Milton Keynes University Hospital NHS Foundation Trust

Board of Directors

Public Meeting Agenda

Meeting to be held at 10.00 on Friday 9 March 2018 in the Board Room, Witan Gate House, 500-600 Witan Gate, Milton Keynes MK19 1ES.

Item No.	Title	Purpose	Type and Ref.	Lead
1. Introduction and Administration				
1.1	Apologies	Receive	Verbal	Chairman
1.2	Declarations of Interest • Any new interests to declare • Any interests to declare in relation to open items on the agenda	Noting	Verbal	Chairman
1.3	Minutes of the meeting held in Public on 5 January 2018	Approve	Pages 3-12	Chairman
1.4	Matters Arising/ Action Log	Receive	Pages 13-14	Chairman
2. Chair and Chief Executive Strategic Updates				
2.1	Draft Minutes of the Council of Governors Meeting held on 23 January 2018	Receive	Pages 15-26	Chairman
2.2	Chairman's Report	Receive and Discuss	Verbal	Chairman
2.3	Chief Executive's Report	Receive and discuss	Pages 27-30	Chief Executive
2.4	Sustainability and Transformation Partnership	Note	Verbal	Chief Executive
3. Quality				
3.1	Patient Story	Receive and Discuss	Verbal	Director of Patient Care & Chief Nurse
3.2	Mortality update report	Discuss and Note	Pages 31-52	Medical Director
3.3	Nursing Staffing Update	Receive and Discuss	Pages 53-58	Director of Patient Care & Chief Nurse
3.4	Update on 7 day services	Receive and Discuss	Pages 59-68	Medical Director
4. Performance and Finance				
4.1	Performance report Month 10	Receive and Discuss	Pages 69-82	Deputy Chief Executive
4.2	Finance update report Month 10	Receive and Discuss	Pages 83-90	Director of Finance
4.3	Workforce update report Month 10	Receive and Discuss	Pages 91-104	Director of Workforce
5. Assurance and Statutory Items				
5.1	Board Assurance Framework	Receive and Discuss	Pages 105-122	Director of Corporate Affairs
5.2	Trust readiness for the	Receive and	Verbal	Director of

Item No.	Title	Purpose	Type and Ref.	Lead
	General Data Protection Regulation	Discuss		Corporate Affairs
5.3	Health and Safety Update	Discuss	Pages 123-126	Director of Corporate Affairs
5.4	(Summary Report) Quality and Clinical Risk Committee – 30 January 2018	Note	Pages 127-130	Chair of Committee
5.5	(Summary Report) Finance and Investment Committee - 5 February 2018	Note	Pages 131-134	Acting Chair of Committee
5.6	(Summary Report) Workforce and Development Assurance Committee – 5 February 2018	Note	Pages 135-138	Chair of Committee
5.7	(Summary Report) Charitable Funds Committee – 5 February 2018	Note	Pages 139-140	Chair of Committee
6. Administration and closing				
6.1	Questions from Members of the Public	Receive and Respond	Verbal	Chair
6.2	Motion to Close the Meeting	Receive	Verbal	Chair
6.3	Resolution to Exclude the Press and Public	Approve	The Chair to request the Board pass the following resolution to exclude the press and public and move into private session to consider private business: *"That representatives of the press and members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted."*	Chair

Milton Keynes University Hospital NHS Foundation Trust

BOARD OF DIRECTORS MEETING

Minutes of the Board of Directors meeting held in PUBLIC on Friday 5 January 2018 in Room 6, Education Centre, Milton Keynes University Hospital

Present:

Simon Lloyd	Chairman
Joe Harrison	Chief Executive
John Blakesley	Deputy Chief Executive
Andrew Blakeman	Non-executive Director (Chair of Quality and Clinical Risk Committee)
Parmjit Dhanda	Non-executive Director
Ogechi Emeadi	Director of Workforce
Robert Green	Non-executive Director (Chair of Audit Committee)
Mike Keech	Director of Finance
Lisa Knight	Director of Patient Care and Chief Nurse
David Moore	Non-executive Director (Chair of Finance and Investment Committee
Tony Nolan	Non-executive Director (Chair of Workforce and Development Assurance Committee)
Ian Reckless	Medical Director

In Attendance:

Kate Burke	Director of Corporate Services
Caroline Hutton	Director of Clinical Services
Julie Wakefield	
Ade Kadiri	Company Secretary

2018/01/01	**Welcome**
1.1	The Acting Chairman welcomed all present to the meeting and wished all a Happy New Year.
2018/01/02	**Apologies**
2.1	There were no apologies for this meeting.
2018/01/03	**Declarations of interest**
3.1	No new interests had been declared and no interests were declared in relation to the open items on the agenda.
2018/01/04	**Minutes of the meeting held on 3 November 2017**

4.1	The minutes of the public Board meeting held on 3 November 2017 were accepted as an accurate record, subject to the following amendments: • Paragraph 8.7 – the course of action to be taken to improve response rates to the staff survey are still being considered. • Paragraph 11.1 – the second half of the second sentence to read: "…but the Medical Director confirmed that neither of these is significant."
2018/01/05	**Matters Arising/ Action Log**
5.1 5.2	There were no matters arising in addition to those included on the agenda. The action log was reviewed in turn: <u>351 Committee summary reports</u> The Chief Nurse indicated that the volunteers had extended an invitation to non-executive directors to come and observe their work, and shadow them as this would be the best way to understand what they do. This was acknowledged as a good idea, and the opportunity is to be taken up.
2018/01/06	**Draft Minutes of the Council of Governors' Meeting held on 14 November 2017**
6.1	The draft minutes of the Council of Governors' meeting held on 14 November 2017 were received and noted.
2017/01/07	**Chairman's Report**
7.1 7.2 7.3	The Chairman recorded his thanks to all staff for the excellent job they had done over the Christmas period, and since, in addressing the challenges in A&E. He fed back on an NHS Providers meeting for Chairs and CEOs that he had attended before Christmas. This had been an opportunity to meet Baroness Dido Harding, the new Chair of NHS Improvement. The main messages she conveyed were: • The NHS is the best health service in the world. It could be more efficient, but it does need more resources • There needs to be more of a focus on removing variation in quality and promoting innovation • There are significant and worrying shortfalls in the planning for the skills for the future. There is much work to be done in this area. Elections to staff and public constituencies of the Council of Governors are coming up. **Resolved**: The Board **noted** the Chairman's report.
2018/01/08	**Chief Executive's Report**
8.1	The Chief Executive drew the Board's attention to the written summary of

	discussions at the recent Management Board meeting. He had been in attendance at a private meeting with the Secretary of State for Health on workforce issues. The Minister knows about MKUH and is aware of the Medical School. This was a good opportunity to showcase the work that is being done.
8.2	The Chief Executive was positive about the meeting with Baroness Harding, indicating that she had given a clear summary of where NHS Improvement currently is and its likely future relationship with NHS England.
8.3	The Trust had managed relatively well in the period between Christmas and New Year, although there had been a few spikes of extreme pressure. The Chief Executive made reference to a tweet from Dr Ben White, who had previously been involved in litigation with the Secretary of State over the junior doctor contract, about A&E department being full and closed to new patients. This had been extensively re-tweeted and generated significant media interest, but it was inaccurate. In fact the Trust was in a better position than it had been at the same time in the previous year. In response to a question as to why the specific points made were not responded to by the Chief Executive in his media interviews, the point was made that the political context meant that it was preferable to address those messages offline.
8.4	In response to a question about the extent to which non-emergency procedures have had to be cancelled in the light if the winter pressures, the point was made that the winter plan that had previously been communicated to the Board was being followed. The Trust is not implementing blanket cancelation of electives, but is instead assessing the bed position on a daily and weekly basis. Some elective procedures have been cancelled and some outpatient clinics reduced, but that had been planned pre-Christmas. There is a serious concern nationally about flu – there has been an eightfold increase in cases since Christmas, although this has mainly been in the South West thus far. The Trust has seen a large number of A and B flu cases, but not the Australian strain yet.
8.5	David Moore noted that on one day, the Trust had received 95 ambulances. It was confirmed that once NHS England publishers the national figures, enquiries would be made as to why there had been that many. The Trust's escalation plans are to be reviewed, as the pressure is likely to continue. Thought would also need to be given to the provision of support to staff going forward. **Resolved**: The Board **noted** the Chief Executive's Report.
2018/01/09	**Patient Story – The "Hug in a Bag" initiative**
9.1	Christina Riley, a nurse who had previously worked in the Emergency Department attended, along with Michaela Tait, Patient Engagement Manager, to deliver a patient story on the "Hug in a Bag" initiative which had recently won a Nursing Times award.
9.2	Ms Riley explained that while working in the Emergency Department as part of the preceptorship programme for newly qualified nurses, she had embarked on a project to assess how the experience of women in the early stage of pregnancy who miscarry could be improved. She had come up with the "Hug in a Bag" idea, which

	was to give women in this position a simple bag containing a number of practical items including pads, tissues, some information about what is likely to happen next, and possible sources of support.
9.3	At about the same time, it had been noted that the Trust had received complaints from a number of women and their relatives, relating to the lack of support for them at this difficult time. The Head of Complaints subsequently met with a number of these women all of whom felt that the "Hug in a Bag" was a fantastic idea. Further input was sought both from the Women's Health and Communications teams, and the initiative was implemented, with universally positive feedback.
9.4	The idea was subsequently shared regionally and nationally, with the NHS Leadership Academy, as a result of which the team was asked to apply for the Nursing Times award in the emergency and critical care category. A case was put together and it was recently announced that the initiative had won the award. It was also noted that the idea is in line to pick up other regional and national awards.
9.5	It was confirmed that the initiative had been shared with other trusts, but no other organisations had yet made contact to discover more about the work. The point was also made that the idea could be adapted and rolled out in other areas – this is currently being worked on. It was also noted that the costs involved are negligible. **Resolved**: The Board **noted** the patient story and the success of the Hug in a Bag initiative.
2018/01/10	**Mortality Update Report**
10.1	The Medical Director presented this regular report. With regard to the quantitative elements of the Trust's mortality rate, he reported that the Trust's HSMR remains statistically below the national average, and there is no national outlier. The SHMI rate is 1.01 and is as expected.
10.2	Although the quantitative measures are positive, is was acknowledged that they do not necessarily reveal the whole picture. A process for reviewing deaths has been set up in conjunction with the Academic Health Sciences Network. 211 deaths (82%) were investigated in Q2, and of these, it was found that in about 2% to 4% of cases there were lessons that could have been learnt, but the outcomes would still have been the same. In only 0.5% of cases was it found that death could have been avoided. The Trust is working with the AHSN to train a cohort of senior clinicians to undertake reviews of deaths, and with Bucks NHS Trust to train local medical examiners.
10.3	In response to a question as to whether there is a link between avoidable deaths and the Serious Incident process, it was confirmed that an avoidable death would always be regarded as a Serious Incident. In response to a further question as to how actions from the review group are carried out, the point was made that these are tracked by the relevant clinical lead, and that all actions arising from the investigation of an SI are followed up by an Executive Director. It was acknowledged that there have been significant increases in the number of deaths that are reviewed in the Trust. The December/January period was the first time that there was a requirement to report, and the Trust is regarded as being above average nationally

	in this area.
10.4	The Learning from Deaths conference had stressed the importance of the family experience in reviewing deaths – it is essential that clinicians are open and transparent where it is felt that their loved one's death could have been avoided.
10.5	With regard to end of life care, the point was made that the Trust is currently going through the Gold Standard programme with a view to enabling this service to become outstanding. **Resolved**: The Board **noted** the Mortality Update report.
2018/01/11	**Nursing Staffing Update**
11.1	The Chief Nurse presented this routine report on nursing staffing. Recruitment activity is progressing well - there are 45 nursing vacancies in the Medicine Directorate, and as such all of the newly qualified nurses will be going into that directorate. Paediatrics continues to be a challenging area, and the Trust is therefore continuing to recruit adult nurses into this area, which is clinically acceptable. There are 10 midwife vacancies, and the Trust is awaiting the outcome of the Birthrate Plus analysis which will be presented to the Board in March. **Action: Director of Patient Care and Chief Nurse**
11.2	The Chief Nurse confirmed that she is comfortable that the nurse to patient ratios is appropriate, and indicated that the position on ward 23 at nights is to be reviewed. David Moore raised a question about the cost benefit of recruiting nurses from the Philippines. In response, the Chief Nurse made the point that the Trust only pays for the nurses once they have arrived in the UK. It was confirmed that 7 Filipino nurses are now working in the hospital, in relation to whom the Trust has paid £20k to £30k. The nurses that have been recruited are very good, but it is recognised that this type of recruitment is not viable in the long term, and it is kept under constant review.
11.3	Parmjit Dhanda suggested that if the Trust does decide to go back to the Philippines, it should seek to recruit a larger number of nurses. The Chief Nurse was doubtful about the success of such a venture on the basis that changes to the Nursing and Midwifery Council's English test had not had the desired outcomes. She noted that some trusts are going to India, but indicated that they do not have enough nurses themselves.
11.4	A question was raised about the potential impact of cutting the enhanced bank rate, and the possibility that this could drive up agency use. In response it was stated that the Trust's bank rate is generous, to the extent that some regular staff are opting instead to work on the bank. Some areas will be kept on the enhanced rate, and the position will be reviewed on a two monthly basis. The Chief Executive asked what would happen if a member of ward staff phones in sick. In response, it was noted that staffing is 4 times a day – if a ward is short of staff, other wards or areas would offer up their own staff. This process is overseen by the ward sisters.
11.5	In response to a question as to why the Trust had decided not to participate in the national commitment to move patients who are fit for discharge into certain areas, the Chief Nurse made the point that the Trust has a rehabilitation ward (14) and it

	actively manages such patients. The Trust would rather focus on the "Stop PJ Paralysis" initiative which aims to get patients out of bed and moving.
2018/01/12	**Approach to Safety Checklists within the Trust**
12.1	The Medical Director presented this paper which had been prepared as a result of discussions at the tail end of 2017 following a series of Never Events that had occurred during that year. The key issue at this Trust is that although checklists are completed, there are questions about the culture in theatres. Historically, the loop around deficits was not being closed, but this is now being considered. Compliance with the WHO checklist is currently reported to the Board – it would be for the team to consider how any new approach would be reflected.
12.2	A key issue is the time out phase just before the surgery starts. The Trust has recently started using a newly re-designed form. The surgeon is ultimately responsible for its completion, but it is a team issue. The intention is not to focus too much on the form but on the culture. There were different circumstances around last year's Never Events, but there is a need for consistency in practice around the checklist. There could be a case for modulating some aspects of the process – including who actually completes the form. Oversight of the review process is to be delegated to the Quality and Clinical Risk Committee, and an update is to be presented to the Board in six months' time **Action: Medical Director**
12.3	The Chief Executive clarified that in reviewing its approach, the Trust is going the extra mile to build on its systems and processes with a view to making them exemplary. However, Andrew Blakeman indicated that he was not convinced that the Trust has set the right tone on how best to get the processes changed. **Resolved**: The Board **noted** the update report on the approach to safety checklists.
2018/01/13	**Update on the Electronic Patient Record Programme**
13.1	The Director of Clinical Services presented this report, indicating that this is the first of a series of regular Board updates. This report sets out the position as at 22 December 2017. The Trust is now at the implementation of phase B stage. The Align programme has been completed and the organisation is now halfway through Engage, using the 'agile' approach – and operational teams have been engaged in developing a model build.
13.2	Phases 1 and 2 of Integration Testing have been completed. The exit criteria for test issues is that there are no priority 1 or 2 issues – these are defined as significant issues in relation to which the Trust would not wish to go live with the system until they are resolved. Any such issues would be taken through the Clinical Advisory Group (CAG), which is chaired by the Medical Director, and the Health Informatics Programme Board (HIPB), chaired by the Chief Executive. The current position is that there are 5 Priority 1 and 9 Priority 2 issues. Cerner has committed to fixing these and closing them down over the next fortnight. The Director of Clinical Services confirmed that these would have no implications on the go live date. Progress reporting is to continue on a weekly basis, with the frequency of HIPB

	meetings increased to fortnightly. There are no major issues, but if they are not resolved before go live, they could prove difficult to address later.
13.3	A number of steering groups have been set up, each chaired by an Executive Director. The training workstream is underway, and staff are starting to book onto the schedules that have been created. An operational readiness group has been established, and this reports to the HIPB. The Deputy Chief Executive chairs the group charged with considering how best to procure the electronic devices that will be used in clinical areas, and the Director of Corporate Affairs chairs the groups looking at communications and engagement, risk management and governance.
13.4	Tony Nolan enquired how different a clinician's working experience would be as a result of the introduction of eCare. He also made mention of the current capacity issues within the Trust. The Chief Nurse explained that from a nursing perspective, the eCare assessment documents are based on what is currently in use, but that the real difference would be in the introduction of electronic prescribing and drug rounds, which would be a significant change to existing processes. She remarked that there are only a few integrated drug trollies available in the UK, and the Trust has been fortunate to find one. The Director of Clinical Services noted that there has been operational input into the project from an early stage, and this has been helpful. A play environment has been set up, enabling operational teams to start to understand what the new environment will look like. She added that the Align phase of the programme is assessing future gaps. Teams are beginning to understand the realities of working with a real-time system, but it is a significant challenge.
13.5	It was noted that Cerner has worked with many trusts around the country, and MKUH has been in regular contact with some of them, particularly West Suffolk. The Chief Executive made the point that the Trust is not changing its Patient Administration System (PAS). The go live date has already been pushed back from the beginning of March, but it is recognised that implementation of any IT system is a major risk, and some aspects will not go to plan. Andrew Blakeman indicated that he was assured by the implementation plan as set out, particularly the involvement of all of the Executive Directors in chairing the steering groups. However, Julie Wakefield cautioned that the training plan appears optimistic, considering the winter pressures, and she was also worried about the number of admittedly smaller issues that need to be resolved. **Resolved:** The Board **noted** the eCare update.
2018/01/14	**CQUIN update: Healthy Food (1b)**
14.1	The Chief Nurse presented this report on progress against CQUIN indicator 1b. She reported that there had been much positive feedback on the changes that had been made in the offer at Eaglestone Restaurant. **Resolved**: The Board **noted** the CQUIN update.
2018/01/15	**Performance Report Month 8**
15.1	The Deputy Chief Executive introduced the Month 8 Performance Report. He indicated that changes would be made to the report from next month in relation to

	length of stay and the reporting of E-coli. The following points were highlighted: • There are concerns about the need to get to 90% in order to access STF payments • RTT performance has deteriorated, but the Trust is still performing well nationally compared to others • The Trust is reporting a number of 52 week waits.
15.2	It was noted that there had been some positive movement in relation to delayed discharges. The Director of Clinical Services made the point that having more social workers on site had contributed to these improvements.
15.3	The increase in 52 week waits was attributed to a combination of patients exercising their choice as to when they wanted to receive treatment, and a number of patients who were not medically fit to have their operations. There are two patients who are awaiting specialist kits from the United States – the question was raised whether such cases ought to be referred to a tertiary centre. It is expected that th0e situation will start to improve shortly, and moving forward, the trajectory appears more positive. It was also confirmed that steps are being made to sure that these patients do not suffer harm as a result of the delays.
15.4	The Deputy Chief Executive explained that the Trust's ED performance is better than it was last year, but that a large number of breaches had been reported by Urgent Care. This has been taken up with the CCG, but it would be important to ensure that the screening initiative is not exacerbating any difficulties that the unit might be encountering. The unit has acknowledged that this is not the case. **Resolved**: The Board **noted** the Month 8 Performance Report.
2018/01/16	**Finance Update Report Month 8**
16.1	The Director of Finance presented the Month 8 position. He noted that at month 6, NHS Improvement was reporting a combined provider deficit of over £300m. In fact the position has since deteriorated further. For MKUH the summary position is as follows: • On a control total basis, the Trust is £162k adverse to plan in month. YTD, it is £824k behind the control total. The finances have deteriorated in month 7 because although both outpatient and elective performance is above plan, MRET and readmissions, as well as maternity and critical case, continue to erode income. • On the costs side, pay is above plan as a result of an increase in non-elective work and high cost drugs • For Q3, the Trust will receive £751k (and the MK system £250k) for winter. It would be important to understand the requirements for this funding. • With regard to STF, it was noted that the Trust had received a letter in Q2 changing the requirements, but no such letter has been received for Q3, which should mean that the Trust will be able to access this funding. • Shortfalls remain on the Transformation Programme. • The Trust still has not received confirmation about its capital loan. The

	Director of Finance will be discussing next steps with the Chief Executive.
16.2	The Director of Finance commented that the Trust faces some big risks, but the expectation is that the control total will be achieved. The Chief Executive made the point that MKUH is in a better position than a number of other organisations. He stated that the criteria for achieving the STF bonus fund remains unclear, but that the Trust will not jeopardise patient safety in an effort to achieve this.
16.3	In response to a question from Tony Nolan about capital, the Chief Executive acknowledged that even restricting funding from the Trust's 'business as usual' capital only to those projects that are critical to patient safety is becoming a challenge in the absence of the loan. This has been communicated to NHS Improvement.
16.4	With regard to the ED, the Chief Executive stated that the public may have been receiving the message that they should not be coming to hospital because it is so busy. He acknowledged that cancelling elective care meant that patients are sometimes left in pain. The Trust's focus is that patients receive the right care – they should not have to wait unnecessarily. **Resolved**: The Board **noted** the Month 8 Finance update report.
2018/01/17	**Implementation of the General Data Protection Regulation**
17.1	The Director of Corporate Affairs introduced this update for the Board's information. She stated that this EU Regulation will be retained on the UK statute books, and it will replace the Data Protection Act. There are 5 key areas that the Information Governance team are working on with a view to amending the Trust's procedures: • Right if access • Right to object • Right to erasure (to be forgotten) • Right to be informed • Right to rectification
17.2	The Audit Committee has received an action plan as to how the Trust will achieve compliance. This represents a significant change, but good progress is being made. Julie Wakefield made the point that the most important aspect is to understand the data that the organisation holds and how it is used. The Trust is working with the Data Protection Alliance and additional guidance is expected. It was acknowledged that erasure is a particularly difficult issue. **Resolved**: The Board **noted** the GDPR update.
2018/01/18	**Health and safety update**
18.1	The Director of Corporate Affairs presented this update. She indicated that the Trust had received a number of fire notifications – work is being done with the Fire Service to address the number of false alarms. It was noted that the rate of both health and safety training and compliance checklist completions has improved. The Board also

	noted the reduction in violence.
18.2	With regard to fire cladding, the Deputy Chief Executive informed the Board that a small action plan had been agreed. He indicated that all of the cladding on the site is made of steel rather than aluminium, but that the records are incomplete. **Resolved**: The Board **noted** the Health and Safety update.
2018/01/19	**Summary Reports**
19.1	The Board noted the contents of the summary reports of recent Board Committee meetings as follows: • Audit Committee meeting held on 12 December 2017 – the Committee Chair informed the Board that in relation to data quality, an action plan and assurance plan had been requested. There are concerns about delivery of the internal audit plan. It was also suggested that Committee Chairs will need help in completing the risk management reports. • Finance and Investment Committee meetings held on 6 November and 18 December 2017 – the Committee Chair indicated that there was much discussion at the December meeting on MRET and readmissions, and it was agreed that the relevant paper would be circulated to all Board members. It was also suggested that the Transformation Programme needs to be re-calibrated • Workforce and Development Assurance meeting held 6 November 2018 – with regard to staff health and wellbeing, the Committee Chair commended the range and depth of support that is now available. The next step is to uplift the offer with regard to sports and social activities. The point was made that the Trust's apprenticeship levy amounts to £1.2m, but the Trust has only attracted 10 apprentices under the new scheme.
2018/01/20	**Questions from Members of the Public**
20.1	A member of the Council of Governors in attendance raised a question as to what would happen in the event that elective surgery needs to be cancelled as a result of a flu outbreak. The Chief Executive made the point that capacity planning across the Trust is an ongoing process, but there has been a specific focus on the management of displaced patients over the next few months.
20.2	The same governor questioned whether there is a plan to inform the local media of the positive developments and performance at the Trust. The Director of Corporate Affairs highlighted the positive coverage that the Trust has received from the national media and indicated that the main local newspaper had been invited to do an in-depth piece on the Trust.
2018/01/21	**Any other business**
21.1	There was no other business.

	All					Action log – All items				
	Public/ Private	**Action item**	**Mtg date**	**Agenda item**		**Action**	**Owner**	**Due date**	**Status**	**Comments/Update**
Board of Directors	Public	349	7 Jul 2017	19.7	Health and Safety update	Consideration to be given to the provision of a sprinkler system across the hospital, with a view to ensuring that patients, staff and visitors have enough time to escape in the event of a fire. This is to be reflected in the next health and safety update	Kate Burke	9 Mar 2018	Closing	On the agenda
Board of Directors	Public	351	11 Nov 2017	18.2	Committee Summary Reports	The Chief Nurse agreed to provide an update on volunteering within the Trust to the next Public Board	Lisa Knight	5 Jan 2018	Closed	The Chief Nurse provided an update to the Board and invited the NEDs to take the opportunity to "shadow" volunteers.
Board of Directors	Public	352	5 Jan 2018	11.1	Nursing Staffing Update	The Birthrate Plus analysis of the Trust's midwifery workforce needs is to be presented at the March Board meeting	Lisa Knight	9 Mar 2018	Open	To be deferred as Birthrate Plus have not yet produced their analysis
Board of Directors	Public	353	5 Jan 2018	12.2	Approach to Safety Checklists within the Trust	The process of completing the safety checklists in theatres is to be reviewed at the Quality and Clinical Risk Committee and an update is to be presented at the Board in six months' time	Ian Reckless	6 Jul 2018	Open	

Board of Directors	Public	354	2 Feb 2018 (private)	10.7	Research and Development Strategy	A Board update on research and development activity is to be presented at the July meeting	Ian Reckless	6 Jul 2018	Open	

Milton Keynes University Hospital NHS Foundation Trust

MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST COUNCIL OF GOVERNORS' MEETING

DRAFT minutes of a meeting of the Council of Governors' of the Milton Keynes University Hospital NHS Foundation Trust, held in public at 5.00pm on Tuesday the 23 January 2018, in room 6 of the Education Centre at Milton Keynes University Hospital, Milton Keynes

Present:
Simon Lloyd - Chairman

Public Constituency Members:
William Butler (WB)
Jean Button (JB)
Alan Hastings (AH)
Alan Hancock (Aha)
Amanda Jopson (AJ)
Carolyn Pierson (CP)
Peter Skingley (PS)
Liz Wogan (LW)

Appointed Members:
Andrew Buckley (AB) - Milton Keynes Council
Maxine Taffetani (MT) - Healthwatch Milton Keynes

Staff Constituency Members:
John Ekpa (JE)
Keith Marfleet (KM)
Lesley Sutton (LS)

In Attendance:

Executive Directors
John Blakesley(JB) - Deputy Chief Executive
Mike Keech (MK) - Director of Finance
Lisa Knight (LK) - Director of Patient Care and Chief Nurse

Non Executive Directors
Parmjit Dhanda (PD)
Bob Green(BG)
David Moore (DM)
Tony Nolan(TN)

Also in Attendance
There were two members of the public

Adewale Kadiri (AK) - Company Secretary
Carol Duffy (CD) - Governor and Membership Manager

1.	**WELCOME & ANNOUNCEMENTS**
	The Chairman extended a warm welcome to everyone present at the meeting.
1.1	**APOLOGIES**
	Apologies for absence were received from, Andrew Blakeman, Kate Burke, Douglas Campbell, Ogechi Emeadi, Paul Griffiths, Joe Harrison, Caroline Hutton, Robert Johnson-Taylor, Clare Hill, Ian Reckless, Clare Walton, Matt Webb, Kim Weston and Jill Wilkinson
1.2	**DECLARATIONS OF INTEREST**
	There were no new declarations of interest received and no interests received in relation to any other open items on the agenda.
1.3	**MINUTES**
(a)	**Minutes from the Council of Governors meeting held on the 14 November 2017.** The draft minutes of the meeting held on the 14 November 2017 were considered. **<u>Resolved:</u> That the draft minutes of the meeting held on the 14 November be agreed as a correct record of the meeting.** .
(b)	**MATTERS ARISING / ACTION LOG**
7.2	**Matters Arising** It was confirmed that the representative for the Charitable Funds Committee is Public Governor Douglas Campbell **Action Log** There were no outstanding action log items. **<u>Resolved:</u> That the action log as updated at the meeting was received.**
2	**CHAIRMAN AND CHIEF EXECUTIVE REPORTS**
(a)	**Chairman's Report**
	A very successful Governor and Non-Executive Director event took place on the 22 November 2017 at Herons Lodge. NHS Providers GovernWell who provide the national training programme to equip all NHS Foundation trust Governors, with the skills to undertake this important role were also able to join the day. The event provided a good opportunity for more interaction between the Non Executive Directors and Governors. The Chairman reported that the agenda for Council of Governor meetings is to be revisited. It is intended that non-executive director participation be enhanced, as the role of the Council of Governors is to hold the non-executives to account.

	The Chairman recorded his thank you to all staff throughout the hospital for the excellent work undertaken during the winter pressures in what were at times very challenging circumstances. The Chairman went on to say that the organisation had pulled together in times of great pressure; putting patients first and doing the very best possible to make sure safe care was provided. Due to David Moore's Non Executive Director tenure coming to an end, The Chairman reported that this was to be David's last attendance at a Council of Governors Meeting. On behalf of the Governors the Chairman thanked David Moore for his interest, support and contribution which was always welcomed and valued. **<u>Resolved:</u> That the Chairman's report be received and accepted.**
(b)	**Chief Executives Report,**
	The Deputy Chief Executive drew the Council of Governors attention to the written summary, of the outcome of discussions at the December Management Board meeting and other key developments. In response to a question from Public Governor Liz Wogan, The Deputy Chief Executive reported that with regard to the review to centralise the management of the administrative teams supporting outpatient activity, that there were about 200 members of staff who would be affected, In response to a question from Public Governor Alan Hastings, The Deputy Chief Executive informed, that the Full Business Case had been approved and plans were being made for Bedford and Luton and Dunstable Hospitals to merge to become a new Foundation Trust with effect from from the1 April 2018. In response to a question from Public Governor Alan Hancock, The Deputy Chief Executive stated, that there had been one meeting of the Board for the specific care system which had involved the key stakeholders and the accountable officers of the four organisations. In response to a question from Public Governor Peter Skingley, The Deputy Chief Executive reported that although the vast majority of imaging was provided by the Trust, there were occasions when speciality imaging was required that would then be undertaken outside of the Trust. **<u>Resolved</u>: That the Chief Executive's report be received and accepted.**
3.	**Sustainability and Transformation Partnerships (STP)**
	In response to a question from Public Governor William Butler, The Chairman reported on local partners within the Milton Keynes health and social care system such as the Council, Milton Keynes CCG and Community Health services working together to deliver the best possible care to the local population whilst work with the STP is continuing. A very recent joint board meeting held between the Trust and Milton Keynes CCG which was very constructive.

	<u>Resolved:</u> That the Sustainability and Transformation Partnership update be received.
7.2	**Quality Account Local Indicator**
	The Director of Nursing and Chief Nurse gave a presentation to Governors on the Quality Account Indicators 2018/19 and the following was highlighted:- • The Quality Accounts are annual reports to the public about the quality of services that providers of healthcare deliver and their plans for improvement • They are a statutory requirement for the Trust and the guidelines are stringently set out. • 3 External Audits are required, 2 are mandated and 1 is to be chosen by the Governors • In 2017/18, ED access target and RTT (Referral to Treat) were the mandated areas and Appraisals was chosen and approved by the Trusts Council of Governors. • The guidance for 2018/19 although not received, it was expected that the mandated areas will again be the ED and RTT. • The suggestions for the Governors consideration for the chosen areas were:- o Radiology reporting times o Reporting times for ECOLI In response to a question from Public Governor Alan Hancock, The Director of Patient Care and Chief Nurse reported that as radiology backlogs had been identified following CQC inspections in other areas.The Chief Inspector of Hospitals Professor Ted Baker, had written to all NHS acute and community NHS Trusts to advise them of the CQC's priority to review radiology reporting. In response to a question from Public Governor Alan Hastings, The Director of Patient Care and Chief Nurse reported that a recent benchmarking exercise at the Trust had shown a slight increase of ECOLI. **<u>Resolved:</u> That Radiology reporting times was approved as the Local Quality Account Indicator for 2018/19**
	Quality Priorities 2018/19 The Director of Patient Care reported that as part of the Quality Accounts for 2018/19 the Trust is required to choose at least 3 quality priorities for the year:- • The 2017/18 Quality Priorities were:- o Sepsis o Saving Babies Lives o Patient/Staff Experience o Improving Discharge • The Director of patient Care described each of the following proposed Quality Priorities for 2018/19 with rationale for inclusion:- o Patient Safety – WHO checklist o Patient Experience – The Gold Standard framework FOR End of Life Care o Clinical Effectiveness – Improving outpatients

	<u>Resolved:</u> That Patient Safety – WHO checklist, Patient Experience – The Gold Standard framework FOR End of Life Care and Clinical Effectiveness – Improving outpatients was approved as the Quality Priorities for 2018/19. A question that was submitted from Public Governor Alan Hastings was communicated by the Chairman. In response, The Director of Patient Care and Chief Nurse reported that although the numbers of Nurses at the Trust had remained static in recent years, there was an increase in staff establishment with the opening of three new wards at the Trust. The Director of Patient Care and Chief Nurse reported that The Trust had also successfully recruited seven Nurses from the Philippines and there were expected to be more on the way. There was a national shortage of band 5 nurses which was a challenge and a concern for the future was for the numbers of students coming through and the availability of bursaries. However, the Nursing Associates whose training is funded by the Trust were doing very well and the hope was to undertake training for more. The Director of Patient Care and Chief Nurse left the meeting
4.2	**Finance Report Month 8**
	The Director of Finance presented the Month 8 position and the following was highlighted:- • At month 6, NHS Improvement was reporting a combined provider deficit of over £300m. The position has since deteriorated further. • On a control total basis, the Trust is £162k adverse to plan in month. YTD, it is £824k behind the control total. The finances have deteriorated in month 7 because although both outpatient and elective performance is above plan, MRET and readmissions, as well as maternity and critical case, continue to erode income. • Shortfalls remain on the Transformation Programme. • The Trust still has not received confirmation about its capital loan. The Director of Finance will be discussing next steps with the Chief Executive In response to a question from Public Governor William Butler, the Director of Finance reported that receipt of the capital loan to support the capital programme is becoming increasingly urgent and stated that finances would not be diverted from safety and critical schemes. **<u>Resolved:</u> That the Finance Report for Month 8 be received**
3.1	**Update on Estate Development**
	The Deputy Chief Executive provided the update for the Estate Development and reported on the Academic Centre's official opening which was due soon. Work was continuing for a completion date towards the end of April for the Multi Storey Car Park, however upcoming work on the car park requires that a crane is to be on site which will mean that part of the ring road around the trust will be closed for a few

	weeks. **<u>Resolved:</u> That the Update on the Estate Development be received.**
3.2	**Healthwatch Milton Keynes**
	A presentation from Healthwatch Milton Keynes was given by the Chief Executive of Healthwatch Milton Keynes Maxine Taffetani. • The mission of Healthwatch Milton Keynes is to provide local people with a strong independent voice on health and social care issues and to influence the way that these services are planned, provided and delivered. • Since 2013, Healthwatch Milton Keynes has been working hard to understand what people want from health and care. • Healthwatch Milton Keynes is here to make sure that health and social services work for the people that use them by:- o Listening and representing o Shaping and influencing o Information, Signposting and advice o Holding to account • Activity highlights 2017/18 o Enter and View o Getting People Home o Mental Health o GP Access o Dentistry o Young Carers • How Healthwatch Milton Keynes can best work with the Hospital Governors o Extend reach into the community o Resources o Community Engagement o Promoting membership In response to a question from Public Governor Liz Wogan, Maxine Taffetani reported that Healthwatch Milton Keynes facilitate the Patient Participation Group Network Meetings which was an emerging relationship.
4.1	**Integrated Performance Report Month 8**
	The Deputy Chief Executive introduced the Month 8 Performance Report and reported that changes would be made to the report from next month in relation to length of stay and the reporting of E-coli. The Referral to Treat (RTT) performance was not achieved but the Trust was still performing well nationally compared to others. **<u>Resolved:</u> That the Integrated Performance Report Month 8 be received.**

5.1	**(Summary Report from) Finance and Investment Committee**
	Non Executive Director David Moore, the Chairman of the Committee presented the summary report from the Finance and Investment Committee Meeting held on the 6 November and 18 December 2017. The following was highlighted:- • An update had been provided at the last Board Meeting on the audit of readmissions and discussions were ongoing with the CCG on both the rebasing of the MRET tariff and the re-investment of MET monies and theses are to be raised at the next joint board meeting between the Trust and the CCG. • At month 7, £1.4m worth of savings were achieved against a plan of £0.5m. The programme is £750k behind plan but agency has significantly underspent. • Agency spend is now lower than bank spend for the first time. Public and Lead Governor Liz Wogan, took the opportunity to thank, with all best wishes for the future, at his last Council of Governors Meeting, David Moore Non Executive Director and Chairman of the Finance and Investment Committee. Appointed Governor Andrew Buckley left the meeting **<u>Resolved:</u> That the Finance and Investment Committee Summary Report be noted.**
5.2	**(Summary Report from) the Workforce and Development Assurance Committee**
	Tony Nolan, Non Executive Director and Chairman of the Workforce and Development Assurance Committee presented the summary report for the meeting held on the 6 November 2017. The following was highlighted. • Agency controls and usage, the reduction in pay costs in the last quarter was noted. Premium staff costs at below £900k for September were reported to be the lowest in many years. • There has been some very good work such as using bank staff to fill shifts rather than agency. • An analysis on why people leave is to be received and discussed at the next Workforce and Development Assurance Committee Meeting. • It was the view of the Committee that opportunities remain to highlight and build upon the 'Sports and Social' infrastructure at the hospital to encourage the set up e.g. more hospital teams. **<u>Resolved:</u> That the summary report from the Workforce and Development Assurance Committee be noted**
5.3	**(Summary report from) the Audit Committee**
	Bob Green, Non Executive Director and Chairman of the Audit Committee presented the summary report of the Audit Committee meeting held on the 12 December 2017. • In relation to data quality, an action plan and assurance plan had been requested.

	• There are concerns about delivery of the internal audit plan. • It was also suggested that Committee Chairs will need help in completing the risk management reports. **<u>Resolved:</u> That the the summary report of the Quality and Clinical Risk Committee meeting held on the 12 December 2017 was noted.**
6.	**Healthwatch Milton Keynes Update**
	Maxine Taffetani, appointed governor from Healthwatch Milton Keynes presented the Healthwatch Milton Keynes update • Healthwatch Milton Keynes would like to thank the hospital staff for their continued support and engagement whilst we have delivered our second Enter and View visit on Ward 24. • Patient experience, on the whole, was extremely positive and the discharge planning process working well. So far, over the course of our Enter and View activity, we have found that where there are clear, simple clinical pathways in place, discharge planning is generally unproblematic. • However, where patients have more complex needs, and clinical pathways aren't as clear, planning and achieving timely discharge is challenging. It is these situations where we have found patient confidence in the system, and their experience is less positive. • The report on Ward 24 is currently with the hospital for comment and will be published within the next month. • Healthwatch Milton Keynes plans to continue, and conclude our Enter and View of patient experience of Red2Green, with informal agreement to visit Maternity and the Discharge Lounge. **<u>Resolved:</u> That the Healthwatch Milton Keynes Update Report be noted.**
6.1	**Engagement Group Update**
	Alan Hastings Public Governor as Chair of the Engagement Group, provided the update from the Engagement Group Meeting that took place on the 6 December 2017 and the following was highlighted:- o The main discussion centred round the Membership and Engagement Strategy Action Plan 2015-17. This was due for review to cover the period 2018-20. o The meeting agreed that the Action Plan would be sent to all Governors for comment. Carol issued the current version on 14th December under cover of a message from the Engagement Group Chair requesting comments. Thanks go to those that responded. o A further meeting was held between Alan, Amanda and Carol to look at the comments received which will be considered and incorporated within the document. o The completed document will then be taken to the next Engagement Group Meeting being held on the 14th February for further consideration before being

	presented to the Board of Directors for approval. o It was thought that initial concentration should be on the following actions:- o Asking all Public Governors to distribute copies of 'The Year in Review' newsletter and Membership Application Form to surgeries and other meeting locations in their Constituencies; o Appointed Governors to do the same in their organisations and Staff Governors to do the same to the Wards and offices in their areas. o All Public Governors to contact their Parish Councils. o Help the Lead Governor, Liz Wogan, with the stand that she has kindly offered to set up in the Main Entrance. o Being involved to develop the next 'Meet the Members' event. o Be involved to start organising the Annual Members Meeting 2018. **<u>Resolved</u>**: **That the Engagement Group Update be received and accepted.**
6.2	**North Site Development Operational Group**
	Deferred until the next meeting
7.	**Governor Elections**
	The Governor and Membership Manager provided the update on the Governor Elections and the following was highlighted :- • Governor Elections were being held for current vacancies and tenures nearing completion for the following constituency areas :- o Public - Emerson Valley, Furzton and Loughton Park, o Public – Linford South, Bradwell and Campbell Park o Public - Walton Park, Danesborough, Middleton and Woughton o Public – Outer Catchment area that includes Buckingham, Winslow, Leighton Buzzard, Linslade, Newton Longville, Woburn Sands o Public – Extended area that includes the remainder of the county areas not covered in the outer catchment area of Northamptonshire, Buckinghamshire, the unitary council area of Luton and the district council of Cherwell, Oxford City and South Oxfordshire. o Staff – Non Clinical Admin and Clerical, Estates, Finance, HR and Management • Timetable :- o Deadline for receipt of Nominations is 31 January 2018 o Notice of Poll/Issue of Ballot Packs 15 February 2018 o Declaration of Result 14 March 2018

	Resolved: That the Governor Elections Update be noted.
7.1	**Lead Governor**
	Further to previous Chairman and Governor discussions, the Chairman presented the Lead Governor process and timetable that will take place when Public Governor Liz Wogan's tenure as rotational Lead Governor finishes on the 11th May 2018. The following was highlighted:- • The appointment as Lead Governor will be for an 18 month term, with a maximum of three appointments for any single Governor. • There is no lower restriction on the time served as a governor for eligibility as Lead Governor. • It will be for each candidate to demonstrate their suitability for the role in the course of the election process. • To put themselves forward candidates must have at least one year left or their current tenure • The nomination submissions are to be made to the Governor and Membership Manager. • Candidates supporting statements are to be made to the Governor and Membership Manager. • If there is more than one candidate, a vote to elect a Lead Governor of the Council of Governors is to be held at the next Council of Governors Meeting. **Resolved: That the Lead Governor Process was approved.**
7.4	**Motions and Questions from Council of Governors**
	The Chairman communicated the question that had been submitted from Public Governor Alan Hastings. In response to the question the Deputy Chief Executive reported that the Trust does not have any contracts with Carillion. **Resolved: That the Motions and Questions from the Council of Governors be received and accepted.**
7.5	**Annual Work Plan**
	The Annual Work Plan was considered and any items pertaining to this meeting are to be added. **Resolved: That the Annual Work Plan be noted.**
7.6	**Any other business**

	There was none
7.7	**Date and Time of next meeting** The date of the next meeting of the Council of Governors is on the 20th March 2018 at 5.00pm in room 6 at the Education Centre.
7.8	**RESOLUTION TO EXCLUDE THE PRESS AND PUBLIC** **Resolved: that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted.**

Carol Duffy
Governor and Membership Manager
13 February 2018

Meeting title	**Board of Directors**	**Date: 9 March 2018**
Report title:	**Chief Executive's Report**	**Agenda item: 2.3**
Report author	**Name: Joe Harrison**	**Title: Chief Executive**
FoI status:	**Public document**	

Report summary				
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [ ]	**Decision** [ ]
Recommendation	The Board is asked to note the update from the Chief Executive summarising the outcome of discussions at the February Management Board meeting and other key developments.			

Strategic objectives links	All
Board Assurance Framework links	None
CQC regulations	None
Identified risks and risk management actions	None
Resource implications	None
Legal implications including equality and diversity assessment	None

Report history	
Next steps	
Appendices	None

Chief Executive's Report - key points arising from the Management Board meeting on 21 February 2018

1. **Chief Executive's update**

- The Chief Executive highlighted the recent visits to the Trust by Jeremy Corbyn and Jeremy Hunt, and the broadly positive media coverage that had accompanied both visits. The Secretary of State is to be invited back for a more in-depth tour of clinical areas.

2. **7 day services**

- There are 4 priority standards under the 7 day services framework. There are local challenges to implementing these, but potential options are being identified.
- The twice a year benchmarking exercise indicates that the Trust is making good progress towards compliance.
- There is a potential difficulty in that the reference period clashes with the go live date for EPR.
- There is concern about the cost of implementing these standards within the context of an already fraught financial situation for most provider organisations. It would be important to carefully prioritise any additional investment. Full use should also be made of technology where appropriate.

3. **Options for the Eatery**

- The preferred option for reopening the Eatery is to create a new in-house outlet that will complement existing facilities.
- There is likely to be a small capital cost to refurbish the premises and equipment.
- The expectation is that it would be open for breakfast and lunch, but it would need to offer something unique in order to be viable.
- This is to be a staff only facility, and it would therefore be important to get their views on the offer in the first instance.

4. **Patient Led Assessment of the Care Environment (PLACE)**

- The action plan focusing on those areas where the Trust is an outlier is to be presented at the next meeting.

5. **Trust-wide non-RTT position**

- The Trust had noted the increasing number of patients awaiting an outpatient appointment who are not on RTT pathways. In response to targets for services to significantly reduce the number of such patients by 31 March 2018, good progress has been made overall, but there are still some problem areas.
- NHS Improvement will be visiting in late March to assess progress.

6. **Performance Report**

- The cancer 62 day target was met, and the Trust is back on track in relation to diagnostics. However, there was concern at the number of open pathways, which could mean that the number of 18 week breaches is also on the rise.
- Close attention is being given to the number of patients who would have been waiting for 52 weeks or more.

- The Trust is reporting a Never Event, relating to a patient transferred from a hospice whose medication was wrongly administered. No harm came to the patient, but the incident has been reported as required.

7. Finance Report

- At month 10, the Trust was £174k adverse to plan, but there was improvement in some areas.
- Outpatient performance is back on track, driven by specific specialities and the non-RTT work. However, Surgery remains in difficulty in terms of the number of cancellations.
- Pay costs remain high, but bank shift rates are soon to change.
- Next year's control total will be a deficit of £15m, meaning the Trust will need to make an extra £4m worth of savings which will be a challenge.

8. Q3 Patient Experience and Complaints report

- 360 complaints were received during the quarter but only 27% of them were formal. The PALS team has done much work in this regard.
- The themes emerging from complaints remain broadly the same, with a wide range of communications issues being cited. Staff attitude has also crept up as an area of concern.
- The Trust benchmarks well on the patients' Friends and Family Test, but patients are still saying in various surveys that their experience of using Trust services is poor.

9. Agency update

- The Trust has maintained its good performance and stayed below its ceiling, but it would need to do more next year.
- Managers need to manage their succession planning better to avoid gaps between resignation and a new employee starting.

10. Strategic Modernisation Programme Board

- It is vital that a solution is found for the location of a new aseptic suite
- The new multi-story car park is to open in April
- Construction of the Cancer Centre should start in May.

11. Risk Management Report

- Violence and abuse of staff by patients, relatives and members of the public remains an issue

12. Minutes of the Workforce Committee

- Exit interviews and onboarding surveys have provided fascinating messages, connecting with messages ermerging from appraisals
- The values underpinning the We Care programme are being revisited, and harassment advisers have been engaged.
- There is concern around the low uptake of apprenticeships.

Meeting title	**Board of Directors**	**Date: 9 March 2018**
Report title:	**Mortality update report**	**Agenda item: 3.2**
Lead director **Report author** **Sponsor(s)**	**Dr Ian Reckless** **Dr James Bursell**	**Medical Director** **Associate Medical Director**
FoI status:	**Publicly disclosable**	

Report summary				
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** [x]	**Decision** ☐
Recommendation	To note			

Strategic objectives links	Improve patient safety
Board Assurance Framework links	
CQC outcome/ regulation links	Trust objective – patient safety This report relates to CQC: Regulation 12 – Safe care & treatment Regulation 17 – Good governance
Identified risks and risk management actions	Mortality data outside the expected range would be of public & regulatory body concern
Resource implications	None
Legal implications including equality and diversity assessment	This paper has been assessed to ensure it meets the general equality duty as laid down by the Equality Act 2010

Report history	This is a regular paper at Trust Board
Next steps	To note
Appendices	N/A

Executive Summary

This paper summarises the Trust's current position in relation to mortality based on the latest Dr Foster data available and as discussed through the Trust's mortality review group (MRG). In addition, it reports upon the qualitative review work undertaken within services to examine the care provided by the Trust to patients who have died (through the mortality and morbidity, M&M, meeting framework), including the assessment of 'avoidability'.

Definitions

Case mix – Type or mix of patients treated by a hospital

Morbidity – Refers to the disease state of an individual or incidence of ill health

Crude mortality – A hospital's crude mortality rate looks at the number of deaths that occur in a hospital in any given year and then compares that against the amount of people admitted for care in that hospital for the same time period. The crude mortality rate can then be set as the number of deaths for every 100 patients admitted

SMR - Standardised Mortality Rate (SMR). A ratio of all observed deaths to expected deaths.

HSMR – Hospital Standardised Mortality Rate (HSMR). This measure only includes deaths within hospital for a restricted group of 56 diagnostic groups with high numbers of national admissions; it takes no account of the death of patients discharged to hospice care or to die at home. The HSMR algorithm involves adjustments being made to crude mortality rates in order to recognise different levels of comorbidity and ill-health for patients cared by similar hospitals.

SHMI – Summary Hospital-level Mortality Indicator (SHMI). SHMI indicates the ratio between the actual number of patients who die following treatment at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated. It includes deaths which occur in hospital and deaths which occur outside of hospital within 30 days (inclusive) of discharge.

Relative Risk – Measures the actual number of deaths against the expected number deaths. Both the SHMI and the HSMR use the ratio of actual deaths to an expected number of deaths as their statistic. HSMR multiplies the Relative Risk by 100.

- A HSMR above 100 = There are more deaths than expected
- A HSMR below 100 = There are less deaths than expected

Dr Foster
Third-party tools used to report the relative position of Milton Keynes University Hospital NHS Foundation Trust (MKUH) on national published mortality statistics. The trust recently renewed its relationship with Dr Foster Intelligence - therefore some of the graphs may look different.

HSMR

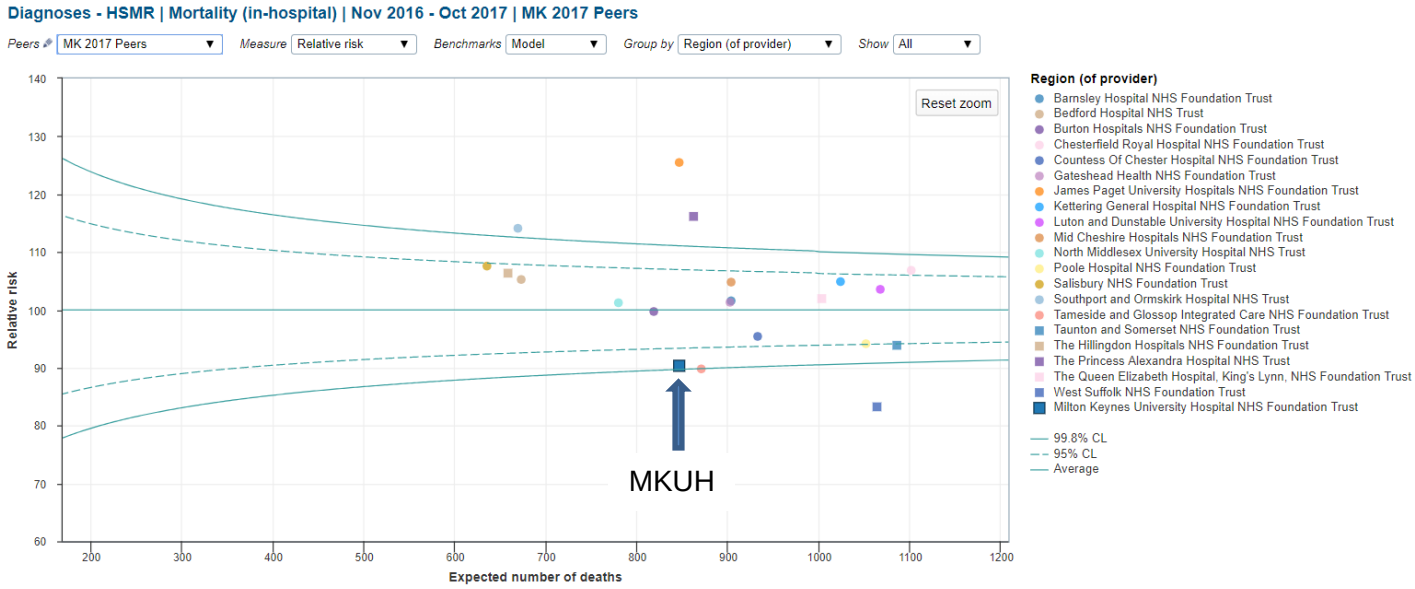
Data period: November 2016 – October 2017

Key Highlights:

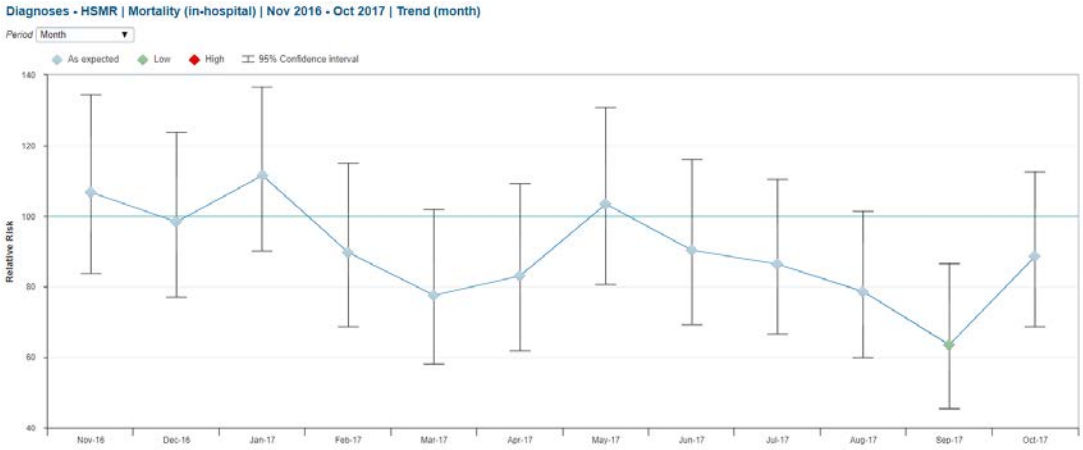
- HSMR relative risk for 12 month period = **90.3** 'lower than expected' range
- Crude mortality rate within HSMR basket = **3.2%** (MKUH local acute peer group rate = 3.9%)
- **1 significant negative outlier** was identified within the HSMR basket for this period. This HSMR diagnostic basket was 'other lower respiratory diseases'.

The Trust currently ranks 3rd (3rd lowest HSMR relative risk value) against its MKUH peer group and 22nd lowest (best) against national peers. The Trust is one of only 4 Trusts from 21 within the peer group with an HSMR which is statistically 'lower than expected'.

HSMR Funnel Plot – Trust vs. MKUH peer group (November 2016 – October 2017*)*

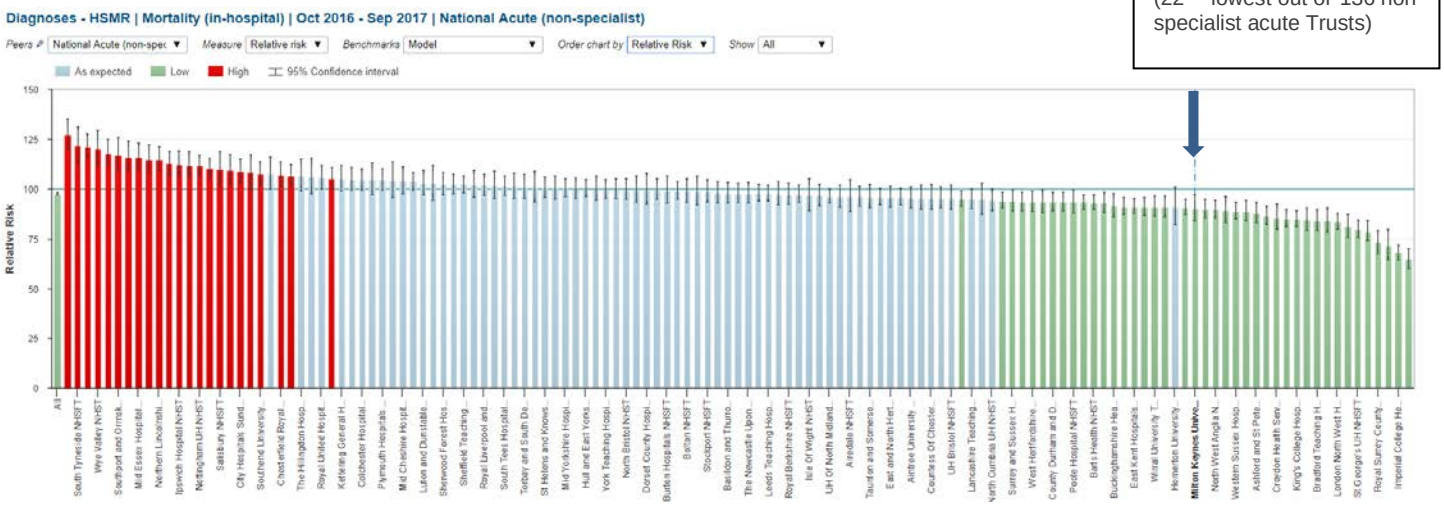


Trust level HSMR monthly performance for rolling year (November 2016 – October 2017)



HSMR position vs. national acute peers: November 2016 – October 2017

HSMR = **90.3** 'lower than expected'
(22nd lowest out of 136 non specialist acute Trusts)



HSMR relative risk = 90.3 'lower than expected' (22nd lowest out of 136 non-specialist acute). 1st lowest ranking indicates the trust with the lowest (best) HSMR relative risk.

HSMR by diagnosis group: November 2016 – October 2017

In the period November 2016 to October 2017, there was 1 outlying diagnostic group that included a significantly higher than expected number of deaths. Of note, in the period October 2016 to September 2017 (a further 12 month HSMR data period that has also been published since the January 2018 Public Board meeting) there were 0 (zero) outlying diagnosis groups.

The negative outlying diagnostic group in the period November 2016 to October 2017 period was 'other lower respiratory diseases'. This outlying 'red flag' was discussed at the February Mortality Review Group meeting.

This diagnostic group had previously alerted in September 2017 and was discussed at the September Mortality Review Group meeting. The diagnostic group was investigated by the coding team and it related to the deaths of 12 patients with complex respiratory conditions requiring input

from tertiary centres and with multiple co-morbidities. It was decided following discussion that no further action was necessary and the red flag was only present for a 2 month period before then losing statistical significance. In view of this diagnostic group once again becoming a negative outlier, the Mortality Review Group in February once again reviewed information from the coding team and it was decided to request that these deaths are reviewed in greater depth by the Respiratory team. This report has been requested to be submitted to the May 2018 Mortality Review Group meeting. A review of 'acute bronchitis' cases has also been requested in view of the fact that in April 2017 this diagnostic group was a negative outlier, and remained so for a 3 month period, and the group wished to explore any possible link between these 2 respiratory categories. In relation to acute bronchitis, it had previously been felt that this alert was secondary to a propensity to diagnose (and code for) 'lower respiratory tract infection, LRTI' even in the presence of chest X-ray changes which make a diagnosis of 'pneumonia' more appropriate. This has no impact upon clinical care but will act to raise the likelihood of death for patients with lower respiratory tract infection / LTRI.

CUSUM (Tracking Runs of Negative Outcomes)

In the period November 2016 to October 2017 there were no new CUSUM alerts. There have been no new CUSUM alerts since the Public Board meeting in September 2017.

SHMI

Data period: July 2016 – June 2017 (most up to date data available)

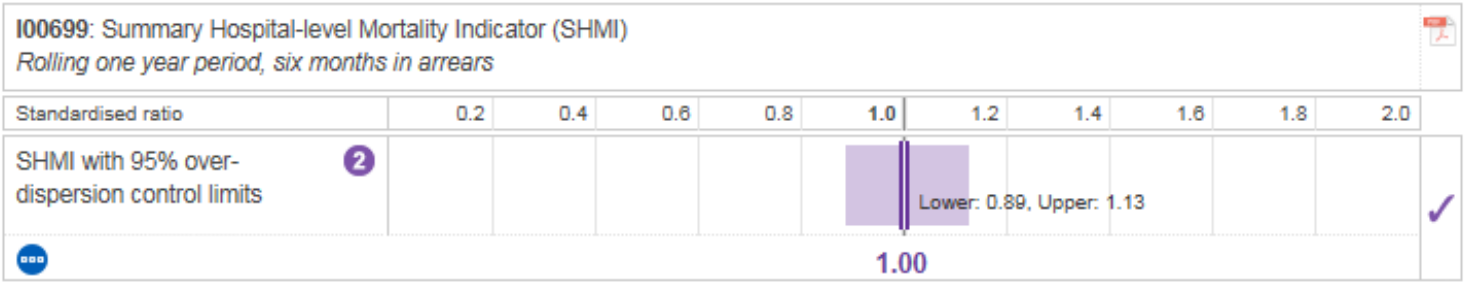
The Summary Hospital-level Mortality Indicator (SHMI), which includes out of hospital deaths occurring within 30 days of discharge, is measured by the Health and Social Care Information Centre (HSCIC). The SHMI relative risk is the ratio between the actual number of patients who die following treatment at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated. A SHMI score below 1.00 is better than average.

Key Highlights:

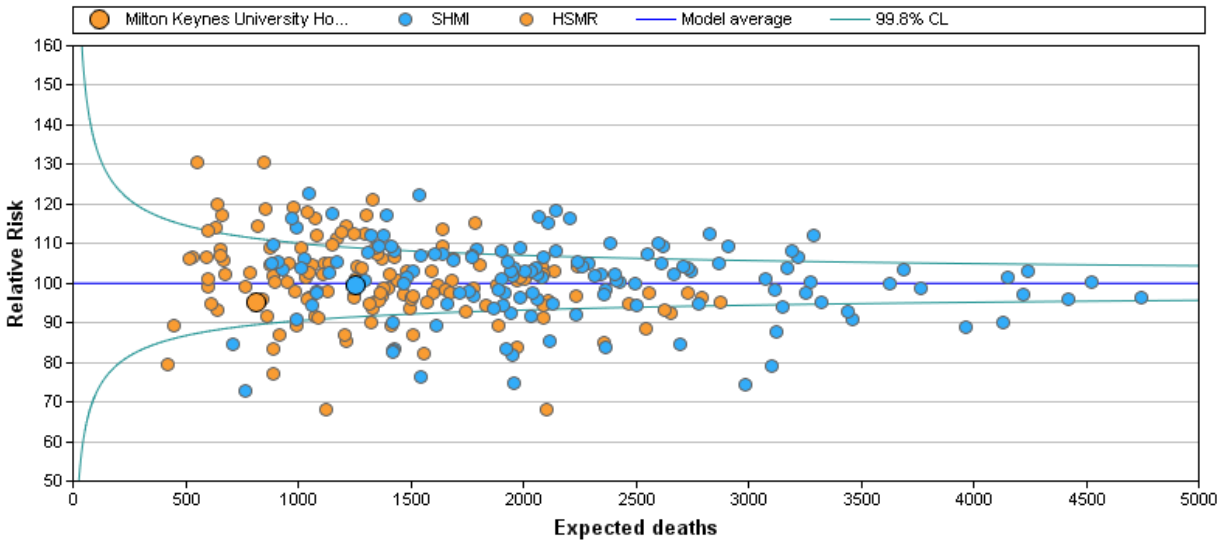
The latest SHMI published in March 2017 by HSCIC for the rolling 12 months to March 2016 = 0.995 '**as expected'** range.

The Trust ranked 53rd in SHMI performers among the 136 non-specialist acute trusts in England (ranking 1 = lowest or 'best' SHMI) on 12 month data to June 2017. The Trust previously ranked 66th on 12 month data to March 2017 and 90th in SHMI on 12 month data to September 2016.

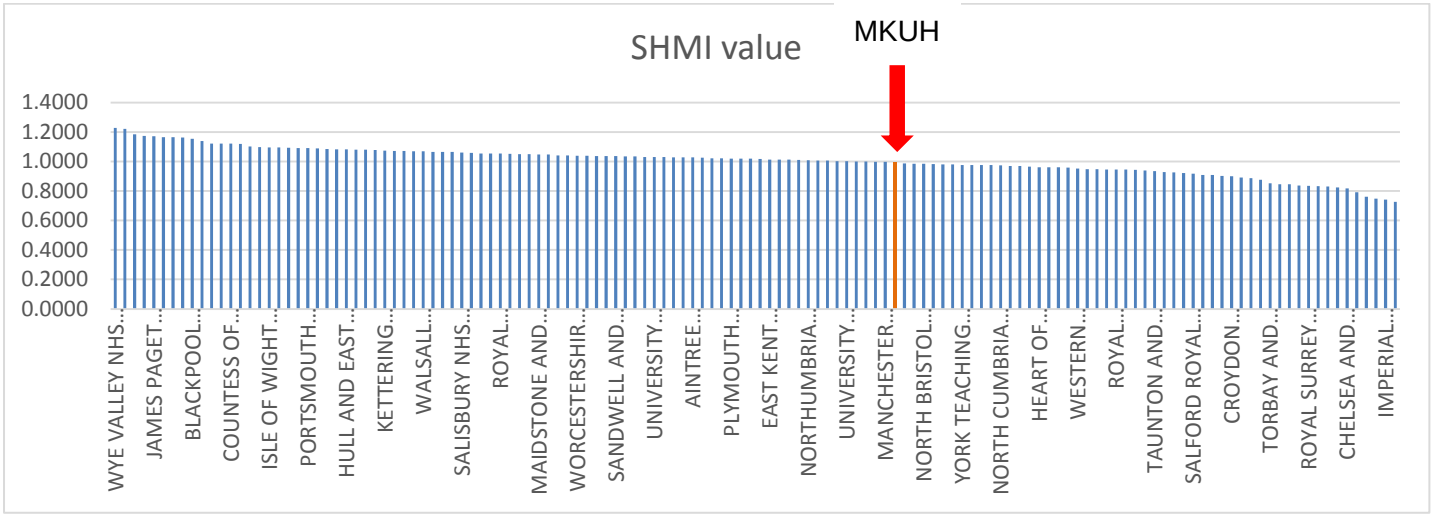
Summary Hospital-level Mortality Indicator (SHMI) • July 2016 - June 2017



SHMI and HSMR by provider (all non-specialist acute providers) for all admissions in July 2016 to June 2017



SHMI position vs. national acute peers: July 2016 – June 2017



Investigations of Deaths

In November 2017 the Trust published quarterly data (quantitative and qualitative) relating to deaths within the hospital in line with National Quality Board guidance.

Quarterly data will be published over the next 12 months at Trust Public Board meetings in May 2018, July 2018, November 2018 and January 2019.

The Trust is training multidisciplinary staff members in the use of Royal College of Physicians (RCP) methodology for Structured Judgement Review (SJR) case note review. By May 2018, 10 Trust employees will have been trained in this RCP methodology. Changes are being made to the structure and function of Morbidity and Mortality meetings across the Trust to incorporate data and information from these SJRs and to facilitate the process by which 'lessons learnt' are reviewed and actioned across the Trust.

The Trust continues to review progress against the NQB Learning from Deaths benchmarking tool (Appendix 1) and CQC Learning from Deaths Monitoring and Inspection Tool (Appendix 2).

Perinatal Mortality Review Tool

The Trust has registered to use the national Perinatal Mortality Review Tool (PMRT) launched in February 2018. PRMT is designed to be used by all Trusts in England to improve the review of perinatal deaths by providing an objective, robust and standardised tool that also engages parents in the review process. The Department of Health's ambition is to reduce stillbirth and neonatal death rates by 50% by 2025. Obstetricians, midwives, neonatal nurses, neonatologists, and members of the obstetric governance team will need to be trained on the web-based system to undertake multidisciplinary reviews of all perinatal and neonatal deaths. Cases will be discussed at meetings of a PMRT Review Group and quarterly reports generated for dissemination and escalation through Trust Risk Governance structure. The local use of PMRT will also be discussed at the Regional Thames Valley Obstetric Governance meeting as reviews will be scrutinised by regional networks.

Role of Medical Examiner

Following the 1st meeting of the Academic Health Service Network (AHSN) Regional Mortality Review Group, the Trust is looking to adopt a modified system of Medical Examiner as piloted elsewhere nationally and regionally. This model uses a number of trained senior doctors to undertake the role rather than 1 individual Medical Examiner. The purpose of the Medical Examiner is to provide scrutiny of in-hospital deaths and to confirm the cause of death. Pilots across the country have also demonstrated additional benefits to the role that have included an improved quality in the certification of deaths, a reduction in the number of deaths referred to the Coroner as well as improved communication with next of kin with increased transparency and openness when discussing deaths. The trust will consult with HM Senior Coroner for Milton Keynes before a final decision around the system to be implemented.

Appendices:

Appendix 1;

National Quality Board Learning from Deaths benchmarking tool

Recommendation benchmark learning

Appendix 2;

CQC Learning from Deaths Monitoring and Inspection Tool

Learning from deaths monitoring a

National Guidance on Learning from Deaths (NQB) benchmarking February 2018

Recommendation	Current status	Action required	Rag status	Due date	Trust Lead	Progress
Board level leader to take responsibility for learning from deaths Non –Executive Director (NED) to take oversight of the process	Ian Reckless as Medical Director has delegated responsibility to James Bursell (Associate Medical Director) Andrew Blakeman as chair of the Quality & Clinical Risk Committee (QCRC)	Review of reports for Board to include learning from deaths				
Clear engagement with bereaved families treating them as equal partners & with a clear, honest, compassionate & sensitive approach	Initial letter from Head of Risk & Clinical Governance included in Bereavement packs advising of Trust investigating deaths & offering families Contributions	Ongoing monitoring of feedback received from relatives Consideration of enhanced involvement		Ongoing	Tina Worth	Further consideration on how best to include bereaved families in investigations. Initial response from families is low with either 'thanks for care given' or a few queries to be taken to mortality review meetings & subsequent feedback by e-mail/letter.
Staff to have enhanced skills & training to support learning from deaths agenda	No current staff training specific to mortality reviews. Externally accredited root cause analysis and human factors training run in 2016, 2017 and 2018 with consultant engagement	Establish training programme when training requirements options/requirements apparent		TBC	James Bursell	Training on structured judgement reviews ongoing with 4 staff trained to date and 10 more planned April 2018. Cascade training to follow as required.
Governance policy & processes/arrangements that facilitate the response to, review,		Specialty review of processes for NQB specified cases against the Annex in the framework		September 2017	James Bursell/Tina Worth	Policy for Mortality & Morbidity M&M) review process and reporting in place.

National Guidance on Learning from Deaths (NQB) benchmarking February 2018

investigation and reporting/sharing of deaths & learning. To include: • Learning disabilities deaths • Infant/child deaths • Still birth/maternal deaths • Mental health needs deaths • Inclusion of case note reviews using a structured approach e.g. Structured Judgement reviews (SJRs) • Include deaths within 30 days of leaving the Trust						Further updates required in relation to NQB. Review of reports for M&M Review Group & QCRC to include more learning from deaths Correlation of learning from the coronial system (inquests)
Collect on a quarterly basis specified data on deaths Publish quarterly through a (public) agenda item paper at Board Publication of data	Data produced by the Information Team in Excel spreadsheet for Divisions to report on	Inclusion of deaths 30 days post discharge Production of a mortality dashboard		April 2017 July 2017 (quarter 2) October 2017 (quarter 3)	Information Team	Monthly data report provided Data provided for public Board on a quarterly basis

National Guidance on Learning from Deaths (NQB) benchmarking February 2018

(dashboard) & learning points to include: • Trust in patient deaths • Emergency Department (ED) deaths • Deaths subject to case reviews (& estimates of how many deaths were judged more likely to have been due to problems in care)						
Quality Accounts to include learning & actions & an assessment of the impact of the actions that the Trust has taken	Not required 2016/17.	Drafting of 2017/2018 report in progress.		June 2018	Ade Kadiri	

CQC Learning from Deaths Monitoring and Inspection Tool – Short Guide [Interim Guidance - 5 September 2017]

Well-led 8: are there robust systems and processes for learning, continuous improvement and innovation?

Well-led 8.3 How effective is participation in and learning from internal and external reviews, including those related to mortality or the death of a person using the service? Is learning shared effectively and used to make improvements?

Background

This tool is designed to provide a systematic way to assess how providers learn from reviews and investigation of deaths. The method builds on CQC's thematic review "Learning, candour and accountability" published in December 2016 (http://www.cqc.org.uk/publications/themed-work/learning-candour-and-accountability). This found that "many carers and families do not experience the NHS as being open and transparent and opportunities are missed to learn across the system from deaths that may have been prevented."

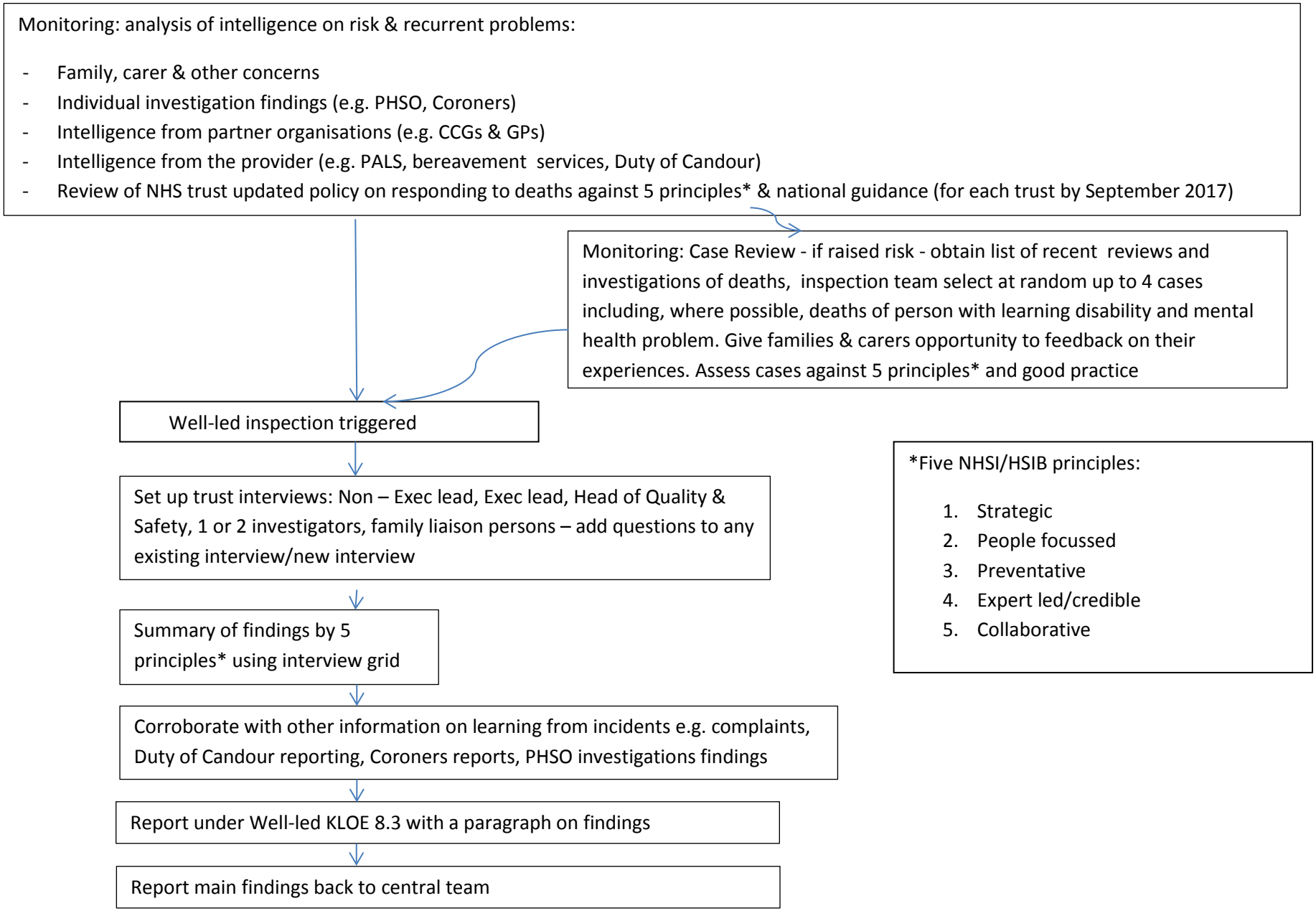
It should be applied to services provided by NHS acute, community and mental health trusts. It excludes services such as those that are NHS funded but provided by independent providers. This is the same scope as the CQC thematic review.

The approach tests the progress NHS trusts have made in meeting national guidance on Learning from Deaths, that sets out what families and carers should expect, and will highlight any good practices. The national guidance issued on March 2017 (https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf) focusses on NHS acute care, with later national guidance expected on NHS provided mental health services and NHS provided community health services. This is the start of a development journey for NHS trusts and CQC is not expecting trusts to have implemented all the requirements in the short period since March, especially as some guidance has still to be issued. So we are looking at where NHS trusts have got on their development journey.

This guidance uses a set of good practice principles that have been developed by the NHSI Safety Team and the Healthcare Safety Investigation Branch. The method has been piloted in the summer 2017 at three NHS trusts, two acute and a mental health provider, and through public comment through the CQC website and electronic community, with around 100 responses which have helped shape the approach.

An overview of the review process is given in the flowchart below. Further detail on the approach is in the Long Guide to Learning from Deaths, published alongside this document.

Flowchart of Method for Assessing Provider's Learning from Deaths



Reporting findings for the Well-led Inspection Report

It is suggested that a single summary section is drafted for the inspection report under the heading 'Learning from Deaths' under Key Lines of Enquiry.

Well-led 8: are there robust systems and processes for learning, continuous improvement and innovation?

Well-led 8.3 How effective is participation in and learning from internal and external reviews, including those related to mortality or the death of a person using the service? Is learning shared effectively and used to make improvements?

The key elements to cover are:

1. Progress made on setting up a method of reviewing and investigating deaths to meet the national guidelines
2. Whether deaths of people with a learning disability are reviewed and investigated to the same good standard as other deaths
3. Family and carer involvement
4. Evidence that the reviews and investigations reduce reoccurring problems
5. Evidence that common themes across complaints cases, serious incidents and deaths are brought together and addressed
6. Board oversight and challenge to ensure that the reviews and investigations stop reoccurring problems

We want to use these paragraphs on findings to analyse for a follow-up national report on what our inspections have found. Also to provide further details could you, at the end of the inspection, please complete the proforma at the Annex and return to paul.durham@cqc.org.uk . Thank you.

Questions to ask during the on-site inspection

These questions are structured around a set of principles developed by the NHS Improvement Safety Team and the Healthcare Safety Investigation Branch. You can print this table and use it during interviews to record findings.

Key principle: Strategic – the focus is on quality of output and not just quantity of reporting; resources are invested in identifying cases and investigated work to support good quality outputs.

Question	Yes	No	Comment
What policy and process do you have/are developing to identify deaths for review and investigation to meet the national guidance on learning from deaths? (National Guidance expects each NHS trust should publish an updated policy by September 2017)	√		Mortality Review and Learning from Deaths Policy (Adults) last reviewed in July 2017 & due for review September 2019 includes mortality review processes in accordance with the national guidance
What progress has been made on publishing quarterly data on deaths? (National Guidance expects the publication of the data and learning points from it by the end of December 2017)	√		Mortality paper & data published at the January 2018 public Board meeting and will continue quarterly
What work is done with partners to explore learning across care settings and pathways?	√		As part of an ongoing improvement process around learning from deaths the Trust is involved in a project, led by the Academic Health Service Network (AHSN), to establish regional approaches to mortality issues
How are people with a learning disability or mental health needs identified?	√		By clinical coding identifiers and specialty reviews then taken to the Mortality and Morbidity Review Group (MMRG)
How are reviews and investigations of deaths resourced?	√		The Risk Management Team have a Clinical Governance Facilitator (CGF) & Clinical Governance & Risk Administrator for each division, who support the clinicians with the invetsigations of deaths
Who is the Board lead on deaths? What board discussion is there?	√		Medical Director with delegated responsibility to the Associate Medical Director. Frequent papers with detailed discussion as per minutes.
How is learning from deaths, incident investigations, complaints, coroners reports, etc. co-ordinated?	√		The Head of Risk & Clincial Governance has oversight of all of these areas, with the Serious Incident Review Group (SIRG) used as the weekly forum for discussions
What progress has been made –are there specific examples? What further plans are there?	√		Clinical and nursing staff attended Royal College of Physicians teaching programmes in October and November and there are plans to roll out training to a cohort of consultants in 2018.

How do you ensure that actions are delivered? Are there any examples were the Board has challenged the activities?	√		All mortality meetings from Clincial Service Unit (CSU) level to the Mortality Board have tracked action logs. Divisional mortality quarterly reports to the MRG include reviews on action logs as assurance on progress

Key principle: People focussed – patients, families, carers and staff are active and supported participants.

Question	Yes	No	Comment
How does the trust engage with families and carers in reviews and investigations of deaths?	√		A letter is included in the Trust bereavement pack informing families that the Trust has a process in place to ensure that the care provided to all patients who die within our hospital is reviewed. Whilst in the majority of cases death is not unexpected, this process aims to ensure that any possible lessons about care and/or treatment can be learnt by the healthcare team. Families are advised that if they have any concerns in relation to the care of their relative, the Trust is happy to ensure that these are included in the review, and the Trust would welcome them raising these. The Head of Risk & Clinical Governance is the point of contact  Bereavement letter C comments_IR final.do(
How does the trust seek feedback from families and carers after every death? (as this should help drive which deaths are reviewed)	√		As above. Where families get in touch these cases are either forwarded for M&M review or if not applicable to casue of death forwarded to the Complaints Team
Where appropriate, how did the trust ensure the family and/or carers received an early and genuine apology? (as required under Duty of Candour Regulation 20 for a notifiable safety incident)	√		For all incidents escalated as serious incidents (SIs) an initial letter of apology is written which also invites families to be involved in the investigation process. This is followed up on completion of the investigation with the offer to share the investigation report and/or meet to discuss. For all death related incidents not escalated as SIs a letter of

			apology is also sent along the same lines. This is clearly outlined in the Trust Incident Reporting Policy
Did they help set the terms of reference?	√		Where families offer concerns or have questions these are included in the terms of reference for investigations
How can families & carers raise concerns during the process?	√		Initial point of contact is the Bereavemnt Office, followed by the Head of Risk & Clinical Governance. The Trust also has a complaints service
What support is provided to families?	√		The Bereavement Office provide families with a list of places to seek support from.  HELPFUL ORGANISATIONS FOR
How does the trust handle communication with families who do not engage?	√		The Trust would not look to 'force' families to be involved. The PALS Service is there as an alternative medium if preferred
Who handles the liaison (a single named person)?	√		Head of Risk and Clincial Governance however this is one of the many elements of her role, rather than a bespoke one person service provision
How are the family & carers kept informed about timescales and findings?	√		By letter, e-mail or phone. Timescales can vary depeding on due dates of meetings & if investigation linked to the SI process
What monitoring is done to ensure family & carer needs are delivered?	√		There is an open invitation for families to feedback to the Head of Risk & Clincial Governance, and invite families in if/where they feel their concerns have not been addressed. Feedback on information shared with families to date has been positive rather than negative
What feedback does the trust collect from families on how well they are engaged?	√		Any feedback from families on Trust engagement is taken throughthe MMRG for discussion & actioning
Have family & carers been involved in improving the process?	√		Not directly, however the Trust is open to their involvement if/where helpful and any comments they have made have been duly considered
Staff are active and supported participants:	√		CSU meetings are multidisciplinary, with the support from the

What support is available for staff involved in deaths? Do staff feel supported and fairly treated if they are open and honest about mistakes and errors? What proportion of investigations carried out include interviews with all key staff involved in care to identify exactly how and why things went wrong?			Risk Management Team. A no blame culture is encouraged at all M&M meetings Debrief meetings are held after traumatic/complex/emergency death situations Staff can access support through Health a& WellBeing & Care First The Trust has an outsourced legal provider who provies legal support for inquest cases The Trust's mission statement includes "a hospital committed to learning, to honesty, and to the best possible care and experience for every patient, every time" Incident investigations are undertaken at differently depending on the level of investigation required, some of which may not require statements. The collation of statements is covered in the Trust Incident Reporting Policy, linking to the National Patient Safety Agency (NPSA) tools.

Key principle: Preventative (investigations for learning) – all investigations identify and act on deep-seated causal factors to prevent or measurably and sustainability reduce recurrence. They do not seek to determine liability, attribution or cause of death.

Question	Yes	No	Comment
Do you have evidence of any examples of good learning where previous recurrent incidents have been reduced or prevented following implementation of improvements from investigations into deaths? (good practice examples)			
What are the key features of the trust's review and investigation process?	√		All Surgical & Women/Child Health deaths are investigated in accordance with Trust policy, as well as those linked to learning disabilities or significant mental health issues. For medical deaths a process of screening isutilised whereby a significant proportion of deaths can be diverted away from undergoing a 1st Structured Judgement Review (SJR). This requires the responsible clinician (Consultant) to make a positive

			affirmation as to the quality of care across a number of domains, with the screening Form 1 Part B providing a clear evidence trail for accountability in the decision. To enhance this process and as additional assurance there will be a quarterly subset of deaths either randomly chosen by the CGFs from deaths that had been screened out or from Hospital standardised mortality ratio (HSMR) outlier categories that will require presentation at M&M meetings for validation and assurance of the process Any deaths subsequently where care was suboptimal & there was a probable avoidability of the death, an incident is reported on the Datix system & the case discussed at SIRG to see if it meets SI criteria
For deaths of people with a learning disability or severe mental health problem: How do you review and investigate a death of a person with a learning disability? Can the trust identify those people who have died who have a learning disability? How does the trust respond? What method is used to investigate deaths? How do you involve families? What oversight does the CCG provide? What are the biggest risks you manage?	√		All patient deaths associated linked to learning disabilities or significant mental health issues are always investigated in line with the SJR model, (using clinical coding to capture this cohort) & involving/feeding back to familes in the usual way The Trust engaes in the Learning Disability Mortality Review (LeDeR) Programme The Trust has an excellent working relationship with the Learning Disabilities Lead (in the CCG) and access to mental health teams if/where required The Trust meet with representatives from the CCG quarterly at Trust Mortality Group meetings to discuss issues related to mortality. This includes review of HSMR and SHMI data. The CCG receive SI reports (the format of SI repors is as agreed with the CCG) as per Trust policy which will include deaths where learning was identified and action plans made.

Key principle: Expertly led/credible - led by experts; open, honest and transparent; objective; planned; timely and responsive; systematically and system-based; trustworthy; fair and just.

Question	Yes	No	Comment
Can you talk me through the process you use to review and investigate deaths? - System-based approach (e.g. Working with partners such as GPs)? - Training, support and expertise available (e.g. safety investigation, human factors, improvement science)? - Resources available (e.g. dedicated time) - Proportionate to incident and risk? - Clear terms of reference? - Clear what evidence used? - Did families receive the information they needed (under Duty of Candour)? - Are investigators independent of the care provided? - Bespoke plan for each investigation? - Responsive at start, timely in completion (e.g. within 60 days)? - Seek to report the truth accurately (e.g. accounts of staff and families?) - Fair and just (e.g. promotes a safe and open culture) - Collect feedback from families and carers? - Was the report clearly written and easy to read?	√		All Surgical & Women/Child Health deaths are investigated in accordance with Trust policy, as well as those linked to learning disabilities or significant mental health issues. For medical deaths a process of screening isutilised whereby a significant proportion of deaths can be diverted away from undergoing a 1st Structured Judgement Review (SJR). This requires the responsible clinician (Consultant) to make a positive affirmation as to the quality of care across a number of domains, with the screening Form 1 Part B providing a clear evidence trail for accountability in the decision. To enhance this process and as additional assurance there will be a quarterly subset of deaths either randomly chosen by the CGFs from deaths that had been screened out or from Hospital standardised mortality ratio (HSMR) outlier categories that will require presentation at M&M meetings for validation and assurance of the process Deaths are reviewed by a clinician, using SJR methodology, that is independent of the case. The Associate Medical Director role has delegated management of the M&M process for the Trust to designated CSU M&M leads that lead on mortality to ensure that the M&M reviews terms and processes meet Trust policy and national guidance. M&M meetings are held monthly in most specialties M&M meetings provide Action plans related to lessons to be learnt from deaths that are then incorporated in Divisional Action PPlans, Divisional Actin Plans are incorporated in quarterly Divisional Reports that are reviewed by the Associate Medical Director at the Mortality Review Group. These reports are the basis of the quaterly reports submitted by the Associate Medical Director to Trust Public Board meetings containing quantitiave and qualitaiive data and information on

- Clear what improvements in care were needed? - Clear who needed to take action? - Are there capacity issues that prevent the organisation from learning and improving in a timely manner? - Process to audit so can focus on cases that provide most learning? - Can you point to improvements in care due to this activity?			deaths.

Key principle: Collaborative – supports system-wide investigation (cross pathway/boundary issues); enables information sharing and action across systems; facilitates collaboration where multiple investigations are ongoing.

Question	Yes	No	Comment
What proportion of the trust's investigations of deaths are completed in collaboration with referring or receiving providers?	√		A small number where required (information sourced from GPs/tertiary providers if relevant)
What mechanism does the trust use to identify which improvements are effective?	√		The Trust M&M meetings at all levels are used to determine improvement with an escalation route through the corporate M&M strucure
What mechanisms does the trust use to share with partner organisations improvements made?	√		Sharing of RCA investigations associated with patient deaths
What are the challenges and achievements?	√		The challenge is getting feedback

Annex – feedback of findings to the central support team

Please complete the form below, providing whatever details you believe appropriate, and return to paul.durham@cqc.org.uk

Principle	Good practice	Requiring further development
1. Strategic – the focus is on quality of output and not just quantity of reporting; resources are invested in identifying cases and investigated work to support good quality outputs.		
2. People focussed – patients, families, carers and staff are active and supported participants.		
3. Preventative (investigations for learning) – all investigations identify and act on deep-seated causal factors to prevent or measurably and sustainability reduce recurrence. They do not seek to determine liability, attribution or cause of death.		
4. Expertly led/credible - led by experts; open, honest and transparent; objective; planned; timely and responsive; systematically and system-based; trustworthy; fair and just.		
5. Collaborative – supports system-wide investigation (cross pathway/boundary issues); enables information sharing and action across systems; facilitates collaboration where multiple investigations are ongoing.		
Details of good practice examples:		

Meeting title	Board Of Directors	**Date:** 9 March 2018
Report title:	Nursing Staffing Report	**Agenda item:** 3.3
Lead director **Report author Sponsor(s)**	**Name:** Lisa Knight **Name:** Matthew Sandham	**Title:** Director Of Patient Care/Chief Nurse **Title:** Associate Chief Nurse
FoI status:	**Public document**	

Report summary							
Purpose *(tick one box only)*	**Information**	x	**Approval**		**To note**	x	**Decision**	
Recommendation	That the Board receive the Nursing Staffing Report.						

Strategic objectives links	Objective 1 - Improve patient safety. Objective 2 - Improve patient care.
Board Assurance Framework links	Inadequate staffing are contributory issues for BAF risks 1.1 and 1.4.
CQC outcome/ regulation links	Outcome 13 staffing.
Identified risks and risk management actions	
Resource implications	Unfilled posts have to be covered by Bank or agency staff, with agency staff having a resource implication.
Legal implications including equality and diversity assessment	None as a result of this report.

Report history	To every Public Board
Next steps	
Appendices	Appendix A

Board of Directors Report on Nursing and Midwifery staffing levels Amalgamated report for December 2017and January 2018

1. Purpose

To provide Board with:-

- An overview of Nursing and Midwifery staffing levels.
- An overview of the Nursing and Midwifery vacancies and recruitment activity.
- Update the Board on controls on nursing spend.

2. Planned versus actual staffing and CHPPD (Care Hours per Patient Day)

We continue to report our monthly staffing data to 'UNIFY' and to update The Trust Board on our monthly staffing position.

CHPPD is calculated by taking the actual hours worked divided by the number of patients on the Ward at midnight.

CHPPD = hours of care delivered by Nurses and HCSW
Numbers of patients on the Ward at midnight

CHPPD	Total Patient Numbers	Registered Midwives/Nurses	Care Staff	Overall
December	15062	4.4	2.9	7.3
January	15942	4.2	2.7	6.9

Hospital Monthly Average Fill Rates for October and November 2017

Month	RN/RM Day % Fill Rate	HCA/MCA Day % Fill Rate	RN/RM Night % Fill Rate	HCA/MCA Night % Fill Rate
December	85.2%	106.7%	100.6%	135.6%
January	85.7%	104.3%	101.9%	130.7%

We have seen a slight drop in both fill rates as well as CHPPD following the increased demand for escalation beds in January.

A Ward by Ward breakdown of fill rates for the two months has been included in the Appendix A

3. Recruitment

Our estimated vacancies in February 2018 are:

61 vacancies in Medicine, most of these are on the elderly care wards. Medicine has a rolling advert and has agreed a recruitment plan for 2018 including an open day on the 24th March

22 wte band 5 vacancies in Surgery – Surgery continues to recruit on a rolling advert and had a successful recruiting day on the 24th February interviewing 12 Band 5 candidates. Theatre staff with experience at Band 6 level continues to be an area hard to recruit to with 11 wte vacancies

13 wte band 5/6 vacancies in Maternity.

10 wte band 5 residual vacancies in Paediatrics, following the recruitment of the 8 students who are due to start in September. Paediatrics continues to be challenging due to the recognised national shortfall of paediatric Staff Nurses.

4. Nursing and Midwifery Student Numbers- 2017 & 2018

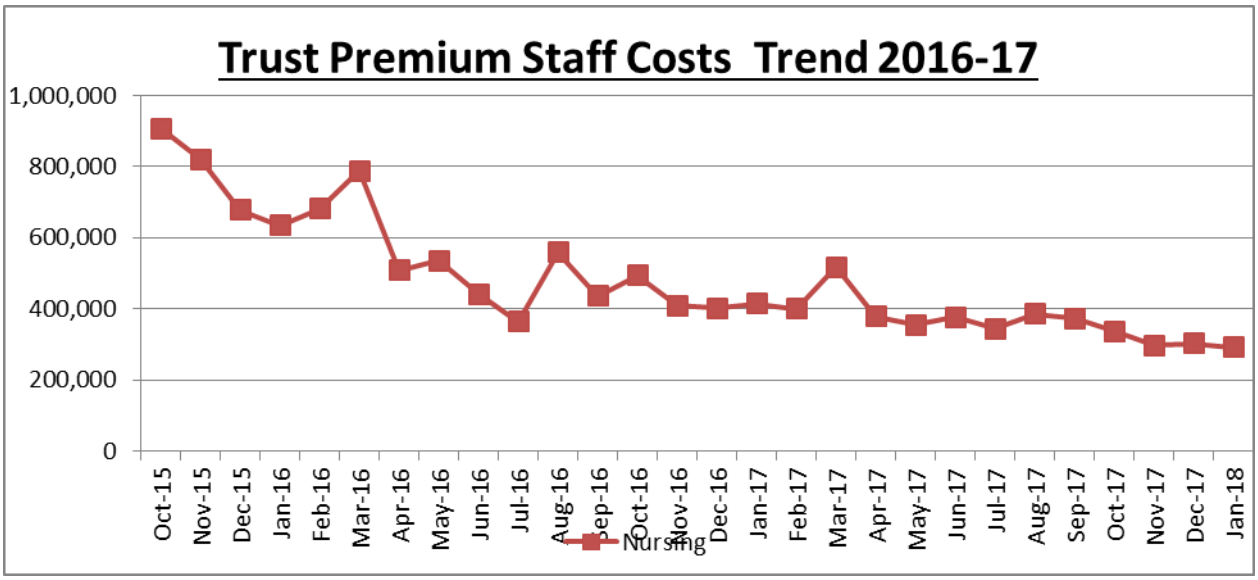
University	Field	March 2017	September 2017	March 2018	September 2018
The University of Northampton	Adult BSc	23	43	15 **(35 expected)**	TBC
The University of Bedfordshire	Adult BSc	6	0 **(6 expected)**	0 **(6 expected)**	TBC
The University of Bedfordshire	Adult MSc	0	0	4 **(10 expected)**	TBC
The University of Northampton	Child BSc	-	14	-	TBC
Bucks New University	Child BSc	2	2	TBC	TBC
The University of Bedfordshire	Child BSc	-	4 **(New agreement of 4)**	-	TBC
The University of Northampton	Midwifery BSc	12	21	19	TBC

The above information shows a breakdown of Student Nurses and Midwives cohort numbers we expect to train in any given year. Each course take 3 years so on average there are over 350 student nurses and midwives being trained at any one time. It has been our strategy to continually increase the number of students we train as the main method of recruitment. We employ well over 95% of the students we train on qualification.
Any downturn in these numbers will have a significant impact on our ability to staff the hospital in the future.

The removal of the bursary for Nursing and Midwifery programmes was implemented in September 2017 immediately impacting on uptake of places nationally.
We are working collaboratively with the universities to fill as many places as possible and are planning student recruitment events jointly over the next few months to try to fill September's places.

Our nursing associates have completed the first year of their training, and qualify in April 2019. This is a cohort of 10 students. The business case for a further, larger September cohort of nursing associates is in train and may go some way to mitigating some of the shortfall but the routes to registration with the NMC are still in consultation phase and there are many

5. Controlling Premium Cost



Agency nursing expenditure continued to stabilise in December and January, this against a backdrop of needing to staff winter escalation areas – which is likely to have contributed to the reduced CHPPD in month. In March bank rates are due to reduce to slightly above agenda for change rates – we wait to see if this will contribute to a reduction in fill rates and possibly increased agency staffing costs.

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Fill rates for Nursing, Midwifery and Care Staff December 2017

Ward Name	Day		Night		Care Hours Per Patient Day (CHPPD)			
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
MAU Ward 1	83.4%	112.1%	97.1%	135.4%	837	4.3	2.3	6.6
MAU Ward 2	87.4%	100.3%	103.2%	151.5%	818	3.3	3.0	6.2
Ward 3	69.9%	72.9%	92.4%	96.8%	737	3.0	3.2	6.2
Ward 5	77.7%	85.4%	121.1%	95.9%	614	6.3	1.2	7.5
DoCC	90.7%	85.1%	89.9%	-	224	23.3	1.2	24.6
Ward 7	82.9%	85.6%	101.1%	104.3%	732	3.5	3.6	7.1
Ward 8	82.0%	106.1%	101.1%	137.2%	757	3.4	3.2	6.5
Ward 9	77.8%	88.7%	91.9%	87.1%	623	4.5	1.1	5.7
Ward 10	88.7%	85.5%	96.8%	-	305	4.8	2.3	7.1
Ward 14	83.5%	144.6%	100.1%	124.2%	739	2.9	3.4	6.3
Ward 15	87.4%	115.7%	98.1%	164.4%	891	3.3	3.1	6.4
Ward 16	85.2%	92.5%	126.2%	116.3%	895	3.2	2.3	5.5
Ward 17	85.5%	111.8%	98.4%	138.6%	771	4.1	2.6	6.7
Ward 18	85.9%	91.8%	103.3%	131.2%	861	3.1	3.5	6.6
Ward 19	78.6%	141.4%	95.8%	146.2%	927	2.6	3.7	6.3
Ward 20	81.3%	128.9%	98.1%	136.2%	764	3.8	3.4	7.2
Ward 21	82.5%	166.2%	100.0%	220.7%	733	3.5	4.2	7.7
Ward 22	87.4%	89.3%	100.2%	98.4%	650	3.9	2.3	6.2
Ward 23	84.0%	128.3%	101.6%	151.7%	1113	3.3	4.0	7.4
Ward 24	88.8%	105.3%	98.9%	-	445	5.1	1.3	6.4
Labour Ward	95.5%	81.7%	94.6%	0.0%	216	23.6	1.7	25.3
NNU	105.8%	85.1%	111.9%	78.7%	410	9.5	1.5	11.0

Fill rates for Nursing, Midwifery and Care Staff January 2018

Ward Name	Day		Night		Care Hours Per Patient Day (CHPPD)			
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
MAU Ward 1	83.4%	112.2%	99.4%	119.9%	810	4.5	2.3	6.8
MAU Ward 2	84.8%	118.2%	102.8%	185.0%	871	3.0	3.3	6.3
Ward 3	109.8%	107.1%	157.8%	139.0%	1057	3.4	3.2	6.7
Ward 5	77.4%	86.7%	106.1%	99.9%	609	6.0	1.2	7.2
DoCC	83.2%	75.9%	88.5%	-	216	23.0	1.2	24.2
Ward 7	79.5%	85.5%	100.1%	104.6%	786	3.2	3.4	6.5
Ward 8	76.3%	108.6%	100.0%	141.9%	761	3.2	3.2	6.4
Ward 9	86.0%	79.0%	96.0%	100.0%	704	4.3	1.0	5.3
Ward 10	96.0%	87.1%	95.2%	-	374	4.0	1.9	5.9
Ward 14	84.8%	149.5%	96.8%	137.1%	739	2.9	3.5	6.4
Ward 15	80.0%	87.6%	100.1%	119.4%	868	3.3	2.3	5.6
Ward 16	86.7%	93.6%	109.8%	106.5%	914	3.2	2.2	5.4
Ward 17	80.0%	93.9%	100.0%	125.7%	792	3.9	2.2	6.1
Ward 18	77.5%	99.1%	100.0%	129.4%	859	2.9	3.7	6.5
Ward 19	81.2%	121.1%	100.0%	189.9%	950	2.6	3.8	6.4
Ward 20	78.8%	108.0%	98.8%	117.1%	810	3.5	2.7	6.2
Ward 21	82.8%	123.5%	98.9%	141.9%	751	3.4	2.8	6.2
Ward 22	88.2%	100.4%	98.9%	112.7%	664	3.9	2.6	6.4
Ward 23	80.7%	115.4%	101.7%	139.4%	1156	3.1	3.5	6.6
Ward 24	87.4%	85.5%	100.7%	-	501	4.5	1.1	5.5
Labour Ward	101.2%	82.2%	99.1%	0.0%	260	21.3	1.5	22.8
NNU	104.2%	89.9%	107.1%	65.2%	490	8.5	1.2	9.7

Meeting title	Trust Board	**Date:** 9 March 2018
Report title:	7 Day Services	**Agenda item: 3.4**
Lead director **Report author** **Sponsor(s)**	**Name:** Dr Ian Reckless **Name:** Elisa Scaletta	**Title:** Medical Director **Title:** Deputy Business Manager
FoI status:	Publicly disclosable	

Report summary	This report provides Trust Board with information regarding 7 Day Services and the 4 priority standards contained therein. This report outlines: each department's current position against these standards; the gaps identified; possible interventions to close these gaps; and, associated costs.			
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [ ]	**Decision** [ ]
Recommendation	Trust Board is invited to assist in determining the organisation's approach to achievement of the standards, in the context of the financial resources available. In particular, Trust Board is invited to comment upon the prioritisation outlined in this paper.			

Strategic objectives links	Improve patient safety
Board Assurance Framework links	▪ Improve patient safety ▪ Deliver key targets ▪ Improve clinical effectiveness
CQC regulations	NHS England delivering 7 day hospital services (10 standards)
Identified risks and risk management actions	Non-compliance with standards monitored by regulators
Resource implications	Full compliance is likely to require significant additional resources (e.g. additional consultants, senior nurses and other staff working at weekends – requiring a premium and / or reducing staff availability during the working week).
Legal implications including equality and diversity assessment	

Report history	First report to Board. Previously discussed at Clinical Quality Board and Management Board.
Next steps	Determination of feasibility of investment, and prioritisation of specific elements within the overall package.

1. Purpose of the Report

This report provides Trust Board with information regarding 7 Day Services and the 4 priority standards contained therein. This report outlines: each department's current position against these standards; the gaps identified; possible interventions to close these gaps; and, associated costs.

2. Context

A series of clinical standards for seven-day services in hospitals was developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh (then NHS Medical Director) and involving a range of clinicians and patients. The standards were founded on published evidence and consistent with the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. Ten standards were agreed and are now being rolled out across the NHS in England in acute hospitals. With the support of the AoMRC, four of these were identified as 'priority' clinical standards on the basis of their potential to positively and significantly impact upon patient outcomes.

The four priority standards are:

Standard 2 – Time to first consultant review
Standard 5 – Access to diagnostic tests
Standard 6 – Access to consultant-directed interventions
Standard 8 – Ongoing review by consultant twice daily for high dependency patients, daily for others

The purposes of the standards are: to deliver safer patient care; to improve patient flow through the acute system; to enhance patients' experience of acute care; to reduce the variation in appropriate clinical supervision at weekends; and potentially, to mitigate the excess mortality that has been shown in large studies to be associated with weekend admission to hospital. The latter element is not without controversy.

3. Body of the Report

a) Breakdown of the four priority standards

The 4 priority standards, detailed below, are usefully divided into two pairs: standards 2 and 8, and standards 5 and 6.

Standards 2 and 8 are specific to individual specialties – time of first consultant review from admission and frequency / regularity of consultant reviews that patients experience during their hospital stay.

Standard 5 and 6 are best applied Trust wide, looking at how various services support other individual specialties (e.g. access to diagnostics and interventional services).

Standard 2 – Time to first consultant review (individual specialties)

All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital. The standard is more exacting (within 6 hours) in daylight hours.

Standard 8 – Ongoing review by consultant twice daily for high dependency patients, daily for others (individual specialties)

- All patients with high dependency needs should be seen and reviewed by a consultant twice daily.
- Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

The national target is for 50% of services to be compliant by March 2018, with all 4 priority standards to be fully implemented across the NHS by 2020. It remains unclear how performance will be judged on a Trust / regional / national basis. NHSI has previously expressed a hope that MKUH would be delivering 7DS by April 2018 (contributing to a positive regional / national picture).

Standard 5 – Access to diagnostic tests (Trust Level)

Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week:

- Within 1 hour for critical patients
- Within 12 hours for urgent patients
- Within 24 hours for non-urgent patients

Standard 6 – Access to consultant-directed interventions (Trust Level)

Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols. These interventions would typically be:

- Critical Care
- Interventional radiology
- Interventional endoscopy
- Emergency general surgery
- Emergency renal replacement therapy
- Urgent radiotherapy
- Stroke thrombolysis
- Percutaneous coronary Intervention
- Cardiac pacing (either temporary via internal wire or permanent)

Approach

Meetings have taken place with Operational Managers and CSU Leads to try and establish where departments currently sit against the four priority standards. The purpose of these meetings was to obtain an honest and realistic self-assessment on the basis that it is preferable to be conscious of service gaps at an early stage. Following identification of service gaps, further meetings have taken place with the Divisional Directors to critically appraise the data provided by each specialty and look at ways of closing the gaps.

A high level report on the gaps, potential interventions and 'best guess' costs was discussed at Management Board on 21 February. On the following pages, summary findings are presented as follows –

A. 'Trust-wide Standards' (standards 5 and 6), by standard
B. 'Service-level Standards' (standards 2 and 8), by Division

In prioritising the potential interventions to close the identified gaps against 7DS service standards, three categories have been assigned as follows:

- Work in progress (discussions are underway)
- First order priority – subject to approval of direction of travel, aim to progress / work up early during 2018/19 (modest cost and/or significant positive clinical impact).
- Second order priority – subject to approval of direction of travel, keep in mind as a future service development but not currently a priority for revenue funding in 2018/19 (high cost and/or modest positive clinical impact).

Prioritisation across the standards is summarised on page 8.

A. Trust-wide Standards

Standard 5

Key Issues:

- Requirement for scheduled ultrasound lists 7 days per week including a full sonographer list on a Saturday and Sunday.
- Requirement for clear 'access criteria' (indications) for inpatient echocardiography (technician or cardiologist) in order to better manage demand.
- Insufficient staffing (echo technicians).
- Timetabling of MRI slots to ensure that urgent inpatient cases are scheduled according to clinical need rather than deferred to the end of an elective list.
- Need to establish routine endoscopy lists with capacity to accommodate selected inpatients 7 days a week.

Potential Interventions:

- Additional echocardiography staff (known to be hard to recruit)
- Discussion with other organisations in relation to weekend GI bleed rota and establishing 7 day scheduled endoscopy lists on site.

Indicative Costs:

- Not possible to determine at this point in time although endoscopy and echocardiography work should both self-fund (tariff-based outpatient capacity) and offer the potential to reduce length of stay.

Prioritisation of interventions:

- Both interventions are 'work in progress'.

Standard 6

Key Issues: • Existing arrangements are *ad hoc* and informal. • The STP is currently not able to provide effective interventional radiology services.
Potential Interventions: • Formalisation of pathways with Oxford.
Indicative Costs: • Patients being transferred will attract a *Payment by Results* tariff payment and any additional cost should be modest.
Prioritisation of interventions: • This intervention is work in progress.

B. Service-level Standards (standards 2 and 8)

Women's & Children's Division

Women's Health:

Key Issues: • Confirmation required around whether patients who are admitted under a named Consultant but have their care delivered and led by a Midwife, need to be seen by a Consultant on admission or daily. This question would be easier to address in a formally recognised midwifery led unit (MLU). • Existing arrangements for weekday emergency gynaecology cover are insufficient. Prospective consultant cover for leave is not in place, with the default position being combined consultant cover across obstetrics and gynaecology (as per on-call arrangement). • Weekday evening presence (either from the labour ward consultant or the on-call consultant) does not currently allow routine review of afternoon gynaecology admissions within the 7 day services standard. • Weekend provision is not always sufficient (according to obstetric service pressures). Gynaecology inpatients are less likely to be prioritised.
Potential Interventions: • 'Annualisation' of consultant job plans to incorporate prospective cover of weekday gynaecology. • Job plan review for weekday evenings to permit review of newly admitted gynaecology patients. • Potential for elective Caesarean Sections and gynaecology ward round

provided by a second consultant on one weekend day. • Potential to split weekend's on-call (Friday/Sunday and Saturday duties). • Need to better define gynaecology and obstetric patients / pathways where care can be delegated. • Potential contribution of technology enabled review (e.g. Skype consultations).
Indicative Costs: • £25,000 - £50,000
Prioritisation of interventions: • Suggested interventions are all 'first order' priorities.

Children's Health:

Key Issues: • Summer consultant job plans insufficient to allow 6-14h review standard to be met routinely. • All PAU attendances (even if ambulatory) are currently subject to 7 day service standards. • There is only one ward round on NNU (neonates) on each weekend day.
Potential Interventions: • Additional consultant resource of up to 2 WTE (may be offset by reduced middle grade staffing at some points of the day) extending consultant presence from 09:00 – 21:00, Monday to Sunday. • Role of technology – eCare for identification of patient groups and Skype for virtual consultations.* • Exploration of an appropriate enhanced OP tariff for selected PAU patients.* • Enhanced paediatric phlebotomy input. • Expansion of the winter service covering 52 weeks.
Indicative Costs: • £100,000 - £200,000
Prioritisation of interventions: • Suggested interventions are a combination of 'first order' (*) and 'second order' priorities.

Medicine Division

Key Issues:

- Insufficient consultants to achieve daily review.
- Insufficient juniors to support consultant in delivering daily reviews and/or to undertake delegated reviews.
- Conflicting priorities for patient review hindering achievement of 6-14h standard (acuity, shift times of doctors in training, flow, 7 day service standards).
- Relative lack of senior nurses on wards at weekends (co-ordinating / orchestrating consultant activity).
- Weekend frequency for consultant already very much higher than was the case 18 months ago.

Potential Interventions:

- Additional consultant sessions at weekends (likely 4 additional sessions per weekend) – with additional appointments required to achieve this given high weekend frequency at present.
- Enhanced gastroenterology presence at weekends.*
- Additional two junior doctors at weekends and/or development of ANP rota.*
- More consistent senior nurse presence on wards at weekends (band 6 and 7) to orchestrate ward rounds and board rounds.*
- Role of technology – eCare for identification of patient groups.*
- Expectation of consultant review of all medical patients that have arrived in the hospital up until at least 20:00 before handover.*

Indicative Costs:

- £300,000 - £500,000

Prioritisation of interventions:

- Suggested interventions are a combination of 'first order' (*) and 'second order' priorities.

Surgery Division

Key Issues:

- ITU job plans not designed to incorporate twice daily consultant review.
- T&O conflicted between several different duties (trauma list and ward round).
- Split site working in urology does not allow consistent 7 day service standards.
- No formal board rounds in ENT.
- Not enough Consultant cover in General Surgery at weekends.
- Location of General Surgery patients.

Potential Interventions:

- ITU job planning to include a second daily ward round at weekends.*
- Separation of ward round and trauma list duties for consultants in T&O.*
- Role of Skype and virtual consultation.
- Review of arrangements in place for urology admissions and on-call provision (split site).
- Virtual board rounds.
- Additional ANP for Ward 23 to help with patient flow.

Indicative Costs:

- £100,000 - £200,000

Prioritisation of interventions:

- Suggested interventions are a combination of 'first order' (*) and 'second order' priorities.

4. Prioritisation

In prioritising the potential interventions to close the identified gaps against 7DS service standards, three categories have been assigned as follows:

- Work in progress (discussions are underway)
- First order priority – subject to approval of direction of travel, aim to progress / work up early during 2018/19 (modest cost and/or significant positive clinical impact).
- Second order priority – subject to approval of direction of travel, keep in mind as a future service development but not currently a priority for revenue funding in 2018/19 (high cost and/or modest positive clinical impact).

The proposed interventions and indicative values are summarised in the table below:

Work in progress

- Additional echocardiography staff (known to be hard to recruit)
- Discussion with other organisations in relation to weekend GI bleed rota and establishing 7 day scheduled lists on site.
- Formalisation of pathways with Oxford [consultant-directed interventions].

Approximate cost: modest (not quantified at present)

First Order Priorities

- 'Annualisation' of consultant job plans to incorporate prospective cover of weekday gynaecology [women's].
- Job plan review for weekday evenings to permit review of newly admitted gynaecology patients [women's].
- Potential for elective Caesarean Sections and gynaecology ward round provided by a second consultant on one weekend day [women's].
- Potential to split weekend's on-call (Friday/Sunday and Saturday duties) [women's].

- Need to better define gynaecology and obstetric patients / pathways where care can be delegated [women's].
- Potential contribution of technology enabled review (e.g. Skype consultations) [multiple specialties].
- Role of technology – eCare for identification of patient groups and Skype for virtual consultations [multiple specialties].
- Exploration of an appropriate enhanced OP tariff for selected PAU patients [paediatrics].
- Enhanced gastroenterology presence at weekends.
- Additional two junior doctors at weekends and/or development of ANP rota [medicine].
- More consistent senior nurse presence on wards at weekends (band 6 and 7) to orchestrate ward rounds and board rounds [multiple specialties].
- Role of technology – eCare for identification of patient groups [multiple specialties].
- Expectation of consultant review of all medical patients that have arrived in the hospital up until at least 20:00 before handover.
- ITU job planning to include a second daily ward round at weekends.
- Separation of ward round and trauma list duties for consultants in T&O.

Approximate cost: £200,000 – 450,000

Second Order Priorities

- Additional consultant resource of up to 2 WTE (may be offset by reduced middle grade staffing at some points of the day) extending consultant presence from 09:00 – 21:00, Monday to Sunday [paediatrics].
- Enhanced paediatric phlebotomy input [paediatrics].
- Expansion of the winter service covering 52 weeks [paediatrics].
- Additional consultant sessions at weekends (likely 4 additional sessions per weekend) – with additional appointments required to achieve this given high weekend frequency at present [medicine].
- Role of Skype and virtual consultation.
- Review of arrangements in place for urology admissions and on-call provision (split site).
- Virtual board rounds.
- Additional ANP for Ward 23 to help with patient flow [surgery].

Approximate cost: £325,000 – 500,000

5. Recommendation / Actions

Board is invited to assist in determining the organisation's approach to achievement of the standards, in the context of the financial resources available. In particular, Board is invited to comment upon the prioritisation outlined in this paper.

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Trust Board	Date: 9 March 2018
Report title:	Performance Report indicators for 2017/18 (Month 10)	Agenda item: 4.1
Lead director Report author Sponsor(s)	Name: John Blakesley Name: Hitesh Patel	Title: Deputy Chief Executive Title: Associate Director of Performance and Information
FoI status:	Disclosable	

Report summary	Lists the proposed key performance metrics for the Trust for the financial year 2017/18			
Purpose *(tick one box only)*	Information [x]	Approval [ ]	To note [ ]	Decision [ ]
Recommendation				

Strategic objectives links	All Trust objectives
Board Assurance Framework links	None
CQC outcome/ regulation links	
Resource implications	None
Legal implications including equality and diversity assessment	None

Report history	None
Next steps	None
Appendices	None

Trust Performance Summary: January 2018

1.0 Summary

This report summarises performance in January 2018.

The Trust continues to be dominated by non-elective demand with the lagging indicators continue to show the hospital under stress. With inpatient occupancy at 98.8% the hospital will always perform inefficiently (as seen by ward discharges before midday, increasing readmissions, stranded and super stranded patients) DToCs performance had improved significantly but is now on the rise again. Short term clinical quality appears unaffected with pressure ulcers and HCAI performing well.

This operational pressure directly affects the Trust's ability to meet the emergency access standard in A&E and we achieved 87.9% albeit against a national backdrop of England only achieving 85.3% placing the Trust at 30th out of 137.

On the elective side the RTT target was not achieved in month at 89.4% down from (90.7% last month) and is likely to continue to deteriorate further over the coming weeks. In December the England performance was 87.8% with MKUH being 96th (down from 54th) out of 159 Trusts. Of continued concern is the numbers of breaches over 52 weeks as this will ensure that we are seen as an outlier (December data show the Trust at 124th in the country).

2.0 Sustainability and Transformation Fund (STF)

Performance Improvement Trajectories

January 2018 performance against the Service Development and Improvement Plans (SDIP):

ID	Indicator	DQ Assurance	Target 17-18	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change
4.1	ED 4 hour target (includes UCS)		95%	92.9%	91.5%	87.9%	✗	▲
4.2	RTT Incomplete Pathways <18 weeks		92%	92.1%		89.4%	✗	▬
4.9	62 day standard (Quarterly)		85%	85%		87.1%	✓	▼

In January 2018, ED performance improved marginally from 87.7% in December 2017 to 87.9%. This was lower than both the 95% national target and the Trust's NHS Improvement trajectory (92.9%). However, despite the disappointment of not achieving these milestones in January, the performance compares favourably to the national A&E performance, which was 85.3% in January 2018, and furthermore reinforces challenges across the health system to achieve this target.

The criteria to receive the full STF performance based funding for A&E in Q3 was to achieve 90.18% or higher. The Trust actually achieved 90.4% for the quarter, so secured the full amount of STF.

At the end of January 2018, the referral to treatment (RTT) national operating standard of 92% for incomplete pathways was not achieved. An aggregate performance of 89.4% was reported, which was consistent with the previous month. This also compares well to the latest NHS England statistics which, at the end of December 2017, reported 88.2% of patients waiting less than 18 weeks.

The 85% Cancer 62 day standard was achieved in Quarter 3 of 2017/18, closing at 87.1%.

3.0 Urgent and Emergency Care

Urgent and emergency care operated under sustained winter pressures during January 2018:

ID	Indicator	DQ Assurance	Target 17-18	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change
2.4	Cancelled Ops - On Day		1.0%	1.0%	1.1%	1.9%	✗	▼
3.2	Ward Discharges by Midday		30%	30%	23.2%	19.3%	✗	▼
3.4	30 day readmissions		6.4%	6.4%	8.2%	8.3%	✗	▼
3.9	Ambulance Handovers >30 mins (%)		5%	5%	5.9%	9.6%	✗	▲
4.1	ED 4 hour target (includes UCS)		95%	92.9%	91.5%	87.9%	✗	▲

Cancelled Operations on the Day

In January 2018, there was a notable increase in operations that were cancelled on the day for non-clinical reasons. In fact, the 52 on the day cancellations in January 2018 was the most reported in a calendar month since October 2015 (56) and represented 1.9% of all planned elective operations.. Of these, 37 (70%) were attributed to bed availability. Consultant unavailability was the next most frequently cited reason for last minute cancellations, accounting for nine (17%) of the total. Emergency pressures coupled with capacity issues, particularly highlighted by the increase in stranded patients exacerbated the challenges faced by the Trust in January.

Readmissions

The readmission rate was again higher than expected, with a rate of 8.3% in January 2018. Medicine accounted for the minor increase compared to December 2017, with a rate of 13.4%. Surgery and Women and Children both preserved a consistent rate compared to the previous month.

Delayed Transfers of Care (DTOC)

The number of DTOC patients reported at the end of January 2018 was 33. This was an increase of 5 compared to the number reported at the end of December 2017. This increase had a significant impact on the number of bed days lost due to DTOCs throughout the month.

Ambulance Handovers

The percentage of ambulance handovers that took longer than 30 minutes was reduced to 9.6%, still above the 5% threshold but a reduction on the previous month. There were 36 handovers reported to have taken longer than 60 minutes during January 2018 compared to 59 in December 2017. Despite the performance being above the expected level in January 2018, and the challenges faced by the Trust further in the pathway such as bed availability, the downward trend in handovers is a positive outcome given the circumstances.

4.0 Elective Pathways

ID	Indicator	DQ Assurance	Target 17-18	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change
3.1	Overnight bed occupancy rate		93%	93%	97.4%	98.8%	✗	▼
3.5	Follow Up Ratio		1.50	1.50	1.53	1.51	✗	▲
4.2	RTT Incomplete Pathways <18 weeks		92%	92.1%		89.4%	✗	▬
5.6	Outpatient DNA Rate		5%	5%	6.1%	6.2%	✗	▲

Overnight Bed Occupancy

Bed occupancy continued above the desired levels at 98.8%. This was a small increase in occupancy compared to December 2017. Statistics recently published by NHS England stated that the average occupancy rate for general and acute beds open overnight was 87.1% during Q2 2017/18.

Follow up Ratio

Planning outpatient capacity to cope with new referrals is impacted by the demand for follow ups. Following an increase between June 2017 and August 2017 to an average of close to 1.6, the follow up ratio has been consistent at an average of 1.52 since September (M6).

RTT Incomplete Pathways

Meeting the RTT national standard and NHS Improvement trajectory represents a huge challenge for the Trust. Performance however remained constant despite very high occupancy levels and the high number of cancelled elective operations. The Trust reported six patients at the end of January who had a waiting time of 52 weeks or more; all these patients were in the Trauma & Orthopaedic specialty.

Diagnostic Waits <6 weeks

Diagnostics performance was back up to expected levels at the end of January with less than 1% of patients waiting more than six weeks. There were again a large number of breaches in Endoscopy services and a large number of breaches reported for Audiology Assessments.

ENDS

Performance Report 2017/18
January 2018 (M10)

Milton Keynes University Hospital NHS Foundation Trust

OBJECTIVE 1 - PATIENT SAFETY										
ID	Indicator	DQ Assurance	Target 17-18	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
1.1	Mortality - (HSMR)		100	100		90.3	✓	▼		
1.2	Mortality - (SHMI) - Quarterly		1	1		1.00	✓	▲		
1.3	Never Events		0	0	3	0	✓	▬	✗	
1.4	Clostridium Difficile		20	17	10	2	✗	▼	✓	
1.5	MRSA bacteraemia		0	0	3	0	✓	▬	✗	
1.6	Pressure Ulcers Grade 2, 3 or 4 (per 1,000 bed days)		0.86	0.86	*Not available*					
1.7	Falls with harm (per 1,000 bed days)		0.19	0.19	0.13	0.07	✓	▲	✓	
1.8	WHO Surgical Safety Checklist		100%	100%	100%	100%	✓	▬	✓	
1.9	Midwife : Birth Ratio		30	30	30	32	✗	▼	✓	
1.10	Incident Rate (per 1,000 bed days)		40	40	32.30	27.48	✗	▼	✗	
1.11	Duty of Candour Breaches (Quarterly)		0	0	1	1	✗	▼	✗	
1.12	E-Coli				24	2		▲		

OBJECTIVE 2 - PATIENT EXPERIENCE										
ID	Indicator	DQ Assurance	Target 17-18	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
2.1	FFT Recommend Rate (Patients)		94%	94%	93.9%	93.0%	✗	▬	✗	
2.2	RED Complaints Received		10	8	2	0	✓	▬	✓	
2.3	Complaints response in agreed time		90%	90%	86.2%	87.3%	✗	▼	✗	
2.4	Cancelled Ops - On Day		1.0%	1.0%	1.1%	1.9%	✗	▼	✗	
2.5	Over 75s Ward Moves at Night		2,000	1667	2,396	268	✗	▼	✗	
2.6	Mixed Sex Breaches		0	0	4	0	✓	▬	✗	

OBJECTIVE 3 - CLINICAL EFFECTIVENESS										
ID	Indicator	DQ Assurance	Target 17-18	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
3.1	Overnight bed occupancy rate		93%	93%	97.4%	98.8%	✗	▼	✗	
3.2	Ward Discharges by Midday		30%	30%	23.2%	19.3%	✗	▼	✗	
3.3	Weekend Discharges		70%	70%	69.1%	71.6%	✓	▲	✗	
3.4	30 day readmissions		6.4%	6.4%	8.2%	8.3%	✗	▼	✗	
3.5	Follow Up Ratio		1.50	1.50	1.53	1.51	✗	▲	✗	
3.6.1	Number of Stranded Patients (LOS>=7 Days)		188	188		271	✗	▼		
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)		84	84		107	✗	▼		
3.7	Delayed Transfers of Care		25	25		33	✗	▼		
3.8	Discharges from PDU (%)		16%	16%	13.6%	15.7%	✗	▼	✗	
3.9	Ambulance Handovers >30 mins (%)		5%	5%	5.9%	9.6%	✗	▲	✗	

OBJECTIVE 4 - KEY TARGETS										
ID	Indicator	DQ Assurance	Target 17-18	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
4.1	ED 4 hour target (includes UCS)		95%	92.9%	91.5%	87.9%	✗	▲	✗	
4.2	RTT Incomplete Pathways <18 weeks		92%	92.1%		89.4%	✗	▬		
4.3	RTT Patients Waiting Over 18 Weeks		911	932		1403	✗	▲		
4.4	RTT Total Open Pathways		11,388	11,798		13,189	✗	▲		
4.5	RTT Patients waiting over 52 weeks			0		6	✗	▼		
4.6	Diagnostic Waits <6 weeks		99%	99%		99.0%	✓	▲		
4.7	All 2 week wait all cancers (Quarterly)		93%	93%		95.6%	✓	▬		
4.8	31 days Diagnosis to Treatment (Quarterly)		96%	96%		100.0%	✓	▬		
4.9	62 day standard (Quarterly)		85%	85%		87.1%	✓	▼		

OBJECTIVE 5 - SUSTAINABILITY										
ID	Indicator	DQ Assurance	Target 17-18	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
5.1	GP Referrals Received		60,189	49,753	50,935	5,183	✓	▲	✓	
5.2	A&E Attendances		89,338	73,575	74,013	6,975	✗	▼	✓	
5.3	Elective Spells (PBR)		26,522	21,982	20,820	2,085	✗	▲	✗	
5.4	Non-Elective Spells (PBR)		32,365	27,112	28,537	2,988	✓	▲	✓	
5.5	OP Attendances / Procs (Total)		377,608	312,641	294,111	31,837	✗	▲	✗	
5.6	Outpatient DNA Rate		5%	5%	6.1%	6.2%	✗	▲	✗	

OBJECTIVE 7 - FINANCIAL PERFORMANCE										
ID	Indicator	DQ Assurance	Target 17-18	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
7.1	Income £'000		223,967	185,548	185,926	20,036	✓	▲	✓	
7.2	Pay £'000		(158,813)	(132,367)	(132,131)	(13,706)	✗	▼	✓	
7.3	Non-pay £'000		(67,625)	(56,175)	(60,354)	(6,688)	✗	▼	✗	
7.4	Non-operating costs £'000		(12,954)	(10,752)	(10,325)	(1,130)	✗	▼	✓	
7.5	I&E Total £'000		(15,426)	(13,745)	(16,884)	(1,488)	✗	▲	✗	
7.6	Cash Balance £'000		2,504	3,203		4,597	✓	▲		
7.7	Savings Delivered £'000		10,500	7,875	5,697	730	✗	▼	✗	
7.8	Capital Expenditure £'000		(28,389)	(17,769)	(10,005)	(1,715)	✓	▲	✓	

OBJECTIVE 8 - WORKFORCE PERFORMANCE										
ID	Indicator	DQ Assurance	Target 17-18	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
8.1	Staff Vacancies % of establishment		14%	14%		12.0%	✓	▲		
8.2	Agency Expenditure %		10%	10%	7.4%	7.4%	✓	▼	✓	
8.3	Staff sickness - % of days lost		4%	4%		4.2%	✗	▬		
8.4	Appraisals		90%	90%		86.0%	✗	▲		
8.5	Statutory Mandatory training		90%	90%		90.0%	✓	▬		
8.6	Substantive Staff Turnover		14%	14%		11.4%	✓	▲		
8.7	FFT Response Rate Staff (Quarterly)		18%	18%	20.4%	19.8%	✓	▼	✓	

OBJECTIVES - OTHER										
ID	Indicator	DQ Assurance	Target 17-18	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
O.1	Total Number of NICE Breaches		8	8		55	✗	▼		
O.2	Rebooked cancelled OPs - 28 day rule		95%	95%	68.3%	40.0%	✗	▼	✗	
O.3	Maternity Bookings <13 weeks		90%	90%	88.0%	90.4%	✓	▲	✗	
O.4	Overdue Datix Incidents >1 month		0	0		57	✗	▼		
O.5	Serious Incidents		58	48	40	2	✓	▲	✓	
O.6	Dementia Measures Met ✎		3	3		3	✓	▬		
O.7	Energy Consumption (GJ)		200,684	164,780	197,795	22,308	✗	▲	✗	
O.8	Completed Job Plans (Consultants)		90%	90%		93%	✓	▲		

Key: Monthly/Quarterly Change

▲	Improvement in monthly / quarterly performance
▬	Monthly performance remains constant
▼	Deterioration in monthly / quarterly performance
	NHS Improvement target (as represented in the ID columns)
✎	Reported one month in arrears

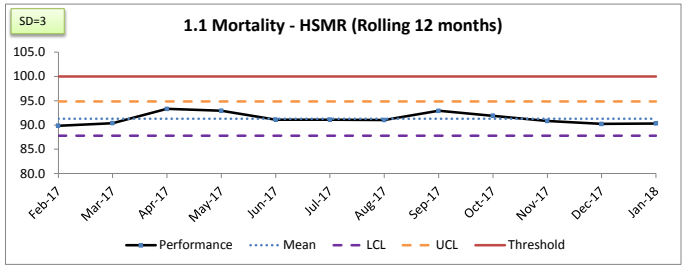
YTD Position

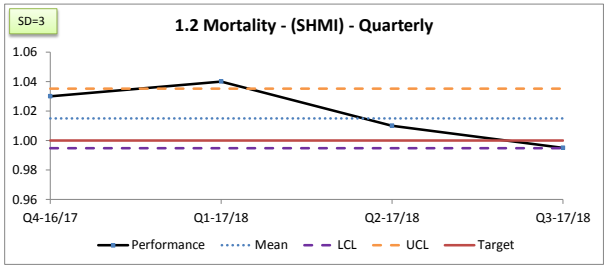
✓	Achieving YTD Target
	Within Agreed Tolerance*
✗	Not achieving YTD Target
✗	Annual Target breached

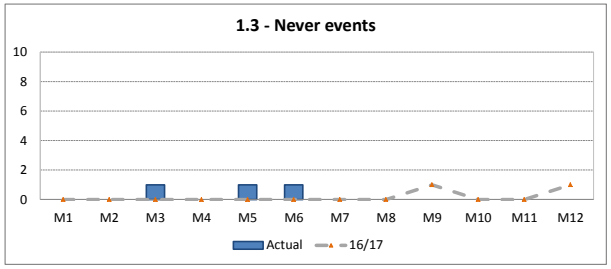
Data Quality Assurance Definitions

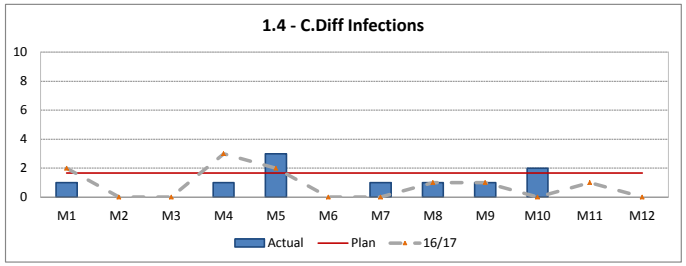
Rating	Data Quality Assurance
Green	Satisfactory and independently audited (indicator represents an accurate reflection of performance)
Amber	Acceptable levels of assurance but minor areas for improvement identified and potentially independently audited * /No Independent Assurance
Red	Unsatisfactory and potentially significant areas of improvement with/without independent audit

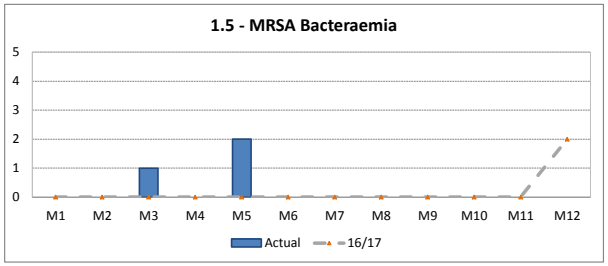
* Independently Audited – refers to an independent audit undertaken by either the Internal Auditor, External Auditors or the Data Quality Audit team.

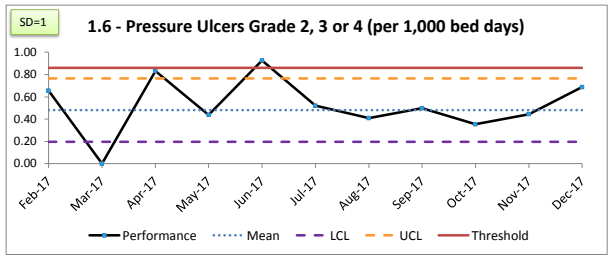


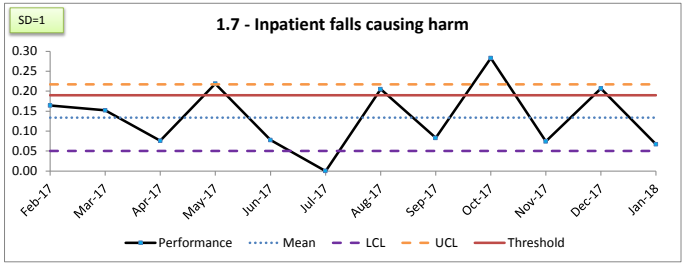


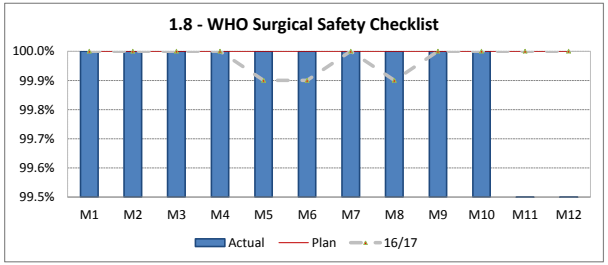


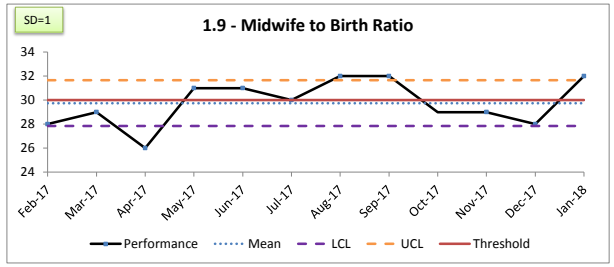


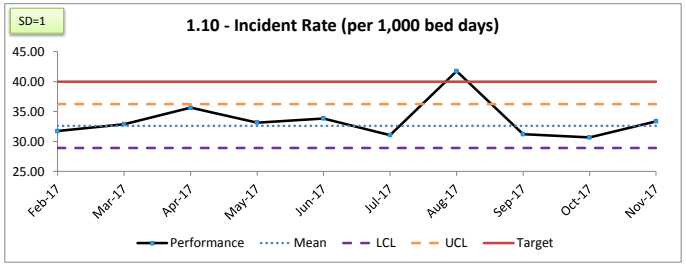


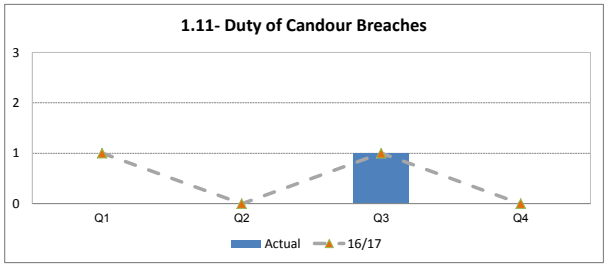


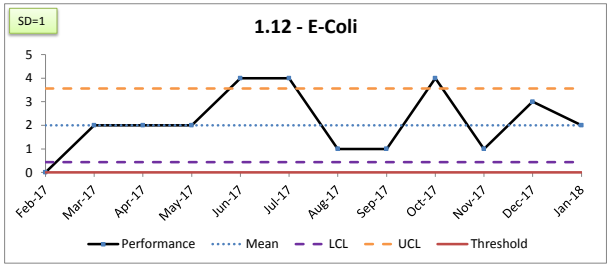












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- Average on a rolling 12 months/quarterly
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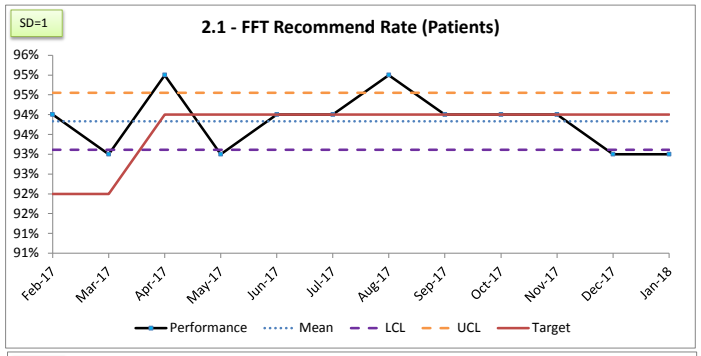
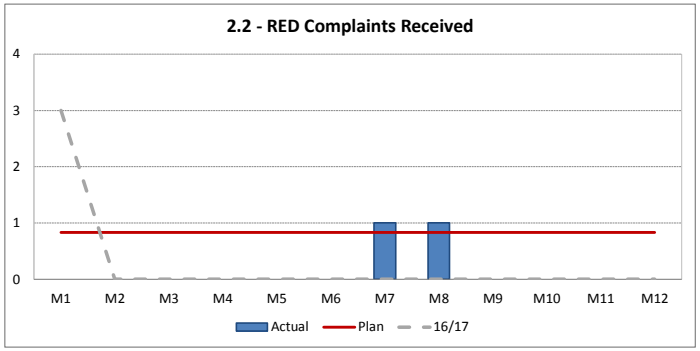
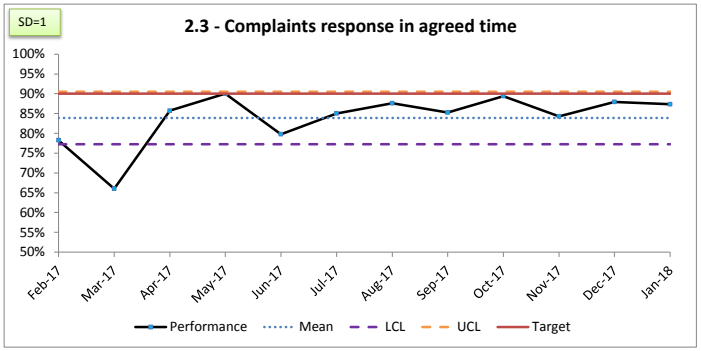
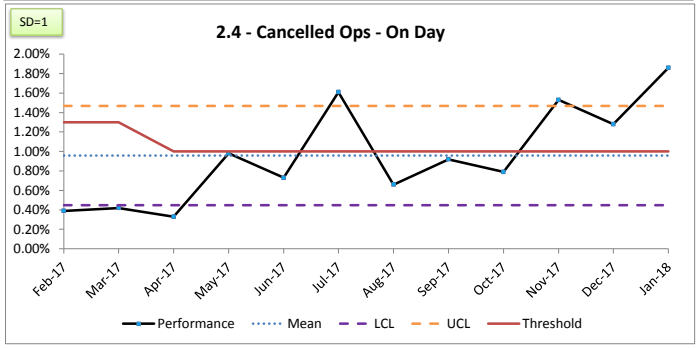
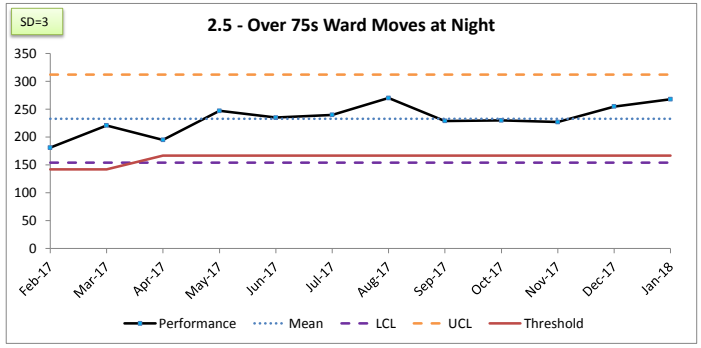
OBJECTIVE 2 - PATIENT EXPERIENCE

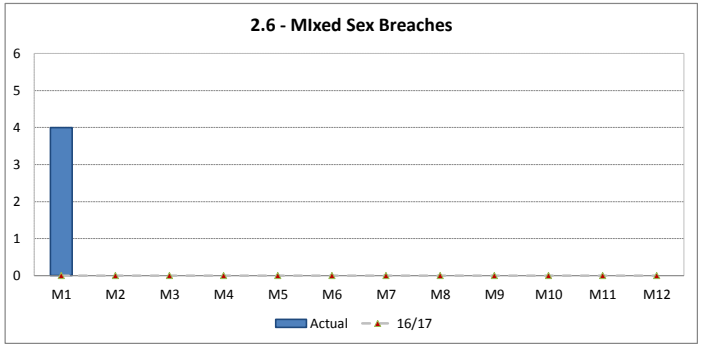












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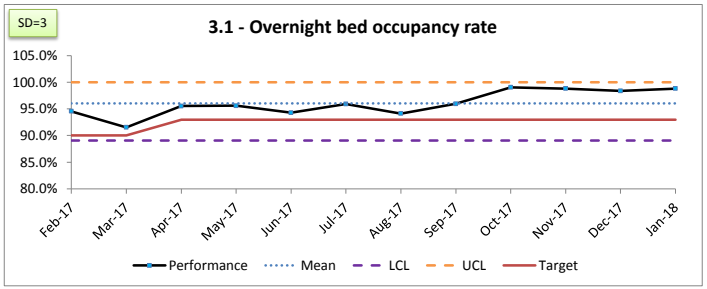
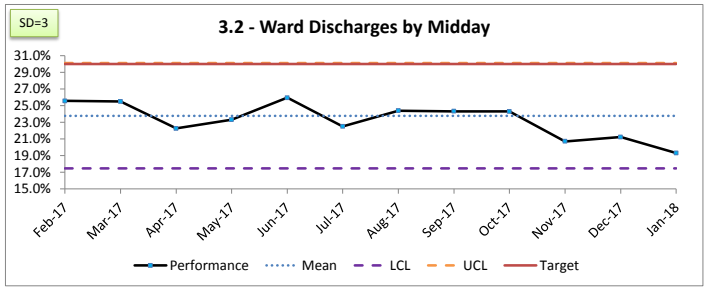
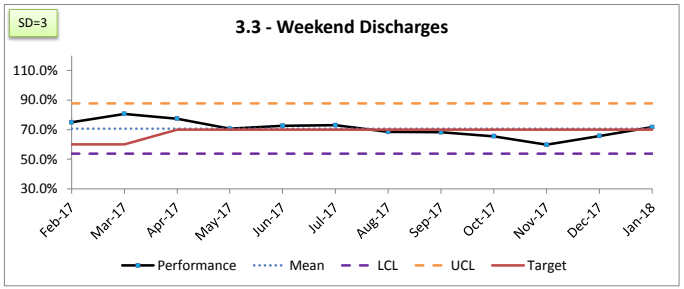
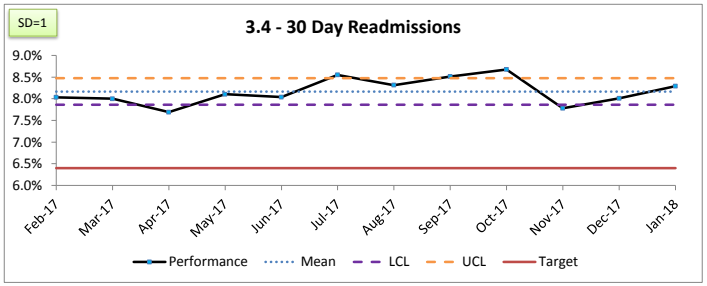
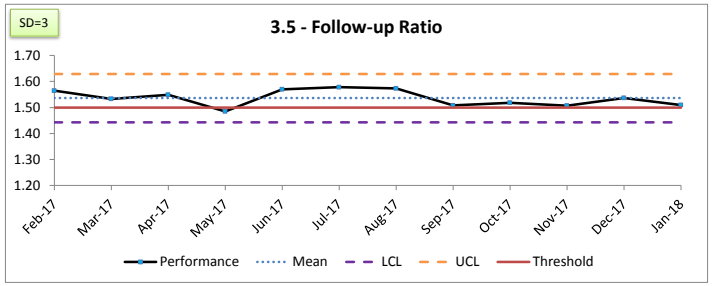
OBJECTIVE 3 - CLINICAL EFFECTIVENESS

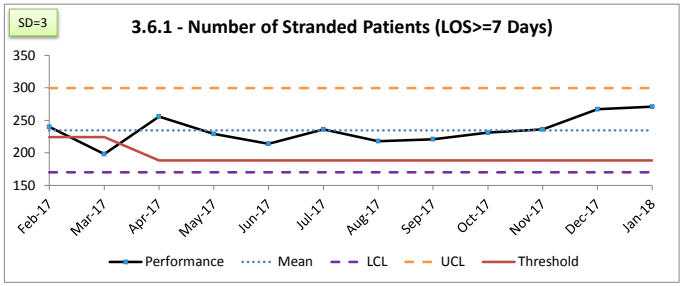


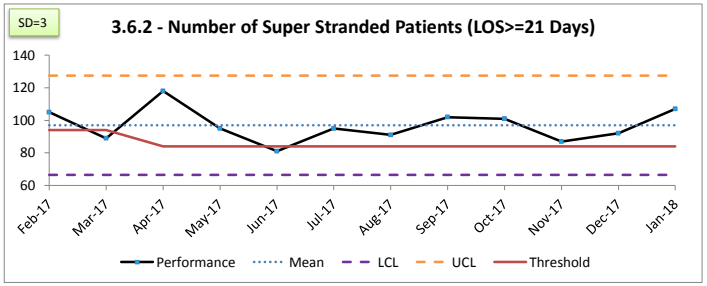


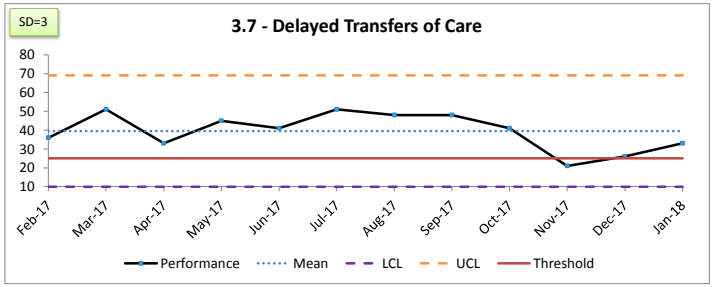


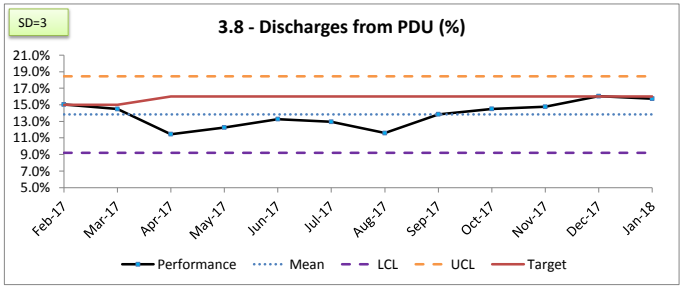


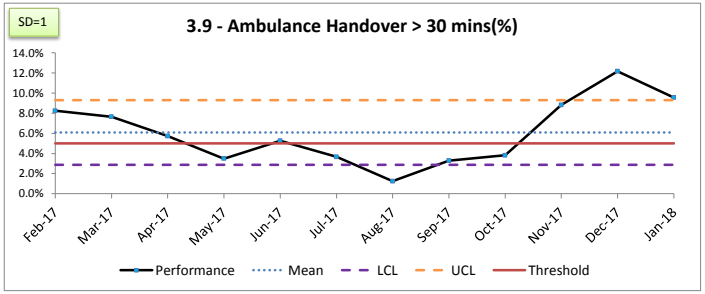












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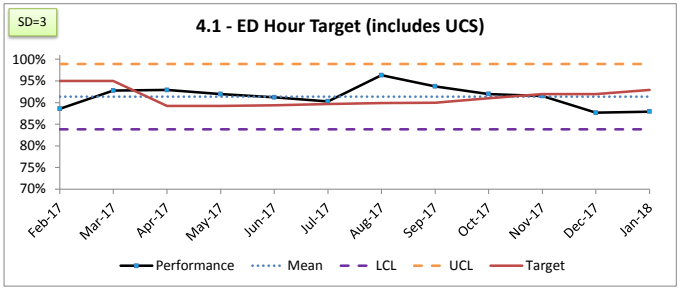
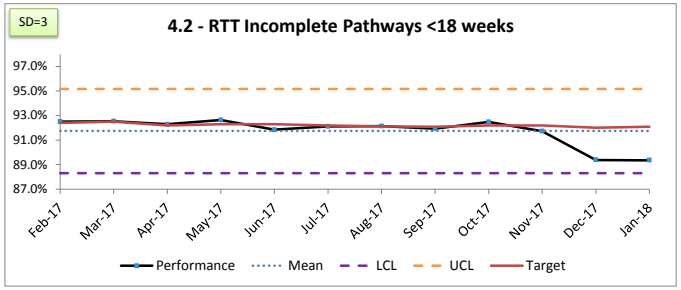
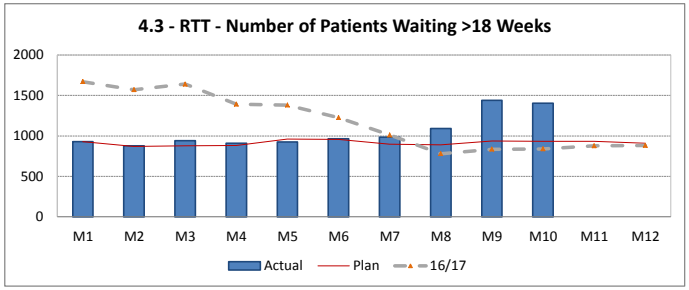
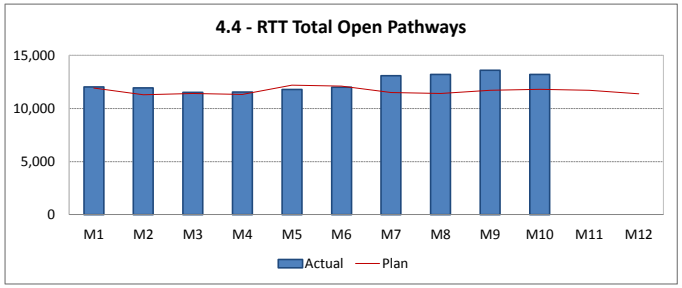
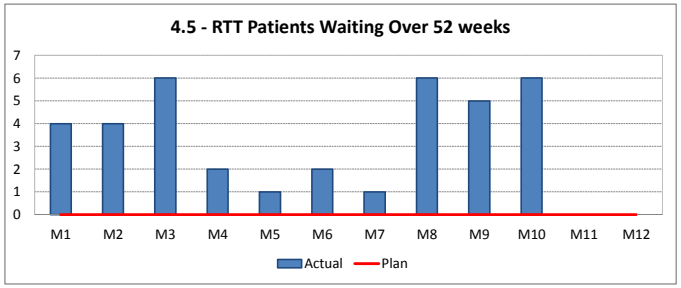
OBJECTIVE 4 - KEY TARGETS

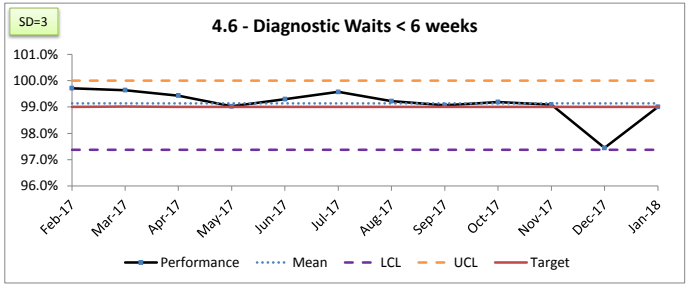


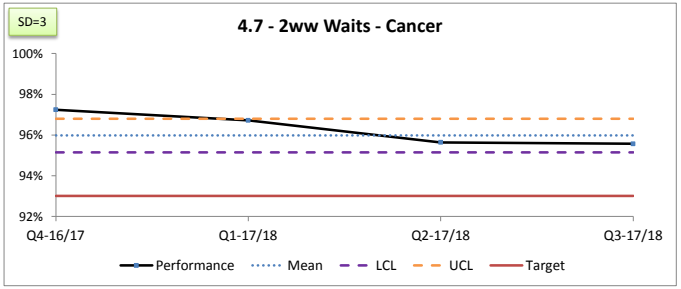


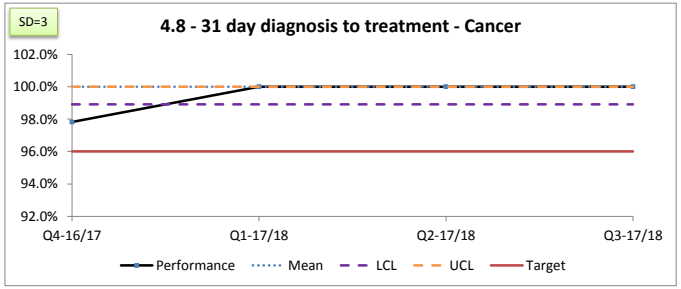


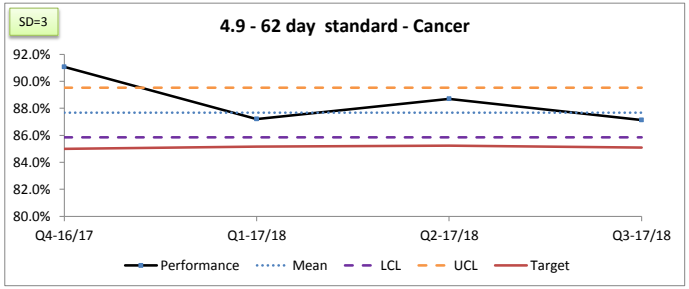












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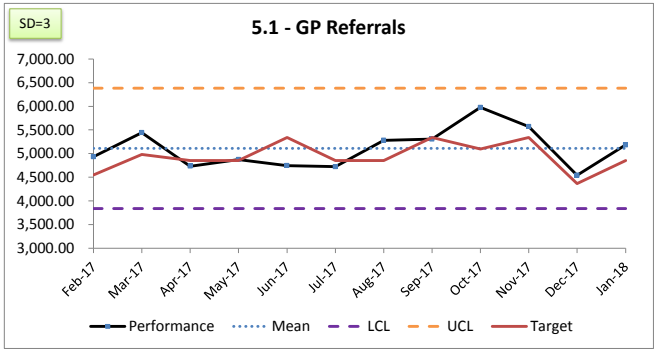

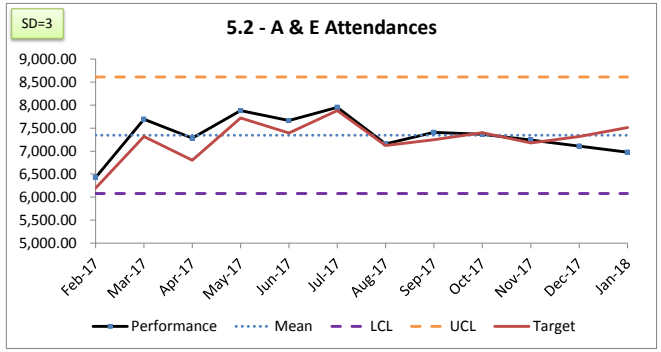

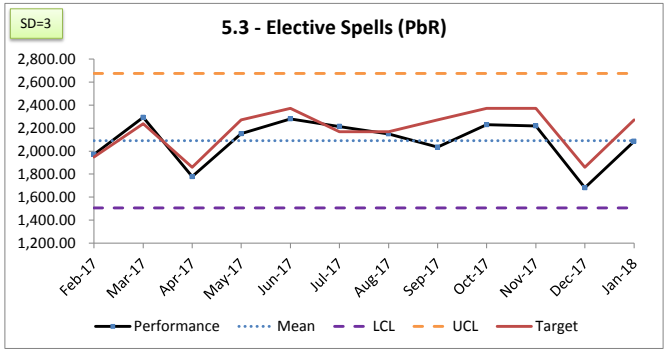

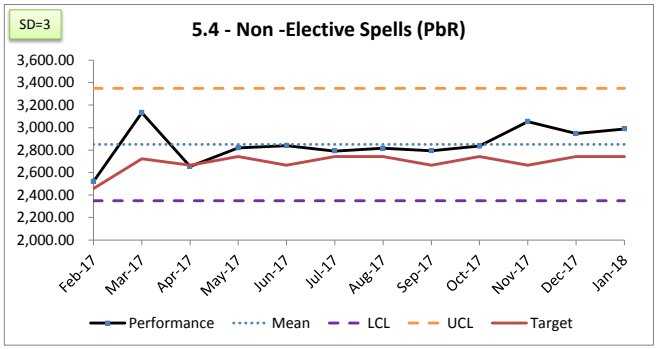

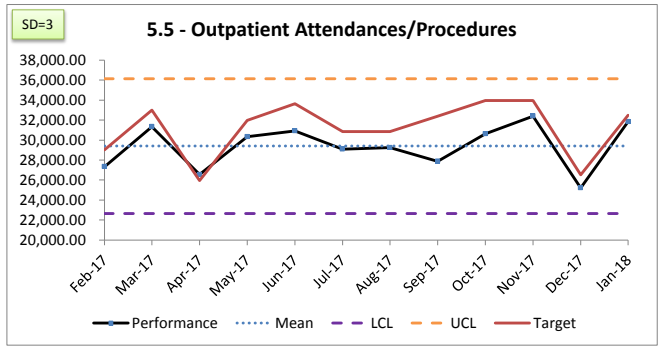

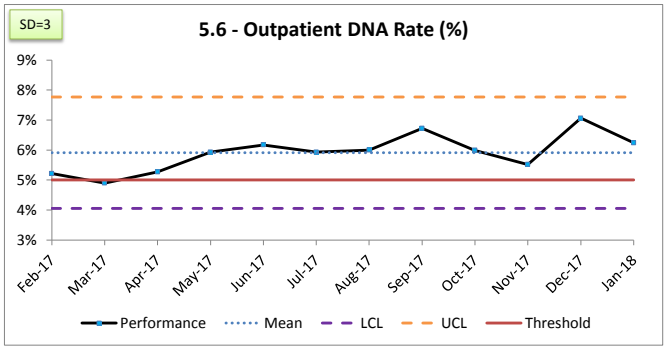

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- Performance activity on a rolling 12 months/quarterly
- Average on a rolling 12 months/quarterly
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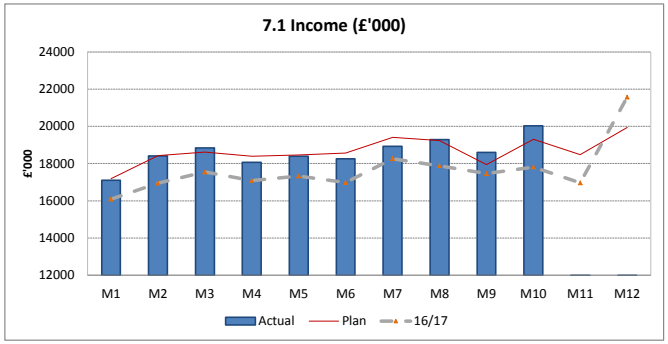
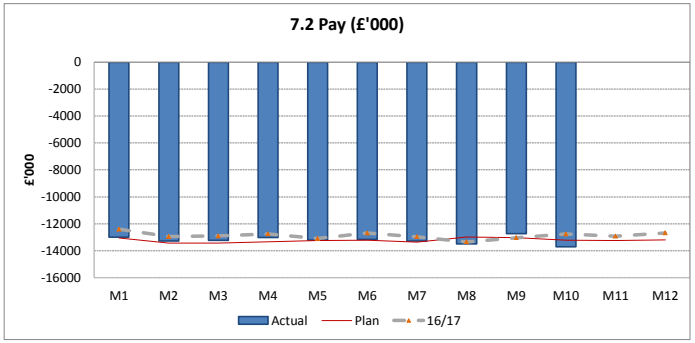
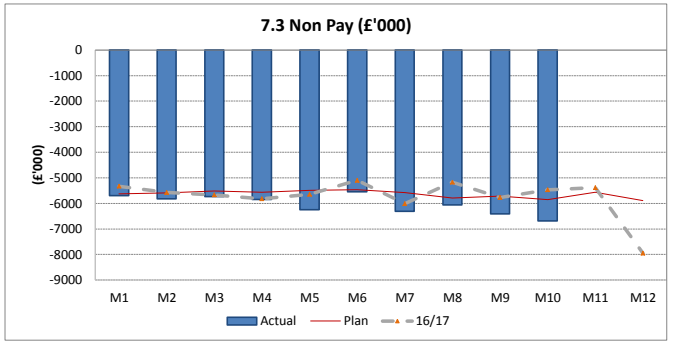
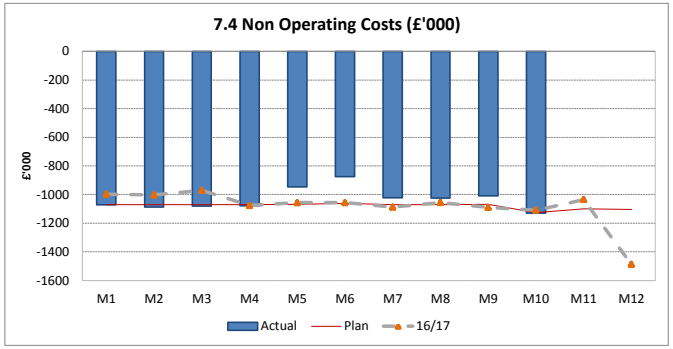
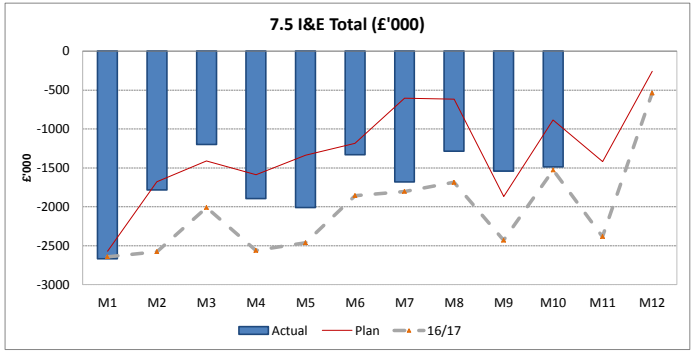
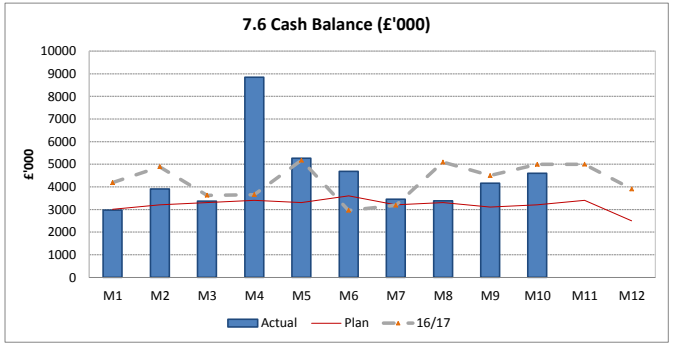

7.1 Income (£'000)
£'000
24000
22000
20000
18000
16000
14000
12000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
16/17

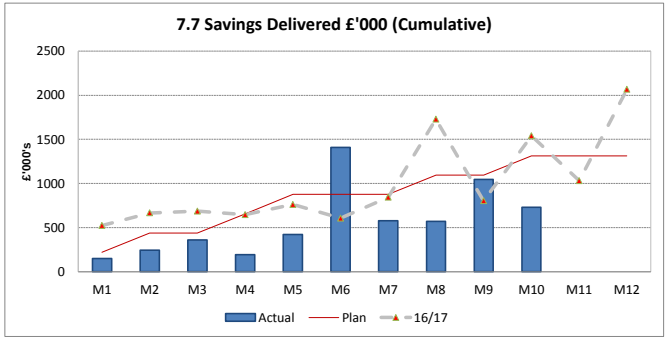

7.2 Pay (£'000)
£'000
0
-2000
-4000
-6000
-8000
-10000
-12000
-14000
-16000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
16/17

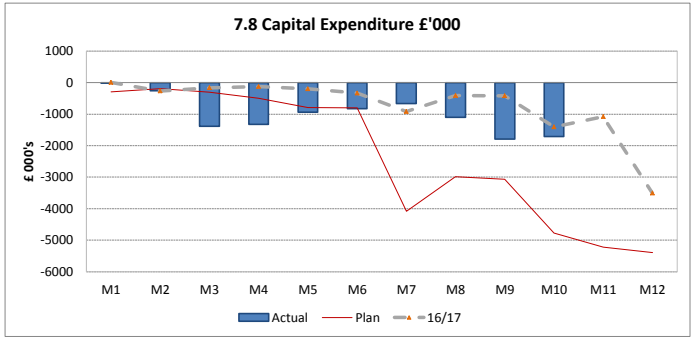

7.3 Non Pay (£'000)
(£'000)
0
-1000
-2000
-3000
-4000
-5000
-6000
-7000
-8000
-9000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
16/17


7.4 Non Operating Costs (£'000)
£'000
0
-200
-400
-600
-800
-1000
-1200
-1400
-1600
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
16/17

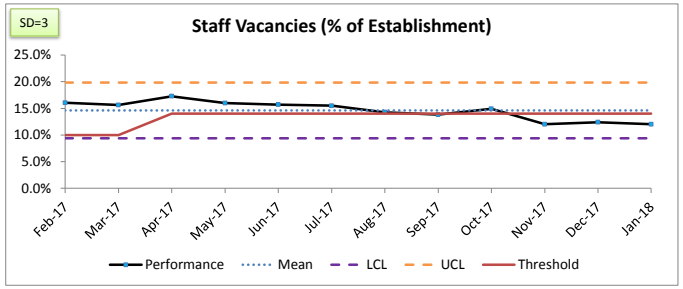

7.5 I&E Total (£'000)
£'000
0
-500
-1000
-1500
-2000
-2500
-3000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
16/17

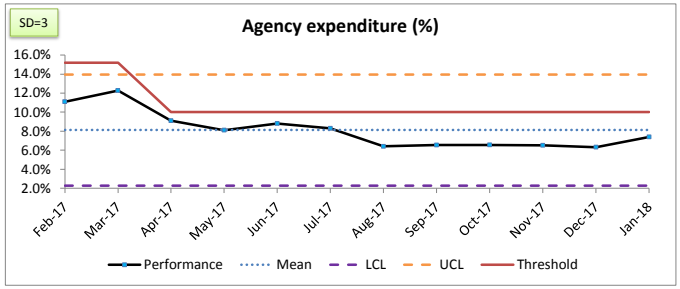

7.6 Cash Balance (£'000)
£'000
10000
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
16/17

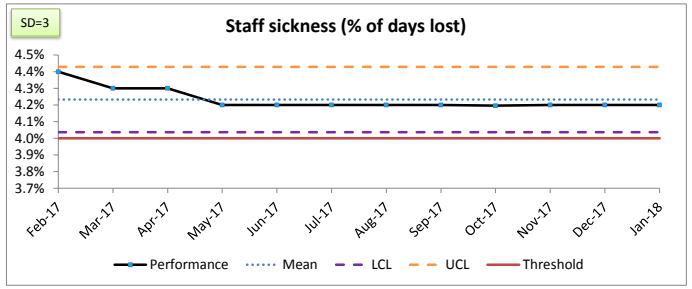

7.7 Savings Delivered £'000 (Cumulative)
£'000's
2500
2000
1500
1000
500
0
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
16/17

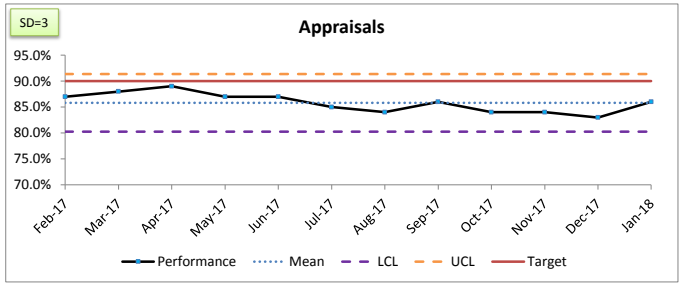

7.8 Capital Expenditure £'000
£'000's
1000
0
-1000
-2000
-3000
-4000
-5000
-6000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
16/17

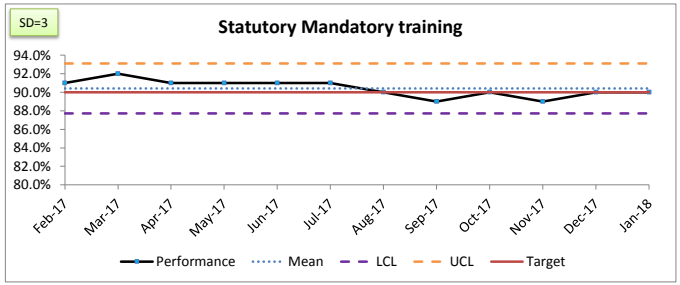
OBJECTIVE 8 - WORKFORCE PERFORMANCE

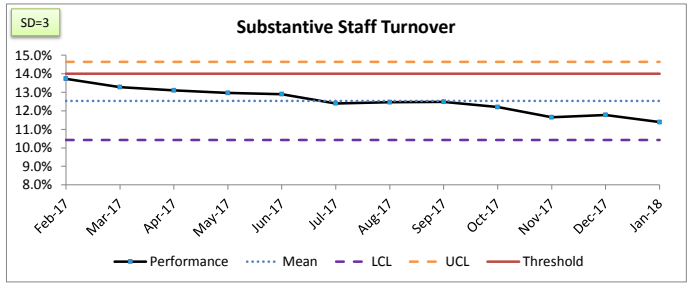


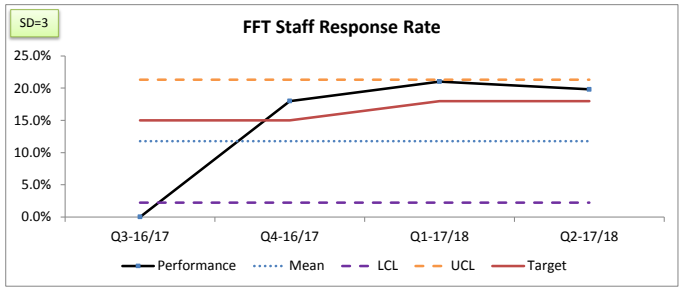












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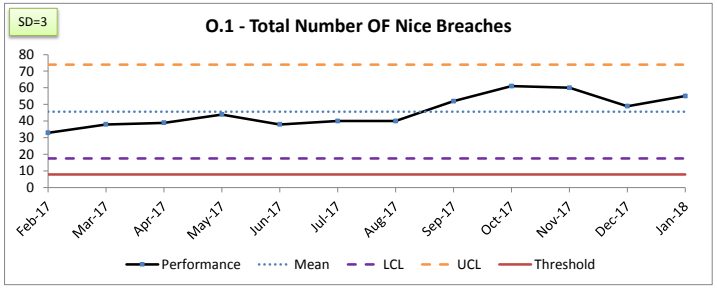

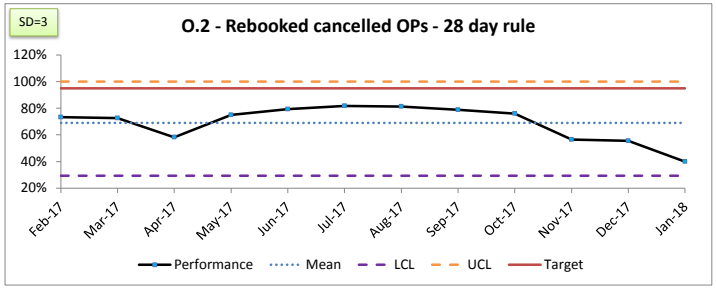

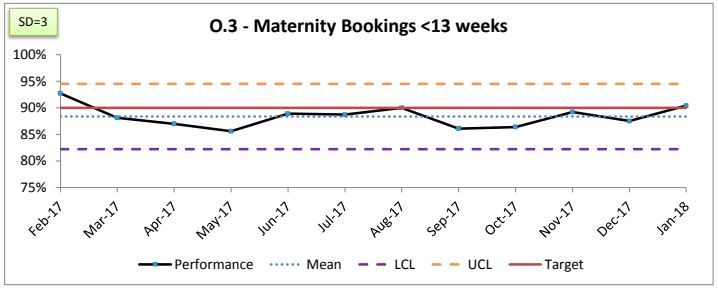

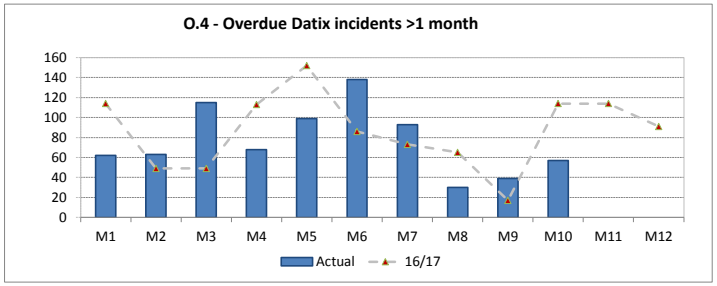

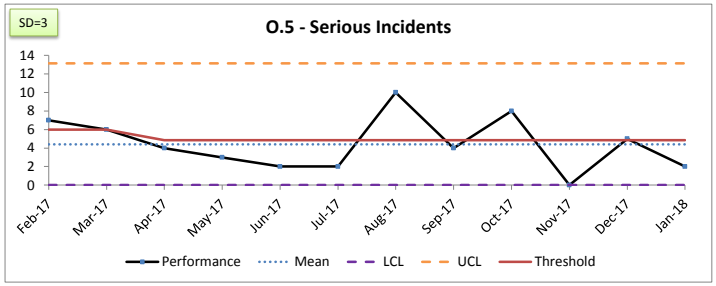

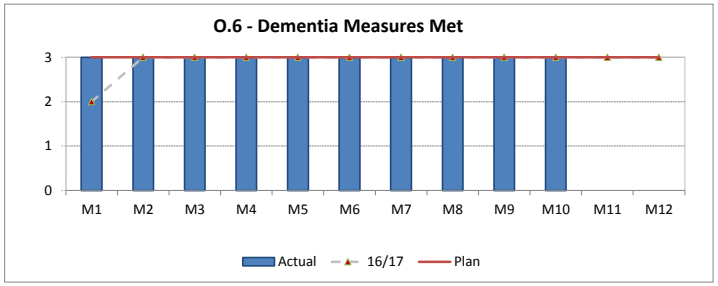

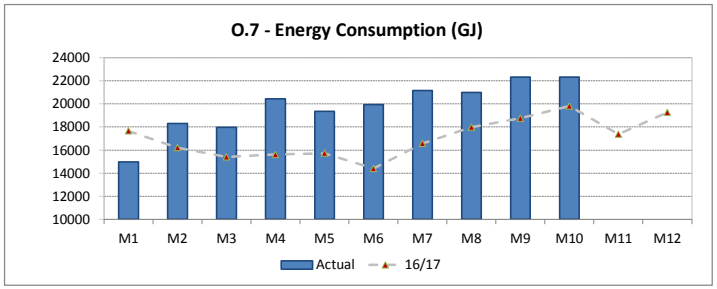

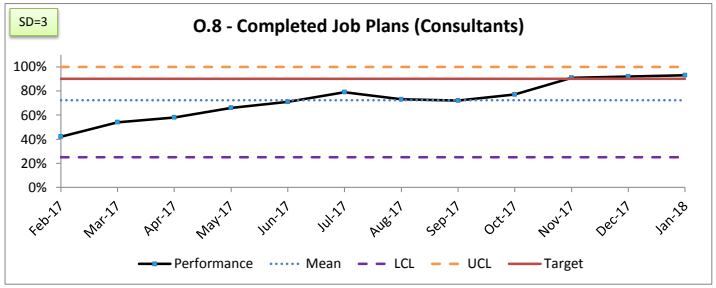

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- Performance activity on a rolling 12 months/quarterly
- Average on a rolling 12 months/quarterly
- Lower Control Limit (LCL)
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Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Public Board	Date: 9 March 2018
Report title:	Finance Paper Month 10 2017-18	Agenda item: 4.2
Lead director Report authors	Mike Keech Daphne Thomas Christopher Panes	Director of Finance Deputy Director of Finance Head of Management Accounts
FoI status:	Private document	

Report summary	An update on the financial position of the Trust at Month 10 (January 2018)			
Purpose *(tick one box only)*	Information ☐	Approval ☐	To note ☒	Decision ☐
Recommendation	Public Board to note the contents of the paper.			

Strategic objectives links	5. Developing a Sustainable Future 7. Become Well-Governed and Financially Viable 8. Improve Workforce Effectiveness
Board Assurance Framework links	
CQC outcome/ regulation links	Outcome 26: Financial position
Identified risks and risk management actions	
Resource implications	See paper for details
Legal implications including equality and diversity assessment	This paper has been assessed to ensure it meets the general equality duty as laid down by the Equality Act 2010

Report history	None
Next steps	None
Appendices	1 to 3

FINANCE REPORT FOR THE MONTH TO 31st JANUARY 2018

PUBLIC BOARD MEETING

PURPOSE

1. The purpose of the paper is to:

    - Present an update on the Trust's latest financial position covering income and expenditure; cash, capital and liquidity; NHSI financial risk rating; and cost savings; and
    - Provide assurance to the Board that actions are in place to address any areas where the Trust's financial performance is adversely behind plan at this stage of the financial year.

EXECUTIVE SUMMARY

2. *Income and expenditure* –The Trust's deficit for January 2018 was £1.5m which is £0.6m adverse to plan and £0.2m adverse to the control total in month. Year to date the Trust is £3.2m adverse to plan and £0.2m adverse to its control total.

3. *Cash and capital position* – the cash balance as at the end of January 2018 was £4.6m, which was £1.4m above plan. This was mainly due to the late notice receipt of income from CCGs for in-year over-performance and timing of capital expenditure. The Trust has spent £10.0 on capital year to date of which £4.6m relates to EPR.

4. *NHSI rating* – the Use of Resources rating (UOR) score is '3', which is in line with Plan, with '4' being the lowest scoring.

5. *Cost savings* – overall savings of £0.7m were delivered in month against an identified plan of £0.8m. Overall £8.3m of plans has been identified and validated against a £10.5m target.

INCOME AND EXPENDITURE

6. The headline financial position can be summarised as follows:

All Figures in £'000	Month Plan	Month Actual	Month Var	YTD Plan	YTD Actual	YTD Var	Full Year Plan	Full Year Forecast	Full Year Var
Clinical Revenue	16,162	17,001	839	162,129	163,053	924	194,357	196,984	2,627
Other Revenue	1,839	2,108	269	15,040	17,201	2,161	18,310	19,219	909
Total Income	18,001	19,109	1,108	177,169	180,254	3,085	212,667	216,203	3,536
Pay	(13,260)	(13,706)	(446)	(132,585)	(132,130)	455	(158,813)	(159,813)	(1,000)
Non Pay	(5,851)	(6,688)	(837)	(56,175)	(60,388)	(4,214)	(67,625)	(70,806)	(3,181)
Total Operational Expend	(19,111)	(20,394)	(1,283)	(188,759)	(192,518)	(3,759)	(226,438)	(230,619)	(4,181)
EBITDA	(1,109)	(1,285)	(175)	(11,591)	(12,264)	(673)	(13,772)	(14,416)	(644)
Financing & Non-Op. Costs	(1,077)	(1,075)	1	(10,256)	(9,778)	480	(12,354)	(11,708)	646
Operational net Surplus/(Deficit)	**(2,186)**	**(2,360)**	**(174)**	**(21,847)**	**(22,042)**	**(194)**	**(26,125)**	**(26,124)**	**1**
Adjustments to reach control total:									
Performance STF	256	256	0	1,764	1,764	0	2,190	2,190	0
Financial STF	596	596	0	3,833	3,833	0	5,110	5,110	0
CT Rounding	0	0	0	(36)	0	36	(23)	(4)	19
Control Total Deficit (incl. STF)	**(1,334)**	**(1,508)**	**(174)**	**(16,286)**	**(16,445)**	**(158)**	**(18,848)**	**(18,828)**	**20**
Donated income	500	75	(425)	3,000	75	(2,925)	4,000	4,000	0
Donated asset depreciation	(50)	(55)	(5)	(495)	(549)	(54)	(600)	(659)	(59)
CT Rounding	0	0	0	36	0	(36)	23	4	(19)
Reported deficit	**(884)**	**(1,488)**	**(604)**	**(13,745)**	**(16,919)**	**(3,173)**	**(15,425)**	**(15,483)**	**(58)**

Monthly and year to date review

7. The **deficit** in month 10 is £1,488k which is £604k adverse against a planned deficit of £884k and £3,174k adverse year to date (YTD) against a planned deficit of £13,745k. However on a control total basis the Trust is £168k adverse in the month and £158k adverse YTD (with the difference substantially relating to donations for the cancer centre which are planned and not yet received but which do not form part of the Trust's control total).

   Income was above Plan in the month due to higher levels of non-elective income combined with a recovery in outpatient, maternity income and receipt of winter funding.

8. **Operational costs** in January are adverse to plan by £1,283k and adverse £3,759k YTD.

9. **Pay costs** are £446k adverse to budget in Month 10 and £455k favourable YTD. Positive variance on agency and locum is offset by higher substantive and bank expenditure.

   Substantive costs have increased from month 9 and remain at a high level. The increase over the prior run rates due to initiatives to reduce agency and is in part due to payment of additional hours of current staff to limit the use of agency.

10. **Non pay costs** were £837k adverse to plan in month and £4,214k YTD to support higher than Plan activity levels including high costs drugs, one-off costs relating to unbudgeted increases in rates and undelivered budgeted cost savings.

11. **Non-operational costs** are £4k negative in month and £425k positive YTD (due to lower than budgeted interest costs).

    Further analysis of the income and costs can be found in Appendix 1 - Statement of Comprehensive Income & Expenditure

FORECAST PERFORMANCE

12. The Trust is forecasting to meet its full year Plan however there is a significant risk around achievement of the A&E performance element of STF funding for Q4 (total of £768k) due to the requirement to meet the 95% A&E 4 hour wait target for the month of March. Other significant risks relate to cost savings achievement and contract challenges from commissioners.

COST SAVINGS

13. In Month 10, £730k was delivered against an identified plan of £834k and £5,697k of an identified plan of £6,634k YTD.

14. YTD £5,697k has been delivered against a budgeted target of £7,875k leaving a variance of £2,178. £8.3m of plans have been identified against a target of £10.5m which represents a risk to delivering the full year Plan as noted above.

CASH AND CAPITAL

15. The cash balance at the end of January 2018 was £4.6m, which was £1.4m above plan. This was mainly due to the late receipt of income from CCG's for in year over-performance and timing of capital expenditure. The details of the Trust's current loans are shown below. The Trust is still waiting for a decision from DH in respect of the revenue loan due for repayment in March 2018.

16. The **statement of financial position** is set out in Appendix 3. The main movements and variance to plan can be summarised as follows:

    - Current assets are above plan by £7.4m. The main variance relates to receivables £5.5m, inventories £0.5m and cash £1.4m above plan.

    - Current liabilities are above plan by £39.6m. This is being driven by the re-categorisation of part of the NHSI loan from non-current to current borrowings £31.2m, Deferred Income £0.8m and Trade and Other Creditors £7.7m above plan offset by provisions £0.1m

17. The Trust has spent a total of £10m on capital year to date of which £4.6m relates to EPR. Capital spend is £7.7m behind plan due principally to:

    - The timing of the cancer centre build which has been delayed due to issues with the original P21 partner achieving Guaranteed Maximum Price (GMP); and

    - Delays to the pharmacy robot and aseptic suite projects due to lack of requested funding from DH.

18. Funding of £4.8m has now been confirmed by NHSI for the ECare programme.

RISK REGISTER

19. The following items represent the finance risks on the Board Assurance Framework and a brief update of their current position:

a) Continued DH cash funding is insufficient to meet the planned requirements of the organisation.

Funding to cover the planned financial deficit in 2017/18 is subject to approval by DH on a monthly basis. The overall funding risk has reduced somewhat compared to previous reports due to the recent confirmation of capital funding of £4.8m noted above.

b) The Trust is unable to achieve the required levels of financial efficiency within the Transformation Programme.

The Trust has a challenging target of £10.5m to deliver for the 2017-18 financial year. At month 10 the Trust is behind plan on delivery, but is working to accelerating scheme identification.

c) The Trust is unable to keep to affordable levels of agency (and locum) staffing.

The Trust has an annual agency ceiling of £15.12m in 2017-18 which is in line with the level included in the financial plan. At month 10, the Trust's spend is favourable to planned levels and is forecast to achieve the full year target, however in month Agency has increased.

d) The Trust is unable to access £7.3m of Sustainability & Transformation Funding.

In order to receive the full amount of Sustainability and Transformation funding in 2017-18, the Trust needs to achieve its financial control total (linked to 70% of funding), and meet performance standards in respect of urgent and emergency care (linked to 30% of funding). The targets are measured on a quarterly basis. The Trust met its requirements for quarter 1, 2 and 3 but meeting the target for Q3 as noted above is at significant risk.

e) Main commissioner is unable to pay for the volume of activity undertaken by the Trust.

If the Trust over performs against the contract this places financial pressure on the Trust's commissioners who are more likely to challenge other areas in the contract such as the application of penalties. A significant level of contract challenges have been raised by commissioners in particular with the new (more stringent) process for authorisation of Procedures of Limited Clinical Value (PoLCV) and this represents a further risk to achieving the financial plan.

RECOMMENDATIONS TO THE BOARD

20. Public Board is asked to note the financial position of the Trust as at 31st January 2018 and the proposed actions and risks therein.

Appendix 1

Milton Keynes Hospital NHS Foundation Trust
Statement of Comprehensive Income
For the period ending 31st January 2018

	January 2018			10 months to January 2018			Full year
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME							
Outpatients	3,724	3,733	9	35,012	33,280	(1,732)	42,277
Elective admissions	2,713	1,933	(780)	24,592	22,355	(2,237)	29,654
Emergency admissions	4,753	5,429	676	46,889	51,375	4,486	56,021
Emergency adm's marginal rate (MRET)	(112)	(310)	(198)	(1,101)	(2,424)	(1,323)	(1,314)
Readmissions Penalty	(103)	(107)	(4)	(1,013)	(2,396)	(1,383)	(1,208)
A&E	1,087	1,064	(23)	10,639	10,671	32	12,919
Maternity	1,921	1,893	(28)	19,080	18,142	(938)	22,825
Critical Care & Neonatal	578	580	2	5,711	5,057	(654)	6,814
Excess bed days	0	0	0	0	0	0	0
Imaging	357	765	408	3,456	3,523	68	4,171
Direct access Pathology	434	406	(29)	4,001	3,756	(246)	4,801
Non Tariff Drugs (high cost/individual drugs)	1,035	1,391	356	10,219	12,606	2,386	12,190
Other	(227)	224	451	4,644	7,108	2,464	5,512
Clinical Income	**16,162**	**17,001**	**838**	**162,129**	**163,053**	**924**	**194,663**
Non-Patient Income	**3,191**	**3,035**	**(156)**	**23,637**	**22,873**	**(763)**	**29,610**
TOTAL INCOME	**19,353**	**20,036**	**682**	**185,766**	**185,926**	**160**	**224,273**
EXPENDITURE							
Total Pay	**(13,260)**	**(13,706)**	**(446)**	**(132,585)**	**(132,130)**	**455**	**(159,120)**
Non Pay	(4,815)	(5,297)	(481)	(45,955)	(47,783)	(1,827)	(55,435)
Non Tariff Drugs (high cost/individual drugs)	(1,035)	(1,391)	(356)	(10,219)	(12,606)	(2,386)	(12,190)
Non Pay	**(5,851)**	**(6,688)**	**(837)**	**(56,175)**	**(60,388)**	**(4,214)**	**(67,625)**
TOTAL EXPENDITURE	**(19,111)**	**(20,394)**	**(1,283)**	**(188,759)**	**(192,518)**	**(3,759)**	**(226,745)**
EBITDA*	**243**	**(359)**	**(601)**	**(2,994)**	**(6,592)**	**(3,597)**	**(2,472)**
Depreciation and non-operating costs	(989)	(989)	0	(9,380)	(8,940)	440	(11,308)
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**(747)**	**(1,348)**	**(601)**	**(12,373)**	**(15,533)**	**(3,159)**	**(13,779)**
Public Dividends Payable	(137)	(141)	(4)	(1,372)	(1,387)	(15)	(1,646)
OPERATING DEFICIT AFTER DIVIDENDS	**(884)**	**(1,488)**	**(604)**	**(13,745)**	**(16,920)**	**(3,174)**	**(15,425)**
Adjustments to reach control total							
Deferred Income	(500)	-75	425	(3,000)	-75	2,925	(4,000)
Donated Assets Depreciation	50	55	5	495	549	54	600
Control Total Rounding	0	0	0	-36	0	36	0
CONTROL TOTAL DEFECIT	**(1,334)**	**(1,508)**	**(174)**	**(16,286)**	**(16,446)**	**(159)**	**(18,825)**

* EBITDA = Earnings before Interest, Taxation, Depreciation and Amortisation

Milton Keynes Hospital NHS Foundation Trust
Statement of Cash Flow
As at 31st January 2018

	Mth 10 £000	Mth 9 £000	In Month Movement £000
Cash flows from operating activities			
Operating (deficit) from continuing operations	(13,759)	(12,606)	(1,153)
Operating surplus/(deficit) of discontinued operations			
Operating (deficit)	**(13,759)**	**(12,606)**	**(1,153)**
Non-cash income and expense:			
Depreciation and amortisation	7,449	6,653	796
(Increase)/Decrease in Trade and Other Receivables	(277)	1,241	(1,518)
(Increase)/Decrease in Inventories	(18)	(6)	(12)
Increase/(Decrease) in Trade and Other Payables	333	1,142	(809)
Increase/(Decrease) in Other Liabilities	606	282	324
Increase/(Decrease) in Provisions	(1,178)	(1,166)	(12)
Other movements in operating cash flows	(3)	(4)	1
NET CASH GENERATED FROM OPERATIONS	**(6,875)**	**(4,464)**	**(2,411)**
Cash flows from investing activities			
Interest received	13	11	2
Purchase of Property, Plant and Equipment, Intangibles	(6,187)	(4,713)	(1,474)
Net cash generated (used in) investing activities	**(6,174)**	**(4,702)**	**(1,472)**
Cash flows from financing activities			
Public dividend capital received	700	600	100
Loans received from Department of Health	16,200	11,795	4,405
Loans repaid to Department of Health	(636)	(636)	0
Capital element of finance lease rental payments	(135)	(121)	(14)
Interest paid	(1,201)	(1,060)	(141)
Interest element of finance lease	(275)	(248)	(27)
PDC Dividend paid	(913)	(913)	0
Net cash generated from/(used in) financing activities	**13,740**	**9,417**	**4,323**
Increase/(decrease) in cash and cash equivalents	**691**	**251**	440
Opening Cash and Cash equivalents	**3,906**	**3,906**	
Cash and Cash equivalents at start of period for new FTs			
Cash and Cash equivalents changes due to transfers by absorption			
Closing Cash and Cash equivalents	**4,597**	**4,157**	**440**

Milton Keynes Hospital NHS Foundation Trust
Statement of Financial Position as at 31st January 2018

	Audited Mar-17	Jan-18 FY17 Plan	Jan-18 FY17 Actual	In Mth Mvmt	YTD Mvmt	% Variance
Assets Non-Current						
Tangible Assets	160.4	162.4	159.3	(3.1)	(1.1)	(0.7%)
Intangible Assets	5.7	9.3	9.3	0.0	3.6	62.5%
Other Assets	0.3	0.3	0.5	0.2	0.2	70.5%
Total Non Current Assets	**166.4**	**172.0**	**169.1**	**(2.9)**	**2.7**	**1.6%**
Assets Current						
Inventory	3.0	2.6	3.1	0.5	0.0	0.2%
NHS Receivables	16.6	11.9	14.5	2.6	(2.1)	(12.5%)
Other Receivables	3.2	2.5	5.4	2.9	2.2	69.9%
Cash	3.9	3.2	4.6	1.4	0.7	17.8%
Total Current Assets	**26.7**	**20.2**	**27.6**	**7.4**	**0.9**	**3.2%**
Liabilities Current						
Interest -bearing borrowings	(32.2)	(1.0)	(32.2)	(31.2)	(0.0)	0.1%
Deferred Income	(1.6)	(1.5)	(2.2)	(0.8)	(0.6)	35.5%
Provisions	(3.1)	(2.0)	(1.9)	0.1	1.2	-38.5%
Trade & other Creditors (incl NHS)	(15.5)	(23.1)	(30.8)	(7.7)	(15.3)	98.7%
Total Current Liabilities	**(52.4)**	**(27.6)**	**(67.1)**	**(39.5)**	**(14.7)**	28.1%
Net current assets	**(25.7)**	**(7.4)**	**(39.6)**	**(32.2)**	**(13.9)**	**54.1%**
Liabilities Non-Current						
Long-term Interest bearing borrowings	(55.0)	(116.7)	(76.6)	40.1	(21.6)	39.4%
Provisions for liabilities and charges	(0.9)	(0.8)	(0.9)	(0.1)	0.0	0.0%
Total non-current liabilities	**(55.9)**	**(117.5)**	**(77.5)**	**40.0**	**(21.6)**	38.7%
Total Assets Employed	**84.8**	**47.1**	**52.0**	**5.0**	**(32.8)**	**(38.7%)**
Taxpayers Equity						
Public Dividend Capital (PDC)	96.1	96.2	96.9	0.7	0.8	0.8%
Revaluation Reserve	70.6	64.9	70.6	5.6	(0.1)	-0.1%
I&E Reserve	(98.8)	(114.1)	(115.5)	(1.4)	(16.7)	16.9%
Total Taxpayers Equity	**67.9**	**47.0**	**52.0**	**4.9**	**(16.0)**	**(23.5%)**

Meeting title	**Trust Board**	**Date: 9 March 2018**
Report title:	**Corporate Workforce Information Monthly Report**	**Agenda item:** 4.3
Lead director **Report author**	**Name: Ogechi Emeadi** **Name: Andrew Harris**	**Title: Director of Workforce** **Title: Workforce Information Analyst**
FoI status:		

Report summary	This report provides a summary of key workforce key performance indicators for the full year ending 31 November 2018. Detailed quarterly workforce information reports are also submitted to, and discussed at, workforce assurance and development committee, including all sections within the monthly report but with further splits by; clinical division, age profiling by staff group, divisional sickness absence and employee relations case management date.			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** x	**Decision** ☐
Recommendation	*Recommended Board Actions:* Take note of the first monthly corporate workforce information report.			

Strategic objectives links	8. Workforce effectiveness
Board Assurance Framework links	
CQC outcome/ regulation links	Well led, outcome 13: staffing
Identified risks and risk management actions	1606 - IF we are unable to recruit sufficient numbers of qualified nurses THEN we may be unable to provide staffing levels as we would wish LEADING TO reduction in patient experience and clinical risk. 1608 - IF there is inability for employees to undergo a well-structured appraisal THEN they will not have a development plan and a review of their performance LEADING TO the inability to meet CCG Target which is 90% 1609 - IF staff are unable to remain compliant in all aspects of mandatory training linked to their job requirements THEN staff may not have the knowledge and skills required for their role LEADING potential patient/staff safety risk and inability to meet CCG compliance target for 2015-2016 of 90% 1613 - IF there is inability to retain staff employed in critical posts THEN we may not be able to provide safe workforce cover LEADING TO clinical risk.
Resource implications	
Legal	

implications including equality and diversity assessment	

Report history	None
Next steps	
Appendices	Appendix to ‘Corporate Monthly Workforce Information report’ provides further definition as to job roles within staff group descriptors.

Corporate Workforce Information

Monthly Report

Month 10 – January 2018

Reported in February 2018

Workforce Planning Manager and Workforce Information Analyst

1.1 Introduction

This information provides a summary of the key workforce information for the Trust for the full year ending 31st January 2018 unless otherwise stated.

The data summarised in this report was extracted from the Electronic Staff Record System (ESR) unless otherwise stated. The staff groups referred to are those defined in the national Occupational Code Manual.

This report is the first monthly report and presents a selection of key workforce indicators and information from the full range included in the quarterly report.

The quarterly report is routinely presented at workforce board, management board, JCNC and workforce and development assurance committee, for assurance purposes.

1.2 Overview

Workforce Report Summary:

Indicator	Measure	31/03/2017	30/06/2017	30/09/2017	30/11/2017	31/01/2018	Section Page No.
Staff in post (as at report date)	WTE	2901.3	2935.7	2950.1	2990.1	**2018.8**	***3***
	Headcount	3370	3406	3415	3455	**3496**	
Staff Costs (12 months)	%, Temp Staff Cost	17.9%	17.5%	17.1%	16.6%	**16.1%**	***4***
	%, Temp Staff Usage	14.5%	14.6%	14.8%	14.9%	**14.7%**	
Absence (12 months)	%, Absence Rate	4.2%	4.2%	4.2%	4.2%	**4.1%**	***5***
	- %, Absence Rate - Long Term	2.4%	2.3%	2.4%	2.4%	**2.3%**	
	- %, Absence Rate - Short Term	1.8%	1.9%	1.8%	1.8%	**1.8%**	
Starters, Leavers and T/O rate (12 months)	WTE, Starters	377.6	370.0	369.7	372.1	**359.7**	***7***
	Headcount, Starters	429	417	420	426	**409**	
	WTE, Leavers	359.5	348.3	339.4	315.1	**309.4**	
	Headcount, Leavers	416	404	397	371	**365**	
	%, Leaver Turnover Rate	13.3%	12.9%	12.5%	11.6%	**11.6%**	
Statutory/Mandatory Training	%, Compliance	91%	91%	89%	89%	**90%**	***9***
Appraisals	%, Compliance	88%	87%	86%	84%	**86%**	***10***
Appendix	Professional, Scientific and Support Staff						***11***

2 Staff in Post

The Trust's staff in post (excluding bank and locums):

Milton Keynes University Hospital NHS FT	Jan 2017	Jan 2018	Increase
WTE	2873.9	**3018.8**	144.9
Headcount	3348	**3496**	148

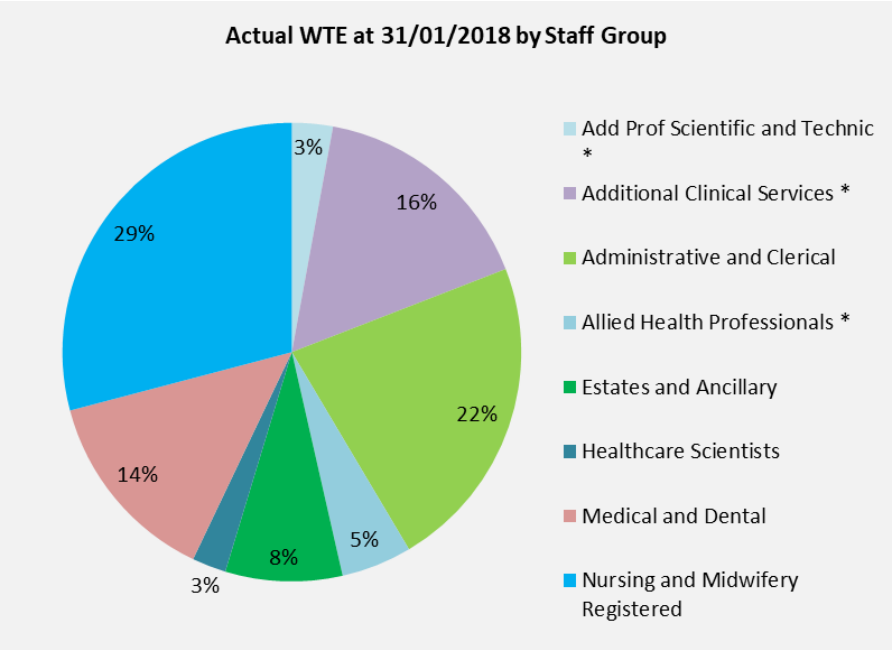
The Trust's staff in post has increased over the last two years as follows:

Milton Keynes University Hospital NHS FT	Jan 2016	Apr 2016	Jul 2016	Oct 2016	Jan 2017	Apr 2017	Jul 2017	Oct 2017	Jan 2018
WTE	2844.9	2854.4	2894.3	2884.4	2873.9	2906.8	2954.3	3008.1	**3018.8**
Headcount	3293	3310	3356	3357	3348	3377	3424	3478	**3496**

The Trust's staff in post by whole time equivalent (WTE) was 3018.8 as at 31 January, which is an increase of 144.9 WTE since January 2017.

The Trust's headcount is 3496, an increase of 148 since January 2017. The Trust's largest group of staff is registered nurses and midwives, followed by administrative and clerical staff.

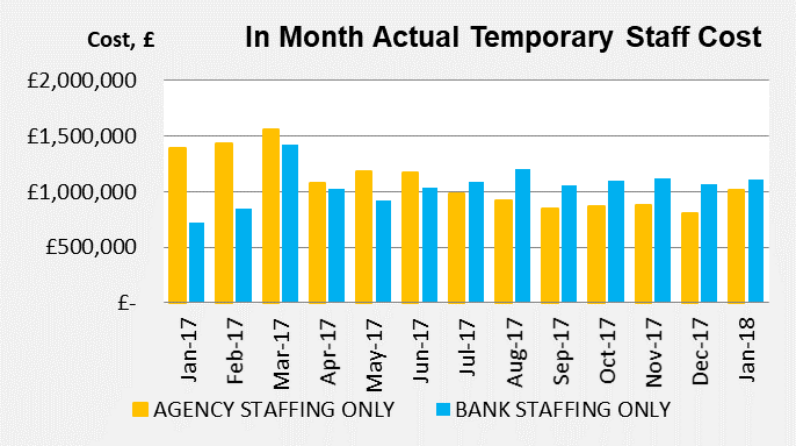
The largest positive variances of staff in post since January 2017 have been in professional, scientific and technical, medical and dental staff.



Staff Group	Jan 2017		Jan 2018		% Variance	
	WTE	Headcount	WTE	Headcount	WTE	Headcount
Add Prof Scientific and Technic *	77.1	89	**87.0**	**100**	12.8%	12.4%
Additional Clinical Services *	488.9	579	**489.7**	**586**	0.2%	1.2%
Administrative and Clerical	633.5	728	**675.1**	**765**	6.6%	5.1%
Allied Health Professionals *	137.7	163	**150.3**	**175**	9.2%	7.4%
Estates and Ancillary	240.6	334	**248.9**	**342**	3.4%	2.4%
Healthcare Scientists	74.6	80	**72.3**	**81**	-3.1%	1.3%
Medical and Dental	375.4	389	**417.1**	**431**	11.1%	10.8%
Nursing and Midwifery Registered	846.2	986	**878.5**	**1016**	3.8%	3.0%
Totals	2873.9	3348	**3018.8**	**3496**	5.0%	4.4%

** Please see appendix for list of job types in these staff groups.*

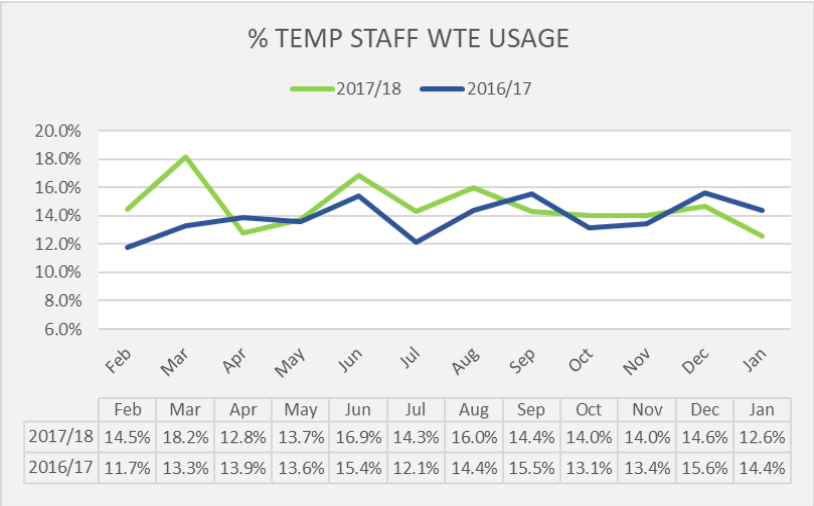
3 Staff Costs (taken from financial ledger)



In Month Actual Cost, £	AGENCY STAFFING ONLY	BANK STAFFING ONLY
Jan 2017	£ 1,391,366	£ 722,926
Feb 2017	£ 1,434,614	£ 843,718
Mar 2017	£ 1,559,442	£ 1,418,143
Apr 2017	£ 1,082,008	£ 1,022,026
May 2017	£ 1,180,326	£ 923,042
Jun 2017	£ 1,169,320	£ 1,032,187
Jul 2017	£ 984,807	£ 1,087,326
Aug 2017	£ 923,142	£ 1,200,715
Sep 2017	£ 847,519	£ 1,060,227
Oct 2017	£ 864,701	£ 1,100,245
Nov 2017	£ 873,458	£ 1,119,658
Dec 2017	£ 801,641	£ 1,068,729
Jan 2018	£ 1,014,154	£ 1,110,814
2017/18	**£ 12,735,133**	**£ 12,986,831**

The total staff costs (including employer national insurance costs, employer pension costs and the total cost of substantive and temporary staff) for the 12 months to 31 January was £159,521,260 (12 months to 31 January 2017 - £150,950,553).

Bank use and expenditure has remained higher than the same for agency since July 2017

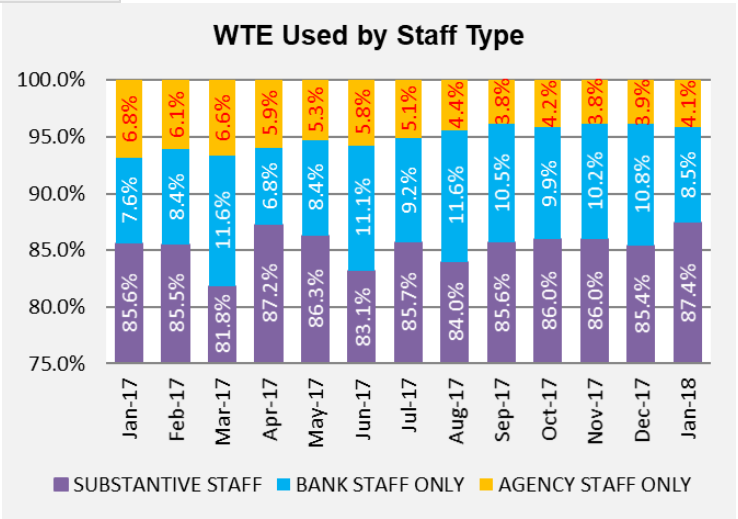


	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2017/18	14.5%	18.2%	12.8%	13.7%	16.9%	14.3%	16.0%	14.4%	14.0%	14.0%	14.6%	12.6%
2016/17	11.7%	13.3%	13.9%	13.6%	15.4%	12.1%	14.4%	15.5%	13.1%	13.4%	15.6%	14.4%

The temporary staff usage (bank + agency) for the year was 5947.4 WTE, which was 14.7% of total WTE staff employed.

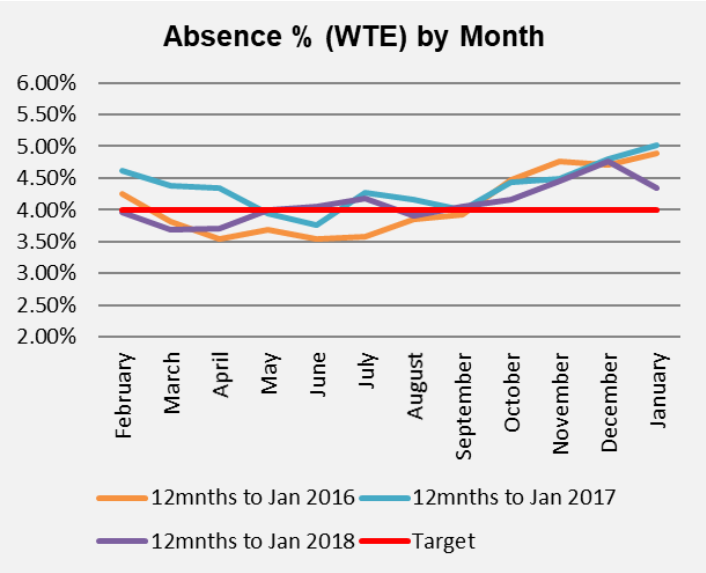
Agency staff usage was 4.9% of the total WTE staff employed for the year but was 8.0% of the total annual staff expenditure, predominantly driven by medical and dental agency locums.

The Trust target for Agency Staff Expenditure for 2017/2018 is 10.0%.

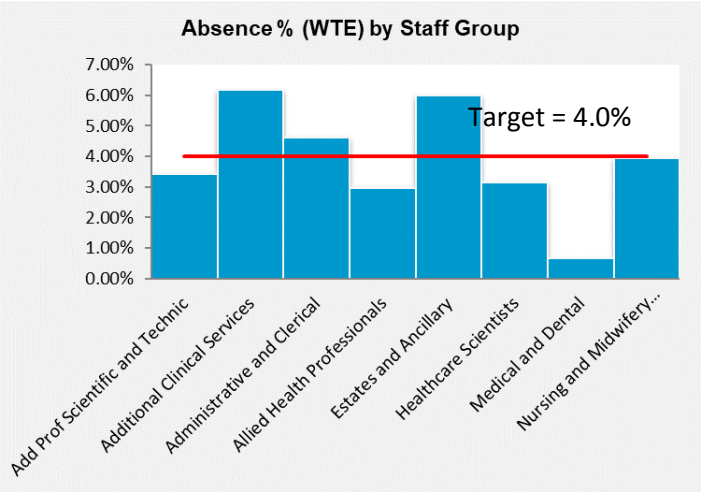


4 Sickness Absence

The sickness absence rate (12 months to 31 January 2018) for the Trust is shown below (the Trust target for the 12 month sickness absence rate is set at 4.0% for 2017/18 (2016/17 4.0%).



Month	Absence % (WTE) 12mnths to Jan 2016	12mnths to Jan 2017	12mnths to Jan 2018
Feb	4.25%	4.61%	3.96%
Mar	3.82%	4.37%	3.68%
Apr	3.54%	4.34%	3.70%
May	3.69%	3.94%	4.00%
Jun	3.54%	3.76%	4.05%
Jul	3.58%	4.28%	4.17%
Aug	3.86%	4.16%	3.91%
Sep	3.93%	4.00%	4.06%
Oct	4.46%	4.43%	4.15%
Nov	4.76%	4.49%	4.46%
Dec	4.71%	4.80%	4.76%
Jan	4.89%	5.01%	4.34%



Staff Group	Absence % (WTE)	Short Term	Long Term
Add Prof Scientific and Technic	3.42%	1.87%	1.55%
Additional Clinical Services	6.18%	2.88%	3.30%
Administrative and Clerical	4.61%	1.70%	2.90%
Allied Health Professionals	2.97%	1.35%	1.62%
Estates and Ancillary	6.00%	2.41%	3.59%
Healthcare Scientists	3.14%	1.32%	1.82%
Medical and Dental	0.68%	0.24%	0.43%
Nursing and Midwifery Registered	3.93%	1.93%	2.01%
Totals	**4.11%**	**1.80%**	**2.31%**

The trust's overall sickness absence levels have been lower than the same period for the last two financial years since October 2017.

The varying levels of absence by staff group are not uncommon to acute NHS trusts - steps are being taken to address under-reporting of sickness absence in the medical and dental profession.

The drafting of a new sickness, absence and attendance policy will help the trust to manage its levels of sickness absence down further, following implementation and training. It will also help to increase visibility of reasons for sickness absence through improved reporting. Over 30% of sickness absence is for 'reasons unknown'.

More detail on sickness absence is reported and discussed at divisional executive performance reviews (monthly) and workforce and development assurance committee (quarterly).

The table below shows the top 10 absence reasons for the year to 31 January 2018:

Absence Reason	Headcount	Number of Episodes	Absence Days	FTE Lost	Absence Rate %	Trust Ranking
Unknown / Not Declared	**1,366**	**2,100**	**16,891**	**13,743.52**	**31.2**	**1**
S10 Anxiety/stress/depression/other psychiatric illnesses	199	273	7,765	6,554.99	14.9	2
S12 Other musculoskeletal problems	279	336	5,146	3,836.80	8.7	3
S13 Cold, Cough, Flu - Influenza	1,016	1,349	4,032	3,449.31	7.8	4
S25 Gastrointestinal problems	878	1,198	3,829	3,355.39	7.6	5
S11 Back Problems	223	290	3,097	2,529.09	5.7	6
S28 Injury, fracture	71	76	1,793	1,402.07	3.2	7
S17 Benign and malignant tumours, cancers	16	24	1,753	1,245.95	2.8	8
S15 Chest & respiratory problems	128	158	1,487	1,350.40	3.1	9
S30 Pregnancy related disorders	72	142	1,422	1,142.00	2.6	10

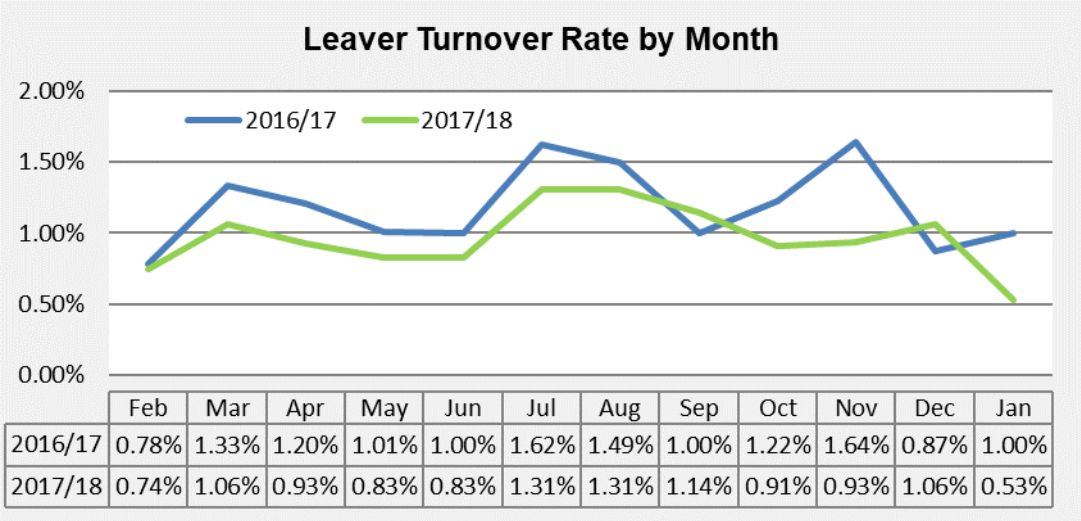
Acute Sickness Absence Returns

The following table summarises the return rate of submitted returns from Trust areas that do not submit through 'Healthroster':

Number of areas reporting sickness absence by:	Acute Absence Returns			
	3 months to 30 Nov 2017		3 months to 31 Jan 2018	
Division	Returns Due	% Submitted	Returns Due	% Submitted
Core Clinical	53	72.5%	53	69.8%
Corporate Services	72	66.7%	72	74.5%
Medicines Unplanned Care	32	58.8%	33	52.0%
Surgical Planned Care	37	53.6%	37	52.7%
Women's and Children's	8	50.0%	8	45.8%
Trust Total	**203**	**63.9%**	**204**	**64.5%**

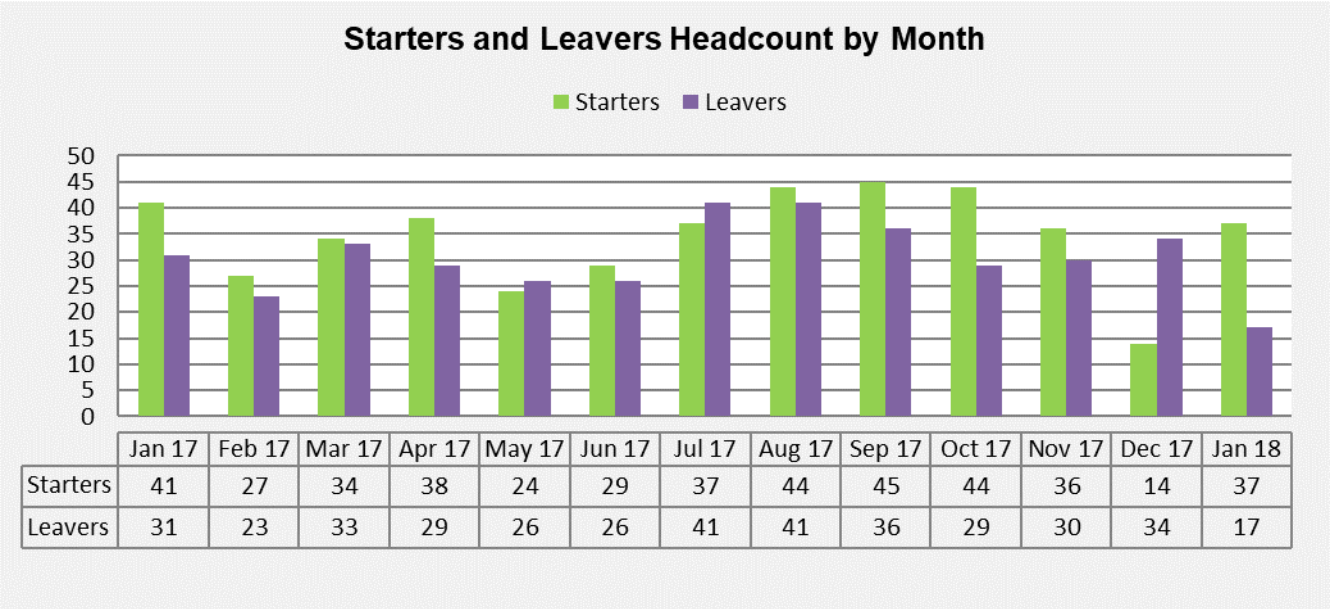
5 Starters, Leavers and Staff Turnover (Permanent Staff)

The permanent staff turnover rate by month for the year February 2017 to January 2018 (annual turnover rate of 11.57%; Trust Target – 14.00%) and the previous year to 31st January 2017 (annual turnover rate of 13.90%; Trust Target – 14.00%) are summarised on the chart below:



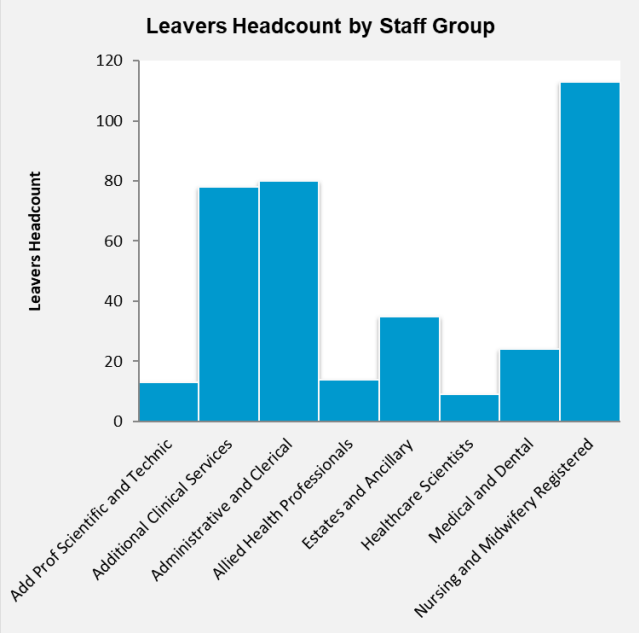
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2016/17	0.78%	1.33%	1.20%	1.01%	1.00%	1.62%	1.49%	1.00%	1.22%	1.64%	0.87%	1.00%
2017/18	0.74%	1.06%	0.93%	0.83%	0.83%	1.31%	1.31%	1.14%	0.91%	0.93%	1.06%	0.53%

The starters and leavers by month for the period February 2017 to January 2018 are:



	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18
Starters	41	27	34	38	24	29	37	44	45	44	36	14	37
Leavers	31	23	33	29	26	26	41	41	36	29	30	34	17

The leavers by staff group for the year to January 2018 are shown below and the headcount leaver turnover rate of each staff group is included in this report:



Staff Group	Leavers Headcount	Headcount 31/01/2018	Leaver Turnover Rate%
Add Prof Scientific and Technic	13	100	13.9%
Additional Clinical Services	78	586	13.3%
Administrative and Clerical	79	765	10.7%
Allied Health Professionals	14	175	9.3%
Estates and Ancillary	35	342	11.1%
Healthcare Scientists	9	81	12.1%
Medical and Dental	24	431	9.6%
Nursing and Midwifery Registered	113	1016	11.7%
Trust Total	**365**	**3496**	**11.6%**

Overall, the trust's leaver turnover rate has been lower in 2017/18 than it was in 2016/17. This is due to a number of interventions that the trust has undertaken, as reported at workforce and development assurance committee e.g. onboarding and exit questionnaires, staff engagement and staff support activities.

There is a national focus on retention and the trust in engaged in development sessions run by NHS Improvement and NHS Employers to support the retention agenda and gain greater benefit locally.

6 Statutory Mandatory Training and Appraisal Compliance

A - Statutory Mandatory Training Compliance

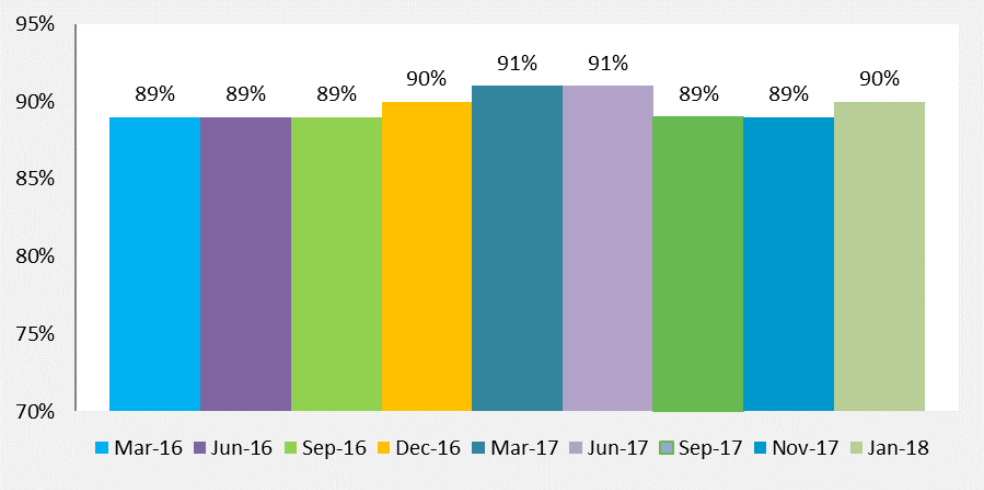
The tables below detail the statutory mandatory training compliance as at the end of January 2018. The statutory mandatory training compliance level is set for FY 2017/18 as 90%.

Training Compliance by Division	
Core Clinical	93%
Corporate Services	94%
Medicines Unplanned Care	88%
Surgical Planned Care	88%
Women's and Children's	90%
Trust Total Compliance	**90%**

Training Compliance by Competence	
Blood Components Awareness - 2 Year	86%
Equality Diversity and Human Rights - 3 Years	92%
Fire Safety - 2 Years	91%
Health Record - Once only	99%
Health Safety and Welfare - 3 Years	93%
Infection Prevention and Control - Level 1 - 3 Years	96%
Infection Prevention and Control - Level 2 - 1 Year	86%
Information Governance - 1 Year	87%
Medicines Management - 2 Year	88%
Mental Capacity Act - 3 Year	92%
Moving and Handling - Level 1 - 3 Years	92%
Moving and Handling - Level 2 - 3 Years	87%
NHS Conflict Resolution (England) - 3 Years	86%
Resuscitation - Level 2 - Adult Basic Life Support - 1 Year	79%
Safeguarding Adults - Level 1 - 3 Years	97%
Safeguarding Adults - Level 2 - 3 Years	92%
Safeguarding Children - Level 1 - 3 Years	92%
Safeguarding Children - Level 2 - 3 Years	90%
Safeguarding Children - Level 3 - 1 Years	79%
Total Trust Compliance	**90%**

Data is available for all managers via the BI system, which produces data from Trust to departmental to individual level. Our compliance levels are a key metric at Trust Board and form part of the Divisional performance reviews. The table below indicates our steady progress in achieving our compliance target.

The variation in compliance from March 2016 to January 2018 is shown:

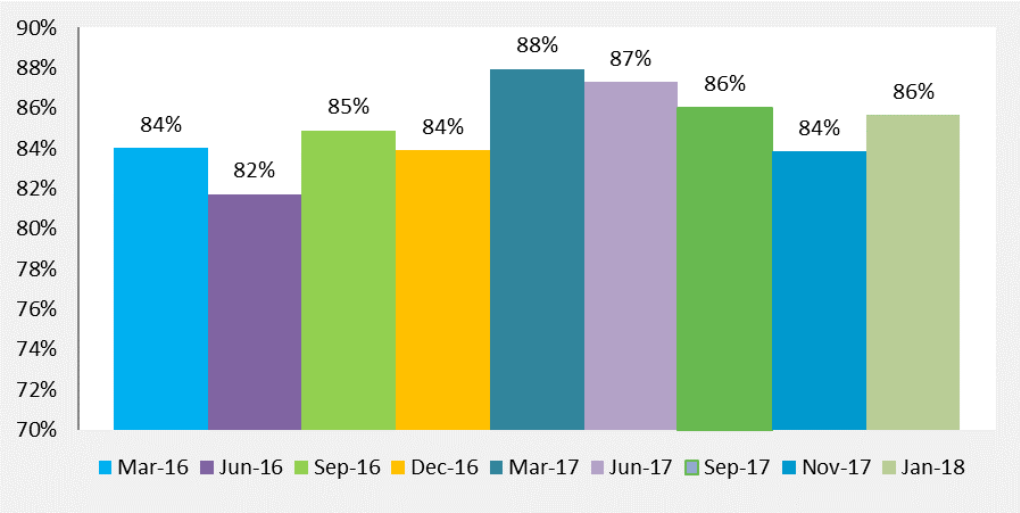


B - Appraisal Compliance Summary

The table below summarises appraisal compliance as at the end of January 2018. The compliance level has been set for FY 2017/18 as 90%.

Appraisal Completion by Division		
Core Clinical		96%
Corporate Services		85%
Medicines Unplanned Care		79%
Surgical Planned Care		75%
Women's and Children's		91%
Total Trust		**86%**

The variation in compliance from March 2016 to January 2018 is shown:



Data is available for all managers via the BI system, which produces data from Trust to departmental to individual level. Our compliance levels are a key metric at Trust Board and form part of the Divisional performance reviews.

Appendix – Professional, Scientific and Support Staff

Staff Group		
Additional Professional, Scientific and Technical	**Allied Health Professionals**	**Additional Clinical Services**
Technicians and Practitioners for: Chemical Pathology Dental Medical Photography Medicines Information & Management Occupational Health Operating Department Ophthalmic Imaging Opthalmology Orthotics Pharmacy Plaster Technician X-Ray **Other:** Bereavement Officer Chaplains Clinical Skills Instructor Psychologist	**Qualified Staff:** Dietician Occupational Therapist Orthoptist Physiotherapist Radiographer	**Trainees and Support Staff for:** Pharmacy Operating Department Physiotherapy Healthcare Science Imaging Decontamination **Other:** Healthcare Assistant Nursery Nurse Phlebotomist Play Specialist

Milton Keynes University Hospital
NHS Foundation Trust

Board Assurance Framework 2018/19

Exec Lead	Risk Ref	Objective	Committee	Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance				Residual risk rating	Progress since last report	Further mitigation/assurances	Completion date	Target risk score
								Level 1 Operational (management)	Level 2 Oversight functions (Committees)	L3 Independent	Overall					
IR	1-1	SO1	Quality & Clinical Risk	Unsafe practice due to overwhelming demand for emergency care	Significant volume of patients and lack of patient flow from ED through to base wards once there is a decision to admit	4x5=20	Operational plans in place to cope with prolonged surges in demand Cancelling of non-urgent elective operations	Current year to date performance as reported on the Trust dashboard under 95%	Performance dashboard presented to and scrutinised by QCRC, FIC, Management Board and Trust Board	External auditors carry out limited assurance testing of performance against the 4 hour ED indicator	Satisfactory	4x4=16		Continue the implementation of ED streaming, Continue the roll out of Red2Green and SAFER across the hospital in order to improve flow through the hospital.		2x5=10
IR	1-2	SO1	Quality & Clinical Risk	Failure to appropriately embed learning and preventative measures following Serious Incidents	Failure to appropriately report, invesitgate and learn from incidents and complaints	5x2=10	Incident Reporting Serious Incident Review Group Simulation RCA training Cultural work (inc Greatix and FTSU Guardians	Incident reports Harm caused by incidents a low propotion of the total		CCG satisfaction with RCA reporting Stakeholder involvement with RCA/SI investigation	Satisfactory	4x2=8				4x2=8
IR	1-3	SO1	Quality & Clinical Risk	Failure to recognise and respond to the deteriorating patient	Non compliance with the NEWS protocols; failure to appropriately escalate NEWS scores or failure to clinically assess patients outside protocols (i.e. 'hands on, eyes on' patients who are ill but not triggering on NEWS)	4x3=12	National NEWS protocol in place Level 1 pathway in place	Performance is reported to the Clinical Quality Board and is regularly audited Serious Incident Review process eCare Standardised mortality review		Coronial review of deaths	Satisfactory	3x3=9				4x2=8
LK	2-1	SO2		Failure to provide an appropriate patient experience	Despite largely positve feedback that is received via social media and through the Friends and Family Test, the Trust has scored relatively poorly in most of the annual patient surveys. There are also a number of recurring themes from complaints, including poor	4x4=16	Risk and incident reporting awareness campaign ongoing Risk and incident training programme in place Integrated Datix system Embedded governance and assurance teams to provide more resource, internal challenge and audit. Lesson of the week shared through the weekly CEO message, supported by divisional publications, briefings and plenary. Appointment of Picker to manage FFT responses and capture more qualitative feedback from patients Appointment of patient experience manager; clinical leads Launch of hellomynameis across the Trust	Oversight at Risk and Compliance Board and Serious Incident Review Group	Oversight at Quality and Clinical Risk Committee and at the Quality and Clinical Risk Committee – reports include details of themes from complaints and evidence that learning is taking place	Improved scores and benchmarked results in the key patient experience surveys	Low	3x4=12		Feedback from various patient surveys – inpatient, maternity, ED and children's.		3x3=9

			Quality & Clinical Risk				Implementation of new complaints system, and raising the profile of complaint handling across the divisions Receipt of patient stories at the Trust Board Production and monitoring of action plans followjng annual patient surveys Real time feedback provided as appropriate to issues and comment on social media								
IR	3-1	SO3	Quality & Clinical Risk	Lack of assessment against and compliance with best evidence based clinical practice through clinical audit	Insufficient resource to introduce or embed process and lack of engagement by clinicians	3x4=12	Forward audit plan agreed and published annually Clinical audit leads in place with new (2018) job descriptions and agreed time within job plans Clinical governance leads and audit support in place to support audit leads in CSUs/ divisions Audit assessment process in place - supported and monitored by clinical governance leads and central audit support team New clinical governance structure (2018) in place to improve oversight and escalation of audit	Oversight and scrutiny at Clinical Effectiveness Board; Risk and Compliance Board and Clinical Quality Board Internal compliance monitoring and reporting monthly Reporting to CIGs and divisional management meetings	Oversight at the Quality and Clinical Risk Committee and the Audit Committee	External audi (KPMG) reivew in 2017/18 which identified areas for improvement. On forward audit plan for external audit review in 2018/19.	Satisfactory	3x3=9				2x3=6
KB	3-2	SO3	Quality & Clinical Risk	Lack of assessment against and compliance with NICE guidance	The Trust has a significant backlog of NICE guidelines	3x4=12	Monthly assessments of compliance against published NICE baseline assessments Process in place to manage baseline assessments with relevant clinical lead - supported by clinical governance leads Independent review by compliance and audit lead Requires clinical engagement and ownership	Oversight and scrutiny at Clinical Effectiveness Board; Risk and Compliance Board and Clinical Quality Board Internal compliance monitoring and reporting monthly Reporting to CIGs and divisional management meetings	Oversight at the Quality and Clinical Risk Committee	None currently	Low	3x3=9				3x2=6
CH	4-1	SO4	Executive Management	Failure to meet the 4 hour emergency access standard	The Trust is unable to meet the target to see 95% of patients attending A&E within 4 hours	4x5=20	Operational plans in place to cope with prolonged surges in demand Cancelling of non urgent elective operations New elective surgical ward open to reduce liklihood of above control Opening of escalation beds Working with partners for social, community and primary care	Divisional and Trust performance reports Rates of discharge; DTOC	A&E Delivery Board	Ongoing NHSI review of key indicators Internal audit work on data quality Quality Report testing of key indicators by external auditors	Satisfactory	4x4=16				3x2=6
CH	4-2	SO4	Executive Management	Failure to meet the key elective access standards - RTT 18 weeks, non-RTT and cancer 62 days	The Trust is unable to meet the 18 week RTT and 62 day cancewr targets, and unable to reduce its non-RTT backlog as required	4x3=12	Regular PTL meetings Work on improving administrative pathways Work with tertiary providers on breach allocations RTT and non-RTT action plans	Divisional and Trust performance reports Management Board scrutiny and oversight of RTT and non-RTT action plans	Finance and Investment Committee scrutiny of financial and operational performance Quality and Clinical Risk Committee oversight	NHSI regional information on performance against key access targets	Satisfactory	3x3=9				3x3=9

JB	4-3	SO4	Audit	Failure to ensure adequate data quality leading to patient harm, reputational risk and regulatory failure	Data quality governance and processes are not robust	4x5=20	Robust governance around data quality processes including executive ownership Audit work by data quality team	Oversight of progress against action plans by Data Quality Compliance Board	Standing agenda item at the Audit Committee	Outcome of Internal audit assessment of data quality Outcome of External Audit Quality Report testing Outcome of NHSI review	Satisfactory	3x5=15				3x3=9
JB	5-1	SO5	Audit	Failure to adequately safeguard against major IT system failure (deliberate attack)	Weakneses in cyber security leave the trust vulnerable to cyber attack	3x3=9	Investment in better quality systems GDE investment NHS Digital audits and penetration tests	Results of penetration and phishing tests	Audit Committee review of cyber security	Performance against NHS Digital standards	Good	3x2=6				3x2=6
JB	5-2	SO5	Finance & Investment	Failure to adequately safeguard against major IT system failure (inability to invest in appropriate support systems/infrastructure)	Lack of suitable and timely investment leaves the Trust vulnerable to cyber attack	3x3=9	2 dedicated cyber security posts funded through GDE All Trust PCs less than 4 years old Robust public wifi network EPR investment	Robust capital prioritisation process overseen by Managment Board	Oversight of IT investment strategy and decision making by the Finance and Investment Committee	External oversight of uses of the GDE funding	Good	3x2=6				3x2=6
CH	5-3	SO5	Executive management	Failure to successfully deploy EPR in a way that diminishes disruption	That the roll out of EPR disrupts clinical and operational services	5x3=15	Robust programme management, including executive oversight Involvement and engagement of all operational and clinical staff Good undertsanding of risks at go live and either accepting or planning for them Understanding the phasing of the programme and the specific operational challenges at each phase	Oversight by the Health Informatics Programme Board chaired by trhe Chief Executive and attended by all Executives. This Board reports to Management Board, and in turn, Trust Board	Regular updates to the Finance and Investment Committee Updates to the Trust Board Council of Governors, and shortly to the Trust membership			4x3=12				4x2=8
CH	5-4	SO5	Executive Management	Failure to maximise the benefits of EPR	That the Trust does not derive all of the bemnefoits in terms of efficiency and productivity from the EPR system as had been anticipated in the business cases	4x3=12						3x2=6				3x2=6

OE	7-1	SO7	Finance & Investment	Inability to keep to affordable levels of agency and locum staffing	Inability to recruit to difficult to recruit to posts (across disciplines but particularly in medicine) Short notice sickness absence Poor planning around activity peaks Poor rostering of annual leave/ other leave requirements Increased requirement for enhanced observation levels of care National price caps mean that in a range of areas the Trust has little prospect of full compliance in short term future.	5x4=20	Weekly vacancy control panel review agency requests. Control of staffing costs identified as a key transformation work stream Bank rates and enhancements Capacity planning Robust rostering and leave planning Escalation policy in place to sign-off breach of agency rates Fort-nightly executive led agency reduction group meeting with aim of delivering reduction in both quantity and cost of agency used. Agency cap breaches are reported to Divisions and the FIC .	Transformation plans with tracked delivery. Oversight at the Vacancy Control Panel. Action plan reviews at fortnightly Executive Director Meetings Divisional deep dive sessions Monthly reports to Workfoirce Board and then to Management Board	Performance reported to the F&I Committee Oversight by the Workforce and Development Assurance Committee	Internal audit assessment on the use of medical locums NHSI performance review meetings NHSI agency weekly returns		4x3=12	The Agency spend up to mth 10 is £9.8m, in mth £1.0m . The Trust's Y/E ceiling is £15.15m. The trust is below the target future months run-rate of £2.7m and is performing better than its agency plan year to date.	1.More robust and comprehensive capacity planning. 2.Consistent approach to rostering and leave planning across the trust.	Current and ongoing	4x3=12
	7-2	SO7	Finance & Investment	Timing and release of capital and revenue funding for 2017/18		5x5=25	Ongoing dialogue with NHSI regarding status of cash commitment from the DH. Revenue funding for July has been approval by the DoH in the form of an uncommitted term loan. Revenue plan submitted in line with 2017/18 control total of £18.8m deficit. The Trust is reaching its limit of being re-profiling its Capital Expenditure for 2017-18 until it receives Strategic capital funding approval. Currently only funds of emergency nature are being released by the Trust.	Capital Expenditure is reviewed at the monthly capital control group and management board	Updates reported to the F&I Committee and Trust Board on a monthly basis	The Trust discusses the position at its monthly PRM calls with NHSI		5x5=25	No progress, awaiting outcome from NHSI and DH		Current and ongoing	3x2=6
MK	7-3	SO7	Finance & Investment	Inability to achieve the required levels of financial efficiency within the Transformation Programme	Increased unplanned activity Inability to identify sufficient savings schemes, or to achieve the expected levels of savings Inability to deliver identified schemes	5x4=20	Tracker in place to identify and track savings and ensure they are delivering against plan Savings measured against trust finance ledger to ensure they are robust and consistent with overall financial reporting All savings RAG rated to ensure objectivity	Fortnightly CIP review meetings between with the Director of Service Development, DoF, divisional managers and project managers Recovery plans requested for off-track schemes Savings plan for 17/18 financial year not yet fully identified.	Monthly CEO chaired Transformation Board oversight, providing leadership and scrutiny of programme delivery			4x5=20	Savings plans of £8.3m identified up to mth 10 against a full year target of £10.5m	Further saving schemes to be identified to meet the £10.5m target for 2017/18	Current and ongoing	3x3=9
	7-4	SO7	Finance & Investment	Disagreement with main commissioner over the level of performance that they are prepared to fund	MKCCG has included £4m of QUIP schemes within its contract with the trust for 2017-18. Historically this has not delivered Over performance is not payable until up to four months after the activity undertaken, putting pressure on cash flows CCG financial position is such that ability to hold their financial plan will be challenging if over-performance continues at	5x4=20	Clearly defined quarterly reconciliation process of contract payments made with close monitoring of the payment for over performance invoices. Escalation of issues to NHSI for intervention where required.	Twice monthly meetings with MKCCG, attended by the DoF and the Deputy CEO to discuss contractual and actual levels of activity	Updates reported to the F&I Committee and Trust Board on a monthly basis			4x4=16	The trust agreed a financial settlement for mths 1-6 , expected payment for this in February 2018, mths 7 onwards over-performance is still being discussed with the MK CCG	The Trust to continue to work closely with the CCG on demand management solutions.	Current and ongoing	3x3=9

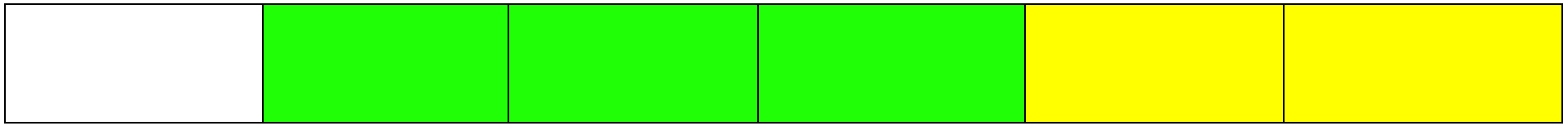
MK	7-5	SO7	Finance & Investment	The Trust is unable to access £7.3m of Sustainability & Transformation Funding	That Trust does not meet the performance targets in relation to the A&E 4 hour standards and cancer treatment and therefore does not qualify for STF	5x5=25	In order to receive the full amount of £7.3m of S&T funding in FY 2017-18, the Trust needs to achieve its financial control total (ie 70% of the funding) and its A&E performance trajectory (30% of the funding). The Trust has agreed a control total of £18.8m deficit and its performance trajectory with NHSI and is forecasting to achieve its control total	Financial performance and A&E performance is reviewed at the Executive Director meetings.	F&I committee reviews the monthly financial performance against the control total and receives updates in respect of the A&E performance a monthly basis. The Trust Board reviews A&E performance as well as financial performance on a monthly basis			4x4=16	The Trust has met its mth 10 Finance control total and achieved Q3 A&E target	The Trust will continue to closely monitor its performance against the financial and activity targets	Current and ongoing	3x4=12
MK	7-6	SO7	Finance and Investment	The Trust fails to utilise available capital funding according to strategic and clinical priorities	That the process of prioritising projects oin which the Trust's limited capital funds should be spent does not properly align with its broader strategic priorities	3x4=12	CBIG forum including clinical, corporate and executive representation Capital prioritisation programme	Management Board processes		Internal audit oversight of capital programme						
LK	7-7	SO7	Board of Directors	Failures in compliance leading to regulatory intervention (CQC)	That the Trust fails to meet the CQC's fundamental standards and receives a critical report foollowing an inspection	4x3=12	The Trust has a well defined process in place, led by the Clinical Governance team, for esnuring that all divisions and clinical areas are individually able to demonstrate compliance with the core requirements, and that the Trust as a whole has the correct policies, processes and behaviours in place on an ongoing basis	Regular engagement with the local CQC relationship manager		Well Led peer review exercise to be held with kingston Hospital						3x2=6
OE	8-1	SO8	Workforce	Inability to recruit to critical vacancies	National shortages of appropriately qualified staff in some clinical roles, particularly at consultant level Competition from surrounding hospitals Buoyant locum market National drive to increase nursing numbers leaving market shortfall (demand outstrips supply)	4x4=16	Participation in local and regional job fairs Targeted overseas recruitment activity Apprenticeships and work experience opportunities Exploration and use of new roles to help bridge particular gaps Use of recruitment and retention premia as necessary Use of the Trac recruitment tool Use of a system to recruit pre-qualification students Use of enhanced adverts, wsocial media and recruitment days Rollout of a dedicated workforce website	Vacancy control panel Divisional deep dive sessions Monthly reports to Mangement Board Workfoce Board oversight Use of workfoce planning templates Outcomes from the recruitment and retention task and finish group Workforce transformation reports	Quarterly reports to the Workforce and Development Assurance Committee	NHSI Model Hospital benchmarking Staff survey results						3x2=6

OE	8-2	SO8	Workforce	Inability to retain staff employed in critical posts	Poor working and management envinroment, lack of progression or development opportunities make it difficult to retain key staff	4x3=12	Variety of organisational change/staff engagement acitivities, e.g. Event in the Tent Schwartz Rounds and coaching collaboratives Recruitment and retention premia We Care programme Onboarding and exit strategies/reporting Staff survey Learning and development programmes Health and wellbeing initiatives, including P2P and Care First Staff friends and family results/action plans Links to the University of Buckingham Staff recognition - staff awards, long service awards, GEM Leadership development and talent management	Monthly reports to Workforce Board and Managment Board Workforce transformation reports	Reports to Workforce and Development Assurance Committees and the Finance and Investment Committee	NHSI Model Hopsital benchmarking, Staff survey results						3x2=6
KJ	9-1	SO9	Finance & Investment	Failure to achieve the required level of investment (including appeal funds) to fund the Cancer Centre	Lack of suitable and timely engagement with key players within the city and wider area during the private phase of the appeal, and an inability to enthuse and gain the support of potential donors more broadly, means that the Charity is unable to achieve the required level of charitable contribution to the project	4x3=12	Fundraising strategy and plan in place Financial forecasts under very regular scrutiny Experienced consultancy engaged to support existing senior and experienced fundraising staff Tactical plan for private and public appeal phase developed and implemented	Regular reporting to Committee Operational oversight	Oversight at Charitable Funds Committee	Appeal Leadership Committee	Satisfactory	3x3=9				3x2=6
JH	10-1	SO10	Board of Directors	Inability to progress the Milton Keynes Accountable Care System and wider ACS/STP programme	Lack of effective collaboration among all the key local partners means that the goal of a comprehensive and integrated place based health and social care solution within MK is not realised	3x3=9	Chief Executive and Executive team engagement both at ICS and MK Place levels. MK Place leaders chairing 3 of the 5 ICS priority workstreams	Direct MKUH senior invokvement in decision making. Regular CEO progress updates to Management Board	Standing agenda item at the Trust Board							3x2=6

BAF Heat Map


1 None
2 Minor
3 Moderate
4 Major
5 Catastrophic
5 Certain
1-1
4-1
7-4
4-3
7-2
7-5
4 Likely
3-1
7-6
8-2
3-2
2-1
2-2
2-4
8-1
4-4
2-5
7-3
7-1
5-1
7-3
3 Possible
5-1
10-1
10-2
5-2
9-2
4-2
5-3
5-4
7-7
3-2
8-2
9-1
1-3
2 Unlikely
1-2
1 Rare

BAF Heat Map



5x5 Matrix

Likelihood (frequency)	Consequence (impact/severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Rare (1)					
Unlikely (2)					
Possible (3)					
Likely (4)					
Highly Likely (5)					

Consequence Score

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

			RIDDOR/agency reportable incident An event which impacts on a small number of patients	Mismanagement of patient care with long-term effects	
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff	Uncertain delivery of key objective/service due to lack of staff	Non-delivery of key objective/service due to lack of staff

			Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence

		Elements of public expectation not being met			
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood Score					
Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly

How often might it/does it happen					frequently

BAF ID	Risk Description	Risk Score
1-1	Unsafe practice due to overwhelming demand for emergency care	(4x5) = 20
1-2	Failure to appropriately embed learning and preventative measures following Serious Incidents	(5x2) = 10
1-3	Failure to recognise and respond to the deteriorating patient	(4x3) = 12
2-1	Failure to provide an appropriate patient experience	(4x4) = 16
3-1	Lack of assessment against and compliance with best evidence based clinical practice through clinical audit	(3x4) = 12
3-2	Lack of assessment against and compliance with NICE guidance	(3x4) = 12
4-1	Failure to meet the 4 hour emergency access standard	(4x5) =20
4-2	Failure to meet the key elective access standards - RTT 18 weeks, non-RTT and cancer 62 days	(4x3) = 12
4-3	Failure to ensure adequate data quality leading to patient harm, reputational risk and regulatory failure	(4x5) = 20
5-1	Failure to adequately safeguard against major IT system failure (deliberate attack)	3x3 = 9
5-2	Failure to adequately safeguard against major IT system failure (inability to invest in appropriate support systems/infrastructure)	(3x3)= 9
5-3	Failure to successfully deploy EPR in a way that diminishes disruption	(5x3)=15
5-4	Failure to maximise the benefits of EPR	(4x3)=12
7-1	Inability to keep to affordable levels of agency and locum staffing	(5x4)=20
7-2	Timing and release of capital and revenue funding	(5x5) = 25
7-3	Inability to achieve the required levels of financial efficiency within the Transformation Programme	(5x4) = 20
7-4	Disagreement with main commissioner over the level of performance that they are prepared to fund	(5x4) =20
7-5	The Trust is unable to access £7.3m of Sustainability & Transformation Funding	(5x5) = 25
7-6	The Trust fails to utilise available capital funding according to strategic and clinical priorities	(3x4) = 12
7-7	Failures in compliance leading to regulatory intervention (CQC)	(4x3)=12

8-1	Inability to recruit to critical vacancies	4x4=16
8-2	Inability to retain staff employed in critical positions	4x3=12
9-1	Failure to achieve the required level of investment (including appeal funds) to fund the Cancer Centre	4x3=12
10-1	Inability to progress the Milton Keynes Accountable Care System and wider ACS/STP programme	3x3=9

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Board of Directors	**Date: 9 March 2018**
Report title:	Health & Safety Update	**Agenda item: 5.3**
Lead director **Report author** **Sponsor(s)**	Kate Burke Marion Fowler Tina Worth	Director of Corporate Affairs Health & Safety Advisor Head of Risk & Clinical Governance

Report summary	This report provides information in relation to health, safety and welfare activity undertaken within the Trust during Q3 (October to December 2017) and up to 27 February 2018. It includes a summary of incidents, concerns and positive achievements during the period in order to provide assurance in relation to health and safety management compliance.			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** x	**Decision** ☐
Recommendation	Board are asked to note the contents of the report.			

Strategic objectives links	1. Improve Patient Safety 4. Deliver Key Targets 7. Become Well-Governed and Financially Viable 8. Improve workforce effectiveness 9. Make best use of the estate
Board Assurance Framework links	N/A
CQC outcome/ regulation links	Regulation 12 – Safe Care and Treatment Regulation 15 – Premises and equipment Regulation 17 – Good governance Regulation 18 - staffing
Identified risks and risk management actions	Staff, patient, third party injury Personal injury claims Failure to meet duties under health and safety legislation Enforcement action, formal notices, prosecution Poor patient experience Media interest/adverse publicity
Resource implications	Personal injury claims
Legal implications including equality and diversity assessment	Failure to meet statutory and regulatory duties of health and safety legislation. Failure to provide safe place of work, safe working practices and equipment and failure to provide competent advice in relation to manual handling.

Report history	The information provided is extracted from the Health & Safety Committee meetings held on 22nd January 2018
Next steps	Ongoing monitoring at Health & Safety Committee

1. Purpose of the Report

This report highlights health, safety and welfare activity across the Trust during Q3 October to December 2017 and up to 27th February 2018; and upward reports information discussed at the Trust Health & Safety Committee meeting held on 22nd January 2018.. The report covers incidents, concerns and other relevant health and safety information. Information provided is in relation to health and safety only, the incidents reported relate mainly to staff and third party accidents that have been as a result of work or work activities.

2. Fire Update (referencing Board Action Log)

Water Sprinklers

The Fire Code guidance document HTM 05-02, in paragraph 5.68, does not require the installation of sprinklers in buildings except those which are in excess of 30m in height. It does state that when designing healthcare premises the design team should consider the benefits of a sprinkler system and provides some guidance as to the benefits. Further paragraphs in that section and elsewhere in the document do permit the reduction in fire resistance to elements of structure, compartmentation and separation of hazardous areas where sprinklers are installed.

The retrospective fitting of a sprinkler system in the hospital would require a sizable capital outlay, be extremely disruptive to patient / clinical areas and require the installation of at least one large water supply tank.

Consideration will be given to reviewing the automatic suppression system to protect high value areas; or other areas where loss due to fire would potentially cause major disruption to the working of the Trust in providing care to patients - an example being the Trust Main IT data server locations.

Fire Safety Update

In general terms the Trust, as the Responsible Person, is compliant with the requirements of the Regulatory Reform (Fire Safety) Order 2005 (FSO).

There is a programme of reviewing the existing fire risk assessments (FRA) on an annual basis. During the planned review of a number of these it was identified that changes have been made to certain areas requiring the completion of a new FRA which will be carried out in the next month.

An interim FRA has been completed for the New Academic Centre and once fully occupied a further one will be carried out.

The fire safety measures within the hospital are serviced and maintained as part of the Planned Preventative Maintenance Programme. Particular area in relation to fire safety include the fire alarm system, emergency lighting system, compartmentation, fire resisting doors, fire exit doors and fire extinguishers.

A training programme in relation to fire safety awareness is in place. The fire safety awareness workbook and assessment is currently being updated as is the induction and refresher presentation. These should be in place for the new training year commencing 1 April 2018. In addition to this the Trust will be commencing the training of the Trust Fire Wardens. An appropriate and competent trainer has been identified with the intention that this will be commence in May 2018.

3. Incident Reporting

Violence and abuse was the most reported incident category during Q3 with total of (129) incidents recorded on DATIX, (105) were directed at staff, and (3) were recorded as sexually inappropriate behaviour. These types of incident continue to cause concern. Although the harm levels being sustained are not recorded as significant, staff that are routinely and consistently exposed to violence

and abuse can eventually be subject to work related stress and anxiety. It is important that measures are taken to ensure the risks around violence and aggression are assessed; documented and adequate controls are in place to mitigate the risks including the provision of suitable training and support for staff post incident. Conflict resolution training has now been taken over from Boulder Training by Ikon and includes practical training.

There was also an increase in the number of incidents reported under the category of "slip, trip or fall on level". No single theme or area has contributed to this increase, although lack of staff awareness and dynamic assessment of their work areas does appear to contribute. In addition there was an increase in accidents reported during December 2017 (especially for level 4 of the multi storey car park) when a period of cold weather was experienced with temperatures dropping below zero with ice and snow causing issues around site.

3.1 Reporting of Injuries, Diseases and Dangerous Occurrence Regulations 2013 (RIDDOR) – reports to the Health & Safety Executive

The Trust is legally obliged to report certain workplace accidents, injuries, ill health and dangerous occurrences to the Health & Safety Executive within a legally defined timeframe dependent upon the incident. http://www.hse.gov.uk/riddor/

There were 3 RIDDORS reported in Q3:

- Manual handling - collecting theatre sets whilst pulling trolley back to HSDU pulled back and shoulder
- Slip, trip, fall - slipped on wet floor left by domestic, no signage evident
- Staff accident - chair dropped whilst staff member sitting on it

Of concern is that these accidents are not always reported in a timely manner by staff concerned/managers thus breaching the reporting timeframe.

4. Claims received

No new claims were received or settlements during this period.

5. Health & Safety Executive Contacts & Prosecutions

There have been no contacts from the Health & Safety Executive (HSE) in this quarter and no prosecutions brought by the HSE which need to be shared with the Trust.

6. Issues raised

- **Quarterly Health & Safety Inspection Checklists**

These assist in gauging compliance with legislation and Trust policy and allow for action planning of future work plan/streams to fill gaps identified. In this quarter the target of 65% was not reached, 62% returns were received. This is an improvement on Q2 however.

- **Manual Handling Advisor Vacancy**

The Manual Handling Advisor left the Trust at the beginning of December 2017 and has not been replaced. The post has gone out to advert, however there has been no success in shortlisting during this round of recruitment. This leaves a gap in compliance for the Trust in terms of the absence of competent advice in relation to manual handling.

Cover is being provided for statutory and mandatory training, however there is currently no expert to provide clinical advice. A business case is being drafted to consider an upgrade of the post since it is felt this would entice more appropriate applicants

Manual handling is managed by Staff Health & Wellbeing – the concern has been placed on the risk

register.

- **Office space**

Risks and concerns continue to be raised in relation to office space and porta cabin use. These are monitored through the Committee.

- **Hydrotherapy pool**

Risk assessment following a recent serious incident (SI) where a patient fall and fractured her hip – at the SI meeting with the patient more information came to light in relation and there was further review by the investigator in respect of access to emergency equipment if required, ease of resuscitating patients in a pool side area or small changing area, accessibility of hoists to help fallen patients from the floor and fire evacuation procedures. A meeting has been scheduled to assess these concerns and to complete a risk assessment and a new policy has been implemented to support safe management of patients feeling unwell when using the pool.

- **Escalation areas**

Various risk assessments for escalation areas have been completed and are being reviewed. The use of those areas of escalation and any safety risks posed had been raised at JCNC (staff side forum).

6. Positive achievements

- Completion of review into Food Safety Management within the Trust with positive outcomes. Report to next Health & Safety Committee sitting 12th March 2018
- Health, Safety & Welfare Training exceeded the Trust Target of 85% achieving 92% attendance.
- Drafting and consultation of Health & Safety Risk Assessment process.

Recommendations

The Board is asked to reiterate to note the contents of this report.

Milton Keynes University Hospital NHS Foundation Trust

Quality and Clinical Risk Committee Summary Report

1. Introduction

The Quality and Clinical Risk Committee met on 30 January 2018.

2. Key matters

The following items were presented to the Committee:

Role of this Committee

- The Chairman explained that he had had discussions with the Chief Nurse and Medical Director about the role of this Committee, which is to monitor processes for effectiveness and provide assurance to the Board that these are working effectively. A new report is to be introduced, piloted at this meeting, to be completed by the Chief Nurse and Medical Director, setting out in general how it feels to be in the hospital. This will set the tone for the rest of the agenda.

Action log (highlights)

- Efforts are to be made to see if common themes could be drawn from serious incidents, claims and complaints.
- The Trust wants to attract more volunteers, and a new volunteer strategy is being written – to be brought back.

Quarterly highlight report (pilot)

The top things, positive and challenging, occupying the Medical Director's mind included:

  - Over the last 6-12 months, the Trust has done well on consultant recruitment.
  - The Trust has been able to recruit Professor Simon Bowman to lead on research and development.
  - The quality and transparency of job planning is improving and all consultants now have job plans.
  - The Trust has done well to hit the 7 day service targets for stroke. However, there are concerns about what the 7 day service requirements as a whole will mean for small to medium sized hospitals.
  - There is a backlog of patients waiting for elective care but who are not on the RTT clock as they are not covered by the core metrics. This is being managed but there are still some unknowns.
  - Emergency readmissions.
  - eCare – this is a major change programme.
  - Vulnerable services – there are services where reliance is on an individual or there are challenges with recruitment.

Clinical Quality Board Assurance Framework (BAF) and Risk Register Report

- The new BAF template was presented. It is still in development with further Executive Director input required. The focus of the document is on assurance and is designed to be easier to engage with.
- The role of the BAF is to drive the Board agenda – it was accepted that the risks set out in the document cover all of the key areas of the Trust's work. It was agreed that a column for action plans would be incorporated to enable the Committees to assess whether these are adequate to address the particular risk.
- The internal auditors are due to complete their audit of the BAF shortly.

Exception report for the Quality Dashboard

- The Committee requested further information regarding ambulance handovers over 30 minutes.

- A question was raised, in relation to the average age and complexity of patients, whether the Trust has the correct indicators in place.

Quarterly Patient Experience Report

- Response times have improved slightly, with only two specialities lagging behind.
- Appointment cancellations have increased considerably.
- The Trust has come out poorly in the maternity survey, rated 67th out of 68 Picker trusts.

Mortality update

The Trust's mortality rate, as measured by the HSMR and SHMI continues to be lower than or within the expected range.

Divisional Deep Dive – Medicine

- This is the second of the divisional deep dives. In terms of the issues that the Division is most focused on, they highlighted the importance of getting patients into the right beds. A number of changes and have been made to surgical pathways following the introduction of ward 24. Steps are also being made to comply with the findings from the Getting it Right First Time (GIRFT) reviews.
- The winter pressures have meant that the day surgery beds are being used for emergency admissions. Plans are now being made to treat some Trauma and Orthopaedic patients at weekends to help recover performance.
- There are particular issues around urology, with long waits for a number of patients. Innovative steps have been taken to address the issues and the waiting list has now considerably reduced.
- There are challenges around staffing both in terms of nurses and doctors. Overall turnover within the division is 14%, but there are some specialities where this is higher. Nationally, there are shortages of breast surgeons, ODPs and theatre nurses.
- Ideally, the hospital would be running at 80-85% of capacity, and as such, the Trust would need 10% more beds, although there may be issues staffing these.
- Rollout of the Red2Green initiative in Surgery has been challenging, as it is difficult to run ward rounds with all the consultants in attendance. However, there is buy-in across the division and there are examples of success in wards 20 and 24.
- A change that would make the most impact for the division would be for the Medicine division to look more closely at lengths of stay. The Trust needs to work harder with other agencies on suitable packages of care to facilitate timely discharges.

Quarterly Trust-wide Progress Report – Serious Incidents

- 13 serious incidents in Q3, 4 of which were due to sub-optimal care, all from different specialities.
- Efforts are being made to derive more learning from incidents, but more needs to be done to integrate the outcomes of clinical audit.

Internal Auditor's Report into Clinical Audit

- This was a very disappointing and surprising draft report, but it was acknowledged that there is an issue around the Trust's inability to evidence that its commitments around clinical audit are being met.
- Nevertheless, there are aspects of the report that the Trust does not agree with, and the final version will contain management responses.
- Changes are being made to the administrative processes around clinical audit, but it would be important to ensure that there is effective oversight of the programme, including by this Committee. There is need to ensure that there is clarity around clinical audit priorities, and that there is an improved focus on its governance. It was acknowledged that this would not be a quick fix, but the first step would be to agree some sensible metrics. Suggestions for improvement are to be presented at the next meeting.

Compliance with processes for assessing performance against NICE guidance
It was acknowledged that there are some issues in relation to engagement and compliance in this area. The Trust is required to perform a baseline assessment of each guideline to determine if it is applicable, but this is not always happening within a reasonable timeframe. A further report setting out plans for improvement, will be presented at the next meeting.

3. Items for Escalation to the Board

- The hospital is very busy
- The Trust does not appear to have a clear plan for improving the patient experience
- The clinical audit and NICE guidance assessment processes are failing and need to be fixed urgently. There is to be increased oversight and governance around both processes by this Committee.

4. Conclusions

The committee was assured that the hospital remains safe, and commended the engaged and professional executive team.

The Board is asked to note this report and the specific items escalated for the Board's attention.

Milton Keynes University Hospital NHS Foundation Trust

MEETING OF THE FINANCE AND INVESTMENT COMMITTEE HELD ON 5 February 2018

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

- The Committee approved the Waste Management Contract Business Case.

Matters referred to the Board for final approval:

- There were no matters that were referred to the Board for final approval.

Other matters considered at the meeting:

1. Minutes of the last meeting and Matters Arising:

   I. Consultant productivity – The Trust's Patient-Level Costing System (PLICS) will provide a more detailed view of productivity, and the national Model Hospital framework will also include a section on doctor productivity.
   II. Despite support from NHS Improvement, no progress has been made with regard to EPR funding.
   III. The temporary reduction in the number of University of Buckingham medical students coming to MKUH has been planned as part of steps to enable the university grow its numbers through other sites, with the overall aim of considerably increasing the total size of the school.

2. Performance Dashboard:

The Committee noted:

   I. The pattern of high attendance in A&E and the low number of electives continues, reflecting the winter pressures. The pressure has now eased off slightly, but the hospital remains extremely busy.
   II. The A&E 4 hour target and front door streaming targets were both met, but it was not clear that the Trust would be able to achieve the 4 hour target of 95% in March 2018, meaning that the Trust would not be in a position to achieve STF funding.

3. Finance Report:

The Committee noted that:

I. At M9, the Trust is reporting that it is meeting its control total.
II. Clinical income is below plan, and although high cost drugs have improved the underlying position, this is offset by additional costs.
III. There have been big increases in MRET and readmission penalties.
IV. An agreement has been reached with MKCCG for M1-6 to avoid contract arbitration.
V. £751k winter funding was received in full in M9
VI. Without EPR funding, the Trust would run out of money by mid-March. NHS Improvement is fully aware of the situation.

4. Agency update

It was noted that spend is likely to increase during the last 3 months of the year, although the Trust is expected to remain within its £15.12m ceiling. This is in part due to the reduction in bank premiums which comes into effect in March, as well as a fall in the number of applications for nursing posts. It was noted that the agency market has changed, and there is now less of an incentive to do agency work.

5. Transformation Programme update

The following points from the report were highlighted:

I. Performance to date is below £5m against a £6.5m plan, and the forecast outturn is £7.4m against a plan of £10.5
II. Actions are being taken to improve performance going into next year, and plans are being prioritised, such that a good proportion of the total could be identified before the start of the year.
III. Performance in relation to the cross-cutting procurement programme has been mixed. Some specific work has been done with STP partners, but there does not appear to be much enthusiasm for joint procurement initiatives. The Trust is therefore seeking such opportunities elsewhere.
IV. The point was made that the focus of transformation is on increasing productivity rather than cost savings – the Trust needs to ensure that it is using all its resources, human and material, to their full capacity.
V. Changes are to be made to the way that transformation is managed and the team is to be brought within the Director of Finance's remit.

6. Timeline for strategic capital projects

As a result of the lack of movement on DH capital funding, it would not be possible to proceed with the aseptic suite and pharmacy robot projects this year. The schemes that are already underway are broadly on track, but there has been a delay to the start of the construction of the Cancer Centre. The Trust is in discussion with a P22 supplier, but no contract has yet been signed.

7. Financing the Trust's car park development

An unsecured loan with a private company had been approved in principle by the Board, subject to a review of options by this Committee. The Committee raised questions about the most cost effective way of drawing down the funding in response to which the Director of Finance expressed the opinion that it would be possible to draw down part but not all of the money as required.

8. Governance of Global Digital Exemplar (GDE) Programme

The £5m that is to be paid to the Trust as a Fast Follower to the GDE programme will be received over 3 years. It will be used to fund investment in digital projects, such as devices and support to support the Trust's broader IT agenda.

9. Other Business

New planning guidance for 2018/19 has been issued and will be circulated to the NEDs. The final plan will be ready by the end of April.

The Committee members thanked David Moore for the skill and care with which he had chaired the Committee, and for the support he provided to the Executive Directors in attendance.

10. Risks highlighted during meeting for consideration to CRR/BAF

None

Milton Keynes University Hospital NHS Foundation Trust

Workforce and Development Committee Summary Report

1. Introduction

The Workforce and Development Committee met on 6 November 2017. A summary of key issues discussed is provided below.

2. Workforce

2.1 **Staff Story** – One of the two hospital chaplains attended to provide the staff story. She had been at the Trust since 2014, having previously been a local church minister who also did some work at a local hospice. The chaplain enjoys the variety within the role, and sees it as one of her main duties to be there to listen to the concerns, serious or mundane, of patients and staff. She does find some aspects of the role harrowing, including comforting parents who have suffered a miscarriage or lost a young child, but finds her engagements with people coming to the end of their lives quite powerful. The chaplain has a passion for staff health and wellbeing and was instrumental in the setting up od the Peer to Peer (P2P) listening service – which many staff have found useful, and in relation to which the number of volunteers is constantly growing. In terms of things that she would change, the chaplain is concerned about the extent to which staff feel the need to respond to emails etc. outside of work hours.

The Committee were grateful for the insights that the chaplain provided. For future meetings, it was agreed that members of staff who could perhaps give a more challenging account of their work at the Trust be invited to tell their story. These would include a junior doctor, an ED nurse and a member of staff-side

2.2 **Workforce Quarterly Report** – This was received, and it was noted that it only covered 2 months of the quarter. Highlights included the fact that the vacancy rate had fallen to 12% during the course of year, with the best position recorded in November. Turnover was similarly lower, while statutory and mandatory training and appraisal rates had risen slightly to 89%. It was noted that all the key indicators were moving in the right direction, with the exception of in the Emergency Department.

2.3 **NHS National Staff Survey 2017** – Picker only – this survey had been run by Picker and not the Department of Health. Highlights are that there had been a reduction in the response rate to 42%. In terms of the Trust's performance compared to last year, there were 5 questions on which responses were significantly better and 3 questions on which they were significantly worse. The Trust is moving in the right direction, but it remains a national outlier. There is disappointment that the results were not better, considering the efforts that management had put into staff engagement during the course of the year, including Event in the Tent.

In terms of next steps, focus groups are to be set up to think about ways to improve things, and some divisions are implementing their own ideas. An update on this is to be presented at the next meeting.

2.4 **Staff Friends and Family Test** – The Quarter 2 results of this test show that the response rate has dipped to 19%, indicating an actively disengaged workforce, although the proportion of staff who would recommend the Trust remains high.

2.5 **Agency controls and usage** – The management processes for agreeing agency use are being tightened up, with retrospective authorisation no longer allowed. At the same time, further innovation is being introduced into the recruitment process, including greater use of social media platforms. There has been some reduction in staff bank pay rates, and the possible impact of this is being monitored. There are currently no plans to establish an STP-wide bank with Luton and Dunstable and Bedford Hospitals.

2.6 **Staff health and wellbeing report** – It was noted that the CQUIN for health and wellbeing will be partially achieved. Use is being made of the workforce website to help staff become involved with and to set up sporting and social events. Eyesight testing is to be made available on site. The Trust has exceeded the 75% for staff flu vaccination, and is also supporting patient vaccination.

2.7 **Staff retention** – The Committee received feedback from the onboarding and exit surveys. The findings from the onboarding surveys were mainly positive, with most new starters meeting their manager on the first day, and receiving a clear explanation of their duties within the first week of their employment. There was however concern that almost 8% of nerw starters did not feel welcomed at the Trust. At 12 months, almost all staff expressed satisfaction at their decision to join the Trust, although there were a few complaints about pay and benefits, job roles and workload.

Less than half of all leavers currently complete an exit survey, and the sample size is not yet large enough to enable any conclusions to be drawn as to why people leave and what leavers' impressions of the Trust are. There was some concern, however, that 20% of those surveyed reported bullying and harassing behaviour.

2.6 **Equality and Diversity** – The report on the findings of the Workforce Race Equality Standard 2017 (WRES) was presented. The WRES was incorporated into the NHS standard contract in 2015 with a view to making workforce race equality mandatory within the service. The two main messages highlighted in this report, as it relates to this Trust, were that around 2.5% more staff from a BME background than from a White background had experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months, and that 21% more White than BME staff believe that the Trust provides equal opportunities dfor career progression or promotion. It was noted that these results had not been expected. An action plan for addressing these and other issues raised by the report will shortly be published in the Trust's website.

2.7 **We Care update** – The extent to which this agenda overlaps with the staff survey and health and wellbeing was noted. the focus over the next few months will be on ensuring that the We care values become more integral to the work of the Trust, but there was an acknowledgement that there is a need for a re-launch, with a new vision and purpose.

3. **Education**

3.1 Education Update – The work experience opportunities for GCSE and A Level students were acknowledged. There is still no clarity around the Health Education England funding arrangements. Clarity is also being sought as to whether the Trust ought to be aligned with the Thames Valley region or East Midland and East.

3.2 Medical Education Update – Highlights included:

- A development programme for new consultants
- Information that has been made available for international medical graduates on the Trust's workforce website, and
- The appointment of a new consultant educational lead.

4.1 Board Assurance Framework – The new BAF template, setting out the risks specific to this Committee were noted.

4.2 Minutes – The minutes if the following meetings were noted: Workforce Board dated 30 October 2017; MK Undergraduate Quality Group on 13 November and 4 December 2017; Medical School Steering Group on 28 November 2017 (for the future, these are to be presented at the Workforce Board).

The Board is asked to note the summary report.

Charitable Funds Committee Summary Report

1. Introduction

The Charitable Funds Committee met on 5 February 2018.

2. Key matters

The following items were presented to the Committee:

Matters arising –

- A scoping exercise about how to establish independence in terms of decision making, including an explanation of the corporate trustee model, is to be carried out and presented at the March Board meeting.

Update from the Fundraising Practice

- Significant senior engagement activity with key players, both corporate and individual within the Milton Keynes area is ongoing. There is much interest in the project among some of the city's household names, and some firm promises of support have been received.
- The appeal remains on track for its public launch this June, and it is expected that at least one major donation would have been received by then.
- Work is being done to ensure that the fundraising team received the support it needs, both in terms of finance and personnel. An update on how these arrangements are progressing is to be presented at the Committee's next meeting.

Update on other charitable activities

- The Christmas appeal achieved its target.
- The fundraising team is working with the divisions to draw up a portfolio of items to fundraise for.
- There are a number of significant donations in the pipeline.
- A large number of fundraising champions have been identified within the Trust, and part of their role would be to signpost potential donors to the Fundraising team.

Charitable Fund Request – management and development costs relating to the hospital arts collection

- This request was for the funding of the maintenance and curation of the Trust's collection. The request was approved.

Charitable Funds Finance Report

- Income remains slightly below forecast, but expenditure has also slowed down.
- The charity's balance includes a recharge to the Trust for staff costs.
- Additional staff are to be appointed on a fixed term basis to support the Cancer Centre appeal.
- There is recognition of the team's accommodation needs, and this issue is to be taken up by the Executive.

Covering the costs of fundraising

- The Finance Director was clear that it would be wrong for the charity to be funded by the Trust.
- Consolidation of the smaller funds is to be revisited, and it is likely that money held in those funds that have been inactive for some time will be used to fund the work of the charity as a whole.

3. Risks highlighted during the meeting for consideration on BAF/SRR

Cancer Centre appeal short and long term funding
Overall level of charity funding