Board of Directors
Public Meeting Agenda

Meeting to be held at 10am on Thursday 11 March 2021 remotely via Teams in line with social distancing

Item No.	Title	Purpose	Type and Ref.	Lead
1. Introduction and Administration				
1.1	Apologies	Receive	Verbal	Chair
1.2	Declarations of Interest • Any new interests to declare • Any interests to declare in relation to open items on the agenda	Noting	Verbal	Chair
1.3	Minutes of the meeting held in Public on 14 January 2021	Approve	Pg 4	Chair
1.4	Matters Arising	Receive	Verbal	Chair
2. Chair and Chief Executive Strategic Updates				
2.1	Chair's Report	Receive and Discuss	Verbal	Chair
2.2	Chief Executive's Report • Covid-19 response update • Planned Care Update • Staff Survey Headlines	Receive and Discuss	Verbal	Chief Executive
3. Quality				
3.1	Patient Story	To Note	Presentation	Director of Patient Care and Chief Nurse
3.2	Serious Incident Report	To Note	Pg 10	Medical Director
3.3	Nursing Staffing Report	To Note	Pg 16	Director of Patient Care and Chief Nurse
3.4	Responses to the Ockenden Report: Assessment and Assurance Tool	Receive and Discuss	Pg 23	Director of Patient Care and Chief Nurse
3.5	Safeguarding Children and Young People Update	Receive and Discuss	Pg 57	Director of Patient Care and Chief Nurse
3.6	Freedom to Speak Up Guardian - 2020/21 Annual Report	Receive and Discuss	Pg 64	Freedom to Speak Up Guardian

Item No.	Title	Purpose	Type and Ref.	Lead
4. Performance and Finance				
4.1	Performance Report Month 10	To Note	Pg 72	Deputy Chief Executive
4.2	Finance Report Month 10	To Note	Pg 84	Director of Finance
4.3	Workforce Report Month 10	To Note	Pg 94	Director of Workforce
4.4	Staff Health and Wellbeing Update	To Note	Pg 99	Director of Workforce
5. Strategy and Investment				
5.1	Revised Estates Strategy: 2020-2025	For Approval	Pg 109	Deputy Chief Executive
6. Assurance and Statutory items				
6.1	Significant Risk Register	To Note	156	Director of Corporate Affairs
6.2	Board Assurance Framework	Receive and Discuss	Pg 195	Director of Corporate Affairs
6.3	(Summary Reports) Finance and Investment Committee – 11 January 2021 01 February 2021 01 March 2021	Note	 Pg 247 Pg 248 Pg 249	Chair of Committee
6.4	(Summary Report) Charitable Funds Committee – 18 February 2021	Note	Pg 250	Chair of Committee
6.5	(Summary Report) Quality and Clinical Risk Committee – 22 February 2021	Note	Pg 251	Chair of Committee
6.6	(Summary Report) Workforce and Development Assurance Committee – 20 January 2021	Note	Pg 252	Chair of Committee
6.7	Use of Trust Seal	Note	Pg 254	Director of Corporate Affairs
7. Administration and Closing				
7.1	Questions from Members of the Public	Receive and Respond	Verbal	Chair

Item No.	Title	Purpose	Type and Ref.	Lead
7.2	Motion to Close the Meeting	Receive	Verbal	Chair
7.3	Resolution to Exclude the Press and Public	Approve	Resolution to Exclude the Press and Public 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	

Milton Keynes University Hospital NHS Foundation Trust

BOARD OF DIRECTORS MEETING

Draft Minutes of the Board of Directors meeting held in PUBLIC on January 14, 2021 remotely via Teams due to pandemic.

Present:

Simon Lloyd (SL)	Chairman
Joe Harrison (JH)	Chief Executive
Ian Reckless (IR)	Medical Director
John Blakesley (JB)	Deputy Chief Executive
Kate Jarman (KJ)	Director of Corporate Affairs
Sophia Aldridge (SA)	Interim Director of Finance
Matthew Sandham	Associate Head of Nursing
Heidi Travis (HT)	Non-Executive Director (Chair of the Finance & Investment Committee
Helen Smart (HS)	Non-Executive Director (Chair of the Quality and Clinical Risk Committee)
Nicky McLeod (NMc)	Non-Executive Director (Chair of the Workforce Development & Assurance Committee)
Haider Husain (HH)	Non-Executive Director
John Lisle (JL)	Non-Executive Director
Luke James (LJ)	Associate Non-Executive Director
Dilip Layanage	Clinical Fellow

In attendance:

Alison Marlow (AM)	Trust Secretary (minutes)
Dilip Layanage	Clinical Fellow

Other attendees

Alison Davis	Incoming Trust Chair
Professor Oliver Pearce	Consultant Orthopaedic Surgeon (for Item 3.1)
Caroline Middleton	Senior Sister (for item 3.1)

1	**Welcome**
	The Chairman welcomed all present to the meeting.
1.1	**Apologies**
	Apologies were received from Andrew Blakeman. Due to site pressures apologies were also received from Nicky Burns-Muir, Emma Livesley, Danielle Petch.
1.2	**Declarations of interest**
	No new interests had been declared and no interests were declared in relation to the open items on the agenda.
1.3	**Minutes of the meeting held on November 5, 2020**
	These were approved by the Board.
2	**Chairman and Chief Executive's Reports**
2.1	**Chairman's Report**

	Simon Lloyd welcomed Alison Davis who will be taking up the post of Chair from February 1, subject to ratification by the Council of Governors at their meeting next week. He said the new Director of Finance would be joining the Trust on February 24 and thanked Sophia Aldridge for doing a fantastic job of holding the fort during the interim period. SL wished to reiterate the Board thanks for the outstanding effort being made by all staff at the hospital while the site continued to face immense pressure. **Resolved**: The Board **noted** the Chairman's Report
2.2	**Chief Executive's Report** Joe Harrison reported that the site reached its to-date peak of 235 Covid positive inpatients about 10 days ago. He said he hoped that numbers would now reduce and that currently there were 198 inpatients. He said the less good news was that over 308 patients had died with Covid, including over 200 in the second wave compared to first. There were currently 340 staff off sick (both with Covid or isolating or for other reasons, with a rough split of 40%, 40% and 20% respectively). Ian Reckless said that the headline on the number of patients told only part of the story. He said all patients had some specific and challenging needs. He said that the bulk of patients being cared for were deconditioned as they had been here a week or more and therefore muscle mass was suffering and it was hard to get such patients on the move again, even in normal circumstances let alone with staff shortages. He said the key risk factors were general beds, ICU beds, staffing and oxygen, with ICU and staffing the most challenging areas. Joe Harrison said he was delighted that the Trust had vaccinated nearly 10k people since December and commended the fantastic effort by Danielle Petch and Jill Wilkinson. He said around 3k staff had been vaccinated, around 4k over 80s and also 3k other health and social care staff. He referred to recent media activity, including a big article in the Guardian and said that the expectation was that if clinical teams wished to do more media then it would be facilitated. To support staff, Kate Jarman and team have launched 12 Weeks of Wellbeing, connecting staff and particularly offering support to those working from home. Haider Husain said it was great to hear what the Trust was doing to support staff and that the burden on them had been heavy. He asked about support for palliative care staff. Ian Reckless said the mortuary team were under great pressure too and both were small teams and that the Trust was doing everything it could to ensure that seniors and executives were visible and supportive. He said that matrons were out and about on the wards all the time and admitted that it was difficult for staff but that the Trust was doing everything it could to support them. Kate Jarman said many staff had been redeployed and that teams were very good at debriefing. She said there would be a Time to Talk day as part of 12 Weeks of Wellbeing, but also there would be certain initiatives like free coffees etc to encourage people to take a break. She said the team recognised that not everything worked for everybody.

	She said virtual wellbeing check in sessions were starting next week, with the first one on sleep. She also stressed that the Trust should not forget about mental health after the pandemic when staff may be feeling stress and trauma for a for a long time afterwards. Nicky McLeod thanked Kate and agreed that staff wellbeing was an important topic. She asked if any work was being done with CNWL. Kate Jarman said the Trust had access to CNWL psychologists and that Beds and MK had launched a platform for staff to get immediate telephone access. She said a booklet containing all relevant information was in production. Helen Smart extended her thanks to the team and particularly commented on the work of the communications team in ensuring that staff were kept informed, in addition to media coverage. She asked if there were enough volunteers. Joe Harrison said external volunteers had been offered vaccinations if they wanted to come back and help, and that 50 staff had volunteered to do a range of roles, including medical students who had come in as healthcare support workers. Simon Lloyd asked how paediatric services were coping. Ian Reckless said that at the moment it was relatively quiet for winter, possibly due to reduced social interaction. **The Board noted the Chief Executive's Report**
3	**Quality**
3.1	**Patient Story** Professor Oliver Pearce and Senior Sister Caroline Middleton gave an insightful presentation into the use of MyMobility, an app that could be used to track and support the progress of patients receiving hip or knee replacement. Professor Pearce gave the clinician's view and explained the benefits of the app while Caroline Middleton demonstrated the usefulness of the app from both a patient and nursing perspective in that the app allowed clinicians to track rehabilitation progress of the patient and also allow the patient to get in touch and therefore staff could address any potential issues in real time. Simon Lloyd said it was an excellent presentation highlighting great initiatives. Helen Smart agreed and thanked the presenters. She asked how this information was shared. Oliver Pearce explained that prior to COVID-19 every month a UK or foreign hospital would send a group of clinicians to have lectures and visits and see the app in operation. He said there was a queue of people waiting to do this. Additionally, there were twice-yearly rapid recovery conferences attended by mixed multi-disciplinary teams. Papers were also published in academic journals. Luke James commented that it was a fantastic development. He did ask about the possibility of missed patient communication via the app especially if volumes increased, but Oliver Pearce said often people ended up going to their GP with issues rather than calling the hospital, but the benefit of the app was that three people shared the call screening and could identify those who needed to see a surgeon or physiotherapist more quickly. He said the app was an extra resource as opposed to a new resource. Caroline Middleton added that the information from patients was added to eCare so that it would be recorded in the patient record. John Lisle asked if the app was integrated into the broader system environment. This is not currently the case, but John Blakesley did point out that there were

	other hospital apps in development and that it was a matter of pace and timing before this happened, commenting that Zesty (MyCare) was the most likely vehicle for this. **Resolved: The Board thanked Professor Pearce and Caroline Middleton for their presentation.**
3.2	**Nursing Staffing update** The paper was taken as read, and Ian Reckless said some of it was now in a different context from the current situation. He highlighted the positive situation of nursing staff who weren't previously in inpatient roles – this was being well managed. Helen Smart commented on the high standard of the paper. She asked about pressures on medical teams. Ian Reckless said there were great challenges, and that people were working extremely hard. He said compared to phase 1, when all electives were stopped, this time the staffing situation concerned wards – he said about 20% of clinics which were registrar or trainee led, had been reduced to allow more staff to do night shifts on wards. He said they had deployed more anaesthetists to ICU, with only urgent and cancer surgery going ahead.
3.3	**Ockenden Report Trust Response** Ian Reckless said this was a seminal report for the NHS and in some ways could be compared to the Francis report. The Ockenden report initially started because of concerns raised by two sets of parents. He said they should be congratulated for taking things higher and higher. Their concerns led to the identification of 23 cases of neonatal or maternal harm. Donna Ockenden undertook a review and from those 23 cases, there are now 1862 cases under review over care and outcomes. This report is based on first 250 cases reviewed. He said the report gave familiar messages in terms of maternity units up and down the country, with the key themes of multi professional working and the review of women and families; the importance of kindness and civility; how we identify and respond to risks; how we learn when things go wrong; organisational memory and executive team turnover. He said that MKUH was lucky to have a stable team here. He said that one thing about the report was the rate of C-sections. He said it had been a mantra in the NHS for years that C-sections should be minimised and it appeared that Shrewsbury took this very seriously and did only 11% of C-sections in one year instead of an expected 24%. He said MKUH had sent a holding letter as requested which was included in the Board Papers. He said the Trust had done a lot of work over the last five years, following a difficult period in 2013/14 and that there was evidence and assurance around the work done in recent years. He said the Report would be picked up in the Quality and Clinical Risk Committee and brought back to Board in due course.
4	**Performance and Finance**
4.1	**Performance Report M8** This was noted and taken as read by the Board.
4.2	**Finance Report M8** This was noted and taken as read by the Board.
4.3	**Workforce Report M8**

	This was noted and taken as read. Simon Lloyd stressed that the primary aim was that staff remained fit and safe both physically, mentally and emotionally.
5.	**Strategy and Investment**
5.1.	**Winter Escalation Plan/Covid second wave plan** This was discussed earlier in the meeting.
5.2	**Estates Development Update** John Blakesley reported that the Maple Unit had now been demolished. .
6.	**Assurance and Statutory items**
6.1	**Significant Risk Register** Simon Lloyd asked Board members to follow this up outside the meeting if required.
6.2	**Board Assurance Framework**. Kate Jarman explained that this had changed slightly this month with pink boxes showing escalating or new risks, which were almost exclusively linked to managing the pandemic. Some of these risks had already been discussed at Finance & Investment Committee earlier in the week. She brought the Board's attention to the risks around oxygen use, levels of staff sickness and the risks linked to another surge of activity and resulting overwhelm. She said the Trust was continuing to manage nosocomial infection, which also features on the IPC (Infection Prevention and Control) BAF and that this issue would be reported both at Board and Quality and Assurance Committee in the future. She said that some risks would come and go on the BAF that that some were operational and in normal times wouldn't feature on the BAF. Heidi Travis welcomed the fact that some items featured and then would be removed as if made the BAF very much a live document. She thanked KJ for her work on this. Helen Smart also said she found it reassuring to see the changing risks and the assurance put in place as a result. She said it demonstrated how the Trust aligned gaps and reassurance and therefore was very helpful. IR wanted to make it clear that the Board didn't believe it has issues in its obstetric department but that when a report such as the Ockenden was published regarding activity in another organisation, the Trust had an absolute duty to make sure it was discussed. Joe Harrison commented that as a Board and executive, it was a very thorough BAF. Simon Lloyd also congratulated KJ on a very good piece of work.
6,3	**Summary Reports from the Finance and Investment Committees on November 2 and November 30.** **These were approved by the Board.**

7.	**Administration and Closing**
7.1	**Question from Members of the Public** There were no questions from members of the public
7.2	**Any Other Business** Joe Harrison wished to formally record the Board's thanks to Simon Lloyd for being Chair. He thanked Simon for his personal and professional guidance and said he would be missed. He was very pleased about Alison's appointment as Simon's successor. Simon Lloyd commented that he wouldn't have been able to fulfil his role without the exceptional support he had received from everybody at MKUH. He said that obviously the previous 12 months weren't quite the final year he was envisaging but the pandemic had increased his admiration for the fantastic job, the outstanding people and the team dedication in evidence over the past year. He said being the Chair had been a privilege and wished Alison Davis all the best for the future. The meeting closed at 12 noon

Meeting title	Trust Board	11 March 2021
Report title:	Serious Incident (SI) report	Agenda item: 3.2
Lead director **Report author** **Sponsor(s)**	Dr Ian Reckless Kate Jarman Tina Worth	Medical Director Director of Corporate Affairs Head of Risk & Clinical Governance
FoI status:	Public document	

Report summary	This report provides an overview of Serious Incidents reported in January and February 2021. This is to provide the Board with a high-level view on SI types and trends and a brief summary of linked programmes of work in response to incidents. A detailed Serious Incident Report is scrutinised at every Quality and Clinical Risk Committee.			
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [ ]	**Decision** [ ]
Recommendation	The Board is asked to review the information contained in this report.			

Strategic objectives links	Refer to main objective and link to others 1. Improve Patient Safety 3. Improve Clinical Effectiveness 4. Deliver Key Targets 7. Become Well-Governed and Financially Viable
Board Assurance Framework links	Lack of learning from incidents is a key risk identified on the BAF
CQC outcome/ regulation links	This report relates to: This report relates to CQC: Regulation 12 – Safe care & treatment Regulation 17 – Good governance Regulation 20 – Duty of Candour
Identified risks and risk management actions	Lack of learning from incidents is a risk identified on the BAF
Resource implications	Breaches in respect of SI submission incur a £1,000 penalty fine Breaches in respect of the Duty of Candour have potential for penalty fine of £2,500 if taken forward from a legislative perspective & up to £10,000 from a Commissioning contract perspective.
Legal implications including equality and diversity assessment	Contractual and regulatory reporting requirements. Legal requirement for Duty of Candour.

Report history	Serious Incident Review Group, Quality and Clinical Risk Committee
Next steps	Monthly SI overarching issues reporting
Appendices	Appended

Purpose of Report

This report is designed to give a summary of Serious Incidents (SIs) to the Board every two months (to each public Board). This report is in addition to a detailed Serious Incident report received at the Quality and Clinical Risk Committee at each of its meetings.

The purpose of this report is to be transparent around the Serious Incidents reported and investigated by the Trust, whilst maintaining the confidentiality of patients and families involved; and to provide assurance to the Board that the Trust has an effective and appropriate framework for the reporting and investigating of incidents, and ensuring actions are undertaken to reduce the likelihood of their recurrence.

Serious Incident Report January and February 2021

There were 19 new SIs reported in January and February. These are summarised in the table below.

STEIS number	Category	Details
2021/6	Maternity Service - Unexpected admission to Neonatal Unit/NNU (Labour Ward)	Baby admitted to the Neonatal Unit immediately after his birth and subsequently transfer to Great Ormond Street and the John Radcliffe Hospitals for further care.
2021/7	Delayed diagnosis (Patient Services - Diabetic Eye Screening)	A number of patients had been clinically validated (assessed) and not booked into an outpatient clinic due to the impact of the Covid-19 pandemic. This has resulted in potential harm for one patient.
2021/403	Delayed diagnosis (Patient Services – Respiratory/ Thoracic)	A patient attended a first outpatient appointment in 2018 and was not booked for a follow-up appointment. The patient returned under a new referral pathway in 2020 with metastatic cancer. Investigation to establish the potential harm caused by a lack of follow-up appointment in 2018.
2021/981	Medication incident (Ward 9)	Gentamicin (antibiotic) administered 12 hours before it was due. In babies, this presents a potential risk of long-term hearing loss.
2021/982	Maternity Service - Unexpected admission to NNU (Labour Ward)	Baby readmitted to the Neonatal Unit for phototherapy to treat jaundice.
2021/1567	Maternity Service - Unexpected admission to NNU (Labour Ward)	Baby readmitted to the Neonatal Unit on day three of life due to14% weight loss.
2021/1568	Delayed diagnosis (Acute Medicine)	A patient was admitted on 25/12/2021 and a dislocation to her left elbow not diagnosed until 4/1/21.
2021/2124	Venous Thromboembolism VTE (Urology)	A patient experienced an unavoidable pulmonary embolism (PE)
2021/2159	Maternity Services (Labour Ward)	Home birth - missed opportunities to support mother
2021/2160	Medication incident (Pharmacy)	A patient's medication history was incorrectly amended from Quinine to Quetiapine during their

		admission resulting in the incorrect prescribing and administration of Quetiapine
2021/2161	Maternity Services (Labour Ward)	Major obstetric haemorrahge (MOH)
2021/3331	Delayed diagnosis (Eye Clinic/Admin pathway)	A patient was seen in the Eye Clinic. And incidental finding suspicion of glaucoma was made, with the patient referred to the Glaucoma clinic. The patient experienced a delay in being seen and the left eye pressure was noted to have increased.
2021/2789	New pressure ulcer (Ward 8)	Deep tissue injury to heel.
2021/3455	Medication incident (Labour Ward)	Overdose of Paracetamol (administered orally & intravenously/IV)
2021/3330	New pressure ulcer (Ward 16)	Deep tissue injury to heel.
2021/2880	Fetal incident (Labour Ward)	Baby unexpectedly admission to the Neonatal Unit
2021/2874	New pressure ulcer (Ward 1)	Deep tissue injury to heel.
2021/3329	Delayed diagnosis (MSK)	A patient's MRI scan reported rectosigmoid growth. This finding was not acted upon. Four months' later the patient presented with obstructing rectosigmoid cancer.
2021/4003	New pressure ulcer (Ward 24)	Deep tissue injury to heel.

Trends and Concerns January and February 2021

The Serious Incident Review Group has commissioned a review of all incidents under the following themes in January and February:

1. Pressure ulcers
2. Delayed diagnosis (outpatient pathways)
3. Major obstetric haemorrhage
4. Medication errors

The review will look at any themes from incident investigations, review actions taken to prevent recurrence, identify any potential gaps and link quality improvement and appreciative inquiry programmes to ensure a comprehensive approach to action and learning. This work will be considered at the Trust Executive Group.

Glossary of Terms

Datix - Supplier of patient safety, healthcare and risk management software systems for incident and adverse events reporting

Serious incident - Serious incidents are events in healthcare where there is the potential for learning or the consequences to patients, families, carers, staff or organisations are so significant that they warrant using additional resources to mount a comprehensive response.

'Never Events' - Serious Incidents that are 'serious largely preventable patient safety incidents that should not occur if the available preventative measure had been implemented by healthcare providers'

'Being Open' - Being open is a set of principles that healthcare staff should use when communicating with patients, their families and carers following a patient safety incident in which the patient was harmed. A culture of openness, honesty and transparency, includes apologising and explaining what happened to patients, carers and relatives.

Duty of Candour - The duty of candour requires all health and adult social care providers registered with CQC to be open with people when things go wrong. This is a legal duty which applies to individuals and the corporate body.

STEIS - Strategic Executive Incident System (STEIS) is a single reporting structure which allows for management information to be shared across the country and for organisations to benchmark its performance against others.

Stop clock guidance - A stop clock request can be made to the CCG where there are circumstances that make a timely completion of the RCA investigation within the set contractual time frame difficult or not possible to comply with.

RIDDOR – Work related accidents and injuries. The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.

Down grade request – Where investigation has highlighted that the incident was unavoidable or where the Trust's involvement did not have any correlation to the incident and was in line with best practice, an incident can be downgraded and removed from the Trust's serious incident log.

Trust's Serious Incident Review Group (SIRG) – The Trust's Serious Incident Review Group consisting of executive and senior staff who ensure a systematic, holistic, multi-disciplinary and proactive approach to the management of SIs and who hold divisions to account for non-compliance.

Root Cause Analysis (RCA) – A problem solving investigation process designed to identify the contributory factors and ultimate root cause of an incident and facilitate appropriate actions based on the evident learning. The Trust uses standard templates for RCA investigations.

Preventing Future Death (PFD) report – The Coroners and Justice Act 2009, places a statutory duty on coroners to make reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be undertaken to prevent future deaths. These are also known Regulation 28 reports.

For Information

Serious Incident Reporting Process and Timeframes

All potential serious incidents are approved at Executive level and by the CEO before being reported on STEIS.. SIs currently have an internal 20-day deadline for draft RCA reports to be completed and presented at SIRG. Once approved by SIRG the RCAs are submitted to the Clinical Commissioning Group (CCG) for review by day 45. Any breaches in submission will incur a penalty of £1,000. If the CCG have any questions concerning the RCA reports, or require more information this is managed through the Risk Management Team. RCA reports are only closed on STEIS and Datix once the CCG feel assured appropriate learning is in place and evidence has been submitted to support the completion of the RCA action plans from two randomly chosen SIs.

The Trust uses Datix to register and track all SIs including the attaching of all associated evidence documentation. Datix also enables reports to be generated by location, incident type and date etc. to help with analytical review and deep dives.

SIRG

SIRG was introduced to ensure that there was a corporate, senior robust process for the approval of SIs, with Trust wide sharing and learning, analysis of trends and multi-disciplinary approval of RCA and action plans. The group has representation from the divisions and is chaired weekly by the Medical Director, Associate Medical Director or Director of Corporate Affairs. In a no-blame environment, staff are invited to present their draft RCAs and take any questions from the group before approval is given or request for representation at a later date. All moderate incidents from the preceding week are also discussed to determine if they meet SI criteria &/or require further investigation. SIRG has very much seen a significant improvement in the quality of RCAs and the analysis of incidents, with smarter and achievable action plans to allow follow through of the learning and evidence that it has been completed and/or embedded.

The Risk Management Team subsequently track submission of the required RCA action plan evidence within the due date (five working days of the agreed due date) with breaches reported on the weekly SI live log spreadsheet and Divisions held to account for noncompliance.

SIRG also reviews all incidents reported with a grading of moderate or above on the Datix system the preceding week, to consider if the grading is appropriate and/or further information is required to determine an SI. By taking this approach all incidents that are reported with a higher severity are collaboratively reviewed and

discussed enabling cross-specialty scrutiny. Trends are also assessed from an incident category perspective and contributory factors.

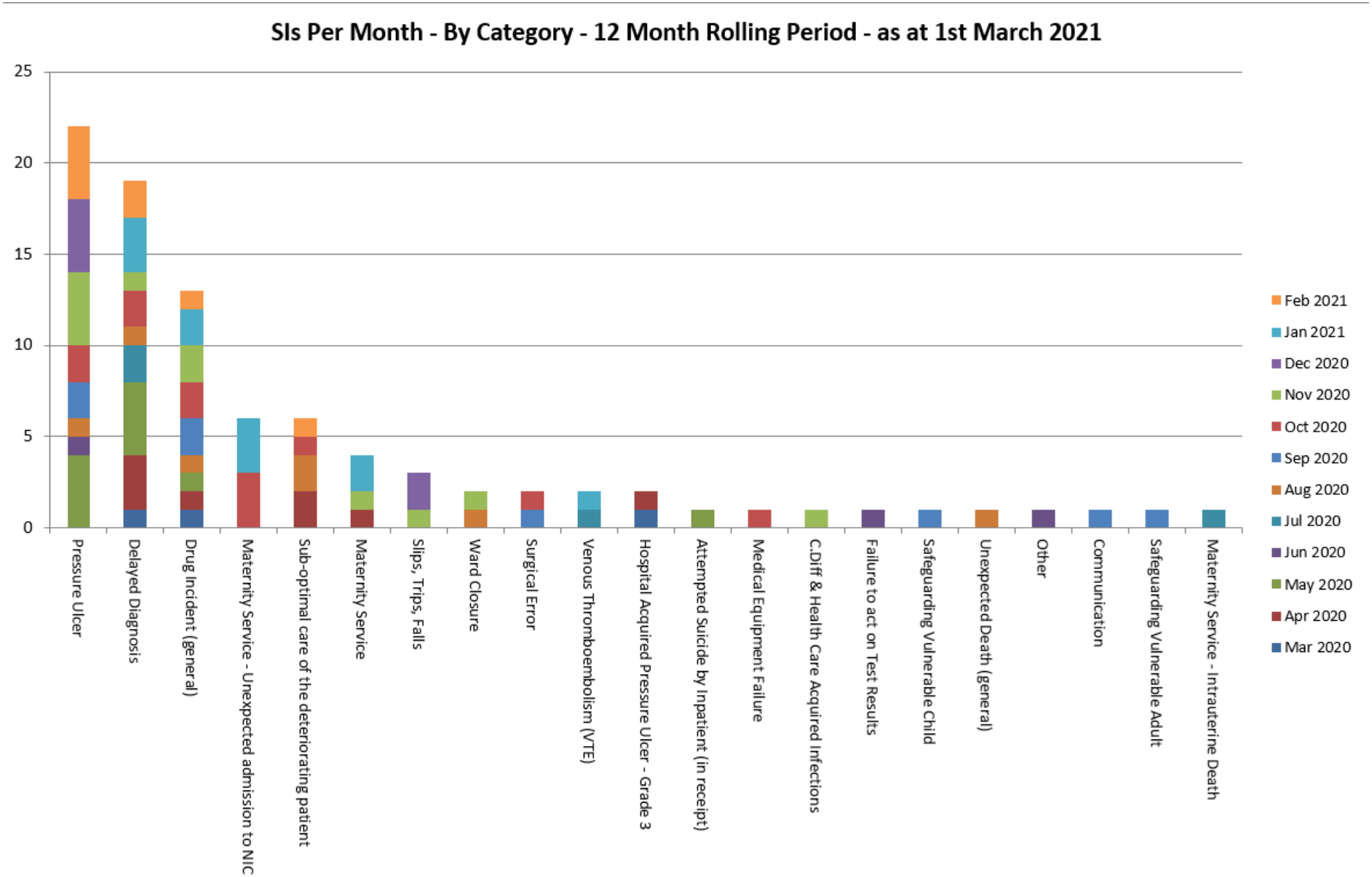
SIRG receives monthly reports on inquests, claims and SIs which focus on trend analysis and learning and any areas of concern for further review.

During Covid SIRG continues to meet via Microsoft Teams weekly.

Mortality and Morbidity (M&M) Proces

The Trust has robust processes in place to ensure that all deaths are reviewed in line with the Department of Health and Social Care (DHSC) national guidance on learning from deaths. As part of this process where deaths at M&M meetings are deemed to be avoidable and/or there were significant care/quality concerns and the death has not previously been reported as an incident on Datix, a retrospective incident report is logged enabling these deaths to be investigated as SIs through the RCA process. Particular attention is focused on any learning disability deaths in line with the national DHSC position.

	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Total
Pressure Ulcer	0	0	4	1	0	1	2	2	4	4	0	4	22
Delayed Diagnosis	1	3	4	0	2	1	0	2	1	0	3	2	19
Drug Incident (general)	1	1	1	0	0	1	2	2	2	0	2	1	13
Maternity Service - Unexpected admission to NICU	0	0	0	0	0	0	0	3	0	0	3	0	6
Sub-optimal care of the deteriorating patient	0	2	0	0	0	2	0	1	0	0	0	1	6
Maternity Service	0	1	0	0	0	0	0	0	1	0	2	0	4
Slips, Trips, Falls	0	0	0	0	0	0	0	0	1	2	0	0	3
Ward Closure	0	0	0	0	0	1	0	0	1	0	0	0	2
Surgical Error	0	0	0	0	0	0	1	1	0	0	0	0	2
Venous Thromboembolism (VTE)	0	0	0	0	1	0	0	0	0	0	1	0	2
Hospital Acquired Pressure Ulcer - Grade 3	1	1	0	0	0	0	0	0	0	0	0	0	2
Attempted Suicide by Inpatient (in receipt)	0	0	1	0	0	0	0	0	0	0	0	0	1
Medical Equipment Failure	0	0	0	0	0	0	0	1	0	0	0	0	1
C.Diff & Health Care Acquired Infections	0	0	0	0	0	0	0	0	1	0	0	0	1
Failure to act on Test Results	0	0	0	1	0	0	0	0	0	0	0	0	1
Safeguarding Vulnerable Child	0	0	0	0	0	0	1	0	0	0	0	0	1
Unexpected Death (general)	0	0	0	0	0	1	0	0	0	0	0	0	1
Other	0	0	0	1	0	0	0	0	0	0	0	0	1
Communication	0	0	0	0	0	0	1	0	0	0	0	0	1
Safeguarding Vulnerable Adult	0	0	0	0	0	0	1	0	0	0	0	0	1
Maternity Service - Intrauterine Death	0	0	0	0	1	0	0	0	0	0	0	0	1
Total	3	8	10	3	4	7	8	12	11	6	11	8	91


SIs Per Month - By Category - 12 Month Rolling Period - as at 1st March 2021
25
20
15
10
5
0
Pressure Ulcer
Delayed Diagnosis
Drug Incident (general)
Maternity Service - Unexpected admission to NIC
Sub-optimal care of the deteriorating patient
Maternity Service
Slips, Trips, Falls
Ward Closure
Surgical Error
Venous Thromboembolism (VTE)
Hospital Acquired Pressure Ulcer - Grade 3
Attempted Suicide by Inpatient (in receipt)
Medical Equipment Failure
C.Diff & Health Care Acquired Infections
Failure to act on Test Results
Safeguarding Vulnerable Child
Unexpected Death (general)
Other
Communication
Safeguarding Vulnerable Adult
Maternity Service - Intrauterine Death
Feb 2021
Jan 2021
Dec 2020
Nov 2020
Oct 2020
Sep 2020
Aug 2020
Jul 2020
Jun 2020
May 2020
Apr 2020
Mar 2020

Meeting title	Board of Directors	**Date:** March 11th 2021
Report title:	Nursing Staffing Report	**Agenda item: 3.3**
Lead director **Report author** **Sponsor(s)**	**Name:** Nicky Burns-Muir **Name:** Matthew Sandham Emma Thorne	**Title:** Director of Patient Care/Chief Nurse **Title:** Associate Chief Nurse Workforce Matron
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

Board of Directors Report on Nursing and Midwifery staffing levels Amalgamated report for October and November 2020

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.

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

CHPPD	Total Patient Numbers	Registered Midwives/Nurses	Care Staff	Overall
December	11398	5.0	3.2	8.2
January	11407	5.1	3.1	8.2

Month	**RN/RM Day % Fill Rate**	**HCA/MCA Day % Fill Rate**	**RN/RM Night % Fill Rate**	**HCA/MCA Night % Fill Rate**
December	74.3%	69.2%	91.2%	98.5%
January	73.6%	67.9%	89.2%	92.1%

- *December and January 2020/21 data are included in Appendix 1.*

Areas with notable fill rates

During the months of December 2020 and January 2021 the Trust had activated their nursing staff surge plan, therefore the data recorded per ward does not entirely reflect the staff allocated on the day. The surge staff can not be allocated to a clinical area as this would require a reallocation of budget. A separate nursing surge staff rota was recorded to collate hours and ensure safer staffing levels were maintained.

Are we safe ?

3. Recruitment Overview

The Trust has remained proactive with Nursing & Midwifery recruitment throughout the pandemic. The Senior Nursing Workforce team continue to collaborate with HR with recruitment initiatives to optimise nursing and midwifery recruitment across the organisation.

Medicine

Band	WTE Vacancy	Percentage	Turn over percentage
Band 2	3.19 WTE	3.1%	6.9%
Band 5/6	31.2 WTE	9%	6%

Surgery

Band	WTE Vacancy	Percentage	Turn Over percentage
Band 2	7.55 WTE	5%	6%
Band 5/6	28 WTE	12 %	5%

Women's and Children

Band	WTE Vacancy	Percentage	Turn Over percentage
Band 2	3.65 WTE	10%	6 %
Band 5/6	23 WTE	10.7%	2%

3.1 Health Care Support Workers Recruitment

As reported in previous reports, the Chief Nursing Officer for England, Ruth May, has recommended that organisations take a zero-tolerance approach to Healthcare Support Workers (HCSW) vacancies. The Trust has therefore been commissioned to work with NHSI on a 'Accelerated Healthcare Support Worker Recruitment Scheme'. The aim of the program is to reduce vacancies swiftly, enhance the onboarding process (including mentorship, training, and pastoral support to candidates), deliver training to optimise safety, and enable staff to be competent and safe in practice.

For MKUH we are required to recruit 61WTE HCSW that have commenced employment within the Trust by the end of March 2021.

Since January 2021, 34WTE HCSW positions have been offered, with 10WTE HCSW already started. Following interviews in February 2021 a further 26WTE posts have been offered bring the total offered posts to 60WTE.

All new HCSW's will now receive an intensive two-week bespoke induction program aimed at ensuring that our HCSW workforce are fully prepared and trained in the fundamentals prior to commencing their roles. Each day of the training the new recruits will meet the Executive team members and a cross section of senior roles from across the organisation including the Freedom to Speak Up Champion and the BAME network Chair.

To achieve the ambitious target, set by NHSI we will introduce new starters in cohorts of 16 throughout February and March 2021 using Ward 12 as the dedicated training facility whilst available.

Chief Nursing Officer of England Ruth May promotes that NHS Trusts should focus on recruiting HCSW without experience that could develop their career in the NHS. The Apprenticeship Manager has therefore engaged with the Princes Trust for their experience with helping young people expand and explore a career in health.

Princess Trust Healthcare programme

The Princes Trust have been given funding from the Department of Health and Social Care to support young people aged 18-30 into roles in Healthcare.

The Princes Trust have over 40 years of experience helping young people expand the opportunities available for them. They offer a variety of employability opportunities and are keen to support Trusts in engaging with this demographic. A collaboration between our organisations supports the NHS People Plan 'Local Recruitment' Actions as well as Talent for Care 'Widening Participation, It Matters! ' strategic framework. Currently a number of Milton Keynes residents are unemployed as a direct result of the impact of COVID-19. MKUH is one of the largest local employers and we want to promote equal employment opportunities that are accessible for all.

Programme

The HCSW pilot cohort will commence on the 22nd of February 2021 with places offered to 15 young people.

The learning and development team will deliver a half-day session relating to Trust specific content and support in mock interview activity. During this first week individuals will be supported to apply for HCA vacancies using a separate link to apply. This will ensure an interview is offered as per our agreement with the Princes Trust. Candidates will then be invited to interview alongside standard 'NHS job' applicants in February 2021.

The Princes Trust will offer all participants six months of 1:1 mentoring following successful appointment. As evidenced in other Trusts, this additional pastoral support reduces attrition rates. The Trust invited 12 young people to interview in February2021.

Staff Nurses Band 5

The Trust currently has 70WTE Band 5 vacancies. The most recent advert for Medicine and Surgical Nurses has attracted 51 applicants and shortlisting is currently being undertaken.
The Workforce Matron continues to work with the learning environment leads to plan and facilitate recruitment education and workshops for student nurses to ensure that MKUH is their first choice to work.

Junior Sister/ Charge Nurse Band 6

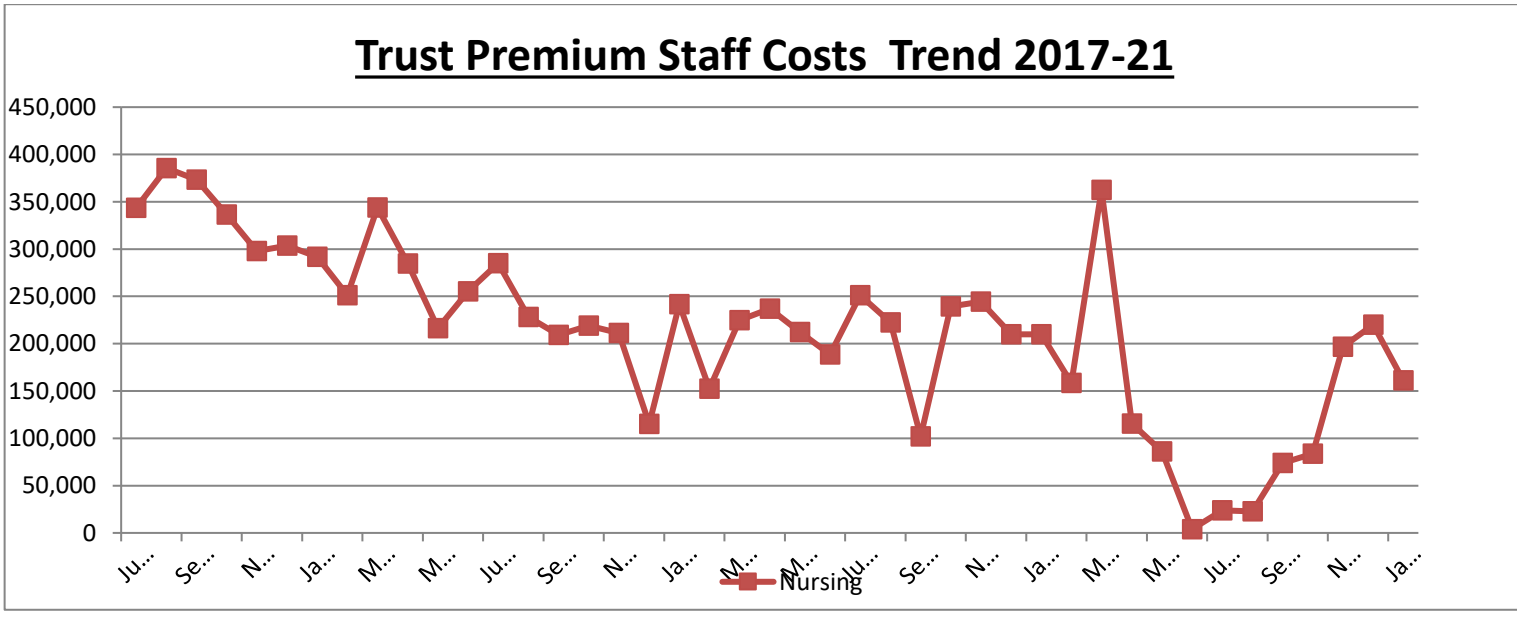
As an organisation we are investing in senior clinical leadership by ensuring that each in-patient ward has a Junior Sister/Charge Nurse on every shift. This is to optimise clinical decision making and ensure positive patient experience and safety outcomes and drive high standards of care.
This is an exciting opportunity for Staff Nurses to develop their career and leadership journey with us, thus retaining staff that may have considered seeking promotion outside of the organisation.
Successful applicants will automatically enroll on the Band 6 Leadership Programme that will support them in the Band 6 Junior Sister/ Charge Nurse position.
The roles are currently out to advert, and interviews will take place in March 2021.

Nursing Staffing Surge Plan

In the second wave of the pandemic nursing staff with ICU experience were redeployed from other clinical areas and specialities to support the increase in ICU patients. The Trust also increased capacity by opening Ward 22 and a respiratory HDU.
The surge plan was activated on 7th December 2020. In total we have deployed 13,500 clinical hours over a 3-month period. At the peak we were deploying over 30 surge staff per day. The demand has dropped significantly over the past three weeks as the Trust returns to more normal levels of activity and staff sickness has reduced.

Are we effective?

4. Agency graph



During the period of December and January the agency cost did increase and this is comparable with the same period in 2018/19 driven mainly by staff sickness or isolating due to COVID-19.
In November 2020 Gold command agreed to use off framework agency nurses to support the patient safety risk in specialist areas such as critical care.

CHPPD for Nursing, Midwifery and Care Staff December 2020 (Appendix 1)

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	81.4%	88.9%	99.2%	111.2%	680	5.3	2.3	7.6
MAU 2	63.8%	68.6%	103.7%	100.0%	238	10.5	6.8	17.4
Phoenix Unit	42.2%	11.3%	40.0%	53.5%	205	4.9	2.7	7.6
Ward 15	74.5%	79.2%	94.3%	90.3%	669	6.2	5.0	11.2
Ward 16	72.4%	73.9%	83.9%	111.4%	563	4.5	3.2	7.7
Ward 17	73.2%	86.3%	96.8%	135.5%	664	4.7	2.6	7.3
Ward 18	76.4%	72.8%	100.0%	103.2%	800	3.1	3.0	6.1
Ward 19	72.2%	57.8%	97.8%	95.7%	658	3.6	3.1	6.7
Ward 20	77.4%	61.4%	99.1%	102.2%	726	3.9	2.5	6.4
Ward 21	79.3%	69.2%	92.9%	78.5%	505	5.6	2.3	7.9
Ward 22	73.1%	44.6%	95.6%	66.7%	519	4.9	3.3	8.2
Ward 23	80.8%	95.7%	91.9%	141.4%	1131	3.2	4.1	7.2
Ward 24	76.5%	65.0%	86.2%	96.3%	503	3.8	3.2	7.1
Ward 3	67.5%	70.7%	88.2%	100.0%	687	3.2	3.4	6.6
Ward 5	67.8%	64.4%	91.1%	58.1%	268	12.0	1.9	13.9
Ward 7	62.2%	64.2%	91.4%	84.9%	447	4.7	4.6	9.3
Ward 8	78.6%	76.1%	99.0%	100.0%	686	3.6	2.5	6.1
ICU	96.6%	115.8%	102.1%	-	238	23.9	1.9	25.8
Labour Ward								
Ward 9	76.2%	94.8%	70.2%	91.3%	887	2.6	2.5	5.1
Ward 10								
NNU	70.6%	79.1%	86.9%	93.5%	324	11.7	2.2	13.8

CHPPD for Nursing, Midwifery and Care Staff January 2021 (Appendix 1)

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		76.5%	70.5%	86.4%	93.0%	612	5.5	2.1	7.6
MAU 2		70.9%	77.3%	95.7%	95.6%	501	5.0	3.4	8.4
Phoenix Unit		89.1%	53.4%	93.5%	104.8%	543	4.1	2.9	7.0
Ward 15		75.6%	68.0%	90.5%	87.5%	440	9.1	7.9	17.0
Ward 16		45.0%	39.5%	42.8%	62.9%	371	3.8	2.6	6.5
Ward 17		69.3%	70.3%	81.5%	100.0%	632	4.4	2.1	6.6
Ward 18		78.1%	69.2%	99.1%	104.3%	810	3.0	2.9	5.9
Ward 19		75.4%	66.2%	94.8%	100.0%	858	2.9	2.6	5.5
Ward 20		72.2%	61.3%	92.6%	102.2%	636	4.1	2.9	7.0
Ward 21		74.0%	68.1%	92.8%	67.7%	469	5.8	2.3	8.2
Ward 22		63.8%	56.3%	86.1%	86.1%	513	4.4	3.2	7.7
Ward 23		77.5%	84.1%	97.6%	122.2%	1058	3.5	3.8	7.2
Ward 24		81.5%	67.5%	103.4%	91.7%	500	4.4	3.7	8.1
Ward 3		49.2%	59.5%	61.3%	70.8%	817	2.9	2.9	5.8
Ward 5		64.2%	40.6%	87.1%	16.1%	244	12.6	1.0	13.6
Ward 7		74.1%	78.9%	97.8%	91.5%	600	4.0	4.0	8.0
Ward 8		75.4%	69.3%	92.7%	104.8%	649	3.6	2.6	6.2
ICU		108.6%	171.3%	122.4%	-	297	22.0	2.5	24.5
Labour Ward									
Ward 9		74.9%	83.3%	78.8%	81.6%	510	4.7	3.8	8.6
Ward 10									
NNU		71.2%	55.4%	84.5%	67.7%	347	11.1	1.4	12.5

Maternity services assessment and assurance tool

We have devised this tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of *effective* implementation to their boards, Local Maternity System and NHS England and NHS Improvement regional teams. Rather than a tick box exercise, the tool provides a structured process to enable providers to critically evaluate their current position and identify further actions and any support requirements. We have cross referenced the 7 IEAs in the report with the urgent clinical priorities and the ten Maternity incentive scheme safety actions where appropriate, although it is important that providers consider the full underpinning requirements of each action as set out in the technical guidance.

We want providers to use the publication of the report as an opportunity to objectively review their evidence and outcome measures and consider whether they have *assurance* that the 10 safety actions and 7 IEAs are being met. As part of the assessment process, actions arising out of CQC inspections and any other reviews that have been undertaken of maternity services should also be revisited. This holistic approach should support providers to identify where existing actions and measures that have already been put in place will contribute to meeting the 7 IEAs outlined in the report. We would also like providers to undertake a maternity workforce gap analysis and set out plans to meet Birthrate Plus (BR+) standards and take a refreshed view of the actions set out in the Morecambe Bay report. We strongly recommend that maternity safety champions and Non-Executive and Executive leads for Maternity are involved in the self-assessment process and that input is sought from the Maternity Voices Partnership Chair to reflect the requirements of IEA 2.

Fundamentally, boards are encouraged to ask themselves whether they really know that mothers and babies are safe in their maternity units and how confident they are that the same tragic outcomes could not happen in their organisation. We expect boards to robustly assess and challenge the assurances provided and would ask providers to consider utilising their internal audit function to provide independent assurance that the process of assessment and evidence provided is sufficiently rigorous. If providers choose not to utilise internal audit to support this assessment, then they may wish to consider including maternity audit activity in their plans for 2020/21.

Regional Teams will assess the outputs of the self-assessment and will work with providers to understand where the gaps are and provide additional support where this is needed. This will ensure that the 7 IEAs will be implemented with the pace and rigour commensurate with the findings and ensure that mothers and their babies are safe.

Section 1

Immediate and Essential Action 1: Enhanced Safety

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

- Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.

- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.

- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?
Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Link to urgent clinical priorities:

(a) A plan to implement the Perinatal Clinical Quality Surveillance Model
(b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
Currently we are working with Cerner who are developing a solution nationally for our electronic patient record 'eCare' to provide a process of collating data to populate a Maternity Services Dashboard.	We have developed an inhouse interim system to collate data.	Creation of a full maternity services dashboard and plan to share at LMNS.	Action is underway to progress system from eCare to inform real-time dashboard.	Maternity IT Department Information/ performance department ongoing	eCare support IT Admin Support in place Trust support required to agree and complete process with Cerner.	Risk register Risk assessments Guidelines SOPs Review of dashboards in regular divisional and departmental governance Meetings.
External clinical specialist opinion is gained from all qualifying cases via HSIB	We use HSIB reports and recommendations to drive improvements. Reports reviewed at departmental governance meetings. There were 2 HSIB cases in 2020. The cases are presented through the Audit meeting.	Action plans created from HSIB reports and recommendations. Action plans go to SIRG. Plans are overseen and actions reviewed by Risk Midwife and reviewed on a monthly basis with Trust Risk and Safety Co-ordinator	Continue to report all qualifying cases to HSIB	Risk Midwife Ongoing		No risk identified. Quarterly reviews with HSIB.
All SI's go to Trust Board	Action plans are developed and signed off by SIRG (Serious	Reduction in incidents and evidence of ongoing learning and	Continue to report at SI's at Trust Board.	Trust Risk Lead		No risk identified

	incident review group) and SI are monitored through QCRC (Quality and clinical risk committee) and Trust Board.	development of guidelines as identified and required.	Development of a maternity specific report for Trust Board.	Ongoing		
We have shared SI's across the LMNS and plan to continue to share regularly with the LMNS	An SI panel was set up in the LMNS which had begun to share learning across BLMK.	Only in its infancy so too early to demonstrate effectiveness.	Development of process with LMNS	LMNS Trust Board	Support from LMNS	All SI's are sent to the CCG for scrutiny and oversight
We plan to share a summary of SI key issues to the LMNS Board			Development of process with LMNS	LMNS Trust Board	Support from LMNS	All SI's are sent to the CCG for scrutiny and oversight
We plan to regularly share all SI's and an overview quarterly to the LMNS.			Development of process with LMNS	LMNS Trust Board	Support from LMNS	All SI's are sent to the CCG for scrutiny and oversight
Maternity Safety Highlight Reports	LMNS oversight and scrutiny	Audit Monitoring for trends and themes LMNS dashboard to benchmark locally	Change TOR for the LMNS Strategic Board	Maternity Unit LMNS Trust Board	Maternity Team Informatics Team LMNS support Board Safety Champions Non Executive Director involvement	Risk register Risk assessments Guidelines SOPs
PMRT is undertaken on all applicable cases using the PMRT website tool	We use PMRT report and recommendations to drive improvements.	Action plans created from PMRT reports and recommendations. All PMRT cases go to SIRG with a 72 hour	Continue to report all qualifying cases to PMRT	Risk Midwife Ongoing		No risk identified

		report. RCA carried out if necessary.				
We can confirm that 100% of cases are reported to HSIB and NHS Resolutions	We use HSIB report and recommendations to drive improvements.	Action plans created from HSIB reports and recommendations.	Continue to report all qualifying cases to HSIB.	Risk Midwife Ongoing		No risk identified
A thematic analysis of stillbirths and neonatal deaths over an 18 month period covering January 2019 to October 2020 has been completed.	Mortality Review Group CSU Meetings Divisional Meetings	Reduction in Incidents Actions plans from RCA's Introduction of AI (Appreciative Inquiry) approach to incidents.	Education and Training as identified from incidents and actions plans. Plan to undertake a second thematic analysis of still births and neonatal deaths after 6 months. This will take place end of April 2021 to include all stillbirths and neonatal deaths between November 2020 and April 2021.	Risk Midwife April 2021 Bereavement Midwife April 2021 QI Team		Risk register Risk assessments Guidelines SOPs Engagement of external partners in the use of AI for incidents.
Model released Friday 18/12/20 - Commitment to review this and complete a gap analysis by end February 2021 in order to strengthen quality arrangements	The Trust will use this tool to enhance perinatal safety through consistent delivery, measurement and reporting.	Recommendations implemented - Reduction in avoidable perinatal harm/SI's - Benchmarking against other units, where available, to inform learning and improvement	Gap analysis against each element and associated action required now the model has been received - Maternity Dashboard to be strengthened in line with the model - The Trust will seek to secure external	QI Team Senior leadership Team by end Jan 2021	QI Team Support to develop a plan to implementation.	Research perinatal clinical quality surveillance model. Continue to view each death using the PNMRT and implement any immediate actions, and

			review of all serious incidents - Pursue a partner LNMS relationship (single LNMS). This would strengthen our ability to benchmark externally and also reduce the burden on a single provider to action and deliver changes required.			this is reported to Trust Board - the Trust will use its governance and assurance processes to ensure timely review, and response to any incidents to ensure immediate actions and any learning

Immediate and essential action 2: Listening to Women and Families
Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

Link to Maternity Safety actions:
Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
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?

Link to urgent clinical priorities:

(a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.
(b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

What do we have in place currently to meet all requirements of IEA 2?	How will we evidence that we are meeting the requirements?	How do we know that these roles are effective?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?
The Trust awaits National Guidance to						

create an independent senior advocate role which will report to both the Trust and the LMS Boards.						
The appointment of a NED lead is underway with the Chairman and Chief Nurse.	Reviewing the newly produced role descriptor to ensure the most appropriate NED is identified.			New Chair of the Trust commenced 1.02.21 Reviewing all NED Champions 17.02.21 to ensure most appropriate NED to fulfil role descriptor. Chief Nurse March 2021		Board Level Maternity Safety Champions
We have an Executive Director with specific responsibility for maternity services	Executive Director in place – Chief Nurse					No risk
MVP meetings where parents are involved and service user voices are heard.	Minutes of MVP meetings LMNS MVP Meetings	Improvement in patient experience Reduction in complaints Agenda/ Minutes /Action plans Interaction and membership of the groups.	Continued engagement with MVP Ongoing collaboration Increasing ethnic and social diversity of membership	MVP Chairs MVP Maternity Team Patient and Family Experience Team.		No risk identified
Healthwatch Report 2019 where service users were involved	Service user feedback used to create the report.		Ongoing support of Health Watch	Healthwatch Ongoing		No risk identified

and their opinions and experiences sought			accessing service users within the Trust			
COVID-19 coproduction with MVP -Stepping stones document	Service user feedback used to create the document.		MVP Chair Evaluation of document .			No risk identified
Antenatal Education	Attendance Feedback from those attending	Consistent contact from women and families accessing information and support using facebook live sessions during Covid 19. Attendance feedback from those attending in form of live feedback during sessions on social media platform.	Develop a coherent antenatal education strategy which is inclusive and accessible to all using co-production with women accessed via MVP.	Community Matron	Financial resources Online infrastructure Scoping exercise to research what is available.	Virtual antenatal provision
Birth Afterthoughts	Weekly clinic	Birth Afterthoughts survey goes to PMA team for annual report and to identify any issues raised by women and families attending.	Promotion of the QRG Code to encourage feedback	PMA's		No risk identified
Professional Midwifery Advocates (PMA)	On call availability Monday to Friday 9 to 5 via hospital switchboard Minutes of Meetings	Agenda/ Minutes /Action plans	Annual Report to be presented to Board Level Safety Champions.	PMA's June 2021		No risk identified

Social Media Platforms	Preferred mode of communication for a high percentage of women. Feedback from MVP and social media events showed a very high number of women accessing the sessions.		Increase social media engagement with the support of the communications department	Communication Department Patient and Family Experience Team	Communication Department	
Meet the Midwife sessions for women in CoC teams and Homebirth Team. Held monthly for each team as a way to introduce women and their families to all members of the team.	Attendance at the meetings. Birth Choice and birth planning discussed. Feeding methods, support, antenatal education.					No risk identified
Picker Maternity Survey	Patient Experience Board	Departmental action plans from patient feedback. Discussed at Trust Board		Maternity Teams CSU Leads Patient and Family Experience Team		
Friends and Family Test	Patient Experience Board	Results discussed and actioned as necessary in departmental governance meeting. Friends and Family is displayed on ward boards and outpatient areas.	Need to develop regular feedback process from FFT results.	Maternity Teams Patient and Family Experience Team		
Picker National Maternity Survey	Feedback and results Action plans created from findings	Improvement in our National Maternity Survey				

Facebook Live events	Service user engagement	During COVID-19 Antenatal education was delivered using facebook live with very high level of engagement	Formulation of a rolling programme of online antenatal education is underway	Community Midwifery Matron	Midwifery Support IT support	Meet the Midwife online sessions
Online referral with links to health promotion and fast track access to women with medical conditions ie Sickle Cell	Audit of gestation at access Audit of identification of women with specific medical conditions and early access to screening in line with our guidelines for women with medical conditions.	Early access to screening for women with medical conditions	Further refinement of online booking tool to include further information and education resources	Antenatal and Newborn Screening Lead Midwife Ongoing	IT support Communication support to communicate changes to women	Information delivered during booking appointment . Risk Assessment
PMRT is undertaken on all applicable cases and families are invited to raise any concerns.	We use PMRT report and recommendations to drive improvements.	Action plans created from PMRT reports and recommendations	Continue to report all qualifying cases to PMRT	Risk Midwife	Action plans created from PMRT reports and recommendations	Continue to report all qualifying cases to PMRT
We have two board level safety champions for maternity. We are able to demonstrate that the Board level safety champions meet bimonthly with Trust Safety Champions	Meet to review on bimonthly basis the ten safety standards and any maternity obstetric issues. Action log of issues and minutes.	Board level safety champions undertake walkrounds in maternity to engage with staff in safety discussions issues are fed back in quarterly meetings .		Head of Midwifery Divisional Director CSU Leads for Gynae/obstetrics/ neonatal		Board level safety champions

Immediate and essential action 3: Staff Training and Working Together
Staff who work together must train together

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.

- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.

- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

Link to Maternity Safety actions:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

(a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
(b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place

What do we have in place currently to meet all requirements of IEA 3?	What are our monitoring mechanisms?	Where will compliance with these requirements be reported?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?
Confirmation of PROMPT Training with MDT will be validated through the LMNS going forward.	Compliance Evaluation	LMNS Quality meeting CSU meetings Divisional meetings	Training paper to Executives to increase from 3 to 5 days mandatory protected training for all midwives to meet	Exec Team February 2021 PDM Team	Financial support	

		Trust Board QCRC	all requirements – approved Feb 21.			
90% not met. As of end of January the accumulative total is 83% across the MDT	Compliance Staff rota of attendance	CSU Divisional Management Board		PDM Team Operational managers.	Ongoing support from PDM Team	
Twice daily Consultant-Led and present MDT ward rounds over 5 days per week can be confirmed	Currently, there are twice daily consultant led ward rounds and a virtual teleconference takes place at 22:00 daily which is recorded with auditable outcomes.				Awaiting publication of further guidance which will be implemented.	
Twice daily Consultant-Led and present MDT ward rounds over 7 days per week CAN NOT be confirmed	Currently, there are twice daily consultant led ward rounds and a virtual teleconference takes place at 22:00 daily which is recorded with auditable outcomes.				Awaiting publication of further guidance which will be implemented	
We do have confirmation of maternity training budget.	All funds derived directly or indirectly from Health Education England are ringfenced for their intended purpose and are managed by the Medical Director (via the Director of Medical Education) and Chief Nurse. The same is the case with funding for maternity staff training. Multi-professional training is a priority for the Trust with a particular emphasis on courses such as PROMPT. The Trust has a state-of-the-art simulation facility (opened in 2018) and encourages various forms of in-situ simulation training. The Trust has actively invested in high-fidelity equipment including SIM-Mum. The Trust is also able to evidence additional training and development activity in the maternity sphere across 2020/21 including: a formative review of the training environment in O&G (Berendt Consulting); team away day - service development through a lens of patient safety (Professor Suzette Woodward); and Appreciative Inquiry in maternity (Professor Belinda Dewar). This has been funded over and above any funding specifically allocated to maternity safety. The trust has also participated in MatNeoSIP. The CNST Maternity Incentive Scheme (MIS) refund is not formally ringfenced for the exclusive purpose of improving maternity safety. This is in line with standard accounting practices across the NHS where formal ringfencing is rarely appropriate in the stewardship of public funds. That said, the projected / achieved MIS refund value is allocated to the Women's and Children's					

	Division and essentially offsets annual cost improvement programme (CIP) requirements in the area. The end result is functional ringfencing. It should also be noted that with regards to safety improvement initiatives there is no arbitrary financial limitation on funding available, every request is considered on its own merits and so the ringfencing or otherwise does not limit the ability of the organisation or department to invest in improving maternity safety.					
The maternity unit undertook a Birth Rate + assessment in April 2018	Recruitment timescales. Vacancy rate Staffing numbers triangulated with births.	CSU Divisional Management Board HR report Trust Board	Ongoing monitoring of staffing levels Research staffing tool which takes account of Continuity of Carer model.	Head of Midwifery Ongoing Trust Board		
CTG Training - Edwin Chandrahan, Dawes Redman training	Evaluation Compliance	CSU meetings Divisional meetings Trust Board CQRM LMNS Quality meeting	Training paper to Executives to increase from 3 to 5 days mandatory training	PDM Team Ongoing	Funding Fetal Surveillance Midwife	No risk identified
K2 training annually as part of mandatory training	Evaluation Compliance	LMNS Quality meeting CSU meetings Divisional meetings Trust Board CQRM	Training paper to Executives to increase from 3 to 5 days mandatory protected training for all midwives to meet all requirements – approved Feb 21	Midwives Doctors PDM Team Ongoing	Funding	No risk identified
Skills and drills	Evaluation Compliance	CSU meetings Divisional meetings Trust Board CQRM LMNS Quality meeting		PDM Team Ongoing	Funding	No risk identified

Human factors Training. A Human Factors faculty is being developed within the Trust to facilitate training once or twice per month	Evaluation Compliance	Safety Champions to attend once identified		PDM Team QI Team Ongoing	Funding	No risk identified
Human factors train the trainer. One off study day in July 2020	Further funding from HETV to send more staff on train the trainer training April/May 2020			PDM Team Ongoing	Funding	No risk identified
Appreciative Inquiry introduced as a way of reviewing incidents exploring the feelings and experiences of staff and women.	November 2020 Evaluation Compliance	CSU meetings Divisional meetings Trust Board CQRM LMNS Quality meeting	Further staff training	HoM ADO Ongoing QI Team	Funding	No risk identified
3 MDT training events LMNS	Participation	LMNS Quality meeting				No risk identified
Annual Staff Survey	Feedback	CSU Divisional Trust Board	Action plan formulated from feedback	Head of Midwifery Divisional Triumverate.		
Gap Grow	Compliance	CSU, Divisional Board			Funding?	No risk identified
'Hotwash' sessions as evidence of using AI technique to start conversations, share stories and co-create	Attendance Feedback	CSU Divisional	Act upon feedback and lessons learned from process	QI Team		No risk identified

change in a safe non blame culture						

Immediate and essential action 4: Managing Complex Pregnancy
There must be robust pathways in place for managing women with complex pregnancies

Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

- Women with complex pregnancies must have a named consultant lead
- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team

Link to Maternity Safety Actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

What do we have in place currently to meet all requirements of IEA 4?	What are our monitoring mechanisms?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
We can confirm a named Lead Consultant for complex pregnancies and another lead clinician for complex fetal medicine cases.	We plan to introduce monitoring mechanisms in place.	Once the monitoring is in place, the result will be reported to CSU meeting and an audit cycle of compliance will be established.	We need to monitor if all complex patients are coming to the named clinicians and the specialist clinics. Clear identification process to be	External referral record will be kept by the lead clinicians (maternal and fetal medicine). Internal referrals need to come	Will need midwifery support to keep record of referrals from anc.	We will conduct a quick scoping audit of all patients on general ANC lists in last 2 weeks of January to

We refer to John Radcliffe Hospital Oxford when required.			developed to ensure oversight of patients referred to local MDT (Cardiac, renal, haematology, neurology, gastroenterology) or external referral to Oxford.	through the lead clinicians for governance purposes. A Diary will be used whilst the longer term solution with electronic diary is being developed Both of these will be continuous processes starting from the beginning of Feb 21	We will need a doctor or midwife for data collection. SPA time is required to conduct audit (i.e make audit tool, engage staff, increase awareness review results) and present at meetings.	ensure that no high-risk patient is put on these. Usually, high risk patients automatically get referred to the respective lead clinicians.
We can confirm we have an agreement on criteria for referral to maternal medicine specialist centre	Audit	CSU				
Women with complex pregnancy have a named consultant	We plan to introduce monitor compliance that women with complex pregnancy have a named consultant.		Develop a guideline with an audit cycle to monitor all women with complex pregnancies	Antenatal Clinic Lead Midwife		Datix any women who are identified as not being referred and ensure they are allocated to an appropriate named consultant.
Women with complex pregnancies are referred for specialist involvement and management plans developed from	Risk assessment is carried out using the risk assessment booking form for all women.		Develop a Guideline with an audit cycle to monitor all women with complex pregnancies.	Antenatal Clinic Lead Midwife		Datix any women who are identified as not being referred and escalate to ensure women

booking risk assessment						is placed on correct pathway.
We can confirm compliance with some elements of SBLV2. There are five elements and we are compliant with various actions within each element.	Action Plan Compliance and trajectory is reliant upon meeting standards such as Fetal Surveillance Midwife and Ultrasound capacity. Oxford are going to support with training for doppler scans to enable compliance. Trajectory of compliance .	CSU Divisional	Create a dashboard to provide assurance on compliance. Carry out SGA Audit to establish the current baseline.	Consultant Midwife	Dedicated Midwife for SBL/Fetal surveillance Midwife	Workstream Leads for each element
We can confirm we have a consultant in place for complex pregnancy and regular audit						

Immediate and essential action 5: Risk Assessment Throughout Pregnancy
Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

- All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional
- Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.

What do we have in place currently to meet all requirements of IEA 5?	What are our monitoring mechanisms and where are they reported?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
We can confirm that we are compliant with some elements of Saving babies Lives Version 2 There are five elements, and we are compliant with various actions within each element	Saving Babies Lives Action Plan Compliance and trajectory is reliant upon meeting standards such as Fetal Surveillance Midwife and Ultrasound capacity. Oxford are going to support with training	CSU meetings Operational CQRM meeting Trust Board	Audits Monitoring of the action plan is with the Consultant Midwife.	Consultant Midwife Midwifery and Obstetric teams	MDT engagement Ultrasound	Guidelines SOP

	for doppler scans to enable compliance. Audits					
We can confirm that we have risk assessment at antenatal appointments. Risk assessment at booking appointment, first consultant appointment, 28 week appointment and 36 week appointment.	Risk Register	CSU meetings Trust Executive Group Audit afternoon	Development of a paper risk assessment to be used until an electronic tool is developed. Development of an electronic risk assessment tool for every contact in eCare. Audit of compliance post implementation of tool.	MDT April 1st 2021	MDT to develop tool eCare support team. CNIO	Communication to MDT Paper risk assessment handheld records
Review of place of birth in risk assessment at antenatal contact. Booking appointment and 36 week appointment. 'My personalised Maternity Journey ' booklet which is given out with every booking.	Audit	Audit afternoon	Further education with offer of place of birth. Develop accessible information for women regarding choice of place of birth setting expectations related to the options with an evolving clinical picture.		Comms Team Patent and Family Experience Team.	Communication to MDT Paper risk assessment handheld records Guidelines SOP
Consultant Midwife Clinic	Clinical Care plans	Consultants meeting Labour ward forum CSU	Support ongoing provision of clinic	Consultant Midwife Senior Midwife	Midwifery Input	SOP

Personalised Care Plans are in place as of February 2021 planned audit to be undertaken .	Audit Patient and Family Experience Team	Audit afternoon	Implementation of Personalised Care plans	LMNS April 2021	LMNS Training	PMA's Consultant Midwife Community Midwives plans
Online referral with links to health promotion and fast track access to women with medical conditions ie Sickle Cell	Electronic referral has questions and links to follow to fast-track women who identify they have a medical condition. Audit	Audit afternoon CSU	Further refine links to women in the online referral system	MDT April 1st 2021		Communication to MDT Paper risk assessment handheld records Guideline SOP
Gap Grow Training	Compliance	CSU Divisional	Continue to monitor compliance with practice development department keeping live log of compliance	Practice Development Team Ongoing		

Immediate and essential action 6: Monitoring Fetal Wellbeing

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -

- Improving the practice of monitoring fetal wellbeing –
- Consolidating existing knowledge of monitoring fetal wellbeing –
- Keeping abreast of developments in the field –
- Raising the profile of fetal wellbeing monitoring –
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported –
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

What do we have in place currently to meet all requirements of IEA 6?	How will we evidence that our leads are undertaking the role in full?	What outcomes will we use to demonstrate that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support	How will we mitigate risk in the short term?

					do we need?	
PROMPT Training	Clear job description for obstetric and midwifery leads Annual PDR Achievement of set objectives from job descriptions	Compliance records Reduction in CTG interpretation incidents	Training paper to Executives to increase from 3 to 5 days mandatory training Business case to develop a lead role for fetal surveillance midwife Lead Obstetrician identified through job planning	HoM ADO PDM Team	Financial support Trust Board	PDM with an interest in CTG monitoring Guidelines
Plan to identify midwife or obstetrician with demonstrated expertise to focus on and champion best practice in fetal monitoring .			Develop the role of a fetal surveillance Midwife. Review specialist midwives remits.	Head of Midwifery	Financial support	K2 Training Practice development Midwife CTG Meeting
CTG Training - Edwin Chandrahan, Dawes Redman training	Clear job description for obstetric and midwifery leads Annual PDR Achievement of set objectives as defined in job description	Compliance records Reduction in CTG interpretation incidents	Business case to develop a lead role for fetal surveillance midwife Lead Obstetrician identified through job planning	HoM ADO PDM Team	Ring fenced finances for training	PDM with an interest in CTG monitoring Guidelines

K2 training annually	Clear job description for obstetric and midwifery leads Annual PDR Achievement of set objectives as defined in the job description	Compliance records Reduction in CTG interpretation incidents	Training paper to Executives to increase from 3 to 5 days mandatory training	HoM ADO PDM Team	Ring fenced finances for training	PDM with an interest in CTG monitoring Guidelines
CTG meetings	Clear job description for obstetric and midwifery leads Annual PDR Achievement of set objectives as defined in the job description	Compliance records Reduction in CTG interpretation incidents	Business case to develop a lead role for fetal surveillance midwife Lead Obstetrician identified through job planning	PDM Team		PDM with an interest in CTG monitoring Guidelines

Immediate and essential action 7: Informed Consent
All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care

Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care

Women's choices following a shared and informed decision-making process must be respected

Link to Maternity Safety actions:

Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Link to urgent clinical priorities:

a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

What do we have in place currently to meet all requirements of IEA 7?	Where and how often do we report this?	How do we know that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Place of birth information is easily accessible.		Picker Maternity Survey. Continuity of Carer Team survey which is shared with MVP and Lead Midwife for data	Develop online resources for women with place of birth choices Develop a robust system to document that place of birth is	Community Midwifery Matron June 2021	IT Support Communications MVP co-production support	Community Midwifery

		and outcomes to produce reports Survey shared with PALS	discussed and documented			
Information is easily accessible for aspects of maternity care through antenatal intrapartum and postnatal period		Picker Maternity Survey Continuity of Carer Team survey	Develop further online resources	Community Midwifery Matron April 2022	IT Support Communications MVP co-production support	Community Midwifery
Maternity Website		Patient satisfaction survey Picker Maternity Survey Number of complaints on Trust performance dashboard	Development of the maternity website to include access to all current guidelines Research decision making tools available and their application in practice	Community Midwifery Matron Communications department Maternity and obstetric teams	IT Support Communications MVP co-production support Patient and Family Experience Team	Community Midwifery
Personalised Care plans. Women's choices are respected and evidenced.	'My personalised Maternity Journey' document developed across the LMNS is being used and given to all women at booking.	Audit Number of complaints on Trust performance dashboard	Follow up feedback process to provide timely feedback from women.	April 2021 LMNS	Community Midwifery Matron Patient and Family Experience Team	
Confirmation of working to embed a method of recording decision making processes that includes women's participation.			Development of a maternity informed consent SOP Informed consent training	Head of Midwifery April 2022		

			Research decision making tools available			
Informed consent Policy exists which is Trust wide			Development of a maternity informed consent SOP Informed consent training Research decision making tools available to assist women and professionals to ensure informed consent.			Development of Maternity Informed Consent Policy
PILs	Patient Experience Board CSU meetings Divisional meetings Guidelines Meetings			Develop widening participation with diversity and inclusion a priority to inform PILs.	Patient and Family Experience Team	Regular review and update of PILS
Guidelines	CSU meetings Divisional meetings Guidelines meetings					Regular review and update of guidelines
Online referral with links to health	Audit	Audit afternoon CSU	Further refine links to women in the online referral system			Paper risk assessment handheld records

promotion and ANNB screening advice						
Advocates	PALS Complaints	Audit Patient feedback	Awaiting national guidance on Advocacy Training on unconscious bias		Communication department Practice Education Team.	PMA's Birth Afterthoughts Midwifery advocacy Appreciate Inquiry Human factors training Civility
Information on Trust Website regarding care pathways. Links to sickle cell, diabetes, weight management, smoking cessation, Blood born virus and place of birth option.					IT support to develop Trust Website	

Section 2

MATERNITY WORKFORCE PLANNING

Link to Maternity safety standards:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard
Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.

What process have we undertaken?	How have we assured that our plans are robust and realistic?	How will ensure oversight of progress against our plans going forwards?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Medical Workforce The Guardian of Safe Working Hours submits reports to the Trust Board, with detailed discussion at the Workforce Assurance sub-committee of the Board.	Monitoring of exception reports	Denary report feedback	Action plan from Deanery visit	College Tutor CSU lead DME		
Trainee responses to GMC surveys are reviewed via the Trust's Medical and Dental Education Committee (MADEC),	The Trust Board's Quality and Clinical Risk Committee (an assurance sub-committee of the Board, led by non-executive directors)	GMC Survey Feedback from Junior Doctor Forum	Conduct monthly Junior Doctor Forum	College Tutor		

and escalated by exception.	has had detailed discussion of trainee experience in obstetrics and gynaecology across 2019 and 2020.					
Midwifery Workforce Midwifery workforce planning system in place	Birthrate Plus assessment and plan in place April 2018 Midwife to Birth ratio One to one care in labour	Bi monthly maternity staffing paper to Trust Board Midwife to birth Ratio Continuity of Carer staffing recommendations followed	Continual recruitment to vacancies Escalation of staffing concerns to Board Safety Champions 2 yearly staffing review Staff survey Monitoring recruitment and retention of staff Scoping exercise to assess whether Birth Rate + is the most appropriate staffing model to use.			Bank and Agency usage

MIDWIFERY LEADERSHIP

Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care

The seven steps to strengthen midwifery leadership
1 A Director of Midwifery in every trust and health board, and more Heads of Midwifery across the service
2 A lead midwife at a senior level in all parts of the NHS, both nationally and regionally
3 More consultant midwives
4 Specialist midwives in every trust and health board
5 Strengthening and supporting sustainable midwifery leadership in education and research
6 A commitment to fund ongoing midwifery leadership development
7 Professional input into the appointment of midwife leaders

The Head of Midwifery is part of the triumvirate leadership within the Women's and Children's Division and is responsible and accountable to the Executive Chief Nurse. There is a Deputy HOM role recently introduced to the leadership structure to strengthen the senior leadership within midwifery, providing the HOM with the ability to deliver all aspects of their portfolio and strengthen the external partnership collaborative working across the LMNS. The deputy role will also give exposure and insight for the post holder into the HOM role and provides succession planning and career development. There are 11 specialist midwives that cover the breadth of services and governance required to meet the standards including bereavement midwife; safeguarding lead midwife; perinatal midwife; teenage pregnancy midwife; risk midwife; guidelines midwife; diabetes specialist midwife; infant feeding specialist midwife; outcome and data midwife; antenatal and newborn screening midwife. Additionally, there are 3 Practice Development Midwives. The Trust provides a 2 year preceptorship programme and a band 6 leadership development course. There are research studies with a research midwife who is supported by the research and development team with a professional responsibility to the HOM. The Trust actively supports the leadership development of midwives and provides a wide range of courses internally and externally with NHS Leadership Academy and HEI's. Funding is available for master's modules and courses to develop midwives in their career progression. We currently have 1 consultant midwife and currently advanced practice is under review across the organisation to provide a framework to support advanced practice and academic careers. At the recent HOM interviews the regional Chief Midwife was a panel member.

NICE GUIDANCE RELATED TO MATERNITY						
We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.						
What process do we have in place currently?	**Where and how often do we report this?**	**What assurance do we have that all of our guidelines are clinically appropriate?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
The Trust has Implementation and Management of NICE Guidance Policy that outlines roles & responsibilities & processes for NICE review/base line assessments & action plans for areas where not/unable to comply	NICE compliance is reported as a Trust KPI (total number of nice breaches) on Trust & divisional dashboards which are received at TEG & highlighted at CSU/Divisional governance meetings	Trust has a robust approval process for clinical guidelines, including reference review by the Library before local sign off, presentation at Trust Documentation Committee & final approval at Trust Executive Group	With Covid, breaches in NICE guidance have increased due to limits on clinical staff involvement – review & rag rate for those of priority	Clinical Governance Leads with relevant clinical staff		

Meeting title	**Trust Board**	**Date: 11.03.21**
Report title:	**Directorate of Patient Care**	**Agenda item: 3.5**
Lead director **Report author** **Sponsor(s)**	**Name: Nicky Burns-Muir** **Name: Sam Donohue**	**Title: Director of Patient Care and Chief Nurse** **Title: Deputy Chief Nurse**
FoI status:		

Report summary							
Purpose *(tick one box only)*	**Information**	x	**Approval**		**To note**	x	**Decision**
Recommendation	For information.						

Strategic objectives links	Objective 1. – Improve Patient Safety Objective 2. – Improve Patient Care
Board Assurance Framework links	
CQC regulations	
Identified risks and risk management actions	
Resource implications	Increased safeguarding activity and complexity.
Legal implications including equality and diversity assessment	None as a result of this report.

Report history	

1. Purpose of the Report

The presentation of children and young people to Milton Keynes University Hospital (MKUH) who require a safeguarding referral has altered in pattern and complexity since the onset of the COVID-19 pandemic. The purpose of this paper is to provide the Trust Board with an overview of children's and young people safeguarding activity in quarters 1 - 3, prior to the Board receiving the Annual Safeguarding report later in 2021.

2. Context

The Trust recognises that safeguarding is everybody's business and has specific responsibilities and duties in respect of safeguarding children and young people.

Safeguarding Children includes:

- Protecting children from ill-treatment
- Preventing Impairment of children's health and development
- Ensuring children grow up in circumstances consistent with the implementation of safe and protected care
- Taking action to enable all children to have the best outcomes in life

The conditions created by the COVID-19 pandemic have altered the access children and young people have to spaces outside of their home, increasing vulnerability and impacting access to social support and connections. National research led by the NSPCC (2020) [1] identified 3 areas of risk:

1) Increase in stressors to parents and care givers
2) Increase in children's and young people's vulnerabilities
3) Reduction in normal protective services.

The national concern in regard to the safety of children and young people has been mirrored locally. Throughout the last year we have worked closely with colleagues and services across Milton Keynes to address this increased risk, liaising with local services to ensure that these vulnerable children and their families stay within our sight.

3. Activity

3.1 Pattern and number of safeguarding referrals

There were 624 multi-agency referrals (MARF) for children and young people originating from MKUH between April and December 2020. The number of referrals dropped in April and May 2020 (corresponding with the first national lockdown) and rose to a peak of 100 referrals in November 2020. In comparison in 2019 there was a total of 798 referrals, and these were spread more consistently across each quarter.

3.2 Rationale for referral

The 624 MARF referrals from April to December 2020 were predominantly created by the emergency department who have seen an:

[1] NSPCC (2020) Isolated and Struggling. Social isolation and the risk of child maltreatment, in lockdown and beyond. NSPCC: London.

- Increase in the complexity of mental health challenges amongst children and young people.
- Increase in the number of young people who require Tier 4 Mental Health Placement
- Increase in the number of infants (under 2 year olds) attending with injuries.

The pattern of referrals made by the emergency department was sporadic with an increase in referrals from 13 in May to 84 in November 2020.

Table 1: MARF referrals by department

MARF Department Referrals April - December 2020										
Department	April	May	June	July	August	September	October	November	December	Total
Emergency Department	17	13	57	48	57	49	74	84	69	468
Maternity	7	9	8	15	9	4	13	11	17	93
Occupational Therapy	0	0	0	1	0	0	0	0	0	1
Other	1	9	1	0	0	0	0	0	0	11
Paediatrics	1	6	7	5	3	3	1	3	2	31
Safeguarding	1	0	3	1	3	6	1	2	2	19
Ward 1	0	0	0	0	0	0	1	0	0	1
Total	**27**	**37**	**76**	**70**	**72**	**62**	**90**	**100**	**90**	**624**

Of these 624 referrals the majority were for mental health concerns (an increase from last year), the child behind the adult and child exploitation. There were also 89 referrals for additional support for families which included housing support and early interventional work.

The complexity of referrals has been noted locally and nationally and the emergency department and inpatient wards have seen a rise in complex children requiring physical and/or mental health support in the last year. There has also been a rise in young people age 16-18 year admitted to our adult inpatient wards.

Table 2: Referrals by theme

Referral Theme April - December 2020	April	May	June	July	August	September	October	November	December	Total
Child Behind the Adult	3	6	13	15	15	7	15	7	18	99
Child Exploitation	7	6	14	9	6	10	10	13	8	83
Child Mental Health	4	6	13	11	22	24	32	54	38	204
Domestic Abuse	0	3	1	0	1	3	0	1	1	10
Maternity	2	4	7	12	3	3	6	4	6	47
Other	2	0	0	0	0	1	0	0	0	3
Parental Mental Health	1	1	1	1	1	1	0	1	1	8
Section 17	0	0	0	0	0	0	1	2	0	3
Section 20	0	0	0	1	2	1	0	1	2	7
Section 47	2	0	3	3	3	6	3	6	0	26
Sexual Abuse	0	0	0	1	0	0	0	0	0	1
Substance Misuse	4	1	8	6	8	0	7	5	5	44
Support	2	10	16	11	11	6	16	6	11	89
Total	**27**	**37**	**76**	**70**	**72**	**62**	**90**	**100**	**90**	**624**

3.3 Outcome of referral

To date 102 of these referrals have been actioned and closed, 38 closed with no action, 95 signposted for early help and 116 open to children's social care services. The remainder are in process of being reviewed.

Table 3: Outcome of referral

MARF Outcomes	Q1	Q2	Total
Actioned and Closed	48	54	102
Closed No Action	15	23	38
Open to Children's and Family Practice	33	62	95
Open to Children's Social Care	47	69	116
Total	**143**	**208**	**351**

3.4 Child Protection medicals

There has so far been a slight increase in the number of Child Protection Medicals undertaken by the Trust in Q1/Q2/Q3 2020. Consistent with the MARF referrals there was an increase in Child Protection medicals in July following the ceasing of lockdown and October once schools had reopened.

Table 4: CP Medicals per month

Month	April	May	June	July	August	September	October	November	December
No CPM	0	2	5	7	4	3	6	2	0

4. Collaborative working

There are multiple examples of close collaborative working across agencies to improve the outcomes of vulnerable children and young people, and to build resilience in the system as the complexity of cases increases. The resource available across the system to provide appropriate support and places of safety is of concern and topic of current discussion across MKUH and partner agencies.

4.1 Board level collaboration

The Chief Nurse attends the MK Together Management Board, the deputy chief nurse attends the MK Assurance Board and the Head of Nursing for Quality and Safeguarding chairs the MK Case Review Board. Each of these boards have membership drawn across

health, social care, education, police and community services. The Chief Nurse also chaired the Restraint Review at Oak Hill Training Centre (a local secure centre for young people in custody) in 2020.

4.2 Case reviews

Case reviews are undertaken when a child dies or is seriously harmed. They are undertaken by the MK Together multi agency panel and result in learning identified and a corresponding action plan.

Since April 2020 there have been 8 case reviews, 4 of which are new referrals, 1 a delayed referral (delay due to legal case) and a further 3 that have been completed and being processed for points of multiagency learning.

Specific themes drawn from the case reviews in 2020 has been the need for identification of parental responsibility, the role of fathers and step-fathers and the need for increased professional curiosity and questioning. Additional training on professional curiosity has been developed by one of the system partners and disseminated with front door teams at MKUH.

4.3 CCG Safeguarding collegiate working

During the first wave of the pandemic Milton Keynes CCG safeguarding colleagues joined the safeguarding team at MKUH. The collegiate working and mutual appreciation of roles has enhanced the working relationship across the system and was positively appraised by all involved.

4.4 Covid-19 Young People meeting

This was established during first wave of the pandemic to facilitate oversight of complex families. The meeting is chaired by the Lead Nurse of Children's Services at MKUH and represented by CCG, CNWL and CAMHS. The group is currently on hold due to the redeployment of the MK CCG safeguarding staff to support the regional vaccination programme.

4.5 Safeguarding Leads

The CNWL and MKUH Safeguarding Leads meet regularly to discuss safeguarding cases that cross both sectors of the health economy.

5. Safeguarding Children training

Safeguarding children training is mandatory for all MKUH staff. The level of training required depends on the staff members contact with children within their roles and includes training on Child Sexual Exploitation, Female Genital Mutilation, Neglect and Perplexing presentations (Fabricated Induced Illness).

Table 5 Safeguarding Children Training Level

Level 1	All non-clinical staff and volunteers
Level 2	All clinical staff
Level 3	All high-risk areas, i.e. Emergency Department, Paediatrics and Maternity
Level 4	All Lead personnel e.g. Lead Nurse Safeguarding Children/ Executive Lead.

During the first wave of COVID-19 all safeguarding training, in line with national directives moved to an online format. Our training compliance has remained over 90% at Level 1 and 2 and over 86% at level 3. The team will look to move to a blended learning model in the new year for level 3 training incorporating learning from the serious case reviews.

Month	April	May	June	July	August	September	October	November	December
Level 1	96%	95%	96%	97%	97%	96%	96%	97%	97%
Level 2	95%	94%	95%	95%	96%	96%	96%	96%	97%
Level 3	91%	89%	87%	89%	88%	86%	87%	91%	89%

6. Recommendations

A comprehensive annual report will be brought to Trust Board in June 2021. It is recommended that the Board note the increase in complexity of safeguarding referrals for children and young people seen in 2020 .

Meeting title	Board	Date: March 2021
Report title:	Freedom To Speak Up (FTSU) Annual Report	Agenda item: 3.6
Lead director Report author	Name: Danielle Petch Name: Philip Ball	Title: Director of Workforce Title: Lead FTSU Guardian
FoI status:	Public	

Report summary	This report is to provide an update on the FTSU activities across the Trust in 2020			
Purpose *(tick one box only)*	Information [x]	Approval [ ]	To note [ ]	Decision [ ]
Recommendation	Trust Board is asked to note the contents of the report.			

Strategic objectives links	
Board Assurance Framework links	
CQC outcome/ regulation links	Well Led Outcome 13 : Staffing
Identified risks and risk management actions	
Resource implications	
Legal implications including equality and diversity assessment	

Report history	None
Next steps	
Appendices	None

Freedom to Speak Up Guardian Annual Report 2020

Executive Summary

This is the annual Freedom to Speak Up (FTSU) report is for the period January 2020 to December 2020. The Freedom to Speak Up Guardian (FTSUG) is a developing role across the NHS and within Milton Keynes University Hospital (MKUH). Philip Ball, is Lead Guardian and Lead Nurse Palliative and End of Life Care.

The National Guardian's Office (NGO) expects Guardians to report twice a year to the Trust Board in person.

In the year under consideration, six concerns have been raised, including one involving a joint complaint. Five were reported as having some element of bullying and harassment involved, one with some detriment. At the time of writing four cases were dealt with through intervention with line managers or workforce directorate assistance. One case was complicated by the actions of the person speaking up, and they have since left the Trust. The last case outstanding is moving towards resolution, though that is likely to lead to a resignation.

There have been some changes in the people acting as Guardians during this time even though COVID-19 restrictions led to the closure of the main office of the NGO and the lack of face-to-face training. This was rectified by the end of 2020 with the provision of introductory training, provided online by the NGO.

The Lead Guardian has recruited new FTSU Guardians and FTSU Champions over the last year. The new Guardians are Jade Browning, Karen Philips, Angela Legate, Lizzie Taylor and Christina Theophile-Clarke. These are now supported by seven FTSU Champions who act a first points of contact and signposts to the FTSU Guardians where required. The FTSU Champions from MKUH and other workplaces benefited from a bespoke training package delivered in Dec 2020 online by Liz Keay, Regional FTSU Trainer, arranged and facilitated by Philip Ball. The edited training recording has since been shared with other FTSU Guardians across the East of England FTSU network.

Until these FTSU Guardians there was only one FTSU Guardian at MKUH in 2020. Protected time for FTSU Guardians was agreed and put into Trust policy during the year. This is being operationalised with managers as the Trust resumes BAU following Covid-19 adjustments.

Developing the Role and profile of the Freedom to Speak Up Guardian in MKUH

The Freedom to Speak Up Guardian is not part of the management structure of the Trust and is able to act independently in response to the concerns being raised. The FTSU Guardian reports directly to the Chief Executive, and this gives them access to the executive directors of the Trust. The Guardian is usually supported by an Executive and Non-Executive Director. There are two key elements to the role:

- To give independent, safe, and confidential advice and support to members of staff who wish to raise concerns that could have an impact on patient safety and experience.
- To promote a culture where members of staff feel safe to raise concerns and do not fear adverse repercussions as consequence.

There is a dedicated email address freedomtospeakup@mkuh.nhs.uk for staff to contact the FTSU Guardians, a telephone extension is available (ext. 86296), and there is now a mobile phone number that is a direct route to contact a FTSU Guardian 07779 986470. This way of contacting the FTSU Guardians is particularly useful for staff who do not normally use email. This has a drawback in that the caller can be anonymous making feedback and changes difficult.

The NGO has encouraged the development of the FTSU Ambassador/Champion role – mainly as a way of signposting staff either to the FTSU Guardians, or to other support systems within the organisation, where their concerns may be more appropriately addressed. This has been particularly helpful in MKUH where the only FTSU Guardian for much of 2020 already had a full-time role. At the time of writing 5 people were trained to be FTSU Guardians and 7 FTSU Champions were identified. This willingness to become engaged in FTSU activity is a testament to the openness of the Trust. The NGO has since restarted introductory training online for FTSU Guardians.

Freedom to Speak Up activities in the Trust – working on the culture

Philip Ball has been participating in East of England FTSU Guardians network meetings and attending web-based events put on the NGO. October is the Speak Up Month and with the aid of the Communications team engaged in daily activity on social media, particularly Twitter.

As noted earlier in this paper, one of the aims of Sir Robert Francis' recommendation was to help establish a culture of openness within the NHS. The MKUH FTSU Guardian, supported by the Director of Workforce as executive lead, is helping to achieve this in several ways including:

Raising awareness: All new staff are to be given information about Freedom to Speak Up as part of corporate induction and presentations have been given to student nurses and medical students. Philip Ball has recorded a video introduction that is with the Learning and Development team for final editing. The NGO has provided a short web-based training package that all staff can access, via https://www.e-lfh.org.uk/programmes/freedom-to-speak-up/ and it is hoped to have this embedded in induction training requirements. A training package for Executives at Board level is expected to be rolled out soon.

An improved intranet page is in place and fresh posters with names of FTSU Guardians and with reminders of ways to speak up has been prepared. Making sure that communications about staff support include references to FTSU, as this has been lacking on occasion.

The FTSU Guardian plans to set up a programme, time permitting, whereby FTSU Guardians and or FTSU Champions attend team meetings to deliver short presentations to promote FTSU. The FTSU Guardians may also be invited to attend meetings of the newly formed staff networks.

Staff Development: Unregistered care staff can often find it harder to raise concerns but spend most time in direct contact with patients. There is a need to develop opportunities to engage with professional groups and within leadership development training to empower staff to feel confident about speaking up, and to prepare managers to receive feedback from their staff when they have concerns.

Influencing cultural change: FTSU will be a key workstream in the MKUH MKWay/Kinder Culture programme being rolled out throughout 2021. This programme aims to develop a kind, supportive, collaborative culture across the Trust, enabling people to speak up safely. It is hoped this programme will not only raise awareness of and embed a culture of speaking up but also reduce bullying and harassment across the Trust.

Plans for 2021 -

- With the appointment of Philip Ball as a new FTSU Guardian, and the appointment of new FTSU Guardians and FTSU Champions, it is intended that the approach to FTSU be re-launched during 2021 and for October 2021, as it is the 'Speak Up' month.
- The addition of questions on the leaver's questionnaire about awareness of the FTSU Guardians and whether they had used the service.
- To participate in the development of the role of the Freedom to Speak Up Guardian and become active in the new East of England regional group.
- Evaluation of the effectiveness of the Freedom to Speak Up Guardian role in the Trust through use of feedback to the FTSU Guardian about how well use of the service has worked.
- Become regular contributors to team, departmental and divisional meetings; engage with networks such as the Disability and BAME that are developing at MKUH.
- Develop a FTSU leaflet that can be given to all new starters as well as current staff, with a version available in the Trust Intranet.

Recommendation

The Trust Board is asked to note the contents of this annual report by the Freedom to Speak Up Guardian.

Philip Ball, FTSU Guardian, 2nd March 2021

The Freedom to Speak Up Guardian

We want to have a culture of raising and reporting concerns.

Philip Ball is your Lead Freedom to Speak Up Guardian, working with the other Guardians at MKUH

The Freedom to Speak Up Guardian is a role which has been developed nationally following recommendations from the Francis Report. Every NHS organisation is required to appoint a FTSU Guardian to be an independent point of contact for those wishing to raise concerns.

What do the Guardians do?

Clarify – What was / is the issue?

Explore - What happened and who was involved?

Options – Help decide what should happen next

Actions – Depending on the issue, support, signposting, further exploration

What does this involve?

- Providing immediate support and signposting for staff members raising concerns, determining the best course of action, and advising the staff member of their options
- Start the facilitation of discussions between staff and management as appropriate
- Act as the interface between employees and other areas of our Trust in cases where employees wish to remain anonymous
- Be a link to staff side colleagues to gain support and improve resolution results
- To keep a record of concerns raised and feedback as appropriate
- Further develop a culture of openness and freedom for staff to raise concerns to their managers that will be explored and resolved, and lessons shared.

Guidance for staff – Raising Concerns

1 Role of the Freedom to Speak Up Guardian (FTSUG)

This is an independent, impartial role in the organisation with direct access to the board of directors and supported by the National Guardian Office. The role was created primarily as additional support to staff who have concerns and to promote a more effective speaking up organisational culture.

Speaking up to a guardian is the first step in discussing the concern you have. The discussion can be by telephone, online, in person, or an email meeting. The guardian can help you express your concern, review what you have already done, explore options, agree an action plan, and ensure you are receiving the appropriate support.

There are clear boundaries to the role of the guardian, that is, not to replace or undermine existing support mechanisms (for example trade unions, professional bodies, line managers, human resources). It is not the role of the guardian to become involved in investigations or representation of staff; however, the guardian does need to ensure the appropriate actions are being taken.

2 Status of discussions

It is hoped that staff will feel comfortable to raise your concern openly. Any information provided to your Freedom to Speak Up Guardian will remain confidential, unless agreed otherwise or in situations where confidentiality cannot be kept; for example, patient care and safety, criminal activity, safeguarding, health and safety. At the end of the discussion, the FTSUG will summarise agreed actions and clarify which other persons are to be involved and how much information they should be given.

It will be usual to involve HR management, where a situation relates to people issues. Equally, if the concern can be shared with line management, experience shows that this will help to achieve an effective resolution. Furthermore, wherever possible and in the most appropriate way, any staff member (who is subject of concern) will be advised of the concern and its content. How this will be done will be fully discussed.

3 Information Governance

The FTSUG will log the concern raised in a confidential database. The information captured includes category of concern, job role, key dates, desired outcome, actions agreed, feedback and learning, and monitoring for equality and diversity purposes. This record of concerns is confidential to the FTSUG and the Head of Patient Safety and Safeguarding. The record is used for reporting purposes: to the hospital board twice-yearly and the National Guardian Office. No individual is identified in any report made.

4 Is there a difference between raising a concern and whistleblowing?

Our Trust's Speaking Up policy and procedure covers the widest range of concerns, some of which will be directed to other Trust policies and procedures, for example grievance, dignity and respect in the workplace and fraud. You will hear a few phrases in relation to this area: speaking up, whistleblowing, raising concerns. MKUH wants to make it as easy as possible for staff to raise concerns particularly when the normal line manager or support arrangements are not working. A discussion in the first instance with the FTSUG will help assess how best to do this.

The Trust's overriding principle is that it welcomes staff raising concerns in a culture of openness and dialogue. The same legal protection will be given to all workers who raise a concern which falls within the Public Interest Disclosure Act guidelines.

5 Support to staff raising concerns

MKUH will not tolerate harassment or victimisation of a worker who has raised a concern; workers in this situation have legal rights with regards to this. If you feel you are being subjected to this treatment because of raising your concern, you should inform the manager dealing with your concern or the FTSUG. They will take the appropriate action, including following policies and procedures to remedy the situation.

6 Monitoring progress

The FTSUG will stay in touch with you at appropriate intervals to monitor progress or share updates, as relevant.

7 Feedback to staff raising concerns

In the spirit of openness and transparency, which characterises an effective speaking up culture, staff raising concerns will be updated on outcomes, however, where patient confidentiality or our Trust's employment obligations to its staff are concerned, it will not always be possible to give full feedback on the actions being taken. When the concern is closed, feedback on the process and support given to staff will be requested to maximise learning and inform future practice.

Where can I get help, support, and advice?

MKUH Guardians mobile – 07779 986470 leave a message if not immediately answered

Email: freedomtospeakup@mkuh.nhs.uk

Or contact Philip:

Tel: 01908 997302
Ext: 87302

Trust Performance Summary: M10 (January 2021)

1.0 Summary

This report summarises performance at the end of January 2021 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. It is important to highlight that the NHS Constitution Targets remain in situ and are highlighted in the table below.

Target ID	Target Description	Target
4.1	ED 4 hour target (includes WIC)	**95%**
4.2	RTT- Incomplete pathways < 18 weeks	**92%**
4.7	RTT- Patients waiting over 52 weeks	**0**
4.8	Diagnostic Waits < 6weeks	**99%**
4.9	All 2 week wait all cancers %	**93%**
4.10	Diagnosis to 1st Treatment (all cancers) - 31 days %	**96%**
4.11	Referral to Treatment (Standard) 62 day %	**85%**

However, given the impact of COVID-19 the performance of certain key NHS targets for January 2021 have been directly impacted. To ensure this is reflected, the monthly trajectory of these targets have been amended to ensure the revised trajectory is reasonable and reflect a level of recovery for the Trust to achieve and sustain the target set out in the NHS Constitution over the next 12 months.

2.0 Sustainability and Transformation Fund (STF)

Performance Improvement Trajectories

January 2021 performance against the Service Development and Improvement Plans (SDIP):

ID	Indicator	Target 20-21	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)	90.0%	90.0%	94.0%	83.4%	✗	▼	✓	
4.2	RTT Incomplete Pathways <18 weeks	79.0%	75.0%		53.2%	✗	▼		
4.9	62 day standard (Quarterly)	85.5%	85.5%		84.8%	✗	▲		

In January 2021, ED performance was 83.4% which was below the 95% national standard and the 90.0% NHS Improvement trajectory. This was the lowest performance reported for this standard for the financial year 2020/21.

When comparing the Trust's ED performance in January 2021, MKUH performance was better than the national overall performance of 78.5%. (see Appendix for details). MKUH also continues to compare favourably across the Peer Group comparator.

The Trust's RTT Incomplete Pathways <18 weeks performance stood at 53.2% against a national target of 92% at the end of January 2021. Undoubtedly, the performance of this key performance indicator continues to be adversely impacted by Covid-19.

The Trust has in place activity recovery plans, which will support further improvement in RTT performance and closely manage the cancellation of any non-urgent elective activity and treatment for patients on an incomplete RTT pathway.

Cancer waiting times are reported quarterly, six weeks after the end of a calendar quarter. They are initially published as provisional data and later finalised in line with the NHSE revisions policy.

For Q2 2020/21, the Trust's final 62-day standard performance (from receipt of an urgent GP referral for suspected cancer to first treatment) was 84.8% against a national target of 85%.

The final performance of the percentage of patients who started treatment within 31 days of a decision to treat was 94.8% against a national target of 96%. The percentage of patients who attended an outpatient appointment within two weeks of an urgent referral by their GP for suspected cancer was 81.8% against a national target of 93%.

3.0 Urgent and Emergency Care

In January 2021, two of the six key performance indicators measured in urgent and emergency care showed an improvement:

ID	Indicator	Target 20-21	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%	0.10%	0.06%	✓	▲	✓	
3.2	Ward Discharges by Midday	27%	27%	19.5%	14.3%	✗	▼	✗	
3.4	30 day readmissions			8.5%	8.8%		▼		
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)	53	53		76	✗	▼		
3.9	Ambulance Handovers >30 mins (%)	5%	5%	4.7%	8.6%	✗	▲	✓	
4.1	ED 4 hour target (includes UCS)	90.0%	90.0%	94.0%	83.4%	✗	▼	✓	

Cancelled Operations on the Day

In January 2021, one operation was cancelled (due to no HDU bed being available) on the day for non-clinical reasons.

Readmissions

The Trust's 30-day emergency readmission rate was 8.8% in January 2021 (the readmission rate in January 2021 may include patients that were readmitted with Covid-19). Although this was a very slight increase compared to the December 2020 readmission rate of 8.7%, it was an improvement when compared to readmission rates for May 2020 to August 2020.

Delayed Transfers of Care (DTOC)

The number of DTOC patients reported at midnight on the last Thursday of January 2021 was 10, six patients in Surgery and four patients in Medicine. This was the lowest number of delayed transfers reported since the end of July 2020 (8) and a notable reduction on December 2020 (16).

Length of Stay (Stranded and Super Stranded Patients)

The number of super stranded patients (length of stay of 21 days or more) at the end of the month was 76. This was the highest number of super stranded patients reported for the financial year 2020/21 and represents a net increase of 18 patients compared to the end of December 2020

Ambulance Handovers

In January 2021, the percentage of ambulance handovers to the Emergency Department taking more than 30 minutes was 8.6%. This was an improvement when compared to the December 2020 percentage of 11.6% but still the second highest percentage reported in the year to date since April 2020. Undoubtedly the performance of this key performance indicator has been adversely impacted by Covid-19.

4.0 Elective Pathways

ID	Indicator	Target 20-21	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%	76.2%	88.5%	✓	▲	✓	
3.5	Follow Up Ratio	1.50	1.50	1.72	1.47	✓	▲	✗	
4.2	RTT Incomplete Pathways <18 weeks	79.0%	75.0%		53.2%	✗	▼		

Overnight Bed Occupancy

Overnight bed occupancy was 88.5% in January 2021. This was consistent with the overnight occupancy level reported during December 2020, which was the highest that has been reported for this indicator during the financial year to date.

Follow up Ratio

The Trust outpatient follow up ratio in January 2021 was 1.47. This was an improvement on the December 2020 ratio of 1.61 and below the threshold of 1.50 for only the second time this financial year to date.

RTT Incomplete Pathways

The Trust's RTT Incomplete Pathways <18 weeks at the end of January 2021 was 53.2% and the number of patients waiting more than 52 weeks without being treated was 450. These patients were in Surgery (393 patients), Medicine (44 patients) and Women and Children (13 patients).

The performance of this key performance indicator is likely to have been directly influenced by the recent circumstances in the hospital as a result of Covid-19.

Diagnostic Waits <6 weeks

The Trust did not meet the national standard of fewer than 1% of patients waiting six weeks or more for their diagnostic test at the end of January 2021, with a performance of 74.9%. The January 2021 performance was lower than the December 2020 performance 81.5% the lowest that has been reported since the end of May 2020 and likely to have been influenced by the recent circumstances in the hospital as a result of Covid-19.

5.0 Patient Safety

Infection Control

In January 2021 there was one reported case of Clostridium difficile (C. diff) in Ward 19, four reported cases of E. coli (one case in Ward 17, one case in Ward 19, two cases in Ward 6 (DoCC)) and one reported case of MSSA in Ward 23(ACU). There were no reported cases of MRSA.

ENDS

Appendix 1: ED Performance - Peer Group Comparison

The following Trusts have been historically viewed as peers of MKUH:

- Barnsley Hospital NHS Foundation Trust
- Buckinghamshire Healthcare NHS Trust
- Homerton University Hospital NHS Foundation Trust
- Kettering General Hospital NHS Foundation Trust
- Mid Cheshire Hospitals NHS Foundation Trust
- North Middlesex University Hospital NHS Trust
- Northampton General Hospital NHS Trust
- Oxford University Hospitals NHS Foundation Trust
- Southport and Ormskirk Hospital NHS Trust
- The Hillingdon Hospitals NHS Foundation Trust
- The Princess Alexandra Hospital NHS Trust
- The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust

Burton Hospitals NHS Foundation Trust and Luton And Dunstable University Hospital NHS Foundation Trust were part of the peer group, but since Burton Hospitals NHS Foundation Trust merger with Derby Hospitals NHS Foundation Trust and Luton And Dunstable University Hospital NHS Foundation Trust merger with Bedfordshire Hospitals NHS Foundation Trust these trusts have ceased to exist. Note: In May 2019, fourteen trusts began field testing new A&E performance standards and have not been required to report the number of attendances over 4hrs since then. Kettering General Hospital NHS Foundation Trust, part of the MKUH peer group, is one of the fourteen trusts and therefore data for this trust is not available on the NHS England statistics web site (https://www.england.nhs.uk/statistics/).

November 2020 to January 2021 ED Performance Ranking

MKUH Peer Group Comparison - ED Performance	Nov-20	Dec-20	Jan-21
Homerton University Hospital NHS Foundation Trust	95.0%	85.7%	86.0%
Barnsley Hospital NHS Foundation Trust	76.9%	78.2%	85.2%
Milton Keynes University Hospital NHS Foundation Trust	92.2%	84.4%	83.4%
Southport And Ormskirk Hospital NHS Trust	82.8%	81.7%	78.2%
Mid Cheshire Hospitals NHS Foundation Trust	83.5%	71.2%	78.1%
Buckinghamshire Healthcare NHS Trust	81.4%	79.3%	76.9%
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	74.6%	67.1%	72.5%
North Middlesex University Hospital NHS Trust	88.8%	76.9%	71.4%
The Hillingdon Hospitals NHS Foundation Trust	84.2%	77.6%	71.4%
Oxford University Hospitals NHS Foundation Trust	85.3%	79.9%	71.2%
The Princess Alexandra Hospital NHS Trust	80.7%	73.2%	69.8%
Northampton General Hospital NHS Trust	72.7%	65.8%	67.8%
Bedfordshire Hospitals NHS Foundation Trust	-	-	-
Kettering General Hospital NHS Foundation Trust	-	-	-

*MKUH performance excludes the pending requirement to incorporate NHS 111 appointments at UCS.

Board Performance Report 2020/21
January 2021 (M10)

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

OBJECTIVE 1 - PATIENT SAFETY									
ID	Indicator	Target 20-21	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
1.1	Mortality - (HSMR)	100	100		NA	✗	▼		
1.2	Mortality - (SHMI)	100	100		NA	✗	▼		
1.3	Never Events	0	0	1	0	✓	▬	✗	
1.4	Clostridium Difficile	15	<13	3	1	✓	▼	✓	
1.5	MRSA bacteraemia (avoidable)	0	0	1	0	✓	▬	✗	
1.6	Falls with harm (per 1,000 bed days)	0.12	0.12	0.27	0.09	✓	▲	✗	
1.7	Midwife : Birth Ratio	28	28	27	25	✓	▼	✓	
1.8	Incident Rate (per 1,000 bed days)	40	40	72.13	54.31	✓	▼	✓	
1.9	Duty of Candour Breaches (Quarterly)	0	0	0	0	✓	▬	✓	
1.10	E-Coli	20	<17	18	4	✗	▼		
1.11	MSSA	8	<7	9	1	✓	▼	✗	
1.12	VTE Assessment	95%	95%	98.0%	98.2%	✓	▼	✓	

OBJECTIVE 2 - PATIENT EXPERIENCE									
ID	Indicator	Target 20-21	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.2	RED Complaints Received			0	0		▬		
2.3	Complaints response in agreed time	90%	90%	92.1%	93.2%	✓	▼	✓	
2.4	Cancelled Ops - On Day	1.0%	1.0%	0.10%	0.06%	✓	▲	✓	
2.5	Over 75s Ward Moves at Night	2,000	1,667	835	98	✓	▲	✓	
2.6	Mixed Sex Breaches	0	0	5	0	✓	▬	✗	

OBJECTIVE 3 - CLINICAL EFFECTIVENESS									
ID	Indicator	Target 20-21	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%	76.2%	88.5%	✓	▲	✓	
3.2	Ward Discharges by Midday	27%	27%	19.5%	14.3%	✗	▼	✗	
3.3	Weekend Discharges	70%	70%	64.1%	56.0%	✗	▼	✗	
3.4	30 day readmissions			8.5%	8.8%		▼		
3.5	Follow Up Ratio	1.50	1.50	1.72	1.47	✓	▲	✗	
3.6.1	Number of Stranded Patients (LOS>=7 Days)	198	198		196	✓	▼		
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)	53	53		76	✗	▼		
3.7	Delayed Transfers of Care	25	25		10	✓	▲		
3.8	Discharges from PDU (%)	15%	15%	8.4%	5.4%	✗	▼	✗	
3.9	Ambulance Handovers >30 mins (%)	5%	5%	4.7%	8.6%	✗	▲	✓	

OBJECTIVE 4 - KEY TARGETS									
ID	Indicator	Target 20-21	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)	90.0%	90.0%	94.0%	83.4%	✗	▼	✓	
4.2	RTT Incomplete Pathways <18 weeks	79.0%	75.0%		53.2%	✗	▼		
4.4	RTT Total Open Pathways	18,878	19,656		25,013	✗	▼		
4.5	RTT Patients waiting over 52 weeks		0		450	✗	▼		
4.6	Diagnostic Waits <6 weeks	99%	99%		74.9%	✗	▼		
4.7	All 2 week wait all cancers (Quarterly) ✎	93.0%	93.0%		81.8%	✗	▼		
4.8	31 days Diagnosis to Treatment (Quarterly) ✎	96.2%	96.2%		94.8%	✗	▲		
4.9	62 day standard (Quarterly) ✎	85.5%	85.5%		84.8%	✗	▲		

OBJECTIVE 5 - SUSTAINABILITY									
ID	Indicator	Target 20-21	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
5.1	GP Referrals Received	Not Available		45,121	3,674	Not Available	▲	Not Available	
5.2	A&E Attendances			61,179	5,708		▲		
5.3	Elective Spells (PBR)			12,680	1,373		▲		
5.4	Non-Elective Spells (PBR)			19,000	2,206		▼		
5.5	OP Attendances / Procs (Total)			245,640	24,977		▲		
5.6	Outpatient DNA Rate			6.3%	6.2%		▲		

OBJECTIVE 7 - FINANCIAL PERFORMANCE									
ID	Indicator	Target 20-21	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
7.1	Income £'000	Not Available		239,177	24,750	Not Available	▼	Not Available	
7.2	Pay £'000			(165,281)	(17,484)		▲		
7.3	Non-pay £'000			(70,057)	(7,117)		▲		
7.4	Non-operating costs £'000			(12,879)	(749)		▲		
7.5	I&E Total £'000			(9,039)	(600)		▲		
7.6	Cash Balance £'000				53,312		▲		
7.7	Savings Delivered £'000			1,895	172		▼		
7.8	Capital Expenditure £'000			9,279	2,423		▼		

OBJECTIVE 8 - WORKFORCE PERFORMANCE									
ID	Indicator	Target 20-21	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
8.1	Staff Vacancies % of establishment	10%	10%		10.8%	✗	▬		
8.2	Agency Expenditure %	4.1%	4.1%	2.8%	2.8%	✓	▲	✓	
8.3	Staff Sickness % - Days Lost (Rolling 12 months) ✎	4%	4%		4.8%	✗	▼		
8.3b	Staff Sickness % - Days Lost (Monthly - Including Covid-19) ✎	4%	4%	4.4%	6.1%	✗	▼	✗	
8.3c	Staff Sickness % - Days Lost (Monthly - Excluding Covid-19) ✎	4%	4%	3.9%	4.0%	✓	▼	✓	
8.4	Appraisals	90%	90%		92.0%	✓	▲		
8.5	Statutory Mandatory training	90%	90%		95.0%	✓	▬		
8.6	Substantive Staff Turnover	10%	10%		8.2%	✓	▲		

OBJECTIVES - OTHER									
ID	Indicator	Target 20-21	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
O.1	Total Number of NICE Breaches	10	10		44	✗	▼		
O.2	Rebooked cancelled OPs - 28 day rule	95%	95%	43.8%	0.0%	✗	▬	✗	
O.4	Overdue Datix Incidents >1 month	0	0		150	✗	▼		
O.5	Serious Incidents	45	<38	78	11	✗	▼	✗	
O.8	Completed Job Plans (Consultants)	90%	90%		86%	✗	▬		

Key: Monthly/Quarterly Change

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

YTD Position

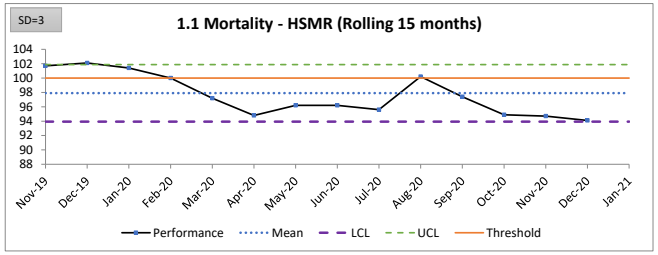
✓	Achieving YTD Target
	Within Agreed Tolerance*
✗	Not achieving YTD Target
✗	Annual Target breached

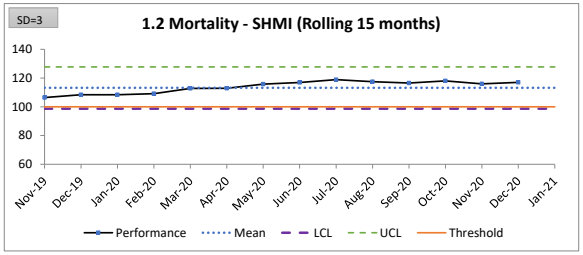
Data Quality Assurance Definitions

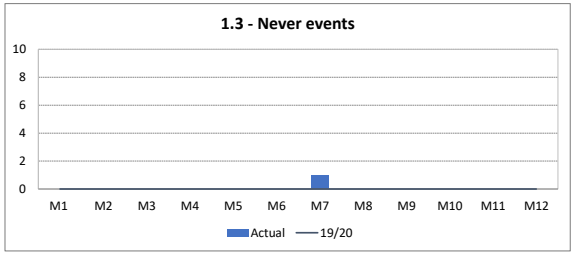
Rating	Data Quality Assurance
Green	Satisfactory and independently audited (indicator represents an accurate reflection of performance)
Amber	Acceptable levels of assurance but minor areas for improvement identified and potentially independently audited * /No Independent Assurance
Red	Unsatisfactory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

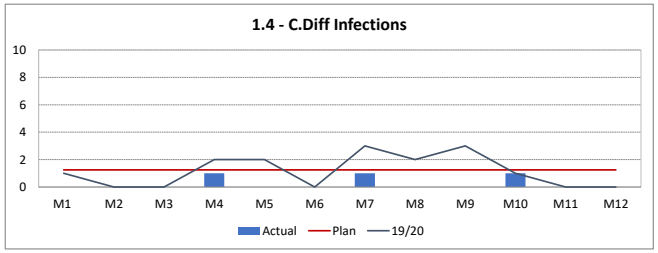
* Independently Audited – refers to an independent audit undertaken by either the Internal Auditor, External Auditors or the Data Quality Audit team.

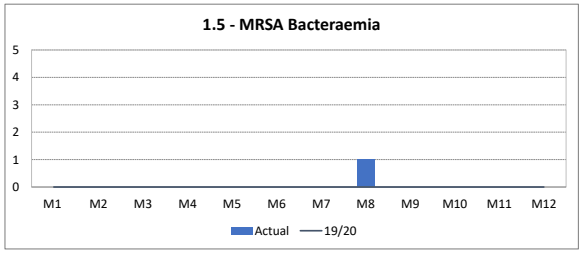
Date Produced: 11/02/2021

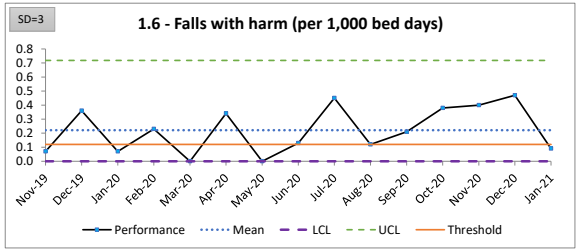


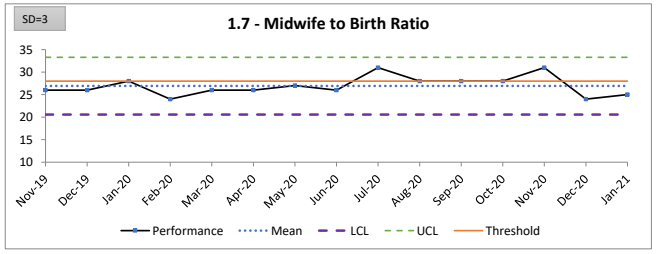


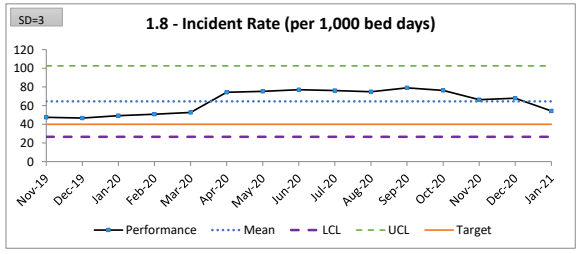


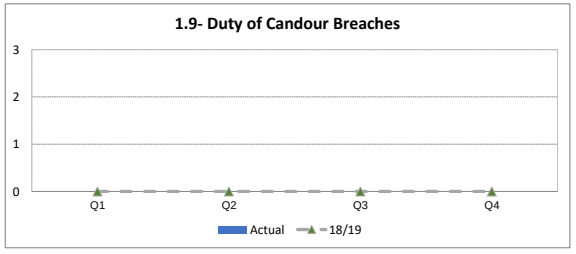


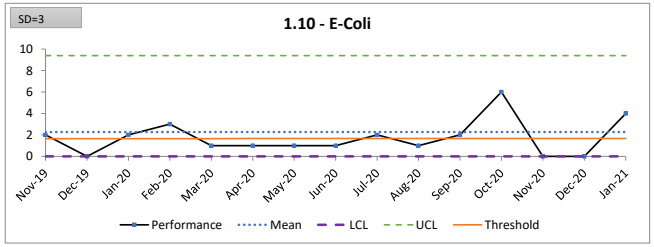


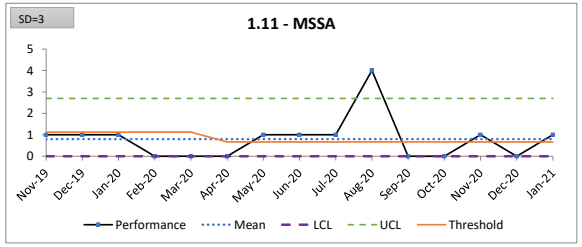


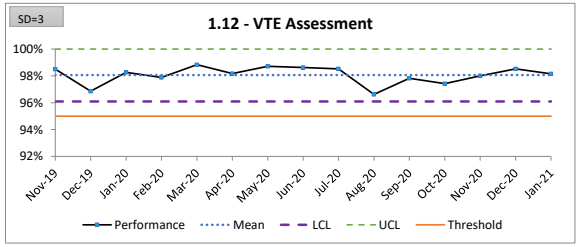












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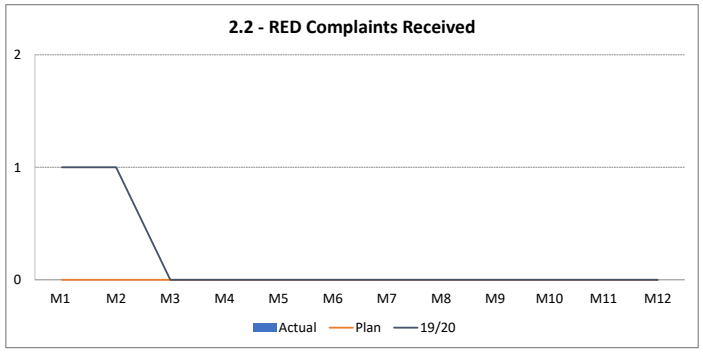

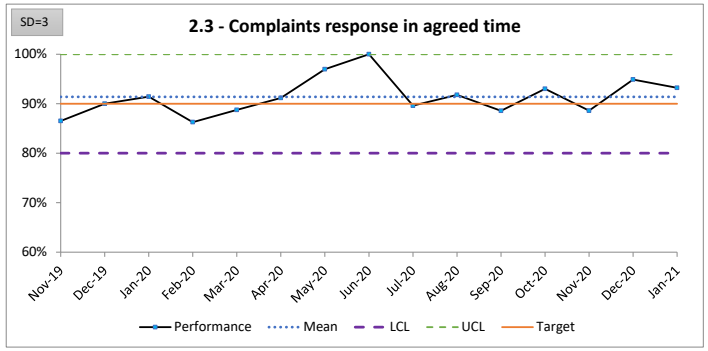

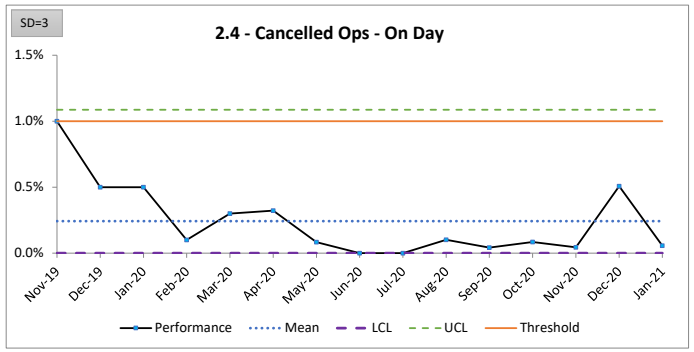

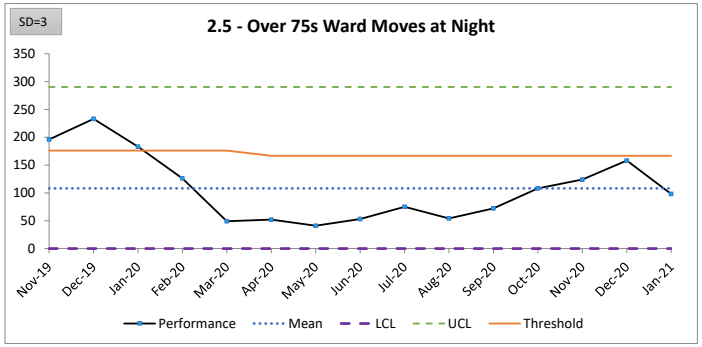

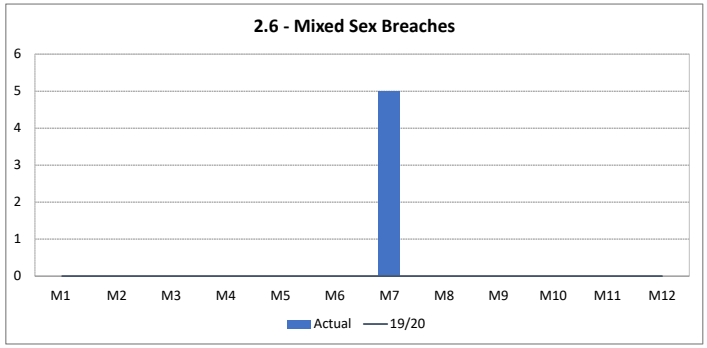

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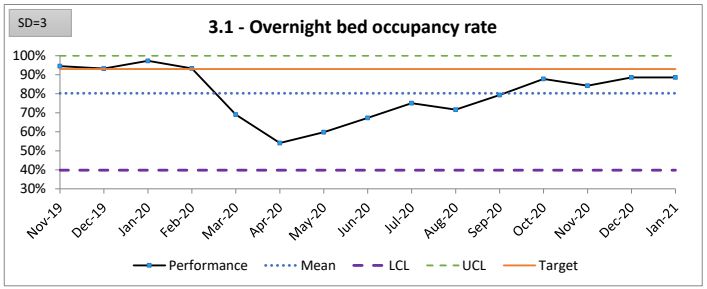
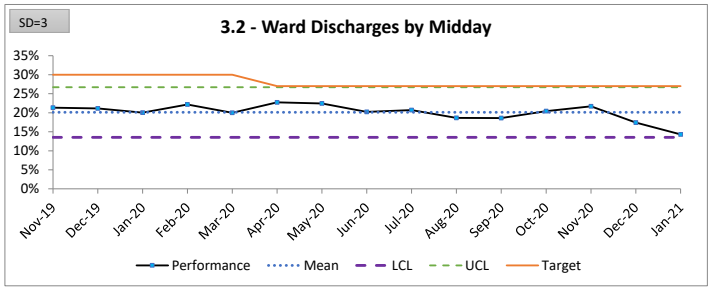
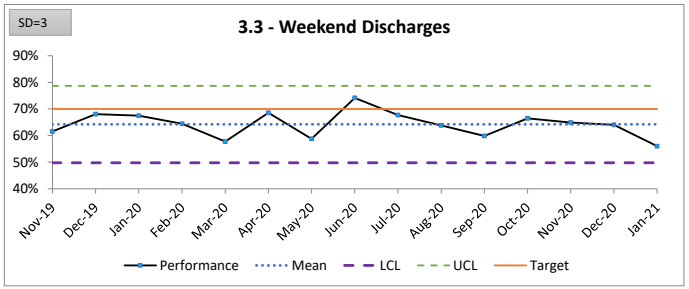
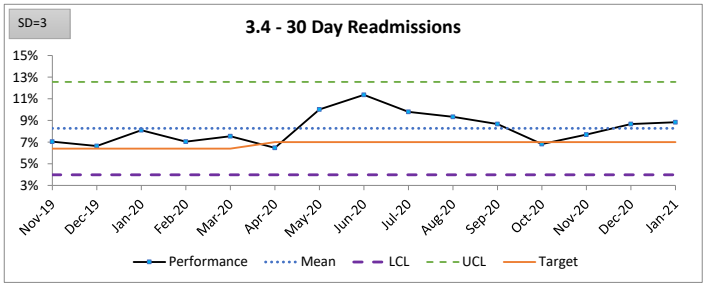
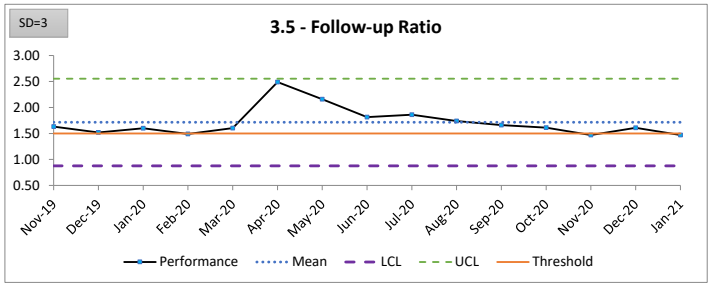
OBJECTIVE 3 - CLINICAL EFFECTIVENESS

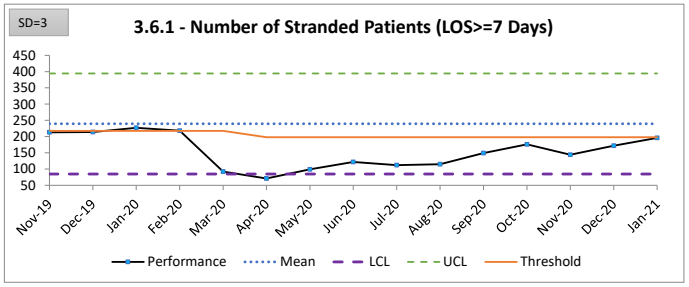


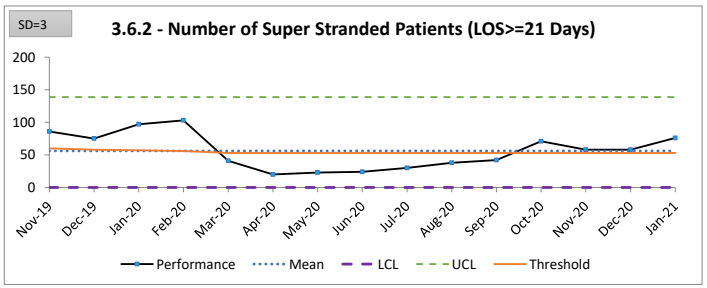


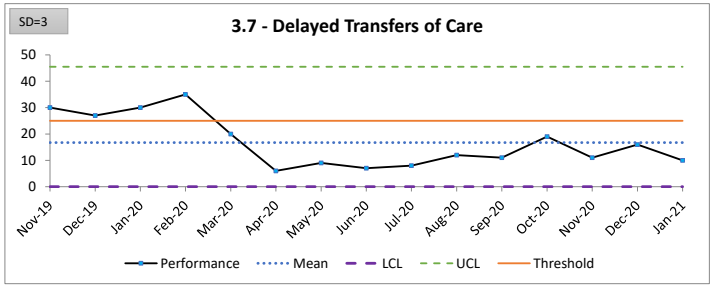


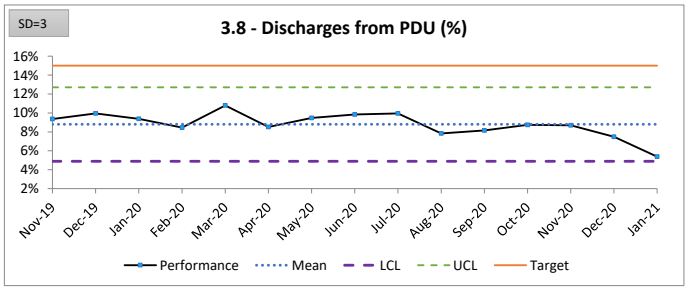


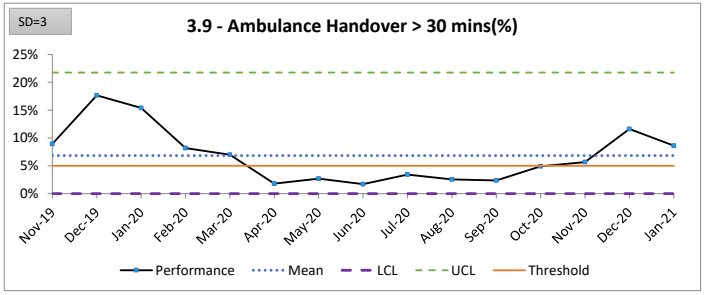












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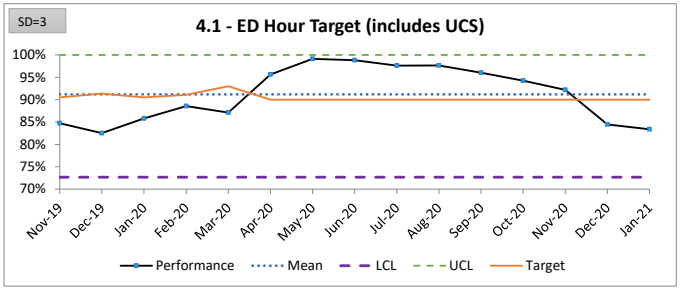
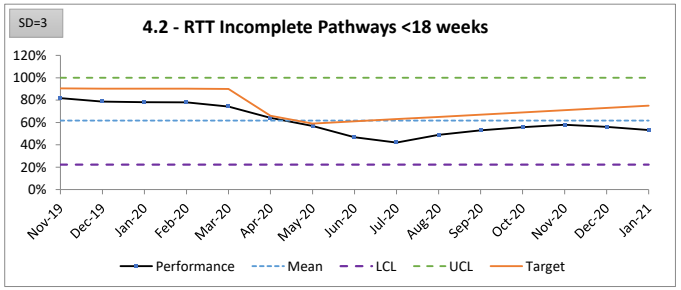
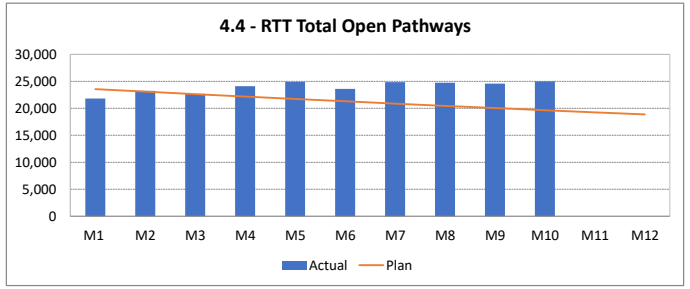
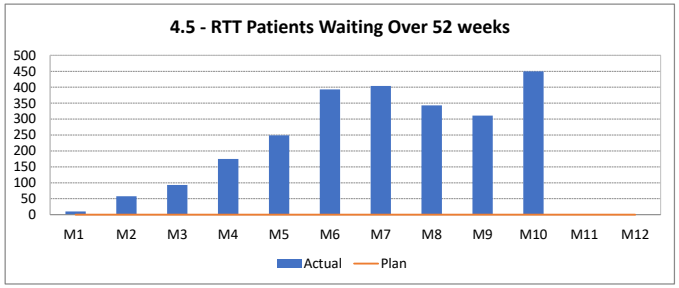
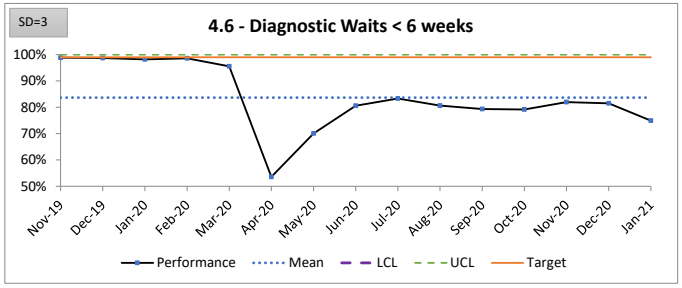
OBJECTIVE 4 - KEY TARGETS

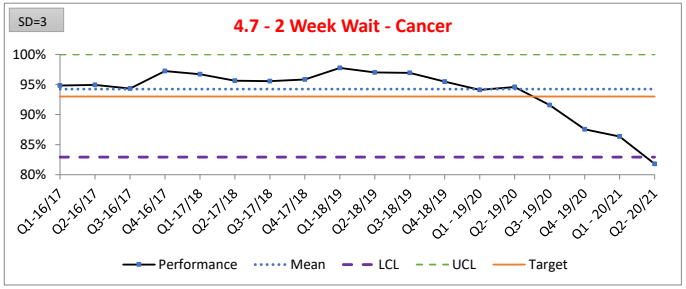


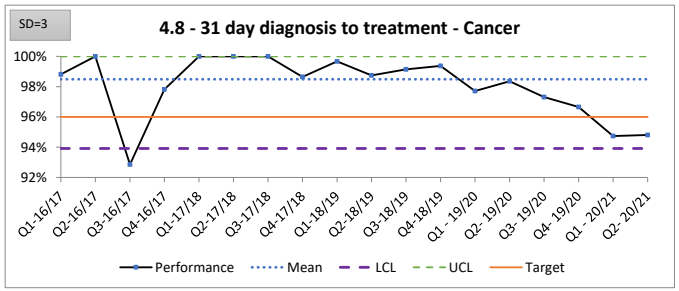


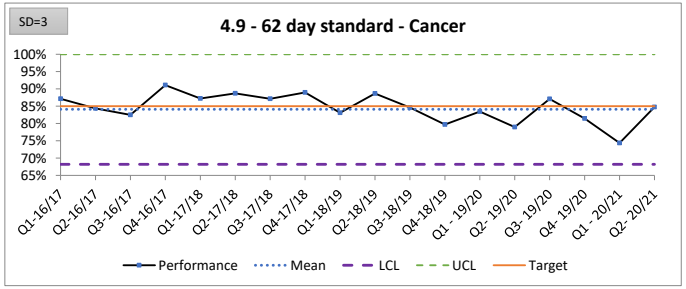












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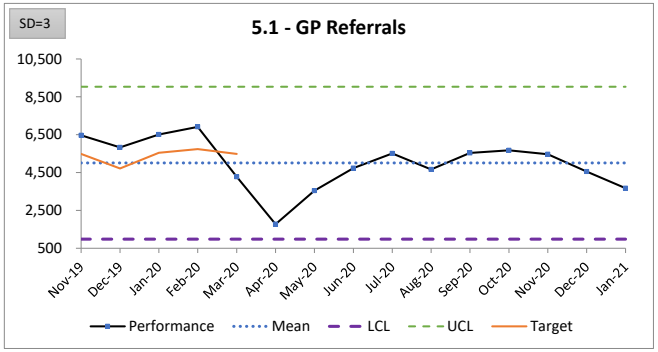

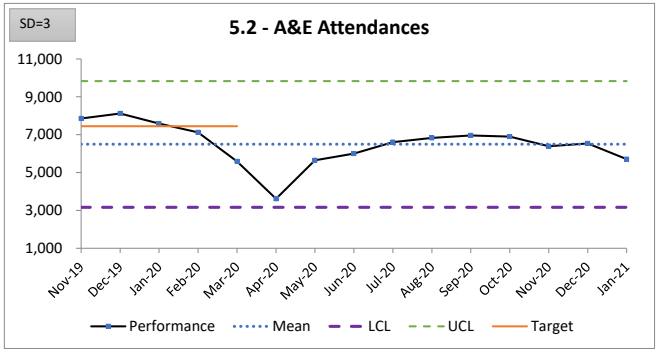

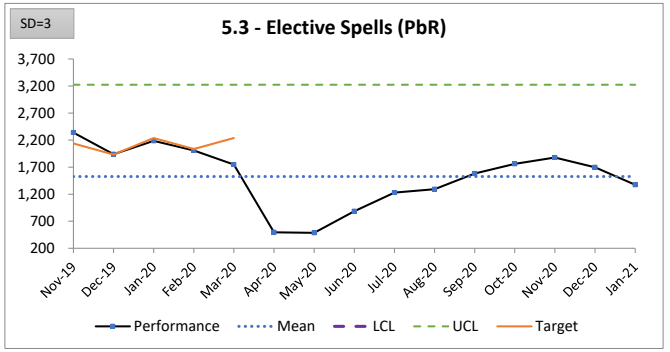

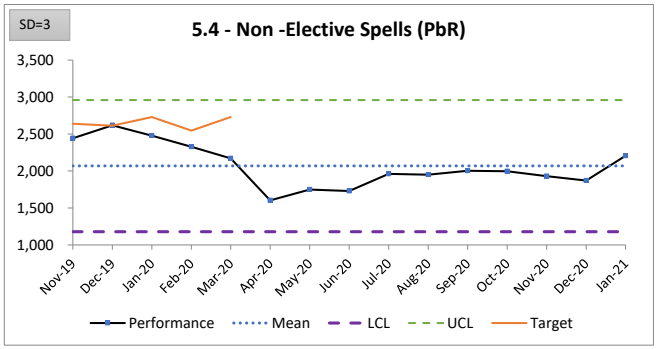

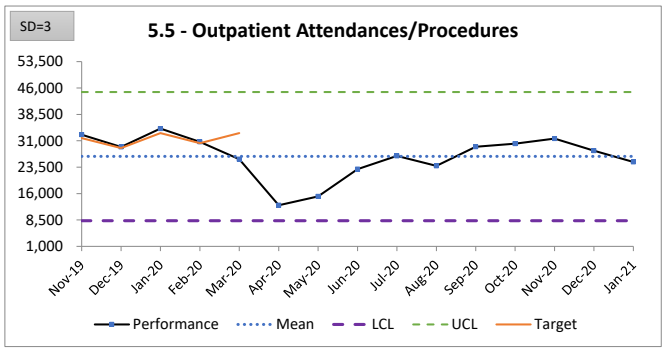

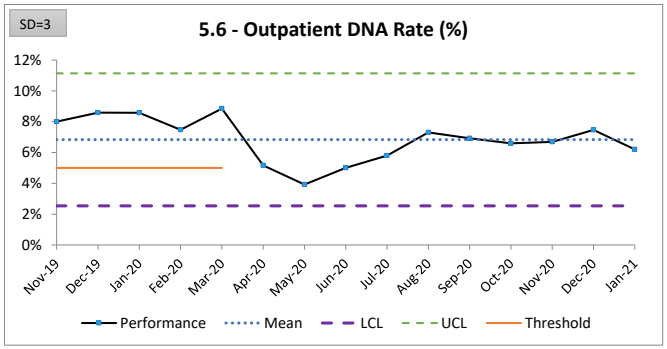

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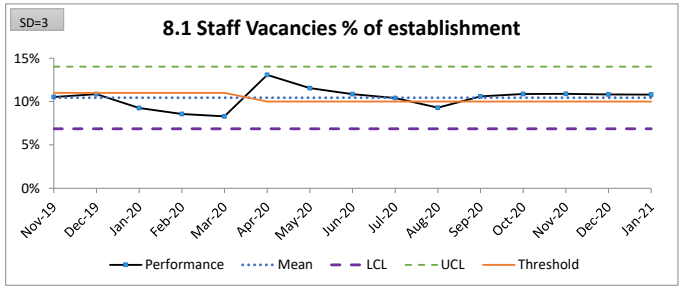
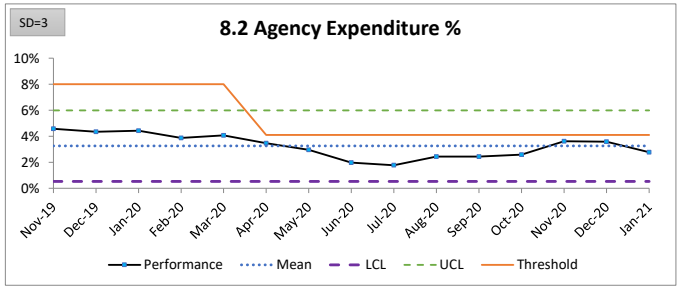
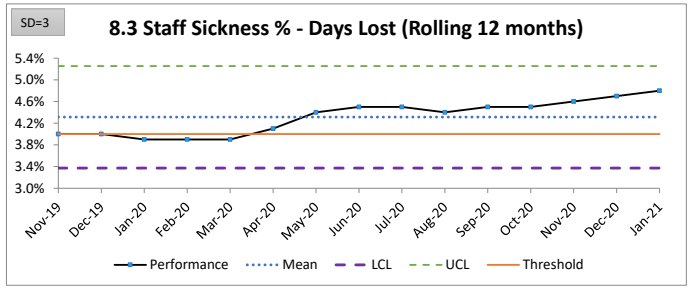
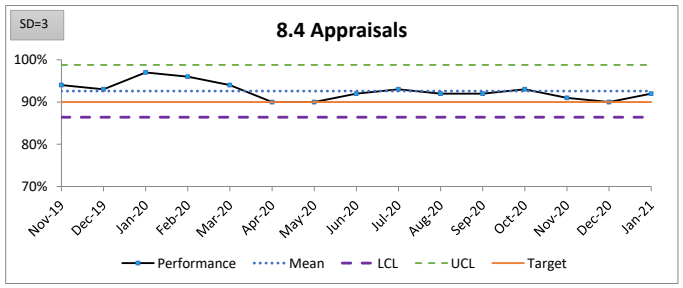
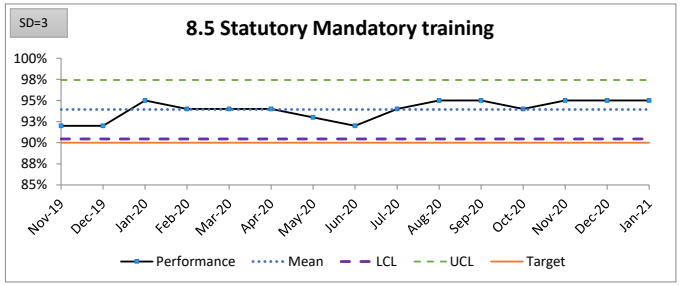
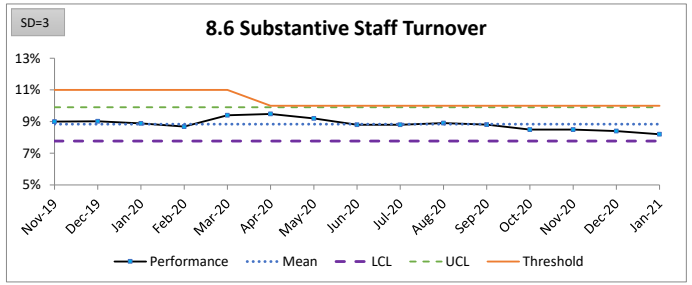






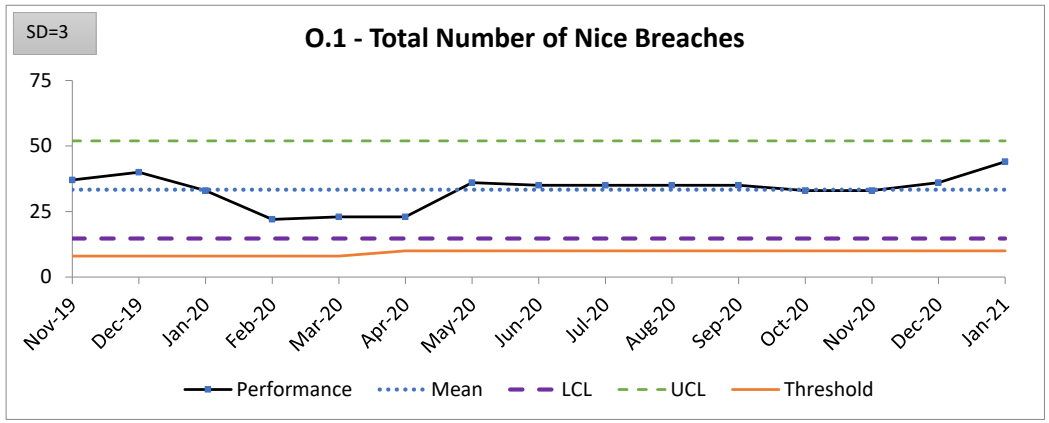


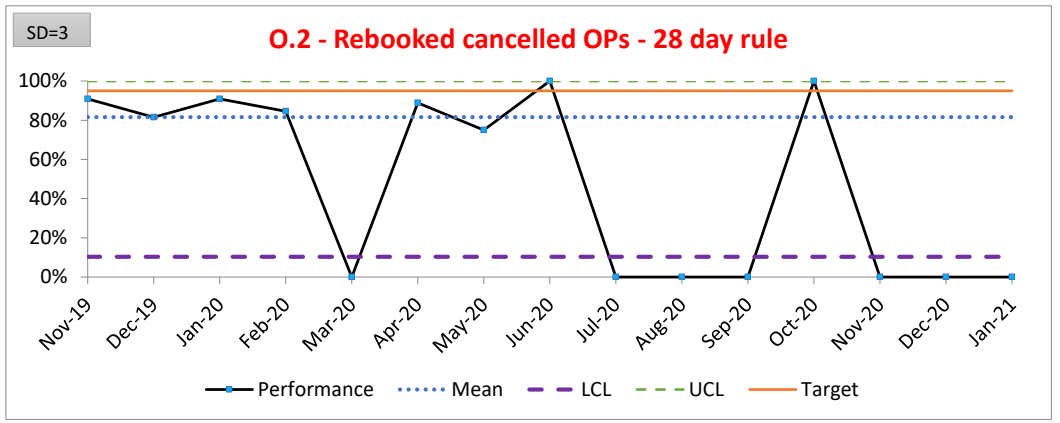


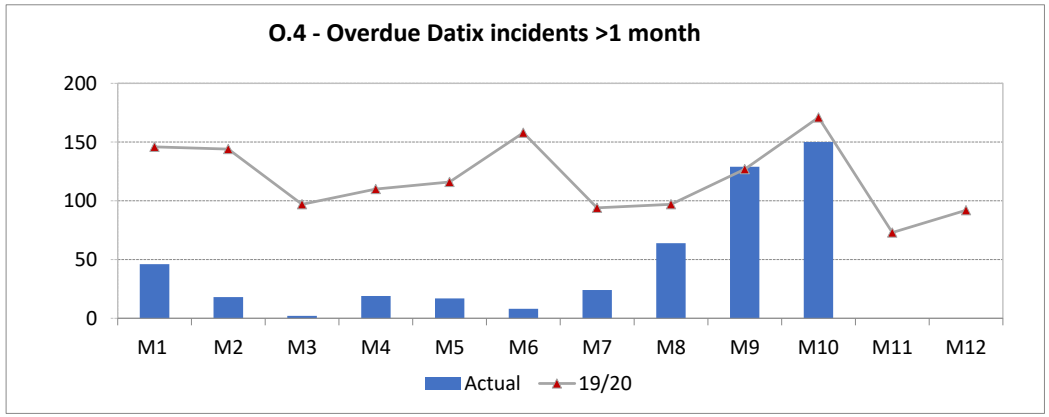


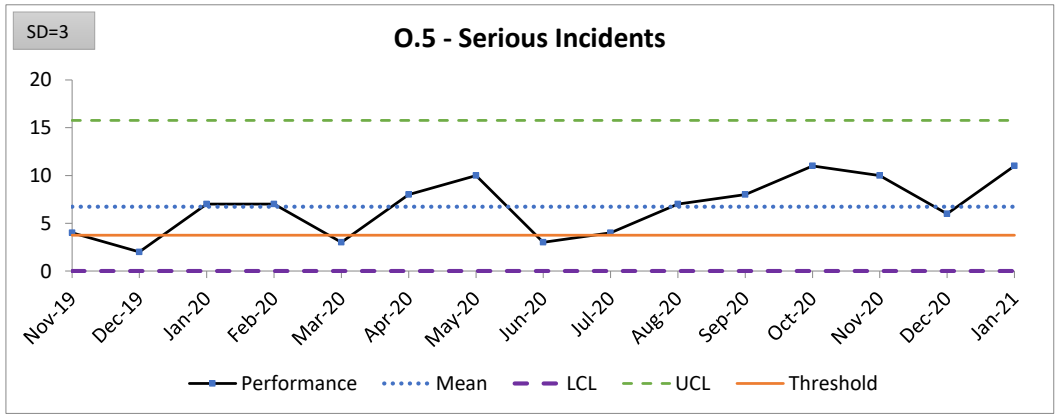
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories









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Performance activity on a rolling 15 months/quarterly
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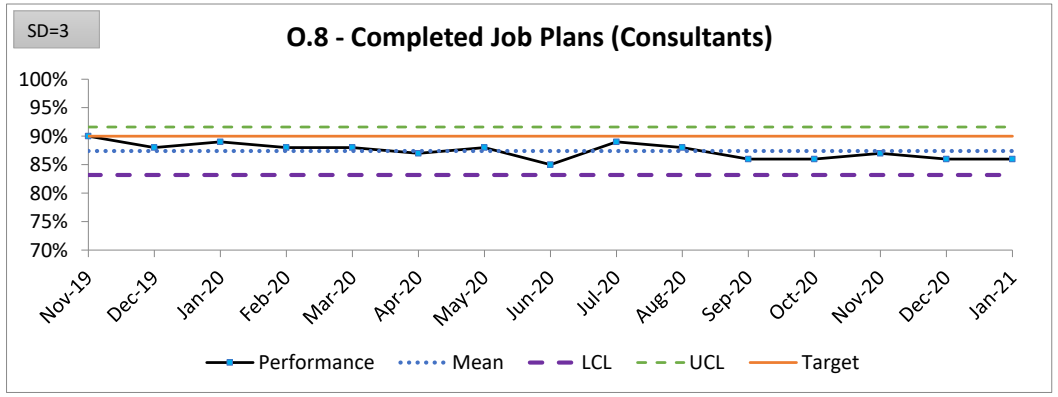

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Public Board Meeting	Date:
Report title:	**Finance Paper Month 10 2020-21**	**Agenda item: 4.2**
Lead director **Report authors**	Sophia Aldridge Chris Panes	Director of Finance Head of Management Accounts
FoI status:	Public Document	

Report summary	**An update on the financial position of the Trust at Month 10 (January 2021)**			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** X	**Decision** ☐
Recommendation	Trust Board to note the contents of the paper.			

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

Report history	None
Next steps	None
Appendices	1 to 3

FINANCE REPORT FOR THE MONTH TO 31st JANUARY 2021

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.
   - Provide assurance that the Trust is adequately responding to change in funding regime and additional financial impacts of the COVID-19 pandemic.

EXECUTIVE SUMMARY

2. Due to COVID-19 (covid) the Trust's previously submitted budget has been suspended and the Trust is being funded by a national block payment. For M1-6, the block payment was made up of three components; a fixed amount based on run rate from last year, a top up amount to address a deficit from the block and a covid top up by return for additional covid related costs (allowing the Trust to report a breakeven position). For M7-12 the block payment has been revised with the top up amount being restricted to a fixed envelope and the implementation of an "elective incentive scheme" to encourage Trusts to meet its activity targets. For the second half of the year the Trust plans to report a deficit of £3.6m.

3. *Income and expenditure* – Against the revised plan the Trust has reported a positive variance of £196k against (£5,994k negative YTD) a planned deficit of £762k (£2,386k YTD) for January 2021. The YTD position includes an in-month adjustment to the untaken annual leave accrual of £5,914k, which is expected to be an allowable overspend at year end. Excluding the annual leave adjustment, the Trust would have reported a negative variance of £72k YTD. Within this position the Trust has claimed an additional £1.2m (£8.7m YTD) of income directly related to the COVID-19 outbreak (against which the Trust is able to evidence an additional £8m of costs relating to covid).

4. *Cash and capital position* – the cash balance as at the end of January 2021 was £53.3m, which was £14.9m above the revised plan.

   The Trust has spent £15.9m on capital up to month 10 which relates to £3.8m on Imaging projects , £3.1m HIP2, £1.1m Nuance, £0.7m Pathway Unit, , £0.3m UEC, , £0.1m Radiotherapy development and £6.8m patient safety and clinically urgent capital expenditure.

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

6. *Cost savings* – As of M10 £2.1m of schemes have been identified and added to the trust tracker with a delivery of £1.9m YTD.

INCOME AND EXPENDITURE

7. The Trust is required to report externally against a revised plan based on the national block funding arrangement. However, in order for the Trust to get a better understanding of the Trust's cost base and how this has been impacted by covid, the Trust is also monitoring performance against a planned position that would meet the original financial control total (excluding the regional 0.5% additional efficiency requirement). The tables below summarise performance against the revised plan and the Trust's original plan. For the purposes of the report, the narrative discusses performance against the Trust's original plan and the revised forecast plan.

Revised Forecast Plan:

All Figures in £'000	Month 10 Plan	Month 10 Actual	Month 10 Var	Month 10 YTD Plan	Month 10 YTD Actual	Month 10 YTD Var	Full Year Plan	Full Year Actual	Full Year Var
Clinical Revenue	18,546	18,679	133	183,401	183,934	533	220,494	220,494	0
Other Revenue	1,350	1,436	86	13,052	13,822	770	15,762	15,762	0
Total Income	19,896	20,114	218	196,453	197,755	1,302	236,256	236,256	0
Pay	(16,649)	(17,484)	(835)	(159,483)	(165,281)	(5,798)	(192,395)	(192,395)	0
Non Pay	(7,169)	(7,117)	52	(67,778)	(70,055)	(2,277)	(82,197)	(82,197)	0
Total Operational Expend	(23,818)	(24,601)	(783)	(227,261)	(235,337)	(8,076)	(274,592)	(274,592)	0
EBITDA	(3,922)	(4,487)	(565)	(30,808)	(37,581)	(6,773)	(38,336)	(38,336)	0
Financing & Non-Op. Costs	(1,178)	(705)	473	(12,575)	(12,198)	377	(14,931)	(14,931)	0
Control Total Deficit (excl. top up)	**(5,100)**	**(5,192)**	**(92)**	**(43,383)**	**(49,779)**	**(6,396)**	**(53,267)**	**(53,267)**	**0**
Adjustments excl. from control total:									
FRF	0	0	0	0	0	0	0	0	0
MRET	0	0	0	0	0	0	0	0	0
National Block	0	0	0	0	0	0	0	0	0
National Top up	3,413	3,413	0	32,697	32,697	0	39,523	39,523	0
COVID Top up	925	1,213	288	8,300	8,702	402	10,150	10,150	0
Control Total Deficit (incl. top up)	**(762)**	**(566)**	**196**	**(2,386)**	**(8,380)**	**(5,994)**	**(3,594)**	**(3,594)**	**0**
Donated income	0	10	10	14	23	9	14	14	0
Donated asset depreciation	(68)	(44)	24	(679)	(680)	(1)	(815)	(815)	0
Impairments & Rounding	0	0	0	0	0	0	0	0	0
Reported deficit/surplus	**(830)**	**(600)**	**230**	**(3,051)**	**(9,037)**	**(5,986)**	**(4,395)**	**(4,395)**	**0**

Performance against original internal plan:

All Figures in £'000	Month 10 Plan	Month 10 Actual	Month 10 Var	Month 10 YTD Plan	Month 10 YTD Actual	Month 10 YTD Var	Full Year Plan	Full Year Forecast	Full Year Var
Clinical Revenue	18,683	16,138	(2,545)	193,131	152,239	(40,892)	233,455	233,455	0
Other Revenue	1,596	1,436	(160)	16,138	13,832	(2,307)	19,295	19,295	0
Total Income	20,279	17,573	(2,706)	209,269	166,070	(43,199)	252,749	252,749	0
Pay	(15,083)	(17,484)	(2,402)	(150,485)	(165,281)	(14,796)	(180,692)	(180,692)	0
Non Pay	(6,828)	(7,117)	(289)	(68,486)	(70,055)	(1,569)	(82,026)	(82,026)	0
Total Operational Expend	(21,910)	(24,601)	(2,691)	(218,971)	(235,337)	(16,365)	(262,718)	(262,718)	0
EBITDA	(1,632)	(7,028)	(5,396)	(9,702)	(69,266)	(59,564)	(9,969)	(9,969)	0
Financing & Non-Op. Costs	(1,192)	(705)	487	(11,914)	(12,198)	(283)	(14,299)	(14,299)	0
Control Total Deficit (excl. PSF)	**(2,824)**	**(7,733)**	**(4,909)**	**(21,616)**	**(81,464)**	**(59,848)**	**(24,268)**	**(24,268)**	**0**
Adjustments excl. from control total:									
FRF	0	0	0	14,838	0	(14,838)	19,788	19,788	0
MRET	269	0	(269)	2,690	0	(2,690)	3,238	3,238	0
National Block	0	2,541	2,541	0	31,695	31,695	0	0	0
National Top up	0	3,413	3,413	0	32,687	32,687	0	0	0
COVID Top up	0	1,213	1,213	0	8,702	8,702	0	0	0
Control Total Deficit (incl. PSF)	**(2,555)**	**(566)**	**1,989**	**(4,088)**	**(8,380)**	**(4,292)**	**(1,242)**	**(1,242)**	**0**
Donated income	200	10	(190)	400	23	(377)	1,000	1,000	0
Donated asset depreciation	(68)	(44)	24	(680)	(680)	0	(816)	(816)	0
Impairments & Rounding	0	0	0	0	0	0	0	0	0
Reported deficit/surplus	**(2,423)**	**(600)**	**1,823**	**(4,368)**	**(9,037)**	**(4,669)**	**(1,058)**	**(1,058)**	**0**

Monthly and year to date review

8. The **deficit excluding central funding (top up) and donated income** in month 10 is £7,733k which is £4,909k adverse to the Trust's original plan; this is due to a combination of:
    - The national block contract income being lower than clinical income assumed in the internal plan (and agreed as part of the heads of terms with Milton Keynes CCG);
    - Lower non-clinical income streams due to lower activity volumes (e.g. parking income);
    - The impact of covid on the Trust's cost base.

    However, on a control total basis after the block payment and top up income the Trust has reported a £566k deficit position for the month and £8,380k YTD which is £196k favourable to the revised plan position in month and adverse by £5,994k YTD.

    Included within the YTD position is an £5,914k annual leave adjustment and £8,059k of direct covid costs (excluding loss of non-clinical income which is outside the scope of provider claims) against which the Trust expects to receive an additional £8,702k top-up.

    The impact of the elective incentive scheme has not been reported in month due to the number of COVID beds being above 15% of the total bed base.

9. **On a payment by results basis, income (excluding block, top up and donations effect)** against the original plan is £2,706k adverse in January and £43,199k YTD with significant reductions in non-elective activity and low levels of activity following suspension of non-urgent elective activity earlier in the year and the occurrence of the second wave (clinical income is £2,545k adverse to plan in month and £40,892k YTD).

However, the shortfall on clinical income is offset by the top-up payments which act as both a) a replacement of the financial recovery fund that would otherwise have been in place; and b) additional payments to cover shortfalls on clinical income as a result of the impact of covid.

Against the revised trust plan/forecast income is £218k favourable in month and £1,302k year to date

10. **Operational costs** in January are adverse to the original plan by £2,691 in month and £16,365k YTD. Against the revised plan/forecast operational costs are adverse by £783k in month & £8,076k YTD

11. **Pay costs** are £2,402k adverse to budget in Month 10 and £14,796k YTD against the original plan. Against the revised plan pay costs are £835k adverse in month and £5,798k adverse YTD. The YTD position includes a increase of £5,914k against untaken annual leave accrual. High costs against substantive, bank and agency include direct covid related costs due to changes in rotas, additional hours and cover of sickness/self-isolation.

12. **Non-pay costs** were £1,569k adverse to the original plan in month and £289k adverse YTD. Against the revised plan non pay reported a £52k adverse favourable in month and £2,277k adverse YTD.

13. **Non-operational costs** are £511k favourable in month and £283k adverse YTD, this is a result of increase in PDC costs offset by timing differences in depreciation.

COST SAVINGS

14. Work on tracking and delivering schemes has resumed following a temporary suspension due to COVID. The Trust has submitted its financial plan which includes a target of £5m for CIP delivery by year end.

15. As of at M10 £2.1m of schemes have been identified and added to the trust tracker with a delivery of £1.9m YTD. The most recent surge in COVID cases has similarly prevented reinstatement of business as usual focus on cost efficiency schemes.

CASH AND CAPITAL

16. The cash balance at the end of January 2021 was £53.3m, which was £14.9m above the revised plan.

17. On 2 April 2020, the Secretary of State for Health and Social Care, announced that over £13bn of debt will be written off as part of a major financial reset for NHS providers. As a result, the Trust's Department of Health and Social Care interim revenue support and capital loans (totalling £130.8m as at 31 March 2020) was repaid in September 2020 and replaced with Public Dividend Capital for which there is no repayment obligation.

18. 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 above plan by £2.0m; this is driven by timing of capital projects.
- Current assets are above plan by £2.5m, this is due to receivables £12.4m below plan, offset by cash £14.9m above plan.
- Current liabilities are above plan by £15.4m. This is being driven by Trade and Other Creditors £18.8m above plan (of which £6.0m relates to untaken annual leave and £11.4m relates to capital) and Provisions £0.1m above plan, offset by deferred income £3.5m below plan.
- Non-Current Liabilities are on plan.

The Trust has spent £15.9m on capital up to month 10 which relates to £3.8m on Imaging projects , £3.1m HIP2, £1.1m Nuance, £0.7m Pathway Unit, , £0.3m UEC, , £0.1m Radiotherapy development and £6.8m patient safety and clinically urgent capital expenditure.

The key performance indicators have been met except for creditor days.

RISK REGISTER

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

a) There is a risk that if the expenditure position cannot be appropriately controlled given the Trust's historic deficits then the cash available to meet its financial obligations will be insufficient

The Trust currently has sufficient cash balances to manage its obligations. Monthly cash flow forecasting is undertaken to establish at which point the Trust balances become close to £1m (historically the value advised by NHSEI to be held). The balances have been artificially inflated in 2020/21 owing to and additional months funding from CCGs pushed out to Trusts to support them owing to Covid. It is likely that this will be corrected in March 21

b) There is a risk that delays in the business case approvals process (including regulatory approvals), and/or delays in capital funds being made available (through PDC financing or other sources) prevent the Trust from being able to progress its entire capital programme in 2020/21 leading to a missed opportunity in the event funds cannot be carried forward to future years.

The Trust has a significant capital plan in place for 2020/21 which will lead to significant improvements in the hospital estate, infrastructure, reductions in backlog maintenance and support the Trust's Covid-19 response. The Trust is working closely with regulators to ensure capital funds are made available in order to deliver the capital programme.

c) As a result of Covid-19, the trust incurs additional costs and/or has a reduction in income that leads to its financial position becoming unsustainable.

PBR contracts have been replaced with block contracts and top-up payments available where COVID-19 leads to costs over block amounts. The revised blocks will continue for the remainder of the year. The Trust is in constant dialogue with NHSI/E regarding funding.

d) There is a risk that if the Trust is unable to successfully tender for external audit services in 2021 then financial audits and other required annual assurance exercises will not take place leading to the Trust failing in its statutory obligations.

Trust's current external audit contract ends August 21. The trust is looking to place a direct award for 1 year's contract with its current external audit firm

e) There is a risk that the Trust has insufficient resources (financial or otherwise) or has insufficient physical capacity in order to clear the waiting list backlogs that occurred as a result of the COVID-19 pandemic, leading to delays in patients receiving treatment and a potential long-term financial pressure for the Trust through a requirement to deliver higher levels of activity each financial year.

The Trust has developed its recovery plans and is working closely with regulators to ensure sufficient resources are made available to ensure successful delivery.

RECOMMENDATIONS TO BOARD

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

Appendix 1

Milton Keynes Hospital NHS Foundation Trust
Statement of Comprehensive Income
For the period ending 31st January 2021

	January 2021			Year to Date			Full year
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME							
Outpatients	3,827	3,143	(684)	42,063	29,616	(12,447)	51,328
Elective admissions	2,206	1,078	(1,129)	23,806	14,056	(9,751)	29,148
Emergency admissions	6,300	6,018	(282)	61,785	49,783	(12,002)	73,776
Emergency adm's marginal rate (MRET)	(277)	(279)	(3)	(2,712)	(2,649)	63	(3,238)
Readmissions Penalty	0	0	0	0	0	0	0
A&E	1,303	997	(306)	12,965	10,439	(2,526)	15,489
Other Admissions	266	188	(78)	2,608	1,812	(796)	3,114
Maternity	1,726	1,724	(2)	17,565	17,445	(120)	21,186
Critical Care & Neonatal	561	490	(71)	5,504	5,028	(476)	6,572
Excess bed days	0	0	0	0	0	0	0
Imaging	439	385	(54)	4,736	3,448	(1,288)	5,799
Direct access Pathology	378	292	(86)	4,073	2,990	(1,083)	4,987
Non Tariff Drugs (high cost/individual drugs)	1,465	1,664	200	15,802	15,288	(514)	19,348
Other	488	438	(50)	4,934	4,982	(760)	5,946
National Block Top Up	0	2,541	2,541	0	31,695	31,695	0
Clinical Income	**18,683**	**18,679**	**(4)**	**193,131**	**183,934**	**(9,197)**	**233,455**
Non-Patient Income	**2,065**	**6,072**	**4,007**	**34,066**	**55,244**	**21,177**	**43,321**
TOTAL INCOME	**20,748**	**24,750**	**4,002**	**227,197**	**239,177**	**11,980**	**276,775**
EXPENDITURE							
Total Pay	**(15,083)**	**(17,484)**	**(2,402)**	**(150,485)**	**(165,281)**	**(14,796)**	**(180,692)**
Non Pay	(5,363)	(5,452)	(89)	(52,684)	(54,767)	(2,083)	(62,678)
Non Tariff Drugs (high cost/individual drugs)	(1,465)	(1,664)	(200)	(15,802)	(15,288)	514	(19,348)
Non Pay	**(6,828)**	**(7,117)**	**(289)**	**(68,486)**	**(70,055)**	**(1,569)**	**(82,026)**
TOTAL EXPENDITURE	**(21,910)**	**(24,601)**	**(2,691)**	**(218,971)**	**(235,337)**	**(16,365)**	**(262,718)**
EBITDA*	**(1,163)**	**149**	**1,312**	**8,226**	**3,841**	**(4,385)**	**14,057**
Depreciation and non-operating costs	(1,000)	(493)	507	(9,994)	(9,731)	264	(11,995)
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**(2,163)**	**(344)**	**1,819**	**(1,768)**	**(5,891)**	**(4,122)**	**2,063**
Public Dividends Payable	(260)	(256)	4	(2,600)	(3,147)	(547)	(3,120)
OPERATING DEFICIT AFTER DIVIDENDS	**(2,423)**	**(600)**	**1,823**	**(4,368)**	**(9,037)**	**(4,668)**	**(1,058)**
Adjustments to reach control total							
Donated Income	(200)	(10)	190	(400)	(23)	377	(1,000)
Donated Assets Depreciation	68	44	(24)	680	680	0	816
Control Total Rounding	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0
PSF/FRF/MRET	(538)	0	538	(17,799)	0	17,799	(23,026)
CONTROL TOTAL DEFICIT	**(3,093)**	**(565)**	**2,527**	**(21,887)**	**(8,380)**	**13,508**	**(24,268)**

Appendix 2

Milton Keynes Hospital NHS Foundation Trust
Statement of Cash Flow
As at 31st January 2021

	Mth 10 £000	Mth 9 £000	In Month Movement £000
Cash flows from operating activities			
Operating (deficit) from continuing operations	(5,660)	(5,340)	(320)
Operating surplus/(deficit) of discontinued operations			
Operating (deficit)	**(5,660)**	**(5,340)**	**(320)**
Non-cash income and expense:			
Depreciation and amortisation	9,501	9,032	469
(Increase)/Decrease in Trade and Other Receivables	7,057	7,873	(816)
(Increase)/Decrease in Inventories	(9)	(12)	3
Increase/(Decrease) in Trade and Other Payables	15,312	12,821	2,491
Increase/(Decrease) in Other Liabilities	19,193	18,941	252
Increase/(Decrease) in Provisions	(56)	(168)	112
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows	(23)	(14)	(9)
Other movements in operating cash flows	(4)	(3)	-1
NET CASH GENERATED FROM OPERATIONS	**45,311**	**43,130**	**2,181**
Cash flows from investing activities			
Interest received	4	4	0
Purchase of intangible assets	(4,323)	(4,406)	83
Purchase of Property, Plant and Equipment, Intangibles	(5,164)	(4,313)	(851)
Sales of Property, Plant and Equipment			
Net cash generated (used in) investing activities	**(9,483)**	**(8,715)**	**(768)**
Cash flows from financing activities			
Public dividend capital received	134,814	134,814	0
Loans repaid to Department of Health	(130,852)	(130,852)	0
Capital element of finance lease rental payments	(184)	(165)	(19)
Interest paid	(273)	(273)	0
Interest element of finance lease	(234)	(210)	(24)
PDC Dividend paid	(2,096)	(2,096)	0
Receipt of cash donations to purchase capital assets	23	14	9
Net cash generated from/(used in) financing activities	**1,198**	**1,232**	**(34)**
Increase/(decrease) in cash and cash equivalents	**37,026**	**35,647**	1,379
Opening Cash and Cash equivalents	**16,286**	**16,286**	
Closing Cash and Cash equivalents	**53,312**	**51,933**	**1,379**

Appendix 3

Milton Keynes Hospital NHS Foundation Trust
Statement of Financial Position as at 31st January 2021

	Audited Mar-20	Jan-21 YTD Plan	Jan-21 YTD Actual	In Mth Mvmt	YTD Mvmt	% Variance
Assets Non-Current						
Tangible Assets	143.2	148.6	149.7	1.1	6.5	4.5%
Intangible Assets	16.1	14.8	15.7	0.9	(0.4)	(2.5%)
Other Assets	0.9	0.9	0.9	0.0	0.0	0.0%
Total Non Current Assets	**160.2**	**164.3**	**166.3**	**2.0**	**6.1**	**3.8%**
Assets Current						
Inventory	3.4	3.4	3.4	0.0	0.0	0.0%
NHS Receivables	18.7	18.5	7.7	(10.8)	(11.0)	(58.8%)
Other Receivables	6.9	12.5	10.9	(1.6)	4.0	58.0%
Cash	16.3	38.4	53.3	14.9	37.0	227.0%
Total Current Assets	**45.3**	**72.8**	**75.3**	**2.5**	**30.0**	**66.2%**
Liabilities Current						
Interest -bearing borrowings	(131.3)	(0.0)	(0.0)	0.0	131.3	-100.0%
Deferred Income	(2.3)	(25.0)	(21.5)	3.5	(19.2)	834.8%
Provisions	(1.5)	(1.3)	(1.4)	(0.1)	0.1	-6.7%
Trade & other Creditors (incl NHS)	(38.9)	(42.6)	(61.4)	(18.8)	(22.5)	57.8%
Total Current Liabilities	**(174.0)**	**(68.9)**	**(84.3)**	**(15.4)**	**89.7**	(51.5%)
Net current assets	**(128.7)**	**3.9**	**(9.0)**	**(12.9)**	**119.7**	**(93.0%)**
Liabilities Non-Current						
Long-term Interest bearing borrowings	(5.8)	(5.8)	(5.8)	0.0	0.0	0.0%
Provisions for liabilities and charges	(1.6)	(1.6)	(1.6)	0.0	0.0	0.0%
Total non-current liabilities	**(7.4)**	**(7.4)**	**(7.4)**	**0.0**	**0.0**	0.0%
Total Assets Employed	**24.1**	**160.8**	**149.9**	**(11.0)**	**125.8**	**522.4%**
Taxpayers Equity						
Public Dividend Capital (PDC)	105.3	245.4	240.1	(5.3)	134.8	128.0%
Revaluation Reserve	48.4	48.4	48.4	0.0	0.0	0.0%
I&E Reserve	(129.6)	(132.6)	(138.6)	(6.0)	(9.0)	6.9%
Total Taxpayers Equity	**24.1**	**161.2**	**149.9**	**(11.3)**	**125.8**	**522.0%**

Meeting title	**Trust Board**	**Date: 04 March 2020**
Report title:	**Workforce Information 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:	**Public**	

Report summary	This report provides a summary of workforce Key Performance Indicators for the full year ending 31 January 2020 (Month 10) and relevant Workforce and Organisational Development updates to Trust Board.			
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [x]	**Decision** [ ]
Recommendation	Trust Board is asked to note and receive the Workforce Report for Month 10.			

Strategic objectives links	Objective 8: Investing in our people
Board Assurance Framework links	BAF risks 19-24
CQC outcome/ regulation links	Well Led Outcome 13: Staffing
Identified risks and risk management actions	
Resource implications	
Legal implications including equality and diversity assessment	
Report history	
Next steps	
Appendices	

1. Purpose of the report

1.1. This report provides a summary of workforce Key Performance Indicators for the full year ending 31 January 2020 (Month 10), covering the preceding 13 months.

2. Summary of Key Performance Indicators (KPIs) and Compliance

Indicator	Measure	Target	01/2020	02/2020	03/2020	04/2020	05/2020	06/2020	07/2020	08/2020	09/2020	10/2020	11/2020	12/2020	01/2021
Staff in post (as at report date)	WTE		3138.9	3152.5	3177.3	3177.0	3238.8	3266.8	3276.7	3227.3	3243.8	3245.1	3256.5	3251.3	**3250.0**
	Headcount		3620	3636	3666	3656	3723	3761	3766	3707	3727	3728	3738	3729	**3730**
Establishment (as at report date - as per finance data)	WTE		3448.3	3452.3	3456.3	3690.8	3698.6	3693.9	3694.0	3693.0	3690.2	3699.9	3702.2	3706.8	**3702.6**
	%, Vacancy Rate *(for Cost Centres, excludes Reserves)*	10%	9.0%	9.1%	8.1%	13.9%	12.4%	11.6%	11.3%	12.6%	12.1%	12.3%	12.0%	12.3%	**12.2%**
Staff Costs (12 months)	%, Temp Staff Cost		14.0%	13.9%	13.8%	13.8%	13.3%	12.9%	12.5%	12.2%	12.1%	11.9%	11.7%	11.7%	**11.6%**
	%, Temp Staff Usage		14.3%	14.3%	14.2%	14.1%	13.6%	13.2%	12.8%	12.5%	12.2%	12.0%	11.9%	11.8%	**11.8%**
Absence (12 months)	%, 12 month Absence Rate	4%	3.9%	3.9%	4.1%	4.4%	4.5%	4.5%	4.4%	4.5%	4.5%	4.6%	4.7%	4.8%	***5.0%***
	- %, 12 month Absence Rate - Long Term		*2.2%*	*2.2%*	*2.2%*	*2.3%*	*2.4%*	*2.4%*	*2.3%*	*2.4%*	*2.4%*	*2.6%*	*2.6%*	*2.7%*	***2.7%***
	- %, 12 month Absence Rate - Short Term		*1.7%*	*1.7%*	*1.9%*	*2.1%*	*2.1%*	*2.1%*	*2.1%*	*2.1%*	*2.1%*	*2.1%*	*2.1%*	*2.2%*	***2.3%***
	%,In month Absence Rate - Total		4.2%	4.2%	6.5%	7.6%	4.7%	3.4%	3.3%	3.6%	4.0%	4.1%	5.0%	6.1%	***6.5%***
	- %, In month Absence Rate - Long Term		*2.2%*	*2.3%*	*2.5%*	*3.3%*	*3.0%*	*2.1%*	*2.2%*	*2.5%*	*2.5%*	*2.7%*	*2.6%*	*3.6%*	***3.0%***
	- %, In month Absence Rate - Short Term		*1.9%*	*1.9%*	*4.0%*	*4.3%*	*1.7%*	*1.4%*	*1.1%*	*1.1%*	*1.5%*	*1.4%*	*2.4%*	*2.5%*	***3.5%***
	- %, In month Absence Rate - COVID-19 Sickness Absence				1.4%	3.8%	1.3%	0.5%	0.2%	0.2%	0.2%	0.2%	1.1%	2.1%	***3.2%***
Starters, Leavers and T/O rate (12 months)	WTE, Starters		340.2	339.3	362.1	369.4	363.3	355.1	355.9	362.0	360.5	336.0	329.9	329.2	**313.0**
	Headcount, Starters		390	388	414	424	415	406	408	414	413	386	376	373	**358**
	WTE, Leavers		255.1	245.9	268.3	270.4	259.9	249.5	251.7	251.5	249.0	241.2	244.7	240.1	**233.7**
	Headcount, Leavers		297	289	315	318	306	295	298	298	295	286	291	286	**278**
	%, Leaver Turnover Rate	10%	9.0%	8.7%	9.4%	9.6%	9.2%	8.8%	8.8%	8.9%	8.8%	8.5%	8.5%	8.4%	**8.2%**
	%, Stability Index		85.4%	85.1%	85.7%	84.4%	85.6%	86.3%	86.4%	86.3%	86.8%	87.0%	86.9%	87.2%	**87.1%**
Statutory/Mandatory Training	%, Compliance	90%	95%	94%	94%	94%	93%	94%	94%	95%	95%	94%	95%	95%	**95%**
Appraisals	%, Compliance	90%	97%	96%	94%	90%	90%	92%	93%	92%	92%	93%	91%	90%	**92%**
Medical and Dental Appraisals	%, Compliance	90%	84%	89%	97%	97%	95%	92%	92%	93%	86%	88%	87%	90%	**86%**
Time to Hire (days)	General Recruitment	35	59	54	48	66	58	60	49	51	48	47	41	56	**49**
	Medical Recruitment (excl Deanery)	35	93	26	30	36	59	54	40	81	97	71	32	49	**34**
Employee relations	Number of open disciplinary cases			14				26	26	26	27	28	25	22	**19**

2.1. The Trust's **vacancy rate** has reduced slightly to 12.2%. New starters fluctuate in pre-employment stages as the large volume of "between and intra-lockdowns" recruitment activity moves into and out of process on a case-by-case basis. Further support has been enabled across the Workforce Directorate to support recruitment activity for the MK Mass Vaccination Centre and large cohorts of Healthcare Support Workers in collaboration with Nursing and Midwifery colleagues to drive the vacancy level down towards nationally led targets.

2.2. Overall **staff absence** remains high at 5.0%. In-month short term absence continues to represent a large proportion of this increase and is attributed to colleagues' ability to deal with the physical, emotional and communicable impacts of the Coivd-19 pandemic. The absence related infection rate in particular has increased alongside regional public health and Trust inpatient trends from 0.2% in October to 3.2% at the end of January 2021. The reported levels are likely to reduce in coming months as the 2nd wave of the pandemic moves into a falling prevalence phase.

2.3. **The stability index figure** (defined as *proportion of staff in post at end of period who were in post at beginning of period).* The stability index figure has decreased slightly in-month to 87.1%. Stability within the organisation is crucial during turbulent times and is helpful to understand the longer-term impact of our various influencing interventions and staff support programmes. The 13-month trend shows an increase of almost 2%.

2.4. **Time to hire** has again decreased following the impact of targeted interventions to reduce this to acceptable levels in recent months. Medical staffing time to hire has continued to experience delays in issuing visas. UK Border Agency (Visas and Immigration) centres are open but quarantine restrictions remain in place for incoming new entrants in line with national guidance from the Foreign and Commonwealth Office, contributing to the adverse impact on the reported level.

2.5. **Employee Relations cases** have remained fairly static when compared to previous reporting months. As reported in M9, case volumes have stabilised as the number of cases resolved at informal level in line with the Trust's Fair and Just Culture principles remains high. A detailed Employee Relations case report is produced on a quarterly basis for Workforce Board and JCNC.

2.6. **Statutory and mandatory training** compliance is at 95% and **appraisals** compliance is at 92%, an increase of 2% since Month 9. The Trust is now in month 2 of a temporary 3-month extension to appraisal. The Learning and Development Team will recommence its reminders and support process in March to support an increasing trend.

3. Continuous Improvement, Transformation and Innovation

3.1. The Trust has continued to support processes and procedures enacted during the first and second lockdowns. This includes increasing swabbing capacity and staff support

call lines over 7 days. An increased team of call handlers continue to support the growing volume of calls for support, advice and welfare purposes.

3.2. The volume of **individual risk assessments** being received has stabilised following a resurgence in December as colleagues revisited and revised their personal risk assessments. The Trust's best practice approach to individual risk assessments has enabled it to stand by previous outcomes for colleagues in the wake of revised Clinically Extremely Vulnerable criteria recently published by UK Government, which now mirrors the existing Trust process more closely.

3.3. Colleagues continue to use their allocated **Lateral Flow Device (LFD)** tests kits and these were distributed to substantive staff, and bank staff where stocks allowed. Steps have recently been taken to improve reporting volumes.

3.4. The Trust's **Covid-19 vaccination programme** has now seen over 20,000 vaccinations administered in-line with the Government prioritisation order and criteria. This includes members of the public and health and social care staff. Large scale correspondence has been sent by the Trust to ensure that first vaccination recipients have the maximum opportunity to receive their second vaccination in line with the national guidance.

3.5. A centralised call bureau has been established within the Workforce team to support the mass booking process of second vaccinations and following reminders sent to health and social care colleagues across the BLMK ICS.

3.6. The second dose process has been underway since 22nd February, 11 weeks after the first dose vaccinations began. The feedback for the centre has been exceptional.

4. Culture and Staff Engagement

4.1. The **National NHS Staff Survey 2020** report has been received from Quality Health. Data. At this point, the report remains under embargo by the NHS Staff Survey Coordination Centre, for internal use only. The embargo will be lifted concurrently to their publication on 11 March 2021. Reports will subsequently be forwarded via Executive Directors to Trust Executive Group (TEG), Clinical Divisions and Corporate areas as release dates allow. Following this a full improvement plan for each area, based on survey results, will be drafted.

4.2. Planning has commenced for of the Trust's **Living our Values** (Creating a Kinder, Safer Culture) programme. This programme will complement and enhance Appreciative Inquiry approaches to Quality Improvement and will commence in Quarter 4 of 2020/21 in line with the timescales outline in the Trust's NHS People Plan delivery plan. Early meetings of key Trust stakeholders and external partners are ongoing to support delivery through use of shared objectives and language.

5. Current Affairs & Hot Topics

5.1. The Trust's **'12 Weeks of Wellness'** programme has commenced to help to support the Trust's workforce through its Covid-19 recovery, with an enhanced package of support for colleagues to access and benefit from.

5.2. The Trust's Workspace intranet site has been enhanced to promote and engage colleagues and share resources. In February, the Trust's Time to Talk commenced with a MS Teams based relaxation session from Clinical Psychologist, Dr Sue Peacock. Nick Elston, returned to talk about anxiety and the importance of talking about mental health. Virtual Care Circles and Live Q&A events were led by Executive Directors to support the Trust's vaccination programme and flexible working. Virtual social clubs were also established and have proved a success in their early stages (Click and Connect).

5.3. In March, the Trust's Walk the World virtual challenge commences with free pedometers available to help colleagues to achieve their goal to walk a Divisional content. It is envisaged that this will help to support physical activity as Spring arrives and a healthy dose of internal team-based competition.

6. Recommendations

6.1. Trust Board is asked to note and receive the Workforce Report for Month 10.

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Trust Board**	**Date: March 2021**
Report title:	**Staff Health and Wellbeing Report**	**Agenda item: 4.4**
Lead director **Report author**	**Name: Danielle Petch** **Name: Danielle Petch**	**Title: Director of Workforce** **Title: Director of Workforce**
FoI status:	**Public**	

Report summary	This report provides a summary of the support available to staff throughout the Covid-19 pandemic.			
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [x]	**Decision** [ ]
Recommendation	Trust Board is asked to note and receive the report.			

Strategic objectives links	Objective 8: Investing in our people
Board Assurance Framework links	BAF risks 19-24
CQC outcome/ regulation links	Well Led Outcome 13: Staffing
Identified risks and risk management actions	
Resource implications	
Legal implications including equality and diversity assessment	
Report history	
Next steps	
Appendices	

1. Introduction

1.1. The Trust has made many changes to the workforce and health and wellbeing processes and procedures during the pandemic. The workforce at MKUH was most likely slightly better prepared than other Trusts for Covid-19 as the Trust had run the Wuhan quarantine facility prior to the widespread UK pandemic. As a result, the workforce had a better idea of what to expect than perhaps staff at other Trusts. Numerous MKUH colleagues had already been trained and fitted for PPE and were familiar with taking swabs. The workforce had also had the opportunity to consider and process the personal implications of possible Covid-19 exposure. However, when the pandemic took hold in the UK it became apparent that, although slightly ahead of other Trusts, much more support would be needed to help the workforce through this very difficult time.

1.2. The welfare of our workforce has been at the forefront of our minds throughout the pandemic. A number of initiatives have been put in place in both waves/surges one and two order to ensure our staff are looked after and cared for while they are looking after and caring for our patients.

1.3. This paper details the initiatives which have been in place to support staff throughout the pandemic.

2. Psychological and Physical Support

2.1. A large number of psychological and physical health initiatives have been put in place.

a) <u>Close monitoring of any staff sickness and welfare calls to those who are unwell</u>

Throughout the pandemic an average of 115 colleagues a day were at home either off sick or working from home as a result of self-isolating due to suspected Covid-19. At its peak (April 2020) at over 412 colleagues were absent at one time due to Covid-19 related illness/self-isolation. During the peak of the second wave, 247 colleagues were absent for the same reasons.

All staff who are absent with Covid-19/suspected Covid-19 or isolating due to a family member being suspected of having Covid-19 are contacted each day by one of the team via telephone. These calls are to check on the welfare of our staff, making sure they are in good spirits and that they have basic necessities, such as food and medication. Where a need is identified volunteers are made aware of the issue and the necessary supplies are collected and delivered. These daily calls are especially vital for staff who live alone as this may be the only person they speak with that day.

The average number of welfare calls each day has been as high as 143 during the first wave. Almost 15,500 outgoing calls have been made to MKUH staff since March.

b) Staff Covid-19 inbound call line

We introduced a 7 day a week inbound call line which staff can ring to ask any Covid-19 related questions. The questions include topics such as PPE, self isolation, Covid-19 symptoms, child care issues and many more. At its height this call line received on average between 100 and 150 calls a day, peaking at 259 in April 2020. In total approx. 11,300 calls have been received.

c) Extensive Health and Wellbeing Services

Alongside our regular telephone counselling service, Employee Assistance Programme (EAP) we introduced a secondary telephone EAP and a face to face counselling service. These have been in regular use throughout the pandemic. Alongside these local offerings there are also national services in conjunction with groups such as the Samaritans. These services are well publicised to our staff and are readily available to both the outbound welfare call handlers and the inbound staff Covid-19 call handlers.

In addition to this some areas also engaged the services of a Clinical Psychologist to help the staff work through and manage their experiences. This additional support was most useful in Covid-19 high impact areas such as ICU.

Many staff also made use of the existing staff support services such as the Peer2Peer listening service, the Mental Health First Aiders and attendance at Schwartz Rounds.

As part of the 12 Weeks of Wellness every staff member received a pack, posted to their home address, which contained a booklet detailing the support services available, along with their contact details, as well as a free drinks voucher and some spring seeds.

d) Creation of the staff hub & ED quiet room

The Trust created a staff hub, originally in the old Macmillan Unit and more latterly in its new permanent home near the Eaglestone Restaurant. This is a safe space staff can attend to take a few moments to relax and recharge with colleagues. This is especially important given the distressing progress of this illness and the recovery rate. It is vital staff have a safe place to process their feelings or simply to have a quiet place to reflect.

As well as the staff hub there is also the recently introduced quiet room in the Emergency Department.

Next steps for the improvement of staff rest/break facilities include refreshing and improving staff rooms, funded in part by charity monies, including funds from the Capt. Sir Tom campaign. This work remains ongoing.

e) Staff food parcels & donations

Baskets of essentials and small treats were delivered to each ward and department to keep staff refreshed and hydrated during this time. These were very well received by staff and were much appreciated. The contents of the baskets were largely a result of the many donations of items we received from the population and companies of Milton Keynes.

The workforce particularly enjoyed the large number of Easter Eggs and Lindt bunnies which were donated, enough for one per staff member.

The Trust also received some monies from the Capt. Sir Tom campaign, which was used to create “goody bags” for staff. These were well received and much appreciated.

Donations of individually wrapped chocolates and cakes continue from local charities and stores.

f) Staff swabbing

The Staff Health and Wellbeing team have swabbed all staff off with Covid-19 who met the national criteria for swabbing. The Trust had sufficient swabbing capacity to support demand throughout the pandemic; over 3150 staff swabs have been taken across the Trust’s Wards, the Ward 12 hub and a standalone Pod which was initially outside the Paediatric Accident and Emergency Department and more recently relocated to the rear of the Academic Centre.

In April 2020, the Trust participated in an NHS England initiative to swab asymptomatic staff. The majority of the first 500 booking slots were filled within the first hour of the call centre opening. The Trust increased capacity shortly thereafter and over 1000 staff were swabbed during the 2 day event.

The Trust also participated in two research based antibody screening programmes. Close to 1300 staff were screened in the first programme, followed by a further 2700 staff in the second.

The Trust continues to participate in Covid-19 research studies as resources allow.

g) Lateral Flow Testing

The Trust commenced its participation in asymptomatic Lateral Flow Testing in December 2020. This has required an extensive supply and distribution exercise in collaboration with colleagues from Receipt and Distribution and Workforce. Training videos, a user guide and a QR code-based reporting system have been developed internally. Positive results are routinely picked up by the call handling team and booked for a PCR test/swab within 16 hours.

To date, in excess of 31,700 tests have been performed by the MKUH workforce.

Asymptomatic staff testing has been particularly important in preventing the spread of the Covid-19 infection as colleagues who have tested positive through Lateral Flow Tests are required to self-isolate immediately after a positive result is returned, pending a PCR test/swab.

h) BAME Workforce & Covid-19

It emerged during the pandemic that the BAME workforce were more severely impacted by Covid-19 than the non-BAME workforce. There was a national response published in relation to this and the Trust followed this guidance. In addition to this MKUH held BAME Q&A sessions and engaged with the local British Association of Physicians of Indian Origin (BAPIO) Lead and the Medical Advisory Committee (MAC) to discuss the issues. Following this early engagement, the formation of the MKUH BAME network was accelerated and agreement was reached for a Leadership Inclusion Council. Recruitment to this council is currently underway. Applications to join this group have been received and the first meeting is due to take place in the coming weeks.

i) Risk assessment and reasonable adjustments to “at risk” staff

All staff were asked to complete a Covid-19 workforce risk assessment. In fact, MKUH was the first Trust to reach 100% of staff assessed or opted out. The risk assessments were carried out by the staff member and their manager and for staff with certain medical these were reviewed by the Divisional Triumvirate and then forwarded to the Trust Risk Assessment Panel, which consists of an Executive Director, Occupational Health and HR. This panel reviews the Divisional recommendation and then makes the final recommendation as to whether the staff member may continue with no adjustments, be moved to a lower risk area, either in the department, Division or elsewhere in the Trust, or work from home.

Following feedback from BAME engagement events any colleagues who were BAME, over 55 years of age and in an aerosol generating procedure area, or over 60 and in an aerosol generating procedure area were invited to have a risk discussion with the Occupation Health Physician. An appeal process was also developed to review cases further.

The outcome of the risk assessment panel requires people to continue as normal, move to a lower risk area or work from home (during shielding times only). Any colleagues who are unable to adhere to the outcome in their regular work area are passed to the Covid-19 redeployment pool who identify an alternative suitable work location.

To date, 1312 risk assessment forms have been reviewed by panel. All staff have had a risk assessment with their manager or have opted out. New starters now receive a risk assessment as part of their onboarding.

Most recently the Government extended shielding until the end of March 2021 and extended the shielding pre-requisites. The Trust did not need to amend its processes and procedures as a result of this as the recent changes simply aligned the national guidance with the best practice approach the Trust was following.

j) Redeployment Pool

Where it has not been possible for colleagues to continue in their current role, either as a result of there being no "lower risk area" for them following panel review, or because their regular work is not taking place, a process is in place to allow the Trust to assess their skills and move them to another role on a temporary basis. This includes roles such as switchboard and the welfare call lines. In addition, this group have also surveyed 500+ administrative staff in the first wave and the entire Trust in the second wave, asking them to identify which areas of front line work they would be able to undertake, should the need arise. This includes tasks such as cleaning, unpacking and delivering stores etc.

k) Care Support Circles

When shielding came to an end following the first wave it became clear that the majority of the shielded staff were very worried about returning to site. The Trust undertook a series of engagement events with these staff members, led by the Director of Workforce, to ensure their concerns were heard and that they were briefed about and reassured that all necessary steps to safeguard their return to the workplace had taken place. These included full workplace risk assessments to ensure all measures had been taken to make our workplaces safe and secure.

To ensure these team members did not feel alone Care Support Circles were formed to provide a peer support mechanism. These were very well received and a similar model is being put in place for those suffering with the condition Long Covid.

When the second wave of shielding comes to an end the Care Support Circles will be revisited as required.

l) Long Covid Support Group

Alongside the Long Covid Clinic being formed in MK which Occupational Health can refer to the OH team have also started and MKUH Long Covid Support Group. This Group aims to bring together suffers of Long Covid and provide support and practical advice for the management of their condition. The Trust Physiotherapy team have also volunteered to work with Long Covid sufferers, advising about reasonable adjustment for their workplace.

m) First Covid Vaccination Centre in BLMK

The Trust was asked to be the first Covid vaccination site in the ICS and was one of the first in the country. The Trust has consistently delivered a high number of vaccinations since the centre opened on 8th December 2020. The centre has delivered over 20,000 first doses and recently began its second dose programme.

It has been agreed that the centre will move out of the Academic Centre at the end of March and relocate to the town centre Mass Vaccination Centre at Saxon Court. The centre will then be run by Saxon Court but MKUH will transfer the administrative and registered staff currently working in the MKUH centre.

Hosting the centre at MKUH was a real benefit for the MKUH workforce as it allowed them easy and fast access to the vaccine.

3. Financial & Practical Support

3.1. A series of financial and practical support programmes were also put in place to help staff during this time.

a) Work from home/agile working

The Trust allowed staff the flexibility to work from home, another location at the hospital or from Witan Gate at their discretion, providing they could carry out their duties from the new location. This was especially valued by staff as it allowed many staff, including shielding staff, to continue to work through the pandemic and contribute to the Covid-19 response.

b) Hotel Accommodation

MKUH arranged a contract with the local Holiday Inn for staff to use the hotel during the pandemic. Any staff member who was unable to return home, either due to shielding a family member or a desire to be close to site was able to use this facility. 899 nights of hotel were used and this is testament to the dedication of Team MKUH.

c) Covid-19 sick/isolation pay

The regular NHS terms and conditions were enhanced during Covid-19 ensuring no staff member lost out financially as a result of being unable to work due to Covid-19. Substantive staff who were shielding/isolated also had any regular overtime/bank elements of their pay protected during the time they were absent.

d) Enhanced special leave/carer's leave

Prior to the pandemic the Trust had recently expanded the special leave and carer's leave policy to be more generous than the NHS standard. This has been especially helpful during the pandemic, offering another avenue of flexibility for staff.

e) Quarantine flexibilities

In order to assist MKUH colleagues to take advantage of the travel corridors or to visit relatives abroad in non-corridor countries the Trust was one of the first to introduce flexible arrangements for those who found they had to quarantine upon return from abroad. This process was mandatory for all staff travelling abroad, including those using travel corridors, as it ensured plans are put in place for any eventuality. The staff member agreed with their manager prior to their leave that in the unfortunate circumstance they needed to quarantine they either:

- Worked from home (either undertaking their regular duties or duties the manager has arranged for them specially to facilitate their leave)
- Used additional annual leave
- Owed the hours back to the Trust
- Used paid leave

This flexibility ensured all colleagues could take leave to go abroad, including to countries which required quarantine upon return.

This same approach was used for staff who need to isolate as a result of a loved one isolating pre-surgery or if they needed to be at home for childcare reasons. In this instance they may also have used carer's leave.

f) Domestic abuse policy

In response to the rising number of domestic abuse cases being reported nationally the Trust implemented at pace a generous domestic abuse policy. It is hoped no member of staff will need to use it but it is in place if required. Since the launch of the policy many Trusts and private companies have requested a copy so they too can implement it in their workplace.

g) Selling or carrying forward annual leave

The Trust recognised that not all staff will be able to use all their annual leave this year. To ensure staff do not lose their leave, either this year or next, the Trust has introduced a policy which allows all staff to carry over up to 20 days statutory leave and up to 10 days contractual leave. The Trust has also introduced a policy to allow employees to sell back any unused contractual leave. These two initiatives allow colleagues to avoid losing any annual leave.

Alongside these initiatives the Trust has also been encouraging all staff to take leave when they can throughout the pandemic and asked that all staff take at least 2 weeks leave (pro rata) over the summer.

h) Training moved online

Alongside allowing remote access to key clinical systems the Trust also moved a large portion of statutory and mandatory training online. Whilst this may seem

small in the scope of the general pandemic it was actually quite valuable for staff as it presented an opportunity for even entirely ward based staff to undertake some activity at home, very valuable for those needing to quarantine at home. This was another way staff could continue to fulfil some of their duties from home and so avoid the need to use unpaid leave.

4. Recruitment and Staffing

4.1. Alongside the support arrangements for our existing workforce we also undertook a series of additional activities to boost our workforce numbers.

a) Fast track of 300 volunteers

During the first wave 300 volunteers approached the Trust to offer their services. These were cleared by recruitment and once ready to work passed to the volunteer team for deployment.

b) Fast track of 100+ new bank workers

Over 100 people registered to work via our Bank during this time. These were cleared by recruitment and once ready were passed to the clinical teams for deployment to service areas.

c) Substantive offer to bank staff

At the beginning of the pandemic Bank staff were offered the option to migrate to a substantive contract (vacancies allowing) as this allowed them to be rostered in advance and to benefit from full NHS terms and conditions. A reliable and regular supply of experienced staff was essential during this time and we were pleased a large number of bank workers chose this option.

d) Bring Staff Back

The Trust was an active participant in the national Bring Staff Back Campaign and benefited from a number of previously retired workers who returned to the NHS.

e) Overseas recruitment

Throughout the pandemic the team continued to clear overseas recruits. Unfortunately, upon arrival in the UK these new team members had to quarantine for 14 days. As they were new to the UK and usually did not have family in the area, most took up residence in our staff accommodation. The health and wellbeing call handlers made regular contact with these staff and the Workforce and Accommodation teams ensured they had access to everything they could need to isolate immediately upon arrival in a new country. We made sure they felt welcomed and valued at what was doubtless a very daunting time.

f) Recruitment for the MK Mass Vaccination Centre

At the request of MK Place the Trust undertook streamlined recruitment for the town centre Mass Vaccination Centre, recruiting and clearing over 25 administrators.

5. Recommendations

5.1. Trust Board is asked to note and receive the report.

Meeting title	**Trust Board**	**Date: 04/02/2021**
Report title:	**Estates Strategy: 2020-2025**	**Agenda item: 5.1**
Lead director **Report author** **Sponsor(s)**	**Name: John Blakesley** **Name: Chris Todd** **Name: Phil Eagles**	**Title: Deputy CEO** **Title: Programme Director – Strategic Estates** **Title: Associate Director of Estates**
FoI status:		

Report summary							
Purpose *(tick one box only)*	**Information**		**Approval**	x	**To note**		**Decision**	
Recommendation	The Board are asked to approve the 2020-2025 Estates Strategy which builds upon the previously approved 2018 document by integrating the HIP (Health Infrastructure Plan) Programme with current Business as Usual (BAU) planning. The Masterplans illustrate the overall proposed changes to the site as part of the programme including greater detail for 2020-2025 and more indicative planning for the 2025-2030 cycle (i.e. illustrating the programme is part of a long term strategic investment. The ERIC (Estates Return Information Centre) and 6-facet backlog data has been updated to include the 2019-2020 data (as submitted to NHSEI). The estates strategy also includes strong reference to the plans to move MKUH towards Net Zero Carbon (NZC) and more detail is currently being developed on how to phase this work over the coming decade.						

Strategic objectives links	• Improving Patient Experience by developing high-quality healthcare environments. • Improving Clinical Effectiveness by ensuring the estate actively supports patient pathways and clinical decision-making. • Improving Patient Safety by reducing critical infrastructure risk • Make Best Use of Estate, ensuring effective master-planning for the site to improve clinical adjacencies. • Develop a Robust and Sustainable future and Good Corporate Citizen by aiming for Net Zero Carbon and ensure the Hospital can meet the needs of the MK population.
Board Assurance Framework links	Failure to achieve improvements in the patient survey – a Critical Success Factor for the HIP Programme 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 Trust's capital programme – the Programme will be supported with CDEL cover.

	Workforce Risks – these will each be supported by high quality working environments, aiding both recruitment and retention. Insufficient capacity in the Neonatal Unit to accommodate babies requiring special care – the Women's and Children's Hospital resolves this risk
CQC regulations	Regulation 15 (Premises and Equipment) directly, but supporting multiple other regulations (e.g. Reg. 10 Dignity and Respect, Reg. 12 Safe Care and Treatment)
Identified risks and risk management actions	Risk 2942 - Trust unable to undertake HIP (Health Infrastructure Plan) Programme to ensure the organisation can meet the needs of a growing population in and around Milton Keynes.
Resource implications	The Estates Strategy reflects the development of the HIP Programme in line with the Trusts submitted Strategic Outline Case (SOC), this is expected to be funded as part of the New Hospitals Programme. The Redevelopment Team and Estates Team would ensure the correct appropriate support to deliver the Strategy.
Legal implications including equality and diversity assessment	None-specifically

Report history	This Estates Strategy is a significant update of the 2018 Strategy.
Next steps	Annual Review by Board Report on Progress.
Appendices	None

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NHS
Milton Keynes
University Hospital
NHS Foundation Trust

MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST

ESTATES STRATEGY: 2020 - 2025

DECEMBER 2020

As a teaching hospital, we conduct education and research to improve healthcare for our patients. During your visit students may be involved in your care, or you may be asked to participate in a clinical trial. Please speak to your doctor or nurse if you have any concerns.

Chief Executive: Joe Harrison
Chairman: Simon Lloyd

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1. INTRODUCTION

The Milton Keynes University Hospital NHS Foundation Trust's Estates Strategy was produced in January 2018. This update of the Estates Strategy includes revisions to reflect the key changes since 2018, including the:

- Development of the Bedfordshire Luton & Milton Keynes ICS Estates Strategy (July 2018) and Checkpoint (July 2019);
- Publication of the NHS Long-Term Plan (January 2019);
- Publication of the DHSC Health Infrastructure Plan (September 2019);
- Announcement of HIP funding for MKUH NHSFT (December 2019);
- Completion of the Trust's Cancer Centre (March 2020);
- Publication of 'Delivering a net zero national health service' by the DHSC (October 2020);
- Development of the Strategic Outline Case for the MKUH HIP programme (November 2020); and
- Ongoing development of the Trust's Energy & Infrastructure Strategy (due to be completed in December 2020).

It should be noted that the Trust's Estates Strategy has not been rewritten in full - the content of this document is mainly drawn from the 2018 Estates Strategy, with additional material taken from other key documents, including the BLMK ICS estates strategy, the Trust's Annual Report for 2019/20 and the draft SOC for the MKUH HIP programme.

It is currently intended that a new Estates Strategy will be produced by the Trust in 2021.

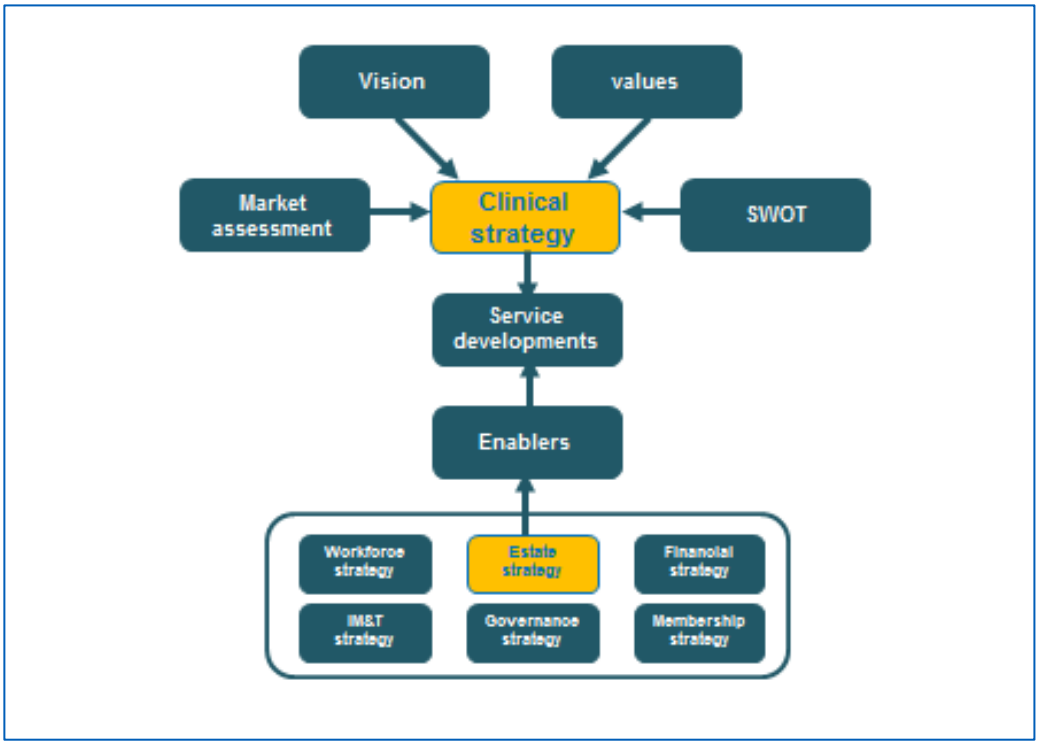
Scope of the Estates Strategy

The scope of the strategy is all the estate the Trust uses, but inevitably the strategy focuses on the Milton Keynes Hospital site at Eaglestone. Responsibility for the estate carries risk; risk of non-compliance with statutory and Care Quality Commission (CQC) standards; financial risks in relation to affordability as well as the cost of under-utilised space and the management of backlog maintenance. Managing these risks and meeting statutory responsibility for the management of the estate asset make the development of an estate strategy essential.

Purpose of the Estates Strategy

This estate strategy sets out how the Trust can ensure that it operates from an estate that is fit for purpose for the current demand and which also supports and enables delivery of high quality, safe and effective care over the next five years. The diagram below sets out the link between enablers, including the estate strategy and the clinical strategy which in turn reflects the Trust's vision, values, external and internal influences.

Figure 1: Estate strategy/clinical strategy relationship



This version of the Trust's Estates Strategy is intended to provide the local strategic estates context to the development of the proposals set out in the MKUH HIP Programme Strategic Outline Case that was approved by the Trust Board in November 2020 and to reflect the latest thinking in terms of the Trust's estates needs and associated capital programme over the next five years.

Structure of the Document

This document follows the structure recommended in the relevant guidance, including "Estatecode", HBN 00-01 and HBN 00-08. It aims to describe in one place:

- The condition and "performance" of the Trust's current estate;
- The service-led or estate-led reasons change is needed;
- A comprehensive estate investment programme.

This document summarises plans for developing and managing the estate over the next five years and is designed to meet the Trust's service and business needs.

2. WHERE ARE WE NOW?

2.1 Overview

2.1.1 This section of the Trust's revised Estates Strategy provides summary information on the MKUH site, developments since the previous version of the Estates Strategy produced in 2018, details of site occupation and usage, and commentary on key issues such as backlog maintenance, environmental sustainability and the impact of the Covid-19 pandemic.

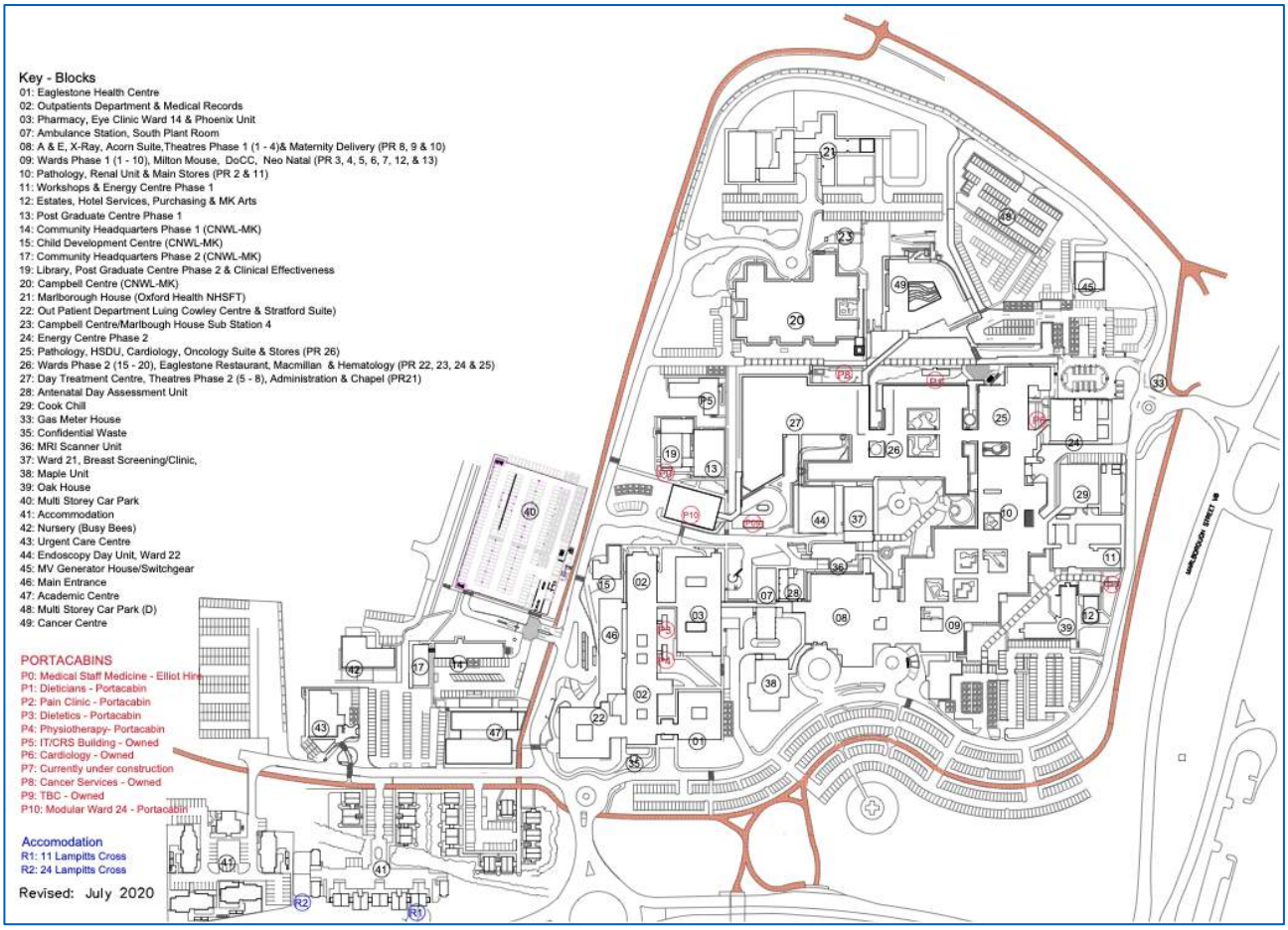
2.2 Description of the Existing Estate

The main Trust estate is located on the hospital campus at Standing Way, Eaglestone; most of the 15.73 hectares campus is owned by MKUH, however Oxford Health NHS Foundation Trust (OHFT) and NHS Property Services (NHPS) own portions of the land to the north and west side of the campus [Appendix 1].

The site is well located, approximately 2.5 miles from the retail centre of Milton Keynes with access to the A421; there are over 2,100 car parking spaces on-site (with more planned) and the site is served by local buses. The Milton Keynes "Redways route" dissects the front of the hospital linking into other parts of the Milton Keynes network. In addition, a helicopter pad utilised by air ambulance services is located close to the A&E at the front of the site, adjacent to the main surface level car park.

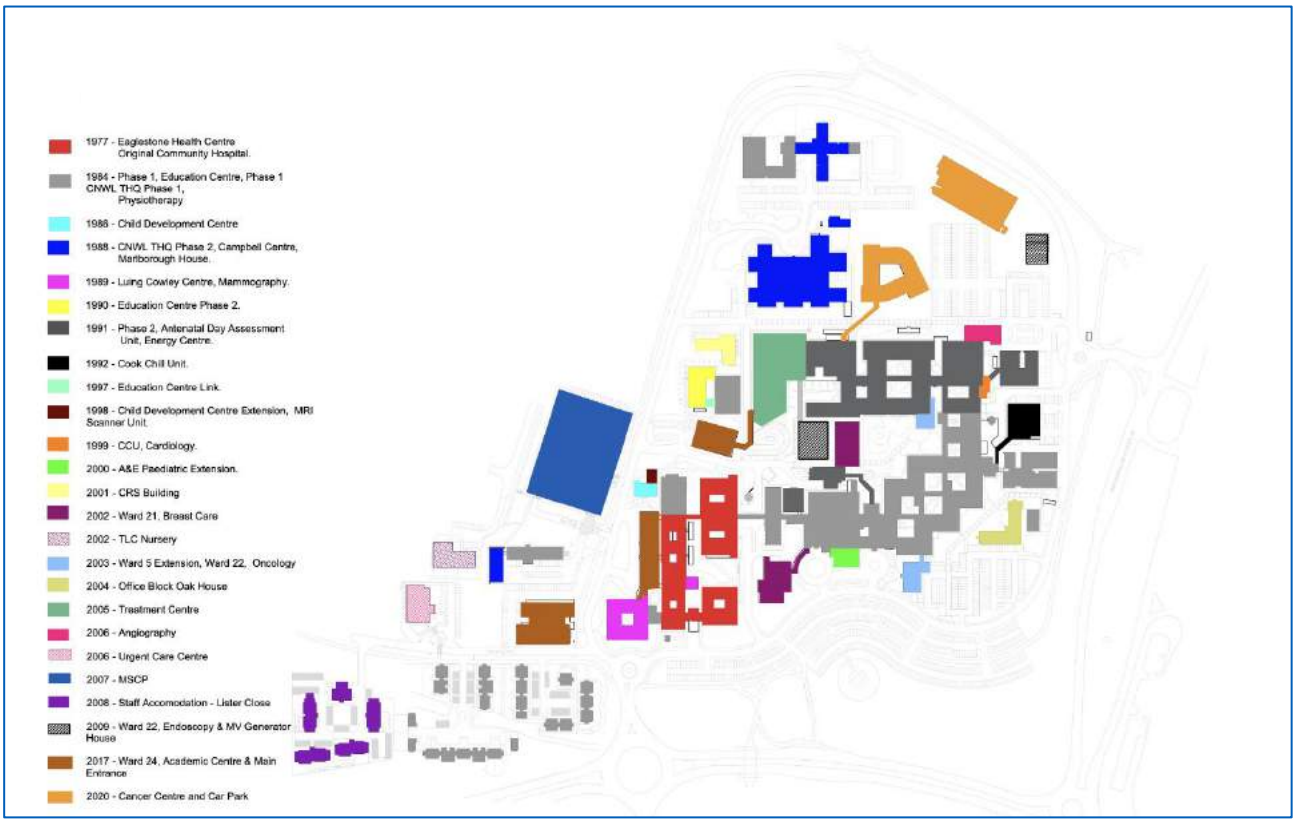
The following diagram shows the buildings on the MKUH site [see also Appendix 2]:

Figure 2: MKUH site



Approximately 31% of the estate was constructed between 1975 and 1984 and circa 39% of the estate is less than 15 years old. The development of the site since 1977 is illustrated in the following below [see also Appendix 4]:

Figure 3: Site development since 1977



The following table summarises some of the key estate metrics, comparing the position as at 31st March 2020 with the reported position reported in the 2018 Estates Strategy.

Figure 4: Key estates metrics

	2018	2019/20
Total MKUH Gross Internal Floor Area[1]	84,176m^2	91,380m^2
Total MKUH Occupied Floor Area[2]	59,557m^2	63,196m^2
Total Clinical Floor Area	40,054m^2	46,466m^2
Total Non-Clinical Floor Area	19,503m^2	16,730m^2
Proportion Clinical Space	67%	73%
Proportion Non-Clinical Space	33%	27%
Occupied Floor Area Not Functionally Suitable	n/a	5.33%
Clinical Floor Area Not Functionally Suitable	1.12%	1.50%
Occupied Floor Area Empty/Under-Used[3]	n/a	2.70%
Backlog Maintenance Liability	£21.3m	£18.5m

[1] Includes multi-storey car park and excludes space leased to other organisations
[2] Excludes multi-storey car park and space leased to other organisations
[3] Target is 2.5%

The principal factors driving the increase in floor area are the development of the new Cancer Centre (see below) and additional car parking facilities. It is anticipated that the empty/under-used floor area will be reduced in the very near future and that the Trust will be well below its target of 2.5% for this metric.

Asset Value

In 2018/19 the Trust adopted a modern equivalent asset principle which reflected an alternative site valuation. In adopting the Modern Equivalent Asset – with alternative site approach, the valuation of land and buildings reflects the extent of estate required for the provision of the same service as already provided by the existing estate but not in the same form or location.

Following an assessment from the Trust's valuer, valuing the estate on an alternative site valuation basis has led to a lower reported Current Value for accounting purposes. This arises from better configuration of the hospital estates (reducing circulation space) and a reduction in the land valuation. The current Alternative Site valuation of MKUH is £117,046,882, as shown below.

Figure 5: MKUH alternative site valuation

Block	Alternative Site Value (£)
A & E - BLK E	4,354,227
CANCER SERVICES - BLK D	7,936,146
ESTATES ADMIN - BLK I	10,976,737
MEDICINE WARD - BLK A	16,690,150
MULTI-STOREY CAR PARK - BLK M	14,505,695
OUTPATIENTS – BLK H	9,621,684
PHARMACY AND STORES – BLK F	2,444,777
POST GRAD CENTRE – BLK G	2,335,007
SURGERY WARD – BLK B	20,816,483
TREATMENT CENTRE – BLK J	2,106,629
UNALLOCATED HOSPITAL AREA – BLK K	2,662,279
WOMEN AND CHILD WARD – BLK C	8,108,429
ENERGY CENTRE BOILER PLANT	368,938
NEW SUBSTATION AND SWITCH GEAR	443,878
LAND	3,420,000
EXT. WORKS	10,255,824
TOTAL	**117,046,882**

Cancer Centre

The Trust's new £15m Cancer Centre was completed and fully operational in early March 2020. The new Centre brings significant improvements to the treatment of cancer patients in Milton Keynes and the surrounding areas. While cancer services were previously provided across three locations on the hospital site, the new centre offers oncology, clinical haematology and cancer- related chemotherapy services, inpatient and outpatient services alongside a wellbeing support service, allowing MKUH to significantly improve the quality of its cancer services whilst also helping to increase capacity.

Figure 6: Cancer Centre images and floor layouts

The Cancer Centre includes 24 inpatient beds, 28 chemotherapy assessment bays, an outpatient's department, an information and wellbeing centre, an aseptic preparation unit and staff accommodation. The facility is owned by ADMK, a wholly-owned subsidiary of the Trust.

In the future, the Trust also has plans to develop and build further cancer services on site, including radiotherapy bunkers, subject to the agreement of the tertiary provider at Oxford.

Pharmacy

The Trust undertook a reconfiguration and refurbishment of the existing pharmacy department as part of an overall reconfiguration of pharmacy services at MKUH. The new pharmacy which was delivered over four phases to ensure the existing department remained operational throughout the works included the provision of a new pharmacy robot, developing more robust medicines management across the site, as well as redesigning the flows of goods as they are received into the department. The IT and dispensing strategy was also reconfigured alongside the project and additional infrastructure was designed into the scheme to allow for future service trends. The pharmacy upgrade was completed in 2020.

A new aseptic suite was developed as part of the Cancer Centre project.

Other Developments Since 2018

In addition to completing the Cancer Centre and the Pharmacy upgrade, the main capital developments at MKUH since January 2018 include:

- Completion of the Academic Centre (owned by Buckinghamshire University on land leased to them by the Trust)
- Investment to the patient environment within the inpatient ward areas
- Rolling programme of Fire Compartment Upgrade works
- Programme to upgrade ventilation systems to provide comfort cooling
- Upgrade to Medical Air Systems
- Upgrade to Lighting on site in public and patient areas including LED for the main MSCP
- Upgrade and expansion of Site HV network to support Cancer Centre
- Upgrade of Medium Voltage Generation Sets to enable compliance with the emissions regulations
- Upgrade to site wide CCTV System
- Investment in passenger lifts to address backlog defects
- Installation of water attention system to support the development of the Cancer Unit and the future development of the North site development area
- Rolling programme of other statutory items (including electrical testing, asbestos, etc) and estates maintenance

In total, the Trust has invested circa £21.4m in its estate in the period from April 2018 to March 2020.

2.3 Site Occupation & Use

2.3.1 Several other NHS organisations provide services from the MKUH site; there are also a small number of non-health service providers on-site. The plan below [Figure 7] shows the location of blocks leased by MKUH to third parties [see also Appendix 5] – Figure 8 below provides a summary of these arrangements.

Figure 7: Leased areas

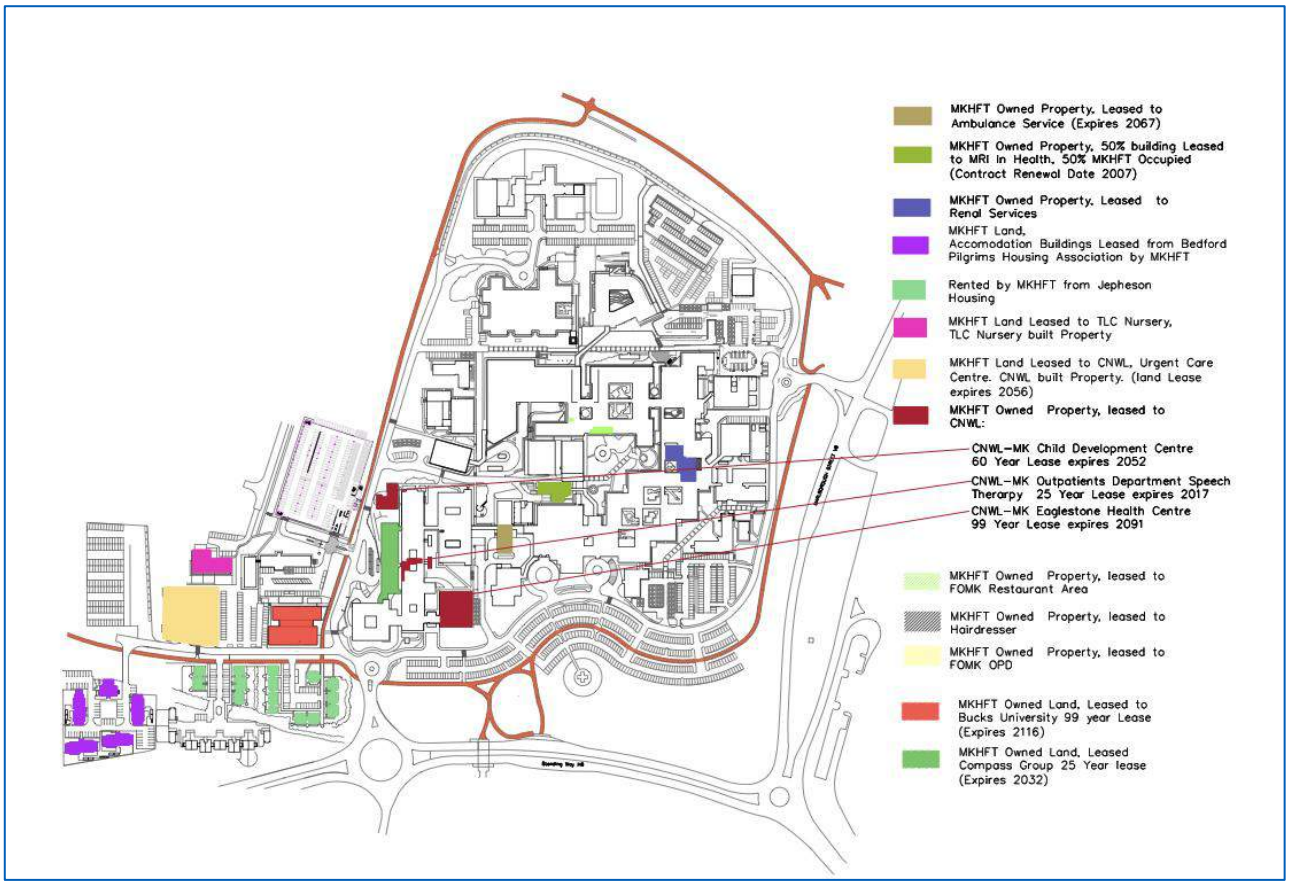


Figure 8: Other site users

Organisation	Building/ area occupied	Notes
CNWL	Eaglestone Health Centre	CNWL have a long lease on the Eaglestone Health Centre property (99-year lease commenced 1 April 1992), CNWL would need to agree for its services to be relocated for the Trust to be able to develop that part of the estate. The building is part of the oldest estate and unless CNWL choose to vacate the building it will remain outside of the scope of the Trust estates strategy. Whilst the property is known to contain asbestos, MKUH only needs to maintain the structure and exterior in reasonable and serviceable state with the costs charged back to CNWL. It is not possible to break the lease unless the building becomes uneconomic to repair.
CNWL	The Campbell Centre	Freehold title owned by NHSPS and leased for mental health services – access will need to be maintained to the property. CNWL are reviewing the long-term use of this property.
CNWL	Community services HQ	An NHSPS owned property, leased to CNWL, the 'L' shaped building is located adjacent to the multi-storey car park and the Trust owns part the freehold title where the building has been extended.

Organisation	Building/ area occupied	Notes
CNWL	Child Development Centre	Although not within existing proposals for relocation, the child development centre, occupied by CNWL by way of a long lease (60 years commencing 1st April 1992, ends 2052) has similar occupational rights as the Eaglestone Health Centre lease. Situated between the new multi storey car park and a secondary entrance into the hospital, the single storey structure may reduce the trusts ability to construct a design led solution of the outpatients occupied building.
Oxford Health	Marlborough House	Freehold title owned by Oxford Health NHS Foundation Trust – access will need to be maintained to the property.
South Central Ambulance Service	Ambulance station	SCAS currently holds a long lease on the ambulance station in the centre of the site, however a new 15-year lease is due to be completed on an alternative part of the site near the Acorn building. The lease will include break clauses for SCAS and the Trust.
Oxford University Hospitals	Renal Unit	This space is rented from the Trust on a short-term basis.
Milton Keynes Urgent Care Services	Urgent Care Centre	The urgent care centre is managed by NHSPS, with the Trust a 40% shareholder in the provider organisation. Any re-use of the building would require agreement with NHSPS and the consent of the majority share owners which could be a barrier to redevelopment plans. There is a 50-year lease on the building which expires in 2056. If the building were vacated NHSPS would be able to charge resulting void costs to Milton Keynes CCG.
Buckinghamshire University	Academic Centre	The University of Buckingham has constructed a new academic centre on land leased from the Trust, on a 50-year lease which expires in 2056. There is a lease back of space to the Trust for a 5-year term (from 01/08/2018) and the Trust holds rights of renewal under the L&TA.
TLC Nursery	Busy Bees Nursery	A purpose-built nursery with five rooms and suitable for children aged from three months to five years. The building was constructed by the nursery operator with a ground lease for 25 years which commenced in March 2003. The nursery is not specifically for the use by the Trust.
Bedford Pilgrims Association	Staff accommodation	Bedford Pilgrims Association provides units of staff accommodation upon land leased from the Trust.
Jephson Housing	Staff accommodation	Jephson Housing also provides units of staff accommodation upon land leased from the Trust.
Retail units	Various	The Trust has also leased some retail areas to a variety of operators.

2.4 Estate Appraisal

The performance of NHS properties is measured through the use of a six-facet survey. The Trust undertakes an annual review of the 6 facet survey data and this is undertaken on a rolling 20% per year programme.

The table below summarises the latest appraisal at block-level [full details are shown in Appendix 6] – a site plan showing blocks by condition score is shown in Figure 10 below [see also Appendix 7].

Figure 9: Six facet survey results summary – 2020

Block	Condition	Functional Suitability	Quality	Statutory Compliance	Overall
Site	B	n/a	n/a	n/a	**B**
Eaglestone Health Centre	C	C	C	D	**C**
Old Outpatients Department	C	C	C	D	**C**
Pharmacy, Eye Clinic & Ward 14	C	C	C	D	**C**
Ambulance Station	C	C	C	D	**C**
Main Entrance, A & E	C	B	B	D	**C**
Wards 1 – 10	D	B	B	D	**D**
Pathology	C	C	B	C	**C**
Main Boiler House & Workshops	C	B	B	C	**C**
Facilities Department	C	B	B	B	**B**
PGC & Extension	B	B	B	C	**C**
Childs Development Centre	C	B	C	B	**C**
Education Centre – Phase 2	C	B	B	C	**C**
Luing Colwey	C	D	C	C	**B**
Energy Centre	C	n/a	n/a	B	**C**
HSDU, EBME, Haematology	C	B	B	B	**C**
Ward Block Phase 2	C	B	B	B	**C**
Theatres/Admin & Treatment	C	B	B	B	**C**
ADAU (Old Endoscopy)	C	C	C	C	**C**
Cook Chill	B	B	B	B	**B**
Gas Store	B	n/a	n/a	B	**B**
Waste Store	B	n/a	n/a	B	**B**
MRI Scanner	B	B	B	B	**B**
Ward 21 & Breast Screening	B	B	B	B	**B**
Maple Ward	B	B	B	B	**B**
Oak House Offices	B	B	B	B	**B**
MSCP	D	n/a	n/a	B	**D**
Ward 22 & Endoscopy	B	B	B	B	**B**
MV Generator	B	n/a	n/a	B	**B**
Cancer Centre	A	A	A	B	**A**
Admissions Portacabin	B	B	B	B	**B**
Dietitians Portacabin	B	B	B	B	**B**
Physio Portacabin	B	B	B	B	**B**
IT Portacabin	B	B	B	B	**B**
Cardiology Portacabin	B	B	B	B	**B**
Specialist Nurses Portacabin	B	B	B	B	**B**
11 Lampitts Cross	C	n/a	n/a	B	**C**
24 Lampitts Cross	C	n/a	n/a	B	**C**

The appraisal shows that the majority of the Trust's estate is in a satisfactory condition in relation to quality, physical condition, functional suitability and statutory compliance, although there are a number of buildings which are rated in category C, which is below the acceptable level.

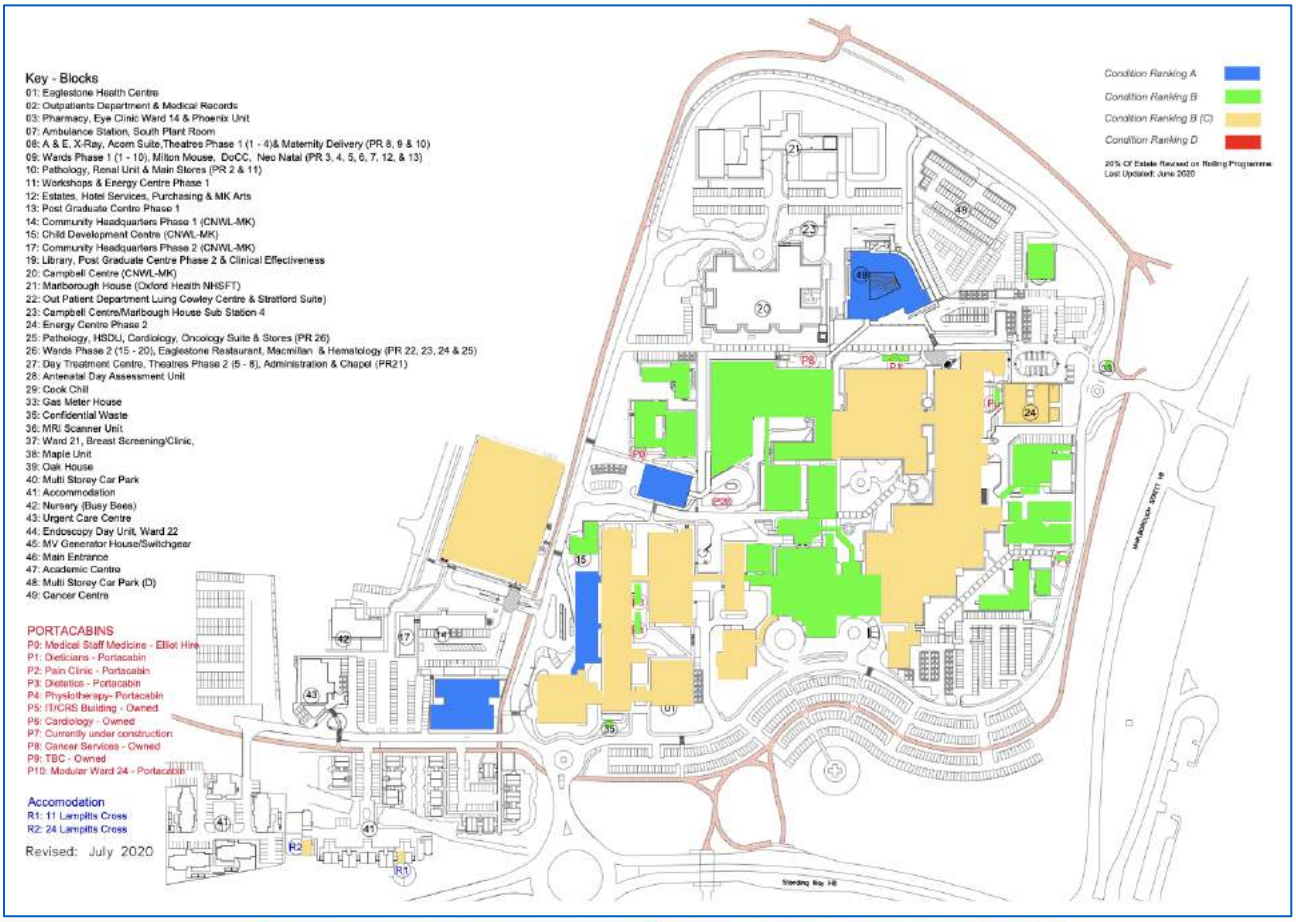
The areas rated D for Statutory Compliance are the original Community Hospital and Phase 1 buildings. The physical condition of fire integrity cannot be assured in some areas; the Trust has in-place an action-plan agreed with Buckinghamshire Fire and Rescue, funded via the Capital Programme, to upgrade the relevant areas whilst additional management interventions take place, and this is recorded on the Trusts risk register and reviewed in-line with Trust policy.

Statutory compliance is managed through the Estates Governance Group; the Trust has in place a statutory compliance manager that is supported by Authorising Engineers for each of the HTM disciplines (except HTM07). Each report annually (quarterly for HTM04) and key defects/ risks are added to the Trust's Risk Register and progress is monitored through the group and when appropriate by the Health and Safety Committee that reports direct to the Trust Board.

In addition to the HTMs, the Trust also manages Asbestos in-line with the CAR and this reports to that group and compliance against HSAW Act. Risks identified by these work streams are recorded and monitored using the Trust Risk Register, this is also reviewed on a quarterly basis.

The Trust is in the process of transferring its compliance Dashboard to the Premises Assurance Model (PAM) over the next 12 months with a view to having this fully operational by 31/12/2021

Figure 10: MKUH site plan by building condition



2.5 Backlog Maintenance

The Trust's reported total backlog maintenance liability as at the end of 2019/20 was £18.5m, which was circa £3m lower than the liability reported in the 2018 Estates Strategy. Of the total 2019/20 backlog maintenance liability, circa 65% (£12m) related to the critical infrastructure risk – the "high risk backlog" figure was £5m (27%).

The planned MKUH HIP programme will address some of the existing backlog maintenance issues, but further investment will be required to eradicate the total liability.

2.6 Fire Safety

Following the Grenfell Tower disaster in June 2017, NHSI asked all NHS Trusts to provide assurance with regards to its management of fire risk. The Trust provided the following response:

- All Trust risk fire related assessments have been reviewed and confirmed as being in date and current.
- A mandatory staff annual fire awareness programme is in place.
- Buildings greater than two stories high with a cladding system in place and which are used for patient accommodation were identified – the Trust identified one, the Treatment Centre.
- For building identified (the Treatment Centre), the cladding system was checked to establish any potential risk – on reviewing the manuals for the Treatment Centre, it was established that the cladding system used was not one that had been identified as being of concern.
- The Trust undertook and completed the requested site fire inspection with the local fire authority. This inspection established no areas of significant concern
- The Trust has been asked by the local fire authority, to undertake further assurance checks on the cladding system installed to the Treatment Centre to confirm that the cladding system was installed to the recommended standards. This work was undertaken in 2018.

In addition, the Trust continues to invest, on a rolling basis, monies to upgrade and maintain key systems including: fire doors; emergency lighting; detection systems; fire-fighting equipment; fire compartmentation; fixed wire testing; and portable appliance testing.

2.7 Environmental Sustainability

The Trust is committed to sustainability and to reducing its impact on the environment. In particular the Trust has focussed on reducing carbon emissions as part of the national sustainability agenda. The following table shows CO_2 performance per annum to date.

Figure 11: Annual carbon emissions

Year	CO_2 Emissions (Tonnes)
2012/13	11,183
2013/14	10,508
2014/15	9,786
2015/16	9,426
2016/17	9,660
2017/18	9,728
2018/19	9,075
2019/20	9,241

The slight increase in emissions in 2019/20 is mainly attributable to additional demand on the site as a whole, with the opening of the new Cancer Centre. There is an increased reliance on the Trust's medium voltage generators and its combined heat and power plants, both of which provide more efficient power and heating to the hospital and can export electricity back to the grid.

The Trust is putting in place plans to achieve the new targets for reducing carbon emissions by 2040 set out in 'Delivering a net zero national health service' [published in October 2020], and to support Milton Keynes Council's aspiration to be net zero carbon by 2030. The Trust will also develop plans to meet the new Net Zero Carbon Hospital Standard which is due to be released in spring 2021 and is intending to produce its new Green Plan in 2021.

2.8 Impact of Covid-19

The Trust is fully cognisant of the potential for the Covid-19 pandemic (and other similar occurrences in the future) to impact on its service and estates requirements. This creates an even greater need than normal for the Trust to be able to respond to change during its capital planning, design and business case processes and for the Trust's estate to be fully flexible and adaptable.

The Trust has undertaken a number of capital support works to allow the Trust deal with the impact of the Covid – 19 Pandemic. In addition to the medical equipment provided, the Trust has undertaken to adapt a number of areas to allow them to be used as high acuity beds for a short period of time, for escalation. These works have including the following areas:

- Ward 12;
- Phase 2 theatre recovery;
- Day Treatment Centre;
- Former Macmillan Unit;
- Staff Rest Hub; and
- Extended dining room facilities (for social distancing).

In addition to the above the Trust has also provided a number of storage facilities on and off site for equipment and PPE and also modular test Pods for patients and staff.

The Trust has identified a number of issues relating to the future development of the MKUH site that may be affected by changing requirements related to the Covid—19 pandemic, including (but not limited to):

- Capacity pressures;
- Provision of single rooms (and the ability to isolate infectious patients);
- Infection control standards;
- Point-of-care testing;
- Ability to zone departments;
- Standardisation of facilities and processes;
- Flexibility to support new technologies;
- Ability to support social distancing (both for patients and staff);
- Patient/visitor/staff physical and mental wellbeing;
- Storage of equipment and supplies;
- Remote working; and
- Virtual care.

The provision of Covid-19/pandemic safe facilities, protecting staff, patients and visitors from contracting infectious diseases, will be a major benefit from the planned development of new facilities at the MKUH [see section 3.6].

The Trust will apply all emerging guidance and lessons learned from elsewhere (particularly the HIP programme schemes) to ensure that resilience to the Covid-19 pandemic, and other potential emergency situations, is built into its Estates Strategy.

3. WHERE DO WE WANT TO BE?

3.1 Overview

The future development of the Trust's estate will be driven by the need to expand capacity to meet the significant projected population growth in Milton Keynes, to enhance the environmental sustainability of the site and to continue to make best use of the available facilities.

The Trust has an ambitious capital investment programme over the next five years, aligned to the national Health Infrastructure Plan (HIP), and is developing further proposals to upgrade site infrastructure through a new Energy & Infrastructure Strategy, which will be completed by the end of the year.

This chapter of the Estates Strategy outlines the local, system-wide and national policies and strategies that provide the context to the Trust's estates needs and plans and summarises the main developments that the Trust expects to deliver over the next five years to provide a picture of where the MKUH site will be in 2025. The strategic context sections are replicated in the Strategic Outline Case for the MKUH HIP programme, demonstrating the strategic alignment of the Trust's investment plans.

3.2 Local Strategic Context

The Trust serves the entire Milton Keynes local authority area, as well as two additional wards in Aylesbury Vale.

Demographic Profile

Milton Keynes has a very high population growth rate. The population grew by 36,100 people between 2001 and 2011 to 249,895. This was a 17.5% increase, the 7th fastest of all local authorities in England. The latest analysis (2018-based, published 2019) estimated the population at 268,807, which is a further growth of 7%.

The number of people aged 85 and over is projected to double by 2035 and there will be higher than average growth in the number of adults aged 65 and over and in the number of children and young people aged 10-19 years old.

Age Profile

The Milton Keynes population age profile is slightly younger than England as a whole. In 2018, 23.1% of the Milton Keynes population were aged under 16 compared with 19.2% in England. Further, 63.1% of the Milton Keynes population are aged 16-64 compared with 62.9% in England. Therefore, a smaller proportion 13.8% of the Milton Keynes population are aged 65+ compared with 18.2% in England. However, the proportion of older people is growing.

The population of those aged 65+ is projected to be 16.2% in 2026 and 18% by 2031, with the proportion of those aged 80+ also rising by more than 2%. The health of Milton Keynes elderly is poorer than average, indeed in the area immediately to the west of the hospital where 10% of the population have bad or very bad health, 73% of these are aged 70 or over.

Ethnicity

In 2011, 26.1% of the population in Milton Keynes were from a black and minority ethnic group compared with 20.2% in England and 13.2% in 2001. The 2018 Annual Population Survey estimates the BAME population to have risen to 37.6%. This indicates that the BAME population has risen by 8% since 2011. This is corroborated by the school census where the proportion of BAME children in Milton Keynes schools is 36%.

Migration

The number of Milton Keynes residents born outside of the UK more than doubled from 20,500 (9.9%) of the population in 2001 to 46,100 (18.5%) in 2011. This is significantly higher than England as a whole (13.8%). 6,200 residents in Milton Keynes were born in EU accession countries, accounting for 2.5% of the population compared with 2.0% in England as a whole.

Estimates of the present proportion of the population of Milton Keynes born outside of the UK is over 52,000, which is between 19%-22.5% of the population. However, in 2018 47% of all live births in Milton Keynes were to parents where one or both were born outside of the UK.

Deprivation

The Indices of Multiple Deprivation (IMD 2019) highlight which areas had higher proportions of children aged 0 to 15 living in income-deprived families. In Milton Keynes there are seven areas in the 10% most deprived areas for child poverty in the country, most of which are close to the Hospital.

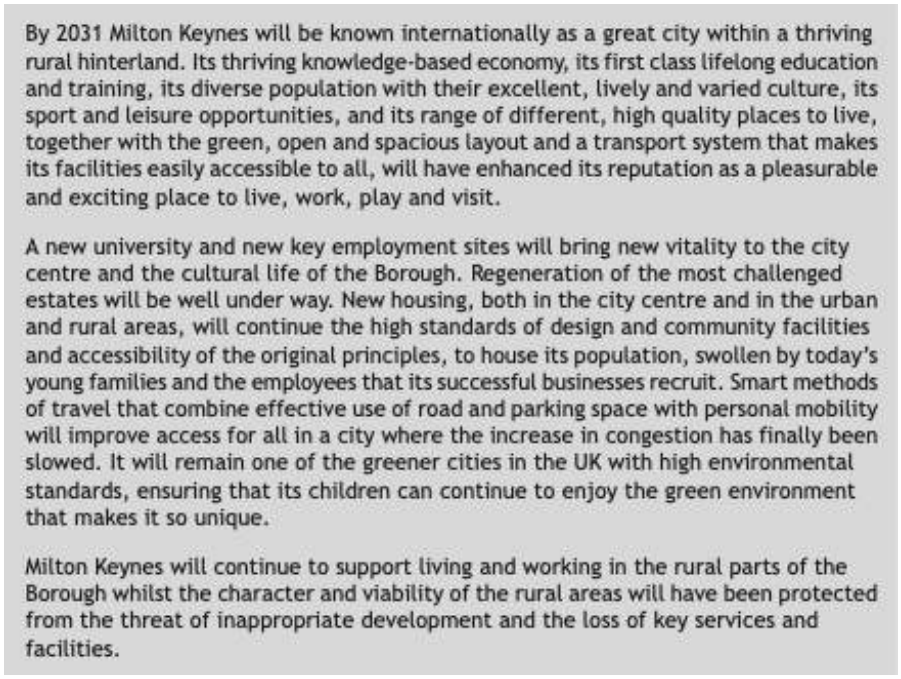
When access to services and affordability of housing are considered, the true nature of inequality, including health inequality is understood. The ‘Access to Housing and Services Domain’ measures the financial accessibility of housing and location of services - 18% of the Milton Keynes Borough is in the most deprived 10% of the country. In the South East region, only Slough has a higher average level of deprivation on this domain. However, Slough does not have the statistical combination with child poverty, having no areas in the most deprived 10% on the IDACI.

Additionally, in Milton Keynes more than 75% of all children in poverty are in households where at least one person is working (children in non-working household is estimated at 4,900). This creates a ‘perfect storm for child poverty’, making Milton Keynes almost unique in the mix of these three aspects of poverty.

Milton Keynes Local Plan

The new Local Plan for Milton Keynes, Plan:MK, was adopted by Milton Keynes Council at its meeting on the 20 March 2019 and now forms part of the Council's Development Plan, replacing both the Core Strategy (2013) and saved policies of the Local Plan (2005). Plan:MK sets out the Council’s strategy for meeting the Borough’s needs until 2031 and will be reviewed prior to that end date in order to be able to respond to a number of emerging strategies and infrastructure developments, notably the MK Futures 2050 work, progress on East-West Rail and on the Cambridge-Milton Keynes-Oxford growth corridor. Plan:MK sets out a clear vision for the city as shown below.

Figure 12: Vision for Plan:MK



Before 2031, the council proposes to facilitate the building of at least 26,500 new homes (with a contingency for an additional 10%); which equates to 1,765 new properties every year. The council have told the government that the city has the capacity to absorb an additional 8,000 homes over and above the *Plan:MK* target if national infrastructure monies were made available. Local planners are assuming an average of 2.4 people per house meaning population growth could be anywhere between 63,600 to 89,160 by 2031 based on housing growth. As discussed in 3.1 above, the Office of National Statistics is forecasting that Milton Keynes will experience significant population growth, but the *Plan:MK* level of house building may result in growth greater than ONS predictions because these do not necessarily account for planning decisions. Much of this housing growth will be in areas relatively close to the hospital: south-east Milton Keynes and Eaton Leys. Planning assumptions are that the likely demographics linked to the new housing, is young families with small pre-school and primary school aged children.

The implication for health estates is a reinforcement of the need for:

- Sufficient capacity to meet rising demand driven by overall population growth and ageing within the population;
- Research and development facilities to contribute to the university teaching of future health professionals;
- Estates that meet the health care needs of a changing population; and
- Ways of transporting patients, staff and supplies that are consistent with 'greener' policies.

Specifically, *Plan:MK* will require estates development that contributes to:

- Safe, healthy, sustainable built environments; and
- Reduced CO^2 emissions through community energy networks, renewable energy developments, reduced waste generation, increased recycling and sustainable transport initiatives.

The local authority is very supportive of the Trust; it has part funded health facilities through use of development monies from Section 106 and the local tariff regime, and would like to see the hospital campus grow to provide both more capacity to meet rising demand and to repatriate specialist services to the local area e.g. radiotherapy. The hospital was deliberately developed on a large campus to allow for expansion both "sideways" and "upwards".

Historical arrangements for infrastructure levies on developers have centred on Section 106 and for the expansion areas of Milton Keynes, a tariff regime under which developers agreed to a standard contribution of £18,500 per residential dwelling and £260,000 per hectare of commercial land. Tariff funds were then spent on local and strategic infrastructure (the hospital counts as "strategic infrastructure"). Using these funds, the council has invested £16.23m in MKUH developments such as the hospital ring road, changes to the boiler house and back-up generators (noting that the fund is not meant to pay for developments normally paid for by NHS capital monies).

Milton Keynes was famously "planned for the motor car" and the use of public transport across the town is low - it accounts for 7% of journeys, a percentage the council want to increase to circa 10%. The council's transport plans focus more on driverless cars and hybrid/ e-cars than buses (driverless cars are being tested in Milton Keynes), in part because cuts to council funding has reduced the local authority's ability to subsidise buses. There are no significant constraints on the development of more car parking on the hospital site.

Discussions have been held with the Council regarding the Trust's HIP programme (see below) and the Council has confirmed its support for the proposed developments. The Trust intends to enter into a new Planning Agreement with the Council for its HIP Programme and to make a planning application for each scheme in summer 2022.

Impact of Population Growth

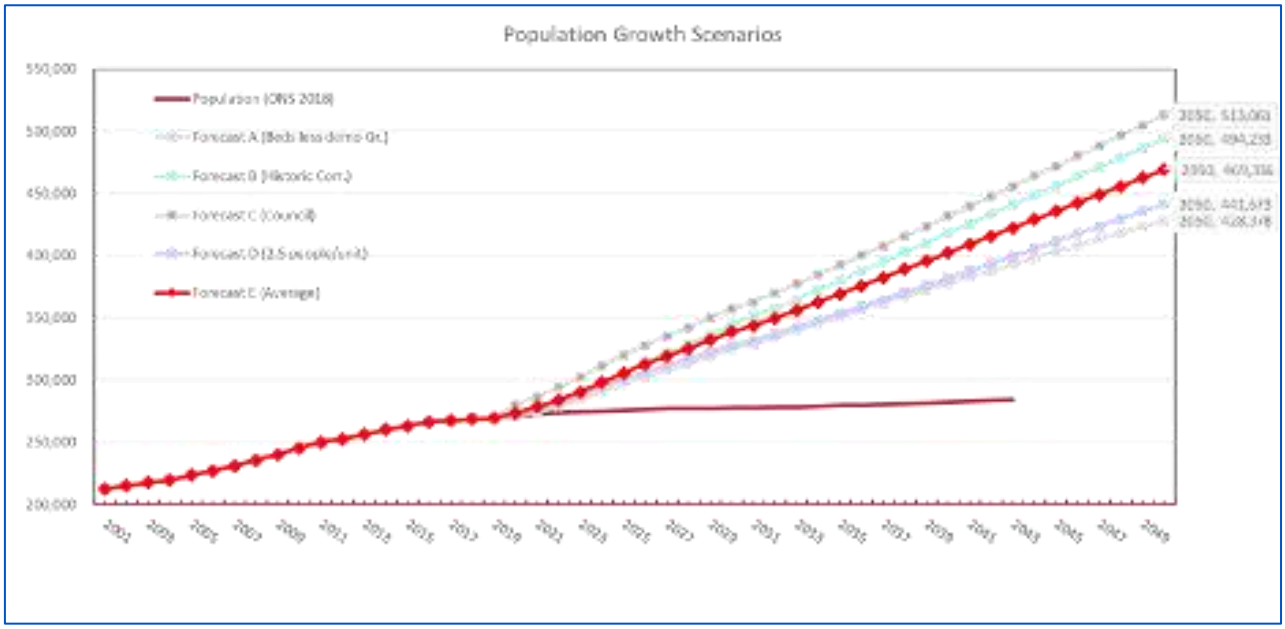
As explained above, the population of Milton Keynes is forecast to grow by 72% to circa 469k over the next 30 years. The Trust has commissioned an analysis of how the population of Milton Keynes is expected to change in the future and what impact this is estimated to have on the Trust's capacity requirements. The analysis has been developed using a combination of national and local statistics and has included input and review from Milton Keynes Council and Milton Keynes CCG.

In order to determine population levels for the purposes of modelling the new hospital facilities, four different scenarios were considered (in addition to use of raw ONS data only):

- Forecast A: Increase in housing capacity (bedrooms) less demographic growth (on the basis that this is already included in the housing capacity future requirements)
- Forecast B: Population change based on historic correlation between housing growth and population
- Forecast C: Milton Keynes Council estimate of 3.5 people per household based on housing mix (future housing growth assumes a richer mix with larger houses than were built historically)
- Forecast D: NHS Milton Keynes CCG historic estimate of 2.5 people per housing unit

An average of forecasts A, B, C & D was calculated (Forecast E) to address the gap between the four projections. The impact of these growth forecasts on Milton Keynes population levels is shown in Figure 13 below.

Figure 13: Milton Keynes population growth scenarios



Following discussions held with MK CCG and NHSEI/DHSC, the Trust approved Forecast E for the purposes of further modelling of the capacity required on the MKUH site. Forecast E represents a prudent estimate of the expected significant population growth whilst recognising that adopting lower levels of growth could potentially undersize the new hospital facilities. Further details of the population analysis are provided in Appendix 8.

3.3 System Strategic Context

The Trust is part of the Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care System (ICS), formerly known as the Sustainability and Transformation Partnership (STP). The population of the four local areas of Bedford Borough, Central Bedfordshire, Luton and Milton Keynes is circa 1m.

The map below shows the geographical relationship between the Trust, its BLMK ICS partners and key healthcare providers in the area surrounding BLMK.

The ICS has produced its draft plan for health and care in Bedfordshire, Luton and Milton Keynes for the next five years. This document has not yet been finalised and published, but it contains important strategic information that provides the local/regional context to the MKUH HIP programme.

The emerging ICS plan includes the following priorities for the Milton Keynes “place”:

- Health communities and prevention;
- Primary and out of hospital care;
- Maternity, children and young people;
- Major health conditions;
- New models of care;
- Enabling workstreams.

The Trust's future estates strategies and capital investment proposals are designed to contribute to the ICS priorities and plans for Milton Keynes.

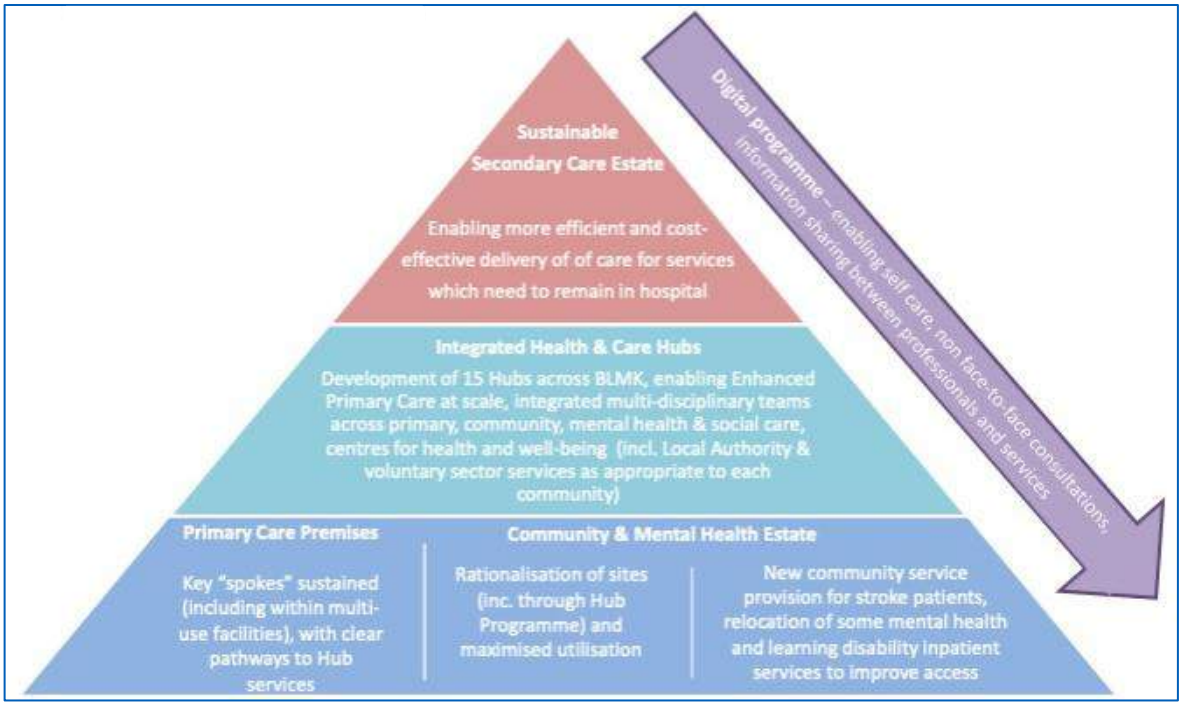
BLMK ICS Estates Strategy

The BLMK Estates Strategy was produced in July 2018 and supplemented with a "checkpoint" update issued to NHSEI in July 2019 (these documents are not publicly available as they contain commercially sensitive information). Both documents articulate the need for capital investment to ensure sustainable secondary care services and it was noted that each acute Trust, including MKUH NHSFT, had a number of priority projects to support sustainability and to enable transformation and collaboration within clinical services.

The 2018 Estates Strategy articulated the ICS's comprehensive approach, i.e. encompassing a wide range of funding sources; resolving considerable back-log maintenance; addressing needs from the local neighbourhood to the hospital; and accommodating considerable population growth;

The strategy set out a vision for the BLMK ICS estate, as shown below.

Figure 14: Vision for the BLMK estate



The BLMK Estates Strategy also outlined the estates implications of the ICS's service strategy themes [see Figures 15 and 16 below]. The documented estates priorities for MKUH included:

- The Pathway Unit
- Replacement of CT and MRI scanners;
- Expansion of the Neonatal Unit at MKUH; and
- Development of a redesigned Women & Children's Block at MKUH.

These ICS estates priorities are fully reflected in the Trust's revised estates strategy.

Figure 15: BLMK ICS service strategy estates implications

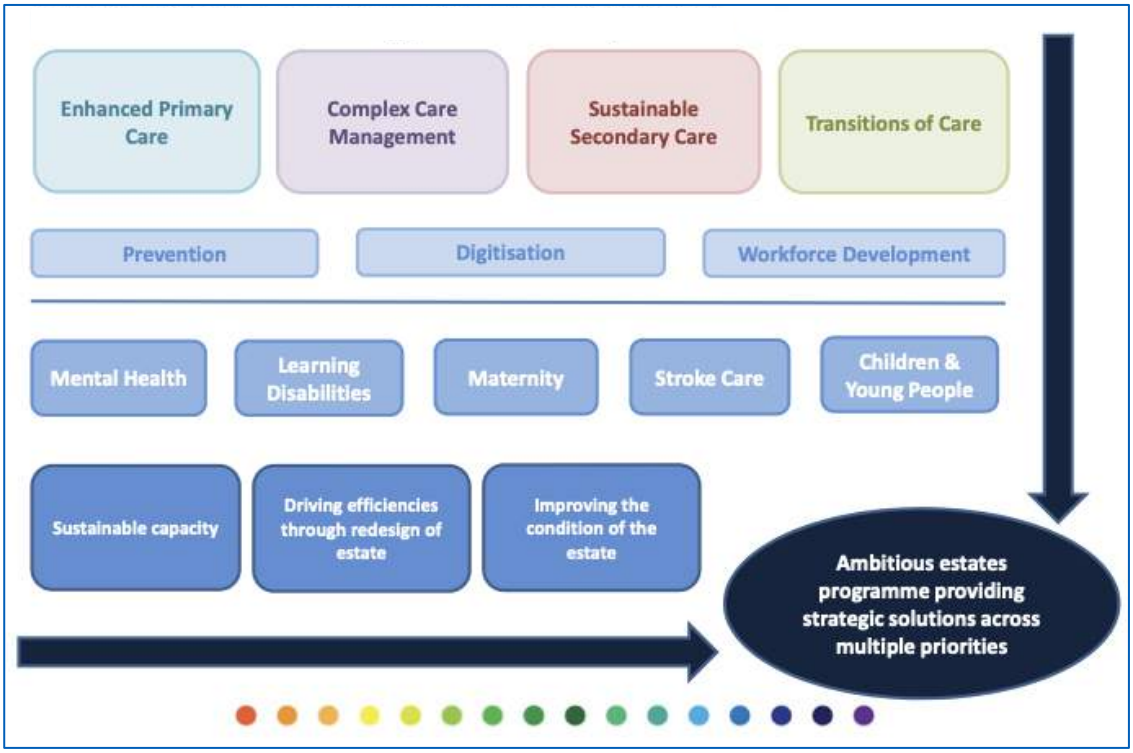
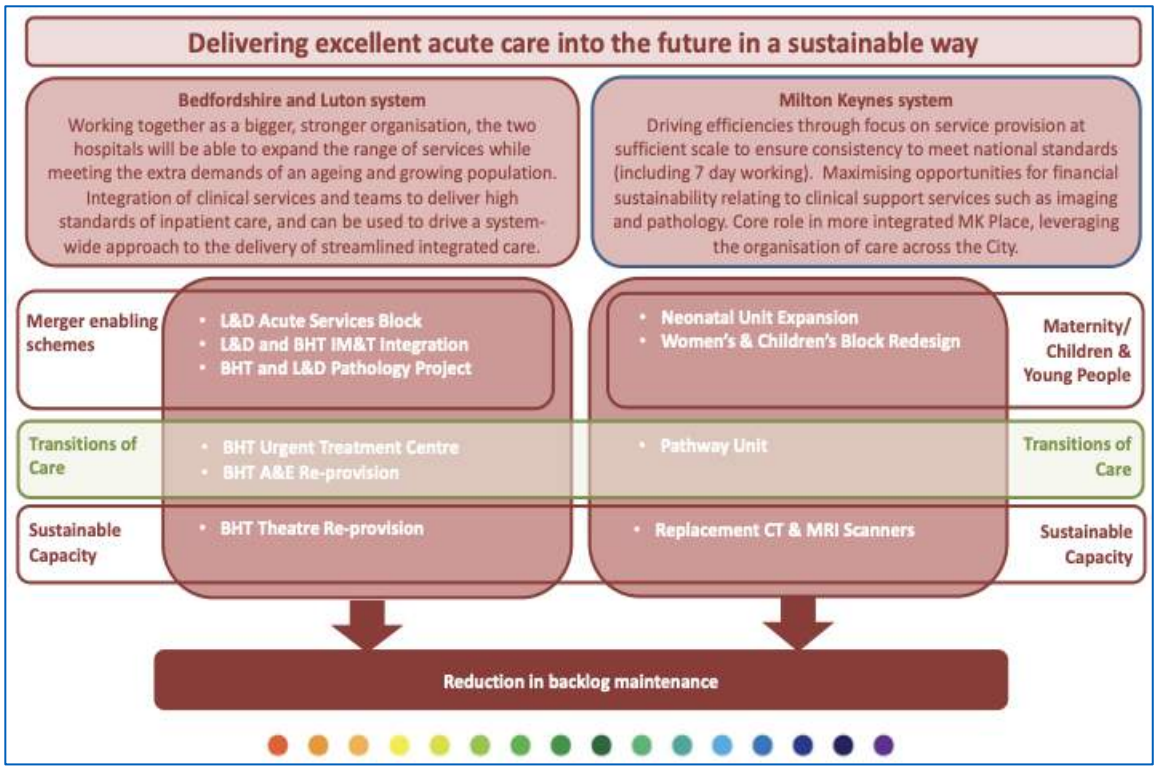


Figure 16: BLMK ICS sustainable secondary care strategy



The 2019 Estates Strategy "Checkpoint" noted that *"upgrades to key facilities at all three acute sites remain a priority for BLMK ICS, and are likely to feature in future bids for national capital funding"* and the ICS draft long term plan identifies producing proposals for developments at MKUH for post-2024 as one its key estates priorities. Thus, both the BLMK ICS draft long term plan and the BLMK ICS estates strategy support the need for capital investment at MKUH, as articulated in this Estates Strategy.

3.4 National Strategic Context

The national context for the MKUH HIP programme consists primarily of the Carter Review (2016); the Government Response to the Naylor Review (2018); the NHS Long Term Plan (2019); and the DHSC Health Infrastructure Plan (2019). The key points relevant to the Trust's Estates Strategy are summarised below.

Carter Review

The Carter Review, published in February 2016, reviewed the operational productivity and efficiency of NHS hospitals focusing on workflow, workforce, pharmacy and medicines optimisation and estates and procurement management. The report identified significant and unwarranted variation in costs and practice which, if addressed, could save the NHS £5bn. The report acknowledged that the overall average is not sufficient and more needs to be done to bring poor performance up to meet the best.

In relation to estates and facilities, the Carter Review recommended that:

- All Trusts estates and facilities departments should operate at or above the benchmarks for the operational management of their estates and facilities functions by April 2017
- all Trusts (where appropriate) should have a plan to operate with a maximum of 35% of non- clinical floor space and 2.5% of unoccupied or under-used space by April 2020, so that estates and facilities resources are used in a cost effective manner.
- every Trust should have a strategic estates and facilities plan in place, including a plan for investment and reconfiguration where appropriate for their whole estate, taking into account the trust's future service requirements;
- Trusts should invest in energy saving schemes such as LED lighting, combined heat and power units, and smart energy management systems,
- Trusts should ensure better data accuracy by improving the governance and assurance of the ERIC data; and
- Trusts should ensure that estates and facilities costs are embedded into patient costing and service line reporting systems.

The Trust's performance in relation to the Model Hospital estates metrics, which were established in response to the Carter Review, is outlined in chapter 2 of this Estates Strategy.

Naylor Review

The Naylor review, published in March 2017, sets out recommendations on how the NHS can make best use of its property and estate and by doing so, generate money to reinvest in patient care and deliver the reforms set out in the Five Year Forward View. The Naylor report sets out the importance of ensuring that NHS property and estate support clinical need by aligning clinical and capital plans; this will enable the NHS to build capacity and capability across their estate. In order to encourage the NHS to rationalise their estate and move towards affordable, sustainable and long-term estates solutions, the Naylor review sets out plans for capital receipts of surplus land to be reinvested in local services. The review places emphasis on the importance of long-term capital investment strategic planning.

In its response to the Naylor Report, published in January 2018, the Government set out its vision of an efficient, sustainable and clinically fit-for-purpose estate, where the NHS

- provides a modern estate equal to delivering the vision of the Five Year Forward View (subsequently replaced by the NHS Long-Term Plan) and new models of care;
- makes sure local strategic estates planning reflects changing delivery models, in particular the planned shifts of activity into primary care that was set out in the 5YFV;
- aligns with current and future clinical service strategies, for the benefit of patients, local communities and partners in the Sustainability and Transformation Partnerships/Integrated Care Systems;
- proactively takes steps to maintain its assets and reduce backlog maintenance;
- replaces what cannot be cost-effectively maintained and releases what it no longer needs, maximising receipts which can be reinvested into new premises and new services, while boosting economic growth and creating new homes;
- understands the cost of its estate, with comprehensive, accurate and comparable information underpinning estates-related decision making; and
- draws on expert advisers where it needs to, but builds its own capabilities to become an effective informed client on estates matters.

The Trust has adopted these principles, where relevant, in developing and implementing its Estates Strategy.

NHS Long Term Plan

The overriding aim of the NHS Long Term Plan is to redesign patient care to make the NHS fit for the future and to get the most value for patients out of every pound of taxpayers' investment.

The LTP aims to do this by:

- Moving to a new service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting.
- Setting out new, funded, action the NHS will take to strengthen its contribution to prevention and health inequalities.
- Identifying key priorities for care quality and outcomes improvement for the decade ahead.

The LTP also includes a wide-ranging and funded programme to upgrade technology and digitally enabled care across the NHS.

DHSC Health Infrastructure Plan

The aim of the Health Infrastructure Plan, published in September 2019, is to deliver a long-term, rolling five-year programme of investment in health infrastructure. At the centre of this is a new hospital build programme, as well as investment into diagnostics and technology and eradicating critical safety issues in the NHS estate. The HIP aims to ensure that the NHS can deliver its services in world class facilities and that new hospital facilities will deliver the Government's priorities for the NHS in a co-ordinated approach.

The HIP sets out the expectation that all NHS organisations will work with NHSEI to manage capital in a more strategic way and emphasises that the NHS "must deliver on the commitment made in the Long Term Plan to make better use of capital investment and its existing assets, to help drive the planned improvements in services in a way that is financially sustainable and delivers the maximum possible return for investment". This includes Trusts taking ongoing responsibility for the maintenance of its estate as well as making sensible, service-led capital investment decisions.

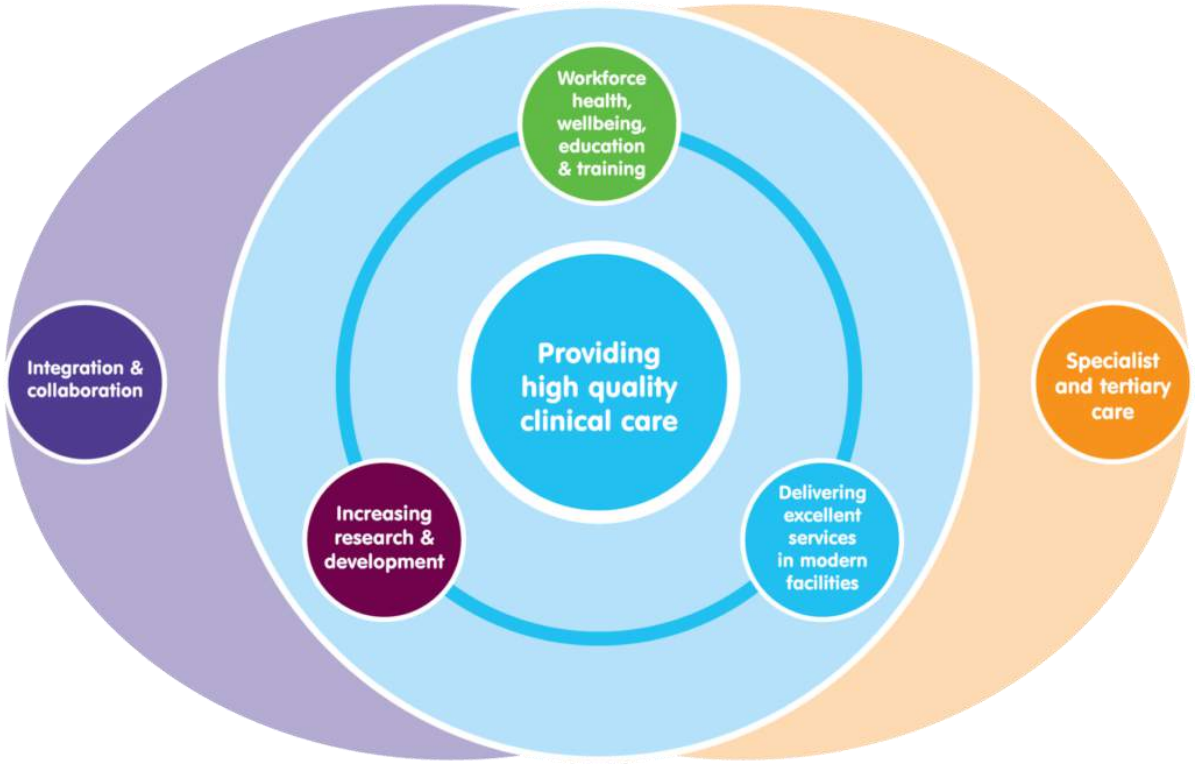
MKUH NHSFT was named as one of the Trusts included in the nationwide programme of major hospital building projects that was described in the HIP [see below]. Further confirmation of the Trust's inclusion in the programme was provided in the Government announcement at the end of October 2020.

3.5 Estates Vision & Principles

In five years' time the Trust aims to be operating from an estate which is fit for purpose and which enables delivery of high quality, safe, sustainable and affordable clinical services to its patients. This means an estate which is in a good condition, is functionally suitable for the services being provided, provides a "healing environment", is environmentally sustainable (working towards the Net Zero Carbon target), is accessible to local people, is affordable and which is designed around changing service needs.

The Trust's refreshed vision, values, strategy and objectives for Milton Keynes University Hospital are collected under the banner of "The MK Way", which provides the framework in which the Trust operates. The Trust's vision is *"to be an outstanding acute hospital and part of a health and care system working well together".* The Trust's strategy has five key priorities, as shown below.

Figure 17: Trust strategic priorities



Estates Objectives

The Trust's strategy is underpinned by its ten strategic objectives, which have been in place for the last five years

1. *Improving patient safety*
2. *Improving patient experience*
3. *Improving clinical effectiveness*
4. *Delivering key performance targets*
5. *Developing MK at place*
6. *Developing teaching and research*
7. *Being well governed and financially viable*
8. *Investing in our people*
9. *Developing our estate*
10. *Being innovative and sustainable*

Figure 18: Trust objectives

The implications of the Trust's strategy and objectives for the estates strategy are summarised below.

Figure 19: Estate implications of the Trust's objectives

Objective	Implications
Deliver key performance targets	The configuration of clinical departments must support efficient and effective care processes; so that physical layouts do not hinder prompt decision-making and patient flow through diagnosis, treatment and discharge.
Develop a robust and sustainable future	Estates must be properly maintained, so that services are not disrupted by estates failure; or discourage staff and contribute to excessive turnover.
Develop robust and innovative teaching and research	Estates must be developed (built, adapted) to support a growing teaching and research role; estates development will often be undertaken with the collaboration of teaching and research partners.
Become well-governed and financially viable	Estates should be efficiently used, so that resources are not unnecessarily consumed.
Investing in our people	Estates should reflect the value that the Trust places on staff, with safe and comfortable environments; and with minimal failures of building services.
Developing our estate	Estates planning should ensure that buildings and spaces within them are not overcrowded or under-used; and are fit for purpose.
Being innovative and sustainable	Estates should become 'greener' over time (in line with the Net Zero Carbon targets), to reduce the impact on the environment; investment should aim to improve the quality of the built environment; opportunities for local employment and career development should be supported.

Core Principles

The Trust has developed the following key principles for how it will ensure its estate supports delivery of services over the next five years:

- The estate will be functionally suitable, comply with the law, and adhere to healthcare standards and codes of practice;
- The estate is an enabler, not a driver, of service delivery;
- The estate will be fit for purpose;
- The Trust will ensure that services within our buildings are in the “right place”;
- The Trust will maximise utilisation of its estate;
- The Trust will seek to design in flexibility from its estate;
- The estate will be environmentally sustainable;
- The Trust will maximise value for money and economic benefit to the taxpayer from the estate;
- The Trust will work with local public-sector partners to optimise the public-sector estate.

Ensuring the estate is **functionally suitable** means making sure building design (at individual room and department level) reflects intended use. The Trust’s buildings will meet all legal requirements, for example in relation to fire safety and Equalities Act legislation. The Trust will also comply with healthcare standards, such as those relating to mixed sex accommodation and The Hygiene Code. The Trust will be cognisant of health building notices (HBNs) when making changes to buildings, but recognises that HBNs are guidance only. The Trust will also create an environment which is conducive to patient healing and the needs of an increasingly older patient group. Any new buildings, whether owned or leased, will be designed to offer maximum future flexibility of use. Building design will be shaped and informed by discussion with patients.

The estate should **enable the delivery of high quality clinical services** to local people. This means that the estate strategy will respond to the needs of the clinical strategy and not vice versa. The estate will need to change to reflect the anticipated increase in the number of people attending the hospital as the population of Milton Keynes grows. The estate strategy must also respond to commissioner and partner plans as set out in the STP as well as the Trust’s own emerging clinical strategy.

Ensuring the estate is **fit for purpose** means maintaining properties to a minimum of “condition B”. The Trust will continue to aim to have all high- risk backlog maintenance eliminated over a five-year rolling programme. The Trust will also agree a “more accessible” description of “fit for purpose” for onward communication of this strategy which is less reliant on technical six facet terminology and which would be understood by patients, their carers and staff.

Ensuring that services within Trust buildings are **in the right place** means making sure, so far is possible, that services are located appropriately to meet patient and service needs. For example, where beneficial, services will be co-located with related Trust services (and related services from other organisations) i.e. beneficial clinical adjacencies will be prioritised through a concept of "zoning" areas within the main hospital. In doing so the Trust will seek to minimise the distances patients have to walk within the hospital to attend different services. Where economically viable to do so services will be provided off site closer to some of the communities served.

Maximising estate utilisation will be encouraged by measuring utilisation over 24/7 not 9-5. A culture which views buildings as being a "health community resource" rather than a service "X" facility will be engendered. The need for estate will be minimised wherever possible by adopting agile and mobile working practices, and minimising fixed desk spaces.

Obtaining **maximum flexibility** means an estate that can be altered with the minimum of disruption as service need and population demand changes. This involves adaptable design philosophies and avoiding long-term lease commitments wherever possible.

Operating an **environmentally sustainable estate** links to the Trust's objective of "developing a robust and sustainable future" and means that the Trust will use the estate to minimise the environmental impact of service delivery. This includes ensuring that building refurbishments include investment in efficient heating, cooling and lighting systems and make ensure any new builds are designed to reduce energy use. The Trust will also continue to seek opportunities to develop its own renewable energy supplies e.g. the potential to install solar panels will be considered.

Maximising value for money and economic benefit to the taxpayer means we will adhere to the principles and objectives set out in the Naylor and Carter reports. It necessitates minimising the on-going costs of each property through the delegation of budgetary management responsibility to service managers assisted by the estates team. Trust buildings will be maintained on a regular basis to avoid higher long-term maintenance costs. All accommodation requests, moves, acquisitions and divestitures are to be co-ordinated by estates. Surplus assets will be made available for sale or re-use.

We will **work with partners** to contribute to making sure that the estate across Milton Keynes meets the principles described above. Where MKUH is the landlord for other public-sector organisations we will act in a way to assist them in delivering safe, good quality, efficient services from our building. We will ensure that all third-party occupancies are recorded and are supported by legally binding contracts making clear the responsibility of the Trust and each tenant.

Creating A Healing Environment

The Trust wants an estate that provides a good quality environment. This raises the issue of how the design of physical environments can impact upon healing (and efficiency). Research has identified a range of positive outcomes including reductions in hospital acquired infections (HAIs), falls, medical errors, pain, patient stress, patient depression and length of patient stay, as well as improvements in staff "outcomes" arising from better physical environments.

For example: reducing HAI by appropriate use of single rooms; reducing falls through design of floors, doorways, handrails and toilets, and decentralised nurse stations; and Reducing pain, stress and depression through exposure to views of nature, to higher levels of daylight, displaying visual art and reducing environmental stressors such as noise.

There is evidence that art, design and environmental enhancements can have a positive impact on health and well-being of patients (and staff) thus speeding the recovery process – the Trust has recognised this and has developed the largest body of public art in Milton Keynes.

Architectural design, internally and externally, can be especially important for patients with dementia, helping to simplify way-finding, reduce anxiety and control "wandering"; exposure to art in healthcare environments has been found to reduce anxiety and depression; and patients suffering from severe depression have been shown to have shorter stays if they had sunny rooms rather than rooms that were always in shade. The Trust has recognised the value of using and maintaining the courtyard areas as open spaces within the MKUH site. The courtyards are maintained by charity and volunteer groups to further provide a link to the MK community that take great pride in the hospital that supports them.

The efficiency of staff can be improved through the use of hot desks/touch points in conveniently located buildings, supported by an IT infrastructure enabling staff to access systems from any trust (or potentially partner) building, and the provision of sufficient bookable meetings rooms and break out space to support teams coming together for team meetings, case conferences etc.

With an ageing local population, it is inevitable that the proportion of patients who have dementia will increase – the Kings Fund estimate that 25% of people accessing acute hospital services have dementia and the number of people with dementia is expected to double during the next 30 years. Research into how health facilities need to be redesigned to make them "dementia friendly" has demonstrated that relatively inexpensive interventions, such as changes to lighting, floor coverings and improved way-finding, can have a significant impact. Evaluation has shown that environmental improvements can have a positive effect on reduction in falls, violent and aggressive behaviours, and staff recruitment and retention.

Wherever possible the features discussed above will be designed into buildings as part of the implementation of this estates strategy.

3.6 MKUH HIP Programme

In December 2019, the Trust was informed that it was going to be the recipient of 'seed funding' from the Department of Health and Social Care's HIP2 (Health Infrastructure Plan) as part of a planned £200m+ hospital redevelopment programme in Milton Keynes. The Trust has developed proposals (i.e. the "MKUH HIP programme") to significantly expand and enhance its clinical facilities through delivering a capital investment programme aimed at meeting future projected capacity needs.

The need for new facilities at Milton Keynes University Hospital (MKUH) is driven primarily by the extensive forecast population growth in the town explained above. In addition, the Trust needs to make major improvements to its facilities for maternity, neonatal and paediatric services in order to meet national standards and provide an environment of appropriate quality for patients, mothers, babies, carers, families and staff.

Through the production of the Strategic Outline Case the Trust considered a broad range of options for expanding capacity on the MKUH site. As a result of the options appraisal process the Trust concluded that at this stage the MKUH HIP programme to 2025 should incorporate the development of: a new Women & Children's Hospital; a new Surgery Block; a new Imaging Centre; and an Intermediate Care Centre (in refurbished vacant ward accommodation).

The MKUH HIP programme is expected to cost in the region of £244m, with the majority of the funding (£239m) coming from the Government's Health infrastructure Plan (HIP) programme [as advised by the DHSC in October 2020]. It is anticipated that the MKUH HIP programme will be delivered in full by 2025. Details of the proposed capital developments are provided in chapter 4.

The Strategic Outline Case was submitted to NHSEI in November 2020 to obtain confirmation in principle of the availability of circa £239m HIP capital funding for the MKUH HIP programme and to provide approval to proceed to development of the Outline Business Case. Subject to SOC approval, Trust is anticipating commencing work on the OBC in early 2021 and submitting the business case by the end of 2021.

3.7 Longer Term Developments

The proposals set out in the MKUH HIP programme SOC will enable the Trust to provide new facilities for surgical, critical care, maternity, neonatal, paediatric, imaging and intermediate care services and meet the projected future capacity needs in those services for at least a 15-year period from 2025. However, the Trust is likely to require additional capacity for other clinical services, particularly medical services, and it will need to ensure that there is sufficient support accommodation on the site. The Trust may also need to respond to potential major service reconfigurations across the region, which would further increase the capacity requirements at MKUH.

The Development Control Plan [section 3.10] shows a second phase of site development from 2030 onwards (which reflects the "do maximum option" considered in the MKUH HIP programme SOC). This second phase could include a new medical ward block and would provide the opportunity to expand and upgrade key clinical and non-clinical support departments. Further consideration to the long-term development of the site will be given in the next revision of the Trust's Estates Strategy.

3.8 External Stakeholders' Plans

As described in section **Error! Reference source not found.**, there are several other h ealthcare providers operating from the hospital – the sections below summarise their plans for on-site services. The Trust's estate strategy must be mindful of these plans.

Central and North-West London NHS Foundation Trust

CNWL are updating their estate strategy for community and mental health services in Milton Keynes against a background of their contract being extended in 2019. CNWL's strategic aim is to rationalise the number of sites they use in the city from 34 to three hubs (north, south and central) and a small number of spokes.

CNWL has undertaken travel analysis and reviewed the Milton Keynes plan to assess the optimal locations for their three hubs and based on this work have concluded that the Milton Keynes hospital site is the best location for their central community hub. The hospital site already hosts the following CNWL facilities and services: Eaglestone Health Centre; the Child Development Centre; Speech and Language Therapy; the Campbell Centre which is a mental health inpatient and ambulatory care unit; a small number of community teams based within the main hospital; and the CNWL's headquarters for Milton Keynes.

CNWL have plans to alter the provision at the Campbell Centre but these are at an early stage of development. The remaining community health and corporate functions on-site require approximately 1,900 m^2 of accommodation split between services linked to the main hospital (various therapies, children's services etc) which require 442m^2 of space within the main hospital and community and corporate services which could be anywhere on the site and which require 1,435m^2.

Although CNWL's optimal solution would be to co-locate the second group of services in one building (they are currently split between the health centre and headquarters) this is a relatively low priority. Currently CNWL's expressed position is that they would be willing to move from the Eaglestone Health Centre to alternative premises on-site provided the move was at the cost of MKUH and that there was no increase in cost of the annual charge to CNWL.

CNWL is also considering vacating the building used as their Trust HQ. Should this happen, the Trust would seek to acquire the building form NHS Property Services, which would provide long-term development opportunities towards the rear of the site. The Trust is fully supportive of CNWL's aspirations and will work to support CNWL in meeting its future estates needs both on and off the MKUH site.

Oxford Health NHS Foundation Trust

OHFT own Marlborough House which is on the north edge of the hospital campus. Marlborough House is a purpose build medium secure psychiatric unit which would require conversion if used for alternate services, although we anticipate OHFT services to remain on-site for the period covered by this strategy.

Oxford University Hospitals NHS Foundation Trust

Oxford University Hospitals (OUH) operates a renal unit at MKUH. The unit is provided from cramped accommodation within the main hospital and would ideally move to alternate larger accommodation whilst remaining on-site. OUH have stated that they would accept a higher lease charge if this were to happen.

OUH is also developing a business case for the development of a radiotherapy service on-site - a development zone has been earmarked for the facility [see section 3.10].

NHS Property Services

NHS Property Services (NHPS) owns the Urgent Care Centre (UCC) and the community health services headquarters buildings on-site. The UCC houses some community health services alongside urgent care. The Trust's plans for the redeveloped A&E and assessment unit include co-locating the urgent care service with A&E have now been significantly delayed. In the longer term with the development of a GP federation the use of this building may change.

South Central Ambulance Service NHS Foundation Trust

South Central Ambulance Service (SCAS) have now moved to the Blue Light Hub (opened October 2020) and are in the process of agreeing a lease to occupy a small amount of space in close proximity to the A&E to support the Hospital Ambulance Liaison Officer (HALO) and PTS services on-site, to ensure effective triage and discharge respectively for the place of Milton Keynes.

3.9 Energy & Infrastructure Strategy

Through the publication of *'delivering a net zero national health service'* the NHS has recognised a need to respond to the health emergency that climate change brings - an approach which will be embedded into everything it does now and in the future.

In establishing its approach the NHS embarked on a process to identify the most credible and ambitious date that the health service could reach net zero emissions. This work comprised an international call for evidence, with nearly 600 submissions provided in support of further commitments on climate change; a robust analytical process and the guidance of a newly formed NHS Net Zero Expert Panel.

Two clear and feasible targets emerge for the NHS net zero commitment, based on the scale of the challenge posed by climate change, current knowledge, and the interventions and assumptions that underpin this analysis:

- For direct emissions the NHS control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032
- For the emissions the NHS can influence (our NHS Carbon Footprint Plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

In response to the national policy direction for sustainability, and the local commitment by Milton Keynes Council to achieve net zero carbon by 2030, the Trust has commissioned the development of a robust and scalable Energy and Infrastructure Strategy that is due to be completed by the end of 2020.

The Trust is firmly committed to adopting the operational energy targets documented in the draft client brief for new NHS health care buildings, minimising embodied carbon in new capital projects, including undertaking embodied carbon mitigation reviews, calculations and pioneering during the design process, and offsetting residual carbon emissions resulting from the construction and operation of new buildings. The Energy & Infrastructure Strategy will therefore align with the MKUH HIP programme proposals described in the Strategic Outline Case and will support the delivery of net zero carbon new buildings and refurbishments.

The strategy will also demonstrate how a programme of fabric and servicing improvements to the residual estate can be delivered. In particular the strategy will outline the route map to removing gas heating from the site, articulate how smart technologies can be utilised to minimise energy demand and articulate how renewable energy and storage technologies can be incorporated on site.

Following the updated guidance, the Trust will produce a Green Plan in 2021, which will be reflected in the revised Estates Strategy, when this document is updated.

3.10 Development Control Plan

The Trust has produced a Development Control Plan that reflects current developments, the MKUH HIP programme proposals and the potential longer term use of the MKUH site. The DCP is presented in three phases covering the periods 2020 – 2025, 2025 – 2030 and 2030 onwards. For completeness, all three phases of development are illustrated in the site plans below (larger versions of the plans are provided in Appendices 9 - 12).

Figure 20: DCP 2020 - 2025

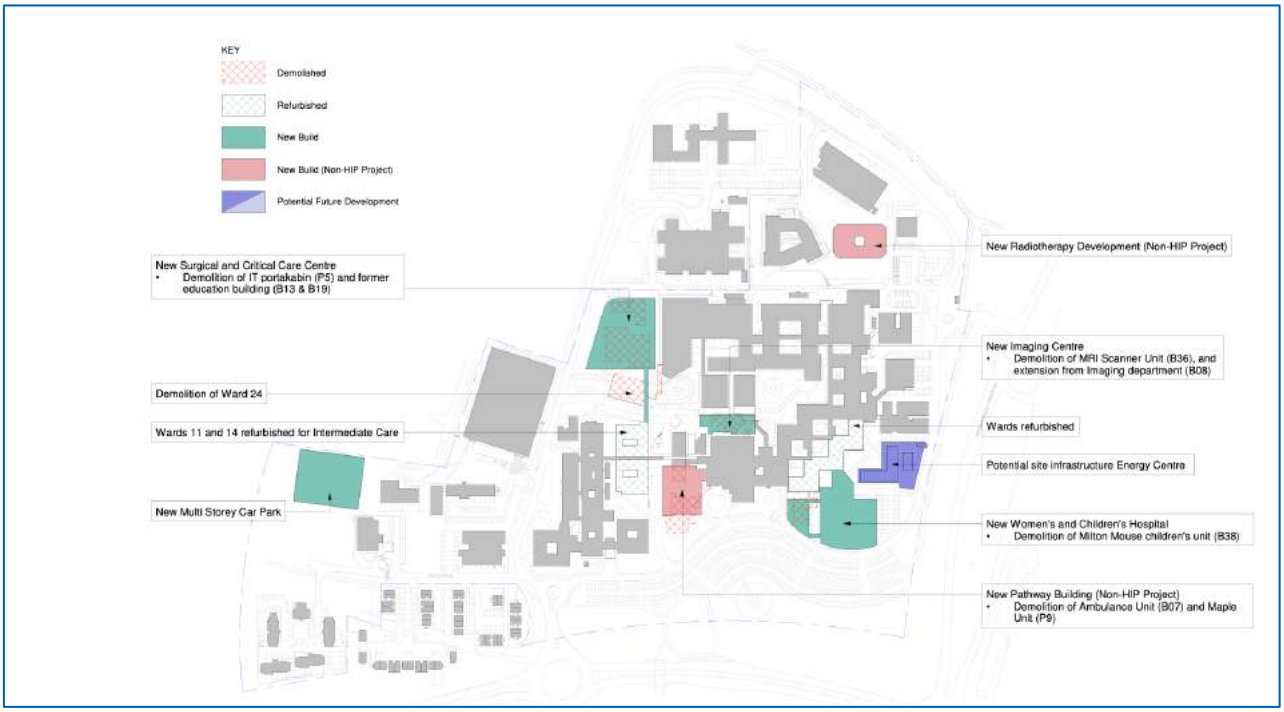


Figure 21: DCP 2025 - 2030

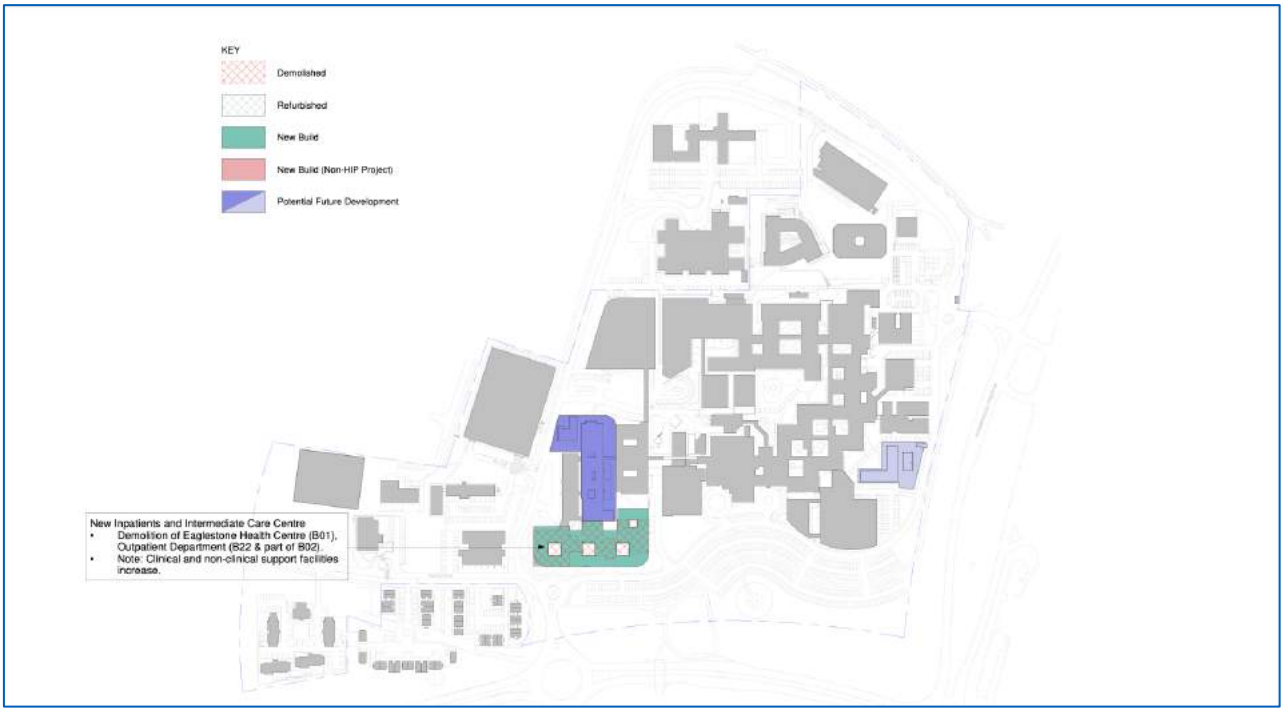


Figure 22: DCP 2030 Onwards

Figure 23: DCP All Phases

4. HOW WILL WE GET THERE?

4.1 Overview

In five years' time the MKUH aims to be operating from an estate which is fit for purpose and which enables delivery of high quality, safe, sustainable and affordable clinical services to its patients. This means an estate which is in a good condition, is functionally suitable for the services being provided, provides a "healing environment", is environmentally sustainable, is accessible to local people, is affordable and which is designed around changing service needs.

This chapter in the Trust's Estates Strategy sets out details of a series of capital investment proposals which are designed to respond to these aims and to meet the future estates needs driven by the projected population expansion.

4.2 Current Developments

Following completion of the Cancer Centre and pharmacy relocation in 2020, the principal ongoing capital project at MKUH is the development of the Pathway Unit. In addition, the Trust is proceeding with a series of enabling works to facilitate the first HIP programme schemes that are due to commence in 2021 [see below].

Pathway Unit

Work has commenced on the development of the new Pathway Ambulatory Care Unit which will also include a 26-bed ward to manage the flow of emergency medical admissions into the Trust. The Unit will take referrals from the Emergency Department, outpatient clinics and primary care. The location of the new Pathway Unit is shown in Figure 24.

Figure 24: Pathway Unit location

Patients attending the unit will receive full nursing and medical assessments of their physical and healthcare needs. Treatment options will be discussed and initiated within this area with a plan that either allows them to return home or be admitted to an appropriate medical ward. The Unit will be managed by a clinical and nursing team consisting of medical consultants, a ward sister and senior staff and supported by a whole range of healthcare professionals.

The Pathway Unit will provide: rapid assessment, diagnosis and initial treatment of emergency medical patients; rapid access for GPs; rapid access to nurse led clinics; rapid access to diagnostic services; and follow up consultant clinics. It will ensure that patients are admitted to the appropriate beds wherever possible and will enable an informed decision as to whether the patient requires admission or can be discharged home or to residential care with a plan of treatment. The Unit will be part of a Trust wide initiative, working closely with the Emergency Department to create an “acute care pathway” which is being designed to simplify the patient journey, improve the services we offer and enhance the patient experience.

Enabling Works

The Trust has agreed accelerated enabling works of circa £7.8m for the MKUH HIP programme, in discussion with NHSEI and DHSC. The proposed enabling works clear the land that will be used for the major HIP schemes by moving ground level parking into a new car park and by undertaking some demolition work. The other elements of the scheme provide for reliant oxygen supply and start creating the necessary electrical infrastructure to support the final schemes.

The enabling schemes include:

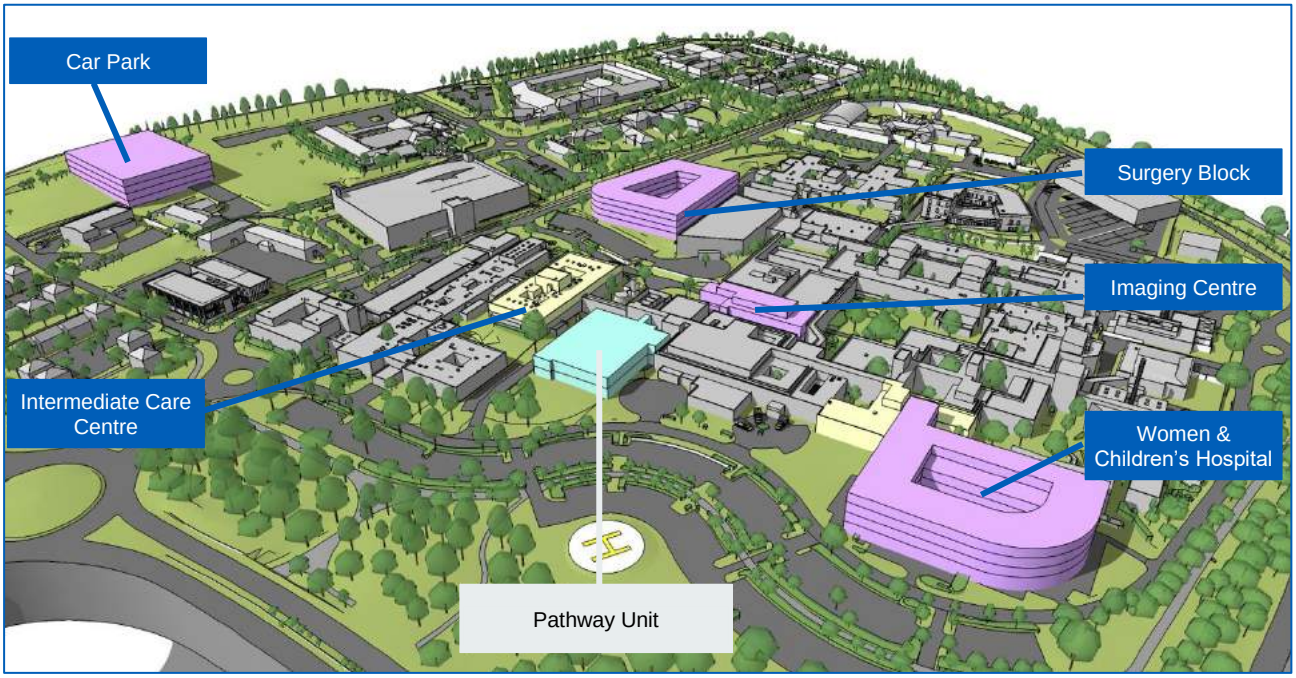
- LV5/6 Sub Station Upgrade;
- Medium voltage generator No 3;
- Second Oxygen VIE flask;
- Site wide HV system upgrade;
- South Site infrastructure upgrade;
- Car Park 3 development; and
- Office fit out.

The Trust is also in discussion with NHSEI regarding potential additional early funding to support completion of the multi-storey car park and to progress the Intermediate Care Centre and Imaging Centre schemes [see below].

4.3 Future Developments

As noted in section 3.6 above, the Trust has produced a set of proposals for future capital development, incorporated into a single “MKUH HIP programme”. The following image illustrates the indicative massing of each of the planned new developments:

Figure 25: MKUH HIP capital schemes



In addition, the Trust is continuing to work up plans to develop radiotherapy facilities at MKUH, improve the site infrastructure and deliver other capital schemes aimed at enhancing clinical and non-clinical facilities. Details of the planned future developments at MKUH are provided below.

Intermediate Care Centre

The proposed Intermediate Care Centre scheme involves reconfiguring and refurnishing two vacant wards, in close proximity to the new Pathway Unit, to provide 40 beds and rehabilitation facilities. It is anticipated that the intermediate care service will be delivered in partnership with CNWL.

There is a shortage of purpose-built intermediate care/rehabilitation facilities in the community, which means that patients (typically frail elderly) who require step-up/step-down care have to be treated on dispersed acute wards, which acts against active rehabilitation and early discharge. The general acute wards do not include the rehabilitation facilities typically provided in dedicated intermediate care units, an omission which the Trust intends to address in the design of the Intermediate Care Centre.

Subject to confirmation of HIP funding [see section 4.4], the Trust intends to commence work on the Intermediate Care Centre in April 2021. The new facility is scheduled to be operational in spring 2022.

Imaging Centre

The need to replace outdated imaging equipment and increase diagnostic capacity at MKUH is noted in the BLMK STP/ICS Estates Strategy and has been addressed through the development of an Outline Business Case for a new Imaging Scanner Centre.

The Trust has considered a range of options and concluded that the optimum solution would be to develop a new two-storey facility adjacent to the existing MRI building. The new facility would house two CT scanners and two MRI scanners. providing outpatient and some inpatient scanning, with provision for 24/7 ED cover where required.

It is proposed that the Imaging Scheme would be part-funded through the MKUH HIP programme, with the balance being funded by the Trust. Subject to approval, the new facility is due to be completed by December 2022.

Surgery Block

The Trust's 2018 Estates Strategy identified the expected need to expand inpatient ward and theatre capacity at MKUH to meet the increasing demand arising from population growth in Milton Keynes. The Trust has developed a proposal to construct a new Surgery Block adjacent to the existing phase two theatres – this scheme is included in the MKUH HIP programme.

It is proposed that the new block will include 92 surgical inpatient/day-case beds, 16 critical care beds, four operating theatres and a surgical outpatients department. In addition to accommodating projected future growth, the new facility will enable the Trust to 'repatriate' some surgical activity for Milton Keynes residents that is currently delivered by other NHS and private sector providers.

Women and Children's Hospital

The planned enhancement and expansion of maternity, neonatal and paediatric facilities is documented in both the Trust's and the BLMK STP's 2018 estates strategies and forms a key component of the proposed MKUH HIP programme. The Trust intends to build a new hospital facility on land currently occupied by a car park (a replacement multi-storey car park will be provided). The new Women and Children's Hospital will replace all the existing maternity, neonatal and paediatric clinical facilities and will have capacity for up to 6,000 births.

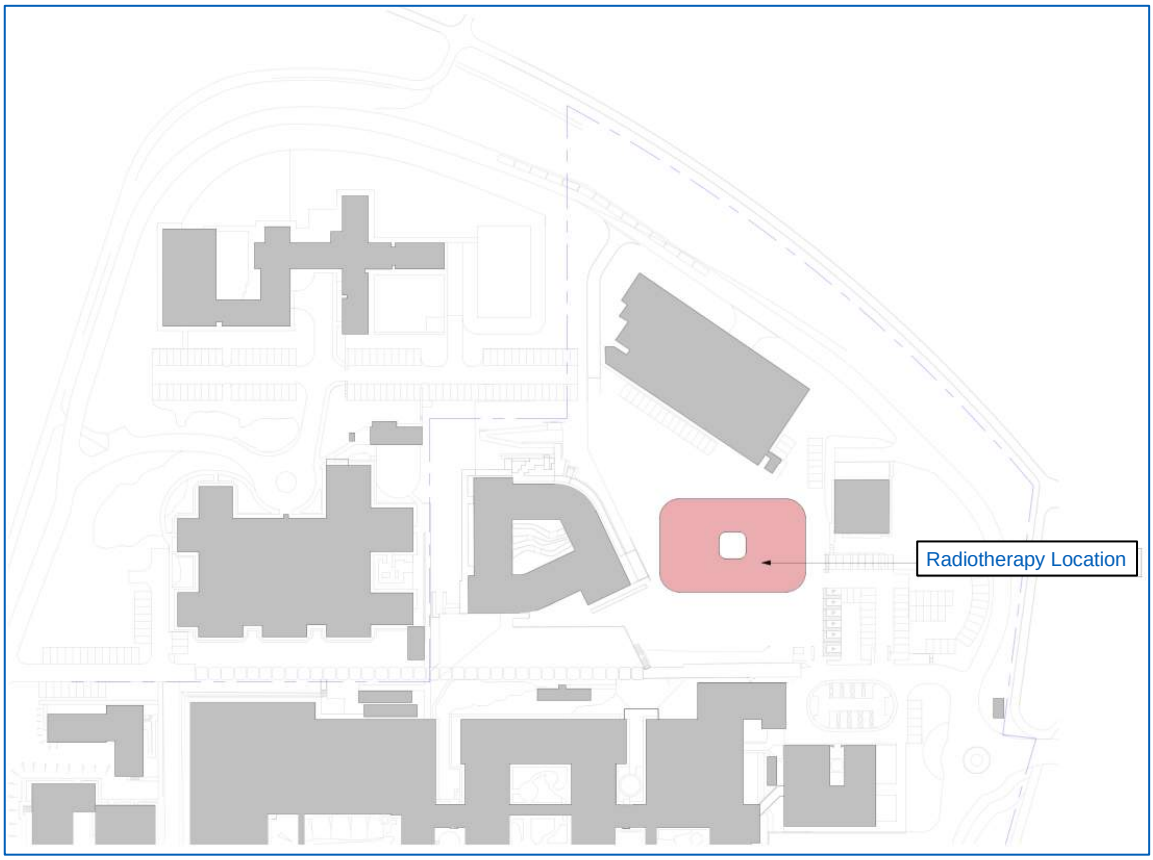
It is currently anticipated that the new Women and Children's Hospital will incorporate 51 maternity beds/birthing rooms (including a dedicated Midwifery-Led Unit), two maternity theatres, ante-natal and post-natal outpatients and assessment unit, 26 neonatal cots, 48 paediatric beds, paediatric assessment unit and a dedicated paediatric outpatients department.

Radiotherapy

Oxford University Hospitals NHS Foundation Trust has produced a Strategic Outline Case to develop a radiotherapy satellite service on the MKUH site. OUH took over responsibility for providing radiotherapy to the Milton Keynes population when Northampton General Hospital gave the Trust notice on the service and currently provide the service through a mix of a sub-contract with a private provider in Milton Keynes and from OUH's Churchill Hospital radiotherapy centre in Oxford.

The OUH plans to set-up a satellite radiotherapy service in Milton Keynes to reduce the need for patients to travel. The Trust has reserved a plot of land adjacent to the Cancer Centre for the development [see Figure 26 below] and feasibility work is currently taking place to support the scheme.

Figure 26: Radiotherapy development location



Site Infrastructure Schemes

In addition to the on-site enabling works described above, the Trust is planning further improvements to the infrastructure at the MCUH site, including:

- Upgrade to Main MSCP to address back log maintenance issues;
- Upgrade to LV2/2a LV Substation and Generation Set;
- Upgrade of current helipad on current or new location;
- Upgrade to flat roof areas in phase 1 and 2 to address back log issues;
- Install PV panels on upgraded roof areas to assist with the off-setting of energy usage and carbon emissions; and
- Installation of the third 2MW MV Generation Set to maintain the site infrastructure capacity.

Additional schemes may be identified following completion in 2020 of the Trust's new Energy & Infrastructure Strategy [see section 3.9].

4.4 Capital Investment Programme

The Trust has identified its minimum capital investment proposals for the next five years, reflecting: backlog maintenance and minor works; site infrastructure schemes; committed developments; the MKUH HIP programme; and other potential developments.

The Trust will need to consider the source of funds for its investments and its resulting ability to service associated debt. The Trust's internally generated cash (generated from the depreciation charge and any surplus from cash from operations) has traditionally been sufficient to fund only modest works to maintain the estate and tackle backlog maintenance issues – it would be reasonable to assume these funds could cover the backlog requirement over the next five years.

Public dividend capital funding for the Pathway Unit and the MKUH HIP programme has been provisionally agreed with NHSEI/DHSC, subject to the business case approvals process. Any additional investments will require alternate funding sources which could include: DHSC loans; contributions from the local authority using money provided under infrastructure levies; public/ private partnerships which could require MKUH to take a head lease; commercial loans; and charitable donations.

The following table sets out the Trust's expected capital investment programme over the next five years as currently planned:

Figure 27: Capital investment programme

Scheme	Value (£m)	Funding	Timescale
Backlog Maintenance	5	Trust	2021 - 2026
Roof Replacement	8	Trust	2021 - 2026
Energy Centre	8	Trust	2022 - 2025
Ward Refurbishment	5	Trust	2022 - 2026
Pathway Unit	15	STP Wave 4	2022 - 2023
HIP Enabling Works Phase 1	8	HIP	2021
HIP Enabling Works Phase 2	13	HIP	2022
Intermediate Care Centre	12	HIP	2022
Imaging Centre	13	HIP/Trust	2022
Surgery Block	95	HIP	2024
Women & Children's Hospital	103	HIP	2025
Other Minor Capital Schemes	4	Trust	2021 – 2026
Total	**289**	**-**	**2021 – 2026**

As shown, planned capital investment over the next five years is expected to be at least circa £289m – this is subject to confirmation. A full five-year capital investment programme will be outlined in the next full revision of the Trust's Estates Strategy.

In addition, other NHS organisations are likely to continue to invest in their estate at the Standing Way site. The Trust will continue to facilitate the capital development plans of its key stakeholders as required.

The level of capital investment required by the Trust over the next five years will need to represent a balance between delivering the vision and remaining financially viable and competitive in a changing NHS environment, whilst continuing to deliver healthcare services to the community. It is likely that new service transformation/reconfiguration programmes at local or regional level may drive the need for additional capital investment over and above that already identified.

5. CONCLUSIONS

As explained, the Trust's Estates Strategy dates back to January 2018. The document set out the Trust's vision and aspirations for its estate and articulated future development and investment proposals based on the assessed estates needs at that time.

The 2018 document noted that:

- The Trust had a comparatively well-maintained estate;
- Much of the estate had reached an age at which increasing levels of investment were likely to be required to extend the useful life of buildings and to continue to comply with health building standards;
- Circa £21m investment would be needed to resolve physical condition and statutory compliance issues;
- Further investment would be needed to meet increasing levels of activity both directly (more clinical capacity: assessment space, inpatient beds, theatres etc) and indirectly (additional car parking and road layout changes);
- The challenge to the Trust would be to find affordable ways to deliver the new and enhanced capacity needed; and that
- Circa £120m of potential capital investments had been identified by the Trust.

Since 2018 there have been a number of key strategic initiatives such as the production of the BLMK STP/ICS Estates Strategy, the NHS Long-Term Plan and the Health Infrastructure Plan, all of which impact on the future development of the MKUH site. This revision to the Trust's Estates Strategy reflects the key changes since 2018, whilst recognising that a more in depth update to the Estates Strategy will be needed in the near future.

This version of the Estates Strategy shows that:

- The Trust has made progress with its planned developments, particularly through completing the Cancer Centre;
- The total backlog maintenance liability has reduced;
- Proposals have been made for a major new capital investment programme (MKUH HIP) to meet future capacity needs;
- The Trust is developing its strategies for improving environmental sustainability and achieving the Net Zero carbon targets; and
- The Trust continues to work with its partner organisations who occupy the MKUH site to make best use of the estate.

The Trust plans to carry out a full update of its Estates Strategy in 2021.

APPENDICES

1. Site ownership
2. Site plan by block
3. Site plan by level
4. Site plan by building age
5. Leased areas
6. Condition Survey Data 2020
7. Site plan by building condition
8. Population Growth Analysis
9. DCP – Phase 1
10. DCP – Phase 2
11. DCP – Phase 3
12. DCP – All Phases

Meeting title	Board of Directors	**Date:** March 2021		
Report title:	Significant Risk Report	**Agenda item: 6.1**		
Lead director	**Name:** Kate Jarman	**Title:** Director of Corporate Affairs		
FoI status:	**Public**			
Report summary	This report shows the profile of significant risks across the Trust by type and area. Currently there are no risks that require escalation to the BAF from the Significant Risk Register. The Significant Risk Register is reviewed at the Audit Committee and Quality and Clinical Risk Committee. .			
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [ ]	**Decision** [ ]
Recommendation	The Board is asked to note the content of this report			

Strategic objectives links	All
Board Assurance Framework links	All

CQC outcome/ regulation links	Governance/ Well Led
Identified risks and risk management actions	Significant Risk Report
Resource implications	
Legal implications including equality and diversity assessment	

Report history	To every Board
Next steps	
Appendices	

Significant Risk Report (Summary of Activity March 2020)

Board Information:

This report shows the profile of significant risks across the Trust by type and area.

Currently there are no risks that require escalation to the BAF from the Significant Risk Register. Risks are managed in accordance with the Trust's risk management strategy.

The Board is asked to note the content of this report.

Significant Risk Register – Summary of High Scoring Risks

Summary of the Significant Risk Register – March 2021

Executive Responsible	Division	Specialty	Description	Controls in place	Current Risk Rating	Current Risk Level
Deputy CEO	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	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. Emergency Planning Officer has been sent the plan for review and comment.	15	High / Significant Risk

Director of Operations	Core Clinical & Support Services - Clinical Support Services	Physiotherapy	There is a risk that Children's Physiotherapists are not able to run to their full capacity in order to treat all children on their caseload/waiting list	Physiotherapy staff timetables designed to avoid clusters of staff all working in the CDC at the same time. Room booking system in place. All have been in place for years; the problem is worsening as the building is shared with other teams which are growing.	15	High / Significant Risk

Director of Corporate Affairs	Corporate Affairs	Clinical Governance	There is a risk that changes required to practice as a result of clinical audit are not implemented and we are not meeting best practice criteria	Audit report templates available to identify audit action plans. Monitoring via Clinical Audit & Effectiveness Committee (CAEB) TOR CAEB revised to include quality improvement, GIRFT etc Escalation/exception reporting to Management Board Refresh of Sharepoint data base to assist with data capture, with Level 1 audit a priority Transformation Team audit	15	High / Significant Risk

Director of Patient Care / Chief Nurse	Directorate of Patient Care	Patient Experience	The MUST conformance criteria were set out in the NHS accessible information specification for compliance by the 31st July 2016	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	15	High / Significant Risk

Deputy CEO	Estates	Estates	There is a risk of roof failure in relation to flat roofs across the Trust	1. Inspections and repairs as needed. 2. Updated annual 6 facet survey by Oakleaf 3. Large patch repairs undertaken as emergency business cases 4. 1 x Post Grad roof fully replaced 19/20. 5. Ward 10 - 50% of roof patch repairs completed 19/20 6. Phase 1, Phase 2 and Community Hospital survey completed.(52 roof leaks noted in 12 months Jan 19 - Aug 20) 16 leaks in 1st week of October 2020 7. Pharmacy small roof replaced September 20. 8. Business Case written for full replacement of identified areas.	15	High / Significant Risk

Director of Operations	Core Clinical & Support Services - Clinical Support Services	Physiotherapy	Unable to meet the demand for existing patients leading to increased waiting times Unable to develop existing outpatient services Unable to optimse student placements	1. Extended working hours 2. Introduction of shift pattern 3. Introduction of telephone triage clinics 4. Group treatment sessions	15	High / Significant Risk

Director of Operations	Core Clinical & Support Services - Diagnostic & Screening	Pathology	There is a risk that the available space within Cellular Patholgy will not be enough to meet the demands of the service as workload continues to expand	Storage of specimens minimised. No unnecessary specimens stored Storage period reduced from 6 weeks to 4 weeks with the approval of Pathologists and Clinical Lead	15	High / Significant Risk

Director of Operations	Core Clinical & Support Services - Clinical Support Services	Dietetics	The risk is that the paediatric team can not provide a full dietetic service to children and young people in the Milton Keynes area	Existing staff are working some additional hours but this remains insufficient to meet the needs of the service.	15	High / Significant Risk

Medical Director	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	1. Requested support from the network CRN 2. Discussed with other Trusts Partners regarding their existing contracts	15	High / Significant Risk
Deputy CEO	IT	Information Technology	IF the IT Department does not have a stock of replacement network switches, THEN if a switch fails a replacement will need to be sourced, procured, delivered, and installed, LEADING TO a delay in bringing up to 48 devices back online, potentially losing IT devices for a whole area/department for up to two weeks.	There is no stock left.	15	High / Significant Risk

Director of Corporate Affairs	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.	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. Updates made to Q-Pulse and SharePoint	15	High / Significant Risk

Deputy CEO	IT	Information Technology	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.	-DISCUSSED WITH LINE MANAGER AND ESCALATED -TEMPORARY RADIO COMMUNICATION SYSTEM 3. User group formed with IT & EBME to identify options	15	High / Significant Risk

Deputy CEO	Performance & Information	Information	The Trust Information data warehouse could fail or be subjected to a security attack.	There are reactive controls in to support the data warehouse using the in-house teams, including daily check of the servers, deleting redundant information stored on the server is conserve space. Additionally, A business case to migrate the information platform to Microsoft Azure platform has been submitted to the Executive directors for consideration and awaiting a decision.	15	High / Significant Risk

Director of Operations	Core Clinical & Support Services - Diagnostic & Screening	Imaging	Lack of space for appropriate management of CT and MRI with additional issues of lack of scanners to manage the increasing demand.	Extended working hours and days, some scans sent off site to manage demand. Reduced appointment times to optimise service. 1.12.20 no change to risk rating services remain challenged due to lack of basic capacity made worse by Covid social distancing and cleaning issues. IS provider approached to provide more MRI capacity	15	High / Significant Risk

Director of Operations	Core Clinical & Support Services - Clinical Support Services	Physiotherapy	Increasing numbers of patients being added to the physiotherapy outpatient waiting list, in addition to those on hold due to the COVID-19 pandemic, resulting in waiting times of well over 18 weeks for any type of intervention. A further increase in referrals may result from patients with post-COVID symptoms	- Virtual management of patients - Video and telephone clinics - Additional IT sourced to support virtual management - Reconfiguration of department to support virtual working and enable social distancing along with staff working from home - recovery plans are being written/in place to enable essential patients to be seen in the department of a face to face basis - Educational material including exercise programmes and access to youtube clips are made available to patients	15	High / Significant Risk
Deputy CEO	Estates	Estates	The current risk is that there is not enough space in the Medical Equipment Library(MEL) to carry out the required cleaning process to comply with the appropriate guidelines set by CQC and MHRA.	Staff members are taking processed equipment straight to the shelving areas as soon as it is cleaned to avoid cross contamination. This ensure equipment is kept separate, but this is not a productive method of working.	15	High / Significant Risk

Director of Operations	Core Clinical & Support Services - Diagnostic & Screening	Screening Services	Delayed detection of breast screening cancers due to COVID 19	Restart proposal approved by the Trust, SQAS and PHE. Guidance issued as to the management of the women to ensure that no-one is missed has been issued by Hitachi/PHE and has been implemented by the programme.	15	High / Significant Risk

Director of Operations	Core Clinical & Support Services - Clinical Support Services	Physiotherapy	There is a risk that the Health Physiotherapy Service is unable to meet its referral demand	Non clinical time including training, development and audit are being minimised to increase the number of available patient appointments Job plans are being completed by all staff to show impact on workload Patients are being booked into group where possible instead of individual appointment slots Recruited to all vacant posts To explore options for supporting dictation of letters to free up clinical capacity.	15	High / Significant Risk

Director of Patient Care / Chief Nurse	Core Clinical & Support Services - Clinical Support Services	HSDU	Annual and quarterly test reports for Autoclaves and washer disinfectors used for a critical process have not been received in a timely manner from the estates department. in line with HTM guidelines reports should be signed off by the user, an authorized person and/or an authorized engineer for compliance after testing, reports are going up to 6 weeks without being viewed by any of the above yet machines are in use. under the FMEA (failure modes and estimation analysis) we should be able to prove control, monitoring and validation of the sterilisation process as a control measure and we cannot. not having a AP(D) to maintain the day to day operational aspects of the role is a further risk, as both units are reviewed 1 day per month - a bulk is this time is spend checking records and the other aspects of the AP(d)role do not get the sufficient time required to review and follow up.	Estates management informed and plans in place to receive reports on time and to standard. Independent monitoring system in place monitoring machine performance. Weekly PPM carried out on machinery. An action plan has been created by estates, to include training both the specialist estates officer so he can gain the recognised qualification he needs to carry out the role of the Authorised person for decontamination(AP(D)) and for additional training of the estates competent persons(CP(D) who test the decontamination equipment.	15	High / Significant Risk

Director of Operations	Core Clinical & Support Services - Clinical Support Services	Physiotherapy	Poor outcomes for children and young people referred to the children's physiotherapy service	Coding and prioritizing of referrals 1:1s and caseload supervision	15	High / Significant Risk
Director of Operations	Surgical - Head & Neck	Ophthalmology	Insufficient experienced schedulers/patient pathway co-ordinators to support Ophthalmology Service	1. Preventative & mitigating controls - review of patients who had been revalidated - plan to discuss issues with patient access team	16	High / Significant Risk

Director of Finance	Finance	Financial Accounting	There is a risk that if the Trust is unable to successfully tender for external audit services in 2021 then financial audits and other required annual assurance exercises will not take place LEADING TO the Trust failing in its statutory obligations.	1. Trust's current external audit contract ends August 21. The trust is looking to place a direct award for 1 years contract with its current external audit firm	16	High / Significant Risk

	Women's & Children's Health - Children's Health	Children's Services	Following PCPCH guidance, and health issues the Registrar's rota is potentially impacted by the need to ensure some Registrars do not attend COVID risk areas- and only work in NNU. This reduces the ability to support busy shifts across the unit and potentially delays the acute pathway flow	Consultants will offer back up out of hours, when possible as 2 Consultants are also COVID high risk.	16	High / Significant Risk
Director of Operations	Women's & Children's Health - Children's Health	Children's Services	Ward 5 store rooms unfit for purpose, unsafe storage of equipment and consumables could result in significant harm to staff and delays in access equipment and consumables resulting in delay in care provision	Tidy daily- it does not improve the situation for any significant amount of time	16	High / Significant Risk

Medical Director	Surgical - Musculoskeletal	Trauma & Orthopaedics	There is a risk to head injury patients not being appropriately cared for as they are not being treated in accordance with NICE guidance (CG176: Head injury: assessment and early management, updated September 2019)	1, 2 & 3. Preventive controls - On going discussions with Senior Medical Team - CSU Lead to escalate via trauma network - Alert process is in place for escalation within T&O & externally. - Resources available at tertiary site for advice/support 1, 2 c& 3. mitigating controls - Policy for management of head injuries has been developed - Awaiting appointment of head injury liaison Nurse	16	High / Significant Risk

Director of Operations	Surgical - Musculoskeletal	Trauma & Orthopaedics	There is a risk to head injury patients not being appropriately cared for as they are not being treated in accordance with NICE guidance (CG176: Head injury: assessment and early management, updated September 2019)	1, 2 & 3. Preventive controls - On going discussions with Senior Medical Team - CSU Lead to escalate via trauma network - Alert process is in place for escalation within T&O & externally. - Resources available at tertiary site for advice/support 1, 2 c& 3. mitigating controls - Policy for management of head injuries has been developed - Awaiting appointment of head injury liaison Nurse	16	High / Significant Risk

Director of Operations	Core Clinical & Support Services - Diagnostic & Screening	Screening Services	The 10yr old mammography machine in BS2 could fail due to its age. The increased amount of unplanned downtime this year is consistent with aging equipment. With the introduction of new technologies the availability of replacement parts is a worry. A replacement part needed to be shipped from Chicago.	Comprehensive service contract All faults reported immediately to external contractor / physicist for support. Robust QA systemin process to monitor system performance. This is reviewed weekly by medical physics.	16	High / Significant Risk

Director of Clinical Services	Operations	Patient Discharge	Risk that patient discharges will significantly be delayed, especially those requiring complex coordination of the discharge process	Covering a small number of shifts with former Discharge Coordinator carrying out bank shifts, when available. Offered bank shift to train an Agency Nurse who has shown an interest in the role. Recruited in to one vacancy and interviewing in to Bucks Coordinator role on 2/8/19. Reviewed role and delegated minor responsibilities to Rotational Operations Liaison Officers. Support requested from key nursing areas who have the skills to support a number of aspects relating to the role & discharge process- awaiting confirmation	16	High / Significant Risk

Deputy CEO	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.	Support in place, upgrade ETA Pending Capital funding	16	High / Significant Risk
Director of Operations	Core Clinical & Support Services - Pharmacy	Pharmacy	There is a risk that Pharmacy Policies and Procedures may not be reviewed and updated in a timely manner	Development of eCare Try to release staff to review policies	16	High / Significant Risk

Director of Corporate Affairs	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	Due to the number of staff within the area, some staff have to work from home (rota basis) Mobile air conditioning units distributed. Plumbed in water cooler in situ. .	16	High / Significant Risk

Director of Operations	Surgical - Anaesthetics & Theatres	Emergency Theatres	Theatre staff will not be available out of hours to staff phase 1 activity across obstetrics and emergency lists if elective lists overrun 1) currently theatres cannot mix emergency and elective patients - previously 23% of emergency cases were addressed in gaps in elective cases 2) Issues are also at 6pm as cannot combine recovery areas, these also have to be kept separate.	1. Preventative controls - agreement with Divisional Director of Operations for Surgery to staffing of late shift - Theatre 1 (elective PM) now vacant and staffing used for emergency, surgical and theatres skills permitting. - Review of staffing rota - extended to 7pm. - Staff are requested to stay longer for urgent cases 1. Mitigating controls - Discussion with Phase 1 to prioriitise lists including obstetrics - Requests for planned over runs to be made early - Team are progressing with plan to implement 3 booked sessions per list which may address robotic surgery or predictable over runs but will not address unpredictable causes of over runs. This will also need to be addressed in job planning.	16	High / Significant Risk

Director of Finance	Finance	Financial Management	There is a risk that the Trust has insufficient resources (financial or otherwise) or has insufficient physical capacity in order to clear the waiting list backlogs that occurred as a result of the COVID-19 pandemic, leading to delays in patients receiving treatment and a potential long-term financial pressure for the Trust through a requirement to deliver higher levels of activity each financial year.	"1. Monitoring of the Trust's waiting list through divisional meetings, executive performance meetings, and Trust board sub-committees (including the Finance and Investment Committee); 2. Recovery plans developed in accordance with guidance issued by NHS England and NHS Improvement, including financial forecast to assess the impact of increasing activity alongside COVID-19 measures. 3. Financial incentive scheme in place to provide additional funding for performing activity in excess of baseline levels set by regulators 4. Capital and revenue bids submitted to regulators in order to provide additional finance resource to create additional capacity to increase activity volumes at the Trust."	16	High / Significant Risk

Director of Finance	Finance	Financial Management	There is a risk that the Trust has insufficient resources (financial or otherwise) or has insufficient physical capacity in order to clear the waiting list backlogs that occurred as a result of the COVID-19 pandemic, leading to delays in patients receiving treatment and a potential long-term financial pressure for the Trust through a requirement to deliver higher levels of activity each financial year.	"1. Monitoring of the Trust's waiting list through divisional meetings, executive performance meetings, and Trust board sub-committees (including the Finance and Investment Committee); 2. Recovery plans developed in accordance with guidance issued by NHS England and NHS Improvement, including financial forecast to assess the impact of increasing activity alongside COVID-19 measures. 3. Financial incentive scheme in place to provide additional funding for performing activity in excess of baseline levels set by regulators 4. Capital and revenue bids submitted to regulators in order to provide additional finance resource to create additional capacity to increase activity volumes at the Trust."	16	High / Significant Risk

Director of Corporate Affairs	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	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 10. Standard Operating Procedure re Risk & Governance Team supporting the closure of incident investigations during unprecedented demand on service (e.g. Covid-19	16	High / Significant Risk

				Pandemic) approved - February 2021 11. Patient Safety Framework introduced		

Director of Operations	Surgical - Surgery	General Surgery	There will be increased demand for Endoscopy sessions	1. Preventive controls - Ongoing monitoring - currently managing own demand. - Regular review of clinic slots - especially colorectal clinics. - Consultant running 1 extra list - Team outsourcing to Blakelands for extra sessions. - Employing additional Locums which is a risk in its self - Running additional endoscopy sessions either with locums or substantive staff with a huge financial consquence	16	High / Significant Risk

Director of Operations	Women's & Children's Health - Children's Health	Neonatal	Overcrowding and insufficient space in the Neonatal Unit, exacerbated by need for social distancing due to COVID-19	1. Reconfiguration of cots to create more space and extra cots and capacity, though this still does not meet PHE or national standards 2. Parents asked to leave NNU during interventional procedures, ward rounds etc. Restricted visiting during COVID 3. Added to capital plan 4. Feasibility study completed	20	High / Significant Risk

Director of Operations	Core Clinical & Support Services - Pharmacy	Pharmacy	The risk is there will be insuffient staff in pharmacy to meet demands of the organisation and ensure patient safety in the use of medicines.	Actively recruiting, listening events with staff, identifying quick wins from staff to reduce turnover, implementing 1-1 system to support staff, reviewing work activities of 8a's and above to identify what could stop for a period of time.	20	High / Significant Risk

Director of Operations	Operations	Emergency Planning	The risk of capabilities in responding to a Novel Coronavirus (COVID-19) impacting on patient care within clinical and non-clinical services, with the inability to maintain safety for staff and patients due to national pressures on supplies and infrastructure.	COVID-19 operational and contingency plans in place reviewed through Silver and Gold command structure, with meeting recorded through action logs PPE logged daily covering delivery and current stock	20	High / Significant Risk
Director of Patient Care / Chief Nurse	Women's & Children's Health - Women's Health	Obstetrics & Maternity	Poor patient experience, inability of Trust to provide maternity care locally for some women (during times of peak demand on service, delays in clinical care) and potential increased readmission rate due to reduced length of stay	Daily huddle & bed state reviews Escalation process Review of obstetric clinical pathways	20	High / Significant Risk

Deputy CEO	IT	Information Technology	Removal of IT links to Primary Care and the Community	HBL have confirmed they will only rollback for an extremely limited time.	20	High / Significant Risk

Meeting title	Trust Board	**Date:** March 2021		
Report title:	Board Assurance Framework	**Agenda item: 6.2**		
Lead director	**Name:** Kate Jarman	**Title:** Director of Corporate Affairs		
FoI status:	**Public**			
Report summary	Board Assurance Framework containing the principal risks against the Trust's objectives			
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [ ]	**Decision** [ ]
Recommendation	The Board is asked to review the content of the Board Assurance Framework			

Strategic objectives links	All
Board Assurance Framework links	All
CQC outcome/ regulation links	Governance/ Well Led (Regulation 17)
Identified risks and risk	

management actions	
Resource implications	
Legal implications including equality and diversity assessment	

Report history	To every Board
Next steps	
Appendices	

The Board Assurance Framework – Summary of Activity March 2021

Covid-19 Risks

Covid-19 continues to present a dynamic risk environment. In the January Board report, there were a number of escalating risks relating to the operational mangement of the Covid-19 pandemic. The majority of these are now de-esclating and are summarised below. TThere remains a significant and escalating risk in relation to the restoration of services due to the protracted and prolongued impact of the Covid-19 pandemic. This is the most significant operational and safety risk on the Board Assurance Framework currently.

Care Delivery

1. **ITU capacity (RISK 6 – DE-ESCALATING)**
2. **Oxygen capacity (DE-ESCALATING)**

		Risk	**Impact**	**Score**	**Controls**
Quality & Clinical Risk	Deputy CEO	If demand for O2 exceeds 1,600 L/Min then there is a risk that pressure will fall leading to the possibility of system failure	The Trust is supplied with liquid O2 stored in a VIE. This is converted to gaseous 02 with a theoretical maximum usage of 1,800 L/Min. if demand increases then there is a risk of inadequate supply to meet the clinical demand or system failure as the evaporators freeze	5x2=10	Daily monitoring of demand and detailed planning of capacity. Small quantities of O2 from portable cylinders are available but would not support patient care demand. More robust business continuity plans for main ICU area. Daily collection of ward and departmental usage supported by clinical policies to setting of O2 ceilings

3. **Disruption to elective services (RISK 5 and RISK 12 – ESCALATING RISK)**

4. **Nosocomial infections (Covid-19) – see IPC Board Assurance Framework**

5. **Staff sickness – DE-ESCALATING RISK**

		Risk	Impact	Score	Controls
Workforce	Director of Workforce	High levels of staff sickness/ isolating households mean the Trust is unable to adequately staff services	Staffing levels compromise the delivery of care and the safety of patients	5x3=15	Daily monitoring of staff sickness and impact at Gold Command and multiple times daily across the site (escalated through command structure) Redeployment of staff where necessary Significant investment in staff welfare and wellbeing Staff vaccination programme

6. **Services overwhelmed – DE-ESCALATING RISK**

		Risk	Impact	Score	Controls
Quality & Clinical Risk	CEO	Contingency and continuity plans are not sufficient to cope with extreme Covid-19 surges	Services are overwhelmed, all other care is stopped – potential for harm in other patient groups	5x2=10	Robust contingency plans – continually reviewed at multiple levels organisationally, regionally and nationally Established local networks and surge plans

Strategic Risks to be Reviewed to the BAF at April Seminar

1. HIP2 programme and estate development – given the scale and timeframe of this programme it is recommended that the Board consider the risks against the Trust's strategic aim of making best use of the estate
2. Use of health information – the Trust has recently launched access to health data with Apple, enabling patients using MyCare to access

3. Use of health information –It is recommended that the Board consider whether it should consider further opportunistic risk around the use of health information for clinical research purposes against the Trust's strategic aims of developing teaching and research and being innovative and sustainable.

The Board Assurance Framework

The Board Assurance Framework (BAF) details the principal risks against the Trust's strategic objectives.

- The BAF forms part of the Trust's risk management framework, which includes the corporate risk register (CRR), divisional and directorate risk registers (down to ward/ department service level).
- Risks are scored using the 5x5 risk matrix, and each risk is assigned a risk appetite and strategy. Definitions can be found summarised below and are detailed in full in the Trust's risk strategy.
- Board sub-Committees are required to rate the level of assurance against each risk reviewed under their terms of reference. There is an assurance rating key included to guide Committees in this work.

Strategic Objectives

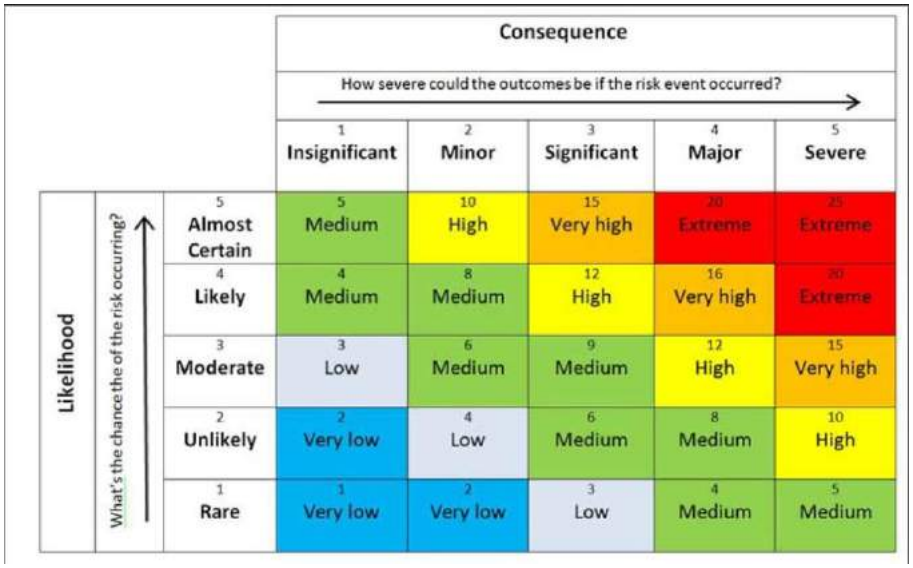
1. Improving patient safety
2. Improving patient experience
3. Improving clinical effectiveness
4. Delivering key performance targets
5. Developing MK at place
6. Developing teaching and research
7. Being well governed and financially viable
8. Investing in our people
9. Developing our estate
10. Being innovative and sustainable

Risk treatment strategy: Terminate, treat, tolerate, transfer
Risk appetite: Avoid, minimal, cautious, open, seek, mature

Assurance ratings:

Green	**Positive assurance**: The Committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat/ opportunity. There are no gaps in assurance or controls and the current exposure risk rating is at the target level; or gaps in control and assurance are being addressed.
Amber	**Inconclusive assurance:** The Committee is not satisfied that there is sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy.
Red	**Negative assurance:** There is sufficient reliable evidence that the current risk treatment strategy is not appropriate to the nature and/or scale of the threat or opportunity.

5X5 Risk Matrix:

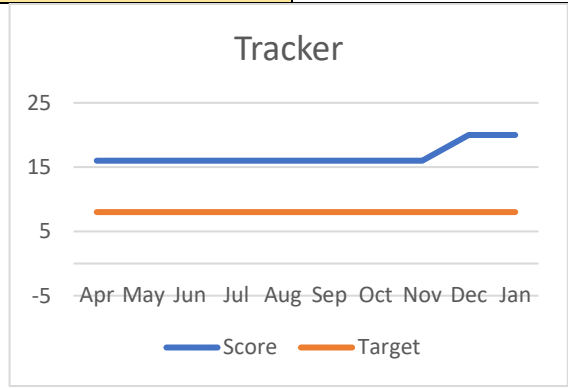


Likelihood (What's the chance the of the risk occurring?)	Consequence: 1 Insignificant	2 Minor	3 Significant	4 Major	5 Severe
5 Almost Certain	5 Medium	10 High	15 Very high	20 Extreme	25 Extreme
4 Likely	4 Medium	8 Medium	12 High	16 Very high	20 Extreme
3 Moderate	3 Low	6 Medium	9 Medium	12 High	15 Very high
2 Unlikely	2 Very low	4 Low	6 Medium	8 Medium	10 High
1 Rare	1 Very low	2 Very low	3 Low	4 Medium	5 Medium

RISK 1: Ability to maintain patient safety during periods of overwhelming demand

Strategic Objective 1: Improving Patient Safety

Strategic Risk	Ability to maintain patient safety during periods of overwhelming demand				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Chief Operating Officer	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	01/03/21	**Risk Rating**	12	8		

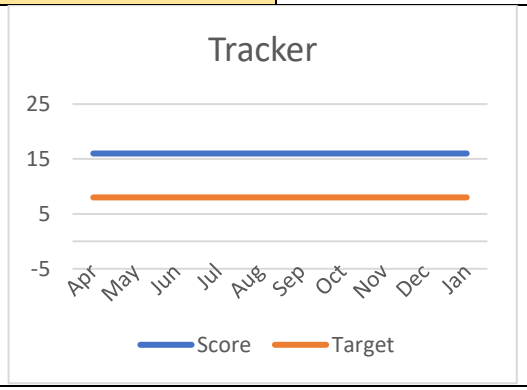


Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Significantly higher than usual numbers of patients through the ED Significantly higher acuity of patients through the ED Major incident/ pandemic	Clinically and operationally agreed escalation plan Adherence to national OPEL escalation management system Clinically risk assessed escalation areas available			System-wide (MK) partnership board			

RISK 2: Failure to embed learning and preventative measures following serious incidents/ Never Events

Strategic Objective 1: Improving Patient Safety

Strategic Risk	Failure to embed learning and preventative measures following serious incidents/ Never Events				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Medical Director	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	01/03/21	**Risk Rating**	12	8		

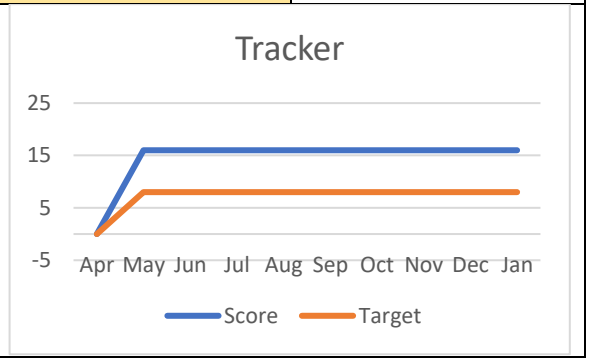


Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Not appropriately reporting, investigating or learning from incidents. A lack of systematic sharing of learning from incidents. A lack of evidence that learning has been shared	Improvement in incident reporting rates SIRG reviews all evidence and action plans associated with Sis Actions are tracked Trust-wide communications in place	Establishing Learning and Improvement Board Establishing Divisional Quality Governance Boards QI/ AI strategies and processes well embedded	October 2020 - ongoing October 2020 - ongoing	NRLS data			

	Debriefing systems in place Training available Appreciative Inquiry training programme started (December 2020)		October 2020 - ongoing				

RISK 3: Failure to manage clinical risk during periods of sustained or rapid change

Strategic Objective 1: Improving Patient Safety

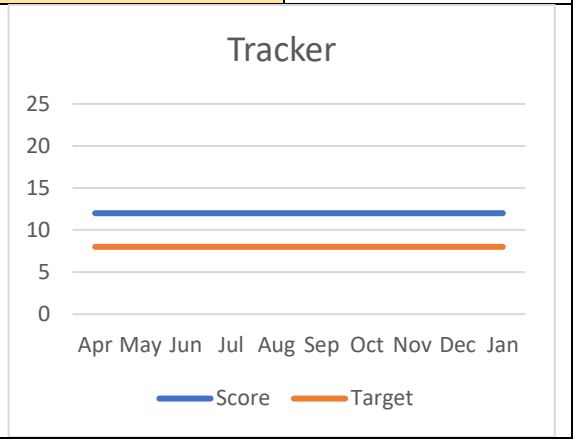
Strategic Risk	Failure to manage clinical risk during periods of sustained or rapid change					**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm	
Executive Lead	Medical Director	**Consequence**	4	4	**Risk Appetite**	Avoid	
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat	
Date of Review	01/03/21	**Risk Rating**	16	8			

Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
Rapid or sustained period of upheaval and change caused by the Covid-19 pandemic and need to respond and maintain clinical safety and quality	Board approved major incident plan and procedures Rigorous monitoring of capacity, performance and quality indicators Established command and control governance mechanisms	Inability to accurately predict or forecast levels of activity and risk		MK place-based and ICS-based planning and resilience fora Regional and national data and forecasting			

RISK 4: Failure to manage clinical risk that materialise as a result of significant digital change programmes

Strategic Objective 1: Improving Patient Safety

Strategic Risk	Failure to manage clinical risk that materialise as a result of significant digital change programmes				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Deputy CEO	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	01/03/21	**Risk Rating**	12	8		



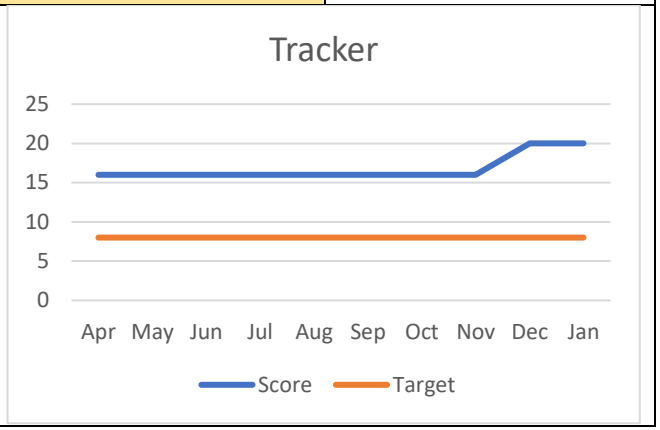
Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
Inadequate assessment of clinical risk/ impact on clinical services or practices Inadequate resourcing	Robust governance structures in place with programme management at all levels Clinical oversight through CAG Thorough planning and risk assessment	IT resourcing remains a pressure point	Continue to maintain programme governance and keep resourcing under review	Established governance and external/ independent escalation and review process		Continued iterative testing of products post-roll out	

Inadequate training	Regular review of resourcing Regular review of progress Risks and issues reported						

RISK 5: Failure to provide capacity to match demand for elective care, including cancer and screening programmes **ESCALATING RISK**

Strategic Objective 1: Improving Patient Safety

Strategic Risk	Failure to provide capacity to match demand for elective care, including cancer and screening programmes				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	COO	**Consequence**	5	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	01/03/21	**Risk Rating**	20	8		



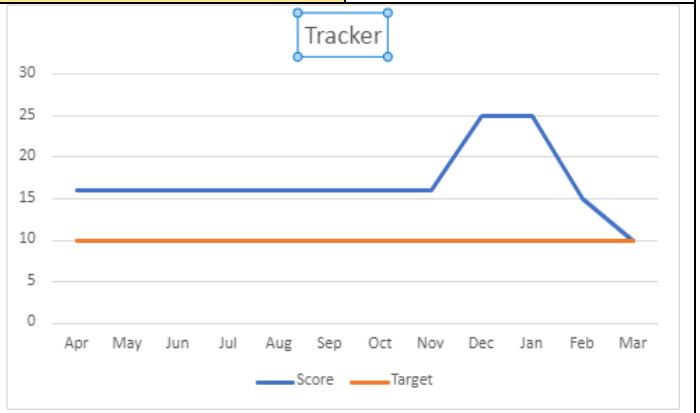
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Cessation of all routine elective care, including cancer screening and other pathways, during the peaks of the Covid-19 pandemic – INCREASING RISK	Granular understanding of demand and capacity requirements with use of national tools. Robust oversight at Board. Robust oversight through quality governance		Continue to maintain programme governance and keep resourcing under review	Established governance and external/ independent escalation and review process			

Inability to match capacity with demand	committees and boards Daily divisional and CSU management Agreement of local standards and criteria for pathway management Long-wait harm reviews						

RISK 6: Inability to cope with demand for ITU and inpatient care due to the Covid-19 pandemic

Strategic Objective 1: Improving Patient Safety

Strategic Risk	Inability to cope with demand for ITU and inpatient care due to the Covid-19 pandemic				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Medical Director	**Consequence**	5	5	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat
Date of Review	01/03/21	**Risk Rating**	10	10		

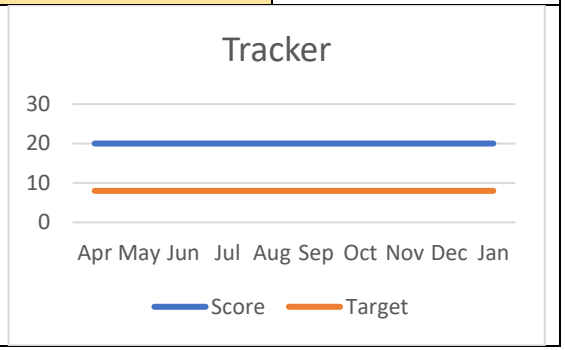


Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
Demand for ITU and inpatient beds exceeds capacity, including escalation capacity within the hospital	Increased capacity across the hospital Increased capacity for ITU Clear escalation plans	Inability to accurately forecast hyper-localised surges		Tested escalation plans Part of regional network			

RISK 7: Deterioration in patient experience of clinical oncology (radiotherapy) pathways, including range of and access to treatment

Strategic Objective 2: Improving Patient Experience

Strategic Risk	Deterioration in patient experience of clinical oncology (radiotherapy) pathways, including range of and access to treatment				**Strategic Objective**	Improving Patient Experience
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Medical Director	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	5	2	**Risk Treatment Strategy**	Treat
Date of Review	01/03/21	**Risk Rating**	20	8		



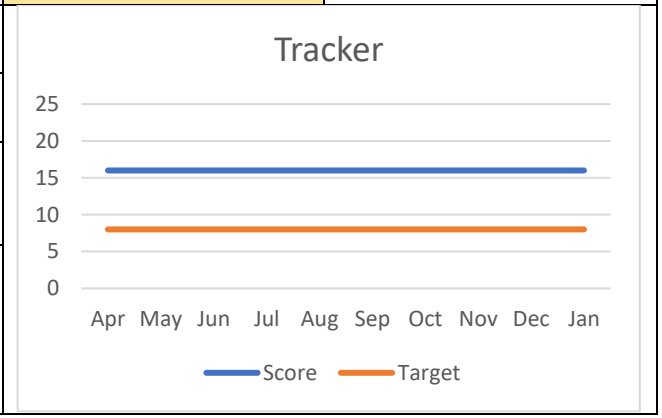
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Break down in the established relationship (sub contract) between Oxford University Hospitals and the private Genesis Care facility (Linford Wood, Milton Keynes) which has provided local radiotherapy to MK residents for the last six years.	Contingency for the provision of treatment to patient in Oxford. Promotion of ongoing discussion between OUH and Genesis about the ongoing provision of palliative and prostate radiotherapy at Linford Wood (a limited contract extension). Promotion of agreement between	Contracting and commissioning process outside the Trust's direct control or management	Continued lobbying for resolution	Lines of assurance outside the Trust's direct control	Lines of assurance outside the Trust's direct control	Continued work with partners	

This breakdown results in less choice and longer travel distances for patients requiring radiotherapy. Patients tend not to differentiate between the different NHS provider organisations. This risk materialised 16.12.2019 when the contract expired and no extension was agreed.	OUH and Northampton General Hospital to facilitate access to facilities at Northampton for those who prefer treatment in this location. Promotion of rapid options appraisal and decision making at OUH and MKUH in relation to a medium to long term solution for radiotherapy provision on site at Milton Keynes University Hospital (build, operation, governance etc...) and route to capital funding. Proactive communications strategy in relation to current service delivery issues.						

RISK 8: Lack of improvement in patient surveys

Strategic Objective 2: Improving Patient Experience

Strategic Risk	Lack of improvement in patient surveys				**Strategic Objective**	Improving Patient Experience
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Chief Nurse	**Consequence**	4	4	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	01/03/21	**Risk Rating**	16	8		



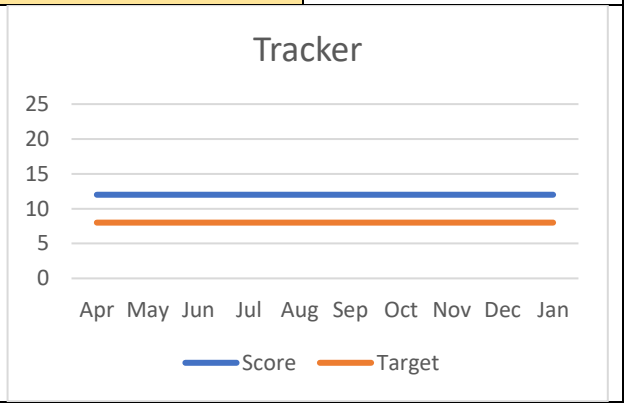
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Lack of appropriate intervention to improve patient experience (measured through the national surveys)	Corporate Patient Experience Team function, resources and governance arrangements in place at Trust, division and department levels, including but not limited to: • Patent Experience Strategy			PLACE surveys FFT results Local srveys			

	• Learning Disabilities Strategy • Dementia Strategy • Nutrition steering group • Catering steering group • Domestic planning group • Discharge steering group • Induction training Quarterly Patient Experience Board , monthly meetings and supporting substructure of steering groups						

RISK 9: Failure to embed learning from complaints

Strategic Objective 2: Improving Patient Experience

Strategic Risk	Failure to embed learning from complaints				**Strategic Objective**	Improving Patient Experience
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Chief Nurse	**Consequence**	4	4	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	01/03/21	**Risk Rating**	12	8		



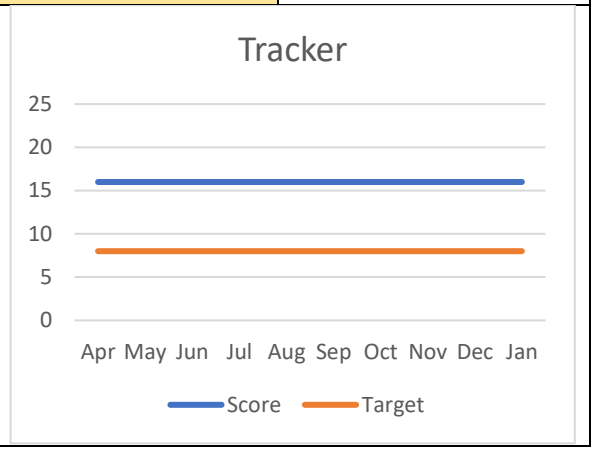
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Lack of appropriate intervention to improve patient experience (measured through the national surveys)	Corporate Patient Experience Team function, resources and governance arrangements in place at Trust, division and department levels, including but not limited to: • Patent Experience Strategy			PLACE surveys FFT results Local surveys			

	• Learning Disabilities Strategy • Dementia Strategy • Nutrition steering group • Catering steering group • Domestic planning group • Discharge steering group • Induction training Quarterly Patient Experience Board , monthly meetings and supporting substructure of steering groups						

RISK 10: Failure to meet the requirements of clinical compliance regimes, including audit, policies, NICE

Strategic Objective 3: Improving Clinical Effectiveness

Strategic Risk	Failure to meet the requirements of clinical compliance regimes, including audit, policies, NICE				**Strategic Objective**	Improving Clinical Effectiveness
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Director of Corporate Affairs	**Consequence**	4	4	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	01/03/21	**Risk Rating**	16	8		



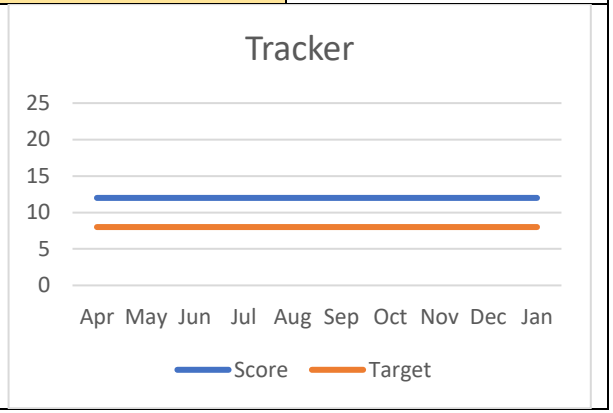
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
1. Lack of understanding/ awareness of audit requirements by clinical audit leads 2. Resources not adequate to support data collection/ interpretation/ input	1. Designated audit leads in CSUs/ divisions 2. Clinical governance and administrative support - allocated by division 3. Recruited additional clinical governance post to medicine to support			Integrated Governance and Compliance Board External benchmarking			

3. Audit programme poorly communicated 4. Lack of engagement in audit programme 5. Compliance expectations not understood/ overly complex	audit function (highest volume of audits) 3. Audit programme being simplified, with increased collaboration and work through the QI programme 4. Audit compliance criteria being segmented to enable focus on compliance with data returns; opportunity for learning/ changing practice and communication/ engagement 5. Monthly review of all compliance requirements, including NICE and policies						

RISK 11: Failure to ensure adequate data quality leading to patient harm, reputational damage and regulatory failure

Strategic Objective 3: Improving Clinical Effectiveness

Strategic Risk	Failure to ensure adequate data quality leading to patient harm, reputational damage and regulatory failure				**Strategic Objective**	Improving Clinical Effectiveness
Lead Committee	Audit	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Deputy CEO	**Consequence**	4	4	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	01/03/21	**Risk Rating**	12	8		

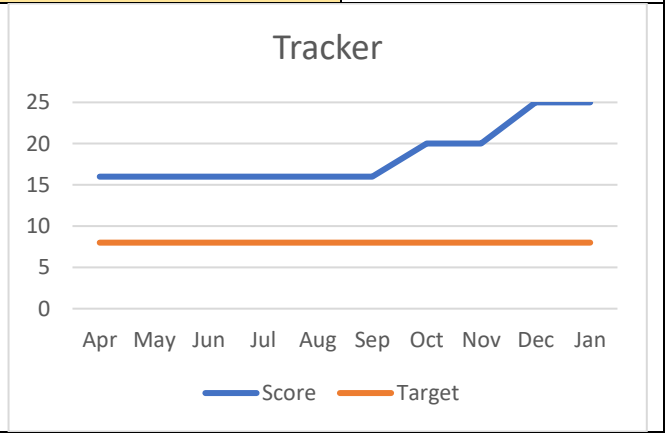


Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Failure to ensure adequate data quality leading to patient harm, reputational risk and regulatory failure because data quality processes are not robust	Robust governance around data quality processes including executive ownership Audit work by data quality team			Data Quality Board External benchmarking			

RISK 12: Failure to meet elective waiting time targets due to seasonal emergency pressure or further Covid-19 surges **ESCALATING RISK**

Strategic Objective 4: Meeting Key Targets

Strategic Risk	Failure to meet elective waiting time targets due to seasonal emergency pressure or further Covid-19 surges				**Strategic Objective**	Meeting Key Targets
Lead Committee	TEG	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	COO	**Consequence**	5	5	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	27/10/20	**Risk Rating**	20	10		



Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Elective activity is suspended (locally or by national directive) to enable the Trust to cope with emergency demand or further Covid-19 surges, resulting in increasing waits for patients needing elective treatment –	Winter escalation plans to flex demand and capacity Plans to maintain urgent elective work and cancer services through periods of peak demand Agreed plans with local system	Unpredictable nature of both emergency demand and the surge nature of Covid-19 Workforce and space (in pandemic) rate limiting factors	Continued planning and daily reviews (depending on Opel and incident levels)	Emergency Care Board (external partners) Regional and national tiers of reporting and planning			

including cancer care	National lead if level 4 incident, with established and tested plans Significant national focus on planning to maintain elective care						

RISK 13: Failure to meet the four-hour emergency access standard **RECOMMENDED FOR DE-ESCALATION FROM BAF FOR FURTHER COVID-19 SURGES**

Strategic Objective 4: Meeting Key Targets

Strategic Risk	Failure to meet the four-hour emergency access standard						**Strategic Objective**	Meeting Key Targets
Lead Committee	TEG	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm		
Executive Lead	COO	**Consequence**	5	5	**Risk Appetite**	Minimal		
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat		
Date of Review	27/10/20	**Risk Rating**	16	8				

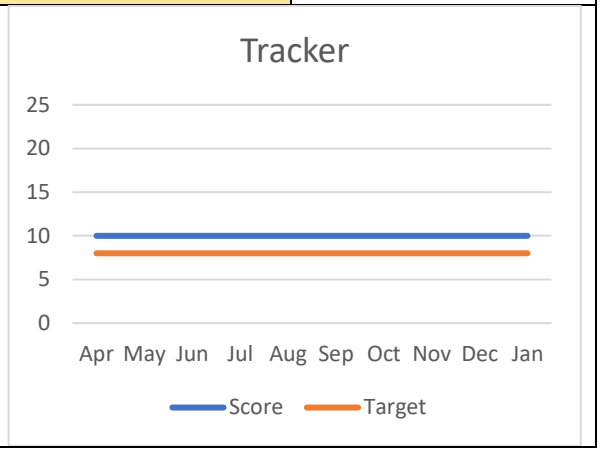
RECOMMENDED FOR DE-ESCALATION FROM BAF FOR FURTHER COVID-19 SURGES

This has been a long-standing risk on the BAF and significant risk register. Given the current Covid-19 surges/ further waves, it is recommended that this is de-escalated from the BAF for the duration of the pandemic to enable the Board to focus on the unique strategic risks to the emergency department posed by Covid-19. The risk around meeting the standard and ED demand will remain on the significant risk register.

RISK 14: Failure to adequately safeguard against major IT system failure (inability to invest in appropriate support systems/infrastructure)

Strategic Objective 7: Being Well Governed and Financially Viable

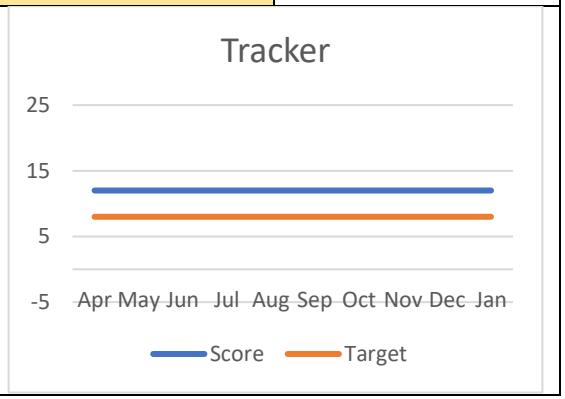
Strategic Risk	Failure to adequately safeguard against major IT system failure (inability to invest in appropriate support systems/infrastructure)				**Strategic Objective**	Being Well Governed and Financially Viable
Lead Committee	Finance and Investment	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial
Executive Lead	Deputy CEO	**Consequence**	5	4	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat
Date of Review	01/03/21	**Risk Rating**	10	8		



Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Lack of suitable and timely investment leaves the Trust vulnerable to cyber attack	2 dedicated cyber security posts funded through GDE All Trust PCs less than 4 years old Robust public wifi network EPR investment	None identified	Continued review	External review and reporting			

RISK 15: There is a risk that delays in the business case approvals process (including regulatory approvals), and/or delays in capital funds being made available (through PDC financing or other sources) prevent the Trust from being able to progress its entire capital programme in 2020/21 leading to a missed opportunity in the event funds cannot be carried forward to future years.

Strategic Objective 7: Being Well Governed and Financially Viable

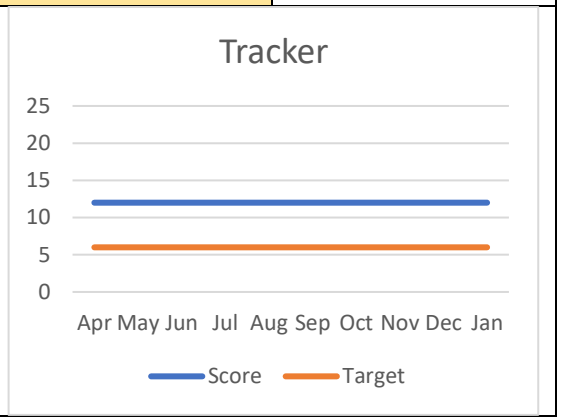
Strategic Risk	There is a risk that delays in the business case approvals process (including regulatory approvals), and/or delays in capital funds being made available (through PDC financing or other sources) prevent the Trust from being able to progress its entire capital programme in 2020/21 leading to a missed opportunity in the event funds cannot be carried forward to future years.				**Strategic Objective**	Being Well Governed and Financially Viable	
Lead Committee	Finance and Investment	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial	
Executive Lead	DoF	**Consequence**	4	4	**Risk Appetite**	Cautious	
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat	
Date of Review	11/01/21	**Risk Rating**	12	8			

Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
Despite increased investment being made available to respond to covid-19, the national NHS capital financing regime remains under	1. Capital prioritisation process in place (through the Trust's Capital Control Group (CCG) and Clinical Board Investment Group (CBIG) to ensure the	The Trust has only limited influence on the national policy regarding the capital funding regime and the constraints on	Continued review	External review and reporting			

significant pressure. Capital expenditure limits have been implemented for NHS provider organisations and whilst the Trust's capital plan is within this envelope there have, in the past, been delays in funds being received to support capital investment.	Trust prioritises its capital schemes its resources effectively. 2. Alternative funding sources identified to support continued investment in the Trust's estate and physical infrastructure in line with requirements in the event that funding is not made available. 3. Close working with regulator partners to ensure the Trust is supported through the approvals process and any delays can be escalated through the NHS regional finance/capital teams.	the national CDEL.					

RISK 16: There is a risk that as a result of the COVID-19 pandemic the Trust incurs additional costs, has a reduction in income or is unable to deliver services efficiently leading to financial position being unsustainable.

Strategic Objective 7: Being Well Governed and Financially Viable

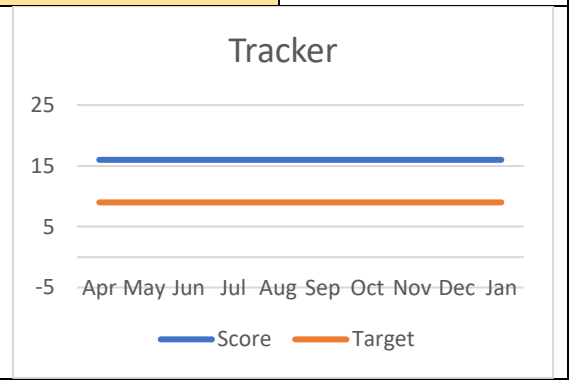
Strategic Risk	There is a risk that as a result of the COVID-19 pandemic the Trust incurs additional costs, has a reduction in income or is unable to deliver services efficiently leading to financial position being unsustainable.						**Strategic Objective**	Being Well Governed and Financially Viable
Lead Committee	Finance and Investment	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial		
Executive Lead	DoF	**Consequence**	4	3	**Risk Appetite**	Cautious		
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat		
Date of Review	11/01/21	**Risk Rating**	12	6				

Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
Increases in staff costs and non-pay costs in order to manage covid-19 Claims from suppliers under the Procurement Policy Note	1. PbR contracts replaced with block contracts (set nationally) for clinical income; 2. Top-up payments available where covid-19 leads to additional costs over	The financial envelope within which the Trust / BLMK ICS has to operate has not been announced - the Trust has only limited influence over	Continued review	External review and reporting			

Reduction in clinical income as a result of changes in clinical models and fewer hospital admissions Reductions in commercial income streams as a direct result of covid-19. Social distancing measures (patients and staff) Enhanced cleaning regimes leading to lower throughput	and above block sum amounts (until September 2020); 3. Financial controls remain in place for approval of additional spend above budgeted levels; 4. Re-focus of transformation programme to ensure continued productivity and efficiency improvements	how this amount is set.					

RISK 17: There is a risk that the Trust has insufficient resources (financial or otherwise) or has insufficient physical capacity in order to clear the waiting list backlogs that occurred as a result of the COVID-19 pandemic, leading to delays in patients receiving treatment and a potential long-term financial pressure for the Trust through a requirement to deliver higher levels of activity each financial year.

Strategic Objective 7: Being Well Governed and Financially Viable

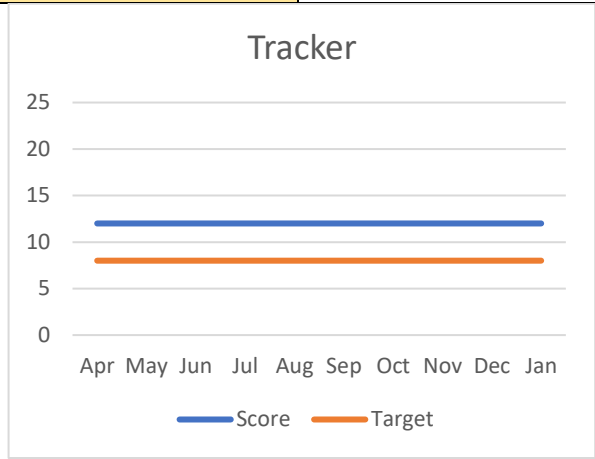
Strategic Risk	There is a risk that as a result of the COVID-19 pandemic the Trust incurs additional costs, has a reduction in income or is unable to deliver services efficiently leading to financial position being unsustainable.						**Strategic Objective**	Being Well Governed and Financially Viable
Lead Committee	Finance and Investment	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial		
Executive Lead	DoF	**Consequence**	4	4	**Risk Appetite**	Cautious		
Date of Assessment		**Likelihood**	4	3	**Risk Treatment Strategy**	Treat		
Date of Review	11/01/21	**Risk Rating**	16	9				

Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
The COVID-19 pandemic led to the delay or cancellation of procedures and clinics which resulted in an increase in the size of the waiting	1. Monitoring of the Trust's waiting list through divisional meetings, executive performance meetings, and Trust board sub-committees (including the Finance and	The Trust has only limited control over the allocation of additional financial resources to support its recover plans.	Continued review	External review and reporting			

list (at the Trust and across the NHS more broadly). On-going measures in response to COVID-19 (such as social distancing measures) have the potential to reduce the available physical capacity at the Trust.	Investment Committee); 2. Recovery plans developed in accordance with guidance issued by NHS England and NHS Improvement, including financial forecast to assess the impact of increasing activity alongside COVID-19 measures. 3. Financial incentive scheme in place to provide additional funding for performing activity in excess of baseline levels set by regulators 4. Capital and revenue bids submitted to regulators in order to provide additional finance resource to create additional capacity to increase activity volumes at the Trust.						

RISK 18: Insufficient capacity in the Neonatal Unit to accommodate babies requiring special care (finance and quality risk)

Strategic Objective 7: Being Well Governed and Financially Viable

Strategic Risk	Insufficient capacity in the Neonatal Unit to accommodate babies requiring special care						**Strategic Objective**	Being Well Governed and Financially Viable/ Patient Safety
Lead Committee	Finance and Investment and Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial		
Executive Lead	DoF	**Consequence**	4	4	**Risk Appetite**	Cautious		
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat		
Date of Review	11/01/21	**Risk Rating**	12	8				

Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
The current size of the Neonatal Unit does not meet the demands of the service. This risks high numbers of transfers of unwell babies and potential delayed repatriation of	Reconfiguration of cots to create more space Additional cots to increase capacity Parents asked to leave NNU during interventional	External timeframe and approval process for HIP2 funding	Continued review	External review and reporting			

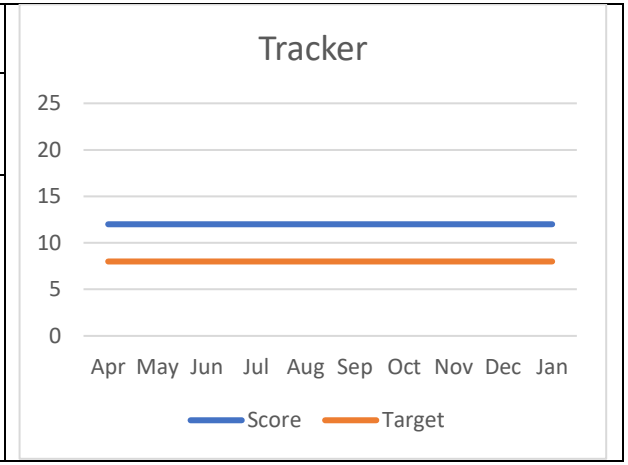
babies back to the hospital. There is a risk that if the Trust continues to have insufficient space in its NNU, the unit's current Level 2 status could be removed on the basis that the Trust is unable to fulfil its Network responsibilities and deliver care in line with national requirements.	procedures, ward rounds, etc to increase available space HIP2 funding for new Women and Children's Hospital announced						

New RISK: There is a risk that the Trust will be unable to successfully tender for external audit services in 2021 THEN financial audits and other required annual assurance exercises will not take place LEADING TO the Trust failing in its statutory obligations (finance and quality risk)

Strategic Objective 7: Being Well Governed and Financially Viable

Strategic Risk	There is a risk that the Trust will be unable to successfully tender for external audit services in 2021 THEN financial audits and other required annual assurance exercises will not take place LEADING TO the Trust failing in its statutory obligations (finance and quality risk)				**Strategic Objective**	Being Well Governed and Financially Viable	
Lead Committee	Finance and Investment	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial	

Executive Lead	DoF	**Consequence**	5	4	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	3	3	**Risk Treatment Strategy**	Treat
Date of Review	01/02/21	**Risk Rating**	15	9		



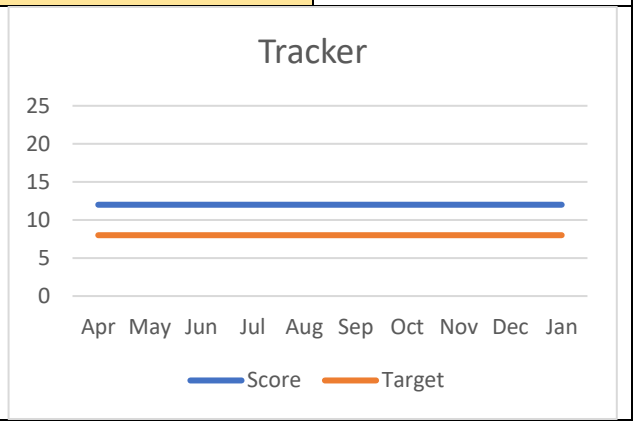
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
A number of audit firms are not bidding for audits currently due to Pricing – there have been recent changes in regulatory requirements increasing costs, in addition framework contracts were tendered a number of years ago and the rates are no longer at a level	The Trust is looking to extend its current External Audit Contract by a year through a direct award for its current external auditors	After the years extension. The Trust will go out to tender, however the Trust has only limited control over which audit firms will take up offers to tender even though they are a framework	Continued review and updates provided to the Audit Committee	External review and reporting			

that audit firms would consider acceptable Capacity- due to Covid many audit clients in other sectors have moved their audit timetables which has caused capacity issues							

RISK 19: Inability to retain staff employed in critical posts

Strategic Objective 8: Investing in Our People

Strategic Risk	Inability to retain staff employed in critical posts				**Strategic Objective**	Investing in Our People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	01/03/21	**Risk Rating**	12	8		



Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Proximity to tertiary centres Lack of structured career development or opportunities for progression Benefits packages elsewhere	Variety of organisational change/staff engagement activities, e.g. Event in the Tent Schwartz Rounds and coaching collaboratives Recruitment and retention premia We Care programme Onboarding and exit strategies/reporting		Continued review	External review and reporting			

Culture within isolated departments	Staff survey Learning and development programmes Health and wellbeing initiatives, including P2P and Care First Staff friends and family results/action plans Links to the University of Buckingham Staff recognition - staff awards, long service awards, GEM Leadership development and talent management Succession planning Enhancement and increased visibility of benefits package Recruitment and retention focussed workforce strategy and plan to fill vacancies, develop new roles and deliver improvement to working experience/environment Enhanced Benefits Package						

RISK 20: Inability to recruit to vacancies in the short term (0-18 months)

Strategic Objective 8: Investing in Our People

Strategic Risk	Inability to recruit to vacancies in the short term (0-18 months)						**Strategic Objective**	Investing in Our People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff	At target level – no tracker	
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Cautious		
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Tolerate		
Date of Review	01/03/21	**Risk Rating**	8	8				

Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
National shortages of appropriately qualified staff in some clinical roles, particularly at consultant level for dermatology and acute medicine, and at middle grade level for urology and trauma and orthopaedics	Active monitoring of workforce key performance indicators Targeted overseas recruitment activity Apprenticeships and work experience opportunities Exploration and use of new roles to help bridge particular gaps Use of recruitment and retention premia as necessary Use of the Trac recruitment tool to		Continued review	External review and reporting			

Competition from surrounding hospitals Buoyant locum market National drive to increase nursing establishments leaving market shortfall (demand outstrips supply)	reduce time to hire and candidate experience Rolling programme to recruit pre-qualification students Use of enhanced adverts, social media and recruitment days Rollout of a dedicated workforce website Review of benefits offering and assessment against peers Creation of recruitment "advertising" films Recruitment and retention focussed workforce strategy and plan to fill vacancies, develop new roles and deliver improvement to working experience/environment Targetted recruitment to reduce hard to fill vacancies						

RISK 21: Inability to recruit to vacancies in the long term (19+ months)

Strategic Objective 8: Investing in Our People

Strategic Risk	Inability to recruit to vacancies in the long term (19+ months)						**Strategic Objective**	Investing in Our People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff	At target level – no tracker	
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Cautious		
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Tolerate		
Date of Review	01/03/21	**Risk Rating**	12	12				

Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
National shortages of appropriately qualified staff in some clinical roles, particularly at consultant level Brexit may reduce overseas supply Competition from surrounding hospitals	Monitoring of uptake of placements & training programmes Targeted overseas recruitment activity Apprenticeships and work experience opportunities Expansion and embedding of new roles across all areas		Continued review	External review and reporting			

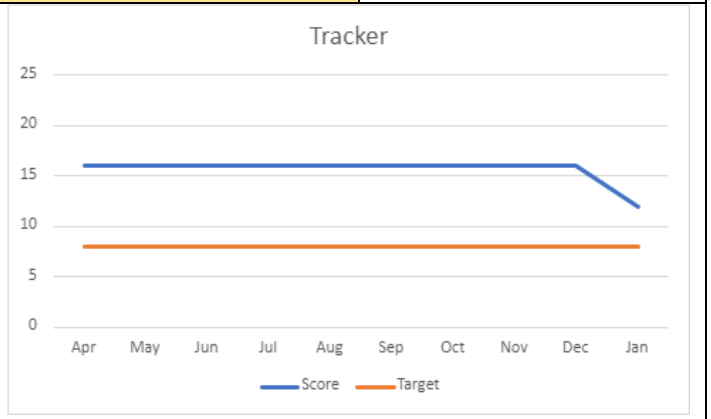
Buoyant locum market National drive to increase nursing establishments leaving market shortfall (demand outstrips supply) Large percentage of workforce predicted to retire over the next decade Large growth prediction for MK - outstripping supply Buoyant private sector market creating competition for entry level roles New roles upskilling existing senior qualified staff creating a likely gap in key roles in future (e.g. band 6 nurses)	Rolling programme to recruit pre-qualification students Use of enhanced adverts, social media and recruitment days Review of benefits offering and assessment against peers Development of MKUH training programmes Workforce Planning Recruitment and retention focussed workforce strategy and plan to fill vacancies, develop new roles and deliver improvement to working experience/environment International workplace plan Assisted EU staff to register for settled status and discussed plans to stay/leave with each to provide						

Reducing potential international supply New longer training models	assurance that there will be no large scale loss of EU staff post-Brexit						

RISK 22: Removal of up to 11 trainees from the department of Obstetrics and Gynaecology as a result of concerns about the training environment (workforce and safety risk)

Strategic Objective 8: Investing in Our People

Strategic Risk	Removal of up to 11 trainees from the department of Obstetrics and Gynaecology as a result of concerns about the training environment				**Strategic Objective**	Investing in Our People/ Patient Safety
Lead Committee	Workforce/ Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff
Executive Lead	Medical Director	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	18/01/21	**Risk Rating**	12	8		



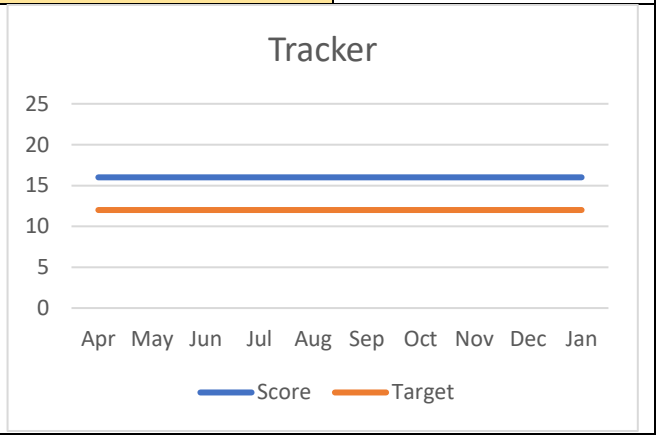
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Poor training environment: lack of standardisation of process; variable levels of support; and, persistent concerns around behaviours by consultants	Heavy involvement from clinical leaders outside the department (DD, DME, MD). Change in clinical leadership model within the service.	To date, we have not recruited to the additional posts approved in order to move away from a single tier middle grade rota 24/7. This currently sits		Positive initial work with Professor Belinda Dewar (Wee Culture) across the maternity department, using appreciative inquiry.			

perceived as belittling / inappropriate / bullying. Risk raised in November 2019 following HEE TV quality meeting.	Formative external review (Berendt consulting). Close liaison with HEE TV Head of School. Developmental work with consultant body and other senior clinicians in relation to vision and agreement of an ambitious forward-looking programme of work. Agreement around further investments within the department to improve the working lives of trainees and the quality of the training environment.	with the Head of School as a rotation is envisaged. The COVID-19 situation has resulted in additional complexity (development work etc...).		HEETV undertook a virtual visit on 04/12/2020 and the risk score (HEE intensive support framework) was reduced from 'category 3 – major concerns' to 'category 2 – significant concerns'. For further review at HEEE TV June 2021 Quality Committee,			

RISK 23: Ability to maintain a safe working environment during the Covid-19 pandemic

Strategic Objective 8: Investing in Our People

Strategic Risk	Ability to maintain a safe working environment during the Covid-19 pandemic				**Strategic Objective**	Investing in Our People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	01/03/21	**Risk Rating**	16	12		



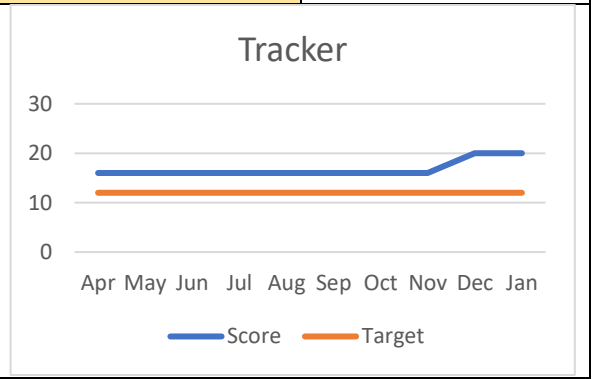
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Ability to maintain a safe working environment during the Covid-19 pandemic due to a lack of equipment, including PPE, or inadequate staffing numbers	Incident command structure in place Oversight on all critical stock, including PPE Immediate escalation of issues with immediate response through Gold/ Silver	None currently – noted that this risk may escalate very quickly					

	National and regional response teams in place						

RISK 24: Risk of staff burnout during or due to the Covid-19 pandemic

Strategic Objective 8: Investing in Our People

Strategic Risk	Risk of staff burnout during or due to the Covid-19 pandemic				**Strategic Objective**	Investing in Our People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff
Executive Lead	Director of Workforce	**Consequence**	5	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	01/03/21	**Risk Rating**	15	12		



Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
Staff burnout due to high-stress working environment, conditions of lock-down, recession and other social factors	Significant staff welfare programme in place, with mental health, physical health and support and advice available Staff Hub in use Remote working wellness centre in place	Significant uncertainty about next wave of the pandemic and how it will affect staff	Continued monitoring, continued communication and engagement with staff about support systems	Regular virtual all staff events Surveys		Package of measures to support remote workers	

	12 weeks of wellbeing focus January to March						

Agenda item 6.3
Public Board 11.03.21

Meeting of the Finance and Investment Committee held on 11 January 2021

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

Endoscopy Equipment – A business case was presented seeking capital investment of £1.2m, and revenue investment of £118k in 21/22, £249k in 22/23 and ongoing, for the purpose of new Olympus equipment for additional two off-site endoscopy rooms at Whitehouse Park. The investment was being sought in response to the NHSE/I COVID-19 Adapt and Adopt Endoscopy Recovery Programme, to increase capacity and to support the opportunity of being a healthcare pioneer for community diagnostic hubs and the separation of acute and elective diagnostics in the community.

Matters referred to the Board for final approval:

Dermatology Contract – The Committee recommended that the Trust Board approve the award of the contract for the Dermatology Service to a third-party provider. The Board. The award of the third-party contract in January 2021.

Matters considered at the meeting:

- With regard to the Performance Dashboard M8, elective surgery had all but ceased, due to increasing COVID-19 infections, but the organisation continued to maintain emergency and cancer care services. Acuity was a key issue as patients were moving on to NIV and ventilation, increasing pressures on ITU and high dependency areas, as well as on oxygen levels which peaked at a usage level of 83%.
- With regard to the Finance Report M8, the organisation was largely on plan, but a deterioration was expected in December 2020 due to increased pressures on areas such as agency working.
- The COVID-19 pandemic has had a significant impact on the financial position of the Trust driving a significant reduction in non-COVID-19 activity and high COVID-19 related additional expenditure. It was expected that for 2021/22, the Trust would reduce its COVID-19 specific costs and revert to a more conventional national PbR or local negotiated funding arrangement.
- Internal discussions on next year's budget and objectives continued to progress.

Agenda item 6.3
Public Board 11.03.21

Meeting of the Finance and Investment Committee held on 01 February 2021

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

- The Committee approved the Procurement Strategy, subject to a Board discussion on additional non-executive roles.

Matters referred to the Trust Board:

- **Cisco IT Network Business Case –** The Committee recommended that the Trust Board approve a business case for the investment of £2.5m to replace the Trust's IT network including telephony, Wi-Fi, core network and edge switches. The Board approved the business case in February 2021.
- **Laboratory Information Management System (LIMS) Business Case –** The Committee recommended that the Trust Board approve a business in support of a capital programme to replace the Trust's aged Laboratory Information System (LIMS) with a new system as part of the South 4 Pathology Partnership (S4PP), and which would improve cyber security and resilience. The Board approved the business case in February 2021.
- **Mammography Business Case** – The Committee recommended that the Trust Board approve a business in support of a capital programme to replace an aged mammography unit with a new version that was supported by advanced imaging technology. The Board approved the business case In February 2021.

Matters reported at the meeting:

- Regarding the M9 Performance Dashboard, the Committee noted that while COVID-19 infections were declining, acuity remained a significant challenge for the Trust with ICU and the high dependency areas permanently fully occupied with very sick patients.
- The Trust was managing pressures from a staffing perspective, particularly within specialist teams who were struggling to take leave as backfill arrangements were challenging. 'Beak glass' agencies were being approached in order to maintain adequate levels of safety.
- Elective activity remained suspended but emergency cases continue to be treated.
- Regarding the M9 Finance Report, the in-month position was being negatively impacted by an in-month adjustment to the significant untaken annual leave accrual.
- Internal discussions on next year's budget and objectives continued to progress.

Agenda item 6.3
Public Board 11.03.21

Meeting of the Finance and Investment Committee held on 01 March 2021

REPORT TO THE BOARD OF DIRECTORS

Matters reported at the meeting:

- Regarding the M10 Performance Dashboard, the Committee noted that while COVID-19 infections continued to decline, the Trust was working to manage the challenge of keeping non-COVID pathways clear in order to manage the elective recovery whilst ensuring staff were able to take annual leave to rest and recover.
- The Trust was also managing a particular and growing area of concern relating to the rise in children presenting to hospital with mental health issues. This presented a particular challenge for Paediatrics, requiring additional resource of agency registered mental health nurses.
- Regarding the M9 Finance Report, the Committee noted the deterioration of plan versus actual spend due to the impact of COVID in January 2021.
- Regarding Agency Usage, agency demand in January 2021 was higher than normal, though supply was not available and bank staff were used instead. The Committee noted that the requirement for additional mental health and ITU staff was the cause of the increased demand for agency staff.

Milton Keynes University Hospital NHS Foundation Trust

Agenda item 6.4
Public Board 11/03/2021

Meeting of the Charitable Funds Committee held on 18 February 2021

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

- The Committee ratified the decision to approve the procurement of iPads to support patient and staff communication during the COVID-19 pandemic.
- The Committee approved the Charitable Funds Policy, Procedure and Guidance, subject to minor amendments being completed.
- The Committee approved the request for charitable funding to purchase 3 Draeger BabyLeo incubators.

Matters referred to the Board for final approval:

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

Summary of matters considered at the meeting:

Fundraising Update – Income to date in 2020/21 was £483k against a forecast target of £475k, and significant funds were due to be received from NHS Charities Together and an individual.

Charity Funds Finance Update – To date this year, income was at £434k and expenditure was at £273k, leaving a cash balance of £591k.

Charity Strategy Update – The Committee noted the progress of the Charity Strategy Development process.

Agenda item 6.5
Public Board 11/03/2021

Meeting of the Quality & Clinical Risk Committee held on 18 February 2021

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

The Committee approved the Clinical Strategy.

Summary of matters considered at the meeting:

Clinical Quality Risks on the Board Assurance Framework (BAF) – COVID-19 related - COVID-19 risks were being de-escalated and this would be reflected in the version which would be submitted to the March 2021 Trust Board meeting.

Infection Prevention and Control (IPC) BAF - The IPC BAF was regularly being reviewed and progressed.

COVID-19/Site Update- Presentation – The Committee noted that:

- The number of COVID-19 patients continued to decline significantly from a peak of 235 in January 2021;
- A review of the records of deceased patients was being conducted to determine how those who were infected with COVID-19 in hospital, caught the infection. The Trust was liaising with the bereaved families to ensure that all lessons were shared as appropriate;

Quality Dashboard M10 – The Nursing Directorate will be commissioning a deep dive investigation to find out why there was an increasing number of patient falls.

2021-22 Quality Priorities – The Committee was informed that due to the COVID-19 pandemic there had been little opportunity to focus on the 2020/21 quality priority areas. The Trust planned to role forward those quality priority areas to 2021/22.

Review of CQC and Regulator Interface - the date for a CQC Well-Led inspection of the Trust would be scheduled before the end of March 2021 and would involve a small group of senior members of staff. The Trust was expecting a more expansive CQC inspection visit imminently.

Agenda item 6.6
Public Board 11/03/2021

Workforce & Development Assurance Committee Meeting held on 20 January 2021

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

No matters were approved by the Committee.

Matters referred to the Board for final approval:

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

Summary of matters considered at the meeting:

NHS People Plan, Workforce Strategy and Plan Update - The Committee noted that NHS People Plan was on track to be delivered in the Trust, with most areas being RAG-rated 'green'.

Equality, Diversity and Inclusion - The Committee was informed that though the post of Patient Services and Experience Lead was vacant, the progress of the Patient Experience Strategy was being monitored by the Nursing, Midwifery and Therapies Board. The Patient Experience team was hopeful that they could achieve the Strategy's targets post-COVID-19 in 2021/22.

Objectives Update - One objective, around the utilisation of the Ryalto app as a communications tool, was not progressing as expected due to the provider having been bought out by another company. The Committee was informed that the new provider was beginning to progress with the work they needed to undertake to support the app. All other objectives were on track to be achieved.

HR Systems and Compliance Report - E-roster, as a shift management tool, was currently being utilised by 85% of the Trust, from 71% as at October 2020. SafeCare, an online system designed to effectively manage and deploy the nursing establishment across the hospital, had been fully rolled out and was being utilised. 'Time to hire' worsened in December 2020, as managers struggled to set time aside for shortlisting tasks while the rate of COVID-19 infections was rising but was beginning to improve. The Committee congratulated the department on the amount of work undertaken and progress to date, particularly the Medical Staffing Team for their exemplary work around consultant interviews.

Workforce Information Quarterly Report - The Committee noted the following:

1. Appraisal and mandatory training rates were stable;
2. Agency spend had increased in December 2020 and was expected to continue increasing in January 2021 due to staffing pressures related to the COVID-19 pandemic;

3. 300 members of staff were off work daily due to COVID-19 reasons, which was significantly higher than the 100 who were off sick on a daily before the pandemic;
4. Reporting of 'unknown sickness' was close to zero;
5. Agency workers had been recruited to staff, or backfill for, the COVID-19 vaccine centre, supported by volunteers and recently retired people. A company that specialised in nurse training and vaccination had also provided trained vaccinators and were also helping to deliver the vaccination service.

Staff Health & Wellbeing (SHWB) Report – Telephone-based support continue to be provided for staff who may have been infected with COVID-19 as well as those recovering from the infection. Additional support had also been set up for staff suffering from 'long COVID' or are returning from 'shielding' from the pandemic. Steps were being taken to ensure that staff, especially those on ICU, were aware of and were accessing the relevant counselling support to help with any trauma and psychological issues they may be suffering due to their care for COVID-19 patients. The Trust was taking steps to ensure that staff could rest and recover, after the pandemic, while managing the waiting list backlog.

Organisational Development and Talent Management - The Culture and Leadership Programme remained in development. 46% of the staff completed the Staff Survey.

Education Update - 10 nursing associates had now qualified, and as an early implementer, the Trust has demonstrated that the model was viable.

Apprenticeship Strategy – The Strategy to be completed and ready for review at the next meeting in April 2021. The Committee noted the excellent progress made with the number of people taking up apprenticeships in the Trust.

Workforce Board Assurance Framework Risks – Workforce-related risks had been enhanced to take the impact of COVID-19 into account. The Committee was assured that the mitigations in place were adequate.

Workforce Risk Register - Noted.

Any Other Business - The Committee was informed that, as at the end of January 2021, there had been no wastage of the COVID-19 vaccine, and that about 80% of substantive hospital staff have been vaccinated. The vaccination programme was set to be extended to bank, ambulance, hospice and funeral staff, as well as others involved in the provision of healthcare within Milton Keynes.

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Board of Directors**	**Date: 4 March 2021**
Report title:	**Use of Trust Seal**	**Agenda item: 6.7**
Lead director **Report author Sponsor(s)**	**Name: Kate Jarman** **Name: Julia Price**	**Title: Director of Corporate Affairs** **Title: Assistant Trust 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 February 2021						

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 full meeting of the Board.

2. Context

Since the last Trust Board, the Trust Seal has been executed as follows:

04 February 2021
P22, FA Template A: Major Work Project, MKUH Pathway, Unit: for Stage 4 Contract

18 February 2021
JCT minor works building contract HV Generator

03 February 202
Engrossment Lease, Engrossment Deed of Surrender and Engrossment Agreement to Surrender for the South-Central Ambulance Service Ambulance Station.