as well as working with current international midwives across both sites to best shape the programme moving forward and optimise retention.

Luton and Dunstable Hospital Site

- Matron for community and antenatal clinic appointed and due to start with the Trust on 5th September 2022
- Matron for inpatients (Wards and DAU) appointed, and is due to commence in post on 22nd August 2022.
- 10 wte Maternity care assistants offered jobs at the recruitment event on 28th May 2022, and are currently going through the recruitment process.
- 23 student midwives offered jobs (Cross-site) on the Recruitment events on the 4th June 2022 and 11th June 2022.

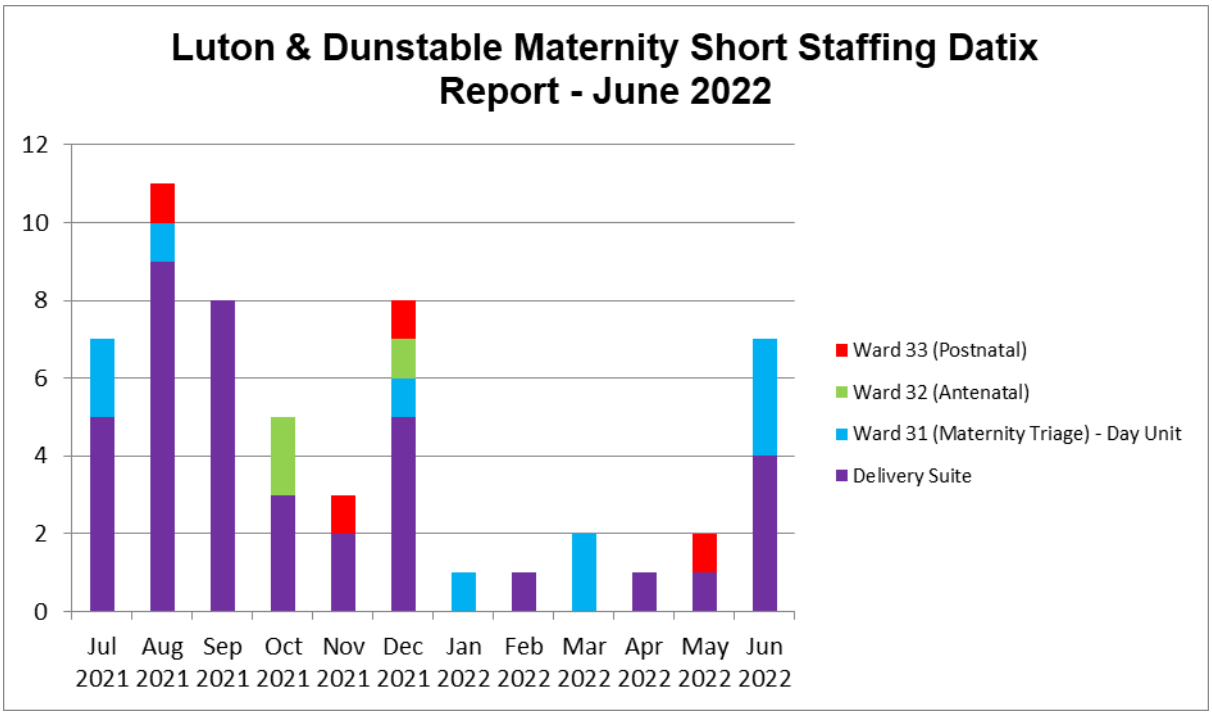
Bedford Hospital Site

- A Return to Practice (RtP) completed her programme and is now in numbers an additional RTP is now in progress.
- 1x B7 Delivery Suite Coordinators started in June, another appointed in July
- Lead PMA post on the Bedford site has been appointed with September start
- Legacy Midwife on the Bedford site has been appointed with autumn start pending banding review.
- As mentioned above we have 12 RMs (internationals) 1 has their PIN, 3 passed their OSCE, 2 have their OSCEs booked for July, 1 in Aug, a further 2 for Sept and 3 to be scheduled.

INCIDENT REPORTING RELATING TO STAFFING

The trend in incident reports completed in relation to midwifery staffing is shown in the tables below. There were 7 incident reports relating to midwifery staffing for the month of June 2022 on the Luton and Dunstable Site. This is an increase in the number of incidents being reported and covers all areas within the service and reflective of the slight increase in activity compared to the previous month.

LUTON AND DUNSTABLE SITE INCIDENT REPORTING



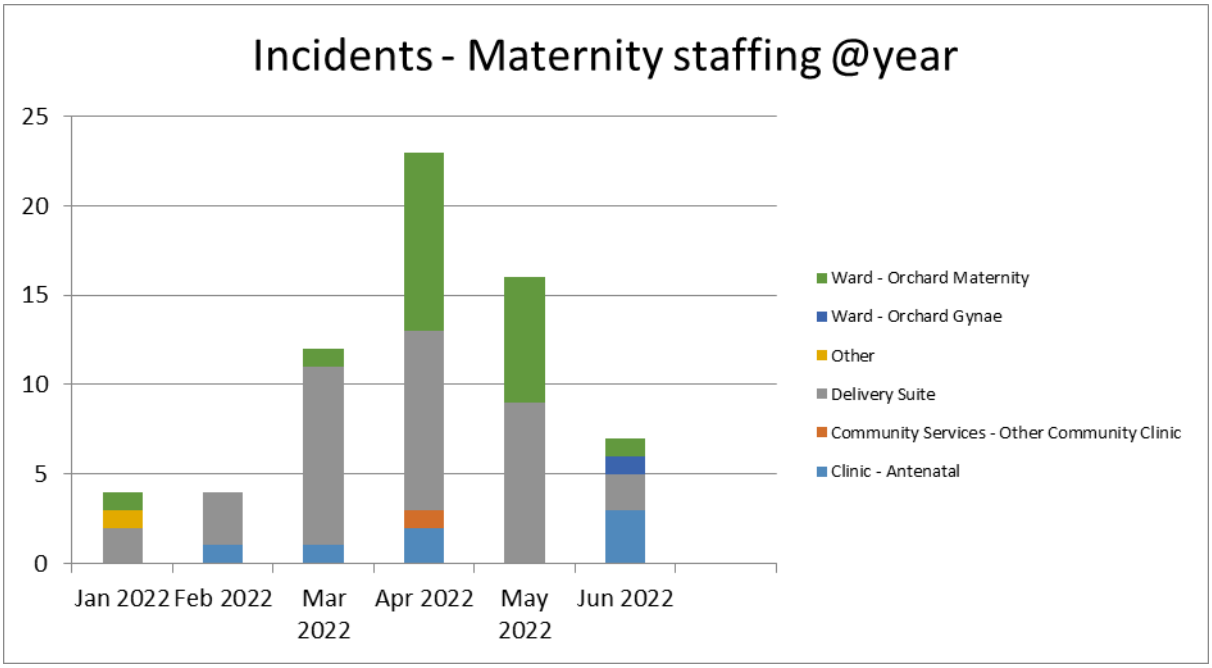
The seven staffing Datix's related to staffing on the Delivery Suite and Ward 31. The head of midwifery is working with the clinical midwifery manager for delivery suite to support the allocation of three midwives per shift on Triage, to support with staffing in this area.

Safety is monitored through the daily staffing meetings, through the weekly Local incident review panels, which are attended by the Midwifery Managers and/or Director of Midwifery.

Datix reporting around staffing has oversight from the site Head of Midwifery and all Datix's raised are reviewed to ensure appropriate escalations are in place and no harm or near misses are identified as a result.

BEDFORD SITE INCIDENT REPORTING

The 7 staffing related incidents reported for the month of June '22 at Bedford were a decrease on previous reporting's. 2 related to Delivery Suite, 1 on Orchard ward, 1 related to Orchard Gynaecology. There were no staffing incidents reported for community but 3 for Antenatal clinic, the highest noted for the year. The loss of supernumerary status of the Delivery Suite Coordinator was again the top reported red flag as noted above.



RECOMMEDATIONS

The Quality Committee is asked to note:

- The night fill rate in June for registered staff at BH for the night shift increased to 82.63%. The fill rates for unregistered staff also showed a slight reduction in night but increased for day.
- There was a slight decrease in fill rates for registered and unregistered staff, for both the day and night shifts at LDH in June 2022.
- The Luton Site Vacancy RM is 62.51 WTE (26.8%) and the Bedford Site Vacancy RM 34.87 WTE (30%).
- The Maternity service at LDH has been on divert on one occasion. The maternity services at BH have been diverted on 4 occasions in June.
- The supernumerary status of the Labour ward coordinator has decreased at BH from 76.9% in May to 71.1% in June and LDH had a decrease from 95.7% in May to 90.6% in June 2022 and the trust met compliance for Safety Action 5 in month.
- One to One care in labour was achieved 97.2% of the time at BH and 97.2% of the time at LDH. 77 Red flags were raised at the LDH and 78 at BH

Emma Hardwick
Director of Midwifery
20th July 2022

GLOSSARY OF DEFINITIONS

Supernumerary status - *"When she/he is not available to provide this help & support to staff caring for women, e.g. she/he is caring for a woman who requires 1:1 care, Red Flag 10 should be triggered and recorded." – Birth Rate Plus Team/CNST standard*

One to One care - *Refers to providing 1-2-1 care (one midwife to one woman) usually within the confirmed stage of active labour having commenced.*

Categories I – V -

"Categories I and II reflect normal labour and outcome and are predominantly midwife led care. Categories III – V reflect increasing levels of need. Category III are women who may have had an induction of labour or continuous fetal monitoring for known/suspected risk and delivery. Category IV might be a woman who has had a well-managed elective C/S or one who has had a normal delivery with a healthy infant, but had had a long labour, received an epidural or an episiotomy with sutures. Category V usually related to emergency operative delivery, associated medical/obstetric problems, unexpected emergencies or stillbirth" – Birth Rate Plus FAQs

Information Governance (IG) Quarterly Board Report
July 2022

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

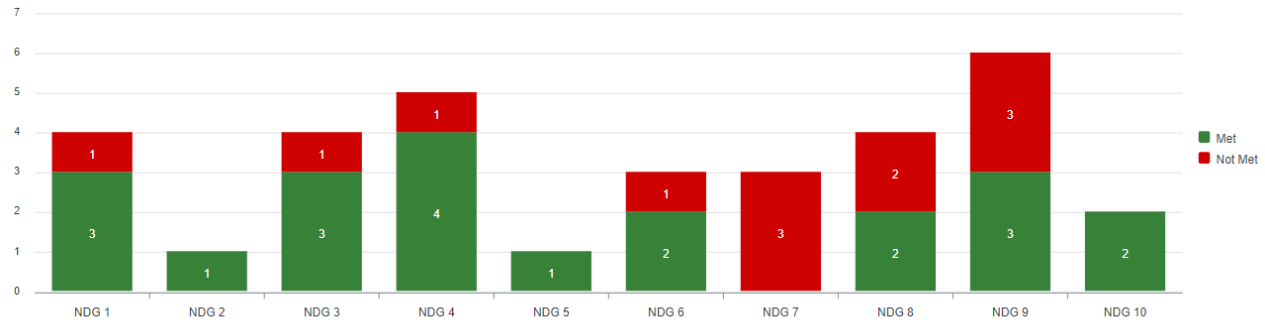
Data Security and Protection Standards for health and care sets out the National Data Guardian's (NDG) data security standards. Completion of the Toolkit self-assessment, by providing evidence and judging whether The Trust meets the assertions, demonstrates that the organisation is working towards or meeting the NDG standards.

DSPT Submission

The Trust published its assessment on the 30th June. 96 of the 109 mandatory evidence items were provided.

The Trusts current status is **Standards Not Met** whilst NHSD review our action plan. If NHSD agree that the improvement plan is acceptable they will amend the status to **Approaching Standards**

To achieve Standards met compliance The Trust must meet the requirements of all assertions.



NDG 1 - Personal confidential data
NDG 2 - Staff responsibilities
NDG 3 - Training
NDG 4 - Managing data access
NDG 5 - Process reviews
NDG 6 - Responding to incidents
NDG 7 - Continuity planning
NDG 8 - Unsupported systems
NDG 9 - IT protection
NDG 10 - Accountable suppliers

Improvement Plan

NHSD have made important changes to the way they review Trust Improvement plans. Previously, plans were only accepted if the date of completion was within 6 months of submission regardless of whether if it was achievable.

The Trust Improvement plan now has realistic deadlines of completion and progress for all outstanding requirements will be monitored via the DSPT Working group on a bi-monthly basis.

The current Improvement plan has had input from all relevant stakeholders and any non-compliant assertions have had responsibility assigned.

Key Bullet Points

- Bi-Weekly DSPT working group with all relevant stakeholders to attend
- Stakeholders listed in the RC9 Improvement plan above to be added onto the DSPT for accountability
- Agenda Item to be added to the Technology Program for outstanding IT DSPT requirements.

DSPT Deadlines

Baseline February 2023

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.

1 Incident was reported via the DSPT in the last quarter.

Data Privacy Impact Assessment (DPIA)

The SCR (Shared Care Record) DPIA is still a major DPIA in progress and this is being completed alongside IG colleagues from partner organisations. Current considerations and discussions surrounding the on-boarding process are in progress.

Data Flow Mapping & Departmental Information Assets

Data Flow Mapping – 88%

Departmental Assets - 86%

Key Bullet points;

- The percentage of completed returns haven't changed.
- Reminders sent to all remaining departments with an extended deadline to August 2022

System Information Asset Register

The merged IAR is now 60% completed.

Key Bullet Points

- IG Officer has been tasked with contacting all relevant stakeholders & populating the data onto the spreadsheet.
- ALL DPIA's reviewed and Information uploaded to the Trust IAR Spreadsheet.

- Continue to review Contract & Procurement system (Accord) against listed systems to help populate the Asset Register.
- Monitored through Bi monthly DSPT Working Group

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.

This function continues to be extremely busy and the department continues to see an increase in the complexity of requests for medical records from Solicitors, patients, Police, Courts, Council and other professional bodies.

In the last quarter 64% of SAR requests were completed within the 30 day deadline which is a decrease of 9% on compliance rate.

Year 2022/2023		No of requests	Breached legal deadline	Compliance with deadline
Q1	April-June	**978**	**353**	**64%**
Q2	July – September			
Q3	October – December			
Q4	January – to March			

Key Bullet Points

- IEP now fully implemented within the SAR function, minimising the use of discs for imaging and expediting the process.
- Staff training, absence and the volume of requests continue to impact on the legal deadlines.

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 FOI compliance figures for all FOI requests remain poor. We have recently recruited for the position of FOI officer to coordinate this function from November and have put further escalation processes in place to capture pending breaches.

The 20 day compliance figures have fallen significantly again in the last quarter to 35%

Year 2022/2023		No of requests	Breached 20 day deadline
Q1	April-June	**195**	**127**
Q2	July – September		
Q3	October – December		
Q4	January – March		
Total Received			

Key Bullet Points

- FOI continues to face significant challenges in receiving information back from departments
- Areas with biggest non-compliance are Information and HR – however these departments do receive a significant number of requests
- Other departments we face challenges with include Women/Children and to a lesser degree, Finance.
- FOI Officer has a weekly call with Information team as well as staying in regular contact with other departments – despite this, we still have significant non-compliance with returns.
- FOI Officer regularly escalates significant breaches and these are pushed up to relevant senior managers – still no improvement seen.
- Overall attitude toward FOI within the trust is one of indifference and a significant shift is required to address this.

A Monthly FOI meeting with all relevant stakeholders has been arranged to improve The Trusts cultural view.

Mandatory IG Training

The compliance target required by the Data Protection Security Toolkit (DSPT) is 95% of all staff must be trained annually.

The current percentage of staff compliant with annual IG training has fallen to 75.5%

- The Trust has now aligned pay progression to ESR
- The IG team will continue to actively contact staff members that are non-compliant and guiding them to the most appropriate training.

Bedfordshire Hospitals NHS Foundation Trust

Board of Directors

Wednesday 27th July 2022

Report title:	**Performance Reports**			**Agenda item: 7**
Executive Director(s):	Quality and Performance L Lees, Chief Nurse, C Jones, Deputy CEO, C Thorne, Director of Quality and Safety Governance, P Tisi, Medical Director, Finance Matt Gibbons, Director of Finance Workforce Angela Doak, Director of Human Resources			
Report Author	**As above**			
Action *(tick one box only)*	**Information** ☐	**Approval** ☐	**Assurance** x	**Decision** ☐
Recommendation	To note the contents of the report for assurance.			

Report summary	**Quality Summary** • The majority of falls continue to lead to no or low harm on both sites and any moderate or severe harm incidents are reviewed at a local incident review group to ensure early learning. There is an increasing number of patients requiring enhanced observation. • As with falls, all new pressure ulcers (those that have developed in hospital) continue to be reviewed at a weekly pressure ulcer review group enabling clinical teams to share relevant information and identify improvements required. • Incident reporting rates remain positive and within normal variation. Overall reporting trends remain similar across both sites. • 14 Serious incidents have been reported (5 Bedford and 9 at L&D) and are currently being investigated. Improvement activity is also noted. • There were 176 deaths from all causes (BH, no.66, LDH, no.110) in June 2022, including 2 elective deaths at LDH (to be validated). This is 21 fewer deaths across Bedfordshire Hospitals in month and 50 more deaths when compared to June 2021. • The number of complaints has been increasing with 82 in May 2022.

	Performance Summary Operational performance continues to reflect the extraordinary pressure on the organisation, with emergency care indicators and cancer performance of particular concern. System partners are working to support the organisation to improve flow out of the hospital and avoid admissions in support of improving the emergency care indicators. Cancer clinical leads are working with service managers to continue to progress improvement actions to support a continued reduction in the number of patients exceeding 62 days on open pathways. Planned care performance continues on track in terms of waiting list recovery, and is forecast to meet the targets of maintaining zero 104 week waits and getting to zero 78+ week waiters by the end of the financial year. • In June 2022 the average time in department for patients that were admitted was 419 minutes (compared to 427 in May 2022). This reflects a significant improvement at the Bedford site which resulted from an improvement in overall bed occupancy and flow through the hospital improving in June 2022. However, there has been a gradual lengthening of time at the L&D due to the acuity of patients presenting to the site. Urgent action is underway with commissioners. • There has been an increase in time for ambulance handovers in June following a decrease in May 2022. The Trust is not achieving the 65% target and is currently at 36.4%. • The stroke target remains extremely challenging due to Covid and the pressures at the hospital. It remains a key quality priority. • The Trust performance for 62 day cancer waits dropped again in May 2022 to 61.1% as a result of high numbers of breaches in Urology and Lower GI at the Luton site and Urology, Lung and Breast at the Bedford site. • The Trust is working towards the next target for patients to be seen within 78 weeks by April 2023. We are forecasting to meet this target. • The RTT Waiting List has not stabilised to the September 2021 level as the ongoing pandemic is causing pressures in the system. The teams are improving the process to develop more 'real time' clock stops. • The DNA rate remains high and the text message service reminder service was re-introduced in June 2022. **Finance Summary** • The Trust delivered a deficit of £2.9m, this is against a £0.1m surplus plan. • The Trust's pay spend is £0.8m overspent year to date. Non-pay is £1.1m overspent year to date. The Trust has recognised £1m of the additional inflation monies to mitigate the pay and non-pay overspends. • Based on estimated M3 Elective recovery fund performance, the Trust provided for £3.6m of underperformance as the Trust was well below 104%.

	• Capital spend is £14.5m against a revised plan of £89.0m. The Trust spent £8.9m against £27.2m Trust CDEL. **Workforce Summary** • Between April and May sickness reduced by 0.84% to 4.24% in May 2022 from 5.08% in April • Vacancy rates have reduced slightly from 11.03% in May 2022 to 10.80% in June 2022. • The overall turnover increased from 15.60% in May 2022 to 16.12% in June 2022 • The overall agency run rate is 10.20% lower in June 2022 when compared to June 2021 equivalent to 24.75 FTE fewer agency staff. • The overall bank run rate was 24.94% higher in June 2022 when compared to June 2021 equivalent to 151.4 FTE more bank workers. • The overall training compliance rate increased by 0.26% in June to 79.45% • The overall appraisal rate increased by 1.17% in June to 67.36%
Legal Implications / Regulatory requirements / Strategic objectives and Board Assurance Framework	The national access targets and financial performance form part of the NHS provider Single Oversight Framework which determines the segmentation, and therefore the level of autonomy and support needs attributed to the Trust, by NHSI/E. CQC Oversight
Jargon Buster	Superstranded patients - Someone who has spent 21 days or more in hospital. Nervecentre - An Electronic Patients Record Solution that includes patient observation and clinical care.

Bedfordshire Hospitals
NHS Foundation Trust

Quality and Performance

August 2022

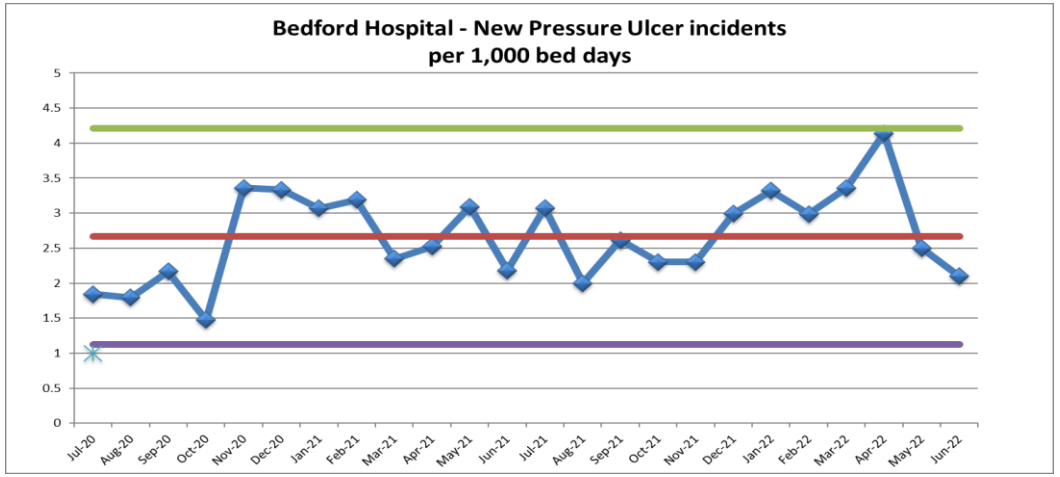
(April-June) 2022

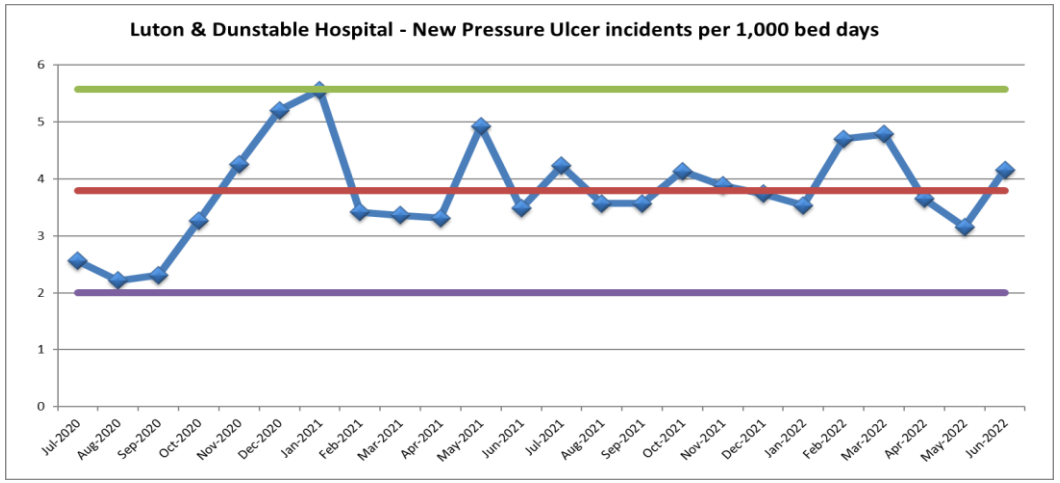
Chief Nurse
Medical Director
Deputy Chief Executive
Director of Quality and Safety Governance

Safe

Bedfordshire Hospitals NHS Foundation Trust

Harm Free Care – Pressure Ulcers





All new pressure ulcers (those that have developed in hospital) continue to be reviewed at a weekly pressure ulcer review group enabling clinical teams to share relevant information and identify improvements required.

A quality improvement project is planned with the Trusts therapy staff which will aim to:

- Raise awareness of the therapist role in pressure area care.
- Increase therapist involvement in the identification of pressure area care risks for individual patients on their caseload.
- Enable therapist to intervene and manage patient's pressure care needs.
- Promote the role of therapists in the management of pressure area care within the Trust

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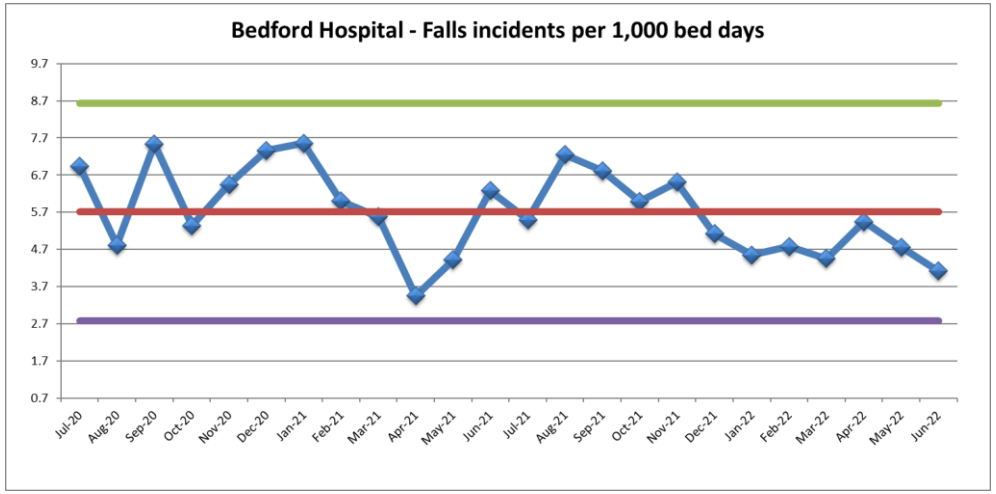
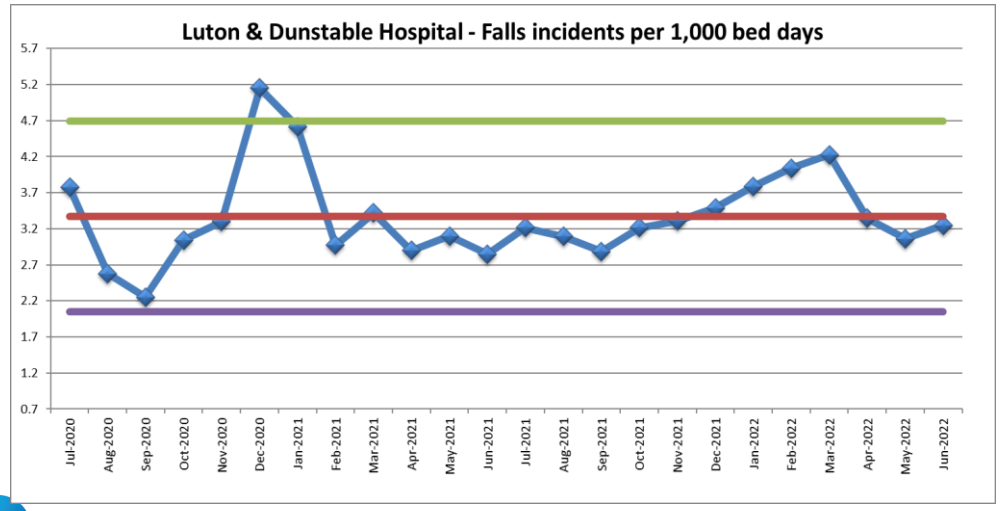
Harm Free Care – Falls





The majority of falls continue to lead to no or low harm on both sites and any moderate or severe harm incidents are reviewed at a local incident review group to ensure early learning.

An increasing number of patients require enhanced observation of care due to confusion and other underlying medical conditions in order to reduce their risk of falls.

A programme of education is being conducted by the Falls Practitioner for ward staff on the process of Bay Watch. This involves ensuring a dedicated member of staff is allocated to a group of patients and if for some reason they have to leave the area another member of staff is substituted for this role to ensure continued patient observation and safety.

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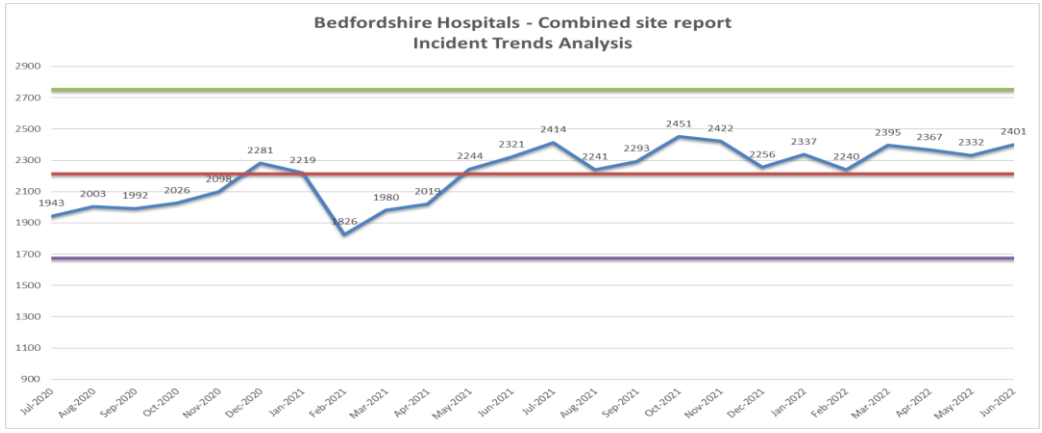
Incident Reporting

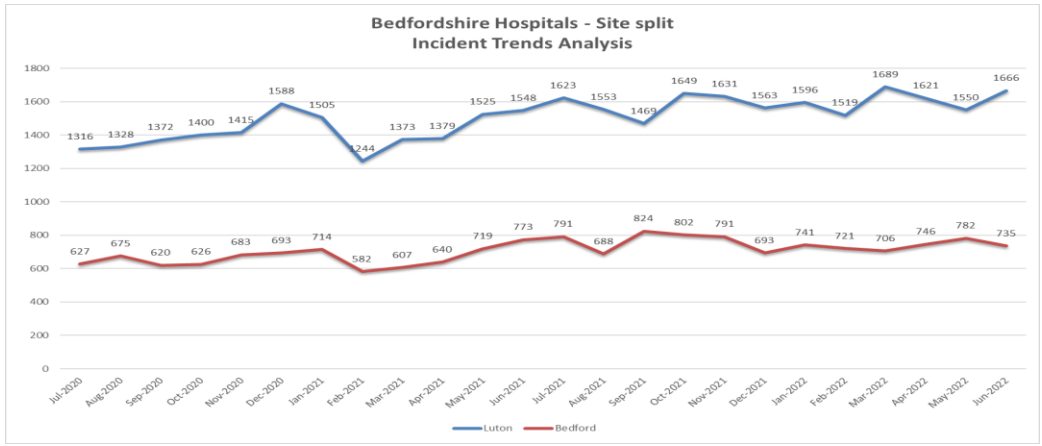
Number of Incidents reported over a two year period up to June 2022 (combined Trust figure)



High incident reporting is indicative of a good safety culture and this chart provides the trend of reported incidents across both the Bedford and Luton & Dunstable hospital sites.

Incident reporting rates remain positive and within normal variation.

Number of Incidents reported by site over a two year period up to June 2022 (split by site)



This chart splits and compares the incident reporting at both sites.

Whilst overall reporting trends remain similar across both Trust sites the Clinical Risk team will be undertaking some awareness work and training across the Trust with an emphasis at our Bedford site to ensure incident reporting levels are maintained.

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Serious Incidents

Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified.

Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

A total of **14** events have been declared as serious incidents across the both Trust sites during April – June 2022

**Note: Any incidents meeting the criteria for a Healthcare Safety Investigations Bureau (HSIB) incident review are now routinely declared as serious incidents in line with requirements of the "Ockenden" report publication.*

5 Serious Incidents were declared for the Bedford hospital site

- 2 x incidents of delay in cancer diagnosis potentially leading to poorer outcome
- Potentially avoidable death following surgery
- Potential delay in diagnosis of obstructed hernia.
- An accidental cut to a central venous catheter possibly causing air embolism leading to stroke.

9 Serious Incidents were declared for the Luton and Dunstable Hospital site

- 2 x Possible delay in referral leading to ophthalmology treatment delay
- Delay in medication administration
- Baby born requiring therapeutic cooling*
- Delivery of baby leading to a 4th degree tear
- Omission of medication potentially leading to harm
- Potential missed pathology on ultrasound scan with baby born in poor condition
- Intrapartum Stillbirth
- Intrauterine death

**Therapeutic cooling is a process where the baby's temperature is carefully lowered after a traumatic labour experience. The process protects the brain by minimizing the production of toxic substances that can cause brain injury.*

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Improvement activity related to previously investigated Serious Incidents

Responding appropriately when things go wrong in healthcare is a key part of the way we can continually improve the safety of the services we provide to our patients. We know that healthcare systems and processes can have weaknesses that can lead to errors occurring and, tragically, these errors sometimes have serious consequences.
Therefore as a Trust we focus on the outputs of our incident investigation processes to capture areas for continuous improvement and shared learning.

The following list provides an example for some of the work either completed or on going which has resulted from previously reported incidents:

Delay In Diagnosis / Treatment Pathway

- The lymph node biopsy pathway has been revised and is now implemented following two incidents where this was found to have an impact on timeliness of treatment.
- The lower gastro intestinal pathway has been updated with improvements to optimal selection of diagnostic modality.
- A revised review process has been implemented to ensure that patients requiring radiotherapy are monitored and tracked.
- Ophthalmology service have implemented a patient review triage process and will move to electronic triaging to avoid misinterpretation of handwritten instructions.
- Ophthalmology service developing specific standard operating protocols for management of high risk Ophthalmology Outpatients – this is to include failsafe processes.
- Service to undertake a pathway mapping for all sub specialities, high risk Ophthalmology areas to support onward management needs and resourcing

In Patient Care

- Reminders to ward staff regarding Covid – 19 swabbing regimes and the correct procedures for donning and doffing PPE were increased following a nosocomial infection

Safe

Bedfordshire Hospitals NHS Foundation Trust

Improvement activity related to previously investigated Serious Incidents (continued)

Wrong site surgery – Never Event

- The endoscopy service have ensured all staff are retrained regarding the checks requited for identification of patients when attending for a procedure
- The service have implemented a protocol such that patients with the same or similar names are not scheduled for procedure on the same day. If this is not possible, a different time of day will be selected and flagged to staff .

Post Surgical Care

- Patients returning from theatre should be reviewed in the recovery area if they are scoring high on the NEWS chart.
- Service to ensure that management of bleeding after a surgical procedure is based on the clinical picture by the multidisciplinary team.
- Service are required to ensure staff are enabled and encouraged to escalate for a second opinion where there difference of opinion in care management.
- In pregnant people any concerns with ongoing bleeding must be reviewed by the on call obstetrician.

Maternity Services

- Service should ensure that the Community Midwifery Unit should be able to provide level 2 care to women and, if unable to do so, there should be a clear escalation pathway.
- Service must ensure that staff understand that if a woman is triggering on their CMU and MOEWS charts they must be escalated for prompt medical review.
- Service should ensure that when a woman is using home blood pressure monitoring they are provided with clear documented parameters for results and have a point of contact should they be abnormal.

Bedfordshire Hospitals NHS Foundation Trust

Mortality

There were 176 deaths from all causes (BH, no.66, LDH, no.110) in June 2022, including 2 elective deaths at LDH (to be validated). This is 21 fewer deaths across Bedfordshire Hospitals in month and 50 more deaths when compared to June 2021.
In addition there were 13 Emergency Department deaths (non-admitted, BH, no.6, LDH, no. 7).
Across Bedfordshire Hospitals, from March 2020 to June 2022 the total no. COVID-19 related deaths reported on CPNS is 1809, 25 in month (BH no. 9, LDH no. 16), 5 more deaths than the previous month.
19 deaths are reported in month for patients with a first positive test for COVID-19, across both hospital sites (BH no.8, LDH no.11), of these deaths, 1 (5%) was in a patient with a first positive COVID-19 result ≥15 days. This is illustrative of a gradual decreasing trend
26 deaths are reported in month for patients with a first positive test for COVID-19, across both hospital sites (BH no.12, LDH no.14), of these deaths, 1 (4%) were in patients with a first positive COVID-19 result ≥15 days, compared to 5 (16%) in April 2022. This illustrates a gradual decreasing trend.
There were 15 deaths within 24 hours of admission in June 2022 (BH no.8, 1 fewer death and LDH no.7, 4 fewer deaths when compared to May 2022), accounting for 12% and 6% of all deaths in month across both hospital sites.
There were 160 excess deaths across the 12 rolling months (July 2021 - June 2022) for BH and 75 excess deaths for LDH when compared to the five year pre-COVID-19 average (figures 1a and 1b).

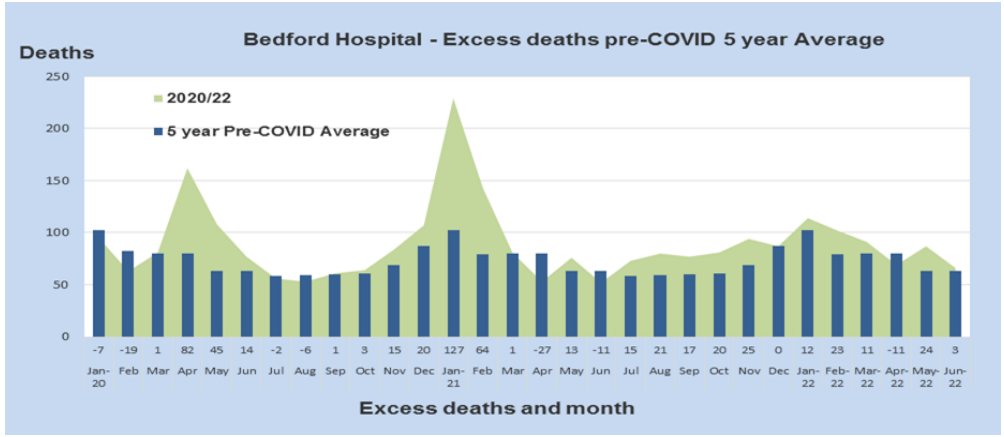

Figure 1a

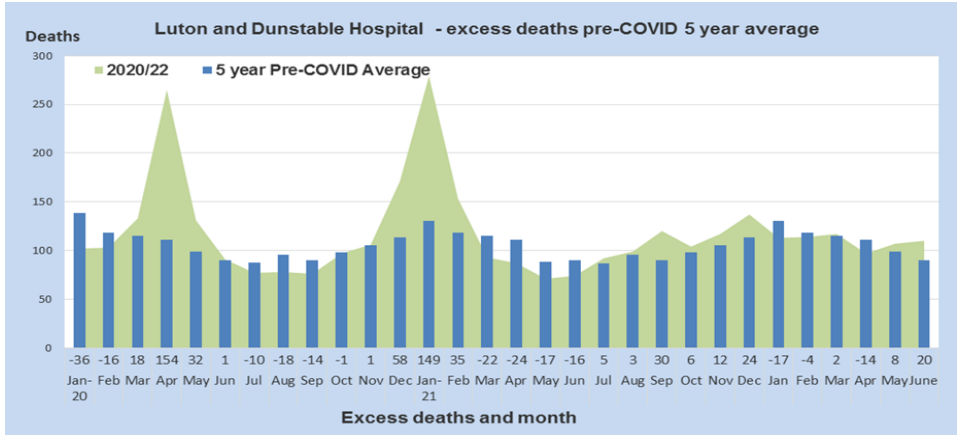

Figure 1b

Bedfordshire Hospitals NHS Foundation Trust

Mortality cont …

When compared to the five year (pre-pandemic) average, in June 2022, there were 25 more deaths reported (BH, no. 3 and LDH, no.20). The cumulative no. of excess deaths for Bedfordshire Hospitals in 2022 (January - June) is 57 (BH, no.62, LDH, no. - 5), figures 2a and 2b

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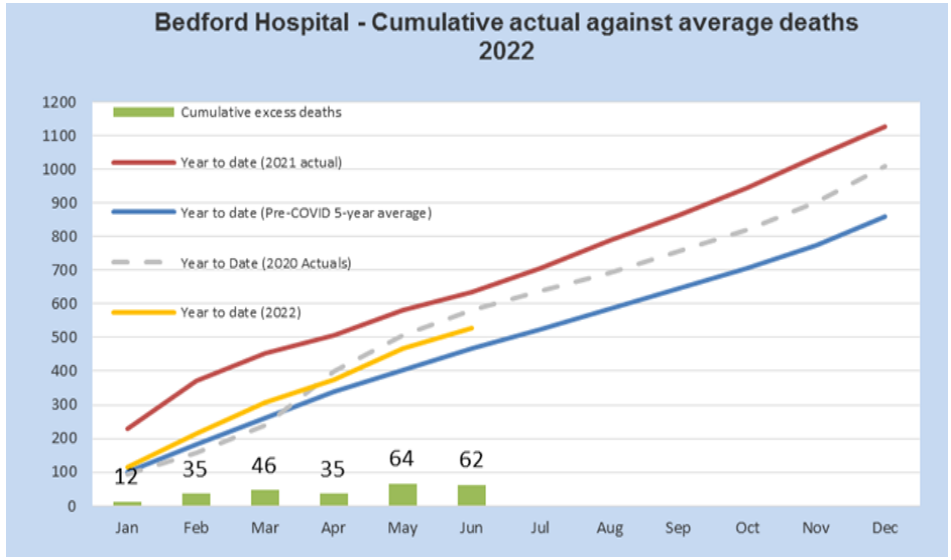


Figure 2a

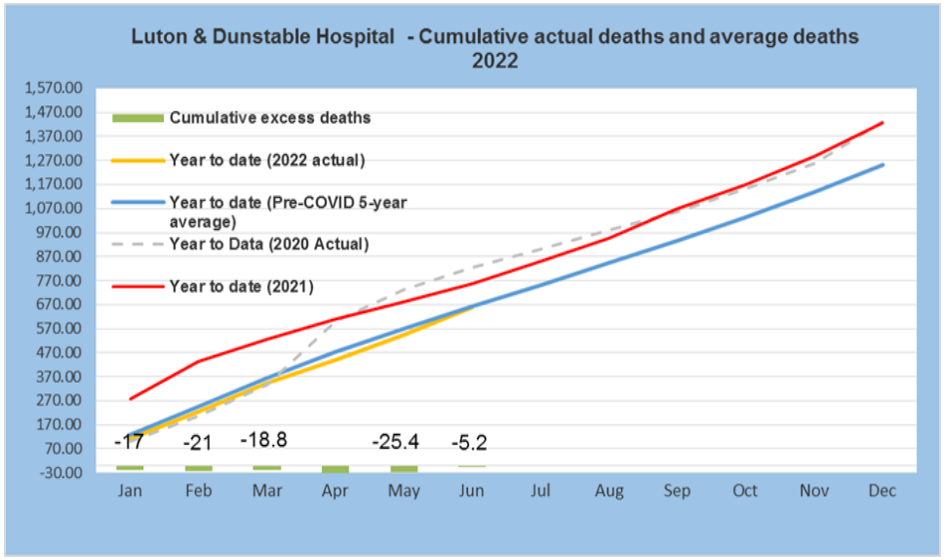


Figure 2b

Bedfordshire Hospitals NHS Foundation Trust

Mortality cont …

National Indicators

SMR - (March 2022) is 112.08 for Bedfordshire Hospitals (↓13.0 in month) (BH, 121.87, ↓25.47 and LDH, 105.04, ↓3.28).
HSMR - (March 2022) is 105.43 for Bedfordshire Hospitals (↓12.19 in month) (BH, 112.0, ↓26.83 and LDH, 100.42, ↓1.36)
RAMI - (March 2022) is 96.1 for Bedfordshire Hospitals (↓7.07 in month) (BH, 99.18, ↓19.82 and LDH, 93.69, ↓ 10.73). RAMI values will be subject to amendment following a data refresh.

HSMR, RAMI exclude COVID-19 cases, SMR covers all deaths, including COVID-19 cases. All three indicators have been standardised for age, gender and case mix (figure 3).

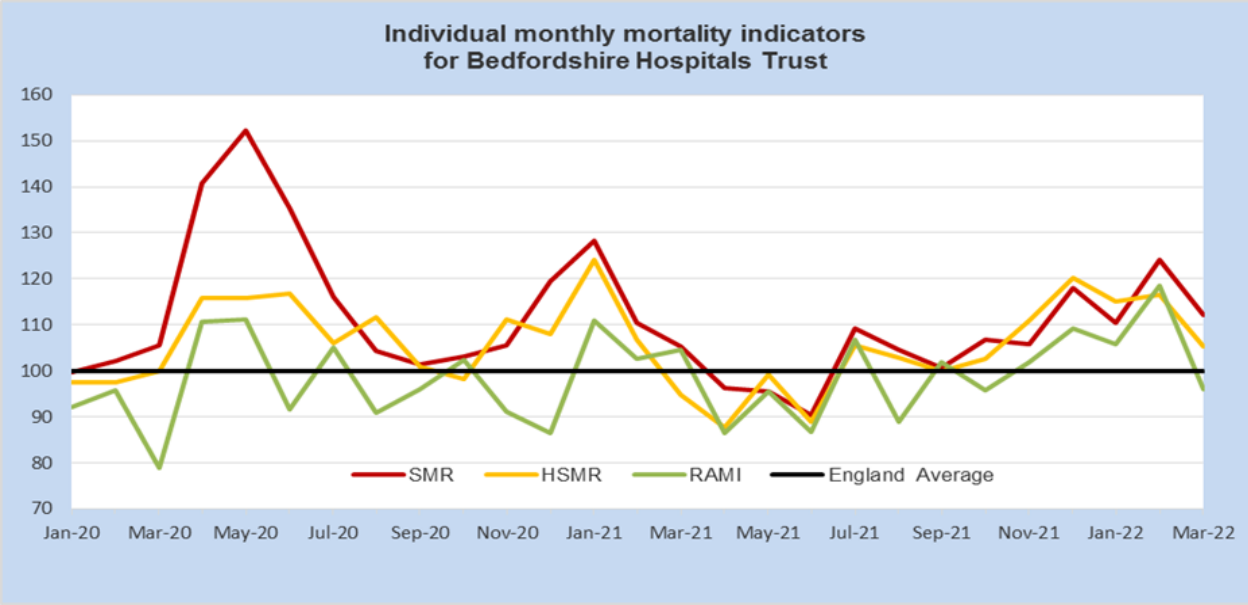


Figure 3

Bedfordshire Hospitals NHS Foundation Trust

SHMI
SHMI includes any deaths occurring in the 30 days after discharge and excludes COVID-19 cases.
For the 12 months ending January 2022 is 105.37 (↓1.38 in month) for Bedfordshire Hospitals (BH, 119.53 ↑1.01 and LDH, 96.74 ↓2.79)

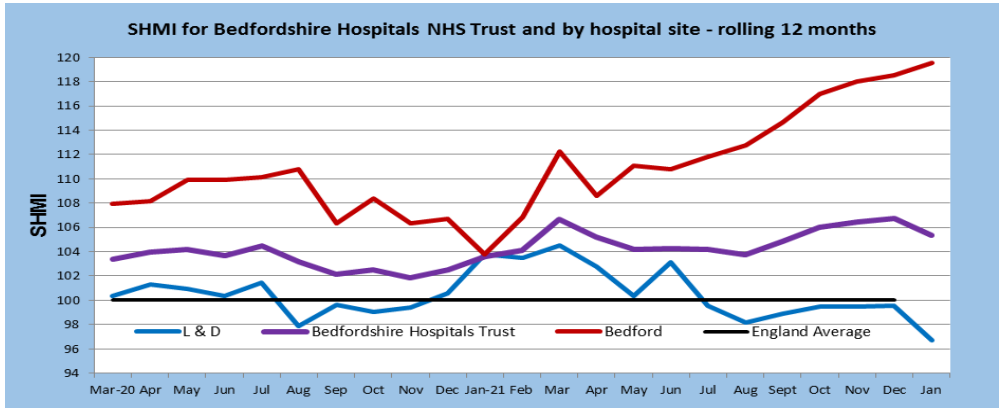


Figure 4

While all national indicators remain in the 'as expected' range for Bedfordshire Hospitals, the SHMI for Bedford Hospital site is 'higher than expected' for the fourth consecutive month.

Following analysis undertaken in collaboration with CHKS to better understand the SHMI trend for Bedford Hospital, areas were identified for further focus. These include exploration of any data processing or exclusion issues.
These 'deep-dive' work streams are underway with a plan to present the findings at the Quality Committee

SMR *- Standardised Mortality Ratio, ratio between the number of expected deaths and the number of actual deaths*
HSMR *- Hospital Standardised Mortality Ratio, adjusts for factors that affect in-hospital mortality rates, such as patient age, sex, diagnosis, length of stay, comorbidities and admission status*
RAMI *- Risk Adjusted Mortality Index, used to assess if inpatient mortality deviates from the expected, taking risk factors into consideration*
SHMI *- Summary Hospital-level Mortality Indicator, ratio between the actual numbers of in-patients who die and the number that would be expected to die on the basis of average England figures*

Caring

Bedfordshire Hospitals NHS Foundation Trust

Complaints / Patient Feedback

Complaints	July 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	April 22	May 22	Jun22
Number received	49	56	56	53	56	46	54	61	59	64	82	65
Number received per 1000 bed days	1.65	1.79	1.77	1.66	1.81	1.46	1.73	2.09	1.86	1.92	2.45	1.94
Number of breached complaint responses (>45 days)	43	42	23	36	36	37	16	24	34	31	27	27
Complaints upheld by PHSO	0	0	0	0	0	0	0	0	0	0	0	1 (partial)
Number of compliments received	208	173	186	314	208	394	209	201	211	138	155	172
Number of PALS contacts	1257	1028	1161	1095	1143	821	1232	1151	948	1379	1066	1160
Number of PALS concerns	450	376	317	312	304	277	272	220	219	338	261	303

The Emergency Departments (ED) on both sites recorded the most complaints in Q1 with a common theme of waiting times. This correlates with the increased capacity and activity which both sites were experiencing pressure at this time.

Volunteers and patient feedback

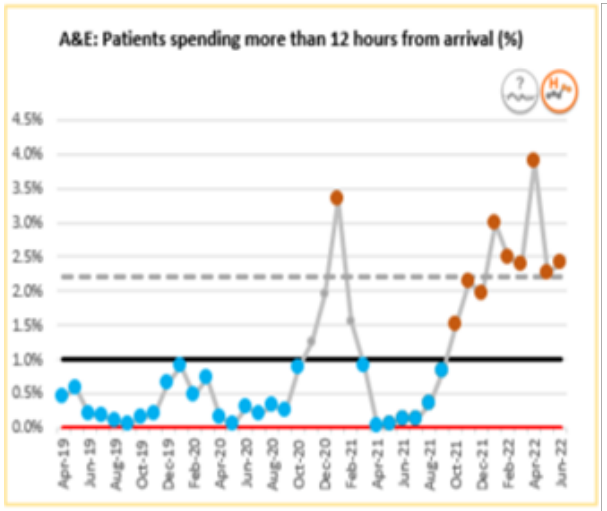
With the lifting of restrictions it is positive to see volunteers joining us back on both sites. The Patient Experience Team is working closely with the Voluntary Services Team and a number of volunteers have been identified to assist with gathering Friends & Family feedback on the Luton site initially. It is expected to be repeated on the Bedford site in Q2.

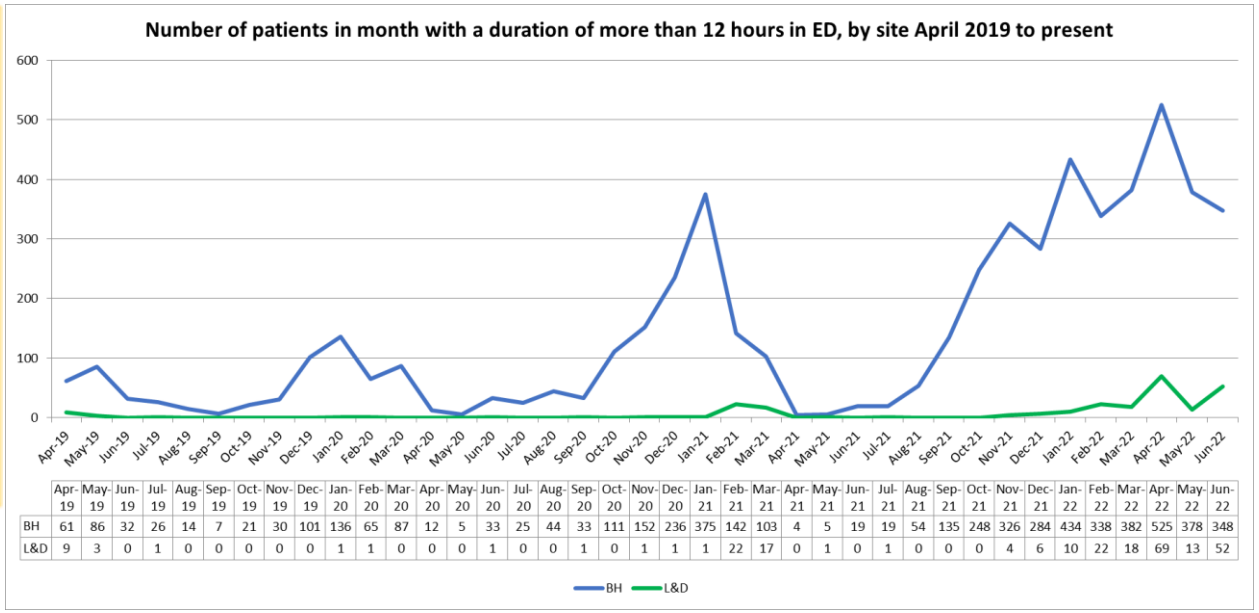
Urgent & Emergency Care

Effective

Patients spending more than 12 hrs from arrival in ED

Description: This metric is the proportion of Service Users attending A&E who wait more than 12 hours from arrival to discharge, admission or transfer, with the internal expectation for 22/23 that it is never more than 2% at the Bedford site and that performance returns to 0% of patients exceeding 12 hours duration in department at the L&D site.





	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
BH	61	86	32	26	14	7	21	30	101	136	65	87	12	5	33	25	44	33	111	152	236	375	142	103	4	5	19	19	54	135	248	326	284	434	338	382	525	378	348
L&D	9	3	0	1	0	0	0	0	0	1	1	0	0	0	1	0	0	1	0	1	1	1	22	17	0	1	0	1	0	0	0	4	6	10	22	18	69	13	52

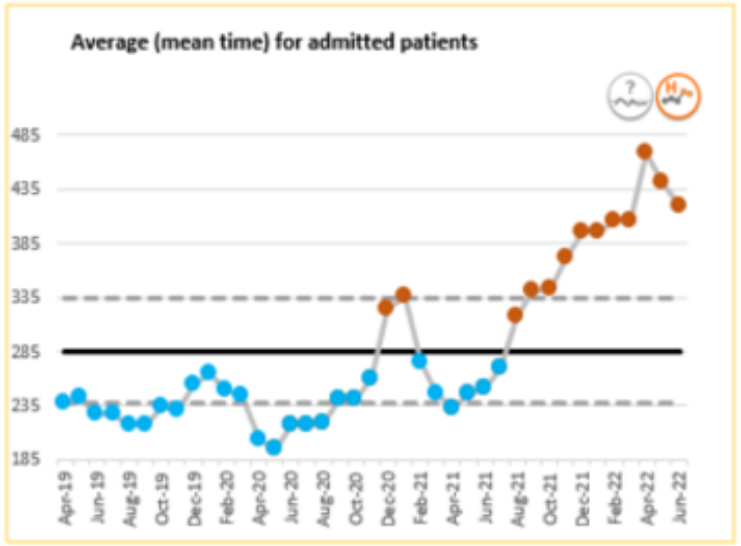
The trend in high bed occupancy and Covid-19 pressures started to result in very increased numbers of patients occupying space in the ED in winter 2020/21, and then a steadily increasing pressure from Autumn 2021. Concurrently, both sites have seen deterioration in performance against this metric with particular challenges at the Bedford site which has regularly reported over 4% of patients spending more than 12 hours in the department. In June 2022 the number of patients exceeding 12 hours in department has held steady overall, but with a deterioration at the Luton site and an improvement at the Bedford site. This is consistent with the patterns of higher operational pressure Luton during June 2022, and ongoing staffing pressures at both sites.

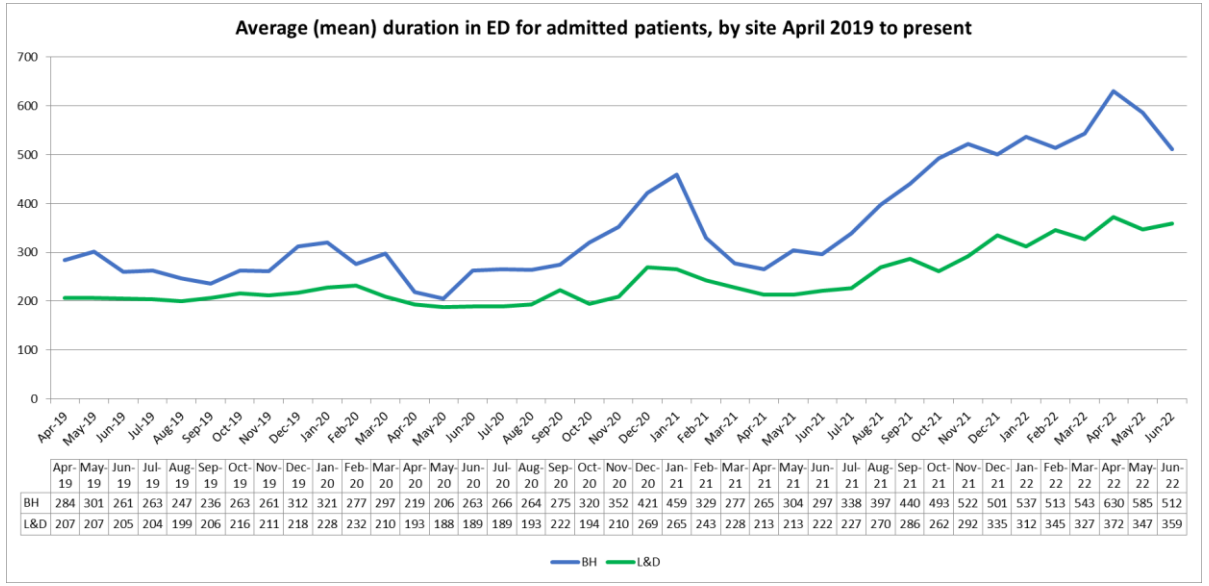
Key actions continue to focus on improving flow out of the departments and the transformation programme underway at the Bedford site is the key mechanism for delivering improvement in this area, as well as the continued drive at both sites on reducing super-stranded patients and a step-change downwards in our use of contingency beds. The number of psychiatric pathway delays has been escalated to the BCA Operational Leadership group with a proposal for this to feature as a key quality priority for autumn 2022.

Effective

Average wait for admitted patients from ED

Description: This is the total number of minutes that admitted patients have waited in ED divided by the total number of admitted patients, per month.





	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
BH	284	301	261	263	247	236	263	261	312	321	277	297	219	206	263	266	264	275	320	352	421	459	329	277	265	304	297	338	397	440	493	522	501	537	513	543	630	585	512
L&D	207	207	205	204	199	206	216	211	218	228	232	210	193	188	189	189	193	222	194	210	269	265	243	228	213	213	222	227	270	286	262	292	335	312	345	327	372	347	359

The charts shows the change in performance against this standard from Autumn 2021 as the hospital bed occupancy reverted to pre-pandemic levels, but pressures from covid and the corresponding reduction in flexibility of use of the bed base resulted in patients waiting longer for beds in ED.

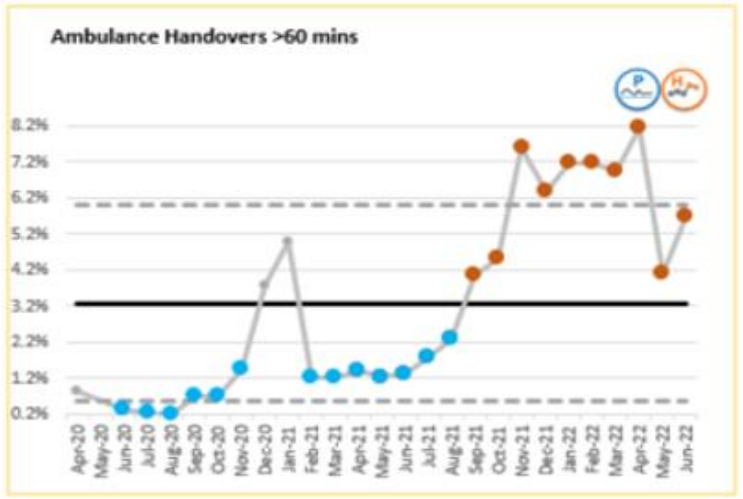
In June 2022 the average time in department for patients that were admitted was 419 minutes (compared to 427 in May 2022). This reflects a significant improvement at the Bedford site which resulted from an improvement in overall bed occupancy and flow through the hospital improving in June 2022.

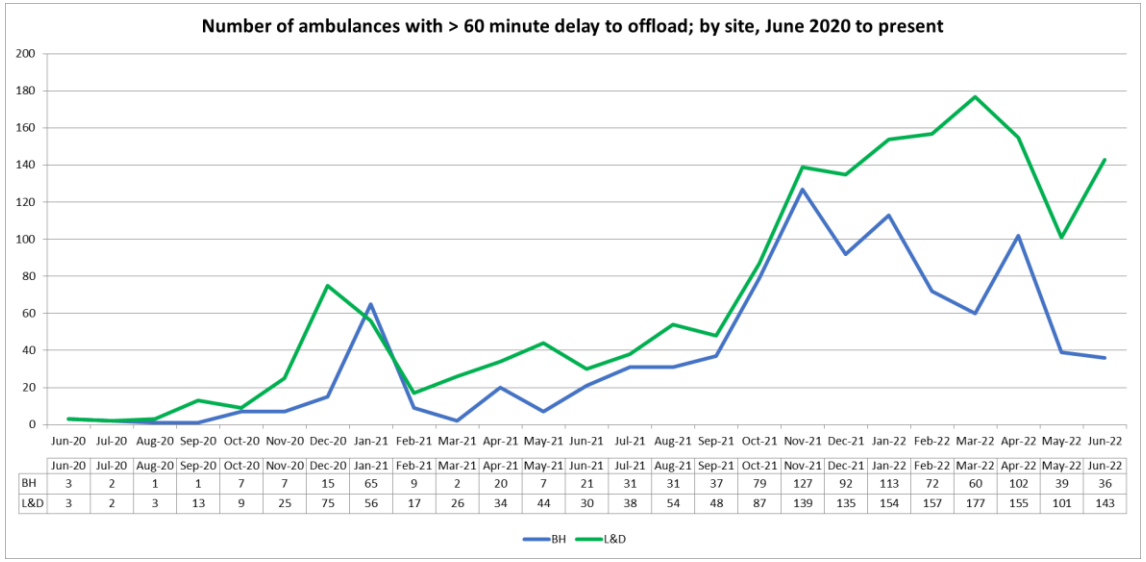
The persistent gradual lengthening of time in the department at the Luton site is of concern and reflects the high acuity of patients presenting to the site and the extraordinarily high use of contingency beds for the year. Urgent action is underway with commissioners to ensure that the number of super stranded patients in the organisation reduces (those with a length of stay of more than 21 days), which will have a positive impact on flow and admission from the ED.

Effective

Ambulance handovers greater than 60 mins

Description: This is the number of recorded ambulance handovers that took more than 60 minutes as a % of the total number of recorded handovers in month.





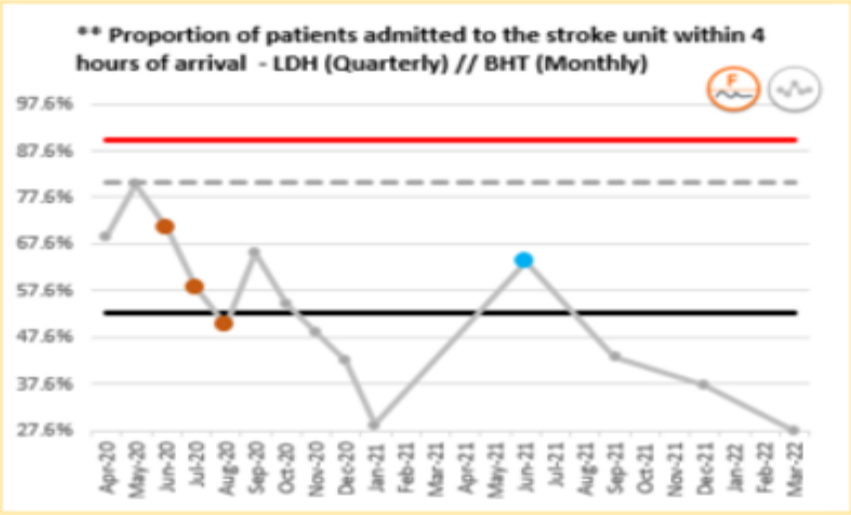
	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
BH	3	2	1	1	7	7	15	65	9	2	20	7	21	31	31	37	79	127	92	113	72	60	102	39	36
L&D	3	2	3	13	9	25	75	56	17	26	34	44	30	38	54	48	87	139	135	154	157	177	155	101	143

The operational focus for the organisation is minimise ambulances delayed for more than 30 minutes, with the aim to only have vehicles waiting to handover for over 60 minutes in the most exceptional situations.

In June 2022 we saw a deterioration in the % of vehicles taking more than 60 minutes to offload from 4.1% in May to 5.6%. This was a result of the significant site pressures at the L&D resulting in significant difficulties clearing cubicles to offload ambulances. Bedford site continues to consistently perform best in region against this indicator. Previous actions described to reduce time to admission and minimise patients in the Emergency Department for more than 12 hours are all key to deliving improvement against this indicator.

The current contractual target is for greater than 65% of ambulances to handover within 15 minutes. The Trust-wide performance in month in June 2022 was 36.4%.

4 Hours to Stroke Unit



Description

The numerator here is the number of patients who were admitted to a stroke unit within and including 4 hours of arrival at the hospital; the denominator is all the patients in the cohort (excluding the patients who were admitted to ITU/CCU/HDU).

This target is based on best practice that every patient with an acute stroke should gain rapid access (in less than 4 hours) to a specialist stroke unit. It is a key metric not only in terms of the Stroke service and its effectiveness but also acts as an indicator for how well the rest of the Trust is doing (bed pressures result in patients not being in the most appropriate beds, and high occupancy limits the ability of ED to be responsive and fast-track strokes to the specialist unit).

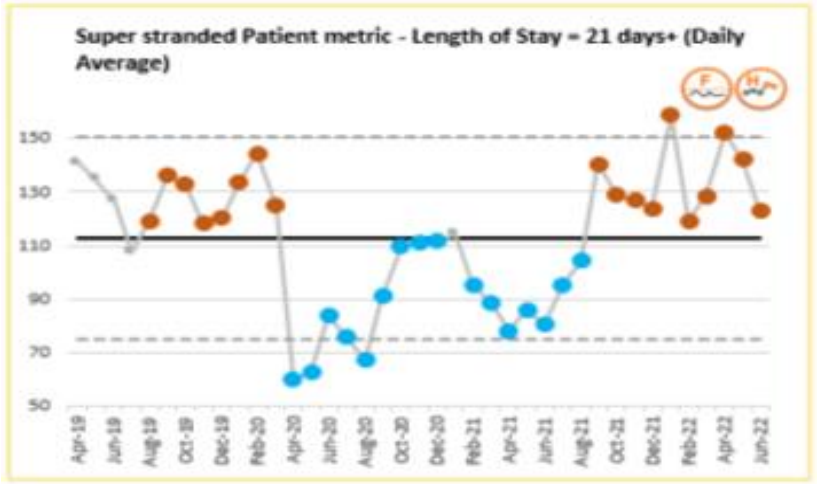
Data is obtained quarterly at Luton from the SSNAP audit results. The operational pressures articulated in earlier pages of the report are similarly demonstrated in the time to stroke unit, which was extremely challenging in Q4 due to several periods where we had Covid-19 patients on the stroke ward which impacted the ability to admit to all of the beds. Capacity issues at spokes sites also reduced the timeliness of repatriation of stroke patients, and staffing pressures across health services impacted onward flow to neurorehab placements.

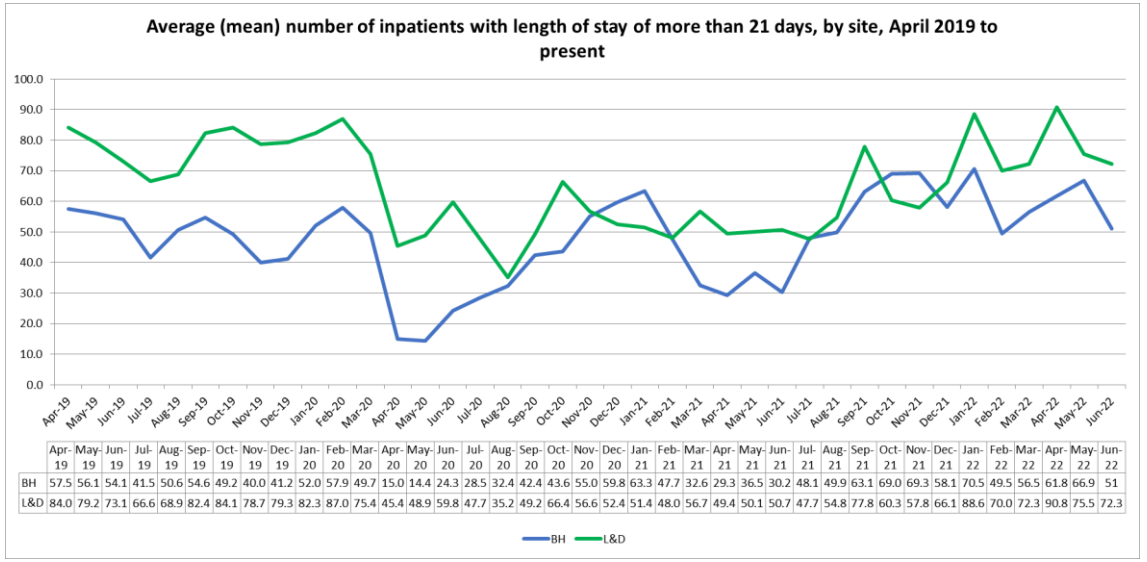
This remains a key quality priority for the organisation and at all times the aim is to have empty stroke beds in order to support new admissions. The specialist nature of the beds means that they are not easily made resilient to extraordinary circumstances such as covid outbreaks, however the continuing focus on early identification of stroke patients and escalation and stepdown processes to spoke sites is an improvement priority for the stroke service.

Effective

Super Stranded Patients

Description: Average number of patients per day residing in hospital for over 21 days in any given month





	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
BH	57.5	56.1	54.1	41.5	50.6	54.6	49.2	40.0	41.2	52.0	57.9	49.7	15.0	14.4	24.3	28.5	32.4	42.4	43.6	55.0	59.8	63.3	47.7	32.6	29.3	36.5	30.2	48.1	49.9	63.1	69.0	69.3	58.1	70.5	49.5	56.5	61.8	66.9	51
L&D	84.0	79.2	73.1	66.6	68.9	82.4	84.1	78.7	79.3	82.3	87.0	75.4	45.4	48.9	59.8	47.7	35.2	49.2	66.4	56.6	52.4	51.4	48.0	56.7	49.4	50.1	50.7	47.7	54.8	77.8	60.3	57.8	66.1	88.6	70.0	72.3	90.8	75.5	72.3

The number of super stranded patients (those patients residing in hospital for more than 21 days) provides a key barometer reading of the effectiveness of discharge and patient flow throughout the integrated care system.

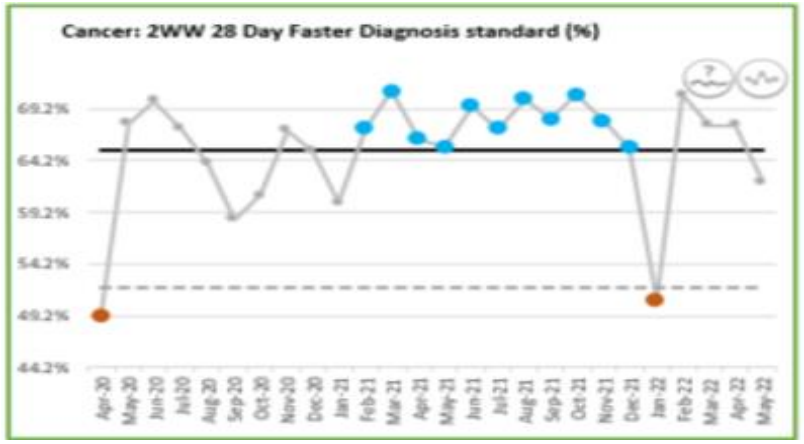
There has been a further drop in June 2022 on both sites compared to May 2022 for the number of patients per day on average that have been in hospital for longer than 21 days. However, the persistently high numbers seen since autumn 2021 continue to add to the operational pressures and remain significantly in excess of the numbers seen in summer 2021 which are the system target levels.

The daily system quick fire calls and refresh of escalation processes for these patients, which are often the most complex cohort of patients, are a critical component of the winter planning process for this year and will focus on system wide ownership of maintaining levels at less than 100 across Bedfordshire.

Cancer Care

Cancer: 28 day faster diagnosis

Description: The numerator is the number of patients receiving a diagnosis within 28 days; the denominator is the total number of patients referred for a suspected cancer.

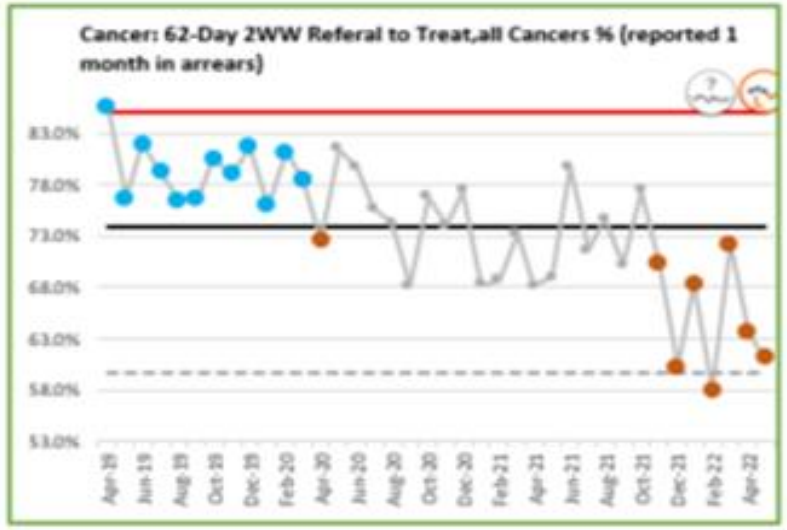


The Faster Diagnosis Standard (FDS) is a performance standard introduced to ensure patients who are referred for suspected cancer have a timely diagnosis - 75% within 28 days by March 2024.

The whole-trust performance dropped in May 2022 to 62.1% and continues to be below the 70% aspiration for this year. The combined Trust figure results from deterioration in both site's performance; 64.1% at the Bedford site and 59.6% at the Luton site respectively. As described in previous reports, the capacity in many areas remains fragile with high levels of staff absence continuing, exacerbated by the continued increase in referral numbers compared to pre-pandemic (19.4% increase for the first 3 months of the year) .

Particular services of concern are breast due to the difficulties in maintaining 2 week wait to first appointment due to radiology capacity, urology because of consultant staffing, template biopsy and histopathology capacity and lower GI because of high increase in referral volumes and difficulties in administering the straight to test pathways.

Cancer: 62 Day treatment breaches



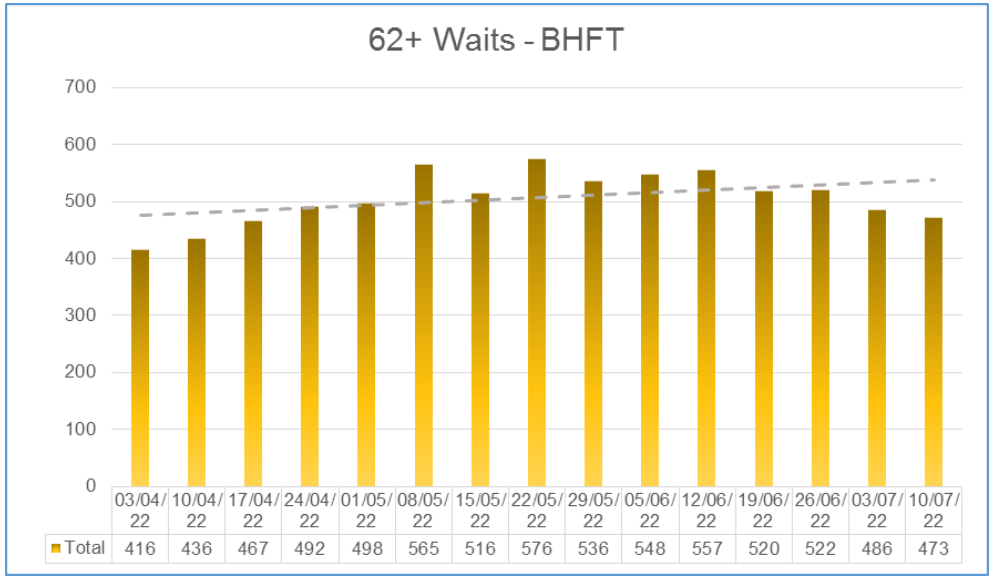
The target for all cancer treatment pathways is for at least 85% of patients to start their first treatment for cancer within two months (62 days) of an urgent GP referral.

The whole-trust performance dropped again in May 2022 to 61.1% as a result of high numbers of breaches in Urology and Lower GI at the Luton site and Urology, Lung and Breast at the Bedford site.

The next slide looks in more detail at the number of patients in total that are currently waiting more than 62 days on an open cancer pathway which gives a more 'live' status of the current cancer pressures and an improving picture.

Cancer: Patients on open pathways waiting more than 62 days

Description: The total number of patients referred for a suspected cancer who have not had a first definitive treatment, or discharge at day 63 of their pathway.



The number of patients exceeding 62 days on an open cancer pathway had been increasing since the beginning of April 2022 but has seen a slow steady weekly decrease since the 12th June 2022.

The system target is for Bedfordshire to reduce to below 167 open pathways by the end of March 2023, so a significant improvement in the 28 day faster diagnosis performance and the closure of pathways is critical to ensuring we meet this steep improvement trajectory.

Detailed action plans are established with Urology, Lower GI and Gynae leads and work continues with the cancer alliance to identify opportunities to support this backlog reduction.

Planned Care

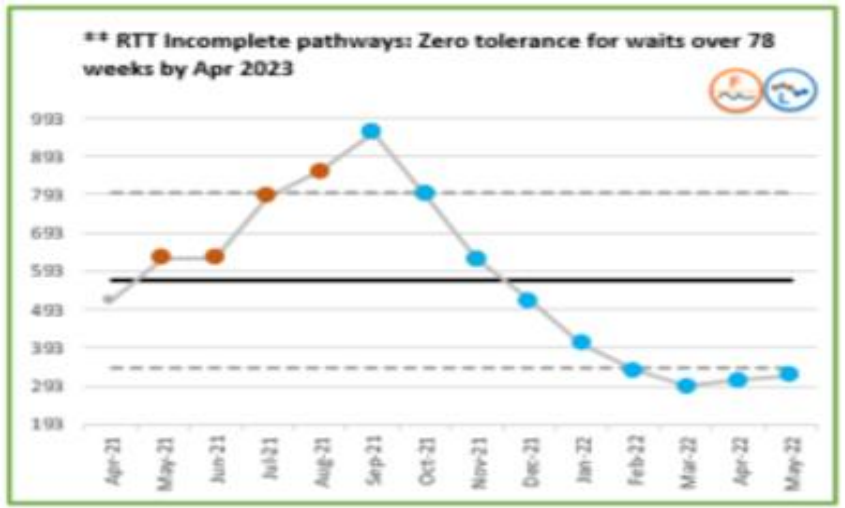
Zero 78 week RTT waits by April 2023

The latest planning guidance sets an expectation that systems will eliminate waits of over 78 weeks by April 2023, except where patients choose to wait longer or in specific specialties. This is in addition to maintaining a position of zero 104 week waits from Jul 2022.

Since 26th June 2022, the Trust has reported 0 patients over 104 weeks and is on track to maintain this position.

As at 18th July there were 312 patients on routine pathways waiting over 78 weeks. Trajectories have been set for every specialty to ensure that all patients who are currently waiting are clock stopped before reaching 78 weeks at the end of March 2023. So far the teams have reduced the 'at-risk' cohort from 17,204 patients at the beginning of April to 8,731 at the 3rd July. Of these, 2302 patients already have a date for treatment.

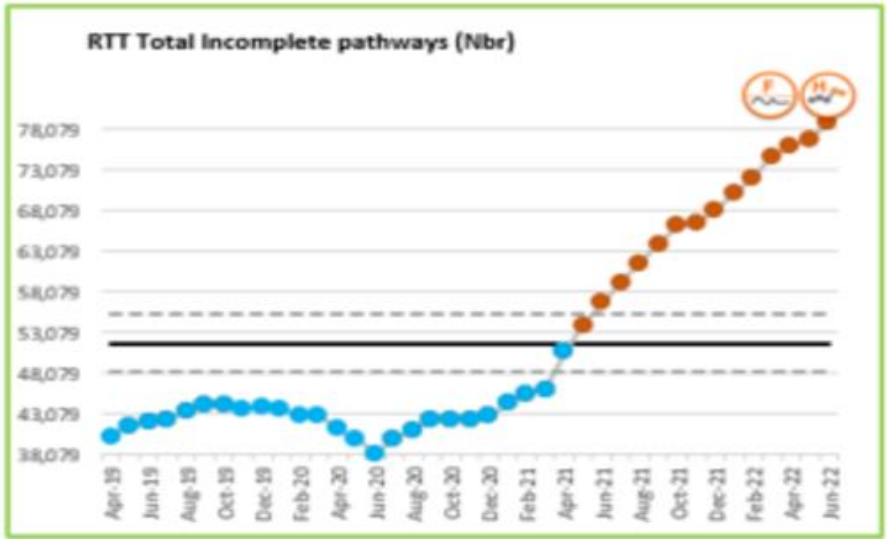
Overall, the trust is forecasting to meet this target and has a strong process in place for overseeing progress against trajectories.



Description

Count of total number of patients on any (inpatient or outpatient) incomplete pathway for over 78 weeks.

Total Incomplete RTT Pathways (Waiting List)



During 2021/22 one of the key expectations was that waiting lists would be stabilised at the September 2021 level. With the pressures created by the ongoing pandemic this is notably no longer the case. However, the Trust views this metric as a significant indicator of the effectiveness of the capacity management plans that sit with the Service Lines, as well the effectiveness of system-wide initiatives such as Advice & Guidance, and PIFU.

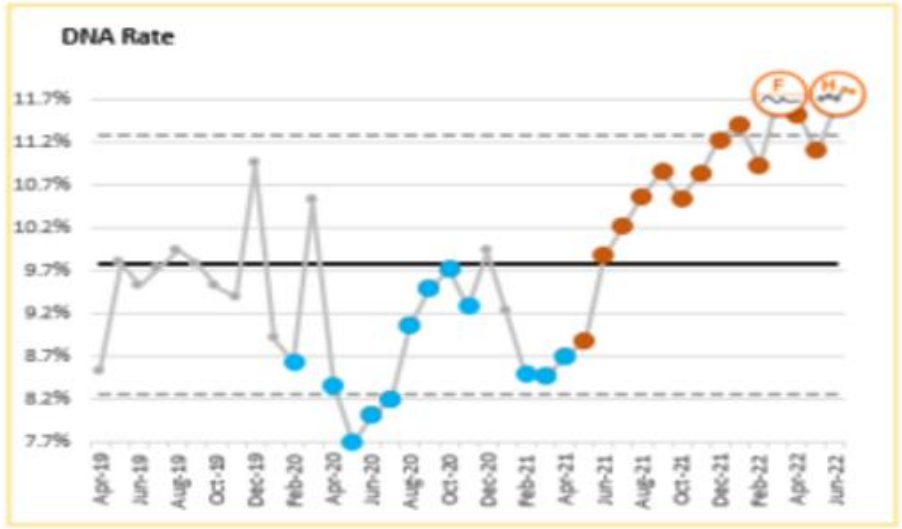
The rate of growth month on month has steadily slowed during 2021/22 and as capacity increasingly opens with reduction in Covid-19 control measures, the number of open pathways is expected to stabilise. The operational focus for the patient access team has been on the longest waiting patients. Process improvement to increase the number of real-time clock stops (as opposed to waiting for month-end validation) will be an important contribution to reversing this growth.

Description

This metric is the total number of patients referred by a GP or primary care practitioner who do not yet have a recorded first treatment or 'clock stop'. It represents the total number of open 18 week pathways, regardless of how long the patient has been waiting.

Effective

OP DNA Rate



Elective recovery is contingent on a number of factors. One of the emerging themes is the adverse change in DNA rate that has been observed across the large majority of specialties. This represents a significant opportunity as this is underutilised capacity.

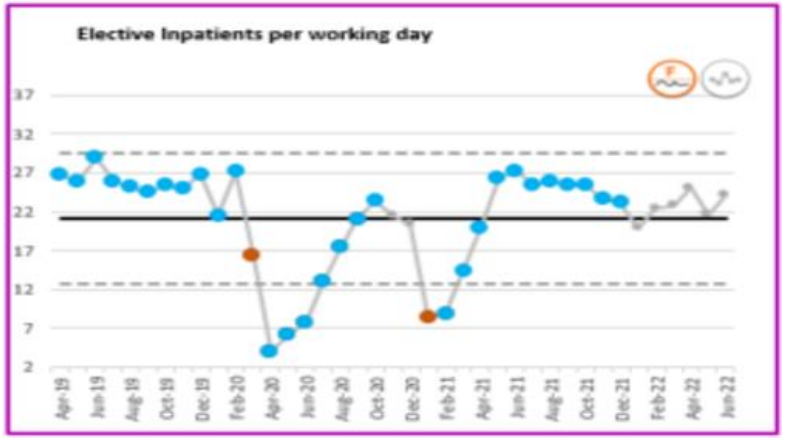
Outpatient services have been working with the digital team to re-introduce a text message appointment reminder system. This went live at the end of June 2022 and is expected to reduce DNAs by at least 5% with a direct conversion to activity seen and clock stops.

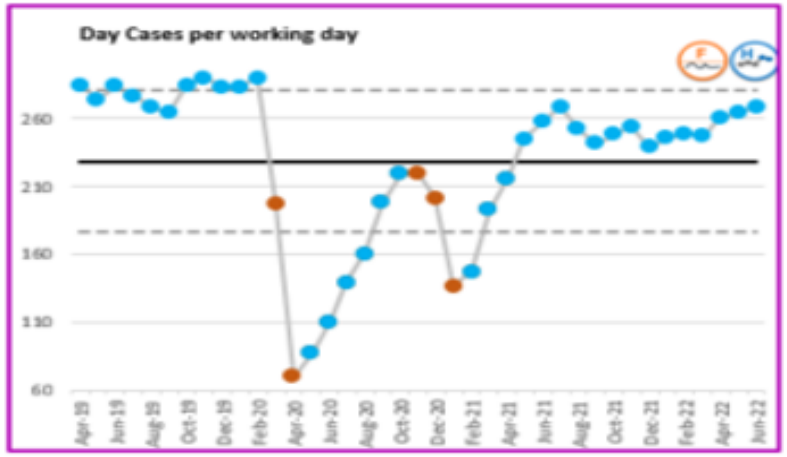
Description

The numerator here is the number of outpatients (first & follow up) who do not attend (DNA) a booked appointment; the denominator is the total number of booked appointments.

Effective

Elective Admission per working day – IP & DC





As the Trust moves into a post-pandemic way of working the expectation is that the number of elective inpatients per working day will continue to increase from a low point in January.

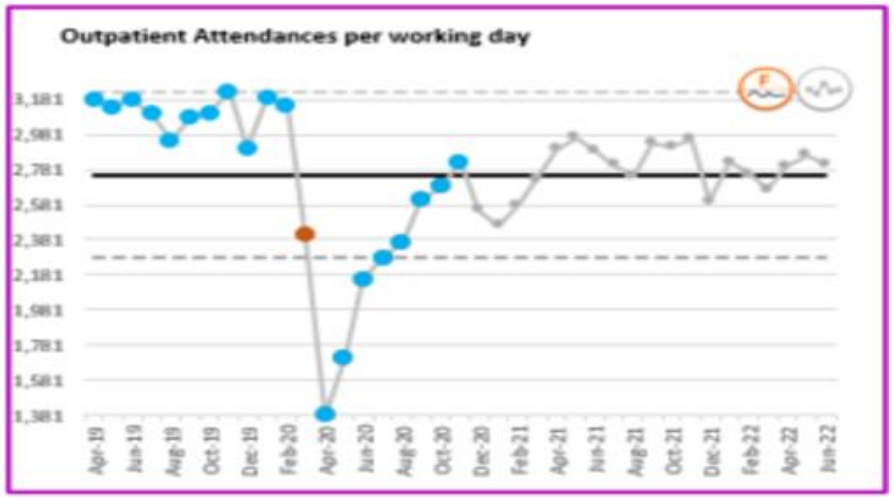
Main interventions include recruitment of additional theatres staff for the Bedford hospital site in order to improve resilience and reduce cancellations of theatre lists when unplanned absence prevents full theatres utilisation. The investment in pre-op assessment at the Bedford site will also reduce the number of patients whose surgery cannot proceed on the day. At the Luton site, a return to the historic strong focus on 6 week theatre scheduling and ensuring surgical cover for every list are also expected to yield a significant impact on patient numbers. This has been impeded due to vacancies across both clinical and managerial teams, but should improve significantly during the coming months. There is current work underway to mitigate an emerging risk in the endoscopy unit at Luton, which has a significant wte registered nurse vacancy from June 2022.

<u>Description</u>

Average number of elective inpatients (or daycases) admitted per working day.

Effective

OP Attendances per working day



The impact of the pandemic can clearly be seen on daily outpatient activity (average for working days in month), which has only recovered to around 80 - 85% of the 2019/20 baseline (although note this varies significantly by specialty).

As described above, reducing DNA rate immediately improves this position. Re-opening waiting rooms to pre-pandemic capacity will support increased throughput through clinics with improvement beginning from May 2022. Opportunities to increase the number of clinics running virtually are being pursued by a number of specialties, and the additional Cauldwell space on the Bedford site should also improve the activity run rate from September 2021. This is a key metric for understanding operational effectiveness and can be significantly affected by workforce pressures.

Description

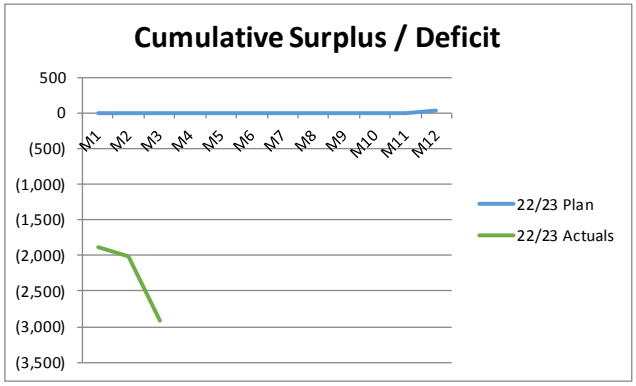
Average number of total outpatients attending per working day.

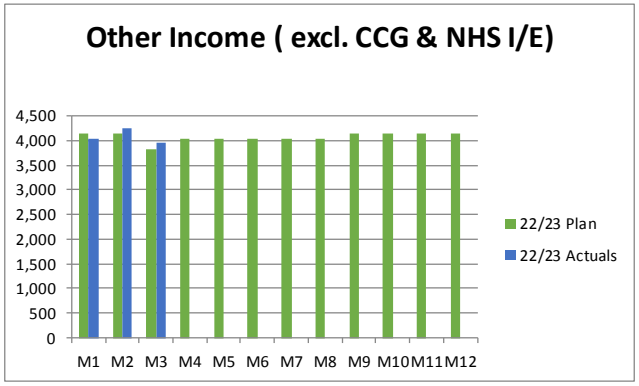
Public Board
27th July 2022

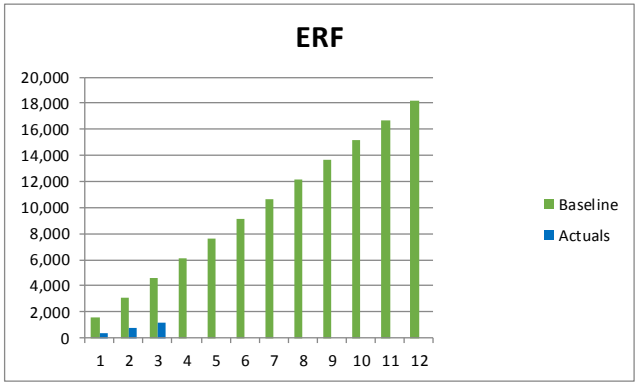
Report title:	Finance Paper			**Agenda Item: 7.2**	
Executive Director(s) and Title(s)	Matthew Gibbons, Director of Finance				
Report Author(s) and Title(s):	Ricky Shah, Deputy Director of Finance				
Purpose: *(select one box only)*	**Receive** [x]	**Approval** [ ]	**Assurance** [ ]	**Information** [ ]	**Note** [ ]
Action Required:	Note monthly finance performance				

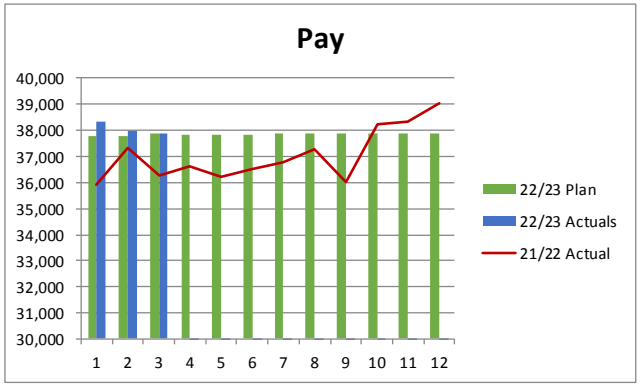
Report Summary / Purpose of Report:	The Trust delivered a deficit of £2.9m, this is against a £0.1m surplus plan. The Trust's pay spend is £0.8m overspent year to date. Non-pay is £1.1m overspent year to date. The Trust has recognised £1m of the additional inflation monies to mitigate the pay and non-pay overspends. Based on estimated M3 Elective recovery fund performance, the Trust provided for £3.6m of underperformance as the Trust was well below 104%. Capital spend is £14.5m against a revised plan of £89.0m. The Trust spent £8.9m against £27.2m Trust CDEL.
Links to Strategic Board Objectives /Risk Register / Board Assurance Framework	5. Developing a robust and sustainable future 7. Become well-governed and financially viable
Links to Regulations/ Outcomes/External Assessments	
Jargon Buster: Please detail acronyms in the report	ERF – Elective Recovery Fund CDEL – Capital Departmental Expenditure Limit LVA – Low Value Activity

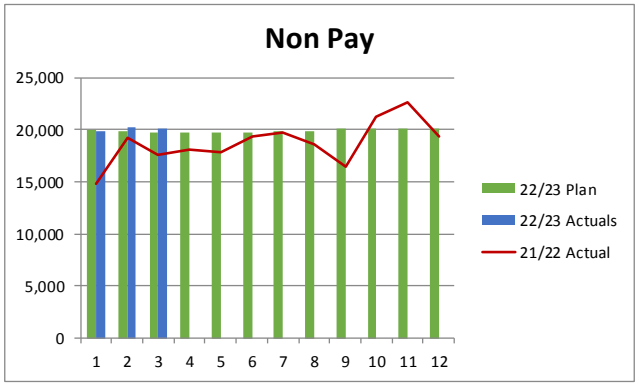
Finance in a page

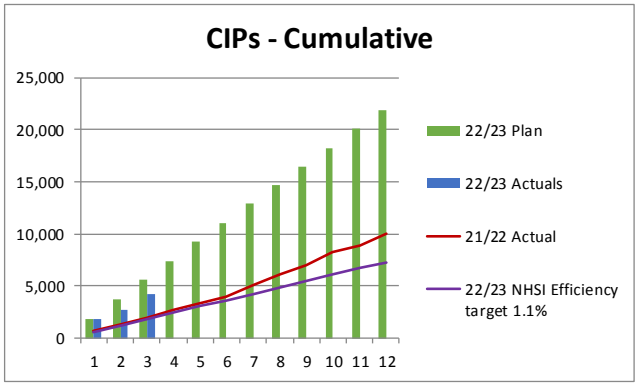


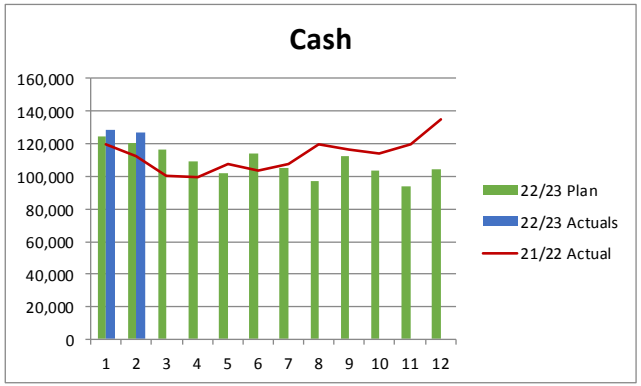


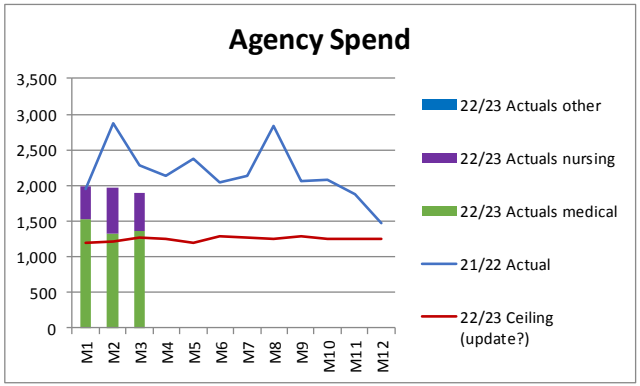


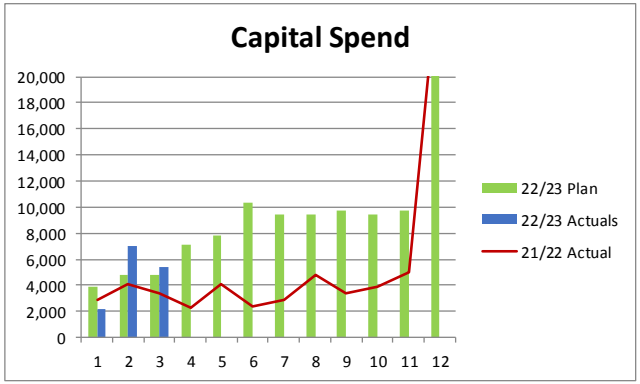




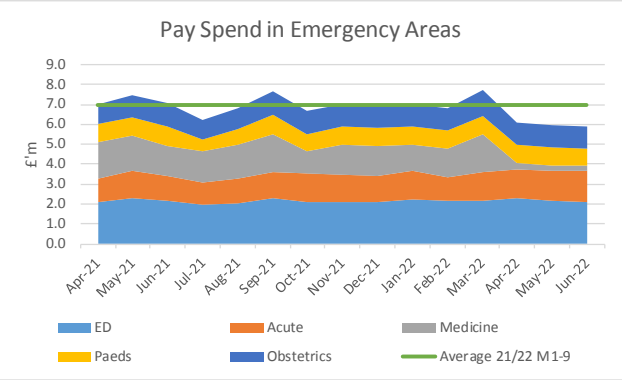


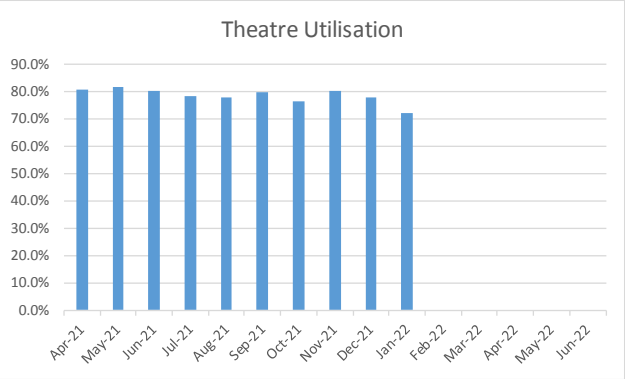


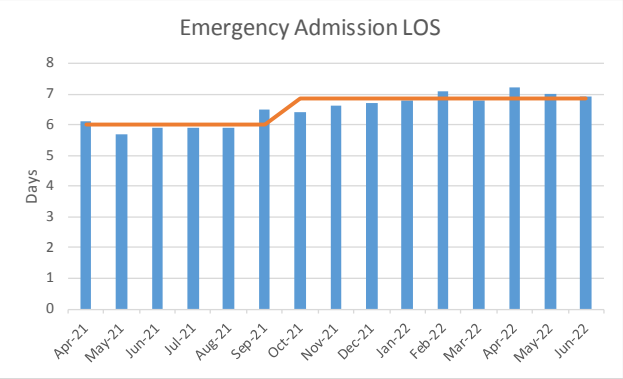


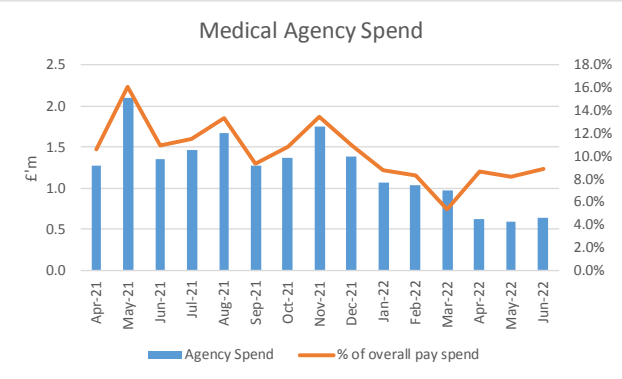


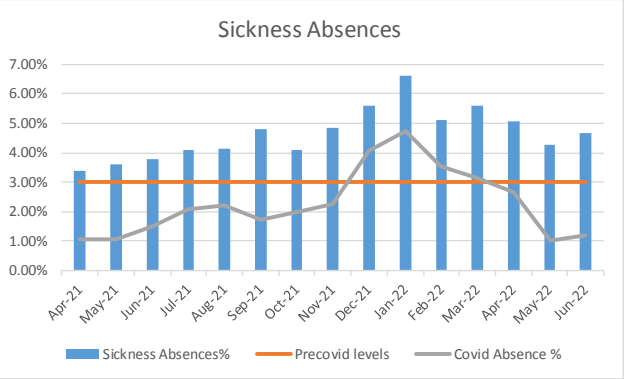
Finance Performance Indicators

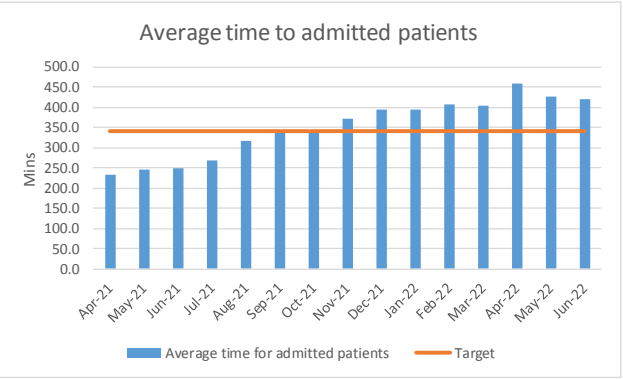




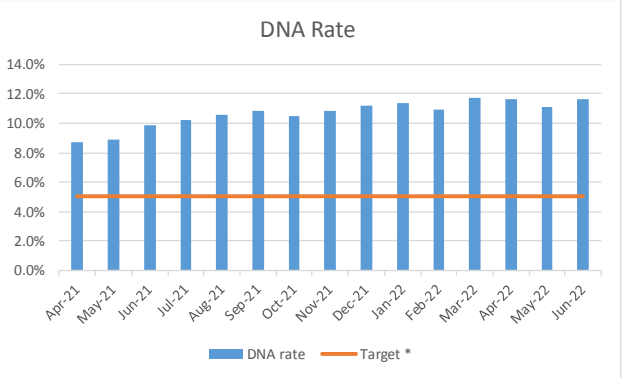


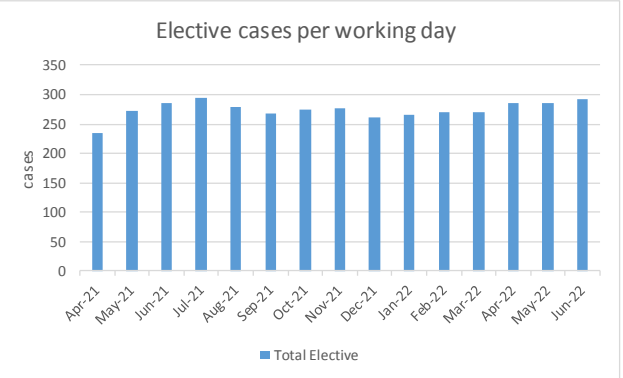






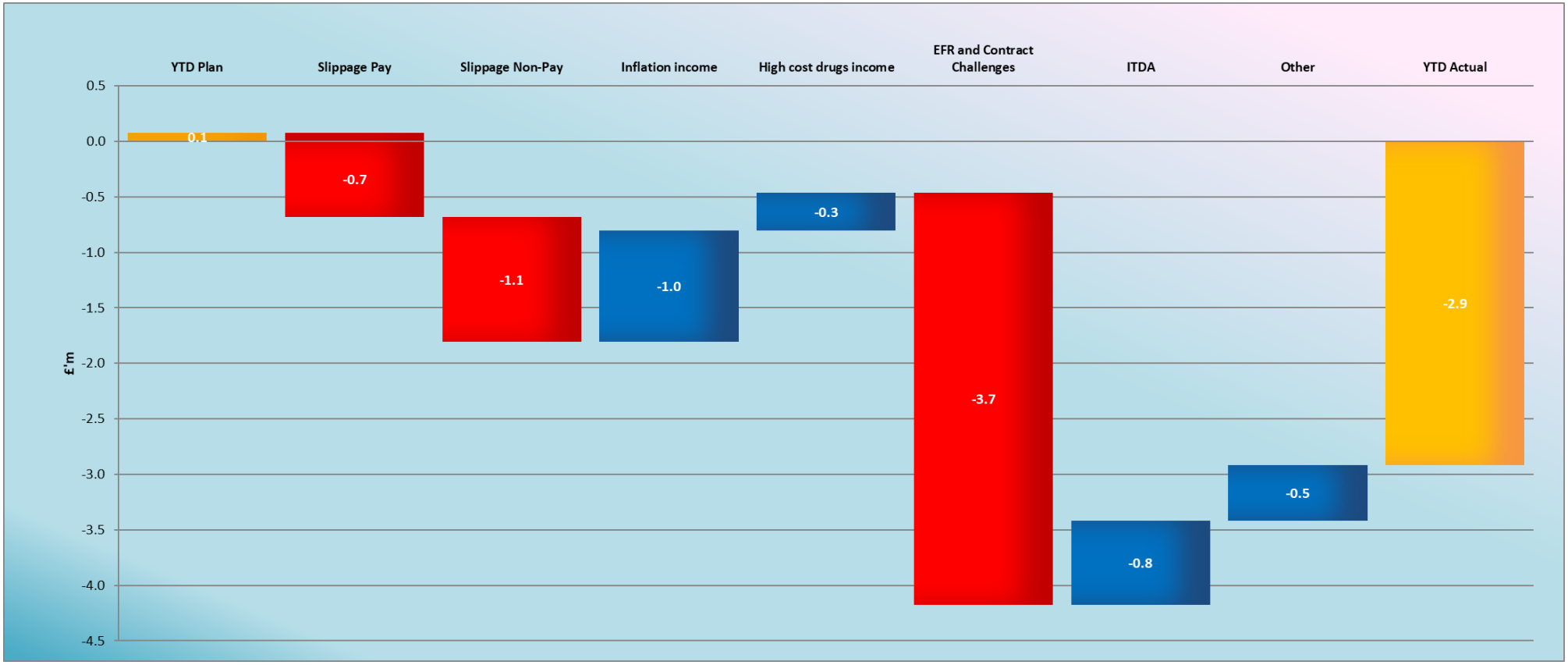
ERF % achievement - with high impact specialties included





*Model Hospital data on DNA% (National Mean is 5.87%, upper quartile is sub 5%.)
**Long term will look to replace theatre utilisation with number of unutilised theatre lists

Revenue and Expenditure Bridge between Budget and Actuals



Income and Expenditure Statement

Operating Income and Expenditure	Year Actuals 2021/22 £'000	Full Year Budget 2022/23 £'000	YTD Budget 2022/23 £'000	YTD Actuals 2022/23 £'000	YTD Variance 2022/23 £'000	In Month Budget 2022/23 £'000	In Month Actuals 2022/23 £'000	In Month Variance 2022/23 £'000
NHS Contract Income	651,372	653,817	163,441	164,862	1,422	54,667	53,711	-956
Other Income	62,842	48,752	12,089	12,230	141	3,810	3,961	151
Total Income	**714,214**	**702,569**	**175,530**	**177,093**	**1,563**	**58,477**	**57,672**	**-805**
Consultants	88,616	82,497	20,629	21,597	968	6,897	7,223	326
Other Medics	68,709	68,157	17,039	18,377	1,338	5,673	5,950	276
Nurses	168,445	175,294	43,746	42,775	-971	14,604	14,394	-210
Scientific, therapeutic & technical	74,765	77,115	19,279	18,721	-557	6,480	6,222	-259
Other Pay	44,016	51,122	12,745	12,729	-17	4,211	4,074	-137
Total Pay	**444,551**	**454,186**	**113,439**	**114,199**	**760**	**37,866**	**37,863**	**-3**
Drugs	54,957	54,223	13,556	13,928	372	4,519	4,716	197
Clinical Supplies	66,405	56,664	14,204	14,523	319	4,749	4,987	238
General Supplies	30,265	31,739	7,935	8,195	260	2,645	2,617	-28
CNST	26,732	23,514	5,879	5,877	-1	1,960	1,959	0
Other Non-Pay	62,217	49,028	12,136	12,307	170	3,890	4,360	470
Total Non-Pay	**240,576**	**215,169**	**53,709**	**54,829**	**1,120**	**17,762**	**18,638**	**877**
EBITDA	**29,087**	**33,214**	**8,381**	**8,065**	**-317**	**2,849**	**1,171**	**-1,678**
ITDA	28,738	33,214	8,305	7,550	-755	2,768	2,119	-649
Trading Position	**349**	**0**	**77**	**515**	**438**	**80**	**-948**	**-1,029**
Inventory Donation from DHSC Inc.	2,435	0	0	0	0	0	0	0
Cost of Inventory donation from DHSC	-2,435	0	0	0	0	0	0	0
ERF and Contract Challenges	0	0	0	-3,627	-3,627	0	-1,028	-1,028
Total Operating Surplus/Deficit (-)	**349**	**0**	**77**	**-3,112**	**-3,188**	**80**	**-1,976**	**-2,057**
Impact of Impairments	93	0	0	0	0	0	0	0
Depreciation of Donated Assets	1,060	886	221	200	-22	74	52	-22
Donated Assets Income	-453	-886	-221	-6	215	-74	-6	67
Remove impact of consum. donated by DHSC	497	0	0	0	0	0	0	0
Adj. Financial Performance Surplus/Deficit	**1,547**	**0**	**77**	**-2,918**	**-2,995**	**80**	**-1,930**	**-2,011**

- The Trust has delivered a £2.9m deficit year to date against a £0.1m suplus plan.

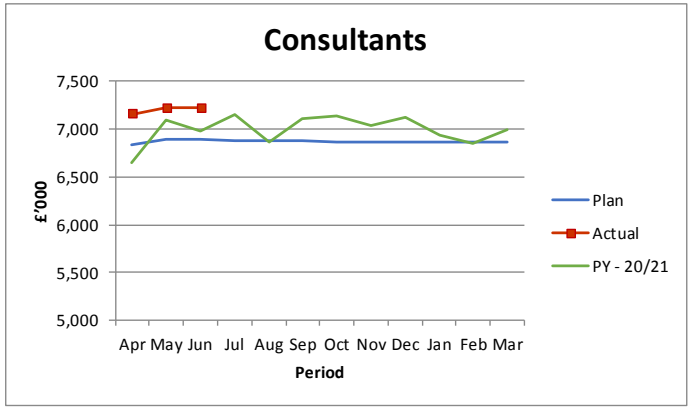
- NHS contract income overperformance relates to £1m inflation monies, £0.3m high cost drug income and £0.1m of out of envelope covid costs reimbursement.

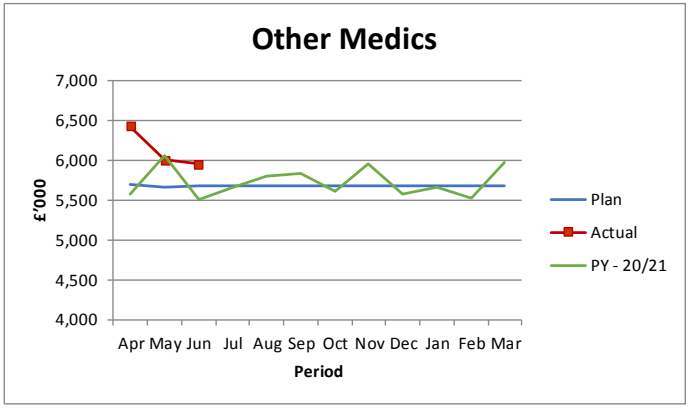
- The main contributory factor is under delivery against the 104% ERF target. The Trust has assumed the minimum payment, which is 25% of total ERF funding. This results in a £3.6m reduction in income.

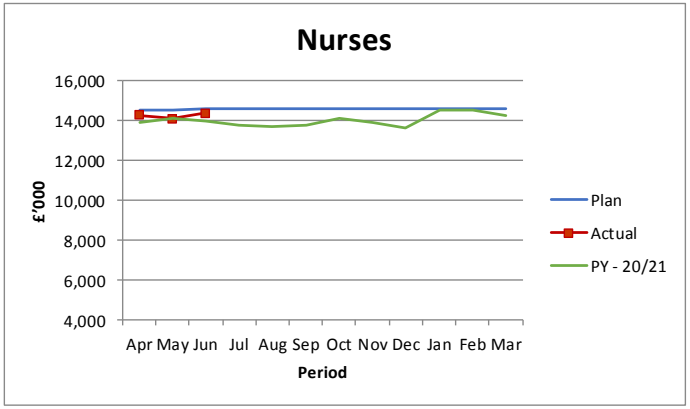
- Medical pay remains high across consultants and other medics and is running at higher than 21/22 levels. The key areas of overspend are in Paediatrics £421k, Maternity £248k, Upper GI £202k, Medical day units £108k, T&O £109k, Theatres £103k and Haematology £99k.

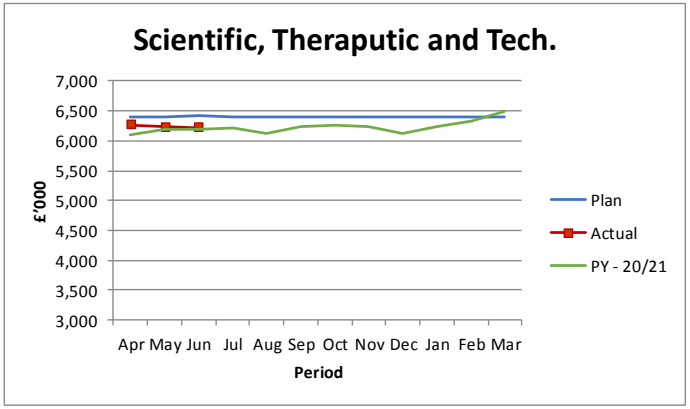
- Overall Non-pay is overspent by £1.1m. Drugs are in part offset by 0.3m of HCD income. General Supplies £260k overspent YTD. £239k relates to outsourced catering and cleaning services. Clinical Supplies is £319k overspent YTD.This is made up of £140k Trauma products, £96k imaging maintenance contracts and £68k outsourced reporting. The other non-pay variance mainly relates to £130k energy costs and £226k onwork permit applications

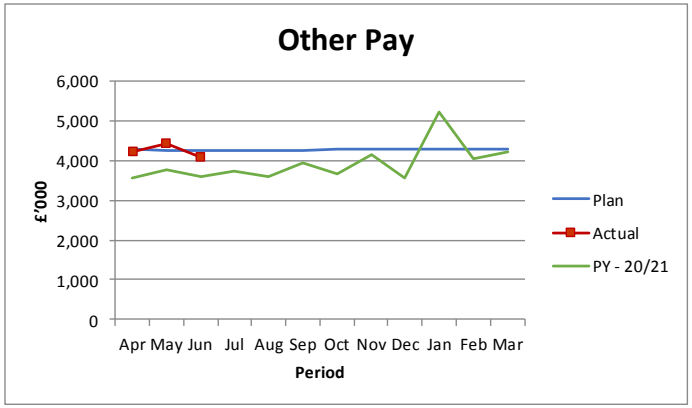
Pay Trends











Overall the Trust has not had a good start to 22/23, with overspends on consultant and other medical spend lines. Quarter 1's spend was significantly above 22/23 levels.

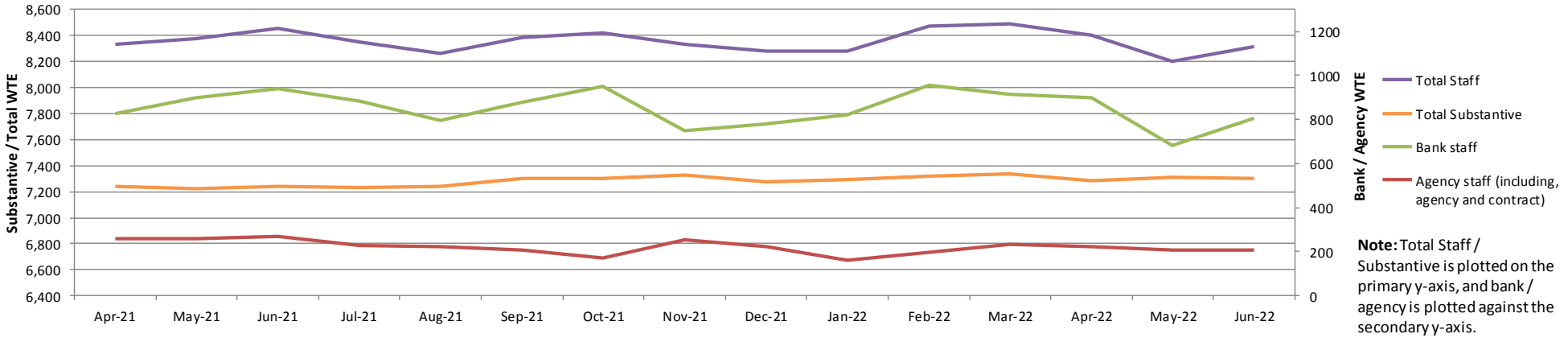
Consultant spend is £326k over in month. In line with the last 2 months spend. The key areas leading to the overspend are Dermatology £158k, Clinical Haematology £139k, Maternity £94k, Acute medicine £93k, Pathology £82k, Imaging £81k, Cardiology £64k and Paediatrics £61k.

Other medics spend is £276k over in month. The key areas of concern are Paediatrics £360k, T&O £201k, Upper GI £171k, Maternity £153k and Medicine £108k and Respiratory £100k.

At a macro level, nursing spend is underspent year to date. Spend is now more in line with 21/22 levels. However, Acute Medicine £194k (Escalation Ward £54k), Emergency Medicine £141k (Bedford ED £94k,), Surgical wards £156k (Richard Wells and Howard Ward £105k) and Care of the Elderly Wards £134k are overspending. This is being offset by vacancies in NICU and Delivery suite and Maternity wards.

Substantive, Bank and Agency Staff – Provider Workforce Return

	2021/22												2022/23		
	Month 1 Apr-21 WTE	Month 2 May-21 WTE	Month 3 Jun-21 WTE	Month 4 Jul-21 WTE	Month 5 Aug-21 WTE	Month 6 Sep-21 WTE	Month 7 Oct-21 WTE	Month 8 Nov-21 WTE	Month 9 Dec-21 WTE	Month 10 Jan-22 WTE	Month 11 Feb-22 WTE	Month 12 Mar-22 WTE	Month 01 Apr-22 WTE	Month 02 May-22 WTE	Month 03 Jun-22 WTE
Registered nursing, midwifery and health visiting staff (substantive total)	2,317	2,309	2,318	2,325	2,334	2,332	2,363	2,380	2,380	2,389	2,390	2,410	2,377	2,369	2,357
Registered Scientific, therapeutic and technical staff (substantive total)	805	802	801	794	796	819	813	813	812	805	805	805	803	805	800
Registered ambulance service staff (substantive total)	2	2	2	2	2	2	2	0	0	0	0	0	2	3	2
Support to clinical staff (substantive total)	2,200	2,200	2,204	2,211	2,192	2,211	2,178	2,160	2,129	2,154	2,159	2,150	2,134	2,166	2,161
Total NHS infrastructure support (substantive total)	874	868	873	871	880	887	886	894	891	885	891	889	880	880	891
Medical and dental (substantive total)	1,043	1,040	1,040	1,028	1,038	1,047	1,055	1,077	1,059	1,060	1,071	1,082	1,083	1,083	1,087
Any other staff (substantive total)	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Total Substantive	**7,244**	**7,223**	**7,240**	**7,235**	**7,244**	**7,300**	**7,299**	**7,328**	**7,274**	**7,296**	**7,319**	**7,339**	**7,281**	**7,309**	**7,301**
Bank staff	**825**	**898**	**940**	**884**	**797**	**877**	**951**	**750**	**778**	**822**	**955**	**914**	**899**	**683**	**808**
Agency staff (including, agency and contract)	**261**	**257**	**270**	**228**	**223**	**208**	**170**	**255**	**223**	**162**	**196**	**235**	**224**	**206**	**209**
Total Staff	**8,330**	**8,378**	**8,451**	**8,347**	**8,264**	**8,385**	**8,420**	**8,333**	**8,275**	**8,280**	**8,470**	**8,488**	**8,404**	**8,199**	**8,318**



Note: Total Staff / Substantive is plotted on the primary y-axis, and bank / agency is plotted against the secondary y-axis.

Agency Spend

£'000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
22/23 Monthly Plan	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	
22/23 Monthly Actual	2,262	2,271	0	0	0	0	0	0	0	0	0	0	
21/22 Monthly Actual	1,955	2,873	2,279	2,143	2,369	2,043	2,137	2,836	2,068	2,087	1,873	1,476	
22/23 Cum. Plan	2,000	4,000	6,000	8,000	10,000	12,000	14,000	16,000	18,000	20,000	22,000	24,000	
22/23 Cum. Actual	2,262	4,533											
21/22 Cumm. Actual	1,955	4,828	7,107	9,250	11,618	13,661	15,799	18,635	20,702	22,789	24,662	26,138	
Plan	**2,000**	**2,000**	**2,000**	**2,000**	**2,000**	**2,000**	**2,000**	**2,000**	**2,000**	**2,000**	**2,000**	**2,000**	**4,000**
22/23 Medics Plan	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	3,600
22/23 Nurses Plan	460	460	460	460	460	460	460	460	460	460	460	460	1,380
22/23 Other Clinical Plan	220	220	220	220	220	220	220	220	220	220	220	220	660
22/23 A&C Plan	120	120	120	120	120	120	120	120	120	120	120	120	360
Actuals	**2,262**	**2,271**	**2,142**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**6,675**
22/23 Medics Actuals202301	1,523	1,330	1,367	0	0	0	0	0	0	0	0	0	4,220
22/23 Nurses Actuals	465	641	535	0	0	0	0	0	0	0	0	0	1,642
22/23 Other Clinical Actuals	238	273	216	0	0	0	0	0	0	0	0	0	727
22/23 A&C Actuals	36	27	24	0	0	0	0	0	0	0	0	0	87

Contract Income	Income by Commissioner

Commissoner £m	Annual Budget	YTD Budget	YTD Actual	YTD Variance
NHS Bedford Luton Milton Keynes CCG	526.0	131.5	132.3	0.8
NHS England	33.1	8.3	8.3	0.1
Herts Valley Service Agreement*	33.1	8.3	8.3	0.1
E&N Herts Service Agreement*	0.0	0.0	0.0	0.0
Aylesbury Vale CCG Service agreement	5.1	1.3	1.3	0.0
LAT - East of England	21.4	5.3	5.4	0.0
LAT - Midlands	1.0	0.3	0.3	0.0
NHS England Drugs Adjustment	0.0	0.0	0.0	0.0
NHS England - Cost and Volume Drugs	19.4	4.9	5.2	0.4
CDF Drugs	1.7	0.4	0.4	0.0
Hep C Drugs	0.2	0.1	0.0	0.0
NHS England Devices	1.0	0.2	0.2	0.0
Northamptonshire CCG	2.8	0.7	0.7	0.0
Cambridgeshire & Peterborough CCG	2.4	0.6	0.6	0.0
Norfolk & Waveney CCG	0.9	0.2	0.2	0.0
North Central London CCG	0.8	0.2	0.2	0.0
Low Value Activity Contracts (LVA)	3.8	1.0	1.0	0.0
Total Contract Income	**652.7**	**163.2**	**164.5**	**1.3**

Headway is being made in agreeing contracts for 22/23. BLMK CCG contracts have been signed. Herts and West Essex CCGs value have been agreed in principle. The remaining CCGs are looking to finalise over the next few weeks.

ERF values are incorporated within these budget values. Underperformance has been accounted for at a global level in the I&E.

The overperformance against the BLMK, NHS England and Herts Valley relates to application of some of the additional inflation monies.

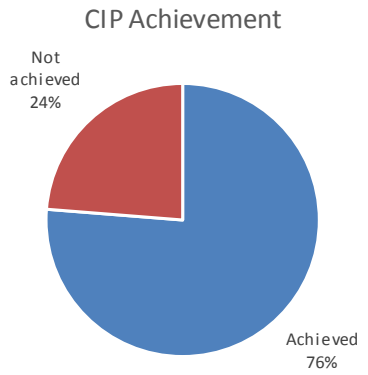
* When CCGs become ICSs from 1st July, Herts Valley CCG and East and North Herts CCG will merge to become Hertfordshire and West Essex CCG. Hence the budget appears on the Herts Valley line.

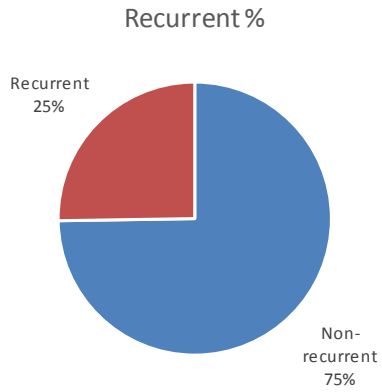
Cost Improvement Programme – £4.2m delivered against £5.5m plan

Overall the Trust is achieving 76% of its cost improvement programme. Key area of underperformance is in constraining vacancy factors in multiple areas in addition to reductions in agency across Medicine and care of the Elderly.

BAU Merger title for FIP reporting	YTD Plan	YTD Actual	YTD Var	Comments
Vacancy Factors	2,719	2,208	512	
Reduction in Agency	369	126	243	Medicine and Care of the Elderly
Private Patient Income Generation	300	223	77	Marginally behind
CNST Bonus Monies	264	264	0	
Procurement	221	197	24	
Other	212	176	36	
Pathology -TOM Saving	167	104	62	
Endoscopy 5th room - PYE savings	163	163	0	
Cauldwell Slippage	135	135	0	
Stretch Savings	135	72	62	
Drugs Optimisation	125	42	83	
Pay	124	124	0	IT service desk are no longer replenishing stock
VAT Saving	114	98	17	
IT Hardward Savings	93	14	79	
Capital medical equip. purchase	74	74	0	
ELFT support for Mental Health nursing spend	64	64	0	
Blood Contract Saving	55	45	10	
Professional and Consultancy Fees	38	19	19	
2% increase in Education LDA	36	12	24	
Mental Health Income	31	28	3	
Saving on cleaning contract	24	8	16	
Covid Spend	23	0	23	
Maternity Pathways Income Recovery	21	21	0	
Cross site Merger benefit	20	7	13	
Theatre Productivity	17	1	15	
Travel Expenses	14	14	0	
Grand Total	**5,561**	**4,240**	**1,320**	

Recurrent/ Non Recurrent	YTD Plan	YTD Actual	YTD Var
Non-recurrent	4,094	3,170	924
Recurrent	1,467	1,071	396
Grand Total	**5,561**	**4,240**	**1,320**





*2/3rds of the non-recurrent is vacancy factor which is actually a recurrent CIP as there is a natural level of vacancy factor

Statement of Financial Position

Statement of Financial Position	Closing 31 Mar 22 £000s	Closing 30 Jun 22 £000s
Non-Current Assets		
Property, plant and equipment	341,768	380,887
Trade and other receivables	2,716	2,689
Other assets	1,836	1,797
Total non-current assets	**346,320**	**385,373**
Current assets		
Inventories	8,819	7,819
Trade and other receivables	15,135	11,251
Cash and cash equivalents	135,016	119,776
Total current assets	**158,970**	**138,846**
Current liabilities		
Trade and other payables	-95,612	-88,708
Borrowings	-2,219	-4,076
Provisions	-3,927	-3,920
Other liabilities	-6,003	-5,678
Total current liabilities	**-107,762**	**-102,382**
Total assets less current liabilities	**397,528**	**421,837**
Non-current liabilities		
Borrowings	-26,313	-51,307
Provisions	-7,293	-7,280
Total non-current liabilities	**-33,606**	**-58,588**
Total assets employed	**363,922**	**363,250**
Financed by (taxpayers' equity)		
Public Dividend Capital	256,433	256,433
Revaluation reserve	26,153	28,593
Income and expenditure reserve	81,336	78,224
Total taxpayers' equity	**363,922**	**363,250**

CAPITAL PLAN

Report for Month 3

The 22/23 CDEL allocation for Bedfordshire Hospitals is £27.2m of a total of £43m for the STP. The overall capital plan comes to £89m, including centrally funded and donated asset schemes.

The Trust has spent £14.5m on capital this year. The Trust spent £8.9m against the CDEL limit of £27.2m.

The capital plan has been updated to reflect the proposed increase in the UEC project within the CDEL. This is subject to FIP approval.

Capital Plan

£m	Funding Source	Requires Bus Case	2019/20 Actual	2020/21 Actual	2021/22 Actual	2022/23 FOT	2022/23 Act	2023/24 FOT	2024/25 FOT	2025/26 FOT	Total	Commentary By exception
Site Redevelopment team &O'hds	Internal		0.4	0.9	0.7	1.0	0.2	1.1	1.0	0.0	**5.1**	**In line with report at Hospital Redevelopment**
Enabling Schemes (PDC funded)	PDC - Other		0.1	0.9	0.0	0.0	0.0	0.0	0.0	0.0	**1.0**	
Enabling Schemes (internally funded)	Internal		0.1	7.7	4.7	0.3	0.0	0.0	0.0	0.0	**12.7**	
New Clinical Buildings (PDC funded)	PDC - ASB		0.0	0.0	5.6	44.9	5.6	67.5	0.0	0.0	**118.0**	**Net position in 22/23 £40m**
New Clinical Buildings (internally funded)	Internal		1.2	2.2	0.7	0.0	0.0	2.0	20.4	2.0	**28.4**	**Need to understand overall phasing**
PDC - ASB - Match Spend to Approval	PDC - ASB		0.0	0.0	0.0	15.1	0.0	-15.1	0.0	0.0	**0.0**	
PDC - ASB - Match Spend to Approval	Internal		0.0	0.0	0.0	-15.1	0.0	15.1	0.0	0.0	**0.0**	
Lewsey Road Carpark	Internal		0.0	0.1	-0.2	0.0	0.0	0.0	0.0	0.0	**-0.1**	
Lewsey Road Carpark (PDC)	PDC - Other		0.1	4.9	0.0	0.0	0.0	0.0	0.0	0.0	**5.0**	
Helipad - see offset below	Internal	Y	0.0	0.0	0.0	0.0	0.0	0.0	19.7	0.0	**19.7**	
Energy Centre Building	Internal		0.3	1.7	9.6	5.1	1.1	1.2	0.0	0.0	**17.9**	
Energy Conservation Measures (Salix)	Internal		0.1	0.9	3.8	2.0	-0.4	2.5	0.0	0.0	**9.2**	
Generators	Internal		2.2	0.3	0.9	0.0	-0.2	0.0	0.0	0.0	**3.4**	
Electrical Infrastructure	Internal		3.2	2.7	0.0	1.3	0.0	0.0	0.0	0.0	**7.2**	
Hospital Redevelopment (sub-total)			**7.5**	**22.3**	**25.8**	**54.6**	**6.3**	**74.3**	**41.1**	**2.0**	**227.6**	
Hospital Redevelopment Additional Staff Approval	Internal		0.0	0.0	0.0	0.6	0.0	0.6	0.6	0.0	**1.8**	**In line with report at Hospital Redevelopment**
UEC - Luton	PDC - UEC		0.0	4.2	12.8	0.0	0.0	0.0	0.0	0.0	**17.0**	
UEC - Luton (Trust)	Internal		0.0	-3.0	-4.5	13.7	2.5	2.2	0.0	0.0	**8.4**	**Some slippage expected into 23/24**
Cauldwell Centre Refurbishment	PDC - Other	Y	0.0	0.0	5.9	0.0	0.0	0.0	0.0	0.0	**5.9**	
Cauldwell Centre Refurbishment (internal)	Internal	Y	0.0	0.0	-4.8	5.3	0.9	0.0	0.0	0.0	**0.5**	
Bedford Electrical Infrastructure	Internal	Y	0.0	0.0	0.1	2.4	0.4	1.0	0.0	0.0	**3.5**	**Some slippage expected into 23/24**
UEC - Bedford (Trust)	Internal		0.0	-1.4	1.4	0.2	-0.1	0.0	0.0	0.0	**0.1**	
UEC - Bedford	PDC - UEC		0.0	3.8	0.0	0.0	0.0	0.0	0.0	0.0	**3.8**	
UEC - Bedford (External Donation) - CT Scanner	Donated		0.0	0.0	0.0	0.8	0.0	0.0	0.0	0.0	**0.8**	
ED 2nd floor fit out/ CT enabling	Internal	Y	0.0	0.0	0.0	2.6	0.1	0.0	0.0	0.0	**2.6**	
Primary Care Hub	PDC - Other		0.0	0.0	0.0	0.0	0.0	7.1	0.0	0.0	**7.1**	
Vascular theatres	Internal		0.0	0.0	0.0	0.3	0.0	0.0	0.0	0.0	**0.3**	
Trust Wide DCP	Internal		0.0	0.0	0.0	0.3	0.0	0.0	0.0	0.0	**0.3**	
Total Hospital Redevelopment			**7.5**	**25.9**	**36.7**	**80.6**	**10.1**	**85.2**	**41.7**	**2.0**	**279.5**	
Medical Equipment	Internal		6.0	4.0	4.0	1.8	2.1	0.8	0.8	2.0	**19.4**	**Limit as £12m included in ASB above**
BAU Estate (incl backlog)	Internal		3.1	6.0	6.7	2.0	0.7	2.0	2.0	5.0	**26.8**	
BAU IT	Internal		0.6	2.7	3.0	1.0	0.2	1.0	1.0	1.0	**10.3**	
BAU CapEx			**9.7**	**12.7**	**13.7**	**4.8**	**3.0**	**3.8**	**3.8**	**8.0**	**56.4**	

Capital Plan Continued

£m	Funding Source	Requires Bus Case	2019/20 Actual	2020/21 Actual	2021/22 Actual	2022/23 FOT	2022/23 Act	2023/24 FOT	2024/25 FOT	2025/26 FOT	Total	Commentary By exception
Hospital Redevelopment - Other Depts	Internal		0.0	0.2	0.2	0.0	0.0	0.0	0.0	0.0	**0.5**	
Imaging Corridor Works	Internal		0.6	0.5	0.0	0.0	0.0	0.0	0.0	0.0	**1.2**	
Helipad offset	Internal	Y	0.0	0.0	0.0	0.0	0.0	0.0	-19.7	0.0	**-19.7**	
PAS	Internal	Y	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**	**Not affordable in current plan**
IT Merger Enabling - Part of £168m	Internal		0.1	1.4	1.4	2.0	0.1	2.0	1.1	0.0	**8.0**	
Pathology Joint Venture (PDC) - Part of £168m	Internal		1.8	1.1	0.0	0.0	0.0	0.0	0.7	0.0	**3.6**	
GDE - Next Phase Business Cases (EPR)	Internal	Y	0.0	0.0	2.5	0.0	0.1	0.0	0.0	0.0	**2.5**	
STP Portal - Phase 2 (includes HSLI Digital monies)	Internal		0.0	-2.1	0.9	2.0	0.2	-0.7	0.0	0.0	**0.0**	
Pharmacy Robot	Internal		0.0	0.0	0.7	0.2	0.2	0.0	0.0	0.0	**0.9**	
Prior Year Schemes - Internal	Internal		7.3	-3.1	2.5	0.0	0.3	0.0	0.0	0.0	**6.7**	
Prior Year Schemes - PDC - GDE	PDC - GDE		7.7	3.6	0.0	0.0	0.0	0.0	0.0	0.0	**11.3**	
Prior Year Schemes - PDC - Other	PDC - Other		2.5	15.4	9.5	0.0	0.0	0.0	0.0	0.0	**27.4**	
Other - Luton	Internal		0.3	0.2	0.3	0.0	0.3	0.0	0.0	0.0	**0.8**	
Other (PDC) Non IT (internal 22/23)	Internal		0.0	0.0	-1.0	0.0	0.0	0.0	0.0	0.0	**-1.0**	
Digital Pathology/ Imaging (Trust)	Internal		0.0	0.0	-1.3	0.9	0.2	0.4	0.0	0.0	**0.0**	
ED X-Ray to Cauldwell	Internal	Y	0.0	0.0	0.4	0.0	0.0	0.0	0.0	0.0	**0.4**	
Vascular theatres - PDC	PDC - Other	Y	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	**1.0**	
Vascular theatres - Slippage	Internal		0.0	0.0	-0.6	0.0	0.1	1.8	0.0	0.0	**1.2**	
UEC - Bedford (Charity funding)	Donated		0.0	0.0	0.4	0.0	0.0	0.0	0.0	0.0	**0.4**	
Donated Assets/ Impact of IFRIC12	Donated		0.2	2.5	0.2	0.8	0.0	0.0	0.0	0.0	**3.7**	
Normal slippage	Internal		0.0	0.0	0.0	-2.2	0.0	-5.4	-0.1	7.7	**0.0**	
Other	Internal		0.6	0.0	0.3	0.0	0.0	0.0	0.0	9.8	**10.6**	
Other Schemes			**21.2**	**19.6**	**17.4**	**3.7**	**1.4**	**-1.9**	**-17.9**	**17.5**	**59.6**	
Combined BAU capital plan			**38.4**	**58.1**	**67.8**	**89.1**	**14.5**	**87.0**	**27.5**	**27.5**	**395.5**	

Capital Funding Sources

Source of Funding			2019/20 Actual	2020/21 Actual	2021/22 Actual	2022/23 FOT	2022/23 Actual ytd	2023/24 FOT	2024/25 FOT	2025/26 FOT	Total	By exception
Internal			27.8	22.8	32.5	27.5	8.9	27.5	27.5	27.5	**165.7**	**Needs to be £27.5m**
PDC - ASB			0.0	0.0	5.6	60.0	5.6	52.4	0.0	0.0	**118.0**	
PDC - GDE			7.7	3.6	0.0	0.0	0.0	0.0	0.0	0.0	**11.3**	
PDC - UEC			0.0	8.0	12.8	0.0	0.0	0.0	0.0	0.0	**20.8**	
PDC - Other			2.7	21.2	16.3	0.0	0.0	7.1	0.0	0.0	**47.3**	
Donated			0.2	2.5	0.6	1.6	0.0	0.0	0.0	0.0	**4.9**	
Combined BAU capital plan			**38.4**	**58.1**	**67.8**	**89.1**	**14.5**	**87.0**	**27.5**	**27.5**	**368.0**	

Changes Since April FIP					Actual	2022/23	2022/23	2023/24	2024/25	2025/26	Total	
Opening			38.4	58.1	67.8	89.0		87.0	34.1	27.5	**374.5**	
Slippage								-1.0	1.0		**0.0**	
											0.0	
Other											**0.0**	
Change to Capital Plan			**38.4**	**58.1**	**67.8**	**89.0**	**0.0**	**86.0**	**35.1**	**27.5**	**374.5**	

SUMMARY POSITION

- Between April and May sickness reduced by 0.84% to 4.24% in May 2022 from 5.08% in April
- Vacancy rates have reduced slightly from 11.03% in May 2022 to 10.80% in June 2022.
- The overall turnover increased from 15.60% in May 2022 to 16.12% in June 2022
- The overall agency run rate is 10.20% lower in June 2022 when compared to June 2021 equivalent to 24.75 FTE fewer agency staff.
- The overall bank run rate was 24.94% higher in June 2022 when compared to June 2021 equivalent to 151.4 FTE more bank workers.
- The overall training compliance rate increased by 0.26% in June to 79.45%
- The overall appraisal rate increased by 1.17% in June to 67.36%

LUTON & DUNSTABLE UNIVERSITY HOSPITAL SITE

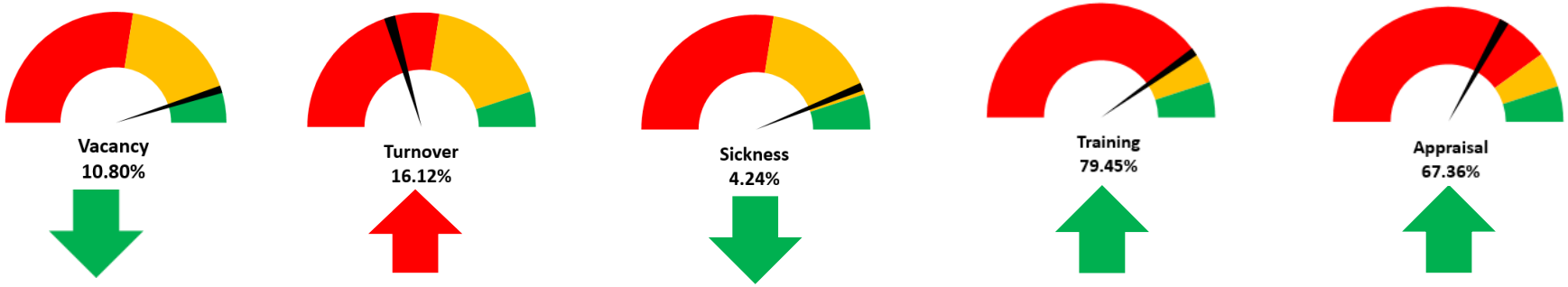
Compared to the previous month:

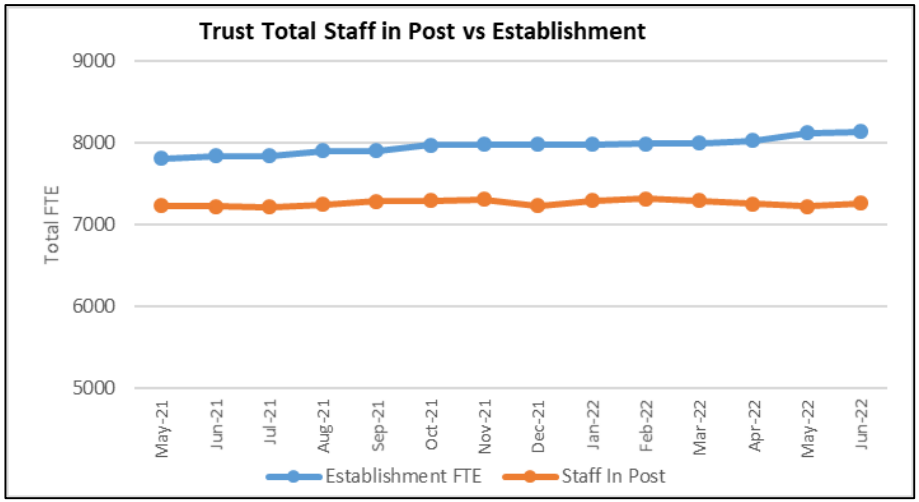
- Sickness absence reduced from 4.04% to 3.90%
- Turnover increased from 15.14% to 15.66
- Vacancy rates reduced by 0.06% from 13.47 to 13.41%
- Appraisals decreased marginally by 0.11% from 67.96% to 67.84%
- Mandatory training compliance increased by 0.35% from 78.67% to 79.01%
- Bank FTE usage in June 2022 increased by 10.34%% in month and is 27.5% higher compared to June 2021
- Agency FTE usage in June 2022 increased by 3.61% in month and has a 15.13% lower run rate compared to June 2021.

BEDFORD HOSPITAL SITE

Compared to the previous month:

- Sickness absence reduced from 5.57% to 4.78%
- Turnover increased marginally from 16.30% to 16.83%
- Vacancy rates reduced 0.54% from 6.92% to 6.38%
- Appraisals increased by 3.16% from 63.45% to 66.61%
- Mandatory training compliance increased by 0.03% 81.01% to 81.04%
- Bank FTE usage in June 2022 increased by 6.95% in month and is 3.87% higher compared to June 2021.
- Agency FTE usage in June 2022 increased by 8.39% in month and has a 0.29% lower run rate compared to June 2021.





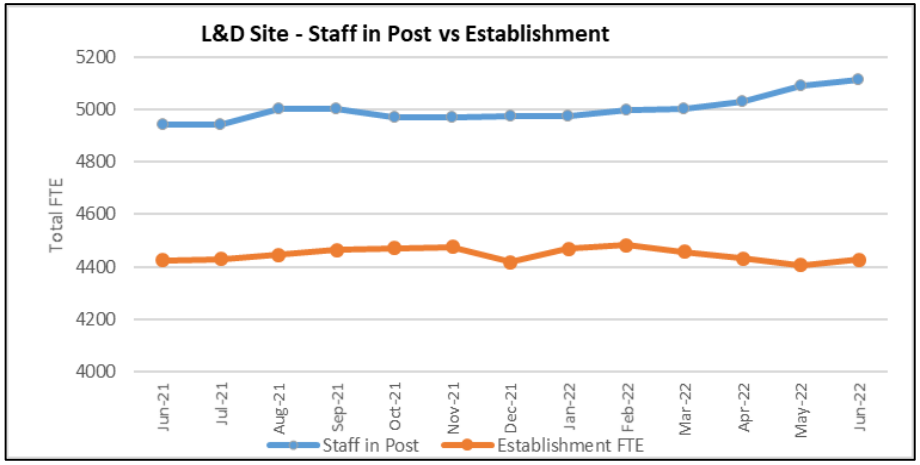
Trust Level Summary

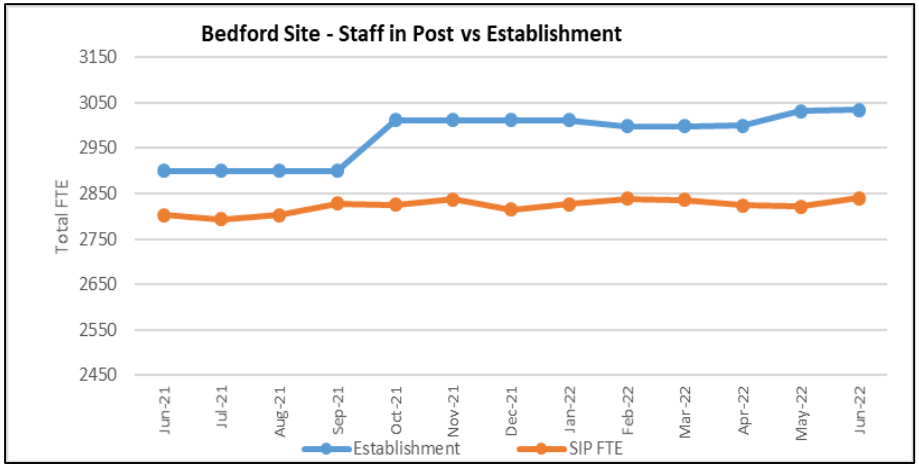
The Trust's overall Staff in Post (SIP) by Whole Time Equivalent (WTE) increased by 40.07 WTE between May 2022 and June 2022.

During the last 12 months the growth rate has been 0.62% (July 2021 to June 2022).

There was an increase in establishment of 92.09 FTE in May as work to update the establishment continues.

The increase in establishment in October is as a result of the of the establishment reconciliation work with the greatest impact at the Bedford site where the establishment was 110.94FTE mainly in Nursing and Midwifery and support workers. This is reflected in the change to the vacancy position on the next slide.





L&D Site

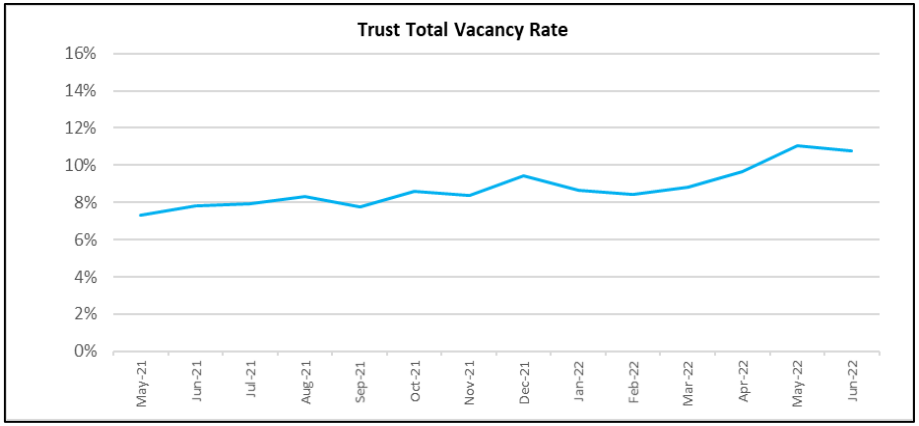
The L&D site overall Staff in Post (SIP) by Whole Time Equivalent (WTE) reduced by 1.92WTE between July 2021 and June 2022. Over the last 12 months the SIP reduced by 0.04% and is due to reduction in Estates and Ancillary staff by 11.68WTE (Porters and HSDU Tech) and reduction in additional clinical services staff by 31.49WTE (CSW). The staff in post increased by 21.06 WTE between May 2022 and June 2022.

Bedford site

The BH site overall Staff in Post (SIP) by Whole Time Equivalent (WTE)) increased by 46.93 WTE between July 2021 and June 2022. Over the last 12 months the SIP increased by 1.66%. The staff in post increased by 19.01WTE between May 2022 and June 2022.

VACANCY

Reporting Period: June 2022

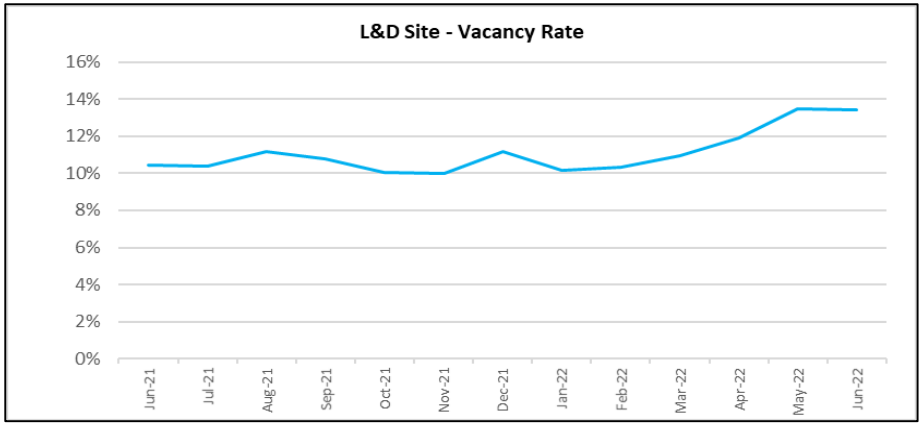


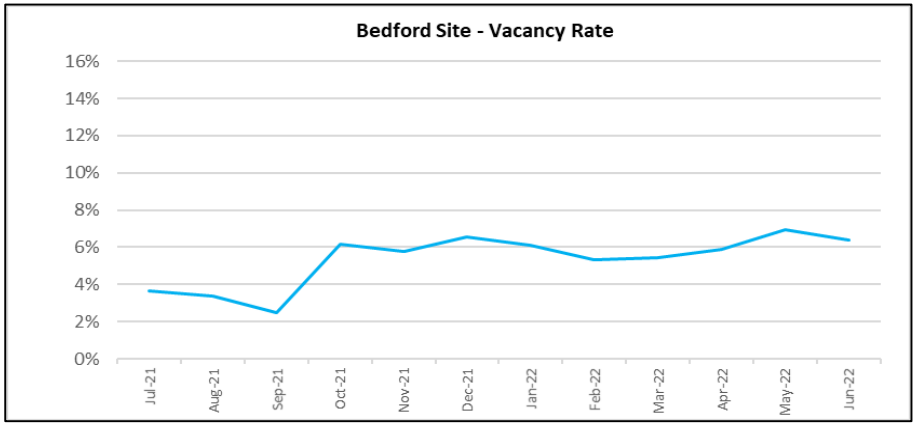
Trust Level Summary

The overall vacancy rate increased over the last 12 months from 7.91% in July 2021 to 10.78% in June 2022 despite the update to funded establishments.

Registered nursing and midwifery vacancy rates are currently 13.23% and have increased by 0.54% from May 2022 and have increased by 4.71% over the last 12 months to June 2022.

Medical and dental vacancy rates have reduced by 1.43% over 12 months to June 2022, currently at 2.22%, which is 0.87% lower than in May 2022. Recruitment to remaining gaps continues with success in recruitment of NHS locums where possible to fill senior medical roles for vacancy hotspots.





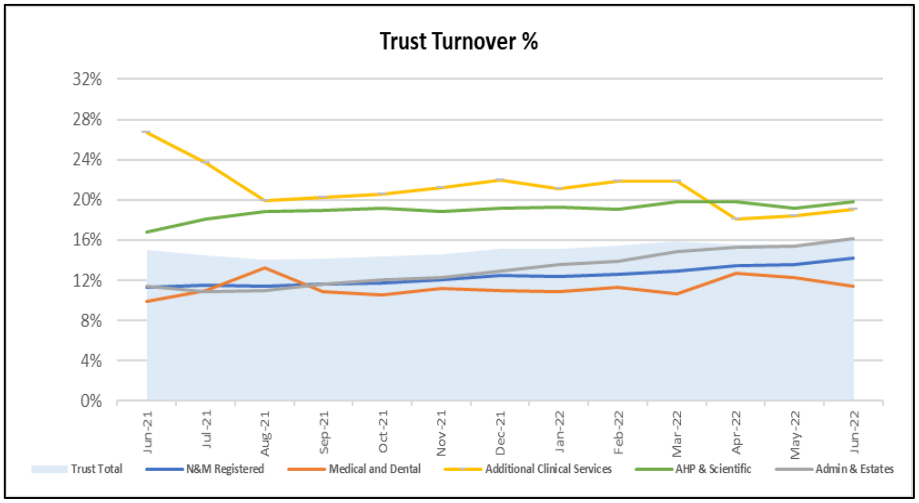
Overseas Recruitment Update

15 overseas nurses started in post throughout June (6 on the L&D site and 9 at Bedford). There are currently 20 nurses scheduled to arrive throughout July and August. Additional overseas campaigns are planned for July in Theatres (Bedford), Paediatrics (Luton) and the general wards. Successful campaigns took place in June for Endoscopy (Luton) with 2 job offers being made and also for the generic ward areas with 19 job offers made. There were 14 OSCE passes throughout the month across both sites.

A further 2 overseas midwives started in post in June (1 on each site). To date there are now 21 overseas midwives in post. 4 of these have now passed their OSCE with further exams scheduled over the next 3 months. 1 overseas midwife is scheduled to arrive in July with a further 6 scheduled for August.

Band 5 Nursing & Midwifery Vacancies

There are currently approximately 176.43 WTE band 5 nursing & midwifery vacancies across the two sites (119.87 WTE at Luton and 56.56 WTE at Bedford). The main reason for this increase in vacancy is due to increased establishment in NICU on the Luton site by 14.67 WTE. We continue to recruit both locally and from overseas and have a consistent pipeline in place. There are currently 81 overseas nurses and midwives (35 at Luton and 46 at Bedford) in various stages of their NMC registration and will convert to Band 5's over the next few months. There are also 85 nurses under offer via local recruitment. Taking into account pipeline, known leavers and current overseas nurses transferring into band 5 positions the adjusted band 5 vacancy figure is -4.96 WTE.



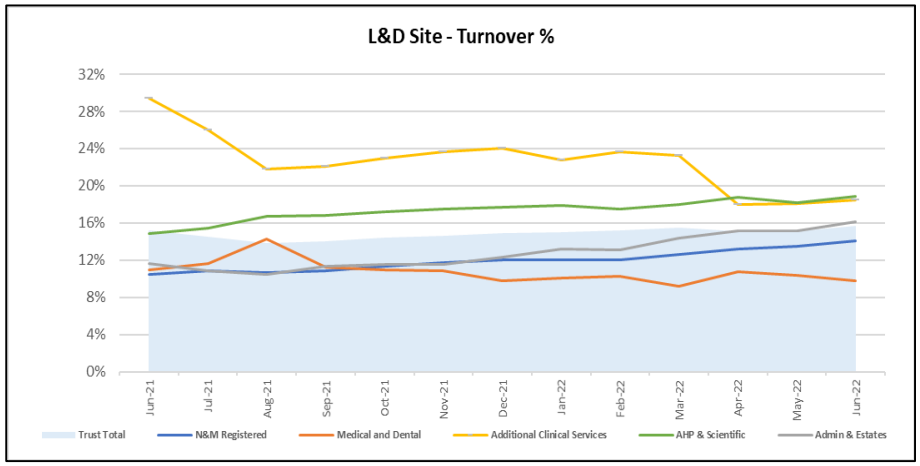
Trust Level Summary

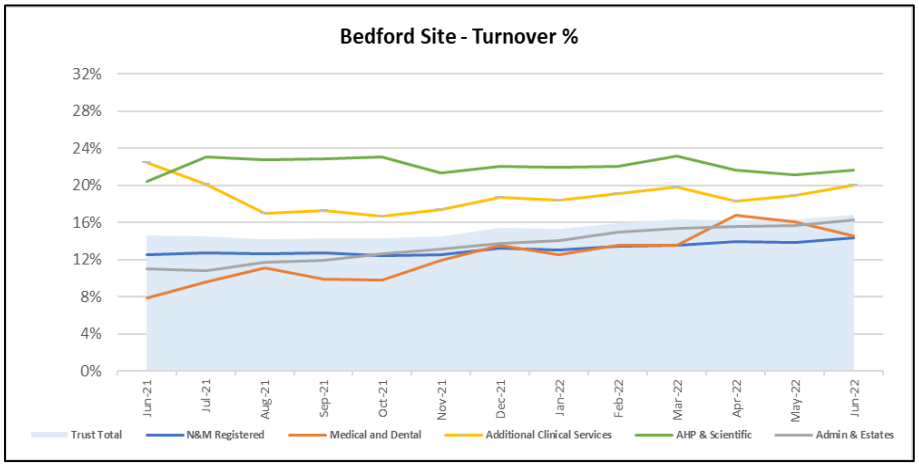
The nursing and midwifery staff group turnover has been increasing (2.61%) over the last 12 months to June 2022 and is currently 14.16% a 0.55% increase on May 2022.

Hotspots remain amongst Allied Health Professionals, (physiotherapists, Operating Department Practitioners and Radiographers) The turnover for Additional professional and scientific staff group increased by 0.65% in June and has a 1.78% increase compared to July 2021.

Additional Clinical Services staff group turnover decreased by 4.62% over 12 months to June 2022 and now stands at 19.07% which is 0.63% higher than last month.

As a result of increased turnover across the NHS, NHSI wrote to all Trusts. As a result we are establishing a group to look at implementing a bundle of measures designed to reduce turnover based on career stages including: a self diagnostic tool, promotion of our preceptorship framework support for early careers, legacy mentoring schemes, national pension seminars and development of menopause policy/guidance.



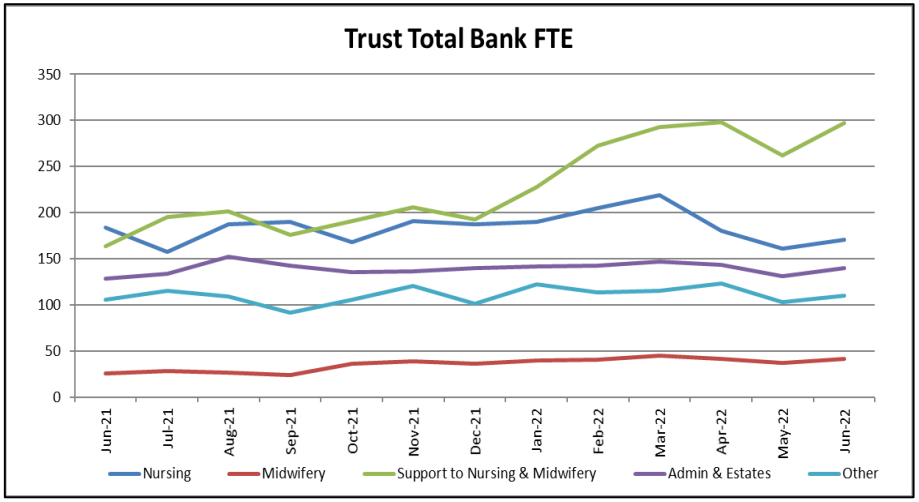


L&D Site

Turnover increased by 0.53% between May 2022 and June 2022. Allied Health Professionals and Scientific staff turnover increased by 0.70%. However, there were small increases amongst the other staff groups. The highest of which was in the Admin and Estates staff group 0.91%. The top leaving reasons in May 2022, were Relocation 24%, Retirement Age 15%, Promotion 15%. Across all leaving reasons 22% transferred to another NHS Organisation.

Bedford site

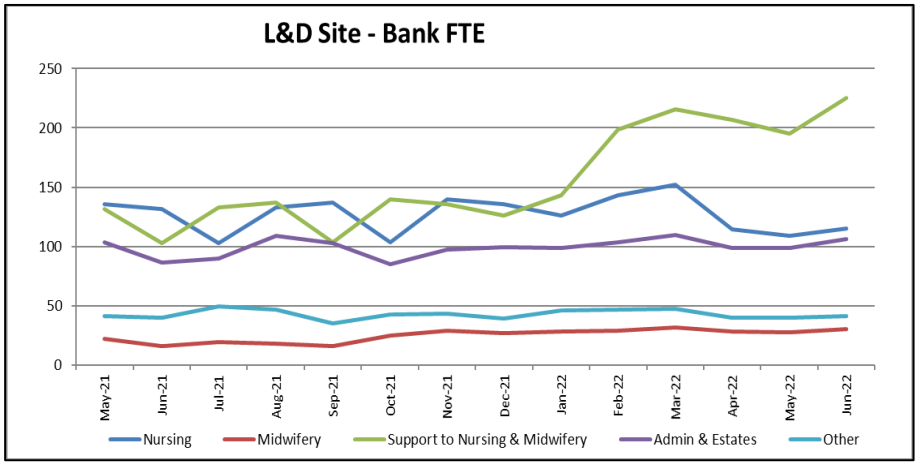
Overall turnover increased by 0.52% between May 2022 and June 2022. The highest increased in turnover was in the Additional Clinical Services staff group by 1.11%. The top leaving reasons in May 2022 for all staff groups were Retirement 25%, Employee Transfer 21% and equal on 11% relocation and flexi-retirement. Across all leaving reasons 21% transferred to another NHS Organisation.

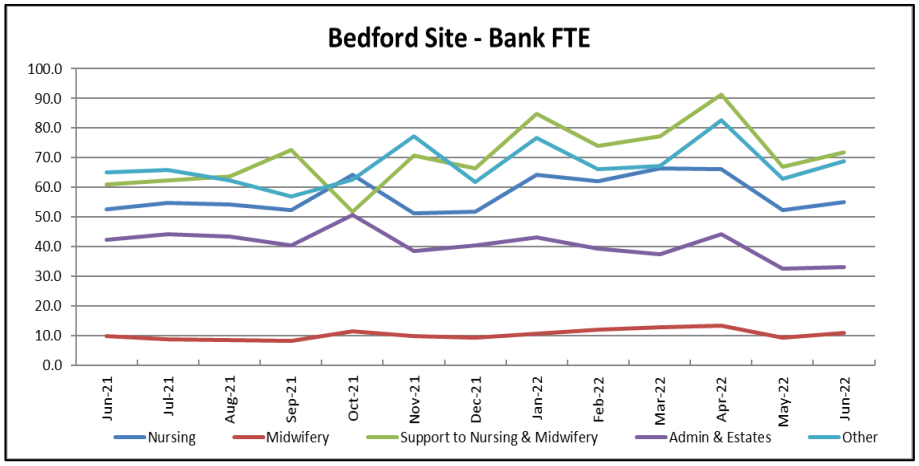


Trust Level Summary

Overall bank usage is 9.25% in May 2022 as compared to May 2021 equivalent to 22.9 FTE fewer bank workers. The bank run rate was 24.94% higher in June 2022 when compared to June 2021 equivalent to 151.4 FTE more bank workers.

Whilst there has been an increase in bank workers following the easing of lockdown restrictions May 2022 remains 22.47% lower than pre-pandemic levels.



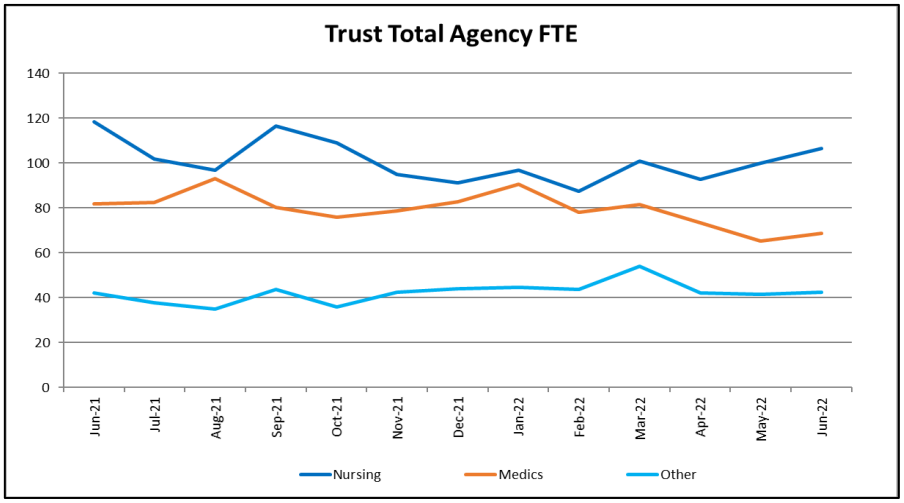


L&D Site:

Bank use has increased by 8.2% from June 2021 to June 2022 equivalent to 142.5 WTE more bank workers in June 2022 compared to June 2021 . Bank FTE usage in June 2022 increased by 10.34% from May 2022.

Bedford site:

Bank use has increased by 3.87% between June 2021 and June 2022 equivalent to 8.9 FTE more bank workers in June 2022 compared to June 2021. Bank FTE usage in June 2022 has increased by 6.95% from June 2022.

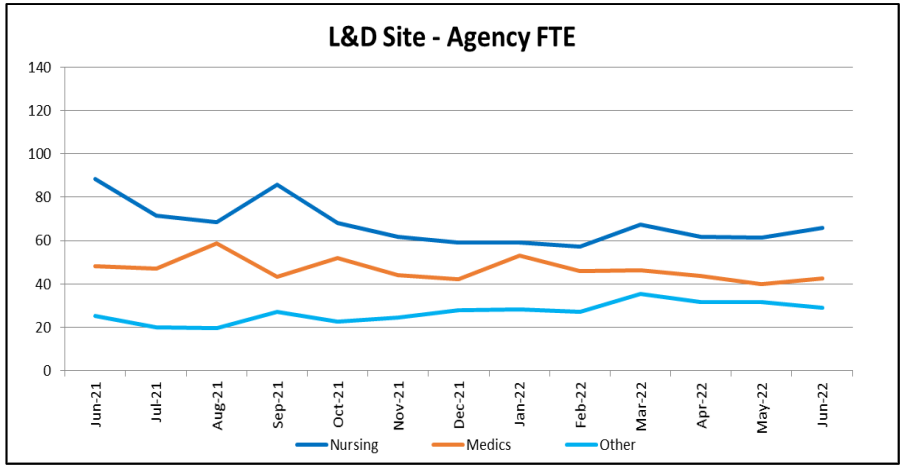


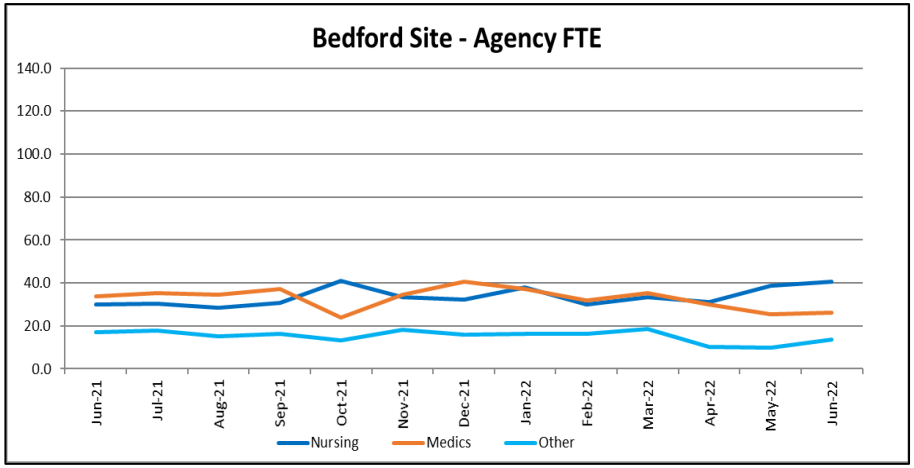
Trust Level Summary

Overall Agency usage reduced by 10.20% in June 2022 as compared to June 2021 equivalent to 24.7 FTE fewer agency staff. The June run rate increased by 5.32% compared to May 2022 equivalent to 11 more agency workers.

There was an increase in the use of nursing agency of 6.16% between May 2022 and June 2022, which was equivalent to 6.57FTE more nursing agency staff.

Medical agency locums increased in the month by 4.96% equivalent to 3.40 FTE more medical agency staff.



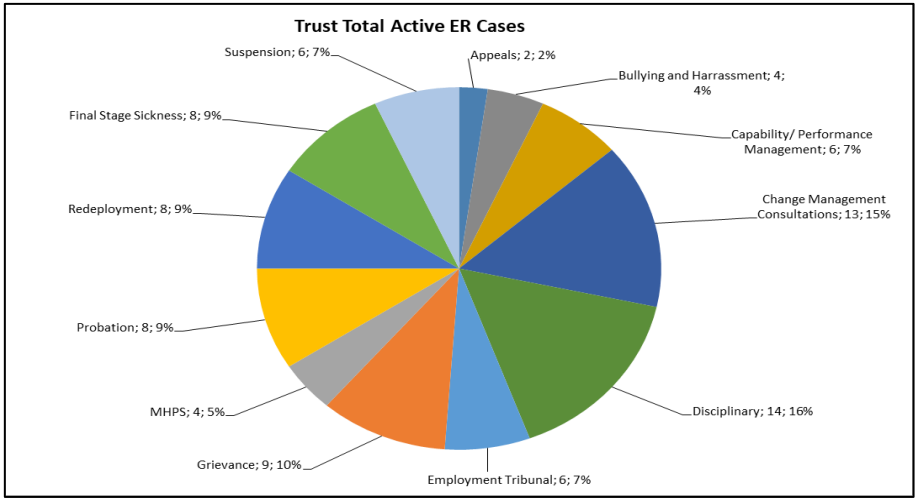


L&D Site

Agency use has a 15.13% lower run rate in June 2022 compared to June 2021 equivalent to 24.5 FTE fewer agency staff. Medical agency locums increased by 6.35% between May 2022 and June 2022 equivalent to 2.7 FTE more agency staff. Nursing agency increased by 4.6FTE (6.98%) in June 2022 as compared to May 2022.

Bedford site

Agency use has a 0.29% lower run rate in June 2022 compared to June 2021 equivalent to 0.23 FTE fewer agency workers. Medical agency locums increased by 2.67% between May 2022 and June 2022 equivalent to 0.7 FTE more agency staff. Nursing agency increased by 2.0 FTE (4.83%) in June 2022 as compared to May 2022.



Trust Level Summary

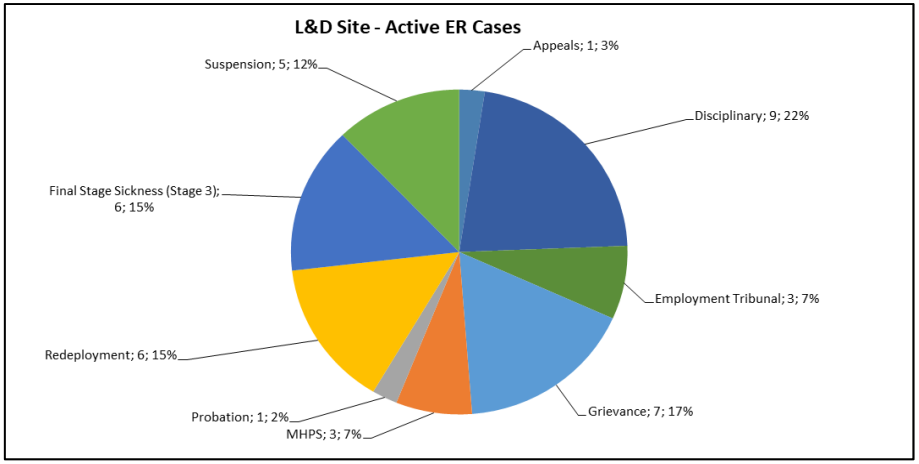
The number of Employee Relations cases being managed over the last month has increased considerably and now stands at 88, from 73 last month (21.9%).

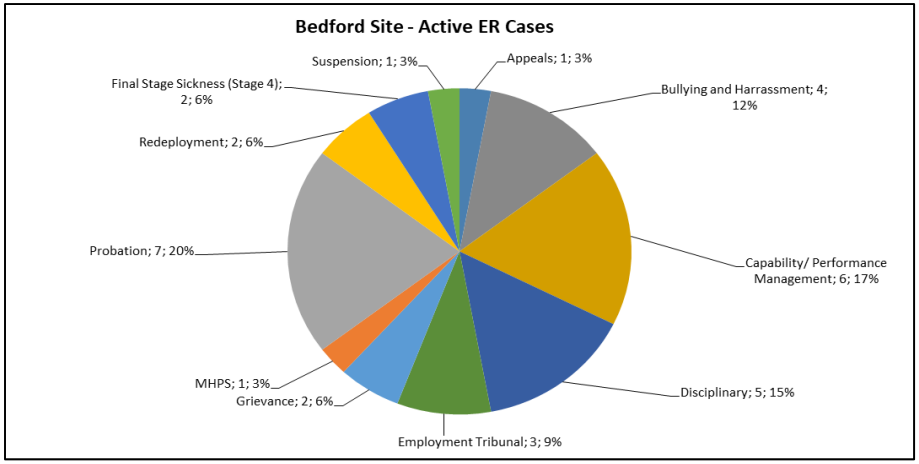
The level of activity in respect of consultation exercises is currently at 13; 9 are on-going and 4 in the planning stages. One consultation has closed and is in discussion prior to final implementation.

There remain 4 Maintaining High Professional Standards (MHPS) cases which are on-going.

There are currently 6 Employment Tribunal Cases, at various stages across both sites, though one case has now been heard and the Trust is awaiting the outcome.

Key
Data labels show the case type, number of cases and percentage





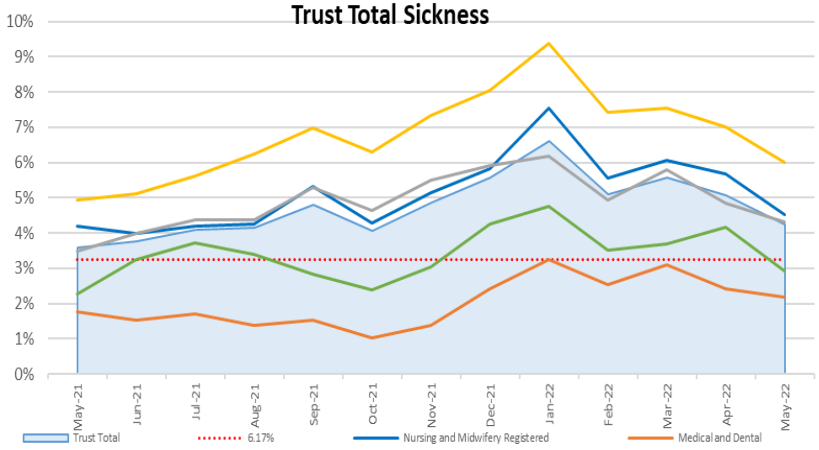
The number of disciplinary cases across both sites now stands at a total of 20 cases including 6 individuals who have been suspended whilst disciplinary investigations are on-going. Disciplinary cases in Bedford currently stands at 5 cases in June (including 1 suspension) and there are currently 14 cases, with 5 individuals on suspension at the Luton Site. There are currently a small proportion of cases involving assault (verbal/physical), dereliction of duty, absence without leave, inappropriate posts on Social Media and unprofessional behaviour, with no clear themes emerging.

There has been a decrease (18.2%) in the number of grievances (collective and individual) across the Trust this month, and there are now 9 active cases, for which resolution is currently being sought. The number of complaints of bullying and harassment has risen and now stands at 4; all of which are on the Bedford Site and work continues across all of these cases to bring them to a satisfactory resolution.

There has been a considerable increase in the number of redeployment cases, now at 8 cases due to health/capability and end of fixed term contracts.

SICKNESS*

Reporting Period: May 2022



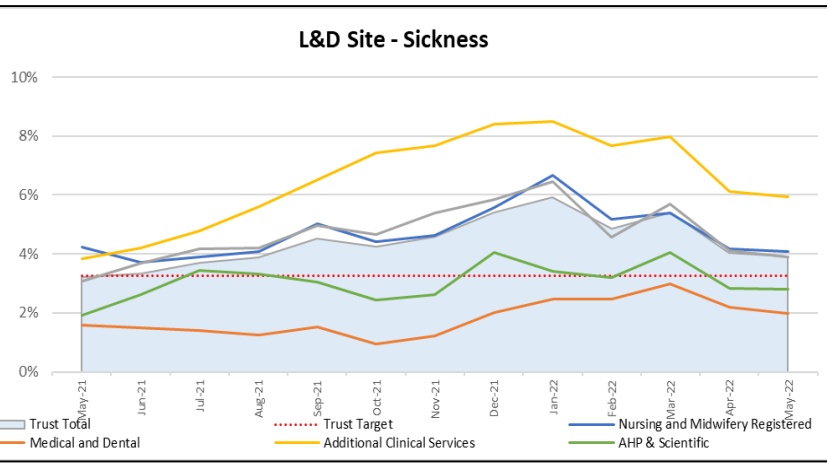
Trust Level Summary *

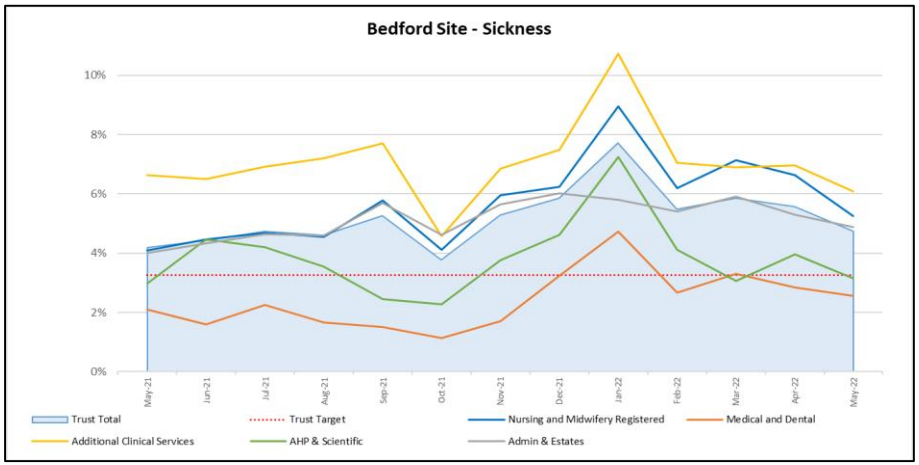
Overall sickness levels have decreased from a peak of 7.27% in April 2020, as a result of the COVID pandemic, to 4.23% in May 2022.

Sickness levels in May were at a higher level (0.13% higher) compared to the same period last year and 0.85% lower as compared to April 2022.

The highest absence rates for May were within Additional Clinical Services 6.0%, Nursing and Midwifery 4.54% and Admin & Estates 4.32%.

* Please note that Sickness data is reported a month arrears due to system interface timings





L&D Site

There was decrease of 0.14% between April and May 2022 to 3.90% sickness, and is 0.67% higher compared with the same period last year. Most staff groups are showing a marginal decrease compared to last month with the highest absence rate being Additional Clinical Services 5.95% .

Bedford Site

There was an overall reduction of 0.82% between April and May 2022 to 4.75% and is 01.56% higher than the same period last year. Most staff groups are showing an in month decrease compared to last month. The highest sickness absence rate was for Additional Clinical Services at 6.08% closely followed by nursing and midwifery at 5.26%.

Training and Appraisal Project : Getting BACK on TRACK

During the last two years of the pandemic understandably less focus was placed on compliance with mandatory training and appraisal and as a result compliance rates have slipped. Therefore on 25th July we are launching a new project to support staff and managers to get their compliance levels **BACK on TRACK** .

The target for the Trust is for all staff to complete their mandatory training and have an up-to-date appraisal by no later than the 31st December 2022. This will require a huge effort from everyone but this is a shared responsibility and we all need to play a part.

Over the next 6 months the Training & Learning Team will be providing additional support for departments and services to co-create bespoke plans and provide tools to achieve compliance. This includes easy and flexible access to training facilities and resources. We are also working with service leaders to identity champions in each service area who will help us develop a social movement to move towards a culture of aligned to our values that will see us all taking individual professional responsibility to maintain 100% training and appraisal rates.

Why are appraisals and mandatory training so important?

Ensures safe and effective care	• Keeps clinical practice up to date and refreshes essential skills • Staff have the right knowledge, skill and support to carry out their duties in the safest ways possible, minimising any risk of harm
Ensures a safe working environment	To make sure we work, and deliver care in, a safe environment in a safe way
To meet professional standards	To support staff to maintain revalidation and other professional standards
Creates a positive workplace culture THRIVE (Teamwork, Honesty & openness, Respect, Inclusivity, Valuing people, Excellence)	Promotes a fair and respectful working environment, where behaviours are routed in the Trust's THRIVE values, staff feel supported, included and safe to speak up about any concerns.

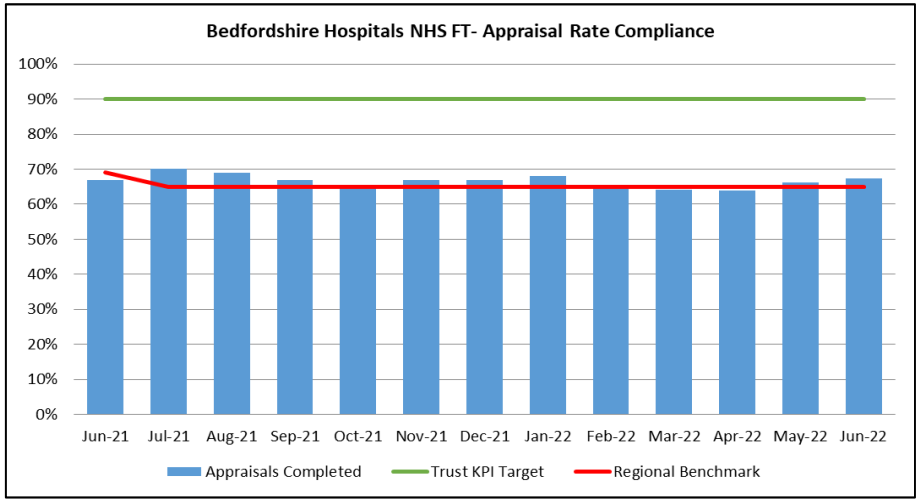
BACK on TRACK Launch Week

	Luton	Bedford
Monday 25th July	**Mandatory Training on Tour:** Areas with low compliance will be contacted with a time slot of when the Training and Learning Team will visit with workbooks to support our patient facing colleagues.	
Tuesday 26th July	**Mandatory Training on Tour:** Areas with low compliance will be contacted with a time slot of when the Training and Learning Team will visit with workbooks to support our patient facing colleagues.	
	11:00 am **Pay Progression Presentation** via Teams	
Wednesday 27th July	**11:00-13:00 -Nova House Foyer** - Drop in to check compliance & collect workbooks. Refreshments & other freebies available!	**11:00-13:00 -The Swannery** - Drop in to check compliance & collect workbooks. Refreshments & other freebies available!
Thursday 28th July	**Mandatory Training on Tour** - Low compliance areas will receive an email with a time when our team will visit your area with workbooks.	
Friday 29th July	09:00-15:00 - Chiltern Training Rooms - **Supported E-learning Sessions**. Book a place syra.Khan@ldh.nhs.uk	09:00-15:00 - Education Centre - **Supported E-learning Sessions**. Book a place Jay.sidhu@bedfordhospital.nhs.uk
	Book in to complete your training or drop by for any queries/reset your ESR Username and Password	Book in to complete your training or drop by for any queries/reset your ESR Username and Password
	11:00 am **Pay Progression Presentation** via Teams	

In preparation for the launch…
The Executive Team recognise the importance of mandatory training and appraisals and have been drawing attention to this and the upcoming project in the all staff briefing and summer engagement events.

Training and appraisal information has been made a core part of the data set which is monitored at the executive Service Line oversight meetings.

Some initial bespoke plans have been developed with service lines and initial feedback is that they are making a difference.



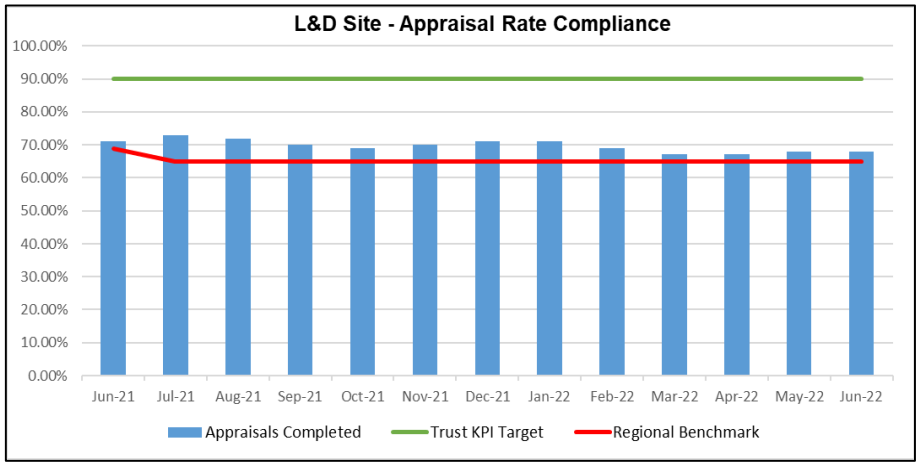
Trust Level Summary

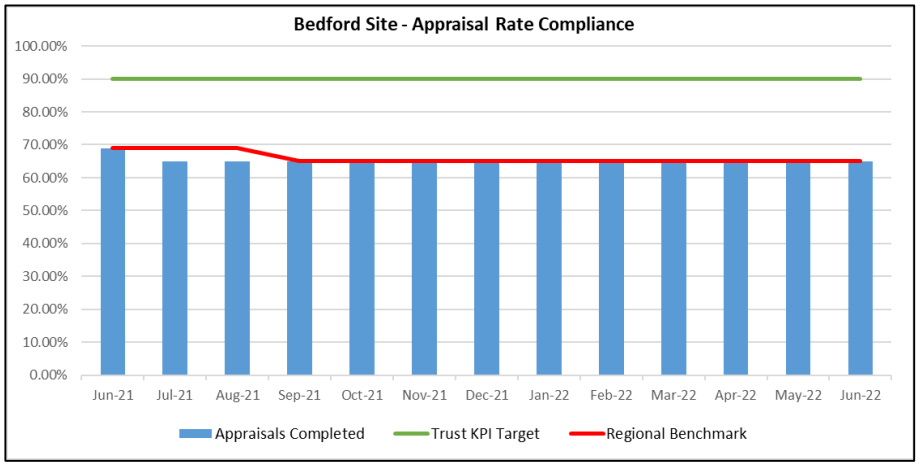
The appraisal compliance rate has increased by 1.17% overall across Bedfordshire Hospitals NHS Foundation Trust.

The new paperwork has been launched and is now in use. We are promoting use of the new documentation with help of briefings, the Intranet and The Week. Initial feedback has been largely positive and any feedback passed to us will be used to ensure future training packages are as useful as possible.

We expect that now we have launched the new policy and paperwork for pay-step review meetings, compliance will improve as this makes things easier for those with cross-site responsibilities and teams.

Supportive measures are being provided wherever possible to assist managers with improving compliance. This includes appraisal planners, and we are looking into using software to further streamline the planning process for large areas.





Site Specific Level Summary

There has been a 1.17% increase across the Trust for the month of June to 67.36%.

L&D Site:

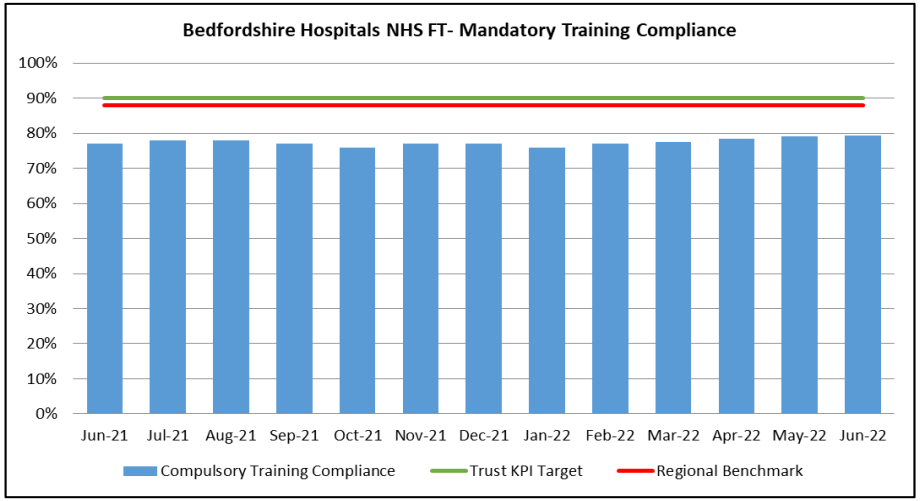
The overall appraisals' compliance rate for June 2022 has decreased by 0.11% to 67.84%.

Bedford Site:

The overall appraisal rate for June 2022 has increased by 3.16% to 66.61%.

MANDATORY TRAINING

Reporting Period: June 2022

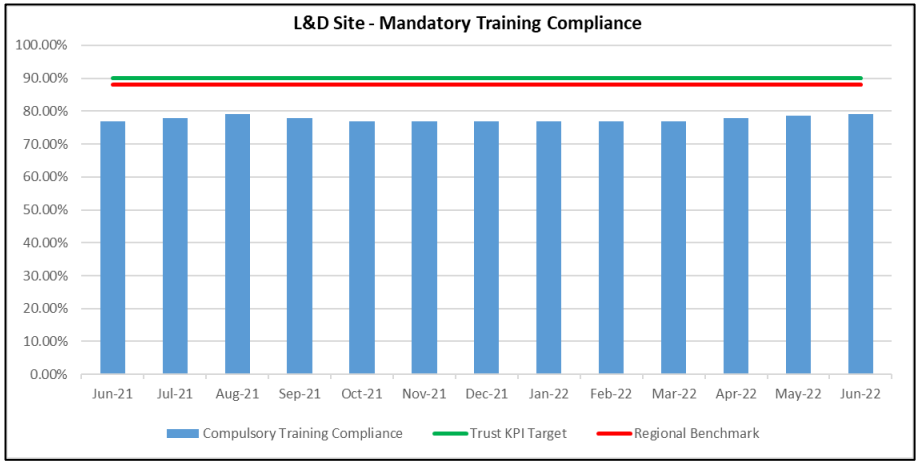


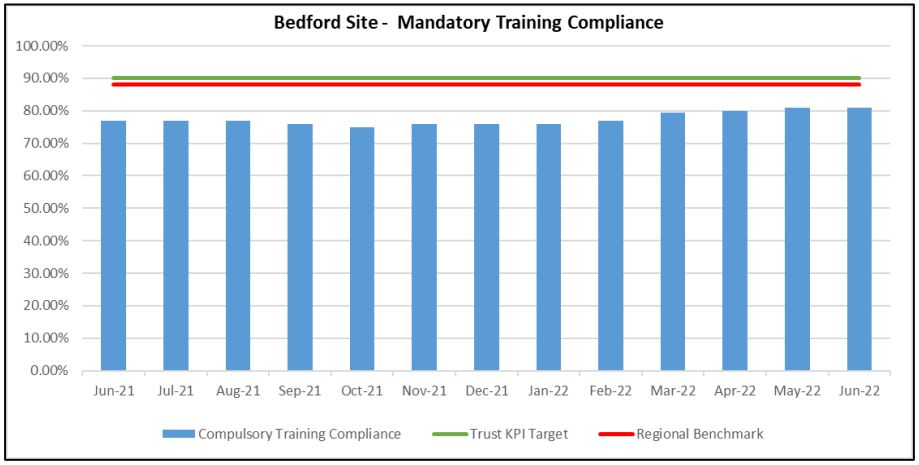
Trust Level Summary

Compliance for June 2022 has seen an overall marginal increase of 0.26% (79.45%).

To assist managers with quick access to important information, the following changes have been made to the monthly reports as part of the **BACK on TRACK** project:

- Monthly Dashboard to Subject Matter Experts (SMEs) and Service Line Leads (SLLs)
  - Inclusion of a percentage change on the main sheets and a new progress monitoring page which tracks the progress from the last month, plus the last 12 months.
- Cost Centre Reports
  - There is now a total compliance by individual column so that managers can clearly track whether the 90% target has been met for Pay Progression Purposes.
  - The Pay Step Date column now only shows a date if it is pay affecting.





Site Specific Summary

Training compliance has increased (0.26%) across the Trust throughout the month of June 2022 bringing the overall compliance 79.45%.

L&D Site:

The overall mandatory training compliance rate during the June period sits at 79.01%, which is an increase of 0.35%

Bedford Site:

The overall mandatory training compliance rate during the June period sits at 81.04%, which is an increase of 0.03%.

MANDATORY TRAINING BY SUBJECT

Reporting Period: June 2022

Bedfordshire Hospitals NHS FT - Core Mandatory Training Compliance	Equality, Diversity & Human Rights	Fire Safety	Health, Safety and Welfare	Infection Control 1	Infection Control 2	Information Governance	Moving and Handling (Loads) Level 1	Moving and Handling (People) Level 2	Conflict Resolution - Level 1	Preventing Radicalisation - Basic Prevent Awareness	Resuscitation - Level 1 (E-Learning)	Adult Basic Life Support	Newborn Basic Life Support	Paediatric Basic Life Support	Safeguarding Adults Level 1	Safeguarding Adults Level 2	Safeguarding Children Level 1	Safeguarding Children Level 2	Average Total Compliance
Trust Target	90%	90%	90%	90%	90%	95%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
June 2021	87.00%	83.00%	87.00%	91.00%	81.00%	72.00%	87.00%	65.00%	79.00%	84.00%	80.00%	60.00%	54.00%	35.00%	88.00%	85.00%	84.00%	85.00%	77.00%
July 2021	87.00%	84.00%	88.00%	90.00%	82.00%	73.00%	87.00%	66.00%	81.00%	83.00%	79.00%	59.00%	55.00%	39.00%	87.00%	87.00%	83.00%	87.00%	78.00%
August 2021	87.00%	84.00%	89.00%	90.00%	82.00%	74.00%	87.00%	67.00%	82.00%	83.00%	79.00%	59.00%	59.00%	39.00%	87.00%	88.00%	82.00%	88.00%	78.00%
September 2021	87.00%	84.00%	88.00%	89.00%	79.00%	75.00%	87.00%	67.00%	82.00%	83.00%	75.00%	57.00%	58.00%	38.00%	85.00%	88.00%	81.00%	87.00%	77.00%
October 2021	86.00%	81.00%	87.00%	88.00%	76.00%	74.00%	85.00%	66.00%	83.00%	79.00%	76.00%	57.00%	53.00%	44.00%	85.00%	84.00%	82.00%	85.00%	76.00%
November 2021	86.00%	84.00%	87.00%	87.00%	72.00%	75.00%	88.00%	75.00%	84.00%	80.00%	75.00%	57.00%	59.00%	44.00%	84.00%	83.00%	81.00%	84.00%	77.00%
December 2021	86.00%	83.00%	87.00%	87.00%	71.00%	75.00%	87.00%	74.00%	85.00%	80.00%	73.00%	55.00%	58.00%	46.00%	84.00%	82.00%	81.00%	84.00%	77.00%
January 2022	85.88%	81.89%	86.95%	86.16%	69.76%	75.19%	86.57%	72.71%	84.45%	80.21%	71.73%	56.35%	56.00%	47.35%	83.69%	82.21%	79.76%	84.23%	76.17%
February 2022	86.00%	81.00%	87.00%	87.00%	69.00%	74.00%	86.00%	73.00%	85.00%	80.00%	70.00%	59.00%	63.00%	48.00%	85.00%	82.00%	79.00%	85.00%	77.00%
March 2022	87.19%	81.52%	87.32%	87.91%	70.39%	75.03%	86.53%	74.57%	86.01%	82.28%	66.27%	60.56%	65.40%	50.44%	86.54%	82.28%	79.29%	85.59%	77.51%
April 2022	87.91%	83.10%	88.12%	88.55%	70.68%	75.56%	86.86%	74.36%	86.47%	83.67%	68.02%	61.14%	65.34%	51.67%	88.83%	82.63%	80.64%	85.97%	78.31%
May 2022	87.47%	84.30%	88.63%	89.16%	71.86%	76.16%	87.26%	75.82%	86.99%	84.40%	64.16%	65.83%	71.67%	53.55%	89.55%	82.00%	80.33%	86.20%	79.19%
June 2022	87.13%	84.07%	88.56%	88.76%	71.31%	75.51%	87.33%	76.22%	87.19%	84.29%	65.98%	68.22%	72.54%	55.51%	88.51%	82.39%	79.90%	86.69%	79.45%
Change from last month	-0.34%	-0.23%	-0.07%	-0.40%	-0.55%	-0.65%	0.07%	0.40%	0.20%	-0.11%	1.82%	2.39%	0.87%	1.96%	-1.04%	0.39%	-0.43%	0.49%	0.26%

Bedford Site- Core Mandatory Training Compliance	Equality, Diversity & Human Rights	Fire Safety	Health, Safety and Welfare	Infection Control 1	Infection Control Level 2	Information Governance	Moving and Handling (Loads) Level 1	Moving and Handling (People) Level 2	Conflict Resolution - Level 1	Preventing Radicalisation - Basic Awareness	Resuscitation - Level 1 (E-Learning)	Adult Basic Life Support	Newborn Basic Life Support	Paediatric Basic Life Support	Safeguarding Adults Level 1	Safeguarding Adults Level 2	Safeguarding Children Level 1	Safeguarding Children Level 2	Average Total Compliance
Trust Target	90%	90%	90%	90%	90%	95%	90%	90%	90%	90%	90%	90%	90%	90%	90%		90%	90%	-
June 2021	88.00%	87.00%	90.00%	92.00%	77.00%	72.00%	88.00%	56.00%	69.00%	80.00%	-	64.00%	68.00%	31.00%	89.00%	89.00%	77.00%	90.00%	77.00%
July 2021	88.00%	86.00%	90.00%	91.00%	77.00%	72.00%	87.00%	57.00%	72.00%	80.00%	-	63.00%	64.00%	36.00%	88.00%	90.00%	76.00%	90.00%	77.00%
August 2021	88.00%	85.00%	90.00%	91.00%	79.00%	74.00%	87.00%	58.00%	74.00%	80.00%	-	62.00%	65.00%	36.00%	87.00%	90.00%	74.00%	91.00%	77.00%
September 2021	87.00%	83.00%	90.00%	88.00%	78.00%	75.00%	87.00%	55.00%	75.00%	80.00%	-	59.00%	64.00%	35.00%	84.00%	91.00%	72.00%	91.00%	76.00%
October 2021	86.00%	78.00%	87.00%	89.00%	75.00%	74.00%	85.00%	53.00%	76.00%	71.00%	-	56.00%	62.00%	46.00%	83.00%	88.00%	74.00%	88.00%	75.00%
November 2021	87.00%	85.00%	87.00%	88.00%	72.00%	76.00%	87.00%	62.00%	79.00%	81.00%	-	52.00%	56.00%	46.00%	84.00%	87.00%	76.00%	85.00%	76.00%
December2021	86.00%	84.00%	87.00%	87.00%	72.00%	76.00%	86.00%	62.00%	81.00%	82.00%	-	51.00%	58.00%	46.00%	84.00%	87.00%	75.00%	86.00%	76.00%
January 2022	85.35%	82.21%	87.21%	86.94%	72.54%	77.40%	86.43%	61.12%	81.83%	82.65%	-	50.30%	56.10%	45.91%	84.43%	86.44%	74.30%	85.83%	75.71%
February 2022	86.00%	82.00%	87.00%	87.00%	75.00%	77.00%	87.00%	63.00%	83.00%	83.00%	-	53.00%	63.00%	48.00%	86.00%	86.00%	73.00%	87.00%	77.00%
March 2022	87.73%	81.91%	87.90%	89.41%	76.92%	78.82%	87.59%	66.27%	86.33%	86.81%	-	57.52%	76.52%	49.82%	90.00%	86.84%	73.71%	88.00%	79.54%
April 2022	88.73%	84.25%	89.18%	90.07%	76.97%	79.38%	87.53%	66.57%	86.68%	87.64%	-	58.27%	71.21%	50.99%	91.23%	87.09%	74.51%	88.44%	79.93%
May 2022	87.95%	85.21%	89.60%	91.10%	76.95%	79.58%	88.09%	69.11%	87.65%	89.05%	-	63.62%	72.93%	53.48%	92.33%	87.03%	75.06%	88.45%	81.01%
June 2022	87.65%	85.09%	89.16%	90.36%	77.96%	80.30%	88.68%	70.38%	88.41%	88.18%	-	64.99%	70.68%	54.01%	90.31%	87.63%	75.16%	88.81%	81.04%
Change from last month	-0.30%	-0.12%	-0.44%	-0.74%	1.01%	0.72%	0.59%	1.27%	0.76%	-0.87%	-	1.37%	-2.25%	0.53%	-2.02%	0.60%	0.10%	0.36%	0.03%

L&D Site - Core Mandatory Training Compliance	Equality, Diversity & Human Rights	Fire Safety	Health, Safety and Welfare	Infection Control 1	Infection Control 2	Information Governance	Moving and Handling (Loads) Level 1	Moving and Handling (People) Level 2	Conflict Resolution - Level 1	Preventing Radicalisation Basic Prevent Awareness	Resuscitation - Level 1 (E-Learning)	Adult Basic Life Support	Newborn Basic Life Support	Paediatric Basic Life Support	Safeguarding Adults Level 1	Safeguarding Adults Level 2	Safeguarding Children Level 1	Safeguarding Children Level 2	Average Total Compliance
Trust Target	90%	90%	90%	90%	90%	95%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
June 2021	86.00%	81.00%	85.00%	90.00%	83.00%	71.00%	87.00%	70.00%	85.00%	86.00%	80.00%	57.00%	50.00%	40.00%	88.00%	83.00%	87.00%	83.00%	77.00%
July 2021	87.00%	83.00%	87.00%	89.00%	85.00%	73.00%	87.00%	71.00%	87.00%	85.00%	79.00%	57.00%	51.00%	43.00%	87.00%	85.00%	87.00%	85.00%	78.00%
August 2021	86.00%	84.00%	88.00%	89.00%	83.00%	75.00%	87.00%	71.00%	87.00%	85.00%	79.00%	57.00%	57.00%	43.00%	87.00%	86.00%	86.00%	86.00%	79.00%
September 2021	86.00%	84.00%	87.00%	89.00%	80.00%	75.00%	87.00%	73.00%	87.00%	84.00%	75.00%	55.00%	55.00%	41.00%	86.00%	85.00%	86.00%	85.00%	78.00%
October 2021	86.00%	83.00%	87.00%	88.00%	76.00%	75.00%	85.00%	74.00%	87.00%	83.00%	76.00%	57.00%	50.00%	42.00%	86.00%	82.00%	86.00%	84.00%	77.00%
November 2021	86.00%	83.00%	87.00%	86.00%	72.00%	75.00%	89.00%	83.00%	87.00%	80.00%	75.00%	59.00%	60.00%	42.00%	84.00%	81.00%	84.00%	82.00%	77.00%
December 2021	86.00%	83.00%	87.00%	86.00%	70.00%	74.00%	88.00%	81.00%	87.00%	80.00%	73.00%	59.00%	58.00%	46.00%	85.00%	79.00%	85.00%	82.00%	77.00%
January 2022	86.23%	81.68%	86.77%	85.60%	68.07%	73.76%	86.66%	80.18%	86.14%	78.78%	71.73%	60.71%	55.97%	49.21%	83.16%	79.58%	83.41%	83.22%	76.71%
February 2022	87.00%	80.00%	87.00%	87.00%	66.00%	72.00%	85.00%	79.00%	86.00%	78.00%	70.00%	63.00%	63.00%	49.00%	84.00%	79.00%	84.00%	83.00%	77.00%
March 2022	86.84%	81.26%	86.93%	86.79%	66.36%	72.54%	85.83%	80.01%	85.81%	79.60%	66.27%	62.78%	61.56%	51.21%	84.02%	79.40%	83.14%	84.04%	76.91%
April 2022	87.38%	82.37%	87.44%	87.44%	66.90%	73.10%	86.43%	79.33%	86.34%	81.36%	68.02%	63.18%	63.08%	52.47%	87.11%	79.89%	84.78%	84.41%	77.83%
May 2022	87.15%	83.71%	88.00%	87.75%	68.79%	73.94%	86.72%	80.16%	86.57%	81.71%	64.16%	67.42%	71.18%	53.63%	87.56%	78.88%	83.90%	84.78%	78.67%
June 2022	86.78%	83.41%	88.16%	87.66%	67.18%	72.38%	86.44%	80.01%	86.40%	82.11%	65.98%	70.57%	73.26%	57.23%	87.29%	79.10%	82.96%	85.32%	79.01%
Change from last month	-0.37%	-0.30%	0.16%	-0.09%	-1.61%	-1.56%	-0.28%	-0.15%	-0.17%	0.40%	1.82%	3.15%	2.08%	3.60%	-0.27%	0.22%	-0.94%	0.54%	0.34%

Key

< 80%	80% - 89%	>= 90%	Please note that IG only has to be above 95% to achieve green rating

Communicating Health and wellbeing messages

In the Trusts weekly newsletter 'The Week', there are always Health and wellbeing related initiatives/topics featured, examples over previous weeks:-

- Promotion of the upcoming summer staff engagement events - Good, Better, Best.
- No smoking
- Cycling – Dr Bike
- Staff discounts
- CiC promotion
- Take heART activities
- Love your liver roadshow event
- Menopause - establishment of a new page on the intranet signposting to resources and support
- Promotion of BLMK Hot chocolate hour webinars – which concentrate on various psychological health support mechanisms
- Why you should move more – benefits that exercise can bring

Schwartz Rounds

The second Schwartz round took place virtually on 17th May.
The theme for this was Covid, Pregnancy and Beyond, 90 individuals attend Following sessions attendees are asked to complete a feedback form, and are able to obtain a certificate of attendance.

Schwartz rounds provide a structured forum where both clinical and non-clinical staff, come together to discuss the emotional and social aspects of working in healthcare. Evidence shows that these rounds can reduce professional hierarchies and improve communication between colleagues. Staff who regularly attend, feel less stressed and isolated at work.

Feedback below (quoted from the forms):

- "a really relevant and powerful discussion"
- "Very brave and powerful"
- "It was powerful, I am really happy I attended"
- "Such a lovely session, loved listening to everyone's stories"
- "Lunch break well spent"

The next meeting is due to take place on 5th July "The Patient I will never forget"

Peer Listener network

The peer listener network service is aimed at providing a listening ear to colleagues during a time of need and is based on the principles of psychological first aid.

Listening is an important and powerful person-to-person process that can help to provide containment and support. Colleagues are often the first people that a stressed or worried member of staff will approach. This is why the network consists of staff who are motivated, and trained in Mental Health First Aid, to provide listening and support when needed.

The service is not formal counselling, coaching or therapy, although peer listeners will be able to provide information about specialist services should they be needed.

Peer Listeners have the opportunity to meet with Amanda Spong one of our Clinical Psychologists on a regular basis for support, guidance and in order to report back themes from conversations. Themes are then used to determine further levels of support or information required.

One of the most commonly reported themes during April/May was around workload, work stress, and managing difficult events at work. These issues came up in four logs. Equally, issues concerning family stress, caring responsibilities, and bereavement came up in four logs. Concerns about patient safety were reported twice. Two further conversations involved issues about confrontation between staff and concerns about discrimination. There was one conversations concerning abuse from a relative.

CiC – Employee assistance programme providers

As part of our ongoing commitment to employee wellbeing, on 16th June, our employment assistance programme providers, CiC, presented a Microsoft Teams session on the support they can offer to staff, specifically around the non-counselling services such as financial, legal and family care services during the post pandemic times. Fifty members of staff were in attendance, and the session was recorded for future access by others.

The focus of the session was around: How to access the EAP (Employee Assistance Programmes), Emotional support available, Legal services, Family care services and Financial - Managing debt, Budgeting, Credit card, Investments, Pensions Savings, Tax and Banking.

Take heART – enhancing health and wellbeing through the arts

The "take heART" Art Group secured funding from Arts Council England's "Let's Create Jubilee Fund" (distributed by the Bedfordshire and Luton Community Foundation) and NHS Charities Together to support a celebratory project with 2 main outcomes.

The first of these outcomes was to commission local artist Anne-Marie Abbate and photographer Shaun Armstrong to produce large scale vinyl artworks for display on both hospital sites. These were inspired by the poem by Michael Rosen called "These are the Hands", written for and about NHS staff. The theme of the artworks is Human Touch and they are interpretations of microscopic images of touch receptors in our skin. The artworks are displayed alongside the poem.

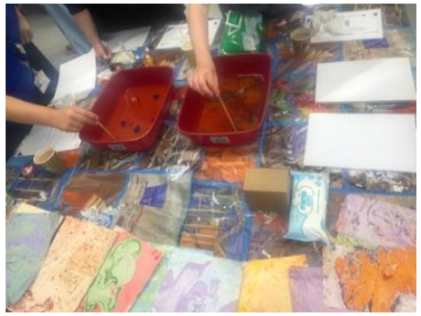
The second outcome was 6 creative workshops for staff. 4 of these were drop-in sessions across both our main sites with approx. 120 attendees. Staff were encouraged to produce small pieces to take away with them.

The final 2 workshops will be longer sessions to be held in July where staff will directly contribute to a further artwork to hang alongside the Human Touch vinyl works. 100 Creative packs were also distributed to staff who were unable to attend the workshops.

Another central theme of the project was kindness, and large numbers of gifts (262) were given out to staff (by staff) through random acts of kindness.

The whole Jubilee project has been very well supported and received by staff at all levels of the organisation.

Further funding was secured from The Culture Challenge at Bedford Creative Arts to support local artist Katie Allen to create posters with the help of local school children. These posters are on display around the hospitals and display messages that were taken directly from the last staff engagement event of words of advice that staff members would give to a colleague to make their day better.



Bedfordshire Hospitals NHS Foundation Trust

Board of Directors

Wednesday 27 July 2022

Report title:	**Quality Committee Report**					**Agenda item: 8**
Executive Director(s):	**Annet Gamell, Non-Executive Director, Chair of Quality Committee**					
Report Author	**Executive Directors**					
Action *(tick one box only)*	**Information** ☐	**Approval** ☐	**Assurance** x	**Decision** ☐		
Recommendation	Trust Board to note the Quality Committee Report for May and June 2022					

Report summary	This Report updates the Board of Directors regarding the matters discussed at the Quality Committee meetings held on 25 May 2022 and 22 June 2022
Legal Implications / Regulatory requirements / Strategic objectives and Board Assurance Framework	CQC NHSI Quality Accounts (External Audit) Quality objectives
Jargon Buster	Harm Free Care – A set of metrics including falls and pressure ulcers that are nationally monitored CQUIN - Commissioning for Quality and Innovation – a set of quality measures that are nationally and locally mandated that the Trust is incentivised financially to achieve

QUALITY COMMITTEE REPORT

TO BOARD OF DIRECTORS

1. Introduction

This Report updates the Board of Directors regarding the matters discussed at the Quality Committee meetings held on 25 May 2022 and 22 June 2022.

2. Update on COVID-19

The Committee received monthly updates on inpatient numbers of Covid positive patients, noting a plateau in numbers in June although incidence across the Region is trending upwards.

3. Performance Metrics and Recovery Plans

The Deputy Chief Executive presented a new format of a performance dashboard.

Operating performance and elective recovery was discussed and the Quality Committee noted the challenges particularly relating to cancer performance and the high number of ambulance handover delays as the system has been overwhelmed with activity. For elective recovery, pathway improvements are slow and have been impacted by staff absences. Assurance was given that the Trust is doing all that we can to mitigate.

The Quality Committee noted the increase in length of stay for April, which was impacted by delays to discharge to the community over Easter due to staff shortages. A new group has been developed within BLMK which is bringing senior leaders/partners together to discuss and action these issues.

The Quality Committee acknowledged the immense pressures and consuming nature of the activity within the Trust.

4. Infection Prevention and Control (IPC)

The Quality Committee received monthly Infection Prevention and Control updates. The Director of Infection Prevention and Control (DIPC) briefed on current Covid variants and ongoing infection and prevention measures in place within the hospital.

Other respiratory infections and the mandatory reporting of other infections including E.Coli, C.Difficile, Klebsiella and multi-drug resistant organisms were noted. With regard to C.Difficile, numbers are above trajectory and the team is reviewing the cases to understand what can be done to reverse the trend.

5. Maternity

The Director of Midwifery presented the Perinatal Quality Surveillance Tool reports at each meeting which provided an overview of the maternity clinical metrics and update on progress on actions relating to the quality improvement plan, CQC, CNST Year 4, the Ockenden Report and Safety Champion activities.

With regard to CNST (Clinical Negligence Scheme for Trusts) year 4 actions, the Committee received a report outlining the amended criteria and updated on the current assessment progress on Safety Actions. The areas of moderate to high risk were highlighted and discussed. A maternity workforce CNST standard 4 report was received in May which highlighted the requirements requiring sign off at Board level and acknowledging engagement with the RCOG guidance 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology (June 2021)'.

The Chief Nurse reported that a mock CQC inspection was undertaken of the maternity units at both sites and feedback was positive.

The monthly midwifery staffing reports were received at each meeting and the fill rates, red flag reporting, supernumerary status and 1:1 care in labour were noted. The Quality Committee acknowledged that vacancy continues to be a concern on both sites and recruitment is slow, although assurance was given that there is a pipeline of overseas and newly qualified midwives.

6. Nursing Staffing

The Nursing Staffing reports were received for assurance. The Director of Nursing highlighted that staffing continues to be very challenged on a daily basis with complex patients, the ongoing need to continue to provide cover for contingency areas and staff sickness due to Covid. The Quality Committee were assured that no significant harm has been reported.

7. Harm Free Care

The Director of Nursing gave updates on falls and pressure damage incidence for both hospitals, noting that harm free care has remained low.

With regard to pressure damage, there has been some dedicated work taking place with teams to ensure that validation is accurate.

8. Serious Incidents (SI) and Incidents

The Director of Quality and Safety Governance reported that incident reporting is good. Awareness campaigns as to the importance of incident reporting continues on both sites.

The Committee noted the serious incidents (SIs) reported within the period and learnings from previous reported SIs.

9. Patient Safety Alerts

Patient safety alerts are official notices issued by NHS England/ Improvement which give advice or instructions to NHS bodies on how to prevent specific types of incidents which are known to occur in the NHS and cause serious harm or death.

The following national safety alerts have been published during the reporting period

April - May 2022:

- Inadvertent oral administration of potassium permanganate. Potassium permanganate is supplied in concentrated forms, either as a 'tablet' or a solution, which requires dilution before use. These concentrated forms resemble an oral tablet or drink and if ingested are highly toxic.

  The alert asks both secondary and primary care providers to take action to assess if use of potassium permanganate can be reduced; to ensure safer prescribing and labelling, and to ensure it is stored safely.

  Implementation of actions for this alert is required by 4th October 2022.

- NovoRapid PumpCart in the Roche Accu-Chek Inight insulin pump: risk of insulin leakage causing hyperglycaemia and diabetic ketoacidosis.
  The MHRA has had reports of harm associated with insulin leakage for the NovoRapid PumpCart prefilled insulin cartridge in the Accu-Chek Insight Insulin pump. In some patients, there were serious consequences arising from inadequate supply of insulin, including diabetic ketoacidosis (DKA).

  Implementation of actions for this alert is required by 26 November 2022.

The Quality Committee receives a monthly summary report of the alerts and note implementation of alerts by the Patient Safety team.

Quality Committee were also informed of a Central Alert System (CAS) notification with regard to V60 ventilators. Immediate mitigations had been effected and new pumps have been procured for delivery in July.

10. Mortality

The Medical Director highlighted the mortality data for both sites, and noted the Covid deaths by month.

The upwards reports from the Learning from Deaths Board were received by the committee and data noted.

The Quality Committee received a report providing an analysis of the potential drivers for the high SHMI on the Bedford site. It was noted that there were a number of contributory factors, one being with regard to ensuring that all co-morbidities are included in coding.

11. **Quality Account**

The draft Quality Account was received at the May meeting for comment. The Quality Committee approved the Quality Account on behalf of the Board of Directors at the June meeting for publishing on the Trust public website by the end of June 2022.

12. Safeguarding Report

The Quarter 4 Safeguarding report was received for assurance. The Chief Nurse highlighted a significant increase in referrals of children and the complexity of some cases with particularly long lengths of stay in hospital.

13. Upwards Reports from Other Committees

Upwards reports from the Clinical Quality Operational Board (CQuOB) and Specialist Committee Operational Board (SCOB) were received by the Quality Committee and escalations discussed.

14. Internal Audit

There were no internal audit reports presented to the Quality Committee in May and June 2022.

15. Risk Register and Board Assurance Framework

The Quality Committee received reports outlining the new risks to be added to the risk register and the risks due for review by the Committee were discussed and updated.

The Associate Director of Corporate Governance presented a paper outlining the risks and controls relating to Objective 2 and Objective 4 of the Board Assurance Framework.

16. Fractured Neck of Femur Update

The General Manager for Trauma and Orthopaedics attended the May meeting and provided the latest performance data in respect of fractured neck of femur patients. Quality Committee discussed the optimum patient journey and acknowledged the building blocks, change in culture and daily pressures that impact on pathways across all services.

17. Stroke update

The latest Sentinel Stroke National Audit Programme (SSNAP) data was presented to the Quality Committee in June highlighting that the L&D rating had dropped to a C rating. The General Manager and Clinical Director were in attendance and discussed the key domains for attention. The challenges to ring fence stroke beds when contingency areas are used due to the high admissions was acknowledged.

18. Cleaning Standards

The Director of Estates shared a presentation on the progress on the implementation of the national standards of healthcare cleanliness and explained the realignment to the new standards. The results will be in star ratings and the Quality Committee will receive a quarterly report.

Bedfordshire Hospitals NHS Foundation Trust

Board of Directors

Wednesday 27 July 2022

Report title:	**Finance, Investment & Performance Committee Report**			**Agenda item: 9**
Executive Director(s):	**Matthew Gibbons**			
Report Author	**Ian Mackie**			
Action *(tick one box only)*	**Information** ✓	**Approval** ☐	**Assurance** ☐	**Decision** ☐
Recommendation	Trust Board to note the FIP Committee Report for May 2022 and June 2022.			

Report summary	This report contains a summary of the deliberations of the FIP Committee during May 2022 and June 2022. The financial – revenue & capital – performance (including results up to the end of Month 3.
Legal Implications / Regulatory requirements / Strategic objectives and Board Assurance Framework	

Bedfordshire Hospitals NHS Foundation Trust
FIP Committee Report to the Board

27th July 2022

The Board should note the following items discussed at the FIP Committee meetings from 25th May 2022 and 22nd June 2022.

1. Financial Position

On the 22nd June the Committee noted that the FT delivered a deficit of £2m, this was against a £2.5m deficit plan for the financial year 22/23.

The Committee noted that the FT's pay spend is £0.8m overspent year to date. Non-pay is £0.2m overspent year to date. The FT has recognised £0.8m of the additional inflation monies to mitigate the pay and non-pay overspends.

Based on estimated M2 Elective recovery fund performance, the FT provided for repayment of £2.3m of ERF monies as performance was well below 104%.

The Finance, Investment and Performance Committee noted the update to the year to date position.

2. Capital

Capital spend is £7m against a revised plan of £89m. The FT spent £5.3m against £27.2m FT CDEL.

The Finance, Investment and Performance Committee noted the update.

3. Business & Investment Decisions

Business Case – ED Phase 2 and CT Urgent and Emergency Care Phase 2

An updated cost plan was presented to the Board for phase 2 which showed a cost increase from last year's cost plan of £360k. £3.08m vs £2.72m. The variance is driven by prolongation, market conditions and design development reflecting a change to the ventilation solution. Cost savings will continue to be identified as the project progresses with the ambition of moving towards the baseline budget.

The Programme Board supported the recommendation to proceed with procurement of equipment and to appoint a contractor for the first floor fit out. The revised cost will be reflected in the FT's capital plan.

The Finance, Investment and Improvement committee approved the request for additional funding of £360k commensurate with the request to procure the CT equipment and appoint the contractor for the first floor fit out.

Commercial Report

The Anticipated Final Cost (AFC) reflecting the Luton main scheme and enabling is £228.9m against a baseline budget of £228.6m. The wider Redevelopment Programme Commercial report reflected an AFC £276m against a baseline budget of £275.96m.

Managing Variations

Regarding the approval process for technical and strategic changes to the Redevelopment budget for building the Acute Services Block, all projects within the Redevelopment portfolio including the adjacent ward block and the associated enabling works.

It was confirmed that the changes will be categorised as either:

1) Technical Changes below £125k but subject to a monthly cap of £0.5m

2) Technical Changes above £125k

3) Strategic Changes of any value

The value of £125k has been chosen as it aligns with the scheme of delegation on revenue that "Business decisions outside the approved trading plan that exceed an annual revenue expenditure value of £125k". This is clearly intended for revenue and therefore doesn't directly apply. It is proposed that this value is kept under review to ensure it gives an appropriate level of control.

The Finance, Investment and Performance Committee approved the Managing Variations amendments.

The Finance, Investment and Performance committee noted the update.

4. Other Matters

Annual Plan update

The Committee noted updates to the annual plan following confirmation that the additional funding allocation passed down to ICSs has been allocated to the component parts of the system. The FT's proportion is £6.8m.

The CEOs and CFOs met on 13th June and determined that the level of risk had reduced sufficiently for all BLMK ICS organisations to submit a breakeven plan on 20th June in line with guidance.

Accounts – Update

The committee noted the delay in submitting the FT's accounts and that NHSEI had been informed. The FT has been asked to upload the Finance return template (but to signify that these are not the final accounts)

Additionally it was confirmed that BDO accepted the delay was the result of BDO internal issues.

Contract Update

The Committee noted confirmation that the contract with BLMK had been signed. Other highlights were as follows

Pursuing the remainder of the NHSEI and associate CCG contracts by the end of June. It was highlighted that all of the contracts will be 'Blocked' for everything other than 'Elective' performance.

Corporate Governance

The committee discussed the risks assigned to FIP.

Risk ref	Risk Description	Agreed conclusion
1211	Backlog Maintenance	Maintain risk. Linked to the Redevelopment.
1734	Investments made without knowing payment is confirmed	Maintain risk. We are still having to make decisions with an unknown financial regime for 2023/24.
1735	2022/2023 Financial Target	With the additional inflation monies from the centre this risk can be reduced to 4x3. There was a discussion around the pay inflation strike risk. MG reported that any pay increase historically has been funded by the centre so the Trust should be mitigated against an impact. However, they usually link it with a higher CIP requirement. If there were to be a strike, this would impact our recovery programme and retaining staff.
1736	System wide finance target	Maintain risk until we understand the full risk of the exposure of the financial performance of other system partners.
890	Lack of Medical Equipment rolling replacement	Maintain risk. We are satisfied with the current mitigations.

Risk ref	Risk Description	Agreed conclusion
	programme	
1759	Capital spend/CDEL risk	Maintain risk. We have started the year strongly but we are tight on the capital plan.

The committee discussed the emerging risk on the maternity CNST achievement. However, it was agreed at this time that the financial implication was not material.

Assurance Framework Update

The Committee discussed the Board Assurance Framework referencing the objectives and strategic risks allocated to FIP.

Risk 3.2 – The FT does not deliver the recovery plans – The committee agreed to increase this risk to 4x4 due to the significant impact of DNA rates across the high volume specialties.

The committee discussed the ICS and the impact on those requirements on the financial performance of the system. There is a Board Objective on the ICS allocated to the Board. It was agreed to add a risk for the financial performance of the system to this objective and also ensure that FIP had oversight.

Risk 6.1 – The FT does not proceed with planned development work – the committee agreed to adjust this risk to reflect the need for a flexible master plan to be able to respond to CDEL and extraordinary offers from the centre. We need to reflect that there are constraints, risks and opportunities.

Progress Report on CNST

The Committee noted changes to the technical guidance.

The key highlights were as follows.

Moderate to High Risk –

Safety Action 2 – Maternity Services Data Set: Some support required from performance team to complete evidence ensure delivery of compliance.

Safety Action 3 – Transitional Care and Avoiding Term admissions: Cross site obstetric leadership now in place to develop traction on BH site. Transitional care pathway and staffing model needs implementing BH site.

Safety Action 5 - Midwifery Workforce Planning – Evidence required demonstrating 100% compliance with supernumerary LW co-ordinators status.

Safety Action 6 - Implementing Saving Babies Lives care bundle V2 – Work streams in place to restart programmes with close monitoring.

It was acknowledged that the service would continue to pursue full achievement of the metrics, however recent changes to the guidance will make this more challenging.

The Finance, Investment and Performance Committee noted the update.

5. Items for Escalation to the Board

None.

Bedfordshire Hospitals NHS Foundation Trust

Board of Directors

Wednesday 27 July 2022

Report title:	**Redevelopment Committee Reports**			**Agenda item: 10**
Executive Director(s):	**Melanie Banks, Director of Redevelopment and Strategic Planning**			
Report Author	**Melanie Banks**			
Action *(tick one box only)*	**Information** [x]	**Approval** [ ]	**Assurance** [ ]	**Decision** [ ]
Recommendation	The Board of Directors are asked to note the content of the paper.			

Report summary	This report provides an overview of the activity within the Redevelopment team over the last quarter, from 04/05/22 – 22/07/22. A significant amount of construction work is taking place on the L&D site with construction of the Energy Centre (EC), the New Clinical Buildings (NCB) and the Emergency Department (ED) extension and refurbishment. The EC is due to complete in October 2023. The NCB project has progressed well since construction commenced in January 22 and the team have formed a good working relationship with the contractor, Kier. The ED project remains challenging due to a number of risks that have been realised, this has had a negative impact on cost and on programme and with each risk, there is the added impact of market conditions impacting time and money. The Trust accepted a high level of risk when the contract was let to Willmott Dixon and as a result, a further budget uplift will be recommended to FIP on the 27 July 22 to support completion of the project. A number of projects are under construction at Bedford Hospital which directly support backlog, infrastructure and site resilience as well as Covid recovery. Projects being designed or procured have been overwhelmingly impacted by current market conditions which continue to experience upward pricing pressures. This will force difficult decisions to be made moving forward in relation to capital planning and capital bids.
Legal Implications / Regulatory requirements / Strategic objectives and Board Assurance Framework	N/A

Bedfordshire Hospitals
NHS Foundation Trust

Redevelopment Committee Reports – Update to Trust Board
Wednesday 27th July 2022

1. **Introduction**
   This report provides an overview of the activity within the Redevelopment team over the last quarter, from 04/05/22 – 27/07/22.

2. **Acute Service Block and New Ward Block, L&D**
   The Trust entered into contract with Kier in January 22. Activity in the first 6 months has focussed on finalising key design packages for procurement by Kier, establishing the site team and set up and undergoing demolition and groundworks and now building the building frame. A number of changes have been approved as per the contract mechanism, in support of an efficient design solution which continues to drive value for money and to tackle risks. The project remains within the parameters agreed in terms of programme, cost and quality, with a healthy contingency left in the budget.

3. **Urgent and Emergency Care**
   The Luton ED project continues to be a challenging project, for the Trust, team and contractor. The Trust accepted a number of risks when it let the contract to Willmott Dixon, most of these risks have come to fruition, and additionally, unknown risks at the time of agreeing a project scope, have come to fruition. The project continues to pick up estates backlog, not foreseen at the project onset and with every change, the price of works are compounded by the current market conditions. On the 27th July, FIP will be asked to consider a further budget uplift to address the anticipated risks to project completion.

   Phase 2 at BH comprises two elements, the first element includes the first floor modular fit out to enable the CT scanner to be accommodated in the department. The contractor is 4 weeks in to an 8 week fit out project which is progressing well, on programme and within budget. The second element which includes construction to support the CT installation is ready to go to market, programme will need to dovetail with completion of the HV substation, a key enabler and risk to the success of this project.

4. **Energy Centre (EC), L&D**
   The EC is subject to a 12 week delay given events in 2021 (sub-contractor performance) and more recently, events around the discovery of residual asbestos in the tunnels. The construction works have progressed well and the project due to complete in October 22 remains within budget with a healthy contingency. The key risk remains the coordination of works between the three principal contractors and the delivery of upgrade works to plant rooms will need to be carefully coordinated due to the potential risk impact on hospital functions.

5. **Cauldwell, BH**
   The Cauldwell project delivers two floors of flexible outpatient space and is nearing completion. The project remains on programme and within budget.
   A number of strategic changes are being discussed to support operational pressures within service lines, these have not yet been agreed.

6. **Electrical Infrastructure, BH**
   The Trust are in contract with WT Portsmouth to deliver the project. Planned completion is April 23 but there are a number of risks being experienced that may impact this, including the very recent discovery of asbestos not found during survey work. The impact of this is currently being worked through, but expected to be 6 weeks.

7. **Primary Care Hub**
   The Trust remain committed to working with and across the ICS to support the roll out of the Hub programme. The Trust are undertaking a project in North Bedford that looks to refurbish a LIFT asset and a Trust asset to create a Hub for one Primary Care Network. A full business case is expected at the end of September 22. The allocation made in 2018 was for £7.08m, this is under significant pressure given market conditions, to deliver the key objectives of the project.

Melanie Banks
Director of Redevelopment and Strategic Planning
22 July 2022

Bedfordshire Hospitals NHS Foundation Trust

Board of Directors
Date

Report title:	**Charitable Funds Committee Reports to Board of Directors**			**Agenda item: X**
Non-Executive Director(s):	**Simon Linnett, Chair**			
Report Author	**Matthew Gibbons – Director of Finance** **Sarah Amexheta – Head of Charity**			
Action *(tick one box only)*	**Information** ☐	**Approval** ☐	**Assurance** ☒	**Decision** ☐
Recommendation	To note the contents of the report for assurance			

Report summary	The Charitable Funds Committee held a meeting on the 19th May 2022.
	
	Key points to note for the Board:
	
	• Out of Committee bid agreed £1200 for Nurses day.
	• £340k of the total received for the CT scanner donation at the L&D, outstanding amount expected this financial year.
	  ○ Further update on donation requested for next CFC Meeting.
	  ○ Invitation to donor to come onsite to be extended by the CFC Chair.
	• Captain Tom Moore Gardens story plaque is now in place.
	• Bedford General Fund is in deficit, reasoning to be presented at next CFC meeting by finance.
	• Agreed a subcommittee will review Investment portfolios, with consideration to tender and amalgamation of funds.
	• Agreed that after consultation some of the designated funds will be closed and funds returned to general funds.
	• Agreed that the Bedford General Fund and L&D general fund will be amalgamated.
	• Investment representatives presented the position of the portfolios. The NICU investment bonds are expiring, Finance to review.
	• Risk register was updated, with a risk flagged regarding refund pin on card machines, which finance is looking at.
	• Charity Commission name change outstanding, Jenny Pigott and Victoria Parsons chasing.
	• Agreed to support legacy maintenance cost £1248.80 for Warden Hill Estate.

	Charity Report - . The Charity Team highlighted the change in donor behaviours and spoke to the report, highlighting: a. the year's income at £1.35m, b. recent successes in both fundraising and volunteering, including a considerable take up on youth engagement. c. It was noted that Covid and the helipad pause have had a detrimental impact on income generation. d. The focus going forward is to create a robust Acute Service block appeal, regrow volunteering across both sites, increase retail provision and develop the work experience program. • Noted Take Heart project is progressing well with £11,645 donated to support the programme. • The Board to review Trustee lists for grant giving Trusts and let Charity team know of any connection to the following charities: o Wolfson Foundation o Basil Samuel Charitable Trust o Apax Foundation o Garfield Weston Foundation o Thompson Family Charitable Trust • Bedford Hospital Charity and friends reported back that they had hit their £1m target to support A&E at Bedford, adding on an ultrasound scanner. • An update was given on the fundraising for the Paediatric stabilisation room, with £42k raised, the Committee agreed to support the commitment by moving £39k from the Paediatric fund into the Appeal fund so that works could commence. Tanith Ellis also in support. • A new template and guidance document for Charitable Fund bid requests was presented to the committee and approved. **Approved Bids** • Approved: Elderly Wards (both sites) – Happiness programme for dementia patients. £29,790 from LD1A • Approved: Long Service Awards (both sites), £4,984 (plus VAT) • Approved: Someries butterfly garden (Bedford), £5,200. • Approved: Trolley Service (Luton), £4,600 • Approved: Radiology – Mauro Chair (Luton), £1,875. • Approved: Bariatric PhD study (both sites), £37,500 from multiple funds to be agreed between Finance / Operations Director. Operations Director to liaise with project leads on funding split and reporting back on progress. • Approved: Daisy Awards additional request (both sites), £3,654 • Approved: Engagement Events (both sites), £106,940. • Action to review scheme of delegation • Confirmed to Bedford Hospital Charity and Friends additional wellbeing space was not needed at present, as it

	was funded through budget.
Legal Implications / Regulatory requirements / Strategic objectives and Board Assurance Framework	Charity Commission
Jargon Buster	

Bedfordshire Hospitals NHS Foundation Trust

Board of Directors

Wednesday 27th July 2022

Report title:	**Workforce Committee Report**			**Agenda item: 12**
Non-Executive Director(s):	**Tansi Harper**			
Report Author	**Angela Doak, Director of HR**			
Action *(tick one box only)*	**Information** ☐	**Approval** ☐	**Assurance** x	**Decision** ☐
Recommendation	The Board is asked to note the report for assurance			

Report summary	The report contains a summary of the considerations of the Workforce Committee which met on 13th July 2022. Consideration was given/progress was noted in the following areas aligned to the People Plan Priorities: **Looking after our people** 1. Staff Wellbeing 2. Freedom to Speak Up Guardian 3. Staff Engagement 4. Culture & OD progress reports 5. Health and Wellbeing framework **Belonging in the NHS** 6. Staff Networks 7. Gender pay gap report **Growing for the future** 8. Nursing Workforce Assurance Framework **New ways or working and delivering care** 9. Mandatory training & Appraisal – Back on Track **Spotlight topic** 10. Sustainability 11. Redevelopment **Governance** 12. Workforce Board report 13. Risk Register 14. Matters for Escalation 15. HMRC update
Legal Implications / Regulatory requirements / Strategic objectives and Board Assurance Framework	NHSI, Equality Act, CQC Strategic Objective 1 - Attract, value and develop the best people to deliver outstanding care in an environment where people can THRIVE

LOOKING AFTER OUR PEOPLE

1. Staff Wellbeing

An update on communicating Health and Wellbeing messages in the week was including the Workforce report. Other written updates highlighted the recent Schwartz Round, Peer Listener Network and the Employee Assistance Programme CiC.

The Health & Wellbeing Framework, which will be use to shape the Health & Wellbeing Strategy, will be presented at the September meeting.

2. Freedom to Speak Up (FTSU) Guardian report

There have been a number of new concerns raised between April and June 2022. The concerns were in the main around quality, levels of support, attitudes and behaviours and patient safety. The FTSU Guardians had either reached a satisfactory conclusion to the issues or were in the process of doing so.

The Peer Listeners report to the Trust's Clinical Psychologist for support and feedback on the trends and issues raised by staff. One of the themes identified was the importance of recognition and thanks for staff who generally feel unappreciated. However, it was reported that the staff engagement events and recognition of long service initiatives has been well received. The Take heART creative workshops were also reported as helping staff to feel valued and appreciated.

There is now more engagement from the Guardians with junior doctors on both sites with support from Dr Nisha Nathwani, The Guardians now attend MDT Preceptorship training and the induction training for new overseas midwives. Pathways for junior doctor representatives to contact the guardians are being developed and communicated.

3. Staff Engagement

The Staff Engagement event was held during the first two weeks of July (4-8 July at Bedford and 11-15 July at Luton). Values messages and other elements were weaved into the hour long sessions and the "Thank you" Friday with free food (breakfast, lunch and afternoon tea) for all staff was well received.

4. Culture and OD Progress report

The committee received a paper which provided a summary of the progress made in establishing an OD faculty and the associated work plan.

The creation of an OD Faculty has embraced the best-from-both of our organisation's OD and leadership development functions. Professional OD staff from both sites have brought to the new organisation a wealth of experience in the design and delivery of bespoke leadership programmes from Board to Ward, alongside participation in national and regional leadership development initiatives and knowledge and experience of the theory and practice of collective leadership.

The committee heard that the work plan was on track and a firm foundation established. The plan is grouped into the following areas:

- Foundation (OD Infrastructure),
- Affinity (staff) Networks,
- Organisational & Leadership Development-Board,
- Organisational & Leadership Development – senior managers,
- Medical Leadership Development,
- Long Term Integration and Support,
- Culture Integration,
- Health and Wellbeing, Feedback and Learning

5. Health and Wellbeing Framework

The committee received a paper describing the NHS Employers Health and Wellbeing Framework and how we are utilising it to inform the development of our Health and Wellbeing Strategy. The Health and Wellbeing Framework is a developmental tool that provides a way to self-assess against 7 key topics:

- Personal health and wellbeing
- Relationships
- Fulfilment at work
- Environment
- Managers and Leaders
- Data insights
- Professional wellbeing support

Communication was highlighted as an area of improvement and metrics will be reviewed at the next committee meeting. The implications of the framework will be discussed at the next Strategic Wellbeing meeting.

BELONGING IN THE NHS

6. Staff Networks

The committee received a paper from the BAME staff network which highlights a focus on growing the network and creating awareness on health topics that affect ethnic minorities.

There are now are over 430 members and the network are working collaboratively with LGBTQ plus staff network who will present at a Grand Round. A sickle cell awareness event will be held in September and those staff affected have been invited to this event.

7. Gender Pay Gap (GPG)

The national data has been reported as required for the year ending 2021 which is the first time that data will be submitted as the merged organisation. The committee received the detailed gender pay gap report and were assured that the measures identified in the paper would be taken forward and developed into a work plan.

GROWING FOR THE FUTURE

8. Nursing Workforce report

Progress continues to be made with the organisation remaining fully compliant against 23 standards and partially compliant against 6. These 6 are all areas that are all either dynamic actions that will constantly require review or action or are long term strategic actions that are making progress. None put staff, patients or the organisation at risk.

Across the NHS the turnover of staff is increasing and a letter has been issued by NHS England and the Trust is establishing a group to look at a bundle of measures designed to reduce turnover based on career stages including:

- a self-diagnostic tool,
- promotion of our preceptorship framework support for early careers,
- legacy mentoring schemes,
- national pension seminars
- development of menopause policy/guidance.

NEW WAYS OF WORKING AND DELIVERING CARE

9. Mandatory Training and Appraisal Trajectory

The committee heard the details of the launch of the new project the bring training and appraisal compliance back on track over the next six months following a deterioration of compliance over the pandemic. The “Back on Track” project will be launched on 25th July 2022 to support staff and managers to achieve compliance levels.

The target for the Trust is for all staff to complete their mandatory training and have an up-to-date appraisal by no later than the 31st December 2022. Over the next 6 months the Training & Learning Team will be providing additional support for departments and services to co-create bespoke plans and provide tools to achieve compliance. This includes easy and flexible access to training facilities and resources.

We are also working with service leaders to identity champions in each service area who will help us develop a social movement to move towards a culture aligned to our values and that will see us all taking individual professional responsibility to maintain 100% training and appraisal rates.

The launch week will see a series of events over both main hospital sites including visiting clinical areas, stands in key areas, and supported eLearning sessions. There will also be training on the implementation of the “pay step review” which requires staff to be complaint with training and appraisals before they are able to move through their pay scale.

SPOTLIGHT TOPICS

10. Sustainability

The committee received an update from Bharathi Brown on the work the Trust is doing on sustainability. Bharathi gave an overview of the Trust's green plan and how this fits with the national objectives. The main domains of work are in Estates and Facilities, transport, medicines, pharmacy, food and nutrition and Digital transformation. There is senior executive and non-executive leadership for the sustainability committee and an upcoming programme of education and engagement and training for staff. One of which took place was bike week that saw Matt Gibbons – Director of Finance cycling into work.

11. Redevelopment

The committee received an update from Kyle McClelland on the plans and progress of the redevelopment Programme. The committee heard how work has started on how the workforce will transition into the new buildings and the changes that this will require.

GOVERNANCE

12. Workforce Trust Board report

The committee considered the workforce board report and in particular the following points:

- Vacancy rates have decreased by a small margin
- Turnover rates are slightly higher than the same period last year.
- Sickness rates are starting to decrease
- Appraisal and mandatory training rates have both increased

The committee recommended developing the measures for retention and the potential inclusion of additional metrics such as a stability index and different was of analysing the available data.

13. Risk Register

The committee reviewed the risk register and agreed that the appropriate risks were on the register and the risk scores remained unchanged.

14. Matters for Escalation

An update on the ongoing issues with the HMRC was provided. The slow progress from HMRC in this regard will be escalated and a formal complaint raised with the HMRC.

Bedfordshire Hospitals NHS Foundation Trust

Board of Directors

Wednesday 27th July 2022

Report title:	**Annual Audit & Risk Committee Report to Board**			**Agenda item: 13**
Non-Executive Director:	Steve Hone, Non-Executive Director			
Report Author	Victoria Parsons, Associate Director of Corporate Governance			
Action *(tick one box only)*	**Information** ☐	**Approval** ☐	**Assurance** x	**Decision** ☐
Recommendation	The Board is asked to note the Annual Audit & Risk Committee Report.			

Report summary	This report sets out how the Audit & Risk Committee (A&RC) has fulfilled its role during 2021/22. An annual work plan, based on the terms of reference (as approved by the Board) was reviewed and approved in March 2021.
Legal Implications / Regulatory requirements / Strategic objectives and Board Assurance Framework	A robust internal control framework supports delivery of the Trust's strategic objectives
Jargon Buster	RSM – Trust Internal Auditors

Annual Audit & Risk Committee Report to Board

1. Introduction

This report sets out how the Audit & Risk Committee (A&RC) has fulfilled its role during 2021/22. An annual work plan, based on the terms of reference (as approved by the Board) was reviewed and approved in March 2021. The 2021/22 work plan is attached at Appendix 1.

2. Attendance of the Audit & Risk Committee

The Committee met on four occasions during the year and were quorate at each meeting (minimum of Chair plus 2 non-executive directors).

Also in attendance were internal audit, counter fraud and the Associate Director for Corporate Governance and Director of Finance, for all meetings. External audit gave apologies for one meeting. The Joint Medical Directors/Medical Director did not attend any meetings due to clinical responsibilities related to Covid and recovery. No significant clinical risk issues arose that could not be addressed by placing reliance on representation and assurance from the Quality Committee subcommittee, (attended by the Joint Medical Directors/Medical Director and members of the A&RC).

3. Activity during the year

Governance, Internal Control and Risk Management

The A&RC fulfilled this aspect of its role through:

- receipt of progress reports from external audit, the local counter fraud specialist, and internal audit. The latter were instrumental in alerting the Audit & Risk Committee to low, medium, high and critical risk areas and ensuring that appropriate action was being taken through the 'progress on outstanding recommendations' report;
- Updates from the various sub-committees, attended by members of the A&RC, were provided which reported emerging governance and assurance risks; and

- Review of the Board Assurance Framework and Risk Registers for completeness and accuracy.

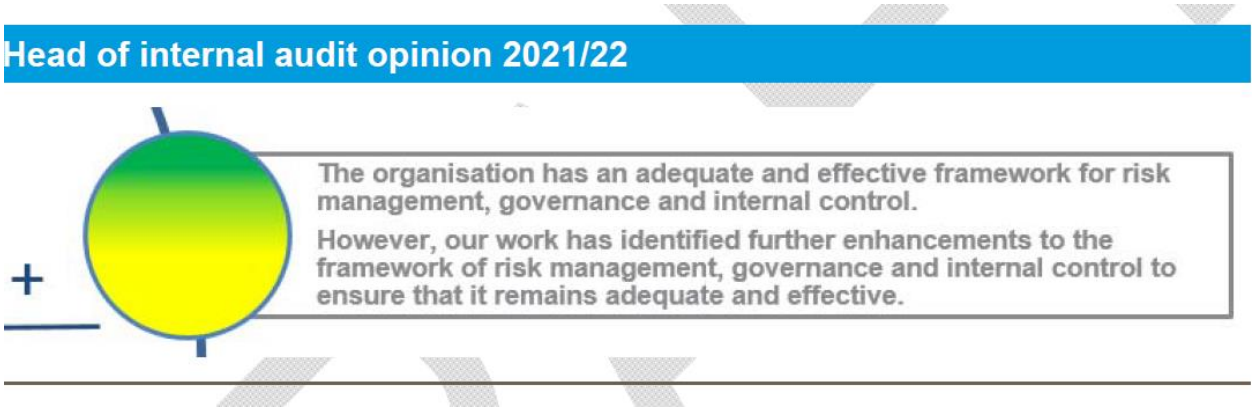
The Trust's Governance Statement has been drafted on the basis of the various sources of assurance over governance, internal control and risk management and known weaknesses as reported to the A&RC.

The A&RC also received various management reports which monitored compliance with and changes to the Standing Orders, Standing Financial Instructions and Scheme of Delegation. These included the Register of Interests, Loss and Compensations payments, Hospitality Register and the circumstances when standing orders were waived.

Appendix 2 is an extract from the 2021/22 Annual Report describing the role of the Committee and how it fulfilled this role.

Internal Audit

The annual audit plan, as agreed at the Committee, was delivered over the course of the year. The Annual Report, as reported at the June 2022 committee, concluded:



The Committee requests attendance by senior representatives to provide formal briefings on implementation of high and critical risk actions if required. This process has provided evidence that recommendations have been implemented. The Committee will continue to monitor and escalate to hold officers to account. Over the last year outstanding recommendations have been assigned to the relevant sub-committee for monitoring of implementation and to improve accountability, which has proved successful in maintaining continual focus and progression. All legacy actions have been implemented. Management now need to ensure timely production of evidence that actions have been successfully addressed on an ongoing basis.

It should be noted that External Audit, Internal Audit and Counter Fraud contracts have been retendered for the 2021/22 financial year.

External Audit
The focus of the external audit work during 2022/22 has been opinion based i.e. to provide assurance that the financial statements give a true and fair view. This was through identification of the risks facing the Trust, establishing whether they are mitigated by the risk management arrangements, and assessing internal control and the risk of material misstatement. In addition the external audit gives a Value for Money conclusion based on the requirements of the National Audit Office. The Annual Governance Report was reported at the June 2022 A&RC. Feedback during the year has suggested that there are no significant concerns.

External Audit also provide Technical Updates which assist the Committee with challenging and obtaining assurance from management on relevant issues in the Health Sector.

Financial Reporting
Final approval is planned at the Private Board on 15 June 2022.

The draft accounts, annual governance report and supporting commentary within the Annual Report were reviewed by the A&RC in June 2022.

The accounting policies were updated and approved by the A&RC to reflect changes to the Annual Reporting Manual and current practices in March 2022.

NHS Improvement/England has not made any formal announcements during 2021/22 relating to the Trust's financial performance.

Counter Fraud
The A&RC received regular progress reports on delivery of the annual counter fraud programme including outcomes of investigations of fraud allegations. There were no incidents raising concern over the control environment for prevention of fraud.

Quality Assurance
The A&RC has received regular sub-committee updates over the year and a report from the Freedom to Speak Up Guardian. These reports provided the Audit & Risk Committee with the assurance that there were adequate controls in place to review, monitor and action the Trust objectives. Of particular note, the updates from Quality Committee has provided assurance on the effectiveness of improvements in Clinical Governance and adequacy of clinical audit, acknowledging that there is a need to continue with the improving trend.

Reporting to the Council of Governors

The external auditor, BDO will report the 2021/22 Annual Management Letter to the August 2022 Council of Governors meeting.

Charitable Trust Annual Accounts and Trustees' Report

The Committee has reviewed the Annual Accounts and the Trustees' Report of the Charitable Trust for the year ended 31 March 2021 and confirmed their filing with the Charity Commissioners.

Conclusion

During 2021/22 the Audit & Risk Committee fulfilled its role as set out in its terms of reference and is satisfied that adequate controls exist over governance, the system of internal control and risk management.

RECOMMENDATION

The Board is asked to note the Annual Audit & Risk Committee Report.

Steve Hone
Chair of the Audit & Risk Committee (during 2021/22)
June 2022

Appendix 1: Audit & Risk Committee Work Plan	March	May	Oct	Feb
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		✓		

Appendix 2: Audit and Risk Committee Report

Audit and Risk Committee Report

The Audit and Risk Committee reviewed financial and operating performance and compliance against national and regulatory standards. A comprehensive work plan is agreed each year which ensures oversight and monitoring of risks, mitigations and issues relating to the financial statements, internal controls and compliance with regulatory, statutory responsibilities and internal policies and procedures which in turn enables action to be escalated as appropriate, i.e. officer attendance to explain critical risk or failure to implement internal audit recommendations and escalation to the Board where appropriate. An annual report of the Committee's activities and how the Committee has fulfilled its role is reported by the Chair of the Audit & Risk Committee to the Board and the Council of Governors. The Committee has had close oversight throughout the year of the Board Assurance Framework and principal risks on efficiency planning and sustainability.

Internal Audit
The Audit and Risk Committee has been assured by the Head of Internal Audit Opinion on the Trust's internal control environment and positive approach to identifying, assessing and mitigation planning to risks.

External Audit
The Audit and Risk Committee engages regularly with the external auditor throughout the financial year, including holding private sessions with Non-Executive Directors on the Audit and Risk Committee.

The Audit and Risk Committee considers the external audit plan, technical updates, any matters arising from the audit of the financial statements and the Quality Account and any recommendations raised by the external auditor.

The External Audit programme is scheduled to focus on key areas of risk and for 2021/22 the areas of audit risk were:

- The valuation of land and building
- Revenue recognition
- Management override of control
- Fraudulent expenditure recognition

The ISA260 report has not yet been reported to the Trust.

The appointment of the auditor was made in 2021 as a result of a competitive process under a procurement compliant framework. The appointment was subject to Council of Governors agreement. Reports from External Audit are received and reviewed at each Audit and Risk Committee to assess the effectiveness of the external audit programme. External Audit are yet to complete the required testing against the controls in the fee agreed with the Trust.

The organisation's going concern status has been specifically discussed with the External Auditors in relation to the financially challenging environment the Trust faces. Assurance on the accounts review of the "going concern" opinion is based on risk to service continuity and that the Trust is able to confirm service continuity and therefore going concern status over the medium term.

Bedfordshire Hospitals NHS Foundation Trust

Board of Directors

Wednesday 27th July 2022

Report title:	**Sustainability Committee Report**			**Agenda item: 14**
Non-Executive Director(s):	**Simon Linnett, Chair**			
Report Author	**Bharathi Brown**			
Action *(tick one box only)*	**Information** ☐	**Approval** ☐	**Assurance** x	**Decision** ☐
Recommendation	To note the contents of the report for assurance			

Report summary	Key points to note for the Board Progress update on key focus areas and priorities of the Green Plan
Legal Implications / Regulatory requirements / Strategic objectives and Board Assurance Framework	NHSI Net Zero
Jargon Buster	ICS – Integrated Care System

SUSTAINABILITY COMMITTEE REPORT

Introduction

This Report updates the Board of Directors regarding the matters discussed at the Sustainability Committee meetings held on the 20th July 2022.

The Committee received a progress update report, outlining progress made against the key targets and priorities of the action plan and a business case for additional resources to deliver the Green Plan.

1. Travel and Transport

Staff and patient travel survey was completed in June, across all Trust sites and the draft travel plan has been developed. The draft plan has been shared with stakeholder groups for feedback and the recommendations will be shared with the Sustainability Committee on the 18th August 2022.

Dr Bike initiative was delivered at both sites by Bedford and Luton Borough Councils. Bikes were repaired and recycled bikes were sold at affordable prices.

The Trust also participated in Bike Week in June to encourage more staff to take up cycling to work.

2. Medicines and Anaesthetic Gases

Desflurane vs Sevoflurane: Our consultant anaesthetists have made tremendous progress in reducing the usage of desflurane (more carbon emission than the alternative sevoflurane) within the Trust. In June 2021, the use of desflurane was 24.6% and Sevoflurane was 76.4%. June 2022 data shows that the use of desflurane has been significantly reduced to 3.6% across the two sites, with L&D site using 0% since March 2022.

Nitrous Oxide (N_2O): Redevelopment team is working with Kier, contractor for the Acute Services Block to develop design options to include the scavenging system in the new build maternity/labour ward and putting destruction unit in the plant room to break down the scavenged N_2O and / or taking the piped N_2O out of theatres.

3. *Models of care and Virtual outpatient appointments*

The NHS Trusts are expected to see 25% of the out-patients virtually where clinically appropriate. The Trust's performance year to date (April 2022 - June 2022) is 21.2%. Sustainability team is working with a Neurologist, who is passionate about sustainability and out-patient team to increase the number of patients they see virtually.

4. Additional resources for the sustainability team

The progress on delivering the priority actions have been somewhat limited due to the one member team. The committee has approved the business case to fund a band 4/5 Travel and Transport Co-ordinator to deliver the travel plan recommendations and to upskill some internal resources to deliver some of the priority areas at pace and provide resilience within the team.

5. Food and Nutrition

Catering teams on both sites are undertaking a review on nutrition content of the meals that are provided for staff and patients; waste; packaging; procurement (locally sourced or elsewhere) and digital ordering system to understand the process and set the baseline.

6. Digital transformation

Sustainability team has agreed the key short and long term priorities with the Trust's digital team to take forward. Some of the actions agreed are reforestation to offset digitalising medical records, Digital systems to reduce the use of paper records, reducing the use of single-use printers 250 (BH) 1340 (L&D), rolling out electronic patient record (EPR) and Enabling more remote / agile working and practices (Staff meetings, multi-disciplinary meetings).

7. Supply chain and procurement

The Trust switched the procurement of standard paper to recycled paper in May 2021. The cost of the papers in Jan 2020 – Dec 2020 was £38k, Jan 2021 – Dec 2021 saw the cost at £32k and from Jan 2022 to date the cost has reduced even further to £11k in six months.

Head of procurement is working very closely with the ICS and national teams in developing a green procurement strategy.

8. Estates and Facilities

Energy: The Trust has replaced 7606 light fittings with LED lighting with an anticipated reduction of 576 tCO2/year. A further installation of LED lights across sites are planned for 700 at L&D and 323 at BH.

The Trust has now procured a specialist company to develop a roadmap to net zero carbon for the Trust's infrastructure element across the two sites.

Waste: Sharpsmart embedded at BH with a reduction of 58 tCO2/year and currently being trialled at L&D at the Medical Block. Theatre waste audit underway at L&D with an enthusiastic anaesthetist. BH has successfully implemented the office waste separation. Education on waste and recycling is ongoing.

9. Workforce and Leadership

The Trust has a very committed leadership team that supports the sustainability agenda. Sustainability e-learning modules are available on the Electronic Staff Record (ESR) portal. Next steps will be ensuring sustainability becomes part of staff induction and tender packages.

Bedfordshire Hospitals NHS Foundation Trust

Board of Directors

Wednesday 27th July 2022

Report title:	Risk Register			Agenda item: 15
Executive Director(s):	All Executives			
Report Author	Victoria Parsons, Associate Director of Corporate Governance			
Action *(tick one box only)*	Information ☐	Approval ☒	Assurance ☐	Decision ☐
Recommendation	Note the activity on the risk register and approve the new risks.			

Report summary	This report is to update the Board on governance reviews of the Board Level Risk Register and new risks. There have been reviews of the risks on the risk register at the following meetings: • Board of Directors Private Meeting 4th May 2022 • Executive Board 26th July 2022 • Quality Committee 25th May and 22nd June 2022 • Finance, Investment and Performance Committee 22nd June 2022 • Workforce Committee 13th July 2022 New risks have been reviewed and are recommended for approval by the Board: • 1810 – Increase of violence and aggression towards clinical staff (high) • 1811 – Pathology Integration (medium) Emerging Board Level risks Digital Safety Risk (currently a departmental risk), Overcrowding in ED and Continuity of Care in Maternity (currently a service line risk)
Legal Implications / Regulatory requirements / Strategic objectives and Board Assurance Framework	NHS I – Trust Governance Framework CQC – All regulations and outcomes MHRA All Objectives
Jargon Buster	MHRA – Medicines and Healthcare Products Regulatory Authority Datix – Incident Reporting system used to report risks Nosocomial – Location acquired infections

Risk Register Governance

The Risk Register is reviewed by the Sub-Committees of the Board in line with their terms of reference.

Each committee reviews the risks assigned as Board Level and ensures that the content is updated.

As part of the integration programme, the Datix system will be integrated into one system.

Board of Directors Review

Board reviewed high board level risks on the 4th May 2022:

Risk ref	Risk Description	Agreed conclusion
1672	Ultrasound scanning	Maintain risk
1431	Fractured Neck of Femur	Maintain risk
1423	Mandatory Training	Maintain risk
1211	Backlog Maintenance	Maintain risk
650	Bed pressures	Maintain risk
1509	Staff Health and Wellbeing	Maintain risk
669	Appraisal Rate	Maintain risk
1433	Ligature Points	Maintain risk
1200	Cyber Security	Maintain risk
1629	Nosocomial Infections	Maintain risk
1595	Maternity Services Bedford Reputation Risk	Maintain risk
1596	Maternity Services Bedford Patient Safety Risk	Maintain risk
1703	Increased demand for mental health care	Maintain risk
1704	Maternity Pressures	Maintain risk
1705	Diagnostic capacity	Maintain risk
1592	Patient Harm due to COVID delays	Maintain risk
1652	ED Blue Light transfers to other hospitals	Maintain risk
1639	Outpatient Clinic Room availability and capacity	Maintain risk
1776	Disjointed Outpatient Administration	Maintain risk
1738	Maternity Safeguarding	Maintain risk
1631	Clinical Correspondence	Maintain risk
1711	Echocardiography backlog	Maintain risk
906	Medicine Shortages	Maintain risk
1735	2022/2023 Financial Target	Maintain risk
1736	System wide finance target	Maintain risk

The Board noted the new risks and the emerging risks were noted and discussed.

Quality Committee (QC)

QC reviewed clinical and performance board level risks on 25th May and 22nd June 2022

Risk ref	Risk Description	Agreed conclusion
1595	Maternity at Bedford reputation	Maintain risk
1628	Nosocomial Infections	Maintain risk
650	Bed pressures	Maintain risk
1958	Maternity at Bedford patient safety	Maintain risk

Risk ref	Risk Description	Agreed conclusion
1433	Ligature Points	Maintain risk
796	Patient Experience	Maintain risk
1757	104 week waits	Maintain risk
1762	Lack of Ultrasound Scanning	Reduce risk
1422	CQC Infection Control Practices	Maintain risk
1431	Fractured Neck of Femur	Maintain risk
1018	HSMR	Maintain risk and reframe
1592	Patient Harm due to COVID delays	Maintain risk
640	Business Continuity	Maintain risk
796	Patient Experience	Maintain risk
906/ 2832	Pharmacy supplies	Maintain risk
1652	ED Blue Light transfers to other hospitals	Maintain risk
1639	Outpatient Clinic Room availability and capacity	Maintain risk
1703	Increased demand for mental health care	Maintain risk
1704	Maternity Pressures	Maintain risk
1705	Diagnostic capacity	Maintain risk

Emerging risks – Litigation post COVID, pathology integration.

Workforce Committee Review

Reviewed board level risks on the 13th July 2022:

Risk ref	Risk Description	Agreed conclusion
1210	Vacancy	Maintain risk
1166	Redevelopment models of care and workforce	Maintain risk
1423	CQC Regulatory Action - Mandatory Training -	Maintain risk
669	Appraisal	Maintain risk
1509	Staff Well Being	Maintain risk
1754	Turnover	Maintain risk

FIP Committee Review

Reviewed board level risks on the 20th June 2022.

Risk ref	Risk Description	Agreed conclusion
1211	Backlog Maintenance	Maintain risk
1734	Investments made without knowing payment is confirmed	Maintain risk
1735	2022/2023 Financial Target	Reduce risk
1736	System wide finance target	Maintain risk
890	Lack of Medical Equipment rolling replacement programme	Maintain risk.
1759	Capital spend/CDEL risk	Maintain risk.

Emerging risks on the maternity CNST achievement (not considered financially material) and the pay inflation and any strike action.

Executive Board Review
The Executive Board reviewed all Board Level Risks on the 26th July 2022.

No amendments were made to the risks.

Risk Review

Risks from both sites were reviewed and approved between 25th April 2022 – 21st July 2022. The below were allocated as Board Level:

- 1810 – Increase in violence and aggression to clinical staff (high)
- 1811 – Pathology Integration (medium)

Emerging Board Level risks Digital Safety Risk, Overcrowding in ED and Continuity of Care in Maternity, violence and aggression to staff, pathology integration

Risks were closed – the below at Board level:

- 1592 – delays from Covid – emerging risk on recovery

Bedfordshire Hospitals NHS Foundation Trust

Board of Directors

Wednesday 27th July 2022

Report title:	Corporate Governance Report			**Agenda item 16**
Executive Director(s):	**Executive Directors**			
Report Author	Donna Burnett – Trust Board Secretary			
Action *(tick one box only)*	**Information** ☐	**Approval** [x]	**Assurance** ☐	**Decision** ☐
Recommendation	The Board to note progress and ratify the sub-committee Terms of Reference.			

Report summary	The report details updates on the following issues: • Council of Governors • Membership Update • Use of the Trust Seal • Terms of Reference for Ratification
Legal Implications / Regulatory requirements / Strategic objectives and Board Assurance Framework	NHS Provider Licence NHS Improvement Code of Governance NHSI/E national guidance April 2020
Jargon Buster	Seal – use of the official Trust logo on contract documents authorised by two Executive Directors

1. Council of Governors

Current Composition of the Council of Governors:

Bedfordshire Hospitals NHS Foundation Trust currently has 37 governors. Since the last Board meeting there has been no change to the composition of the Council of Governors:

Public Governors:

- 8 for Luton
- 6 for Central Bedfordshire
- 2 for Hertfordshire
- 5 for Bedford Borough and Surrounding Counties
- 12 Staff Governors (1 vacancy)
- 4 Appointed Governors (1 vacancy)

2. Council of Governor Elections

Council of Governor Elections will take place in 2022 for the following constituencies.

Public: Luton - 5 vacancies
Staff: Nursing & Midwifery - 1 vacant position (L&D site)
Staff: Professional & Technical - 1 vacant position (L&D site):
Staff: Non-Clinical: Admin, Clerical, Managers, Ancillary & Maintenance - 1 vacant position (L&D site)
Staff: Non-Clinical: Admin, Clerical, Managers, Ancillary & Maintenance - 1 vacant position (Bedford site)

3. Council of Governors Remuneration and Nomination Committee

The Council of Governor's Remuneration and Nomination Committee is chaired by Yvette King, Public Governor for Bedford Borough (and its surrounding counties). Committee members remain very busy at present with their involvement in the recruitment process for a Chair of the Trust.

4. Governor Committee Meetings and Working Groups

Council of Governor meetings are now being held through hybrid meetings: both in person and virtually. Governors continue to be actively engaged with driving improvement for patients through their work at the Outpatients Assurance Group and the Patient Experience Group. Governors continue to be involved in audit and inspections supporting quality improvement across the Trust.

Governor Engagement
Almost half of our governors attended the summer staff engagement events that took place throughout July at both hospital sites. This provided governors with an opportunity to talk and engage with staff and gain an insight into their views.

5. Membership

There was a great turnout at the medical lecture held in May at the Rufus Centre. The focus of the lecture was 'Living with Diabetes' hosted by Dr Shiu-Ching Soo, Dr Alison Melvin and Julia Pledger. Over 120 members of the public attended this popular health event. The next membership event will take place in October with a medical lecture on 'Ophthalmology – A Healthy Eye' with dates to be confirmed shortly.

Annual Members Meeting

The next Annual Members meeting will take place in September. Further details will be made available on the Trust's website.

6. Use of the Trust Seal

Date used	Seal number	Subject	Supporting information
4/5/22	196	Bedfordshire Hospitals NHS Foundation Trust, Luton Borough Council and Thames Water Utilities Limited under S104 of the Water Industry Act 1998 relating to sewers and the L&D Hospital Site.	
5/5/22	197	Bedfordshire Hospitals NHS Foundation Trust and RG Carter Cambridge Ltd. Building contract incorporating and amending the NEC4 Engineering and Construction Contract June 2017 edition option A (with January 2019 amendments) n relation to the Cauldwell Centre at the Bedford Hospital Site.	
5/5/22	198	Bedfordshire Hospitals NHS Foundation Trust and Portsmouth and Co Limited Building Contract incorporating and amending the NEC4 Engineering and Construction Short contract June 2017 edition (with amendments October 2020) in relation to the electrical infrastructure works on the Bedford Hospital South Wing Campus	
9/5/22	199	NEC4 Engineering and Construction Contract for works comprising of design and refurbishment of Levels 1 and 2 of the Caudwell Centre for form new Outpatients Department on the Bedford Site.	

7. Terms of Reference requiring Board ratification

Finance, Investment and Performance Committee (appendix 1)

Quality Committee (appendix 2)
Digital Strategy Committee (appendix 3)
Workforce Committee (appendix 4)
Audit and Risk Committee (appendix 5)

Appendix 1

Bedfordshire Hospitals
NHS Foundation Trust

TERMS OF REFERENCE

FINANCE INVESTMENT AND PERFORMANCE COMMITTEE (FIP)

Status:	Sub-committee of the Board of Directors
Purpose:	The Committee provides financial analysis, advice, and oversight of the budget, capital schemes and investment approvals. Their responsibility is to ensure the organisation is operating with the financial resources it needs to provide services to the community.
Chair:	Non-Executive Director
Membership:	Non-Executive Director (Chair) 3 additional Non-Executive Directors Chief Executive Deputy Chief Executive Director of Finance Chief Nurse Joint Medical Director
Attending as required:	Director of Human Resources Director of Estates Chief Information Officer Director of Redevelopment 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:	Service Line Representation (by invite) Board Secretary for Governance agenda items Deputy Director of Finance Associate Director of Performance & Information 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 a summary report submitted to the Board of Directors. This summary report will be 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 update on the effectiveness of the committee 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 (>£0.125m) 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-development programme.
- To review progress of the Re-development 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 and not reported to other Board sub-Committees.
- 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, Lead Nurses/Midwives named as leads for targets, to account for poor or underperformance against either key financial targets or delivery of the Re-development programme and to agree corrective action or a revised position.
- To oversee the balanced scorecard standards.

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.
- To receive a report from the Redevelopment Board and any required business cases.

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 financial 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 Trust 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 at FIP. It was

agreed that this responsibility was owned by the Chief Executive Officer and not the Non –Executives

Workplan:

Each meeting:

- Finance position
- Business Cases
- Contract updates
- Agency expenditure
- 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

To be agreed in October 2020
To be reviewed October 2021
Updated February 2021
Reviewed and Updated March 2022

Appendix 2

Bedfordshire Hospitals NHS Foundation Trust

QUALITY COMMITTEE

Status:	Sub-committee of the Board of Directors
Chair:	Non-Executive Director
Membership:	Non-Executive Directors x 4 (including the committee chair) Chief Executive Deputy Chief Executive Chief Nurse Medical Directors Deputy Medical Director Director of Human Resources Director of Quality and Safety Governance Director of Integration and Transformation
Other management membership:	Deputy Director of Quality and Safety Governance Deputy Chief Nurse Trust Board Secretary Associate Director of Corporate Governance
In Attendance:	Service Line 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:	The Quality Committee 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 the Quality Committee is, on an exceptional needs basis, granted delegated authority to make decisions on time critical issues arising between planned meetings of the committee. 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 Quality Committee meeting.

Quorum: 6 members, to include 2 Non-Executive Directors

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

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

Reporting: The minutes of the Quality Committee meetings shall be formally recorded and a report submitted to the Board of Directors.

A report shall be made following each Quality 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.

Provide update on the effectiveness of the committee 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 & Social Care 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. A focus on driving improvement in all aspects of quality; safety; clinical effectiveness and patient experience
    b. that strategic priorities are focused on those which best support delivery of Trust objectives in relation to quality and patient safety.
    c. compliance with contractual quality obligations
    d. that integration work across both hospital sites supports a focus on driving improved quality and patient safety

4. ***To receive***:
    a. information on trends and 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 Quality Operational Board and the Specialist Quality Operational Board
c. receive a report on the Equality and Diversity priorities in relation to patients
d. 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
e. A report from its formal sub-committee the Patient Experience Council

5. ***To receive assurance:***
    a. from the Clinical Quality Operational Board and the Specialist Quality Operational Board in accordance with the Quality reporting framework.
    b. on performance in relation to Trust wide patient safety projects.
    c. from the Clinical Quality Operational Board and the Specialist Quality Operational Board that reports from Clinical Service lines using available quality & safety key performance indicators and data sets are used to in order to identify areas of good and poor performance & inform future planning and service delivery.
    d. From Maternity to receive reports on the serious incidents, Ockenden, quality improvement programmes, CQC and CNST compliance and progress with external report recommendations.
    e. that decisions of national groups are implemented.
    f. that feedback from patients, users and other stakeholders is used to inform policy and practice.
    g. on the implementation and annual review of the Trust's quality strategy and priorities .
    h. that the Trust is safeguarding adults and children and other vulnerable groups
    i. 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

Members Responsibilities:

4. Individual members are expected to act as champions of the Quality Committee 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.

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

6. 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 the Quality Committee

Work Plan:

Each meeting:

- Risk Register
- CQUIN Monitoring
- Serious Incident (SI) Reporting (SI's and Action Plans)
- Mortality Report
- Quality Account Priorities

Quarterly

- Infection Control Report
- Integration Report
- Patient Experience Report
- Patient Experience Council Report
- Review against the Trust Objectives related to quality impact assessments in relation to redevelopment

Annually

- External Audit - Quality Account
- Children's Safeguarding
- Adult Safeguarding
- Cancer Peer Review
- Research and Development
- Review of the Terms of Reference
- Assurance of Equality and Diversity related to patients

As required

- CQC Insight Report
- CQC Inspections
- Internal Audits
- External Reports
- Contribution around quality from BCA

Agreed in April 2021

Reviewed and updated March 2022

Appendix 3

Bedfordshire Hospitals NHS Foundation Trust

TERMS OF REFERENCE

DIGITAL (IM&T) STRATEGY COMMITTEE

Status:	Sub-committee of the Board of Directors
Chair:	Non-Executive Director
Membership:	3x Non-Executive Director Chief Executive Deputy Chief Executive Chief Nurse Chief Information Officer Deputy Director of IT Digital Consultant – IM&T Strategy & Merger Clinical Representation on a rotational basis made of 2 of: Solutions Board Clinical Chair CCIO Medical Director 3x Clinical Leads
In Attendance:	Other Executive Directors, managers or advisors may be invited to attend as necessary.
Meeting Frequency:	Meetings shall be held not less than 4 times a year. The Chief Executive or Deputy Chief Executive may request a meeting if they consider that one is necessary *[e.g. to review major decisions or changes which do not align with a scheduled meeting]*.
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: Authority, Accountability and Chairs Action:	The Digital Strategy Board is a formal sub-committee of the FT Board of Directors and complies with the Standing Orders and the Scheme of Delegation. The Board 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.
Quorum:	4 members. In the absence of the Chair of the Digital Strategy Board the Non-Executive Directors will nominate a replacement.
Reporting:	The minutes of the Digital Strategy Board meetings shall be formally recorded.

A report shall be made following each Digital Strategy Board meeting to the next Board of Directors meeting if there are issues which need to be considered by the Board of Directors.

Objectives:

1. Digital Strategy Assurance - The Digital Strategy Board will provide assurance regarding the Trust's Digital Strategy and its ongoing review and development. This will include providing assurance that:
1.1 The Trust's Digital Strategy is aligned to and supports the Trust' clinical and business objectives and plans.
1.2 The Digital Strategy takes account of relevant national goals and directives and supports the collaborative goals of the wider health and social care community.
1.3 Governance arrangements and review processes are in place to ensure the Digital Strategy is updated and revised to reflect changing internal and external factors.
1.4 To ensure effective communication and engagement around Digital is in place within the Trust and other stakeholder groups.
1.5 To ensure arrangements are in place to assess and deliver benefits of innovative technology and information for use in decision making.

2. IT Strategy Delivery- The Digital Strategy Board will review progress in implementation of the Trust's Digital Strategy, in particular providing assurance that:
2.1 Progress is being made in line with the Digital Strategy at the level of major programmes and projects.
2.2 Variance is being monitored and documented and is being managed through appropriate project/programme governance.
2.3 The strategy implementation programme is identifying and managing risks and issues effectively.
2.4 Ensure capacity to deliver required standards of skills and support for the Trust 24/7, 7 days a week and the appropriate expert contracts to ensure the Trust maintains an excellent level of Cyber resilience, infrastructure speed and capacity and other associated enablers to ensure digital excellence striving for HIMSS level 7 is maintained.
2.5 Ensure staffing skills, numbers and support are futureproofed to deliver the quality of service the Trust needs as an Acute site offering full emergency services.

3. Partnerships
3.1 To ensure effective collaboration with partner organisations and other stakeholders in relation to the implementation of the Digital solutions and sharing of systems in a controlled manner, to provide the best possible outcomes for all.
3.2 To build links with other partner organisations to support Digital strategic direction as appropriate.
3.3 To ensure appropriate recommendations and links are made to FIP to support and embrace approved innovation projects.
3.4 To assess, with input from the Solutions Board, the compatibility, feasibility, viability, priority and impact of any new digital requirements arising as part of service design, national requirements, local need etc. and to agree priorities and business benefit.

Clarification of the relationship with other Boards/Committees may be helpful if there is risk of overlap or ambiguity – e.g. FIP, Merger Programme Board, GDE Joint Executive Group, etc.

Programme Board Members Responsibilities:

7. Individual members are expected to act as champions of the Trust's Digital Strategy and wider 'Digital Agenda' within the Trust and the wider health community. Members are empowered to discuss issues with interested parties outside of the meeting, subject to any confidential information shared.

8. To provide recommendations for improvements in processes, reporting, and governance where required in support of optimising Digital Strategy definition and delivery, and securing the required resources to deliver this.

Workplan:

Each meeting:

- Update report from the CIO
- If relevant, update reports from major Digital Programmes or Projects, such as GDE and Digital Integration Programmes
- Note of business of other committees by exception – but always an update from the Solutions Board & Capital Control Group relating to IM&T.

Annually:

- Review of Digital Strategy Plan and Digital Capital Plan for the next year.

Agreed on 9 October 2019
Reviewed September 2020
Reviewed April 2022

Appendix 4

Bedfordshire Hospitals NHS Foundation Trust

TERMS OF REFERENCE

WORKFORCE COMMITTEE (WFC)

Status:	Sub-committee of the Board of Directors
Chair:	Non-Executive Director
Membership: **Non-Executive:**	Non-Executive Director x 3 (including Chair)
Executive Directors:	Chief Nurse Chief Executive and/or Deputy Chief Executive Medical Director/ Director of Human Resources Director of Finance/ Senior Finance Manager
Directors:	Director of Culture and Organisational Development Director of Medical Education
Other Trust Management:	Associate Directors HR Associate Director of Corporate Governance and/or Corporate Governance Manager
	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, the NEDs present will nominate a NED Chair.
In Attendance:	Head of OD and Learning Head of Staff Engagement and Wellbeing Freedom to Speak up Guardian (as required) Other representatives as appropriate
Meeting Frequency:	Quarterly for 2022/23 moving to Bi-monthly for 2023/24
	The Chair may convene additional meetings of the Committee if necessary to consider business that requires urgent attention
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.
Purpose:	To provide assurance to the Trust Board in all aspects of workforce.
	Monitor the delivery of a workforce strategy

	Receive and review relevant workforce related matters on the Board Assurance Framework in order to gain assurance on the controls in place and progress in addressing any gaps in control and assurance. Receive and review Board level workforce related risks in order to gain assurance on the controls in place to mitigate the risk Review any workforce and education issues referred to the Committee by the Board of Directors or any other Board sub-committee. Develop an annual work programme agreed by the Committee
Extent of Delegation:	Workforce 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 is, on an exceptional needs basis, granted delegated authority to make decisions on time critical issues arising between planned meetings. 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:	50% of membership, to include 2 Non-Executive Directors
Accountability:	The Chair of the Committee along with the Director of Human Resources will maintain a direct link to the Board of Directors. The Director of Human Resources will report to the Chief Executive and report progress to the formal Executive on a regular basis and any other formal Committee as required.
Reporting:	The minutes of the workforce Committee shall be formally recorded A report shall be made following each Committee 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. A quarterly report and update on the effectiveness of the committee will be provided to the Audit and Risk Committee
Objectives:	**Objectives:** Receive a report at each meeting from the Executive lead for the Committee covering the key workforce performance metrics and any issues escalated from relevant executive groups.

To oversee the development and implementation of a Human Resources Strategy aligned to deliver the organisational objectives of the Trust. The Strategy should include measureable objectives focussing on:

- NHS People Plan
- Strategic workforce information and planning
- Recruitment and retention
- Education, learning and organisational/leadership development
- Staff experience and engagement, reward, recognition and health and wellbeing

Receive and review reports on significant concerns or adverse findings highlighted by regulators, peer review exercises, surveys (including NHS Staff Survey) and other external bodies in relation to areas under the remit of the Committee, seeking assurance that appropriate action is being undertaken to address these.

To receive updates on employee relations activity (taking into account the letter from Chair, NHSI of 23rd May 2019 – Learning lessons to improve our people practices)

To receive a regular report on equality and diversity in the Trust and specifically review the Workforce Race Equality Standards (WRES), Workforce Disability Equality Standards (WDES); Gender Pay Gap report and all other relevant reports prior to sign off by the Trust Board.

To monitor workforce Board level risks

Approve the terms of reference of internal audits relating to human resources and monitor the implementation of any action plans arising from them.

Members Responsibilities:

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

10. To set targets and agree control systems to ensure delivery of the Trust Objectives.

11. 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 Workforce.

Workplan:

Each Meeting
Key Performance Indicators and other key reports.
Risk Register

Annually
HR Strategy
NHS Staff Survey results

Terms of Reference

As Required

- Internal Audits
- Assurance Framework

Revision Control

Version Number	Date	Comments/Details	Approved By
1.1	15/09/19	Draft	A. Doak/ R.Mintern
1.2	22/10/19	Approved	A. Doak/ R.Mintern
1.3	01/10/20	Updated to take into consideration Merger plus OD and Culture Strategy	A. Doak/ R.Mintern
1.4	04/11/2020	Reformatted to Trust Template	A. Doak/ R.Mintern
1.5	04/11/2020	Amended following the Board for typo and recommendations from Internal Audit	
1.6	20/04/2022	Draft update	

To be reviewed April 2023

Appendix 5

Bedfordshire Hospitals NHS Foundation Trust

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 will comprise of five Non-Executive Directors (including the committee chair) with the exclusion of the Chairman and the Chair of the Finance Committee.
In Attendance:	Head of Internal Audit Director of Finance Head of Financial Control Board Secretary/Associate Director of Corporate Governance Clinical Representative (Medical Director invited to attend as required) Director of Quality and Safety Governance 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: Authority, Accountability and Chairs Action:	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. 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:

12. 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.

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

14. 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; Quality Committee; Redevelopment; Remunerations & Nominations; and Formal 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 March 2022

Audit & Risk Committee Work Plan	March	May	Sept/Oct	Jan/Feb
Reports/ Recommendations from Sub Committees & Assurance Processes:				
○ Assurance Framework	✓	*	✓	✓
○ Risk Management	✓	✓	✓	✓
○ CQC Regulation & Registration	*	*	*	*
○ Information governance	*	*	*	*
○ Sub Committees –Quality, Finance, Investment and Performance, Workforce, Digital, Redevelopment, Rems and Noms, 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.

Bedfordshire Hospitals
NHS Foundation Trust

TERMS OF REFERENCE

FINANCE INVESTMENT AND PERFORMANCE COMMITTEE (FIP)

Status:	Sub-committee of the Board of Directors
Purpose:	The Committee provides financial analysis, advice, and oversight of the budget, capital schemes and investment approvals. Their responsibility is to ensure the organisation is operating with the financial resources it needs to provide services to the community.
Chair:	Non-Executive Director
Membership:	Non-Executive Director (Chair) 3 additional Non-Executive Directors Chief Executive Deputy Chief Executive Director of Finance Chief Nurse Joint Medical Director
Attending as required:	Director of Human Resources Director of Estates Chief Information Officer Director of Redevelopment 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:	Service Line Representation (by invite) Board Secretary for Governance agenda items Deputy Director of Finance Associate Director of Performance & Information 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 a summary report submitted to the Board of Directors. This summary report will be 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 update on the effectiveness of the committee 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 (>£0.125m) 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-development programme.
- To review progress of the Re-development 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 and not reported to other Board sub-Committees.
- 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, Lead Nurses/Midwives named as leads for targets, to account for poor or underperformance against either key financial targets or delivery of the Re-development programme and to agree corrective action or a revised position.
- To oversee the balanced scorecard standards.

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.
- To receive a report from the Redevelopment Board and any required business cases.

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 financial 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 Trust 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 at FIP. It was agreed that this responsibility was owned by the Chief Executive Officer and not the Non –Executives

Workplan:

Each meeting:

- Finance position
- Business Cases
- Contract updates
- Agency expenditure
- 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

To be agreed in October 2020
To be reviewed October 2021
Updated February 2021
Reviewed and Updated March 2022

Bedfordshire Hospitals
NHS Foundation Trust

QUALITY COMMITTEE

Status:	Sub-committee of the Board of Directors
Chair:	Non-Executive Director
Membership:	Non-Executive Directors x 4 (including the committee chair) Chief Executive Deputy Chief Executive Chief Nurse Medical Directors Deputy Medical Director Director of Human Resources Director of Quality and Safety Governance Director of Integration and Transformation
Other management membership:	Deputy Director of Quality and Safety Governance Deputy Chief Nurse Trust Board Secretary Associate Director of Corporate Governance
In Attendance:	Service Line 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:	The Quality Committee 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 the Quality Committee is, on an exceptional needs basis, granted delegated authority to make decisions on time critical issues arising between planned meetings of the committee. 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 Quality Committee meeting.

Quorum: 6 members, to include 2 Non-Executive Directors

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

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

Reporting: The minutes of the Quality Committee meetings shall be formally recorded and a report submitted to the Board of Directors.

A report shall be made following each Quality 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.

Provide update on the effectiveness of the committee 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 & Social Care 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. A focus on driving improvement in all aspects of quality; safety; clinical effectiveness and patient experience
b. that strategic priorities are focused on those which best support delivery of Trust objectives in relation to quality and patient safety.

c. compliance with contractual quality obligations
d. that integration work across both hospital sites supports a focus on driving improved quality and patient safety

4. ***To receive***:
    a. information on trends and 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 Quality Operational Board and the Specialist Quality Operational Board
    c. receive a report on the Equality and Diversity priorities in relation to patients
    d. 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
    e. A report from its formal sub-committee the Patient Experience Council

5. ***To receive assurance:***
    a. from the Clinical Quality Operational Board and the Specialist Quality Operational Board in accordance with the Quality reporting framework.
    b. on performance in relation to Trust wide patient safety projects.
    c. from the Clinical Quality Operational Board and the Specialist Quality Operational Board that reports from Clinical Service lines using available quality & safety key performance indicators and data sets are used to in order to identify areas of good and poor performance & inform future planning and service delivery.
    d. From Maternity to receive reports on the serious incidents, Ockenden, quality improvement programmes, CQC and CNST compliance and progress with external report recommendations.
    e. that decisions of national groups are implemented.
    f. that feedback from patients, users and other stakeholders is used to inform policy and practice.
    g. on the implementation and annual review of the Trust's quality strategy and priorities .
    h. that the Trust is safeguarding adults and children and other vulnerable groups
    i. 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

Members Responsibilities:

1. Individual members are expected to act as champions of the Quality Committee 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 the Quality Committee

Work Plan:

Each meeting:

- Risk Register
- CQUIN Monitoring
- Serious Incident (SI) Reporting (SI's and Action Plans)
- Mortality Report
- Quality Account Priorities

Quarterly

- Infection Control Report
- Integration Report
- Patient Experience Report
- Patient Experience Council Report
- Review against the Trust Objectives related to quality impact assessments in relation to redevelopment

Annually

- External Audit - Quality Account
- Children's Safeguarding
- Adult Safeguarding
- Cancer Peer Review
- Research and Development
- Review of the Terms of Reference
- Assurance of Equality and Diversity related to patients

As required

- CQC Insight Report
- CQC Inspections
- Internal Audits
- External Reports
- Contribution around quality from BCA

Agreed in April 2021

Reviewed and updated March 2022

Bedfordshire Hospitals NHS Foundation Trust

TERMS OF REFERENCE

DIGITAL (IM&T) STRATEGY COMMITTEE

Status:	Sub-committee of the Board of Directors
Chair:	Non-Executive Director
Membership:	3x Non-Executive Director Chief Executive Deputy Chief Executive Chief Nurse Chief Information Officer Deputy Director of IT Digital Consultant – IM&T Strategy & Merger Clinical Representation on a rotational basis made of 2 of: Solutions Board Clinical Chair CCIO Medical Director 3x Clinical Leads
In Attendance:	Other Executive Directors, managers or advisors may be invited to attend as necessary.
Meeting Frequency:	Meetings shall be held not less than 4 times a year. The Chief Executive or Deputy Chief Executive may request a meeting if they consider that one is necessary *[e.g. to review major decisions or changes which do not align with a scheduled meeting]*.
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: Authority, Accountability and Chairs Action:	The Digital Strategy Board is a formal sub-committee of the FT Board of Directors and complies with the Standing Orders and the Scheme of Delegation. The Board 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.
Quorum:	4 members. In the absence of the Chair of the Digital Strategy Board the Non-Executive Directors will nominate a replacement.
Reporting:	The minutes of the Digital Strategy Board meetings shall be formally recorded.

A report shall be made following each Digital Strategy Board meeting to the next Board of Directors meeting if there are issues which need to be considered by the Board of Directors.

Objectives:

1. Digital Strategy Assurance - The Digital Strategy Board will provide assurance regarding the Trust's Digital Strategy and its ongoing review and development. This will include providing assurance that:
1.1 The Trust's Digital Strategy is aligned to and supports the Trust' clinical and business objectives and plans.
1.2 The Digital Strategy takes account of relevant national goals and directives and supports the collaborative goals of the wider health and social care community.
1.3 Governance arrangements and review processes are in place to ensure the Digital Strategy is updated and revised to reflect changing internal and external factors.
1.4 To ensure effective communication and engagement around Digital is in place within the Trust and other stakeholder groups.
1.5 To ensure arrangements are in place to assess and deliver benefits of innovative technology and information for use in decision making.

2. IT Strategy Delivery- The Digital Strategy Board will review progress in implementation of the Trust's Digital Strategy, in particular providing assurance that:
2.1 Progress is being made in line with the Digital Strategy at the level of major programmes and projects.
2.2 Variance is being monitored and documented and is being managed through appropriate project/programme governance.
2.3 The strategy implementation programme is identifying and managing risks and issues effectively.
2.4 Ensure capacity to deliver required standards of skills and support for the Trust 24/7, 7 days a week and the appropriate expert contracts to ensure the Trust maintains an excellent level of Cyber resilience, infrastructure speed and capacity and other associated enablers to ensure digital excellence striving for HIMSS level 7 is maintained.
2.5 Ensure staffing skills, numbers and support are futureproofed to deliver the quality of service the Trust needs as an Acute site offering full emergency services.

3. Partnerships
3.1 To ensure effective collaboration with partner organisations and other stakeholders in relation to the implementation of the Digital solutions and sharing of systems in a controlled manner, to provide the best possible outcomes for all.
3.2 To build links with other partner organisations to support Digital strategic direction as appropriate.
3.3 To ensure appropriate recommendations and links are made to FIP to support and embrace approved innovation projects.
3.4 To assess, with input from the Solutions Board, the compatibility, feasibility, viability, priority and impact of any new digital requirements arising as part of service design, national requirements, local need etc. and to agree priorities and business benefit.

Clarification of the relationship with other Boards/Committees may be helpful if there is risk of overlap or ambiguity – e.g. FIP, Merger Programme Board, GDE Joint Executive Group, etc.

Programme Board Members Responsibilities:

1. Individual members are expected to act as champions of the Trust's Digital Strategy and wider 'Digital Agenda' within the Trust and the wider health community. Members are empowered to discuss issues with interested parties outside of the meeting, subject to any confidential information shared.

2. To provide recommendations for improvements in processes, reporting, and governance where required in support of optimising Digital Strategy definition and delivery, and securing the required resources to deliver this.

Workplan:

Each meeting:

- Update report from the CIO
- If relevant, update reports from major Digital Programmes or Projects, such as GDE and Digital Integration Programmes
- Note of business of other committees by exception – but always an update from the Solutions Board & Capital Control Group relating to IM&T.

Annually:

- Review of Digital Strategy Plan and Digital Capital Plan for the next year.

Agreed on 9 October 2019
Reviewed September 2020
Reviewed April 2022

Bedfordshire Hospitals
NHS Foundation Trust

TERMS OF REFERENCE

WORKFORCE COMMITTEE (WFC)

Status:	Sub-committee of the Board of Directors
Chair:	Non-Executive Director
Membership: **Non-Executive:**	Non-Executive Director x 3 (including Chair)
Executive Directors:	Chief Nurse Chief Executive and/or Deputy Chief Executive Medical Director/ Director of Human Resources Director of Finance/ Senior Finance Manager
Directors:	Director of Culture and Organisational Development Director of Medical Education Associate Directors HR
Other Trust Management:	Associate Director of Corporate Governance and/or Corporate Governance Manager 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, the NEDs present will nominate a NED Chair.
In Attendance:	Head of OD and Learning Head of Staff Engagement and Wellbeing Freedom to Speak up Guardian (as required) Other representatives as appropriate
Meeting Frequency:	Quarterly for 2022/23 moving to Bi-monthly for 2023/24 The Chair may convene additional meetings of the Committee if necessary to consider business that requires urgent attention
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.
Purpose:	To provide assurance to the Trust Board in all aspects of workforce.

	Monitor the delivery of a workforce strategy Receive and review relevant workforce related matters on the Board Assurance Framework in order to gain assurance on the controls in place and progress in addressing any gaps in control and assurance. Receive and review Board level workforce related risks in order to gain assurance on the controls in place to mitigate the risk Review any workforce and education issues referred to the Committee by the Board of Directors or any other Board sub-committee. Develop an annual work programme agreed by the Committee
Extent of Delegation:	Workforce 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 is, on an exceptional needs basis, granted delegated authority to make decisions on time critical issues arising between planned meetings. 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:	50% of membership, to include 2 Non-Executive Directors
Accountability:	The Chair of the Committee along with the Director of Human Resources will maintain a direct link to the Board of Directors. The Director of Human Resources will report to the Chief Executive and report progress to the formal Executive on a regular basis and any other formal Committee as required.
Reporting:	The minutes of the workforce Committee shall be formally recorded A report shall be made following each Committee 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. A quarterly report and update on the effectiveness of the committee will be provided to the Audit and Risk Committee

Objectives:	**Objectives:**
	Receive a report at each meeting from the Executive lead for the Committee covering the key workforce performance metrics and any issues escalated from relevant executive groups. To oversee the development and implementation of a Human Resources Strategy aligned to deliver the organisational objectives of the Trust. The Strategy should include measureable objectives focussing on: • NHS People Plan • Strategic workforce information and planning • Recruitment and retention • Education, learning and organisational/leadership development • Staff experience and engagement, reward, recognition and health and wellbeing Receive and review reports on significant concerns or adverse findings highlighted by regulators, peer review exercises, surveys (including NHS Staff Survey) and other external bodies in relation to areas under the remit of the Committee, seeking assurance that appropriate action is being undertaken to address these. To receive updates on employee relations activity (taking into account the letter from Chair, NHSI of 23rd May 2019 – Learning lessons to improve our people practices) To receive a regular report on equality and diversity in the Trust and specifically review the Workforce Race Equality Standards (WRES), Workforce Disability Equality Standards (WDES); Gender Pay Gap report and all other relevant reports prior to sign off by the Trust Board. To monitor workforce Board level risks Approve the terms of reference of internal audits relating to human resources and monitor the implementation of any action plans arising from them.
Members Responsibilities:	1. Individual members are expected to act as champions of Workforce within the Trust and wider health community. Members are empowered to discuss workforce 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 Trust 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 at Workforce.
Workplan:	**Each Meeting** Key Performance Indicators and other key reports.

Risk Register

Annually
HR Strategy
NHS Staff Survey results
Terms of Reference

As Required
- Internal Audits
- Assurance Framework

Revision Control

Version Number	Date	Comments/Details	Approved By
1.1	15/09/19	Draft	A. Doak/ R.Mintern
1.2	22/10/19	Approved	A. Doak/ R.Mintern
1.3	01/10/20	Updated to take into consideration Merger plus OD and Culture Strategy	A. Doak/ R.Mintern
1.4	04/11/2020	Reformatted to Trust Template	A. Doak/ R.Mintern
1.5	04/11/2020	Amended following the Board for typo and recommendations from Internal Audit	
1.6	20/04/2022	Draft update	

To be reviewed April 2023

Bedfordshire Hospitals NHS Foundation Trust

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 will comprise of five Non-Executive Directors (including the committee chair) with the exclusion of the Chairman and the Chair of the Finance Committee.
In Attendance:	Head of Internal Audit Director of Finance Head of Financial Control Board Secretary/Associate Director of Corporate Governance Clinical Representative (Medical Director invited to attend as required) Director of Quality and Safety Governance 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: Authority, Accountability and Chairs Action:	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. 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;
  Quality Committee; Redevelopment; Remunerations & Nominations; and Formal 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

Audit & Risk Committee Work Plan	March	May	Sept/Oct	Jan/Feb
Reports/ Recommendations from Sub Committees & Assurance Processes:				
○ Assurance Framework	✓	*	✓	✓
○ Risk Management	✓	✓	✓	✓
○ CQC Regulation & Registration	*	*	*	*
○ Information governance	*	*	*	*
○ Sub Committees –Quality, Finance, Investment and Performance, Workforce, Digital, Redevelopment, Rems and Noms, 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.