Board of Directors

Public Meeting Agenda

Meeting to be held at 11.00 am on Wednesday 10 July 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 3 May 2019	Approve	Pages 3-12	Chairman
1.4	Matters Arising/ Action Log	Receive	Pages 13-14	Chairman
2. Chair and Chief Executive Strategic Updates				
2.2	Chairman's Report	Receive and Discuss	Verbal	Chairman
2.3	Chief Executive's Report • CQC inspection update • Trust Objectives	Receive and discuss	Verbal Presentation	Chief Executive
3. Quality				
3.1	Patient Story	Receive and Discuss	Presentation	Director of Patient Care and Chief Nurse
3.2	Nursing staffing update	Receive and Discuss	Pages 15-22	Director of Patient Care and Chief Nurse
3.3	CNST Maternity Incentive Scheme Board assurance statement and sign-off	Approve	Pages 23-52	Director of Patient Care and Chief Nurse
4. Performance and Finance				
4.1	Performance report Month 2	Receive and Discuss	Pages 53-66	Deputy Chief Executive
4.2	Finance update report Month 2	Receive and Discuss	Pages 67-74	Director of Finance
4.3	Workforce update report Month 2	Receive and Discuss	Pages 75-80	Director of Workforce
5. Assurance and Statutory Items				
5.1	Risk Management • Board Assurance Framework 2019/20 update • Significant Risk Register	 Receive and Discuss Information	 Pages 81-88 Pages 89-108	Director of Corporate Affairs
5.2	Guardian of Safe Working Hours Annual Report 2018/19	Information	Pages 109-126	Guardian of Safe Working Hours

Item No.	Title	Purpose	Type and Ref.	Lead
5.3	Medical Revalidation Annual Report 2018/19	Approve	Pages 127-138	Medical Director
5.4	Learning from Gosport	Note	Pages 139-144	Medical Director
5.5	Management Board upward report	Receive and Discuss	Pages 145-146	Chief Executive
5.6	(Summary Report) Finance and Investment Committee – 29 April & 3 June 2019	Note	Pages 147-150	Chair of Committee
5.7	(Summary Report) Workforce and Development Assurance Committee – 29 April 2019	Note	Pages 151-154	Chair of Committee
5.8	(Summary Report) Charitable funds Committee – 29 April 2019	Note	Pages 155-156	Chair of Committee
5.9	Use of the Trust Seal	Note	Pages 157-158	Trust Secretary
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 3 May 2019 in Room 6, Postgraduate Centre, Milton Keynes University Hospital

Present:

Simon Lloyd	Chairman
Joe Harrison	Chief Executive
Andrew Blakeman	Non-executive Director (Chair of Quality and Clinical Risk Committee)
Caroline Hutton	Director of Clinical Services
Mike Keech	Director of Finance
Nicky Burns- Muir	Director of Patient Care and Chief Nurse
Ian Reckless	Medical Director
Heidi Travis	Non-executive Director (Chair of Finance and Investment Committee)
Helen Smart	Non-executive Director
Parmjit Dhanda	Non-executive Director
Tony Nolan	Non-executive Director
John Clapham	Non-executive Director
Nicky McLeod	Non-executive Director

In Attendance:

Kate Jarman	Director of Corporate Affairs
Ian Wilson	Associate Non-executive Director
Adewale Kadiri	Company Secretary
Helen Leigh	Senior Sister, Paediatrics (item 3.1)
Jane Grant	Head of Audiology Services (item 3.1)

2019/05/01	**Welcome**
1.1	The Chairman welcomed all present to the meeting.
2019/05/02	**Apologies**
2.1	Apologies for this meeting were received from John Blakesley and Danielle Petch.
2019/05/03	**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.
2019/05/04	**Minutes of the meeting held on 1 March 2019**
4.1	The minutes of the public Board meeting held on 1 March 2019 were accepted as an accurate record of that meeting.
2019/05/05	**Matters Arising/ Action Log**

5.1	There were no matters arising in addition to those included on the agenda. The action log was reviewed in turn: <u>363 Finance update month 10</u> An executive directors' seminar is to be convened shortly to agree an aspirational agency target. Open <u>364 Workforce report</u> The flu vaccination exercise is still in progress. To be revisited. Open.
2019/05/06	**Chairman's Report**
6.1	The Chairman gave feedback from the recent NHS England/Improvement round table meeting. Some legislative proposals are to be put forward with the aim of enabling system delivery. It is also intended to help take system working outside the remit of the Competition and Markets Authority. The point was made at the meeting that these proposals will not focus on giving NHSI control over mergers or capital spend.
6.2	The Chairman thanked Parmjit Dhanda for his support at the charity supporters' event. He acknowledged some very good speeches by some of the supporters of charity. The Cancer Centre appeal is ongoing, with 2 weeks of activity coming up, including a soapbox derby. The Chairman had recently toured the site and confirmed that the project remains on schedule. It will be a major step forward in the way cancer patients are cared for in the city.
6.3	The Chairman had received an email from the Lead Governor giving positive feedback about the MyCare review session.
6.4	Parmjit Dhanda referred to the upcoming Gala Dinner, suggesting that it would be nice to have a NED table. The Chairman indicated that 16 tables had been pre-sold; at least 250 guests would need to sign up for it to be a success. **Resolved**: The Board **noted** the Chairman's' Report
2019/05/07	**Chief Executive's Report**
7.1	The Chief Executive informed the Board that 15 organisations have visited the Trust to find out about MyCare since the last Board meeting.
7.2	He had attended the launch of the TenX Advisory Board – a medical technology venture capital fund. Lord Hunt, who has chaired a number of tech companies, chairs the Board and was in attendance. This is an opportunity to gain first-hand knowledge of upcoming developments. There were 3 presentations – from NHS Providers, the Kings Fund and NHS England.
7.3	Parmjit Dhanda raised a question about the extent to which issues around ethics and data protection are considered as part of the drive towards the greater use of technology. The Chief Executive made the point that the

	Trust's involvement in this venture provides exposure to the latest ideas and innovations without commitment. The Trust will ensure that it follows all the guiding principles around information governance and ethics. He explained that this is part of a longer-term process to determine what the Trust wishes to engage in.
7.4	The Medical Director added that NHS boards are well equipped to ensure that the wider patient interest is protected, with the existence of the SIRO and Caldicott Guardian functions. Andrew Blakeman, however, felt that there is insufficient transparency around the Trust's technology portfolio and future plans. The Chief Executive explained that the Trust aims to engage formally with its technology partners at the right time but that in most cases, that time had not yet arrived. Regarding eCare, there is the potential to develop a relationship with Cerner; with Ryalto, the staff booking app, a commercial proposition is to be made in June, similar to that with Zesty. These proposals will be discussed in more detail at the strategy day in June.
7.5	There was a fire incident at the Eaglestone Centre. Some damage was caused, but the asbestos in the building remains undisturbed. The Trust is in conversation with CNWL and the insurers as to how quickly the building can be restored to its full use.
7.6	There is excitement in the organisation in the lead up to the Event in the Tent. Non-executive directors were reminded that they are free to attend.
7.7	The Chief Executive reported on a meeting of the NHSI/E East of England region. It was noted that the Cambridge and Peterborough system had not yet signed its control total as the result of a £70m gap in their finances. There is also a gap in the BLMK system, but there are plans in place to close this. Because Cambridge and Peterborough have been unable to show how this gap will be closed, a letter had been sent from Ann Radmore, the Regional Director asking other systems to find a further savings. However, initial conversations had indicated that even if systems are able to make these additional savings, there is little appetite to hand these over to Cambridge and Peterborough. BLMK would like to help, but as the financial year is only 32 days old, it is too early for say whether it would be able to do so.
7.8	Parmjit Dhanda sought clarity on the relationship between the Trust, BLMK and the region. In response, the Chief Executive stated that although the Trust's proposed move to the BOB ICS had not been supported by some partners within BLMK, the MK place is being allowed to align with appropriate networks outside of BLMK on a case by case basis; for example, it now works with Thames Valley on emergency planning. He stressed that MK funding will not leave the system without good reason. However, the Trust is already being adversely affected on a macro level – a proportion of PSF funding is at risk as a result of the possibility that some organisations in BLMK will miss their control totals. MKUH has negotiated mitigations, but there is the realisation that it is part of a wider health system.
7.9	Regarding the CQC process, the Chief Executive announced that the Well Led review, which is the final leg of the assessment, is about to start. The inspection team will probably wish to interview most Board members. The assessment will end next Thursday afternoon, and a final report aggregating findings from the three different stages, will be provided in the summer. The

	feedback from the use of resources and service inspection stages has been largely positive.
7.10	The long service awards are to be held next week – NEDs were encouraged to attend.
7.11	A Next Generation GP programme has been set up across the BLMK footprint. One of the key considerations going forward would be how the Trust engages more fully and formally with primary care. **Resolved**: The Board **noted** the Chief Executive's Report.
2019/05/08	**Patient's Story**
8.1	Helen Leigh, Senior Sister in Paediatrics and Jane Grant attended to provide the patient story. They presented on the work of the Learning Disabilities Steering Group and gave the example of an autistic child who had been unable to attend a series of outpatient appointments as his parents felt that the environment in the department was not right for him. As a result, the audiology department coordinated with other relevant specialities and arranged for the child to have all of the various procedures done in one go under general anaesthetic.
8.2	The arrangements were made with two weeks of planning. The team were keen to meet with the child beforehand – to find out how he communicated and what to expect, and as such they went to meet him at his school. They wanted to know about him and give him the opportunity to find out about them. The team went to the school in their uniforms so that this would not be a surprise to the child when he came into hospital. They managed to weigh him and found out about his preferred activities. The room was set up for him and made as safe as it could be.
8.3	Planning was done with anaesthetics, and on the day of the procedures the patient was brought in at 11:30, ensuring that there were no unnecessary delays. Discussions were held as to how pre-medication would be managed. The school was asked to bring in his favourite cup. The whole process went smoothly, and the patient was happy going up to theatre. The team were also able to take his bloods while he was in theatre.
8.4	The process had restored the family's faith in the service and the child's mother gave very positive feedback. The teamworking had been exemplary - it had the child's best interest at heart and achieved this.
8.5	Andrew Blakeman commended this example of fantastic joined up care, noting that health outcomes for people with learning disabilities are not generally good. He asked how many people would be able to access this sort of care. Helen Leigh indicated that another young patient is on a similar pathway, and that the team has worked with other autistic children. She explained that if they were able to get a good pathway in place, it would be possible to deliver this routinely. Engagement with the community paediatricians would be required to identify needs.
8.6	The Medical Director enquired about the role of play specialists. It was explained that they are vital in distracting young patients from the painful impact of procedures, but also in helping to build relationships. There are

	currently two such specialists in paediatrics and funding for a third. As an example of their importance, Helen Leigh cited the case of a 17-year-old who underwent an ENT procedure in outpatients without any general anaesthetic.
8.7	Tony Nolan enquired how patients who might need this service would be flagged in A&E. Jane Grant explained that she uses her knowledge to help raise the awareness of the challenges of autism. Efforts are also being made to try to reduce sensory assaults and making cubicles available and safe is important. She stressed that there is no standard type of autism. The team has ideas about the things that can and need to be changed.
8.8	Andrew Blakeman asked whether there are things that other trusts are doing that MKUH could copy, and in response Jane Grant indicated that she was not aware of this as it was the first time that they had done it. She acknowledged that wider conversations need to be had with partners across the health economy. The Director of Clinical Services made the point that there are opportunities within eCare to flag patients where necessary. **Resolved**: The Board resolved to **note** the Patient's Story.
2019/05/09	**Nursing Staffing Update**
9.1	The Director of Patient Care and Chief Nurse presented this report. She informed the Board that the Care Hours per Patient Day (CHPPD) rate had decreased in March as a result of the higher total number of in-patients. The Neonatal Unit had a high CHPPD due to the low number of babies admitted during the month. A version of the Safer Care Nursing Tool has now been produced for Paediatrics and has been utilised on two occasions in recent months indicating gaps around high dependency care.
9.2	Regarding recruitment, the Chief Nurse stated that difficulties remain regarding Band 5 nurses and healthcare assistants. It was noted, however, that most of the HCAs who are on the bank only work at MKUH. Premium staff costs are going down year on year, although there was a blip in March as a result of annual leave. This Trust will be one of the first sites to welcome occupational therapy graduates from the University of Bedfordshire. The first cohort of nursing assistants qualified in April, and one of those from this Trust won a Nursing Times award.
9.3	In response to a question from Helen Smart about overseas recruitment, the point was made that nurses recruited from the Philippines have generally done well and tended to stay on, and as such the Trust is interested in launching another recruitment exercise there. The bar for the English language test has now been lowered slightly. A decision is being made as to when the exercise should commence.
9.4	The positivity of the Therapies update was noted, and the question was raised as to how AHP priorities align with those for nursing. The Chief Nurse explained that planning for the new Pathway Unit is focused on what is needed in totality for patient care and who can best deliver this. The role of Therapies is evolving nationally. Parmjit Dhanda stressed the importance of maintaining the blend of professional input and the Chef Nurse confirmed that the role of Therapies could be included within the Safer Care tool.
9.5	Ian Wilson referred to the gaps highlighted by the tool and questioned how

	the Board could be assured of safety. The Chief Nurse confirmed that staffing levels are safe. She explained that this is a relatively new tool, and that it is triangulated with other available data. There is an awareness that there are more respiratory problems over the winter months, and a different establishment is therefore in place over this period. On the other hand, training tends to be booked for the summer months. **Resolved**: The Board resolved to **note** the nursing staffing report.
2019/05/10	**CNST Maternity Incentive Scheme Action Plan and Position Statement**
10.1	The Medical Director introduced this item, informing the Board that over the years, NHS Resolution have introduced a number of schemes with the aim of lowering risk within the health service. This particular incentive scheme is specifically focused on reducing risk in maternity services, and it aims to ensure that boards pay attention to this service, giving the scheme a high profile. The Medical Director confirmed that maternity services are taken seriously in this organisation. The paper has been presented for the Board to note the steps being taken to ensure that the Trust remains on track to meet its action plan. It would be for NHS Resolution to determine this; the RAG rating is the Trust's own self-assessment.
10.2	In response to a question from the Chairman about litigation costs, the Medical Director stated that these continue to rise nationally, and that some of this increase is attributable to the Duty of Candour. John Clapham questioned whether the problems at Telford and Shrewsbury have also contributed to this increase. The Medical Director agreed that this may have been the case, but that this scheme had been created in response to the concerns at Morecambe Bay. **Resolved**: The Board resolved to **agree** the action plan and **note** the progress that had already been made.
2019/05/11	**Mortality update report**
11.1	The Medical Director presented this routine report setting out the Trust's current position in relation to mortality. He made reference to the latest HSMR figure, noting that traditionally the Trust's rate had been lower than expected – it is now as expected. The rate has been gradually climbing this year since the implementation of eCare – indeed the data includes 6-7 months' worth of eCare data. It is possible that the ability of clinical coders to capture information may have been impaired, and that the rate will continue to climb until the Trust has 12 months' worth of data.
11.2	Considering divisional HSMR performance for the year, there was one negative outlying diagnosis group – 'fracture neck of femur'. 5 deaths with this diagnosis were checked, and no concern were uncovered.
11.3	8 doctors have been appointed as medical examiners at the Trust, with some of them starting at the end of May. Andrew Blakeman observed that only 2 deaths were found to have had care quality concerns in Q1 and 1 in Q2, and he asked that the number of reviews conducted be increased in order that lessons can be learnt. The Medical Director remarked that there can sometimes be a reluctance for professionals to contemplate that their

	practice has led to deaths.
11.4	In response to a further question from Tony Nolan about the independence of the review process, Dr Reckless explained that the process here is consistent with national policy, and that all unusual deaths are reviewed. He conceded that in the Medicine division where there are a lot of deaths, reliance is placed on the honesty of doctors. Tony Nolan then asked how it would be possible to spot rogue doctors, in response to which the Medical Director mentioned random sampling, and the objective to review 25% of all deaths. Nicky McLeod queried whether trend analysis is conducted. The Medical Director explained that efforts are made to do this, but they are sometimes hampered by challenges around the correct attribution of care. However, this is less of a problem in surgical practice
11.5	The Medical Director explained that SHMI had previously been the government's preferred metric as it includes out of hospital death occurring within 30 days of discharge. Traditionally, the Trust's SHMI rating has been less positive than HSMR and there are concerns about the quality of the data that informs it. The difference between HMSR and SHMI is the palliative care coding. SHMI has been tested as part of the quality reporting process. **Resolved**: The Board resolved to **note** the mortality update report.
2019/05/12	**7-day Services update**
12.1	The Medical Director presented this update. He explained that previously seven-day services had been assured through national audit. Now trusts are required to publish their progress against achievement of the standards through the Board. This update covers the 4-week period between mid-March and April, and it was noted that there have been some improvements.
12.2	Nicky McLeod noted the relatively low numbers and enquired whether this was to do with the shortage of consultants or an inability to meet the standards. The Medical Director indicated that it was a bit of both, referring to the fact that there are fewer consultants available at weekends. He made the point, however, that seeing a consultant daily is not that important for every patient, and some improvements can be facilitated through eCare.
12.3	The Medical Director also drew attention to problems around interventional radiology and stressed the need to formalise the relationship with Oxford University Hospitals. **Resolved**: The Board resolved to **note** the update on 7-day services
2019/05/13	**Performance Report Month 1**
13.1	The Chief Executive introduced this routine report and highlighted the following points: • RTT – the Trust has done a good job in getting performance against the 18-week target back over 90%, which is significantly above the national average • A&E performance is similarly positive

	• The cancer performance target was missed in Q4, although other hospitals involved in the care of MK patients bear some responsibility for this. The Trust would need to determine how to ensure that it is not seen as failing.
13.2	Nicky McLeod enquired about what the Trust had done to improve RTT. In response, the Chief Executive highlighted the importance of focusing on individual patients. He did however note that the Trust has missed the target to reduce the size of its waiting list, meaning longer waiting times for some patients. The Medical Director pointed out that the number of referrals to general surgery has fallen, but much work has already been done around the management of capacity and demand. Consideration is also being given to the acquisition of a surgical robot.
13.3	Helen Smart drew attention to the issue of non-attendance at outpatients and enquired whether there are any particular hotspots. The Director of Corporate Affairs explained that the focus is on ensuring that processes are followed appropriately. Some work is currently being done with 3 CSUs and a more detailed update will be presented at the next meeting of the Quality and Clinical Risk Committee – mostly around staff training and making more use of MyCare.
13.4	The Chief Nurse stated that there had been 2 pressure ulcers in Theatres. Much promotional work is being done around devices. As at year end, the Trust had recorded 3 Never Events: • Extraction of a wrong tooth • Inaccurate dispensing of Insulin, and • Retained swab post vaginal bleeding.
13.5	Parmjit Dhanda noted the reduction in ambulance handover delays and enquired whether the ambulance trust is content that MKUH is doing all it can in this area. The Chief Executive confirmed that the working relationship between the two organisations is very good and referred to work that is underway to enable the sharing of systems which should bring about significant improvements.
13.6	It was noted that the workforce metrics are all going in the right direction. The Board commended the team for this. **Resolved**: The Board resolved to note the Month 12 Performance Report.
2019/05/14	**Finance Report Month 12**
14.1	The Director of Finance presented this regular report. He noted that as this is the Month 12 report setting out the full year position, there is much movement. There is a positive variance of £113k against the overall position, but the Trust had committed to do better than the control total. The Trust has finished just over £1m better in total, representing very good performance. In the last 4 years, the Trust has offered up £15m to support the national position.
14.2	The Trust has been awarded the full amount of PSF that was available to it - £3m. However, from an ICS perspective, there was an adverse variance as a

	result of difficulties in other organisations.
14.3	In Month 12, there were some areas of adverse variance, such as on agency spending, but this is regarded as a blip. The Trust achieved £10.8m in efficiencies against a £10.1m target. There is to be a change in contract form for 2019/20. This will require a focus on underlying efficiency, control of the cost base and having the right systems in place.
14.4	The Chief Executive congratulated all concerned for delivery of yet another positive performance against the control total, and he confirmed that the incentive funding provides more capital for the organisation's use. **Resolved**: The Board **noted** the month 12 Finance Report.
2019/05/15	**Workforce Report Month 12**
15.1	The Director of Workforce presented this report and highlighted the following: • The number of staff in post has increased again, with the largest increase in clinical staff. • The vacancy rate has reduced • There has been a further reduction in turnover – involvement in the NHSI retention programme has helped • On temporary staffing, the Trust remains below its agency ceiling • The sickness absence rate is below the 4% Trust target. • Statutory and mandatory training and appraisal rates are both at or above the 90% target.
15.2	The Director of Workforce indicated that detailed conversations have taken place both at the Workforce Board and the Workforce and Development Assurance Committee in relation to the Staff Survey results. Several issues had been raised in the survey, including around bullying and harassment and discrimination. It was noted, however, that similar issues are being faced by other organisations. Some focused work would need to be done with various teams across the Trust. The Chief Executive confirmed that the results have been broken down by department which is quite useful. He observed that some of the more negative responses had come from staff from the professional support services, as against frontline clinical colleagues.
15.3	Helen Smart commended the fantastic progress that had been made in challenging circumstances. **Resolved:** The Board **noted** the Month 12 Workforce Report.
2019/05/16	**Board Assurance Framework**
16.1	The Director of Corporate Affairs presented the end of year summary of the BAF, showing how ratings of the various risks had moved throughout the year. She stated that the organisation's risk appetite is as set last year, and the 2019/20 risks will go into the committee cycle for scrutiny and challenge of controls and actions, and consideration of ratings. There is a need to assess the appropriateness of target scores. This will be done at the next Board meeting.

16.2	The Board noted that in 2018/19 the highest scoring risks were around patient experience, meeting constitutional targets and the main commissioner's ability to fund the Trust's performance. It was recognised, however, that for most staff, the main risk would be staff shortages. It would be important to ensure that the different perspectives about the main risks facing the organisation are recognised.
16.3	Andrew Blakeman expressed the opinion that clear demonstrable progress had been made in the way the Trust records and manages risk, but that there is more to be done before its processes could be recognised as best in class. **Resolved**: The Board **noted** the contents of the Board Assurance Framework.
2019/05/17	**Board Committee summary reports**
17.1	The Board noted the contents of the summary reports of recent Board Committee meetings as follows:
17.2	<u>Audit Committee:</u> Andrew Blakeman confirmed that the Committee has scrutinised the BAF and how it is used. The next step should be to use it to drive the Board agenda – joining up what the Trust is trying to achieve with those things that it is trying to avoid.
17.3	<u>Finance and Investment Committee</u> Heidi Travis confirmed that the Committee has been working with the Director of Finance and his team in getting the Annual Plan through its various iterations. **Resolved**: The Board **noted** the Board Committee summary reports
2019/05/18	**Questions from members of the public**
18.1	There were no questions from members of the public
2019/05/19	**Any other business**
	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	362	11 Jan 2019	10.7	Nursing staffing report	The Chief Nurse agreed to carry out a baseline assessment for allied health professional staff	Nicky Burns-Muir	10 July 2019	Open	The Chief Nurse has met with the Head of Therapies, and has contacted other local hospitals with a view to benchmarking the Trust's position
Board of Directors	Public	363	1 Mar 2019	11.2	Finance Update Month 10	The Director of Workforce is to consider, in conjunction with the rest of the executive team, what an aspirational agency target should look like	Danielle Petch	10 July 2019	Open	An aspirational agency target is to be agreed by the Executive Directors
Board of Directors	Public	364	1 Mar 2019	12.2	Workforce Report	A more granular report on the take up of the flu vaccine in the various parts of the hospital is to be produced	Danielle Petch	10 July 2019	Open	The flu vaccination exercise is still in progress. To be revisited

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Board of Directors			**Date:** 10 July 2019			
Report title:	Nursing Staffing Report			**Agenda item: 3.2**			
Lead director **Report author Sponsor(s)**	**Name:** Nicky Burns-Muir **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	Appendices 1 and 2

Board of Directors Report on Nursing and Midwifery staffing levels Amalgamated report for April 2019 and May 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 monthly staffing data to 'UNIFY' and to update the Trust Board on the monthly staffing position.

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

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

CHPPD	Total Patient Numbers	Registered Midwives/Nurses	Care Staff	Overall
April	14575	4.8	3.2	8.0
May	15331	4.8	3.1	7.9

Hospital Monthly Average Fill Rates for April 2019 and May 2019

Month	RN/RM Day % Fill Rate	HCA/MCA Day % Fill Rate	RN/RM Night % Fill Rate	HCA/MCA Night % Fill Rate
April	83.4%	105.5%	96.8%	129.4%
May	85.3%	102.4%	98.9%	127.8%

Ward breakdown of fill rates for April and May 2019 are included in Appendix 1.

The CHPPD hours decreased in May due to a higher total number of in- patients.

Areas with notable fill rates

The Neonatal Unit and Department of Critical Care had a higher CHPPD due to lower number of patients admitted in both April and May.

3. Recruitment

All divisions have rolling adverts out on the NHS job site and are in the process of developing the programme for open days for this financial year 2019/20.

Maternity have run an exceptional recruitment campaign for Midwives with all their vacancies now fully filled and with an additional reserve list of Midwives which has been successfully utilised for attrition.

Medicine Division carried out an open day on the 22nd June 2019 using social media as the main driver with short videos of staff nurses speaking about their experience of working in medicine division and the benefits of the Trust preceptorship programme. The marketing message used was 'Your Career Starts Here' and resulted in significant numbers of Registered Nurses and Health Care Assistants attending with interviews and job offers given on the day.

The Surgical Division have a planned bespoke recruitment event for Ward 20 who currently have the highest vacancies on the 18th July 2019 using a different model with candidates being offered a talk about the Ward including a patients perspective of what 'matters to me'. Following this there will be an opportunity for candidates to use 'Round Robin' style clinical skills stations to see all aspects of colorectal nursing and the opportunities for learning on Ward 20. This unique event has already attracted much interest and there is confidence Ward 20 will recruit to all vacant posts.

Qualified Staff Vacancies

Division	WTE vacancies now	% vacancy now	Post recruited to	Residual WTE vacancy	Residual % vacancy
Women's & Children	17.55	9%	9wte	8.55wte	5%
Medicine	91wte	24%	27.8wte	60wte	17%
Surgery	38.06wte	16%	18.8wte	20,14wte	9.5%

Total vacancy rate for qualified nurses' including new staff in post approx. **14.5%**

HealthCare Assistant Vacancies

Division	WTE vacancies now	% vacancy now	Post recruited to	Residual WTE vacancy	Residual % vacancy
Women's & Children	4.12wte	3%	4.12wte	0wte	0%
Medicine	91wte	24%	25.8wte	12.7wte	6%
Surgery	13.67wte	13%	5.6	9.07wte	7.5%

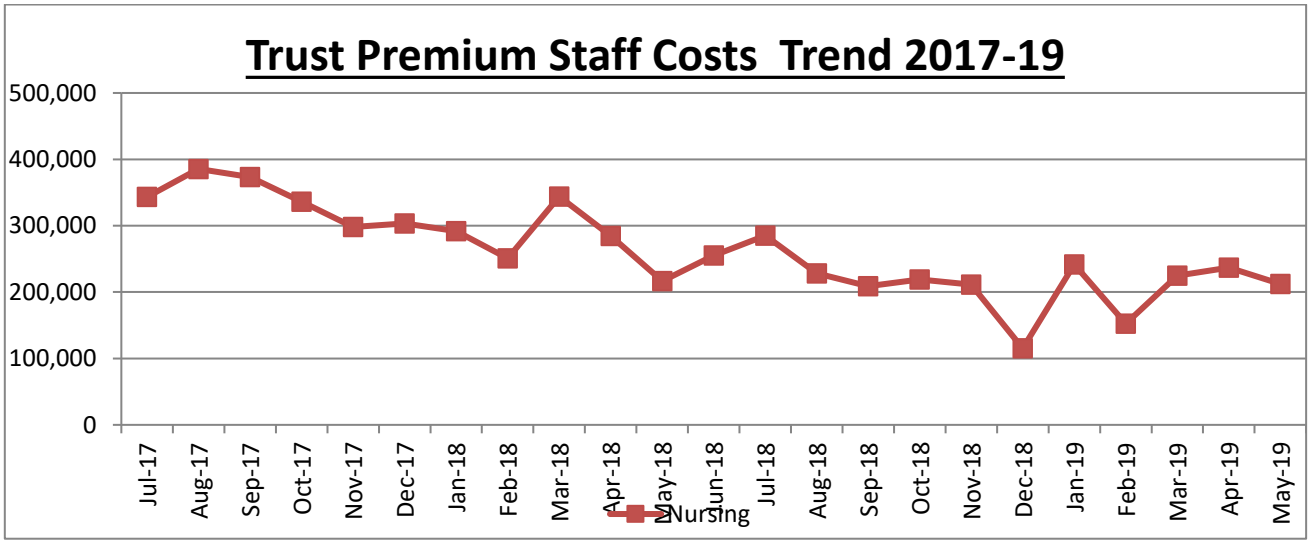
Total Trust vacancy rate for HCA's including new staff in post approx. **7%**

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

Within these figures the areas with the highest vacancy factor currently are – Wards 14, 15 and 20. These wards are monitored and supported by the Matrons on a daily basis and overseen by the Heads of Nursing to ensure safe staffing levels are maintained.

4. Controlling Premium Cost

Agency nursing expenditure continues to stabilise with a small peak in April attributed to staff using their remaining annual leave for the financial year 2018/19.



5. HCA (Health Care Assistant) Recruitment

NHS Improvement are supporting several NHS Trusts to reduce their HCA vacancies to 0 %. Currently we are report a 7 % vacancy factor and a turnover rate of 8% as reported in the Workforce Board report.

Monthly recruitment days for HCA's are planned in conjunction with the HR recruitment team using an assessment centre model to ensure we recruit staff who demonstrate our Trust values. The frequency and focused approach to HCA recruitment will allow for a more efficient and timely process.

Currently, we use agency HCA's to provide care and support for our most vulnerable patients as 'Enhanced Observers'. We are developing a comprehensive plan to eliminate the use of all agency HCA's in November 2019 by changing the care model and including this activity within the ward nursing team. This will provide both a cost saving and improve the consistency of quality care delivery for these vulnerable patients.

6. Retention

Retention of nursing staff is a fundamental issue both nationally and locally. With the recent publication of the Interim NHS Peoples Plan retention is highlighted as a key focus area for the NHS to address. We are focusing on retention to ensure new and existing staff are being supported and encouraged to remain at MKUH with a range of initiatives.

We are currently reviewing our prectorship programme to consider extending beyond a year as feedback informs us that this programme provides newly qualified staff with valuable networks and access to senior nursing and peer support.

The nursing and midwifery education strategy has a workstream to develop a career pathway with opportunities for development and progression to offer staff options at points in their career to support retention.

In Month 2 as reported in the Workforce Board report Nursing and Midwifery turnover rate is 7.1 % with the National average being 11%. This improvement has been due the work carried out as part of the NHSi Retention action plan.

In collaboration with HR we have successfully recruited a Workforce Matron and a key component of this role will contribute to retention of our current staff as the lower than national average of 7.1% for MKUH still accounts for 72 nurses and midwives leaving each year .

7. Registered Adult Nurse Training

All NHS acute providers were approached to scope the placement capacity for student nurses with a request to increase to 25% in order to develop the future pipeline of nurses. We undertook an exercise and have agreed in collaboration with Northampton University to increase our placements by 25% which also attracts funding to support more student at MKUH which is positive step forward and will contribute to our future workforce challenges.

Practice education are planning future events for young people to raise the profile of nursing careers and the variety of roles and pathways that are on offer to influence the future generation to enter nursing.

8. Nursing Associates

The first cohort of nursing associates are now registered with the Nursing and Midwifery Council and integrated into the registered nurse establishments on Ward 18/ 3 and ED . We are delivering a bespoke inhouse training programme for medication administration in July 2019 to provide additional support and guidance on this area of practice by setting the expected standards for our nursing associates.

Several areas have approached the senior team requesting to have nursing associates within their establishment which is a positive response to this new role.

One of our cohort 1 nursing associates received the first ever Nursing Times Award for ‘Nursing Associate Trainee of the Year’ in May 2019.

Appendix 1

Fill rates for Nursing, Midwifery and Care Staff April 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	85.7%	116.8%	105.1%	135.0%	659	5.8	2.9	8.7
MAU 2	97.0%	127.7%	100.4%	179.4%	771	3.7	3.7	7.4
Phoenix Unit	82.0%	113.3%	102.2%	146.7%	701	3.1	3.9	7.0
Ward 15	84.2%	115.2%	98.4%	176.6%	858	3.5	3.1	6.6
Ward 16	81.0%	118.3%	100.9%	161.6%	864	3.3	3.1	6.3
Ward 17	80.0%	117.2%	100.0%	150.0%	756	4.3	2.7	7.0
Ward 18	91.3%	109.3%	105.3%	132.2%	829	3.4	3.9	7.4
Ward 19	71.0%	110.7%	106.7%	155.6%	843	2.9	4.2	7.1
Ward 20	82.5%	96.7%	102.9%	124.4%	737	4.0	2.9	6.9
Ward 21	87.2%	112.8%	102.2%	136.4%	725	3.8	2.6	6.4
Ward 22	87.4%	88.7%	101.1%	108.3%	645	4.2	2.3	6.5
Ward 23	87.1%	99.4%	101.7%	113.0%	1034	3.8	4.0	7.8
Ward 24	88.9%	93.9%	97.0%	-	495	4.8	1.0	5.8
Ward 3	87.1%	94.6%	100.0%	115.6%	831	3.2	3.4	6.6
Ward 5	80.8%	142.8%	112.8%	133.3%	558	6.7	2.0	8.7
Ward 7	85.6%	106.5%	97.8%	141.1%	685	3.9	4.8	8.7
Ward 8	75.9%	91.0%	99.9%	101.7%	740	3.3	2.6	5.9
DOCC	83.7%	75.0%	81.9%	-	152	31.9	1.6	33.5
Labour Ward								
Ward 9	79.5%	91.6%	84.4%	98.0%	1153	2.3	1.9	4.1
Ward 10	82.9%	-	92.0%	-	323	4.1	0.0	4.1
NNU	57.2%	69.5%	71.6%	81.6%	216	14.3	2.7	17.0

Appendix 1

Fill rates for Nursing, Midwifery and Care Staff May 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	83.2%	108.5%	102.8%	122.5%	718	5.4	2.6	8.0
MAU 2	103.6%	93.6%	105.0%	135.3%	813	3.9	2.7	6.6
Phoenix Unit	86.4%	98.2%	101.0%	133.9%	711	3.3	3.5	6.8
Ward 15	83.1%	101.4%	100.0%	159.7%	861	3.5	2.9	6.4
Ward 16	84.8%	104.2%	98.7%	125.8%	896	3.4	2.6	6.0
Ward 17	80.7%	111.2%	100.0%	153.3%	758	4.5	2.7	7.2
Ward 18	97.4%	114.9%	99.0%	162.3%	842	3.5	4.5	8.0
Ward 19	82.5%	109.5%	105.4%	155.9%	861	3.2	4.2	7.4
Ward 20	84.5%	113.0%	100.9%	118.2%	758	4.2	3.0	7.2
Ward 21	89.7%	95.9%	103.2%	112.8%	693	4.1	2.4	6.5
Ward 22	87.8%	88.3%	100.0%	122.6%	653	4.2	2.5	6.7
Ward 23	84.9%	111.6%	101.0%	121.8%	1058	3.7	4.4	8.1
Ward 24	89.5%	86.5%	99.5%	-	475	5.1	0.9	6.0
Ward 3	85.7%	98.3%	100.0%	129.0%	865	3.2	3.6	6.8
Ward 5	75.6%	150.0%	112.6%	127.2%	597	6.4	1.9	8.2
Ward 7	84.8%	103.3%	101.1%	140.8%	708	4.0	4.7	8.8
Ward 8	79.6%	95.3%	102.2%	114.5%	749	3.5	2.8	6.3
DOCC	79.7%	85.7%	88.7%	-	165	29.8	1.6	31.4
Labour Ward								
Ward 9	77.8%	86.3%	93.9%	96.8%	1368	2.0	1.6	3.6
Ward 10	86.4%	-	97.1%	-	335	4.3	0.0	4.3
NNU	75.5%	88.8%	90.4%	109.1%	447	9.2	1.8	11.0

Meeting title	**Trust Board**		**Date: 10 July 2019**	
Report title:	**Briefing Paper – CNST Report**		**Agenda item: 3.3a**	
Lead director **Report author**	**Nicky Burns-Muir** **Julie Cooper**		**Director of Patient Care and Chief Nurse** **Head of Midwifery and Paediatric Nursing**	
FoI status:	**Disclosable**			
Report summary	This briefing paper provides an update on maternity safety and includes: • Midwifery staffing • Midwife to Birth Ratio • One to one care in labour • Saving Babies Lives Care Bundle Version 1 (Appendix 1) • Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme – year two (Appendix 2) • Perinatal Mortality			
Purpose *(tick one box only)*	**Information** ☐	**Approval** x	**To note** ☐	**Decision** ☐
Recommendation	Trust Board is asked to approve the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme – year two as highlighted in the paper below and in appendix two.			
Strategic objectives links	Objective 1 Improve Patient Safety Objective 2 Improve Patient Experience Objective 3 Improve Clinical Effectiveness			
Board Assurance Framework links	Compliance Patient safety			
CQC fundamental Standards	Well led Safe Responsive			
Identified risks and risk management actions				
Resource implications	Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme – year two rebate of approximately 300K			
Legal implications including equality and diversity assessment	None			
Next steps				
Appendices	Two Appendix • Saving Babies Lives Care Bundle Version 1 (Appendix 1) • Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme – year two (Appendix 2)			

Briefing Paper –CNST Report

Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme – year two
NHS Resolution is operating a second year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. The maternity incentive scheme applies to all acute trusts that deliver maternity services and are members of the CNST. As in year one, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

As in year one, the scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds. Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

Maternity incentive scheme year two: Conditions
In order to be eligible for payment under the scheme, trusts must submit their completed Board declaration form to NHS Resolution (MIS@resolution.nhs.uk) by 12 noon on Thursday 15 August 2019 and must comply with the following conditions:

- Trusts must achieve all ten maternity safety actions, and
- The Trust Board declaration form must be signed and dated by the Trust Chief Executive Officer to confirm that:

    - The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
    - The content of the Trust Board declaration form has been discussed with the commissioner(s) of the Trust's maternity services.
    - The Trust Board must give their permission to the Chief Executive Officer to sign the Board declaration form prior to submission to NHS Resolution.

Evidence for submission

- The Trust Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the Trust Board only and will not be reviewed by NHS Resolution.
- Trust submissions will be subject to a range of external verification points, these include cross checking with: MBRRACE-UK data (Safety action 1), NHS Digital regarding submission to the Maternity Services Data Set (Safety action 2), and against the National Neonatal Research Database (NNRD) for number of qualifying incidents reportable to the Early Notification scheme (Safety action 10)
- Trust submissions will also be sense checked with the Care Quality Commission (CQC).

The Board's attention is drawn to the attached Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme – year two document.

Recommendation
The Board is asked to approve the declaration against the maternity incentive scheme – year two.

Meeting title	Board of Directors	Date: 10 July 2019
Report title:	Maternity incentive scheme (Action point 4b)	**Agenda item: 3.3b**
Lead director **Report author** **Sponsor(s)**	**Name:** Dr Ian Reckless **Name:** Andrew Kerr **Name:** Katy Philpott	**Title:** Medical Director **Title:** Business manager **Title:** General Manager
FOI status:		

Report summary				
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [ ]	**Decision** [ ]
Recommendation	This report is supplied to Board for information only to demonstrate the compliance with current terms and conditions of medical staff.			

Strategic objectives links	• Deliver key performance targets • Develop a robust and sustainable future • Become well-governed and financially viable • Improve workforce effectiveness • Develop as a good corporate citizen
Board Assurance Framework links	
CQC regulations	• Regulation 17: Good Governance • Regulation 18: Staffing
Identified risks and risk management actions	
Resource implications	
Legal implications including equality and diversity assessment	

Report history	
Next steps	Report for information only
Appendices	

1. Executive summary

This report is supplied to Trust Board as evidence of compliance / completion of Action point 4b of the CNST Maternity Incentive Fund.

The report reviews the Trust compliance with the Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6, as further evidence for the CNST Maternity Incentive Fund. A prior paper addressing 4a – GMC National Trainee Survey feedback has already been supplied to Board.

The report looks at the three standards mentioned above and describes current MKUH practice between January 2019 and June 2019, which are already compliant with the standards and no action plan is required.

This report needs to be signed off by Board and this will be used as part of the evidence for the self-declaration for the entire CNST Incentive Scheme, to be submitted to NHS Resolution.

2. Introduction

In its second year, NHS Resolution are providing an incentive to Trusts that meet the ten safety actions designed to improve the delivery of best practice in maternity and neonatal services. This scheme is called the CNST Maternity Incentive Fund.

The scheme has ten actions points that need to be evidenced by trust in order for them to benefit from the scheme. If the Trust that can demonstrate they have achieved all of the ten safety actions, we will recover the element of our contribution to the CNST Maternity Incentive Fund and will also receive a share of any unallocated funds.

This report specifically covers:

- Safety action 4b: Board minutes formally recording the proportion of ACSA standards 1.2.4.6, 2.6.5.1 and 2.6.5.6 that are met by the Trust. Where the Trust does not meet these standards, they must produce an action plan (ratified by the Board) stating how they are working to meet the standards.

This action has two parts, part A covers the GMC trainee Survey and lost training opportunities due to staffing gaps (already provided to board) and this, part B examines compliance with these Anaesthetic ACSA standards.

3. Anesthesia Clinical Services Accreditation (ACSA) standards and MKUH compliance.

Anaesthesia Clinical Services Accreditation is a voluntary scheme for NHS and independent sector organisations from the Royal College of Anaesthetists (RCOA).

The ACSA standard has 5 domains covering:

1. The care pathway
2. Equipment, facilities and staffing

3. Patient experience
4. Clinical governance
5. Sub-specialties

The relevant standards required for the CNST scheme are:

- **1.2.4.6** - **Where there are elective caesarean section lists there are dedicated obstetric, anaesthesia, theatre and midwifery staff.**

  MKUH - Elective caesarean lists are run weekdays with dedicate O&G doctors, anaesthetist, theatre and midwifery staff. MKUH is compliant on this standard.

- **2.6.5.1 - A duty anaesthetist is available for the obstetric unit 24 hours a day, where there is a 24-hour epidural service the anaesthetist is resident.**

  MKUH – Anaesthetic department provides 24/7 cover for the obstetric unit and there is a 24-hour epidural service. There is consultant resident cover between 08:00 – 18:00 (Monday to Friday) and then Specialty Doctor and Senior Registrar cover out of hours (including weekends) backed up by an on-call consultant. MKUH is compliant with this standard.

- **2.6.5.6 – The duty anaesthetist for obstetrics should participate in labour ward rounds**

  MKUH – The duty anaesthetist attends both handovers and rounds on the labour ward. The department audits and monitors ward round attendance on an ongoing basis. MKUH is compliant with this standard.

4. Summary

The above report is supplied for information and approval by the Board in relation to the required actions of point 4b, Maternity Incentive Scheme. The Trust is already compliant with the standards required for the CNST scheme.

5. Actions Pending

Sign-off by Board and then a copy of this report supplied with the Maternity Incentive Scheme submission.

6. Decisions required from the board

Please accept / sign – off this report as evidence for the Maternity Incentive Scheme, Action point 4 B.

References:

NHS Resolution, Maternity incentive scheme, online introduction available at:

https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

NHS Resolution, Maternity incentive scheme – year two, available online at:

https://resolution.nhs.uk/wp-content/uploads/2018/12/maternity-incentive-scheme-year-two.pdf

Royal College of Anesthetists, Anesthesia Clinical Services Accreditation, available online at: https://www.rcoa.ac.uk/acsa

Abbreviations:

CNST	**Clinical Negligence Scheme for Trusts**
O&G	**Obstetrics and Gynaecology**
NHS	**National Health Service**
ACSA	**Anaesthesia Clinical Services Accreditation**
MKUH	**Milton Keynes University Hospital**
RCOA	**Royal College of Anaesthetists**

Maternity incentive scheme - Guidance

Resolution

Trust Name	
Trust Code	

This document **must** be used to complete your trust self certification for the maternity incentive scheme safety actions and a completed action plan must be submitted for actions which have not been met. Please select your trust name from the drop down menu above. Your trust name will populate each tab. **If the trust name box is coloured pink please update it.**

Guidance Tab - This has useful information to support you to complete the maternity incentive scheme safety actions excel spreadsheet. **Please read the guidance carefully.** There are three additional tabs within this document:

Tab A - Safety actions entry sheet - Please select 'Yes' or 'No' to demonstrate compliance with each maternity incentive scheme safety action. Note, entering 'Yes' denotes full compliance with the safety action as detailed within the condition of the scheme. The information which has been populated in this tab, will automatically populate onto tab C which is the board declaration form

Tab B - Action plan entry sheet - This must be completed for each maternity incentive scheme safety action which has **not** been met. If you are not requesting any funding to support implementation of your action plan - Please enter 0. **If cells are coloured pink then please update them.**

Tab C - Board declaration form - This is where you can track your overall progress against compliance with the maternity incentive scheme safety actions. This sheet will be protected and fields cannot be altered manually. If there are anomalies with the data entered, then comments will appear in the validations column (Column I) this will support you in checking and verifying data before it is discussed with the trust board, commissioners and before submission to NHS Resolution. Once the submission has been discussed and approved at trust board, please add an electronic signature into the document. If you are unable to add an electronic signature, the board declaration form can be printed, signed then scanned to be included within the submission.

Any queries regarding the maternity incentive scheme and or action plans should be directed to **MIS@resolution.nhs.uk**

Technical guidance and frequently asked questions can be accessed here :
https://resolution.nhs.uk/resources/maternity-incentive-scheme-year-two

Submissions for the maternity incentive scheme must be received no later than **12 noon on Thursday 15 August 2019** to **MIS@resolution.nhs.uk**

You are required to submit this document (and a signed copy of the board declaration form, if there is no electronic signature added). Please do not send evidence to NHS Resolution.

NHS Resolution

Section A : Please choose your trust in the Guidance tab

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	YES
2	Are you submitting data to the Maternity Services Data Set to the required standard?	YES
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	
4	Can you demonstrate an effective system of medical workforce planning to the required standard?	
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?	
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	
8	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	
9	Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	
10	Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	

NHS Resolution

Section B : Please choose your trust in the Guidance tab

An action plan should be completed for each safety action that has not been met

Action plan 1

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**		**When?**	
Monitoring					

Action plan 2

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the*		
Lead executive director	*Does the action plan have executive*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**		**When?**	
Monitoring					

Action plan 3

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 4

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 5

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 6

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 7

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 8

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 9

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 10

Safety action		**To be met by**	

Work to meet action	*Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	

Action plan owner	*Who is responsible for delivering the action plan?*
Lead executive director	*Does the action plan have executive sponsorship?*

Amount requested from the incentive fund, if required	

Reason for not meeting action	*Please explain why the trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	**Who?**	**When?**
Monitoring			

Maternity incentive scheme - Board declaration Form

Trust name	**Please choose your trust in the Guidance tab**
Trust code	

An electronic signature must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	YES		-	
Q2 MSDS	YES		-	
Q3 Transitional care			-	
Q4 Medical workforce planning			-	
Q5 Midwifery workforce planning			-	
Q6 SBL care bundle			-	
Q7 Patient feedback			-	
Q8 In-house training			-	
Q9 Safety Champions			-	
Q10 EN scheme			-	
Total safety actions	**2**	**-**		
Total sum requested			**-**	

Sign-off process:

Electronic signature

For and on behalf of the board of Please choose your trust in the Guidance tab

Confirming that:

The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

The content of this form has been discussed with the commissioner(s) of the trust's maternity services

If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)

We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group will escalate to the appropriate arm's length body/NHS System leader.

Name:
Position:
Date:

Saving Babies Lives Care Bundle Version One

Evidence and experience tell us more must be done to tackle stillbirth in England. Saving Babies' Lives is a care bundle designed to support providers, commissioners and healthcare professionals take action to reduce stillbirths. Saving Babies' Lives is designed to tackle stillbirth and early neonatal death. It brings together four elements of care that are recognised as evidence-based and/or best practice:

1. Reducing smoking in pregnancy
2. Risk assessment and surveillance for fetal growth restriction
3. Raising awareness of reduced fetal movement
4. Effective fetal monitoring during labour

All four elements of the SBL pathway have been implemented at Milton Keynes

1. **Element one - reducing smoking in pregnancy**
   All women have CO monitoring at booking and women who smoke will follow the SBL serial scan pathway.
   Midwives trained in smoking cessation. Ongoing training for staff in place

2. **Element two - risk assessment and surveillance for fetal growth restriction**
   Following a full antenatal pathway review all women are risk assessed at booking to determine which pathway they will follow (Low risk women will have fundal height measurements and high risk will have serial scans) .
   Gap Grow training for all Midwives and obstetricians takes place annually.
   1 midwife has now completed undertaking ultrasonography training and 1 midwife is in training.
   Business case successful to add additional scanning capacity to meet the needs of the recommended 4 scans on the SBL pathway.

3. **Element three - raising awareness of reduced fetal movement**
   All women receive from booking information related to reduced fetal movements and this discussed at all antenatal appointments.
   All women advised to attend ADAU for assessment following all episodes of reduced fetal movements.

4. **Element four - effective fetal monitoring in labour**
   Weekly CTG meetings with the multidisciplinary team.
   All Midwives and Obstetricians 100% compliant with K2 training. This takes place annually.
   All staff have now completed Human Factors training.

Next Steps

- Gap analysis for Saving Babies Lives Care Bundle Version 2 – MDT workshop to take place in July 2019

In the Saving Babies Lives Care Bundle Version 2 , **Reducing preterm birth** is an additional element to the care bundle developed in response to The Department of Health's 'Safer Maternity Care' report which extended the 'Maternity 4 Safety Ambition' to include reducing preterm births from 8% to 6%. This new element focuses on three intervention areas to improve outcomes which are prediction and prevention of preterm birth and better preparation when preterm birth is unavoidable.

SAVING BABIES' LIVES VERSION 1 WORKSTREAM ACTION PLAN							
Element 1: Reducing smoking in pregnancy			**WORKSTREAM LEAD Nicola Fairgrieve**				
Updated June 2019							
Key Learning Point / Problem/ Concern/	**Recommendations**	**Actions**	**By whom**	**By when**	**Monitored by / date of completion**	**Evidence**	**Progress R= not started/ late / new A = in progress on time G = complete**
Ensure all staff have standardised knowledge	Ongoing training in smoking cessation for all midwives and support staff.	Ongoing smoking cessation training identified for all maternity staff to take place throughout 2019	Smoking cessation lead	December 2019	Cath Hudson	Training dates and list of attendance	Dates booked September to December Data for an LMS training dashboard to be supplied manually or by local training database
To increase promotion of smoking cessation and provide up to date information.	All women to receive information about the risk of carbon monoxide	Smoking cessation information given out at booking Information banners displayed within the maternity unit Smoking cessation champion midwives identified in all areas	Nicola Fairgrieve Julie Cooper	Ongoing	Cath Hudson	Regular Audit	
CO testing of all pregnant women and recording of smoking status at antenantal booking	The importance of CO recording to be emphasised to all midwives.	Ensure all midwives understand the need to record actions Equipment, functionality & replacement requirements to be identified SOP for replacing or repairing equipment	Nicola Fairgrieve	Ongoing	Cath Hudson	Quarterly Audit to monitor compliance Bulletins, staff meetings, messages of the week	SOP in development for replacing or repairing equipment

Key Learning Point / Problem/ Concern/	Recommendations	Actions	By whom	By when	Monitored by / date of completion	Evidence	Progress R= not started/ late / new A = in progress on time G = complete
Insufficient CO monitors available	For all community midwives to have a CO Monitor	Smoking cessation team.	Smoking cessation lead	September 2019	Cath Hudson	Asset register	Monitors distributed to all staff
Ensure appropriate care pathways are followed	All staff to be aware of referral pathways	If CO reading identifies exposure to smoke or high reading, referral to stop smoking services on an opt out basis	All midwives	Ongoing	Cath Hudson	Quarterly Audit	Referral template to stop smoking service updated
Referral pathway to include feedback and follow up processes	Feedback from council smoking cessation team to all community midwives	Individual feedback given monthly to community midwives	Council smoking cessation team.	Ongoing	Cath Hudson	Monthly report	
Improve working relationships between council smoking cessation team and maternity	Dedicated space for smoking cessation team in antenatal clinic	ANC move to surgical corridor will create a counselling room	Julie Cooper	April 2020	Cath Hudson	Dedicated room	

SAVING BABIES' LIVES VERSION 1 WORKSTREAM ACTION PLAN							
Element 2: Risk assessment and surveillance for fetal growth restriction			**WORKSTREAM LEAD** **Melissa Coles**				
Updated June 2019							
Key Learning Point / Problem/ Concern/	**Recommendations**	**Actions**	**By whom**	**By when**	**Monitored by / date of completion**	**Evidence**	**Progress** **R= not started/ late / new** **A = in progress on time** **G = complete**
Improve Gap/Grow training	All Doctors and midwives to be compliant with Gap/Grow training	Raise awareness of training requirements to all staff	PDM administrator	Ongoing	Cath Hudson	Monthly report	To arrange a perinatal Gap/Grow training Monthly report of compliance with Gap/Grow training
Monitor SGA rates	Identification of all SGA cases for Milton Keynes	Monitor perinatal institute data Identification of any missed SGA babies	Cath Hudson Sonography Melissa Coles	Ongoing	Cath Hudson	Audit	Undertake a baseline audit
Undertake full number of scans required as per SBL care bundle (28,31,34,37, 40 weeks)	Need to increase scan capacity	Additional, ultrasound room, machine and staff to perform USS	Simon Nicholson	ongoing	Julie Cooper Cath Hudson	Completion of and fully functioning scan room	Room complete, to follow up training with sonography lead Included on maternity risk register

SAVING BABIES' LIVES VERSION 1 WORKSTREAM ACTION PLAN							
Element 3: Raising awareness of reduced fetal movements			**WORKSTREAM LEAD** **Melissa Coles**				
Updated June 2019							
Key Learning Point / Problem/ Concern/	**Recommendations**	**Actions**	**By whom**	**By when**	**Monitored by / date of completion**	**Evidence**	**Progress** **R= not started/ late / new** **A = in progress on time** **G = complete**
Raise awareness of reduced movements in pregnancy	All women to receive information and advice leaflet by 24 weeks Reduced fetal movement to be discussed at each contact	Improved documentation Implement SBL checklist for reduced fetal movements Review telephone triage documentation	All doctors and midwives Melissa Coles Melissa Coles	ongoing	Cath Hudson	Audit	Baseline audit completed for paper document in October 2018 eCARE baseline audit to be completed

SAVING BABIES' LIVES VERSION 1 WORKSTREAM ACTION PLAN							
Element 4: Effective fetal monitoring in labour			**WORKSTREAM LEAD** **Lydia Stratton-Fry**				
Updated June 2019							
Key Learning Point / Problem/ Concern/	**Recommendations**	**Actions**	**By whom**	**By when**	**Monitored by / date of completion**	**Evidence**	**Progress** **R= not started/ late / new** **A = in progress on time** **G = complete**
CTG Interpretation	All staff providing intrapartum care in any birth setting must be trained and pass competency assessment annually	Completion of K2 CTG training package annually	Midwives and Doctors	Ongoing	PDM team	Monthly reports of K2 compliance	100% of relevant obstetric doctors and midwives will be adequately trained to interpret CTG's
All women receiving intrapartum care have effective fetal monitoring in labour	Buddy system in place with protocol for escalation if concerns are raised All staff are trained in escalation	Fresh ears and fresh eyes rounding	Lydia Stratton-Fry PDM team	Ongoing	Lydia Stratton-Fry PDM team	Audit Training records	CTG training on PROMPT annually Annual protected training week which includes a session on CTG interpretation and escalation

Briefing Paper

Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme – year two

NHS Resolution is operating a second year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. The maternity incentive scheme applies to all acute trusts that deliver maternity services and are members of the CNST. As in year one, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

As in year one, the scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds. Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

Maternity incentive scheme year two: conditions

In order to be eligible for payment under the scheme, trusts must submit their completed Board declaration form to NHS Resolution (MIS@resolution.nhs.uk) by 12 noon on Thursday 15 August 2019 and must comply with the following conditions:

• Trusts must achieve all ten maternity safety actions

• The Board declaration form must be signed and dated by the trust chief executive to confirm that:

- The Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
- The content of the Board declaration form has been discussed with the commissioner(s) of the trust's maternity services.

• The Board must give their permission to the chief executive to sign the Board declaration form prior to submission to NHS Resolution.

Evidence for submission

• The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the trust Board only, and will not be reviewed by NHS Resolution.

• Trust submissions will be subject to a range of external verification points, these include cross checking with: MBRRACE-UK data (Safety action 1), NHS Digital regarding submission to the Maternity Services Data Set (Safety action 2), and against the National Neonatal Research Database (NNRD) for number of qualifying incidents reportable to the Early Notification scheme (Safety action 10)

• Trust submissions will also be sense checked with the Care Quality Commission (CQC).

Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme Year Two				
Updated June 2019				
Safety Action	**Validation process**	**Evidence**	**Rag rating**	**Progress and comments**
Safety Action One Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?	Self-certification by the trust Board and submitted to NHS Resolution using the Board declaration form. NHS Resolution will use MBRRACE-UK data to cross-reference against trust self-certification the number of eligible deaths from Wednesday 12 December until Thursday 15 August 2019.	The maternity department has implemented the National Perinatal Mortality Review Tool (PMRT)		The division considers that maternity safety action 1 is fully met to date. In the time frame recognised there have been 6 cases suitable for review using the PMRT tool. To date 4 cases are fully completed and 2 are in progress and will be completed within the 4 month time scale from the death of the baby.
Safety Action 2 Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Self-certification by the trust Board and submitted to NHS Resolution using the Board declaration form. NHS Resolution will cross-reference self-certification against NHS Digital data	At present we are not compliant with Maternity Services Data Set (MSDS) due to a variety of reasons including: eCARE workflow issues and Cerner eCARE build issues.		The division considers that maternity safety action 2 will be fully met by submission on 5th July 2019.
Safety Action 3 Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme (ATAIN)?	Self-certification by the trust Board and submitted to NHS Resolution using the Board declaration form.	The ATAIN action plan has been signed off by Trust Board May 2019 as well as Local Maternity System (LMS) and ODN. Progress of the action plan is monitored internally and through the LMS. Action Plan monitoring through ATAIN and the Maternity and Neonatal Liaison Groups		The division considers that maternity safety action 3 is fully met.

Safety Action	Validation process	Evidence	Rag rating	Progress and comments
Safety Action 4 Can you demonstrate an effective system of medical workforce planning to the required standard?	Self-certification by the trust Board and submitted to NHS Resolution using the Board declaration form	A report has been submitted to the Workforce Committee, and has been reflected in minutes for Trust Board in May 2019. A further report will be submitted for July Trust Board.		The division considers that maternity safety action 4 is fully met
Safety Action 5 Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Self-certification to NHS Resolution using the Board declaration form	Bimonthly report on staffing to Trust Board Birthrate Plus staffing review undertaken in 2018		Division considers that maternity safety action 5 is fully met.
Safety Action 6 Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?	Self-certification to NHS Resolution using the Board declaration form.	Saving Babies Lives Version 1 update report to Trust Board on 10th July 2019. See Maternity Safety Report 2019 and appendix 1 of the Maternity Safety Report.		The division considers that maternity safety action 6 is fully met
Safety Action 7 Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	Self-certification to NHS Resolution using the Board declaration form.	Always event – Induction of Labour review Maternity MK Maternity Voices Partners (MVP) Meetings Friends and Family Test Maternity MK “Walk the Patch” Maternity 15 Steps MVP Surveys Annual Picker Maternity Survey		The division considers that maternity safety action 7 is fully met
Safety Action 8 Can you evidence that 90% of each maternity unit staff group have attended an ‘in-house’ multi-professional maternity emergencies training session within the last training year?	Self-certification to NHS Resolution using the Board declaration form.	Training records Practical Obstetric Multi-Professional Training (PROMPT) Training programme		The division considers that maternity safety action 8 is fully met

Safety Action	Validation process	Evidence	Rag rating	Progress and comments
Safety Action 9 Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues**?**	Self-certification to NHS Resolution using the Board declaration form	A launch meeting with leads for Maternity and Neonatal Health Safety Collaborative (MNHSC) took place on 2nd May 2019 which included Board level and Trust level Champions as participants. Trust level champion has attended annual national learning event in March 2019 Obstetricians and Midwives and HoM take part in Thames Valley local learning system Board Champions 'walk arounds' in place (NMB). Governance team produce a regular newsletter (the 'Grapevine') to feedback to all staff across maternity about learning from incidents and concerns raised by staff.		The division considers that maternity safety action 9 is fully met
Safety Action 10 Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	Self-certification to NHS Resolution using the Board declaration form NHS Resolution will cross reference Trust reporting against the National Neonatal Research Database (NNRD) number of qualifying incidents recorded for the Trust.	Full compliance with this safety action with a 100% of 2018/2019 qualifying incidents reported to NHS Resolution's Early Notification scheme. Email confirmation from Tina Worth of 100% compliance.		The division considers that maternity safety action 10 is fully met to date In the time frame recognised there have been 6 cases reported for NHS Resolution Early Notification.

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Board of Directors	Date: 10 July 2019
Report title:	Performance Report indicators for 2019/20 (Month 2)	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 2019/20			
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: M2 (May 2019)

1.0 Summary

This report summarises performance as at the end of May 2019 for key performance indicators and provides an update on actions to sustain or improve upon Trust and system-wide performance.

This commentary is intended only to highlight areas of performance that have changed or are in some way noteworthy.

2.0 Sustainability and Transformation Fund (STF)

Performance Improvement Trajectories

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

ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1	ED 4 hour target (includes UCS)		93.0%	91.2%	93.2%	93.0%	✓	▼	✓	
4.2	RTT Incomplete Pathways <18 weeks		90.0%	91.2%		89.2%	✗	▼		
4.9	62 day standard (Quarterly)		85.0%	85.0%		79.4%	✗	▼		

ED performance dropped from 93.4% in April 2019 to 93% in May 2019. Whilst this fell short of the 95% national standard, performance continued ahead of the Trust's NHS Improvement monthly trajectory, which was 91.2%. NHS England national A&E performance in May 2019 was 86.6%.

The referral to treatment (RTT) national NHS operational standard (92%) for incomplete pathways was not achieved by the Trust in May 2019. An aggregate performance of 89.2% was reported, which was a significant decrease of 1.7% on April 2019 performance.

Whilst the Trust's NHS Improvement target of 91.2% for RTT was not met in May 2019, the performance compared favourably to the most recently published combined NHS England RTT performance of 86.5% in April 2019.

Cancer waiting times are reported on a quarterly basis, usually six weeks after the close of a calendar quarter. The Trust performance for the Cancer 62 day standard in Q4 2018/19 (the most recent validated position) was 79.4%, which was below the 85% national target. Nationally, performance across all English providers for the same period was 77.3%.

3.0 Urgent and Emergency Care

Urgent and emergency care continued to operate under pressure in May 2019, as reflected below.

ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.4	Cancelled Ops - On Day		1.0%	1.0%	0.6%	0.5%	✓	▲	✓	
3.2	Ward Discharges by Midday		30%	30%	25.3%	25.1%	✗	▼	✗	
3.4	30 day readmissions				8.2%	7.7%		▲		
3.9	Ambulance Handovers >30 mins (%)		5%	5%	5.8%	5.9%	✗	▼	✗	
4.1	ED 4 hour target (includes UCS)		93.0%	91.2%	93.2%	93.0%	✓	▼	✓	

Cancelled Operations on the Day

The number of elective operations cancelled on the day for non-clinical reasons decreased from 18 in April 2019 to 14 in May 2019. This represented 0.5% of all planned operations during the month, which was within the 1% tolerance.

Of those cancelled on the day, three were due to emergency taking priority while two each were attributed to insufficient time and medication issue. The remaining seven were cancelled for other reasons including consultant availability, administrative issues and further investigation needed.

Readmissions

The emergency readmission rate for the Trust was 7.7%, which was a significant improvement over April 2019. At a divisional level, the readmission rate for Surgery increased to 5.2%, whereas the rates in Medicine and Women & Children decreased to 12% and 2.2% respectively.

Delayed Transfers of Care (DTOC)

The number of DTOC patients at midnight on the last Thursday of May 2019 was 26, which was an increase of six when compared to the end of April position.

Ambulance Handovers

After achieving a performance of 5.6% in April 2019, ambulance handovers taking longer than 30 minutes increased slightly in May 2019 (5.9%). Whilst this continued to be above the 5% tolerance, this was still an improvement compared to the average for 2018/19.

4.0 Elective Pathways

ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
3.1	Overnight bed occupancy rate		93%	93%	93.0%	92.2%	✓	▲	✓	
3.5	Follow Up Ratio		1.50	1.50	1.63	1.61	✗	▲	✗	
4.2	RTT Incomplete Pathways <18 weeks		90.0%	91.2%		89.2%	✗	▼		
5.6	Outpatient DNA Rate		5%	5%	7.8%	7.7%	✗	▲	✗	

Overnight Bed Occupancy

The Trust bed occupancy was below the 93% internal threshold at 92.2% in May 2019. This was the first time it has been below 93% since December 2018. The NHS England national performance for Q4 2018/19 was reported to be 89.1%. Reducing bed occupancy can improve the patient flow through the system and reduce the risk of infection.

Follow up Ratio

Planning outpatient capacity to cope with new referrals is impacted by the demand for follow-ups. The follow up ratio for May 2019 reduced compared to the previous month but was still above the 1.5 threshold, with an average of 1.61 follow up attendances for every new attendance seen.

RTT Incomplete Pathways

The Trust's 18 week RTT performance continued below the 92% RTT national standard. The number of patients waiting more than 18 weeks increased to 1,555 in May from 1,313 in April 2019. The total list size also increased. On a positive note, there were no patients waiting for more than 52 weeks at the end of May 2019.

Diagnostic Waits <6 weeks

In May 2019, the Trust continued to meet the operational standard of less than 1% of patients waiting six weeks or longer for a diagnostic test. NHS England national diagnostic performance in April 2019 was 96.4%.

Outpatient DNA Rate

The outpatient DNA rate decreased from 7.9% in April to 7.7% in May 2019. The DNA rate has been at 7% or above since April 2018. The last time the 5% target was achieved was in April 2017.

DNAs represent clinic capacity that cannot be otherwise utilised. All services should ensure that they adhere to the Trust Access Policy and do what they can to minimise DNA rates.

5.0 Patient Safety

Infection Control

MKUH reported zero cases of CDI, MRSA and MSSA infections in Month 2. There were however two cases of e-Coli reported in May 2019, both in Medicine (Ward 2 and Ward 15).

ENDS

Performance Report 2019/20
May 2019 (M02)

Milton Keynes University Hospital NHS Foundation Trust

OBJECTIVE 1 - PATIENT SAFETY										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
1.1	Mortality - (HSMR)		100	100		99.1	✓	▼		
1.2	Mortality - (SHMI) - Quarterly		1	1	*Reported Quarterly*					
1.3	Never Events		0	0	0	0	✓	▬	✓	
1.4	Clostridium Difficile		22	<4	1	0	✓	▲	✓	
1.5	MRSA bacteraemia (avoidable)		0	0	0	0	✓	▬	✓	
1.6	Falls with harm (per 1,000 bed days)		0.12	0.12	0.04	0.00	✓	▲	✓	
1.7	Midwife : Birth Ratio		28	28	30	31	✗	▼	✗	
1.8	Incident Rate (per 1,000 bed days)		40	40	49.28	51.4	✓	▲	✓	
1.9	Duty of Candour Breaches (Quarterly)		0	0	*Reported Quarterly*					
1.10	E-Coli		20	<4	4	2	✗	▬		
1.11	MSSA				0	0		▬		
1.12	VTE Assessment		95%	95%	98.0%	97.7%	✓	▼	✓	

OBJECTIVE 2 - PATIENT EXPERIENCE										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.1	FFT Recommend Rate (Patients)		94%	94%	*Not Available*					
2.2	RED Complaints Received				2	1		▬		
2.3	Complaints response in agreed time		90%	90%	89.4%	82.7%	✗	▼	✗	
2.4	Cancelled Ops - On Day		1.0%	1.0%	0.6%	0.5%	✓	▲	✓	
2.5	Over 75s Ward Moves at Night		2,111	352	353	188	✗	▼	✗	
2.6	Mixed Sex Breaches		0	0	0	0	✓	▬	✓	

OBJECTIVE 3 - CLINICAL EFFECTIVENESS										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
3.1	Overnight bed occupancy rate		93%	93%	93.0%	92.2%	✓	▲	✓	
3.2	Ward Discharges by Midday		30%	30%	25.3%	25.1%	✗	▼	✗	
3.3	Weekend Discharges		70%	70%	69.5%	73.4%	✓	▲	✗	
3.4	30 day readmissions				8.2%	7.7%		▲		
3.5	Follow Up Ratio		1.50	1.50	1.63	1.61	✗	▲	✗	
3.6.1	Number of Stranded Patients (LOS>=7 Days)		218	218		220	✗	▲		
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)		86	86		89	✗	▲		
3.7	Delayed Transfers of Care		25	25		26	✗	▼		
3.8	Discharges from PDU (%)		15%	15%	8.2%	9.9%	✗	▼	✗	
3.9	Ambulance Handovers >30 mins (%)		5%	5%	5.8%	5.9%	✗	▼	✗	

OBJECTIVE 4 - KEY TARGETS										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1	ED 4 hour target (includes UCS)		93.0%	91.2%	93.2%	93.0%	✓	▼	✓	
4.2	RTT Incomplete Pathways <18 weeks		90.0%	91.2%		89.2%	✗	▼		
4.3	RTT Patients Waiting Over 18 Weeks		1,399	1,288		1,555	✗	▼		
4.4	RTT Total Open Pathways		13,991	14,645		14,442	✓	▼		
4.5	RTT Patients waiting over 52 weeks			0		0	✓	▬		
4.6	Diagnostic Waits <6 weeks		99%	99%		99.0%	✓	▼		
4.7	All 2 week wait all cancers (Quarterly) ✎		93.0%	93.0%		95.5%	✓	▼		
4.8	31 days Diagnosis to Treatment (Quarterly) ✎		96.0%	96.0%		99.4%	✓	▲		
4.9	62 day standard (Quarterly) ✎		85.0%	85.0%		79.4%	✗	▼		

OBJECTIVE 5 - SUSTAINABILITY										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
5.1	GP Referrals Received		64,193	11,434	10,559	5,347	✓	▼	✓	
5.2	A&E Attendances		89,369	14,895	15,094	7,816	✗	▼	✗	
5.3	Elective Spells (PBR)		34,198	5,591	4,392	2,414	✓	▼	✓	
5.4	Non-Elective Spells (PBR)		32,631	5,457	5,812	3,096	✗	▼	✗	
5.5	OP Attendances / Procs (Total)		381,108	62,096	63,796	31,817	✗	▲	✗	
5.6	Outpatient DNA Rate		5%	5%	7.8%	7.7%	✗	▲	✗	

OBJECTIVE 7 - FINANCIAL PERFORMANCE										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
7.1	Income £'000		268,966	43,536	42,969	21,377	✗	▼	✗	
7.2	Pay £'000		(171,021)	(29,265)	(29,412)	(14,545)	✗	▲	✗	
7.3	Non-pay £'000		(77,803)	(13,225)	(13,085)	(6,515)	✓	▲	✓	
7.4	Non-operating costs £'000		(13,359)	(2,186)	(2,171)	(1,064)	✓	▲	✓	
7.5	I&E Total £'000		6,783	(1,140)	(1,699)	(747)	✗	▲	✗	
7.6	Cash Balance £'000		2,500	3,561		8,586	✓	▲		
7.7	Savings Delivered £'000		8,419	562	419	230	✗	▲	✗	
7.8	Capital Expenditure £'000		27,926	3,393	934	605	✓	▼	✓	

OBJECTIVE 8 - WORKFORCE PERFORMANCE										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
8.1	Staff Vacancies % of establishment		11%	11%		13.9%	✗	▲		
8.2	Agency Expenditure %		8%	8%	5.6%	4.9%	✓	▲	✓	
8.3	Staff sickness - % of days lost		4%	4%		4.1%	✗	▼		
8.4	Appraisals		90%	90%		93.0%	✓	▼		
8.5	Statutory Mandatory training		90%	90%		93.0%	✓	▬		
8.6	Substantive Staff Turnover		11%	11%		9.8%	✓	▲		

OBJECTIVES - OTHER										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
O.1	Total Number of NICE Breaches		8	8		93	✗	▲		
O.2	Rebooked cancelled OPs - 28 day rule		95%	95%	89.3%	94.4%	✗	▲	✗	
O.4	Overdue Datix Incidents >1 month		0	0		144	✗	▲		
O.5	Serious Incidents		45	<8	8	7	✗	▼	✗	
O.8	Completed Job Plans (Consultants)		90%	90%		93%	✓	▲		

Key: Monthly/Quarterly Change

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

YTD Position

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

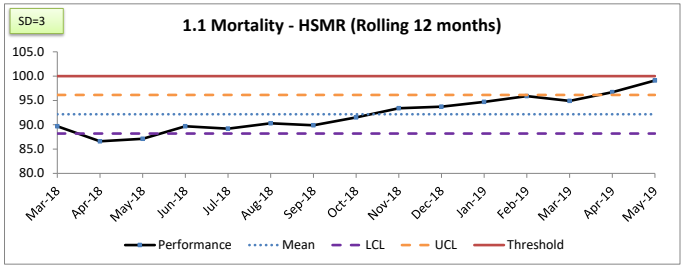
Data Quality Assurance Definitions

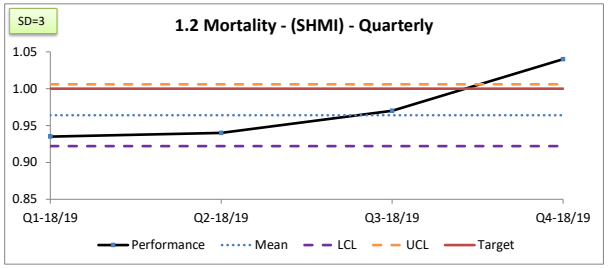
Rating	Data Quality Assurance
Green	Satisfactory and independently audited (indicator represents an accurate reflection of performance)
Amber	Acceptable levels of assurance but minor areas for improvement identified and potentially independently audited * /No Independent Assurance
Red	Unsatisfactory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

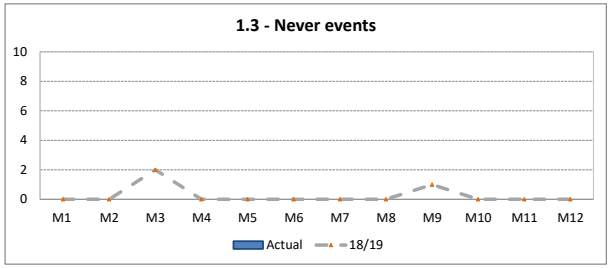
* Independently Audited – refers to an independent audit undertaken by either the Internal Auditor, External Auditors or the Data Quality Audit team.

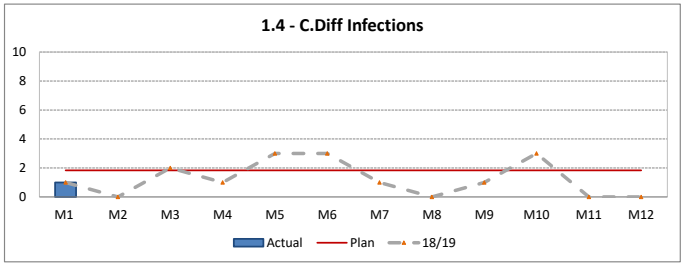
Date Produced: 14/06/2019

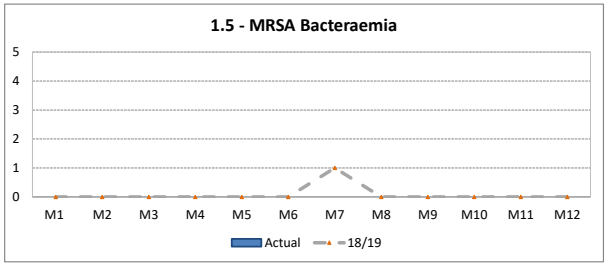
Milton Keynes University Hospital NHS Foundation Trust

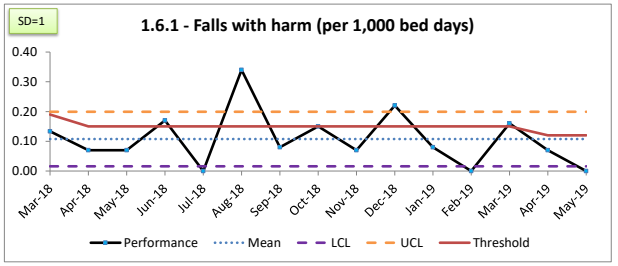


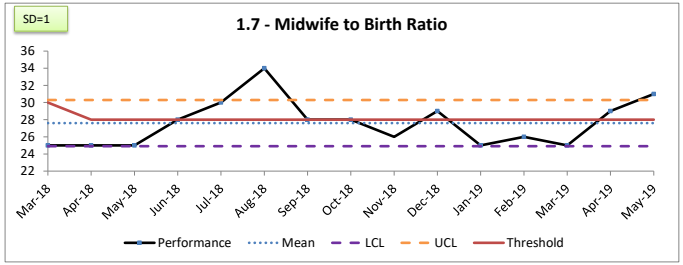


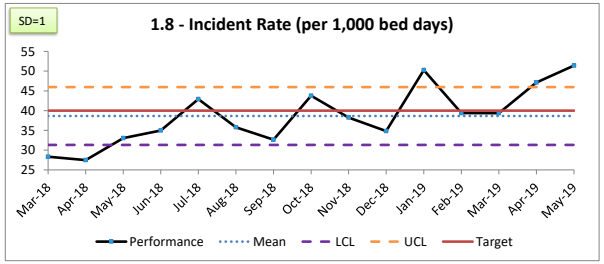


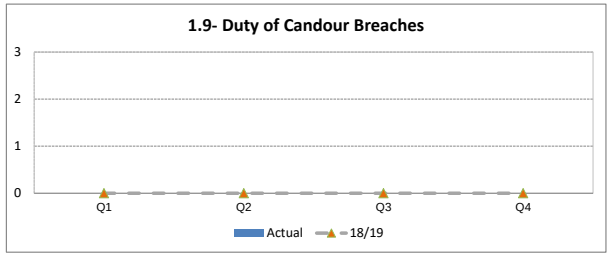


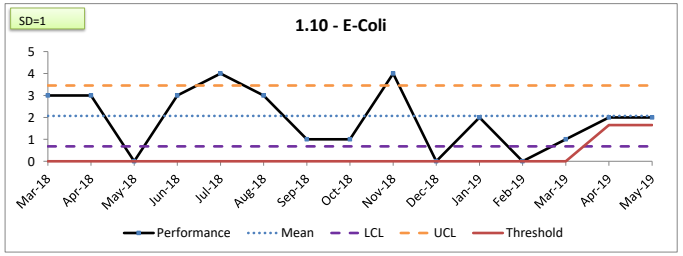


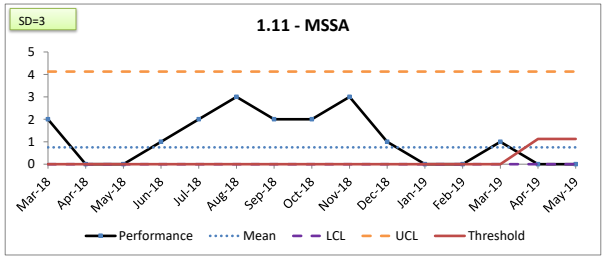


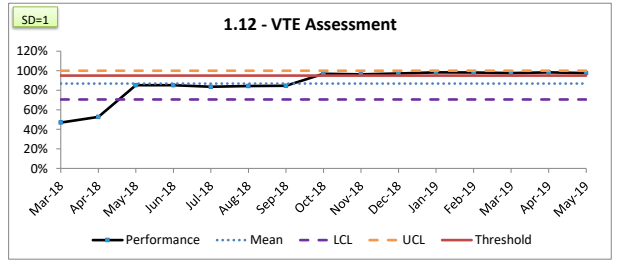












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- Performance activity on a rolling 12 months/quarterly
- Average on a rolling 12 months/quarterly
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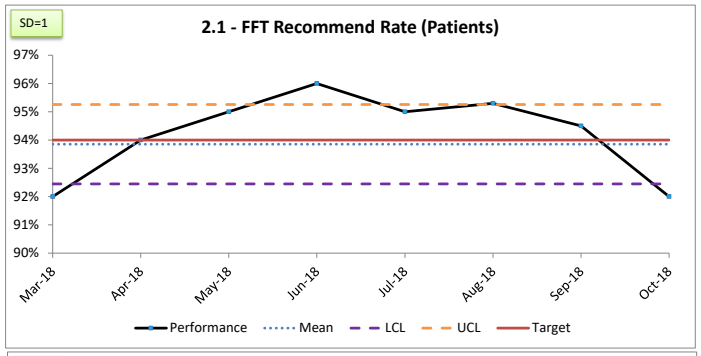
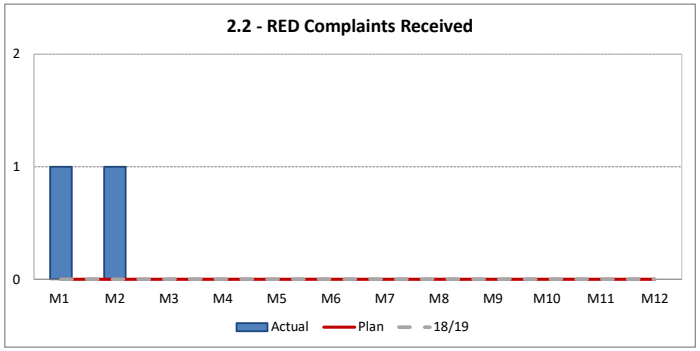
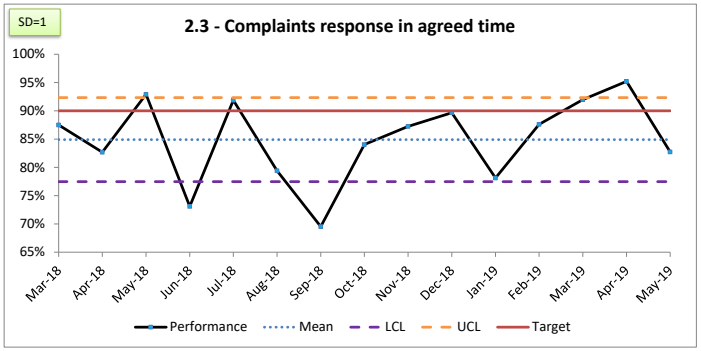
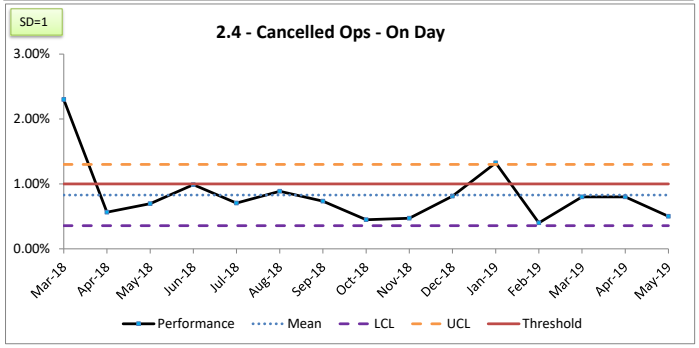
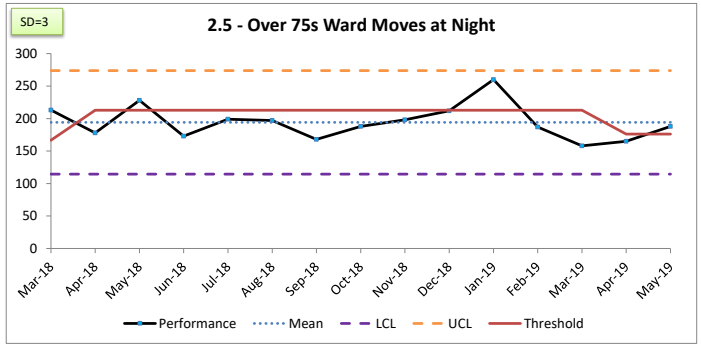
OBJECTIVE 2 - PATIENT EXPERIENCE

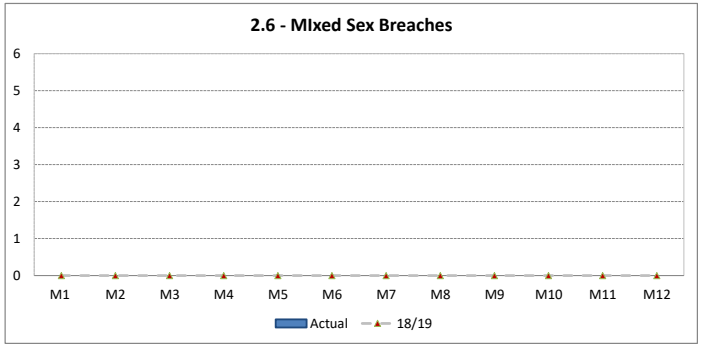












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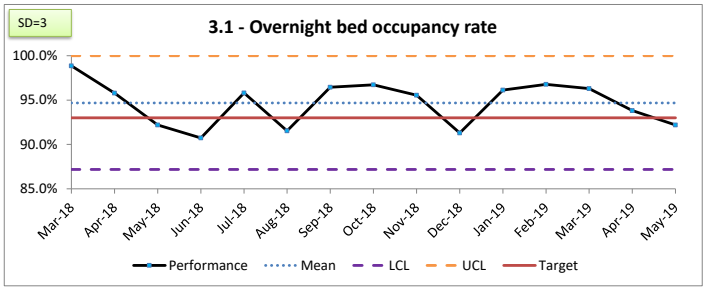
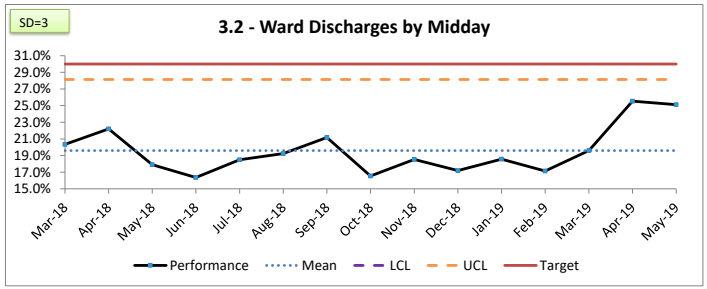
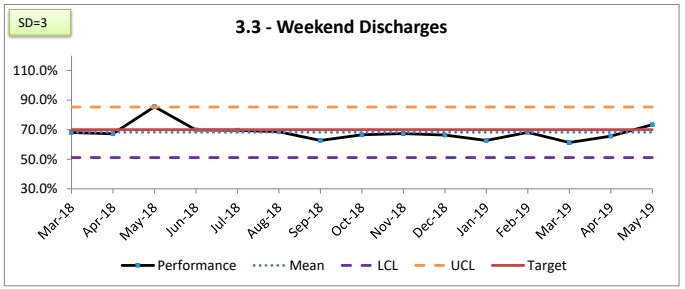
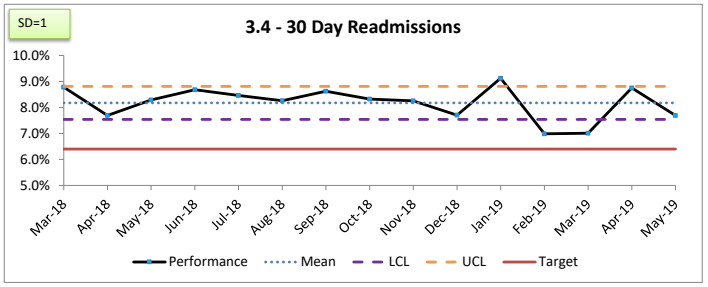
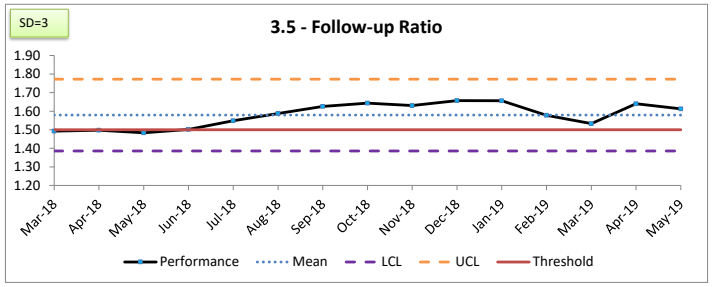
OBJECTIVE 3 - CLINICAL EFFECTIVENESS

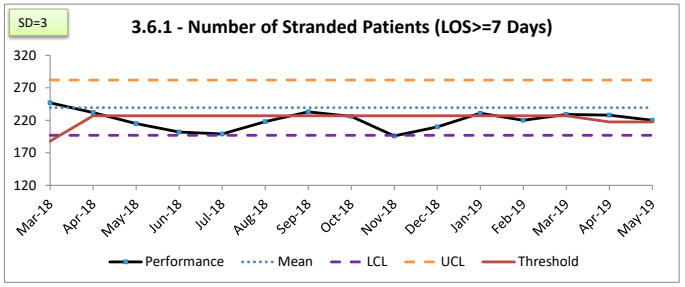


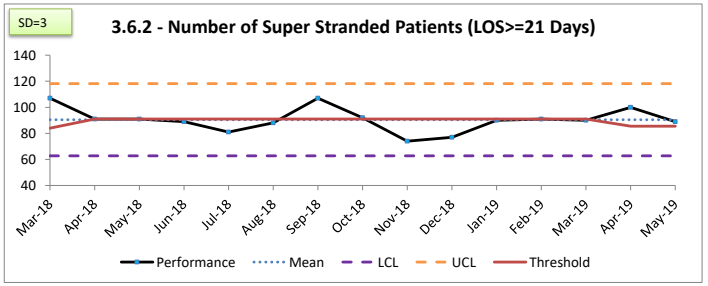


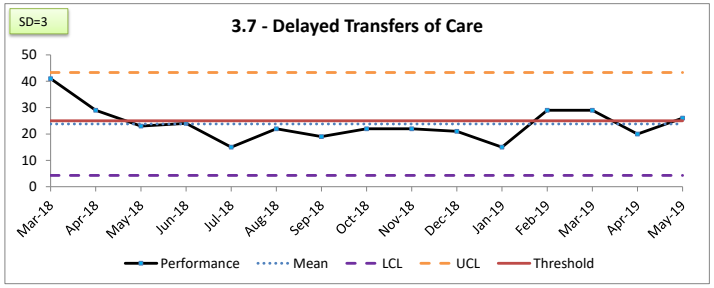


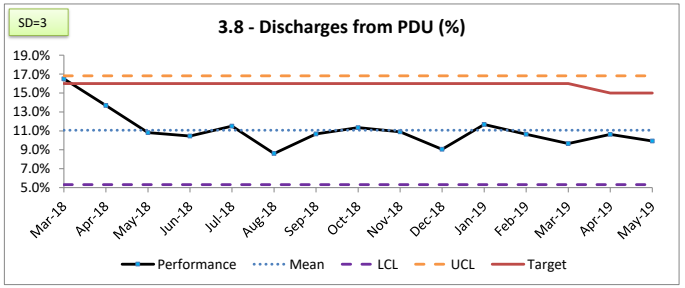


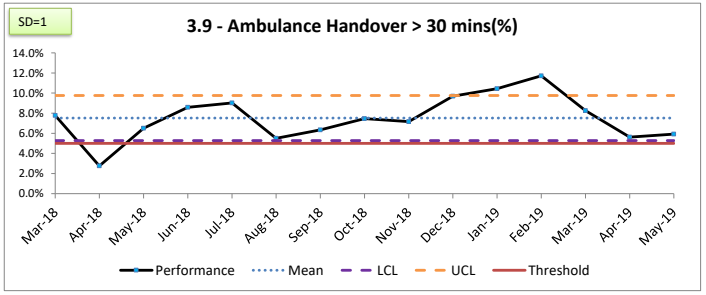












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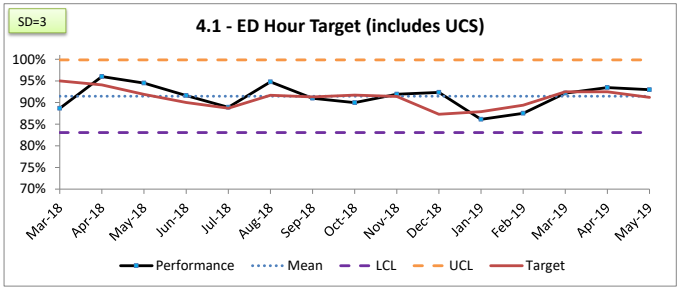
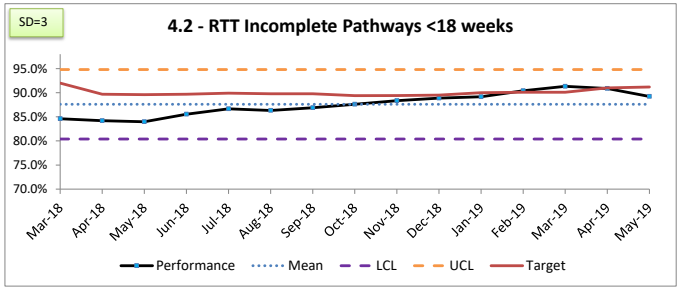
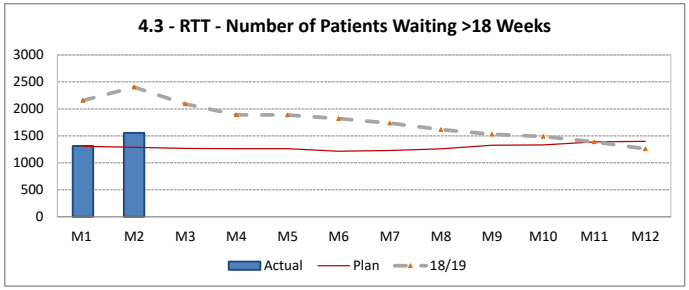
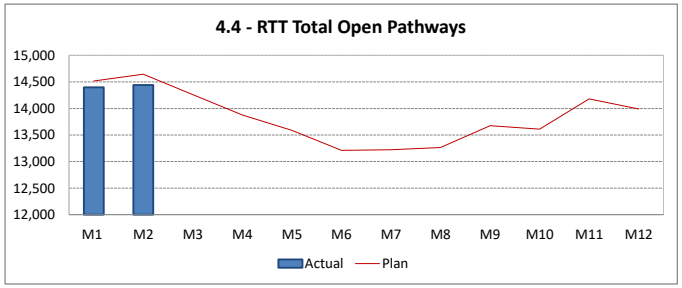
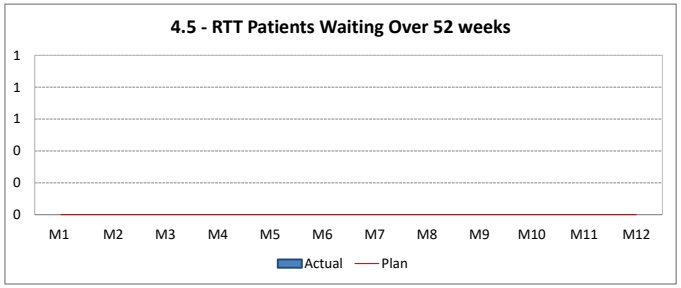
OBJECTIVE 4 - KEY TARGETS

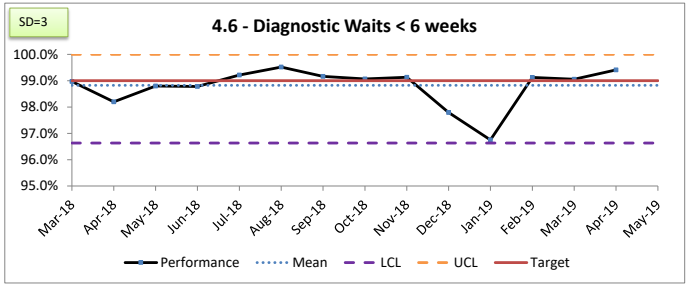


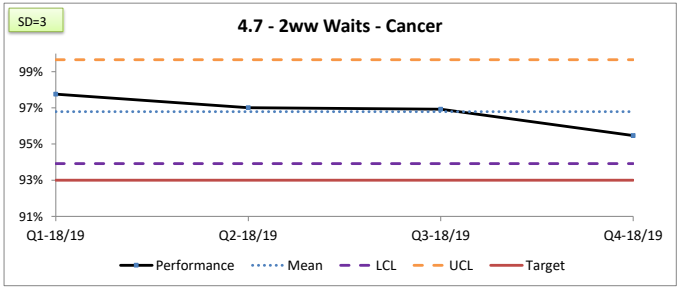


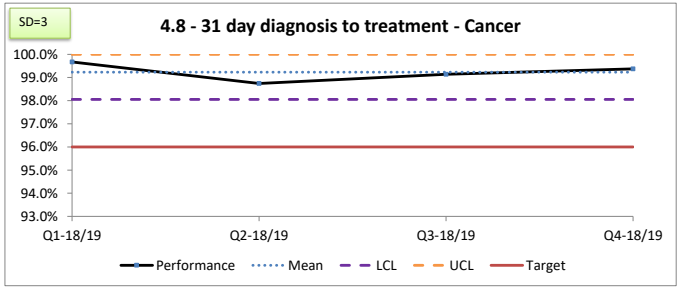


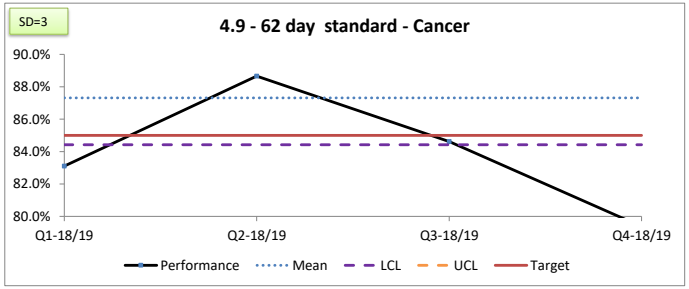












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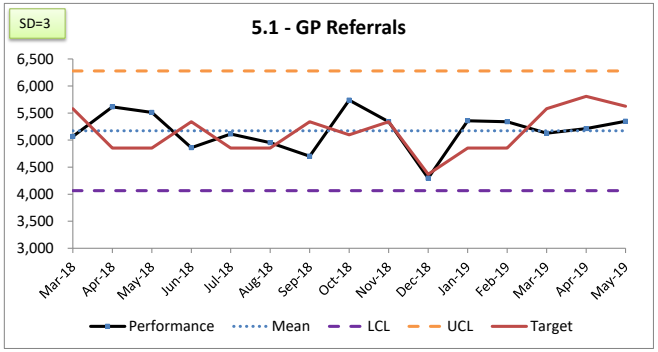
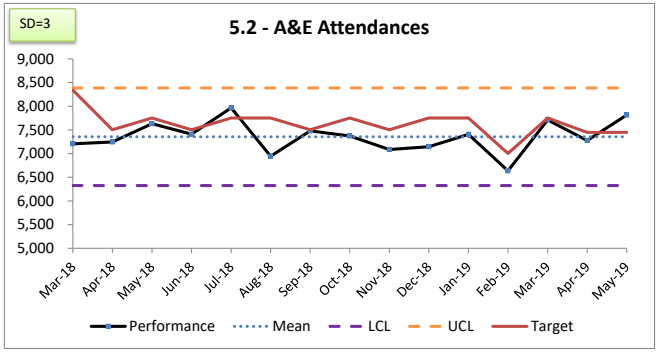
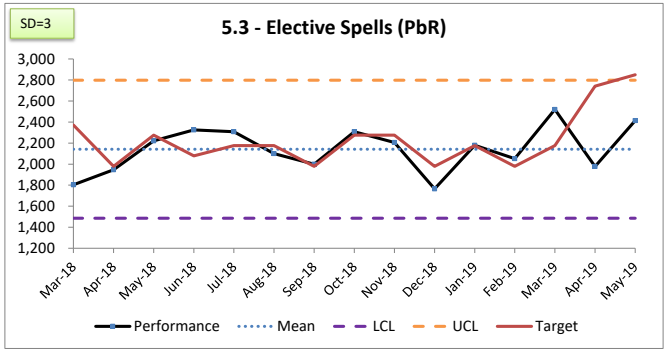
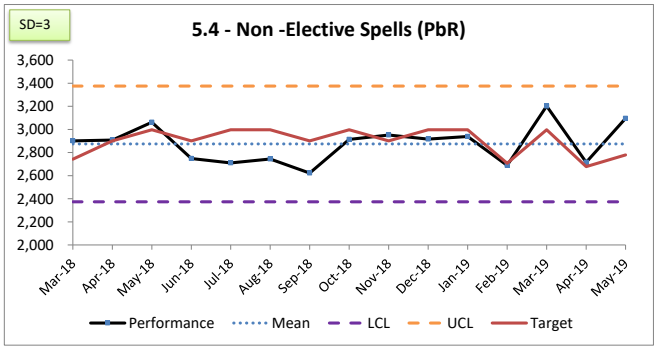
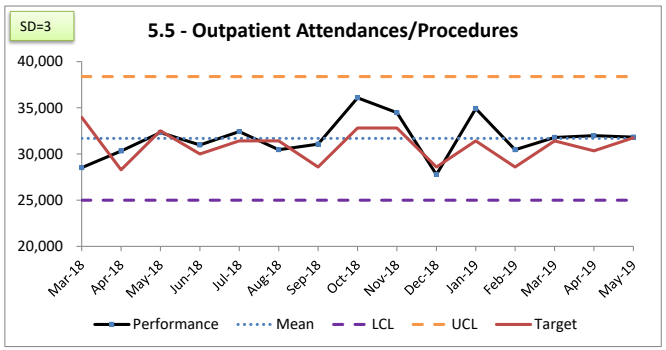
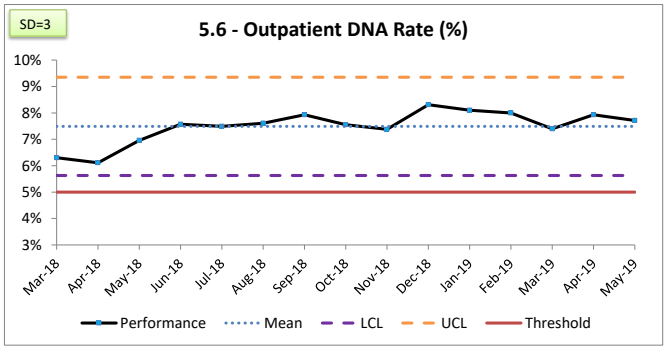






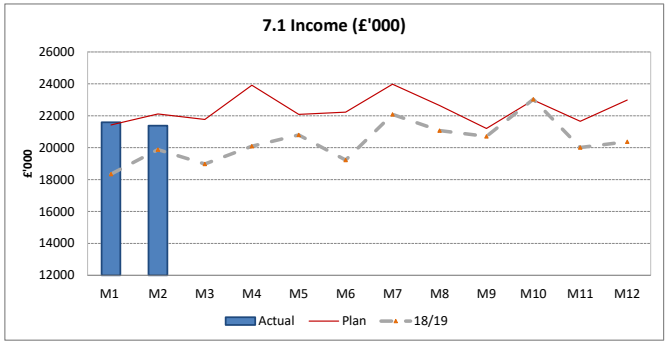


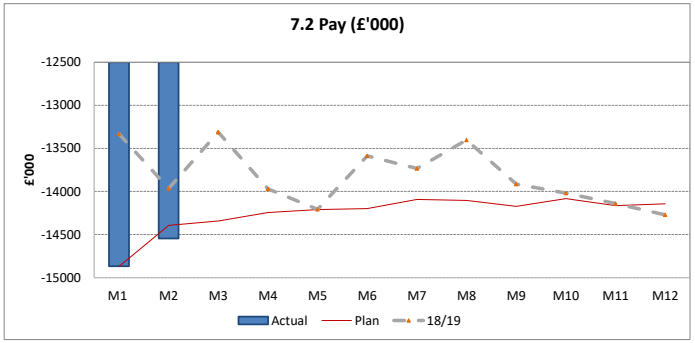


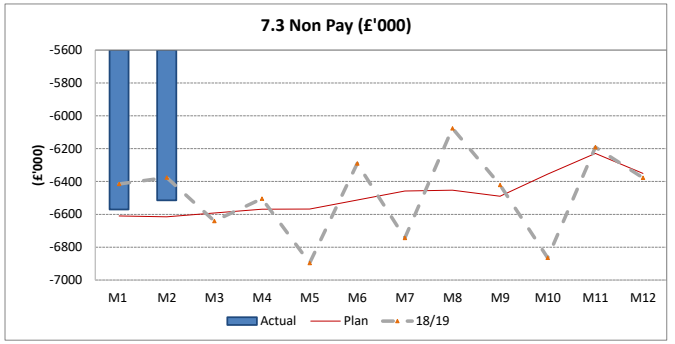


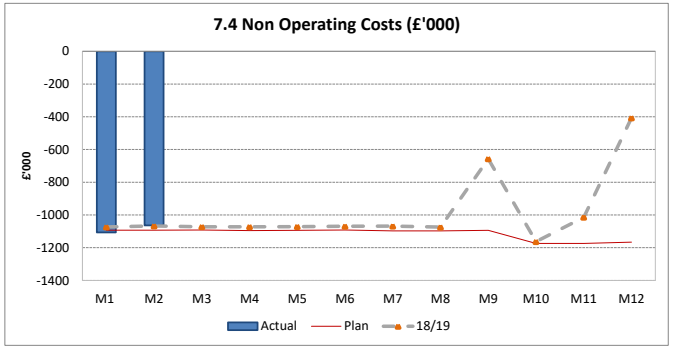
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

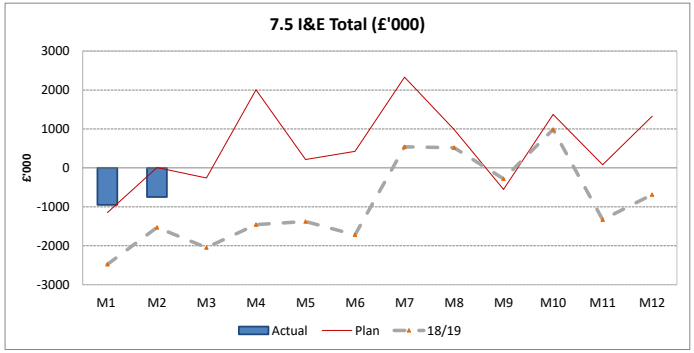
- Performance activity on a rolling 12 months/quarterly
- Average on a rolling 12 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

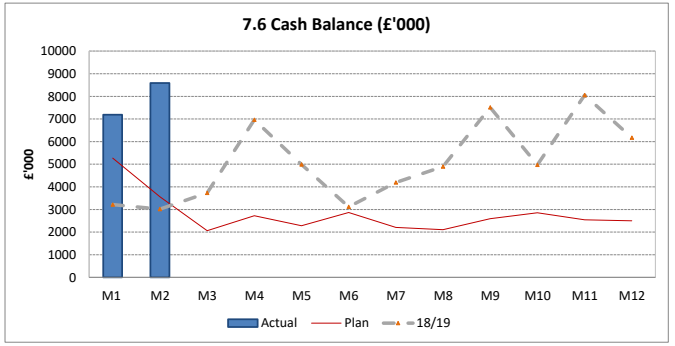

7.1 Income (£'000)
£'000
26000
24000
22000
20000
18000
16000
14000
12000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19

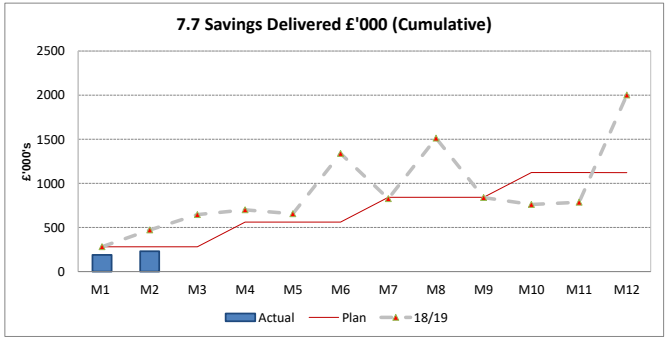

7.2 Pay (£'000)
£'000
-12500
-13000
-13500
-14000
-14500
-15000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19

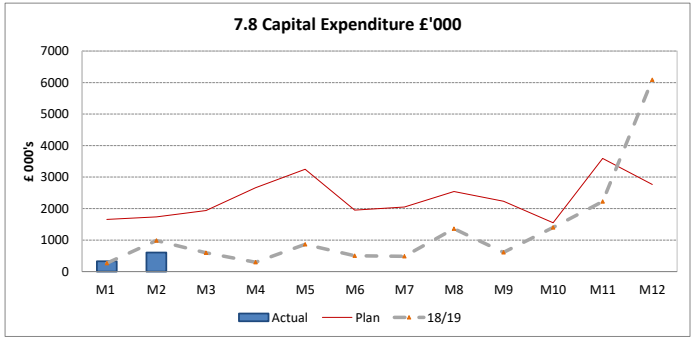

7.3 Non Pay (£'000)
(£'000)
-5600
-5800
-6000
-6200
-6400
-6600
-6800
-7000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19


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
18/19

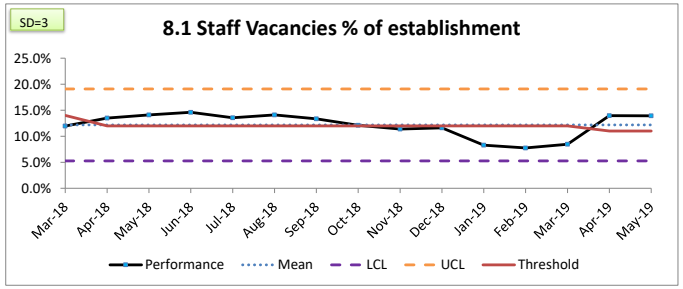

7.5 I&E Total (£'000)
£'000
3000
2000
1000
0
-1000
-2000
-3000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19

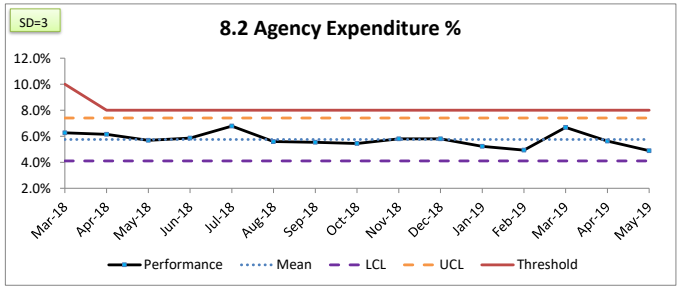

7.6 Cash Balance (£'000)
£'000
10000
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19

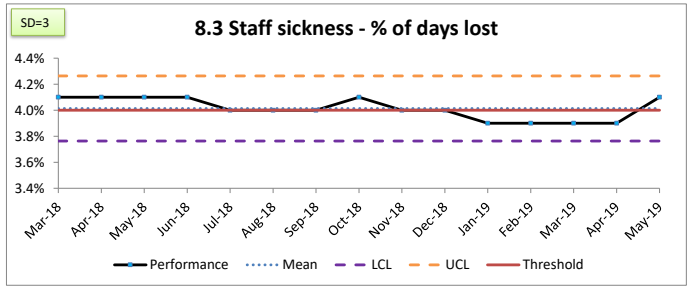

7.7 Savings Delivered £'000 (Cumulative)
£'000's
2500
2000
1500
1000
500
0
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19

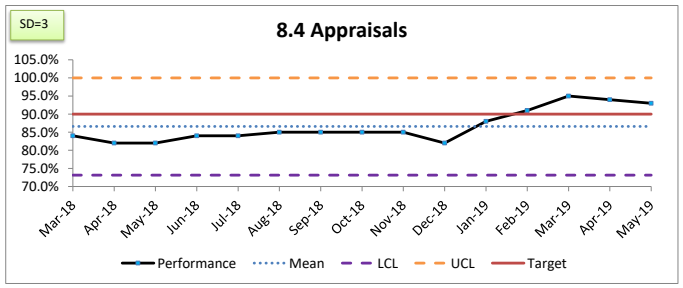

7.8 Capital Expenditure £'000
£ 000's
7000
6000
5000
4000
3000
2000
1000
0
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19

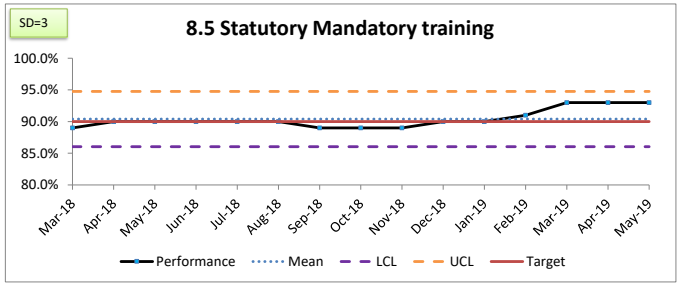
OBJECTIVE 8 - WORKFORCE PERFORMANCE

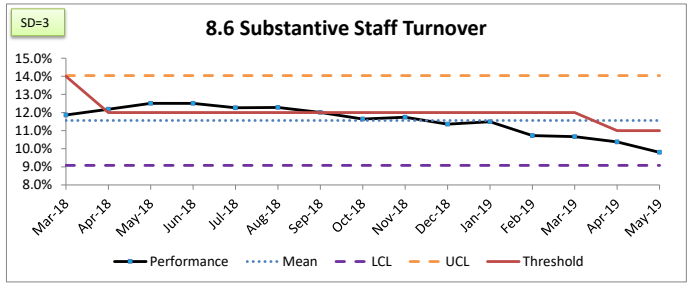












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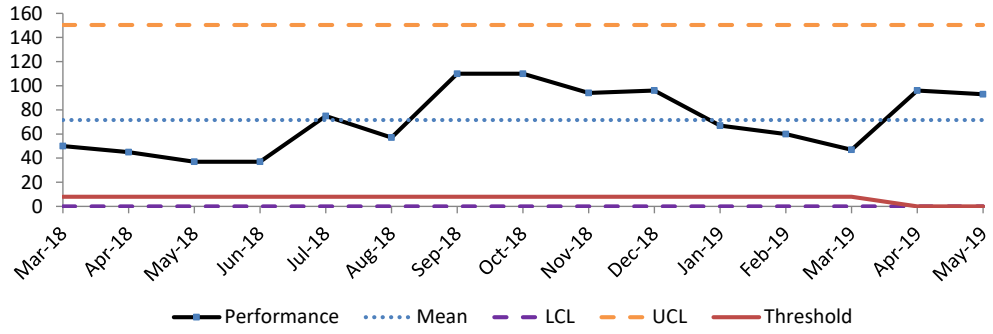
- Performance activity on a rolling 12 months/quarterly
- Average on a rolling 12 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

Milton Keynes University Hospital NHS Foundation Trust

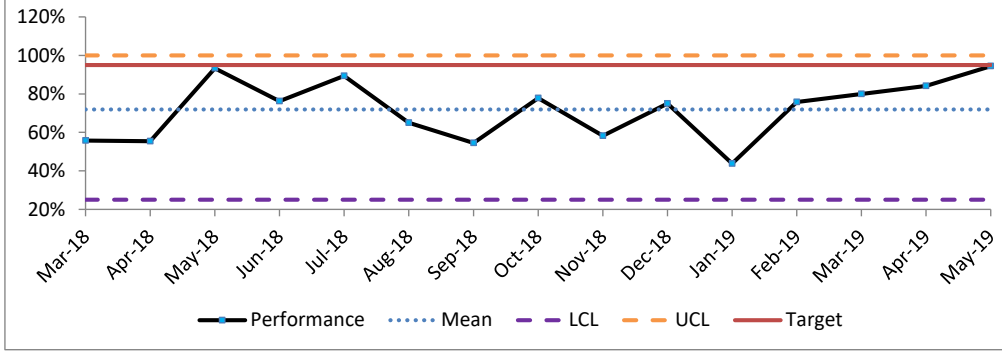
SD=3

O.1 - Total Number OF Nice Breaches

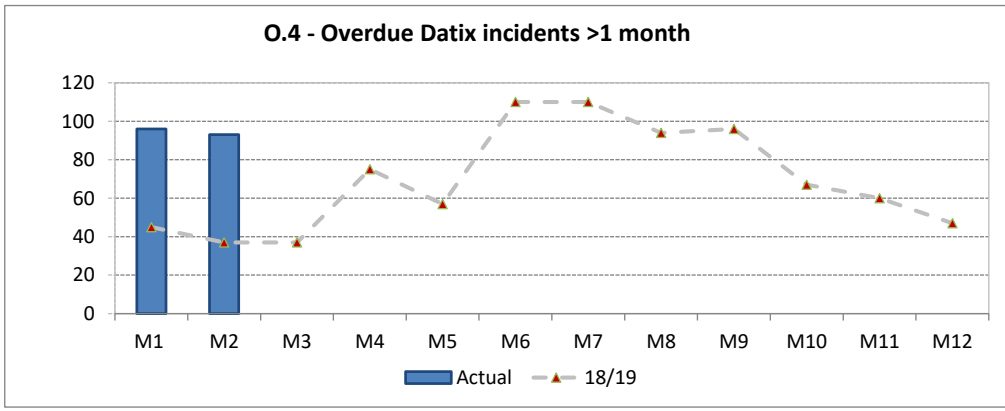


SD=3

O.2 - Rebooked cancelled OPs - 28 day rule

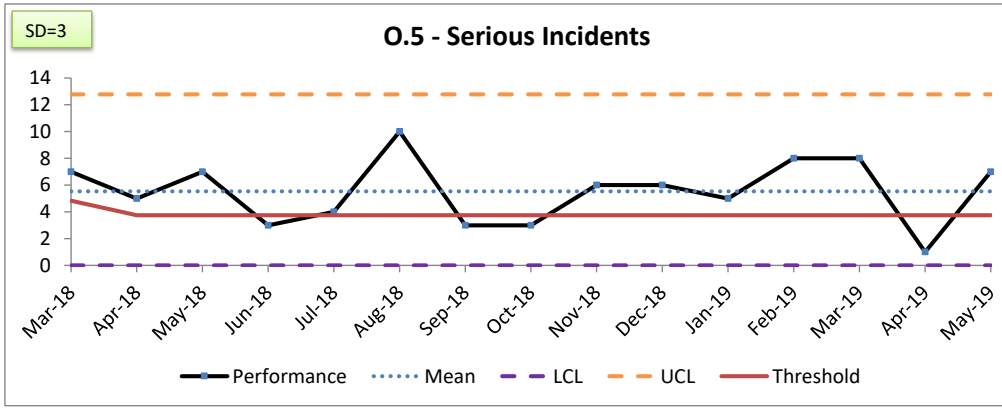


O.4 - Overdue Datix incidents >1 month



SD=3

O.5 - Serious Incidents



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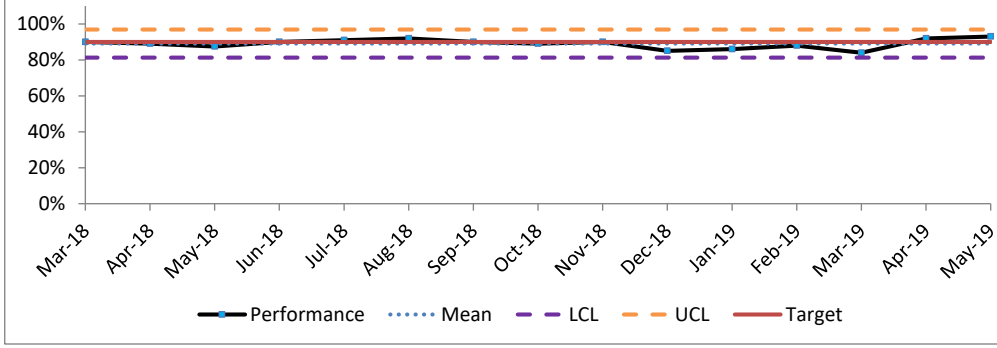
- Performance activity on a rolling 12 months/quarterly
- Average on a rolling 12 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

SD=3

O.8 - Completed Job Plans (Consultants)



Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Public Board	Date: 10 July 2019
Report title:	Finance Paper Month 2 2019-20	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 2 (May 2019)			
Purpose *(tick one box only)*	Information ☐	Approval ☐	To note ☒	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 May 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 deficit for May 2019 was £0.8m which is £0.8m adverse to budget in the month and £0.6m adverse year to date (YTD) which is caused by a timing difference on donated income for the Cancer Centre. The position (excluding PSF & donations) is £0.1m favourable to Trust's control total on a YTD basis.

3. *Cash and capital position* – the cash balance as at the end of May 2019 was £8.6m, which was £5m above plan due to the timing of capital expenditure and receipts. The Trust has spent £0.9m on capital at Month 2 of which £0.2m relates to eCARE, £0.4m Cancer Centre and £0.3m 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 £0.2m were delivered in month against an identified plan of £0.2m and the target of £0.4m. YTD £0.4m has been delivered against a plan of £0.4m and a target of £0.8m. As at month 2, £2.5m of schemes have been validated and added to the tracker against an £8.4m target; however a number of other schemes have been identified and will be included on the tracker subject to a quality impact assessment.

INCOME AND EXPENDITURE

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

All Figures in £'000	Month 2 Plan	Month 2 Actual	Month 2 Var	Month 2 YTD Plan	Month 2 YTD Actual	Month 2 YTD Var	Full Year Plan	Full Year Forecast	Full Year Var
Clinical Revenue	18,377	18,414	37	36,079	36,122	43	218,726	218,726	0
Other Revenue	1,612	1,697	85	3,226	3,315	89	19,085	19,085	0
Total Income	19,989	20,111	122	39,305	39,437	132	237,811	237,811	0
Pay	(14,397)	(14,545)	(147)	(29,268)	(29,412)	(144)	(171,023)	(171,023)	0
Non Pay	(6,595)	(6,575)	19	(13,184)	(13,146)	39	(77,808)	(77,808)	0
Total Operational Expend	(20,992)	(21,120)	(128)	(42,453)	(42,558)	(105)	(248,831)	(248,831)	0
EBITDA	(1,003)	(1,009)	(6)	(3,148)	(3,121)	27	(11,020)	(11,020)	0
Financing & Non-Op. Costs	(1,048)	(1,017)	31	(2,095)	(2,058)	37	(12,570)	(12,570)	0
Control Total Deficit (excl. PSF)	**(2,051)**	**(2,026)**	**25**	**(5,243)**	**(5,179)**	**64**	**(23,590)**	**(23,590)**	**0**
Adjustments excl. from control total:									
PSF	204	204	0	408	408	0	4,083	4,083	0
PSF- ICS	52	52	0	104	104	0	1,037	1,037	0
FRF	740	740	0	1,480	1,480	0	14,807	14,807	0
MRET	270	270	0	540	540	0	3,237	3,237	0
Control Total Deficit (incl. PSF)	**(785)**	**(760)**	**25**	**(2,711)**	**(2,647)**	**64**	**(426)**	**(426)**	**0**
Donated income	865	0	(865)	1,706	1,000	(706)	8,000	8,000	0
Donated asset depreciation	(66)	(47)	18	(131)	(113)	18	(786)	(786)	0
Reported deficit/surplus	**15**	**(807)**	**(822)**	**(1,136)**	**(1,760)**	**(624)**	**6,788**	**6,788**	**0**

Monthly and year to date review

7. The **deficit excluding central funding (PSF, FRF and MRET) and donated income** in month 2 is £1,966k which is £25k favourable to plan in month and £64k favourable YTD. For M2 the Trust recognised full achievement of the central funding allocation of £1,266k (£2,532k YTD).

8. The Trust reported a deficit in month 2 of £807k which is £822k adverse to the budget surplus of £15k which was mainly driven by a negative variance against plan on donated income relating to the Cancer Centre.

9. **Income (excluding PSF/FRF/MRET and donations effect)** is £122k favourable to plan in May and £132k favourable YTD and can be further analysed in Appendix 1

10. **Operational costs** in May are adverse to plan by £68k in month and £45k YTD.

11. **Pay costs** are £147k adverse to budget in Month 2. Bank expenditure has increased by £332k over month 1 as a result of higher usage and changes in the accruals as a result of the move to weekly pay for bank staff. Negative variances against bank and locum are offset by positive variances against substantive and agency.

12. **Non-pay costs** were £19k favourable to plan in month and £39k favourable YTD. Negative variances against education & training expenses, premises & fixed plant and miscellaneous operating expenses are offset by positive variances against high cost drugs, clinical supplies, and outsourcing.

13. **Non-operational costs** are marginally favourable in month.

COST SAVINGS

14. In Month 2, £230k was delivered against an identified plan of £210k and a target of £421k. YTD £441k has been delivered against a plan of £420k and a target of £842k.

15. Currently £2,536k of plans have been validated and added to the tracker against a target of £8,400k; however this is expected to increase quickly over the coming months as identified schemes are validated. The level of schemes that has been identified exceeds the target for the year; however these are currently under review to assess the likelihood of delivery in the context of new a new contract form with the Trust's main commissioner.

CASH AND CAPITAL

16. The cash balance at the end of May 2019 was £8.6m, which was £5.0m above plan due to the timing of receipts and capital spend.

17. 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 £30.6m; this is mainly driven by the revaluation of the Trust estate in 2018/19 and timing of capital projects.

- Current assets are above plan by £9.2m, this is due to cash £5.0m, receivables £3.8m and inventories £0.4m above plan.

- Current liabilities are below plan by £0.1m. This is being driven by deferred income £1.2m and provisions £0.2m above plan offset by Trade and Other Creditors £1.3m below plan.

- Non-Current Liabilities are below plan by £0.5m. This is being driven by provisions £0.2m and borrowings £0.3m below plan.

18. The Trust has spent £0.9m on capital up to month 2 of which £0.2m relates to eCARE, £0.4m cancer centre and £0.3m on patient safety and clinically urgent capital expenditure. Capital spend is expected to accelerate significantly in month 3.

RISK REGISTER

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

a) Constraints on the NHS Capital Expenditure Limit may lead to delays in the Trust receiving its required capital funding or other restrictions being placed on the Trust's capital programme.

The Trust is awaiting further guidance on the extent to which current capital plans are affordable and is liaising with its partners in the Integrated Care System to consider options to reduce the system capital requirement.

b) There is a risk that the Trust does not receive timely confirmation that its revenue loans due for repayment in 2019/20 have been refinanced.

Funding to cover the ongoing funding requirements in 2019/20 is subject to approval by DHSC on a monthly basis and remains a risk in the new financial year. As in previous years the Trust will liaise with NHS Improvement in respect of revenue loans due for repayment in 2019/20.

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

The Trust has a target of £8.4m of which all will need to be delivered through cost reduction, this remains a risk to meeting the Trust's year end control total.

d) The Trusts guaranteed income contract may not deliver the benefits expected and leads to unfunded activity

If the Trust cannot adopt new models of care and reduce levels of activity into the Trust the may be an opportunity cost to the trust in which it delivers significant amounts of unfunded activity at a high cost to the Trust.

RECOMMENDATIONS TO BOARD OF DIRECTORS

20. The Trust Board is asked to note the financial position of the Trust as at 31 May 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 May 2019

	May 2019			2 months to May 2019			Full year
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME							
Outpatients	3,780	3,994	213	7,352	7,496	144	45,166
Elective admissions	2,404	2,366	(38)	4,707	4,624	(83)	28,930
Emergency admissions	6,261	4,938	(1,322)	12,303	11,099	(1,204)	73,498
Emergency adm's marginal rate (MRET)	(276)	(279)	(3)	(542)	(528)	14	(3,238)
Readmissions Penalty	(279)	(279)	0	(559)	(559)	0	(3,353)
A&E	1,201	1,374	173	2,403	2,536	133	14,418
Maternity	1,687	1,983	296	3,341	3,707	366	19,980
Critical Care & Neonatal	517	568	51	1,035	946	(89)	6,362
Excess bed days	0	0	0	0	0	0	0
Imaging	421	491	70	822	948	126	5,053
Direct access Pathology	394	389	(5)	769	781	12	4,726
Non Tariff Drugs (high cost/individual drugs)	1,644	1,620	(23)	3,188	3,132	(57)	19,488
Other	623	1,249	626	1,260	1,940	680	7,695
Clinical Income	**18,377**	**18,414**	**37**	**36,079**	**36,122**	**43**	**218,726**
Non-Patient Income	**3,743**	**2,963**	**(780)**	**7,464**	**6,847**	**(617)**	**50,249**
TOTAL INCOME	**22,120**	**21,377**	**(743)**	**43,543**	**42,969**	**(574)**	**268,975**
EXPENDITURE							
Total Pay	**(14,397)**	**(14,545)**	**(147)**	**(29,268)**	**(29,412)**	**(144)**	**(171,023)**
Non Pay	(4,951)	(4,955)	(4)	(9,996)	(10,014)	(18)	(58,320)
Non Tariff Drugs (high cost/individual drugs)	(1,644)	(1,620)	23	(3,188)	(3,132)	57	(19,488)
Non Pay	**(6,595)**	**(6,575)**	**19**	**(13,184)**	**(13,146)**	**39**	**(77,808)**
TOTAL EXPENDITURE	**(20,992)**	**(21,120)**	**(128)**	**(42,453)**	**(42,558)**	**(105)**	**(248,831)**
EBITDA*	**1,128**	**257**	**(871)**	**1,090**	**411**	**(679)**	**20,144**
Depreciation and non-operating costs	(983)	(934)	49	(1,966)	(1,911)	55	(11,796)
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**145**	**(677)**	**(821)**	**(876)**	**(1,501)**	**(624)**	**8,349**
Public Dividends Payable	(130)	(130)	(0)	(260)	(260)	(0)	(1,560)
OPERATING DEFICIT AFTER DIVIDENDS	**15**	**(807)**	**(822)**	**(1,136)**	**(1,761)**	**(624)**	**6,788**
Adjustments to reach control total							
Donated Income	(865)	0	865	(1,706)	(1,000)	706	(8,592)
Donated Assets Depreciation	66	47	(18)	131	113	(18)	697
Control Total Rounding	0	0	0	0	0	0	0
PSF	(1,266)	(1,266)	0	(2,532)	(2,532)	0	(10,263)
CONTROL TOTAL DEFECIT	**(2,051)**	**(2,026)**	**25**	**(5,243)**	**(5,180)**	**64**	**(11,370)**

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

Appendix 2

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

	Mth 2 £000	Mth 1 £000	In Month Movement £000
Cash flows from operating activities			
Operating (deficit) from continuing operations	(1,133)	(640)	(493)
Operating surplus/(deficit) of discontinued operations			
Operating (deficit)	**(1,133)**	**(640)**	**(493)**
Non-cash income and expense:			
Depreciation and amortisation	1544	793	751
Impairments	0	0	0
(Increase)/Decrease in Trade and Other Receivables	701	241	460
(Increase)/Decrease in Inventories	3	5	(2)
Increase/(Decrease) in Trade and Other Payables	467	(501)	968
Increase/(Decrease) in Other Liabilities	1,054	(178)	1,232
Increase/(Decrease) in Provisions	(10)	(9)	(1)
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows	(1,000)	(1,000)	0
Other movements in operating cash flows		2	(2)
NET CASH GENERATED FROM OPERATIONS	**1,626**	**(1,287)**	**2,913**
Cash flows from investing activities			
Interest received	14	8	6
Purchase of intangible assets	(914)	(570)	(344)
Purchase of Property, Plant and Equipment, Intangibles	(1,252)	(371)	(881)
Sales of Property, Plant and Equipment			0
Net cash generated (used in) investing activities	**(2,152)**	**(933)**	**(1,219)**
Cash flows from financing activities			
Public dividend capital received	0	0	0
Loans received from Department of Health	2,315	2315	0
Loans repaid to Department of Health	(159)	0	(159)
Capital element of finance lease rental payments	(28)	(27)	(1)
Interest paid	(142)	(29)	(113)
Interest element of finance lease	(49)	(27)	(22)
PDC Dividend paid	0	0	0
Receipt of cash donations to purchase capital assets	1000	1000	0
Cash flows from (used in) other financing activities	0	0	0
Net cash generated from/(used in) financing activities	**2,937**	**3,232**	**(295)**
Increase/(decrease) in cash and cash equivalents	**2,411**	**1,012**	1,399
Opening Cash and Cash equivalents	**6,175**	**6,175**	3,668
Closing Cash and Cash equivalents	**8,586**	**7,187**	**5,067**

Appendix 3

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

	Unaudited Mar-19	May-19 Plan	May-19 Actual	In Mth Var to Plan	Var to Mar -19	% Variance
Assets Non-Current						
Tangible Assets	147.3	179.1	146.8	(32.3)	(0.5)	(0.3%)
Intangible Assets	14.2	12.6	14.2	1.6	0.0	0.0%
Other Assets	0.5	0.3	0.4	0.1	(0.0)	(2.0%)
Total Non Current Assets	**162.0**	**192.0**	**161.4**	**(30.6)**	**(0.5)**	**(0.3%)**
Assets Current						
Inventory	3.6	3.2	3.6	0.4	0.0	0.0%
NHS Receivables	23.5	21.2	22.2	1.0	(1.3)	(5.5%)
Other Receivables	6.0	3.8	6.6	2.8	0.6	10.0%
Cash	6.2	3.6	8.6	5.0	2.4	38.7%
Total Current Assets	**39.3**	**31.8**	**41.0**	**9.2**	**1.7**	**4.3%**
Liabilities Current						
Interest -bearing borrowings	(80.2)	(82.1)	(82.1)	0.0	(1.9)	2.4%
Deferred Income	(1.7)	(1.6)	(2.8)	(1.2)	(1.1)	64.1%
Provisions	(1.6)	(1.4)	(1.6)	(0.2)	0.0	0.0%
Trade & other Creditors (incl NHS)	(28.9)	(29.7)	(28.4)	1.3	0.5	(1.7%)
Total Current Liabilities	**(112.3)**	**(114.8)**	**(114.9)**	**(0.1)**	**(2.5)**	2.3%
Net current assets	**(73.0)**	**(83.0)**	**(73.9)**	**9.1**	**(0.8)**	**1.1%**
Liabilities Non-Current						
Long-term Interest bearing borrowings	(53.0)	(53.6)	(53.4)	0.2	(0.4)	0.7%
Provisions for liabilities and charges	(0.8)	(1.1)	(0.8)	0.3	0.0	0.0%
Total non-current liabilities	**(53.9)**	**(54.7)**	**(54.2)**	**0.5**	**(0.4)**	0.7%
Total Assets Employed	**35.1**	**54.3**	**33.4**	**(21.0)**	**(1.7)**	**(4.9%)**
Taxpayers Equity						
Public Dividend Capital (PDC)	101.4	101.5	101.4	(0.1)	0.0	0.0%
Revaluation Reserve	58.3	78.7	58.3	(20.4)	0.0	0.0%
I&E Reserve	(124.5)	(125.9)	(126.2)	(0.3)	(1.7)	1.4%
Total Taxpayers Equity	**35.1**	**54.3**	**33.4**	**(20.9)**	**(1.7)**	**(4.8%)**

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Trust Board**	**Date: 10 July 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:		

Report summary	This report provides a summary of workforce Key Performance Indicators for the full year ending 31 May 2019 (Month 2).			
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, June 2019
Next steps	
Appendices	None

Workforce report – Month 2, 2019/20

1. Purpose of the report

1.1. This report provides a summary of workforce Key Performance Indicators for the full year ending 31 May 2019 (Month 2).

2. Staff in post

2.1. The Trust's staff in post by whole time equivalent (WTE) was 3080.1 as at 31 March 2019; an increase of 59.9 WTE since May 2018.

2.2. The Trust's headcount is 3559, an increase of 56 since May 2018.

2.3. The largest increases of staff in post since May 2018 have been in the Additional Clinical Services, Nursing and Midwifery and Estates and Ancillary staff groups.

3. Vacancy rate

3.1. The Trust's overall vacancy rate is 12.8%; 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. As required under the ongoing Workforce Strategy delivery plan, the teams continue to hold recruitment events/fayres and to investigate innovative means of recruitment to fill vacancies.

3.4. A further driver of this work is the advent of the NHS Interim People Plan in June 2019 which targets a reduction in the Nursing and Midwifery vacancy rate to 5% by 2028 through delivery of several related actions; education, new roles, retention through use of career pathways/development and upskilling, return to practice and cultural change (OD) interventions.

4. Turnover

4.1. The Trust's leaver turnover rate was lower throughout 2018/19 than it was in 2017/18 and this trend has continued into 2019/20. The M2 position is further reduced to 10.0% from 12.6% in May 2018.

4.2. Retention is a key theme in the Trust's Workforce Strategy 2018-21 and is also being further influenced by measures outlined in the NHS Interim People Plan.

5. Temporary staffing

5.1. The temporary staff usage (bank and agency) for the rolling year-to-date was 6014.8 WTE, which was 14.4% of total WTE staff employed.

5.2. Agency staff usage was 3.7% of the total WTE staff employed for the rolling year to date but was 6.0% of the total annual staff expenditure. This is predominantly driven by high cost Medical and Dental agency locums and volume of Nursing agency staff where comparative vacancy rates are above 15%.

5.3. The Trust ceiling for agency staff expenditure for 2019/2020 is £11.1m. The Trust was consistently below the allocated agency expenditure ceiling in 2018/19 and this is anticipated for 2019/20.

5.4. Detailed analysis of bank and agency expenditure is being undertaken to target interventions for greater effect as the Trust seeks to reduce its reliance on temporary staffing into 2019/20.

5.5. Temporary staffing is a key area of the Trust's Workforce Strategy 2018-21. It remains a complex area in which improvement is envisaged through improved systems support and deployment and compliance with regulatory requirements.

6. Sickness absence

6.1. The sickness absence rate (N.B. 12 months to M1, 30 April 2019) has increased to 4.05% against the Trust target of 4.0% (1.73% short term and 2.33% long term).

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

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

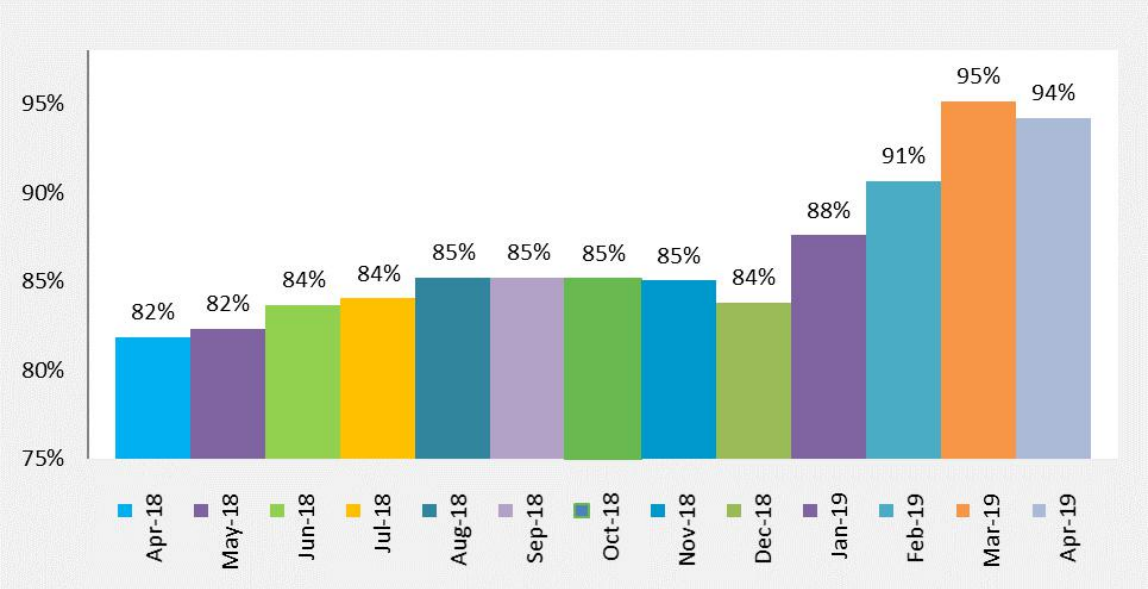
7.1. Statutory and mandatory training compliance as at 31 May 2019 was at 93% against the Trust target of 90%.

Training Compliance by Division	
Core Clinical	95%
Corporate Services	95%
Medicines Unplanned Care	93%
Surgical Planned Care	92%
Women's and Children's	93%
Trust Total Compliance	**93%**

8. Appraisal compliance

8.1. Trust-wide appraisal compliance as at 31 May 2019 is 94%, against the Trust target of 90%.

Appraisal Completion by Division	
Core Clinical	96%
Corporate Services	91%
Medicines Unplanned Care	94%
Surgical Planned Care	93%
Women's and Children's	96%
Total Trust	**94%**



9. The NHS Interim People Plan

9.1. In January 2019, the NHS published its Long Term Plan setting out as 10-year vision for healthcare in England. The Interim People Plan was published on 03 June and, similarly, sets out the vision for people who work for the NHS to enable them to deliver the NHS Long Term Plan, with a focus on the immediate actions that Trusts need to take.

9.2. The plan is broadly categorised into 5 key themes of activity:

a. **Make the NHS the best place to work**: focus on making the NHS an employer of excellence – valuing, supporting, developing and investing in our people.

b. **Improve our leadership culture**: Positive, compassionate and improvement focused leadership creates the culture that delivers better care. Focus on improving our leadership culture nationally and locally.

c. **Prioritise urgent action on nursing shortages**: There are shortages across a wide range of NHS staff groups, However, the most urgent challenge is the current shortage of nurses. Focus on acting now to address this.

d. **Develop a workforce to deliver 21st century care**: Focus on growing our overall workforce, but growth alone is not enough. Transform the workforce with a more varied and richer skill mix, new types of roles and different ways of working, ready to exploit the opportunities offered by technology and scientific innovation to transform care and release more time for care.

e. **Develop a new operating model for workforce**: Continue to work collaboratively and to be clear what needs to be done locally, regionally and nationally, with more people planning activities undertaken by local integrated care systems (ICSs).

9.3. An overview has been produced in respect of deliverables, national, regional and local, for information and discussion, at the Executive Directors meeting. A full and detailed delivery plan is under development and will be shared in due course, with a focus on immediate actions for 2019/20 and cross-over of workstreams already covered by the Trust's Workforce Strategy 2018-21.

9.4. Led by the Deputy Director of Workforce, our teams will develop project plans to deliver the required actions in collaboration with key organisational stakeholders. These plans will be shared widely with Executive Directors, Workforce Board and Management Board. Progress, risk and escalations will be reported via highlight reports to the Director of Workforce to Workforce Board and Workforce and Development Assurance Committee, to allow progress to be monitored.

10. Learning Lessons to Improve our People Practices

10.1. On 24 May 2019, Dido Harding, Chair of NHS Improvement, wrote to Trust Chairs and Chief Executives to outline guidance relating to the management and oversight of local investigation and disciplinary procedures.

10.2. In summary, this guidance was the outcome of an Advisory group, formed by NHS Improvement, as a result of a tragic suicide in 2015 and a subsequent Independent Inquiry.

10.3. The Trust intends to fully adhere to the best practice approach set out in the letter however, attention is drawn to the themes below.

1. Adhering to best practice
2. Applying a rigorous decision-making methodology
3. Ensuring people are fully trained and competent to carry out their role
4. Assigning sufficient resources
5. Decisions relating to the implementation of suspensions/exclusions
6. Safeguarding people's health and wellbeing
7. Board-level oversight

10.4. **Board-level oversight:** Mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Associated data collation and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt.

10.5. Selected employee relations case management data is routinely collected and shared with Workforce Board and Workforce and Development Assurance Committee on a quarterly basis.

10.6. The further report elements and its format as described above, is in development and its first collection will be shared with Trust Board on 05 September 2019.

11. Recommendations

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

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Board of Directors**	**Date: 10 July 2019**
Report title:	**Board Assurance Framework Summary**	**Agenda item: 5.1**
Lead director **Report author** **Sponsor(s)**	**Kate Jarman**	**Director of Corporate Affairs**
FoI status:	**Public**	

Report summary				
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**Discussion** X	**Decision** ☐
Recommendation	The Board is asked to note and discuss the BAF risk summary – particularly those high scoring/ new risks (two); and risks where scores have increased (one).			

Strategic objectives links	All strategic objectives
Board Assurance Framework links	
CQC regulations	Good governance
Identified risks and risk management actions	
Resource implications	
Legal implications including equality and diversity assessment	

Report history	Regular report to Board.
Next steps	Committee in-depth review of risks.
Appendices	Papers follow.

Board Assurance Framework

The Board Assurance Framework (BAF) is being updated against the Trust's strategic objectives, which are currently being agreed. The BAF will go through the Committee cycle to test risks, scores, controls and assurance in detail.

Risks for Escalation to the Board

The BAF has two risks scored at 20. These are:

1. Administrative capacity and compliance with process puts elective care waiting time standard at risk
2. There is a risk that the constraints on the NHS capital expenditure limit (CDEL) lead to delays in the Trust receiving its approved capital funding or other restrictions being placed on the Trusts capital programme.

These are new risks to the BAF (the finance risks having been revised to reflect risks within the current financial year). The administrative capacity risk relates to staffing capacity and following agreed process (including the training of staff) to ensure that elective care is managed as effectively as possible and within elective care waiting time standards. The Quality and Clinical Risk Committee will review this risk in further detail and the Board will receive an update at its September meeting.
The Board should also note the increased risk around the Cancer Centre – this is due to the charitable appeal being behind forecast. The Charitable Funds Committee have received a detailed update on plans.

Board Assurance Framework Risks – 2019/20

Strategic Objective	Risk Ref	Committee	Risk Description	Proximity	Risk Score (consequence v likelihood)						Target	Movement towards target (since April 2019)	Risk Appetite
					June 19	Sept 19	Dec 19	Mar 20	June 20	Sept 20			
SO1: Patient Safety	1-1	Quality and Clinical Risk	Strategic failure to manage demand for emergency care	Next 3 to 6 months	4x3=12						4x2=8	Static	Avoid
SO1: Patient Safety	1-2	Quality and Clinical Risk	Tactical failure to manage demand for emergency care	Next 3 to 6 months	4x3=12						4x2=8	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	4x3=12						4x2=8	Static	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	4x3=12						4x2=8	Static	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						4x2=8	Static	Avoid
SO1: Patient Safety	1-6	Quality and Clinical Risk	Failure to manage clinical risk during significant digital change programmes	Next 3 to 6 months	4x3=12						4x2=8	New	Cautious
SO2: Patient Experience	2-1	Quality and Clinical Risk	Failure to achieve improvements in the inpatient survey	Next 3 to 6 months	4x4=16						4x2=8	Static	Cautious
SO2: Patient Experience	2-2	Quality and Clinical Risk	Failure to embed learning from poor patient experience and complaints	Next 3 to 6 months	4x4=16						4x2=8	Static	Cautious
SO3: Clinical Effectiveness	3-1	Quality and Clinical Risk	Failure to evidence compliance with the annual clinical audit programme	Next 3 to 6 months	4x4=16						4x2=8	Static	Cautious

Strategic Objective	Risk Ref	Committee	Risk Description	Proximity	Risk Score (consequence v likelihood)						Target	Movement towards target (since April 2019)	Risk Appetite
					June 19	Sept 19	Dec 19	Mar 20	June 20	Sept 20			
SO3: Clinical Effectiveness	3-2	Quality and Clinical Risk	Failure to embed learning and evidence action plans following clinical audit	Next 3 to 6 months	4x4=16						4x2=8	New	Cautious
SO3: Clinical Effectiveness	3-3	Quality and Clinical Risk	Lack of assessment against and compliance with NICE guidance	Next 3 to 6 months	4x3=12						4x2=8	Static	Cautious
SO4: Key Targets	4-1	Management Board	Failure to meet the 4 hour emergency access standard	Next 3 to 6 months	4x3=12						4x2=8	Static	Cautious
SO4: Key Targets	4-2	Management Board	Administrative capacity and compliance with process puts elective care waiting time standard at risk	Next 3 to 6 months	4x5=20						4x3=12	New	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	4x4=16						4x2=8	Static	Cautious
SO5: Sustainability	5-1	Audit	Failure to adequately safeguard against major IT system failure (deliberate attack)	Next 3 to 6 months	5x2=10						5x1=5	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	5x2=10						5x1=5	Static	Cautious
SO5: Sustainability	5-3	Management Board	Failure to maximise the financial and clinical	Next 3 to 6 months	4x3=12						4x2=8	Static	Minimal

Strategic Objective	Risk Ref	Committee	Risk Description	Proximity	Risk Score (consequence v likelihood)						Target	Movement towards target (since April 2019)	Risk Appetite
					June 19	Sept 19	Dec 19	Mar 20	June 20	Sept 20			
			benefits of digital transformation										
SO7: Finance and Governance	7-1	Finance	There is a risk that the constraints on the NHS capital expenditure limit (CDEL) lead to delays in the Trust receiving its approved capital funding or other restrictions being placed on the Trusts capital programme.	Next 3 to 6 months	5x4=20						4x3=12	New	Open
SO7: Finance and Governance	7-2	Finance	There is a risk that the Trust does not receive timely confirmation that its revenue loans due for repayment in 2019/20 have been refinanced leading to and potential breach of the DHSC loan agreements and risk to going concern.	Next 12 months	5x3=15						5x2=10	New	Open
SO7: Finance and Governance	7-3	Finance	There is a risk that the Trust is unable to achieve the required efficiency improvements through the transformation programme leading to an overspend against plan and the potential loss of the £5.1m of Provider Sustainability Funding in the event the Trust's control total is not met.	Next 12 months	4x4=16						3x3=9	New	Open

Strategic Objective	Risk Ref	Committee	Risk Description	Proximity	Risk Score (consequence v likelihood)						Target	Movement towards target (since April 2019)	Risk Appetite
					June 19	Sept 19	Dec 19	Mar 20	June 20	Sept 20			
SO7: Finance and Governance	7-4	Finance	There is a risk that the Trust's guaranteed income contract does not deliver the benefits expected and/or leads to an opportunity cost to the Trust in respect of unfunded activity.	Next 12 months	4x4=16						3x3=9	New	Open
SO8: Workforce	8-1	Workforce	Inability to recruit to critical vacancies	Next 3 to 6 months	4x3=12						4x2=8	Static	Minimal
SO8: Workforce	8-2	Workforce	Inability to recruit to critical vacancies in short term (0-18 months)	Next 3 to 6 months	4x3=12						4x2=8	New	Minimal
SO8: Workforce	8-3	Workforce	Inability to recruit to critical vacancies in medium to long term (19+ months)	Next 3 to 6 months	4x3=12						4x2=8	New	Minimal
SO9: Estate	9-1	Finance	Insufficient capacity in the Neonatal Unit to accommodate babies requiring special care	Next 3 to 6 months	4x3=12						4x2=8	Lower	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	4x4=16						4x3=12	Increased	Minimal
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						4x2=8	Static	Minimal
SO10: Corporate Citizen	10-3	Board	Insufficient preparedness for disruption to workforce or supplies (including medications) following	Next 3 to 6 months	4x3=12						4x2=8	Static	Avoid

Strategic Objective	Risk Ref	Committee	Risk Description	Proximity	Risk Score (consequence v likelihood)						Target	Movement towards target (since April 2019)	Risk Appetite
					June 19	Sept 19	Dec 19	Mar 20	June 20	Sept 20			
			withdrawal from the European Union										

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Board of Directors**	**Date: 10 July 2019**
Report title:	**Significant Risk Register**	**Agenda item: 5.1b**
Lead director **Report author** **Sponsor(s)**	**Kate Jarman**	**Director of Corporate Affairs**
FoI status:	**Public**	

Report summary				
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**Discussion** X	**Decision** ☐
Recommendation	The Board is asked to note and discuss the Significant Risk Register and particularly those risks highlighted for escalation (to the Risk and Compliance Board) and the highest scoring risks for clinical and corporate divisions. The Board is also asked to consider the frequency with which it reviews the SRR – quarterly is proposed initially.			

Strategic objectives links	All strategic objectives
Board Assurance Framework links	
CQC regulations	Good governance
Identified risks and risk management actions	
Resource implications	
Legal implications including equality and diversity assessment	

Report history	The Significant Risk Register will be reported to Board on a quarterly basis.
Next steps	Committee in-depth review of risks.
Appendices	Papers follow.

Significant Risk Register

The Trust has a Significant Risk Register which captures all high-scoring risks (scored at 15 and above using the 5x5 risk scoring matrix – detailed in the Trust's Risk Management Framework). The SRR is reviewed every month and Risk and Compliance Board; with upwards reporting to Executive and Divisional Management Boards.

The SRR is also reviewed against the BAF each month, and risks escalated as appropriate. The SRR is also reviewed at the Audit Committee and the Quality and Clinical Risk Committee – although the frequency with which this occurs will be reviewed.

It has been recommended through recent external review, that the Trust Board has more frequent oversight of the SRR in its entirety. The Board is asked to consider and recommend how frequently it wishes to consider the SRR – this paper proposes quarterly in the first instance to provide assurance.

Top Scoring Risks on the SRR

Medicine

Risk ID	Description	Score
Risk 1917:	ED overcrowding	20
Risk 1896:	Ward 14 lift	16
Risk 2063:	Chemotherapy administration	16
Risk 2656:	Waiting time breaches in ED	15
Risk 2500:	Insufficient space in AMU	15
Risk 725:	Follow-up pathway delays (Cardiology)	15

Surgery

Risk ID	Description	Score
Risk 2679:	Colorectal capacity	16
Risk 2589:	Breast capacity	16
Risk 1830:	Anaesthetic middle grade recruitment	15
Risk 2387:	ENT post-operative access to notes	15
Risk 2645:	OMF/ Orthodontic administrative capacity	15

Risk 2652:	DSU escalation and fire evacuation	15
Risk 2653:	Emergency evacuation DSU/ Theatres	15

Core Clinical

Risk ID	Description	Score
Risk 2742:	Timeliness of therapies reviews on medical wards	20
Risk 2743:	Age of imaging equipment in OPD	20
Risk 2719:	CT scanners	16
Risk 1280:	Cellular pathology unable to meet demand	16
Risk 1458:	Pharmacy staffing levels	16
Risk 2055:	Dietetic office environment	16
Risk 2393:	Insufficient ready-made chemo to meet demand	16
Risk 2533:	Paediatric physiotherapy	16
Risk 2685:	Oncology prescriptions not being ordered in 48 hour timeframe	16
Risk 2763:	Chemical pathology staffing	16

Women and Children

Risk ID	Description	Score
Risk 2570:	Overcrowding and insufficient space in NNU	20

Corporate IT

Note: Two risks graded 25 have been reviewed and regraded to 15; a risk relating to server room fire suppression (2545) has also been de-escalated as work is due to commence to mitigate the risk.

Risk ID	Description	Score
Risk 2674:	EDM poor performance	20
Risk 2779:	MRN number sequencing	20
Risk 2783:	WinPath system	20

Risk Scoring and Training

There is an ongoing programme of work to ensure that managers receive appropriate risk training – including in risk assessments, scoring and grading of risks and risk mitigation. The Trust is undertaking an additional piece of work with its internal auditors to review training provided and ensure materials are as effective as possible – particularly for corporate risk leads. Risks are scored using a standard 5x5 matrix, and risk scores are regularly challenged at Risk and Compliance Board and Executive/ Divisional Management Board. Gaps in the SRR are also challenged at these forums.

The age of the risk is also challenged – with risk owners required to review and resubmit existing risks onto the risk register at least annually. This means that some longstanding risks (that may be inherent risks to running a hospital) have a first-identified date, and an annual date-opened. This ensures risks are both actively managed and are seen to be being actively managed through the risk registers.

Board Action

The Board is asked to discuss the SRR, with questions to relevant executive leads for risk owners/ areas and consider any areas for further reporting and assurance. The Board is also asked to consider the frequency with which it receives the SRR (along with the Audit and Quality and Clinical Risk Committees).

Significant Risk Register

ID	BAF	Opened	Risk Owner	Division	Specialty	What is the risk?	What could Cause the Risk to occur?	What Impact could the risk have on the Trust?	C	L	Inherent Risk Rating	Inherent Risk Level	Controls in place	Assurance on Controls	C	L	Current Risk Rating	Current Risk Level	Gaps in Controls	C	L	Target Risk Rating	Target Risk Level	Treatment Type	Action Plan Summary	Date Risk Last Reviewed	Trend	Trend Rationale	Review Due?
2733		18/01/2019	York, Craig	IT	Information Technology	HSCN provides connectivity to the national NHS network (formally known as N3). It is designed to provide a flexible and modern network to deliver the bandwidth demands of today and ensure future proofing for the needs of tomorrow. It will support a number of IT strategies including use of a number of cloud technologies such as Office 365 and Azure. Without HSCN, the risk to the Trust would be significant and would isolate it from all external bodies, customers and users (including CNWL, NHSD etc)	Not renewing the HSCN Services (formerly N3)	The Trust will be without a connection to the national network. This is currently used for critical functions such as Smartcard authentication, Office365 use, TAC and Azure services.	5	5	25	High / Significant Risk	Discussions with the National NHS Framework Provider to support moving from N3 to HSCN have led to an order being placed with a support supplier, who are planning to deliver the service required		5	5	25	High / Significant Risk	Service yet to be delivered successfully.	5	1	5	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required		21/06/2019	Increased	No change	31/07/2019
2717		18/01/2019	York, Craig	IT	Information Technology	Supported storage for the entire organisation. The SAN is part of critical IT Infrastructure; it hosts every virtual server (around 300) as well as storage for multiple databases and file shares. Without any service level agreement or support the Trust, this will result in a catastrophic failure for all stored media including clinical and business critical data. The current SAN is being operated at risk without any support contract in place.	No support for the Current SAN and a rejected business case for extending the support for the the current storage infrastructre	I significant outage / loss of all clinical and business critcal core applications and data.	5	5	25	High / Significant Risk	A business case was submitted and was declined. IT Currently manually manages the current IT Storage and allocates on need basis.		5	5	25	High / Significant Risk	No business case approved, however one being written. New solution required.	5	1	5	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required		28/06/2019	Increased	New Risk	31/07/2019
2764		17/05/2019	York, Craig	IT	Information Technology	EDM - Poor performance, system crashes EDM. IF the EDM system continues to be unreliable, include poor data quality, and log users out of sessions on a regular basis, THEN the Hospital may be forced to cancel further outpatient clinics LEADING TO a potential loss in income, reputation, and significant operational and staffing-related frustration, stress, and overall a poor patient experience.	The level of support provided by the third party is less than adequate and falls short in terms of their ability to increase the performance or stability despite a drip feed of fixes that are applied.	Poor system performance can adversely impact patient care and experience, particularly in outpatients and pre-operative assessment.	4	5	20	High / Significant Risk	The controls so far have not been effective to provide a level of acceptable performance to the EDM system. The level of support provided by the system supplier has not been sufficient to provide this level of surety. Recommendation that this is escalated to the Trust Exec for discussion with third party provider.		4	5	20	High / Significant Risk	Responsiveness from external provider. Alternative 'back-up' plans currently unconfirmed. Still unknown root causes for poor performance and reliability; system supplier slow to respond to these issues, and requiring significant support overhead from MKUH IT.	3	2	6	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required		06/06/2019	No Change	Increase	31/07/2019
2779		26/06/2019	York, Craig	IT	Information Technology	IF any Clinical/IT systems that use MRNs as the primary patient Identifier do not work with MRNs of 7 digits or more, THEN it may not be possible to complete work for any patient that is newly registered or admitted with that size of MRN, LEADING TO potentially catastrophic impacts on patient care.	MRNs are used sequentially, i.e. when a patient attends the hospital (within any context) that has never been to the hospital before, their new record on eCARE is given a new MRN. There are currently 60,000 MRNs left that are only 6 digits long; at some point a patient will attend MKUH and receive MRN 1000000.	If systems (other than eCARE) cannot handle MRNs that are 7 digits long, it may not be possible to use those systems to support or provide patient care. This could have a significant impact, as these systems include the likes of WinPath, ICE, CRIS, Insignia, Unisoft, Datix, McKesson Cardiology, and many more.	4	5	20	High / Significant Risk	It is expected that there is between 3-9 months until the first MRN is generated that is 7 months long; current expectations are that testing will be completed across all of the systems at risk.		4	5	20	High / Significant Risk	Testing required across a high number of systems	4	1	4	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required		26/06/2019	No Change	New Risk	31/07/2019
2742		05/03/2019	Stamp, Mr Jamie	Core Clinical & Support Services - Clinical Support Services	Physiotherapy	Patients referred to Occupational Therapy and Physiotherapy inpatients covering medical wards are not being seen in timely manner	Insufficient inpatient staff numbers allocated to Wards to manage the referrals	deconditioning of vulnerable/complex patients requiring a short period of therapy, increased length of stay, potential readmission,	4	5	20	High / Significant Risk	Daily prioritisation of patients cross covering and review of skill mix locum cover but have not been successful despite approval		4	5	20	High / Significant Risk	Currently unable to identify suitable locum candidates	2	3	6	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required		10/06/2019	No Change	n/a	09/07/2019

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2743		28/01/2019	Nicholson, Mr Simon	Core Clinical & Support Services - Diagnostic & Screening	Imaging	Loss of Imaging Service to OPD area due to the age of the equipment and that manufacturers have advised EBME that they cannot maintain replacement parts.	The age of the out-dated x-ray equipment.	Patients would not be able to have their Imaging performed in the OPD area causing disruption to patient flow with loss of capacity in OPD clinics and income to the Trust as we would not be able to provide GP imaging	4	5	20	High / Significant Risk	Current equipment is still functioning, further failures may not be repairable. Use of a mobile x-ray machine when breakdowns happen.	Service provided with one x-ray room and a mobile machine,and by sending patients to mainx-ray.This is not good for patient flow and experience.	4	5	20	High / Significant Risk	Equipment identified by EBME - to be prioritised for CBIG. Now below the line.	2	2	4	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required		24/06/2019	No Change	same	10/09/2019
2783		28/06/2019	York, Craig	IT	Information Technology	IF the WinPath system is compromised by cyber attack, fails due to an underlying IT infrastructure failure, or is unsupported by Clinisys beyond the length of the current contract, THEN the access to the system, or the function of the system may be compromised or completely lost, LEADING TO potentially catastrophic impact to patient safety, patient care, and clinical effectiveness.	Either a cyber-attack that compromises the system, an underlying IT infrastructure failure, or a partial or complete failure happening through any other cause that happens when Clinisys stop supporting WinPath.	Potentially catastrophic - loss of access to pathology results, loss of a system that automates a lot of processes that are otherwise arduous and introduce significant overhead, resulting in impact to patient safety, patient care, clinical effectiveness, and negative impact to the capacity and morale of the Pathology department.	5	4	20	High / Significant Risk	Daily reboots of parts of the WinPath system. Regular review of issues and consideration of options for improving stability and performance Regular patching of Windows Server 2008 R2 operating system, security applications in place		5	4	20	High / Significant Risk	New server storage needed, potentially future need for new Path system. New Path system that supports new version of windows server operating system Need to secure support for the system, or replace system	5	1	5	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required		28/06/2019	No Change	New risk	31/07/2019
2545		17/01/2018	Chandler, Ollie	IT	Information Technology	IF Fire Suppression systems are not installed into the two IT hub rooms CDP3 and CDP4 THEN the environment will not be subject to controls should a fire start in the room (which can generate significant amounts of heat at times), LEADING TO potential major losses of IT systems across the Trust including major applications such as file storage, email, department-specific systems, Amalga, EDS, etc.			4	5	20	High / Significant Risk	There is air conditioning in each of the rooms, however this is not considered to be a complete control due to the risk of unexpected fault, sparks etc.	ability to control the server rooms environmental properites is essential and this is the appropriate assurance for the control measure in place.	4	5	20	High / Significant Risk	No fire suppression in place as yet. Estates still implementing, and the fire alarm went off. Brand new solution in place was insufficient, and Fire Service Called as a result. New or improved system required.	4	1	4	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	Write business case	08/05/2019	Increased	Increased	31/07/2019
2570	9-1	19/02/2018	Misra, Dr Indranil	Women's & Children's Health - Children's Health	Neonatal	Overcrowding and insufficient space in the Neonatal Unit	Cot spacing does not comply with BAPM guidance. The Unit is seeking to increase both total cot spacing and cot numbers by 4 HDU/ITU cots in line with Network 5 year projections of acuity and demand, and spacing in line with National Recommendations.	Without the increase in cot numbers and corresponding cot spacing we will be unable to meet patient needs or network requirements. This may result in a removal of Level 2 status if we continue to have insufficient space to adequately fulfil our Network responsibilities and deliver care in line with national requirements	5	5	25	High / Significant Risk	Reconfiguration of cots to create more space and extra cots and capacity Parents asked to leave NNU during interventional procedures, ward rounds etc. Added to capital plan Feasibility study completed	NNU Feasibility study in progress awaiting decision of the Board as to whether to proceed with major reconfiguaration and increased cots to meet TVN demand.	5	4	20	High / Significant Risk	Outline business case for NNU rebuild still to be developed by estates department and submitted to CCG/STP partners for consideration.	3	3	9	Moderate / Unacceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	Approval of business case	15/01/2019	No Change	No change	29/03/2019

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1917	1-1 / 1-2 / 1-3 / 4-1	17/03/2016	McCarthy, Mrs Rachel	Medicine - Emergency Medicine	Emergency Department (A&E)	Lack of flow in the organisation leading to unsafe environmentfor patient care causing overcrowding within ED	ED having more than 50 patients in the department at one time and or dependency of patients being cared for	unsafe environment for patients and staff due to bed space capacity, ambulance queues, missed trust targets and crowding the back ED/radiology corridors creating H+S hazard and these continued pressure reduces training experience for trainees risking poor feedback to deanery and consequences thereof. Trust reputation Delay in treatment, diagnosis and potentially avoidable deaths	5	5	25	High / Significant Risk	1. EPIC consultant in place to aid flow within department and speed up decision making 2. Recruitment drive for more consultants ongoing. Active management of Consultant and Registrar gaps in rota daily to ensure filled. 3. Nursing recruitment: almost up to establishment. 4. RAT-ing process and medical specialty referrals having a RAG system developed to prioritise sickest patients to be assessed. 5. Walking majors and resus reconfigured. Expanded Cubicle space in Majors - extra 10 spaces, increased capacity using Acorn Suite. 6. Internal escalation policy in place. CSU lead developing trust escalation criteria to alert trust leads to problems sooner.	Meeting national targets consistently	4	5	20	High / Significant Risk	Ongoing estates work to improve capacity systems	4	4	16	High / Significant Risk	TREAT - above tolerable level - appropriate cost-effective control required	Escalation Guideline now developed - requires ratification at CIG and assurance of being used operationally develop GP Specialty referral to ED RAG rating protocol CSU lead to develop escalation policy to Trust level for when flow/capacity of ED deteriorates	09/05/2019	Increased	improved flow and reconfiguration	30/08/2019
2055		24/05/2016	Stamp, Mr Jamie	Core Clinical & Support Services - Clinical Support Services	Dietetics	The risk is that the trust is failing in its statutory legal duty under the Health & Safety at Work etc. Act 1974, Management of Health & Safety at Work Regulations 1999, Workplace (Health, Safety & Welfare) Regulations 1992 and Display Screen Equipment Regulations 1992 to provide a safe and well maintained place of work including welfare facilities for staff	There are 26 dietetic staff located in the two portacabins on site	1. Physical and mental wellbeing concerns in relation to staff welfare with potential for sickness absence and potential litigation claims 2. Multiple breaches of statutory and regulatory duties leading to interest from the Health & Safety Executive 3.Enforcement action including formal notices; potential criminal prosecution resulting in fines and/or imprisonment dependent upon the action pursued; loss of Trust reputation; adverse publicity	4	4	16	High / Significant Risk	Due to the number of staff within the area, staff have to share workstations, however, this can mean working in cramped conditions. Mobile air conditioning units were on distributed to the portacabin areas in 2016, but have now been removed. Water coolers are situated in both portacabins, which helps to avoid dehydration on very hot days.		4	4	16	High / Significant Risk	The portakabins may not be suitable from a health and safety perspective, so controls in place only serve to mask the problem	2	3	6	Low / Acceptable Risk	TOLERATE - at lowest practicable /cost-effective level	Risk to be reviewed by the Trust when office staff move to into MK Centre	27/03/2019	No Change	Risk score decreased as felt 20 too high	30/04/2019
2063		07/06/2016	Burnie, Ms Sally	Medicine - Haematology & Oncology	Cancer	The risk is that cancers services will not be able to prescribe, check and administer chemotherapy	Impaired access to aria (the trust electronic chemotherapy prescribing system)	1. Patients will not receive chemotherapy (increased clinical service risk due to increased likelihood of dose omissions and patient harm and errors) 2. Trust wide service delivery failure of cancer services (increased patient harm and error and implications on trust activity and income generation).	4	5	20	High / Significant Risk	Issue remains unresolved, multiple pc points on the macmillan unit, oncology suite and pharmacy department affected.		4	4	16	High / Significant Risk	manual process in emergency plan	4	2	8	Moderate / Unacceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	Options to be reviewed and an action plan to be developed	22/05/2019	No Change	review	10/07/2019

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2071		17/06/2016	Chadwick, Ms Helen	Core Clinical & Support Services - Pharmacy	Pharmacy	There is a risk that patient safety and staff working conditions will be compromised within Pharmacy Cancer and Aseptics Department	Pharmacy cancer & Aseptics team run above safe maximum capacity. Lack of electronic scheduling leads to increased queries and delays further impacting adversly on capacity	Potential rise in patient safety incidents, decline in staff morale, excessive workload pressures, staff recruitment retention issues, delays to patients' chemotherapy treatments, inability to provide chemotherapy treatments and clinical trials, inability to efficiently manage/control high cost drug expenditure and potential closure & decommissioning of services	4	5	20	High / Significant Risk	Controls needed are to limit further increase in chemotherapy activity in the current unit as it is noticeable that monitoring trends continue to deteriorate with extra work under current staffing conditions, but this is not feasible as chemotherapy activity is not within our scope of influence		4	4	16	High / Significant Risk	Figures show the unit has been consistently running above safe maximum capacity since November 2015 Recruitment to business case funded posts has improved capacity since its worst but still does not reach recommended levels. Formal QMS system remains outstanding.	4	1	4	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	staffing review, paper to execs on staffing reconfiguration and business case for aseptic staffing	15/04/2019	Increased	Increased Datix reports	31/08/2019
2393		04/07/2017	Chadwick, Ms Helen	Core Clinical & Support Services - Pharmacy	Pharmacy	There is a risk that there is insufficient ready-made chemotherapy to meet demand	Currently only 3 suppliers of ready-made chemotherapy Insubstantial and fragile capacity within external manufacturing units One supplier has recently had a system outage in 3 of their 4 units resulting in an inability to supply. A second supplier has also cut capacity by 25%.	Delay in patient treatment Loss of patient trust in the organisation and their treatment Delays in processing of orders and turn around times for supply. Increased pressure on MKUH Aseptic Unit to manufacture more in house doses, when capacity for the unit is already above capacity as per EL Audit Increased costs to NHSE. Aggressive behaviour - staff to staff and patient to staff.	4	5	20	High / Significant Risk	Managing closely to identify ahead of time when items may not be available. Identifying opportunities to work overtime and keep on top of demand as needed. Liaising with Doctors to ensure prescriptions are completed in advance and to check stock needs for the week ahead, to allow organising for additional manufacturing to prevent large peaks in workflow. Identifying alternative suppliers. Use multiple suppliers Contingency plan in place should problems arise	There seems to be issues with external suppliers everu 2-3 months. June 19 - Bath ASU has redced its production significantly again. We have spread our workload to other providers.	4	4	16	High / Significant Risk	Market remains volatile. We are exposed to rapid market changes. Aseptic unit continues to work over capacity. cracks in our unit reappearing therefore unable to increase locally made products	4	2	8	Moderate / Unacceptable Risk	TOLERATE - at lowest practicable /cost-effective level		26/02/2019	No Change	Recent external unit failures	19/08/2019
2679	4-2	21/02/2018	Makris, Dr Nikolaos	Surgical - Surgery	General Surgery	There may be problems appointing Colorectal service patients within the government target of 2 weeks due to increasing demand on Colorectal Services. Routine patients are not being seen in an attempt to accommodate 2WW patients	Increasing demand on colorectal services and failure to improve current capacity in Colorectal clinics due to insufficient colorectal consultant numbers	Potential for missed diagnosis, poor patient experience, increased complaints/claims. This will also have financial implications the Trust.	4	5	20	High / Significant Risk	1+Every thursday the operational manage, cancer manager and PPC meetins with the cancer lead and reviews all capacity/ and identify or slots or capacty for patients to be seen. However this is reliant on admin time being paid and good will. Routinely placing 2WW patients I follow-up clinics. Staff grade doing one extra clinic per week	RTT position - weekly meetings. 21/02/19 - team reports that there is still a significant number of patients on the RTT list.	4	4	16	High / Significant Risk	- Service is unable to meet increasing demand on service. - Inability to appoint patients within the government target of 2 weeks.	4	2	8	Moderate / Unacceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	Review of Colorectal Service	19/06/2019	No Change	ongoing risk	17/07/2019
2685		11/10/2018	Chadwick, Ms Helen	Core Clinical & Support Services - Pharmacy	Pharmacy	Precriptions from MacMilian and Oncology are not sent down with at least 48hrs notice in advance.This will result in the deadlines to order from our outsourced supplier will be missed.	Defect in Pharmacy Aseptic Unit. See Risk 1628. Pharmacy Not not able to deliver efficent chemo service for patients to meet trust expectations	Late orders impact on scheduled patient treatment and late delivery of chemo treatment to patient. Longerwaiting times fo patient, chemo dispensing errors as staff working under pressure to deliver chemo on time	4	4	16	High / Significant Risk	High levels of Pharmacy resource used to chase prescriptions Advice given to MacMillan unit about appropriate booking times Outsurce to provider with 1 day turnaround Consultants / MacMillian unit reminded frequesntly of need for 48 hours notice	All prescriptons are logged and checked into the department and when orders are submitted, tracking easily those that are late Audit in April 2019 demonstarted a significant number of prescriptions still come to Pharmacy with less than 48 hours notice. Review of Datix indicates numerous issues and complaints about late deliveries	4	4	16	High / Significant Risk	Pharmacy have covered off the gaps they can. Change in prescribing practice required to fill gaps. lack of electroni scheduling system contributes to delays in aptient treatment	2	1	2	Very Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required		20/05/2019	No Change	No change in prescribing practices	15/07/2019

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2589	4-2 / 8-1	21/02/2018	Taylor, Ms Amanda	Surgical - Surgery	Breast Surgery	There may be problems appointing breast care service patients and symptomatic patients within the government target of 2 weeks due to insufficient consultant numbers	Failure to improve current capacity in breast clinics due to insufficient breast consultant numbers	Potential for missed diagnosis, poor patient experience, increased complaints/claims. This will also have financial implications the Trust.	4	5	20	High / Significant Risk	There is now a wednesday stand up meeting with radiology/ nursing/ consultants to review capacity. 1 - Recruitment of consultant breast surgeon - a third Consultant is to be in post from November. 2 - An agreement to progress an associate specialist locum post to help out service. 2 - Additional ad-hoc clinics taking place. 3 - Using the availability of radiologists and radiographer. 4 - 2nd Radiologist starting 25th November 5 - Radiologists both in post as at Jan 2017 6 - Service to consider appointing 4th Consultant.	RTT position - weekly meetings. Service is running additiional clinics to address capacity and demand. 20/03/19 - There are 30 new patients this week. reviewed. Anticipation of issues with Bedford closing.	4	4	16	High / Significant Risk	Service unable to meet capacity and demand for 2 ww patients	4	2	8	Moderate / Unacceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	appointment of Breast Consultant	19/06/2019	Increased	ongoing risk	17/07/2019
1280		28/05/2014	Beech, Jill	Core Clinical & Support Services - Diagnostic & Screening	Pathology	There is a risk that the Cellular Pathology Laboratory will not be able to meet the demands on the laboratory service.	An unprecedented increase in the number laboratory tests needing to be performed on samples and an insufficient number of scientific and support staff to cope with this increase. In addition enhanced IQC / governance procedures introduced to meet accreditation requirements reduces the number of blocks cut per hour.	1. An increasing delay in the turnaround time of diagnoses owing to histopathologists not receiving work in a timely fashion from the laboratory. 2. Histopathology microtomy backlog of 'routine'(non-urgent)specimens from endoscopy, dermatology, colposcopy and surgery. 3. The unavailability of some specimens for reporting by pathologists. 4. The possibility of unexpected malignancies within the backlog. 5.Priority of microtomy work over other essential tasks i.e. Governance, training, preparation for ISO 15189 accreditation 6.Failure to meet urgent and routine KPI targets 7.More samples are	4	5	20	High / Significant Risk	Staff are offered overtime, which a small number take up for short periods. This is not adequate nor sustainable Prioritisation of clinically urgent and 2WW specimens. Prioritisation of microtomy over other laboratory governance tasks. BMS cut up and biopsy transfer takes precedent over other BMS roles, lack of backfill is compounding the capacity. Where possible locum and bank staff are utilised	Available turnaround figure demonstrate some improvement, however TATs are not met.	4	4	16	High / Significant Risk	Vacancies have been appointed to - not all in post are fully trained. Rotation of staff proving difficult due to capaciy pressures. Increasing workload is sustained and a business case for additional laboartory staff resource is written and awaiting approval	3	2	6	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	Appoint to AP and Band 7 vacancies Appointment to vacant band 6 post Develop business case for additional staff resource in Cellular Pathology Submit short business case for presentation to EDs complete business case for additional resource	14/05/2019	No Change	Additional workload sustained	11/06/2019
1458		21/11/2014	Chadwick, Ms Helen	Core Clinical & Support Services - Pharmacy	Pharmacy	Pharmacy staffing levels falling below requirements to effectively deliver services and to run the pharmacy (clinical & technical)THEN patient safety will be compromised	1. Pressures from various staff departures, absence/long term sickness, maternity leave 2. Impact of failed recruitment 3. Time lag from interview appointment to start date for replacements	A rise in patient safety incidents, 1.decline in staff morale, 2.excessive workload pressures on staff 3.absence of pharmacy visits on wards for prescription surveillance and intervention 4.delays to discharges, inpatient and outpatient medication requests 5.varied support for transformational plans, directorate & divisional requests, difficultly managing the drug budget and ensuring compliance to the commissioning requirements for use of HCDs to ensure reimbursement	4	4	16	High / Significant Risk	1. Use of temp or agency staff to allow pharmacy to keep up with some of the demands of the service		4	4	16	High / Significant Risk	Staffing levels too low to support service delivery	4	4	16	High / Significant Risk	TREAT - above tolerable level - appropriate cost-effective control required	Business case to be developed	20/05/2019	No Change	Likelihood felt certain. Raised to 16	15/07/2019

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1472	1-4	08/12/2014	Ewers, Mr Paul	Corporate Affairs	Risk Management	There is a risk that not all known incidents, accidents and near misses are reported onto Trust Incident Reporting System (Datix) and that they will not be robustly investigated within the required timescales	Failure to comply with the Incident Reporting Policy; Poor incident reporting culture; Lack of understanding of the necessity and importance of reporting incidents; Lack of incentives to report incidents due to lack of feedback or poor quality investigation outcomes; Lack of consequences for failing to report; Lack of consequences for poor quality investigations; Lack of computer access to report incidents; Conflicting priorities and lack of time to report; Perceived difficulty in completing the online incident reporting form	The Trust will not have a complete list of incidents occurring in the Trust; Inability to learn from incidents, accidents and near-misses; Inability to stop potentially preventable incidents occurring; Potential failure to comply with Duty of Candour legislation requiring the Trust to report all known incidents where the severity was moderate or higher; Potential under reporting to the National Reporting & Learning System (NRLS); Potential failure to meet Trust Key Performance	4	5	20	High / Significant Risk	1. Incident Reporting Policy 2. Incident Reporting Mandatory/Induction Training 3. Incident Reporting Training Guide and adhoc training as required 4. Datix Incident Investigation Training sessions 5. Daily review of incidents by Risk Management Team to identify potential Serious Incidents and appropriate escalation 6. Serious Incident Review Group (SIRG) ensure quality of Serious Incident Investigations 7. SIRG ensure appropriate reporting of Serious Incidents to Commissioners 8. Staff able to have automatic feedback following investigation approval 9. Incident Reporting Awareness Campaign - September 2017	1. Risk Management Dashboard monitoring trends 2. Weekly overdue incident reporting 3. Routine and exception reports to Risk & Compliance Board 4. Weekly Compliance Report to Executive Team 5. Incident reporting rate and overdue incidents monitored through Trust KPIs 6. Regular reporting to Divisions through Clinical Governance reports 7. Divisional	4	4	16	High / Significant Risk	1. Lack of a high incident reporting culture 2. Lack of robust investigations for non-Serious Incidents 3. Lack of feedback to reporters/staff following incident investigations 4. Staff lack access to a computer to report incidents 5. Staff lack time during shift to report incidents	4	3	12	Moderate / Unacceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	Comms Initiative being developed to coincide with launch of simpler incident reporting form and enhanced Incident reporting training at Induction/Mandatory Training - Complete Quality Improvement Project to be undertaken Recruitment of two new band 7 facilitators - complete Launch the 'SHARE' Incident Reporting Campaign with Comms Team - Complete Letter re-iterating the importance of incident reporting to be sent from CEO via wage slips - Decision made not to undertake - Complete Incident Reporting Handbook for staff to coincide with 'SHARE' launch to be developed - Decision made not to undertake - Complete Consider the increase of accessibility to computers in	23/05/2019	No Change	No change since last review	31/07/2019
1519	7-3	25/02/2015	Keech, Michael	Finance	Financial Management	There is a risk that the Trust is unable to achieve the required efficiency improvements through the transformation programme leading to an overspend against plan and the potential loss of the £5.1m of Provider Sustainability Funding in the event the Trust's control total is not met.	Transformation delivery is not adequately resourced and prioritised and/or schemes are unrealistic and not well planned.	The Trust may not deliver its financial targets leading to TO potential cash shortfall and non-delivery of its key targets	5	4	20	High / Significant Risk	1. Tracker in place to identify and track savings and ensure they are delivering against plan 2. Savings measured against Trust finance ledger to ensure they are robust and consistent with overall financial reporting 3. All savings RAG rated to ensure objectivity 4. Oversight of the transformation programme through the Transformation Programme Board and Management Board.	1. Divisional CIP review meetings in place attended by the DoF, divisional managers and finance business partners. 2. Cross-cutting transformation schemes in place with dedicated programme resource. 3. Savings plan for 19/20 financial year not yet fully identified."	4	4	16	High / Significant Risk	Further saving schemes to be identified to deliver maximum savings in 2019/20	3	3	9	Moderate / Unacceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required		10/06/2019	Decreased	Schemes still need to be worked up	10/07/2019
1593		05/05/2015	Eagles, Phil	Estates	Estates	IF the Trust Fire Doors are not regularly surveyed and remedial works funded THEN remedial work not being completed to required standards LEADING TO failure to meet current safety standards	Insufficient funding of survey and remedial work		4	5	20	High / Significant Risk	1. General maintenance programme in place for repairs. 2. Replacement programme in place, capital approved 19/20, to progress 1st phase of work. 3. A new maintenance, audit and inspections programme has been re-tendered. A new audit and prioritation to be established for 2019 onwards, with prioritised areas as discussed at Management Board July 2019. 4. Capital bids for 19/20 have been approved and 20/21 to support rolling programme. 5. Survey of Hospital Streets completed, awaiting report of 1600 non street doors. Funding on rolling program. 6. Costing of outstanding works to be completed and funding to be agreed. 7. Plant Room Doors surveyed.	Health & Safety Committee External Fire Officer Management board aware of business case and future program of work.	4	4	16	High / Significant Risk	1. No appointed contractor, new contract to be tendered and appointed. 2. Implementation strategy with prioritisation to be provided to Trust Board for Sept 2019.	4	2	8	Moderate / Unacceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	Tender to be started for new rolling program Fire Door work year 5 of 5 year programme approval given and works about to commence (Until March 2017)	29/05/2019	No Change	ONGOING RISK and works	01/07/2019

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1594		05/05/2015	Eagles, Phil	Estates	Estates	IF the Trust Fire Compartmentation are not surveyed and remedial works funded THEN remedial work not being completed to required standards LEADING TO failure to meet current safety standards	Insufficient funding of survey and remedial work.		4	5	20	High / Significant Risk	1. Annual fire inspection with Fire Authority. 2. Capital money set aside. 3. Capital bids for 19/20 and 20/21 rolling program. 4. High risk areas prioritised i.e. pantry /ward areas 5. Re-inspection of Plant Room completed and ongoing audits. 6. All areas audited to maintain compliance ongoing.on an ongoing 7. Works complete in plant rooms Phase 1	Health & Safety Committee External Fire Officer	4	4	16	High / Significant Risk	Awaiting approval of business case. Funding needed for identified areas from survey Identified works in Plant room phase 2 works to be completed. Outpatients to be inspected Inspection of sub compartments to be completed. Quote to be received for other areas to be progressed.	4	2	8	Moderate / Unacceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	Approval given for phase 3 of plan in 2018, further works to be planned in future years	29/05/2019	No Change	ONGOING RISK and works	01/07/2019
1595		05/05/2015	Eagles, Phil	Estates	Estates	IF the Trust Fire Dampers are not surveyed and remedial works funded THEN remedial work not being completed to required standards LEADING TO failure to meet current safety standards	insufficient funding of survey and remedial works		4	5	20	High / Significant Risk	1. Capital money set aside. 2. Specification has been drawn up by Oakleaf 3. Surveys Phases 1 & 2 both levels have been completed. 4. Capital bid to be placed on next 2/3 years capital program 19/20 & 20/21 £195K 5. Business case sent for approval for next phase of works.	Health & Safety Committee External Fire Officer	4	4	16	High / Significant Risk	Phase 3 to be identified by Fire Safety Officer and Estates Manager. Remedial works as result of survey to be specified and addressed. Funding to be agreed	4	2	8	Moderate / Unacceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	Approval given for phase 3 of plan in 2018, further works to be planned in future years	29/05/2019	No Change	ONGOING RISK and works	01/07/2019
1632		17/06/2015	Brown, Mark	Estates	Estates	IF the Trust does not invest in replacing existing emergency lighting across the Trust THEN the Emergency lighting may fail in the event of local power failure LEADING TO poor patient experience and safety, no compliance with regulation, loss of reputation	Age of existing fittings and lack of previous investment.		4	5	20	High / Significant Risk	1. Wards and main streets completed in year 2. Bid to Capital planning for 19/20 funding approved. 3. Future investment requirements identified by PPM , reactive maintenance and Estates Specialist Officer 4. PPM checks in place with regular testing by direct labour. 5. Capital bid to be placed on next 2 years capital program 19/20 & 20/21	No major issues raised by external fire assessment that have not been addressed.	4	4	16	High / Significant Risk	Following recent Wards and main streets completed there are a number of failed units that require replacing.	4	2	8	Moderate / Unacceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	Revisit implementation of phase 3 areas to be identified for 2016/17 and implemented Wards and main streets completed in year 1 of 2 year program. Remaining identified areas to be completed.	29/05/2019	No Change	ONGOING RISK and works	01/07/2019
940	7-4	21/09/2012	Keech, Michael	Finance	Financial Management	There is a risk that the Trust's guaranteed income contract does not deliver the benefits expected and/or leads to an opportunity cost to the Trust in respect of unfunded activity."	1. Inability to put into place demand management to manage activity to contratced values.	Negative impact on Trust cash-flow and ability to meet financial obligations	4	5	20	High / Significant Risk	"1. Clearly defined monitoring of the monthly activity performance with lead commissioner 2. Escalation of issues to senior managers within the Trust. 3. Newly established joint executive contract mobilisation group to assess activity and performance and monitor the delivery of joint initiatives."	1. Clearly defined monitoring of the monthly activity performance with lead commissioner 2. Escalation of issues to senior managers within the Trust. 3. Newly established joint executive contract mobilisation group to assess activity and performance and monitor the delivery of joint initiati 4.Updates reported to the F&I Committee and Trust Board on a monthly basisves.	4	4	16	High / Significant Risk	The Trust to continue to work closely with the CCG on demand management solutions.	3	3	9	Moderate / Unacceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	Maintain dialogue with CCG re Contract Raise risk of dispute over interpretation of Contract with Monitor	10/06/2019	Increased	Increased due to change in contract	10/07/2019
1780		15/12/2015	Gill, Christopher	Estates	Estates	IF fire doors around the Trust are being propped open inappropriately THEN there is a risk in the event of an alarm, fire/smoke will not be contained LEADING TO risk of harm or death to patients, staff and visitors.			4	4	16	High / Significant Risk	1. Staff Training. 2. Audits 3. Risk based assessments. 4. Local Fire evacuation drills		4	4	16	High / Significant Risk	Audit of hold open devices, subject to business case approval for ward kitchens Business case to be created	4	1	4	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required		29/05/2019	No Change	ONGOING RISK and monitoring	01/07/2019

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1830	7-1 / 8-1 / 8-2	15/01/2016	Shamsuddin, Dr Wassim	Surgical - Anaesthetics & Theatres	Anaesthetics	There is a risk that the Anaesthetic Team will be unable to provide an adequate Anaesthetic service due to recruiting or retaining middle grade anaesthetic doctors	Inability to recruit or retain middle grade anaesthetic staff	This will result in potential patient safety incidents, meeting targets, decreased patient and staff satisfaction, increased complaints and possible litigation.	4	4	16	High / Significant Risk	Preventative: Appointment of 2 anaesthetists Use of Locum staff to cover remaining gaps in rota Detective: Monitoring of rotas Monitoring of reported incidents where patient care compromised due to staffing levels Contingency: Interview took place 02/05/18 - potential to appoint 2 middle grades - who could be in post by end of May. Recruitment drive to employ substantive anaesthetic staff Use of existing staff to cover gaps in rota 17/10/2018 - Currently have 5 in pre-employment and 3 waiting to start (within next 3 months) Currently filling gaps with locums	Update 19/06/19 1 member of staff in pre-employment - part time middle grade. 1 in recruitment process. Gaps in the rota continue therefore risk to remain at current rating and level. Recruitment continues to be an issue for the service despite interviews and on-going recruitment processes. By the end of this calendar year there will be a reduction in middle grade staff from 10 to 5(50%). Risk therefore has	4	4	16	High / Significant Risk	There is change in recruitment. There are 300 sessions without cover - Although there are two new starters - 1 MTI and 1 MG, from January there will be 1 vacancy from January 2019, and 2 registrar gaps from Feb 2019 (Mat leave and Deanary) There is insufficient anaesthetic staff to support the service - awaiting appointment Use of locum staff increases safety risk for patients	4	3	12	Moderate / Unacceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	3 anaesthetic staff to be in post	19/06/2019	No Change	Ongoing recruitment issue	17/07/2019
1879		17/02/2016	Beech, Jill	Core Clinical & Support Services - Diagnostic & Screening	Pathology	There is a risk that the flat file structure of the WinPath LIMS system will leave the Trust vulnerable to virus infiltration	WinPath Laboratory Information System (LIMS) is not upgraded to Version 7 Enterprise	Potential reliance on paper based / manual systems to process reporting of laboratory testing and potential extended LIMS downtime / corruption of patient records	4	4	16	High / Significant Risk	Pathology & IT contingency plans Daily backup of pathology systems Work to place pathology in a protected zone progressing	Protective zone (DMZ) established.	4	4	16	High / Significant Risk	WinPath Version 7 Enterprise offers a robust solution but cost is prohibitive Current server is reaching capacity and migration to new survey is urgently required	4	1	4	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	Replacement of current LIMS server and migration of data Oversee migration of current LIMS system to new server and subsequent service pack upgrade Explore with IT department way forward to mitigate risk in absence of full upgrade to Enterprise V7	14/05/2019	No Change	Server is reaching capacity	11/06/2019
1896		04/03/2016	Pickard, Margaret	Medicine - Acute Medicine	Care of Elderly	Ward 14 lift not fit for purpose	Breakdown of current lift Fire Emergency evacuation	patient safety, with potential litigation implications(inquest/claim)or a serious complaint, or a claim under equality and discrimination patients cannot be evacuated easily in the event of ill health, fire or transfer, physically impaired staff and visitors are discriminated against and may not be able to reach the ward or exit the ward Unable to transport patients in or out of the ward Unable to supply hot food Inability to transfer out rubbish and linen leading to an infection prevention and control risk Inability to deliver supplies from procurement without manual handling risks, putting staff at risk	4	4	16	High / Significant Risk	SOP - Operational Contingency procedure for patient food preparation for the ward in the event of a lift failure. approved at RCB 14/3/16 Estates looking at feasibility for reserve lift.	No issues reported in last 6 months	4	4	16	High / Significant Risk	Awaiting Estates review for lift solution. Even with controls in place health and safety risk remains to staff as need to pass hot heavy meal trays up the narrow stair case and operate the swipe only door access at the top. Increased risk of trips and falls harm (litigation possible)	3	2	6	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	Estates to review feasibility of reserve lift to Ward 14 Manual Handling advisor to review risk to patients, visitors, staff access and food/waste delivery procedure if lift breaks (inc. training/risk reduction)	21/05/2019	No Change	no change	31/12/2019

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2778		25/06/2019	Blakesley, John	Estates	Strategic Modernisation Programme	PATHWAY UNIT PROJECT There is a risk that there will be a lack of support for modernisation	1. Lack of project manager and lack of structure for the outpatient reconfiguration project. Relocation of Maple Unit Outpatients Service. 2. If there is a failure to engage with and involve stakeholders	Reduced buy-in causing delay to proposals	4	4	16	High / Significant Risk	Outpatient Reconfiguration Porject is out of scope of SMP Board.	None Identified	4	4	16	High / Significant Risk	1. Project Initiation Document (PID) needs developing 2. Appointment for dedicated Project Managers for the outpatient reconfiguration project 3. Terms of reference required for Outpatients Reconfiguration Project. 4. Conflicting priorities makes it difficult for project team members to attend on a regular basis	4	1	4	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required		25/06/2019	No Change	New Risk	30/09/2019
2735		18/01/2019	York, Craig	IT	Information Technology	IF the internal Trust telephone systems are not upgraded, THEN they will fall into a state where they cannot be supported by the Trust's IT Department or any third-party suppliers, LEADING TO potential loss of telephone systems either in small areas or across the Trust. This would have a significant impact upon operational procedures, especially during critical or busy periods.	Failure of the telephone system, communications being lost across critical areas.	As system versions get older, the likelihood of there being reliability issues increases, the cyber security threat increases, and the risk that telephone system suppliers stop supporting the system increases.	4	4	16	High / Significant Risk	Submission of business case to further enhance the Cisco Equipment.		4	4	16	High / Significant Risk	An upgrade is required, that currently is not funded; business case put to Capital governance process, and project has been prioritised too low to receive funding this FY.	4	1	4	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required		11/06/2019	No Change	Major impact	09/07/2019
2719		23/01/2019	Nicholson, Mr Simon	Core Clinical & Support Services - Diagnostic & Screening	Imaging	CT scanners fail to provide service due to technical obsolesence, high failure rates due to breakdown, an inability to provide the range of scans now required by an acute hospital and the utilisation of high radiation dose rates	Age of CT scanners	Loss of CT service	4	5	20	High / Significant Risk	Running service using current equipment. 50 CT scans per week going to IDC. Extra appointment slots between 5 and 5.30pm by moving meal breaks. Cannulation outside scan rooms.	KPI's and RTT	4	4	16	High / Significant Risk	Patients are being scanned at IDC	2	2	4	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required		24/06/2019	No Change	n/a	02/01/2020
2533	5-4	20/12/2017	Stamp, Mr Jamie	Core Clinical & Support Services - Clinical Support Services	Physiotherapy	The risk is that the paediatric physiotherapy team continue to book patients via TYNDALE and not EPR	The lack of IT network in the offsite base at Stony Stratford Health Centre	1. The data collected for this service will remain inadequate and there 2.The system could fail 3. The service being without a booking system and inadequate data which cannot be captured in the same way as EPR. 4.Reception staff are also using two systems (EPR and TYNDALE) to book patients and this leaves the services vulnerable for the future phases of EPR rollout which will include Paediatrics	4	4	16	High / Significant Risk	Options are still being explored to repatriate staff back to MKUH but there is currently no space on site to support the outpatient clinics. This has been agendered on the Space Committee. A business case has been submitted by IT for off site bases to be supported to enable MK networks rather than relying on existing GP networks which cannot support EPR. This has not been approved at this stage. If TYNDALE stops working we would need to introduce a manual booking system which carries a significant risk for patients using the service.		4	4	16	High / Significant Risk	If Tyndale fails or cannot be access then there is no electronic way of booking paediatric patients for the physiotherapy other than a manual option. A manual option will present risks and patients may get missed, this will also increase workload and the system will be ineffcient.	2	2	4	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required		20/05/2019	No Change	no change	17/06/2019

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2763		16/05/2019	Beech, Jill	Core Clinical & Support Services - Diagnostic & Screening	Pathology	There is a risk that the Chemical Pathology department will not be able to sustain a full 24/7 service due to reduced staffing levels	The service is not adequately staffed by appropriately trained biomedical scientist and support staff as a result of recent vacancies and maternity leave	1.An inability to provide an effective out of hours chemical pathology laboratory service as necessary for the acute hospital service. (NOTE it is recognised that that a minimum of 12 filled rota positions is required for staff wellbeing in the medium-long term). 2.Increased turnaround times for laboratory testing 3.Delays in staff training and competency assessments 4.Delays in implementation of equipment refresh and associated service development 5. compromised management of governance and maintenance of ISO 15189 / Blood Safety and Quality	4	5	20	High / Significant Risk	Use of bank staff where possible Band 8 staff member supports out of hours service Resilience arrangements are in place to cover unexpected out of hours absences Rapid recruitment is underway Special measure in place when number od staff available for out of hours work falls below 10		4	4	16	High / Significant Risk	0	2	2	4	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required		05/06/2019	No Change	0	11/06/2019
2780		26/06/2019	York, Craig	IT	Information Technology	IF the use of temporary access cards continues without review, THEN issues currently experienced associated to their use will continue or worsen, LEADING TO risk to patient safety, patient care, and clinical effectiveness.	Excessive use of temporary access cards without robust controls in place to manage them.	Issues with Pathology and Radiology not knowing who has made requests from eCARE, issues within eCARE with unknown staff documenting and an unclear audit trail across clinical documentation.	3	5	15	High / Significant Risk	Temporary staffing office run the process during the day, site office run the process overnight and weekends.		3	5	15	High / Significant Risk	More robust process that prevents excessive use of temporary access cards.	3	2	6	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required		26/06/2019	No Change	New risk	31/07/2019
2781		26/06/2019	York, Craig	IT	Information Technology	IF Next Of Kin functionality in eCARE that allows staff to unintentionally and incorrectly update a patient record is not fixed by CERNER, THEN patient records will continue to be incorrectly changed/modified (including Names, DOB, Gender, Address, Telephone number), LEADING TO impacts upon patient care, patient safety, and clinical effectiveness.	Poor/broken functionality within eCARE that Cerner have, since September 2018, been unable and unwilling to resolve.	Serious, real impact to patients when their record is subject to being incorrectly and unintentionally modified, leading to letters being sent to the wrong patient, or patients not being identified correctly during their episode of care.	3	5	15	High / Significant Risk	There is a pop-up that is presented to the member of staff that is completing the registration of the child in the system.		3	5	15	High / Significant Risk	The pop-up still allows staff to unintentionally make changes to someone else's record	3	1	3	Very Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required		26/06/2019	No Change	New risk	31/07/2019
2773		13/06/2019	York, Craig	IT	Information Technology	IF the IT Server Storage fills up, fails partially, or fails completely due to its age, THEN many of the IT systems used by the Trust could be lost at once at least temporarily, if not permanently, LEADING to direct impact on patient safety, experience, and clinical effectiveness.	The age of the IT Server Storage platform is over 5 years - this is the age at which the likelihood of a failure increases significantly. This likelihood increases even further should the storage have been running at over 85% capacity for more than a few days at a time; the Trust's server storage has been running at over 90% capacity for a number of months.	A loss of many of the critical IT Systems used across the Trust, including those in use in Pathology, Endoscopy, Radiology, and risk and incident management (WinPath, Unisoft, ICE, CRIS, DATIX, and many more)	5	3	15	High / Significant Risk	Extended overhead with the IT Department, additional ad-hoc expenditure to ensure there is a stock of small replacements, constant capacity review and migration work to reduce the performance burden on the hardware		5	3	15	High / Significant Risk	Support Contract Hardware replacement	5	1	5	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required		13/06/2019	No Change	New Risk	13/09/2019

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2736		18/01/2019	York, Craig	IT	Information Technology	IF the Cisco Network Maintenance contract currently provided by BT is not renewed, THEN there will be a lack of expertise to respond to any future technical faults on the IT Network, LEADING TO extended periods of downtime with no access to any IT resources, including eCARE.	Failure of Communication systems and equipment, resulting in communications being lost across in critical areas.	Without this maintenance contract, waiting time for replacement parts up to 6 weeks (i.e. a loss of up to half of the hospital's IT access for 6 weeks) and we would have to pay tens of thousands for the parts. This would affect business critical areas and potential to all Trust employees.	5	4	20	High / Significant Risk	Submission of business case to provide this level of service with the vendor.		5	3	15	High / Significant Risk	Order to be raised against revenue	5	1	5	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required		21/06/2019	Increased	Decreased slightly	31/07/2019
2740		04/02/2019	Ahmed, Ayca	Estates	Capital Planning	The current bleep system (main system A and back-up system B) is obsolete and no maintenance support contract is available from the company. The risk is that the equipment may not be able to be repaired if failed.	the equipment failure	failure of the current bleep system will have impact on patient care due to clinicians not being contacted via the bleep system	5	4	20	High / Significant Risk	-DISCUSSED WITH LINE MANAGER AND ESCALATED -TEMPORARY RADIO COMMUNICATION SYSTEM 3. User group formed with IM & T & EBME to identify options		5	3	15	High / Significant Risk	Identify costs of possible solutions and create business case.	5	1	5	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required		29/05/2019	No Change	new risk	30/09/2019
2752		17/04/2019	Keetch, Mr Greg	Core Clinical & Support Services - Diagnostic & Screening	Screening Services	Loss of income owing to losing diabetic eye screening programme to an external provider in 2021	Notice has been given that all diabetic eye screening programmes have been given notice of a tender process with the contract being awarded in September 2020 with the new service commencing in April 2021	A loss of income to the trust in excess of 1.25M	3	5	15	High / Significant Risk	Currently following the tender process and will be attending the market engagement event on 15 May 2019		3	5	15	High / Significant Risk	there will be no changes to this risk until the result of the tender process is known in April 2020	3	5	15	High / Significant Risk	TOLERATE - at lowest practicable /cost-effective level		01/05/2019	No Change	no trend	01/04/2020
2753		18/04/2019	Hyem-Smith, Ms Celia	Core Clinical & Support Services - Clinical Support Services	Physiotherapy	Cumulative stress to necks and shoulders. Contributing to and/or exacerbating existing musculoskeletal disorders.	Non-adjustable screen height of WoWs	Health and Safety, financial and legal implications	4	5	20	High / Significant Risk	Templates are being re-structured to factor rest breaks into the working day. Removal of drug drawers to ensure, wherever possible, that posture remains uncompromised. Replacing WoWs with desktops where space allows within treatment cubicles		3	5	15	High / Significant Risk	No alternative to WOWs for the adoption of eCare	2	2	4	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	To fund adjustability of WOWs	10/06/2019	No Change	n/a	09/07/2019
1874		11/02/2016	Tait, Michaela	Directorate of Patient Care	PPI	The MUST conformance criteria were set out in the NHS accessible information specification for compliance by the 31st July 2016	The Trust currently cannot meet all of requirements set out in this specification which is driven by the NHS England, the Equality Act 2010 and Care Act 2014 to ensure patients with a disability are not discriminated against.	1. The CCG as part of the Quality Schedule 2. The CQC recognise the role of this standard as an indicator of high quality care for people with particular information and communication support needs and will be included as part of their inspections of a service. 3. A workstream to the patient led assessment of the care environment (PLACE). Identiication of non compliance could lead to an enforcement action from any of the above performance monitoring stakeholders.	3	5	15	High / Significant Risk	Some of the meeting individual needs resources identified i.e.BSL sign language interpreters, braille, easy read Ongoing EPR agile preparation events E Care launch plan in progress	Patient Experience team are working with external providers and will be picked up as part of the Quality Account	3	5	15	High / Significant Risk	Go live date agreement for EPR - Cerner have confirmed that the system will allow the required alert flags etc. Equality and Diversity Trust legal requirements to be identified, documented in policy and staff advised. This impacts on all policies and guidelines. Interpreting and translation policy - contract now agreed Gap analysis of patient information (sits with Patient Experience) - what is available?	3	2	6	Low / Acceptable Risk	TOLERATE - at lowest practicable /cost-effective level	Steering Group to monitor progress Review of proces for patient information publication & availability	28/02/2019	No Change	First review	28/08/2019

Significant Risk Register

ID	BAF	Opened	Risk Owner	Division	Specialty	What is the risk?	What could Cause the Risk to occur?	What Impact could the risk have on the Trust?	C	L	Inherent Risk Rating	Inherent Risk Level	Controls in place	Assurance on Controls	C	L	Current Risk Rating	Current Risk Level	Gaps in Controls	C	L	Target Risk Rating	Target Risk Level	Treatment Type	Action Plan Summary	Date Risk Last Reviewed	Trend	Trend Rationale	Review Due?
1185	5-4 / 5-5	01/10/2013	Keech, Michael	Finance	Financial Services	"There is a risk that the constraints on the NHS capital expenditure limit (CDEL) lead to delays in the Trust receiving its approved capital funding or other restrictions being placed on the Trusts capital programme."	1. All NHS organisations are being asked to review their financial plans to improve the financial performance; 2. MKUHT and other trust's with significant deficits are being spedifically tasked to justify/improve their financial plan; 3. Capital programme approved in principle but capital loans cannot be put in place until annual revenue plan is approved. 4. Capital bids over £15m must be pre-approved by NHSI	Quality, health and safety risk from not replacing assets at end of useful life and risk of lack of innovation from lack of investment in new technology	5	5	25	High / Significant Risk	"1. Annual plan re-submitted to include only approved capital loans from DHSC. Funding sources identified for other schemes. 2. Capital prioritisation process in place (through the Trust's Capital Control Group (CCG) and Clinical Board Investment Group CBIG) to ensure the Trust prioritises its capital schemes within the scarce resources effectively."	"Capital Expenditure is reviewed at the monthly Capital Control Group and the Management Board"	5	3	15	High / Significant Risk	Further understanding needed on the national capital position and potential consequence for the Trust."	4	3	12	Moderate / Unacceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	Options on EPR to be developed Continuing dialogue with NHSI regarding 2016/17 funding Confirmation of outstanding requirement for December 14 to March 15 - COMPLETE	10/06/2019	Increased	Awaiting approval	10/07/2019
1188	7-2	01/10/2013	Keech, Michael	Finance	Financial Services	There is a risk that the Trust does not receive timely confirmation that its revenue loans due for repayment in 2019/20 have been refinanced leading to a and potential breach of the DHSC loan agreements and risk to going concern.	1. MKUHT and other trust's with significant deficits who have revenue loans do not get support from DH to defer the repayment	Inability of the Trust to continue to operate at its current level	5	5	25	High / Significant Risk	"1. NHSI and DHSC are aware that the Trust is unable to make its revenue loan repayments; 2. DHSC has confirmed that refinancing decisions will be made in 2019/20 where required."	1. Discussion with NHSI regional finance team Monitoring of cash flow forecast within finance department (and reported to Management Board, Finance and Investment Committee and Trust Board)" 2. Updates reported to the Finance and Investment Committee and Trust Board 3.Submission of cash flow forecasts to NHSI to support requests for additional revenue funding.	5	3	15	High / Significant Risk	Specific assurances from NHSI/DHSC that the loans will be rolled over / refinanced in advance of receiving written confirmation / new loan agreements.	5	2	10	Moderate / Unacceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	Options on EPR to be developed to address risk in relation to receiving full funding for the Trust's revenue and capital plans Continued dialogue with NHSI regarding 2016/17 funding Confirmation of outstanding requirement for December 14 to March 15	10/06/2019	No Change	Increased as no confirmation from DH	10/07/2019
725		04/05/2011	McCarthy, Mrs Rachel	Medicine - Internal Medicine	Internal Medicine	Backlog of patients awaiting follow up appointments, delay in cardiology patients being seen leading to delay in diagnosis and treatment	Backlog of follow ups	Poor patient experience. Potential clinical risk patients may not be seen within the required timescales Risk: potential delay in diagnosis treatment and risk to patient safety, increased patient complaints, failure to meet 18 week target, reputational and financial loss.	3	5	15	High / Significant Risk	Decrease in the number of new appointment per clinic and increase in FU appointments - still using Partial Booking process and still high. Increase in Clinics Weekly RTT update meetings. Adjusted templates and validation process. Additional shifts/clinics put on.	Additional capacity found in some areas to work towards reducing overdue reviews. Regular meetings with specialities to review and plan next steps.	3	5	15	High / Significant Risk	awaiting noticeable improvement following monitoring and changes Significant incident of 200 patients being identified as being backlogged - awaiting appointments/clinic slots	3	1	3	Very Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	Provide internal action plan evidence (from EYproject) Review impact of addition of staff grade after 3 months post Increase in cardiology OP capacity	16/05/2019	Increased	ongoing due to capacity	28/06/2019
824		14/10/2011	Eagles, Phil	Estates	Estates	IF the estates infrastructure contingency plans are not adequately tested THEN in the event of a infrastructure failure plans may not succeed LEADING TO contingency plans not being effective and to potential loss of services, poor patient experience, financial loss and loss of reputation	untested contingency plans, in the event of a infrastructure failure plans may not succeed	an increased safety and service disruption risk to patients and staff.	5	4	20	High / Significant Risk	1. Partially tested Contingency Plans. 2. Review of Business Continuity Plan review process completed in conjunction with Gordon Austin assisting with reviewing process and plans. 3. Continuity plans reviewed and shared with team. 4. Noted that plans partially tested during the recent flooding incident.		5	3	15	High / Significant Risk	NIL	5	1	5	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	Testing regimes to be further developed with Gordon Austin	29/05/2019	No Change	see comments	30/09/2019

Significant Risk Register

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1660		29/07/2015	Brooks, Mr Alan	Estates	Security and Car Parking	IF individuals attempt to self harm from rooftops of buildings under Trust management (e.g. multi storey car park), THEN members of staff may attempt to restrain the individual LEADING TO staff member at risk of falling with the individual causing death or suffering back injury, upper limb injury, fractures and other physical injury. This could include individuals who are patients and others within the Trust and patients who are accessing services on Trust site managed by other external organisations i.e. Campbell Centre.	Individual lack of capacity/understanding, diagnosed and undiagnosed mental health, illness related		5	3	15	High / Significant Risk	1. Patients of Trust services assessed as part of clinical assessment. 2. Concerns re non Trust users raised with appropriate service on site. 3. Multi storey car park has edge protection and physical barriers to prevent and deter access. 4. Other vulnerable roof tops assessed and barriers in place as appropriate. 5. Staff attend Risk Management and Health & Safety Training - aware of not to put self at unnecessary risk of personal injury. 6. Only undertake tasks in relation to rooftop incidents that staff have been trained to do. Do not cross boundary of expertise or physical ability. 7. Staff attend conflict resolution training. 8. Alert security in the event of emergency situation. 9. Security staff on site to attend emergency situations. 10. Call Police for assistance. 11. Incidents reported onto DATIX and escalated through senior management chain.		5	3	15	High / Significant Risk	Awaiting outcome from recent coroners report to see if there any further recommendations suggested.	5	1	5	Low / Acceptable Risk	TOLERATE - at lowest practicable /cost-effective level	Monitor to ensure controls put in place following recent incidents are adequate	29/05/2019	No Change	No change	01/07/2019
1672	8-1	07/08/2015	Molyneux, Dr Angus	Core Clinical & Support Services - Diagnostic & Screening	Pathology	There is a risk that the Cellular Pathology Department will be unable to meet the clinical demands of the service.	Increasing workload and lack of Consultant Pathologists to meet service demands	1. Potential inability to meet cancer reporting targets 2. Potential to miss an unexpected malignancy 3. Reporting backlog may also increase	3	5	15	High / Significant Risk	Outsourcing non-urgent work Additional hours worked - in house Pathologists Locum Pathologist in place working limited hours with substantive position recruited to with start date December Prioritising 2 week wait reports Prioritising urgent reports Prioritising work based on clinical information	KPIs are monitored on a monthly basis and show some improvement. It is noted that KPI targets are not met	3	5	15	High / Significant Risk	Staffing levels to meet workload - business case for LAS approved and appointment awaited Appointment to substantive Consultant position made with appointee in post from December, however a resignation has been received and there will be a Consultant vacancy from 16/01/2019. Post being advertised	3	1	3	Very Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	Review of staffing levels based on benchmarking and RCPath recommendations Develop business case that considers medical staff / scientific staff and cancer targets Identify locum consultant histopathologist (s) to manage existing and anticipated shortfall Advertise and appoint to Consultant Histopathologist vacancy	14/05/2019	No Change	Appointee in post but one resignation	11/06/2019
1740		06/11/2015	Worth, Mrs Tina	Corporate Affairs	Clinical Governance	There is a risk that changes required to practice are not implemented and we are not meeting best practice criteria	If recommendations and actions from audit are not evidenced, monitored and completed in the Trust	Potential impact on the top 3 Trust objectives (patient Safety, Clinical Effectiveness, Patient Experience) Potential poor quality of service and associated impact on resources CQC concerns re audit activitu & learning from national audits	3	5	15	High / Significant Risk	Audit report templates available to identify audit action plans. However these are not always being utilised and actions are not always evidenced and monitored Monitoring via Clinical Audit & Effectivess Committee	Limited assurances from RSM audit review Sharepoint has ability for audit action plans to be attached with evidence of compeltion but audit cycle not completed to this level	3	5	15	High / Significant Risk	Capturing audit evidence at specialty CIG meetings including actions to improve practice or examples of good practice. Divisional audit reports at CAEB Sharepoint evidence to support action plan from audits	1	3	3	Very Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	Implementation of KPMG action plan, to be monitored by Audit Committee	08/05/2019	Increased	KPMG Audit / CQC	31/10/2019
2609		26/04/2018	Clubbs, Michael	Project Management Office (PMO)	PMO - Programme	IF the current outstanding vacancies within the Transformation team are not recruited to THEN the planning and scoping for the cross cutting programmes will be compromised LEADING TO delays in delivery of change and service improvement as well as any financial benefits. Despite recent recruitment drives, the transformation team is currently holding 3wte band 8a programme manager vacancies and 1 Band 8a vacancies			3	5	15	High / Significant Risk	Currently out to recruitment for 2x band 8a Programme Manager posts		3	5	15	High / Significant Risk	Fill the vacancies	2	2	4	Low / Acceptable Risk	TOLERATE - at lowest practicable /cost-effective level		12/06/2018	No Change	No change	31/07/2018

Significant Risk Register

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2632	4-2	07/06/2018	Keetch, Mr Greg	Core Clinical & Support Services - Diagnostic & Screening	Screening Services	Potential inability to provide adequate cover to meet demand for Bowel Cancer Screening	A lack of capacity around the county for Bowel Cancer Screening. Owing to the introduction of the FIT test replacing the Guiac FOB Test, there will be a significant increase in the need for Bowel Cancer Screening lists around the county. The identified need is one further list per screening site from December 2018 onwards. The new test will see an increase in uptake of around 7%	If these lists are not put into place, there is a risk of both trusts delaying patient screening, which could impact on patient outcomes and putting the 62 day wait for lower GI cancer targets at risk. There is a potential for patient complaints and risk to reputation of the screening programme	3	5	15	High / Significant Risk	Currently in negotiations with both Trusts to increase capacity		3	5	15	High / Significant Risk	0	2	2	4	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required		31/05/2019	No Change	0	17/06/2019
2640		12/06/2018	Worth, Mrs Tina	Corporate Affairs	Clinical Governance	Clinical Governance and Imaging staff are unable to meet statutory and mandatory Good Governance requirements and accreditations if IT systems do not support their remit.	Existing governance systems do not support meeting Trust /legal/stakeholder requirements and are unsupported by the Trust IT department or an external IT provider	Unable to meet statutory and mandatory Good Governance requirements and accreditations if IT systems do not support their remit.	5	5	25	High / Significant Risk	System in place but requires updating and Q pulse which manages Trust documentation is no longer able to archive since the shared drive was moved.	The controls are ineffective to manage documentation on such a scale to support accreditation. No response from Datix regarding system capabilities. IT support staff no longer able to support - new member of staff commences July 2018 for project to be handed over.	5	3	15	High / Significant Risk	Systems require updating New Trust intranet & document management system review	2	1	2	Very Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required		08/05/2019	No Change	New risk	31/08/2019
2645		16/10/2017	Burns, Ms Samantha	Surgical - Head & Neck	Orthodontics	Insufficient experienced secretaries/co-ordinators in Orthodontics/OMFS	Orthodontics/OMFS are increasingly using co-ordinators who currently cross cover other specialities and do not have the necessary knowledge and skills to support this very specialist area	Potential increase in delays, loss of income, lack of continuity to patient pathways, decreased activity, increased complaints, staff with no formal training affecting staff morale.	3	5	15	High / Significant Risk	Admin review has taken place with restructure now taking place. Cross cover of admin staff recruitment drive to employ additional staff	Monitoring of incidents reported	3	5	15	High / Significant Risk	Admin errors are occuring - letters sent to wrong patients, clinics over/under booked vacancy gaps in all admin support areas	3	2	6	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required		03/05/2019	No Change	ongoing risk	12/07/2019
2652		25/06/2018	Playel, Mrs Jan	Surgical - Anaesthetics & Theatres		There will be unsafe fire evacuation for DSU if it is used as an inpatient escalation area	The travel distances from Bay 4 and 3 in one direction exceeds the 15m limit	- In the event of a fire all patients on ward beds beyond the 15m limit there is escape in only one direction until double doors at unit entrance. - Limited escapes exits available to facilitate safe evacuation for all other DSU patients. - Implementation of emergency evacuation plans for nursing staff. - increased numbers of people within DSU footprint. - Not meeting Statutory requirements – H&S at work, Management regulations and regulatory fire reforms.	5	3	15	High / Significant Risk	External Fire Safety Officer has been commisioned to under take review of DSU and Theatres - awaiting findings report. Fire risks and evacuation plans to be reiterated to all DSU nursing staff – for safe management of emergency evacuation when Unit is used for escalation. Safe plan for using DSU as an escalation area are being developed. Escalation of risk.	Update: 19/06/19 External review report is now available Head of Nursing for Surgery to liaise with Estates Lead to obtain a copy of the risk so that review and regradeding can take place. RCB has also requested review of this risk for clarity on the risk. Meeting to be arranged with Matron when report is received. Development of safe use of DSU as an escalation area Continue to remind staff of fire evacuation processes	5	3	15	High / Significant Risk	There is currently no safe plan for using DSU as an escalation area Implementation of recommendations made by Fire Office	5	2	10	Moderate / Unacceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required		19/06/2019	No Change	Ongoing risk	17/07/2019

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2653		25/06/2018	Playel, Mrs Jan	Surgical - Theatres	Main Theatres	There will be unsafe emergency evacuation for all patients on DSU and in Theatres 11 & 12 if a fire alarm is raised	Inability to reach a final place of safety due to the location of the portacabin's access steps blocking the route	- Limited escape routes if inpatient ward beds and trolley can only access the main escape route onto corridor. - Implementation of emergency evacuation plans for nursing staff. - Not meeting Statutory requirements – H&S at work, Management regulations and regulatory fire reforms.	5	3	15	High / Significant Risk	External auditor for fire safty has been commissioned to review fire safety and a report is pending. Deputy Operational Manager to lead on project to ensure access via fire escape is restored. Nursing and Theatres Staff are all aware of limited escape access Risk has been escalated	Continue to monitor requests for escalation Regular staff updates on fire evacuation processes M Board were advised that 'drawings' have been received re escape route from DSU	5	3	15	High / Significant Risk	There is no safe external emergency escape route	4	1	4	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required		15/05/2019	No Change	Ongoing risk	31/07/2019
2656		28/06/2018	MK0	Medicine - Emergency Medicine	Emergency Department (A&E)	Potential for increased waiting times and breaches within Emergency Department	Due to under staffing levles Sudden surges in activity Capacity in Main Hospital	Poor patient experience, potential for delay in patient treatment/care. Affect on trust reputation. Financial implications to Trust for not meeting 4 hour targets within ED	3	5	15	High / Significant Risk	Staffing areas as best as possible with current staffing templates	Review of incidents relating to care issues Monitoring of standards for waiting times in ED	3	5	15	High / Significant Risk	There may be occasions when staffing does not meet Trust standards Breaches may occur when patient flow is increasd	3	2	6	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	1. Escalation G/L to be ratified and put into operation for the ED. 2. Datix's/72 Hour rpeorts to be monitored through CIG/SIRG	09/05/2019	No Change	Continued risk	29/11/2019
2438		01/09/2017	Colda, Antoanela	Medical Director	Research & Development	R&D department has yearly running staff contracts, not permanent contracts and we are not able to provide longer term contracts for the team	the positions will be not attractive to new applicants and not secure posts for the existing staff members	potential reduce number/quality applications for the existing vacancies	3	5	15	High / Significant Risk	1. Requested support from the network CRN 2. Discussed with other Trusts Partners regarding their existing contracts	1. Able to maintain existing staff 2. Increase staff level	3	5	15	High / Significant Risk	Longer term contracts	2	3	6	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	set up meeting with finance director to review contracts	03/10/2018	No Change	no change	31/12/2019
2500	1-1 / 1-2 / 1-3 / 4-1	10/11/2017	Lindesay, Dr Chris	Medicine - Acute Medicine	Acute Medical	Insufficient space and capacity in AMU	High numbers of GP referrals, high numbers of patients through ED/transferred to AMU	Unable to effectively receive, triage and assess new patients Overcrowding in the waiting room and trolleys based in the corridors and backlog of patients in ED waiting transfer to the unit. Increased risk of delayed identification of unwell or septic patients. Poor patient experience. Staff health and well being. Inability to identified deteriorating patients in these non-clinical areas which could lead to transfer back to ED for more higher level care.	5	3	15	High / Significant Risk	Triage nurse. Bleep holder screening to divert GP referrals to ED if sound unwell on referral on phone. Extended ACU - Mon - Wed up to 22:00hrs 2nd Examination area available on ward 1	Datix's	5	3	15	High / Significant Risk	Space and capacity for quantity of patients to be seen	3	4	12	Moderate / Unacceptable Risk	TOLERATE - at lowest practicable /cost-effective level	Request a quote to have a second triage room in Ward 1 & 2	25/04/2019	No Change	no change	30/08/2019
2387		28/06/2017	Burns, Ms Samantha	Surgical - Head & Neck	ENT	There is a risk that ENT Clinicians will not have access to patient's operation notes for 1 week post-op visits	Patient's operation notes are not scanned into EDM in a timely manner	Potential risk of patients enduring otherwise unnecessary examinations and potential for changes to management plans	3	5	15	High / Significant Risk	1. Trustwide audits of EDM 2. Escalation when notes are not available.	Monitoring of incidents where unavailability of patients records has impacted on patient care. 08/03/19 - no Datix reported incidents where care was compromised due to lack of medical notes. Last informed of concerns in Audust 2018.	3	5	15	High / Significant Risk	Patients continue to be seen by clinicians without notes being present on EDM. TBC - awaiting involvement from medical records	3	1	3	Very Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required		08/03/2019	No Change	Ongoing risk	26/07/2019

Meeting title	Board of Directors	Date: 10 July 2019
Report title:	Guardian of Safe Working Hours Annual Report (18/19)	Agenda item: 5.2
Lead director Report author Sponsor(s)	Name: Dr Ian Reckless Name: Dr Amit Kalla / Ms Phillips / Andrew Kerr Name:	Title: Medical Director Title: GOSWH / DME Title:
FOI status:		

Report summary				
Purpose *(tick one box only)*	Information [x]	Approval [ ]	To note [ ]	Decision [ ]
Recommendation	This report is supplied to Board for information only to demonstrate the compliance with current terms and conditions of medical staff in training.			

Strategic objectives links	• Deliver key performance targets • Develop a robust and sustainable future • Become well-governed and financially viable • Improve workforce effectiveness • Develop as a good corporate citizen
Board Assurance Framework links	
CQC regulations	• Regulation 17: Good Governance • Regulation 18: Staffing
Identified risks and risk management actions	
Resource implications	Compliance with the employer conditions set out in the *Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016*
Legal implications including equality and diversity assessment	

Report history	
Next steps	Report for information only
Appendices	

1. Executive summary

This report is the annual report of Guardian of Safe Working Hours (Guardian): Dr Amit Kalla (Consultant Anaesthetist), covering the period of 1st April 2018 to 31st March 2019.

This report describes the ongoing application of contractual requirements introduced in the new issue of Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016; specifically covering the elements of the Guardian of Safe Working Hours, exception reporting for variation in work hours or educational opportunities, immediate safety concerns, rota design / work schedule review, trainee post vacancies and the junior doctor forum.

In summary Milton Keynes University Hospital has provided the contractual requirements specified in the 2016 Terms and Conditions for doctors in training. Further efforts are required to ensure trainees continue to be aware of the facilities open to them, ensuring that Educational Supervisors are aware of their responsibilities and are responsive and junior doctor rota designs remain compliant with contractual requirements.

Introduction

NHS Employers introduced a new issue of national terms and conditions for doctors in training in August 2016, which affects many factors of the working life of a doctor in training. The implementation of these terms and conditions was phased, across specialties and doctors grades between August 2016 to August 2017, resulting in all doctors in training being covered by these terms and conditions from August 2017.

This report covers April 2018 – March 2019 and covers the system of exception reporting and the role of the Guardian.

Definitions

Work schedules – Each trainee doctor is given a document (work schedule) that describes the expected working hours, shift patterns and pay.

Exception reports – Trainee doctors are provided with a mechanism to report (electronically) when:

> *"When their day to day work varies significantly and/or regularly from the agreed work schedule"*
>
> (NHS Employers 2016, terms and conditions of service for NHS Doctors and Dentists in Training, p 31)

Exceptions are reported by the trainee and reviewed by the Educational Supervisor (typically a consultant) and an outcome agreed.

Work Schedule Reviews - A review of the rota design and staffing numbers due to exception reports.

TOIL - Time off in lieu, for extra work done at a previous time

Fines – Fines levied by the Guardian when a service has breached the conditions set out in the August 2016 Terms and Conditions.

ISC – Immediate Safety Concern is indicated when a doctor feels there is an immediate substantive risk to safety of patients when raising an exception report.

2. Exception Reporting

Milton Keynes University Hospital provides the following in support of the trainee doctors and the exception reporting process:

- An online exception reporting tool
- A Guardian of Safe Working Hours (consultant responsible for overseeing compliance on safe working hours)
- A Director of Medical Education (consultant responsible for overseeing the quality of educational experience)
- A Junior Doctor Forum to discuss exception reports, fines and other arising issues affecting trainee doctors at the Trust.

Number of doctor / dentists in training (total):	161
Number of doctors / dentists in training on 2016 TCS (total):	161
Amount of time available in job plan for guardian to do the role:	1 PAs or 4 hours per week
Admin support provided to the guardian (if any):	0.2 WTE
Amount of job planned time for educational supervisors:	0.25PAs per trainee or 1 hour per week

Please note:

The exception reporting software used by the Trust has been updated since the last quarterly and annual reports produced previously. This update now means that individual incidences of exceptions have been reported here, rather than the number of reports raised (potentially a collection of incidences).

In the 2017/18 board report we counted exception reports raised by trainees (81). In the 2018/19 report we are counting individual incidents (337) rather than the number of reports raised.

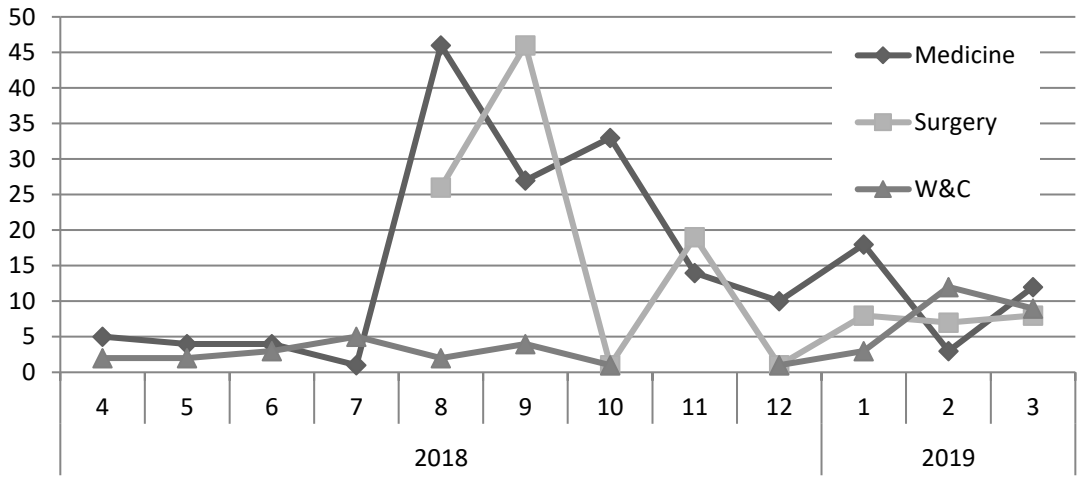
To illustrate:

In the 2017/18 report a trainee would raise one report about being late every day of the week and this would have counted as 1 exception report.

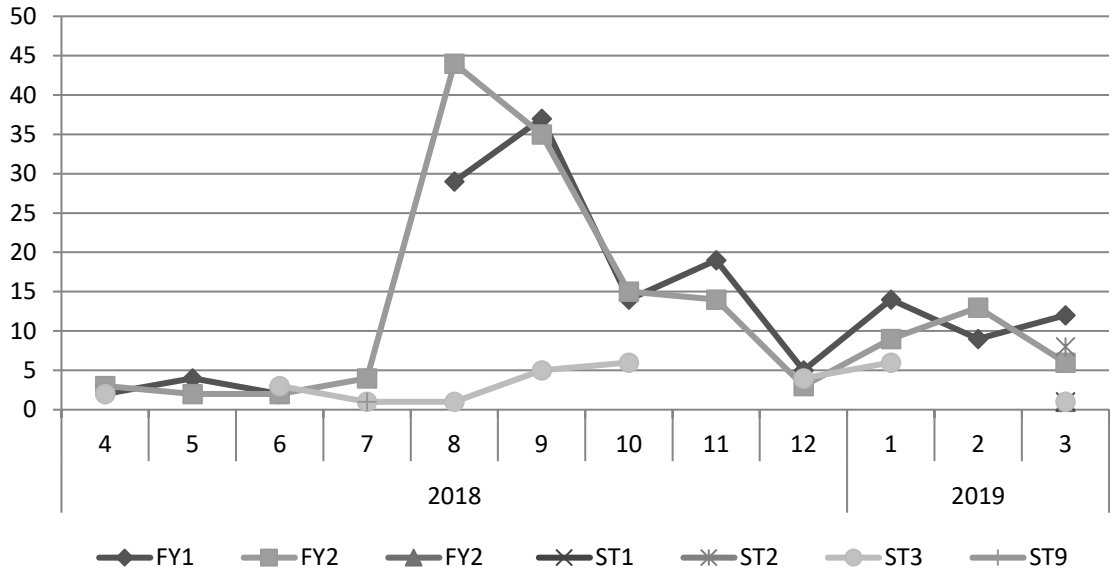
In this year's report the same exception report would be counted as 5 incidents of exception.

Exception Reports Raised

Exceptions by Division, Year and Month



Exceptions by Grade, Year and Month



The below table summarizes all exceptions over the period of 1st April 2018 and the 31st March 2019, by specialty, grade, year and month.

		2018									2019			
Specialty	Grade	4	5	6	7	8	9	10	11	12	1	2	3	Grand Total
Accident and emergency	FY2					1		8	1					10
	ST3							6		3				9
Acute Medicine	FY1							1				2	3	6
	FY2						1		7					8
Anaesthetics	FY2									1				1
	ST3										3			3
Gastroenterology	FY1												1	1
General medicine	FY1	2	4	2		22	16	12	4	4	8			74
	FY2	3		1	1	24	10	6	2	2	9	1		59
	ST2												8	8
General surgery	FY1					7	21	1	15		5	7	8	64
	FY2					1			4					5
Geriatric medicine	FY1									1	1			2
Haematology	ST3			1										1
Obstetrics and gynaecology	FY2		1	1	3		2	1				12	7	27
	ST1												1	1
	ST3			2		1	2			1	3		1	10
	ST9				1									1
Otolaryngology (ENT)	FY2					17	22							39
	ST3						3							3
Paediatrics	FY2		1			1								2
	ST3	2			1									3
Grand Total		**7**	**6**	**7**	**6**	**74**	**77**	**35**	**33**	**12**	**29**	**22**	**29**	**337**

The below table summarizes all exceptions over the period of 1st April 2018 and the 31st March 2019, by grade, type and division.

		Division			
Grade	Type	Medicine	Surgery	W&C	Grand Total
FY1	Educational		1		1
	Hours	78	62		140
	Pattern	1			1
	Service Support	4	1		5
FY2	Educational	7	2	7	15
	Hours	65	33	18	116
	Pattern	1	3	3	7
	Service Support	3	8	1	12
ST1	Hours			1	1
ST2	Hours	8			8
ST3	Educational		3	5	8
	Hours	9	3	8	20
	Pattern	1			1
ST9	Hours			1	1
Grand Total		177	116	44	337

The below table summarizes all exceptions over the period of 1st April 2018 and the 31st March 2019, by specialty, grade and exception report outcome.

		Outcome								
Specialty	Grade	Compensation & work schedule review	Compensation: Overtime payment	Compensation: Time off in lieu	Initial decision upheld	No further action	Organisation changes	Request for more info	Unresolved	Grand Total
Accident and emergency	FY2			10						10
	ST3			6		1		2		9
Acute Medicine	FY1		5	1						6
	FY2	5		2		1				8
Anaesthetics	FY2				1					1
	ST3					3				3
Gastroenterology	FY1								1	1
General medicine	FY1		11	49		3		2	9	74
	FY2	8	7	25	1	10	1		7	59
	ST2		4						4	8
General surgery	FY1		24	37					3	64
	FY2					1			4	5
Geriatric medicine	FY1		2							2
Haematology	ST3			1						1
Obstetrics and gynaecology	FY2	3		8		3			12	26
	FY2								1	1
	ST1			1						1
	ST3			3		3			4	10
	ST9								1	1
Otolaryngology (ENT)	FY2		31						8	39
	ST3		3							3
Paediatrics	FY2					2				2
	ST3								3	3
Grand Total		16	87	143	2	27	1	4	57	337

In summary, reports peak from August to October with 50% (186) of the entire year's exceptions being raised in these 3 months alone. The majority of exceptions are

raised by FY1 and FY2 trainee doctors in General Medicine and FY1 in General Surgical areas.

85% (287) of reports relate to hours exceptions and 7% (24) to educational issues, 5% (17) to service support and 2.6% (9) due to work patterns.

There is clearly a relationship between the August rotation and the number of exceptions raised, particularly around hours. This could be due to learning curve, impact or quality of local induction or exceptions could tail off due to novelty / dissatisfaction with the reporting process.

3. Immediate Safety Concerns

Between 1st April 2018 and the 31st March 2019 a total of 337 exceptions were raised by trainee doctors. Of these, 22 were indicated as immediate safety concerns (ISC).

Division	Specialty	FY1	FY2	ST3	Grand Total
Medicine	Acute Medicine		2		**2**
	General medicine	4	3		**7**
	Haematology			1	**1**
Surgery	General surgery	4			**4**
	Otolaryngology (ENT)		3		**3**
W&C	Obstetrics and gynaecology		5		**5**
Grand Total		**8**	**13**	**1**	**22**

- The Acute, General medical and Surgical ISC relate to staffing issues, with junior trainees feeling that low staff / high burden of their shift was unsafe.

- The Haematology ISC relates a late transfer of patient from the Macmillan Unit without prior Chemotherapy work up.

- The O&G exceptions relate to safe staffing levels and the impact of unplanned sickness.

- The ENT ISC relate to an assigned trainee dropping out of rotation at short notice and a team of 4 being down one doctor.

All ISC are escalated by the ES to the CSU management team.

4. Work schedule reviews

The following exception reports were recorded with a work schedule review outcome.

Division	Grade	Total
Medicine	FY2	13
W&C	FY2	3
Grand Total		**16**

The 13 in medicine were actually raised by 3 FY2's and the 3 in W&C by 2 FY2's. these exceptions did not actual translate into a change in Rota design, but staffing levels and quality of induction. These issues were escalated to departments by education supervisors.

5. Vacancies

The below table summarizes the trainee vacancies by specialty and Quarter.

Vacancies Quarter 1						
Specialty	Grade	Apr-18	May-18	Jun-18	Total gaps (average)	Approx. number of shifts requiring cover (based on template rota)
Medicine:						
A&E	ST3+	3	2	2	2.3	168
A&E	FY2 / ST2	2	2	2	2	144
Cardiology	ST3+	1	1	1	1	72
Gastroenterology	FY2 / ST2	1	1	1	1	72
Geriatric Medicine	ST3+	1	1	1	1	72
Geriatric Medicine	FY2/ ST2	1	1	1	1	72
Respiratory	FY2/ ST2	1	1	1	1	72
Surgery:						
Anesthetics	ST3+	1	1	1	1	60
Women & Children's:						
Paediatrics	ST1/ 3	3	3	3	3	216
Other:						
General Practice	FY2	1	1	1	1	75
Psychiatry	ST1 / 2	1	1	1	1	75
Total		16	15	15	15.3	1098

Vacancies Quarter 2						
Specialty	Grade	Jul-18	Aug-18	Sep-18	Total gaps (average)	Approx. number of shifts requiring cover (based on template rota)
Medicine:						
A&E	ST3+	2	1	0	1	72
A&E	FY2 / ST2	2	0	0	0.6	48
Cardiology	ST3+	1	0	0	0.3	24
Gastroenterology	FY2 / ST2	1	0	0	0.3	24
Geriatric Medicine	ST3+	1	0	0	0.3	24
Geriatric Medicine	FY2/ ST2	1	0	0	0.3	24
MAU	ST3+	0	1	0	0.3	24
Respiratory	ST3+	0	1	1	0.6	24
Respiratory	FY2/ ST2	1	0	0	0.3	24
Surgery:						
Anesthetics	ST3+	1	2	2	1.6	20
ENT	FY2/ST 2	0	1	1	0.6	40
General Surgery	FY1	0	2	2	1.3	88
Women & Children's:						
Obs & Gynae	FY2/ST 2	1	0	0	0.3	23
Core Clinical:						
Histopathology	FY2/ST 2	0	1	1	0.6	50
Other:						
General Practice	FY2	1	1	1	1	75
Psychiatry	ST1 / 2	1	0	0	0.3	25
Total		13	10	7	9.1	609

Vacancies Quarter 3						
Specialty	Grade	Oct-18	Nov-18	Dec-18	Total gaps (average)	Approx. number of shifts requiring cover (based on template rota)
Medicine:						
Geriatric Medicine	ST3+	1	1	1	1	72
Respiratory	ST3+	1	1	1	1	72
Surgery:						
Anesthetics	ST3+	2	2	2	2	60
ENT	FY2/ST 2	1	0	0	0.3	20
General Surgery	FY2/ST 2	1	1	1	1	60
General Surgery	FY1	1	0	0	0.3	22
Women & Children's:						
Obs & Gynae	FY2/ST 2	0	0	1	0.3	23
Core Clinical:						
Histopathology	FY2/ST 2	1	2	2	1.6	125
Other:						
General Practice	FY2	1	1	0	0.6	50
Psychiatry	FY2	0	0	1	0.3	25
Total		9	8	9	8.4	529

Vacancies Quarter 4						
Specialty	Grade	Jan-19	Feb-19	Mar-19	Total gaps (average)	Approx. number of shifts requiring cover (based on template rota)
Medicine:						
Respiratory	ST3+	1	1	1	1	72
MAU	ST3+	1	1	2	1.3	96
Geriatrics	ST3+	1	1	1	1	72
Stroke	ST3+	0	1	1	0.6	48
Surgery:						
Anaesthetics	ST3+	3	2	2	2.3	140
General Surgery	ST3+	1	1	1	1	60
General Surgery	FY2 - ST2	1	1	1	1	60
General Surgery	FY1	1	0	0	0.3	22
ENT	FY2/ St2	0	1	1	0.6	40
T&O	FY2 / ST2	0	1	1	0.6	38
Women & Children's:						
Obs & Gynae	ST3+	1	0	0	0.3	15
Obs & Gynae	FY2 - ST2	1	0	0	0.3	23
Paeds	FY2 - ST3	1	1	1	1	72
Paeds	ST4	0	1	2	1	60
Core Clinical:						
Histopathology	FY2/ST 2	2	1	1	1.3	100
Other:						
Psychiatry	FY2	1	1	1	1	75
Total		**15**	**14**	**16**	**15**	**993**

6. **Fines**

Fines are levied by the Guardian of Safe Working hours on departments for the following reasons:

- a breach of the 48-hour average working week (across the reference period agreed for that placement in the work schedule);
- a breach of the maximum 72-hour limit in any seven days;
- that the minimum 11 hours' rest requirement between shifts has been reduced to fewer than eight
- Where a concern is raised that breaks have been missed on at least 25% of occasions across a four week reference period, and the concern is validated and shown to be correct

Distribution of fined monies is then agreed at the junior doctor forum and individual doctors awarded penalty rate payments for the hours (above normal bank rate) that take then over these contractual limits. NHS employers make it quite clear that fines should be the exception and should never happen if the system of exception reporting is working (Guardian fines factsheet, NHS Employers).

Within the period of this report there have been no fines levied, although it is apparent that trainees on Rota patterns up to a 48 hours average week are coming close to the 48 hour average breach. The contract does not exclude 48 hour patterns but his becomes a problem when excess hours are reported and compensation is being award without consideration of giving time off in lieu. The time of in lieu would bring the average hours back down and provide the trainee with compensatory rest.

A fine has been averted as our Rota designs include an element of prospective cover (assuming a percentage of additional hours to cover colleagues leave) and as the order / repetition of Rota cycle over a training post will vary. Educational supervisors and Rota coordinators are being advised to explore time off in lieu, as the preferred option.

7. Educational Issues

There have been the following reports raised by trainees regarding educational opportunities in this year.

			Year	2018								2018 Total	2019			2019 Total	Grand Total
			Month	4	6	7	8	9	10	11	12		1	2	3		
Division	Specialty	Grade															
Medicine	General medicine	FY2		1			2	1	2	1		7					7
Medicine Total				**1**			**2**	**1**	**2**	**1**		**7**					**7**
Surgery	Anaesthetics	FY2									1	1					1
		ST3											3			3	3
	General surgery	FY1												1		1	1
	Otolaryngology (ENT)	FY2						1				1					1
Surgery Total								1			1	2	3	1		4	6
W&C	Obstetrics and gynaecology	FY2				3						3		2	1	3	6
		ST3			1		1	1			1	4	1			1	5
W&C Total					**1**	**3**	**1**	**1**			**1**	**7**	**1**	**2**	**1**	**4**	**11**
Grand Total				**1**	**1**	**3**	**3**	**3**	**2**	**1**	**2**	**16**	**4**	**3**	**1**	**8**	**24**

In total there were 24 reports during this period (compared to 7 in the previous year)

- 11 were from trainees in Obstetrics and Gynaecology
- 6 were from Drs on the junior tier; 3 missed FY2 teaching sessions and 3 VTS missed GP training sessions due there being no cover available
- 5 were from specialty trainees; 3 reporting missed opportunities for operative training due to theatre cancellations – no staff, no beds and one where an overbooked list was running late so no time for the trainee to do cases; 1 trainee missed U/S training list and another was late for Regional Training Day because of over-running antenatal clinics.

All concerns have been discussed with the tutor and CSU lead and regular trainee forum meeting are held in the department. Staffing and workload remains a challenge for this department which inevitably impacts on training. A learner / trainer review is being facilitated by HEE-TV School of O&G in MKUH on 3rd July 2019.

- 7 were from trainees in general medicine

- 4 were from FY2 Drs who were unable to attend FY2 teaching due to lack of cover on wards

- 3 were from CMTs unable to attend core medicine teaching – including one important skills session again to lack of cover

- Medicine CSU lead and Associate Clinical Tutor have been working to adjust the rotas and staffing levels of the wards to even out cover and facilitate trainees attending mandatory teaching sessions

- 4 were from trainees in anaesthetics

- 1 FY2 Dr reported an overbooked, over-running list where the surgeon asked the consultant anaesthetic consultant not to let trainee do anything to speed things up
- 3 instances where a specialty trainee not doing ICM block was made to cover ICU during the day so missed out on theatre experience

- 2 from trainees in surgery

    - 1 FY1 general surgery missed mandatory FY1 teaching due to no cover available
    - 1 FY2 in ENT missed FY2 teaching due to no cover

There have been widespread concerns this year from Foundation Drs about their attendance rates at the generic teaching programmes. The Foundation School expects trainees to evidence attendance 70% compliance with this teaching. Face-to face attendance should be minimum of 50% and this can be made up to 70% with relevant e-learning. Reviewing the rotas it is clear that in some specialties it is difficult to make 50% even if trainee attended every time they were rostered to be at work during the teaching session. Tutors, CSU Leads and rota co-ordinations have all been asked to make sure their rotas maximise the chances of trainees being able to attend their teaching sessions. From next year trainees will be able to evidence a wider range of educational sessions to meet these requirements which may improve the situation, for example, they could attend the departmental teaching sessions as well as the generic programme sessions.

8. Junior Doctor Forum

The August 2016 Terms and conditions require that the Guardian and Director of Medical Education run a Forum for trainee doctors. This forum is both to provide advice, update, and encourage open discussion of issues with trainee doctors and also to agree distribution of fines levied by the Guardian.

MKUH has run quarterly junior doctor forums since August 2017 and in the main they have been chaired by our Chief Registrar, Dr Sean Noronha up until August 2018 and by Dr Stephanie Horne (ED Registrar) since then. Standing items on the agenda include:

- Updates from Chairman, Guardian, DME, Local Negotiating Committee and Medical Staffing
- Round table discussion from specialties on issues arising since last meeting
- Improvement ideas or up and coming changes

Minutes are taken and shared with all junior doctors, Rota Coordinators, Operational and General Managers, the Director of Clinical services and Medical Director (the Medical Director has attend 2/4 meetings this year).

9. Summary

Exception reporting is being done at a consistent rate and the Educational Supervisors have been resolving them in a timely fashion, although we can improve a bit more on this front. There is a spike in Exception Reports when new trainees join (particularly in August and February). Perhaps better induction and support by senior peers may help here.

Medicine, General Surgery and Women & Children's are the top 3 areas of exception reporting and I have spoken to various stakeholders and there are changes happening albeit slowly in improving staffing and in handovers.

From August 2019, I am hopeful that Medicine will be better staffed and there will be a potential rota change that will benefit / help trainees.

An algorithm has been shared with Educational Supervisors to refresh them about appropriate resolution of issues raised in exception reports and the Trust additional hours form has been shared with both trainees and Educational supervisors to aid resolutions.

When immediate safety concerns (ISC) have been raised by trainees, I have escalated these to CSU triumvirates to ensure awareness and resolution, but the hope is that with the new instruction set, Educational Supervisors will be doing this going forward. We would expect CSUs to resolve these and discuss at the appropriate governance forums.

10. Actions Pending

- I will be looking to arrange meetings with CSU Leads to explore the potential for better quality team-based inductions in August and February with the intention to reduce the learning curve evidence by the raised exception reports at these times.

- I will be arranging ‘refresher’ training for educational supervisors around their involvement in exception report and their resolution.
- I will also be running ‘pop-up’ clinics in areas such as the doctors mess, academic centre, or pre-arranged training sessions, so that trainees can come and feel confident to raise issues about safe working and patient safety issues.

11. Decisions required from the board

None – For information and assurance only.

References:

NHS Employers (2017), Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016, Version 2, 30th March 2017, Available online at:

http://www.nhsemployers.org/-/media/Employers/Documents/Need-to-know/Terms-and-Conditions-of-Service-for-NHS-Doctors-and-Dentists-in-Training-England-2016-Version-2--30-March-2017.pdf

NHS Employers (2017), Guardian fines factsheet, Updated 4th January 2017, Available online at:

https://www.nhsemployers.org/-/media/Employers/Documents/Need-to-know/Guardian-fines-factsheet.pdf?la=en&hash=6E91D80F0899FEBAD76A55EA5DB5242EDDB2DEBD

Report shared with:

- Junior Doctors Forum, 7th June 2019
- Local Negotiating Committee, 12th June 2019

Meeting title	Trust Board	Date: 10 July 2019
Report title:	Medical Revalidation Annual Report	Agenda item: 5.3
Lead director Report author Sponsor(s)	Name: Dr Ian Reckless Name: Elisa Scaletta	Title: Medical Director Title: Deputy Business Manager
FoI status:	PUBLIC	

Report summary	Overview of Appraisal and Revalidation systems and outcomes for 2018-19						
Purpose *(tick one box only)*	Information		Approval	x	To note		Decision	
Recommendation	That the approval of the 'statement of compliance' confirming that the organisation, as a designated body, is in compliance with the regulations is endorsed.						

Strategic objectives links	1. Improve Patient Safety 2. Improve Patient Experience 7. Become Well-Governed and Financially Viable 8. Improve Workforce Effectiveness
Board Assurance Framework links	None
CQC regulations	This report relates to: CQC outcome – 12 (Suitability of staffing) CQC outcome – 14 (Supporting workers) NHLSA standard – 1.9 (Governance) NHSLA standard – 5.1 (Supervision of medical staff in training)
Identified risks and risk management actions	None as a result of this report
Resource implications	None as a result of this report
Legal implications including equality and diversity assessment	None as a result of this report

Report history	Annual Report
Next steps	Completion and submission to NHS England of the 'Statement of Compliance' by the Chief Executive on behalf of MKUH as a designated body

Executive summary

Milton Keynes University Hospital has a prescribed connection with 304 Doctors as a Designated Body for the purpose of Medical Revalidation. This number includes: Consultants; Specialty and Associate Specialist (SAS) doctors; Trust Grade doctors; and NHS locums. It excludes General Dentist Council (GDC) registered dentists, trainee doctors and agency locums.[1]

In the appraisal year from 1st April 2018 – 31st March 2019 (18/19 appraisal year) the following medical appraisals were completed:

- 257 doctors completed an enhanced appraisal
- 10 doctors had approved reasons for not completing an appraisal (8x maternity leave and 2x sick leave)
- 6 doctors completed their appraisal, but the meeting took place after 1st April 2018
- 2 doctors had not yet completed their 18/19 appraisal at the time of completion of the Annual Organisational Audit (AOA) on 31st May 2019.[2]
- 29 doctors are not due their appraisal with MKUH until 19/20

This represents a 94% completion of appraisals in 18/19; however, there were only 8 doctors that did not complete their appraisal before 31st March compared to 13 doctors in 17/18. The percentage is lower this year due to 10 doctors being on either maternity leave or long-term sick, these doctors are not expected to complete an appraisal whilst they are off.

Purpose of the Paper

The purpose of this paper is to assure the Trust Board that we are discharging our statutory responsibilities in respect of Medical Appraisal and Revalidation for doctors who have a prescribed relationship with Milton Keynes University Hospital as designated body.

Background

Medical Revalidation was launched in 2012 to strengthen the way in which doctors are regulated, with the aims of: improving the quality of care provided to patients; improving patient safety; and, increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations **[References 1&2]** and it is expected that Trust Boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and,
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

[1] GDC registrants (dentists) do not revalidate but are appraised under the same Trust policy

and process as their medically registered and licensed colleagues at MKUH. Trainee doctors are appraised by, and connected to, HETV (the Deanery). Agency locums are appraised by, and connected to, their agencies.

[2] Since AOA submission, 1 of these 4 appraisals has been completed and 2 doctors have had their appraisal meeting and have been asked for further documents before sign off.

To ensure that their appraisal is completed on time for 18/19, their appraisal date has been moved back to their original appraisal due date or as close to this as possible. We will continue to do this until everyone's appraisal is in line with their original anniversary month. The Medical Director's Office is also ensuring that all appraisals are scheduled between April – January to also ensure all appraisals are completed within the appraisal year.

The purpose of revalidation is to provide assurance to patients and the public, employers and other healthcare professionals that licensed doctors are up-to-date and fit to practise.

In respect to appraisals, doctors are required to maintain a portfolio of supporting information to demonstrate that they continue to meet the attributes set out in the GMC Domains of Good Medical Practice **[Reference 3]** and this portfolio should include clear evidence of:

- Continuing professional development;
- Quality improvement activity;
- Reflection and learning from significant events;
- Feedback from colleagues;
- Feedback from patients; and,
- Review of complaints and compliments.

Governance Arrangements

a. Organisational structure and responsibilities:

Responsible Officer (RO) – Dr Ian Reckless, Medical Director and Consultant Physician (as of 18 April 2016).

The Responsible Officer has executive responsibility for overseeing the appraisal process for all Doctors with a prescribed connection and making revalidation recommendations to the General Medical Council (GMC). Recommendations are based on assessment of annual enhanced appraisal portfolios and any other governance information available to the RO.

Revalidation Support Committee – Chaired by Mr Graham Anderson (Lay Person)

The Revalidation Support Committee is responsible for reviewing all appraisal portfolios due for revalidation, carrying out triangulation checks on GMC and local concerns, complaints and serious incidents. This occurs prior to the RO making a revalidation recommendation.

The committee also supplies feedback to both appraisers and individual doctors on issues relating to quality of appraisal portfolios at revalidation and can request that additional evidence is supplied in the portfolio.

The revalidation support group is formed of 2 lay representatives, appraisers (Consultants) and a representative from the Medical Director's Office. The committee reports to the Responsible Officer and provides an update to Workforce Board.

Trust Appraisal Leads – Dr Clare Woodward, Consultant in HIV/Genitourinary Medicine and Dr Suresh Menon, Consultant Anaesthetist

The Trust Appraisal leads are responsible for the quality improvement of appraisals in respect to inputs and outputs. The leads deliver this through training, recruitment, and review and performance management of Trust appointed appraisers.

Medical Appraisers – Various Consultants and Specialty Doctors

Medical appraisers are responsible for reviewing and advising individual doctors on their appraisal portfolios and assessing whether they have met the GMC Domains of Good Medical Practice **[Reference 3]**, giving their final recommendation to the Responsible Officer and agreeing a personal development plan with the individual.

Appraisers are trained by an externally recognised training provider. Appraisers are expected to do a minimum of 6 appraisals per year to maintain proficiency.

Our current appraisers are all qualified doctors or dentists of varying grades in the employment of Milton Keynes University Hospital, and have attended certified enhanced appraiser training. They also have access to yearly top-up training and quarterly peer support groups.

Risk Management & Patient Experience Departments

Both the Risk and Patient Experience departments supply information to individual doctors on their named involvement in complaints and Serious Incidents Requiring Investigation (SIRIs). This then provides them with a specific source of evidence to reflect upon in their appraisal portfolio.

The Risk and Patient Experience department then provide the Revalidation Support Committee / Medical Director's Office with reports on named involvement in complaints and serious incidents, for triangulation checks at the point of revalidation portfolio review.

Clinical Line Managers

Clinical line managers (CSU Leads, Divisional Directors) are required to provide a reference at appraisal for each of their direct reports. Clinical Managers are also expected to resolve issues that might arise out of appraisal or non-engagement with the appraisal process.

Medical Directors Office (MDO)

The Medical Director's office is responsible for administering:

- The appraisal system;
- The revalidation reschedule and process;
- Tri-angulation checks on concerns, complaints and serious incidents for doctors for revalidation;
- Communications around revalidation deferrals;
- Administering the non-engagement process;
- All reporting functions and progress monitoring; and,
- Communications with staff around appraisal on behalf of the Responsible Officer.

b. Maintaining accurate lists of prescribed relationships

The list of doctors with a prescribed relationship is maintained from:

- A monthly comparison to the ESR payroll list of currently employed doctors and leavers reports.
- All newly employed doctors receive a letter from the RO in their welcome pack and are encouraged to contact the Medical Director's Office to receive 1-2-1 training to get up and running with their appraisals.

c. Progress Monitoring

Monitoring of appraisal and revalidations is carried out through the following:

1. Quarterly Appraisal Rates

Appraisal rates are reported to the Responsible Officer and then through him to the Regional Responsible Officer and is in the format of a Quarterly Appraisal Return as required by the Framework of Quality Assurance for Responsible Officers and Revalidation.

2. Annual Organisational Audit (AOA)

The AOA is a tool to help ROs and Boards assure themselves that the system underpinning the recommendations they make to the GMC on doctors fitness to practice, the arrangements for medical appraisal and responding to concerns are in place.

3. Annual Board Report

An annual report (this document) is reviewed by the Trust Board to assure members of the progress made and asks them to confirm to the Regional RO that we are fulfilling our statutory requirements.

4. Monthly Engagement Checks & Escalation process

The MDO checks the progress of every due appraisal and escalates overdue appraisals to the Responsible Officer.

d. Policy and Guidance

The current policy was reviewed and amended in December 2016. The new policy and associated documentation was specifically updated to ensure that there is joined up process for appraisal with the University of Buckingham in relation to medical school activities and the lessons learnt since inception of the first policy in 2014.

5. Medical Appraisal

For the 1st April 2018 – 31st March 2019 appraisal year, 94% of appraisals were completed; however, only 8 doctors did not complete their appraisal before 31st March compared to 13 doctors in 17/18. The percentage is lower this year due to 10 doctors being on maternity leave or long term sick, these doctors are not expected to complete an appraisal whilst they are off. The below tables illustrate the appraisal performance for the 18/19 appraisal year by category of doctor. Please note that NHS England has altered the classifications for completed appraisal to include:

Complete Appraisal (1) – The appraisal is completed within the 3 months preceding the appraisal due date, is signed off with 28 days of meeting, and the entire process occur between 1st April and 31st March.

Optional: Completed medical appraisal (1a) - For designated bodies who wish to and can report this figure, this is the number of completed medical appraisals that meet all three standards defined in Measure 1 a) above.

Approved incomplete or missed appraisal (2): – the appraisal was not completed due to unavoidable reasons such as maternity leave, extended sick leave, career break or suspension.

Unapproved incomplete or missed appraisals (3) –Appraisal not completed

Table 1 *– Completed appraisals by grade or contract type for 18/19*

Grade	Total	1: Complete	1A: Complete	2: Approved Incomplete	3: Unapproved In complete
Consultants	182	176	N/A	3	3
SAS Doctors	80	72	N/A	5	3
Temp Post Holders	24	22	N/A	2	0
Other	18	16	N/A	0	2
Total	**304**	**286**	**N/A**	**10**	**8**

From the above table, you can see that there were 8 doctors that had unapproved incomplete appraisals. There were only 2 doctors that had not had their appraisal signed off by 31st May 2019.

Table 2 *– Completed appraisals by grade or contract type for 17/18*

Grade	Total	1A: Complete	1B: Complete	2: Approved Incomplete	3: Unapproved In complete
Consultants	173	98	68	2	5
SAS Doctors	82	34	42	0	6
Temp Post Holders	18	13	5	0	0
Other	11	4	5	0	2
Total	**284**	**149**	**120**	**2**	**13**

a. Appraisers

Currently there are 45 Trust appraisers with an average of 6 doctors per appraiser currently assigned. The agreement is that each appraiser must do up to 6 appraisals per annum.

Each appraisal year, we re-recruit appraisers allowing people to continue, drop-out or take up the role. Every year, the Lead Appraisers and MDO write out to all Consultants and SAS doctors for expressions of interest to being an appraiser. The MDO collate the list and go through this with the Lead Appraisers. Training is then organised for those that have expressed an interest and then the list is reassessed to remove those that will no longer be carrying out appraisals and add those joining. The appraisers are managed by the Lead Appraisers who offers internal training for current appraisers.

Training entails a full day with a certified trainer and each appraiser will receive a certificate demonstrating that they have completed this training.

Further update training is given on a yearly basis for all appraisers and appraisers also have quarterly peer support groups to help them further develop best practice.

b. Quality Assurance

For Appraisers - *Appraiser Quality Assurance Programme*

To ensure ongoing improvement in appraisal:

- Appraisers are recruited and managed by the Trust Appraisal Lead;
- Trust Appraisal Lead is required to review performance of appraisers including doctor's feedback, timeliness of completion of appraisal, quality of inputs (evidence), quality of outputs (appraisal summaries and personal development plans) and compliance to policy. Additional requirements have been detailed in the new draft policy;
- The appraisal lead is required to review appraisals, monitor quality and take appropriate remediation steps if necessary;
- The Medical Appraiser role is recognised within the job plan and attracts a tariff;
- Appraisal feedback from the appraisee is collected after appraisal;
- Appraisers must carry out a minimum of 6 appraisals annually;
- Appraisers must attend quarterly appraiser support groups (private group meetings where appraisal issues can be discussed amongst appraisers and knowledge shared);
- Yearly externally facilitated refresher appraiser training (0.5 day); and,
- New appraisers must attend facilitated training prior to carrying out an appraisal (1 day).

For the appraisal portfolio

To ensure ongoing improvement in appraisal:

- Appraisal portfolios are reviewed by the Revalidation Support Committee with written feedback given to both appraiser and individual where necessary. Specific areas of focus include Complaints, SIRIs, CPD and an agreed PDP.

For the organisation

- Feedback on the doctor's experience of both the appraisal and the systems around it is sought from all individuals after successful completion of appraisal.
- Yearly review of policy and guidance documentation is carried out by the Medical Director's Office.

6. Access, Security and Confidentiality

Appraisal portfolios, revalidation notes and feedback surveys are managed through the electronic database system (Allocate e-Appraisal and e-360). This system is available on any computer with internet access but only registered users with logins and passwords have access. Individuals only have access to their own information and there are a limited number of administration roles (controlled by the RO) that have access to other people's information.

When a doctor leaves the trust their account is closed and they no longer have access to system. However Individual users are able to download all their appraisal portfolios to transfer to a new system if they should desire, but this needs to be done before leaving the Trust.

Any request for appraisal and revalidation information for a doctor must come from the new Responsible Officer or his/her office. This request must be received on a MPIT or similar form and will be handled by the Medical Director's Office and approved for sending by the Responsible Officer. No requests for appraisal data will be supplied to individual doctors who have left the Trust or other agents, other than a new Responsible Officer.

7. Clinical governance

Individual Doctors are required to provide, discuss and reflect on involvement in complaints, compliments or serious incidents. Individuals are required to provide:

- Written evidence from the Patient Experience department and Risk Management detailing all events listed on the Datix system where the individual is named in the past 12 months
- A reference from their clinical line manager indicating involvement in complaints, compliments and Serious Incidents
- A letter from any other external body where the individual practices detailing involvement in any complaints, compliments or SIs.

As part of the role of the Revalidation Support Committee, these reports are also sought independently of appraisal and compared to those discussed in the appraisal.

8. Revalidation Recommendations

Between 1st April 2018 and 31st March 2019, we have made a total of 67 recommendations to the GMC about our doctor's revalidations compared to 24 in the previous year.

There are 3 possible recommendations that can be made by the Responsible Officer through the GMC Connect website:

Revalidate

The requirements of a positive revalidation recommendation from the Responsible officer are:

"Based on the outcomes of such appraisal or assessment, and any other information available to me from relevant clinical and corporate governance systems, I am satisfied that:

- *Where relevant, each of the named medical practitioners is practising in compliance with any conditions imposed by, or undertakings agreed with, the General Medical Council.*

- *Where relevant, each of the named medical practitioners is practising in compliance with any conditions agreed locally".*

There are no unaddressed concerns identified by the above systems and processes about the fitness to practise of any of the named medical practitioners"

- The GMC protocol for making revalidation recommendations **[Reference 4]**

Defer

Deferral is a request to delay the revalidation decision pending either a local management process or for further information. This is a neutral act and does not reflect that there is an issue with an individual doctor. The minimum period of deferral is 4 months and the maximum (for one request) is 12 months. Repeat deferrals are challenged by the GMC revalidation team.

Non-engagement

This is the final confirmation to the GMC that a doctor is not engaging with the process. At this point the GMC enact their own non-engagement process which can ultimately end of with a removal of the licence to practice for the individual involved.

Table 3 *– Summary of recommendations made to the GMC*

Count of Recommendation		Recommendation			
Year	**Month**	**Defer**	**Non-engagement**	**Revalidate**	**Grand Total**
2018	April			2	2
	May			5	5
	June	2		2	4
	July	1		6	7
	August	2		2	4
	September	1		4	5
	October	1		2	3
	November			3	3
	December	1		9	10
2018 Total		**8**		**35**	**43**
2019	January	1	1	7	9
	February	1		7	8
	March			7	7
2019 Total		**2**	**1**	**21**	**24**
Grand Total		**10**	**1**	**56**	**67**

***Deferral requests are typically made because mandatory information is not included in the appraisal, but also (on rare occasions) because an individual is going through a management process that has not been resolved.*

Late recommendations made by the RO to the GMC

We have not made any late recommendations to the GMC.

Higher level Responsible Officer

Each RO has a prescribed connection to NHS England or Department of Health. The Responsible Officer's higher level RO is based at NHS England Midlands and East. The higher level RO will submit revalidation recommendations to the GMC for all ROs connected to them. The recommendation will be based, as it is for all doctors, on information from appraisal and from routine monitoring of performance and fitness to practise.

9. Recruitment and engagement background checks

The recommended employment checks are already carried out by the Human Resources recruitment team and where specific information is required in respect to appraisal information this is collected by the Medical Director's Office.

Where the checks are carried out by a third party, i.e. Locum Agency reliance is placed on the framework agreements/contracts that these checks are done by the agency.

10. Monitoring Performance

Performance of all doctors is monitored through the clinical line management structure of clinical leads for specialties and CSU leads for service units and divisional directors.

11. Responding to Concerns and Remediation

A responding to concerns policy has been created and is now on the Trust intranet.

12. Risks and Issues

There are no specific risks or issues that need to be brought to the Board's attention.

13. Board / Executive Team Reflections

Not applicable

14. Recommendations

The Board to receive the report (noting that it will be shared, along with the annual audit, with the Higher Level Responsible Officer) and to consider any needs/resources highlighted.

The Board is asked to approve the 'statement of compliance' confirming that the organisation, as a designated body, is in compliance with the regulations.

15. References

[1] *The Medical Profession (Responsible Officers) Regulations 2010*, Found at URL:
http://www.legislation.gov.uk/uksi/2010/2841/pdfs/uksi_20102841_en.pdf

[2] *The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012*, Found at URL:
http://www.gmc-uk.org/LtP_and_Reval_Regs_2012.pdf_50435434.pdf

[3] *Good medical Practice*, General Medical Council (2013), Found at URL:
http://www.gmc-uk.org/static/documents/content/Good_medical_practice_-_English_0914.pdf

[4] *The GMC protocol for making revalidation recommendations,* Third Edition, General Medical Council (2014), Found at URL:
http://www.gmc-uk.org/Responsible_Officer_Protocol.pdf_56096180.pdf

12

Meeting title	Trust Board	**Date:** 10 July 2019
Report title:	Learning from Gosport	**Agenda item: 5.4**
Lead director **Report author** **Report author** **Sponsor(s)**	**Name:** Ian Reckless **Name:** Ian Reckless **Name:** Helen Chadwick **Name:**	**Title:** Medical Director **Title:** Medical Director **Title:** Clinical Director for Pharmacy
FoI status:		

Report summary	The Gosport Independent Panel reported in June 2018 on the deaths of 456 patients. The Government published an overarching response in November 2018. There is an expectation that individual NHS Trusts and NHS Foundation Trusts consider the findings of the independent panel. This paper offers an overview of the panel's findings, with further detail on the medicines management elements within appendix 1.			
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [ ]	**Decision** [ ]
Recommendation	Trust Board is invited to receive and discuss this report, suggesting additional actions as necessary.			

Strategic objectives links	
Board Assurance Framework links	
CQC regulations	
Identified risks and risk management actions	
Resource implications	
Legal implications including equality and diversity assessment	

Report history	An identical briefing paper was provided to Management Board on 03 July 2019.
Next steps	
Appendices	Appendix 1 on page 5

Background and Overview

The Gosport Independent Panel reported in June 2018, with the Government publishing its response on 21 November 2018.

A link to the report can be found at https://www.gosportpanel.independent.gov.uk/.

This paper advises Trust Board on the background; outlines external action which may impact upon the Trust; and, encourages reflection on changes that may be appropriate locally. The Government's response has been reviewed by the Medical Director, Director of Nursing and Patient Care, and the Chief Pharmacist.

The Gosport Independent Panel – chaired by Bishop James Jones – was established in 2014 and charged with describing as clearly as possible that which happened at Gosport War Memorial Hospital in Hampshire between 1989 and 2000. Several messages and lessons can be drawn from the panel's work, and these were captured within the Government's response. At a high level, the findings can be summarised as follows:

- 456 patients died where opioid medications had been prescribed and administered without appropriate clinical justification
- There were failures in care
- There were failures in the supervision of care
- There were failures in the response of other organisations to these failures

Four specific failings can be highlighted (*italics* signify quotation direct from the report):

1. *Over many years during which the families have sought answers to their legitimate questions and concerns, they have been repeatedly frustrated by senior figures… The obfuscation by those in authority has often made the relatives of those who died angry and disillusioned… When relatives complained about the safety of patients and the appropriateness of their care, they were consistently let down by those in authority – both individuals and institutions.*

2. *… during the period between 1989 and 2000 at Gosport War Memorial Hospital … There was a disregard for human life and a culture of shortening the lives of a large number of patients. There was an institutionalised regime of prescribing and administering 'dangerous doses' of a hazardous combination of medication not clinically indicated or justified, with patients and relatives powerless in their relationship with professional staff.*

3. *The senior management of the hospital, healthcare organisations, Hampshire Constabulary, local politicians, the coronial system, the Crown Prosecution Service, the General Medical Council and the Nursing and Midwifery Council all failed to act in ways which would have better protected patients and relatives, whose interests some subordinated to the reputation of the hospital and the professions involved.*

4. Nursing staff raised concerns about prescribing and administration of drugs in Gosport War Memorial Hospital (GWMH) in 1991. These concerns were marginalised.

The Government response recognised both the gravity of the situation exposed at Gosport, and the passage of time since the index events. The response referenced several changes required on the background of Gosport – some of which were now in place, others where work was part way through or required going forward. These changes – some of which require local action whilst others are national – are described in table 1 overleaf.

Table 1: Changes required on the background of Gosport

Measures established since 2000	Reforms in place / developing	Areas where further work is still required
Controlled drugs regime (see appendix 1)	Network of Freedom to Speak Up Guardians	Annual reports on whistleblowing / speaking up concerns such that transparency can be demonstrated to other staff
Reforms to role and governance of GMC, General Pharmaceutical Council and NMC	Annual report from the National Guardian	CQC review of how it assesses Duty of Candour
	Whistleblowing concerns routinely shared with local CQC inspector	New national strategy on how feedback can be at the heart of care / improving care – ensuring organisations encourage and welcome feedback
	NHS England to review governance and leadership of the Controlled Drug Accountable Officer role (in place since 2006), and the role of lead officers at NHS England and Local Intelligence Networks (see appendix 1)	Provision of greater support to staff who speak up
	Further development of the learning from deaths / medical examiner processes –from the perspective of medicines safety, also involving and engaging bereaved relatives, and fostering intra- and inter-organisational learning	Review of the place of anticipatory prescribing – guidelines and assurance process (see appendix 1)
	Modernisation of syringe driver stock (following on from 2010 safety alert) (see appendix 1)	GMC to introduce a senior 'patient champion', and NMC to accelerate introduction of 'public support service'
	NHS England and NHS Improvement's new operating model to enhance alignment of national and regional oversight and support	Government to establish an Independent Public Advocate
	Reform of coronial services, including introduction of Chief Coroner	

Appendix 1

Government Response to the Independent Gosport Panel Report – Assurance around Medicines Management at MKUH Assurance at MKUH

Several problems identified by the Gosport Panel Report are centred on prescribing practices and a lack of openness / listening culture within the organisation and the wider health system. This appendix describes how we can gain assurance at MKUH that we do not have a local culture of inappropriate prescribing and use of opioids / other sedating medications in palliative care, or indeed more generally.

Key Medicines Management Findings

Finding One: Opioid usage without appropriate clinical indication

- Pharmacists review opioid prescribing as part of their daily clinical checks. In addition, they check hospital prescribing against the original GP prescription before admission to ensure that the doses are accurate, and to establish whether a patient is opiate naive. This is an element of medicines reconciliation.
- There are guidelines for the management of pain on the intranet and a number of specific pathways for managing post-operative pain.
- Clinical indication is a field within ePMA although is not a mandatory field as this would add significant time to the prescribing process.
- Medicines Management Induction and Mandatory Training includes sections on prescribing of opioids.
- MKUH has a specialist pain team covering both chronic and acute pain. In addition, there is a Palliative Care Team. All patients prescribed medication via a syringe driver are seen daily by the Palliative Care Team. Post-operative patients prescribed a PCA (patient-controlled analgesia) or epidural are automatically referred to the acute pain team via eCare. Patients with 'difficult to manage' pain are referred to the pain team via eCare for management advice.

Finding Two: Anticipatory prescribing with a wide range of doses

- This referred mainly to syringe drivers as Gosport, with huge doses and ranges permitted for nurses to use. It is not possible to prescribe this way on the ePMA system as all doses must be prescribed as a specific dose rather than as a range. An end of life care plan in EPMA helps to guide prescribing.
- We do have 'as required' prescribing for both pain relief and for end of life care. The doses and ranges used however are much lower than anything prescribed in Gosport and are guided by end of life prescribing guidelines available on the intranet. This is supported by the palliative care team.
- It should be noted that the Liverpool Care Pathway (LCP) is not in use at Milton Keynes University Hospital, and nor has it been for several years. Whilst in many cases the LCP facilitated high quality end of life care, it was criticised for leading to an over-standardisation of treatment in clinical environments where training and resources were sub-optimal. The senior clinical leads of NHS England and NHS Improvement have recently written to Trusts in order to ensure that the use of the LCP has not re-emerged.

Finding Three: Continuous opioid usage for patients admitted for rehabilitation or respite care

- Rehabilitation and respite care are not services provided at MKUH.

Finding Four: Continuous opioids starting at inappropriately high doses

- The guidelines used at MKUH, including end of life prescribing, recommend starting at low doses and titrating upwards. Pharmacists review opioid prescribing as part of the daily clinical check.

Finding Five: Opioids combined with other drugs in high doses

- This related to syringe drivers with high doses of diamorphine, midazolam and hyoscine in the same pump. Prescribing of syringe drivers at MKUH is only used in palliative care and there are very robust guidelines in place with support from the Palliative care team. All patients on a syringe driver are seen daily by the Team. Nurses are required to check the syringe driver and the patient 4-hourly. Doses used at MKUH always start with a lower dose and any increase in dose is managed carefully.
- There were also errors reported in the Gosport enquiry due to incorrect use of Graseby 16, 16a and 26 syringe pumps. MKUH does not use these. We use the recommended McKinley T34.

Finding Six: Few patients survived long after starting continuous opioids

- Since May 2019, all deaths occurring at MKUH are screened as part of the Learning from Deaths process by a Medical Examiner. This additional scrutiny offers an important opportunity for assurance. In addition, the relatives of deceased patients are routinely asked to feed concerns of any sort into the mortality review process.

Other sources of assurance in relation to opioid prescribing at MKUH

- Datix reports relating to medicines are reviewed regularly by the Medication Safety Officer and themes are sought. The only theme involving opioids in the last 12 months has been mis-selection of immediate-acting rather than controlled release oral preparations (or vice versa). Educational posters have been provided to wards to support staff in correct product selection.
- The Chief Pharmacist and CD Accountable Officer (Director of Patient Care and Chief Nurse) provide quarterly reports to the Prescribing and Medicines Governance Committee, and the Local Intelligence Network (LIN), of all reported Datix incidents regarding controlled drugs. The Chief Pharmacist attends a quarterly meeting with all other organisations in the CDLIN area where these reports are reviewed. There have been no concerns raised at that meeting about the level of reporting.
- Controlled drugs are strictly controlled at ward level requiring two signatures for administration. Stocks are checked on a daily basis.
- ‘Define’ and ‘Refine’ are systems held in Pharmacy that monitor drug usage patterns. There is an opportunity to increase the use of these systems for scrutiny at the Prescribing and Medicines Governance Committee.
- eCare offers a wealth of data that can be used to compare prescribing habits and patterns across the organisation. This will be utilised going further to analyse prescribing further.
- Non-medical prescribers prescribe within their area of specialisation using the eCare system, so monitoring is included with all other prescribers.

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Board of Directors**	**Date: 10 July 2019**
Report title:	**Report of the Management Board meeting held on 6 February 2019**	**Agenda item: 5.5**
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 July 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 3 July 2019

1. Matters arising

Management Board was updated on the continuing difficulties being experienced by clinical staff in using the Trust's Electronic Data Management System. The issues have been escalated to the system's suppliers and their Managing Director has been asked to come in to the hospital to discuss possible solutions. Feedback received at the meeting indicated that although the system is now more stable than it had been in previous weeks, it remains quite slow, and that this is impacting on service efficiency.

2. Chief Executive update

Executive directors presented on some of the detailed Trust objectives, particularly around patient safety and clinical effectiveness. These are to be shared at Trust Board, and a robust quarterly review system at both Management and Trust Board is to be established.

3. Clinical Quality Board June 2019 highlight report

Management Board was informed that the medical examiner role is now in place and is regarded as a positive development. It was agreed that the role will be discussed in more detail at both Management and Trust Board.

4. Annual Complaints Report 2018/19

Disappointingly, communication continues to be one of the main emerging themes from complaints received in the last year. The high number of complaints about care received in the Emergency Department was noted, although it was acknowledged that the rate is still extremely low when measured against the department's overall footfall. A new divisional reporting tool to help facilitate more timely responses is being piloted by Women's and Children's. The results will be shared in four months' time.

5. Refurbishment and replacement of fire doors

A report was received on the requirement for ongoing maintenance and repairs to the Trust's 2000 fire doors. This had led to a recommendation that £47.5k be invested to deal with the highest priority issues. Management Board approved this proposal in order that this work can be commenced immediately.

Milton Keynes University Hospital NHS Foundation Trust

MEETINGS OF THE FINANCE AND INVESTMENT COMMITTEE HELD ON 29 April and 3 June 2019

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

There were no matters that were approved by the Committee.

Matters referred to the Board for final approval:

No matters were referred to the Board for final approval.

Matters considered at the meetings:

1. 2019/20 contract with Milton Keynes CCG

The Committee received a report from the Director of Finance on the implications of the new Guaranteed Income Contract that the Trust had agreed with Milton Keynes CCG. He explained that the new contract form would give the Trust certainty over the level of income it would receive in 2019/20.

The point was made that the focus of this contract is on providing stability across the whole of the local system. In terms of risks to the Trust, it was noted that an increase in costs arising from higher than planned activity was the most significant, but that there is also a risk of the potential benefits of the new contract form (for example in respect of changes to patient pathways) are not realised. It was acknowledged that adopting this form of contract is a key move towards a fully functioning place-based system.

The requirement to achieve the agreed A&E performance target at the end of the financial year were met, resulting in the Trust securing Provider Sustainability Fund payment of £1.4m.

2. Performance dashboard

At the April meeting, it was noted that the Trust's RTT performance had passed 90% at a time when performance nationally it is deteriorating. However, the total number of open pathways has increased to over 14,500 which mirrors the national position. High bed occupancy was indicative of the time of year, but the number of delayed transfers of care had remained low. A&E performance had been lower than in previous months but remained good in comparison to the position nationally. At the April meeting, it was noted that the readmission rate had dropped, despite continued pressure on the hospital as a result of high patient numbers.

At the June meeting, the Director of Finance reported that the hospital had been busier than expected for the time of year, as a result of which escalation areas had to be opened on occasion. A Board discussion on the adoption of appropriate metrics for the new contract arrangements is to take place in July.

3. Board Assurance Framework:

At the June meeting, it was noted that the capital and revenue risk had been split – the capital risk (7-2) relates to potential policy decisions that could restrict spending for the Trust, which could in turn impact its cost improvement plans. Nationally, there are concerns that the available capital funding is significantly over-subscribed. The rating of the revenue risk (7-3) remained unchanged. An additional risk around the new contract form is to be considered.

4. Finance Report

I. For month 12, it was confirmed to the Committee that the Trust exceeded its £900k stretch target and delivered £1.1m. The Trust secured £8.7m of incentive funding, making additional cash available.

II. Additional funding was provided to CCGs at the end of the year, but Milton Keynes CCG met their target without recourse to this.

III. In terms of areas for improvement, it was acknowledged that the focus on reducing agency spending needs to be maintained, and more needs to be done to improve the cost-base. The divisions are gearing up to working differently under the new contract.

IV. At month 1, it was noted that the overall level of substantive pay was high as a result of the one-off lump sum paid in April to those at the top of their Agenda for Change band. Although the Transformation Programme was behind plan, this is not unusual in month 1 due to a lag in governance processes. Work is being done to identify to identify the full CIP for the year.

5. Agency update

I. Agency spending increased in month 12 as a result of higher use of agency doctors to cover annual leave. Admin and clerical use also increased, particularly in clinical coding. In comparison to the two other acute hospitals within the BLMK area, MKUH's agency spend as a percentage of total pay costs is lower than Luton and Dunstable's but slightly higher than Bedford's.

II. The 2019/20 ceiling has been set at £11.1m which the Trust is confident it can meet;

6. Medical staff cost per Weighted Activity Unit (WAU)

MKUH had been reported as having the highest medical staff costs per WAU (the unit by which activity is measured in the Model Hospital benchmarking tool) in the country. The Finance Director indicated that some of the factors contributing to this statistic are incorrect, but he highlighted that work is on-going to improve medical productivity.

7. 2018/19 National Cost Collection: cost process assurance

The Committee received this annual report, data from which is used to inform the national tariff and Model Hospital. This data will now replace the Patient Level Information and Costing System (PLICS) and is mandated nationally. A recent assurance check on the accuracy of the data gave a 'moderate'

rating which is in line with most other providers. This information will become increasingly useful and will enable the Trust to understand its cost base on a much more granular level. It will also provide a much richer source of comparative data as the Trust is part of a 90-strong benchmarking cohort.

Milton Keynes University Hospital NHS Foundation Trust

Workforce and Development Committee Summary Report

1. Introduction

The Workforce and Development Committee met on 29 April 2019. A summary of key issues discussed is provided below.

2. Workforce

Staff Story
The Pathology Manager attended to provide the staff story. She joined the Trust in 1984 as a very junior member of staff and became the first person from the hospital to pass the relevant professional examination. Since then she has been continually encouraged to progress and to move the service forward. In her time here, she had also benefited from having a mentor who helped instil good values across the team, included a focus on collaborative working, both within and outside the Trust.

It was acknowledged that pathology does not have the highest profile in the hospital, but steps are being taken, including the holding of successful open evenings, to help change this. In terms of opportunities for progression, the manager reminded the Committee that both the Deputy Chief Executive and the General Manager of the Core Clinical division have laboratory sciences backgrounds. The Manager remains optimistic about the future of the service and feels that the new guaranteed income contract presented opportunities for the adoption of a system wide approach.

The Committee thanked the Pathology Manager for attending to share her experiences.

Workforce Information Quarterly Report
Highlights from the report include:

- The WTE figure has increased indicating that more people were recruited than left the organisation during the period. This headcount growth is mostly within corporate services – the administrative review has led to many staff being moved out of the divisions into the corporate directorates.
- The turnover rate is also improving.
- The Trust stayed below its agency spending ceiling for 2018/19.
- Statutory and mandatory training and appraisal were both above target at 91%

Quarter 4 HR Systems and Compliance Report
Highlights from the report include:

- Recruitment of medical staff has been positive with 15 new starters going through pre-employment checks, but the vacancy level for doctors remains at 12.3%. International recruitment is being considered.
- E-rostering is being rolled out across the Trust.
- The Trust's therapies lead is piloting e-job planning for AHPs and this is being well received.

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

- The CQUIN target for flu vaccination has been achieved.
- The staff survey results around health and wellbeing have levelled out, but not declined. A musculo-skeletal physiotherapist has joined the SHWB team
- A multi-faceted approach to the management of work-related stress has been adopted, with the introduction of a stress management toolkit, access to the Employee Assistance Programme and stress management training for managers being made available.

Equality, Diversity and Inclusion update
The Committee was informed that a number of staff networks have either been set up or are in the process of being established. The disability network held its first meeting in April, and the themes were around companionship and a greater understanding of living with a disability. BAME and Women's groups are in the process of being set up, with the latter being championed by the Director of Corporate Affairs who is also the LGBT executive champion. It was agreed that all the networks would benefit from having similar champions.

Staff survey
The Committee received an update on the results of the staff survey, and in the course of the discussion the points raised included the following:

- The Trust's response rate had increased by 7%. It remained 25th out of the 46 Trusts surveyed by Picker, and many of the scores are similar to what they were last year.
- There is some disappointment that there had not been greater improvement, but the introduction of eCare and the admin review were acknowledged as possible reasons for this.
- Overall, responses from staff in corporate teams were significantly better, but more work needs to be done to bridge the gap between perception and reality among staff.
- The work that was commenced last year in addressing low levels of engagement among some pockets of staff is set to continue.
- More work also needs to be done to ensure that appraisals meet staff expectations. This would include providing training for junior and middle managers that would equip them to better support their teams through the process
- A cohort of 20 managers is taking part in the first MK Way Managers' Programme, with two more planned for later in the year. This programme is currently open to existing managers but will in future be available to those new to the role.

Organisational development and talent management
National guidance on talent management is imminent, and regional talent pools are being formed. Staff will be able to apply to join these or can be put forward by their managers. The Committee stressed the importance of building in sufficient capacity to enable people to develop in this way.

3. Education

Education Update
- Statutory and mandatory training compliance is at 93% for the quarter.
- Apprenticeship numbers are rising and there is increased interest in AHPs. The amount of the Apprenticeship Levy that is being spent by the Trust has accordingly increased.

- The graduation ceremony for the first group of medical students to graduate from the University of Buckingham Medical School will take place on 29 June. Many of the students have applied to work in the Trust.
- The Keele Clinical Leadership and Management Course went well and there have been requests to repeat it.

4. Assurance

Guardian of safe working hours
The Committee received reports for quarters 1 to 3. The Medical Director explained the Guardian's role, stressing its independence, and the fact that junior doctors are encouraged to submit exception reports where they have been compelled to work excessive hours and/or their learning opportunities are reduced. Breaches should be discussed with their educational supervisors and resolved, and the Trust can be fined by the Guardian for excessive breaches – some neighbouring trusts have been fined in this manner.

Only a relatively small number of breaches have been recorded here, although complaints about missed educational opportunities in one service have been recorded and raised through other means. The Medical Director stated that he wanted to see more exception reports and had been discussing the issue with some Foundation doctors in recent weeks. The Guardian himself, who is a consultant anaesthetist at the Trust, is also doing work to raise the profile of exception reporting.

The Chief Executive observed that the Trust is an outlier nationally on the staff survey regarding staff working unpaid additional hours. While the guardian of safe working hours is specifically for junior doctors, the Trust is seeking to put measures in place for the protection of all staff.

Board Assurance Framework
The Committee received and considered the workforce related risks on the BAF and the following points were raised:

- Risk 8-1 has been split into two, covering the position around the ability to recruit to critical vacancies now, and in the future. The Director of Workforce indicated that there are few concerns about the position now, but the position from the next 18 months onwards could become more difficult.
- The scoring for risk 8-3 is to be reviewed.
- Risk 8-4 is to be reworded to reflect the effect of Brexit on the national supply of staff.

5. Other business

The Committee was notified of the Trust's new sickness absence policy which was launched last year and has more robust measures in place. The staff health and wellbeing team is a key and active part of this new approach.

The Board is asked to note the summary report.

Charitable Funds Committee Summary Report

1. Introduction

The Charitable Funds Committee met on 29 April 2019.

2. Key matters

The following items were presented to the Committee:

Milton Keynes Hospital Charity draft strategy 2019 to 2021

The Committee acknowledged the importance of agreeing and setting out the vision and strategy for the Charity. One of the main aims of the strategy is to place donors more at the centre of decision making on how funds are spent, and to encourage them to continue to donate. The recent thank you event was cited as an example of this approach. The charity is also seeking to build up legacy funding.

The Committee stressed the importance of building up reserves through regular giving – the strategy anticipates that by 2021, the Charity would have achieved sustainable planned giving. It was also suggested that patients and their families be included as groups that would be approached for support.

The Committee commended the strategy although there were questions whether all of its aims could be delivered within a three-year period. The challenges of gaining traction with local corporates was noted, particularly in the presence of other well established local and national charities.

The Committee noted the Charity's long-term goal of becoming independent of the hospital and advised that thought be given to who the trustees might be.

Fundraising summary paper

- The Be Seen In Green campaign will continue to be the main community fundraising activity
- The installation of contactless donation points across hospital site is under consideration and quotes to carry out the work have been obtained.
- It is expected that a lot of funding will be received towards the back end of the Cancer Centre appeal.
- The Charity is about to receive its first major legacy gift.

Charitable Funds Finance updates

- The Committee acknowledged that only about half of the forecast income for the Cancer Centre appeal has so far been received, noting that much of this income is likely to be back ended. It is also likely that donations will continue to be received even after the Appeal has officially closed.
- Regarding non-Appeal funding, the final position for 2018/19 was better than anticipated and a favourable variance of £16k was achieved.

Updated terms of reference of the Charitable Funds Committee

- It was agreed that the Director of Finance would become a full member of the Committee rather than ex-officio. In the event of a potential conflict of interest, he would simply excuse himself from the particular discussion
- It was agreed that further changes would be made to remove any barriers to the Committee's discretion in considering any applications for funding made to it.
- The Committee noted that the terms of reference already allow for an external individual to be appointed as a member, with the Board's approval.

Other business

It was agreed that further discussions would be held with Arts for Health as to how they will work with the Trust and the Charity going forward on the curation of the artwork and the courtyards.

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

None new.

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Board of Directors**	**Date: 10 July 2019**
Report title:	**Use of Trust Seal**	**Agenda item: 5.9**
Lead director **Report author** **Sponsor(s)**	**Name: Kate Jarman** **Name: Adewale Kadiri**	**Title: Director of Corporate Affairs** **Title: Company Secretary**
FoI status:	**Public**	

Report summary	To inform the Board of the use of the Trust seal.						
Purpose *(tick one box only)*	**Information**	x	**Approval**		**To note**	x	**Decision**	
Recommendation	That the Board of Directors notes the use of the Trust seal for the settlement of the Pathway Unit Stage 2 contract with Galliford Try.						

Strategic objectives links	Objective 7 become well led and financially sustainable.
Board Assurance Framework links	**None**
CQC outcome/ regulation links	**None**
Identified risks and risk management actions	**None**
Resource implications	
Legal implications including equality and diversity assessment	None

Report history	None
Next steps	None
Appendices	

Use of Trust Seal

1. Purpose of the Report

In accordance with the Trust Constitution, this report informs the Board of one entry in the Trust seal register which has occurred since the last meeting of the Board.

2. Context

The Trust Seal was executed on 20 June 2019 for the settlement of the Pathway unit Stage 2 contract with Galliford Try.