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Board of Directors

Public Meeting Agenda

Meeting to be held at 10.00 am on Friday 1 March 2019 in the Conference Room, Academic Centre, Milton Keynes University Hospital.

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 11 January 2019	Approve	Pages 3-14	Chairman
1.4	Matters Arising/ Action Log	Receive	Pages 15-16	Chairman
2. Chair and Chief Executive Strategic Updates				
2.2	Chairman's Report	Receive and Discuss	Verbal	Chairman
2.3	Chief Executive's Report	Receive and discuss	Verbal	Chief Executive
3. Quality				
3.1	Patient Stories	Receive and Discuss	Presentation	Director of Patient Care and Chief Nurse
3.2	Nursing staffing update	Receive and Discuss	Pages 17-22	Director of Patient Care and Chief Nurse
4. Performance and Finance				
4.1	Performance report Month 10	Note	Pages 23-36	Deputy Chief Executive
4.2	Finance update report Month 10	Receive and Discuss	Pages 37-46	Director of Finance
4.3	Workforce update report Month 10	Receive and Discuss	Pages 47-54	Director of Workforce
5. Assurance and Statutory Items				
5.1	Board Assurance Framework	Receive and Discuss	Pages 55-66	Director of Corporate Affairs
5.2	7 Day Services Board Assurance Report	Receive and Discuss	Pages 67-74	Medical Director
5.3	Management Board upward report February 2019	Note	Pages 75-76	Chief Executive
5.4	(Summary Report) Finance and Investment Committee – 4 February 2019	Note	Pages 77-78	Chair of Committee
5.5	(Summary Report) Workforce and Development Assurance	Note	Pages 79-82	Chair of Committee

Item No.	Title	Purpose	Type and Ref.	Lead
	Committee – 4 February 2019			
5.6	(Summary Report) Charitable Funds Committee – 4 February 2019	Note	Page 83	Chair of Committee
6. Administration and closing				
6.1	Questions from Members of the Public	Receive and Respond	Verbal	Chairman
6.2	Motion to Close the Meeting	Receive	Verbal	Chairman
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."*	Chairman

BOARD OF DIRECTORS MEETING

Minutes of the Board of Directors meeting held in PUBLIC on Friday 11 January 2019 in Room 6, Postgraduate 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 Audit Committee)
Parmjit Dhanda	Non-executive Director
Mike Keech	Director of Finance
Lisa Knight	Director of Patient Care and Chief Nurse
Tony Nolan	Non-executive Director (Chair of Workforce and Development Assurance Committee)
Danielle Petch	Director of Workforce
Ian Reckless	Medical Director (from item 3.1)
Helen Smart	Non-Executive Director (Chair of Quality and Clinical risk Committee)
Heidi Travis	Non-executive Director (Chair of Finance and Investment Committee)

In Attendance:

Kate Jarman	Director of Corporate Affairs
Adewale Kadiri	Company Secretary
Lorraine Montgomery	Senior Sister, Ophthalmology (item 3.1)
Jill Kimber	Sister, Ophthalmology (item 3.1)
Louise Norwood-Grundy	Staff Nurse, Ophthalmology (item 3.1)

2019/01/01	**Welcome**
1.1	The Chairman welcomed all present to the meeting.
2019/01/02	**Apologies**
2.1	Apologies for this meeting were received from John Clapham and Caroline Hutton.
2019/01/03	**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.
2019/01/04	**Minutes of the meeting held on 9 November 2018**

4.1	The minutes of the public Board meeting held on 9 November 2018 were accepted as an accurate record of that meeting.
4.2	Helen Smart asked to be provided with more detail around the investigation into 'other perinatal conditions', which had been highlighted as an outlier under HSMR. She agreed to pick this up separately with the Medical Director.
2019/01/05	**Matters Arising/ Action Log**
5.1	There were no matters arising in addition to those included on the agenda.
5.2	The action log was reviewed as follows: <u>360 Nursing staffing report</u> Details of the national guidance had been incorporated into the nursing staffing update at item 3.2. Closed.
2019/01/06	**Chairman's Report**
6.1	The Chairman acknowledged the publication of the NHS Long Term Plan, noting that much of its contents had been expected. The Chief Executive agreed to present the headline implications of the Plan and a financial update at the Board seminar in February. **Action: Chief Executive**
6.2	The Chairman announced that a preferred candidate had been identified following the recent non-executive director appointment exercise, and that the appointment had been approved by the Council of Governors. Referencing and other checks are nearing conclusion in advance of a formal offer being made, and it is expected that the candidate will be at the February seminar.
6.3	The Trust is now able to announce that the Duke of Bedford has agreed to become patron of the Cancer Centre appeal.
2019/01/07	**Chief Executive's Report**
7.1	The Chief Executive informed the Board that the hospital had had a busy time over the Christmas break, but that staff had responded admirably under the pressure.
7.2	The hospital had received an overnight visit from the Secretary of State for Health and Social Care just before Christmas. He spent over 7 hours on site and visited many parts of the hospital including the Emergency Department, maternity, the site office, the paediatric assessment unit and theatres, and he spoke to many members of staff. The Chief Executive explained that the Secretary of State had decided to visit at night in order to gain a more rounded impression of the organisation than he would have got on a formal visit. He was very impressed with the staff and the organisation, and further positive feedback has also been received from his office. The Secretary of State had also been aware of the technological innovations at the Trust.

7.3	The Chief Executive made reference to the report of the interview that he had given to the Guardian newspaper. This has been positively received by the NHS, and a supportive message had been received from Simon Stevens. The piece was also picked up on Twitter by the Secretary of State as a positive reflection of the Trust's work on technology.
7.4	At Q3, the Trust has delivered on its key performance targets, and was therefore able to access £1m of incentive fund monies.
7.5	The Trust has been awarded 5 stars for its patient catering services. The Board congratulated the Catering Team on this achievement.
7.6	The planning guidance for 2019/20 has been published and will be circulated to the Board.
7.7	Following the Chief Executive's handling of the NHS Twitter handle during the summer, it had returned to MKUH over Christmas and was handled by Sarah Crane. She became the first person of faith to have been given the responsibility.
7.8	The Trust has been notified of an impending inspection visit by the CQC. The expectation is that it will take place within the next 8 to 12 weeks. A message is to be sent round the organisation today, asking that staff focus on three areas: • Spending time between now and the date of the visit focusing as they would normally on delivering excellent care and service; • If there are things that need fixing, tell the executive team about them; and • That we continue to get the basics right.
7.9	The Chief Executive maintained that the organisation will not focus unduly on preparing for the inspection, but it would be important to show itself in the best light.
7.10	In response to a question from Parmjit Dhanda about conversations with the Secretary of State, the Chief Executive reported that Mr Hancock was clear that the NHS must reduce to zero the number of patients waiting for 52 weeks, and this had led to an honest conversation about the NHS' performance over the last few winters. The Secretary of State had gained valuable insight from this exchange. **Resolved**: The Board **noted** the Chief Executive's Report.
2019/01/08	**Sustainability and Transformation Partnership**
8.1	The Chief Executive reported that an interesting meeting had been held earlier in the week between the Chairs of the Buckinghamshire, Oxfordshire and Berkshire West ICS (BOB) and BLMK, a senior official from NHS England and all the stakeholders in Milton Keynes. The aim of the meeting was to discuss the relative advantages and disadvantages of the MK Place becoming part of BOB or staying within BLMK. There are strong clinical arguments for moving to BOB, but the CCG is concerned about the implications of such a change. A paper setting out all the pros and cons is to be is to be presented on 28 January for a decision to be made by the MK Place stakeholders. It was noted that BOB are supportive of the move,

	and that this will help to inform the decision.
8.2	As part of this process, all partners within the MK Place would be able to describe where they wish to be. The lead police representative had indicated that the Trust is currently disconnected from multi-party emergency planning and she was clear that a move to work within BOB would help address this. It was noted that Luton and Dunstable Hospital are also supportive of a move. Helen Smart questioned whether, in the event that both BOB and BLMK agree to the move, this would be sufficient for NHS Improvement and England to sanction the change. The Chief Executive stated that their decision would depend on whether, on balance, this is the right thing to do.
8.3	In response to a question, the Chief Executive remarked that rates of delayed discharge have reduced considerably, largely as a result of improved working relationships within the MK Place. There are currently 22 delayed discharges, down from the previous average in the 40s. Latest data also shows that MKUH has performed better than expected in reducing the number of 'stranded' and 'super-stranded' patients – the Trust is 11th nationally. The Chief Nurse acknowledged the hard work of the discharge team in bringing about these improvements, and made special mention of the contribution of Jane Bignall. **Resolved**: The Board **noted** the Sustainability and Transformation Partnership update.
2019/01/09	**Patient's Story**
9.1	Lorraine Montgomery, Jill Kimber and Louise Norwood-Grundy from the Ophthalmology team attended to talk about the work that they had done in setting up and running the Glaucoma Patient group. Lorraine explained that she had had the idea of starting a support group for some time, and had received support from the International Glaucoma Association. She explained that the Eye Clinic is a truly integrated team, and everyone has contributed to the group's success.
9.2	As to how patients can join the group, Lorraine explained that every patient has a regular vision check, and this provides the opportunity to talk to them about the group. If they agree, their details are taken and added to the database. She gave an example of how joining the group can have a positive impact on patients beyond their immediate condition – one patient was observed to have a low demeanour, and nothing appeared to change this until he was informed that at the group he would be able to assist other patients with inserting their eye drops – the idea that he could help others had given him an added sense of purpose. A short video clip was played during the presentation in which a patient and group member sets out the benefits that both he and his family had derived from attending meetings – including a better understanding of his condition and better awareness for his family on how to help him to insert his drops.
9.3	The group started in 2014, and despite some trepidation as to whether anyone would attend the first meeting, 60 people turned up. There are now 200 patients on the database, and 80 to 100 patients attend meetings which are held twice a year. Meetings were previously held on the Trust site, but due to the size of the group they are now held at the Ridgeway Centre. The underlying ethos of the group is

	hope, and the meetings give patients the opportunity to ask questions away from a clinical setting. In terms of next steps, it was noted that patients are now keen to have a dedicated webpage, and this is to be taken forward.
9.4	The Director of Finance enquired whether this idea has been picked up by any other Trusts and Lorraine explained that the team had given some assistance to their counterparts at Stoke Mandeville Hospital in setting up their own group. Tony Nolan asked whether the team had collected objective evidence showing that this intervention changes outcomes and Lorraine indicated that at every meeting a questionnaire is given to all patients, the results from which have shown a direct correlation between an increase in knowledge about the condition and improved clinical outcomes. However further work is to be done to see if such outcomes can be traced directly to attendance at the group.
9.5	The Board congratulated the team on this successful and popular initiative and thanked them for attending to share it. **Resolved**: The Board resolved to **note** the Patient's Story.
2019/01/10	**Nursing staffing report**
10.1	The Director of Patient Care and Chief Nurse presented this routine report. She drew the Board's attention to page 24 of the report, and indicated that the Care Hours per Patient Day (CHPPD) figures as set out are the best that the Trust has ever had. This has not been brought about through an increase in the establishment, but by the fact that the vacancy rate is now much lower. It was noted that October is always a good month as it is when all the newly graduated nurses start.
10.2	The Chief Nurse made reference to the nursing associate role, noting that the Trust's first cohort will compete their training at the end of March. Nationally, the NMC's register opens at the end of this month. The National Quality Board has enquired as to how the Trust will deploy them, and the response has been that they will be used to fill Band 5 roles. Although this could result in savings being made, these will not be taken out and nursing establishments will not be altered. In terms of deployment, a sensible approach is being taken and nursing associates will be sent to lower dependency areas, such as wards 3, 14, 18 and 19. These are some of the less acute parts of the hospital and ward sisters are in agreement with this approach. It was noted that some of these areas also have a high vacancy rate.
10.3	Nursing associates will also be placed in the Emergency Department – they will be well supported as there are 16 qualified nurses there. It was noted that the ED is popular with all the nursing associates. Like fully qualified nurses, nursing associates will be offered a one year preceptorship. The Chief Nurse acknowledged that this is a step into the unknown, and she and her team will continue to review support arrangements for the new role.
10.4	In response to a question from Helen Smart as to the meaning of enhanced observer, the Chief Nurse explained that this refers to what is more widely known as one-to-one nursing – enhanced observation indicates a more caring and potentially less intrusive approach.

10.5	The Chief Executive acknowledged the decision that had been taken not to release savings and asked about the Trust's status with regard to mental health nursing. In response, the Chief Nurse confirmed that the Trust is delivering against its targets in this area. She added that to take out more savings at this stage would be risky, and made the point that according to the safer nursing tool, the Trust is not over-established.
10.6	Heidi Travis noted the uncertainty that exists nationally around the nursing associate role, and asked about the view at this Trust. The Chief Nurse stated that when they first went onto the wards, there was some confusion among staff as to what their status was, in part because the decision had been made to offer the appointment to existing healthcare support workers who carried on in that role for 2 days a week – they are not supernumerary. It was acknowledged that some concerns remain about a possible watering down of the skill mix. However, as this first cohort is so small, the impact of nursing associates may not be known for up to 2 to 3 years.
10.7	Parmjit Dhanda highlighted the importance of blend within clinical teams and asked about how this is captured as between nurses, physios and other practitioners. The Chief Nurse explained that what is set out in the paper has been mandated by the National Quality Board; work is currently being done on developing job plans for therapies. The Chief Executive made the point that the Trust has the opportunity to carry out its own baseline assessment. All of the data is derived from e-Roster; therapists would simply need to be added onto the system. The Chief Nurse agreed to carry out a baseline assessment for allied health professional staff, cross referencing wards and more complex work. **Action: Director of Patient Care and Chief Nurse** **Resolved**: The Board resolved to **note** the nursing staffing report.
2019/01/11	**Mortality update report**
11.1	The Medical Director presented this routine report setting out the Trust's current position on mortality. He explained that the chance of a patient dying at this hospital is 7% lower than the national average, and that there are currently no outlying diagnostic areas. He drew the Board's attention to the output of the qualitative review which found that there are very few deaths with care quality concerns, but he wondered whether the review methodology is sufficiently robust. Discussions on this are taking place with the divisions. The Medical Director stressed the importance of avoiding complacency, emphasising the need for the Trust to improve its offer to patients as there are almost always aspects of care that could be improved.
11.2	In response to a question from Heidi Travis as to the steps that need to be taken to push that improvement boundary, the Medical Director explained that 2 to 3 years ago number of multidisciplinary teams were set up to analyse deaths at the hospital. There were concerns that the national agenda had made the process too rigid, and structured judgement reviews are now in place. It is hoped that this discipline will feed its way into team discussions going forward. **Resolved**: The Board resolved to **note** the mortality update report.

2019/01/12	**Safety of nasogastric feeding**
12.1	The Medical Director introduced this item, informing the Board that a national patient safety alert had been issued previously in respect of nasogastric tube placement, which required that the measures outlined were to be discussed at a public Board meeting. The Trust had undertaken many actions at the time and the position was discussed in other forums (including Clinical Quality Board, with commissioner representation) but not at Public Board. It was pointed out that nasogastric tubes can cause major difficulties if they go into the lungs rather than the gullet.. The Trust has already trained its radiographers to identify and report any problems with tube placement. This was felt to be a much more robust approach than those employed in other organisations (relying upon doctors in training and/or deferring confirmation until working hours). In response to a question from Parmjit Dhanda about the proportion of patients requiring a radiograph to address such problems, the Medical Director indicated that on average about 2 x-rays a day are taken for this reason. **Resolved**: The Board resolved to **note** the update on nasogastric tube safety
2010/01/13	**Performance Report Month 8**
13.1	The Deputy Chief Executive introduced this routine report. He confirmed that the Trust had comfortably met its Q3 target for A&E, providing a financial benefit for the organisation. The team were rightly very proud of this achievement.
13.2	With regard to patients who have been waiting 52 weeks for treatment, the number of breaches remains at 10. The Deputy Chief Executive made the point that a lot of work has gone into robustly managing the position, and he was confident that the Trust is well on the way to getting the number down to 0. Nationally, the RTT position is worsening. This Trust's position suffered last year as a result of winter pressures, but the position now is close to plan at 89% - planning for the Christmas and New Year period was more successful this year and escalation into Day Surgery was not required. The Medical Director acknowledged that many patients are still not being treated within 18 weeks – the Trust acknowledges that this needs to be addressed.
13.3	On the cancer 62 day standard, it was acknowledged that the Trust's performance in October had been disappointing. However performance in November and December had improved to 86.3 and 85.8% respectively, meaning that overall performance for the quarter would be 82%. This means that the Trust will not meet the target for the quarter but remains on track to meet it for the year.
13.4	The Chief Nurse remarked that this winter the Trust is in a better place compared to many other organisations. As a result of some spikes in activity, the Trust had declared that it was at Operational Pressures Escalation Level (OPEL) 3 at the beginning of the week, but it is now back down to OPEL1. A good number of discharges have already taken place today and the hospital is in a good position.
13.5	The Chief Nurse also informed the Board that the number of flu cases nationally is beginning to rise. The strain this year is Flu A and so far the vaccine is proving effective. At this hospital, all the admissions so far have been of patients below the age of 65, vindicating the decision to prioritise elderly patients for vaccination. The

	Chief Nurse highlighted that one neighbouring trust has had to close 4 wards. There have been minimal cases of norovirus so far, but the arrival of a cold snap could change this.
13.6	The Medical Director announced that a Never Event had taken place recently, namely the retention of a vaginal swab for a number of hours following childbirth. The patient did not suffer harm. Commissioners, NHS Improvement and the CQC have been notified. The RCA is nearly complete.
13.7	Helen Smart enquired about readmission rates which she considered to be high. In response the Director of Finance acknowledged that there had been an increase, but observed that the Trust still rates green against this measure on the Model Hospital framework. The Medical Director reminded the Board that about a year ago an audit of around 200 cases was carried out, the results of which were reassuring. There are, however, some areas for improvement, including discharge communication and documentation.
13.8	The Director of Corporate Affairs highlighted the work being done to address the outpatient non-attendance rate. A new deputy general manager for outpatient services has been appointed and will start shortly.
13.9	In response to a question from Andrew Blakeman about the Model Hospital, the Medical Director reassured the Board that this information is routinely included in the material that is provided to them, but that arrangements could be made for the framework to be presented more comprehensively.
13.10	Heidi Travis noted the Trust's relatively good performance over the winter period thus far and asked what this could be attributed to. The Chief Executive observed that because of its size, the hospital is always operating at the margins. He remarked that there is no single factor in the Trust's success. He paid tribute to the work that the Chief Nurse and the Director of Clinical Services have done with partners across the city. Mention was also made of the work of the estates team in opening ward 12 as an escalation area, as well as the Trust's focus on education and training, which has helped in the successful recruitment of doctors and nurses. However, the single biggest factor has been the reduction in the number of delayed discharges which has allowed for better patient flows across the hospital.
13.11	It was noted that there continue to be delays in providing medication for patients who are ready for discharge, and this will be taken up at the Quality and Clinical Risk Committee.
13.12	The Chairman noted the re-introduction of fines in respect of patients waiting for 52 weeks, and asked if the Trust receives support from the CCG in this regard. The Deputy Chief Executive explained that there is not much that they can do. Amendments have been made to the referral system with a view to balancing the load across local hospitals, but often different local providers all have capacity issues in the same specialities. **Resolved**: The Board resolved to note the Month 8 Performance Report.
2019/01/14	**Finance Report Month 8**

14.1	The Director of Finance presented this regular report. By way of context, he informed the Board that at month 6, the acute sector nationally was £1.7bn in deficit, £0.25bn adverse to plan – the system is under intense pressure.
14.2	He highlighted the following points in relation to the Trust's position: • The STP's challenges continue – there is currently an £8m variance to the system control total, but none of this is attributable to MKUH . • The Trust's performance, excluding Provider Sustainability Funding, is £485k favourable to plan in month. Because of the difficulties elsewhere within the STP, taking PSF into account, the Trust's position is £104k adverse to plan. • The Trust has generated a surplus for the first time in a while. This positive position has arisen because the Trust has been able to deliver higher levels of income while maintaining a relatively low cost base. There has also been a high level of discharges. • The Trust is overspent on pay, partly due to the additional cost of funding the Agenda for Change pay award. • Non-pay expenditure is also above plan as a result of the cost of clinical supplies and services as well as high cost drugs and outsourcing.
14.3	The Board was informed that a new line has been added to the headline financial position table around PSF incentive funding. The provider sector had been asked if there was more that could be done to support the national position, and as its response, the Trust has committed to a stretch total of £900k. In addition the Trust will receive bonus funding of £1.8m. This is a positive development for the organisation.
14.4	The position with regard to the cost savings programme has improved, and £8.9m worth of schemes are now on the tracker. Attention is now turning to next year's programme, although the 2019/20 control total is not yet known.
14.5	Heidi Travis asked how the risk around the main commissioner being unable to pay for the volume of activity undertaken would be resolved. In response, the Director of Finance indicated that at the moment, MKCCG is on track financially. A change I that position would lead to an increase in the number of contract challenges, and these would be escalated. This has not yet occurred – such difficulties tend to materialise later in the year. **Resolved**: The Board **noted** the month 6 Finance Report.
2019/01/15	**Planning Guidance**
15.1	The Director of Finance provided an update on the planning guidance for 2019/20. He indicated that this would be the most significant set of changes for a number of years, and highlighted the national drive to return the system to balance. He drew attention to the following headlines: • A change in the tariff mechanism for non-elective income. From next year, a block sum is to be agreed for all non-elective activity, and any variation from

	this would only be paid at 20%. This would be a major challenge for the Trust and it would be important to ascertain as accurately as possible the rate of activity growth that the Trust would expect to see. It was noted, however, that there is a "break glass" clause which could be activated in the event that activity significantly exceeds forecast. • The Market Forces Factor is changing and again it is likely that this would adversely affect the Trust. • £1bn of sustainability funding is to be built into the tariff. • A new £1.05bn fund is to be created to support the sustainability of essential services • A 1.1% tariff efficiency requirement is to be introduced, and there will be an extra 0.5% for organisations that are in deficit. • The value of CQUINs is to be halved and built into the tariff uplift. • The Marginal Rate Emergency Rule (MRET) is to be abolished – the block sum would be reduced based on historical MRET figures. • It is expected that the Trust's control total would be communicated this month.
15.2	The Director of Finance highlighted the incentive to better manage demand as a system.
15.3	The next key date in this process is Monday the 13th of January when the high level return is expected to be delivered. **Resolved**: The Board **noted** the planning guidance update.
2019/01/16	**Workforce Report month 8**
16.1	The Director of Workforce presented this report and highlighted the following: • The number of staff in post continues to grow, but vacancy rates for medical and dental and nursing and midwifery are at 16.7% and 17.5% respectively. These are the highest in the Trust. • On temporary staffing, the Trust has been successful in converting a number of agency staff to bank. Agency spend remains under the ceiling. • The sickness absence rate is holding at 4%. Most managers have now received training on the new policy. • The work with the NHS Improvement retention support group is being put into effect. • Statutory and mandatory training compliance has fallen by 1% and is now slightly below the target. Appraisals are 5% away from where they need to be. It was noted that the changes to the Agenda for Change system for increments will make this mandatory. The Trust has decided to make this a requirement for all staff from 1 April 2019. It was noted that as at M9, statutory and mandatory training compliance is back up to 90%
16.2	There was a discussion about the number of days that are lost as a result of short term sickness absences. It was noted that under-reporting remains an issue, and that there is a national requirement for e-rostering to be rolled out for all staff groups.

	Resolved: The Board **noted** the Month 8 Workforce Report.
2019/01/17	**Freedom to Speak Up update**
17.1	The Director of Workforce introduced this item. She indicated that there had been a national policy refresh and that the Trust's approach mirrors this. The focus nationally is moving towards the creation of a speaking up culture which is already in place here.
17.2	The Chief Nurse was concerned that reference to consultant medical staff having the possibility of direct access to the Chief Executive, which no other staff group has, remains in the policy. The Chief Executive stressed the need to encourage staff to raise any concerns that they might have through as many routes as possible, and he agreed that all staff should be given access to the Medical Director and Chief Executive where necessary. It was also agreed that mention will be made on the intranet that Tony Nolan is the NED lead for speaking up.
17.3	The Chief Executive highlighted the established good practice in this area within the Trust, including the quarterly thematic briefings that he receives from the Freedom to Speak Up Guardians. The Trust is also one of a few organisations to introduce Freedom to Speak Up Ambassadors – a cohort of individuals from across the hospital who will take the message to the grassroots of the organisation, make it easier for staff to raise concerns, and help to create and maintain a culture of transparency across the Trust. He made the point that some of those who have put themselves forward for this new role, have themselves raised concerns in the past.
17.4	It was agreed that the reference to Chairman and Chief Executive in Appendix A would be changed to Chief Executive only. **Resolved**: The Board **noted** the Freedom to Speak Up update and the revised Speaking Up Policy
2019/01/18	**Fit and Proper Person Test policy**
18.1	The Director of Workforce drew the Board's attention to this new policy, which is in line with national guidance in this area. **Resolved**: The Board **noted** the contents of the Fit and Proper Persons Test Policy.
2019/01/19	**Terms of Reference Review**
19.1	The Director of Corporate Affairs re-introduced terms of reference for the Board and the Audit and Finance and Investment Committees, following the further changes that had been suggested at the November meeting. • The updated Board terms of reference were approved, subject to the inclusion of a clause that the Trust will keep as much of its deliberations in the public domain as possible. • For the Audit Committee, it was agreed that oversight of cyber-security would be added as one of its duties.

	• For the Finance and Investment Committee benchmarking and value for money and efficiency are to be added to its list of duties. With regard to attendees, it is to be clarified that the Medical Director attends in his capacity as Chair of the CBIG. **Resolved**: The Board **approved** the changes to the terms of reference of the Board, Finance and Investment Committee and Audit Committee, subject to the inclusion of the further amendments that had been agreed
2019/01/20	**Use of the Trust Seal**
20.1	The Director of Corporate Affairs confirmed that the Trust Seal had been used in relation to the settlement of the Shareholder Agreement for ADMK Ltd, and the Operated Healthcare Facility Agreement between the Trust and ADMK Ltd. **Resolved**: The Board **noted** the use of the Trust Seal.
2019/01/21	**Board Committee summary reports**
21.1	The Board noted the contents of the summary reports of recent Board Committee meetings as follows: • Audit Committee meeting held on 13 December 2018 • Finance and Investment Committee meetings held on 5 November and 17 December 2018 – Heidi Travis highlighted the advantage of the Trust being ahead of the game in relation to the introduction of PLICS • Workforce and Development Assurance Committee meeting held on 5 November 2018 • Quality and Clinical Committee meeting held on 13 December 2018 • Charitable Funds Committee meeting held on 5 November – Parmjit Dhanda indicated that further changes are to be made to the Committee's terms of reference to make it easier for the hospital to apply for funding, in line with legal advice received.
2019/01/22	**Questions from members of the public**
23.1	A publicly elected governor in attendance asked a question about the timescales for a decision on the STP geography. The Chief Executive explained that an options paper is to be presented shortly and that BLMK partners would have formed a view by the end of January. If there is to be a change, there will be a shadow period which is to be agreed.
2019/01/23	**Any other business**
23.1	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	361	11 Jan 2019	6.1	Chairman's Report	The headline implications of the NHS Long Term Plan are to be presented at the next Board seminar	Joe Harrison	1 Feb 2019	Closed	A planning update was presented and discussed at the February Board Seminar
Board of Directors	Public	362	11 Jan 2019	10.7	Nursing staffing report	The Chief Nurse agreed to carry out a baseline assessment for allied health professional staff	Lisa Knight	3 May 2019	Open	

Meeting title	**Board of Directors**				**Date: 1 March 2019**		
Report title:	**Nursing Staffing Report**				**Agenda item: 3.2**		
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:							
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 1

Board of Directors Report on Nursing and Midwifery staffing levels Amalgamated report for December 2018 and January 2019

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.

$$\text{CHPPD} = \frac{\text{hours of care delivered by Nurses and HCSW}}{\text{Numbers of patients on the Ward at midnight}}$$

CHPPD	Total Patient Numbers	Registered Midwives/Nurses	Care Staff	Overall
December	14056	5.1	3.2	8.4
January	15050	4.8	3.0	7.8

Hospital Monthly Average Fill Rates for October 2018 and November 2018

Month	RN/RM Day % Fill Rate	HCA/MCA Day % Fill Rate	RN/RM Night % Fill Rate	HCA/MCA Night % Fill Rate
December	85.8%	102.0%	97.8%	123.9%
January	87.8%	99.5%	98.5%	123.7%

A Ward by Ward breakdown of fill rates for the two months has been included in the Appendix 1.

The CHPPD hours increased in December due to low total number of in-patients.

3. Areas with notable fill rates

Wards 15 had a full review of Enhanced Observation utilisation which continues to remain high on nights. The review demonstrated the need for a senior corporate review of workforce utilisation on ward 15; this review will be reported back in the next Trust staffing report.

4. Nursing Associate

New guidance has been published by NHS Health Education England (HEE) in February 2019 in the deployment of Nursing Associates. All recommendations were reported at 11th January Trust Board report apart from Medicine Management.

Nursing associates are able to administer medicines as part of their role, following additional training and education and where the required governance structures are in place. HEE have provided resources include advisory guidance setting out the expectations for nursing associates who administer medicines to patients and service users.

Supervision to support the new nursing associates in the education and training of medicines management within the confines of local policies will be required. The practice development team are ensuring practising nursing associates have the qualifications, competence, skills and experience to undertake the activities required of them.

5. Recruitment

The corporate team will be participating and the leading on Nursing/ Midwifery recruitment at the Milton Keynes job fair on the 24th/25th March. This job fair will give us to opportunity to advertise, promote and recruit from our local population and beyond.

The Associate Chief Nurse and the newly appointed Head of Human Resources system and compliance are reviewing a case for overseas recruitment plan and will bring back an agreed proposal.

The Division all have rolling adverts out in NHS jobs and are in the process off agreeing open days for the next finical year. The agreed recruitment plan will shared at the next workforce board and presented in the next staffing paper to board.

Qualified Staff Vacancies

Division	wte vacancies now	% vacancy now	Post recruited to	Residual wte vacancy	Residual % vacancy
Women's & Children	19.6wte	9.5%	3.68	15.92wte	8%
Medicine	64 wte	16%	13 .4wte	50.6 wte	13%
Surgery	33wte	12%	6 wte	26wte	10%

Total vacancy rate for the trust for qualified nurses' once new staff in post approx. **12%%**

HealthCare Assistant Vacancies

Division	wte vacancies now	% vacancy now	Post recruited to	Residual wte vacancy	Residual % vacancy
Women's & Children	8wte	6%	2.14wte	5.86wte	5%
Medicine	25wte	15.7%	10wte	15wte	6%
Surgery	15 wte	15%	1wte	14wte	12%

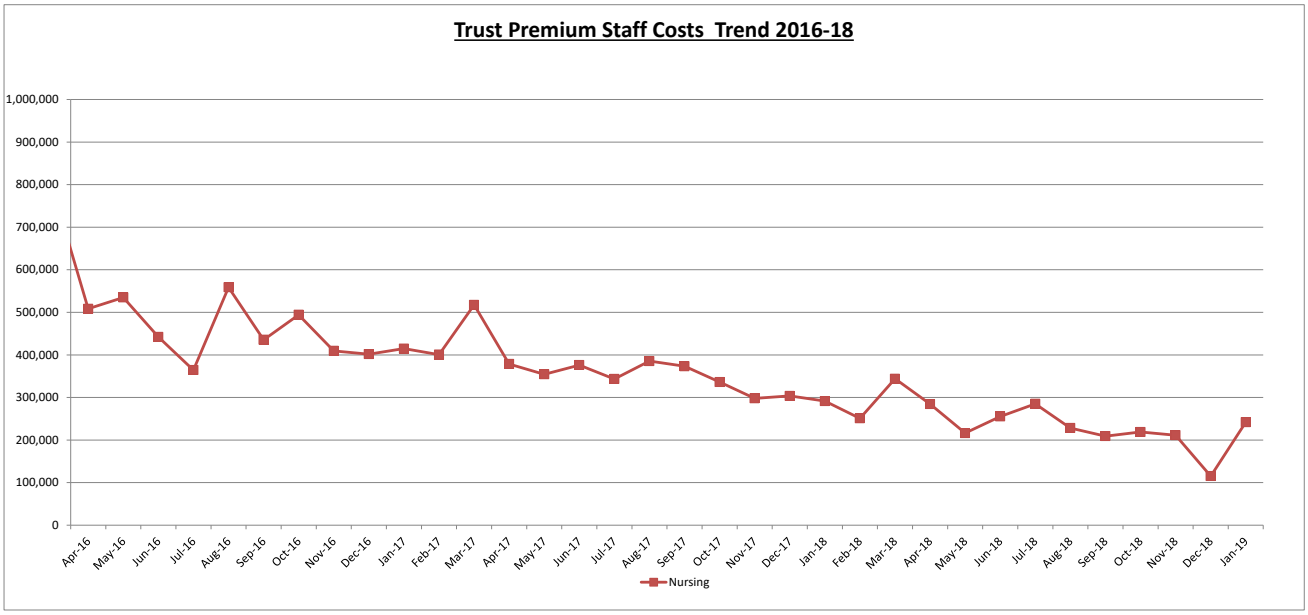
Total Trust vacancy rate for HCA once new staff in post approx.; **9%**

Please note that these figures are dynamic and so are changing on a daily basis – and recruited to posts will still be subject to drop outs. The vacancies need to be validated against vacancies recorded on Electronic Staff Record (ESR).

Within these figures the areas of most concern remain – operating theatres, wards 3, 15, 16 and.20.

6. Controlling Premium Cost

Agency nursing expenditure continues to stabilise with the lost agency cost recorded in December 2018. This is due a combination of availability at Christmas and occupancy.



Fill rates for Nursing, Midwifery and Care Staff December2018

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
AMU	82.7%	122.6%	103.3%	121.1%	741	5.2	2.6	7.9
MAU 2	97.4%	107.5%	105.7%	135.3%	738	4.1	3.3	7.3
Phoenix Unit	84.1%	99.8%	98.9%	130.6%	728	3.1	3.4	6.6
Ward 15	88.1%	123.0%	100.1%	170.5%	860	3.6	3.3	6.9
Ward 16	83.6%	108.4%	100.0%	122.6%	867	3.5	2.7	6.2
Ward 17	80.8%	95.2%	97.6%	125.7%	754	4.4	2.3	6.7
Ward 18	88.3%	105.4%	99.9%	141.4%	840	3.3	4.1	7.4
Ward 19	80.3%	102.4%	100.0%	141.3%	860	3.1	3.9	7.0
Ward 20	82.0%	88.7%	102.6%	98.0%	785	4.1	2.3	6.4
Ward 21	88.4%	90.9%	100.0%	117.7%	708	4.0	2.3	6.3
Ward 22	90.6%	96.1%	101.2%	114.6%	634	4.4	2.6	7.0
Ward 23	86.1%	99.6%	101.5%	107.8%	1104	3.7	3.8	7.5
Ward 24	89.8%	148.1%	94.4%	-	453	5.2	2.2	7.3
Ward 3	84.6%	85.0%	101.1%	103.8%	850	3.2	3.1	6.3
Ward 5	78.7%	124.8%	109.0%	102.7%	594	6.4	1.6	8.0
Ward 7	78.6%	108.0%	98.1%	144.0%	677	3.8	5.1	9.0
Ward 8	83.6%	94.3%	97.8%	120.8%	743	3.7	2.9	6.6
DOCC	84.1%	73.8%	83.8%	-	189	25.5	1.4	26.9
Labour Ward								
Ward 9	82.4%	95.2%	90.8%	83.9%	639	4.5	1.1	5.7
Ward 10	96.0%	83.9%	93.5%	-	256	5.9	2.7	8.6
NNU	93.0%	96.3%	96.0%	86.1%	36	98.1	19.1	117.2

Fill rates for Nursing, Midwifery and Care Staff January 2019

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
AMU	80.7%	116.8%	100.1%	142.2%	782	4.7	2.6	7.3
MAU 2	100.5%	109.1%	104.7%	156.8%	830	3.7	3.1	6.8
Phoenix Unit	87.1%	94.6%	96.8%	121.0%	740	3.1	3.2	6.3
Ward 15	79.3%	126.3%	102.5%	153.2%	890	3.3	3.2	6.5
Ward 16	83.8%	100.1%	96.1%	132.3%	893	3.4	2.6	5.9
Ward 17	79.0%	83.0%	99.5%	124.2%	759	4.4	2.1	6.5
Ward 18	85.7%	108.1%	101.3%	143.3%	863	3.1	4.0	7.2
Ward 19	80.5%	96.7%	100.0%	130.2%	921	2.8	3.4	6.2
Ward 20	82.2%	99.6%	99.7%	119.2%	817	3.8	2.6	6.4
Ward 21	88.7%	110.8%	105.4%	125.8%	783	3.7	2.4	6.1
Ward 22	87.6%	101.0%	101.1%	125.8%	654	4.0	2.7	6.8
Ward 23	84.6%	98.6%	100.8%	103.8%	1147	3.4	3.5	6.9
Ward 24	87.7%	88.0%	98.1%		564	4.2	0.9	5.1
Ward 3	84.8%	80.0%	100.0%	111.8%	856	3.2	3.0	6.2
Ward 5	73.9%	110.6%	109.5%	121.4%	583	6.2	1.6	7.8
Ward 7	151.5%	107.0%	103.4%	148.2%	765	3.5	4.6	8.1
Ward 8	81.2%	88.3%	99.0%	107.9%	772	3.4	2.5	5.9
DOCC	82.7%	106.4%	91.7%		224	23.2	2.1	25.2
Labour Ward								
Ward 9	80.3%	87.7%	91.4%	92.4%	841	3.4	2.2	5.6
Ward 10	82.9%	74.4%	90.5%	84.6%	223	6.1	1.2	7.3
NNU	137.4%	78.1%	86.3%	102.0%	143	27.2	5.0	32.2

Meeting title	Board of Directors	Date: 1 March 2019
Report title:	Performance Report indicators for 2018/19 (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 2018/19			
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: M10 (January 2019)

1.0 Summary

The Trust more in January 2019 demonstrated the expected stress from the winter period. With increased overnight bed occupancy, lower early discharges, increased readmissions and more ambulance handover delays in A&E. On the positive side the number of DToCs were very low however the number of super stranded patients remains obstinately high. The report shows a target for this indicator of 91 that was set at the beginning of the year; NHSI have set the trust a stretched target of a 25% reduction to 69.

On the elective side the RTT performance continues to improve with no 52-week waiters being reported. There appears to be an increase in the outpatient DNA rates that is currently under investigation. The Follow to new ratio is also showing an upward drift.

2.0 Sustainability and Transformation Fund (STF)

Performance Improvement Trajectories

January 2019 performance against the Service Development and Improvement Plans (SDIP):

ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change
4.1	ED 4 hour target (includes UCS)		92.5%	87.9%	91.8%	87.0%	✗	▼
4.2	RTT Incomplete Pathways <18 weeks		90.1%	90.0%		89.2%	✗	▲
4.9	62 day standard (Quarterly)		82.4%	82.4%		85.1%	✓	▲

ED performance deteriorated in January 2019, dropping to 87.0%. This was the first time it has been below 90% since July 2018 and was the lowest monthly performance reported since January 2017. Historically, January is often a challenging period, with this month being especially demanding due to an increase in patient demand, as well as ongoing winter pressures. Performance was below the national standard of 95% and also below the 87.9% NHS Improvement trajectory. It was however better than the NHS England national A&E performance in January 2019, which was 84.4%.

The referral to treatment (RTT) national NHS operating standard of 92% for incomplete pathways was not achieved in January 2019. However, the aggregate performance in the Trust continued to recover and for the fifth consecutive month improved by at least 0.3%. Trust performance also compared favourably to the NHS England combined performance in December 2018 of 86.6%.

Trust delivered against the Cancer 62 day target during Q3, achieving an impressive performance of 85.1%, which was ahead of the NHS Improvement trajectory (82.4%). The most recent combined national statistical reports confirmed that the 62 day standard during Q2 was not achieved, with a performance below that achieved by the Trust (78.6%). The Trust also reported that both the two week wait to see a specialist and 31 day diagnosis to treatment standards were delivered for Q3.

3.0 Urgent and Emergency Care

Performance across urgent and emergency care services continued to operate under pressure in January 2019, as represented across the following range of KPIs:

ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change
2.4	Cancelled Ops - On Day		1.0%	1.0%	0.8%	1.3%	✗	▼
3.2	Ward Discharges by Midday		30%	30%	18.6%	18.6%	✗	▲
3.4	30 day readmissions		6.4%	6.4%	8.3%	9.2%	✗	▼
4.1	ED 4 hour target (includes UCS)		92.5%	87.9%	91.8%	87.0%	✗	▼

Cancelled Operations on the Day

The number of elective operations cancelled on the day for non-clinical reasons increased to 33. This represented 1.3% of all planned operations during the month, which was above the 1% threshold. Of those cancelled, more than half (17) were due to insufficient bed availability. Consultant availability was the next most frequent reason for last minute cancellations, accounting for six of the total.

Readmissions

The 30 day emergency readmission rate increased to 9.2% in January 2019, which was the highest reported rate this year to date. At a divisional level, the rate for Medicine increased to 14.2%. The readmission rates for Surgery and Women & Children remained steady, with both less than 5%.

Delayed Transfers of Care (DTOC)

The number of DTOC patients was reduced to 15 on the last Thursday of the month, which was a reduction of six on December 2018 and the lowest reported since July 2018. The cumulative number of days delayed throughout the month however demonstrated a minor increase when compared with the previous month, highlighting the ongoing challenges related to managing DTOC patients.

Ambulance Handovers

The percentage of ambulance handovers that took longer than 30 minutes increased for the second consecutive month to 10.4% and remained higher than the Upper Control Limit (9.2%). The number of handovers reported to have taken longer than 60 minutes reached 49 January 2019, which was the highest since December 2017. This highlights the challenges in-month relating to patient flow.

4.0 Elective Pathways

ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change
3.1	Overnight bed occupancy rate		93%	93%	93.3%	96.1%	✗	▼
3.5	Follow Up Ratio		1.50	1.50	1.58	1.66	✗	▲
4.2	RTT Incomplete Pathways <18 weeks		90.1%	90.0%		89.2%	✗	▲
4.6	Diagnostic Waits <6 weeks		99%	99%		96.8%	✗	▼
5.6	Outpatient DNA Rate		5%	5%	7.5%	7.9%	✗	▲

Overnight Bed Occupancy

The Trust bed occupancy remained above the 93% internal threshold at 96.1% in January 2019. The NHS England bed statistics for Q2 2018/19 reported an average overnight occupancy rate of 87.3%. Overnight bed occupancy at such high levels can increase the risk of infections and affect the timely admission of emergency and urgent care patients as well as those booked for surgery.

Follow up Ratio

Planning outpatient capacity to cope with new referrals can be adversely impacted by a higher than anticipated demand for follow up appointments. The Trust follow up ratio has been greater than the desired ratio (1.5 follow up attendances for every new attendance) for seven consecutive months.

RTT Incomplete Pathways

RTT performance continued below both the 92% national standard and the NHS Improvement target of 90% at the end of January 2019. The overall waiting list size however continued to reduce and the

number of patients waiting more than 18 weeks also decreased. The number of patients waiting 52 weeks or more was successfully reduced to zero, which was well ahead of the Trust trajectory.

Diagnostic Waits <6 weeks

The Trust had another challenging month in terms of diagnostic waiting times, with performance continuing below the 99% standard at 96.8%. The volume of breaches increased significantly from 109 in the previous month to 173 at the end January 2019. Figures released by NHS England stated that nationally, 3.3% of patients had waited six weeks or more from referral to test at the end of December 2018. This was the reportedly worst performance since February 2008 and goes some way to highlighting the challenges faced across the NHS to manage demand for diagnostics.

Outpatient DNA Rate

The Trust reported a DNA rate of 7.9% in January 2019, which was an improvement compared to the previous month, during which it peaked at more than 8%. DNAs represent capacity that cannot be otherwise utilised, so all services should continue their efforts to address the number of DNAs.

5.0 Patient Safety

Infection Control

Three cases of Clostridium Difficile were reported in January 2019, two in Medical wards (Wards 1 and 3) and one in Paediatrics (Ward 5). Two cases of E-Coli BC were reported, both were in Medical wards (Wards 8 and 18), but there were no reported cases of MRSA or MSSA in the Trust.

NICE breaches

The number of NICE breaches was reduced in January 2019 down to 67 (from 96 in December 2018).

Overdue Datix Incidents

The number of overdue Datix incidents reduced significantly, down from 201 in December to 129 in January 2019.

ENDS

Performance Report 2018/19
January 2019 (M10)

Milton Keynes University Hospital NHS Foundation Trust

OBJECTIVE 1 - PATIENT SAFETY										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
1.1	Mortality - (HSMR)		100	100		94.7	✓	▼		
1.2	Mortality - (SHMI) - Quarterly		1	1	0.95	0.97	✓	▼	✓	
1.3	Never Events		0	0	3	0	✓	▲	✗	
1.4	Clostridium Difficile		20	<17	15	3	✗	▼	✓	
1.5	MRSA bacteraemia (avoidable)		0	0	1	0	✓	▬	✗	
1.6	Pressure Ulcers Grade 2, 3 or 4 (per 1,000 bed days)		0.6	0.6	0.61	0.78	✗	▼	✗	
1.7	Falls with harm (per 1,000 bed days)		0.15	0.15	0.12	0.08	✓	▲	✓	
1.8	WHO Surgical Safety Checklist		100%	100%	100%	100%	✓	▬	✓	
1.9	Midwife : Birth Ratio		28	28	28	25	✓	▲	✓	
1.10	Incident Rate (per 1,000 bed days)		40	40	37.18	49.57	✓	▲	✗	
1.11	Duty of Candour Breaches (Quarterly)		0	0	0	0	✓	▬	✓	
1.12	E-Coli				21	2		▼		
1.13	MSSA				14	0		▲		
1.14	VTE Assessment	Tbc	95%	95%	86.0%	93.8%	✗	▼	✗	

OBJECTIVE 2 - PATIENT EXPERIENCE										
ID	Indicator	DQ Assurance	Target 18-19	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%	Not Available					
2.2	RED Complaints Received		8	7	0	0	✓	▬	✓	
2.3	Complaints response in agreed time		90%	90%	83.0%	78.1%	✗	▼	✗	
2.4	Cancelled Ops - On Day		1.0%	1.0%	0.8%	1.3%	✗	▼	✓	
2.5	Over 75s Ward Moves at Night		2,554	2128	1,989	249	✗	▼	✓	
2.6	Mixed Sex Breaches		0	0	0	0	✓	▬	✓	

OBJECTIVE 3 - CLINICAL EFFECTIVENESS										
ID	Indicator	DQ Assurance	Target 18-19	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%	93.3%	96.1%	✗	▼	✗	
3.2	Ward Discharges by Midday		30%	30%	18.6%	18.6%	✗	▲	✗	
3.3	Weekend Discharges		70%	70%	68.5%	62.9%	✗	▼	✗	
3.4	30 day readmissions		6.4%	6.4%	8.3%	9.2%	✗	▼	✗	
3.5	Follow Up Ratio		1.50	1.50	1.58	1.66	✗	▲	✗	
3.6.1	Number of Stranded Patients (LOS>=7 Days)		227	227		231	✗	▼		
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)		91	91		90	✓	▼		
3.7	Delayed Transfers of Care		25	25		15	✓	▲		
3.8	Discharges from PDU (%)		16%	16%	10.8%	11.7%	✗	▲	✗	
3.9	Ambulance Handovers >30 mins (%)		5%	5%	7.4%	10.4%	✗	▼	✗	

OBJECTIVE 4 - KEY TARGETS										
ID	Indicator	DQ Assurance	Target 18-19	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)		92.5%	87.9%	91.8%	87.0%	✗	▼	✓	
4.2	RTT Incomplete Pathways <18 weeks		90.1%	90.0%		89.2%	✗	▲		
4.3	RTT Patients Waiting Over 18 Weeks		1,287	1,304		1,488	✗	▲		
4.4	RTT Total Open Pathways		12,999	13,040		13,738	✗	▲		
4.5	RTT Patients waiting over 52 weeks			10		0	✓	▲		
4.6	Diagnostic Waits <6 weeks		99%	99%		96.8%	✗	▼		
4.7	All 2 week wait all cancers (Quarterly) ✎		93%	93%		96.9%	✓	▼		
4.8	31 days Diagnosis to Treatment (Quarterly) ✎		96%	96%		99.1%	✓	▲		
4.9	62 day standard (Quarterly) ✎		82.4%	82.4%		85.1%	✓	▲		

OBJECTIVE 5 - SUSTAINABILITY										
ID	Indicator	DQ Assurance	Target 18-19	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	96,636	9,812	✓	▲	✓	
5.2	A&E Attendances		91,290	76,534	73,693	7,408	✗	▲	✗	
5.3	Elective Spells (PBR)		25,528	21,372	21,769	2,586	✓	▲	✓	
5.4	Non-Elective Spells (PBR)		35,287	29,583	28,916	3,343	✓	▲	✗	
5.5	OP Attendances / Procs (Total)		367,859	307,861	319,788	33,909	✓	▲	✓	
5.6	Outpatient DNA Rate		5%	5%	7.5%	7.9%	✗	▲	✗	
5.7	Number of babies delivered				3031	268		▼		
5.8	Number of antenatal bookings				3433	381		▲		

OBJECTIVE 7 - FINANCIAL PERFORMANCE										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
7.1	Income £'000		240,602	198,988	204,200	23,034	✓	▲	✓	
7.2	Pay £'000		(161,048)	(134,682)	(137,443)	(14,020)	✗	▼	✗	
7.3	Non-pay £'000		(71,891)	(61,214)	(65,226)	(6,864)	✗	▼	✗	
7.4	Non-operating costs £'000		(12,893)	(10,744)	(10,386)	(1,163)	✗	▼	✓	
7.5	I&E Total £'000		(5,230)	(7,652)	(8,855)	987	✓	▲	✗	
7.6	Cash Balance £'000		2,500	2,564		4,973	✓	▼		
7.7	Savings Delivered £'000		10,130	7,491	7,351	760	✗	▼	✗	
7.8	Capital Expenditure £'000		29,673	22,858	7,365	1,402	✓	▼	✓	

OBJECTIVE 8 - WORKFORCE PERFORMANCE										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
8.1	Staff Vacancies % of establishment		12%	12%		8.3%	✓	▲		
8.2	Agency Expenditure %		8%	8%	5.7%	5.2%	✓	▲	✓	
8.3	Staff sickness - % of days lost		4%	4%		3.9%	✓	▲		
8.4	Appraisals		90%	90%		88.0%	✗	▲		
8.5	Statutory Mandatory training		90%	90%		90.0%	✓	▬		
8.6	Substantive Staff Turnover		12%	12%		11.5%	✓	▼		
8.7	FFT Response Rate Staff (Quarterly)		15%	15%	14.0%	14.0%	✗	▼	✗	

OBJECTIVES - OTHER										
ID	Indicator	DQ Assurance	Target 18-19	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		67	✗	▲		
O.2	Rebooked cancelled OPs - 28 day rule		95%	95%	71.6%	43.8%	✗	▼	✗	
O.4	Overdue Datix Incidents >1 month		0	0		129	✗	▲		
O.5	Serious Incidents		45	<38	52	5	✗	▲	✗	
O.8	Completed Job Plans (Consultants)		90%	90%		86%	✗	▲		

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/quarter 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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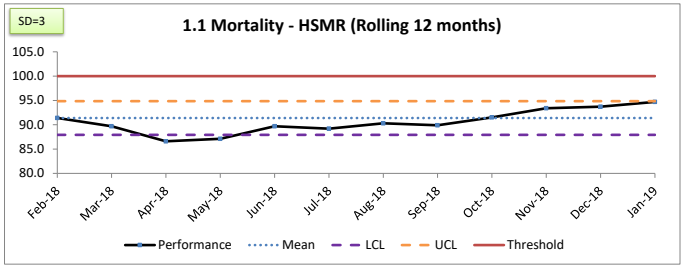

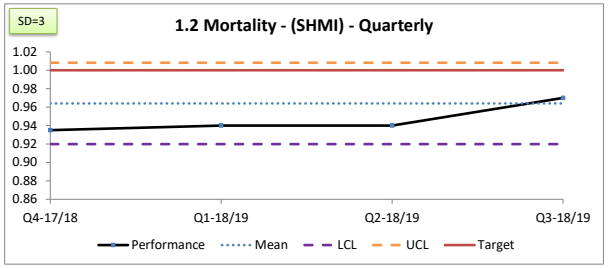

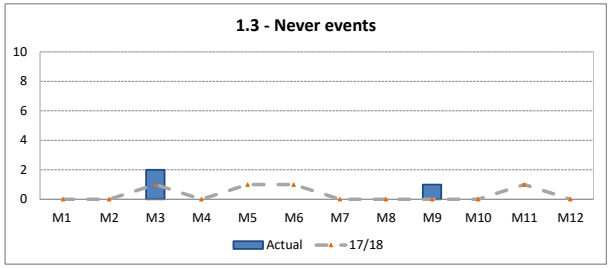

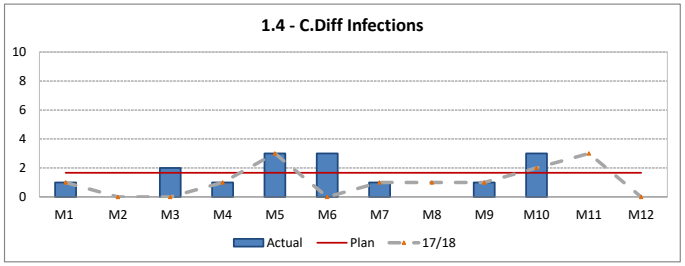

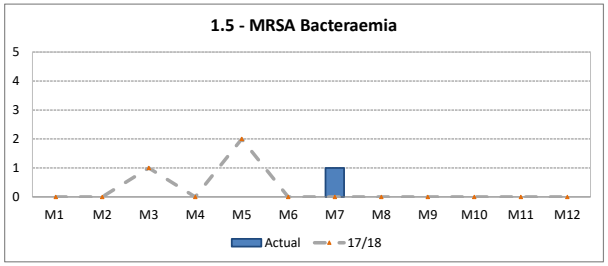

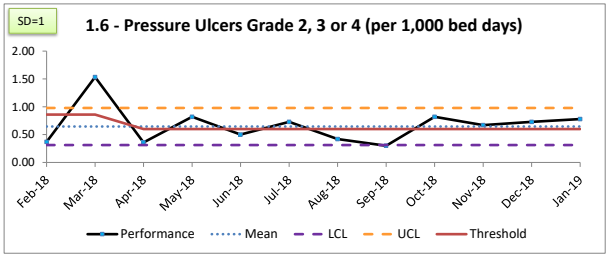

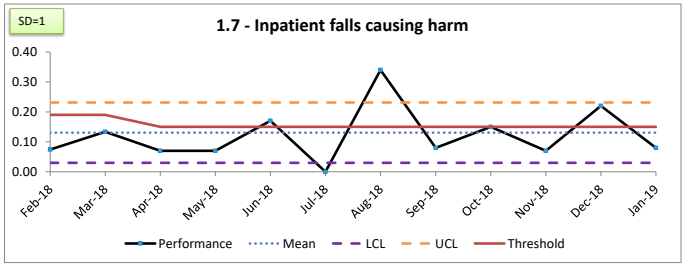

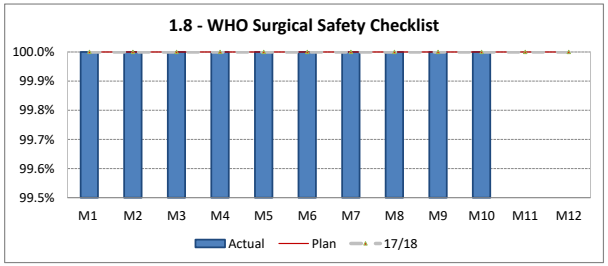

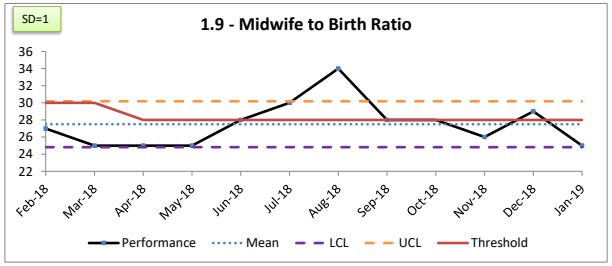

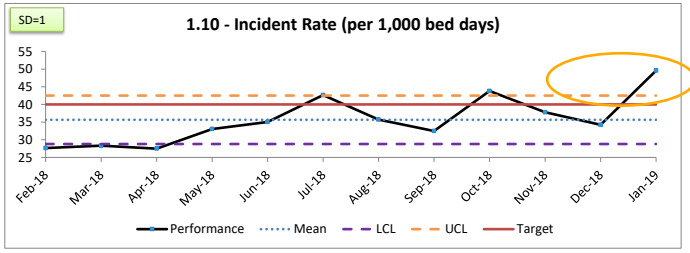

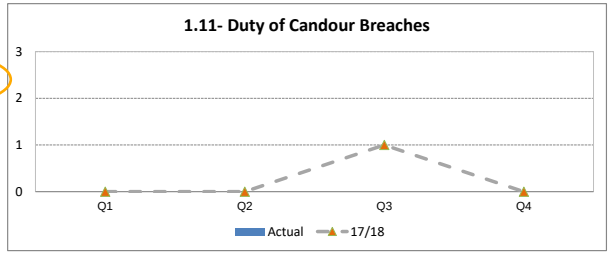

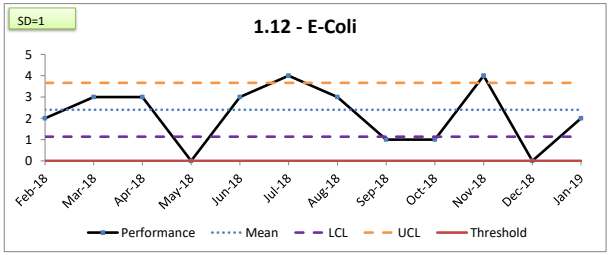

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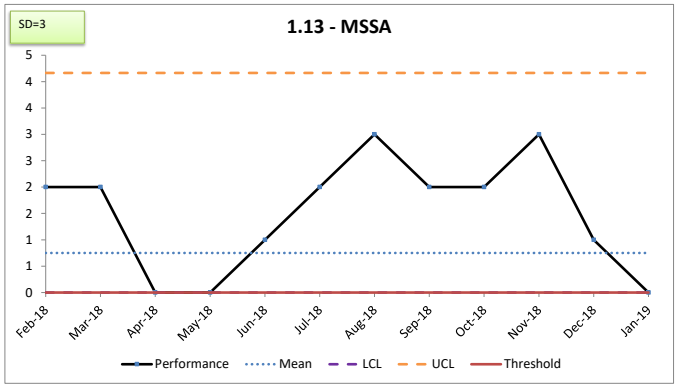

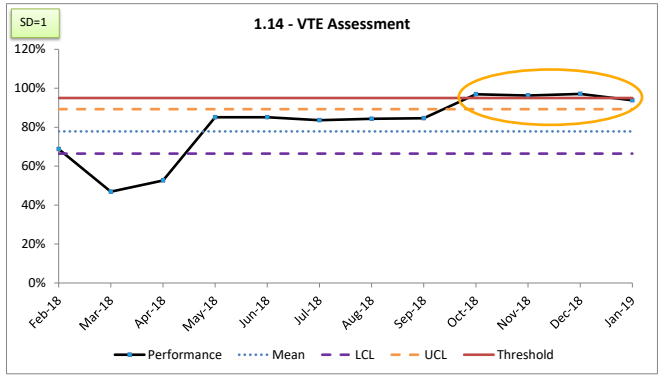

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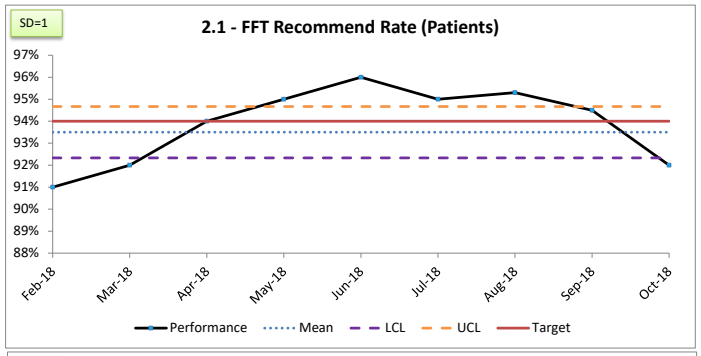
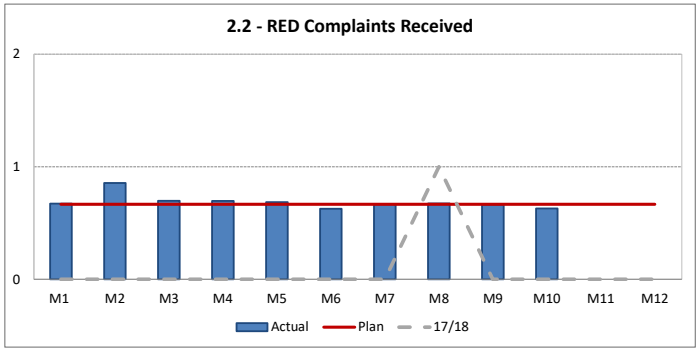
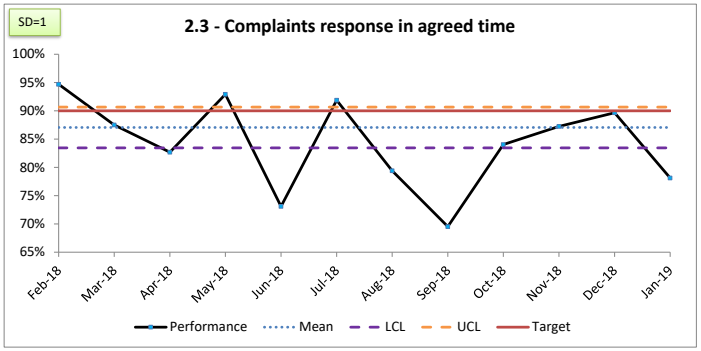
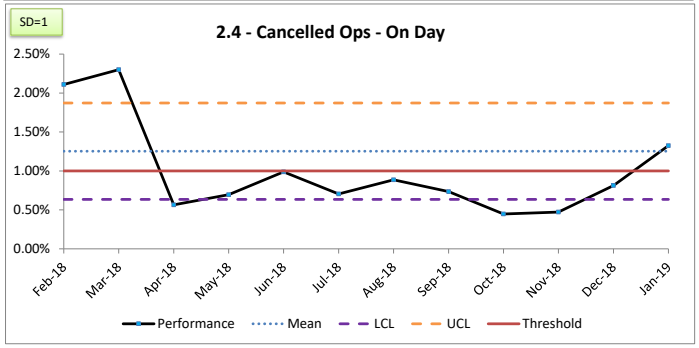
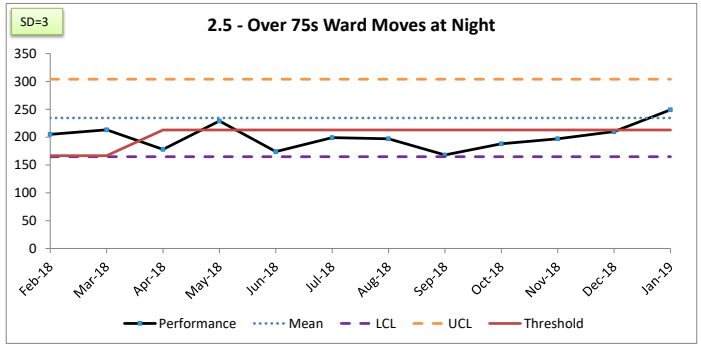
OBJECTIVE 2 - PATIENT EXPERIENCE

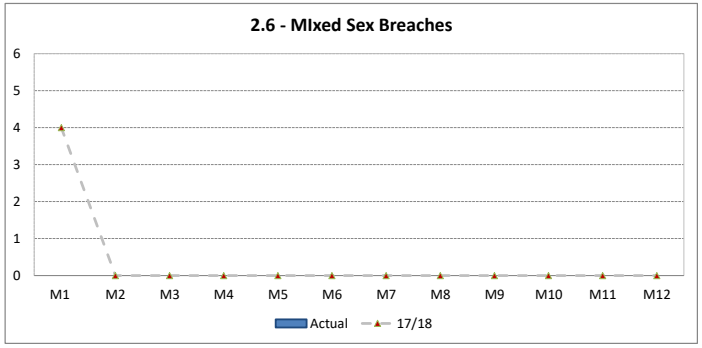












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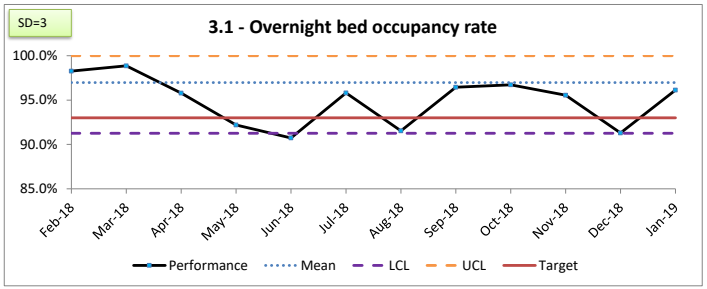
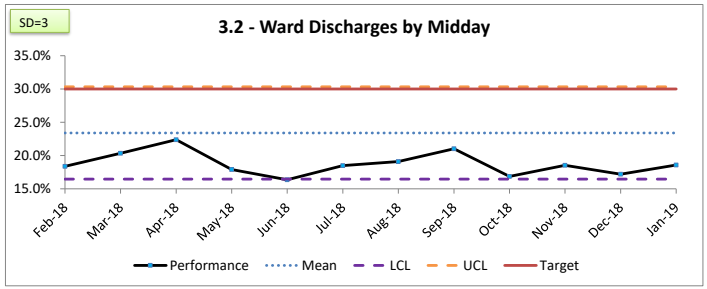
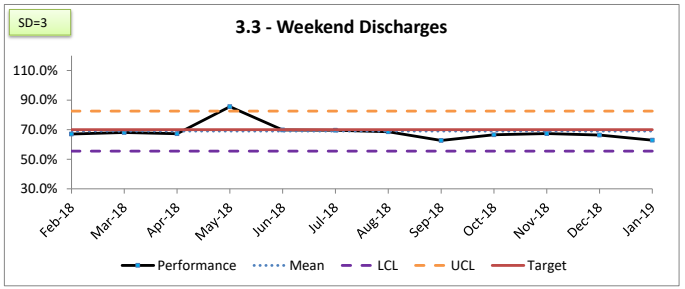
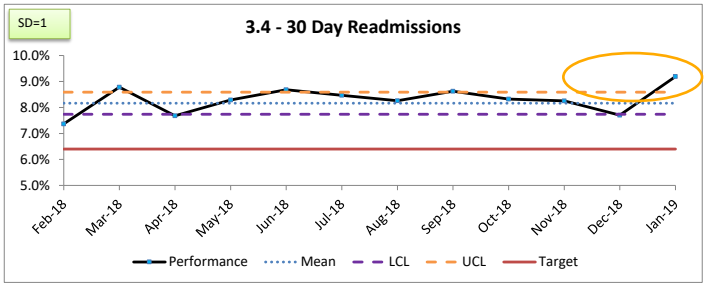
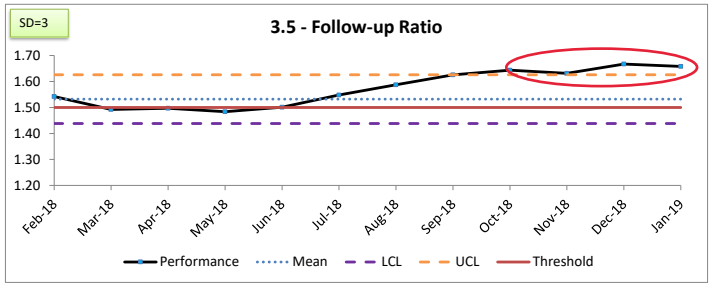
OBJECTIVE 3 - CLINICAL EFFECTIVENESS

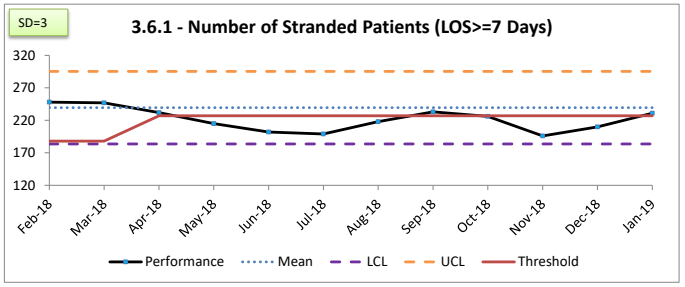


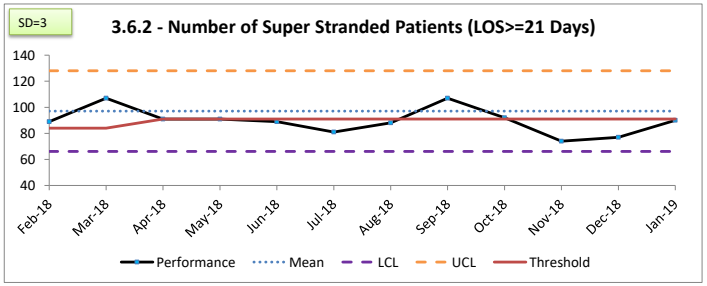


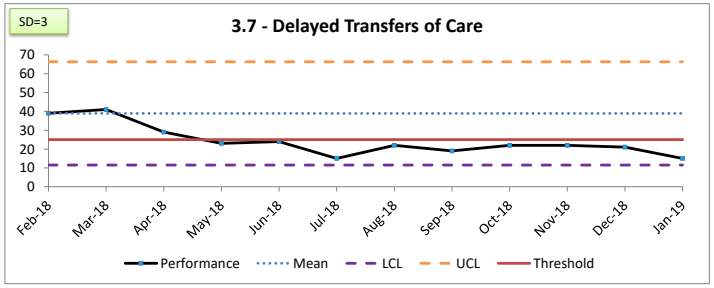


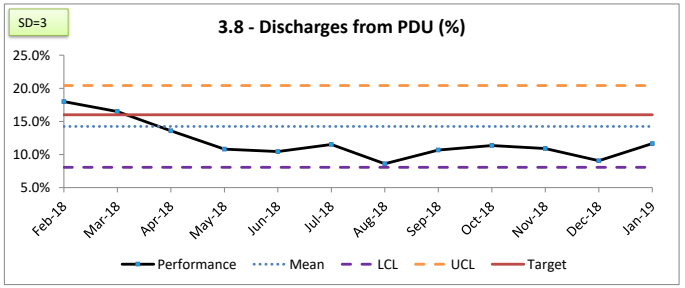


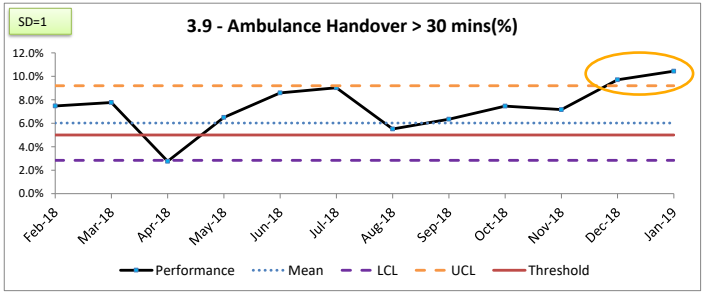












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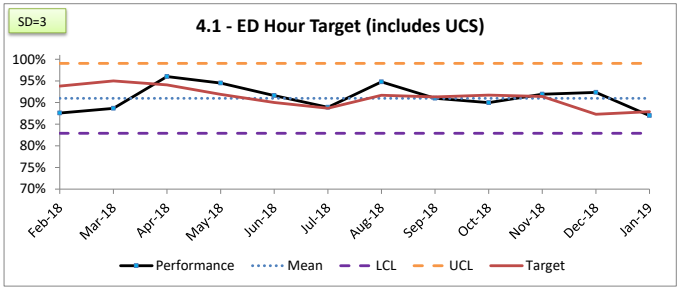
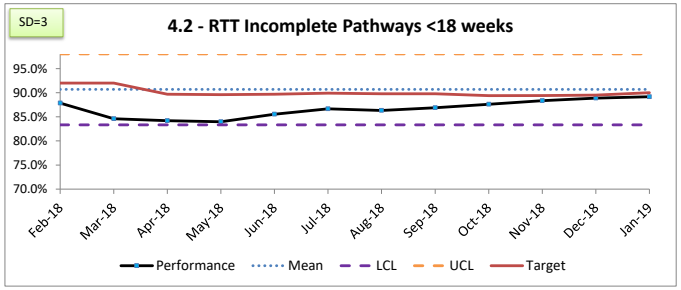
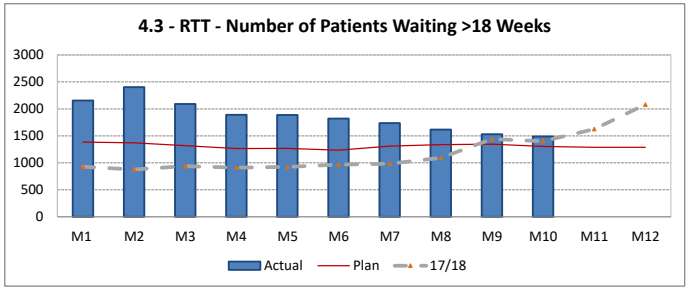
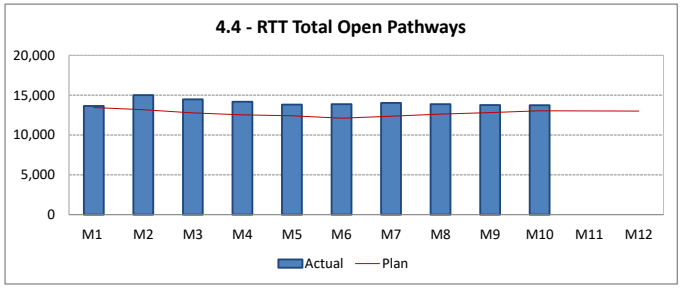
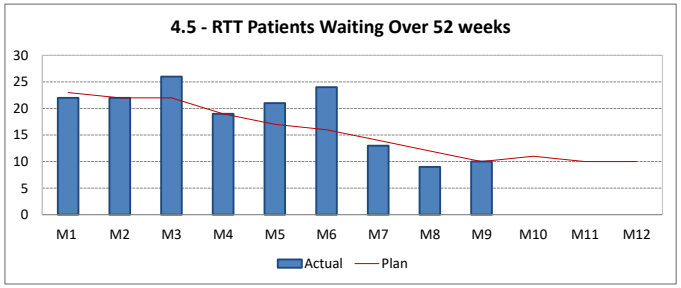
OBJECTIVE 4 - KEY TARGETS

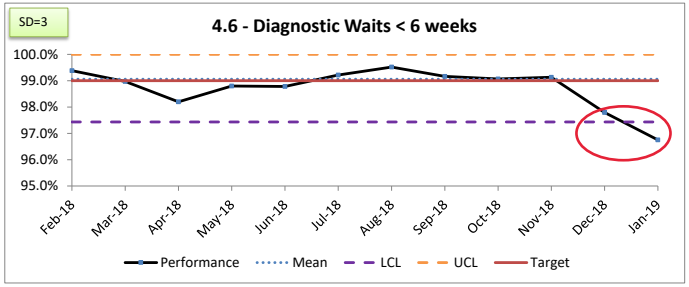


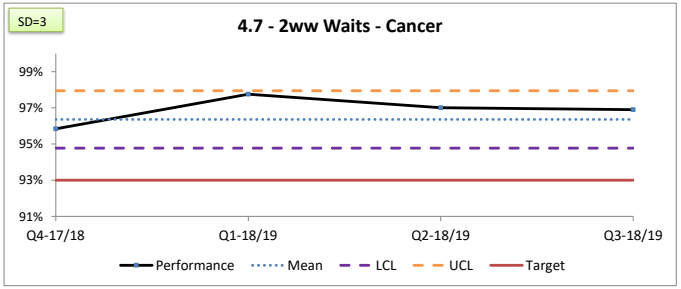


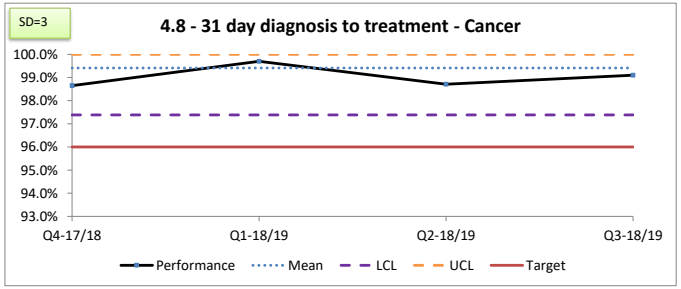


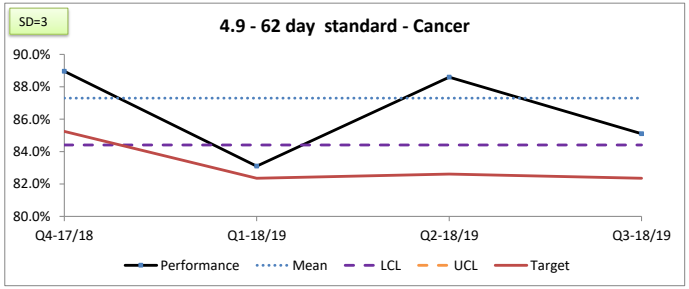












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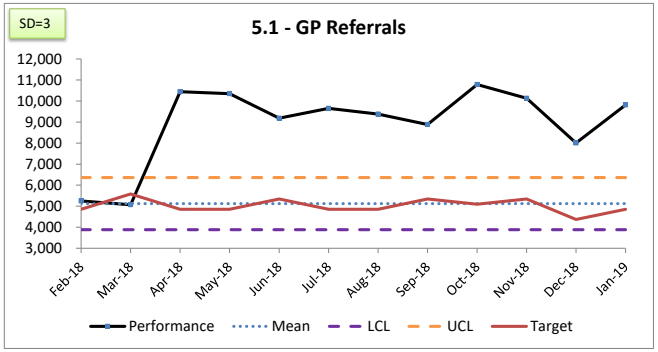

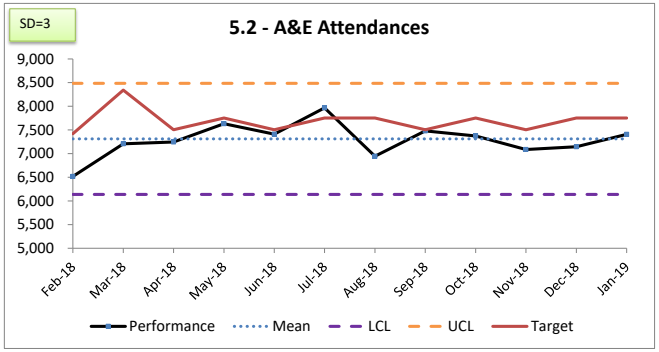

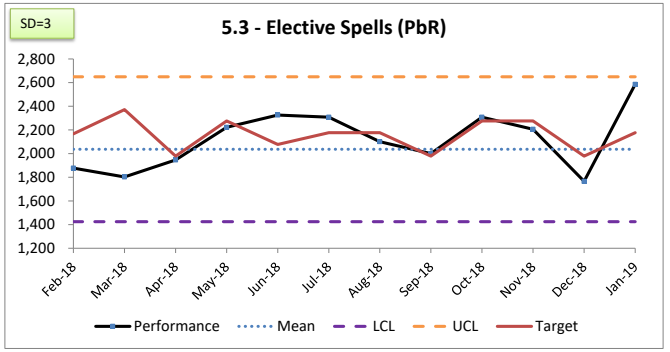

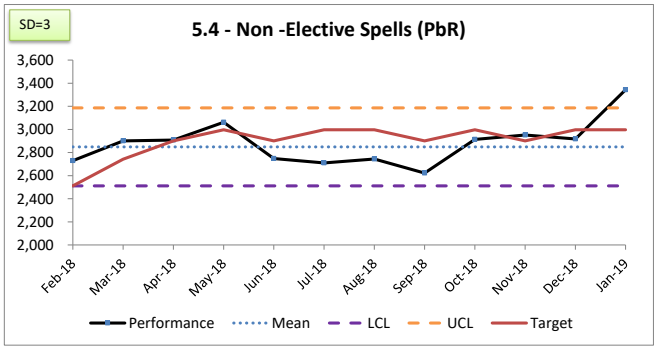

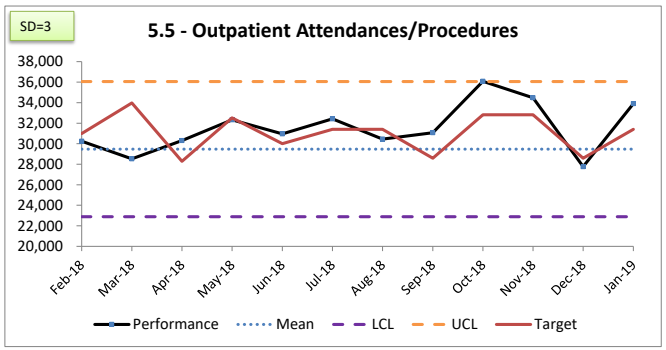

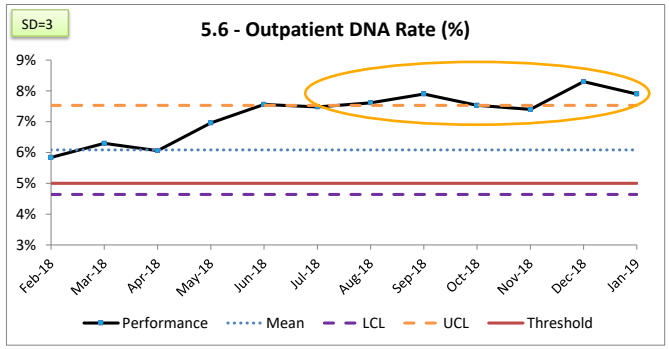

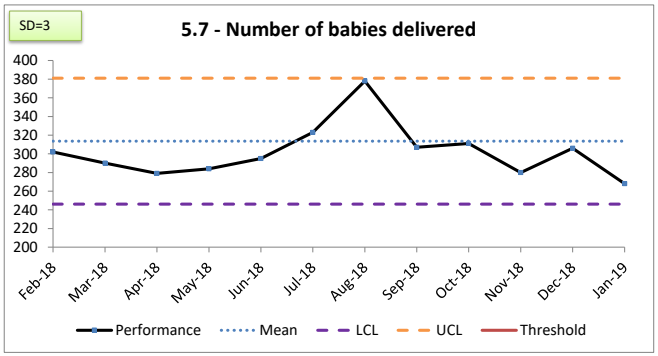

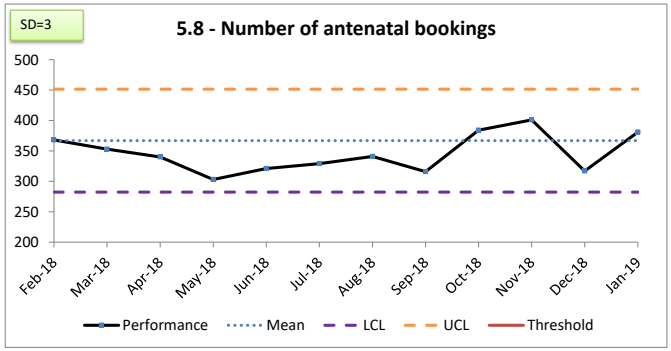

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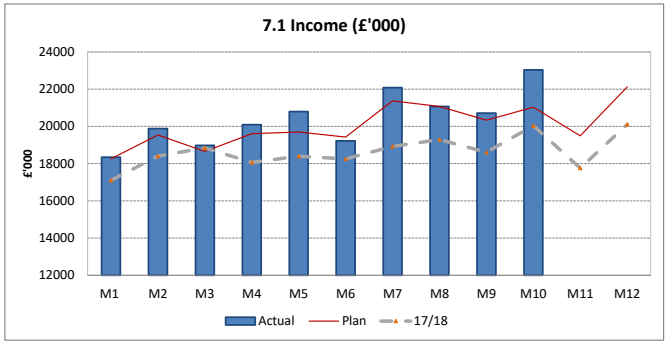
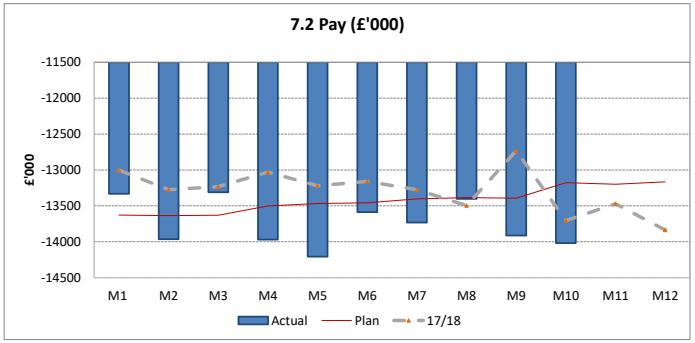
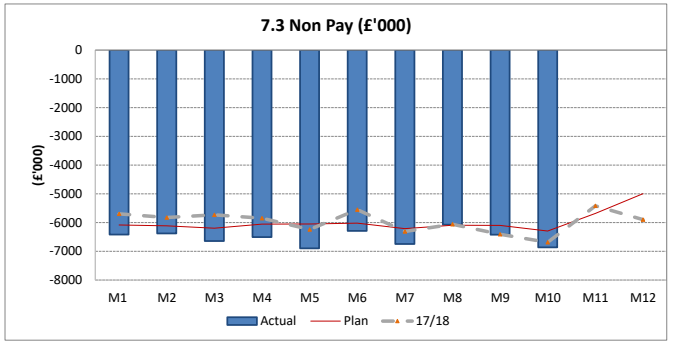
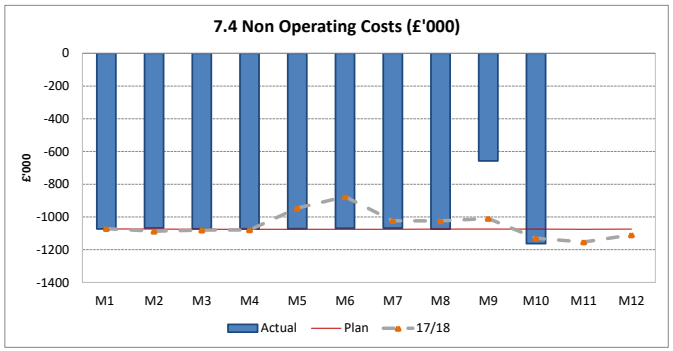
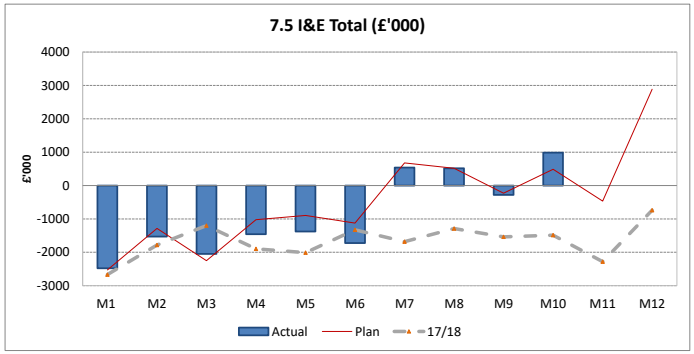
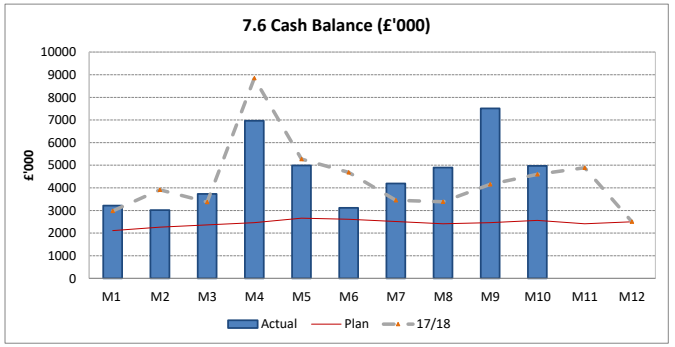

7.1 Income (£'000)
£'000
24000
22000
20000
18000
16000
14000
12000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

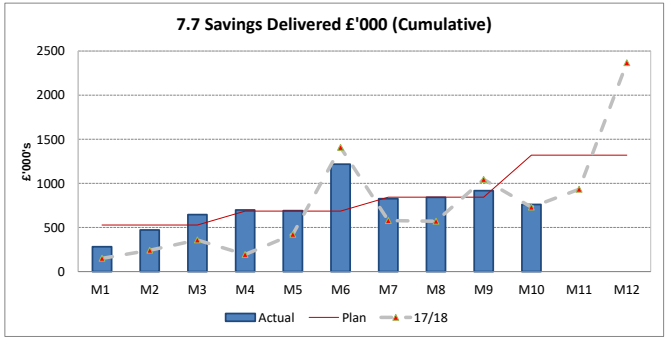

7.2 Pay (£'000)
£'000
-11500
-12000
-12500
-13000
-13500
-14000
-14500
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

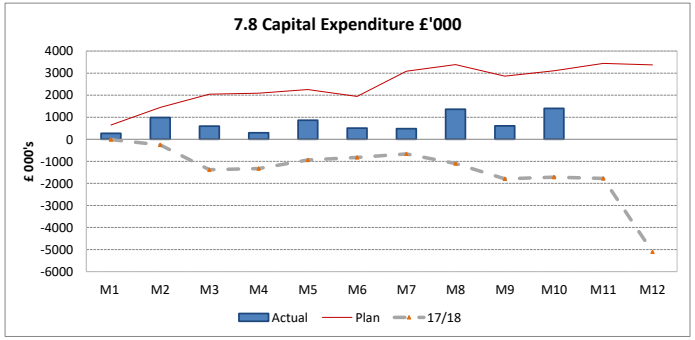

7.3 Non Pay (£'000)
(£'000)
0
-1000
-2000
-3000
-4000
-5000
-6000
-7000
-8000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18


7.4 Non Operating Costs (£'000)
£'000
0
-200
-400
-600
-800
-1000
-1200
-1400
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

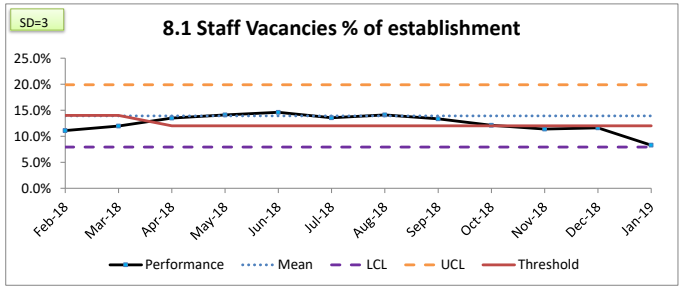

7.5 I&E Total (£'000)
£'000
4000
3000
2000
1000
0
-1000
-2000
-3000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

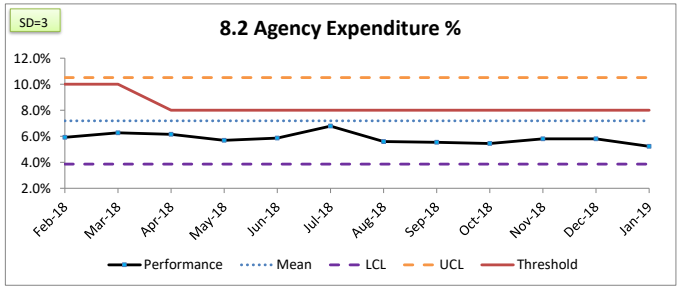

7.6 Cash Balance (£'000)
£'000
10000
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

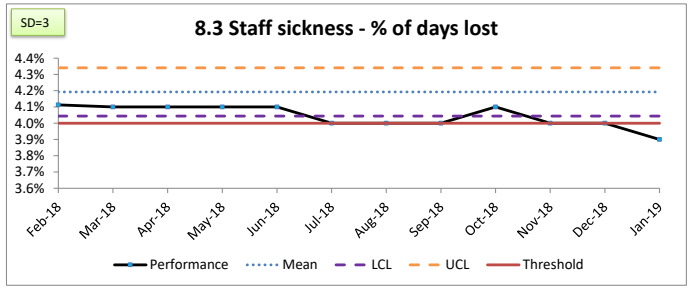

7.7 Savings Delivered £'000 (Cumulative)
£'000's
2500
2000
1500
1000
500
0
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

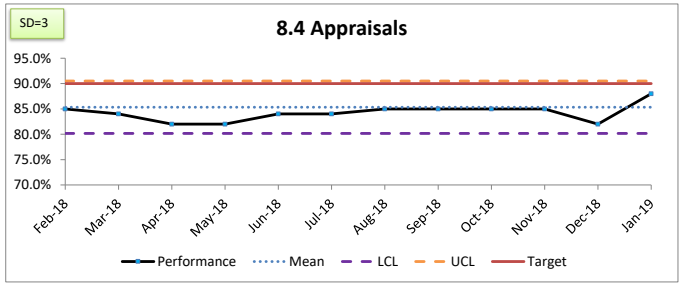

7.8 Capital Expenditure £'000
£ 000's
4000
3000
2000
1000
0
-1000
-2000
-3000
-4000
-5000
-6000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

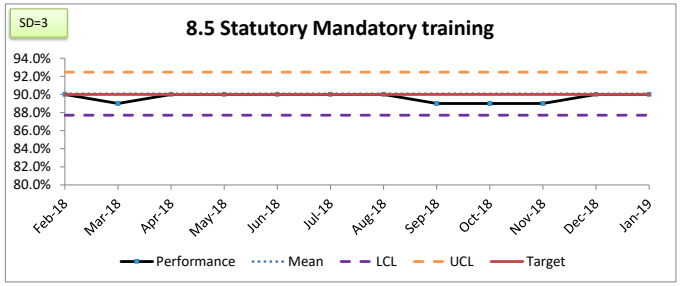
OBJECTIVE 8 - WORKFORCE PERFORMANCE

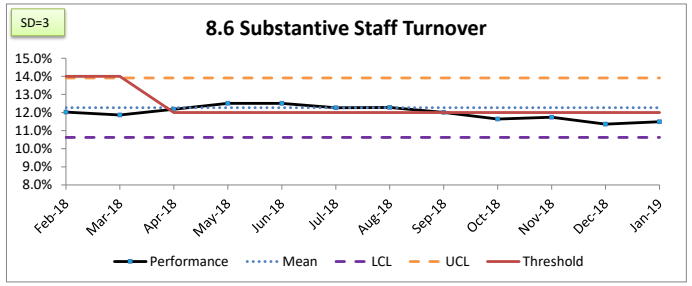


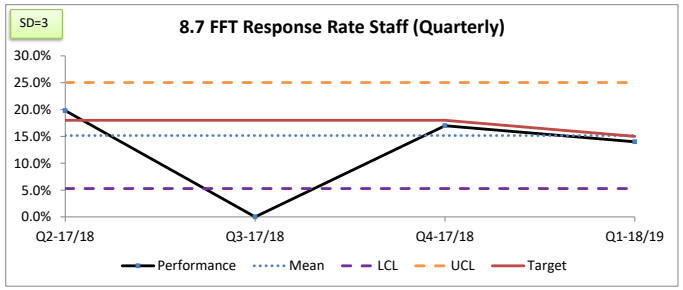








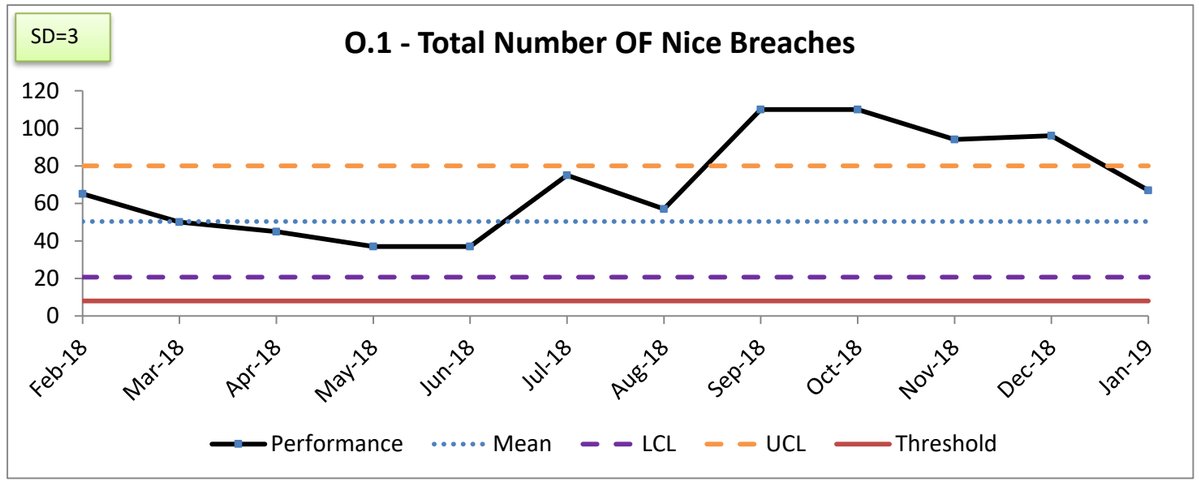


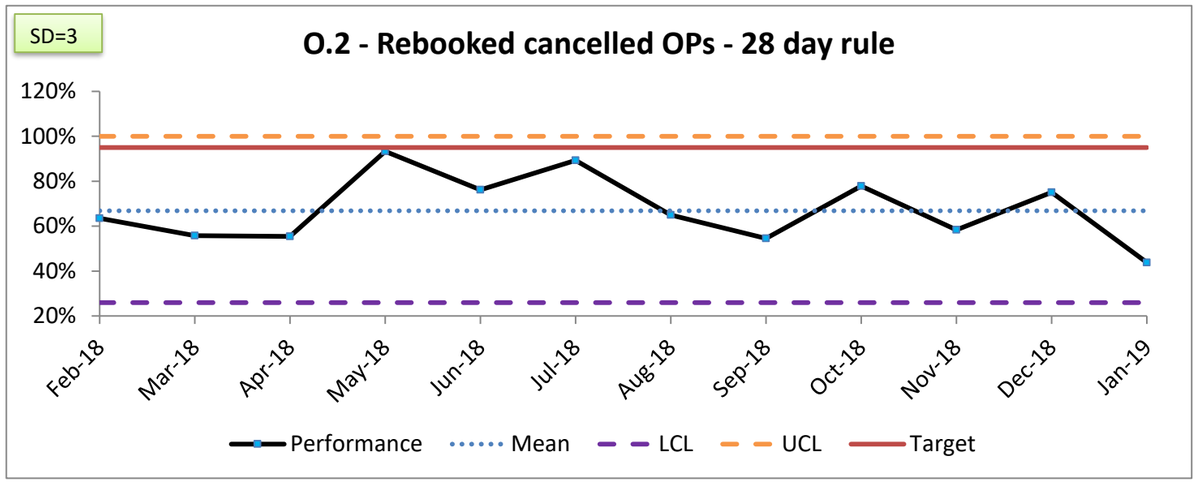


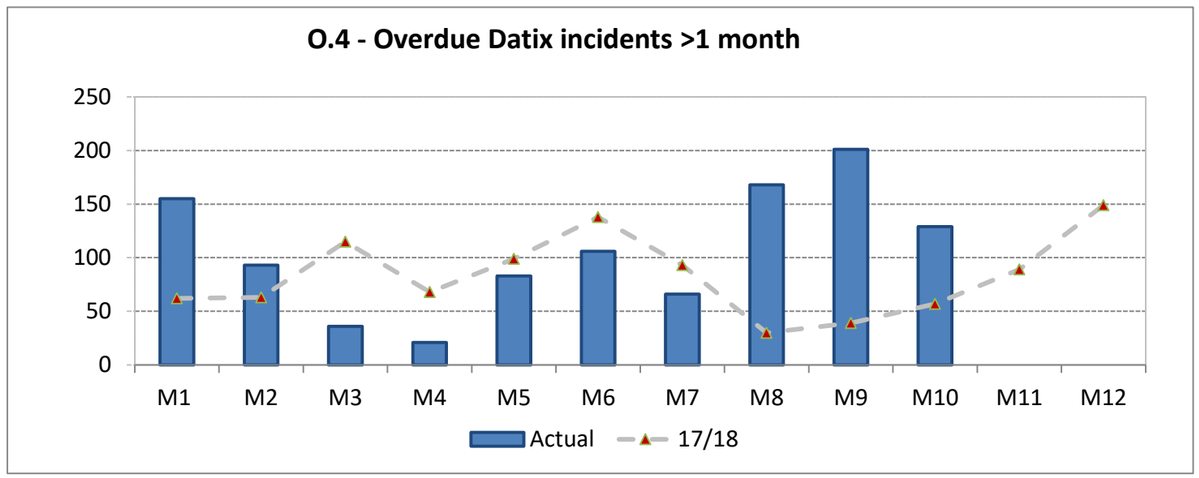
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

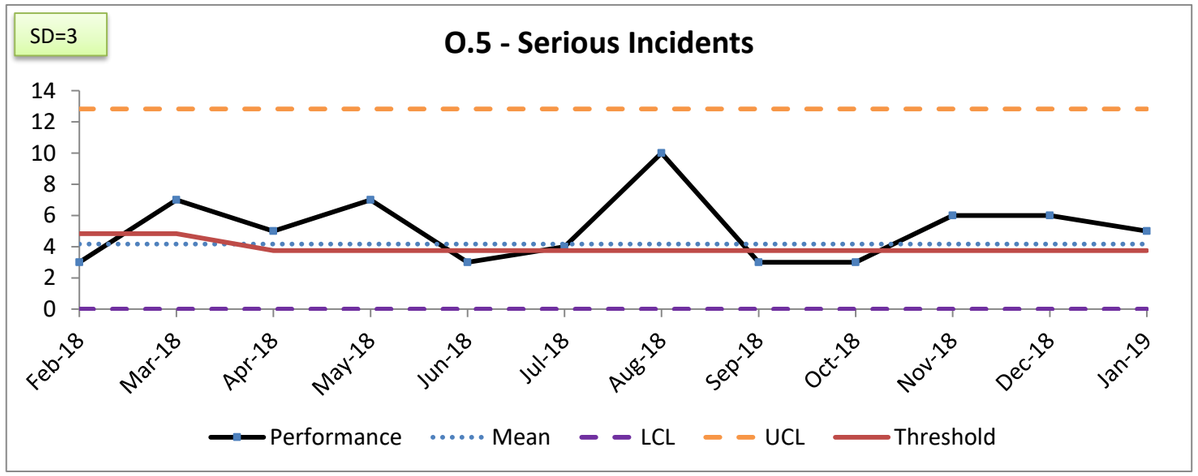
- Performance activity on a rolling 12 months/quarterly
- Average on a rolling 12 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

OBJECTIVES - OTHER









If the LCL is negative (less than zero) it is set to zero.
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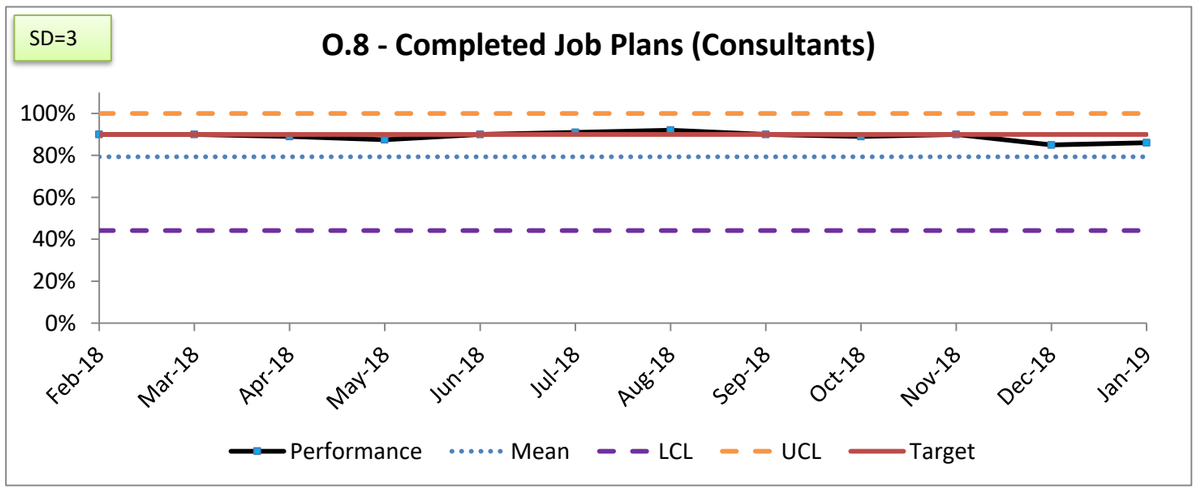
- Performance activity on a rolling 12 months/quarterly
- Average on a rolling 12 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories



NHS
Milton Keynes
University Hospital
NHS Foundation Trust

Meeting title	Board of Directors	Date: 1 March 2019
Report title:	**Finance Paper Month 10 2018-19**	**Agenda item: 4.2**
Lead director **Report authors**	Mike Keech Daphne Thomas Chris 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 2019)**			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** X	**Decision** ☐
Recommendation	Trust 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 2019

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 Trust 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 surplus for January 2019 was £1m which is £0.5m favourable to budget in the month and £1.15m negative year to date although £0.1m better than the Trust's control total (excluding PSF) on a year to date basis.

3. *Cash and capital position* – the cash balance as at the end of January 2019 was £5.0m, which was £2.4m above plan due to the timing of capital expenditure and receipts. The Trust has spent £7.4m on capital up to Month 10 of which £1.5m relates to eCARE, Cancer Centre £2.5m, Multi-Storey Car Park £0.3m, North site infrastructure £0.3m, UEC and GDE £0.2m and £2.5m on patient safety and clinically urgent capital expenditure.

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 £0.8m were delivered in month against an identified plan of £0.8m and the target of £0.8m bringing the total year to date savings achieved to £8m. Overall for the year £9.7m of schemes have been identified, of which £9.2m have been validated and approved against the £10.1m 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	17,038	17,592	554	168,301	171,809	3,507	200,842	207,338	6,496
Other Revenue	1,590	2,156	567	15,940	19,722	3,782	19,107	23,119	4,012
Total Income	18,627	19,748	1,120	184,241	191,531	7,290	219,949	230,457	10,508
Pay	(13,188)	(14,020)	(831)	(134,789)	(137,847)	(3,058)	(161,178)	(165,759)	(4,581)
Non Pay	(6,283)	(6,864)	(581)	(61,108)	(65,551)	(4,443)	(71,762)	(78,284)	(6,522)
Total Operational Expend	(19,472)	(20,884)	(1,412)	(195,897)	(203,398)	(7,502)	(232,941)	(244,043)	(11,102)
EBITDA	(844)	(1,136)	(292)	(11,656)	(11,867)	(212)	(12,991)	(13,586)	(594)
Financing & Non-Op. Costs	(1,016)	(1,105)	(89)	(10,157)	(9,801)	356	(12,191)	(11,597)	594
Control Total Deficit (excl. PSF)	**(1,860)**	**(2,241)**	**(381)**	**(21,813)**	**(21,669)**	**144**	**(25,182)**	**(25,183)**	**(0)**
Adjustments excl. from control total:									
PSF- Performance	359	359	0	2,361	2,361	0	3,079	3,079	0
PSF- Financial	717	717	0	4,713	4,713	0	6,147	6,147	0
PSF- ICS Financial	121	0	(121)	795	0	(795)	1,037	0	(1,037)
PSF- Incentive	210	210	0	1,380	1,380	0	1,800	1,800	0
Control Total Deficit (incl. PSF)	**(453)**	**(955)**	**(502)**	**(12,564)**	**(13,215)**	**(651)**	**(13,118)**	**(14,156)**	**(1,038)**
Donated income	1,000	2,000	1,000	5,500	5,000	(500)	8,592	5,000	(3,592)
Donated asset depreciation	(58)	(58)	(0)	(580)	(584)	(4)	(697)	(701)	(4)
Reported deficit/surplus	**489**	**987**	**498**	**(7,644)**	**(8,799)**	**(1,155)**	**(5,223)**	**(9,857)**	**(4,634)**

7. The table above includes a refresh of the Trust's forecast outturn for the year. The revised forecast follows a review at divisional level of the underlying income and costs, with adjustments for known cost pressures or additional income expected or planned for the final quarter. The revised forecast shows the Trust meeting its stretch target of a £900k improvement on its original control total, with increases in income only partly offset by additional pay and non-pay costs.

8. The **deficit excluding Provider Sustainability Funding (PSF)** in month 10 is £2,241k which is £381k adverse to plan in month. Year to date, the deficit excluding PSF is £21,669k which is £144k better than plan year to date and therefore the Trust is on track to deliver its financial control total for the year. The Trust has met the A&E performance requirements for Q3 and plans to meet Q4 requirements to secure the full PSF funding associated with this element. The STP continues to be behind plan at M10 and as a result the Trust has reported a negative variance of £121k (£795k YTD) in respect of the STP element of PSF, however this has been mitigated by the recognition of £596k of transformation fund income YTD.

9. The Trust reported a surplus in month 10 of £987k which is £498k favourable to the budget surplus of £489k; however the in-month variance included an additional £1,000k donation receipt over plan. The adverse variance of £1,155k YTD is driven by lost PSF linked to the

STP's performance of £795k and an adverse £500k timing difference on donated income offset by a positive variance of £596k transformation funding which was unbudgeted.

10. **Income (excluding PSF and donations)** is £1,120k favourable to plan in January and £7,289k favourable YTD and can be further analysed in Appendix 1.

11. **Operational costs** in January are adverse to plan by £1,412k and £7,502k YTD.

12. **Pay costs** are £831k adverse to budget in Month 10. The variance is a result of high substantive and bank expenditure in month partly due to the higher than budgeted pay award which is largely offset by central funding as noted above (total of £187k in the month) as well as lower than budgeted agency costs.

13. **Non pay costs** were £581k adverse to plan in month and £4,443k YTD. The in-month variances relate to drugs, outsourcing and clinical supplies costs required to deliver the higher than planned activity levels.

14. **Non-operational costs** are slightly higher than plan in month due to an adjustment to interest payable however there is a favourable variance of £352k YTD against interest and depreciation. The lower PDC and depreciation against budget take account of the lower and later capital spend compared to budget.

COST SAVINGS

15. In Month 10, £760k was delivered against an identified plan of £833k and a target of £1,315k.

16. Overall for the year £9.7m of schemes have been identified, of which £9.2m have been validated and approved against the £10.1m target.

CASH AND CAPITAL

17. The cash balance at the end of January 2019 was £5.0m, which was £2.4m above plan due to the timing of capital spend and the draw-down of capital funding. The Trust drew down £1m in month from the Council to support the Cancer Centre.

18. The details of the Trust's current loans are shown below. The Trust required a draw down in in January of £0.6m for revenue and £0.5m for capital.

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

    - Non-Current Assets are below plan by £15.8m; this is mainly driven by the timing of capital projects.

    - Current assets are above plan by £8.2m, this is due to cash £2.4m, receivables £5.7m and inventories £0.1m above plan.

    - Current liabilities are above plan by £1.5m. This is being driven by Trade and Other Creditors £0.4m and borrowings £1.2m above plan, offset by provisions £0.1m below plan. The borrowings are above plan due to the movement in principal repaid from

non-current borrowings and the change in accounting standard (IFRS9) whereby accrued interest is included in the current borrowings value.

- Non-Current Liabilities are below plan by £7.3m. This is being driven by the timing of revenue loan funding from NHSI being different to planned.

20. The Trust has spent £7.4m on capital up to month 10 of which £1.6m relates to ECare, Cancer Centre £2.5m, Multi-Storey Car Park £0.3m, North site infrastructure £0.3m, UEC and GDE £0.2m and £2.5m on patient safety and clinically urgent capital expenditure.

RISK REGISTER

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

a) Continued Department of Health and Social Care (DHSC) cash funding is insufficient to meet the planned requirements of the organisation.

Funding to cover the planned financial deficit in 2018/19 is subject to approval by DHSC on a monthly basis and remains a risk in the new financial year. The Trust also requires additional capital funding in order to progress essential schemes.

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

The Trust has a challenging target of £10.1m to deliver for the 2018-19 financial year. The full target in 2017-18 was not met and the Trust position was secured by non-recurrent items. The Trust is working to close the gap to the full target value.

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

The Trust has an annual agency ceiling of £11.4m in 2018-19 which is in line with the level included in the financial plan. The Trust has manged to maintain its trajectory of agency expenditure over the winter period however there is still significant pressure on the Trust to maintain this level.

d) The Trust is unable to access £10.3m of Provider Sustainability Funding.

In order to receive the full amount of Provider Sustainability Funding (PSF, previously sustainability and transformation funding) in 2018-19, 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 failed to meet the performance standard requirements for quarter Q4 in 2017/18. A part of a first wave integrated care system £1.1m of the Trust's PSF is contingent on the STP as whole meeting its system control total – this represents a significant risk to the Trust given the current STP financial position.

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. For 2018/19 a significant level of contract challenges has 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 risk to recoverability of income.

RECOMMENDATIONS

22. The Board is asked to note the financial position of the Trust as at 31th January 2019 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 2019

	January 2019			10 months to Jan 2018			Full year
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME							
Outpatients	3,612	4,085	474	35,261	36,486	1,225	42,079
Elective admissions	2,356	2,221	(135)	23,707	23,897	190	28,189
Emergency admissions	5,487	5,232	(255)	54,028	53,902	(125)	64,335
Emergency adm's marginal rate (MRET)	(279)	(354)	(75)	(2,756)	(3,483)	(727)	(3,287)
Readmissions Penalty	(221)	(183)	38	(2,177)	(2,250)	(73)	(2,594)
A&E	1,130	1,057	(72)	11,151	10,367	(785)	13,302
Maternity	1,944	1,765	(180)	19,152	17,089	(2,063)	22,856
Critical Care & Neonatal	525	567	42	5,182	5,181	(1)	6,181
Excess bed days	0	0	0	0	0	0	0
Imaging	425	457	32	4,018	4,268	250	4,752
Direct access Pathology	390	405	15	3,825	3,860	35	4,569
Non Tariff Drugs (high cost/individual drugs)	1,407	1,500	93	13,913	15,268	1,355	16,607
Other	263	840	577	2,998	7,224	4,227	3,854
Clinical Income	**17,038**	**17,592**	**554**	**168,301**	**171,809**	**3,507**	**200,842**
Non-Patient Income	**3,997**	**5,442**	**1,446**	**30,689**	**33,176**	**2,487**	**39,763**
TOTAL INCOME	**21,034**	**23,034**	**1,999**	**198,990**	**204,985**	**5,994**	**240,605**
EXPENDITURE							
Total Pay	**(13,188)**	**(14,020)**	**(831)**	**(134,789)**	**(137,847)**	**(3,058)**	**(161,178)**
Non Pay	(4,876)	(5,364)	(488)	(47,195)	(50,283)	(3,088)	(55,155)
Non Tariff Drugs (high cost/individual drugs)	(1,407)	(1,500)	(93)	(13,913)	(15,268)	(1,355)	(16,607)
Non Pay	**(6,283)**	**(6,864)**	**(581)**	**(61,108)**	**(65,551)**	**(4,443)**	**(71,762)**
TOTAL EXPENDITURE	**(19,472)**	**(20,884)**	**(1,412)**	**(195,897)**	**(203,398)**	**(7,502)**	**(232,941)**
EBITDA*	**1,563**	**2,150**	**587**	**3,093**	**1,586**	**(1,507)**	**7,665**
Depreciation and non-operating costs	(942)	(1,016)	(73)	(9,421)	(9,054)	367	(11,309)
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**620**	**1,134**	**514**	**(6,328)**	**(7,469)**	**(1,140)**	**(3,643)**
Public Dividends Payable	(132)	(147)	(15)	(1,316)	(1,331)	(15)	(1,579)
OPERATING DEFICIT AFTER DIVIDENDS	**489**	**987**	**498**	**(7,644)**	**(8,800)**	**(1,155)**	**(5,223)**
Adjustments to reach control total							
Donated Income	(1,000)	(2,000)	(1,000)	(5,500)	(5,000)	500	(8,592)
Donated Assets Depreciation	58	58	0	580	584	4	697
Control Total Rounding	0	0	0	0	0	0	0
PSF	(1,407)	(1,286)	121	(9,249)	(8,454)	795	(10,263)
CONTROL TOTAL DEFECIT	**(1,860)**	**(2,241)**	**(381)**	**(21,813)**	**(21,670)**	**144**	**(23,381)**

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

Appendix 2

Milton Keynes Hospital NHS Foundation Trust
Statement of Cash Flow
As at 31st January 2019

	Mth 10 £000	Mth 9 £000	In Month Movement £000
Cash flows from operating activities			
Operating (deficit) from continuing operations	(5,826)	(7,227)	1,401
Operating surplus/(deficit) of discontinued operations			
Operating (deficit)	**(5,826)**	**(7,227)**	**1,401**
Non-cash income and expense:			
Depreciation and amortisation	7,413	6,663	750
(Increase)/Decrease in Trade and Other Receivables	(3,187)	(322)	(2,865)
(Increase)/Decrease in Inventories	(7)	(8)	1
Increase/(Decrease) in Trade and Other Payables	911	1,761	(850)
Increase/(Decrease) in Other Liabilities	(67)	161	(228)
Increase/(Decrease) in Provisions	(46)	(34)	(12)
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows	(5,009)	(3,009)	(2,000)
Other movements in operating cash flows	(1)	(2)	1
NET CASH GENERATED FROM OPERATIONS	**(5,819)**	**(2,017)**	**(3,802)**
Cash flows from investing activities			
Interest received	42	37	5
Purchase of intangible assets	(1,345)	(1,249)	(96)
Purchase of Property, Plant and Equipment, Intangibles	(6,943)	(5,443)	(1,500)
Net cash generated (used in) investing activities	**(8,246)**	**(6,655)**	**(1,591)**
Cash flows from financing activities			
Public dividend capital received	625	625	0
Loans received from Department of Health	13,825	12,760	1,065
Loans repaid to Department of Health	(636)	(636)	0
Capital element of finance lease rental payments	(126)	(111)	(15)
Interest paid	(1,121)	(953)	(168)
Interest element of finance lease	(256)	(230)	(26)
PDC Dividend paid	(789)	(789)	0
Receipt of cash donations to purchase capital assets	5,009	3,009	2,000
Cash flows from (used in) other financing activities	0		0
Net cash generated from/(used in) financing activities	**16,531**	**13,675**	**2,856**
Increase/(decrease) in cash and cash equivalents	**2,466**	**5,003**	(2,537)
Opening Cash and Cash equivalents	**2,507**	**2,507**	0
Closing Cash and Cash equivalents	**4,973**	**7,510**	**(2,537)**

Appendix 3

Milton Keynes Hospital NHS Foundation Trust
Statement of Financial Position as at 31st January 2019

	Audited Mar-18	Jan-19 YTD Plan	Jan-19 YTD Actual	In Mth Mvmt	YTD Mvmt	% Variance
Assets Non-Current						
Tangible Assets	171.9	184.2	171.0	(13.2)	(0.9)	(0.5%)
Intangible Assets	10.0	13.0	10.5	(2.5)	0.5	5.0%
Other Assets	0.4	0.4	0.3	(0.1)	(0.1)	(25.9%)
Total Non Current Assets	**182.3**	**197.6**	**181.8**	**(15.8)**	**(0.5)**	**(0.3%)**
Assets Current						
Inventory	3.3	3.2	3.3	0.1	(0.0)	(1.2%)
NHS Receivables	19.1	16.3	17.6	1.3	(1.5)	(7.9%)
Other Receivables	4.1	4.4	8.8	4.4	4.7	114.6%
Cash	2.5	2.6	5.0	2.4	2.5	99.4%
Total Current Assets	**29.0**	**26.5**	**34.7**	**8.2**	**5.7**	**19.5%**
Liabilities Current						
Interest -bearing borrowings	(32.3)	(31.5)	(32.7)	(1.2)	(0.4)	1.2%
Deferred Income	(1.6)	(1.6)	(1.6)	0.0	0.0	0.0%
Provisions	(1.4)	(1.4)	(1.3)	0.1	0.1	-3.8%
Trade & other Creditors (incl NHS)	(28.4)	(27.8)	(28.2)	(0.4)	0.2	(0.8%)
Total Current Liabilities	**(63.7)**	**(62.3)**	**(63.8)**	**(1.5)**	**(0.1)**	0.2%
Net current assets	**(34.7)**	**(35.8)**	**(29.2)**	**6.6**	**5.5**	**(15.9%)**
Liabilities Non-Current						
Long-term Interest bearing borrowings	(83.6)	(104.1)	(96.8)	7.3	(13.2)	15.8%
Provisions for liabilities and charges	(1.1)	(1.1)	(1.1)	(0.0)	(0.0)	3.8%
Total non-current liabilities	**(84.7)**	**(105.2)**	**(97.9)**	**7.3**	**(13.2)**	15.6%
Total Assets Employed	**62.9**	**56.5**	**54.7**	**(2.0)**	**(8.2)**	**(13.1%)**
Taxpayers Equity						
Public Dividend Capital (PDC)	99.2	100.4	99.8	(0.6)	0.6	0.6%
Revaluation Reserve	78.7	78.7	78.7	0.0	0.0	0.0%
I&E Reserve	(115.0)	(122.6)	(123.7)	(1.1)	(8.7)	7.6%
Total Taxpayers Equity	**62.9**	**56.5**	**54.7**	**(1.7)**	**(8.1)**	**(12.9%)**

Meeting title	**Trust Board**	**Date: 1 March 2019**
Report title:	**Workforce report**	**Agenda item: 4.3**
Lead director **Report author**	**Name: Danielle Petch** **Name: Paul Sukhu**	**Title: Director of Workforce** **Title: Deputy Director of Workforce**
FoI status:	**Disclosable**	

Report summary	This report provides a summary of workforce Key Performance Indicators for the full year ending 31 January 2019 (Month 10).			
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [x]	**Decision** [ ]
Recommendation	Trust Board is asked to note the Workforce report.			

Strategic objectives links	Objective 8 : Improve Workforce Effectiveness
Board Assurance Framework links	None
CQC outcome/ regulation links	Well Led Outcome 13 : Staffing
Identified risks and risk management actions	1606 - We may be unable to recruit sufficient qualified nurses for safe staffing in wards and departments 1608 - There is a risk that sufficient numbers of employees may not undergo an appraisal to achieve target of 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 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	Full monthly Corporate Workforce Information report - Executive Management Board, Divisional Accountability, 20 February 2019
Next steps	
Appendices	None

Workforce report – Month 10, 2018/19

1. Purpose of the report

1.1. This report provides a summary of workforce Key Performance Indicators for the full year ending 31 January 2019 (Month 10).

2. Staff in post

2.1. The Trust's staff in post by whole time equivalent (WTE) was 3092.6 as at 31 January 2019; an increase of 72.4 WTE since January 2018.

2.2. The Trust's headcount is 3575, an increase of 76 since January 2018.

2.3. The largest increases of staff in post since January 2018 have been in the Additional Clinical Services, Nursing and Midwifery and Healthcare Scientist staff groups.

3. Vacancy rate

3.1. The Trust's overall vacancy rate is 11.4%; this has reduced from 13.1% in September 2018.

3.2. Rolling recruitment adverts are in place for Nursing and Midwifery posts within the clinical divisions, with toolkits for targeted recruitment using social media channels.

3.3. Under the ongoing Workforce Strategy delivery plan, the Recruitment and Medical Staffing teams have now outlined 'hard to recruit' areas/posts for which refreshed strategies are being drafted in collaboration with the clinical divisions, for greater impact on divisional and Trust-wide vacancy factors.

4. Turnover

4.1. The Trust's leaver turnover rate has been lower in 2017/18 than it was in 2016/17 and in line with its trend for Q2 to Q4 has reduced from 12.6% to 11.5% since May 2018.

4.2. In addition to particular retention focused work referenced in previous Trust Board reports, the breadth of organisational development (e.g. the MK Managers Way) and engagement work in the Trust's Workforce Strategy, coupled with the sense of belonging that is fostered by our new values and staff networks, will help the Trust to reduce turnover.

4.3. Work is underway to increase retention, including participation in the NHSI Retention Programme. Reports to the quarterly Workforce Board and the Nursing and Midwifery Board detail the progress made in this regard. Retention is a key theme in the Trust's Workforce Strategy 2018-21.

5. Temporary staffing

5.1. The temporary staff usage (bank and agency) for the rolling year-to-date was 5889.4 WTE, which was 14.2% of total WTE staff employed.

5.2. Agency staff usage was 3.8% of the total WTE staff employed for the rolling year to date but was 6.1% of the total annual staff expenditure. This is predominantly driven by high cost medical and dental agency locums and volume of nursing agency staff.

5.3. The Trust ceiling for agency staff expenditure for 2018/2019 is £11.4m. The Trust is consistently below the allocated agency expenditure ceiling.

6. Sickness absence

6.1. The sickness absence rate (N.B. 12 months to M10, 31 December 2018) has reduced further since M9, remaining below the Trust target of 4.0% at 3.93% (1.75% short term and 2.18% long term).

6.2. Overall, the Trust's sickness absence levels remain lower than the same period for the last two financial years since October 2017.

6.3. Since the implementation of the new Sickness Absence and Attendance policy in December 2018, increased volumes of referrals to Staff Health and Wellbeing are being undertaken by managers and supervisors; this is also increasing activity for the Staff Health and Wellbeing Team and HR Advisory teams.

6.4. The Workforce team continues to identify sickness absence trends and hotspots, providing case management support where appropriate. Cases of intermittent and long term absence are also targeted to improve staff health and wellbeing and elicit improved attendance levels.

6.5. More detail on sickness absence is reported and discussed at Divisional Executive Management Board (Divisional Accountability – monthly), Workforce Board and Workforce and Development Assurance Committee (both quarterly).

7. Statutory and mandatory training

7.1. Statutory and mandatory training compliance as at 31 January 2019 was at 90% against the Trust target of 90%.

7.2. Reassurance of the Divisional and Corporate statutory and mandatory training trajectories has been sought and received at Executive Management Board (Divisional Accountability) to the end of March 2019.

7.3. It is anticipated that the 2018 Agenda for Change pay structure reform will support the Trust's compliance in this area. Policy development is ongoing to support implementation in advance of the pay structure going live on 01 April 2019.

7.4. Correspondence has been sent to all employees outlining details of the new pay structure and the impact of training non-compliance in respect of it. The correspondence included details of current compliance levels by individual course, means of accessing courses, how to correct anomalies and the support mechanisms available to colleagues.

7.5. The Learning and Development team have seen increased volumes of course bookings following receipt of the compliance correspondence and it is expected that compliance levels will continue to increase in line with Divisional and Corporate commitments to Management Board.

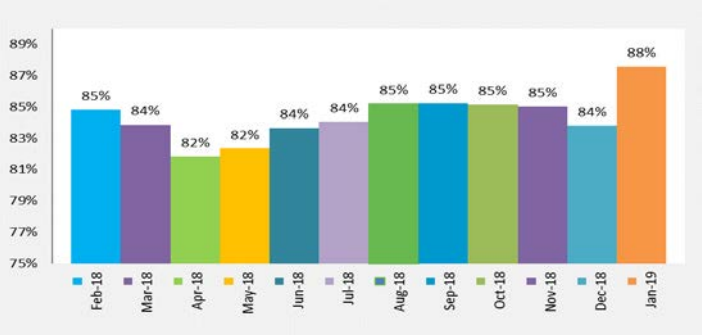
Training Compliance by Division	
Core Clinical	93%
Corporate Services	92%
Medicines Unplanned Care	89%
Surgical Planned Care	88%
Women's and Children's	92%
Trust Total Compliance	**90%**

8. Appraisal compliance

8.1. Trust-wide appraisal compliance as at 31 January 2019 has improved by 4% in month, to 88%, against the Trust target of 90%.

8.2. As outlined at paragraphs 7.3 and 7.4; it is anticipated that the 2018 Agenda for Change pay structure reform and the Trust's recent correspondence to individuals will support the Trust's appraisal compliance improvement plans.

Appraisal Completion by Division	
Core Clinical	94%
Corporate Services	83%
Medicines Unplanned Care	86%
Surgical Planned Care	82%
Women's and Children's	92%
Total Trust	**88%**



9. Flu vaccination compliance 2018/19

9.1. As at week 20 (of 22) of the flu season campaign, the Trust has successfully vaccinated 76.87% of its frontline Health Care Workers (HCW). The Trust reached its 75% target in week 8 of the flu season campaign compared to week 15 in 2017/18.

9.2. Flu vaccination uptake data is completed on a weekly basis and reported one week in arrears. The figures outlined below reflect the position to w/e 15 February 2019.

Total uptake and opt-out rates:

	Total	**%**
Number of frontline HCW	3237	100%
Uptake of vaccine by frontline HCW	2488	76.86%
Opt-out of vaccine by frontline HCW	98	3.02%

Higher-risk areas:

Area name	**Total frontline staff**	**Total vaccinated**	**Opt-Out Total**	**Redeployed**	**Actions taken**
A&E	118	80	9	No	None
Paediatrics	81	64	4	No	None
DOCC	38	32	1	No	None
Maternity	204	106	5	No	None
Ward 16	38	23	4	No	None
MAU 1	39	25	2	No	None
MAU 2	39	23	1	No	None

Reasons given for opt-out

Reason	**Number**
I don't like needles	6
I don't think I'll get flu	32
I don't believe the evidence that being vaccinated is beneficial	24
I'm concerned about possible side effects	20
I don't know how or where to get vaccinated	0
It was too inconvenient to get to a place where I could get the vaccine	0
The times when the vaccination is available are not convenient	0
Other reason	16

Actions taken to reach 100% uptake ambition:

9.3. The annual '#Kungfuthatflu' campaigns started in 2016, using a logo and hashtag designed by a local school child as part of a Trust competition. Uptake has increase annually, standing at nearly 78% at the end of January 2019.

9.4. Throughout the campaign, a range of communication channels were used to promote and educate staff through our Twitter page; CEO weekly newsletter; Health & Wellbeing newsletter attached to payslips; acute user emails; pop up banners; and a dedicated intranet page. The Trust Executive Directors are updated on the progress of the campaign every week with senior managers encouraging and cascading vital information around the campaign to their individual teams.

9.5. The Flu Steering Team comprises; the Flu Lead; Head of Staff Health and Wellbeing; Pharmacy; Infection Control; Director of Workforce; Matrons; and Communications, and meets on a monthly basis leading up to and throughout the campaign to implement initiatives and manage the campaign.

9.6. The Communications Team drafted myth busting posters which were placed in high traffic in clinical areas. The Trust recorded staff that declined the vaccination and the reasons why and used this information to tailor messages sent to staff. Clinical evidence as to vaccine efficacy available through Public Health England was communicated to all staff via the #Kungfuthatflu intranet page.

9.7. A vaccinator “walked the floor” every day/night in the first month to offer the vaccine to staff covering all shifts. This continued throughout the rest of campaign to a lesser degree to ensure all staff had access. The floor walk went to all training and induction sessions held on site, as well as the lunch time restaurants. Drop in clinics were held in the Staff Health and Wellbeing Department and all attending for an Occupational Health appointment was offered the vaccination. The ‘Flu Hub’ was based near the staff restaurant for staff to drop in at allocated times throughout the week.

9.8. Vaccinated employees were selected at random at certain stages of the campaign to win one of 10 prizes: Amazon vouchers; Kindles, Amazon Firesticks and Amazon Echos. These gifts were donated by NHS Staff Benefits in exchange for promoting their website in the CEO Newsletter. Following each vaccine, staff were given gifts of a ‘mop-top’ pen and notebook personalised with the #Kungfuthatflu logo, a lollipop and a sticker.

9.9. In 2018/19 30 peer vaccinators, ranging from managers, staff nurses to pharmacy technicians, competed for the ‘Top Vaccinator’ title. The top 3 vaccinators at the end of the campaign win between 1-3 days additional annual leave.

9.10. A Trust Leaderboard informs the top 16 departments of their uptake both internally and externally through social media.

9.11. The Director of Patient Care & Chief Nurse and the Director of Workforce have continued to provide visible leadership throughout the campaign and have worked as champions to promote the campaign and encourage matrons/managers to increase the uptake of staff vaccinated in their areas.

10. Recommendations

10.1. Trust Board is asked to note the Workforce report.

Meeting title	**Board of Directors**	**Date: 1 March 2019**
Report title:	**Board Assurance Framework**	**Agenda item: 5.1**
Lead director **Report author** **Sponsor(s)**	**Kate Burke**	**Director of Corporate Affairs**
FoI status:	**Public**	

Report summary				
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [ ]	**Decision** [ ]
Recommendation	That the Board notes the risks on the BAF – which have been discussed in detail at Board sub-Committees – and discusses those risks that remain at a high residual rating or that are not at a tolerable level.			

Strategic objectives links	All
Board Assurance Framework links	All
CQC regulations	All domains
Identified risks and risk management actions	Within BAF
Resource implications	Within individual risk action plans
Legal implications including equality and diversity assessment	Pursuant to individual risks

Report history	The BAF is reported to the Board on a quarterly basis (minimum) and to every Board sub-Committee
Next steps	Board Committees
Appendices	Papers follow

Board Assurance Framework

The Board is asked to note the contents of the Board Assurance Framework, the individual risks contained therein having been discussed in-depth at Board sub-Committees.

The Board is asked is pay particular attention to risks where the residual risk rating is rated ‘red’. The Board has set its risk appetite against individual risks, but is noted that some risks are tolerated, although controls, assurances and actions are regularly reviewed and challenged.

There is no significant movement on the BAF in the reporting period – although the BAF will be revised and updated with annual objectives and strategic review in April 2019. The Board should also note that the risk around exiting the EU may also change within the reporting period, depending on external factors.

Exec Lead	Risk Ref	Objective	Committee	SRR link	Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance (First Line - Operational)	Assurance (Second Line - Management)	Assurance (Third Line - Independent)	Assurance Rating	Residual risk rating	Progress since last report	Action Plans	Target risk score
							Consequence v		Level 1 Operational (management)	Level 2 Oversight functions	L3 Independent	Overall				
IR	1-1	SO1	Quality & Clinical Risk	1917/2500	Strategic failure to manage demand for emergency care	Lack of demand management by the local health economy Inadequate primary care provision/ capacity Inadequate community care provision/ capacity Inadequate social care provision/ capacity	4x4=16	Working with partners to manage peak demand periods (e.g expediting discharge; using full community/ social care capacity)	Strategic planning at trust-wide and service level Strategic planning within local health economy (CCG, CNWL, GP Federation)	Regular strategic planning withing the system - include Emergency Care Delivery Board Regular reporting to Management Board; Committees and Trust Board on strategic planning	System-wide Emergency Care Delivery Board Regular NHSI oversight (PRMs) External scruitny through Transformation Board, Health and Wellbeing Board and Health Overview and Scrutiny Committee Part of ICS (STP) priority programme on acute care	Good	4x3=12	Executive strategy session; A&E Delivery Board monthly evidencing progress on DTOCs and system working	System-wide strategic plan	4x2 = 8
IR	1-2	SO1	Quality & Clinical Risk	1917/2500	Tactical failure to manage demand for emergency care	Annual emergency and elective capacity planning inadequate or inaccurate Daily flow/ site managmement plans inadequate or ineffectual Poor clinical/ operational relationships impacting on patient flow through the organisation Poor operational/ managerial relationships impacting on escalation Ineffective engagement with stakeholders to support patient flow day-to-day	4x4=16	Introduction of ED streaming Working with UCC to manage demand Implementation of national flow improvement programmes - Red2Green; 100% Challenge; EndPJParalysis; SAFER Strong clinical and operational leadership and ownership; good team working Clear escalation and well-known and understood flow management and escalation plans Positive relationships with stakeholders through daily working and medium-term planning	Daily operational oversight Medium-term planning at service-level Daily and short/ medium-term planning with local health economy partners to support flow and right care/ right place	Regular strategic planning withing the system - include Emergency Care Delivery Board Regular reporting to Management Board; Committees and Trust Board on strategic planning	System-wide Emergency Care Delivery Board Regular NHSI oversight (PRMs) External scruitny through Transformation Board, Health and Wellbeing Board and Health Overview and Scrutiny Committee Part of ICS (STP) priority programme on acute care	Good	4x3=12	Daily management	Length of Stay Programme Board - 11 key work streams to support flow, including multi-agency input	4x2 = 8
IR	1-3	SO1	Quality & Clinical Risk	1917/2500	Ability to maintain patient safety during periods of overwhelming demand	Significantly higher than usual numbers of patients through the ED Significantly higher acuity of patients through the ED Major incident/ pandemic	5x4=20	Clinically and operationally agreed escalation plan Adherence to national OPEL escalation management system Clinically risk assessed escalation areas available	Daily operational management command structure in place to manage emergency and elective activity safely Clinical site team 24/7 SMOC and EOC 24/7 Daily patient safety huddle	Daily reporting to clinical, oeprational and executive management Daily sit-rep reporting to regulatory and commissioning bodies Twice-monthly oversight at Management Board (formal reporting)	Daily sit-rep reporting and review by external bodies (CCG, NHSI, NHSE)	Good	4x3=12	Daily management	Continue to clinically review escalation plans in line with demand to ensure patient safety is no compromised	4x2 = 8
IR	1-4	SO1	Quality & Clinical Risk	1472	Failure to appropriately embed learning and preventative measures following Serious Incidents, complaints, claims and inquests	Failure to appropriately report, invesitgate and learn from incidents and complaints	5x3=15	All SIs and action plans processed through the Serious Incident Review Group Actions including learning distribution tracked through SIRG Core component of all Clinical Improvement Group Meetings Lessons communicated via Trust-wide channels Debriefing embedded in specialties and corporately Training and skills programme annually Cultural work (inc Greatix and FTSU Guardians	Incident reports and action plans Performance information on incident numbers Emerging or existing trends analysed and reported Repeat incidents analysed and reported - particularly for failure to learn	Serious Incident Review Group Oversight at Clinical Quality Board Oversight at Quality and Clinical Risk Committee	CCG satisfaction with RCA reporting Stakeholder involvement with RCA/SI investigation Internal Audit review of SI process	Satisfactory	5x2=10	Continued QI project on incident reporting in place showing steady improvements	Learning Hub on the intranet (March 2019) Focus on learning at 2019 Event in the Tent Plenary sessions	5x1 = 5

Exec Lead	Risk Ref	Objective	Committee	SRR link	Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance (First Line - Operational)	Assurance (Second Line - Management)	Assurance (Third Line - Independent)	Assurance Rating	Residual risk rating	Progress since last report	Action Plans	Target risk score
							Consequence v		Level 1 Operational (management)	Level 2 Oversight functions	L3 Independent	Overall				
IR	1-5	SO1	Quality & Clinical Risk	2495/2497	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)	5x3=15	National NEWS protocol in place Level 1 pathway in place Successful implementation of NEWS 2 Sepsis screening and training/ awareness programme	Performance is reported to the Clinical Quality Board and is regularly audited Serious Incident Review Group process where issues around deteriorating patient identified eCare implementation supports early earning systems Standardised mortality review process to identify issues and learning	Serious Incident Review Group Oversight at Clinical Quality Board Oversight at Quality and Clinical Risk Committee	Coronial review of deaths	Satisfactory	5x2=10	Good evidence being demonstrated through eCare reporting metrics. Monthly oversight at executive level continues	Individual action plans where incidents reported to prevent repeat incidents ED review meeting March 2019	5x1 = 5
Exec Lead	Risk Ref	Objective	Committee		Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance (First Line - Operational)	Assurance (Second Line - Management)	Assurance (Third Line - Independent)	Assurance Rating	Residual risk rating	Progress since last report	Action Plans	Target risk score
KJ	2-1	SO2	Quality & Clinical Risk	2598	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 communication, unsatisfactory food, and patients being unable to have a proper say in their care	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 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 following annual patient surveys Real time feedback provided as appropriate to issues and comment on social media	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	Peer review through Picker	Satisfactory	4x4=16	Noted improvements in 2018 survey cohort - including second most improved trust in the Picker cohort for the inpatient survey	Agreed patient experience strategy New patient experience board and task groups estabished (November 2018) and agreed work plan in place (10-focussed areas)	4x2 = 8
Exec Lead	Risk Ref	Objective	Committee		Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance				Residual risk rating	Progress since last report	Action Plans	Target risk score

Exec Lead	Risk Ref	Objective	Committee	SRR link	Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance (First Line - Operational)	Assurance (Second Line - Management)	Assurance (Third Line - Independent)	Assurance Rating	Residual risk rating	Progress since last report	Action Plans	Target risk score
							Consequence v		Level 1 Operational (management)	Level 2 Oversight functions	L3 Independent	Overall				
KB/IR	3-1	SO3	Quality & Clinical Risk	2665/2501	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	3x4=12	Clinical Audit and Effectiveness Board established and first meeting held in July 2018 to improve clinical oversight and identify clinical leadership actions or support required. Improvements in compliance noted.	Agreed actions monitored through compliance reporting and CEAB	4x2 = 8
KB/IR	3-2	SO3	Quality & Clinical Risk	767	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		Satisfactory	3x4=12	Clinical Audit and Effectiveness Board established and first meeting held in July 2018 to improve clinical oversight and identify clinical leadership actions or support required. Group continuing to meet Improvements in compliance noted. Increased executive oversight (dedicated	Agreed actions monitored through compliance reporting and CEAB	(4x2) = 8

Exec Lead	Risk Ref	Objective	Committee		Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance (First Line - Operational)	Assurance (Second Line - Management)	Assurance (Third Line - Independent)	Assurance Rating	Residual risk rating	Progress since last report	Action Plans	Target risk score
IR	4-1	SO4	Executive Management	1917/2500	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	Current performance remains better than 2017/18 although variable day-to-day. Work continues with MK system through A&E delivery board.	Length of Stay Programme Board - 11 key work streams to support flow, including multi-agency input Regular MADE events	4x2 = 8
IR	4-2	SO4	Executive Management	2679/2589	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	4x4=16	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	4x4=16	Recovery plans established. Additional resource in surgery and T&O. Alternative models to increase capacity and reduce waiting lists approved. Long waiters actively managed. Increased oversight by executive. Weekly reporting to executive directors.	Monitored through weekly PTL RTT improving on a continued trajectory	4x2 = 8
JB	4-3	SO4	Audit	2705/2572	Failure to ensure adequate data quality leading to patient harm, reputational risk and regulatory failure	Data quality governance and processes are not robust	4x4=16	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	4x3=12	Testing commenced in specialties where new outcome forms have been in active use for three months or more (September 2018).	Regular programme of audit and testing	4x2= 8

Exec Lead	Risk Ref	Objective	Committee	SRR link	Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance (First Line - Operational)	Assurance (Second Line - Management)	Assurance (Third Line - Independent)	Assurance Rating	Residual risk rating	Progress since last report	Action Plans	Target risk score
							Consequence v		Level 1 Operational (management)	Level 2 Oversight functions	L3 Independent	Overall				
Exec Lead	Risk Ref	Objective	Committee		Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance (First Line - Operational)	Assurance (Second Line - Management)	Assurance (Third Line - Independent)	Assurance Rating	Residual risk rating	Progress since last report	Action Plans	Target risk score
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	5x3=15	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	5x2=10	Positive relationship with NHS regulators continues to develop, now evidence of being in top decile of NHS performers nationally.		4x2 = 8
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	4x3=12	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	4x2=8	Positive relationship with NHS regulators continues to develop, now evidence of being in top decile of NHS performers nationally.		4x2 = 8
JB	5-4	SO5	Executive Management	2177/1185	Failure to maximise the benefits of EPR	That the Trust does not derive all of the benefits in terms of efficiency and productivity from the EPR system as had been anticipated in the business cases	4x3=12	eCare operational delivery board being put into place in order to cover the spectrum of optimisation opportunities both financial and non-financial as a result of the implementation (and upcoming upgrades and changes). An initial schedule of opportunities that forecasts a lvel of savings in line with those in the original business case is being monitored against although there is likely to be some slippage against this when taking into account time for the new system to bed-in across the organisation.	Delivery of financial savings against those specified in the original business case. Delivery of non-financial savings, particualrly releasing time-to-case	Reporting and scrutiny at the Finance and Investment Committee, HIPB and Management Board	External peer review with West Suffolk NHS FT and other Cerner sites	Satisfactory	4x2=8	Monthly oversight at executive level continues		3x2 = 6
JB/ KJ	5-5	SO5	Executive Management	1185	Failure to maximise the benefits of the Trust's digital strategy (patient access)	That the Trust does not adequately define its digital strategy to increase and improve patient access to online services and information supporting the management of their own healthcare	4x3=12	Integrated programme plan under development for review at Management Board/ Board in September 2018 Programme resourcing increased to support planning and delivery	Current programme managed through the Outpatients Transformation Board	Reporting and scrutiny at the Finance and Investment Committee, HIPB and Management Board Within agreed risk appetite for innnovation	None yet sought due to innovative nature of developments	Satisfactory	4x2=8	Regular oversight at executive programme boards	Continued review against delivery trajectories	4x1 = 4
Exec Lead	Risk Ref	Objective	Committee		Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance (First Line - Operational)	Assurance (Second Line - Management)	Assurance (Third Line - Independent)	Assurance Rating	Residual risk rating	Progress since last report	Action Plans	Target risk score

Exec Lead	Risk Ref	Objective	Committee	SRR link	Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance (First Line - Operational)	Assurance (Second Line - Management)	Assurance (Third Line - Independent)	Assurance Rating	Residual risk rating	Progress since last report	Action Plans	Target risk score
							Consequence v		Level 1 Operational (management)	Level 2 Oversight functions	L3 Independent	Overall				
	7-2	SO7	Finance & Investment	1188	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 has been approved by the DoH in the form of an uncommitted term loan. Revenue plan submitted in line with 2018/19 control total of £15.8m deficit. The Trust is in on-going dialogue regarding other strategic capital funding apporval in line with its annual plan.	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	Good	4x3=12	The Trust has received a pre-commitment for part of the funding required for the eCARE programme; however, the Trust will continue to seek apporval for funding of other capital schemes in 2018/19 in line with its annual plan. The Trust is seeking clarity over what will happen when its revenue support loan due now for repayment in March 2019 (as the Trust has no reasonable prospect of repaying the loan)	NHS Improvement has advised that interim loans from 2018/19 will be extended.	3x3 = 9
MK	7-3	SO7	Finance & Investment	1519	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 18/19 financial year not yet fully identified.	Monthly CEO chaired Transformation Board oversight, providing leadership and scrutiny of programme delivery	The Trust discusses the position at its monthly PRM calls with NHSI	Satisfactory	4x3=12	The Trust is forecasting to achieve its control total for 2018/19 and has identified more schemes in 2018/19 than at the same time in 2017/18. Therefore the residual risk scoring has been assessed and has been reduced to 16, but the overall programme is still behind what is planned	Further saving schemes to be identified to deliver maximum savings in 2018/19 and full year effect benefits in to 2019/20. The Trust is on plan at M10. The shortfall against the transformation target has been reduced to £1.2m	4x3 = 12
MK	7-4	SO7	Finance & Investment	940	Disagreement with main commissioner over the level of performance that they are prepared to fund	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 a similar level to 2016-17.	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	Escalated to wider system as required	Satisfactory	4x4=16	Over performance for the prior year is still to be discussed with the commissioners and recovery of income remains a significant risk.	The Trust to continue to work closely with the CCG on demand management solutions.	4x3 = 12
MK	7-5	SO7	Finance & Investment	2005	The Trust is unable to access £10.3m of Provider Sustainability Funding (PSF), split into £7.3m General Fund and £3m of additional PSF	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 PSF	5x4=20	In order to receive £7.3m of PSF General Funding in FY 2018-19, the Trust needs to achieve its financial control total (ie 70% of the funding) and its A&E performance trajectory (30% of the funding). To receive the £3m of additional PSF, the Integrated Care System needs to achieve its control total. The Trust has agreed a control total of £15.8m 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	Escalated to wider system as required	Satisfactory	4x3=12	The Trust achieved its Q1 and Q2 finance control total and its A&E target Q1 and Q2 YTD, however there is significant risk that the Trust will not meet the Q4 A&E target of 95% in March, soething the Trust did not achieve in 2017/18. As part of an ICS, part of the Trust's PSF is also contingent on achievement of the STP control; given underlying financial pressures in	The Trust will continue to closely monitor its performance against the financial and activity targets	4x3=12

Exec Lead	Risk Ref	Objective	Committee	SRR link	Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance (First Line - Operational)	Assurance (Second Line - Management)	Assurance (Third Line - Independent)	Assurance Rating	Residual risk rating	Progress since last report	Action Plans	Target risk score
							Consequence v		Level 1 Operational (management)	Level 2 Oversight functions	L3 Independent	Overall				
LK	7-6	SO7	Board of Directors		Failures in compliance leading to regulatory intervention	That the Trust fails to meet the CQC's fundamental standards or other regulatory body requirements (HSE, MHFA, HTA, and etc)	4x4=16	Compliance assessments embedded in divisions and CSUs (through CIGs and compliance reporting) Divisions undertaken Well Led Assessment in quarter three 2017/18 Trust commissioned GGI to prepare for corporate Well Led Assessment review process (undertaken 2018) Corporate governance structure updated to further strengthen quality and compliance oversight and reporting - effective quarter one 2018/19 Further Well Led review work being procured Strong oversight of regulatory compliance in corporate governace system	Oversight through CIGs Oversight at Risk and Compliance Board Oversight at Nursing and Midwifery Board Oversight at Clinical Quality Board Oversight at Management Board	Regular engagement with the local CQC relationship manager Oversight at Quality and Clinical Risk Committee Trust Board engagement in GGI review	Well Led peer review exercise held with Kingston Hospital Commissioned GGI to undertake Well Led Assessment preparatory review	Satisfactory	4x2=8	Chief Nurse leading a review of compliance and performance against CQC KLOEs. Gap analysis and plan reviewed. Part of ongoing programme An external governance review is being commissioned with a view to being commenced in May/June 2019		4x2 = 8

Exec Lead	Risk Ref	Objective	Committee		Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance (First Line - Operational)	Assurance (Second Line - Management)	Assurance (Third Line - Independent)	Assurance Rating	Residual risk rating	Progress since last report	Action Plans	Target risk score
DP	8-1	SO8	Workforce	2499/2589	Inability to recruit to critical vacancies	National shortages of appropriately qualified staff in some clinical roles, particularly at consultant	4x4=16	Active monitoring of workforce key performance indicators Targeted overseas recruitment activity	Vacancy control panel Divisional deep dive sessions	Quarterly reports to the Workforce and Development Assurance Committee	NHSI Model Hospital benchmarking Staff survey results	Satisfactory	4x3=12	The Trust is assured that recruitment is adequate and that there is a ready pool of suitable candidates	More attempts are to be made to optimise the Trust's workforce website.	4x2 = 8
DP	8-2	SO8	Workforce	1830	Inability to retain staff employed in critical posts	Poor working culture within certain isolated teams Perceived more attractive benefits elsewhere Proximity to tertiary centres with perceived better career development opportunities	4x4=16	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 Succession planning Enhancement and increased visibility of benefits package	Monthly reports to Workforce Board and Managment Board Workforce transformation reports Line managers' work on staff retention Supported departmental initiatives in response to staff survey, e.g. We Care programme	Reports to Workforce and Development Assurance Committees and the Finance and Investment Committee	NHSI Model Hopsital benchmarking, Staff survey results NHS Improvement staff retention exercise	Satisfactory	4x3=12	approval of the 3 year Workforce Strategy with a focus on attracting, recruiting and developing staff; creating a healthy workplace and maximising productivity through innovative infrastructure	Staff survey focus groups Creation of Benefits Pckage literature and marketing materials Creation of workforce strategy and plan to deliver improvement to working experience/environment	4x2 = 8

Exec Lead	Risk Ref	Objective	Committee	SRR link	Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance (First Line - Operational)	Assurance (Second Line - Management)	Assurance (Third Line - Independent)	Assurance Rating	Residual risk rating	Progress since last report	Action Plans	Target risk score
							Consequence v		Level 1 Operational (management)	Level 2 Oversight functions	L3 Independent	Overall				
	9-1	SO9	Finance & Investment	2570	Insufficient capacity in the Neonatal Unit to accommodate babies requiring special care	The current size of the Neonatal Unit does not meet the demands of the service. This risks high numbers of transfers of unwell babies and potential delayed repatriation of babies back to the hospital. There is a risk that if the Trust continues to have insufficient space in its NNU, the unit's current Level 2 status could be removed on the basis that the Trust is unable to fulfill its Network responsibilities and deliver care in line with national requirements.	4x4=16	Reconfiguration of cots to create more space Additional cots to increase capacity Parents asked to leave NNU during interventional procedures, ward rounds, etc to increase available space	Daily clinical management and operational oversight NNU feasibility study completed.	Oversight at Trust Baord through capital programme and via risk reporting	Neonatal Network engaged in work programme	Satisfactory	4x3=12	Initial draft cost plan received. Decant solutions and equipment to be assessed.	Outline business case for NNU re-build being developed by the Estates Department and submitted to the STP for consideration	4x2 = 8

Exec Lead	Risk Ref	Objective	Committee		Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance (First Line - Operational)	Assurance (Second Line - Management)	Assurance (Third Line - Independent)	Assurance Rating	Residual risk rating	Progress since last report	Action Plans	Target risk score
KJ	10-1	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	4x2=8	Income forecasts in place and reiewed weekly.		3x2 = 6

Exec Lead	Risk Ref	Objective	Committee	SRR link	Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance (First Line - Operational)	Assurance (Second Line - Management)	Assurance (Third Line - Independent)	Assurance Rating	Residual risk rating	Progress since last report	Action Plans	Target risk score
							Consequence v		Level 1 Operational (management)	Level 2 Oversight functions	L3 Independent	Overall				
JH	10-2	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	4x3=12	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	NHSE/I oversight	Satisfactory	4x3=12			4x2 = 8
JH	10-3	SO10	Board of Directors	2731	Insufficient preparedness for disruption to workforce or supplies (including medications) following withdrawal from the European Union	Inability to recruit or retain staff; inability to prescribe or supply pharmaceuticals; inability to keep hospital stock levels (clinical and non-clinical) at required levels	5x3=15	UK Government putting contingency plans in place Planning through Trust EPRR forums Trust working with NHSI/E to ensure any national directives are complied with	Regular communication with NHSI/E Assurance through EPRR local/ regional and national forums	Oversight at Trust Board	National Government policy	Satisfactory	5x2=10	No progress to note	Action plans as part of EPRR business continuity. Also overseen by Director of Workforce (with rsponsibility for EU exit preparations)	5x1 = 5

Strategic Objective	Risk Ref	Committee	Risk Description	Proximity	Risk Score (consequence v likelihood)							Trend	Target	Movement towards target (since Mar 2018)	Risk Appetite
					Jan-18	Apr-18	Jun-18	Aug-18	Sep-18	Dec-18	Mar-19				
SO1: Patient Safety	1-1	Quality and Clinical Risk	Strategic failure to manage demand for emergency care	Next 3 to 6 months	Not on BAF	(4x3) = 12	(4x3) = 12	(4x3) = 12	(3x4)=12	(3x4)=12	(3X4)=12	⟷	(4x2) = 8	Remains static	Avoid
SO1: Patient Safety	1-2	Quality and Clinical Risk	Tactical failure to manage demand for emergency care	Next 3 to 6 months	Not on BAF	(4x3) = 12	(4x3) = 12	(4x3) = 12	(3x4)=12	(3x4)=12	(3X4)=12	⟷	(4x2) = 8	Remains static	Avoid
SO1: Patient Safety	1-3	Quality and Clinical Risk	Ability to maintain patient safety during periods of overwhelming demand	Next 3 to 6 months	(4x5) = 20	(4x4) = 16	(4x4)= 16	(4x4)= 16	(4x4)=16	(4x4)=16	(4X3)=12	↓	(4x2) = 8	Closer to target	Avoid
SO1: Patient Safety	1-4	Quality and Clinical Risk	Failure to appropriately embed learning and preventative measures following Serious Incidents	Next 3 to 6 months	(5x2) = 10	(5x2) = 10	(5x2) = 10	(5x2) = 10	(5x2)=10	(5x2)=10	(5X2)=10	⟷	(5x1) = 5	Closer to target	Avoid
SO1: Patient Safety	1-5	Quality and Clinical Risk	Failure to recognise and respond to the deteriorating patient	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(3x3) = 9	(5x2) = 10	(5x2)=10	(5x2)=10	(5X2)=10	⟷	(5x1) = 5	Remains static	Avoid
SO1: Patient Safety	1-6	Quality and Clinical Risk	Failure to manage clinical risks through the implementation of eCARE (go-live)	Next 3 to 6 months	Not on BAF	(4x3) = 12	(4x3) = 12	(4x2) = 8	(4x2)=8	Recommend Risk Closed	Risk Closed	↓	(4x2) = 8	Closer to target	Cautious
SO2: Patient Experience	2-1	Quality and Clinical Risk	Failure to provide an appropriate patient experience	Next 3 to 6 months	(4x4) = 16	(4x4) = 16	(4x4)= 16	(4x4)= 16	(4x4)=16	(4x4)=16	(4x4)=16	⟷	(4x2) = 8	Remains static	Cautious
SO3: Clinical Effectiveness	3-1	Quality and Clinical Risk	Lack of assessment against and compliance with best evidence based clinical practice through clinical audit	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3) = 12	(3x4)=12	(3x4)=12	(3X4)=12	⟷	(4x2) = 8	Remains static	Cautious
SO3: Clinical Effectiveness	3-2	Quality and Clinical Risk	Lack of assessment against and compliance with NICE guidance	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3) = 12	(3x4)=12	(3x4)=12	(3X4)=12	⟷	(4x2) = 8	Remains static	Cautious
SO4: Key Targets	4-1	Management Board	Failure to meet the 4 hour emergency access standard	Next 3 to 6 months	(4x5) =20	(4x4) =16	(4x4)= 16	(4x4)= 16	(4x4)=16	(4x4)=16	(4x4)=16	⟷	(4x2) = 8	Remains static	Cautious
SO4: Key Targets	4-2	Management Board	Failure to meet the key elective access standards - RTT 18 weeks, non-RTT and cancer 62 days	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x4) = 16	(4x4)=16	(4x4)=16	(4x4)=16	⟷	(4x2) = 8	Remains static	Cautious
SO5: Sustainability	4-3	Audit	Failure to ensure adequate data quality leading to patient harm, reputational risk and regulatory failure	Next 3 to 6 months	(4x5) = 20	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3)=12	(4x3)=12	(4X3)=12	⟷	(4x2) = 8	Remains static	Cautious
SO5: Sustainability	5-1	Audit	Failure to adequately safeguard against major IT system failure (deliberate attack)	Next 3 to 6 months	(3x3) = 9	(5x2) = 10	(5x2) = 10	(5x2) = 10	(5x2)=10	(5x2)=10	(5X2)=10	⟷	(5x1) = 5	Remains static	Cautious
SO5: Sustainability	5-2	Finance	Failure to adequately safeguard against major IT system failure (inability to invest in appropriate support systems/infrastructure)	Next 3 to 6 months	(3x3) = 9	(4x2) = 8	(4x2) = 8	(4x2) = 8	(4x2)=8	(4x2)=8	(4x2)=8	⟷	(4x2) = 8	Remains static	Cautious
SO5: Sustainability	5-3	Management Board	Failure to successfully deploy EPR in a way that diminishes disruption	Next 3 to 6 months	(5x3)=15	(4x3) = 12	(4x3) = 12	Recommend Risk Closed	Risk Closed	Risk Closed	Risk Closed	↓	(4x2) = 8	Closer to target	Cautious
SO5: Sustainability	5-4	Management Board	Failure to maximise the benefits of EPR	Next 3 to 6 months	(4x3) = 12	Reassessment required	Reassment required	Reassment required	4x2=8	4x2=8	4x2=8	⟷	3x2 = 6	Remains static	Minimal
SO5: Sustainability	5-5	Management Board	Failure to maximise the benefits of the Trust's digital strategy (patient access)	Next 3 to 6 months	Not on BAF	Not on BAF	Not on BAF	(4x3) = 12	(4x3)=12	(4x3)=12	(4X3)=12	⟷	(4x2) = 8	Remains static	Seek
SO7: Finance and Governance	7-1	Finance	Inability to keep to affordable levels of agency and locum staffing	Next 3 to 6 months	(5x4)=20	(4x3) = 12	(5x4)=20	(4x4) = 16	(4x4)=16	(3x4)=12	Risk Closed	↓	(4x3) = 12	Closer to target	Open
SO7: Finance and Governance	7-2	Finance	Timing and release of capital and revenue funding	Next 12 months	(5x5) = 25	(4x4) = 16	(4x4)= 16	(4x4)= 16	(4x4)=16	(4x4)=16	(4x3)=12	↓	(4x3) = 12	Closer to target	Open
SO7: Finance and Governance	7-3	Finance	Inability to achieve the required levels of financial efficiency within the Transformation Programme	Next 12 months	(5x4) = 20	(4x4) = 16	(5x4) = 20	(5x4) = 20	(5x4)=20	(4x4)=16	(4X3)=12	↓	(4x3) = 12	Closer to target	Seek
SO7: Finance and Governance	7-4	Finance	Disagreement with main commissioner over the level of performance that they are prepared to fund	Next 12 months	(5x4) =20	(4x4) = 16	(4x4)= 16	(4x4)= 16	(4x4)=16	(4x4)=16	(4x4)=16	⟷	(4x3) = 12	Remains static	Seek

SO7: Finance and Governance	7-5	Finance	The Trust is unable to access £7.3m of Sustainability & Transformation Funding	Next 3 to 6 months	(5x5) = 25	(4x4) = 16	(5x4) = 20	(5x4) = 20	(5x4)=20	(5x4)=20	(4X3)=12		(4x3) = 12	Closer to target	Seek
SO7: Finance and Governance	7-6	Board	Failures in compliance leading to regulatory intervention (CQC)	Next 12 months	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3)=12	(4x3)=12	(4x2)=8		(4x2) = 8	Closer to target	Cautious
SO8: Workforce	8-1	Workforce	Inability to recruit to critical vacancies	Next 3 to 6 months	(4x4) = 16	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3)=12	(4x3)=12	(4X3)=12		(4x2) = 8	Remains static	Seek
SO8: Workforce	8-2	Workforce	Inability to retain staff employed in critical positions	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3)=12	(4x3)=12	(4X3)=12		(4x2) = 8	Remains static	Seek
SO9: Estate	9-1	Finance	Insufficient capacity in the Neonatal Unit to accommodate babies requiring special care	Next 3 to 6 months	Not on BAF	Not on BAF	Not on BAF	(4x4) = 16	(4x4)=16	(4x4)=16	(4X3)=12		(4x2) = 8	Closer to target	Minimal
SO10: Corporate Citizen	10-1	Charitable Funds	Failure to achieve the required level of investment (including appeal funds) to fund the Cancer Centre	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3)=12	(4x3)=12	(4x2)=8		(4x2) = 8	Remains static	Open
SO10: Corporate Citizen	10-2	Board	Inability to progress the Milton Keynes Accountable Care System and wider ACS/STP programme	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3)=12	(4x3)=12	(4X3)=12		(4x2) = 8	Remains static	Seek
SO10: Corporate Citizen	10-3	Board	Insufficent preparedness for disruption to workforce or supplies (including medications) following withdrawal from the European Union	Next 3 to 6 months	Not on BAF	Not on BAF	Not on BAF	Not on BAF	Not on BAF	(5x2)=10	(5X2)=10		(5x1) = 5	Remains static	Avoid

Meeting title	Trust Board	**Date:** 1 March 2019
Report title:	7 Day Services – Board Assurance Report	**Agenda item: 5.2**
Lead director **Report author** **Sponsor(s)**	**Name:** Dr Ian Reckless **Name:** Elisa Scaletta	**Title:** Medical Director **Title:** Deputy Business Mngr
FoI status:	Publicly disclosable	

Report summary							
Purpose *(tick one box only)*	**Information**	☐	**Approval**	☐	**To note**	x	**Decision** ☐
Recommendation	This report provides Board with an update on progress in the Trust against NHSE's 7-day standards.						

Strategic objectives links	Improve patient safety Improve clinical effectiveness
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	As described within the body of the paper.
Legal implications including equality and diversity assessment	

Report history	First report containing the Board Assurance Framework documentation (likely to become a bi-annual paper).
Next steps	Further report anticipated in six months.
Appendices	Appendix 1 - Assurance template containing local audit data 4th – 17th February 2019 (submitted to NHSE 27/02/2019).

Purpose of the Report

Trust Board is asked to note performance, gaps against standards, and work in progress.

1. Context

- 7 Day Services aim to ensure emergency inpatients have equivalent access to consultant input and key tests / interventions, irrespective of the day of the week.
- There are 10 standards, 4 of which are termed 'priority'.
- NHS providers are expected to meet all 4 priority standards by April 2020.
- Various investments have been planned and agreed internally to assist in meeting standards.
- The Trust has been involved in intermittent national data returns over the last few years.
- From now, progress will be measured using a board assurance process, which involves completing a self-assessment template (appendix 1).
- Trust Board is asked to note performance, gaps against standards, and work in progress. Of note the impact of eCARE (which will make a positive contribution in the medium term) is in a phase of maturation. By way of illustration, it can be more difficult to ascertain whether or not a consultant was physically present at a ward round in the eCARE system than it was in paper notes. Measures are being put in place to improve this.

The 10 standards for seven-day services are:

Standard	Definition
1	Patients involved in shared decision making
2*	**Time to first consultant review**
3	All emergency inpatients must be assessed for complex or ongoing needs within 14 hours by a multi-professional team
4	Handovers led by competent senior decision maker
5*	**Access to diagnostic tests**
6*	**Access to consultant-directed interventions**
7	Liaison mental health services to respond to referrals and provide urgent and emergency mental health care in acute hospitals with 24/7 Emergency Departments 24 hours a day, 7 days a week
8*	**Ongoing review by consultant twice daily for high dependency patients, daily for other**
9	Support services must be available seven days a week
10	Those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement

Priority Standard

2. Recommendation

Trust Board is asked to note performance, and gap against standards, and the work in progress.

Elisa Scaletta

Deputy Business Manager, MDO

Ian Reckless

Medical Director

7 Day Hospital Services Self-Assessment

Organisation	**Milton Keynes University Hospital NHS FT**
Year	**2018/19**
Period	**Autumn/Winter**

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: 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.	73% 120 randomly selected patients with emergency admission followed by discharge / death in the weeks commencing 4th and 11th February 2019 (60 per week). The Medical Director's Office is currently working with the Information Team to try and establish the 'electronic stamp' for the actual admission time as this is one of the issues that has arisen since starting the audit.	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: 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 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	100% compliance except for weekend echo. Some elective lists and Consultant Cardiologist onsite 7 days a week. A business case has been approved to embed inpatient echo capacity 7 days a week, however not yet available. MRI is available within 12 hours.	Echocardiography	Yes available on site	No the test is not available	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available on site	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: 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.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Not Met
		Interventional Radiology	No the intervention is only available on or off site via informal arrangement	No the intervention is only available on or off site via informal arrangement	
		Interventional Endoscopy	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Emergency Surgery	Yes available on site	Yes available on site	
	Formalisation of interventional radiology is currently being reviewed and negotiated with OUH as our tertiary centre. No solution feasible via STP / ICS.	Emergency Renal Replacement Therapy	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Urgent Radiotherapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Cardiac Pacing	Yes mix of on site and off site by formal arrangement	Yes available off site via formal arrangement	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). 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.	We are building pre-populated (auto text) templates into eCare to provide clearer documentation as to whether patient review is delegated to another member of staff. Of note the impact of eCARE (which will make a positive contribution in the medium term) is in a phase of maturation. By way of illustration , it can be more difficult to ascertain whether or not a consultant was physically present at a ward round in the eCARE system than it was in paper notes. Measures are being put in place to improve this. Once Daily: Weekday 60% Once Daily: Weekend 51%	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
S1 - Carers and families receive information about appointments and procedures, gaining consent as appropriate 7 days a week. We work to ensure patients' needs are listened to and recorded. We follow the ethos of John's Campaign which facilitates families and carers to stay with patients, supporting their care plans and decision making. We have a Trust wide 'Your Stay in Hospital' leaflet which gives a range of information to support a patient's stay. We follow the #hellomynameis campaign and elicit feedback from patients, families and carers. There is also a Length of Stay Programme which looks at 11 key areas for improvement. S3 - Daily board rounds on all clinical wards, led by the most senior clinician, which follows the 'Red2Green' approach. Monday to Friday, a Consultant is typically present. MKUH has a Rotational Operational Liaison Officer role to highlight / manage complex discharges, working alongside the MDT. S4 - There is a weekend handover meeting for medical specialties on a Friday afternoon, highlighting patients who require specific review and input over the weekend. Additional handover meetings occur if there are bank holidays that fall away from the weekend. There are also daily meetings at 21:30, 7 days a week. This is always attended by the medical teams (incoming and outgoing), the night ITU registrar, rapid response and the night nurse practitioners. At the night handover meeting all patients who are unwell are discussed, plus any outstanding patients from the day take, any outstanding tasks for inpatients and any operational issues such as staffing gaps. This meeting is typically attended by the on-call medical consultant. S7 - This is in place and provided by Central and North West London NHS Foundation Trust. S9 - There is a duty social worker, 7 days a week for emergencies. There are also the Home First Reablement Team, Home First Nursing Team and Home First Therapies Team. They work on admission avoidance 7 days a week. The Home First Reablement Team also takes discharges from A&E. There are also District Nurses 7 days a week, 24/7. S10 - The Trust has a clinical audit programme (as detailed in the annual Quality Account) and is currently reviewing the interplay between audit, transformation and quality improvement. The trust is committed to an environment of continuous quality improvement using established and proven methodologies.

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 6	No, the standard is not met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 8	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
Intra-arterial clot retrieval is currently available at OUH 08:00 to 16:00 Monday to Friday. It is not yet a 24/7 service. It is hoped that this will occur in the first half of 2019 and MKUH is well placed to offer all patients access to this key service via the integrated MKUH / OUH acute stroke service.

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

Meeting title	Board of Directors	Date: 1 March 2019
Report title:	Report of the Management Board meeting held on 6 February 2019	Agenda item: 5.3
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.			

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 6 February 2019

1. Chief Executive update

There have been a number of changes at divisional general manager level that both strengthen and develop the structure and people. Steve Collins and Rachel McCarthy are swapping their Medicine and Core Clinical roles. Jennifer Kearney, who has significant previous general management experience has taken up her role as General Manager for Surgery. In addition Lynn Neat has taken up a new role of Deputy General Manager for Patient Services, strengthening existing management structures in this area.

2. Q3 Complaints and PALS Report

The PALS team continues to work well in helping to resolve many issues before they become formal complaints. Further work has been requested to ensure that there is further learning from concerns raised and that this is appropriately shared across the Trust. In addition it has been requested by the divisional directors that action plans for improvements are pulled together and completed locally. The Patient Experience Board will take the corporate governance oversight of this area of work and report back to Management Board as appropriate.

3. Incident Reporting quality improvement programme

It is pleasing to recognise that there has been an improvement recently in the volume of incidents being reported, recognising that a high incident reporting rate often suggests a more effective safety culture. Despite this the Trust continues to be identified as a "low incident reporter". Therefore, as part of the increased focus of the Trust on quality improvement a project has now been commenced with the aim of identifying change ideas that would promote further increased incident reporting. Five primary drivers for change – investigation, incident reporting, culture, learning and intelligence data – have been identified, and the importance of staff engagement with the project to ensure that any improvements become part of the Trust's safety culture will be essential. This will be tracked and reported back to Management Board in the coming months.

4. Board Assurance Framework

Following a detailed assessment of both divisional and corporate risks, an additional risk has been added to the BAF with regard to the disruption to workforce or supplies that could be caused following the UK's exit from the European Union.

MEETINGS OF THE FINANCE AND INVESTMENT COMMITTEE HELD ON 14 January and 4 February 2019

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

No matters were approved at either the January or February meetings

Matters referred to the Board for final approval:

No matters were referred to the Board for final approval.

Matters considered at the meetings:

1. Annual Plan update:

At the January meeting, the Director of Finance provided an update on the Trust's key areas of focus in the lead up to the presentation of the 2019/20 annual plan:

I. At month 8, the Trust was just £1.2m short of its CIP target, and although activity levels in the hospital have been high, costs have been kept under control.
II. The Trust is reported as an outlier on the model hospital for its medical staffing costs; however there are specific factors which contribute to this benchmarking performance.
III. For 2019/20 the national tariff changes will mean a circa 5% uplift in tariff related income for the Trust; however this includes reallocation of funds in to national tariff, and the inflationary pressures faced by the Trust are expected to be high.
IV. The Trust's RTT performance is currently at around 90%.

At the February meeting, the Committee received the draft annual plan, the highlights of which included:

I. The Trust is taking a more prudent approach to growth, taking account of concern about affordability for the CCG. However, the Trust is keen to ensure that the planned for levels of growth are realistic and that the assumed benefits from commissioner-led demand management schemes are credible. The Trust expects to submit a plan that would allow it to meet the 2019/20 control total set by NHSI.
II. Expansion of the neonatal unit is a capital priority for the Trust. Funding for the Trust's Pathway Unit has been confirmed and works are expected to commence in 2019/20.

2. Board Assurance Framework:

I. 7-2 (capital and revenue funding) – at the February meeting it was agreed that the rating of this risk be reduced from 16 (4x4) to 12 (4x3) based on advice from NHS Improvement that interim loans due for repayment in 2018/19 will be extended.
II. 7-3 (Transformation Programme) - at the January meeting, it was agreed that the rating for this risk should be reduced from 15 (5x3) to 12 (4x3) based on the number and value of confirmed cost saving schemes. Despite growing confidence that the remaining gap to

fully meeting the target would be bridged, it was agreed in February that the rating should remain at 12.

III. 7-4 (disagreement with main commissioner) – rating to remain the same as this is a live risk in light of ongoing conversations with the CCG

IV. 7-5 (PSF) it was agreed in January that the rating would be reduced from 15 (5x3) to 12 (4x3) as the Trust met its Q3 A&E target and secured £0.9m worth of PSF. Risk remains around Q4 performance and the ICS position, although there is now mitigation in place for the latter.

3. Finance Report

I. At month 9, the Trust was £525k better than plan at the control total excluding provider sustainability funding level. Confidence in meeting the control total at year end is increasing, in spite of fluctuating income predictions.

4. Agency update

I. Agency and locum usage has remained steady over the period and the Trust expects to come in below its agency ceiling for 2018/19 for the second year in succession.

5. Timeline for strategic capital projects

I. There has been slight slippage in the timeline for the construction of the Cancer Centre, but the completion date remains unaffected.

Workforce and Development Committee Summary Report

1. Introduction

The Workforce and Development Committee met on 4 February 2019. A summary of key issues discussed is provided below.

2. Workforce

Staff Story

A Programme Manager on the Transformation Team attended to provide her story. She had initially joined the Trust about 5 years ago as a rota co-ordinator on one of the divisions, a role that was at that time very new to the Trust. The colleague indicated that she had worked across a number of teams in her time here. Overall she had not found any difficulty in integrating into new teams and she considers that the culture across the Trust is generally open and collaborative. She had noticed in her time working on transformation, however, that although staff are ready for change, they do find it difficult to prioritise the work that this entails.

The colleague was particularly positive about the steps that the organisation had taken to improve staff health and wellbeing and she does not feel that the Trust receives enough credit for this. She also confirmed that she had always been supported by managers in terms of accessing learning and development opportunities to aid her progression.

The Committee thanked the colleague for attending to share her experiences.

Workforce Information Quarterly Report

Highlights from the report include:

- The Trust remains below the spending ceiling for agency staffing.
- The 12 month sickness absence rate is below 4%. This reduction was largely attributed to the implementation of the new Sickness Absence Policy. Although the staff survey indicates that some staff may feel under pressure to come to work when they are unwell, but it is believed that this is self-generated due to their commitment to their teams. The message is to be emphasised that people should stay at home if they are not well.
- The leaver turnover rate has continued to decrease, from 12.7% to 11.7% over the last year, and this is better than the Trust's STP peers. Steps are being taken to make it easier for departing staff to complete exit questionnaires in order that the Trust may obtain as much information as possible as to why and in what circumstances staff leave the organisation.
- The Trust is aware of the specialities and areas in which it finds it hard to recruit clinical and non-clinical staff, and is working with local educational partners to focus on filling these gaps. For Medicine, these hard to recruit specialties include gastroenterology, urology and trauma and orthopaedics, while for nursing they are in theatres and on the frailty wards. For all hard to recruit specialities the Trust does have access to agency staff to ensure that patient safety is not compromised.

Quarter 3 HR Systems and Compliance Report
The Trust's success in appointing 24 doctors during the quarter was highlighted, as was the level of activity that had taken place to achieve this. One of the key aims of the HR Systems and Compliance Teams going forward is to seek to reduce the time taken from advert to interview. It was noted that the scale and pace of recruitment from a recent campaign that took place in the city centre was such that some of those expressing interest on the day left the event with a conditional offer of employment.

Staff Health and Wellbeing Report
This staff health and wellbeing report included the following information:

- Uptake by frontline staff of the flu jab has surpassed the 75% target.
- The capacity of the staff physiotherapy service has been increased.
- Over 1000 members of staff used the Peer to Peer support service (P2P) over the last year.
- All staff received a voucher for a free beverage with their January payslip as a thank you for everyone's efforts in 2018.

We Care update
Meetings have been held with staff in the areas that showed the most room for improvement in the 2017 staff survey. One of the common issues raised was the time and effort that it sometimes takes to get the necessary tools and equipment required for everyday efficient and comfortable working. The business case process works well for items costing over £5k. The process for less expensive items, although straightforward, will be reiterated to the teams, to ensure managers are empowered to spend money appropriately. In the departments worked with, there was also a perception of delay in getting new staff into the organisation, although it was noted that this is often to do with the requirement to serve out notice period rather than the pace of the recruitment process.

A succession planning exercise has been commenced, with a view to identifying which deputies may be ready now or could soon be ready to take the next steps in their careers.

A good response had been received to the proposal to set up of a disability network within the Trust.

3. Education

Education Update
- A team from the General Medical Council will be visiting to assess the progress of the Medical School, and they will return in March and May to assess other aspects of the programme. The first cohort of medical students are scheduled to graduate in May.
- All staff have received letters explaining the link that has now been established between the completion of statutory and mandatory training and pay progression. Extra sessions have been put on for all courses in anticipation of the extra demand.
- There are 39 people on apprenticeships in the Trust. New apprenticeships in maternity and physiotherapy have been approved and the next stage is for providers to agree to deliver them.

Workforce Risk Register

It was agreed that the narratives around each of the risks in relation to the ability to recruit and retain clinical workforce will be reviewed to ensure they represent the actions being undertaken to enable the Trust to source sufficient workforce so that it can continue to meet the current and future needs of the population of Milton Keynes.

Feedback from Event in the Tent 2018

The Head of Communications attended to provide an update on steps that were being taken to address issues and suggestions raised at last year's event. These included:

- The introduction of the new strategy, vision and values – The MKWay – and the new branding is being embedded across the organisation. Work is being done to ensure that these values are meaningful to staff on a day to day basis.
- The new Trust website has been launched, and the new intranet (called Work Space) has is also now live. In the future, staff will be able to generate their own sites via Work Space.
- A photographer has been commissioned to take images that will become accessible via Google streetview to assist wayfinding.
- Greatix has proved to be a useful way of sharing best practice and learning and MKUH is now the best trust within the Thames Valley region with regard to its use. It is hoped that the Greatix regional conference in May could be linked to Event in the Tent.

The Board is asked to note the summary report.

Charitable Funds Committee Summary Report

1. Introduction

The Charitable Funds Committee met on 4 February 2019.

2. Key matters

The following items were presented to the Committee:

Update on the Cancer Centre appeal

- The Big Give at the end of November 2018 raised £24,500 against a target of £21,500.
- In place of the Celebrity Just Dance event which has now been postponed until the Spring of 2020, a Gala Ball is to be held on 13 September.
- Various local schools are fundraising for the appeal.
- The charity has once again been awarded gold partner status by the MK Marathon, and 16 relay runners are already signed up.
- Social media reach has increased significantly, and there is ongoing media engagement through one of the local radio stations.
- Members of staff are also getting behind the appeal and the Voluntary Services Team are helping to raise its profile.
- It was agreed that the appeal would be extended for three months to the end of 2019.

Charitable Funds Finance updates

- The need for the charity's long term strategy to focus on balancing capital appeals and other funding was stressed.

Proposal to incorporate the Charity

- It was agreed that the process of incorporation, with the support of external legal advisers, is to commence.
- This work is to be carried out alongside the preparation of the Charity's long term strategy, and the Committee will agree the aims of the new charity.

Updated Terms of Reference of the Charitable Funds Committee

- The Committee agreed to further changes to its Terms of Reference to clarify that the Committee will consider any applications for funding made to it, thereby providing more flexibility

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

None new.