Bundle Trust Board Meeting in Public 12 January 2023

0 10:00 - Agenda
Chair
1. Agenda Board Meeting in Public - 12.01.23 v 2.docx

1 10:20 - Apologies
Chair

2 10:20 - Declarations of Interest
Chair

3 10:20 - Patient Story
Director of Patient Care and Chief Nurse (Presentation)

4 10:20 - Previous Minutes of the Meeting
Chair
4. Minutes Trust Board Meeting in Public 03.11.22 AD.docx

5 10:20 - Matters Arising
Chair
5. Board Action Log Dec .22.pdf

6 10:20 - Chair's report
Chair
6. Chair's Report - Coversheet.docx
6.1 Chair's Report.docx

7 10:25 - Chief Executive's Report
Chief Executive - Verbal

8 10:35 - Serious Incident and Learning Report
Director of Corporate Affairs/ Medical Director
8. SI report for Trust Board January 2023.docx

9 10:40 - Feedback from Maternity Assurance Group
Director of Patient Care and Chief Nurse / Maternity Safety Champion
9. MAG Board Front Sheet Jan 2023.docx
9.1 Draft MAG Minutes 24112022.docx
9.2 MAG action Log updated 24.11.2022.pdf

10 10:45 - Infection Prevention and Control Annual Report
Director of Patient Care and Chief Nurse
10. Annual Report 2022 (IPC) Final.docx

11 10:50 - Pressure Ulcers Quarterly Update (June to November 2022)
Director of Patient Care and Chief Nurse
11. Pressure ulcers quartley update.pdf
11.1 Pressure Ulcers Quarterly Update (June to November 2022).docx

12 10:55 - Maternity Clinical Negligence Scheme for Trusts (CNST) Sign Off
Director of Patient Care and Chief Nurse
12. Trust Board Cover Sheet CNST Jan 2023.docx
12.1 CNST Trust Board Presentation MD NG FINAL (003) (002).pptx
12.2 MIS_Year4_Board_-Declaration_-Form MD.pdf
12.3 MIS-year-4-relaunch-October-2022-v5-Final-HV-approved-1 (002).docx

13 11:00 - Complaints and Patient Advice and Liaison Service (PALS) Quarterly Report
Director of Patient Care and Chief Nurse
13. Q2 2022 to 2023 Complaints and PALS.docx

14 11:05 - Patient and Family Experience Quarterly Report
Director of Patient Care and Chief Nurse

14. Q2 2022 to 2023 Patient and Family Experience.docx

15 11:10 - Item Withdrawn

15.1 11:20 - Break

16 11:30 - Antimicrobial Stewardship - Annual Report

Medical Director

16. Antimicrobial Stewardship Annual Report - 2021-22.docx

17 11:35 - Performance Report

Director of Operations

17. 2022-23 Executive Summary M08.docx

17.1 2022-23 Executive Summary M08 Coversheet v2.docx

18 11:45 - MK Deal Update

Director of Operations

18. General MK Deal SlidePack 1.pptx

19 11:55 - Finance Report

Director of Finance

Public Finance Report Month 8.docx

20 12:05 - Workforce Report

Director of Workforce

20. Workforce Report M8 202223.docx

21 12:10 - Update – Equality, Diversity and inclusion

Director of Workforce

22 12:20 - Recent Board Appointments and the Management of Potential Conflicts of Interest

Chair - Verbal

23 12:25 - Corporate Risk Register

Director of Corporate Affairs

23. Risk Register Report v2.docx

24 12:30 - Declaration of Interests Report

Director of Corporate Affairs

24. Declarations of Interest - Board Report.docx

24.1 2022-23 Register of Gifts and Hospitality.docx

24.2 Appendix 2 - Register of Declaration of Interest 22-23 for Consultants.docx

25 12:35 - Use of Trust Seal

Director of Corporate Affairs

25. Use of Trust Seal Jan 2023.docx

26 12:40 - Summary Reports

Chair

26.1 Audit Committee Summary Report 26.09.22.docx

26.2 Finance and Investment Committee Summary Report 041022.docx

26.3 Finance and Investment Committee Summary Report 011122.docx

26.4 TEC 12.10..22.docx

26.5 TEC 09.11..22.docx

26.6 WDAC Board Committee Summary Report.docx

27 12:45 - Terms of Reference

Director of Corporate Affairs

27.1 Charitable Funds Committee Terms of Reference November 2022 - Draft.docx

27.2 TEC Terms of Reference December 2022 - Draft.docx

28 12:50 - Forward Agenda Planner

Chair

28. Trust Board Meeting In Public Forward Agenda Planner.docx

29 12:55 - Questions from Members of the Public

30 12:55 - Motion To Close The Meeting

31 12:55 - 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."

32 12:55 - Date of Next Meeting

Next Meeting in Public: Thursday, 3 March 2023

33 12:55 - Board Meeting in Public - Appendices

Chair

0. Board Meeting in Public Appendices Front Sheet.docx

17.2 2022-23 Board Scorecard M08.pdf

24.1 Corporate Risk Register - as at 21st December 2022.pdf

Agenda for the Board of Directors' Meeting in Public

Meeting to be held at 10:00 am on Thursday 12 January 2023
in the Conference Room at the Academic Centre and via MS Teams

Item No.	Timing	Title	Purpose	Lead	Paper
Introduction and Administration					
1	10:00	Apologies	Receive	Chair	Verbal
2		Declarations of Interest • Any new interests to declare • Any interests to declare in relation to open items on the agenda • 2022/23 Register of Interests – Board of Directors - Register of Interest - Milton Keynes University Hospital (mkuh.nhs.uk)	Information	Chair	Verbal
3		Patient Story	Receive and Discuss	Director of Patient Care and Chief Nurse	Presentation
4		Minutes of the Trust Board meeting held in public on 03 November 2022	Approve	Chair	Attached
5		Matters Arising	Note	Chair	Attached
Chair and Chief Executive Updates					
6	10:20	Chair's Report	Information	Chair	Attached
7	10:25	Chief Executive's Report • Winter Update	Receive and Discuss	Chief Executive	Verbal
Patient Safety					
8	10:35	Serious Incident and Learning Report	Receive and Discuss	Director of Corporate Affairs/ Medical Director	Attached
9	10:40	Feedback from Maternity Assurance Group	Receive and Discuss	Director of Patient Care and Chief Nurse / Maternity Safety Champion	To Follow

Our Values: We Care-We Communicate-We Collaborate-We Contribute

Board Behaviours: Kindness-Respect-Openness

Item No.	Timing	Title	Purpose	Lead	Paper
10	10:45	Infection Prevention and Control Annual Report	Receive and Discuss	Director of Patient Care and Chief Nurse	Attached
11	10:50	Pressure Ulcers Quarterly Update (June to November 2022)	Receive and Discuss	Director of Patient Care and Chief Nurse	Attached
12	10:55	Maternity Clinical Negligence Scheme for Trusts (CNST) Sign Off	Receive and Discuss	Director of Patient Care and Chief Nurse	Attached
Patient Experience					
13	11:00	Complaints and Patient Advice and Liaison Service (PALS) Quarterly Report	Receive and Discuss	Director of Corporate Affairs	Attached
14	11:05	Patient and Family Experience Quarterly Report	Receive and Discuss	Director of Corporate Affairs	Attached
15		**Item Withdrawn**			
11:20 – Break (10 mins)					
Clinical Effectiveness					
16	11:30	Antimicrobial Stewardship - Annual Report	Receive and Discuss	Medical Director	Attached
Performance					
17	11:35	Performance Report	Receive and Discuss	Chief Operations Officer	Attached **Appendix 1 (from page 169)**
Place					
18	11:45	MK Deal Update	Receive and Discuss	Chief Executive	Attached
Finance					
19	11:55	Finance Report	Receive and Discuss	Director of Finance	Attached
Workforce					
20	12:05	Workforce Report	Receive and Discuss	Director of Workforce	Attached
21	12:10	Update – Equality, Diversity and inclusion	Receive and Discuss	Director of Workforce	Presentation

Item No.	Timing	Title	Purpose	Lead	Paper
Assurance and Statutory Items					
22	12:20	Recent Board Appointments and the Management of Potential Conflicts of Interest	Receive and Discuss	Chair	Verbal
23	12:25	Corporate Risk Report	Receive and Discuss	Director of Corporate Affairs	Attached **Appendix 2 (from page 169)**
24	12:30	Declaration of Interests Report	Receive and Discuss	Director of Corporate Affairs	Attached
25	12:35	Use of Trust Seal	Receive and Discuss	Director of Corporate Affairs	Attached
26	12:40	(Summary Reports) Board Committees • Audit Committee 26/09/22 • Finance & Investment Committee 04/10/22 and 01/11/22 • Trust Executive Committee 12/10/22 and 09/11/22 • Workforce & Development Assurance Committee 20/10/22	Assurance and Information	Chairs of Board Committees	Attached
27	12:45	Terms of Reference • Charitable Funds Committee • Trust Executive Committee	For Approval	Director of Corporate Affairs	Attached
Administration and Closing					
28	12:50	Forward Agenda Planner	Information	Chair	Attached
29		Questions from Members of the Public	Receive and Respond	Chair	Verbal

Item No.	Timing	Title	Purpose	Lead	Paper
30		Motion To Close The Meeting	Receive	Chair	Verbal
31		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.”	Approve	Chair	
12:55		Close			
Next Meeting in Public: Thursday, 3 March 2023					

BOARD OF DIRECTORS MEETING

Minutes of the Trust Board of Directors Meeting in Public held on Thursday, 3 November 2022 at 10.00 hours via Teams

Present:		
Alison Davis	Chair	(AD)
Heidi Travis	Non-Executive Director	(HT)
Haider Husain	Non-Executive Director	(HH)
Gary Marven	Non-Executive Director	(GM)
Bev Messinger	Non-Executive Director	(BM)
Dr Ian Reckless	Medical Director & Deputy Chief Executive	(IR)
Danielle Petch	Director of Workforce	(DP)
Yvonne Christley	Director of Patient Care and Chief Nurse	(YC)
John Blakesley	Deputy Chief Executive	(JB)
Emma Livesley	Director of Operations	(EL)
Terry Whittle	Director of Finance	(TW)

In Attendance:		
Kate Jarman	Director of Corporate Affairs	(KJ)
Dr Dev Ahuja	Associate Non-Executive Director	(DA)
Jason Sinclair	Associate Non-Executive Director	(JS)
Emma Codrington (for Item 3)	Associate Chief Nurse	(EC)
Sharon Robertson (for Item 3)	Patient and Family Experience Matron	(SR)
Luigi Straccia	Membership and Engagement Manager	
Kwame Mensa-Bonsu (via Teams)	Trust Secretary	(KMB)
Julia Price (Minutes)	Senior Corporate Governance Office	(JP)

1 Welcome and Apologies

1.1 AD welcomed all present to the meeting. There were apologies from Professor Joe Harrison, Chief Executive Officer

2 Declarations of interest

2.1 There were no declarations of interest in relation to the agenda items.

3 Patient Story

3.1 YC introduced EC and SR, explaining that significant changes to the patient story were being made focusing more on articulating the patient voice which was so important for clinical teams, helping to recognise that when aspects of a patient's journey do not go well, it can define their whole experience for them and their families.

3.2 EC explained that her role had changed since the presentation had been produced, from Divisional Chief Nurse (Surgery) to Associate Chief Nurse, adding that this story was very close to her heart, and that although there was a negative slant to the story, it was important to understand what it means to look after patients holistically. The patient attended the Urgent Care Centre early in December 2020 during the second wave of the Covid-19 pandemic. He was a relatively healthy man in his 50s with well controlled diabetes. He was sent from the Urgent Care Centre to the Emergency Department because of concern over his oxygen levels. After a few hours he was well enough to return home with antibiotics, 'safety-netted' to return if he felt unwell. He later returned and was admitted to Ward 2 (at that time, a Covid ward) having deteriorated, eventually transferring to the Intensive Care Unit (ICU). EC said that while his vital signs were good, he was clearly not well and was therefore on the 'worry list'. However, he did improve and was stepped down to the respiratory ward but was subsequently ventilated, returning

again to ICU. His wife was able to see him on Christmas Eve but he died later that day. Clinically, his treatment caused no concerns and EC highlighted the difficulties and clinical risks associated with the transfer of very poorly patients. Their belongings would normally be transferred in a red bag but in this instance, the patient's property was placed in an orange clinical waste bag. In the foyer in ICU there was a clinical waste bin for staff to dispose of their full personal protective equipment (PPE) and unfortunately, the patient's property was probably put into the bin. This was not realised until after the patient had died. The loss of the patient's phone was a huge source of distress for the family. It had held the final communications between the patient and his wife and despite honest and open explanations made to the family, the incident had cast doubt over the quality of care provided to the patient. They felt that if the patient's property had been treated so poorly, how could they be sure that his care had been any better. EC explained that there had been an ongoing relationship with the family through the losses and special claims process and EC highlighted the difficulty in expressing the emotional impact of the loss through an application for financial compensation. As a result, there was now clinical representation on the losses and special claims committee. She explained that the most common items to go missing were often glasses, hearing aids and false teeth usually belonging to patients unable to take responsibility for their own property. HH asked if these losses were due to theft or accident and EC explained that the cause was often accidental but where a theft component was considered, the security team and police would become involved. She confirmed that a checklist of belongings was taken on admission but advised that where there were items of significant value, during the pandemic, there were no visitors allowed so items could not be returned home.

3.3 IR commented on how this valuable story highlighted the importance of recognising the impact of first, second and third degree contacts whilst focusing on clinical care.

3.4 HT asked EC how she dealt with these kind of issues on a personal level and she explained that because she cared, she could empathise with this and other families to ensure they were heard and listened to. She reported that the family were now at the point of recognising that no-one had intended this mistake to occur.

3.5 AD thanked EC and SR for a very powerful but sad story.

4 Minutes of the Trust Board Meeting in Public held on 8 September 2022

4.1 The minutes of the Trust Board Meeting in Public held on 8 September 2022 were reviewed and **approved** by the Board.

5 Matters Arising

5.1 The due actions on the log were reviewed as follows.

Action 4 – Board seminar review of patient risks (maternity focus)
IR advised that this would be dealt with through the Maternity Assurance Group, feeding through to Board. Closed.

Action 10 – Scrutiny of the BAF by board sub-committees
A broader discussion on next steps would take place in Part 2 of the meeting. Closed.

Action 17 – Circulation of the Victim's Charter
In response to a question, KJ reported that the Charter was local to the Trust and in the process of being completed. Open

Action 18 – Supply of quarterly violence and aggression figures
KJ advised this would be provided in the next Board report. Closed

Action 19 – Opportunities for patients to discuss their experiences of violent events
KJ advised that it had proved difficult to find people willing to share their experiences. Closed

Action 20 – Research and development for health inequalities
AD reported that a research and innovation hub within the Bedford, Luton and Milton Keynes Integrated Care System (BLMK ICS) was being developed with the aim of supporting ongoing work within the system. Closed

Action 21 – Forward agenda planner and the Green Agenda
The Green Agenda would be discussed at Board in January. Closed

There were no other matters arising.

6 Chair's Report

6.1 The submitted report was taken as read. There was one correction in relation to paragraph 8 where the Board Development Session would take place in the New Year, not in December as stated.

The Board **noted** the Chair's Report.

7 Chief Executive's Report – Overview of Activity and Developments

7.1 IR reported that the hospital was extremely busy, on Operational Pressures Escalation Level (OPEL) 4, though not caused by Covid. Other hospitals were experiencing similar pressures. There were 55 escalation beds open, including Day Surgery, with many outlying patients and there were concerns over the organisation's ability to meet the target at the end of the year of treating patients waiting more than 78 weeks. BM asked if the target was expected to be met and JB explained that the Trust was likely to get quite close to the target, but it could not be sustained nationally and he anticipated that the position would ultimately get much worse in view of the resulting bow wave. Compared to peers, the hospital was doing well but were in the bottom percentile for elective care.

7.2 Across England there had been more than 1000 patients waiting 12 hours or more for emergency treatment but there was a low tolerance of this here with a lot of work undertaken to move patients before the 12 hour deadline.

7.3 HH asked how long the Trust was expected to remain at OPEL 4 and IR advised it was likely to be a few months. EL explained that discharges and hospital avoidance were constrained by staffing challenges elsewhere, impacting on the Trust's performance.

7.4 IR highlighted the challenging winter ahead with cost of living concerns and the threat of industrial action, impacting on the organisation's ability to undertake discretionary work and non-emergency activity. A national table-top exercise would be taking place to test contingencies for industrial action.

7.5 IR informed the Board that a patient with complicated medical issues who was in custody, sectioned under the Mental Health Act, recently died awaiting transfer to a tertiary site. This was reported to the CQC and others and an investigation was underway.

7.6 To date 38% of staff had been vaccinated for flu and Covid as part of the Protect and Reflect Programme. The target was between 70 and 90% which the organisation was on course to meet.

7.7 The Maple Centre opened officially on Monday 31 October with Ward 1 (Medical Admissions Unit) moving to the first floor and Ambulatory Care (medical and surgical) on the ground floor. Services were adapting well and there were no adverse concerns over the new building which provided a great environment, valued and appreciated by patients. In response to a question from GM, IR explained that the Centre would not immediately alleviate the pressures in emergency care as the vacated area would be used to house other wards during refurbishment. He reminded the Board of the investment in staff to enhance the ambulatory care service and further enhancement and investment was anticipated.

7.8 The business case to build the new radiotherapy centre was due to be signed off later that day.

7.9 The Trust had recently hosted a visit from colleagues at Maidstone and Tunbridge Wells Hospital to demonstrate the Trust's digital journey. They were impressed by what had been achieved.

7.10 The Patient Safety team at Milton Keynes University Hospital (MKUH) was Highly Commended for Patient Safety Pilot Project of the Year at the HSJ (Health Service Journal) Patient Safety Awards 2022. The MKUH SAFE (Support and Action Following Events) pilot project was a new approach to responding to and reviewing incidents with a focus on supporting those involved and on highlighting learning opportunities.

7.11 KJ reported that Black History Month had been recognised in October with some great work by the BAME network, challenging the executive team around inclusion and the further work they must do.

7.12 KJ advised that the recently published Kirkup Report into maternity and neonatal services in East Kent would be circulated to the Board and followed up through the Maternity Assurance Group. KJ would also circulate the cost of living winter plan issued by Milton Keynes Council.

The Board **noted** the Chief Executive's update.

8 Feedback from Maternity Assurance Group

8.1 IR advised that the minutes submitted were not the latest set and that there had been a lot of work taking place particularly in relation to the Kirkup Report which, he commented, had made very depressing reading containing elements reminiscent of the Francis Report. There were four broad themes for recommendations from the report:

- National work in the way that maternity care is monitored;
- Non-technical skills around communication and giving care with compassion and kindness;
- Teamworking with a common purpose;
- Organisational behaviour: responding to challenge with honesty. IR highlighted the dangers of extreme positivity and not recognising the reality.

8.2 HT enquired which of the four areas were most relevant to MKUH and IR said that communication and teamwork were two areas that the Trust had been working very hard at but that there was no room for complacency. He reminded the Board of the engagement sessions earlier in the year held by the Executive Team with maternity teams and also of the postgraduate trainee issues in obstetrics some years ago. KJ described an area of particular interest around how the organisation communicated and engaged with families, being demonstrably open and honest. The Trust was one of a small number leading on this work in collaboration with various external groups associated, for example, with bereavement and in particular bereavement through healthcare harm. The work related to improving the complaints process and the way in which the organisation engaged with people through serious incidents, media statements and complaint responses.

8.3 In response to a question from BM, IR agreed to share the key messages for non-executives from the report with them. AD advised that she had attended her first Maternity Voice Partnership meeting and had learned of a non-executive forum which she anticipated would prove useful around sharing tips to gain assurance.

The Board **noted** the feedback from the Maternity Assurance Group.

9 Serious Incident and Learning Report

9.1 IR highlighted the key issues within the report around pressure injuries, deep tissue injuries and medication incidents. The patient safety specialists had undertaken a focused piece of work with the Ward 1 team to develop understanding of the issues around pressure injuries, looking through a different lens from the traditional root cause analysis reports. There was a clear focus within the report on Wards 23 and 25 in terms of medication incidents and deep tissue injuries. IR explained that the majority of wards had 28 beds or less whereas Wards 23 and 25 had 40 beds so it was not unreasonable to expect a greater number of incidents. He added that it was important to note the effect of case mix issues in

relation to where serious incidents might occur adding that Ward 23 was a non-elective surgical ward with many patients coming in with fractured neck of femur requiring more complex care. YC expanded on the detailed quality improvement (QI) programme for Ward 23 in relation to deep tissue injuries and advised that the tissue viability service was based there delivering direct hands on training to clinical staff at the point where issues were identified. Medstrom (bed contractors) also had a strong presence on the ward reinforcing good management of beds. The environment had been decluttered and there was now a strong clinical leadership with a strengthened cohort of Band 6 nurses. She explained that the layout of the ward was challenging. Whilst the ward was maintaining a good record for completing risk assessments such as Waterlow, staff required additional support in ensuring the completion of nutritional assessments, good nutrition being an important component for recovery from fractured neck of femur. The quality improvement programme was part of a trust wide programme and having undertaken a cleansing exercise the wards were now receiving trust wide data on levels of pressure damage. There was also a cultural and leadership programme with Band 7s to assist in maintaining oversight. YC emphasised the importance of these activities in improving the quality of care on the ward.

9.2 Given the high operational pressures and the waiting list backlog, GM asked if more serious incidents were anticipated. IR responded that there had been more serious incidents over the course of the year and it had always been known that Ward 23 was a challenging environment due to its layout and the different surgical specialties treated there.

9.3 HH pointed out that pressure damage and medication errors kept occurring and queried whether staff were provided with all the necessary tools to help avoid these. IR responded that PSIRF, the new national patient safety framework for dealing with incidents, involved patients and staff discussions from the beginning to develop different insights into the causes of these incidents. The aim was to have a trustwide action plan for tissue damage, falls and medication incidents. He advised that commissioners felt the Trust was over-reporting pressure damage when compared to peers and this would be reviewed. YC believed that over-reporting of pressure damage was being caused by inaccurate identification and the tissue viability team were actively working with teams to provide validation and on the spot training. The role of the ward leader was being reviewed to ensure they had oversight on timely assessments and interventions. In addition, tissue viability training for healthcare assistants was planned. The QI programme provided ward teams with dedicated actions to purposefully reduce the numbers which was not something that had been tried before and clinical teams were very engaged with this. In terms of the tools used, YC advised that teams were very familiar with assessment tools such as Waterlow and she did not feel it was the right time to introduce something new. Regarding medication incidents, the move to electronic prescribing meant that errors were more visible than before. Pharmacy staffing had also been a challenge but this was beginning to improve.

9.4 BM asked how community services could link into the improvement plan where patients are admitted with pressure damage. YC advised that a new wound care chart was about to launch which would provide a means to record patients coming in with pressure damage, and feeding the information back to community was critical to the process. YC believed that although the issues were unlikely to be resolved quickly, she remained confident that positive progression and improvement would take place.

9.5 DA asked if other multidisciplinary team members were involved in the QI work and YC responded that this was the later part of the QI programme following requests from Band 6 staff on Ward 23 asking for more engagement from therapy staff.

9.6 There had been a maternal death from post puerperal sepsis after delivery which was of huge concern and was clearly devastating for the family. The death occurred in the community five days after natural birth. There were no obvious causes and the incident had been referred to the Healthcare Safety Investigation Branch (HSIB). The outcome would be reported in due course.

9.7 IR highlighted the letter to the Coroner in response to the Regulation 28 report to prevent future deaths received in May 2022. KJ explained that the Coroner had raised concerns over the disclosure of notes which were not paginated or indexed. She explained that it was not possible to print notes in the traditional way through eCARE, the Trust's electronic patient record system. However, following various meetings with the Coroner, the issue had been resolved to his satisfaction.

The Board **noted** the Serious Incident and Learning Report.

10 Complaints and Patient Advice and Liaison Service (PALS) Annual Report

10.1 KJ would look to ensure this and other annual reports were shared with the Board earlier in the year in future.

10.2 KJ reported that the number of complaints had increased each quarter with a total of 1044 for 2021/22. It was not possible to compare the data with the previous year due to the trust wide system change from Datix to Radar. BM asked whether any analysis had been done to see if the lack of access to family during the pandemic was linked to the high number of complaints. KJ advised that a lookback exercise was planned for all aspects of the pandemic.

10.3 There had been 11 cases referred to the Ombudsman and the ambition was to reduce this number to zero going forward. Improvement was also being sought in complaint response times. KJ highlighted that four of the top five complaint themes related to communication and SR was undertaking some interesting work with wards to address this. An appointments helpline for patients was being considered. HH asked whether internal communications were delaying responses and KJ advised that the PALS office were working with SR to see if some of the layers of interactions between PALS and staff members could be removed.

10.4 GM asked whether there was better reporting of complaints or whether the Trust's ability to deal with them was deteriorating. KJ advised that having just taken over leadership for this area she was not able to provide a clear answer at this time.

10.5 It was agreed that going forward all reports would be accompanied by a front sheet.

The Board **noted** the Complaints and PALS Annual Report.

11 Complaints and Patient Advice and Liaison Service (PALS) Quarterly Report

11.1 The report related to the first quarter (April-June) and replicated the annual report. Acknowledging the innovative work within PALS, KJ advised that the team would be focusing on the statutory service going forward, understanding the core business and addressing the thematic issues. At DA's request, KJ agreed that the next report would include data on the timing of complaints.

11.2 The Board **noted** the Complaints and PALS Quarterly Report.

12 Patient and Family Experience Quarterly Report

12.1 KJ explained how the Patient and Family Experience Team differed from the Complaints and PALS Team and the report summarised how the team had been using appreciative inquiry and the impact of the new patient experience platform purchased last year in providing a rich source of data which could be used to drive change. KJ also highlighted the Trust's achievement in being awarded the Silver Award in the Ministry of Defence Employer Recognition Scheme in relation to veterans' access to care and she agreed to bring back the data on how the organisation meets the Veterans Covenant Healthcare Alliance. KJ advised that she would be considering how to provide data from the various patient surveys commissioned by the CQC into, for example, maternity, paediatric and cancer services, given the length of time these take to come to Board.

12.2 HH noted the top 5 best performing units of critical care, neonatology, endoscopy, physiotherapy and respiratory medicine and queried whether the learning from these was being shared throughout the organisation. KJ recognised that this was an area for improvement and she planned to bring back a patient story focusing on work undertaken as a result of feedback that could be replicated in other areas. She agreed to establish whether the comments were negative or positive for those services highlighted as having the most number of comments.

The Board **noted** the Patient and Family Experience Quarterly Report.

13 Accountability and Support for Theatre Productivity

13.1 EL explained that a national letter had been sent to her and IR regarding Getting It Right First Time (GIRFT - a national programme designed to improve the treatment and care of patients through an in-depth review of services) which had been running for a number of years. A key element of focus had been identified as theatre productivity, the data for which had been hampered by quality issues and the fact that Theatres was one of the last areas to come online with eCARE (the Trust's electronic patient record system). An improvement programme was being worked through and the letter's co-author, Professor Tim Briggs, National Director of Clinical Improvement and Chair of the GIRFT Programme would be coming to the hospital on 9 December 2022. EL advised that the multi-faceted challenges within Theatres would be discussed at Board after the visit.

13.2 HH asked what the Trust's capped theatre utilisation rate was and EL advised that the data structure was not yet set up to meet the requirements of the national dataset and a definitive answer was therefore not available. However, she advised that she regularly reported on cancellations caused by a multitude of reasons. GM asked what level of priority this issue was being given and EL advised that it was high on her priority list in terms of backlog of patients, but until the figures could be reported accurately it was not possible to monitor effectively.

13.3 In response to a question from HH regarding published day surgery rates that had suggested the Trust was not performing well, IR advised that he suspected this was because of the issues around data quality but that he would need to investigate further. He further advised that there were some very deep rooted structural issues within the system that needed resolving. The information on how theatres were being utilised was poor and he stated that the eCARE system was not the issue as the data had been poor before it was implemented. JB advised that the Trust was learning from other organisations how to resolve the issues which he anticipated would take a few weeks.

The Board **noted** the discussion on Accountability and Support for Theatre Productivity.

14 Performance Report for Month 6

14.1 EL reiterated that there were 55 escalation beds open including one ward that had remained open throughout the summer. The increased activity in September was anticipated as people came back from leave and despite all the challenges, compared to 2019/20, upward turns were reported in the Emergency Department, ambulance handovers, outpatients, elective recovery, bed occupancy and staff turnover. There had been a lot of communication from the centre in recent weeks around escalation plans and these continued to be revisited in the Emergency Department to maintain ambulance handover performance. EL confirmed that the Head of Operations at South Central Ambulance Service (SCAS) reported handover delays for Milton Keynes were very short compared to other areas with the longest wait reported as 2 hours. Whilst this was not an ideal length of time, regrettably, across the country, some patients were waiting in ambulances up to 12 hours. An opportunity to reassess some areas in the Emergency Department had arisen as a consequence of the emergency surgical clinic moving to the newly opened Maple Centre.

14.2 Regarding virtual clinics, the Trust was performing poorly at 13.6% against a target of 25%. Pathways at other hospitals were being reviewed to see how this could be improved.

14.3 It was becoming increasingly difficult to sustain urgent and cancer pathways, often maintained at the expense of routine elective work and the number of patients waiting 52 weeks had doubled, adding to the anticipated bow wave referred to under Item 7.1.

14.4 The upward trajectory for Imaging was noted despite two MRI machines breaking down in month.

14.5 IR highlighted the never event that occurred in August, reported in September, where a patient incorrectly had an endoscopy. This related to the OrderComms workflow in eCARE and IR advised there was much learning to take from the incident.

14.6 HT noted the importance of focusing on moving 'non-criteria to reside' patients into the community while there were so many escalation beds open and EL advised that there were currently 61 such inpatients, adding that partner agencies were working hard to gain traction with this.

14.7 GM asked for more context around trends in the report and for more comparative data with peers on metrics other than those related to the Emergency Department.

Action: EL and JB to provide context in trend reporting and to include more comparative data with peers

Action: KMB to schedule a meeting before the end of the year for the Non-Executive Directors with the Associate Director of Performance and Information, Hitesh Patel, to participate in the codesign of the metrics.

The Board **noted** the Performance Report

15 Update on Quality Priorities for 2022-23

15.1 KJ reminded the Board that the priorities were set as part of the Quality Account and this year they related to a reduction in deep tissue injuries, recruitment in elective care to reduce long wait times and a reduction in discharge delays.

16 Finance Report

16.1 TW presented the half year performance with the Trust was reporting a deficit of £4.1m, marginally behind plan however, breakeven continued to be forecast for the end of the year. Pressures included the national pay settlement and potential industrial action together with enhanced bank rates in mitigation of staff sickness and vacancies, and pay to tackle the elective backlog, funding for which would be received to a reasonable extent through the Elective Recovery Funding (ERF) scheme. This would continue to be closely monitored in view of the downstream interventions such as the international recruitment programme.

16.2 Non-Pay was broadly on budget but there was turbulence in respect of inflationary pressures relating to contracts and consumables. Generally, for the first half of the year, the cost burden that had been feared from inflation had not been realised due to protection from contracts signed prior to the peaks currently being seen. However, TW anticipated medium to high levels of turbulence between now and the end of the year.

15.3 NHSE had taken the sensible and pragmatic decision to underwrite the amount in the plan for elective recovery. Looking through a local lens, the Trust was typically amongst the top three performing trusts for ERF and NHSE's approach would not reward the Trust. NHSE was being lobbied to see what could be done flexibly to address this given the amount in the original plan to enhance capacity and outsource activity to maximise the throughput of activity. TW advised resources for this activity could be sustained for this financial year but would need to be discussed at a later date to see what the affordability trade off would become if the policy continued.

15.4 An additional £4.1m funding was received for the national pay award and TW warned that this could result in a residual pressure dependent upon the experience of recruits during the period. He explained that the award was based on the lower range of the various bands.

15.5 Good forecast discussions had been held across the organisation and would be discussed at Finance & Investment Committee before coming to Board. TW explained that one of the main focuses this year would be the runrate for the organisation going into 2023-24 in view of national and macroeconomic challenges. GM highlighted the importance of this work given an expected reduction in the cash balance of around £20m.

15.6 TW reported that there had been some slippage around the timeliness of invoice payments by the outsourced supplier, SBS, but good conversations were being held to resolve the issues.

15.7 Around £6m had been spent on capital schemes at the midway point of the year with an allocation of £17m and the pace would be picking up in the second half of the year. Similar to the forecasting discussions, there was a piece of work around capital spending plans working closely with local scheme leads. Preparatory work with the new auditors ahead of year end was underway to familiarise them with the Trust's finances.

The Board **noted** the Finance Report

16 Workforce Report

16.1 DP highlighted the following from the report.

- The vacancy rate was over 10% and retention rates remained high. Interventions included changing the exit interview process, meeting with teams and departments and holding listening events, as part of the staff survey work addressing specific concerns. A common reason for people to leave were promotion and work/life balance.
- Many staff in Bands 2 and 3 were expected to leave the organisation temporarily for better paid seasonal work, returning to the Trust after Christmas. DP advised this was a more appealing option than ever this year.
- The MK Job Show was busier than ever with lots of interest from physiotherapists, pharmacists and qualified nurses.
- The HR team were very busy with around 400 job offers made.
- Compliance with statutory mandatory training remained above target levels despite the introduction of two new modules: Freedom To Speak Up and Conflict Resolution.
- Another international recruitment campaign was being planned to recruit a further 100 nurses/midwives in addition to the 125 already recruited. In response to a question from BM, DP reported that the international nurses/midwives tended to stay longer than domestic recruits and the Trust worked hard to build that community, undertaking a lot of pastoral work with them. The next challenge for the Trust would be career progression for these individuals.
- A 'Flexi-Pool' was being developed via a Work Any Hours campaign to encourage nurses and healthcare workers to select additional ad hoc shifts if they wished. Ultimately, it was envisaged that they would be able to select their preferred area for these shifts and that the campaign would be extended to the rest of the workforce.
- The Protect and Reflect event had been running for over 4 weeks and had been fully booked until this week when pop-up clinics would be held across the wards, in Oak House and Witan Gate.
- The Equality, Diversity and Inclusion (EDI) Lead would be attending Board to present the annual report. In response to a question from JS, DP advised that the EDI Lead invested heavily in meeting different faith and community groups. The education team were also very active in going into schools and colleges and developing an excellent work experience programme. The talent management strategy was particularly focused on groups with protected characteristics.

The Board **noted** the Workforce Report.

17 Freedom to Speak Up Guardian Report

17.1 DP highlighted the following from the report.

- Three levels of mandatory training had been introduced.
- There were fewer issues raised by staff here than at other trusts suggesting that further work was required to raise the profile. There were other means for staff to raise concerns such as through the Peer 2 Peer scheme.
- The national Freedom To Speak Up Guardian had attended the Event in the Tent.
- An internal audit had highlighted the need to double-check figures before reporting and had recommended that the report was presented to Board twice a year. The policy had also been reviewed.

DP confirmed that staff could report anonymously if they wished and a pilot for a new app would be trialled next year. She further advised that the deputy network chairs had been asked to consider

becoming champions to provide a diverse range of people that everyone could relate to and to boost numbers to enhance accessibility.

The Board **noted** the Freedom to Speak Up Guardian Report

18 Significant Risk Register

18.1 KJ explained that the Board Assurance Framework was under development and would be discussed in Part 2.

18.2 BM noted the duplication of new risks 382 and 388 regarding the MRI emergency exit which KJ would discuss with the Risk Manager and KMB. KJ advised that there was a contingency around the risk which would be discussed at the next Executive Directors meeting. She would also seek clarity regarding Risk 001 on whether this was a new or newly escalated risk. GM requested improvements to the front sheet of the report to include an overview of the Trust's risk position and appetite and KJ to consider this with KMB and the Risk Manager. It was acknowledged that the indicator symbols within the report had not printed correctly.

Action: KJ, KMB and Risk Manager to review the front sheet of the report

The Board **noted** the significant risk register

19.1 Summary Report for the Audit Committee – 18 July 2022

The Board **noted** the report.

19.2 Summary Report for the Finance and Investment Committee Meeting – 6 September 2022

The Board **noted** the report.

19.3 Summary Report for the Quality and Clinical Risk Committee – 20 September 2022

The Board **noted** the report.

19.4 Summary Report for the Charitable Funds Committee – 15 September 2022

The Board **noted** the report.

19.5 Summary Report Trust Executive Committee Meeting – 14 September 2022

The Board **noted** the report.

20 Terms of Reference for Board Sub-Committees

20.1 The Board **approved** the Board Sub-Committee Terms of Reference for:

- Finance & Investment Committee
- Quality & Clinical Risk Committee
- Remuneration Committee
- Workforce & Development Assurance Committee.

The Audit Committee Terms of Reference were approved subject to a discussion by IR with JH regarding clinical or medical representation on that Committee.

20 Forward Agenda Planner

Board **noted** the Forward Agenda Planner.

21 Questions from Members of the Public

21.1 There were no questions from the public.

22 Any Other Business

22.1 There was no other business.

23 The meeting closed at 12:40

Updated 09/11/2022

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

Trust Board Action Log

Action No.	Date added to log	Agenda Item No.	Subject	Action	Owner	Completion Date	Update	Status Open/ Closed
12	07-Jul-22	16.4	Performance Report	Executive Directors to review the content of the report to provide more accessible data	Executive Directors	12-Jan-23	08/09/22 - The revised report would be tested at February 2023 Board Seminar before use at the next Board meeting in public.	Completed
17	08-Sep-22	13.1	Violence and Aggression Programme Update	KJ to circulate the Victim's Charter	KJ	12-Jan-23	Completed	Completed
22	03-Nov-22	14.7	Performance Report	EL and JB to provide context in trend reporting and to include comparative data with peers against the metrics	EL/JB	12-Jan-23	Verbal Update	Open
23	03-Nov-22	14.7	Performance Report	KMB to schedule a meeting before the end of the year for the NEDs to meet with Lee Poulastides (Head of Informatics) to participate in the codesign of the metrics	KMB	31-Dec-22	This was completed after the December 2022 Board meeting	Completed
24	03-Nov-22	18	Significant Risk Register	KJ, KMB and Paul Ewers to review the front sheet of the report to include an overview of the Trust's risk position and appetite	KJ/KMB/PE	12-Jan-23	Verbal Update. To be progressed after the Trust's Risk Appetite Statement has been reviewed.	Open

Meeting Title	**Trust Board**	**Date: 12 January 2023**
Report Title	**Chair's Report**	**Agenda Item Number: 6**
Lead Director	**Alison Davis, Chair**	
Report Author	**Alison Davis, Chair**	

Introduction	**Standing Agenda Item**		
Key Messages to Note	An update for the Board on activity and points of interest including • New Non- Executive and Associate Directors • 'Moonshot' initiative by MK Community Foundation • Reflections on patient experience and end of life care		
Recommendation *(Tick the relevant box(es))*	**For Information** [x]	**For Approval** [ ]	**For Review** [ ]

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	N/A

Report History	N/A
Next Steps	N/A
Appendices/Attachments	Report

Chair's report: January 2023

To provide details of activities, other than routine committee attendance, and matters to note to the Trust Board:

Happy New Year to everyone.

1. We were fortunate once again to have a great deal of interest in our vacant Non-Executive (NED) and Associate posts. From 37 applications we identified a shortlist of 8 and interviewed shortly before Christmas.
   Mark Versallion has been appointed by the Council of Governors (CoG) as a new Non-Executive; Mark's career includes roles as a Commercial Director, Marketing Strategist and Councillor. He also has previous experience as a Non-Executive at Bedfordshire Hospitals NHS Foundation Trust and North West London NHS Hospitals Trust .
   In addition, the CoG has appointed Devdeep Ahuja as a substantive NED, from his previous role as an Associate.
   We welcome Precious Zumbika- Lwanga and Ganesh Baliah as new Associate Non-Executive Directors (ANED)

2. In November there was a visit from an Armed Forces Covenant representative to discuss progress with the project at MKUH. Both Joe Harrison and I attended with Sharon Robertson and Johanna Hrycak (Armed Forces Covenant Support Officer). We received some very positive feedback, especially in regard to the plans to develop veteran support.

   I also attended the Armed Forces Day at MK Dons on the 12th November, part of the Remembrance weekend.

3. The MK Community Foundation launched an ambitious initiative called OneGen Moonshot, on the 24th November with the aim of tackling and reducing childhood poverty. The first meeting brought representatives from organisations across Milton Keynes to hear about the strategy and start to discuss how to make the ambition a reality. Further information is available at https://mkcpp.org.uk/one-gen

4. Also in November, a session called ''Dying to be Heard' was held at the Academic Centre. Lesley Goodman, Experience of Care Lead at NHS England and Jacqui Smith, whose husband died in 2018 at MKUH, both gave presentations reflecting on patient experience and end of life care. Their views and experiences created a lot of discussion amongst those present, especially in terms of how to improve care provided to patients and families at end of life.

5. On the 14th December, despite the cold, the 'ground breaking' ceremony took place for the new radiotherapy centre. We are excited and looking forward to the

completion of the new facility in about 18 months' time, which will provide a significantly better patient experience for those needing the services

6. And lastly I am pleased to report the successful appointment of three more consultants in anaesthetics, urology and trauma and orthopaedics.

Milton Keynes Hospital NHS
NHS Foundation Trust

Meeting title	Trust Board (public)	12 January 2023
Report title:	Incident/serious incident (SI) report	Agenda item: 8
Lead director **Report author** **Sponsor(s)**	Tina Worth	Head of Risk & Clinical Governance
FoI status:	Public document	

Report summary	This report provides a monthly overview of Risk Management processes/systems in relation to serious incidents in the Trust.			
Purpose *(tick one box only)*	**Information** ☐	**Approval** [x]	**To note** ☐	**Decision** ☐
Recommendation	The Board is asked to note the contents of the 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 key risk identified on the BAF
Resource implications	Breaches in respect of SI submission can incur a £1000 penalty fine Breaches in respect of the Duty of Candour have potential for penalty fine of £2,500 if taken forward from a legislative.
Legal implications including equality and diversity assessment	Contractual and regulatory reporting requirements.

Report history	Serious Incident Review Group

	Quality and Clinical Risk Committee, December 2022
Next steps	Monthly incident/SI overarching issues reporting
Appendices	Trends in graphical format

Serious Incident Report November and December 2022

There were 6 new SIs reported on STEIS in November & December 2022. See table below.

STEIS number	Category	Location	Details
2022/23649	Patient fall	Ward 23	Fall resulting in a fractured neck of femur
2022/23651	Death of a patient under a Section of the Mental Health Act	Intensive Care Unit (ICU)	Death of a patient detained under Section 2 of the Mental Health Act.
2022/25218	Suboptimal care deteriorating patient	Emergency Department (ED)	Patient was transferred from ED to ward. Protocol on NEWS review to form basis of investigation.
2022/25219	Hospital acquired venous thromboembolism (VTE)	Medicine	Admitted following fall. Treated for urinary tract (UTI) also. VTE assessment compete two hours after clerking. Correct. Had Dalteparin 5000units throughout admission. Extensive deep vein thrombosis (DVT) diagnosed 5th Aug
2022/26284	Patient fall	Ward 8	Fall with resultant rib fractures.
2022/26875	Child death	Emergency Department (ED)	Involved in road traffic accident (RTA). Since downgraded with ongoing communications with South Central Ambulance Service (SCAS) regarding transfer to trauma centre

Trends/concerns

- Continued low reporting rate for incidents, possibly linked to system issues, site pressures, staff apathy, reporting culture and quality of feedback to reporters on the learning and actions taken
- Continued prevalence of pressure ulcers both community and hospital (only those where there was significant patient harm now reported as SIs, with other reviews and learning feeding into the Harm Improvement Group (HIG)
- Impact of Emergency Department (ED) pressures on timeliness of treatment/care
- Communications on required care linked to patient transfers
- Increased number of falls with harm in December
- Management of complex patients with mental health needs in a busy ED (collaborative working with Chadwick Lodge)
- Medication incidents relating to insulins and management of diabetic ketoacidosis (DKA) and staffs' familiarity on protocols and insulin type variances and effects on blood sugars

Learning Update

QI strategy

The Trust QI strategy and training strategy have been shared with TEC members. Building staff capacity and will within divisions is the main areas of strategic focus to embed a QI culture in our organisation.

2.1 QI Practitioner training commencing February 2023. This is a QI practitioner course of 4-5 separate modules to support clinical and non-clinical colleagues design and implement more efficient patient centred services.

Each division should have a cohort of trained QI Practitioners to support teams within their specialty areas to build capacity and capability. Staff attending QI training will be required to identify and undertake a QI project. Details of training dates can be found in appendix 1. Staff wishing to attend should contact the QI Team.

QI coaching sessions will be available later in the year following on from QI Practitioner level course.

Recommendation : Divisions to share QI training information with staff and support applications for training attendance. Divisional leads to ensure there are adequate staff trained in QI methodologies.

2.2 QI hub

QI team drop in sessions continue each month where QI conversations, sharing of ideas and concerns are discussed.

***2.3 Appreciative Inquiry* (AI)**

Staff engagement learning from every day experience (LIFE) sessions will begin in the Trust in January /February 2023 where patient/staff stories will be shared with staff. Any staff working in the Trust will be invited to attend.

Proposal to be submitted for continuation of action learning sets with the Wee Culture to support on going embedding of AI in the organisation.

Meeting Title	**Trust Board**	**Date: March 2022**
Report Title	**Maternity Assurance Group**	**Agenda Item: 9**
Lead Director	**Name: Yvonne Christley**	**Title: Chief Nurse**
Report Author	**Name: Melissa Davis**	**Title: Head of Midwifery, Gynaecology & Paediatrics**

Key Highlights/ Summary	Maternity Assurance Group is a monthly meeting, implemented to enable a forum where the Board level Maternity & Neonatal Safety Champions, alongside the Non-Exec Director, can review the detail of maternity & neonatal assurance information. This forum supports the review of standard agenda items including: • CNST (Clinical Negligence Scheme for Trusts) • Ockenden • Perinatal Quality Surveillance Model – Maternity & Neonatal Safety Data In November the Maternity Assurance Group discussed and reviewed: • Perinatal Quality Surveillance Dashboard • CNST compliance • Ockenden compliance • Challenge with connectivity in the community • Maternity Voices Partnership updated co-production plan • Perinatal Mortality Review Tool Quarterly Report • Stillbirth Thematic Review • BSOTS triage implementation & progress • Thematic incidents action log to capture quality improvement projects			
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Noting** √	**For Review** √

Strategic Objectives Links	**Patient Safety, Clinical Effectiveness, Patient Experience**
Board Assurance Framework (BAF)/ Risk Register Links	

Report History	**Monthly Maternity Assurance Group**
Next Steps	**Monitor through divisional governance processes**

Maternity Assurance Group (MAG)

Meeting Date:	24th November 2022	**Meeting Time:**	08:00 – 09:00
Location:	Microsoft Teams		

Present:	**Name**	**Job title**	**Initials**
	Alison Davis (Chair) Dr Ian Reckless	Chairman and Non-Executive Director Medical Director and Maternity Safety Champion	AD IR

In attendance:	Melissa Davis, Head of Midwifery, Paediatric and Gynaecological Nursing (MD) Katy Philpott, Associate Director of Operations, Women's and Children's (KP) Katie Selby, Maternity Governance and Quality Lead (KS) Dr Vicky Alner, Divisional Director, Women's and Children's (VA) Emma Mitchener, Deputy Head of Maternity (EM) Yvonne Christley, Chief Nurse (YC) Paula Robinson, Head of Imaging Services (PR)
Apologies:	Kate Jarman, Director of Corporate Affairs (KJ) Miss Nandini Gupta, Clinical Director Obstetrics and Gynaecology (NG)
Minute Taker:	Nicky Peddle – EA to Medical Director

Item	**Minute**	**Action**
1.	**Welcome and Introductions**	
	Apologies received from Kate Jarman and Nandini Gupta	
2.	**Declarations of interest**	
	None declared.	
3.	**Minutes of the last meeting**	
	The minutes of the meeting held on 20th October were accepted as an accurate record.	
4.	**Action log and matters arising**	
	Action 4 MD advised that a dual Patient Safety team/Maternity role is being discussed. Funding not clear at present. Update due March 2023. **Action 10** MD/IR reported significant issues remain with connectivity in the community. Midwives are still updating eCARE retrospectively, potential risk as notes are not always available to review in real time. CDC's also affected. It was noted that access to the Primary Care IT network would be useful.	

	Meeting arranged with Craig York to obtain a full understanding of the situation, discuss issues with mobile provider, and potential mitigations. Update will be provided at MAG in January 2023. **Action 12** MAG requested a paper be presented in January detailing assurances on capacity/ demand working across ultrasonograpers and scanning midwives, quality appropriateness and timelines of scans etc. Specific questions should be emailed to PR ****Action** KP/PR/KS** **Action 14** Business case currently being written. Action carried forward to January. **Action 15** VA meeting with SAS doctor and will update MAG in December. Action closing.	
	Standing items	
5.	**Perinatal Quality Surveillance Model**	
	MD provided a verbal overview as per the PDF circulated prior to the meeting. There were no further comments.	
6.	**CNST**	
	In addition to the information circulated prior to this meeting, the following additional comments were highlighted and discussed: ○ Safety action 2 – MSDS: full assurance awaited. ○ Safety action 5 - Labour Ward Co-Ordinator Supernumerary Status: definition of supernumerary has been updated and we are now confident compliance will be achieved. ○ Safety action 6 - CO Monitoring at 36/40 & Steroid Administration: we will not be compliant with the steroid element and possibly CO monitoring. Regionally, very few Trusts' will achieve compliance. KS advised that antenatal forms are being revised to include mandatory fields for CO monitoring at booking and 36 weeks, which will have a positive impact.	
7.	**Ockenden**	
	MD provided a verbal overview as per the PDF circulated prior to the meeting. There were no further comments.	
	Additional discussion relating to Governance report: • Top 3 risks – Maternity (slide 11) IF there is no dedicated Obstetric Theatres and Theatre Team Maternity do not have a guaranteed emergency theatre available 24hrs a day: it was noted that guidelines and recommendations are not clear. MAG requested SOPs on how a second theatre is accessed when required to demonstrate that we have understood the risk and mitigations are in place. ****Action** paper required for January meeting.** • Women's Internal Open Investigations / improvement plans with no end date – KS reassured MAG that a rolling live thematic action log is in place and is updated as soon as actions are closed. CCG outcome paper will be included in MAG papers to demonstrate closure of SI's.	

	• Audits - VA gave assurances that audits are presented at monthly Audit Meeting and learning is shared. • Guidelines – MD advised that significant improvements have been made regarding outstanding guidelines. Maternity and Gynae are now 95% compliant.	
	Assurance	
8.	**Stillbirth Thematic Review**	
	The report circulated prior to the meeting was taken as read. The following additional comments were highlighted and discussed: • KS reported that consideration is being given to creating a Deprivation Dashboard; 50% of women/service users who had stillbirths were residing in properties that had deprivation codes 1-4. 28.75% of the MKUH population reside in deprivation codes areas 1-4. This is reflected in the MBRRACE report. • MD advised that the data collated demonstrated that COC did not make any difference in relation to the actual outcomes. The LMNS is currently reviewing the evidence base around some of the aspects defined within the COC model. • Recommendation of Aspirin from 12 weeks for women who meet the criteria (page 63) - PGD for midwives has been progressed for midwives for aspirin.	
9.	**Co-Production Plan**	
	MD provided a verbal overview as per the PDF circulated prior to the meeting. The following additional comments were highlighted and discussed: • Please note change in Co-Chair from Rachael to Roxy and Temi. • Full Obstetric engagement is now in place; the Co-Production Plan was co-produced by the senior midwifery leadership team, Nandini Gupta, Erum Khan, and the MVP.	
10.	**BSOTS Triage**	
	EM provided a verbal overview as per the PDF circulated prior to the meeting. The following additional comments were highlighted and discussed: • ****Action** Short paper summarising feedback from midwives and doctors on the new BSOTS 24/7 system (good and bad) and triangulation with management of women and the improvements in terms of pathway/reduction of incidents - required for January meeting.**	
11.	**PMRT Report**	
	KS provided a verbal overview as per the PDF circulated prior to the meeting. The following additional comments were highlighted and discussed: • MAG agreed that it would be helpful if the thematic action log was included when submitting this report to Board.	
13.	**Any other business**	
	• YC expressed concerned regarding staffing and unavailability. MD confirmed that the staff survey and feedback from listening groups have identified aspects which are impacting on MSW experience, these will be mitigated by the Band 2 to 3 MSW project. Additionally, regional funding is supporting a member of the PDM team to work with MSWs around training and extended roles.	

	Annual leave is running as low as 5%, particularly in the midwife line and should be maintained around 16%. MD confirmed that measures are being put into place to ensure E-Rostering targets are being met. • It was agreed to invite PR to either Divisional Board or Women's CSU to provide a regular ultrasound / imaging performance update. VA to facilitate. • CNST submission due February. Papers to go to EDs and LMNS in December for sign off before being presented to MAG and Trust Board in January.	
14.	**Date and time of Next Meeting**	
	22nd December 2022 @ 08:00-09:00 via MS Teams	

ACTION LOG - MATERNITY ASSURANCE GROUP
Updated 24.11.2022

Action No.	Meeting Date	Title	Action	Owner	Due Date	Status	Comments/update/ current status
2	25.08.2022	CNST - Midwifery workforce	Further detail to be added to the breakdown supplied on page 56 of the pack, and birthrateplus 2022 report to be progressed through internal governance structure.	MD	Jan-23	Open	22.09.2022 - Clarify – BirthratePlus advocated a further uplift in establishment following May 2022 exercise. Business case for this to be progressed through usual Trust mechanisms. VA to report back to MAG on progress in January 2023.
4	25.08.2022	Ockenden - Maternity designated patient safety specialist	Escalate to Full Board for wider discussion.	LJ/IR	Mar-23	Open	22.09.2022 - IR and MD to further discuss. Update MAG in November. 24.11.2022 - A dual Patient Safety team/Maternity role is being discussed. Funding not clear at present.
5	25.08.2022	MCoC	Board to agree a 'trigger' for reimplementation associated with a given level of staffing / vacancy rate.	LJ/IR	Jan-23	Open	22.09.2022 - Sits with Workforce Committee - update via Danielle Petch in January 2023.
10	22.09.2022	Connectivity in the community	MAG seeks a better understanding of plans for improved IT connectivity in the community (the issue, the options for resolution / improvement, and anticipated timelines).	John Blakesley	Jan-23	Open	24.11.22 - there are still significant issues with connectivity in the community. Meeting arranged with Craig York to obtain a full understanding of the situation, discuss issues with mobile provider, and potential mitigations. Update will be provided at MAG in January 2023.
12	22.09.2022	Ultrasound Capacity	MAG notes high level concerns about ultrasound capacity (slide 31). MAG requires a detailed update on the position including capacity, demand, demand management, DNA, clinical risk and mitigation etc.	KP/PR/KS	Jan-23	Open	22.09.2022 - invite Paula Robinson to November MAG 24.11.2022 - MAG requested a paper detailing assurances on capacity/ demand working across ultrasonograpers and scanning midwives, quality appropriateness and timelines of scans etc.
14	20.10.2922	Birth Rate Plus 2022	Trust Board commitment to support the implementation of the BR+ 2022 funded establishment in March 2023. MAG requested that this goes through the Trusts BAU mechanism, i.e., the Division, CBIG, and TEC for a view to be taken.	VA/KP/MD	Jan-23	Open	24.11.2022 - Business case currently being written. Action carried forward to January.
15	20.10.2922	Training	An SAS Doctor remains unallocated for PROMPT as he works permanent nights following discussion with occupational health.	VA	Dec-22	Closing	Obtain an understanding of why occupational health advised a doctor work permanent nights and report to MAG. 24.11.2022 - VA meeting with SAS doctor and will update MAG in December.
16	24.11.2022	CNST compliance: Safety action 6 - CO Monitoring at 36/40 & Steroid Administration	Antenatal forms are being revised to include mandatory fields for CO monitoring at booking and 36 weeks. Progress to be reported to MAG.	KS/MD	Dec-22	Open	
17	24.11.2022	Maternity risk: Obstetric Theatres	MAG requested clear SOPs on how a second theatre is accessed when required. Paper to be presented at December meeting.	MD	Jan-23	Open	
18	24.11.2022	BSOTS	MAG requested a short paper summarising feedback from midwives and doctors on the new BSOTS 24/7 system (good and bad) and triangulation with management of women and the improvements in terms of pathway/reduction of incidents	EM	Jan-23	Open	

Annual Report April 2021 – March 2022 for Infection Prevention and Control (IPC)

Authors:

Angela Legate Associate Chief Nurse, IPC.

Graphics: Martin Parker Data Analyst, IPC

Contributors: Biomedical scientists - Microbiology

Purpose. The purpose of this annual report by the Infection Prevention and Control Team is to provide the Board with information on both trust performance and the provision of assurance that suitable processes are being employed to prevent and control infections.

Proposal It is proposed that the Annual Report is accepted by the Board as robust assurance of the Trust's performance in the financial year 2021-22 and that support is given to the areas of focus highlighted within the body of the report for financial year 2022-23.

Financial Implications Whilst it is widely accepted that healthcare associated infection carries both a human and financial cost there are no financial implications resulting from this paper.

Risk There was no material change to the risk at the time of writing.

Communication and Involvement This report is developed by the Infection Prevention and Control Team.

The board is provided with an update on the following:

1 Introduction/Executive summary

2 Performance against alert organisms
3 Infection Control Management (includes the role of the Director of Infection Prevention and Control (DIPC)

4 Cluster and Outbreak associated with Covid-19

5 Surgical Site Infection Surveillance (SSISS)

6 Water Safety and Ventilation

7 Policies/guidelines

8 A rolling programme of ambition

Conclusion

1.Introduction/Executive Summary

The Milton Keynes University Hospitals NHS Foundation Trust (MKUH) is a 550-bed hospital with over 4,000 staff caring for elective and emergency admissions from the local community.

This report details the work the Trust has undertaken this year to ensure discharge of statutory duties in meeting the standards are met, for the prevention and control of infection as detailed in the Hygiene Code which is used by the Care Quality Commission (CQC) to monitor compliance with legislation by the Health & Social Care Act 2008, (revised 2012). It describes the work of the infection prevention and control team (IPCT) and wider staff, both clinical and operational, to reduce the harm associated with infection.

To comply with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections, the IPCT assist the organisation in the development of an annual programme. In addition, on the 4th of May 2020 NHSE/I released a Board Assurance Framework (BAF) for the management of Covid-19 in NHS hospitals to complement the already established assurance and governance processes for Health Care Associated Infection.

Throughout the pandemic, efforts have been made to maintain the highest level of IPC excellence, reducing the risk of nosocomial (hospital associated) infections by making our hospital safer for patients, staff, and visitors.

To support the recovery and restoration of services, the Infection Prevention and Control Team (IPCT) work alongside all disciplines of staff to unpick the complex drivers of behaviours that influence compliance with preventative measures when challenged by a highly infectious agent.

The Trust continues the commitment to improve performance in infection prevention practice, as outlined in the Health and Social Care Act 2008, to deliver:

- continuous improvements of care
- it meets the need of the patient

The reporting year, whilst not completely dominated by the COVID-19 pandemic, still felt its effect across many services and the contribution of Infection Prevention and Control to the Trust response is woven throughout this report.

The year has seen some success and some challenges, and these are highlighted below.

- Ongoing response to the Covid-19 Pandemic. The IPCT have been instrumental in the successes of the local responses.
- 13 cases against a threshold of 10 for case of Closteroides (Clostridium) difficile. The Trust continues to have a low rate of C diff, despite the out turn exceeding our internal ambition.
- Continuous surveillance of caesarean section delivery (CSD)
- Single infection in knee replacement surgery
- Compliance with mandatory IPC education remaining over 90%
- A zero tolerance remains for MRSA – MKUH registered one case in the reporting year
- Nosocomial acquisition of Covid-19 was confirmed in some of our patients despite best practice with avoidance measures

2. Performance against alert organisms The Trust HCAI objectives for Clostridioides difficile infection (CDI), Meticillin Resistant Staphylococcus aureus (MRSA) and Gram-negative bloodstream infections (GNBSI) are determined nationally and usually received from NHSEI prior to the start of the financial year. This allows us to adjust our Trust wide response.
Due to the pandemic, publication of national objectives were suspended temporarily.

As part of our quality improvement commitment to patients, staff and stakeholders, we reviewed our performance for the period 2020-2021 and set internal quality improvement objectives based on our outturn. Once the national objectives were received from NHSEI we then applied these to run alongside our own internal quality improvement objectives.

The position regarding bacteraemia both Gram positive (S. aureus) and Gram negative remains challenging and will remain in focus for the 2022/23 work plan, in combination with the ongoing management of peaks predicted with Covid-19.

HCAI investigations Patients who develop a bloodstream infection in any of the mandatory reportable healthcare associated infection categories (MRSA, MSSA and Gram-Negative Blood Stream Infection, E coli, Klebsiella sp. or Pseudomonas aeruginosa) or develop Clostridiodies difficile infection will have a root cause analysis (RCA).

This is to determine if failure to follow protocol has resulted in harm, and if so, what happened, how we can improve and how, as an organisation, we can grow and learn. Meetings are managed as a multi-disciplinary collaborative process with input from relevant stakeholders including a Consultant Microbiologist and the patient where practicable.

Meticillin Resistant Staphylococcus aureus (MRSA) and Meticillin Sensitive Staphylococcus Aureus (MSSA) Bacteraemia. The term SAB (staph aureus bacteraemia) is used throughout the report by the IPCT into the incidence to date at the MKUH.

All of us, as healthcare workers play an important role in the prevention of bacterial infections and at the most basic level, simple hand hygiene and the adherence to clean/aseptic non touch techniques are vital in preventing and decreasing the prevalence of bloodstream infections.

Both MRSA and MSSA are considered as a serious cause of bloodstream infection associated with significant morbidity and mortality. Complications include deep-seated foci of infection including infective endocarditis, device-associated infection, osteoarticular metastases, pleuropulmonary involvement, and recurrent infection. A collaborative effort of early consultant microbiologist consultation and adherence to the antimicrobial stewardship program is destined to show improved outcomes and therapy optimisation.

Healthcare-associated, hospital-onset SAB refers to those acquired in the hospital, post 48 hours of admission, and may be associated with central-line associated bloodstream infections, ventilator-associated pneumonia, and surgical site infections. With the increasing use of intravascular catheters, haemodialysis lines and peripherally inserted central catheters, there has been a rising incidence of catheter-associated SAB. (catheter in this instance refers to intravenous lines, not urinary catheter).

Risk Factors for SAB include:

• Age	• Underlying medical conditions
• Previous colonisation	• Injection drug use
• Intravascular catheters	• prosthetic devices

Risk factors for SAB include age, underlying medical conditions, previous colonisation, injection drug use, wounds/skin disorders (psoriasis and eczema) the presence of intravascular catheters or prosthetic devices, all of which needs to be recognised when initially assessing patients, planning intervention (elective or emergency) and for that continuing risk assessment becoming integral to individual care.

We have experienced an increase in persons who inject drugs requiring admission for treatment of bloodstream infection caused by *Staphylococcus aureus*. What has not been evident is whether this is connected to transmission within the community, from person to person through high-risk injection drug use practices, such as sharing needles.

The administration of recreational drugs this way impacts on vein health and on numerous occasions, we have noted eCARE documentation detailing several punctures being performed in order to achieve successful peripheral cannulation.

These successive attempts can produce pain and may delay the start of diagnostic treatments or tests. Furthermore, repeated punctures can degrade vascular walls, further, complicating subsequent approaches, and reducing the quality of healthcare

These patients are also recognised ats being at greater risk of infective endocarditis (IE), a life-threatening infection that affects the endocardium, predominantly the valves. Increasing numbers of patients with endocarditis undergo valve surgery. Intravenous drug users (IVDUs) have a 50- to 100-fold higher incidence of endocarditis than the general population.

Compared with the typical patient with endocarditis, those injecting are younger, have fewer predisposing comorbidities, and are more frequently infected with Staphylococcus aureus. Prolonged hospital stay is a requirement for these patients as they need extended duration of intravenous antibiotics. The optimisation of drug rehabilitation services and being able to identify the characteristics in this group of patients that might influence long-term prognosis remain an important area for research.

Complicated V uncomplicated SAB

SAB is notorious for having varied sources of causation. Common sources include catheter-related, pleuropulmonary, osteoarticular, and heart valve. SAB may be further classified as complicated or uncomplicated.

The Infectious Diseases Society of American (IDSA) and in use in the UK, has defined uncomplicated SAB as those in which there is: exclusion of endocarditis, no implanted prostheses, negative follow-up blood cultures drawn two to four days after the initial set, defervescence within 72 hours after initiating appropriate antibiotic therapy, and no evidence of metastatic infection.

Ten cases of MSSA were reported for the MKUH against a threshold of five. A further forty-three cases, identified within 48 hours of admission, classifying them as community onset cases were added to the national database on behalf of the MK community healthcare teams.

A single case of MRSA, on investigation was identified as a possible contaminant as all additional screening of body sites and repeat blood cultures failed to grow MRSA. The incident occurred in a 58-year-old male, with a history of hypertension, admitted 26/08/21 with Covid-19 pneumonitis.
Receiving non-invasive respiratory support up to 04/09/21 when deterioration required intubation and ventilation. A blood culture taken from a central venous catheter grew a mixed growth, suggestive of line colonisation or possible

contamination of sample despite aseptic technique being confirmed when performing phlebotomy. The arterial line and central catheter were changed. All subsequent samples remained negative.

1. **Clostridioides difficile**. Thirteen (13) cases were reported, against a threshold of ten (10.) Most cases were identified in patients cared for in medicine, with just one incident for surgery (trauma and orthopaedic) ward.
2. All patients were over 60 years of age, some having received broad-spectrum antibiotics prior to admission, others receiving antibiotics, short and long-term as part of chronic conditions. All patients were found to have comorbidities that increase the potential for susceptibility to C. diff, both to antigen (gut carriage) and toxin (infection). A weakened immune system including inflammatory bowel disease, underlying cancer, and undergoing chemotherapy or taking steroid medication is also present in some of these patients.
3. Most were prescribed a proton pump inhibitor (PPI) medication in the community i.e., omeprazole/lansoprazole which research indicates that regular use can alter the gut flora, increasing the potential for C diff to occur. Discussion of the need to continue with a PPI is a core element of patient review.
4. Supportive care that includes multidisciplinary assessment of these patients that are prone to electrolyte imbalance, dehydration, malnutrition, and pressure ulcers is vital, as is the review of medication that might exacerbate diarrhoea or exacerbate intra-vascular fluid depletion or kidney injury. This includes stopping laxatives, and reviewing non-steroidal anti-inflammatories (NSAIDs), ACE-inhibitors and diuretics.
5. The precipitating antibiotic is stopped wherever possible, with agents posing less risk of inducing CDI substituted if an underlying infection still requires treatment.

“Back to business”

As we accelerate our progress with “normal” activities, some of the pressures of the pandemic remain in play across the Trust, with the IPCT now advising on greater numbers of infections present in our patients at the time of admission. An increase in antimicrobial resistance is noted.

Actions to mitigate Covid-19 have resulted in a change in behaviour regarding the adoption of preventive measures. Some measures, such as face masks, social distancing, and increased hand hygiene will likely diminish antimicrobial resistance (AMR). In contrast, over-prescription of antibiotics, nosocomial infections, and telemedicine could have contributed to an increase. Everything seems to indicate that this new virus, officially known SARS-CoV-2, (Covid-19) is contributing to

aggravating the current situation concerning the emergence of resistant microorganisms

There are competing theories as to the shift, one of which is that patients with Covid-19 may have received antimicrobial therapy, in part due Covid-19 symptoms able to resemble bacterial pneumonia and whilst our local diagnostics can distinguish viral from bacterial pneumonia, treatment in the assessment areas, for patients presenting as acutely unwell with a pneumonia is likely to include antibiotics in the early phase of therapy.

In addition, faster tests, such as diagnostics measuring C-reactive protein – a biomarker that is elevated in bacterial infections but typically not in viral ones – may in fact be increased in patients with Covid-19. As a result, many patients requiring admission with Covid-19 may be prescribed empirical antibiotics, often in the absence of a microbiological confirmation of the diagnosis

Further to this, patients with Covid-19 often present with or acquire secondary co-infections which require antimicrobial treatment. The severity of this is associated with the pathogens involved, alongside the impact of underlying patient risk factors.

3.Infection control management, including the role of the Director of Infection Prevention and Control (DIPC)

The Chief Executive (CEO) has overall corporate responsibility for the control of infection within the Milton Keynes University Hospitals NHS Foundation Trust (MKUH). The Director for Patient Care, the Chief Nurse is the designated Director of Infection Prevention & Control (DIPC) and is supported in this role by an associate chief nurse for IPC who acts as the deputy.

The infection prevention & control team (IPCT) comprises medical and nursing infection prevention control professionals who are responsible for the day-to-day operation of the infection control service including:

- surveillance and mandatory reporting
- the provision of IPC policies additional to the National manual expected 2022
- an audit programme to ensure that key policies and practices are implemented appropriately
- provision of advice to clinical and management colleagues including:
- monitoring of infection risks
- on-going staff education and training (additional to mandatory)
- appropriate advice in response to major outbreaks of communicable infections

The Infection Prevention and Control Nurses (IPCN`s) have designated areas of responsibility across the organisation and members of the IPCT provide a 24 hour on-call service for provision of infection control advice to clinical and managerial colleagues. Expert reactive and proactive information and advice is available to all

staff, patients, relatives, and carers in respect of healthcare associated infections and the prevention and control of those infections. Strategic advice is provided to enable the Trust to meet necessary standards of care and fulfil its obligations under the Health and Social Care Act 2008 (revised 2012)

The IPCT reports to the IPCC and is directly accountable to the DIPC.

The DIPC is responsible for leading the IPCT and reports directly to the chief executive and the board.

The IPCT is responsible for day-to-day management of infection control and liaises closely with the DIPC

The IPCT key functions are:

The key functions of the team fall into four key domains:

Infection Prevention and Control Committee

The Committee, chaired by the Director of Infection Prevention and Control (DIPC), meet on a quarterly basis and is responsible for:

• Discussing, approving, and monitoring the Infection Prevention and Control plan,

• The development or review of policies, guidelines, and standards

• Setting and monitoring local priorities related to infection prevention and control

• Coordinating and monitoring IPC activity across the Trust

• Evaluating the impact of infection on service delivery

• Supporting the Infection Prevention and Control Team

• Identifying organisational learning

• Supporting the effective implementation of the HCAI Board Assurance Framework (IPC BAF)

The quality provided by the IPC team is enhanced, as is the patient experience, by having laboratories on site, now offering a 24-hour service. This has allowed us to manage extraordinary circumstances across the last year and has been made possible by several workstreams coming to fruition:

1. The MKUH laboratory was the first in the South 4 network to gain accreditation for Covid 19, improving patient and staff safety
2. Greater use of the Maldi analyser, cutting back on time identifying organisms faster, allowing more appropriate antimicrobial usage to support earlier patient discharge/better management
3. Biofire rapid identification of viral/bacterial meningitis in a 4-hour turnaround time, delivering faster, appropriate treatment.
4. Addition of specialist registrar to the team, Dr Amarjeet Kaur
5. Maintaining UKAS accreditation for Serology (2nd time)
6. Maintaining our Key Performance Indicators for testing of C. diff and Covid 19
7. Assisted in setting up of Point of Care Testing (POCT) for Respiratory Syncytial Viruses (RSV) & Covid 19 for paediatrics

4.Clusters and Outbreak associated with Covid-19. There were several nosocomial cases recorded during the reporting year, with both cluster and outbreak managed during the same period. It is widely acknowledged that Delta, Omicron and BA.2 are highly transmissible variants which contributed to increase in cases.

Our hospital has a robust testing programme and many patients who tested positive had no respiratory symptoms. In November the publication of The Infection Prevention and Control for Seasonal Respiratory Infections in Health and Care Settings (including SARS-CoV-2) for winter 2021 to 2022, advised the requirement for care pathways could be defined locally. Given the continued high community prevalence and the emergence of Delta, Omicron and a new variant of concern - BA.2, we continued to use the three specific care pathways (high, medium and low)

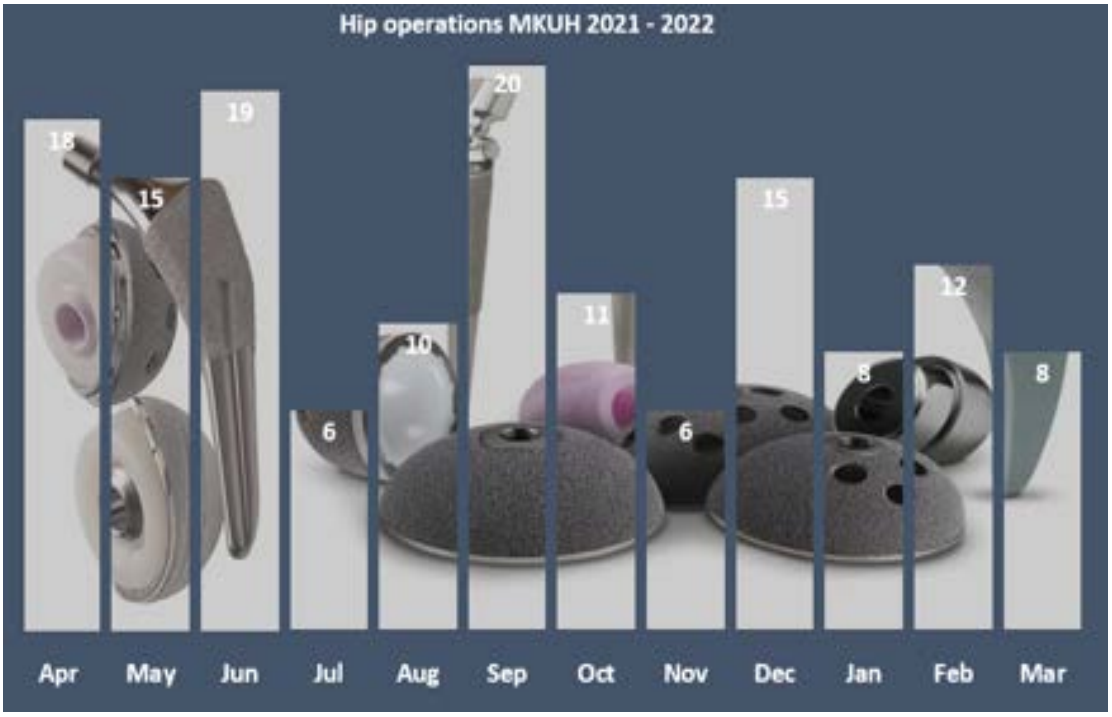
to support patient and staff safety, using local intelligence to flex patient pathways and management.

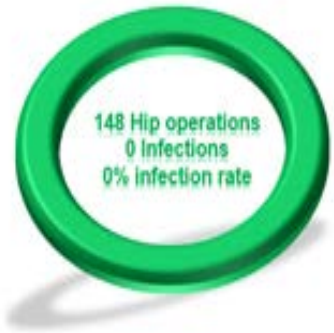
5.Surgical Site Infections (SSI) Hips, Knees and Caesarean Section Delivery.

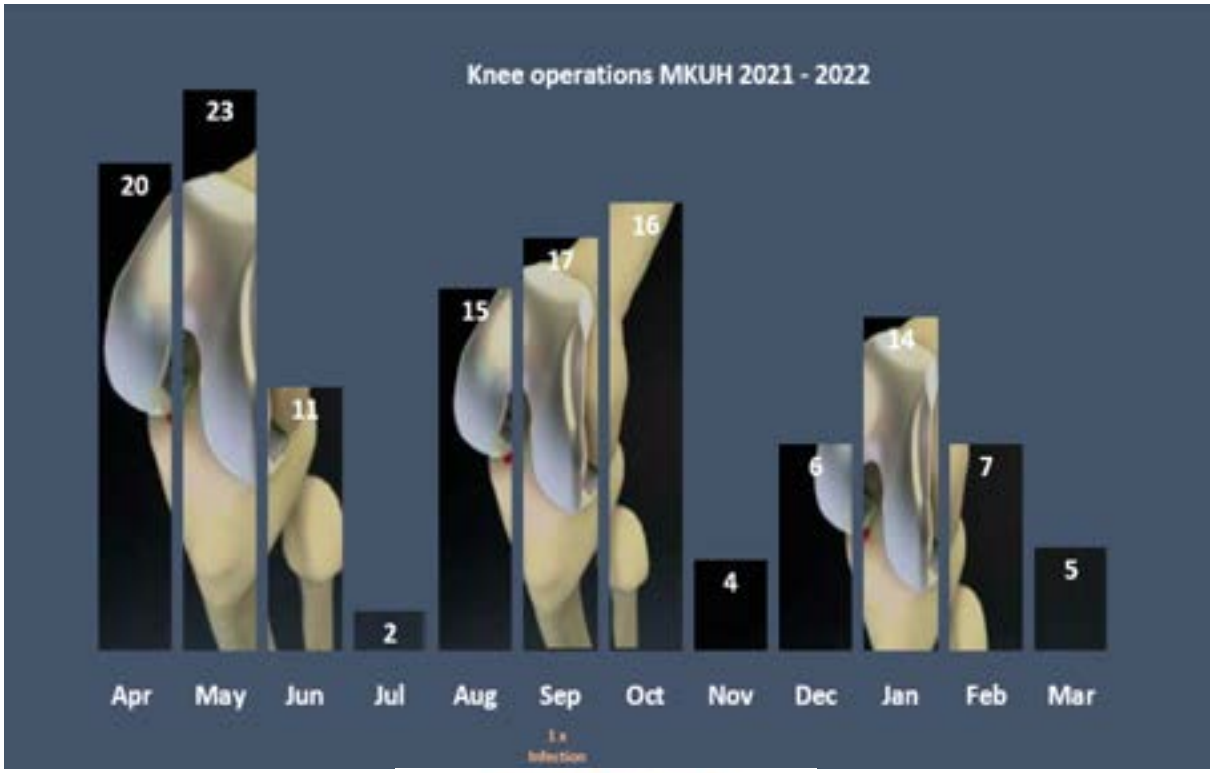
Surgical Site Infection (SSI) for the purpose of national reporting is defined as an infection which happens within a month following surgical intervention and includes three types: superficial incisional SSIs (primary & secondary), deep incisional SSIs (primary & secondary) and organ/space SSIs

We continue to capture surveillance on hips, knees, and caesarean section delivery, monitoring all three on a continuous cycle to better predict trends (successes and less than optimal practice) and are joined on this quality cycle by the relevant consultant surgeon teams, midwives and nurses, and all other allied health professionals that contribute to improving the patient experience/outcome.

The following images are examples of the prosthetic joint kits used for our patients undergoing hip or knee replacement.





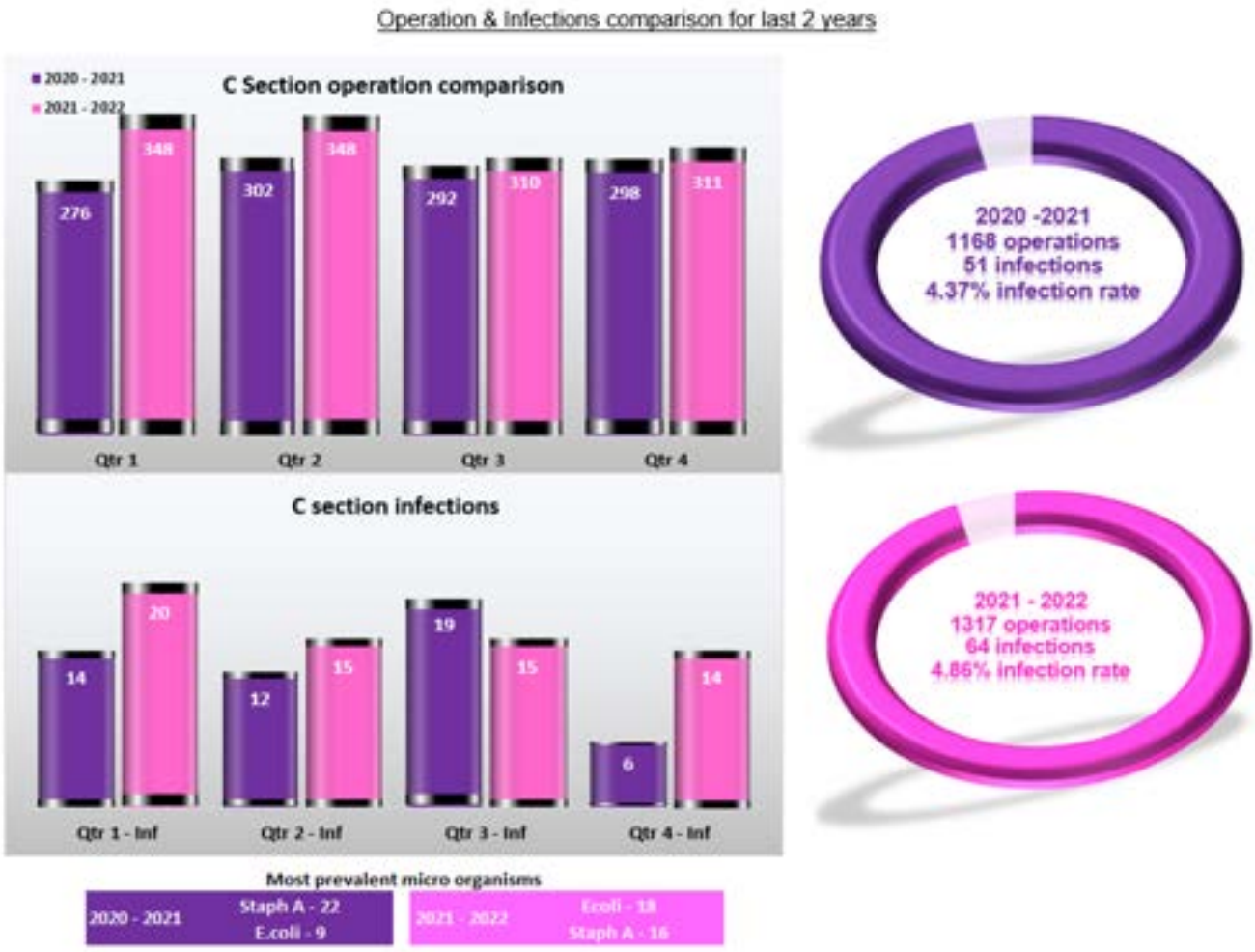


Caesarean section delivery (CSD)

The following piece shows a comparison of the number of Caesarean Section Deliveries in the MKUH across a two-year period and the incidence of infection.

Please note that whilst the level appears high in described infection rates, this often relates to potentially pathogenic (capable of causing disease) material identified from swabs taken from the wound site.

The location of the wound makes it an ideal breeding site for skin commensals in women that have high body mass index (BMI) in addition to pregnancy, in an area of the body that bacteria thrive, is hair bearing, warm and moist.



Klebsiella pneumoniae and Pseudomonas aeruginosa (blood culture positive)

A relatively new addition to the national reporting database is Klebsiella pneumoniae isolated from blood culture. This has gained recognition as a threat to human health due to the emergence of multidrug-resistant strains capable of causing hospital outbreaks and hypervirulent strains associated with severe community-acquired infections.

After E. coli, Klebsiella and Pseudomonas aeruginosa are the most common causative organisms of gram-negative bacteraemia, albeit these species caused substantially lower rates of bacteraemia than E. coli.

Klebsiella pneumoniae has been associated with Covid 19 in a retrospective study undertaken in China, which identified the second most common respiratory pathogen detected from patients with COVID-19 was Klebsiella pneumoniae. The incidence for the MKUH is uploaded monthly to the Board scorecard for HCAI.

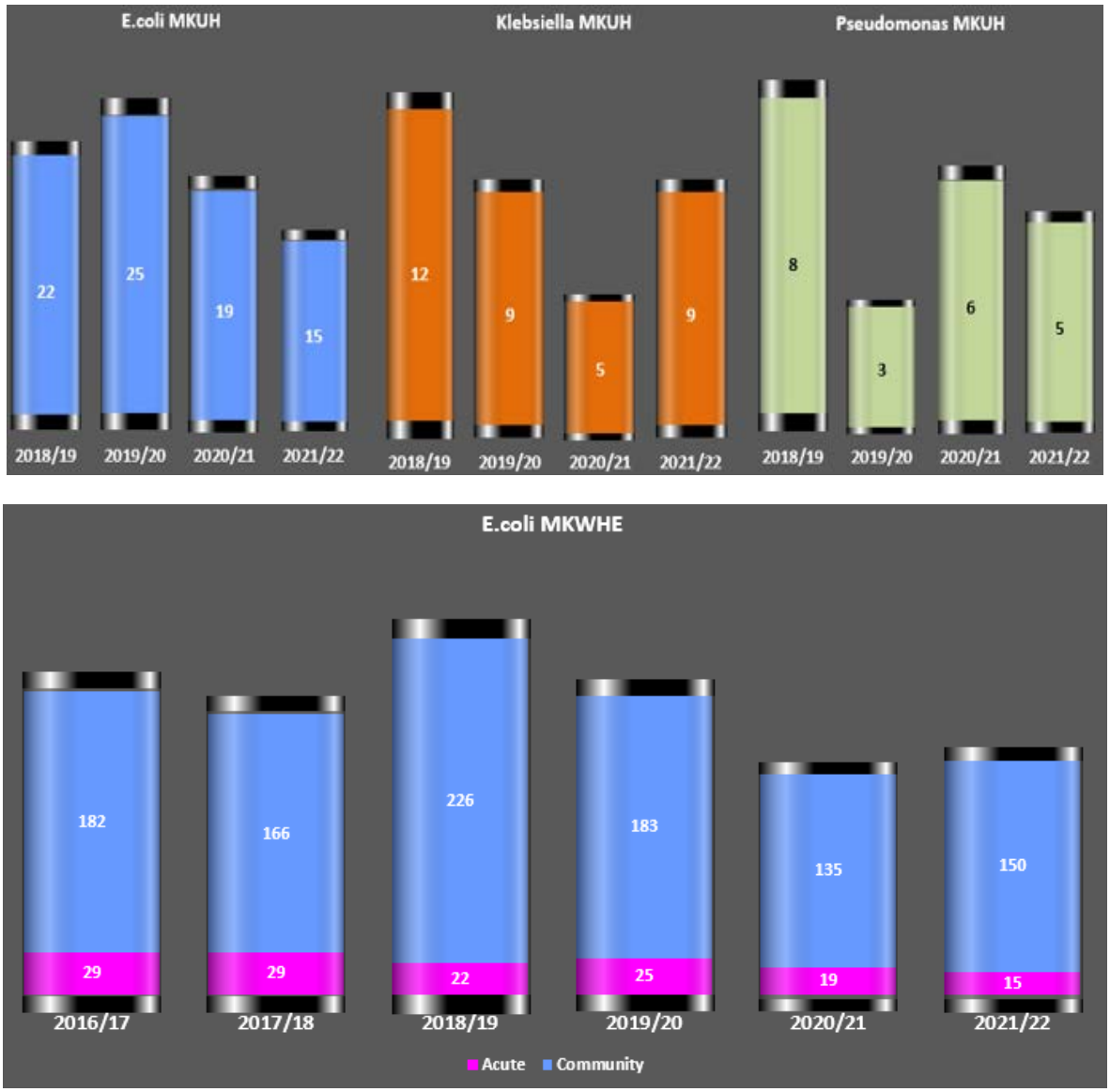
Pseudomonas aeruginosa found in blood culture is also reportable. *Pseudomonas aeruginos*a can present a serious threat to critically ill and immunocompromised patients, from neonates upwards

The most prevalent among the frequently colonised by *P. aeruginosa* body sites are the respiratory system, urinary tract, skin, and gastrointestinal tract

Sometimes described as opportunistic, this pathogen's colonisation of the human gut can be associated with elevated mortality rates of patients in intensive care units (ICU), and its significance as a cause of mortality in the critically ill has been demonstrated in research.

Our water safety programme details our approach to eliminating pseudomonas aeruginosa from our water supply, particularly in those areas described as delivering augmented care – our ICU and neonatal unit in particular. This represents a vital component in the avoidance of Pseudomonas aeruginosa occurring in our most vulnerable patients.

In the April 2021 to March 2022 financial year, the number of Escherichia coli (E. coli) bacteraemia cases remained lower than those seen April 2019 to March 2020, prior to the coronavirus (Covid-19) pandemic. This is reflected across the UK.



MKUH allocated cases and community onset E coli BC: April 2016 – March 2022

6.Water safety. Dr Poonam Kapila, Consultant Microbiologist and Infection Control Doctor, with Angela Legate, Associate Chief Nurse (IPC) are active members of the water safety group (WSG), working alongside the estates and facilities teams in managing and reducing the risk of harm to all users by creating, implementing, and driving the Trust's Water Safety Policies.

Collectively, we identify and mitigate risk through testing, action and adherence to Statutory Regulations, Health Technical Memorandum (HTM) and other respective guidance. A planned schedule is in place for the testing of water samples for pathogens likely to cause harm: Legionella spp., and Pseudomonas aeruginosa.

Where positive results are reported, the IPC approve the process for remedial works and retesting, until outlets return negative samples. All records are shared through the Water Safety Group for review/discussion and provide an assurance through a detailed audit trail of good practice and compliance with the MKUH Water Safety Policy/Plan.

The Water Safety Policy details the following key control measures adopted within our water management procedures and specialist contracts:

- Temperature Control - by keeping hot water hot and well circulated throughout the system, by keeping cold water cold by consumption.
- Turnover - the avoidance of stagnation through usage, ensured by documented flushing
- Chemical Treatment - by dosing the water supply with an approved biocide.
- Testing - by taking strategic water samples frequently and having them laboratory analysed (off site).
- Reactive Action - by pre-defined reaction to laboratory testing trigger points.

Ventilation The Ventilation Safety Group (VSG) supports the Trust response to emerging evidence and with a specialist multidisciplinary platform, continues to review and make well-informed strategic decisions, based on comprehensive advice and guidance on ventilation systems used in the delivery of healthcare.

The VSG brings into focus the requirements of the HTM guidance for healthcare-specific elements of standards, policies, and up-to-date established practice.

Ventilation is used extensively across our hospital to provide a safe and comfortable environment for patients and staff and to control odours. More specialised ventilation is provided to help reduce airborne infection risks in areas such as operating departments, our intensive care unit, isolation rooms and primary patient treatment areas.

The VSG is now established as a multidisciplinary group of specialists, whose remit is to assess all aspects of ventilation safety and resilience required for the safe development and operation of our Trust premises.

The Estates & Facilities continue to ensure all aspects of good practice for ventilation management in the healthcare setting are implemented, the evidence of which is presented to the IPCC, on risk management, and compliance with the Department of Health requirements in relation to ventilation safety.

7.Policies and Guidelines: The IPCT continue to review and revise the trusts policies/clinical guidelines, with some extensions to review dates granted during the pandemic and due in part to the expected launch of a national IPC manual. Amendments to national publications on Covid-19; during 2021-22 saw a significant number of step changes over the course of the year, both nationally and locally. The IPCT respond quickly reviewing and advising the organisation on any operational changes required.

8.A rolling programme of ambitions

The IPCT input is integral to all learning events planned with the divisions to review the findings from MRSA/MSSA and Gram-Negative bacteraemia post infection reviews and the outcomes of the targeted internal review process or RCA investigations initiated as a result.

Given the increasing number of complex infections seen in our local communities, presenting in patients at admission to our hospital, the formation of a multidisciplinary subgroup to review actions from the GNBSI reviews include management of vascular access devices (VAD) and urinary tract infections.

A multifaceted approach, underpinned by strong leadership, effective training programmes, evidence-based guidelines and interventions are seen as key to sustain progress to:

- improve patient safety through reduced infection rates, mortality, length of stay and appropriate antimicrobial prescribing
- improve patient experience through the prevention of avoidable infections and reduced length of inpatient stay
- improved population health through reduced antimicrobial resistance

Expected in April 2022: the National Infection Prevention and Control manual for England. This is an evidence-based practice manual for use by all those involved in care provision in England, to be adopted as mandatory guidance in NHS settings and the principles applied across all care settings.
The manual is aimed at nurturing a consistent UK-wide approach to infection prevention and control, although some operational and organisational details may differ across the nations.

Conclusion

Collectively as a Trust, we recognise our duty of care to protect patients, staff, contractors, and visitors from infection and together we support the drive for effective systematic arrangements for surveillance, prevention, and control.

For many common infections and infectious diseases, early recognition and prompt action can reduce the spread of disease, the severity of the illness and the number of people infected. The basics of IPC will thrive if we incorporate the science behind it and relate it to patient stories.

Commitment to reducing the incidence of healthcare associated infections and, more importantly, maintaining that reduction needs to be core business for all of us, as does ensuring that antimicrobial stewardship becomes one of the key pillars of clinical practice and not just something we consider during world antibiotic awareness week.

Pathogens with epidemic properties have resulted in extraordinary results, especially over the last ten years, with globally reported (and managed) incidents such as the Ebola virus disease outbreaks, the Middle East respiratory syndrome epidemic, and the recent Covid-19 pandemic.

All of these have sharpened the focus on the burden of infection and that of antimicrobial resistance (AMR) and the related harm caused to patients and health care workers.

IPC remains unique in the field of patient safety and quality of care and is universally relevant to every health care worker and patient, at every health care interaction. Without effective IPC it is impossible to achieve quality health care delivery.

Infection prevention and control effects all aspects of health care, including hand hygiene, surgical site infections, injection safety, antimicrobial resistance and how we operate during and outside of emergencies.

Recommendation The board is asked to:

Receive the IPC Annual Report 2021-22 and note the key successes regarding Infection prevention.

Be assured that the IPC team are striving to reduce the rates of Clostridioides difficile, MSSA, MRSA and Gram-negative blood stream infections.

Feel confident on the avoidance measures to reduce nosocomial transmission of viruses associated with respiratory/gastroenteritis illness.

Engage all staff to act with intent with the drive to reduce all avoidable infection.

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Meeting Title	**Trust Board**	**Date: 13 January 2022**
Report Title	Pressure Ulcers Quarterly Update (June to November 2022)	**Agenda Item Number:**
Lead Director	**Yvonne Christly -Chief Nurse**	
Report Author	*Yvonne Christly/Deepa Austin*	

Introduction	*Purpose of the report e.g. Statutory/Assurance*		
Key Messages to Note	This is a quarterly report of pressure ulcer prevalence and summarises the work undertaken at MKUH to manage pressure ulcers and the prevention of ulcers during the period of 1 June 2022 to 30 Nov 2022. Hospital Acquired Pressure Ulcers (HAPU) are an avoidable and costly harm and have a substantial impact on the health-related quality of life of patients. Most HAPUs are preventable and there is a clear link between pressure ulcers and vulnerable adults. Prevalence of pressure ulcers continue to be high during this period. There is a significant increase in both community acquired, and hospital acquired pressure ulcers. Various forms of reviews were conducted which provided clear indication of the contributory factors such as: • Comorbidities and Frailty • Long stay in ED • Delay in risk assessment • Delay in reporting and validation and escalation of pressure ulcers • Essential care delivery • Inappropriate application of equipment • Training and Application of Medstrom pressure mattresses • Medstrom bed and Mattress • Current Tissue Viability Service Demand • Increased LOS and deconditioning **Improvement Programme** Trust wide Quality Improvement programme to reduce pressure ulcer has been developed with four workstreams focusing on education, standards, patient and family involvement, infrastructure, and Culture. The QI programme allows for a structured, systematic approach to identify the key problems and effect sustainable change. It is important to be realistic about what it is possible to change; identifying and utilising the data sources available will determine possibilities and inform the direction of the project and building a team that includes all key stakeholders will improve the chances of success. Finally, it is important to view QI as an ongoing cycle of measurement and re-measurement to embed strategies into everyday practice but also to celebrate positive outcomes as part of the process.		
Recommendation *(Tick the relevant box(es))*	**For Information** x	**For Approval**	**For Review**

	4. *Giving you access to timely care* 5. *Working with partners in MK to improve everyone's health and care* 6. *Spending money well on the care you receive* 7. *Employ the best people to care for you* 8. *Innovating and investing in the future of your hospital*

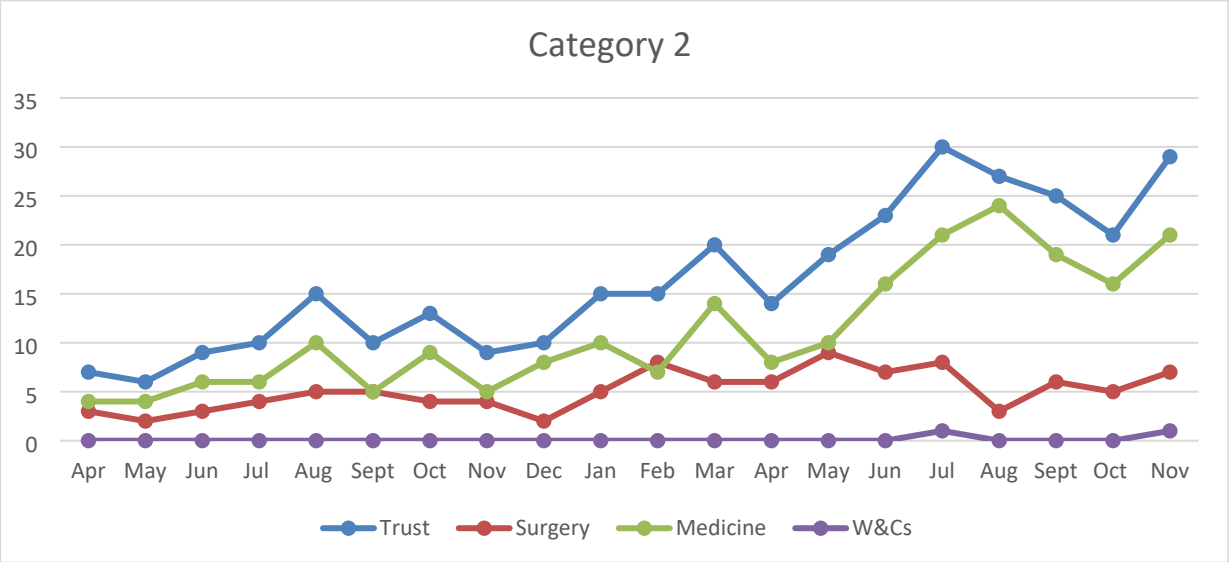
Appendices/Attachments	*Photographic evidence of Medstrom flex mattress, (appendix 1)* *Pressure ulcer QI Diver Diagram (Appendix 2)*

1. Purpose of the report

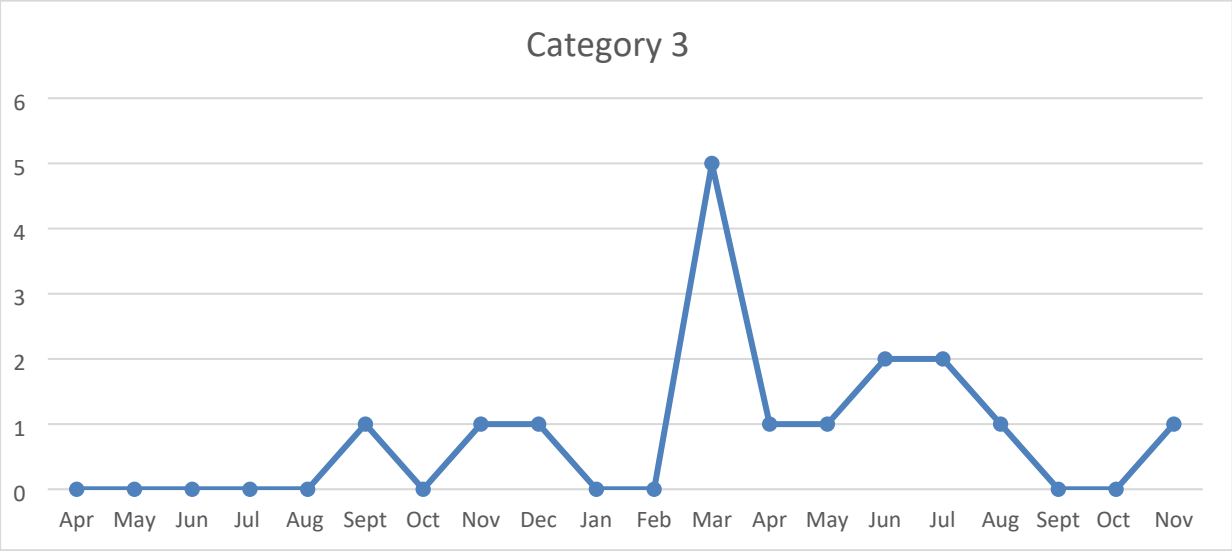
This report provides an update on Hospital Acquired Pressure Ulcers (HAPU) at MKUH between June and November 2022 and summarises the improvement activities designed to reduce the incidence of HAPUs over the next six months.

Incidence of HAPU at MKUH (June to November 2022)

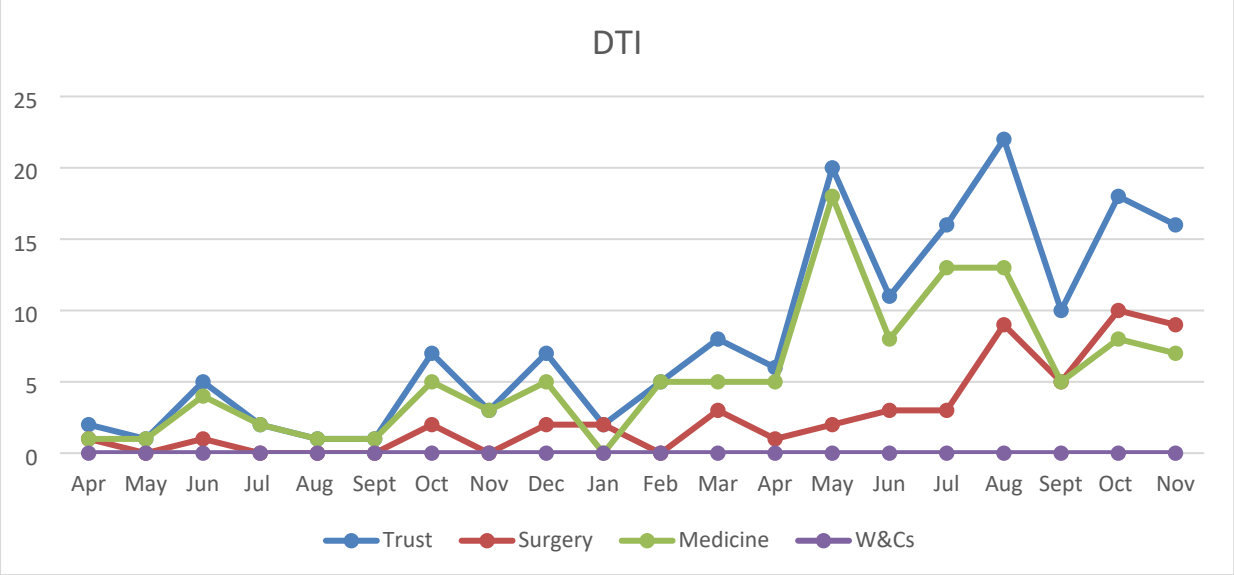
The incidence of HAPUs across all categories has increased in the past six months. As illustrated in the graph below Category 2 HAPUs are a concern in the Medical Division which has seen an increase from 10 in May to more than 20 each month of the reporting period.



There has also been a slight increase in Category 3 HAPUs in June and July however these figures reduced between August and November.



There has also been an increase in deep tissue injuries (DTI) in the Medical and Surgical divisions during the June to November reporting period. A DTI is a type of subcutaneous tissue damage that results from an externally applied mechanical load. DTIs may not be visible in its early stages and most commonly appear on the on the sacrum and the heels. The Trust reports all suspected DTIs as DTIs and does not have a process in place for reviewing and confirming the category of pressure once the damage becomes visible or resolves.



It is important to note that while HAPU incidence is high not all pressure damage is avoidable, and some patients may still go on to develop pressure ulcers despite receiving the best possible care. There is no agreed criteria/assessment for determining pressure ulcers which are avoidable. Seasonal fluctuations, increased activity and patient acuity will also be impacting on the incidence of HAPUs.

Between June 2023 and December 2023 there were 198 HAPUs of which 17 were declared as SIs and 8 incidents were referred as safeguarding concerns. Various forms of reviews were conducted which include 72-hour report, SI report, 'five whys' and thematic reviews based on Appreciative inquiry.

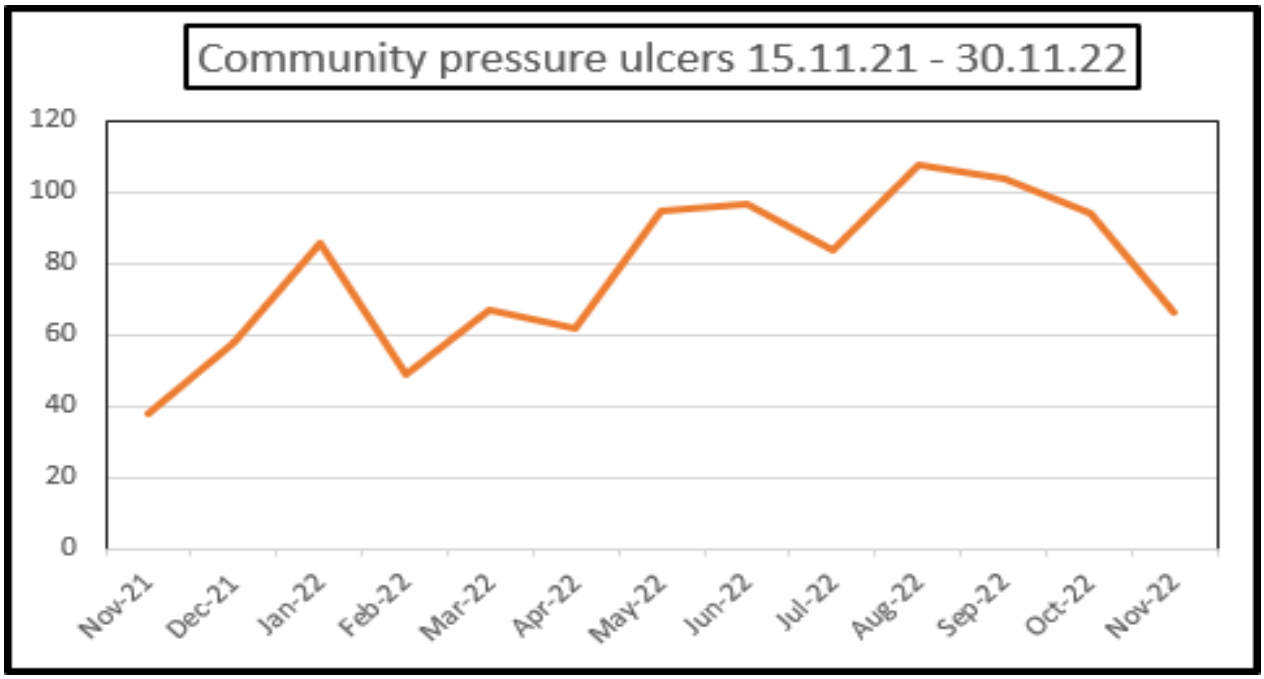
Common findings from staff and patients

- Reduced levels of nursing and HCAs and poor skill mix are the biggest challenge for assessing for pressure damage and for helping to prevent pressure damage by helping patients to mobilise.
- Finding time to help with pressure area care or prevention is difficult when the acuity of patients is high.
- Staff feel frustrated by other departments and teams within the hospital which can lead to a 'them and us' culture.
- Completing assessments and scoring on eCare is prioritised above providing preventative care.
- Accessing pumps for mattresses can be a challenge.
- Availability of food and drink for patients in ED is poor.
- Nurses and HCAs do skin assessments.

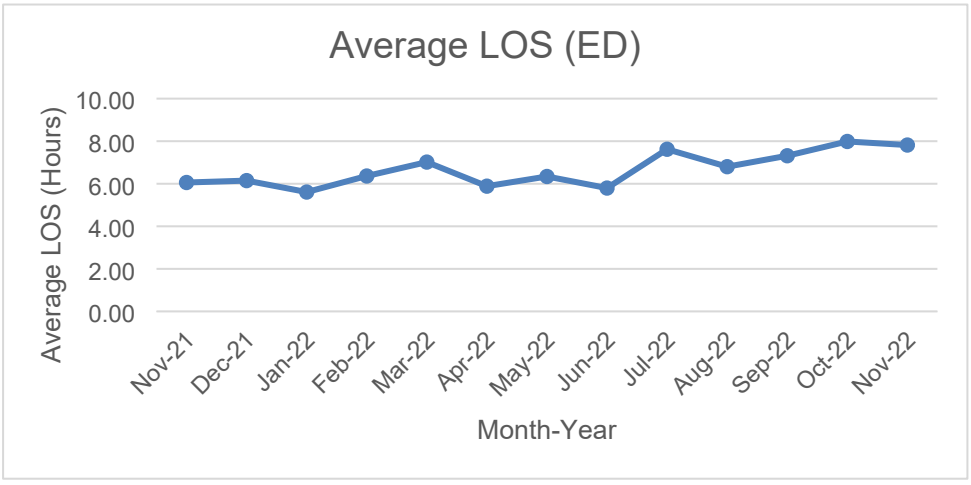
- Opinion on the mattresses is very varied with some describing them as very comfortable and other describing them as painful, 'like a rock'.
- In general, patients really value being encouraged and helped to mobilise or change position.
- Some patients believe that developing pressure damage is an inevitable part of a hospital stay.

Contributory Factors

- **Comorbidities and Frailty –** There are higher number of patients attending Emergency department with pre-existing pressure damage which deteriorates rapidly.

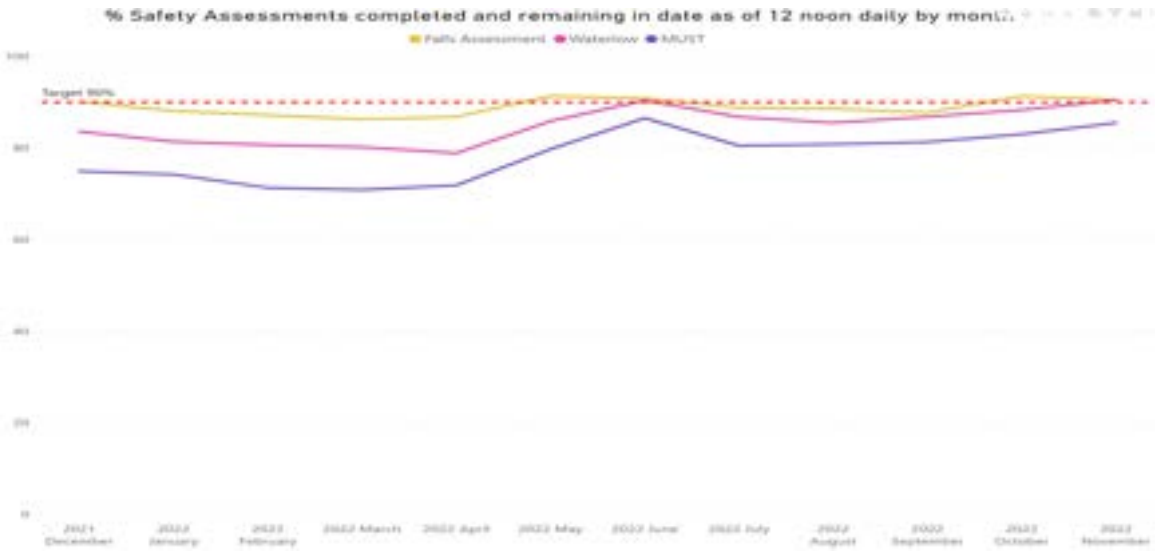


- **Long stay in ED –** Risk for pressure ulcer increases as patients remains in Trolleys or chairs in ED. The graph below shows the average length of stay data (in hours), broken down by month between 1st November 2021 and 30th November 2022 who were over 65 years old at the time of their ED arrival.



- **Delay in Risk Assessment**

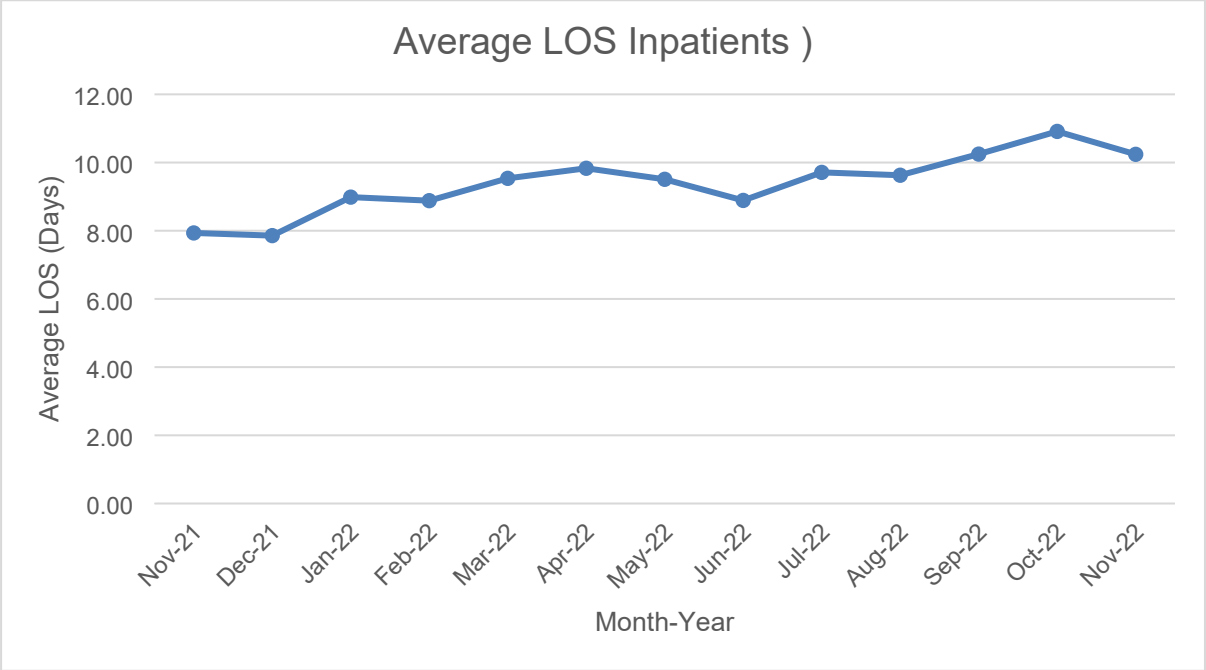
The graph below indicates that compliance for completing risk assessments relevant to the prevention of pressure ulcers routinely falls below the Trust target of 90%. This has improved in October and November for the Waterlow however the timely completion of the MUST score requires more focused attention.



- **Delay in reporting and validation and escalation of pressure ulcers -** Reviews of the pressure ulcer incidents indicates management of pressures ulcer is impacted by delay in reporting and validation of pressure ulcer. Where possible validation of all HAPUs should be undertaken by the Tissue Viability Team to ensure accuracy and promote learning. The absence of Tissue Viability validation can result in excess of 25% error rate.
- **Essential care delivery -** Clinical presentations, acuity and complexity of the patients such as pain, fracture and naso gastric feed affects the quality of repositioning.
- **Inappropriate application of equipment** -e.g. Mepital dressing being used as preventative measure.
- **Inappropriate use of Incontinence products –** Excessive use of Prosken flex pads commonly known as wrap around pads which is only meant to use for doubly incontinent bedbound patients.
- **Training and Application of Medstrom pressure mattresses** – Evidence of lack of awareness of the consequence of using flex mattress with pump attached but turned off. (Mattress gets hard).
- **Medstrom bed and Mattress**- Foam layer on top of the mattress creates a bulge around the middle when bed propped up which creates friction and patients reports uncomfortable. (Appendix1)
- **Current Tissue Viability Service Demand -**Tissue viability is a speciality service that should provide expert knowledge and skills to support clinicians in the prevention, diagnosis, and treatment of all aspects of skin and soft tissue wounds (including acute surgical wounds, pressure ulcers and all forms of leg ulceration). The speciality also covers all aspects of complex wounds, including risk assessment, pain control, odour control, nutrition, reduced mobility, and advice on

specialist equipment. The current clinical workload for the service consists of average of one hundred patient referrals/reviews per month. These referrals are 50% related to pressure ulcers and 50 % to wound management. 0.6wte tissue viability nurse specialist is the only one with the education and training to provide direct clinical advice and guidance. There is also no operational lead or line management for the Tissue Viability service and an absence of expert and seamless service delivery through appropriate leadership and management

- **Increased LOS and deconditioning** – Below graph show the average length of stay for inpatients with Day Cases excluded from the data.



Support and Leadership

- Collaborative work with BLMK - Agreed on SI criteria for Pressure ulcer incidents in relation to impact of harm with time better spent working on actions to improve the patient care/safety.
- Pressure ulcer summit – Pressure ulcer root cause analysis (RCA) reports are reviewed at Section 42 review panel to determine lapse in care and referral to safeguarding prior to presenting at Serious Incident Review Group (SIRG)
- After action review of Garde 3 and pressure ulcer with medical divisional chief nurse with a plan to implement to other division.
- Harm prevention Group – Focuses on pressure ulcer prevention and comprehensive action plan has been developed
- Matron support for timely validation and Top to toe assessments.
- Review of care plan in e-Care
- Business case for the development and reconfiguration of the Tissue Viability service.

HAPU Quality Improvement Programme

The QI programme outlined above allows for a structured, systematic approach to identify the key problems and effect sustainable change. It is important to be realistic about what it is possible to change; identifying and utilising the data sources available will determine possibilities and inform the direction of the project and building a team that includes all key stakeholders will improve the chances of success. Finally, it is important to view QI as an ongoing cycle of measurement and re-measurement to embed strategies into everyday practice but also to celebrate positive outcomes as part of the process. To improve and reduce the incidence of HAPUs at MKUH the QI programme has been broken into the four workstreams outlined below.

Education and Training

- **Registered Staff**
  Improve and implement training for all registered staff on preventing and managing pressure ulcers, how to accurately carry out a risk and skin assessment, how to identify and categories pressure ulcers, how to reposition, information on pressure redistributing devices, discussion of pressure ulcer prevention with patients and their families, what steps to take to prevent new or further pressure damage.

- **Unregistered Staff**
  Improve and implement training on who is most likely to be at risk of developing a pressure ulcer, how to identify and escalate pressure damage, how to reposition, information on pressure redistributing devices and discussion of pressure ulcer prevention with patients and their carers.

- **Registered and Unregistered Bed Management Competencies**
  Ensure all staff have training and completed competencies on the safe and effective management of the hospital bed stock. This training should include a detailed knowledge and understating of the dynamic mattress settings and the management of offloading and repositioning on these surfaces.

- **Waterlow Risk Assessment and Care Planning**
  Improving the accuracy, reliability, and timeliness of Waterlow risk assessments throughout the patient pathway and ensuring patient care plans are fully implemented and evaluated.

Infrastructure and Culture

- **Improved tissue viability referral, triage and diagnostic support**
  Review the referral, triage and diagnostic support pathway between the tissue viability team and clinical areas. The current TVN staffing model makes it difficult for the TVN team to provide direct clinical support to assess, validate and manage pressure damage proactively.

- **Data collection and measurement**
  Work has commenced with the informatics team to ensure that pressure ulcer reporting is accurate, consistent, and accessible to clinical teams to support better local and Trust wide oversight and improvement and better organisational learning from incidents.

  Pressure Area Care and Prevention Audit (Tendable)

- Develop and implement a pressure area and prevention audit to monitor and improve performance against risk assessment completion rates and the subsequent implementation of the care plan.

E-Care

- Examine and improve the ordering and visibility of the risk assessments, repositioning, and care planning charts in that the patients record.

Culture

- Foster a positive culture of skin checks to ensure the importance of skin checks are understood by all members of the team and that associated documentation is clear. Ensure wards and departments comply with best clinical practice as set out in the Trust's Policies and Guidelines with regards to skin care and pressure ulcer prevention and management.

Monitoring progress and outcomes

- **Harms Prevention Group**
  The Trust has an established multidisciplinary Harms Prevention group. This group will oversee and monitor the progress of the improvement work required to reduce hospital acquired pressure ulcers.
- **Pressure Ulcer Prevention and Management Policy**
  Ensure there is a NICE complaint and evidence-based policy that is in date and reflects the complexity of pressure ulcer prevention activities and supports the safe use and management of the beds.

Patient and Family Involvement

- Complaints will be retrospectively reviewed to create a baseline measure of a key issues for patients and families.
- Patients and families to be codesign information, advice, and guidance on how to prevent pressure damage while in hospital.

Conclusion

This paper details a programme of action to reduce harm from hospital acquired pressure ulceration (HAPU) through sustainable strategies highlighted in the improvement programme outlined above. This includes improving processes and compliance, as well as efficiency of resources in the implementation of sound evidence-based care.

Recommendations

The Committee is asked to note the key issues identified and the focus of improvement programme to improve the trust's position in relation to hospital acquired pressure ulceration and the reduction of harm to patients.

Appendix 1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Meeting Title	**Trust Board**	**Date: 12.01.2023**
Report Title	**Maternity Clinical Negligence Scheme for Trusts (CNST) sign off**	**Agenda Item Number: 12**
Lead Director	Yvonne Christley – Chief Nurse	
Report Author	Melissa Davis – Head of Midwifery, Gynaecology & Paediatric Nursing	

Introduction	The CNST presentation and declaration form have been submitted to Trust Board as part of the sign off process for CNST Year 4. The presentation details the expected compliance for each safety action, this is supported by evidence files. board agreement and sign off, based on the evidence and detailed compliance, the CEO is required to discuss compliance with the ICB AO who is also required to sign the declaration form. The evidence is subsequently scheduled for review with the LMNS on 23rd January 2023.		
Key Messages to Note	CNST compliance is currently as detailed below: Safety Action 1 – Compliant Safety Action 2 – Compliant Safety Action 3 – Compliant Safety Action 4 – Compliant Safety Action 5 – Partially Complaint - The Trust is not complaint at present with a funded establishment based on BirthRate+. To achieve compliance, the Trust Board minutes must show the agreed plan, and timescale for achieving the uplift in funded establishment. Recommendation to achieve compliance is included within the presentation. Safety Action 6 – Compliant Safety Action 7 – Compliant Safety Action 8 – Compliant Safety Action 9 – Compliant Safety Action 10 – Compliant		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Review** ☐

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	1. Keeping you safe in our hospital 2. Improving your experience of care 3. Ensuring you get the most effective treatment 4. Giving you access to timely care 5. Working with partners in MK to improve everyone's health and care *6.* Spending money well on the care you receive

Report History	CNST compliance reviewed - Monthly CSU meeting Monthly MAG meeting Monthly LMNS Highlight report, Maternity & Neonatal Quality Meeting, LMNS Board
Next Steps	Trust Board LMNS Board
Appendices/Attachments	1. CNST Trust Board Presentation 2. Maternity Incentive Scheme – Board Declaration Form 3. Maternity Incentive Scheme – Relaunch Guidance

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Maternity Incentive Scheme (MIS) Year 4

- **Melissa Davis – Head of Midwifery**
- **Nandini Gupta – Clinical Director**

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Safety Action 1 - Perinatal Mortality Review Tool (PMRT)

PMRT reporting period: 6th May 2022 – 5th December 2022

a) i. 100% of eligible deaths notified

ii. 95% of all eligible deaths reviewed with PMRT

b) 50% of all eligible deaths reviewed with an MDT team

c) 95% of all eligible deaths the parents have been informed of the review

d) Quarterly reports have been submitted to Trust Board

Safety Action 1 – **COMPLIANT**

Milton Keynes University Hospital NHS Foundation Trust

PMRT

Safety action - 1

All eligible perinatal deaths notified to MBRRACE-UK within 7 working days	A review using the PMRT of 95% of all deaths of babies (suitable for the review), by an MDT and started within 2 months of each death.	At least 50% of all deaths of babies (suitable for the review) will have been reviewed using the PMRT, by an MDT. Each review will have a draft reports should be generated within 4 months and closed within 6 months	At least 95% of all deaths of babies who died at the Trust, the parents have been told about the review and that the parents perspective, questions and concerns have been sought.	Number of HSIB case
16	100%	100%	100%	1

11 cases were PMRT. 5 were termination of pregnancies.

Themes within PMRT

1. The partogram is not consistently used for bereaved service users
   - This has been added to the checklist for midwives to complete when caring for a bereaved family
2. C0 monitoring has been highlighted again and a quarterly audit is now is progress

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Safety Action 2 – Maternity Services Data Set (MSDS)

MSDS reporting period: 6th May 2022 – 5th December 2022

1. Maternity digital strategy in place by 31st October 2022
2. 9 out of 10 CQIM's passed the data quality criteria
3. July 2022 data contained BMI for 90% by 15 weeks
4. July 2022 data contained complex social factors for 955 booked in month
5. July 2022 data contained personalised care plan fields for 95% booked in month
6. July 2022 data contained a valid ethnic category for 90% booked in month
7. Trust Boards to confirm they have passed data quality criteria for CoC including:
   i. Over 5% women on CoC pathway have completed indicator by 29 weeks
   ii. Over 5% women on Coc pathway have the care professional & team ID completed by 29 weeks
   iii. 70% of care activity pregnancy & delivery have a care professional local identifier recorded

Safety Action 2 – **COMPLIANT**

Milton Keynes University Hospital NHS Foundation Trust

MSDS

- MKUH did not achieve criteria 7 related to CoC
- CNST confirms trusts can declare compliance if – sustained engagement with NHS Digital & the Data Quality Submission Tool is supplied to NHS Digital
- MKUH have completed & supplied this, confirming compliance

Safety Action 3 – Transitional Care (TC) Services

Transitional Care (TC) reporting period: To Thursday 2nd February 2023

a) Pathways of care into TC has been jointly approved

b) Pathway of care into TC has been fully implemented & audited quarterly

c) Data recording process to capture all term babies admitted to NNU

d) Data recording process to capture existing TC activity

e) Commissioner returns to Healthcare Resource Groups (HRG) as per neonatal critical care minimum data set

f) Quarterly reviews of admissions to the NNU

g) Action plan to address - local TC pathway audit findings & Avoiding Term Admissions Into Neonatal units (ATAIN)

h) Shared progress with the ATAIN action plan

Safety Action 3 – **COMPLIANT**

Transitional Care

a) Joint pathway to TC approved & in date
b) TC pathway audited monthly & reported through CSU
c) All term admissions to NNU recorded on Badgernet
d) Monthly audits collect TC activity
e) Recorded & available to be shared at request
f) Weekly ATAIN review meetings
g) Live ATAIN action plan & TC action plan in place
h) Progress with ATAIN action plan shared through MAG & the maternity improvement workplan

Milton Keynes University Hospital NHS Foundation Trust

Safety Action 4 - Effective Clinical Workforce Planning

Effective Clinical Workforce Planning reporting period: 16th June 2022 – 5th December 2022

- a) i. Commitment to the RCOG roles & responsibilities of the consultant providing acute care in Obstetrics & Gynaecology
- ii. Monitor compliance of consultant attendance for listed clinical situations
- b) A duty anesthetist is immediately available for the obstetric unit 24 hours a day with clear line of escalation to the supervising anaesthetic consultant
- c) The NNU meets the BPAM standard for medical staffing (action plan where not compliant)
- d) The NNU meets the BPAM standard for neonatal nursing workforce (action plan where not compliant)

Safety Action 4 – **COMPLIANT**

Milton Keynes University Hospital NHS Foundation Trust

Medical Workforce Planning

a) i. Consultant attendance in clinical situations document approved & in place

ii. % Consultant attendance reported monthly

b) Anaesthetic rosters confirm availability of a dedicated anaesthetist for maternity 24/7

c) Tier 1 & 2 medical staffing meets the BPAM requirement – an action plan is in place to achieve tier 4 consultant staffing requirements

d) The NNU nursing workforce tool has been completed, sent to the regional nursing lead & an action plan is in place to achieve compliance in QIS

Milton Keynes University Hospital NHS Foundation Trust

Safety Action 5 - Effective Midwifery Workforce Planning

Effective Midwifery Workforce Planning reporting period: 6th May 2022 – 5th December 2022

- a) Systematic evidence-based process to calculate midwifery staffing
- b) Trust Board to evidence midwifery staffing budget reflects establishment calculated in BR+
- c) Midwifery Co-Ordinator supernumerary status
- d) All women in labour receiving one to one midwifery care
- e) 6 monthly staffing oversight report submitted to board

Safety Action 5 – **Not Compliant**

Midwifery Workforce Planning

a) Birth Rate Plus workforce report 2018 & 2021

b) The Trust is unable at present to evidence midwifery staffing budget reflects establishment calculated in BR+

c) Supernumerary status - action plan in place & compliant November & December 2022

d) 1:1 care in labour 99.3 - 100% & action plan in place

e) Midwifery staffing paper to trust board March 2022 & September 2022

Midwifery Workforce Planning

Milton Keynes University Hospital NHS Foundation Trust

The Trust is not compliant at present with a funded establishment based on BirthRate+ . In order to achieve compliance the Trust Board minutes must endorse the agreed plan, and timescale for achieving the uplift in funded establishment.

Recommendation:

- The Trust Board is asked to support a staged increase of 6 WTE Band 6 midwives, once the service is fully recruited to the current funded establishment.
- The maternity service currently has a vacancy of 26.70 WTE midwives, and therefore as the current funded establishment is not being fully utilised, the service priority is to support recruitment to the current funded establishment.
- A midwifery workforce plan has been developed is predicted that the service will be fully recruited to the current funded midwifery establishment by September 2023.
- A business case is being developed to detail the requirement for the further 6 WTE Band 6 midwife posts and it is suggested that once full recruitment to current establishment is achieved, this should allow for a staged increase in midwifery funded establishment.

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Safety Action 6 - Saving Babies Lives (SBL) Care Bundle v2

Saving Babies Lives Care Bundle v2 reporting period: To Thursday 2nd February 2023

a) Compliance with the full implementation of the 5 care bundle elements:

- Element 1: Reducing Smoking in Pregnancy
- Element 2: Fetal Growth Restriction
- Element 3: Reduced Fetal Movements
- Element 4: Fetal Monitoring in Labour
- Element 5: Reducing Preterm Birth

b) Each element of the care bundle fully implemented

c) Completion & submission of the quarterly care bundle survey

Safety Action 6 – **COMPLIANT**

SBLCBv2

a) All elements of SBLCBv2 on a regular audit cycle to review compliance – all over 80% & action plan in place for element 5

b) Guidelines, SoP's & tools in place to support all SBLCBv2 pathways

c) Reduced quarterly care bundles this reporting period, all submitted to region

Milton Keynes University Hospital NHS Foundation Trust

Safety Action 7 – Mechanism for gathering service user feedback & co-production of services

Service User feedback & co-production reporting period:6th May 2022 – 5th December 2022

- a) Mechanisms in place for gathering feedback
- b) Work with maternity service users through the Maternity Voices Partnership (MVP) to co-produce services

Safety Action 7 – **COMPLIANT**

Service User Feedback

- MVP ToR in place
- Minutes of MVP meetings available
- Written confirmation provided that the service user chair is being renumerated
- MVP workplan agreed & LMNS sign off confirmed
- Written confirmation provided that out-of-pocket expenses can be claimed
- MVP workplan & comms approach includes direct focus on those from underrepresented communities including black, Asian & minority ethnic backgrounds
- MVP co-chairs commenced attending the monthly maternity governance meetings since August 2023

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Safety Action 8 – Local training plan incorporating the core competency framework & 90 % MDT training compliance

Core competency framework training plan & 90% MDT training compliance reporting period :1st August 2022 – 5th January 2023

a) Local training plan incorporating the core competency framework
b) 90% compliance with MDT attendance at PROMPT
c) 90% compliance with MDT attendance at Fetal Monitoring training
d) 90% compliance with MDT attendance at NLS

Safety Action 8 – **COMPLIANT**

MDT Training

a) Approved maternity training plan mapped against core competency document in place

b) Training compliance reported monthly through governance report & 90% compliant in all areas required

Training

Milton Keynes University Hospital NHS Foundation Trust

The reporting period (as per NHS resolution MIS Year 4 guidance) has now been extended is August 2021 – Jan 2023.
There is no a PROMPT in August 2022 due to annual leave.

Maternity specific education and training emphasises multi-professional training as a standard part of continuous professional development, both in routine situations and emergencies.
Mandatory maternity-specific training is any compulsory training that the maternity / obstetric / obstetric anaesthetic service requires its employees to undertake in relation to:
NHS Resolution Year 3
Saving Babies Lives Care Bundle v2
Ockenden Interim Report
NHS Core Competencies
Local Maternity and Neonatal systems (LMNS)

PROMPT - Actual Figures as of 21st December 2022

	Midwives	MCA's	Obstetrician	Anaesthetists	
Number of staff	162	35	38	30	265
Staff trained	158	34	35	30	257
Compliance	98%	97%	92%	100%	97%

PROMPT - as of 21st December 2022
Broken down by obstetric group

	Consultant	Reg/SHO	
	14	24	38
Attended	14	22	36
	100%	92%	95%

PROMPT - as of 21st December 2022
Broken down by Anaesthetic group

	Consultant	Other	
	14	16	30
Attended	14	16	30
	100%	100%	100%

Safety action 8

Training

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Fetal Monitoring Study Day as of 5th December 2022

	Midwives	Obstetrician	
Number of staff	160	36	196
Staff Trained	151	33	184
	94%	92%	94%

Fetal Monitoring- as of 21st December 2022

Broken down by Obstetric group

	Consultant	Reg/SHO	
	13	23	36
Attended	12	21	33
	92%	91%	92%

Safeguarding compliance as of5th December 2022

	Midwives	Doctors
Safeguarding Adults L2	94%	89%
Safeguarding Children L3	97%	81%

NLS Compliance as of 13th December 2022

	No.	Compliant	% Compliant
Midwives	163	152	93%

GROW 2.0 - as of 5th December 2022

	No.	Compliant	% Compliant
Midwives	160	140	88%
Doctors	39	30	77%
Sonographers	17	16	94%

GAP/GROW - as of 7th December 2022

GAP/GROW	No.	Number of out of date	% in date	Previous Month
Midwives	162	19	88%	82%
Doctors	32	1	97%	81%

Milton Keynes University Hospital NHS Foundation Trust

Safety Action 9 – Robust processes to provide Board assurance of maternity & neonatal safety & quality

Process for board assurance of maternity & neonatal quality & safety reporting period :1st April 2022 – 2nd February 2023

a) Pathway detailing how safety intelligence is shared from floor to board (PQSM)

b) Board level safety champions present a locally agreed dashboard to Board including PQSM metrics

c) Trust board has reviewed CoC provision following 1st April 2022 letter to system

d) Board level safety champions actively support capacity & capability building for staff in the Maternal & Neonatal Safety collaborative

Safety Action 9 – **COMPLIANT**

* PQSM – Perinatal Quality Surveillance Model

Milton Keynes University Hospital NHS Foundation Trust

Board Assurance of Maternity & Neonatal Safety & Quality

- Pathway developed & in place from Year 3
- Safety champions pictures visible in clinical areas
- PQSM metrics reviewed monthly at CSU, MAG, Trust Board
- Monthly staff forum with board level maternity safety champions
- Safety concerns dashboard in place reported monthly & visible in clinical areas
- Minutes from March Trust Board confirm CoC letter discussion & decision
- Safety champions support maternity team attendance at Maternity & Neonatal network meetings
- Claims scorecard reported to board, incident & complaint data reported through MAG
- Maternity & Neonatal team actively engaged in the MatNeo improvement programme, including attendance at optimisation forums; patient safety network meeting
- Culture surveys used to inform improvement plans – action plan in place to demonstrate approach
- Maternity Improvement Workplan monitors improvement plans & workstreams

Milton Keynes University Hospital NHS Foundation Trust

Safety Action 10 – Reporting 100% of qualifying cases to HSIB

100% of qualifying cases reported to HSIB reporting period :1st April 2022 – 5th December 2022

a) Reporting 100% of qualifying cases to HSIB

b) Reporting 100% of cases to the Early Notification (EN) scheme

c) For all qualifying cases there is Board assurance that:

i. The family have received information on HSIB and the EN scheme

ii. Compliance with the Health & Social Care Act 2008 – regulations 2014 Duty of Candour (DoC)

Safety Action 10 – **COMPLIANT**

Women's External open investigations

Safety action 10

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Maternity

Incident date	Final report received from HSIB	Incident	Report type	Current status/Themes and learning	Improvement plan update	Information of HSIB/EN	Reported all EN eligible cases to NHSR form 04/22-12/22	Written DoC and HSIB consent
11/04/21	21/10/21	Therapeutic cooling	HSIB	Improvement plan in progress	1 action outstanding (placenta guideline)	Yes		Yes
19/04/21	25/10/21	Therapeutic cooling	HSIB	Improvement plan in progress	Last action moved to improvement tracker – to discuss closure with ICB	Yes		Yes
09/07/21	22/03/22	Therapeutic cooling	HSIB	Improvement plan in progress	2 implementation audits 1 SOP to be completed by 28/02/23	Yes		Yes
15/10/21	06/05/22	Therapeutic cooling	HSIB	Improvement plan in progress	3 outstanding actions to be completed 28/02/2023	Yes		Yes
20/10/21	11/04/22	IUD in labour	HSIB	Improvement plan in progress	1 action onto improvement tracker 2 outstanding action to be completed by 13/02/23	Yes		Yes
16/12/21	05/05/22	IUD in labour	HSIB	Improvement plan in progress	1 action to be completed by 31/01/2023	Yes		Yes
28/06/22		Maternal death	HSIB	Draft report received		Yes	N/A	Yes
15/09/22		SROM IUD	HSIB	Ongoing investigation		Yes	N/A	Yes

Number of cases which met the criteria for referral to HSIB (04/2021-current)	Number of cases referred to HSIB (04/2021-current)	Number of cases accepted by HSIB (04/2021-current)	Number of cases declined by HSIB or family (04/2021-current)
13	13	9	4

Conclusion

Milton Keynes University Hospital NHS Foundation Trust

- The report outlines the Trusts progress against the CNST ten safety actions for year four.
- The Trust can demonstrate it has achieved compliance against all of the safety actions with the exception of Safety Action 5 Midwifery Workforce Planning.
- The Trust Board is asked to support a staged increase of 6 WTE Band 6 midwifes once the service is fully recruited to the current funded establishment.

TheMKWay

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NHS Foundation Trust

Questions ?

Maternity incentive scheme - Guidance

Trust Name	**Milton Keynes Hospital NHS Foundation Trust**
Trust Code	**T164**

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

Guidance Tab - This has useful information to support you to complete the maternity incentive scheme safety actions excel spreadsheet. **Please read the guidance carefully.**

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

There are multiple additional tabs within this document:

Tab A - safety actions entry sheets (1 to 10) - Please select 'Yes', 'No' or 'N/A' to demonstrate compliance as detailed within the condition of the scheme with each maternity incentive scheme safety action. Note, 'N/A' (not applicable) is available only for set questions. The information which has been populated in this tab, will automatically populate onto tab D which is the board declaration form.

Tab B - action plan summary sheet - This will provide you information on your Trust's progress in completing the board declaration form and will outline on how many Yes/No/N/A and unfilled assessments you have. This will feed into the board declaration sheet - tab D.

Tab C - action plan entry sheet - This sheet will enable your Trust to insert action plan details for any safety actions not achieved.

Tab D - Board declaration form - This is where you can track your overall progress against compliance with the maternity incentive scheme safety actions. This sheet will be protected and fields cannot be altered manually. If there are anomalies with the data entered, then comments will appear in the validations column (column I) this will support you in checking and verifying data before it is discussed with the trust board, commissioners and before submission to NHS Resolution.

Upon completion of the following processes please add an electronic signature into the allocated spaces within this document. Two electronic signatures of the Trust's CEO and AO of the ICS will be required in Tab D as outlined in order to declare compliance stated in the board declaration form with the safety actions and their sub-requirements, one signature to confirm that the declaration form has been submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services and two signatures to declare that there are no external or internal reports covering either 2020/21 financial year or 2022/23 that relate to the provision of maternity services that may subsequently provide conflicting information to your Trust's declaration. Any such reports should be brought to the MIS team's attention before 2 February 2023.

If you are unable to add an electronic signature, the board declaration form can be printed, signed then scanned to be included within the submission.

Any queries regarding the maternity incentive scheme and or action plans should be directed to **nhsr.mis@nhs.net**
Technical guidance and frequently asked questions can be accessed here:
https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

Submissions for the maternity incentive scheme must be received no later than 12 noon on **Thursday 2 February 2023** to nhsr.mis@nhs.net
You are required to submit this document signed and dated. Please do not send evidence to NHS Resolution.

Version Name: MIS_SafetyAction_2023_V8

Safety action No. 1

Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 6 May 2022 onwards been notified to MBRRACE-UK within seven working days?	Yes
2	Was the surveillance information for eligible deaths where required, completed within one month of the death?	Yes
3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6 May 2022 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
4	Have at least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6 May 2022, been reviewed using the PMRT, by a multidisciplinary review team?	Yes
5	Were each of these reviews completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death?	Yes
6	Were the reports published within 6 months of death?	Yes
	Q7 and Q8 are linked questions	
7	For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, were parents told that a review of their baby's death will take place?	Yes
8	If parents have not been informed about the review taking place, were the reasons for this documented within the PMRT review?	N/A
9	For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, were parents' perspectives and questions and/or concerns they have about their care and that of their baby sought? This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust.	Yes
10	Have you submitted quarterly reports to the Trust Board from 6 May 2022 onwards? This must include details of all deaths reviewed and consequent action plans.	Yes
11	Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?	Yes

Safety action No. 2
Are you submitting data to the Maternity Services Data Set to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	By 31 October 2022, did your Trusts have an up-to-date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework?	Yes
2	Was the strategy shared with Local Maternity Systems?	Yes
3	Was the strategy signed off by the Integrated Care Board?	Yes
4	Is a dedicated Digital Leadership in place in the Trust?	Yes
5	Has the Digital Leadership at the Trust engaged with the NHSE Digital Child Health and Maternity Programme?	Yes
6	Was your Trust compliant with at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) data quality criteria in the “CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria” data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022?	Yes
Did your Trust's July 2022 data contain:		
7	Height and weight data, or a calculated Body Mass Index (BMI), recorded by 15+0 weeks gestation for 90% of women reaching 15+0 weeks gestation in the month?	Yes
8	Complex social factor Indicator (at antenatal booking) data for 95% of women booked in the month?	Yes
9	Antenatal personalised care plan fields completed for 95% of women booked in the month (MSD101/2)?	Yes
10	A valid ethnic category (Mother) for at least 90% of women booked in the month (MSD001) ?	Yes
Has the Trust Board confirmed that they have passed the associated data quality criteria in the “CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria” data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022 for the following metrics:		
11	i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the Continuity of Carer (CoC) pathway indicator completed.	Yes
	Q12 is for information only	
12	ii. Over 5% of women recorded as being placed on a Continuity of Carer (CoC) pathway where both Care Professional ID and Team ID have also been provided.	No
13	iii. At least 70% of MSD202 Care Activity (Pregnancy) and MSD302 Care Activity (Labour and Delivery) records submitted in the reporting period have a valid Care Professional Local Identifier recorded. Providers submitting zero Care Activity records will fail this criterion.	Yes

Safety action No. 3
Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care by Thursday 16 June 2022 at the very latest		
1	Was the pathway(s) of care into transitional care jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies? Evidence should include: ● Neonatal involvement in care planning ● Admission criteria meets a minimum of at least one element of HRG XA04 but could extend beyond to British Association of Perinatal Medicine (BAPM) transitional care framework for practice ● There is an explicit staffing model ● The policy is signed by maternity/neonatal clinical leads and should have auditable standards. ● The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.	Yes
2	Are neonatal teams involved in decision making and planning care for all babies in transitional care?	Yes
b) The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, Local Maternity and Neonatal Systems (LMNS), commissioner and Integrated Care		
3	Has the pathway of care into transitional care been fully implemented?	Yes
4	Has the pathway of care into transitional care been audited quarterly?	Yes
Audit findings must be shared each quarter. If for any reason, reviews were paused, they must have been recommenced using data from quarter 1 of 2022/23 financial year. Has audit findings been shared with:		
5	The neonatal safety champion?	Yes
6	The LMNS?	Yes
7	The commissioner and Integrated Care System (ICS) quality surveillance meeting?	Yes
8	If your Trust have encountered barriers to achieving full implementation of the policy, has an action plan been agreed and progress overseen by both the board and neonatal safety champions?	Yes
c) A data recording process (electronic and/or paper based) for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place.		
9	Is standard (c) in place?	Yes
d) A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.		
	Q10 and Q11 are linked	
10	Is standard (d) in place? This should be achieved by no later than 16 June 2022.	Yes

11	If not already in place is a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered	N/A
e) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), LMNS and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies.		
12	Is standard (e) in place (as per ODN request)?	Yes
f) Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted or remained on Neonatal Units because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis.		
13	Is an audit trail available which provides evidence that ongoing reviews from year 3 of the maternity incentive scheme of term admissions are being completed as a minimum of quarterly? If for any reason, reviews have been paused, they should be recommenced using data from quarter 1 of 2022/23 financial year.	Yes
14	Is an audit trail available which provides evidence that reviews from Monday 18 July 2022 included **all** term babies transferred or admitted to the NNU, irrespective of their length of stay, are being completed as a minimum of quarterly. If your reviews already included all babies transferred or admitted to the NNU then this should continue using data from quarter 1 of 2022/23 financial year?	Yes
15	Do you have evidence that the review includes the number of transfers or admissions to the neonatal unit that would have met current TC admission criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues and the number of babies that were transferred or admitted to, or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there?	Yes
16	Do you have evidence that findings of all reviews of term babies transferred or admitted to a neonatal unit are reviewed quarterly and the findings have been shared quarterly with the maternity and neonatal safety champions and Board level champion, the LMNS and ICS quality surveillance meeting on a quarterly basis?	Yes
g) An action plan to address local findings from the audit of (standard b) Avoiding Term Admissions Into Neonatal units (ATAIN) reviews, and (standard f) been agreed with the maternity and neonatal safety champions and Board level signed off by the Board no later than 29 July 2022?		
17	Is standard (g) in place?	Yes
h) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting each quarter following sign off at the Board.		
18	Has progress with the revised ATAIN action plan been shared with the maternity, neonatal and Board level safety champions each quarter, following sign off at the Board?	Yes
19	Has progress with the revised ATAIN action plan been shared with the LMNS each quarter, following sign off at the Board?	Yes
20	Has progress with the revised ATAIN action plan been shared at the ICS quality surveillance meeting each quarter, following sign off at the Board?	Yes

Safety action No. 4
Can you demonstrate an effective system of clinical workforce planning to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	**Obstetric medical workforce** Have your Trust Board signed off their engagement with the principles outlined in the Royal College of Obstetricians and Gynaecologists (RCOG) workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service: https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/?	Yes
	Q2 and Q3 are linked	
2	Was compliance of consultant attendance monitored when a consultant was required to attend in person?	Yes
3	Were episodes where attendance was not possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance?	N/A
Do you have evidence that your position with the above RCOG document was shared at least once from May 2022:		
4	At Trust Board?	Yes
5	With Board level safety champions?	Yes
6	At LMNS meetings?	Yes
7	**Anaesthetic medical workforce** Do you have evidence of compliance with Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1? The rota should be used to evidence compliance with ACSA standard 1.7.2.1 *(A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients)*	Yes
	Q8 and Q9 are linked	
8	**Neonatal medical workforce** Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing?	Yes
9	If the requirement above has not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS and also include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies. Do you have evidence of this?	N/A
	Q10, Q11 and Q12 are all linked	
10	**Neonatal nursing workforce** Does the neonatal unit meet the service specification for neonatal nursing standards?	No

11	If the requirement above had not been met in both year 3 and year 4 of MIS, has the Trust Board evidenced progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies?	Yes
12	Has the above action plan been shared with the Royal College of Nursing, LMS and Neonatal Operational Delivery Network (ODN) Lead?	Yes

Safety action No. 5
Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	a) Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed? Evidence should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated	Yes
2	b) Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated in a) above? Evidence should include: ● Midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. ●The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners. ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. -The midwife to birth ratio -The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives. ● Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.	
3	c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service. The Trust can report compliance with this standard if this is a one off event and the coordinator is not required to provide 1:1 care for a woman in established labour during this time. If this is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in their action plan mentioned in the section above. Do you have evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status?	Yes
	Q4 is for information only	
4	If you answered **no** to standard c, have you completed an action plan detailing how the maternity services intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board, and includes a timeline for when this will be achieved? Please note, completion of an action plan **will no**t enable the trust to declare compliance with this sub-requirement in year four of MIS.	N/A
	Q5, Q6 and Q7 are all linked	
5	d) Have all women in active labour received one-to-one midwifery care?	Yes
6	If you have answered **no** to standard d, have you submitted an action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour?	N/A

7	Does the action plan include a timeline for when this will be achieved and has this been signed off by Trust Board?	N/A
8	e) Have you submitted a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period?	Yes

Safety action No. 6
Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle V2?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Do you have evidence that Trust Board level consideration of your organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019? Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract.	Yes
2	Has each element of the SBLCBv2 been implemented? Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (ICB). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network.	Yes
3	The quarterly care bundle survey should be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements. Have you completed and submitted this?	Yes
Element 1 - Reducing smoking in pregnancy Standard a*) Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded.* *Standard b) Percentage of women where CO measurement at 36 weeks is recorded.*		
4	Has the Trust Board received data for **standard a)** from the organisation's Maternity Information System (MIS) evidencing an average of 80% compliance over a four month period (i.e. four consecutive months in during the MIS year 4 reporting timeframe)?	Yes
5	Has the Trust Board received data for **standard b)** from organisation's Maternity Information System or has an audit of 60 consecutive cases been provided to demonstrate >80% of women having a CO measurement recorded at 36 weeks?	Yes
6	Is the audit accompanied by a brief description of the stop smoking strategy within the Trust and any plans for improvement?	Yes
7	If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%. Has this been completed?	Yes
Do you have evidence that the Trust Board has specifically confirmed that within their organisation they:		
8	Pass the data quality rating on the National Maternity Dashboard for the 'women who currently smoke at booking appointment' Clinical Quality Improvement Metric.	Yes
9	Have a referral pathway to smoking cessation services (in house or external)?	Yes
10	Have evidence of an audit of 20 consecutive cases of women with a CO measurement ≥4ppm at booking, to determine the proportion of women who were referred to a smoking cessation service?	Yes
4) Have you generated and reviewed the following outcome indicators within the Trust for four consecutive months within the MIS year 4 reporting period:		
11	Percentage of women with a CO measurement ≥4ppm at booking?	Yes
12	Percentage of women with a CO measurement ≥4ppm at 36 weeks?	Yes
13	Percentage of women who have a CO level ≥4ppm at booking who subsequently have a CO level <4ppm at the 36 week appointment?	Yes
Element 2 - *Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)*		

14	Standard 1) Have you provided evidence showing the percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20 week scan? The relevant data items for these process indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital If your Trust has implemented the Tommy's Centre Risk Assessment and Clinical Decision Tool within a research programme then confirmation of the latter by the Trust Board will meet the requirement that Standards 1, 2 and 3 of Element 2 have been implemented	Yes
15	Has the Trust board received data from the organisation's MIS evidencing 80% compliance or has an in house audit of 40 consecutive cases of women at 20 weeks scan using locally available data or case records been undertaken and submitted to Board to assess compliance with this indicator?	Yes
Do you have evidence that the Trust Board has specifically confirmed within their organisation:		
16	Standard 2) Women with a BMI>35 kg/m^2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards? If a Trust has implemented the Tommy's Centre Risk Assessment and Clinical Decision Tool within a research programme then confirmation of the latter by the Trust Board will meet the requirement that Standards 1, 2 and 3 of Element 2 have been implemented	Yes
17	Standard 3) In pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation? If a Trust has implemented the Tommy's Centre Risk Assessment and Clinical Decision Tool within a research programme then confirmation of the latter by the Trust Board will meet the requirement that Standards 1, 2 and 3 of Element 2 have been implemented	Yes
18	Standard 4) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation?	Yes
19	Standard 5) They have generated and reviewed the percentage of perinatal mortality cases for 2021 where the identification and management of FGR was a relevant issue (using the PMRT)?	Yes
20	Standard 6) Their risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance or a variant has been agreed with local commissioners (ICBs) following advice from the Clinical Network?	Yes
21	Standard 7) You have undertaken a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation. The review should seek to identify themes that can contribute to FGR not being detected (e.g. components of element 2 pathway and/or scanning related issues). The Trust board should be provided with evidence of quality improvement initiatives to address any identified problems. Trusts can omit the above mentioned quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation for quarter 3 of this financial year (2021/22) if staffing is critical and this directly frees up staff for the provision of clinical care.	Yes

Element 3 *Raising awareness of reduced fetal movement.*

A. Percentage of women booked for antenatal care who had received reduced fetal movements leaflet/information by 28+0 weeks of pregnancy.
B. Percentage of women who attend with RFM who have a computerised CTG (a computerised system that as a minimum provides assessment of short term variation).
The SNOMED CT code is still under development for RFM and therefore an in-house audit of two weeks' worth of cases or 20 cases of women attending with RFM whichever is the smaller to assess compliance with the element three process indicators.

If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.

A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%.

	Q22 and Q23 are linked	
22	Have you completed an in-house audit of two weeks' worth of cases or 20 cases of women attending with RFM (whichever is the smaller) demonstrating 95% compliance with the element three process indicators?	Yes
23	If the process indicator scores are less than 95% , have you submitted an action plan for achieving >95%?	N/A
Element 4 *Effective fetal monitoring during labour*		
	You do not need to submit evidence within element 4, as it is included within safety action 8	
Element 5 *Reducing preterm births*		
	Q24, Q26, Q27 and Q28 are linked	
24	a) Has the Trust Board received data from the organisation's MIS evidencing 80% compliance or an in house audit demonstrating that 80% of singleton live births (less than 34+0 weeks) received a full course of antenatal corticosteroids, within seven days of birth?	No
25	b) Has the percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids been recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding?	Yes
26	c) Has the Trust Board received data from the organisation's MIS evidencing 80% compliance or an in house audit demonstrating that 80% of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth?	No
27	d) Has the Trust Board received data from the organisation's MIS evidencing 80% compliance or an in house audit demonstrating that 80% of women have given birth in an appropriate care setting for their gestation (in accordance with local ODN guidance)?	Yes
28	If your process indicator scores for standards a,c or d are less than 80%, do you have an action plan for achieving >80%?	Yes
29	Do you have a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention?	Yes
	Q30 and Q31 are linked	
30	Do women at high risk of preterm birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided?	Yes
31	If this is not the case, has the board described the alternative intervention that has been agreed with their commissioner (ICB) and that their Clinical Network and has agreed this is acceptable clinical practice?	N/A
32	Has an audit of 40 consecutive cases of women booking for antenatal care been completed to measure the percentage of women that are assessed at booking for the risk of preterm birth and stratified to low, intermediate and high risk pathways, and the percentage of those assessed to be at increased risk that are referred to the appropriate preterm birth clinic and pathway? The assessment should use the criteria in Appendix F of SBLCBv2 or an alternative which has been agreed with local ICBs following advice from the Clinical Network.	Yes

33	Does the risk assessment and management in multiple pregnancy comply with NICE guidance or a variant that has been agreed with local commissioners (ICBs) following advice from the provider's clinical network?	Yes

Safety action No. 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 (MVP) to coproduce local maternity services?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you submitted Terms of Reference for your MVP? Do they reflect the core principles for Terms of Reference for a MVP as outlined in annex B of Implementing Better Births: A resource pack for Local Maternity Systems	Yes
2	Do your minutes of MVP meetings demonstrating how service users are listened to and how regular feedback is obtained, that actions are in place to demonstrate that listening has taken place and evidence of service developments resulting from coproduction between service users and staff?	Yes
3	Have you submitted written confirmation from the service user chair that they are being remunerated as agreed and that this remuneration reflects the time commitment and requirements of the role given the agreed work programme? Remuneration should take place in line with agreed Trust processes.	Yes
4	Have you provided minutes of the MVP's work programme, minutes of the MVP meeting which agreed it and minutes of the LMNS board that ratified it?	Yes
5	Do you have written confirmation from the service user chair that they and other service user members of the MVP committee are able to claim out of pocket expenses, including travel, parking and childcare costs in a timely way.	Yes
6	Do you have evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality	Yes
7	Do you have evidence that the MVP Chair is invited to attend maternity governance meetings and that actions from maternity governance meetings, including complaints' response processes, trends and themes, are shared with the MVP	Yes

Safety action No. 8

Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?
In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Can you evidence that:		
1	A local training plan is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programme over 3 years, starting from the launch of MIS year 4 in August 2021. should include the following 6 core modules: • Saving Babies Lives Care Bundle • Fetal surveillance in labour • Maternity emergencies and multi-professional training • Personalised care • Care during labour and the immediate postnatal period • Neonatal life support	Yes
Can you demonstrate at the end of 12 consecutive months within the period of 1st August 2021 until 5th December 2022, 90% of each relevant maternity unit staff group has attended an 'in house' one day multi-professional training day, that includes maternity emergencies?		
2	90% of Obstetric consultants?	Yes
3	90% All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota, including GP trainees?	Yes
4	90% Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)?	Yes
5	90% of Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum)?	Yes
6	90% of Obstetric anaesthetic consultants?	Yes
7	90% of all other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota?	Yes
Can you demonstrate at the end of 12 consecutive months within the period of 1st August 2021 until 5th December 2022, 90% of each relevant maternity unit staff group attended an 'in-house' one day multi-professional training day that includes antenatal and intrapartum fetal monitoring?		
8	90% of Obstetric consultants?	Yes
9	90% of all other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota?	Yes
10	90% of GP trainees who have any obstetric commitment to intrapartum care?	Yes
11	90% of midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres (if applicable)?	Yes

12	Are fetal monitoring sessions consistent with the Ockenden Report recommendations, and include: intermittent auscultation, electronic fetal monitoring with system level issues e.g. human factors, escalation and situational awareness?	Yes
13	Has the Trust board specifically confirmed that within their organisation 90% of eligible staff have attended local multi-professional fetal monitoring training annually as above?	Yes
Can you demonstrate at the end of 12 consecutive months within the period of 1st August 2021 until 5th December 2022, 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended in-house neonatal life support training or a Newborn Life Support (NLS) course?		
14	90% of neonatal Consultants or Paediatric consultants covering neonatal units	Yes
15	90% Neonatal junior doctors (who attend any births)	Yes
16	90% of Neonatal nurses (Band 5 and above)	Yes
17	90% of advanced Neonatal Nurse Practitioner (ANNP)	Yes
18	90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and Maternity theatre midwives who also work outside of theatres.	Yes

Safety action No. 9

Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Have you submitted evidence of a revised pathway which describes how frontline midwifery, obstetric and Board safety champions share safety intelligence between:		
1	a) each other?	Yes
2	b) the Board?	Yes
3	c) new LMNS/ICS quality group?	Yes
4	d) regional quality groups involving the Regional Chief Midwife and Lead Obstetrician to ensure early action and support is provided for areas of concern or need in line with the perinatal quality surveillance model?	Yes
Have you submitted evidence of a revised pathway which describes how frontline neonatal Board safety champions share safety intelligence between:		
5	a) each other?	Yes
6	b) the Board?	Yes
7	c) new LMNS/ICS quality group?	Yes
8	d) regional quality groups involving the Regional Chief Midwife and Lead Obstetrician to ensure early action and support is provided for areas of concern or need in line with the perinatal quality surveillance model?	Yes
Have you submitted evidence that a clear description of the pathway and names of safety champions are visible to:		
9	Maternity staff?	Yes
10	Neonatal staff?	Yes
11	Have you submitted evidence that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified and actions being taken to address any issues?	Yes
12	Have you submitted evidence that discussions regarding safety intelligence, including staff feedback from frontline champions and engagement sessions?	Yes
13	Have you submitted evidence that discussions regarding safety intelligence, including minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022? NB- The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022.	Yes
14	Have you submitted evidence of the engagement sessions (e.g. staff feedback meeting, staff walkaround sessions etc.) being undertaken by a member of the Board?	Yes
15	Have you submitted evidence of progress with actioning named concerns from staff workarounds are visible to maternity staff and reflects action and progress made on identified concerns raised by staff and service users?	Yes
16	Have you submitted evidence of progress with actioning named concerns from staff workarounds are visible to neonatal staff and reflects action and progress made on identified concerns raised by staff and service users?	Yes
17	Have you submitted evidence that the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions to help target interventions aimed at improving patient safety at least twice in the MIS reporting period at a Trust level quality meeting. This can be a board or directorate level meeting?	Yes

18	Has a decision been made by the Board as to whether staffing meets safe minimum requirements to continue rollout of current or planned MCoC teams, or whether rollout should be suspended? This is to be evidenced by a minuted Board level discussion and decision since 1 April 2022 on how a Trust's current workforce position should determine current and future rollout of MCoC. Where more than one discussion has taken place, the most recent discussion should be included in the trust Board submission.	Yes
Is there Evidence of how the Board and Safety Champions have supported staff involved in part d) of the required standard and specifically in relation to:		
19	Active participation by staff in contributing to the delivery of the collective aims of the MatNeo Patient Safety Networks, and undertaking of specific improvement work aligned to the MatNeoSIP national driver diagram and key enabling activities	Yes
20	Engagement in relevant improvement/capability building initiatives nationally, regionally or via the MatNeo Patient Safety Networks, of which the Trust is a member	Yes
21	clinicians identified as MatNeoSIP Improvement Leaders to facilitate and lead work through the MatNeo Patient Safety Networks and the National MatNeoSIP network?	Yes
22	Utilise insights from culture surveys undertaken to inform local quality improvement plans?	Yes
23	oversight of improvement outcomes and learning, and ensure intelligence is actively shared with key system stakeholders for the purpose of improvement	Yes
24	Attendance or representation at a minimum of two engagement events such as Patient Safety Network meetings, MatNeoSIP webinars and/or the annual national learning event by 5th December 2022.	Yes
25	Evidence that insights from culture surveys undertaken have been used to inform local quality improvement plans by 5th December 2022.	Yes

Safety action No. 10

Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you reported all qualifying cases to HSIB from 1 April 2021 to 5 December 2022?	Yes
2	Have you reported all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 April 2022 until 5 December 2022?	Yes
For all qualifying cases which have occurred during the period 1 April 2021 to 5 December 2022, the Trust Board are assured that:		
3	The family have received information on the role of HSIB and NHS Resolution's EN scheme	Yes
4	There has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour	Yes
Can you confirm		
5	Sight of Trust legal services and maternity clinical governance records of qualifying HSIB/EN incidents and numbers reported to HSIB and NHS Resolution.	Yes
6	Sight of evidence that the families have received information on the role of HSIB and EN scheme	Yes
7	Sight of evidence of compliance with the statutory duty of candour.	Yes
8	Complete the field on the Claims Reporting Wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.	Yes

Section A : Maternity safety actions - Milton Keynes Hospital NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Info	Check Response	Not filled in
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes	10	0	0	0	0
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Yes	12	0	1	0	0
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	Yes	19	0	0	0	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	9	0	0	0	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	No	3	0	0	0	1
6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle V2?	Yes	28	0	0	0	0
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 (MVP) to coproduce local maternity services?	Yes	7	0	0	0	0
8	Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an ‘in house’, one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?	Yes	18	0	0	0	0
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes	25	0	0	0	0
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?	Yes	8	0	0	0	0

Section B : Action plan details for Milton Keynes Hospital NHS Foundation Trust

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

Action plan 1

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

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

Action plan 2

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

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

Action plan 3

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

	How?	Who?	When?
Monitoring			

Action plan 4

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

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

Action plan 5

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

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

Action plan 6

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

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

Action plan 7

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

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

Action plan 8

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

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

Action plan 9

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

	How?	Who?	When?
Monitoring			

Action plan 10

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

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

Maternity incentive scheme - Board declaration Form

Trust name	**Milton Keynes Hospital NHS Foundation Trust**
Trust code	**T164**

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	No		-	You have not entered an action plan for this unmet safety action, please check
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**9**	**-**		**You have a validation on 1 safety action. Please recheck the tab B (Safety Actions Summary Sheet) and/or tab C (Action plan entry) before discussing with your board and commissioners before submitting this form to NHS Resolution.**
Total sum requested			**-**	

Sign-off process:

Electronic signature

For and on behalf of the board of Milton Keynes Hospital NHS Foundation Trust

Electronic signature

For and on behalf of the board of Milton Keynes Hospital NHS Foundation Trust

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

Electronic signature

For and on behalf of the board of Milton Keynes Hospital NHS Foundation Trust

Electronic signature

For and on behalf of the board of Milton Keynes Hospital NHS Foundation Trust

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

Electronic signature	
For and on behalf of the board of	Milton Keynes Hospital NHS Foundation Trust

Electronic signature	
For and on behalf of the board of	Milton Keynes Hospital NHS Foundation Trust

Confirming that:
There are no reports covering either **this year (2020/21) or the previous financial year (2019/20)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports should be brought to the MIS team's attention.

Electronic signature	
For and on behalf of the board of	Milton Keynes Hospital NHS Foundation Trust

Electronic signature	
For and on behalf of the board of	Milton Keynes Hospital NHS Foundation Trust

Confirming that:
If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the

Name:	
Position:	
Date:	

Name:	
Position:	
Date:	

Maternity incentive scheme – year four

Conditions of the scheme

Ten maternity safety actions with technical guidance

Questions and answers related to the scheme

October 2022

Contents

Introduction

NHS Resolution is operating year four of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.

The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

The scheme incentivises ten maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved **all** of the **ten** safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that **do not meet** the ten-out-of-ten threshold will **not** recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

Maternity incentive scheme year four: conditions

In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution (nhsr.mis@nhs.net) by 12 noon on Thursday 2 February 2023 and must comply with the following conditions:

- Trusts must achieve **all** ten maternity safety actions.
- The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services
- The Board declaration form must be signed and dated by the Trust's **Chief Executive Officer** (CEO) to confirm that:
  - The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.
  - There are no reports covering either year 2021/22 or 2022/23 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the MIS team's attention before Thursday 2 February 2023.

- The Board must give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be

signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.

- In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICB) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution
  Note: CCG functions will be subsumed into integrated care systems, with CCGs ceasing to exist as statutory organisations by July 2022.

- Trust submissions will be subject to a range of external validation points, these include cross checking with: MBRRACE-UK data (safety action 1 standard a, b and c), NHS England & Improvement regarding submission to the Maternity Services Data Set (safety action 2, criteria 2 to 7 inclusive), and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable (safety action 10, standard a)). Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.
- The Regional Chief Midwives will provide support and oversight to Trusts when receiving Trusts' update at Local Maternity and Neonatal System (LMNS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS compliance in previous years of MIS.
- NHS Resolution will continue to investigate any concerns raised about a Trust's performance either during or after the confirmation of the maternity incentive scheme results. Trusts will be asked to consider their previous MIS submission and reconfirm if they deem themselves to be compliant. If a Trust re-confirm compliance with all of the ten safety actions then the evidence submitted to Trust Board will be requested by NHS Resolution for review. If the Trust is found to be non-compliant (self-declared non-compliant or declared non-compliant by NHS Resolution), it will be required to repay any funding received and asked to review previous years' MIS submissions.
- NHS Resolution will publish the outcomes of the maternity incentive scheme verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution Website).

Evidence for submission

- The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the Trust Board only, and will not be reviewed by NHS Resolution, unless requested as explained above.
- Trusts must declare YES/NO or N/A (where appropriate) against each of the elements within each safety action sub-requirements.
- The Trust must also declare on the Board declaration form whether there are any external reports which may contradict their maternity incentive scheme submission and that the MIS evidence has been discussed with commissioners.

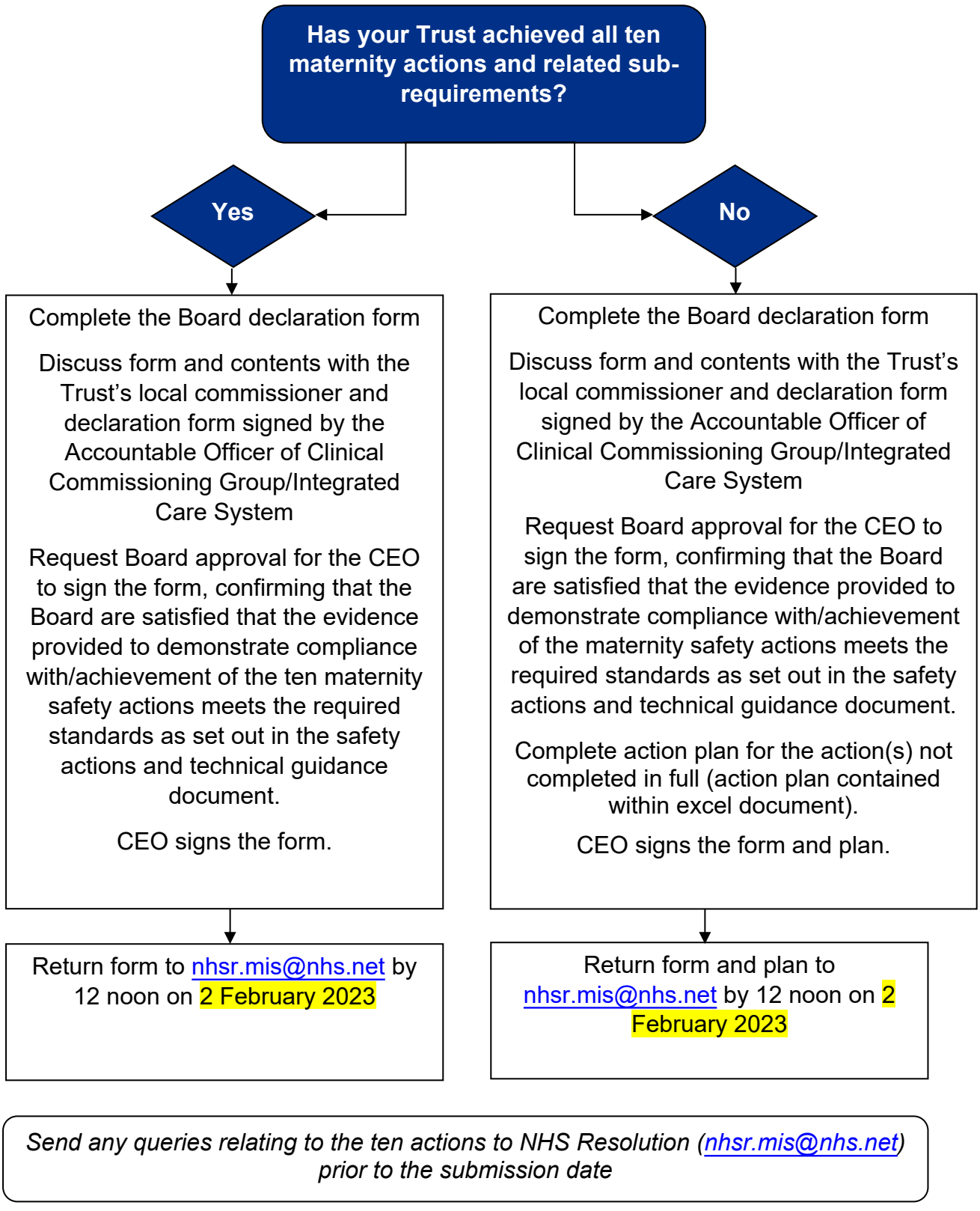
- Trusts will need to report compliance with MIS by Thursday 2 February 2023 at 12 noon using the Board declaration form, which will be published on the NHS Resolution website in the forthcoming months.
- The Trust declaration form must be signed by the Trust's CEO, on behalf of the Trust Board and by Accountable Officer (AO) of Clinical Commissioning Group/Integrated Care System.
- Only for a set amount of safety action requirements, Trusts will be able to declare N/A (not applicable) against some of the sub requirements.
- The declaration form will be available on the MIS webpage at a later date.

Timescales and appeals

- Any queries relating to the ten safety actions must be sent in writing by e-mail to NHS Resolution (nhsr.mis@nhs.net) prior to the submission date.
- The Board declaration form must be sent to NHS Resolution (nhsr.mis@nhs.net) between Thursday 26 January 2023 and Thursday 2 February 2023 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within ten working days from submission date.
- Submissions and any comments/corrections received after 12 noon on Thursday 2 February 2023 will not be considered.
- Further detail on the results publication, appeals and payments process will be communicated at a later date

For Trusts who have not met all ten safety actions

Trusts that have not achieved all ten safety actions may be eligible for a small amount of funding to support progress. In order to apply for funding, such Trusts must submit an action plan together with the Board declaration form by 12 noon on 2 February 2023 to NHS Resolution (nhsr.mis@nhs.net). The action plan must be specific to the action(s) not achieved by the Trust and must take the format of the action plan template which will be provided within the Board declaration form. Action plans should not be submitted for achieved safety actions.


Has your Trust achieved all ten maternity actions and related sub-requirements?
Yes
No
Complete the Board declaration form
Discuss form and contents with the Trust's local commissioner and declaration form signed by the Accountable Officer of Clinical Commissioning Group/Integrated Care System
Request Board approval for the CEO to sign the form, confirming that the Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the ten maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
CEO signs the form.
Return form to nhsr.mis@nhs.net by 12 noon on 2 February 2023
Complete the Board declaration form
Discuss form and contents with the Trust's local commissioner and declaration form signed by the Accountable Officer of Clinical Commissioning Group/Integrated Care System
Request Board approval for the CEO to sign the form, confirming that the Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
Complete action plan for the action(s) not completed in full (action plan contained within excel document).
CEO signs the form and plan.
Return form and plan to nhsr.mis@nhs.net by 12 noon on 2 February 2023
Send any queries relating to the ten actions to NHS Resolution (nhsr.mis@nhs.net) prior to the submission date

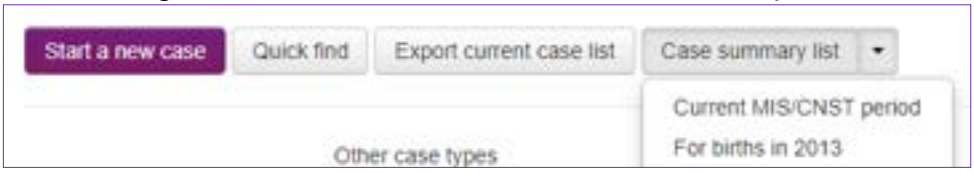
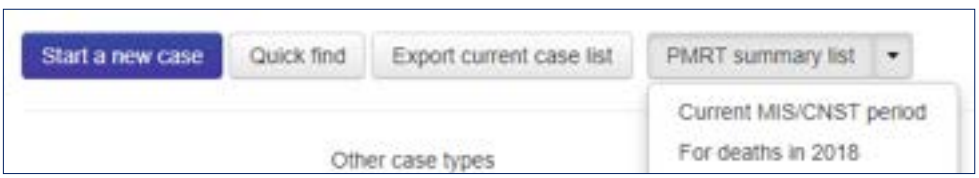
Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

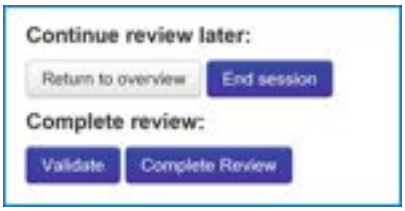
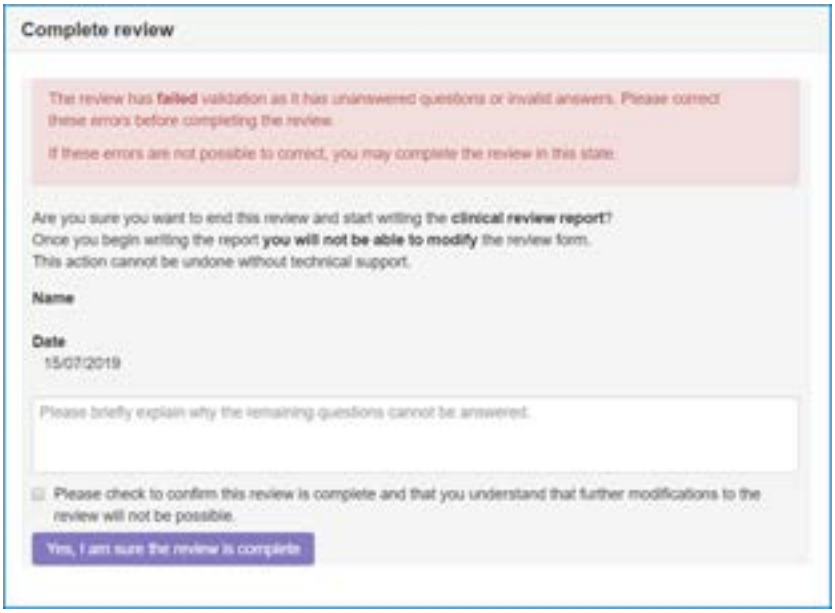
Required standard	a) i. All perinatal deaths eligible to be notified to MBRRACE-UK from 6 May 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter. ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6 May 2022 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust. b) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6 May 2022 will have been reviewed using the PMRT, by a multidisciplinary review team. Each of these reviews will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death. c) For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required.

	d) Quarterly reports will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.
Minimum evidential requirement for Trust Board	Notifications must be made and surveillance forms completed using the MBRRACE-UK reporting website. The perinatal mortality review tool must be used to review the care and reports should be generated via the PMRT. A report has been received by the Trust Board each quarter from 6 May 2022 onwards that includes details of the deaths reviewed and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard c) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.
Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS Resolution will use data from MBRRACE-UK/PMRT, to cross-reference against Trust self-certifications.
What is the relevant time period?	From 6 May 2022 until 5 December 2022
What is the deadline for reporting to NHS Resolution?	Thursday 2 February 2023 at 12 noon

Technical guidance for safety action 1

Technical guidance	
Which perinatal deaths must be notified to MBRRACE-UK?	Details of which perinatal death must be notified to MBRRACE-UK are available at: https://www.npeu.ox.ac.uk/mbrrace-uk/data-collection
What is the time limit for notifying a perinatal death?	All perinatal deaths eligible to be reported to MBRRACE-UK from 6 May 2022 must be notified to MBRRACE-UK within seven working days. When a notification is complete the notification status will show whether surveillance (and review) is required for each case. This is available from the case management screen by clicking on the Case ID and selecting Notification status.  Following notification within seven working days of the perinatal death, the surveillance form, where required, must be completed within one month of the death. If at that stage post-mortem or other investigations are not available and the final cause of death is not confirmed, indicate this in the "Cause of Death/Confirmation of cause of death" section, complete the rest of the information, and close the surveillance form. Once the additional information and the final cause of death is known and confirmed as part of the PMRT review discussion, the reporter should re-open the case, update the relevant sections and close it again. You can reopen the surveillance form from the case management screen. If you need to assign the surveillance form to another Trust for additional information then that death will be excluded from the standard validation of the requirement to complete the surveillance data within one month of the death.

What are the statutory obligations to notify neonatal deaths?	The Child Death Review Statutory and Operational Guidance (England) sets out the obligations of notification for neonatal deaths. This guidance is available at: https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england MBRRACE-UK are working with the National Child Mortality Database (NCMD) team to provide a single route of reporting for neonatal deaths which will be via MBRRACE-UK. Once this single route is established MBRRACE-UK will be the mechanism for directly notifying all neonatal deaths to the local Child Death Overview Panel (CDOP). At that stage, for any Trust not already doing so, a review completed using the PMRT will be the required mechanism for completing the local review for submission to CDOP. This will also be the required route for providing additional information about the death required by the NCMD. Work is underway to provide this single route of reporting with plans to have this in place in the forthcoming months.
How can we keep a check on which of our deaths require surveillance?	There is a report under 'Case summary list' on the MBRRACE-UK case management screen entitled 'Current MIS/CNST period'.  This includes ALL deaths in the Trust which have been notified to MBRRACE-UK and shows the status of the surveillance if required. This will also indicate if surveillance is required and not started/completed.
Which perinatal deaths must be reviewed to meet safety action one standards?	The following deaths should be reviewed to meet safety action one standards: •All late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation) •All stillbirths (from 24+0 weeks' gestation) •Neonatal death (up to 28 days after birth) While it is possible to use the PMRT to review post neonatal deaths (from 29 days after births) this is NOT a requirement to meet safety action one.
How can we keep a check on which of our deaths are suitable for review using the PMRT and their review status?	Within the PMRT authorised users of the PMRT can generate a report for your Trust under 'PMRT summary list' entitled 'Current MIS/CNST period'. This list includes those deaths notified by your Trust which are suitable for review using the PMRT at the point when the report is generated.  This is a list of those deaths notified by your Trust which are suitable for review using the PMRT **at the point when the report is generated**. This report is of ALL deaths in the Trust which have been notified to MBRRACE-UK some of which (for example terminations of pregnancy) are not suitable for review using the PMRT.

What is meant by "starting" a review using the PMRT?	Starting a review in the PMRT requires the death to be notified to MBRRACE-UK for surveillance purposes, and the PMRT to have been used to complete the first review session (which might be the first session of several) for that death. At a minimum all the 'factual' questions in the PMRT should be completed for the review to be regarded as started; it is not sufficient to just open the PMRT tool, this does not meet the criterion of having started a review.
What is meant by "completing a review to the point that at least a draft report has been generated"?	A multidisciplinary review team should have used the PMRT to review the death, then the review progressed to at least the stage of writing a draft report by pressing 'Complete review'.  The tool may raise validation errors at this point. If validation errors appear you need to deal with these in one of two ways: (i) resolve them and then press the 'Complete Review' button again OR (ii) complete the text box with an explanation of why the remaining questions cannot be validated (for example, the mother's hand held notes were lost). Confirm that the review is complete by ticking the box and pressing the button **'Yes I am sure that the review is complete'**.  The report entitled 'PMRT summary list' includes the status of the review, which should be 'Writing report' or 'Review complete'.
What does multi-disciplinary review mean?	The team conducting the review should include at least one and preferably two professionals relevant to the care of the woman and her baby. Ideally the team should include a member from a relevant professional group who is external to the unit who can provide peer review as part of the PMRT review team. It may not be possible to

	include an 'external' member for all reviews and you may need to be selective as to which deaths are reviewed by the team including an external member. Where a HSIB investigation has been carried out the external member could be one or more of the HSIB reviewers involved in the HSIB investigation. Further guidance about multidisciplinary review can be found on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/implementation-support
Review assignment	A feature available in the PMRT is the ability to assign reviews to another Trust for review of elements of the care if some of the care for the women and/or her baby was provided in another Trust. For example, if the baby died in your Trust but antenatal care was provided in another Trust you can assign the review to the other Trust so that they can review the care that they provided. Following their review the other Trust reassigns the review back to your Trust. You can then review the subsequent care your Trust provided Issues with care identified are 'owned' by the Trust which identified them as are the related action plans, but a single report is generated. This ensures that when the report is discussed with the parents all aspects of the care they received can be covered; this should avoid potentially contradictory findings being conveyed and inappropriate advice being given regarding their next pregnancy.
Can the PMRT help by providing a quarterly report which can be presented to the Trust Board?	Reports for your Trust, summarising the results from completed reviews over a period, can be generated within the PMRT by authorised PMRT users for user-defined periods of time. These are available under the 'Your Data' tab in the section entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'. These reports can be used as the basis for your quarterly Board reports and should be discussed with your Trust maternity safety champion.
What deaths should we review outside the relevant time period for the safety action validation process?	We recommend Trusts review all eligible deaths using the PMRT as a routine process, irrespective of the MIS timeframe and validation process.
What should we do if our post-mortem service has a turn-around time in excess of four months?	For deaths where a post-mortem (PM) has been requested (hospital or coronial) and is likely to take more than four months for the results to be available, the PMRT team at MBRRACE-UK advise that you should start the review of the death and complete it with the information you have available. When the post-mortem results come back you should contact the PMRT team at MBRRACE-UK who will re-open the review so that the information from the PM can be

	included. Should the PM findings change the original review findings then a further review session should be carried out taking into account this new information. If you wait until the PM is available before starting a review you risk missing learning opportunities earlier, especially if the turn-around time is considerably longer than four months. Where the post-mortem turn-around time is quicker than this information from the post-mortem can be included in the original reviews.
What should we do if we do not have any eligible perinatal deaths with the relevant time period?	If you do not have any babies that have died between 6 May 2022 and 5 December 2022 then you should partner up with a Trust with which you have a referral relationship to participate in case reviews.
How does the involvement of the Healthcare Safety Investigation Branch (HSIB) in investigations impact on meeting safety action one?	It is recognised that for a small number of deaths (term intrapartum stillbirths and early neonatal deaths of babies born at term) investigations will be carried out by HSIB. Your local review using the PMRT should be started but not completed until the HSIB report is complete. You should consider inviting the HSIB reviewers to attend these reviews to act as the external members of the review team, thereby enabling the learning from the HSIB review to be automatically incorporated into the PMRT review. Depending upon the timing of the HSIB report completion achieving the standards for these babies may therefore be impacted by timeframes beyond the Trust's control. For an individual death you can indicate in the MBRRACE-UK/PMRT case management screen that an HSIB INVESTIGATION is taking place and this will be accounted for in the external validation process.
How does "assigning a review" impact on safety action 1, especially on starting a review?	It is recognised that if you need to assign a review to another Trust this may affect the ability to meet some of the deadlines for starting, completing and publishing that review. This will be accounted for in the external validation process.
We have informed parents that a local review will take place and they have been asked if they have any reflections or questions about their care. However, this information is	In order to address any questions that parents have about their care and why their baby died, parents need to be informed that a review will take place and be given the opportunity to provide their perspective about their care and raise any questions that they have. In order that parents' perspectives and questions can be considered this information needs to be incorporated as part of the review and entered into the PMRT. So if this information is held in another data system it needs to be brought to the review meeting, incorporated into the PMRT and considered as part of the review discussion.

recorded in another data system and not the clinical records. What should we do?	Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials 
We have contacted the parents of a baby who has died and they don't wish to have any involvement in the review process, what should we do?	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of neonatal deaths parents should also be told that a review will be undertaken by the local CDOP. Verbal information can be supplemented by written information. The process of parent engagement should be guided by the parents. Not all parents will wish to provide their perspective of the care they received or raise any questions and/or concerns, but all parents should be given the opportunity to do so. Some parents may also change their mind about being involved and, without being intrusive, they should be given more than one opportunity to provide their perspective and raise any questions and/or concerns they may subsequently have about their care. Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials See especially the notes accompanying the flowchart.
Parents have not responded to our messages and therefore we are unable to discuss the review – what should we do?	As stated above, following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care, and that of their baby, will be undertaken by the Trust (as above). If this does not happen for any reason and parents cannot be reached after three phone/email attempts, send parents a letter informing them of the review process and inviting them to be in touch with a key contact, if they wish. In addition, if causes for concern for the mother's wellbeing were raised during her pregnancy consider contacting her GP/primary carer to reach her. If parents do not wish to input into the review process ask how they would like findings of the perinatal mortality review report communicated to them. Materials to support parent engagement in the local review process, including an outline of role of key contact, are available on the PMRT website at: materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials See notes accompanying the flowchart as well as template letters and ensure engagement with parents is recorded within the parent engagement section of the PMRT.

Is the quarterly review of the Board report based on a financial or calendar year?	This can be either a financial or calendar year. Reports for your Trust summarising the results from reviews over a period time which have been completed can be generated within the PMRT by authorised PMRT users for a user-defined periods of time. These are available under the 'Your Data' tab and the report is entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'. These reports can be used as the basis of your quarterly reports to your Trust Board and should be discussed with your Trust maternity safety champion. Please note that these reports will only show summaries, issues and action plans for reviews **that have been published** therefore the time period selected may need to relate to an earlier period than the current quarter and may lag behind the current quarter by up to six months.
The scheme was paused on 23 December 2021. Trusts were asked to continue to report eligible cases to MBRRACE-UK during the pause. Will the safety action 1 standards be applied to the deaths occurring before the pause date?	Trusts were asked to continue to report eligible cases to MBRRACE-UK during MIS year 4 pause. However, Standard 1 requirements will only be validated for the period after the pause that is, from 6 May 2022 until 5 December 2022.
What should we do if we experience technical issues with using PMRT?	All Trusts are reminded to contact their IT department regarding any technical issue in the first instance. If this cannot be resolved, then the issue should be escalated to MBRRACE-UK as soon as possible. This can be done through the 'contact us' facility within the MBRRACE-UK/PMRT system or by emailing us at: mbrrace.support@npeu.ox.ac.uk
If there are any updates on PMRT for the maternity incentive scheme where will they be published?	Any updates on the PMRT or the MBRRACE-UK notification and surveillance in relation to the maternity incentive scheme safety action, will be communicated via NHS Resolution email and will also be included in the PMRT "message of the day".

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Required standard	This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements. 1. By 31st October 2022, Trusts have an up to date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework. The strategy must be shared with Local Maternity Systems and be signed off by the Integrated Care Board. As part of this, dedicated Digital Leadership should be in place in the Trust and have engaged with the NHSEI Digital Child Health and Maternity Programme. 2. Trust Boards to assure themselves that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022. The data for July 2022 will be published during October 2022. 3. July 2022 data contained height and weight data, or a calculated Body Mass Index (BMI), recorded by 15+0 weeks gestation for 90% of women reaching 15+0 weeks gestation in the month. 4. July 2022 data contained Complex Social Factor Indicator (at antenatal booking) data for 95% of women booked in the month. 5. July 2022 data contained antenatal personalised care plan fields completed for 95% of women booked in the month. (MSD101/2) 6. July 2022 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001) 7. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the

	Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022 for the following metrics: **Midwifery Continuity of carer (MCoC)** i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed. ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided. iii. At least 70% of MSD202 Care Activity (Pregnancy) and MSD302 Care Activity (Labour and Delivery) records submitted in the reporting period have a valid Care Professional Local Identifier recorded. Providers submitting zero Care Activity records will fail this criterion. Criteria i and ii are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation. Criteria iii are fundamental building blocks and a necessary step towards measuring whether or not women have received midwifery continuity of carer (though it is not the complete measurement). The data for July 2022 will be published in October 2022. If the data quality for criteria 7 are not met, trusts can still pass safety action 2 by evidencing sustained engagement with NHS Digital which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS Digital (see technical guidance for further information).
Minimum evidential requirement for Trust Board	1) Criteria 1 will be reported to NHS Resolution as part of trusts' self-declaration using the Board declaration form. For criteria 2 to 7, the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series displays whether trusts have passed the requisite data quality thresholds.
Validation process	All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration

	form. NHS England and Improvement will cross-reference self-certification of criteria 2 to 7 (inclusive) against NHS Digital data
What is the relevant time period?	From 6 May 2022 until 5 December 2022
What is the deadline for reporting to NHS Resolution?	Thursday 2 February 2023 at 12 noon

Technical guidance for safety action 2

Technical guidance	
Regarding criteria 1, we have not started a digital strategy for our maternity service. What support is available?	NHSEI will not be reviewing individual strategies. Support on how to write a strategy can be sought within your own Trust, ICS and Regional Digital Midwife Expert Reference Groups (see below for further information).
Regarding criteria 1, what is meant by having digital leadership in place?	By digital leadership, we mean that the maternity service should have at least 1 person who is dedicated towards working on the digital strategy and improving digital maturity within maternity services. The digital lead does not have to be a clinical member of staff, and could, for example, be a project manager, however they must report to or work alongside a clinician.
Regarding criteria 1, what is meant by engaging with the Digital Child Health and Maternity Programme?	By engaging with the programme, we mean that the digital lead should have made contact and be known to the Regional Digital Midwives Expert Reference group (or equivalent). For further information regarding the Expert Reference Group, please email england.digitalmaternitynhsx@nhs.net
Regarding criteria 1, our Integrated Care Board is unable to sign off our digital strategy. What are the alternative options?	If a Trust already have a pre-existing digital strategy for maternity that aligns with the What Good Looks Like Framework which has been signed off by the appropriate governance, then no further action is needed to meet this criteria. If it is not possible to obtain Integrated Care Board sign-off for new strategies, then sign-off by another appropriate governance board will be acceptable (e.g. LMNS Board).
My maternity service has currently suspended Midwifery Continuity of Carer pathways. How does this affect my data submission for CNST safety action 2?	If your maternity service has suspended Midwifery Continuity of Carer (MCoC) pathways, in your MSDS submission you should report that women are not being placed on these pathways in MSDS table MSD102. This is a satisfactory response for safety action 2 criteria 7i. Consequently, criteria 7ii would not be applicable to your CNST submission as it relates only to women placed on MCoC pathways, and no further action from you would be necessary. However, criteria 7iii does still apply to all maternity services, even if they have suspended MCoC pathways, as we would expect all services to report Care Professional Local Identifier data

Where can I find out further technical information on the above metrics?	Technical information, including relevant MSDSv2 fields and data thresholds required to pass CQIMs and other metrics specified above can be accessed on NHS Digital's website In the "Meta Data" file (see 'construction' tabs) available within the Maternity Services Monthly Statistics publication series: https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics
The following CQIMs use a rolling count across three separate months in their construction. Will my Trust be assessed on these three months? • **Proportion of babies born at term with an Apgar score <7 at 5 minutes** • **Women who had a postpartum haemorrhage of 1,500ml or more** • **Women who were current smokers at delivery** • **Women delivering vaginally who had a 3rd or 4th degree tear** • **Women who gave birth to a single second baby vaginally at or after 37 weeks after a previous caesarean section** • **Caesarean section delivery rate in Robson group 1 women** • **Caesarean section delivery rate in Robson group 2 women** • **Caesarean section delivery rate in Robson group 5 women**	No. For the purposes of the CNST assessment trusts will only be assessed on July 2022 data for these CQIMs. Due to this, trusts are now directed to check whether they have passed the requisite data quality required for this safety action within the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series, as the national Maternity Services Dashboard will still display these data using rolling counts. NHS E&I will externally verify Trust' compliance with criteria 2 to 7.
Will my Trust fail this action if women choose not to receive continuity of carer or a Personalised Care and Support Plan?	**No. This action is focussed on data quality only and therefore Trusts pass or fail it based upon record completeness for each metric and not on the proportion (%) recorded as the metric output.**

The metrics for Midwifery Continuity of Carer appear to have changed. Why is this?	In the last version, there was a metric for placement of women onto midwifery continuity of carer pathways. This has not changed and has simply been broken down into the 2 required data quality measures (see i and ii), to provide more clarity on what is required. The last version also contained a metric to demonstrate evidence of receipt of continuity of carer by women. Current national data quality levels suggest there is much further work to be done for all Trusts to achieve this. Therefore, this has been replaced with a metric (see iii) containing important elements needed to improve the overall data.
The metric for Personalised Care and Support Plans (PCSP) has changed. Why is this?	NHSEI has taken on board feedback that reporting of the PCSP metrics as given previously in this action were not sufficiently aligned to the policy or clinical practice. In addition, we were informed that, as a consequence, Maternity Information Systems had not been appropriately configured to record PCSPs in the way suggested. The replacement metric is the same as that used in last year's MIS, which Trusts successfully reported on. The only difference is that we have increased the reporting threshold from 90 to 95% for the proportion of women with the antenatal PCSP field completed ('yes' or 'no') who were booked in the month. This data still provides useful insight and will contribute towards a more refined measure for PCSPs in future.
What is the Data Quality Submission Summary Tool? How does my Trust access this?	The Data Quality Submission Summary Tool has been developed by NHS Digital specifically to support this safety action. The tool provides an immediate report on potential gaps in data required for CQIMs and other metrics specified above after data submission, so Trusts can take action to rectify them. It is intended to be used alongside other existing reports and documentation in order for providers to be able to create a full and detailed picture of the quality of their data submissions. Further information on the tool and how to access it is available on NHS Digital's website: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/data-quality-submission-summary-tool

For the Data Quality Submission Summary Tool, what does "sustained engagement" mean for the purposes of passing criteria 7?	By "sustained engagement" we mean that Trusts must show evidence of using the tool for at least three consecutive months prior to the submission of evidence to the Trust Board. For example, for a submission made to the Board in November, engagement should be, as a minimum, in August, September and October. This is a minimum requirement and we advise that engagement should start as soon as possible. To evidence this, Trusts should save the Excel output file after running the report for a given month. Three files representing each of the three consecutive months should be provided to your Trust Board as part of the assurance process for MIS. Note – this only becomes a requirement in the event your Trust fails the requisite data quality for the continuity of carer metrics. Also note – in the last version of this action we had asked for evidence of 4 months' use of the tool which included the assessment month. This is no longer the case – any 3 consecutive months before submission of evidence to your Trust Board is sufficient.
The monthly publications and Maternity Services Dashboard states that my Trusts' data has failed for a particular metric. Where can I find out further information on why this has happened?	Details of all the data quality criteria can be found in the "Meta Data" file (see 'CQIMDQ/CoCDQ Measures construction' tabs) which accompanies the Maternity Services Monthly Statistics publication series (https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics). The scores for each data quality criteria can be found in the "Measures" file within the same publication series.
The monthly publications and national Maternity Services Dashboard states that my Trusts' data is 'suppressed'. What does this mean?	Where data is reported in low values for clinical events, the published data will appear 'suppressed' to ensure the anonymity of individuals. However, for the purposes of data quality within this action, 'suppressed' data will still count as a pass.

Where can I find out more about MSDSv2?	https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set
Where should I send any queries?	**On MSDS data** For queries regarding your MSDS data submission, or on how your data is reported in the monthly publication series or on the Maternity Services Dashboard please contact NHS Digital at maternity.dq@nhs.net. **For any other queries**, please email nhsr.mis@nhs.net

Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?

Required standard	a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care. b) The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, LMNS, commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter. c)A data recording process (electronic and/or paper based for capturing **all** term babies transferred to the neonatal unit, regardless of the length of stay, is in place. d) A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered. e) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), LMNS and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies. f) Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted or remained on Neonatal Units because of their need for nasogastric tube feeding, but could have been

	cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis. g) An action plan to address local findings from the audit of the pathway (point b) and Avoiding Term Admissions Into Neonatal units (ATAIN) reviews (point f) has been agreed with the maternity and neonatal safety champions and Board level champion. h) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting.
Minimum evidential requirement for Trust Board	Local policy/pathway available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: **Evidence for standard a) to include:** • There is evidence of neonatal involvement in care planning • Admission criteria meets a minimum of at least one element of HRG XA04 but could extend beyond to BAPM transitional care framework for practice • There is an explicit staffing model • The policy is signed by maternity/neonatal clinical leads and should have auditable standards. • The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.
	Evidence for standard b) to include: • An audit trail is available which provides evidence that ongoing audits from year 3 of the maternity incentive scheme of the pathway of care into transitional care are being completed as a minimum of quarterly. If for any reason, reviews have been paused, they should be recommenced using data from quarter 1 of 2022/23 financial year. • Audit findings are shared with the neonatal safety champion on a quarterly basis. Where barriers to achieving full implementation of the policy are encountered, an action plan should be agreed and progress overseen by both the board and neonatal safety champions.
	Evidence for standard c) to include: • Data is available (electronic and/or paper based) on all term babies transferred or admitted to the neonatal unit. This will include admission data captured via Badgernet as well as transfer data which may be captured on a separate paper or electronic system.

	• If a data recording process is not already in place to capture all babies transferred or admitted to the NNU this should be in place no later than **Monday 18 July 2022.**
	Evidence for standard d) to include: • Data is available (electronic or paper based) on transitional care activity (regardless of place - which could be a TC, postnatal ward, virtual outreach pathway etc.). • Secondary data is available (electronic or paper based) on babies born between 34+0-36+6 weeks gestation at birth, who did not have surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered to inform future capacity management for late preterm babies who could be cared for in a TC setting.
	Evidence for standard e) to include: • Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 are available to share on request, for example to support service development and capacity planning, with the LMNS, ODN and/or commissioner.
	Evidence for standard f) to include: • An audit trail is available which provides evidence that ongoing reviews from year 3 of the maternity incentive scheme of term admissions are being completed as a minimum of quarterly. If for any reason, reviews have been paused, they should be recommenced using data from quarter 1 of 2022/23 financial year. • If not already in place, an audit trail is available which provides evidence that reviews from Monday 18 July 2022, now include **all** term babies transferred or admitted to the NNU, irrespective of their length of stay, are being completed as a minimum of quarterly. If your reviews already included all babies transferred or admitted to the NNU then this should continue using data from quarter 1 of 2022/23 financial year. • Evidence that the review includes: the number of transfers or admissions to the neonatal unit that would have met current TC admission criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues and the number of babies that were transferred or admitted to, or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there.

	• Evidence that findings of all reviews of term babies transferred or admitted to a neonatal unit are reviewed quarterly and the findings have been shared quarterly with the maternity and neonatal safety champions and Board level champion, the LMNS and ICS quality surveillance meeting.
	Evidence for standard g) and h): • An audit trail is available which provides evidence and rationale for developing the agreed action plan to address local findings from the pathway audit (point b) and the ATAIN reviews (point f).Evidence that progress with the action plan has been shared with the neonatal, maternity safety champion, and Board level champion, LMNS and ICS quality surveillance meeting each quarter.
	• Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form
Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form
What is the relevant time period?	a) The expectation is that the pathway has been in place since year 2 of the scheme and should now be business as usual. If for any reason this is not in place it should be by Thursday 16 June 2022 at the very latest. b) The expectation is that the audits have been in place since year 3 of the scheme and should now be business as usual. If for any reason, audits have been paused, they should be recommenced, using data from quarter 1 of 2022/23 financial year and be completed on a quarterly basis. There should be evidence that audit findings are shared with the neonatal safety champion each quarter. c) Reviews of babies transferred to the neonatal unit, including those not captured on BadgerNet and regardless of length of stay should be in place from no later than Monday 18 July 2022. d) Data collection process should have been met and in place in year 3 of the scheme. If for any reason it was not, this should be achieved by no later than 16 June 2022. Secondary data collection process for late pre-terms in place by no later than 16 June 2022. e) Commissioner returns on request – as per ODN request f) The expectation is that the reviews have been in place since year 3 of the scheme and should now be business as usual. If for any reason, reviews have been paused, they should be recommenced using data from quarter 1 of 2022/23 financial year and be completed on a quarterly basis.

	Reviews of babies transferred to the neonatal unit, including those not captured on BadgerNet and regardless of length of stay, should be included from Monday 18 July 2022. If your reviews already included all babies transferred or admitted to the NNU then this should continue using data from quarter 1 of 2022/23 financial year. There should be evidence that review findings have been shared quarterly with the maternity and neonatal safety champions and Board level champion, the LMNS and ICS quality surveillance meeting. g) Evidence of an action plan (to address points b, and f) being agreed with the maternity and neonatal safety champions and Board level champion and signed off by the Board no later than 29 July 2022. h) Evidence of progress with the action plan being shared with the neonatal, maternity safety champion, Board level champion and LMNS and ICS quality surveillance meeting each quarter following sign off at the Board.
What is the deadline for reporting to NHS Resolution?	Thursday 2 February 2023 at 12 noon

Technical guidance for safety action 3

Technical guidance	
Does the data recording process need to be available to the ODN/LMNS/ commissioner?	The requirement for a data recording process has been carried over from year three of the maternity incentive scheme as a means of informing future capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies. This could be captured through existing systems such as BadgerNet or alternatives such as paper based or electronic systems. These returns do not need to be routinely shared with the ODN, LMNS and/or commissioner but must be readily available should it be requested.
What members of the MDT should be involved in Atain reviews?	The expectation is that this is a multi-professional review, as a minimum the care should be reviewed by representation from both maternity and neonatal staff groups. This should include as a minimum; a member of the maternity team (a midwife and / or obstetrician and /or trainee from maternity services) and a member of the neonatal team (neonatal nurse and / or neonatologist/paediatrician and/or trainee from neonatal services).
Why has the standard now been changed to include all babies transferred and admitted to a NNU?	Feedback from regional maternity colleagues identified variation in ATAIN reviews being undertaken, with some units reviewing all babies admitted and transferred to the NNU and some only reviewing those admitted onto Badgernet. There is valuable learning in both and to avoid unwarranted variation and maximise the opportunity to learn, ATAIN reviews must include **all babies transferred or admitted to the NNU for any period of time**. As a minimum, a high-level review of the primary reasons for all transfers and admissions should be completed, with a focus on the most frequent reason(s) for transfer or admission through a deep dive to determine relevant themes to be addressed.
What do you mean by ‘transferred to the NNU’	This is when a baby is transferred to the NNU for any period of observation and / or intervention, regardless of whether this was recorded on Badgernet. **We are fully supportive of this practice and would not discourage perinatal services from doing this as this might impact on safe care being provided.**
We have undertaken some reviews for term	Maintaining oversight of the number of term babies admitted to a Neonatal Unit (NNU) is an important component of sustaining the

admissions to NICU, do we need to undertake more and do all babies admitted or transferred to the NNU need to be included?	ATAIN work to date. The expectation is that reviews have been continued from year 3 of the scheme. If for any reason, reviews have been paused, they should be recommenced using data from quarter 1 of the 2022/23 financial year (beginning 1 April 2022). **This may mean that some of the audit is completed retrospectively.** For units where previous reviews have not included term babies transferred to the NNU with a short stay, or babies not admitted on BadgerNet, reviews must now include these babies no later than Monday 18 July 2022. If your reviews already included all babies transferred or admitted to the NNU then this should continue using data from quarter 1 of 2022/23 financial year. We recommend **ongoing reviews, at least quarterly** of unanticipated term admissions to the NNU to determine whether there were modifiable factors which could be addressed as part of an action plan. A high-level review of the primary reasons for all transfers and admissions should be completed, with a focus on the most frequent reason(s) for transfer or admission through a deep dive to determine relevant themes to be addressed. For example, if 60% of babies are transferred or admitted for respiratory problems, then focus on this cohort of babies and complete a deep dive into identified themes or if 40% of babies were transferred or admitted due to observation for hypoglycaemia and 35% of with hypothermia then focus on these two cohorts of babies. **It is important to monitor emerging trends in transfers and admissions and these should also be factored into the quarterly review. For example, if there is an increasing number of babies transferred each month due to hypothermia, or to receive IV antibiotics, even if this is not the most frequent reason, a deep dive should be performed so that actions are put in place to mitigate any future separation of mother and baby.** In addition to this the number of babies transferred or admitted to the NNU that would have met current TC admission criteria but were transferred to the NNU due to capacity or staffing issues and the number of babies that were transferred or admitted to, or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there should be reported on.
Do we include babies that were transferred to the NNU rather than TC	No, these babies do not need to be captured.

due to the parents declining to stay for TC, but not due to staffing or capacity issues?	
What do mean by quarterly?	Occurring every three months. This would usually mirror the 4 quarters of the financial year, for example quarter 1 covering 01/04/2022-30/06/2022).
ATAIN audit – what should the audit include and is there a standard audit tool?	An audit tool can be accessed below as a baseline template, however the audit needs to include aspects of the local pathway. The audit tool can be found here https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-Trusts/maternity-incentive-scheme/ We recommend that Trusts refer to the auditable standards included in their local TC pathway guideline/policy.
What "*nor were transferred during any admissions*" mean?	This refers to babies that are transferred between Units of a Trust (e.g. if they needs an uplift in care).
"If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0 - 36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admissions, to monitor the number of special care or normal care days where supplemental oxygen was not delivered" **FAQ - If women are booked at another hospital and come in for delivery at our hospital and deliver**	The statement refers only to neonatal transfers (not to e.g. an ex-utero transfer).

here, does this count as a transfer as well as an ex-utero transfer as mum was transferred in not the baby?	
If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0 - 36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admissions, to monitor the number of special care or normal care days where supplemental oxygen was not delivered" **If a baby is transferredfor ITU or HD care initially and subsequently to TC, do we exclude them completely, or just count the special care days they have?**	The aim of this requirement is to count all babies who would be fit for TC when they get to that point- either directly at birth, or subsequently (as this is still mother/baby separation, which is what we are aiming to reduce). If Badgernet/NNAP data is used, it would include babies initially transferredto ITU/HDU. **These babies should be captured as a number but do not need to be included in a detailed review.**
How long have the neonatal safety champions been in place for?	Trust board champions were contacted in February 2019 and asked to nominate a neonatal safety champion. The identification of neonatal safety champions is a recommendation of the national neonatal critical care review and have been in place since February/March 2019.
What is the definition of transitional care?	Transitional care is not a place but a service and can be delivered either in a separate transitional care area, within the neonatal unit and/or in the postnatal ward setting. Principles include the need for a multidisciplinary approach between maternity and neonatal teams; an appropriately skilled and trained workforce, data collection with regards to activity, appropriate admissions as per HRGXA04 criteria and a link to community services.

Where can we find additional guidance regarding this safety action?	https://www.bapm.org/resources/80-perinatal-management-of-extreme-preterm-birth-before-27-weeks-of-gestation-2019 https://www.bapm.org/resources/24-neonatal-transitional-care-a-framework-for-practice-2017 https://improvement.nhs.uk/resources/reducing-admission-full-term-babies-neonatal-units/ https://www.e-lfh.org.uk/programmes/avoiding-term-admissions-into-neonatal-units/ https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/Illness-in-newborn-babies-leaflet-FINAL-070420.pdf Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf (england.nhs.uk)

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Required standard	a) Obstetric medical workforce 1. The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service: https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ 2. Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMNS. **b) Anaesthetic medical workforce** A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients (ACSA standard 1.7.2.1) **c) Neonatal medical workforce** The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If the requirements **had not been met** in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies.

	If the requirements **had been met** in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies. **d) Neonatal nursing workforce** The neonatal unit meets the service specification for neonatal nursing standards. If the requirements **had not been met** in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements **had been met** in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies and share this with the Royal College of Nursing, LMNS and Neonatal Operational Delivery Network (ODN) Lead.
Minimum evidential requirement for Trust Board	**Obstetric medical workforce** Sign off at Trust Board level acknowledging engagement with the RCOG document along with an action plan to review any non-attendance to the clinical situations listed in the document. Trusts should evidence their position with the Trust Board, Trust Board level safety champions and LMNS meetings at least once from the relaunch of MIS year 4 in May 2022. **Anaesthetic medical workforce** The rota should be used to evidence compliance with ACSA standard 1.7.2.1. **Neonatal medical workforce** The Trust is required to formally record in Trust Board minutes whether it meets the recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should evidence progress against the action plan developed in year 3 of MIS to address deficiencies. **Neonatal nursing workforce** The Trust is required to formally record to the Trust Board minutes the compliance to the service specification standards annually using the neonatal clinical reference group nursing workforce calculator. For units that do not meet the standard, the Trust Board should evidence progress against the action plan developed in year 3 of MIS to address deficiencies.

	A copy of the action plan, outlining progress against each of the actions, should be submitted to the Royal College of Nursing (cypadmin@rcn.org.uk), LMNS and Neonatal Operational Delivery Network (ODN) Lead.
Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form
What is the relevant time period?	**a) Obstetric medical workforce** 1. By 16 June 2022 2. By 29 July 2022 and monitored **monthly** from then. **b) Anaesthetic medical workforce** Any six month period between August 2021 and 5 December 2022 **c) Neonatal medical workforce** A review has been undertaken any 6 month period between August 2021 and 5 December 2022. **d) Neonatal nursing workforce** Nursing workforce review has been undertaken at least once during year 4 reporting period (August 2021 and 5 December 2022).
What is the deadline for reporting to NHS Resolution?	Thursday 2 February 2023 at 12 noon

Technical guidance for safety action 4

Technical guidance	
Obstetric workforce standard and action	
How can the Trust board evidence that the department has acknowledged and committed to incorporating the principles of the RCOG document?	Documented evidence of discussion at relevant meetings e.g. consultant meeting, divisional governance meetings, new consultants' induction etc. Circulation to all staff who work in maternity and Gynaecology. Mandatory consultant attendance list to be included in departmental escalation policies.
How can the Trust monitor adherence with the standard?	For example, departments can audit consultant attendance for clinical scenarios or situations mandating their presence in the guidance. Departments may also wish to monitor adherence via incident reporting systems. Feedback from departmental or other surveys may also be employed for triangulation of compliance.
What should a department do if there is non-compliance with attending mandatory scenarios/situations?	Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.
Can we self-certify compliance with this element of safety action 4 if consultants have not attended clinical situations on the mandated list?	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans implemented to prevent subsequent non-attendances. These can be signed off by the Trust Board.
RCOG "Roles & Responsibilities" - Are we required to evidence compliance with the obstetric attendance requirements or also the Gynae ones included in the RCOG list?	Trusts should monitor their compliance against the RCOG standards in relation to Consultants with any obstetric commitment to intrapartum care.
What period is the audit to cover and is it a snapshot or day by day audit?	Trusts should monitor their compliance day by day on a monthly basis from 29 July 2022

Where can I find the roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology RCOG workforce document?	https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/

Anaesthetic medical workforce

Technical guidance	
Anaesthesia Clinical Services Accreditation (ACSA) standard and action	
1.7.2.1	A duty anaesthetist is immediately available for the obstetric unit 24 hours a day. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patient in order to be able to attend immediately to obstetric patients.

Neonatal medical workforce

Technical guidance	
Neonatal Workforce standards and action	
Do you meet the BAPM national standards of junior medical staffing depending on unit designation?	If no, Trust Board should outline progress with the action plan developed in year 3 of MIS and submit this to the Neonatal ODN. There should also be an indication whether the standards not being met is due to insufficient funded posts or no trainee or/suitable applicant for the post (rota gap). There should also be a record of the rota tier affected by the gaps.
BAPM **"Optimal Arrangements for Neonatal Intensive Care Units in the UK. A BAPM Framework for Practice" 2021** **or** **"Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: A Framework for Practice" 2018**	
NICU **Neonatal Intensive Care Unit**	Staff at each level should only have responsibility for the NICU and Trusts with more than one neonatal unit should have completely separate cover at each level of staff during office hours and out of hours. **Tier 1**

	Resident out of hours care should include a designated tier one clinician - Advanced Neonatal Nurse Practitioner (ANNP) or junior doctor ST1-3 NICUs co-located with a maternity service delivering more than 7000 deliveries per year should augment their tier 1 cover at night by adding a second junior doctor, an ANNP and/or by extending nurse practice **Tier 2** A designated experienced junior doctor ST 4-8 or appropriately trained specialty doctor or ANNP NICUs with more than 2500 intensive care days should have an additional experienced junior doctor ST4-8 or appropriately trained specialty doctor or ANNP. (A consultant present and immediately available on NICU in addition to tier 2 staff would be an alternative) **Tier 3** Consultant staff in NICUs should be on the General Medical Council specialist register for neonatal medicine or equivalent and have primary duties on the neonatal unit alone NICUs undertaking more than 4000 intensive care days per annum with onerous on call duties should consider having a consultant present in addition to tier 2 staff and immediately available 24 hours per day. NICUs undertaking more than 2500 intensive care days per annum should consider the presence of at least 2 consultant led teams during normal daytime hours. NICUs undertaking more than 4000 intensive care days per annum should consider the presence of three consultant led teams during normal daytime hours.

LNU **Local Neonatal Unit**	**Tier 1** At least one resident tier 1 practitioner immediately available dedicated to providing emergency care for the neonatal service 24/7 In large LNUs (>7000 births) there should be two dedicated tier 1 practitioners 24/7 to support emergency care, in keeping with the NICU framework **Tier 2** An immediately available resident tier 2 practitioner dedicated solely to the neonatal service at least during the periods which are usually the busiest in a co-located Paediatric Unit e.g. between 09.00 - 22.00, seven days a week LNUs undertaking either >1500 Respiratory Care Days (RCDs) or >600 Intensive Care (IC) days annually should have immediately available a dedicated resident tier 2 practitioner separate from paediatrics 24/7 **Tier 3** Units designated as LNUs providing either >2000 RCDs or >750 IC days annually should provide a separate Tier 3 Consultant rota for the neonatal unit LNUs providing >1500 RCDs or >600 IC days annually should strongly consider providing a dedicated Tier 3 rota to the neonatal unit entirely separate from the paediatric department; a risk analysis should be performed to demonstrate the safety & quality of care if the Tier 3 is shared with paediatrics at any point in the 24 hours in these LNUs. All LNUs should ensure that all Consultants on-call for the unit also have regular weekday commitments to the neonatal service. This is best delivered by a 'consultant of the week' system and no consultant should undertake fewer than 4 'consultant of the week' service weeks annually No on-call rota should be more onerous than one in six and all new appointments to units with separate rotas should either have a SCCT in neonatal medicine or be a general paediatrician with a special interest in neonatology or have equivalent neonatal experience and training
SCU **Special Care Unit**	**Tier 1** A resident tier 1 practitioner dedicated to the neonatal service in day-time hours on weekdays and a continuously immediately available resident tier 1 practitioner to the unit 24/7. This person could be shared with a co-located Paediatric Unit out of hours.

	Tier 2 A resident tier 2 to support the tier 1 in SCUs admitting babies requiring respiratory support or of very low admission weight <1.5kg. This Tier 2 would be expected to provide cover for co-located paediatric services but be immediately available to the neonatal unit **Tier 3** In SCUs there should be a Lead Consultant for the neonatal service and all consultants should undertake a minimum of continuing professional development (equivalent to a minimum of eight hours CPD in neonatology)
Our Trust do not meet the relevant neonatal medical standards (Tier 1, 2 and/or 3) and in view of this an action plan, ratified by the Board has been developed. Can we declared compliance with this sub-requirement?	If the requirements are not met, Trust Board should outline progress against the action plan developed as part of year three of MIS in order to meet the recommendations. Action plan and related progress details should be shared with the Neonatal ODN. This will enable Trusts to declare compliance with this sub-requirement.
When should the review take place?	The review should take place at least once during the MIS year 4 reporting period.
Please access the followings for further information on Standards	BAPM Optimal Arrangements for Neonatal Intensive Care Units in the UK (2021) A BAPM Framework for Practice https://www.bapm.org/resources/296-optimal-arrangements-for-neonatal-intensive-care-units-in-the-uk-2021 Optimal arrangements for Local Neonatal Units and Special Care Units in the UK (2018). A BAPM Framework for Practice https://www.bapm.org/resources/2-optimal-arrangements-for-local-neonatal-units-and-special-care-units-in-the-uk-2018

Neonatal nursing workforce

Technical guidance
Neonatal nursing workforce

Where can we find more information about the requirements for neonatal nursing workforce?	Between 8 August 2021 until 5 December 2022, each neonatal unit should perform a nursing workforce calculation using the CRG work force staffing tool. Units that do not meet the service specification requirement for nursing workforce should have an action plan signed off by their Trust board, as per MIS year 3 requirements. Trust Board should evidence progress against the action plan and share those with the RCN, LMNS and Neonatal ODN.
Our Trust does not meet the relevant nursing standards and in view of this an action plan, ratified by the Board has been developed. Can we declare compliance with this sub-requirement?	If the requirements are not met, Trust Board should evidence progress against the action plan developed in year 3 of MIS to meet the recommendations. The action plan and related progress, signed off by the Trust Board, should be shared with the Royal College of Nursing (cypadmin@rcn.org.uk) and Neonatal ODN Lead. This will enable Trusts to declare compliance with this sub-requirement.

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required standard	a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed. b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above. c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service d) All women in active labour receive one-to-one midwifery care e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period.
Minimum evidential requirement for Trust Board	The report submitted will comprise evidence to support a, b and c progress or achievement. It should include: • A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated • In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. • Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. • The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners. • Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. -The midwife to birth ratio -The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not

	included in clinical numbers. This includes those in management positions and specialist midwives. • Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.
Validation process	Self-certification to NHS Resolution using the Board declaration form
What is the relevant time period?	From 6 May 2022 until 5 December 2022
What is the deadline for reporting to NHS Resolution?	Thursday 2 February 2023 at 12 noon

Technical guidance for Safety action 5

Technical guidance	
What midwifery red flag events could be included in six monthly staffing report (examples only)? **We recommend that Trusts continue to monitor the red flags as per previous year and include those in the six monthly report to the Trust Board, however this is currently not within the minimal evidential requirements but more a recommendation based on good practice**.	• Redeployment of staff to other services/sites/wards based on acuity • Delayed or cancelled time critical activity. • Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing). • Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). • Delay of more than 30 minutes in providing pain relief. • Delay of 30 minutes or more between presentation and triage. • Full clinical examination not carried out when presenting in labour. • Delay of two hours or more between admission for induction and beginning of process. • Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). • Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally. Please see the following NICE guidance for details: www.nice.org.uk/guidance/ng4/resources/safe-midwifery-staffing-for-maternity-settings-pdf-51040125637
Can the labour ward coordinator be considered to be supernumerary if for example they had to relieve staff for breaks on a shift?	The Trust can report compliance with this standard if this is a one off event and the coordinator is not required to provide 1:1 care for a woman in established labour during this time. If this is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in their action plan mentioned in the section above. The role of the co-ordinator includes providing oversight of the labour ward and support and assistance to other midwives. For example: providing CTG 'fresh eyes', giving second opinion and reviews, providing assistance to midwives at birth when required, supporting junior

	midwives undertaking suturing etc. This should not be counted as losing supernumerary status. Supernumerary status will be lost if the labour ward coordinator is required to be solely responsible for any 1:1 care for a labouring woman or relieve for break, (or any short period of time) a midwife who is providing 1:1 care for a high risk woman requiring constant observation. This includes supervising a student midwife providing 1:1 care.
What if we do not have 100% supernumerary status for the labour ward coordinator?	An action plan detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board, and includes a timeline for when this will be achieved. As stated above, completion of an action plan will not enable the Trust to declare compliance with this sub-requirement in year 4 of MIS.
What if we do not have 100% compliance for 1:1 care in active labour?	An action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board, and includes a timeline for when this will be achieved. Completion of the action plan will enable the Trust to declare compliance with this sub-requirement.

Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?

Required standard	1. Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019. Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract. 2. Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network. 3. The quarterly care bundle survey should be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements. The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net from May 2022 onwards. Evidence of the completed quarterly care bundle surveys should be submitted to the Trust board.
Minimum evidential requirement for Trust Board	**Element one** Process indicators: A. Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded. B. Percentage of women where CO measurement at 36 weeks is recorded. Note: The relevant data items for these process indicators should be recorded on the provider's Maternity Information System (MIS) and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. The Trust board should receive data from the organisation's MIS evidencing an average of 80% compliance over a four month period (i.e. four consecutive months in during the MIS year 4 reporting timeframe). If there is a delay in the provider Trust's ability to submit these data to MSDS then compliance can be determined using their interim data recording method. The denominator should still be the total number of women at booking or 36 weeks gestation, as appropriate for each process indicator. If the provider Trust is unable to record these data on their maternity information system an audit of 60 consecutive cases

would be acceptable evidence to demonstrate >80% of women having a CO measurement recorded at 36 weeks. The denominator for the audit should be 60 consecutive women at 36 weeks gestation, whereas the denominator for the electronic audit would be the total number of women at 36 weeks gestation. In addition to this, the audit should be accompanied by a brief description of the stop smoking strategy within the Trust and any plans for improvement.

A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%.

If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.

In addition, the Trust board should specifically confirm that within their organisation they:

1) Pass the data quality rating on the National Maternity Dashboard for the 'women who currently smoke at booking appointment' Clinical Quality Improvement Metric.
2) Have a referral pathway to smoking cessation services (in house or external).
3) Audit of 20 consecutive cases of women with a CO measurement ≥4ppm at booking, to determine the proportion of women who were referred to a smoking cessation service.
4) Have generated and reviewed the following outcome indicators within the Trust for four consecutive months within the MIS year 4 reporting period:
    - Percentage of women with a CO measurement ≥4ppm at booking.
    - Percentage of women with a CO measurement ≥4ppm at 36 weeks.
    - Percentage of women who have a CO level ≥4ppm at booking who subsequently have a CO level <4ppm at the 36 week appointment.

Additional information

If your Trust is planning on using the maternity dashboard to evidence an average of 80% compliance over four months, please be advised that there is a three month delay with MSDSv2 data, for example data submitted at the end of August 2022 will be published on the dashboard at the end of November 2022.

If your Trust does not have an in house stop smoking service or a pathway to an external service, please contact your local authority stop smoking service or escalate to your local maternity system to enable the Trust to ensure provision is in place.

	Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded. **Women declining CO testing at booking / 36 weeks appointment** Standard A and B of element 1 require Trusts to demonstrate that 80% of women had CO testing at booking and at 36 weeks respectively and that this is recorded in the Trusts' information system. In the event of a high number of women declining CO testing a Trust would be at risk of failing standard A and B by not reaching the 80% testing rate. We suggest Trusts proactively monitor their testing rate and consider interventions to maintain adequate compliance.
	Element two **Process indicator:** 1) Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20 week scan (e.g. Appendix D). Note: The relevant data items for these indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. The Trust board should receive data from the organisation's MIS evidencing 80% compliance. If there is a delay in the provider Trust Maternity Information System's ability to record these data at the time of submission an in house audit of 40 consecutive cases of women at 20 weeks scan using locally available data or case records should have been undertaken to assess compliance with this indicator. **A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%.** **If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.** In addition the Trust board should specifically confirm that within their organisation: 2) Women with a BMI>35 kg/m^2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards

	3) In pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation 4) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation. 5) They have generated and reviewed the percentage of perinatal mortality cases for 2021 where the identification and management of FGR was a relevant issue (using the PMRT). 6) Their risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance or a variant has been agreed with local commissioners (CCGs) following advice from the Clinical Network. 7) They undertake a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation. The review should seek to identify themes that can contribute to FGR not being detected (e.g. components of element 2 pathway and/or scanning related issues). The Trust board should be provided with evidence of quality improvement initiatives to address any identified problems. Trusts can omit the above mentioned quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation for quarter 3 of this financial year (2021/22) if staffing is critical and this directly frees up staff for the provision of clinical care.
	Element three Process indicators: A. Percentage of women booked for antenatal care who had received reduced fetal movements leaflet/information by 28+0 weeks of pregnancy. B. Percentage of women who attend with RFM who have a computerised CTG (a computerised system that as a minimum provides assessment of short term variation). Note: The SNOMED CT code is still under development for RFM and therefore an in-house audit of two weeks' worth of cases or 20 cases of women attending with RFM whichever is the smaller to assess compliance with the element three process indicators. **A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%.** **If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.**
	Element four There should be Trust board sign off that staff training on using their local CTG machines, as well as fetal monitoring in labour are

	conducted annually. The fetal monitoring sessions should be consistent with the Ockenden Report recommendations, and include: intermittent auscultation, electronic fetal monitoring with system level issues e.g. human factors, escalation and situational awareness. The Trust board should specifically confirm that within their organization 90% of eligible staff (see Safety Action 8) have attended local multi-professional fetal monitoring training annually as above. Please refer to safety action 8 for more information re training.
	Element five Process indicators: A. Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth. B. Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids. C. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth. D. Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance). Note: The relevant data items for these process indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. If there is a delay in the provider Trust MIS's ability to record these data then an audit of 40 cases consisting of 20 consecutive cases of women presenting with threatened preterm labour before 34 weeks and 20 consecutive cases of women who have given birth before 34 weeks using locally available data or case records should have been undertaken to assess compliance with each of the process indicators. **The Trust board should receive data from the organisation's Maternity Information System evidencing 80% compliance with process indicators A, C and D. The percentage for process indicator B should be as low as possible and can be reported as the proportion.**

	A Trust will not fail Safety Action 6 if the process indicator scores are less than 80%. However, Trusts must have an action plan for achieving >80%. In addition, the Trust board should specifically confirm that within their organisation: • They have a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention. (Best practice would be to also appoint a dedicated Lead Midwife. Further guidance/information on preterm birth clinics can be found on https://www.tommys.org/sites/default/files/2021-03/reducing%20preterm%20birth%20guidance%2019.pdf • Women at high risk of preterm birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided. If this is not the case the board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed is acceptable clinical practice. • An audit of 40 consecutive cases of women booking for antenatal care has been completed to measure the percentage of women that are assessed at booking for the risk of preterm birth and stratified to low, intermediate and high risk pathways, and the percentage of those assessed to be at increased risk that are referred to the appropriate preterm birth clinic and pathway. The assessment should use the criteria in Appendix F of SBLCBv2 or an alternative which has been agreed with local CCGs following advice from the Clinical Network. • Their risk assessment and management in multiple pregnancy complies with NICE guidance or a variant that has been agreed with local commissioners (CCGs) following advice from the provider's clinical network.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	Trusts should be evidencing the position as of 2 February 2023 at 12 noon

Technical guidance for Safety action 6

Technical guidance	
Where can we find guidance regarding this safety action?	SBL care bundle: https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/ The SBLCB v2 Technical Glossary which includes the numerators and denominators for all of the process indicators can be found on the NHS Digital webpages here: https://digital.nhs.uk/binaries/content/assets/website-assets/data-and-information/data-sets/maternity-services/sblcbv2-msds-v2.0-technical-glossary-for-publication.xlsx Any queries related to the **digital aspects** of this safety action can be sent to NHS Digital mailbox maternity.dq@nhs.net For any other queries, please email nhsr.mis@nhs.net
Further guidance regarding element 2 of the SBL care bundle V2	Compliance with the intervention for surveillance of low-risk women does not mandate participation in the Perinatal Institute's Growth Assessment Protocol (GAP) or the use of customised fundal charts. Providers should however ensure that for low risk women, fetal growth is assessed using antenatal symphysis fundal height charts by clinicians trained in their use. All staff must be competent in measuring fundal height with a tape measure, plotting measurements on charts, interpreting appropriately and referring when indicated. All women should have a risk assessment for FGR at booking. It should be appreciated that some women will develop additional risk factors after the booking appointment such as significant bleeding or risk factors that will only be evident after the mid-trimester anomaly scan, such as echogenic bowel or EFW <10th centile. When these risk factors are identified their clinical pathway will change as per SBLCBv2 Figure 6 in Appendix D. If a Trust chooses to meet this standard using an electronic audit which is unable to capture risk factors after booking then the Trust should include a brief description of how women with significant bleeding after booking, echogenic bowel or EFW <10th centile are triaged to the appropriate pathway described in fig. 6 of appendix D in SBLCBv2. There will be a variety of ways Trusts choose to do this, but what is important is that women with these risk factors receive the appropriate care.

	An example might be that when a risk factor is identified at the mid-trimester scan the ultrasonographer alerts the antenatal clinic midwife who then arranges obstetric review and the additional scans indicated. A similar process of escalation should be described for significant bleeding after booking. Confirmation by the Trust Board that the Trust has implemented the Tommy's Centre Clinical Decision Tool within a research programme will meet the requirement that standard 1-2 above have been implemented.
What is the deadline for reporting to NHS Resolution?	2 February 2023 at 12noon

Safety 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 (MVP) to coproduce local maternity services?

Required standard	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 (MVP) to coproduce local maternity services?
Minimum evidential requirement for Trust Board	**Evidence should include:** • Terms of Reference for your MVP. They reflect the core principles for Terms of Reference for a MVP as outlined in annex B of Implementing Better Births: A resource pack for Local Maternity Systems • Minutes of MVP meetings demonstrating how service users are listened to and how regular feedback is obtained, that actions are in place to demonstrate that listening has taken place and evidence of service developments resulting from coproduction between service users and staff. • Written confirmation from the service user chair that they are being remunerated as agreed and that this remuneration reflects the time commitment and requirements of the role given the agreed work programme. Remuneration should take place in line with agreed Trust processes. • The MVP's work programme, minutes of the MVP meeting which agreed it and minutes of the LMNS board that ratified it • Written confirmation from the service user chair that they and other service user members of the MVP committee are able to claim out of pocket expenses, including travel, parking and childcare costs in a timely way. • Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality. • Evidence that the MVP Chair is invited to attend maternity governance meetings and that actions from maternity governance meetings, including complaints' response processes, trends and themes, are shared with the MVP.

Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	From 6 May 2022 until 5 December 2022
What is the deadline for reporting to NHS Resolution?	Thursday 2 February 2023 at 12 noon

Technical guidance for Safety action 7

Technical guidance	
What is the Maternity Voices Partnership?	A Maternity Voices Partnership is a multidisciplinary NHS working group for review and coproduction of local maternity services. For more information see: • Implementing Better Births: A resource pack for Local Maternity Systems Chapter 4 and Annex B • National Maternity Voices
How often should the Maternity Voices Partnership meeting be held?	MVP should meet "no less than four times per year" in line with MVP Terms of Reference template, available here: https://nationalmaternityvoices.org.uk/toolkit-for-mvps/ This should include meeting with Maternity Leadership to ensure progression of the work plan.
We are unsure about the funding for Maternity Voices Partnerships	The maternity commissioner is responsible for facilitating and organising any agreed funding, this may be provided by the commissioner alone or in conjunction with local providers. Local discussions will need to take place to agree how the costs of the Maternity Voices Partnership will be shared between commissioner and provider organisations

Safety action 8: Can you evidence that a **local training plan** is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?

In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', **one-day, multi-professional training day** which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?

Required standard and minimum evidential \requirement	Can you evidence that: a) **A local training plan** is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programme over 3 years, starting from the launch of MIS year 4 in August 2021. b) 90% of each relevant maternity unit staff group have attended an 'in house' one day multi-professional training day, that includes maternity emergencies starting from the launch of MIS year four in August 2021? c) 90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day that includes antenatal and intrapartum fetal monitoring, starting from the launch of MIS year four in August 2021. d) Can you evidence that 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended in-house neonatal life support training or a Newborn Life Support (NLS) course starting from the launch of MIS year four in August 2021.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	Any 12 consecutive months within the period: 1st August 2021 until 5th December 2022

Technical guidance for safety action 8

Technical guidance	
What training should be covered in the local training plan to cover the six modules of the Core Competency Framework?	A training plan should be in place to cover all six core modules of the Core Competency Framework. The training plan will span a 3-year time period and should include the following 6 core modules: • Saving Babies Lives Care Bundle • Fetal surveillance in labour • Maternity emergencies and multi-professional training. • Personalised care • Care during labour and the immediate postnatal period • Neonatal life support
Core competency framework-maternal critical care What is the expectation of those unit that don't provide enhanced maternal critical care in the maternity setting?	This should relate to recognition of deterioration, escalation, stabilisation and monitoring of the woman until transfer takes place
Core competency framework – which modules should our unit focus on?	For MIS year 4, Trusts only need to focus on the 6 core elements – and do not require the 2 modules relating to directly to COVID care (core modules 7 and 8).
Covid-19 impact on training. **Does 'in-house' training have to be face to face?**	We encourage the reinstatement of face to face training wherever possible, however where this is not possible hybrid and/or remote training formats that meet the requirements of the safety actions, can all be counted to meet the proportion of staff attending training.

What training should be covered for the one-day multi-professional training?	The one-day training programme should include: • Antenatal and Intrapartum Fetal monitoring • 4 Maternity emergencies • Neonatal life support Local maternal and neonatal outcomes should be provided on the training days, ideally benchmarked against other organisations with a similar clinical profile. These data may be local, drawing on learning from case studies, local incidents and/or exemplars or from National programmes e.g. National Maternity Perinatal Audit (NMPA), Getting It Right First Time (GIRFT) and others.
What should be covered in the training programme?	**Fetal monitoring and surveillance (in the antenatal and intrapartum period)** Should be consistent with the Ockenden Report (2021) recommendations, and include as a minimum: • Risk assessment • Intermittent auscultation • Electronic fetal monitoring • System level issues e.g. human factors, classification, escalation and situational awareness • Use of local case histories • Using their local CTG machines **Multi-professional maternity emergencies training** • The training day should include 4 of the minimum requirements for multi-professional maternity emergency scenarios, as set out in the Core Competency Framework, with the aim that all scenarios will be covered over a 3-year period. • The 4 scenarios will be based on locally identified training needs, drawing on learning from local serious incidents, near misses and local reviews. • At least one scenario should include a *'learning from excellence'* case study where care was excellent. • Ideally, at least one of the four emergency scenarios should be conducted in a clinical area, ensuring full attendance from the relevant wider multi-professional team. This will enable local system and environmental factors within the clinical setting to be identified with an action plan developed to address issues identified. **Neonatal life support** • All staff in attendance at births should attend local neonatal life support training every year.

	• Attendance on separate certified NLS training for maternity staff should be locally decided but this would be the gold standard. • Those attending a NLS programme every 4 years will attend annual local neonatal life support training in between. Training should include as a minimum: • Preparing for neonatal resuscitation, including suitability of the clinical environment, and preparing the resuscitation device(s) • Identification of a baby requiring resuscitation after birth • Knowledge and understanding of the NLS algorithm, annual updates should be following the latest NLS edition. • The timing and how to call for help within the organisation • Situation, Background, Assessment Recommendation (SBAR) or equivalent communication tool handover on arrival of help.
How do maternity units include the remaining components of the Core Competencies Framework that are not listed above? **The remaining 2 components are:** • **Personalised care** • **Care during labour and the immediate postnatal period**	For the remaining 2 components of the Core Competencies Framework, maternity teams should choose 2 subjects per year from those listed in each of these core competencies, and these should be based on identified unit priorities, audit report findings and locally identified learning (e.g. ATAIN reviews) involving aspects of care which require reinforcing and national guidance. The aim is that all subjects within the Core Competencies Framework will be covered over the three-year period.
Which maternity staff attendees should be included for the 'in house' maternity emergencies multi-professional training day?	Maternity staff attendees should include 90% of each of the following groups: • Obstetric consultants • All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) • Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum) • Obstetric anaesthetic consultants

	• All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota
Training timeframe - What if we had a large number of staff trained in July/ and August 2021– do we then have to have these staff do their training again before 12 months are up?	The MIS year 4 reporting timeframe referred in safety action 8 is between the launch of MIS year 4 in August 2021 and 5th December 2022 with a submission deadline of 2nd February 2023. Trusts should assess their compliance based on the proportion of staff trained in 12 consecutive months within the reporting period. 90% compliance should be demonstrated by the end of the 12 month period.
Should the anaesthetic and maternity support workers (MSWs) attend fetal surveillance in labour and neonatal life support training?	Anaesthetic staff and MSWs are not required to attend fetal monitoring. The staff groups below are not required to attend neonatal resuscitation training: • All obstetric anaesthetic doctors (consultants, staff grades and anaesthetic trainees) contributing to the obstetric rota and • Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit)
What compliance is required for maternity theatre staff?	Maternity theatre staff are a vital part of the multidisciplinary team and are encouraged to attend the one-day maternity emergencies and multi-professional training, however they will not be required to meet MIS year four compliance assessment.
Which staff should be included for immediate neonatal life support training?	Staff in attendance at births should be included for immediate neonatal life support training - listed below: • Neonatal Consultants or Paediatric consultants covering neonatal units • Neonatal junior doctors (who attend any births) • Neonatal nurses (Band 5 and above) • Advanced Neonatal Nurse Practitioner (ANNP) • Midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and Maternity theatre midwives who also work outside of theatres.
Which maternity staff attendees should be included for the local intrapartum fetal	Maternity staff attendees should be 90% of each of the following groups: • Obstetric consultants

surveillance in line with Saving Babies Lives Care Bundle (SBLCBv2)?	• All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres.
Fetal monitoring training- Should GP trainees attend fetal monitoring training as stated in safety action 6/8 even though our unit has a protocol that GP rotational doctors do not undertake CTG reviews in any circumstances?	GP trainees should also attend the fetal monitoring training session if they have any obstetric commitment to intrapartum care.
What if staff have been booked to attend training after (add in date) for the 'in-house' multi-professional training day?	Only staff who have attended the training will be counted toward overall percentage. If staff are only booked onto future training sessions and/or have not attended training, they cannot be counted towards the overall percentage.
Will we meet the action if one of our staff group is below the 90% threshold for the 'in-house' maternity emergencies and multi-professional training day?	No, you will need to evidence to your Trust Board that you have met the threshold of 90% for each of the staff groups by 5th December 2022.
Training compliance - breakdown by staff groups	Compliance should be presented by staff group mentioned e.g. obstetric consultants 90%, obstetric trainees 89%, anaesthetic consultants 92% etc.
What if Covid-19 restrictions are still in place for in house training?	If social distancing guidelines preclude face to face training then remote or hybrid formats will be acceptable.
I am a NLS instructor, do I still need to attend neonatal resuscitation annual training?	If you have taught on a NLS course at least once during that year, you do not need to attend local neonatal resuscitation training as well
I am a Medical Obstetric Emergencies and Trauma (MOET) instructor, do I still need to attend the emergency training session?	MOET instructors do not need to attend annual training if their NLS instructor status is still valid.

I have attended my NLS training, do I still need to attend neonatal resuscitation annual training?	For MIS purposes, not during the same year that you completed NLS training, but you will need to attend neonatal resuscitation training annually for the 3 years in-between each NLS course.
Which members of the team can teach in house neonatal resuscitation training?	Best practice would be for this training to be delivered by a trained NLS instructor. The minimum standard would be for training to be provided by staff who hold an in-date NLS provider certificate and have a teaching role such as a clinical skills facilitator.
Who should attend certified NLS training in maternity?	Attendance on separate certified NLS training for maternity staff should be locally decided but this would be the gold standard.
What is the required timeframe?	One day training on multi-professional, maternity emergencies, including a learning from excellence case study and intrapartum fetal surveillance should be undertaken by each staff group within the MIS reporting period.
Where can I find the Core Competencies Framework and other additional resources?	• NHS England and NHS Improvements Core Competency Framework (December 2020) https://www.england.nhs.uk/publication/core-competency-framework/ • https://www.resus.org.uk/library/2021-resuscitation-guidelines/newborn-resuscitation-and-support-transition-infants-birth • All link to forthcoming national intrapartum fetal surveillance programme • Toolkit for high quality neonatal services (October 2009) http://www.londonneonatalnetwork.org.uk/wp-content/uploads/2015/09/Toolkit-2009.pdf

Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

Required standard	a) The pathway developed in year 3, that describes how safety intelligence is shared from floor to Board, through local maternity and neonatal systems (LMNS), and the Regional Chief Midwife has been reviewed in line with the implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk) The revised pathway should formalise how Trust-level intelligence will be shared with new LMNS/ICS and regional quality groups to ensure early action and support is provided for areas of concern or need. b) Board level safety champions present a locally agreed dashboard to the Board quarterly, including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and walk-abouts; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022. NB, The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022. c) Trust Boards have reviewed current staffing in the context of the letters to systems on 1 April 2022 and 21 September 2022 regarding the roll out of Midwifery Continuity of Carer as the default model of care. A decision has been made by the Board as to whether staffing meets safe minimum requirements to continue rollout of current or planned MCoC teams, or whether rollout should be suspended d) Board level and maternity safety champions are actively supporting capacity and capability building for staff to be involved in the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)
Minimum	**Evidence for points a) and b)**

evidential requirement for Trust Board	• Evidence of a revised pathway which describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence between a) each other, b) the Board, c) new LMNS/ICS quality group and d) regional quality groups involving the Regional Chief Midwife and Lead Obstetrician to ensure early action and support is provided for areas of concern or need in line with the perinatal quality surveillance model. • Evidence that a clear description of the pathway and names of safety champions are visible to maternity and neonatal staff. • Evidence that discussions regarding safety intelligence, including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and engagement sessions; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022 NB- The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022. • Evidence of the engagement sessions (e.g. staff feedback meeting, staff walkaround sessions etc.) being undertaken by a member of the Board. • Evidence of progress with actioning named concerns from staff workarounds are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users. • Evidence that the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions to help target interventions aimed at improving patient safety at least twice in the MIS reporting period at a Trust level quality meeting. This can be a board or directorate level meeting. **Evidence for point c):** This is to be evidenced by a minuted Board level discussion and decision since 1 April 2022 on how a Trust's current workforce position should determine current and future rollout of MCoC. Where more than one discussion has taken place, the most recent evidence should be submitted. **Evidence for point d):**

	Evidence of how the Board and Safety Champions have supported staff involved in part d) of the required standard and specifically in relation to: • active participation by staff in **contributing to the delivery** of the collective aims of the MatNeo Patient Safety Networks, and undertaking of specific improvement work aligned to the MatNeoSIP national driver diagram and key enabling activities • **engagement** in relevant improvement/capability building initiatives nationally, regionally or via the MatNeo Patient Safety Networks, of which the Trust is a member • support for clinicians identified as MatNeoSIP Improvement Leaders to facilitate and lead work through the MatNeo Patient Safety Networks and the National MatNeoSIP network • utilise insights from culture surveys undertaken to inform local quality improvement plans • maintain oversight of improvement outcomes and learning, and ensure intelligence is actively shared with key system stakeholders for the purpose of improvement
Validation process	Self-certification to NHS Resolution using the Board declaration form
What is the relevant time period?	**Time period for points a and b)** • Evidence of a revised written pathway, in line with the perinatal quality surveillance model, that is visible to staff and meets the requirements detailed in part a) and b) of the action is in place no later than 16 June 2022. The expectation is that work has already commenced on this in line with the Ockenden response (Ockenden, 2021). • Evidence that discussions regarding safety intelligence, including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and walk-abouts; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022. NB, The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022.

	• The expectation is that quarterly engagement sessions have continued from year 3 of the scheme. If for any reason these have been paused, they should be recommenced no later than 16 June 2022. The reason for pausing feedback sessions should be captured in the minutes of the Board meeting, detailing mitigating actions to prevent future disruption to these sessions. • Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 16 June 2022. • Evidence that the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (board or directorate) quality meeting each quarter, beginning no later than quarter 2 of 2022/23 (July 2022). **Time period for points c)** • Board level discussion and decision since 1st April 2022 on how a trust's current workforce position should determine current and future rollout of MCoC. Where more than one discussion has taken place, the most recent evidence should be submitted. **Time period for points d)** • Attendance or representation at a minimum of two engagement events such as Patient Safety Network meetings, MatNeoSIP webinars and/or the annual national learning event by 5th December 2022. • Evidence that insights from culture surveys undertaken have been used to inform local quality improvement plans by 5th December 2022.
What is the deadline for reporting to NHS Resolution?	By Thursday 2 February 2023 at 12 noon
Where can I find additional resources?	implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk) Measuring culture in maternity services: Add in link to Safety Culture Programme for Maternal and neonatal services:

	https://drive.google.com/file/d/1bzAqOcf5A5XHR8HWBZnLzH6qsG_SgXoa/view?usp=sharin Maternity and Neonatal Safety Champions Toolkit September 2020 (england.nhs.uk) NHS England » Maternity and Neonatal Safety Improvement Programme

Technical guidance for safety action 9

Technical guidance	
What is the expectation around the Perinatal Quality Surveillance Model?	The Perinatal Quality Surveillance Model must be reviewed and the local pathway for sharing intelligence updated. This revised pathway should: - Describe the local governance processes in place to demonstrate how intelligence is shared from the floor to Board - Formalise how Trust-level intelligence will be shared with the LMNS/ICS quality group and regional quality groups involving the Regional Chief Midwife and Lead Obstetrician
What do we need to include in the dashboard presented to Board each month?	The dashboard can be locally produced and must include; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions' engagement sessions; minimum staffing in maternity services and training compliance. The dashboard can also include additional measures as agreed by the Trust.
We had not continued to undertake monthly feedback sessions with the Board safety champion what should we do?	Parts a) and b) of the required standards build on the year three requirement of the maternity incentive scheme in building visibility and creating the conditions for staff to meet and establish a relationship with their Board safety champions in order to raise concerns relating to safety. The expectation is that Board safety champions have continued to undertake quarterly engagement sessions as described above. Part b) requires that progress with actioning named concerns from staff feedback sessions are visible. This builds on requirements made in year three of the maternity incentive scheme and the expectation is that this should have been continued. If these have not been continued, this needs to be reinstated by no later than 16 June 2022.
We are a Trust with more than one site. Do we need to complete the same frequency of engagement sessions in each site as a Trust on one site?	Yes. The expectation is that the same number of engagement sessions are completed at each individual site on a quarterly basis.
What is the rationale for the Board level safety champion safety action?	It is important to ensure all staff are aware of who their frontline and Board safety champions are if concerns are to be actively shared. Sharing of insights and good practice between

	providers, their LMNS, ICS and regional quality groups should be optimised. The development of a local pathway which describes these relationships, how sharing of information will take place and names the relevant leaders will support this standard to realise its aims. The guidance in the link below will support the development of this pathway. Maternity-and-Neonatal-Safety-Champions-Toolkit--2020.pdf
Where can I find more information re my Trust's scorecard?	More information regarding your Trust's scorecard can be found here https://resolution.nhs.uk/2021/10/28/2021-scorecards-launch/?utm_medium=email&utm_campaign=Resolution%20Matters%20October%202021&utm_content=Resolution%20Matters%20October%202021+CID_ac638a61c8ce1ac278298e3233f234af&utm_source=Email%20marketing%20software&utm_term=2021%20Scorecards%20launch https://resolution.nhs.uk/2020/10/27/claims-scorecards-for-2020/
What are the expectations of the Board safety champions in point d) as it asks that all Trust safety champions are supporting MatNeoSIP?	The Board safety Champions will be expected to continue their support for quality improvement by working with the designated improvement leads to participate and mobilise improvement via the MatNeo Patient Safety Networks. Trusts will be required to undertake improvement including data collection and testing work aligned to the national driver diagram and key enablers. The Board level safety champion will continue to support staff as detailed in the minimum evidential requirements for Trust Board.
What is the expectation for Trusts to utilise previous SCORE culture surveys?	Whilst it is recognised that some Trusts SCORE culture surveys were completed several years ago, identified themes from the surveys are likely to still be relevant as it changes a number of years to change culture. This would include leadership and team dynamics. These insights, and any recent work in these areas should still be used to inform improvement work.
Evidence or representation at a minimum of two engagement events such as Patient Safety Network meeting, MatNeoSIP webinars and/or the annual learning event.	MatNeoSIP Patient Safety Network events have continued during year 4 of MIS with good engagement. Recordings have and can be made available to listen to and feedback regarding the content. PSC also have attendance lists for the events. There are PSN events planned for each quarter of 2022/23.

	The expectation is that Trusts still engage with a minimum of two of these.

Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?

Required standard	A) Reporting of all qualifying cases to HSIB from 1 April 2021 to 5 December 2022 B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 April 2022 until 5 December 2022 C) For all qualifying cases which have occurred during the period 1 April 2021 to 5 December 2022, the Trust Board are assured that: 1. the family have received information on the role of HSIB and NHS Resolution's EN scheme; and 2. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.
Minimum evidential requirement for Trust Board	**Trust Board** sight of Trust legal services and maternity clinical governance records of qualifying HSIB/EN incidents and numbers reported to HSIB and NHS Resolution. **Trust Board** sight of evidence that the families have received information on the role of HSIB and EN scheme. **Trust Board** sight of evidence of compliance with the statutory duty of candour.
Validation process	Self-certification to NHS Resolution using Board declaration form. Trusts' reporting will be cross-referenced against the HSIB database and the National Neonatal Research Database (NNRD), and NHS Resolution database for the number of qualifying incidents recorded for the Trust and externally verify that standard a) and b) have been met in the relevant reporting period. In addition, for standard C1 there is a requirement to complete field on the Claims Reporting Wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.
What is the relevant time period?	Reporting to HSIB – from Wednesday 1 April 2021 to 5 December 2022 Reporting period to HSIB **and** to NHS Resolution - from 1 April 2022 to 5 December 2022

What is the deadline for reporting to NHS Resolution?	By 2 February 2023 at 12 noon

Technical guidance for Safety action 10

Technical guidance

Where can I find information on HSIB?	Information about HSIB and maternity investigations can be found on the HSIB website https://www.hsib.org.uk/
Where can I find information on the Early Notification scheme?	Information about the EN scheme can be found on the NHS Resolution's website • EN main page • Trusts page • Families page
What are qualifying incidents that need to be reported to HSIB?	Qualifying incidents are term deliveries (≥37+0 completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories: • Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) [0r] • Was therapeutically cooled (active cooling only) [Or] • Had decreased central tone AND was comatose AND had seizures of any kind Once HSIB have received the above cases they will triage them and advise which investigations they will be progressing for babies who have clinical or MRI evidence of neurological injury.
Changes in the EN reporting requirements for Trust from 1 April 2021 to 31 March 2022	Between 1 April 2021 to 31 March 2022, all qualifying cases should still be reported to HSIB. HSIB will then inform NHS Resolution of the case. Should you wish to discuss further, please contact HSIB at maternity@hsib.org.uk
Changes in the EN reporting requirements for Trust from 1 April 2022 going forward	With effect from 1 April 2022, Trusts will be required to continue to report their qualifying cases to HSIB via the electronic portal. In addition, Trusts' will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once HSIB have confirmed they are progressing an investigation due to clinical or MRI evidence of neurological injury. The Trust must share the HSIB report with the EN team within 30 days of receipt of the final report by uploading the HSIB report to the corresponding CMS file via DTS. Trusts are advised they should avoid uploading HSIB reports in batches (e.g. waiting for a number of reports to be received before uploading). Once the HSIB report has been shared by the Trust, the EN team will triage the case based on the MRI findings and then confirm to the Trust which cases will proceed to a liability investigation.

Changes in the Outstanding 2021/22 cases to be reported	If there are any outstanding cases which occurred from 1 April 2021 to 31 March 2022, Trust should report them as soon as possible to HSIB, following the process outlined above.
What qualifying EN cases need to be reported to NHS Resolution?	• Trusts are required to report cases to NHS Resolution where HSIB are progressing an investigation i.e. those where there is clinical or MRI evidence of neurological injury. • Where a family have declined a HSIB investigation, but have requested an EN investigation, the case should also be reported to NHS Resolution.
Cases that do not require to be reported to NHS Resolution	- Cases where families have requested an investigation - Cases where Trusts have requested an investigation - Cases that HSIB are not investigating
What if we are unsure whether a case qualifies for referral to HSIB or NHS Resolution?	For cases from 1 April 2022, if the baby has a clinical or MRI evidence of neurological injury and the case is being investigated by HSIB because of this, then the case should also be reported to NHS Resolution via the claims wizard along with the HSIB reference number (document the HSIB reference in the "any other comments box"). Please select Sangita Bodalia, Head of Early Notification (legal) at NHS Resolution on the Claims Reporting Wizard Should you have any queries, please contact a member of the Early Notification team to discuss further (nhr.enteam@nhs.net) or HSIB maternity team (maternity@hsib.org.uk).
How should we report cases to NHS Resolution?	Trusts' will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once they have been confirmed by HSIB as under investigation.
What happens once we have reported a case to NHS Resolution?	On receipt of the HSIB report, following triage, NHS Resolution will overlay an investigation into legal liability. Where families have declined an HSIB investigation, no EN investigation will take place, unless the family requests this.
Candour	Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 provides that a health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided. https://www.legislation.gov.uk/ukdsi/2014/9780111117613/regulation/20 In accordance with the statutory duty of candour, in all relevant cases, families should be 'advised of what enquiries in relation to the incident the health body believes are appropriate' – 20(3)(a) and details of any

	enquiries to be undertaken (20)(4)(b). This includes details of enquiries undertaken by HSIB and NHS Resolution. Assistance can be found on NHS Resolution's website, including the guidance 'Saying Sorry' as well as an animation on 'Duty of Candour' Trust Boards should be aware that if a breach of the statutory duty of candour in relation to a qualifying case comes to light which calls the validity of certification into question this may result in a review of the Trust submission and in addition trigger escalation to the CQC.
Will we be penalised for late reporting?	Trusts are strongly encouraged to report all incidents to HSIB as soon as they occur and to NHS Resolution as soon as HSIB have confirmed that they are taking forward an investigation. Trusts will meet the required standard if they can evidence to the Trust Board that they have reported all qualifying cases to HSIB and where applicable to NHS Resolution and this is confirmed with data held by NNRD and HSIB and NHS Resolution. Where qualifying cases are not reported within two years from the date of the incident, these cases will no longer be eligible for investigation under the Early Notification scheme.

FAQs for year four of the maternity incentive scheme

Does 'Board' refer to the Trust Board or would the Maternity Services Clinical Board suffice?	**We expect Trust Boards to self-certify the Trust's declarations following consideration of the evidence provided.** It is recommended that all executive members e.g. finance directors are included in these discussions. If subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of governance which we may escalate to the appropriate arm's length body/NHS system leader. We escalate these concerns to the Care Quality Commission for their consideration if any further action is required, and to the NHS England and NHS Improvement regional director, the Deputy Chief Midwifery Officer, regional chief midwife and DHSC for information. In addition, we now publish information on the NHS Resolution website regarding the verification process, the name of the Trusts involved in the MIS re-verification process as well as information on the outcome of the verification (including the number of safety actions not passed).
Do we need to discuss this with our commissioners?	Yes, the CEO of the Trust will ensure that the Accountable officer (AO) for their ICB is apprised of the MIS safety action evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the evidence to be submitted to NHS Resolution The declaration form must be signed by both CEO and the Accountable Officer of Clinical Commissioning Group/Integrated Care System before submission.
Our current commissioning systems are changing, what does this mean in terms of sign off?	There have been structural changes for NHS Commissioning as a result of 2022 Health and Care Act. Where this has caused significant reconfiguration and adjustment of commissioning systems, sign off by the accountable lead for commissioning maternity services can be considered
Will NHS Resolution cross check our results with external data sources?	Yes, we will cross reference results with external data sets from: MBRRACE-UK data (safety action 1 point a, b, c), NHS England& Improvement regarding submission to the Maternity Services Data Set (safety action 2, sub-requirements 2 and 3), and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable to HSIB (safety action 10, standard a)). Your overall submission may also be sense checked with CQC maternity data, HSIB data etc. For more details, please refer to the conditions of the scheme.

What documents do we need to send to you?	The Board declaration form will need to be sent to NHS Resolution. Ensure the Board declaration form has been approved by the Trust Board, signed by the CEO and, where relevant, an action plan is completed for each action the Trust has not met. **Please do not send your evidence or any narrative related to your submission to us.** Any other documents you are collating should be used to inform your discussions with the Trust Board.
Where can I find the Trust reporting template which needs to be signed off by the Board?	The Board declaration Excel form will be published on the NHS Resolution website in 2022. **It is mandatory that Trusts use the Board declaration Excel form when declaring compliance to NHS Resolution. If the Board declaration form is not returned to NHS Resolution by 12 noon on Thursday 2 February 2023, NHS Resolution will treat that as a nil response.** **The declaration form will be published later in 2022.**
Will you accept late submissions?	We will not accept late submissions. The Board declaration form and any action plan will need to be submitted to us no later than **12 noon on Thursday 2 February 2023**. If not returned to NHS Resolution by 12 noon on Thursday 2 February 2023, NHS Resolution will treat that as a nil response.
What happens if we do not meet the ten actions?	Only Trusts that meet all ten maternity safety actions will be eligible for a payment of at least 10% of their contribution to the incentive fund. Trusts that do not meet this threshold need to submit a completed action plan for each safety action they have not met. Trusts that do not meet all ten safety actions may be eligible for a small discretionary payment to help them to make progress against one or more of the ten safety actions.
Our Trust has queries, who should we contact?	Any queries prior to the submission date must be sent in writing by e-mail to NHS Resolution via nhsr.mis@nhs.net
Please can you confirm who outcome letters will be sent to?	The maternity incentive scheme outcome letters will be sent to Trust's nominated MIS leads.
What if Trust contact details have changed?	It's the responsibility of the Trusts to inform NHS Resolution of the most updated link contacts via link on the NHS Resolution website. https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-

	scheme-for-Trusts/maternity-incentive-scheme/maternity-incentive-scheme/
What if my Trust has multiple sites providing maternity services?	Multi-site providers will need to demonstrate the evidential requirements for each individual site. The Board declaration should reflect overall actions met for the whole Trust.
Will there be a process for appeals this year?	Yes, there will be an appeals process and Trusts will be allowed 14 days to appeal the decision following the communication of results.
Merging Trusts	Trusts that will be merging during the year four reporting period (August 2021 to February 2023) must inform NHS Resolution of this via nhsr.mis@nhs.net so that arrangements can be discussed. In addition, Trust's Directors of Finance or a member of the finance team must make contact with the NHS Resolution finance team by email at nhsr.contributions@nhs.net as soon as possible to discuss the implications of the changes in the way maternity services are to be provided. This could have an impact on the contributions payable for your Trust in 2022/23 and the reporting of claims and management of claims going forward.

Q&A regarding Maternity Safety Strategy and CNST maternity incentive scheme

Q1) What are the aims of the maternity incentive scheme?

The Maternity Safety Strategy sets out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety.

Using CNST to incentivise safer care received strong support from respondents to our *2016 CNST consultation* where 93% of respondents wanted incentives under CNST to fund safety initiatives. This is also directly aligned to the Intervention objective in our *Five year strategy: Delivering fair resolution and learning from harm.*

Q2) Why have these safety actions been chosen?

The ten actions have been agreed with the national maternity safety champions, Matthew Jolly and Jacqueline Dunkley-Bent, in partnership with NHS Digital, NHS England, NHS Improvement, the Care Quality Commission (CQC), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Obstetric Anaesthetists Association, Royal College of Anaesthetists, HSIB, Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives.

The Collaborative Advisory Group (CAG) previously established by NHS Resolution to bring together other arm's length bodies and the Royal Colleges to support the delivery of the CNST maternity incentive scheme has also advised NHS Resolution on the safety actions.

Q3) Who has been involved in designing the scheme?

The National Maternity Safety Champions were advised by a group of system experts including representatives from:

- NHS England & Improvement
- NHS Digital
- MBRRACE-UK
- Royal College of Obstetricians and Gynaecologists
- Royal College of Midwives
- Royal College of Anaesthetists
- Royal College of Paediatrics and Child Health
- Care Quality Commission
- Department of Health and Social Care
- NHS Resolution
- Clinical obstetric, midwifery and neonatal staff
- HSIB

Q4) How will Trusts be assessed against the safety actions and by when?

Trusts will be expected to provide a report to their Board demonstrating achievement (with evidence) of each of the ten actions. The Board must consider the evidence and complete the Board declaration form for result submission.

Completed Board declaration forms must be discussed with the commissioner(s) of the Trust's maternity services, signed off by the Board and then submitted to NHS Resolution (with action plans for any actions not met) at nhsr.mis@nhs.net **by 12 noon on 2 February 2023**.

Please note:

- Board declaration forms will be reviewed by NHS Resolution and discussed with the scheme's Collaborative Advisory Group.
- NHS Resolution will use external data sources to validate some of the Trust's responses, as detailed in the technical guidance above.
- If a completed Board declaration form is not returned to NHS Resolution by 12 noon on Thursday 2 February 2023, NHS Resolution will treat that as a nil response.

Meeting title	Trust Board	**Date: 9th November 2022**
Report title:	Trust wide report - Q2 2022/23 Complaints and PALS	**Agenda item: 13**
Lead director **Report author** **Sponsor(s)**	Kate Jarman Julie Goodman	Director of Corporate Affairs Head of Patient and Family Experience
FoI status:	Public document	

Report summary	This report provides a quarterly overview of complaints and feedback received through the Complaints and PALS teams and details some of the actions taken as a result of the feedback received.						
Purpose *(tick one box only)*	**Information**		**Approval**		**To note**	x	**Decision**	
Recommendation	The Board is asked to note the contents of the report and make comment as required						

Strategic objectives links	Improving Patient Experience with a link to: • Improving Patient Safety • Improving Clinical Effectiveness • Delivering Key Targets
Board Assurance Framework links	Lack of learning from complaints and feedback is a key risk identified on the BAF
CQC outcome/ regulation links	This report relates to CQC: Regulation 16 – Acting on complaints Regulation 20 – Duty of candour Regulation 17 – Good governance
Identified risks and risk management actions	Lack of learning from complaints and feedback is a key risk identified on the BAF
Resource implications	None
Legal implications including equality and diversity assessment	None
Report history	Trust Executive Committee, November 2022
Next steps	Quarterly reporting detailing analysis and trends and relevant learning from complaints
Appendices	

1. Introduction and purpose

This report details the Trust's overall position regarding the number of complaints received, the type of complaints and the performance in relation to responding to complaints on time during Q2 2022/23.

The overview from a Trust wide perspective is below, followed by a summary of the individual performance of each division.

The purpose of the report is to highlight to the Trust Executive Board the feedback and concerns raised by patients and families that impact on the experience of their care at the Trust.

2. Overall Performance Summary

Measure	Q2 2022/23	Performance indicator	Q1 2022/23
Number of formal complaints	42 (18%)	* 	41 (15.2%)
Number of informal complaints	192 (82%)	* 	228 (84.8%)
Total complaints received (formal and informal)	234		269
Percentage of total complaints responded to in timescales (reported 1 month in arrears)	95.5% (Only able to report from M5 onward)		Radar unable to provide this information until M5.
Number of complainants dissatisfied with the Trust's response (from previous quarter)	Radar unable to provide this information presently		Radar unable to provide this information presently

*A decrease in performance in percentage terms as the aim is to deal with most complaints informally and in a timely manner and in accordance with the complainants' wishes, without the need to raise a formal complaint.

In accordance with national complaint regulations any complaint that is resolved within 24 hours of receipt is not required to be logged or reported by the Trust as a complaint. These are referred to as "white complaints". In Q2, there were 122 complaints resolved within 24 hours, which equates to 34.2% of all PALS cases being logged as a white complaint. This is against a KPI of 30%.

The information from informal complaints resolved in 24 hours is recorded on the Trust's complaints' database to enable the information to be analysed and triangulated with reportable complaints to identify improvement initiatives. The issues highlighted within those complaints that were resolved in 24 hours were:

- **Appointment issues**
- **Clinical Treatment**
    - Delay in sharing of results

    - Treatment/procedure
- **Care of patient**
    - Lack of assistance with mobilisation
    - Insufficient pain management

Challenges

During Q2, there have been significant challenges faced regarding staffing levels within the Complaints and PALS team, which resulted in capacity issues across both services.
The Complaints and PALS team continue to manage long term absences within the team and have taken a number of steps to manage the workload to ensure that the PALS office remains open during its normal opening hours, without exception. The steps taken include:

- Successfully appointing into a Senior PALS Officer role (secondment until March 2023)
- Accessing support from the wider Patient and Family Experience Team
- Advertisement internally to offer bank hours to any band 3 and band 4 administration staff

There have been continued challenges with the use of Radar. One issue to note is the inability of the system to notify Complaints and PALS officers of updates/responses relating to their cases. This proves difficult when managing caseloads, especially with the timely sharing of responses.

The Radar system is unable, at present, to provide a report on the number of complaints being "reopened". Complaints are reopened when complainants express that they are dissatisfied with the outcome of their complaint. The Complaints and PALS team continue to work with Radar to resolve these issues.

In Q2, the PALS team have consistently seen an increase in the complexity of issues raised. These cases are often time consuming and require increased levels of input from staff across the Trust. This is a trend that is being experienced nationally, post Covid. Capacity issues are therefore further exacerbated within the team, especially during periods of sickness or absence leave.

As outlined above, the position of the team is being reviewed following the steps taken to increase capacity and improve the overall resilience within the team.

3. Activity

The Trust received 234 complaints in Q2, and this includes complaints received and managed through both the informal and formal route.

The top 3 issues raised in reportable complaints are as follows:

1. **Communication**
2. **Appointments**
3. **Clinical treatment**

The lack of or inadequate communication with patients and their families continues to be the main issue raised in complaints.

4. Parliamentary Health Service Ombudsman (PHSO)

During Q2, the PHSO have requested information on three complaint files. Further instruction from the PHSO is awaited.

5. Audit

Medical records audit

A requirement of the national complaint regulations is to ensure that complaint's communication is kept separate from medical records. Each quarter an audit is undertaken to gain assurance that details of complaints have not been placed in patient's medical records. Q2 audit confirmed that no complaint records had been filed in medical records.

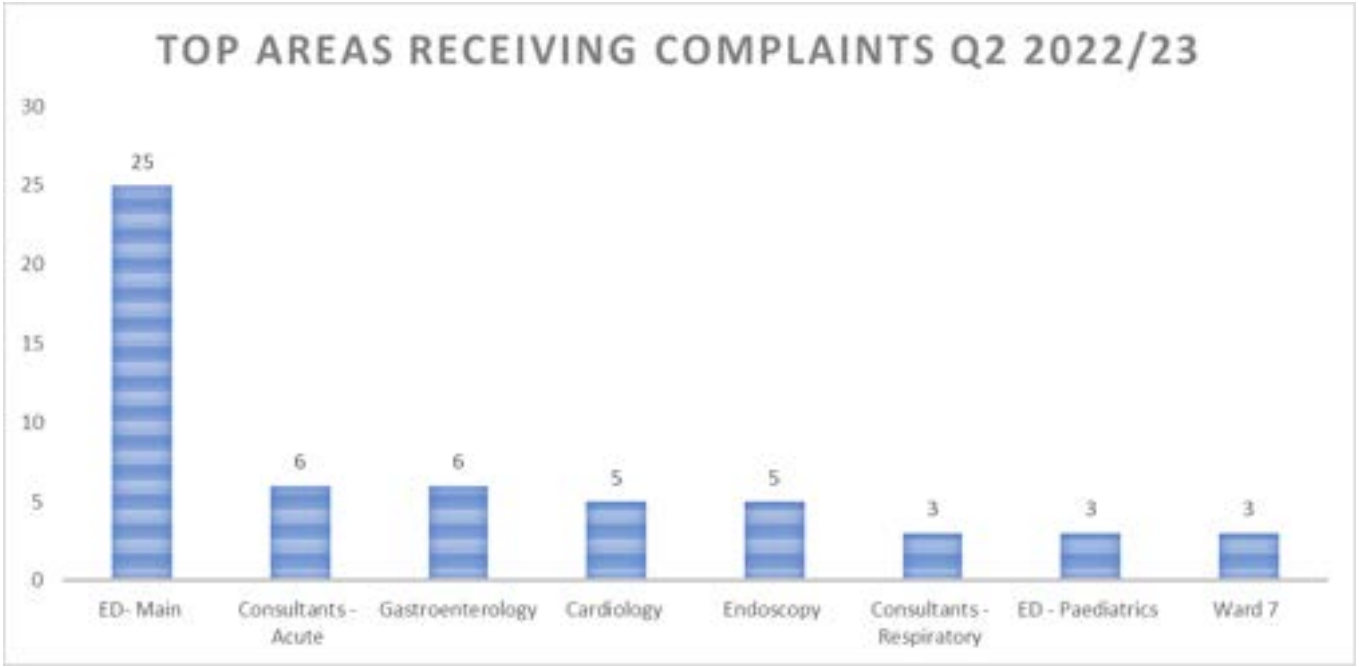
6. Divisional Reports

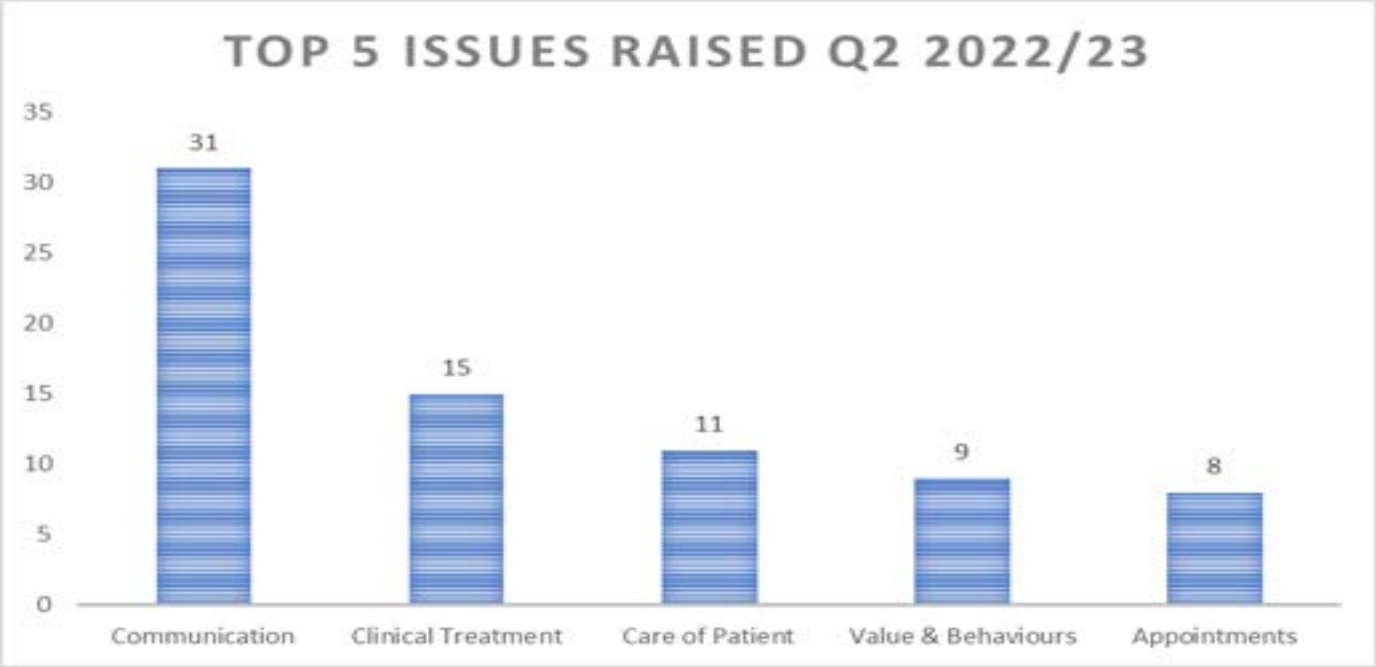
Medicine

Total number of complaints

In Q2 the division received 90 complaints in total, 21 (23.4%) formal complaints and 69 (76.6%) informal complaints.

Focus of Complaints





Improvements made following the receipt of complaints:

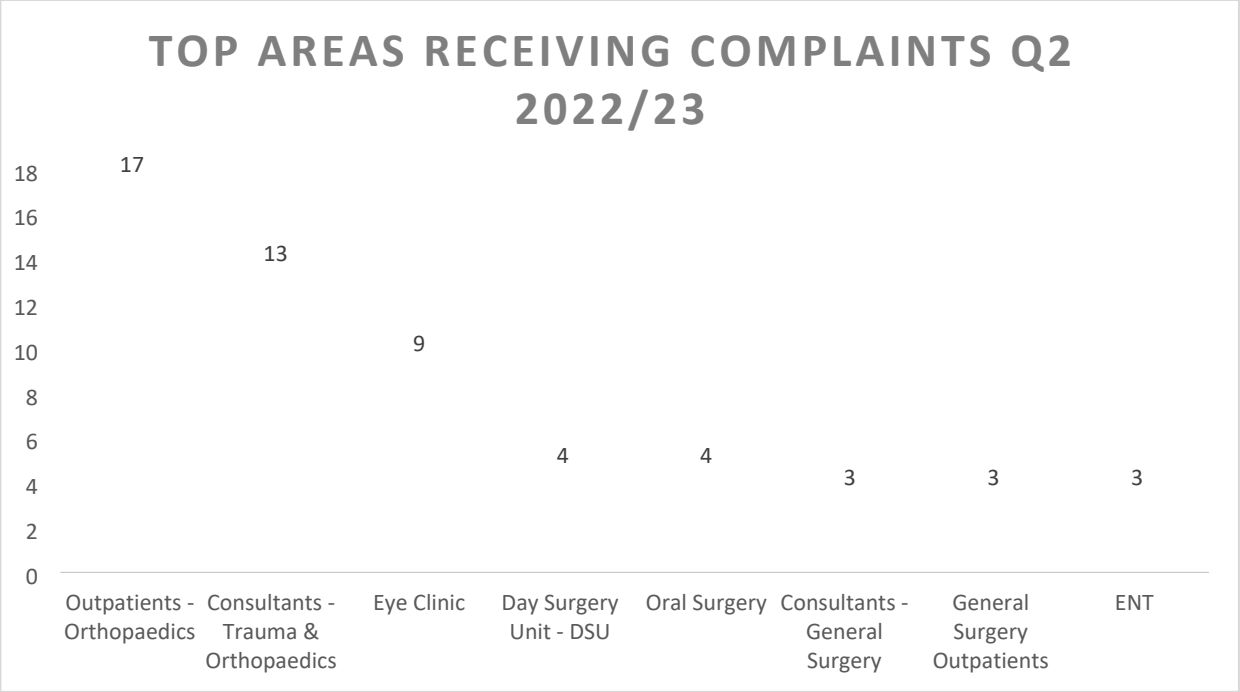
The complainant said:	The improvement was:
That there was a delay in reviewing and actioning a referral sent by the GP. The referral was regarding acute progressive and episodic breathlessness.	The GP had referred the patient to a pilot community respiratory clinic, designed to deal with long term and chronic lung conditions. Following this complaint, a more robust triage process has been put in place resulting in acutely ill patients no longer being referred to this clinic.
A patient was discharged from the Emergency Department with a cannula still in place.	Complaint shared and discussed with Emergency Department managers, to reiterate the importance of ensuring that all discharge processes are followed correctly, including the removal of cannulas.
That they wished to understand why an injury to their shoulder had not been identified, when attending the Emergency Department.	Complaint used as a case study for clinical learning within the department, reiterating the need for a thorough examination, with specific focus on distracting injuries that can mask further injury – as in this case.

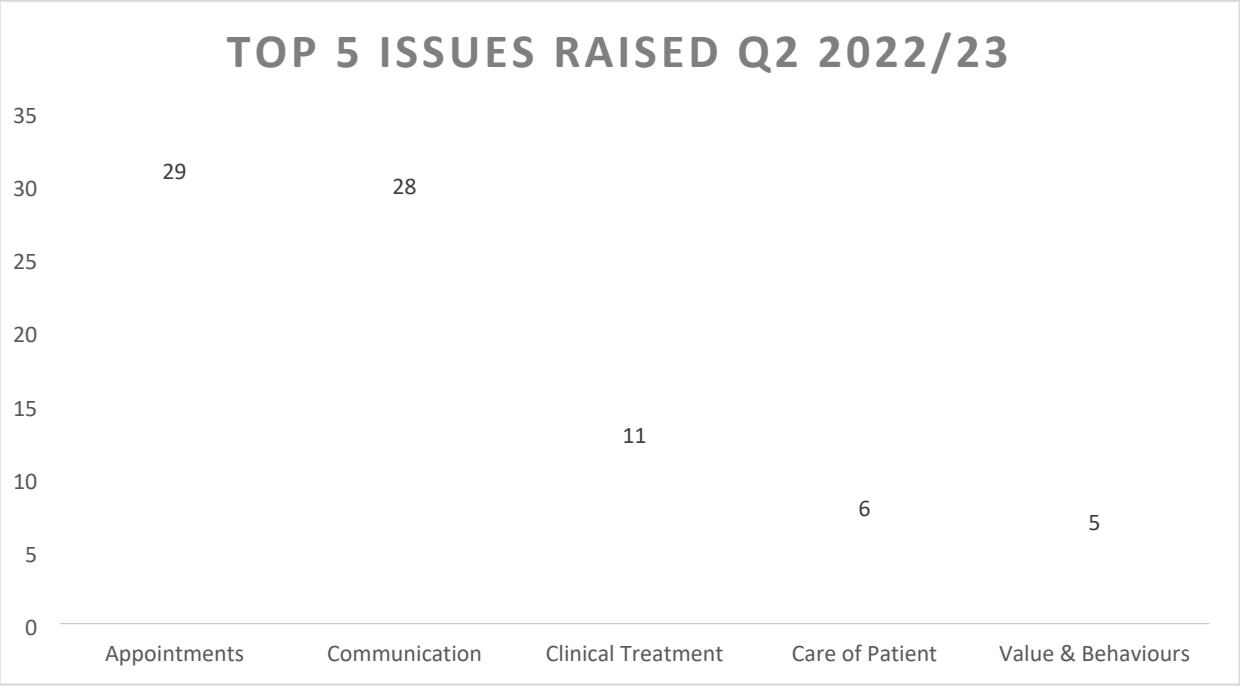
Surgery

Total number of complaints

In Q2 the division received 80 complaints in total, 10 (12.5%) formal complaints and 70 (87.5%) informal complaints.

Focus of Complaints





Improvements made following the receipt of complaints:

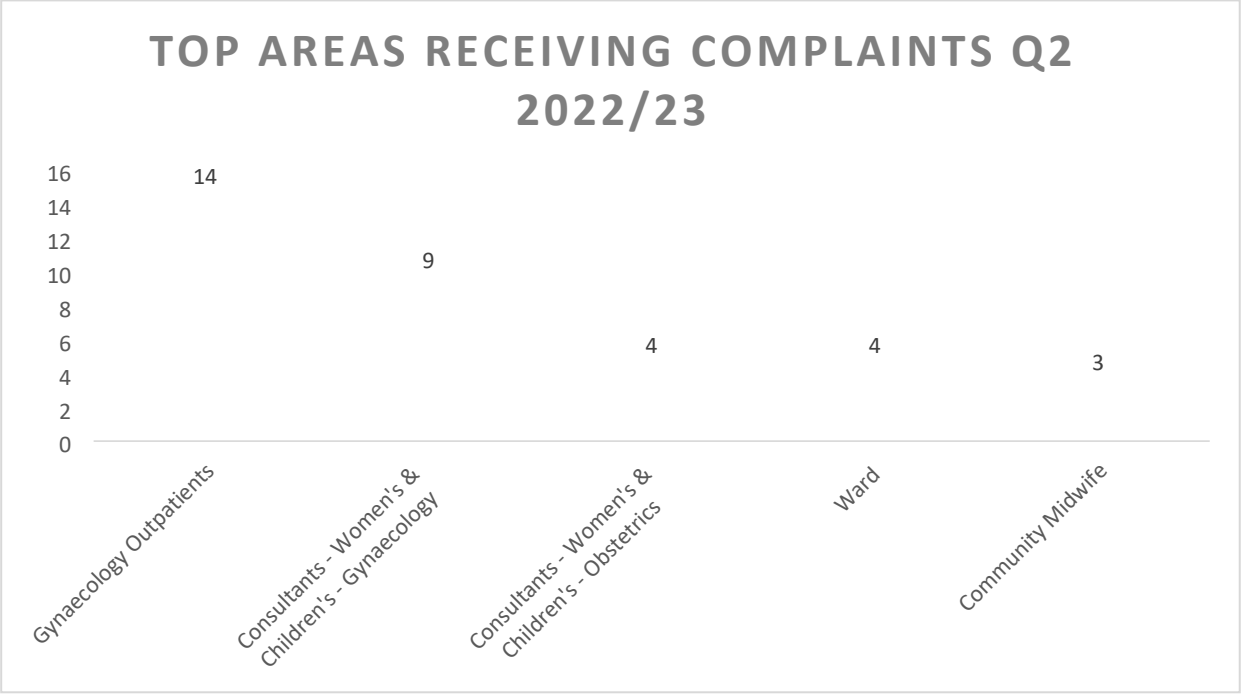
The complainant said:	The improvement was:
That the clip used to mark the area during a mastectomy procedure was not located and removed.	It was not standard practice to localise the clips for mastectomy specimens, and since receiving this complaint the team have requested that an x-ray of the specimen is undertaken to check that the clips are included.

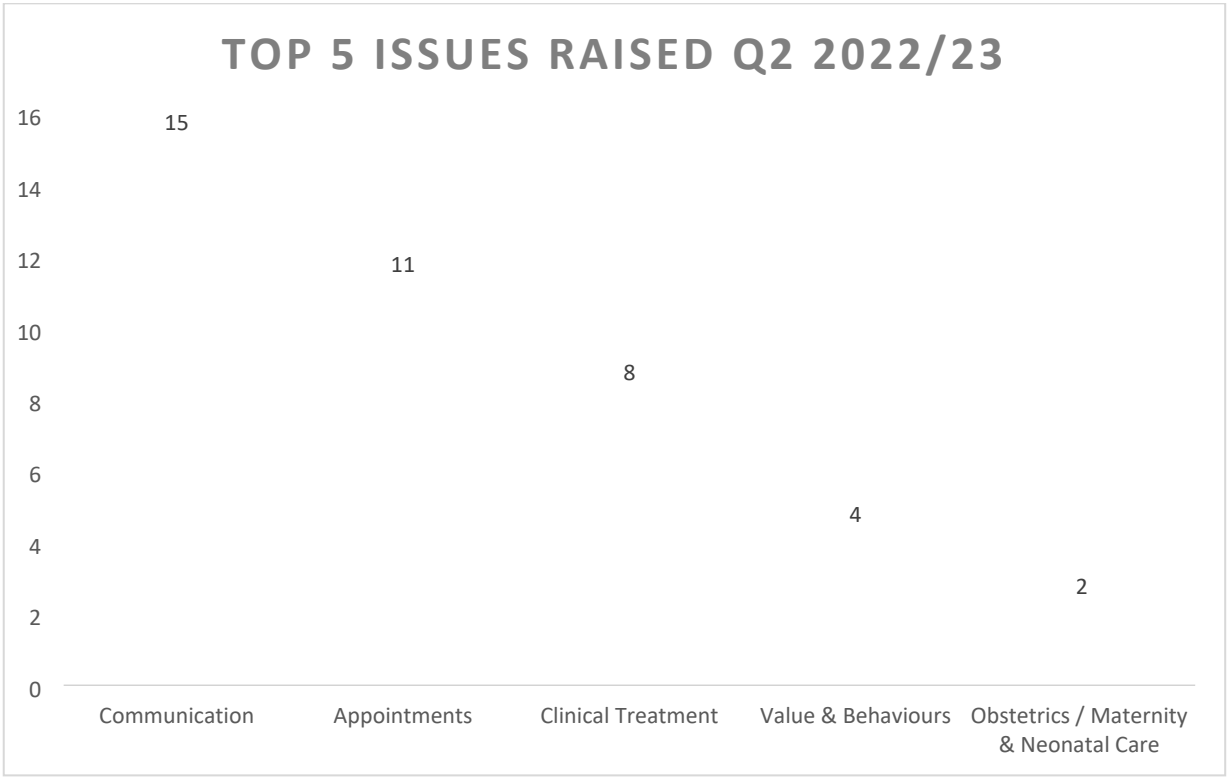
Women and Children's

Total number of complaints

In Q2 the division received 42 complaints in total, 9 (21.4%) formal complaints and 33 (78.6%) were informal complaints.

Focus of Complaints





Improvements made following the receipt of complaints:

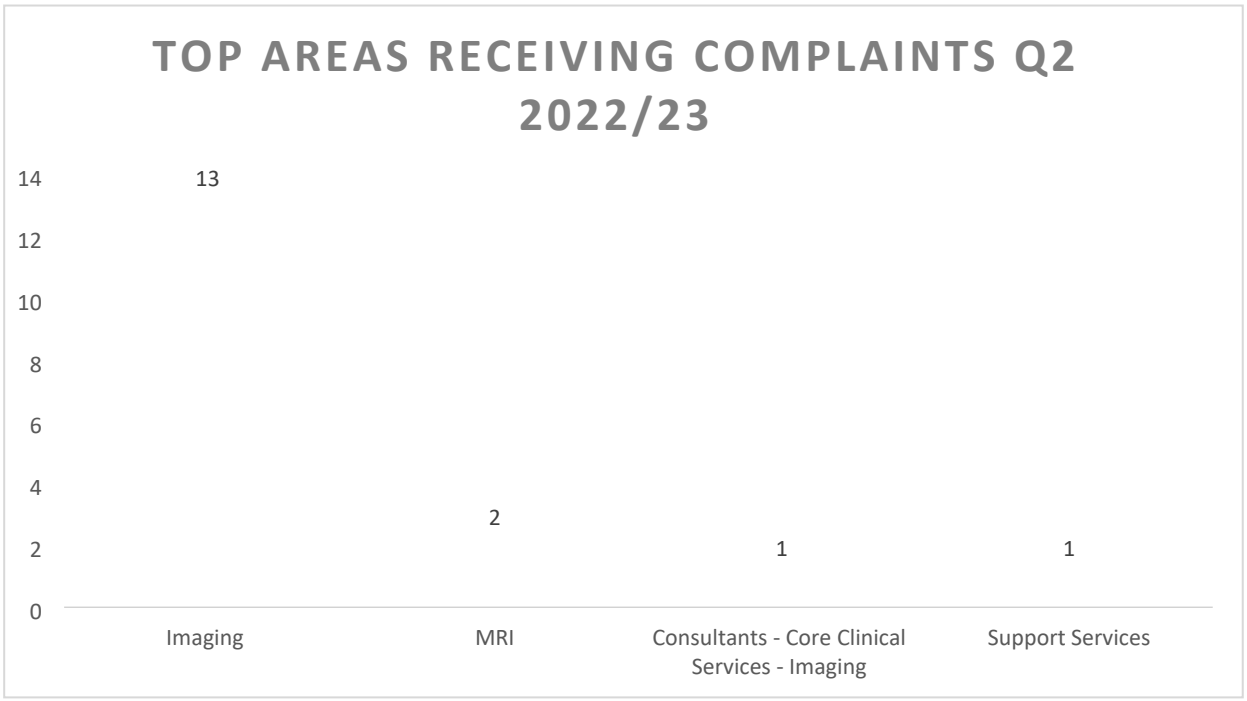
The complainant said:	The improvement was:
That they were left feeling worried and concerned unnecessarily as they were given incorrect information about the antenatal screening programme.	Community midwives undertook training with the antenatal screening team during their protected training afternoon to discuss the screening pathway. The leaflets included in the information pack have also been reviewed and replenished.
That staff did not provide appropriate support with breast feeding.	The continuation of two-day training for all new staff joining the maternity team. Regular updates shared with staff regarding ongoing breastfeeding training. Welcoming back of breast-feeding support volunteers on the wards.

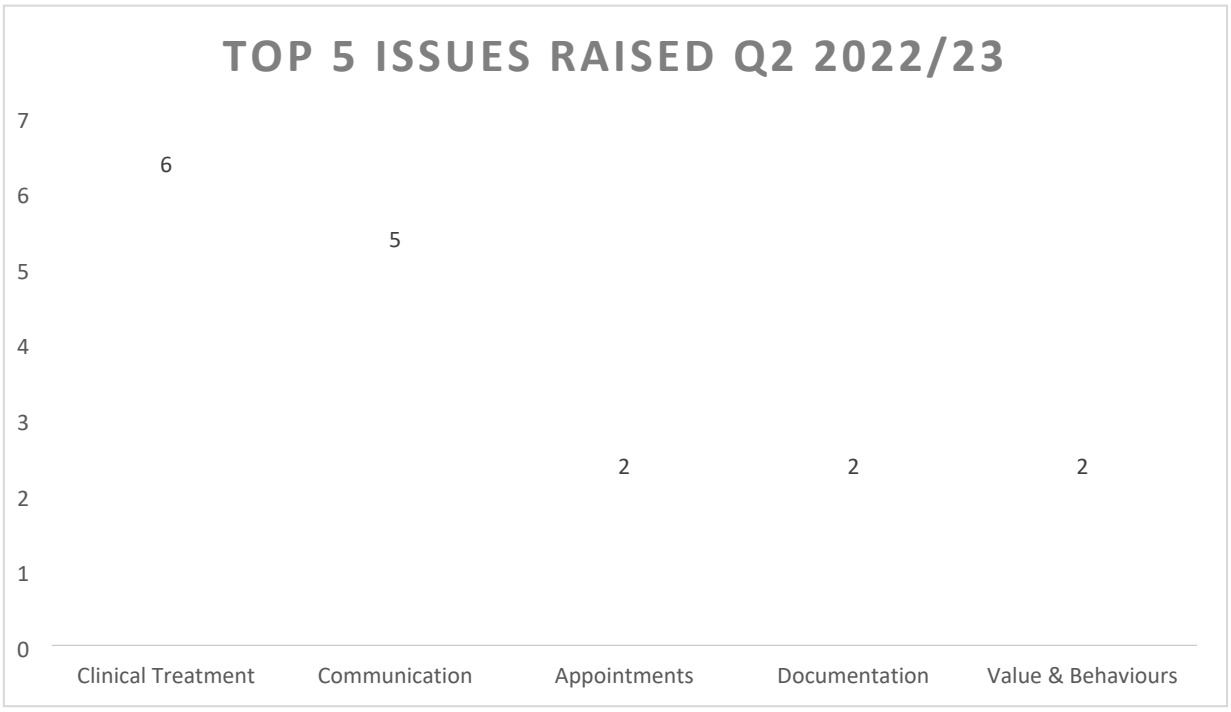
Core Clinical Services

Total number of complaints

In Q2 the division received 18 complaints in total, 2 (11.1%) formal complaints and 16 (88.9%) were informal complaints.

Focus of Complaints





Improvements made following the receipt of complaints:

The complainant said:	The improvement was:
That the review and assessment by the Dietetic team was delayed due to the failings of the referral system.	The process for referrals has been reviewed and changed. All urgent referrals are now automatically booked into a gastroenterology clinic as urgent appointments.

7. Conclusion

The focus continues to be on stabilising the staffing levels within the team and building upon this to ensure timely responses to complaints, ensuring a through resolution is reached. As mentioned previously, challenges are being faced both locally and nationally regarding the number and complexity of complaints received. This quarter's data emphasises the national picture around waiting times and availability of appointments.

Values and behaviours of staff is a theme evident across the concerns received locally. This may be indicative of the pressures widely felt by clinical and operational teams, as well as an element of compassion fatigue.

During Q1 the divisions trialled writing their own formal complaint responses. This is continuing and progressing well. This has resulted in the divisions taking greater ownership of actions resulting from complaints, especially regarding establishing processes to share this learning.

The Complaints Office Manager contacts all complainants wishing to raise a formal complaint. During this conversation the process is outlined and the questions to be asked during an investigation are agreed. During the trial, additional contact with the complainant was made by the Divisional Chief Nurse, to establish whether there may be clinical elements of the complaint that could be addressed immediately. This ensured that each division was proactive in resolving formal complaints promptly, improving the experience for those raising concerns. This adopted practice will continue moving forward.

During Q3 2022/23, the PALS team will continue focus on resolving concerns within 24 hours. A priority for the team is to ensure that the PALS office remains open and accessible during working hours and that the team attend ward areas as requested by patients and families.

Meeting title	Trust Board	Date: 9th November 2022
Report title:	Trust wide report – Q2 2022/23 Patient and Family Experience Report	Agenda item: 14
Lead director **Report author** **Sponsor(s)**	Kate Jarman Julie Goodman	Director of Corporate Affairs Head of Patient and Family Experience
FoI status:	Public document	

Report summary	This report provides a quarterly overview of patient experience, engagement and feedback across the Trust and actions taken to improve patient and family experience.				
Purpose *(tick one box only)*	**Information**	**Approval**	**To note**	X	**Decision**
Recommendation	The Board is asked to note the contents of the report				

Strategic objectives links	Improving patient experience with a link to: • Improving patient safety • Improving clinical effectiveness • Delivering key performance targets • Being well governed • Being innovative
Board Assurance Framework links	Lack of improvement in patient surveys is a key risk identified on the BAF
CQC outcome/ regulation links	This report relates to CQC standards: Person-centered care Good Governance Duty of candour
Identified risks and risk management actions	None
Resource implications	None
Legal implications including equality and diversity assessment	None

Report history	Trust Executive Committee, November 2022
Next steps	Quarterly reporting detailing analysis and trends in patient experience feedback

1. Introduction and purpose

This report details the Trust's overall position regarding patient and family experience feedback and engagement activity for Q2 2022/23.

The purpose of this report is to inform the Trust of feedback received from our patients and their families through a variety of feedback mechanisms and to recognise the work being undertaken by the Patient and Family Experience team. The aim is to identify areas of good practice and areas that require support to improve the patient and family experience.

2. Achievements of the Patient and Family Experience team

Inpatient FFT SMS Option

The team have launched an option for patients, who have had an inpatient stay of one night or more, to complete their FFT feedback via SMS messaging, upon their discharge. Patients will only be contacted via SMS if they are aged 18 years and over. This follows on from the successful launch in Outpatients and the Emergency Department (ED).

The launch for FFT by SMS for inpatients took place on the 1st August 2022. For context, during July 2022 a total of 367 FFT responses were received from inpatients. Following the launch of SMS messaging, a total of 750 responses were received in August 2022, 351 responses via the SMS option. During September 2022, 742 responses were received, 432 via the SMS option.

All FFT comments can be viewed and analysed on the Patient Experience Platform (PEP) dashboard, which all staff are able to view, once they have requested log in details.

The SMS option cannot currently be used for patients under the age of 18 years. The team are therefore exploring different options to increase the FFT feedback received from our younger patients. The Paediatric ED team have developed a display within the area to encourage patients and their families to share their feedback.

Patient Experience Platform (PEP) Q&A Session

To encourage staff to access the PEP, and review and action feedback for their individual areas, the Patient and Family Experience team have put in place online quarterly educational drop-in sessions for staff.

These sessions give staff the opportunity to attend a live demonstration of the platform and ask questions that they may have on the platform and how to interpret the data.

Representatives from PEP Health and from the Patient and Family Experience team were in attendance for the first session on the 11th August 2022. The next session will be held during November 2022.

Inclusion of Compliments on PEP

To ensure as much feedback as possible is available for review on the PEP, any compliments received from patients and are now uploaded to the platform. These can be viewed as a separate category on the platform so staff can celebrate their successes and learning can be taken from all the good work going on throughout the Trust.

An example of one of the compliments received is as follows:

'I just wanted to say a massive thank you to everyone I came in to contact with today. Your care was exceptional, so many of you went above and beyond which made my day stress and worry free. You were friendly. You took your time to explain what was happening. The little chats took the nerves away. You were reassuring, caring and professional. You took my bag to the door, made the best cup of tea and the wards and theatre were spotless! You are the true superheroes'

Well done to Ward 24!

Meaningful Activities Facilitator

The Meaningful Activities Facilitator joined the Patient and Family Experience Team during Q2. MKUH is fortunate to have this service, we are one of only two Trusts in the country to have this role. The post is currently funded by the MKUH Charity until summer 2023 and the hope is to make this a permanent role for the future. The aim of the role is to enrich the experience for any adult patient who is perhaps feeling low in mood, having difficulty being in hospital, or needs some encouragement to support their wellbeing.

The Meaningful Activities Facilitator works with all patients, especially those with a dementia diagnosis, or those experiencing a lengthy hospital stay. A range of activities are offered, from painting and clay work to creative group activities. There have been many positive reports on the difference the activities have made to patients.

A younger patient's feedback was as follows: -

'*I would recommend [meaningful activities] as it put me at ease in a stressful environment, and it helped me get through the difficult times as I was learning new things such as different techniques, strokes and patterns in water colouring painting. This made the time go faster when I was in hospital and I have found another hobby that I didn't realise I would have enjoyed, thank you'*

During Q3 2022/23, volunteering opportunities will become available for those wishing to support this role on a volunteer basis.

New Build Engagement

It is the team's objective, this coming year, to engage with all patient groups and ensure all views are listened to and considered when the Trust is undertaking new developments/projects/changes to services.

Engagement work commenced in August 2022 when various diverse groups attended sessions to hear of the plans for the proposed new women's and children's hospital and surgical block.

The team assisted the New Builds project team in running five sessions for patients/families and the public to learn of the proposed building plans. The aim of the sessions was to gain feedback on what patients/families and the public would like to see in a new build i.e., how they would like it to feel, what could be considered to enable them to have a good experience i.e., decoration, smell, lighting etc.

As the projects develop, engagement will continue to ensure the views of all groups are taken into consideration.

Patient Led Assessment of the Care Environment (PLACE) Audit

The team supported the Hotel Services team to undertake the annual PLACE audit. Patients were recruited by the team and individual team members also took part in the sessions. The PLACE audit entails a team of assessors attending wards and departments to review how the environment supports the provision of clinical care, assessing such things as privacy and dignity, food, cleanliness and general building maintenance and, more recently, the extent to which the environment is able to support the care of those with dementia or with a disability.

Before the annual inspection, during August and September 2022, teams undertook PLACE lite sessions to ensure familiarity with the requirements of the process and the documentation required. The annual PLACE audit took place on the 30th September 2022. The teams covered 11 wards and all the main departments, as well as tasting and providing feedback on the food service.

This year saw a higher level of patient representation to that of previous years resulting in the most comprehensive PLACE inspection ever.

The Hotel Services team are working through the results and will report through their own management structure with a report being presented at the Patient and Family Experience Board.

Healthwatch Annual General Meeting (AGM)

Representatives from the Patient and Family Experience team, along with the Trust Secretary and one of the Trust's Governors attended the AGM on the 22nd September 2022. A display showcasing compliments and FFT feedback was on show and attendees were encouraged to engage in ongoing projects.

Information that will be useful for hospital patients was gained from community groups. This information will be available on the Patient Experience resource trolley, when launched in November 2022. It was insightful to hear of the work undertaken by Healthwatch during the last year and to learn of their plans for the year ahead.

QR Code Project Update

The team have worked during this quarter to finalise the information that is available on a unique QR code which will be displayed on patient's bedside cabinets. The QR code will direct patients and their families to a dedicated ward information page which details any information they may need to know i.e., visiting times, who's who from a uniform perspective, how to access snacks/drinks etc. This project will be launched, with the support of our Communications Team, during November 2022.

Work is being undertaken separately with the Maternity team to use QR codes in a number of their areas. This work will continue following the launch of their new website.

3. **Matron for Patient and Family Experience update**

Matron Group Workstreams

Deep Tissue Injuries (DTI)

With an increase in DTIs the focus for the Matron group has been to take a proactive approach to the management of those injuries. An escalation pathway has been implemented and top to toe assessments have been undertaken on every identified patient and patients at risk. Staff education and training has been a priority with valuable input from the Tissue Viability team.

Communication

The Matron Group strive to improve communication with patients and their relatives and carers. A new communication guide has been piloted on Ward 19. This collaborative approach includes all members of the multidisciplinary team and identifies a team member to update and discuss treatment plans with both patients and their relatives and carers. Early results have identified that there has been a decrease in the number of complaints regarding communication and patient and family experience has improved in this area. Feedback was received from a patient's wife who said, 'the staff were great they kept me updated nearly every day'.

VIP

A Visual Infusion Phlebitis score is a tool used to monitor infusion sites and with the increase in bacteraemia the Matron group are continuing this essential workstream. This is an incredibly large piece of work that includes representation from the practice education department, eCare and IPC team, and includes every healthcare professional who inserts an intravenous cannula. Assurance will be gained through Tendable audits and the Microbiology team.

Patient Safety Team

The Matron for Patient and Family Experience has continued to support the Patient Safety Team and has been involved in the DTI thematic review in ED and Ward 1 and more recently on Ward 23. Using the Appreciative Inquiry (AI) tools and sharing these tools with others has enabled a wider more in-depth understanding of the impact a DTI has on patients and staff caring for these patients.

4. Volunteers Update

Recruitment and numbers of active volunteers

At the end of Q4 2019/20, 183 volunteers were actively volunteering and enhancing the experience of our patients and families. Following Covid, Volunteers have returned but not to the levels of pre covid. Currently the Trust has 83 volunteers.

To ensure that the public are attracted to volunteering opportunities and aware of any vacancies, the volunteer webpages have been updated. The new pages are easier to navigate from the home page. There is also a Volunteering tab along the top of the home page as well as a recurring banner, see https://www.mkuh.nhs.uk/working-at-mkuh/volunteering.

In September 2022, the Voluntary Services team went ‘live’ with the new Assemble system, used for the management and recruitment of volunteers. The process of transferring existing volunteers’ paper files over to this system is ongoing. This will improve and streamline communications, recruitment, and the day-to-day management of volunteers. In Assemble each volunteer will have a personal login to their own Volunteer Portal.

Whilst volunteer recruitment was placed on hold during the pandemic, over 300 prospective volunteers contacted the Trust to make enquiries regarding becoming a volunteer. As soon as the team were in the position to start recruitment the prospective volunteers were contacted with details of the volunteering opportunities available. Within a week 50 applications were received for the 7 roles advertised: Breast Feeding Peer Supporters, Dining Companions, ED support, Meaningful Activities, Patient and Family Experience and Wayfinders. Due to the high volume of applications received and the work involved in shortlisting, interviewing and conducting pre-employment checks, the volunteering opportunities are on hold again.

Butterfly Volunteers

The Butterfly Volunteer Co-ordinator promoted the new service with both internal and external information stands throughout Q2 2022/23. This activity has raised awareness of the new service and currently 40 people are potentially interested in becoming a Butterfly Volunteer.

Induction and Mandatory Training for Volunteers

Since the pandemic, access to mandatory training across the Trust is now by e-learning. Volunteers have access to mandatory training (and optional modules) by eLfH, which has a specific volunteer programme as designed by Health Education England and was approved by the Mandatory Training team as being appropriate. The optional modules allow volunteers to work towards a National Volunteer Certificate with evidence of 60 hours volunteering. The team continue to monitor the expiry dates of existing volunteer training, and this is renewed by redoing the e-learning module. The team are aware that some volunteers have difficulty with e-learning and are currently looking at ways of supporting this small cohort.

New volunteers also attend the ½ day Trust Induction and any other specialist training needed prior to starting their first shift.

5. Learning Disability and or Autism

Patients who have a learning disability and/or autism have been supported throughout Q2 2022/23 by the team. Visits have been made to inpatients to understand the reasonable adjustments that are required to meet their individual needs. Ward staff have then been supported to ensure patients are discharged safely and communication with family members and carers is effective.

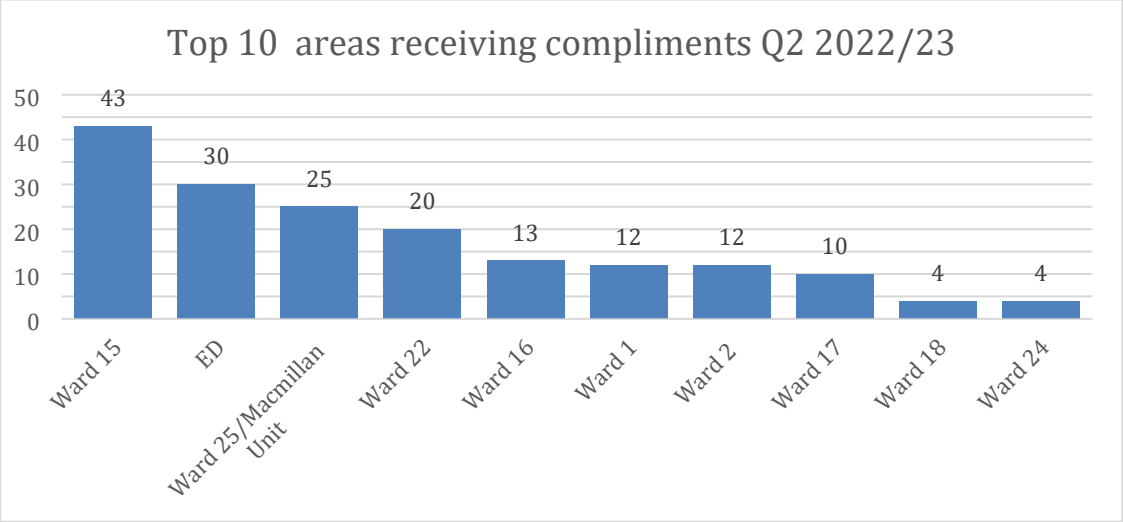
Educating staff and providing training on eCare regarding how to raise a flag / alert and how to document the reasonable adjustments required is ongoing, with assurance gained from Tendable audits.

6. Armed Forces

The Matron for Patient & Family Experience manages the Covenant Fund Trust Support Officer. The Trust has successfully gained Silver Award status. The Trust are fully committed and have identified the next steps to achieve the Gold Award by mid-2023.

7. Compliments

During Q2, the Trust received 243 compliments via email, letter, review sites or telephone calls. This number received in Q1 2022/23 was 107. The large increase is due wards and departments being encouraged, by the Patient and Family Experience team, to share their compliments.



Compliment of the month

The following individuals and teams received recognition for compliments received during the quarter.

MONTH	INDIVIDUAL COMPLIMENT	TEAM COMPLIMENT
July 2022	**Farid Garis – Physio** Thank you for the care you provided to my late husband. You will recall you were one of the few healthcare professionals who recognised the inappropriate nature of his stay and assisted in his subsequent platelet transfusion, avoiding a further admission. As a terminally ill patient for whom I was challenging to seek pathways to ease his last days, I will always be grateful	**AECU** I was sent to this unit 2 weeks in a row and was obviously quite anxious as I was unsure what would happen, on both occasions I felt comfortable and welcome, all staff were constantly checking that all was well and offered drinks and food if needed, when all tests were completed I was taken into a room with a doctor and nurse present who explained their findings and what would happen next, at no time did they rush or make me feel unworthy of their time, thank you all so much you are very special people.
August 2022	**Willie Zapata – Ward 2** I just want to say a huge thank you to this nurse for going above and beyond for my daughter on the night of the 8th August 2022!! I cannot even put into words the appreciation I have of you, I've never known such immense care and kindness. All I can say is thank you which doesn't seem enough. Speaking with you was my pleasure and what you did	**Oral and Maxillofacial** Thank you to all 3 of you for the great patient experience that I had. The appointment was on time, Megan was understanding of my hearing disability and made sure she removed her mask whenever I needed to be spoken to. The star of the show was Samezer as not only did she remove my 3 teeth, but it was totally pain free (even after the anaesthetic wore off) and her

	to make my daughter feel comfortable was just incredibly wonderful of you! Please honour this nurse and Milton Keynes hospital is lucky to have you there! Thank you again Willie for all you did!	professionalism showed when she noticed something in my cheek so removed part of it and sent it off for a biopsy! Well done team
September 2022	**Aimee Durnin – Respiratory Nurse** My father, XXXX, had spent time in the A&E Resus unit on Tuesday 23rd August, struggling to breathe. He was extremely well cared for by all members of staff. Two Respiratory Nurses came to see him there. They also spoke to us on Ward 1 on the Wednesday and were very informative. On Friday 26th August, one of those nurses, Aimee Durnin, came on to Ward 15 for gloves and noticed that my father had changed pallor and was taking his last breaths. Aimee sat with him and held his hand while he passed away. I am so so grateful to her as we were unable to get there in time and I know my father would not have wanted to be alone. Later in the morning whilst we were with him, Aimee came to see us and explained what had happened and how she was with him. Thank you so much Aimee.	**Ward 16** Thank you for all your kindness and care, you really are a credit to our NHS and we really appreciate everything you've done for our Mum. Thank you all so much for the wonderful care my dear Mum received whilst in hospital. You all treated her with the utmost care and dignity, and I am forever in your debt. I just wanted to say thank you to you all, especially Poppy and Lilian, for looking after my Mum in her last days. You have both been angels and thank you from the bottom of my heart.

8. Patient Experience data

Friends and Family Test (FFT)

The team continue to receive a large number of FFT responses following the successful launch of the use of SMS text messaging in outpatients, and the ED for patients over 18 years. With the launch of this option for inpatients during August 2022 it is hoped that further increases will be seen in Q3 2022/23.

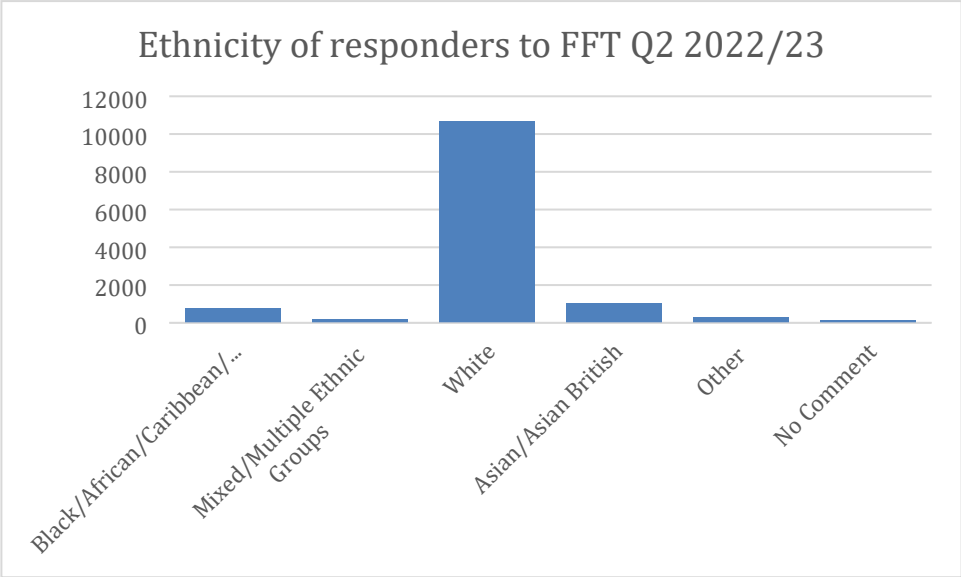
The table below details a comparison of the number of FFT responses received across the Trust for the last four quarters.

Quarter	Total number of responses
Q3 21/22	16499
Q4 21/22	16059
Q1 22/23	12605
Q2 22/23	13164

In Q2 2022/23, 90.3% of responses rated the Trust's services as very good or good.

FFT- Ethnicity

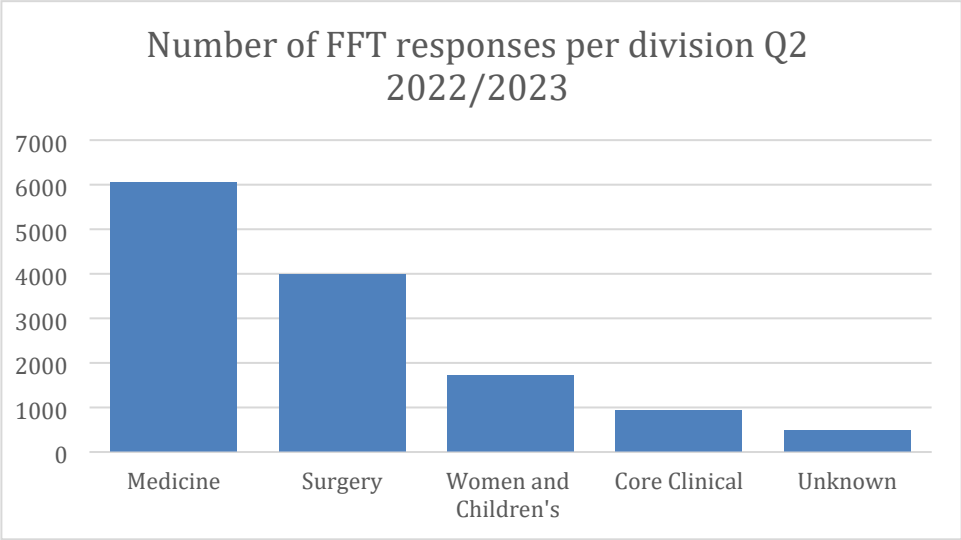
The chart below details the ethnicty of those responding to the FFT, where stated.



The focus for 2022/23 continues to be working with the Trust's Equality Diversity and Inclusion Lead to scope how the Trust can engage further with patients from ethnic minorities to obtain their valuable feedback. FFT inclusion resources are available from the team when required.

Divisonal FFT responses

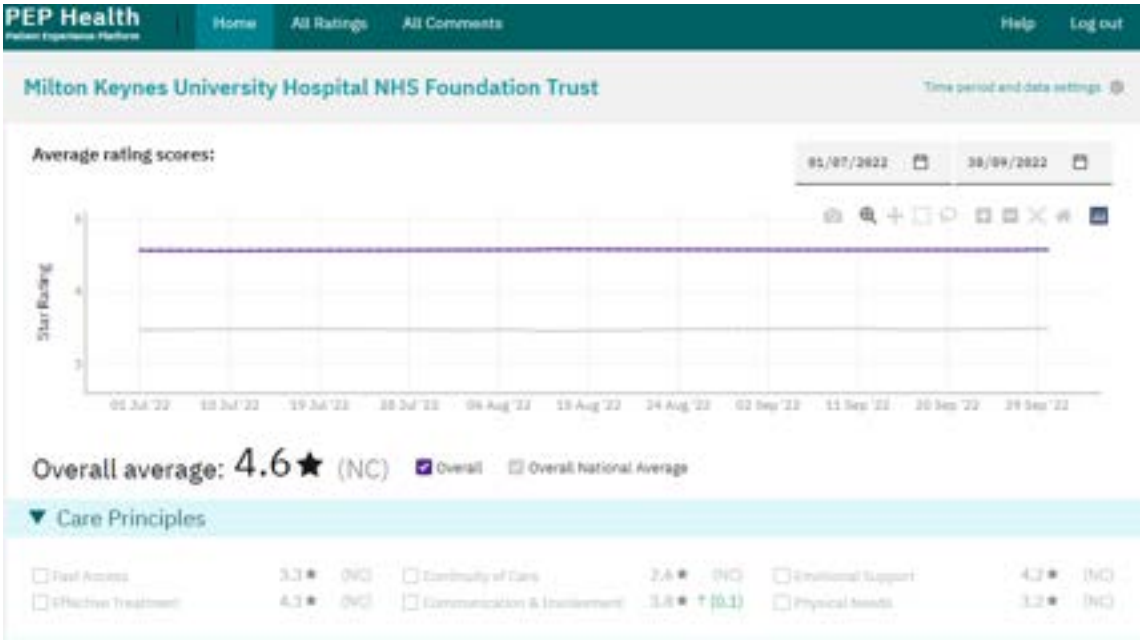
The chart below deails the number of FFT responses per divison for Q2 2022/23.



FFT and comments for social media and online review sites

During Q2, the overall rating for the Trust in relation to positive comments from FFT and comments left on Google review, the NHS website and Twitter, was 4.6* out of 5*.

Below is a screenshot from the PEP Health Trust dashboard for Q2 2022/23.



The top 5 best performing units in respect of postive feedback are:

Endoscopy, Therapies, Breast, Cardiovascular and Haematology and Oncology

The top 5 services with the most comments are:

General Medicine, Emergency Care, Obstetrics, Gynaecology and Haematology and Oncology

Each comment provided in free text form is themed by PEP health and given a star rating. Looking at the overall experience, 9286 comments ranked the service overall, on a ranking of 1 star to 5 stars, as 5 stars.

9. **Surveys**

ED

The ED survey will be sent to patients who attended the ED during September 2022. The results from Picker, the Trust's contractor, are expected in April 2023 and expected to be published by the CQC in September 2023.

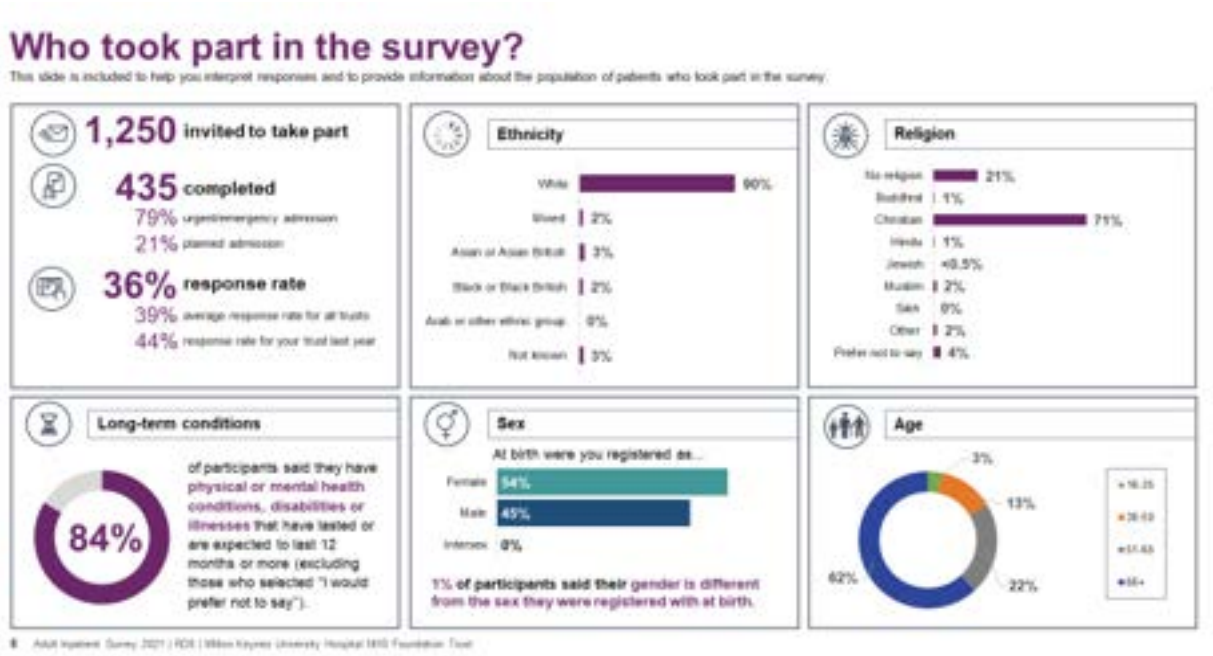
Maternity

The Maternity Survey for 2022 has been undertaken and the results have been shared by Picker. The Maternity team are working in partnership with MVP (Maternity Partnership Voices) MK to draw up action plan in response to the results. The CQC publication is expected to be January/February 2023.

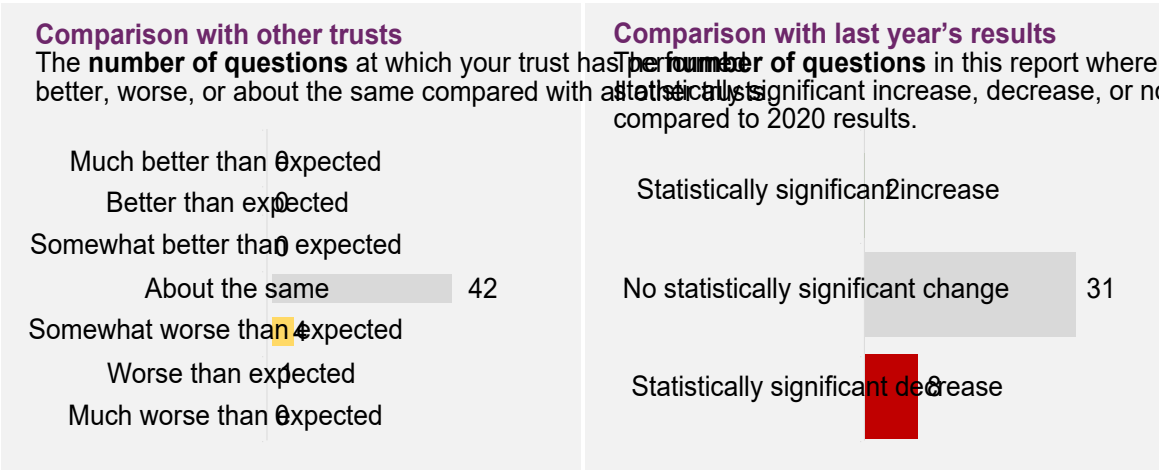
Inpatients

The results from the 2021 inpatient survey were published by the CQC on 30th September 2022.The highlights from the report are detailed below.

Statistics



Summary of findings compared with other Trusts



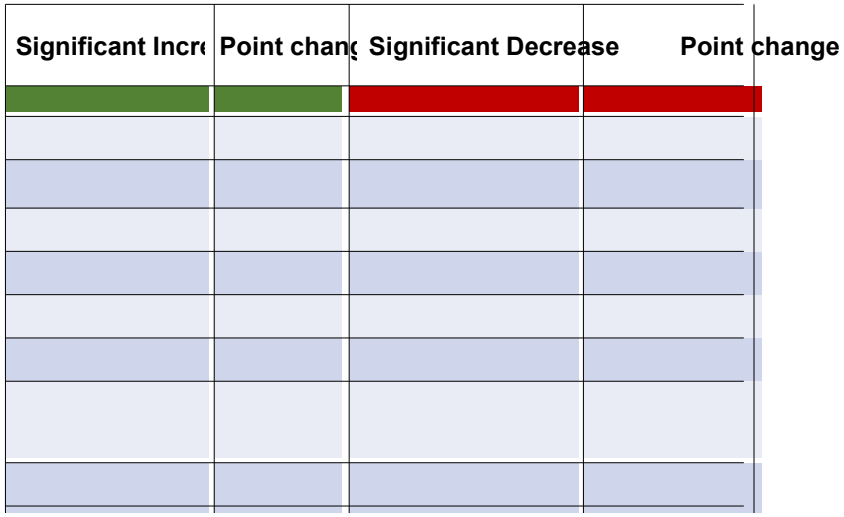
Issues where MKUH were somewhat worse than expected when compared to other Trusts

- Patients were giving contradictory information by staff
- Patients did not feel they were involved in decisions about their care and treatment
- Patients were not able to get a member of staff to help them when they needed attention
- Patients did not always feel they were treated with dignity and respect

Issues where MKUH were worse than expected when compared to other Trusts

- Patients were not given information on their discharge medication

Comparison with 2020 results



Where patient experience is best at MKUH when compared to the average scores of all trusts.

- **Changing wards during the night: staff explaining the reason for patients needing to change wards during the night**
- **Feedback on care: patients being asked to give their views on the quality of their care**
- **Waiting to be admitted: patients feeling that they waited the right amount of time on the waiting list before being admitted to hospital**
- **Support from health or social care services: patients being given enough support from health or social care services to help them recover or manage their condition after leaving hospital**
- **Quality of food: patients describing the hospital food as good**

Where patient experience could improve at MKUH when compared to the average scores of all trusts.

- **Involvement in decisions: staff involving patients in decisions about their care and treatment**

- **Information about medicines to take at home: patients being given information about medicines they were to take at home**
- **Getting help from staff: patients being able to get a member of staff to help them when they needed attention**
- **Communication: patients not being told something by a member of staff that was different to what they had been told by another member of staff**
- **Noise from other patients: patients not being bothered by noise at night from other patients**

What next?

An extraordinary meeting was held following on from the Patient and Family Experience Board in September 2022. This was attended by representatives from the divisional triumvirates, the Chief Nurse and the Head of Patient and Family Experience. The purpose of the meeting was to agree what action would be taken following receipt of the results from the Inpatient Survey 2021. Divisional action plans will be drawn up and agreed at a further meeting which will be held at the end of October 2022 at which time a Trust wide action plan will also be agreed.

10. Conclusion and upcoming events/future plans

This quarter the team have celebrated the improvements being made to support the experience of patients and families. The team work to ensure that there is learning and reflection as a result of the feedback received from patients and families.
The engagement work with patient representatives on projects such as PLACE and the new hospital build has enabled the team to start building a contact list of those that wish to work with the hospital on future projects. The inclusion of the Meaningful Activities Facilitator into the team has given the team further insight into how patient experience can be improved for those patients that are finding their hospital stay difficult. The team are working to ensure this service is recognised across the Trust and staff are aware of the benefits to patients and their teams. The team are also looking forward to volunteers returning to support the work being undertaken.

What to expect Quarter 3 2022/23

- Further work with the Meaningful Activities Facilitator. This includes work to raise the profile of the service, recruitment of volunteers to support activities, the launch of an ‘online shop’ so staff can order activities etc to support their patients and trialling a dedicated Activities Trolley on Ward 14 so that there are always plenty of resources for patients to make the most of.
- With the launch of uploading all the compliments on to the PEP, the team will continue to work with all wards/areas to ensure they are aware of the need to share these with the team. This will include discussions with various teams and producing a flyer and undertaking Trust wide communications.
- The team are working with PEP Health on updates to the dashboard. This includes engaging with various members of staff to get their opinions/thoughts on the improvements.
- With the launch of an option to complete the FFT via SMS messaging for patients over 18 years of age, the team will be working with Paediatric ED and the Quality Lead in Paediatrics to support increasing the feedback received

from our younger patients. This includes a display in the Paediatric ED, and the team are also looking at using a QR code in all the bed spaces for the parents or children to give their feedback.

- The team are working with the AI team on improvements to the 15 steps process in readiness for a relaunch.
- Once the QR code information is available on all patient bedside lockers the project will be launched Trust wide, with the support of the Communications Team.
- The team are working on a separate QR code poster for the maternity areas. This will be undertaken further following the launch of their new website.
- Q3 2022/23 will see the launch of the Patient Experience Resource Trolley. The team will be taking this around the wards, and this will then be managed by the Patient Experience Volunteers once they are in place and trained.
- The team have been working with the Maternity team to create a patient questionnaire regarding screening services.
- The team are working with IT on an extension to the letters to loved one's service. This will be an online greeting card system for the website.
- Information in relation to all patient and family feedback received by the Patient and Family Experience team will be incorporated into the new Quality booklet, to be used as a quality tool on all wards, to ensure all areas are aware of the feedback they receive and celebrate /share that feedback or take forward learning and action as a result of negative feedback.
- The webpages for patient and family experience are to be enhanced by the addition of charity information which will direct patients and their families to where they may find support and assistance from charities and other organisations.
- The team are working with the Head of Quality Improvement on a successes 'Quality Day'. This will showcase the improvement work which is happening across the Trust
- The team are engaging with Age UK to understand what they are hearing from their service users who use hospital services. Age UK will also attend Patient and Family Experience Board, Focus Group B- Feedback.

Antimicrobial Stewardship Annual Report: 2021-22

Meeting title	Trust Board	**Date: 12 Dec 2022**
Lead Director	**Ian Reckless**	
Author	**Prithwiraj Chakrabarti**	
Other Contributor	**Lauren Ramm**	

Report summary				
Purpose *(tick one box only)*	Y **Information**	☐ **Approval**	**To note**	**Decision**
Recommendation				
Strategic objectives links	1. Improve Patient Safety and clinical outcomes 2. Deliver Key Targets			
Board Assurance Framework links	Antimicrobial Stewardship Group Infection Prevention & Control Committee			
CQC outcome/ regulation links	1. Outcome 4/regulation 9 2. Outcome 16/regulation 10 3. Outcome 13/regulation 9			
Identified risks and risk management actions	For information			
Resource implications	Nil			
Legal implications including equality and diversity assessment	Healthcare Act –code of practice criteria Criteria 3- Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance. Also includes, criteria 1,5,6,7,8,9, and 10.			

Executive summary

This report summarizes the key performance indicators and all the major activities performed by antimicrobial stewardship (AMS) team between April 2021 and March 2022. Despite many challenges in 2021-22, the AMS service continued to provide support and vigilance on antimicrobial (AM) consumption at MKUH with some reduction in consumption of total antimicrobials and some selected broad-spectrum antibiotics to bring the consumption rate down to a pre COVID level. AMS support on many other activities had been impacted by the absence of an AM pharmacist throughout the year. However, the AMS ward rounds were continued throughout the period to support AM prescribing.

COVID-19 was a big challenge over the year and impacted significantly on AM stewardship and *C. difficile* infections as the majority of COVID patients were on antibiotics. The introduction of procalcitonin (PCT) based individualised AM stewardship, proactive AM ward rounds, staff-grade microbiologist support, and improved microbiology service, had supported stewardship to keep the total antimicrobial consumption rate below the national average mostly (except in the last quarter when consumption increased slightly). However, MKUH has continued to reduce yearly carbapenem use and stayed below national average.

The Microguide app has been running since 2020 to provide quick guidance on AM prescribing, the contents need further updates. The microbiology laboratory has been working 24 x 7 since Nov 2020 which has significantly supported AMS activity by improving TAT of blood cultures and other critical microbiology results. The last UKAS inspection of the lab in December 2021 was satisfactory but needs more attention to extend the scope towards full laboratory accreditation.

The AMS service also actively participated in research activities and published results in reputable journals. The PCT study supported the use of PCT based individual AM stewardship for COVID and other patients and the approach is regularly practiced in MKUH. There is a national trend of rising AM consumption, *C. difficile* infection and healthcare associated infections in the last year which are reflected in the MKUH performance data, however the *C. difficile* infection rate remained significantly lower in comparison to national and regional average.

Introduction

The Antimicrobial Stewardship (AMS) team drives, supports and monitors the AMS activity at MKUH. The AMS team consists of a Consultant Microbiologist (1 PA activity) and an Antimicrobial Pharmacist (0.75 WTE). However, there was no AM pharmacist support between April 2021 to June 2022 due to an unfilled vacancy. The AMS team reports to the Antimicrobial Stewardship Group (AMSG) members, which meet 5-6 times per year and meetings are chaired by the Medical Director. AMSG consists of clinicians, nurses, pharmacists and managers from different disciplines. AMSG reports in turn to the Prescribing and Medicines Governance Committee (PMGC), and the Patient Safety Board.

AMSG regularly discuss and review various AMS activities along with the national and local AMS targets, review and approve policies and proposals for changes and sets overall governance on AMS activity at MKUH. However, due to COVID constraints and lack of AM pharmacist support, AMS meetings were suspended during April 2021 to March 2022. Regular AMS meetings were back in place on July 2022 since the new AM pharmacist (Lauren Ramm) has joined at MKUH. The main goal of AMS activity at MKUH is focussed on reduction of unnecessary AM consumption by 24 x7 microbiology support and regular AM review round. Irresponsible antimicrobial prescription is the main driver of AM resistance locally, nationally as well as globally. Institutional AM prescribing practice depends on clinician's knowledge, attitude and perception towards AM prescribing behaviour. Therefore, institutional governance on AM usage plays a key role in changing AM prescribing behaviour among clinicians.

The key AMS activities during April, 2021- March, 2022 are summarised below.

1. AMS ward round

Despite staffing problems, AMS ward rounds were continued twice a week with the aim of providing regular AM governance, proactive decision making and improving AM prescribing behaviours. Due to the ongoing COVID pandemic, general use of antibiotics went up. The majority of COVID patients received antibiotics for an average of 5-7 days. AMS rounds focused on rationalising the duration of broad-spectrum AM (piperacillin-tazobactam, meropenem, quinolones and co-amoxiclav) for both COVID and non-COVID patients. Our aim was to prevent a rise of meropenem during the pandemic which usually has a direct and long-term impact on AM resistance.

2. Procalcitonin based individual AM stewardship

Procalcitonin (PCT) is a marker for bacterial sepsis and low PCT value can be a useful guide to stop or switch antibiotics early. PCT based AMS guidance has been updated locally and implemented throughout MKUH since May 2020. A research project has been finished (HRA- IRAS 295166) involving junior doctors and the results were published (Single-centre experience of using procalcitonin to guide antibiotic therapy in COVID-19 intensive care patients - PubMed (nih.gov) DOI: 10.1016/j.jhin.2021.10.010). The research showed a significant decrease in AM consumption among COVID positive patients in ICU if PCT is done within the first 48 hrs of ICU admission.

3. Microbiology laboratory support

The microbiology lab expanded the onsite 24 x7 COVID testing facility to allow patient flow and maintain the standard of care. The laboratory showed good resilience to absorb the work with appropriate support from management. We achieved our goal of at least 100 onsite COVID testing facilities since Jan 2021. The lab continued to provide 24x7 support since December 2020. MALDI-TOF was introduced in Aug 2020, and it has been functioning since December 2020 supporting identification and reporting of significant isolates. The lab has successfully achieved the UKAS accreditation for serology in December 2020 and expanded the scope to COVID diagnostics in 2021. Overall, the 24 x7 service and MALDI-TOF have improved the TAT and quality of reporting of significant samples which has helped early management of difficult infections and appropriate antimicrobial prescriptions.

4. AM policy update

The Trust's AM policy needs to be continually reviewed and updated in response to local and national requirements. The current MKUH AM policy is available via the Trust intranet and microguide app. The AMS team has been working with respective clinical teams and divisions to upgrade local policies and we have updated a further 5 policies up to March 2022. However, alignment of microguide with the updated guidelines is pending due to lack of pharmacy support.

Antibiotic policy updates	Update date	Comment
Gentamicin policy	Mar 2021	Reviewed and ratified
Orthopaedic pre-op guidance	Mar 2021	Policy reviewed & implemented
C. difficile management policy	Sep 2021	Updated as per NICE recommendation
Paediatric AM guidance	Jan 2022	Reviewed
BLMK Antimicrobial Prescribing Guidelines for Primary Care	Nov 2021	Reviewed

5. Antimicrobial e-learning update for Trust's mandatory training

AM mandatory e-learning was updated in August 2020. Further review will be done in April 2023.

6. Microguide AM app

The microguide app has now replaced the Rx guidance as the AM app at MKUH. The transfer of data was completed in March 2021, and the app was made live since this time. However, some updates remain pending due to unavailability of an AM pharmacist during 2021-22.

7. Teaching

The COVID-19 pandemic has impacted on teaching and training. AMS rounds provided a good opportunity for on the spot teaching. A few formal teaching sessions were conducted for nurses, junior doctors and medical students, including the medical grand round (4-5 teaching sessions delivered in 2021-22). There was also one sponsored teaching session organised during AM awareness week.

8. ARK study

The AMS team participated in the ARK (Antibiotic review kit) study in 2019 with an aim to improve AM review within the first 72hr of prescribing. The study involved three interventions. These included a short e-learning training package for all doctors and pharmacists, asking the prescribing doctor to document probable/possible/confirmed infection when prescribing an antibiotic and giving out patient information leaflets to inform patients about the need for AMS. The second intervention has been adopted in e-care. The study helped spread awareness of regular antibiotic review in the participating medical wards. The final part of the study data submission was completed in Oct 2020. The ARK study paper has been submitted to *Lancet Infectious Disease* for publication.

9. AMS audits/QI projects/ Research

The AMS team participated in the Gentamicin prescription in sepsis audit (3rd cycle) as a part of sepsis management at MKUH.

The GBS trial (**GBS3 - The clinical and cost-effectiveness of testing for Group B Streptococcus: a cluster randomised trial with economic and acceptability evaluations) has been** started in 2021 and is ongoing.

The PCT QI project and ARK study have been completed and PCT study results were published, and ARK results are submitted for publication.

A short poster was presented in the Federation of Infection Society conference, 2021 on AM stewardship for COVID patients based on procalcitonin testing in ICU.

10. AMS week

The AMS team celebrated the World Antimicrobial Awareness Week between 18-24th Nov 2021 with some educational activities. There was one sponsored teaching session arranged on AM prescribing and difficult to treat infections. This was presented by national and international speakers.

11. Action plans 2021-22- Progress report

	Action Plan 2021-22	Comment
1.	**Antifungal Stewardship Plan**	Completed. Baseline database has been done. AM review round now includes antifungal review as well.
2.	**Recruitment of AM Pharmacists**	Completed. Lauren Ramm has joined as new AM pharmacist
3.	**AE gentamicin prescription audit action plan and safe gentamicin prescribing**	3rd cycle audit Completed. Gent use within 1 hr of diagnosis of sepsis has increased to 51%. A gent safety dose prompt has been created to alert prescribers about appropriate gent dosing.
4.	**Improvement of Laboratory reporting time and quality of service**	Achieved. Lab service has been continued 24 x7 with improved BC, COVID and other results TAT. Continuation of 24 x7 service may help the current working pattern adopted in other clinical areas.
5.	**Network collaboration for Microbiology IT integration**	Ongoing. Microbiology LIMB harmonisation with 3 other network hospitals have been progressed significantly through regular network meetings.
6.	**Microbiology UKAS scope enhancement and full laboratory accreditation**	COVID testing and Serology accreditation achieved. UKAS review inspection is due in Nov 2022. Further enhancement of scope to be planned after the inspection.
7.	**Microbiology junior doctor post approval and recruitment**	Achieved. Microbiology staff grade junior doctor substantive post has been approved and filled. Thanks to Trust Executive Board for support.
8.	**Nebulised Gent for selected respiratory ward patients**	The proposal could not be moved forward due to COVID outbreak. Further discussion is ongoing to implement this. This will reduce IV broad-spectrum antibiotics for selected patients with early discharge plan.

AMS performance data

PHE regularly publishes data on AMS performance of each NHS trust and the data is available in the public domain. The performance standard is comparable with the national average and other NHS trusts. The PHE data related to AM performance focuses primarily on two parameters.

1. Total AM consumption (DDD-defined daily dose) per 1000 total admissions
2. Total Carbapenem consumption (DDD) per 1000 total admissions

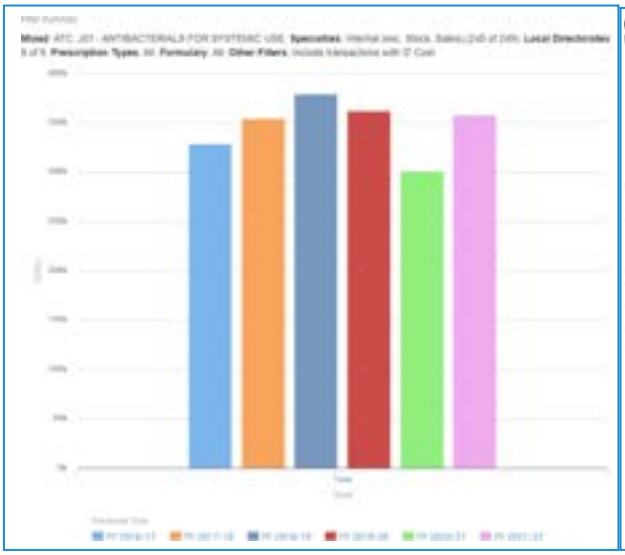
The full performance report for MKUH can be found on the following website

https://fingertips.phe.org.uk/profile/amr-local-indicators

Fig1 PHE data showing AM consumption rate per 1000 admissions at MKUH in 2021-22 has been below the national average till Q3. The sharp rise of antibiotic consumption rate since Q1 was due to the COVID-19 pandemic which was also reflected by a national surge, as almost 90% of COVID patients received antibiotics. In Q4 the total antibiotic consumption has gone slightly above national average which needs to be addressed in 2022-23.

https://fingertips.phe.org.uk/profile/amr-local-indicators

Total systemic antibiotic consumption at MKUH



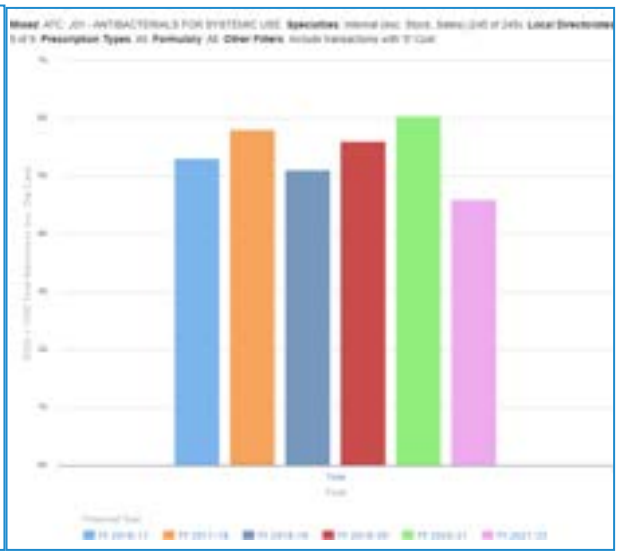


Fig-2.1 (Total DDD of antibacterials) **Fig 2.2 (DDD/1000 admissions)**

Fig 2. Historic data from Rx information showed that there was a gradual rise of total DDDs (total systemic antibiotic consumption) at MKUH since 2015, which was reversed in 2019-20 and continued in 2020-21. However, the sharp fall in 2020-21 was likely due to reduced total admissions during the COVID-19 pandemic (Fig 2.1). Despite the total consumption decreasing during the COVID-19 period, the rate of antibiotic use (DDD/1000 admissions) went up as shown in Fig 2, which has been reversed in 2021-22 (Fig 2.2).

Carbapenem consumption at MKUH

Carbapenems are the broadest spectrum antibiotics. A large proportion of our AMS activity is focused on appropriate prescription and duration of carbapenems in the trust. Meropenem and ertapenem are the two carbapenems used in MKUH. Carbapenem resistance is rapidly rising nationally and internationally, and mostly due to increased use/duration of carbapenems for treating difficult infections. The following figures (fig 3 and 4) showed the trend of carbapenem use in MKUH.

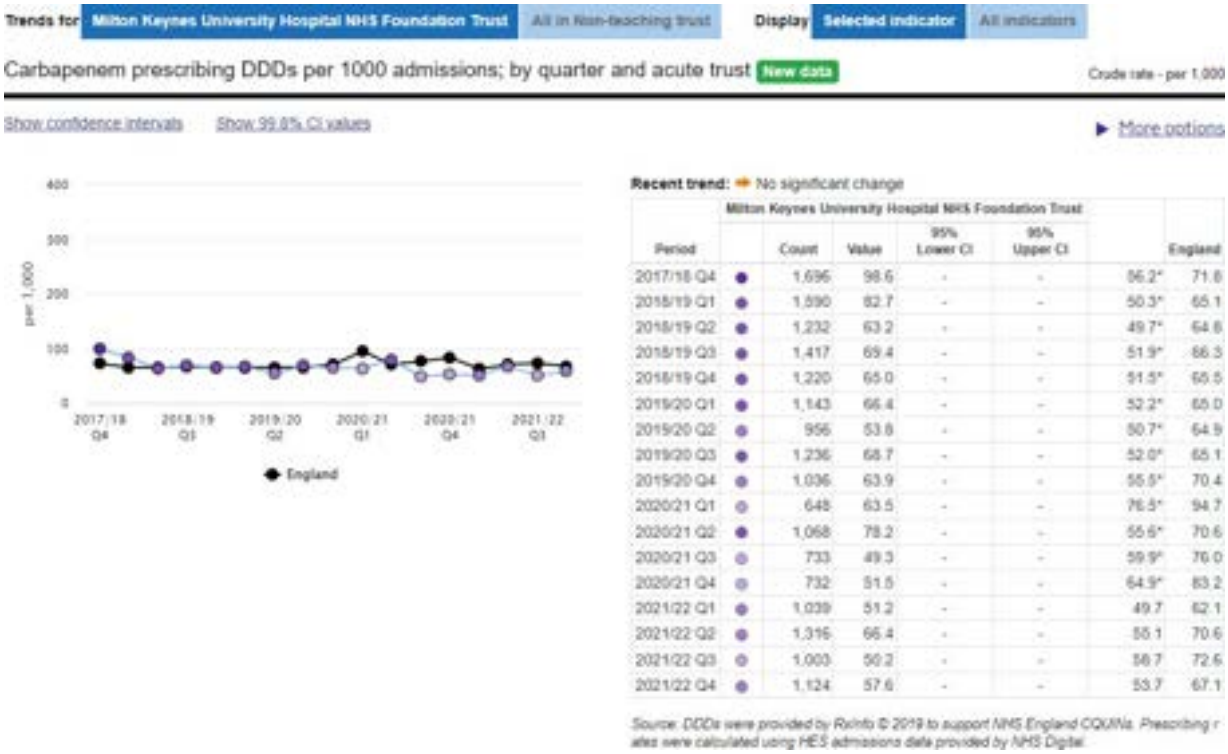
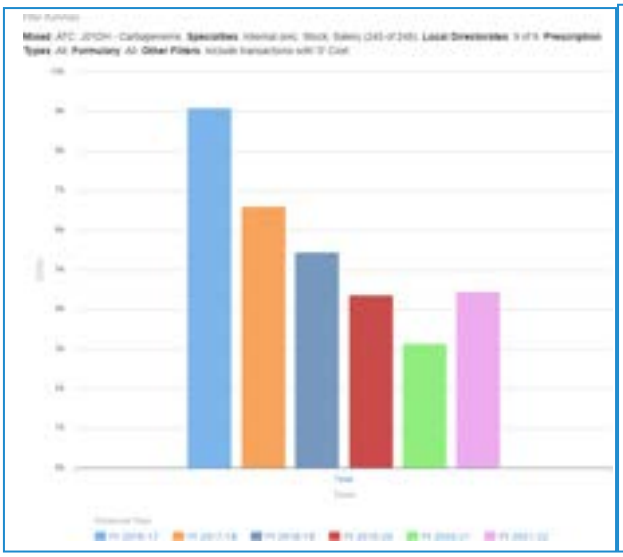


Fig3. PHE data showed MKUH carbapenem use has continued to be below the national average. In Q2 and Q4, there were spikes of carbapenem use which is attributed to the increasing number of complex patients admitted during the pandemic and post pandemic periods. https://fingertips.phe.org.uk/profile/amr-local-indicators

Carbapenem consumption in MKUH



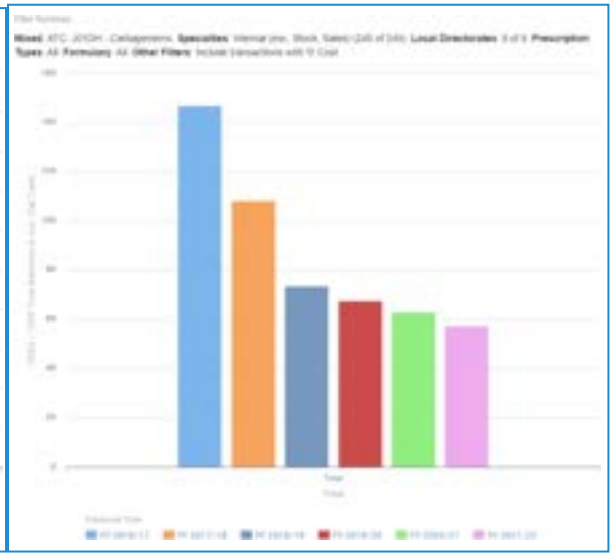


Fig 4.1 (Total DDD of carbapenem) **Fig 4.2 (DDD/1000 admissions)**

Fig 4. Refine data showed total meropenem consumption at MKUH (Fig 4.1). There is a significant stepwise reduction of meropenem over the years. The lowest use of carbapenems (total DDD) was in 2020-21, this was likely due to reduced number of total admissions during the COVID-19 pandemic. However, in 2021-22, the total carbapenem use has gone up to the pre-COVID level (Fig 4.1). When compared to data showing DDDs per 1000 admissions per year, yearly meropenem consumption has gone down and was lowest in 2021-22 (Fig 4.2).

Use of WHO access category (narrower spectrum) antibiotics in MKUH

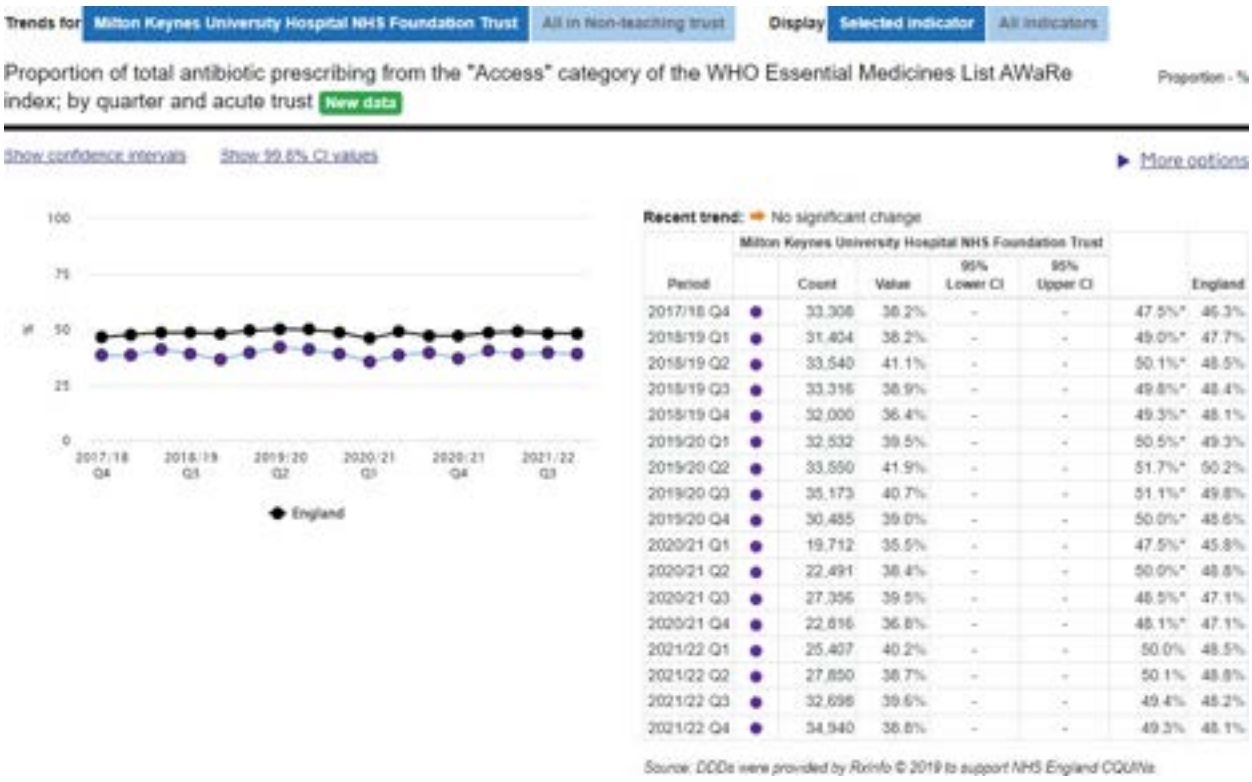


Fig 4. PHE data shows that MKUH needs to increase use of WHO access category drugs. WHO access category indicates narrower spectrum antibiotics. MKUH use co-amoxiclav for sepsis, UTI and chest infections, therefore co-amoxiclav remains the most common choice and is used widely. Unfortunately, co-amoxiclav doesn't come under WHO access category. We are focussing on the reduction of co-amoxiclav for indications such as pre-op prophylaxis (abx changed to Amox/met/gent), uncomplicated pneumonia (amox/doxy), and reduction of AM prescription by improving the diagnosis of UTI in elderly patients.

https://fingertips.phe.org.uk/profile/amr-local-indicators

Piperacillin-Tazobactam (Tazocin) (PT)

PT remains the most valuable 2nd line antibiotic for the majority of infections. High use of PT is the main driver of the spread of ESBL in many countries including the UK. The rise of PT use has been linked with rise of carbapenem use in many hospitals. The AMS round focuses on appropriate use and duration of PT in MKUH.

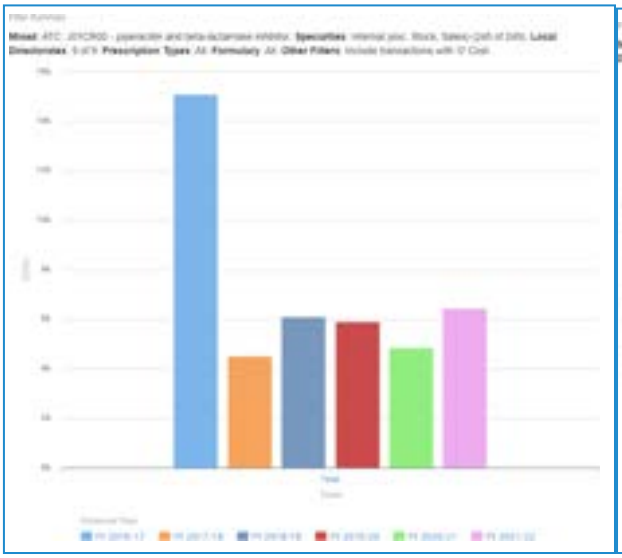


Fig-6.1 (Total DDD of Tazocin)

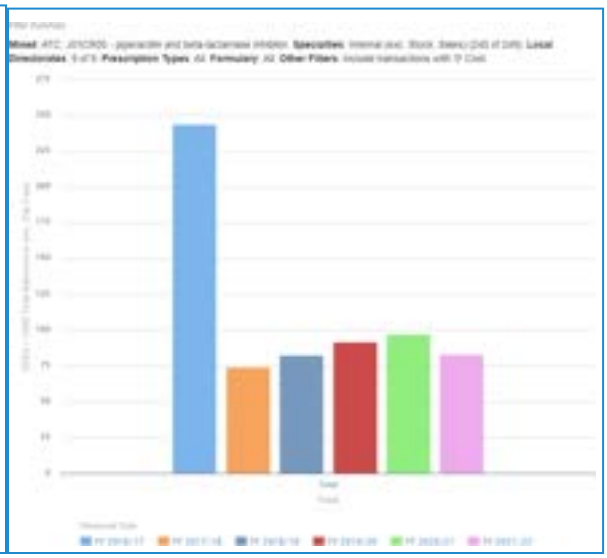


Fig 6.2 (DDD/1000 admission)

Fig 6. Refine data showed total Piperacillin-Tazobactam (Tazocin) use at MKUH (Fig 6.1). The big dip in 2017-18 was likely due to a stock shortage of Tazocin that prompted a change of empiric antibiotic choice from Piperacillin-Tazobactam to co-amoxiclav and gentamicin. Tazocin consumption level remained close to 6K DDD per year however, the drop in 2020-21 may be due to a smaller number of hospital admissions. We are keen to continue PT as a 2nd line to reduce the antibiotic pressure and development of resistance. When the total number of DDDs was compared with the number of DDDs per 1000 admissions/year, Tazocin consumption has reduced slightly in 2021-22 compared to previous years (Fig 6.2).

Co-amoxiclav use in MKUH

MKUH uses co-amoxiclav as the primary antibiotic of choice for the majority of infections. Despite rising gram-negative resistance to co-amoxiclav, combined gentamicin and co-amoxiclav provide good cover for the majority of infections in local the population. The AMS round focuses particularly on the regular review and duration of co-amoxiclav in MKUH.

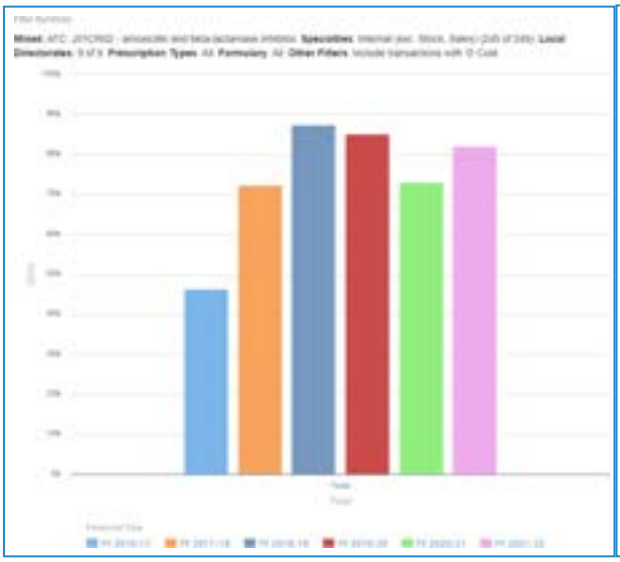


Fig 7.1 (Total DDD of Co-amoxyclav)

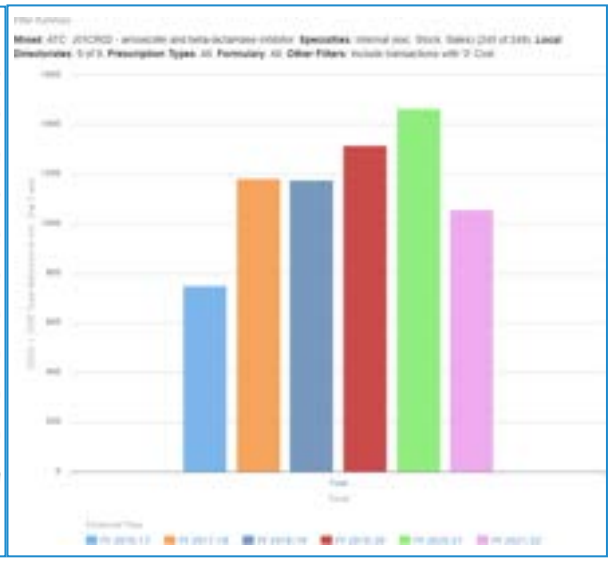


Fig 7.2 (DDD/1000 Admission)

Fig7. Refine data showed Amoxicillin-clavulanic acid (co-amoxiclav) use at MKUH. The total co-amoxiclav use has gone down (Fig 7.1 since 2018-19. However, the drop in 2020-21 may be due to fewer admissions and has gone up again in 2021-22 due to a rise in total admissions (Fig 7.1). When compared to 1000 admissions/year, the co-amoxiclav consumption has gone down in 2021-22 (Fig 7.2)

C. difficile infection trend

Clostridium difficile infection is an indicator of antibiotic practice. Inappropriate antibiotic prescriptions can lead to high numbers of *C. difficile* infections. MKUH reported lower numbers of *C. difficile* infections in comparison to the national average.

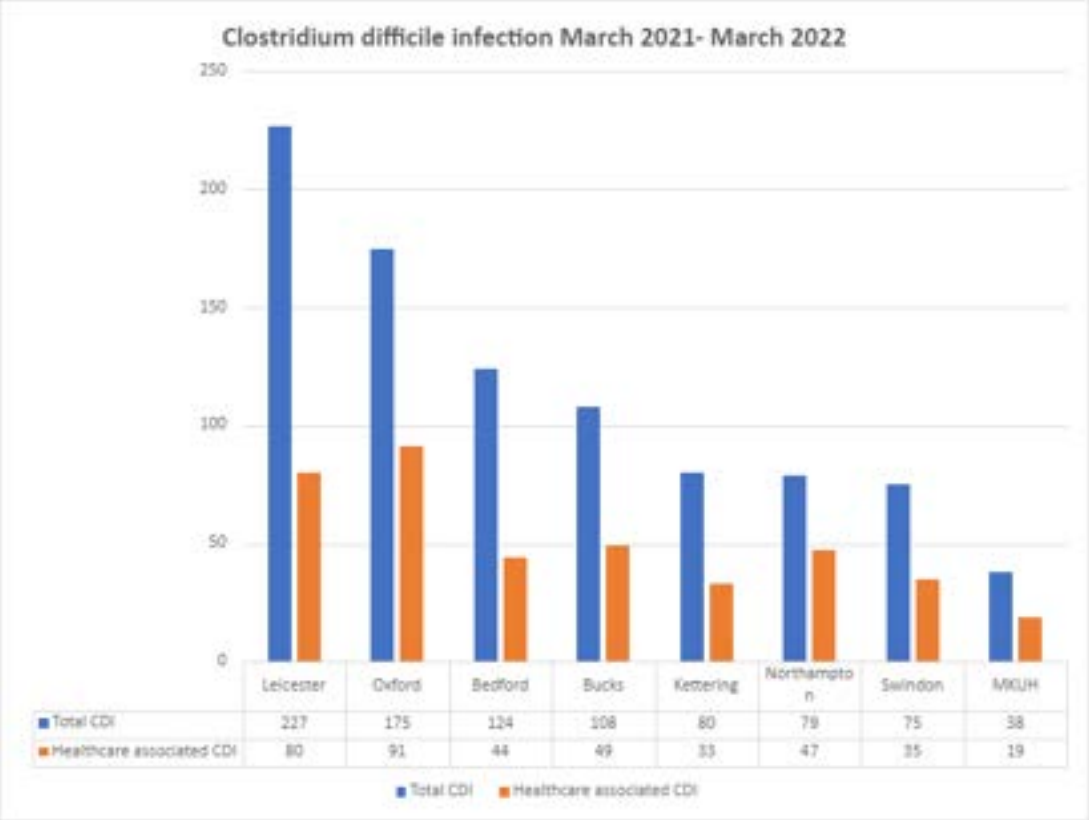


Fig 8 *C. difficile* infection reported, total cases vs healthcare associated infections

Data collected from:

Fig 8: The number of *C. difficile* infections reported by MKUH between March 2021 and March 2022 is low. The number of C. difficile infections nationally has increased due to a rise in antibiotic consumption during the COVID-19 pandemic. A similar trend has been noticed in MKUH but the infection numbers are significantly below the national average and other neighboring trusts.

AM stewardship is a continuous process of governance and improving prescribing behaviour of the clinicians focusing on rationalising and targeting AM use to improve clinical care and reduce harm to patients. The year 2020-2021 was a challenging year for AM stewardship due to the COVID-19 pandemic and our inexperience to treat this new viral infection. The rate of total and broad-spectrum antibiotic consumption had increased throughout this year due to the ongoing pandemic. This was reflected nationally and globally which is likely to impact on AM resistance in the future. The ongoing pandemic, the huge backlog in the NHS, increasing complicated infections and winter pressures could potentially increase the antibiotic use in 2021-22. We are determined to support the stewardship activity focusing on specific areas which are at risk of AM overuse.

Following areas have been identified as focus for 2022-23

The year 2021-22 was a challenging year for infection control and AM stewardship. The hospital remained busy since the beginning of the year; the high bed-occupancy coupled with staff shortages and delay in investigations increased the risk of high AM consumption among various wards including haemto-oncology, respiratory, elderly care and surgical units. The number of MSSA bacteremia and *C. difficile* cases has gone up. Senior clinicians need to be proactive to support AM stewardship and take ownership of AM prescribing practice in their clinical areas. This awareness may have been interrupted by the pandemic wave, but needs to be reiterated again through regular feedback, audits, research, and AM Stewardship meetings.

1. **IV to oral switch: Regional AMS plan**

The regional AM stewardship team of East of England performed an audit to look at the proportion of IV antibiotics of the total antibiotic consumption of various trusts in England. It has been found that the national average is about 25%. We have looked at MKUH data and it varies between 22-27% in different months. We have agreed with the regional team to implement an action plan with a regional aim to reduce the proportion of IV antibiotics to below 20%. The action plan includes an IV to oral switch policy and empowering senior nurses and pharmacists to intervene when IV to oral switch is appropriate.

2. **Update of microguide**

The Microguide app supports all AM prescribers at MKUH by providing updated AM policy. The microguide app was launched in 2020 and is currently one of the highest used apps in the hospital. However, due to unavailability of AM pharmacist for more than one year, many updates are pending which require further attention in 2022-23.

3. **Gentamicin in sepsis audit**

National standard NHS contract requires regular audits on sepsis management. The AMS team conducts regular audits on the timing of co-amoxiclav and gentamicin prescriptions (antibiotic of choice for sepsis at MKUH) to patients diagnosed with sepsis at admission. The last audit showed about 90% of co-amoxiclav and 54% of gentamicin were given to patients within 1 hr of diagnosis of sepsis. Further audit and clinical support will be required to improve the timeliness of gentamicin prescription and administration.

4. **Strategic planning to reduce the broad-spectrum antibiotics (Tazocin/Meropenem/fluoroquinolones)**

As per the NHS standard national contract, every trust is expected to reduce broad spectrum antibiotics in 2022-23 by 4.5% from a 2018 baseline and another 2% by in the next financial year. We need more engagement from clinicians to support strategy planning for overall reduction of broad-spectrum antibiotics.

5. **Carbapenemase producing Enterobacterales (CPE) management plan**

CPE are the most challenging resistant bacteria to cause serious infections. The limited number of suitable antibiotics to treat CPE infections leads to high mortality and morbidity. In a regional audit, we found that if CPE is isolated from a patient (colonized or infected), the length of stay becomes significantly increased (average 25-30 days). So, prevention of CPE transmission in the hospital setting is extremely important to prevent infection by multidrug resistant organisms. UKHSA provides guidelines for CPE screening and management which we have audited in the network hospitals and the action plans are being implemented for MKUH.

6. **Research projects:** -

GBS3 -The clinical and cost-effectiveness of testing for Group B Streptococcus: a cluster randomised trial with economic and acceptability evaluations, the national project has now been ongoing in MKUH with relevant modification of the laboratory procedure for GBS detection. The trial is looking at standardising the GBS screening advice to pregnant ladies with possible reduced exposure to antibiotics during labour.

Another national trial looking at the efficacy of various products for MRSA decolonization has been agreed (TIDE trial) awaiting site initiation visit to start recruitment.

7. Microbiology clinical service upgrades

The microbiology clinical service is a critical component of the AM stewardship practice at MKUH. Both the clinical and laboratory service are now working 24 x7, supporting the urgent needs of the hospital, urgent care as well as community after routine hours (i.e many GP surgeries are now have extended opening hours.). The quick TAT of critical results often facilitate a high quality of care, rapid decision making and early discharges.

Other areas the lab is focussing currently include-

a. Network collaboration for Microbiology IT integration

The microbiology department is involved in the harmonisation of work between the network trusts to develop the new network wide IT system. This system will enable intra-network sample processing and result transfer more efficiently to reduce TAT.

b. Microbiology UKAS scope enhancement and full laboratory accreditation

UKAS accreditation is mandatory for a modern microbiology laboratory as it provides the necessary framework for a quality assured service. The serology section of the MKUH laboratory has already undergone accreditation and the COVID testing has been extended in scope. The department is keen to enhance the scope further this year to apply for accreditation of the whole laboratory.

Conclusion

Despite many challenges in 2021-22, the AMS service continued to provide support and vigilance on AM consumption at MKUH with some improvement in the total amount of antibiotics used and also the consumption of some broad-spectrum antibiotics to bring the consumption rate down to a pre COVID level. AMS support on many other activities has been impacted by the absence of an AM pharmacist throughout the year. The ongoing COVID-19 pandemic was a big challenge over the year and impacted significantly on AM stewardship and *C. difficile* infection as the majority of COVID-19 patients were on antibiotics. The introduction of PCT based individualised AM stewardship, proactive AM ward rounds, staff-grade microbiologist support, and an improved microbiology service have supported the trust to maintain antimicrobial consumption to below the national average (excluding the last quarter where consumption increased) This year the AMS team is keen to focus more on pending issues with microguide, the IV to oral switch project, reduction of healthcare associated infections and strategic planning to reduce broad-spectrum antibiotics.

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Trust Performance Summary: M8 (November 2022)

1.0 Summary

This report summarises performance in November 2022 against 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 due to post-pandemic recovery plans, some local transitional or phased targets have been agreed to measure progress in recovering performance. It should however be noted that NHS Constitutional Targets remain, as highlighted in the table below:

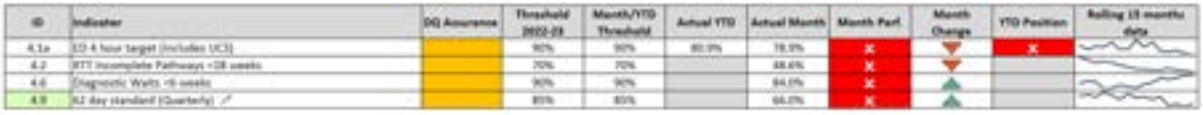
Indicator ID	Indicator Description	Transitional Target	Constitutional Target
4.1a	ED 4 hour target (includes UCS)	90%	95%
4.2	RTT Incomplete Pathways <18 weeks	70%	92%
4.5a	RTT Patients waiting over 52 weeks (Total)	230	0
4.6	Diagnostic Waits <6 weeks	90%	99%

Given the impact of COVID-19, the performance of certain key constitutional NHS targets for November 2022 were directly impacted. To ensure that this impact is reflected, monthly trajectories are in place to ensure that they are reasonable and reflect a realistic level of recovery for the Trust to achieve.

2.0 Key Priorities: Operational Performance Targets

Performance Improvement Trajectories

November 2022 and year-to-date performance against transitional targets and recovery trajectories:



ED performance declined slightly in November 2022 to 78.9%, the lowest percentage year to date. However, MKUH performance exceeded both the national overall performance of 68.9% and the performance of the majority of other trusts within its Peer Group (see Appendix 1).

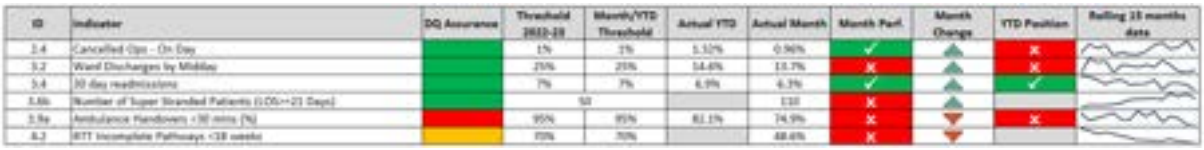
The Trust's RTT Incomplete Pathways <18 weeks performance was 48.6% at the end of November 2022. The total volume of open pathways is now at 38,968, declining from 39,864 in October 2022. The Trust has robust recovery plans in place to support an improvement in RTT performance, while the cancellation of any non-urgent elective activity and treatment for patients on an incomplete RTT pathway is being proactively managed.

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.

In Q2 2022/23, the Trust's 62-day standard performance (from receipt of an urgent GP referral for suspected cancer to first treatment) was 66.0% against a national target of 85%, increasing from 62.3% in Q1 2022/23. The percentage of patients to begin cancer treatment within 31 days of a decision to treat declined slightly to 96.1%, however it remains above the national target of 96%. The percentage of patients to attend an outpatient appointment within two weeks of an urgent GP referral for suspected cancer was 73.1% against a national target of 93%, a deterioration when compared to the previous quarter's performance of 80.6%.

3.0 Urgent and Emergency Care

In November 2022, four of the six key performance indicators measured in urgent and emergency care demonstrated a month-on-month improvement:



Cancelled Operations on the Day

In November 2022, there were 25 operations that were cancelled on the day for non-clinical reasons, representing 0.96% of all planned operations. The majority of the cancellation reasons were related to staffing issues, insufficient time and bed availability.

This was an improvement compared to 49 operations cancelled on the day for non-clinical reasons in October 2022 (2.14% of all planned operations).

Readmissions

The Trust's 30-day emergency readmission rate decreased from 6.9% in October 2022 to 6.3% in November 2022, remaining below the 7% threshold.

Delayed Transfers of Care (DTOC)

The number of DTOC patients reported at midnight on the last Thursday of November 2022 was 30 patients: 24 in Medicine and six in Surgery. The number of patients not meeting the criteria to reside on the same date was 61: 52 in Medicine and nine in Surgery. Performance in both areas improved compared to the last Thursday of October 2022, which saw 36 DTOC patients and 79 patients not meeting the criteria to reside.

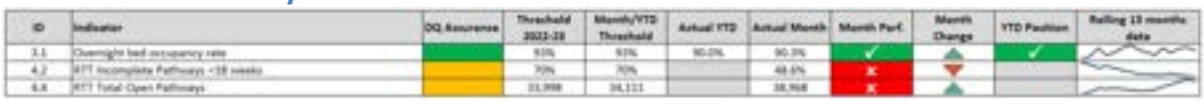
Length of Stay (Stranded and Super Stranded Patients)

The number of super stranded patients (e.g. with a length of stay of 21 days or more) at the end of the month was 110, an improvement compared with 129 at the end of October 2022.

Ambulance Handovers

In November 2022, the percentage of ambulance handovers to the Emergency Department taking less than 30 minutes was 74.9%, remaining consistent compared to 75.5% in October 2022.

4.0 Elective Pathways



Overnight Bed Occupancy

Overnight bed occupancy was 90.3% in November 2022, decreasing from 91.8% in October 2022.

RTT Incomplete Pathways

The Trust's RTT Incomplete Pathways <18 weeks at the end of November 2022 was 48.6% and the number of patients waiting over 52 weeks was 2,444. These patients were distributed across Surgery (2,201), Women and Children (212) and Medicine (31).

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 November 2022, with a performance of 84.0%. However, this was the highest percentage year to date, increasing from 61.9% in April 2022.

The Trust has robust recovery plans in place to support improvement in diagnostic performance and demand is being proactively monitored across modalities to ensure that the plans can be managed.

5.0 Patient Safety

Infection Control

In November 2022, the following infections were reported:

Infection	Number of Infections	Division/ Ward
Klebsiella Spp bacteraemia	3	Medicine (Ward 7 and Ward 19) and Surgery (Ward 20)
C.Diff	2	Medicine (Ward 3 and Ward 14)
MSSA	2	Medicine (Ward 19) and Surgery (Ward 23)
P.aeruginosa bacteraemia	2	Medicine (Ward 3 and Ward 25)
E-Coli	1	Medicine (Ward 25)
MRSA bacteraemia	0	

Note:

- MRSA has breached its zero-tolerance threshold for 2022-23 with two occurrences.
- MSSA has breached its threshold of eight in 2022-23 with 13 occurrences.
- C.Diff has breached its threshold of 10 in 2022-23 with 14 occurrences.

ENDS

Appendix 1: ED Performance - Peer Group Comparison

The following NHS Trusts have historically been considered 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

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 and Bedfordshire Hospitals NHS Foundation Trust, both in the MKUH peer group, are two of those and therefore data for these trusts is not published on the NHS England statistics website.

September to November 2022 ED Performance Ranking

MKUH Peer Group Comparison - ED Performance	Sep-22	Oct-22	Nov-22
Homerton Healthcare NHS Foundation Trust	86.2%	77.1%	79.7%
Milton Keynes University Hospital NHS Foundation Trust	80.3%	79.3%	78.9%
Southport and Ormskirk Hospital NHS Trust	72.5%	73.6%	74.2%
Buckinghamshire Healthcare NHS Trust	69.7%	67.0%	67.4%
Northampton General Hospital NHS Trust	67.4%	72.1%	64.0%
North Middlesex University Hospital NHS Trust	66.9%	63.8%	63.4%
The Hillingdon Hospitals NHS Foundation Trust	57.6%	65.4%	62.8%
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	58.3%	58.1%	59.1%
Oxford University Hospitals NHS Foundation Trust	60.9%	58.2%	57.9%
Mid Cheshire Hospitals NHS Foundation Trust	60.6%	56.7%	57.8%
The Princess Alexandra Hospital NHS Trust	59.1%	52.6%	54.4%
Barnsley Hospital NHS Foundation Trust	65.7%	64.3%	54.0%
Bedfordshire Hospitals NHS Foundation Trust	-	-	-
Kettering General Hospital NHS Foundation Trust	-	-	-

Meeting Title	Trust Board	Date: January 2023
Report Title	2022-23 Executive Summary M08	Agenda Item Number: 17
Lead Director	John Blakesley, Deputy CEO	
Report Author	Information Team	

Introduction	Purpose of the report: Standing Agenda Item

Key Messages to Note	In November 2022:
	
	Emergency Department:
	- There were 8,686 ED attendances, above the monthly year to date average.
	- ED 4-hour performance declined slightly to 78.9%, the lowest percentage year to date. However, performance exceeded both the national performance and the performance of the majority of other trusts within its Peer Group.
	- 74.9% of ambulance handovers took less than 30 minutes, worse than the 15-month average (82.7%) and the worst performance year to date.
	
	Outpatient Transformation:
	- There were 34,916 outpatient attendances, an increase in comparison to November 2019.
	- 12.2% were attended virtually, the lowest percentage to date this financial year.
	- 6.6% of patients did not attend their appointment, above the threshold of 6.0%.
	
	Elective Recovery:
	- There were 2,476 elective spells, an increase in comparison to November 2019.
	- At the end of the month 38,968 patients were on an open RTT pathway. Of these:
	  o 2,444 patients were waiting over 52 weeks, a 1.5% increase compared to October 2022.
	  o 118 patients were waiting over 78 weeks, but zero over 104 weeks.
	- At the end of the month 5,908 patients were waiting for a diagnostic test. Of these patients:
	  o 84.0% were waiting less than 6 weeks; a large improvement compared to 61.9% in April 2022.
	
	Inpatients:
	- Overnight bed occupancy was 90.3%.
	- A significant number of beds were unavailable due to:
	  o 110 super stranded patients (length of stay 21 days or more).
	  o 30 DTOC patients.
	  o 61 patients not meeting the criteria to reside.
	
	Human Resources:
	- Substantive staff turnover remained at 16.9%, the highest rate to date this financial year.
	- Agency expenditure also exceeded its threshold.
	- Appraisals (excluding doctors) and mandatory training completion rates were better than their targets. However, November appraisal completion rate for doctors was only 34.1%.

	Patient Safety: 10 infections were reported and MRSA, MSSA and C.Difficile have all breached their 2022-23 thresholds.		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Review** ☐

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	*1. Keeping you safe in our hospital* *2. Improving your experience of care* *3. Ensuring you get the most effective treatment* *4. Giving you access to timely care* *5. Working with partners in MK to improve everyone's health and care* *6. Increasing access to clinical research and trials* *7. Spending money well on the care you receive* *8. Employ the best people to care for you* *9. Expanding and improving your environment* *10. Innovating and investing in the future of your hospital*

Report History	
Next Steps	
Appendices/ Attachments	ED Performance – Peer Group Comparison

What is the…

THE MK DEAL?

Health and social care

December 2022

What is the background to the MK Deal?

Keeping it **local**

Following the creation of the Bedfordshire, Luton and Milton Keynes Integrated Care Board there was a determination to develop partnership arrangements for MK so we can influence those aspects of commissioning and improvement which are best done at a local level.

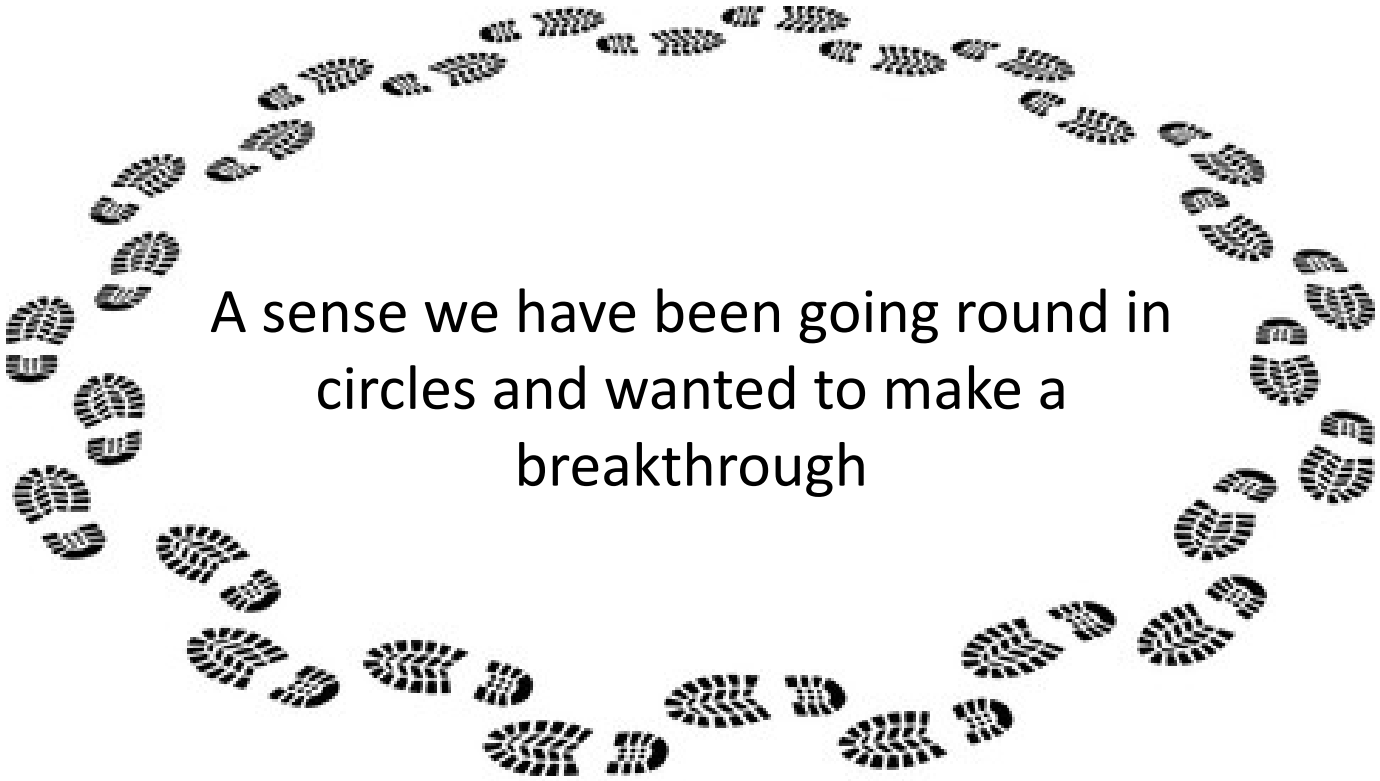
Making it **better**

There was also shared commitment across the local NHS organisations, the council and other partners to continual improvement and making our system work better – and a belief that the solutions to many of our challenges lie in the hands of local organisations and their leaders.

What is the background to the MK Deal?

Keeping it **local**

Making it **better**



Why the language of a deal?

Different

Simple

Mutual

Who is doing the deal?

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Healthwatch
Voluntary Community and Social Enterprise
Milton Keynes Hospital

Buckinghamshire Fire and Rescue
BLMK Integrated Care Board
CNWL

Milton Keynes City Council
Primary Care Network
Thames Valley Police

MK Together | Health and Care Partnership

MK Together | Joint Leadership Team

What is in the deal?

Improving system flow

Tackling obesity

Children and young people's mental health

People with complex needs

What is in the deal?

Improving system flow

Remit to cover:

- Strengthening the day to day management of the urgent care system
- Simplification of existing pathways for care
- More integrated workforce to address workforce shortages
- Planning and delivery of the virtual ward
- Agreement of shared risk management and other clinical policies
- Improved interface with primary care services
- All decisions on the deployment of funding for these services

What is in the deal?

Improving system flow

How will we know if we are making progress:

- Percentage of patients in our hospital not meeting criteria to reside
- 78 week waits at our hospital for elective care
- Number of 30 minute ambulance handover delays at our hospital
- The proportion of older people (65 and over) still at home 91 days after discharge
- Percentage of two hour urgent community response referrals achieving the two hour standard

What is in the deal?

Tackling obesity

Remit to cover:

- Strengthening NHS and Public Health commissioned weight management services.
- Developing new ways to support people lose weight, including the use of wearable technology, use of pharmacological therapies, campaigns in schools and primary care.
- Shaping the food and activity environment to prevent more people reaching an unhealthy weight in the future. Examples include planning policy, licensing, reward of active travel and employment policies.

What is in the deal?

Tackling obesity

How will we know if we are making progress:

- Prevalence of overweight (including obesity) among school children of Reception age
- Prevalence of overweight (including obesity) among school children in Year 6
- Percentage point gap in the prevalence of overweight (including obesity) between the most and least deprived areas, as measured in year 6
- Adult prevalence of overweight/obesity

What else is in the deal?

Children and young people's mental health

Managing complex needs

Both in pre-start phase, to be reviewed in February 2023

How the deal was struck

- The deal was developed by the Joint Leadership Team (JLT) in the first part of 2022.
- It was formally considered by the ICB their first board meeting on **29 July** and received support.
- A decision to enter into a deal was agreed by the MK Health and Care Partnership on **12 October**.
- The ICB signed off on the deal on **24 November.**
- The work on priority one started on **1 December.**

It is, of course, a work in progress but a good platform to build from.

Want to know more?

You can contact

Rebecca Green

rebecca.green@nhs.net

NHS
Milton Keynes University Hospital
NHS Foundation Trust

Meeting title	**Public Board**	**Date:** 12 January 2022
Report title:	**Finance Paper Month 8 2022-23**	**Agenda item:** 19
Lead director **Report authors**	Terry Whittle Sue Fox Cheryl Williams	Director of Finance Deputy Head of Financial Management Financial Controller
FoI status:	Private document	

Report summary	An update on the financial position of the Trust at Month 8 (November 2022).			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** x	**Decision** ☐
Recommendation	Finance & Investment Committee is asked to note the financial position of the Trust as of 30th November 2022 and the proposed actions and risks therein.			
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 Appendix			
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	
Appendices	Pages 12-14

FINANCE REPORT FOR THE MONTH TO 30th NOVEMBER 2022

TRUST BOARD

CONTENTS

EXECUTIVE SUMMARY

(1 & 2.) Revenue – Clinical revenue (ICB block contract and variable non-ICB income) is above plan. Income has been received for the payment of the backdated wage award. Other revenue is above plan due to income received for education and training.

(3. & 4.) Operating expenses – Pay costs are higher than plan due to the payment of the wage award (offset by in-year funding received), increased costs for temporary staff and bank pay enhancements (for sickness and vacancies), and additional pay spend related to elective recovery. Non-pay is broadly on plan with inflationary cost pressures offset by underspends on clinical consumables relating to activity performed.

(5.) Non-operating expenditure – non-operating expenditure is underspent due to interest received.

(8.) Elective Recovery Fund– ERF against the BLMK block has been recorded at planned levels to month 8 following informal guidance that this would not be subject to clawback by NHSE (April – Nov).

(9.) Covid expenditure – reduced costs mainly relating to lower backfill cover of staff shortages for Covid sickness absence.

(11.) Financial Efficiency– The Trust has achieved savings required up to month 8. The Trust has a shortfall in identified and approved schemes compared to the full year savings and is working to mitigate the gap (via additional savings/ERF/cost control).

(12.) Cash – Cash balance is £39.4m, equivalent to 43 days cash to cover operating expenses. Balances include £18m for capital schemes.

(13.) Capital – In line with plan and forecast to be within the CDEL allocation. In month there has been additional CDEL approved for Digital Diagnostics – Imaging of 0.3m. The trust has been advised it is unlikely there will be further CDEL for NHP. IFRS16 lease funding will be centrally held (by NHSE). The forecast has been revised to take account of these items.

(14.) ICS Financial Position – BLMK ICS is broadly on plan up to M8.

Ref	All Figures in £'000	Month 8 YTD Plan	Month 8 YTD Actual	Month 8 YTD Var	Full Year Plan	Full Year Forecast	Full Year Var	RAG
1	Clinical Revenue	203,421	209,359	5,938	307,824	316,657	8,833	
2	Other Revenue	18,010	19,665	1,655	24,340	27,532	3,192	
3	Pay	(140,597)	(148,368)	(7,771)	(208,343)	(220,229)	(11,886)	
4	Non Pay	(66,530)	(66,792)	(262)	(98,408)	(98,547)	(139)	
5	Financing & Non-Ops	(13,634)	(13,217)	417	(20,804)	(20,804)	-	
6	Surplus/(Deficit)	669	646	(23)	4,609	4,609	-	
7	Control Total Surplus/(Deficit)	(4,018)	(3,983)	35	-	-	-	
	Memos							
8	ERF Delivery	5,264	5,264	-	7,381	7,381	-	
9	COVID expenditure	(4,659)	(3,425)	1,234	(5,776)	(4,822)	954	
10	High Cost Drugs	(14,224)	(14,546)	(322)	(21,197)	(21,197)	-	
11	Financial Efficiency	5,558	5,558	-	12,049	12,049	-	
12	Cash	44,584	39,382	(5,202)	29,943	29,943	-	
13	Capital Plan	(9,594)	(9,654)	(60)	(18,288)	(18,168)	120	
14	ICS Financial Position	(4,040)	(3,638)	402	-	-	-	

Key message

The Trust is reporting a £4m deficit (on a Control Total basis) up to November, this is consistent with the plan. National wage award costs in-excess of those planned are mitigated by additional in-year funding. There is a continued pay cost burden from bank enhancements and agency costs, both interventions are required to ensure staff availability to cover sickness and vacancies. These costs exceed the recurrent pay funding available. Activity related non-pay operating costs (e.g., clinical consumables) increased in November. Exposure to further inflationary price changes this year remains high. The Trust has achieved the required level of efficiency savings to date but has a recurrent savings gap (to plan) for the year. The efficiency target increases in the second half of the year at circa 70% of the annual target.

Capital investment is in line with plan on both a cumulative and forecast basis. The cash plan assumes receipt of £5m donated income (Q4) for the Maple Centre. Creditors continue to be paid promptly.

FINANCIAL PERFORMANCE - OVERVIEW MONTH 8

2. **Summary Month 8**

For the month of November 2022, financial performance (on a Control Total basis) is a £0.5m surplus, this is £0.3m better than plan.

All Figures in £'000	Month 8 Plan	Month 8 Actual	Month 8 Var	Month 8 YTD Plan	Month 8 YTD Actual	Month 8 YTD Var	Plan Plan	Plan Forecast	Plan Var
Clinical Revenue	25,693	28,062	2,370	203,421	209,359	5,938	307,824	316,657	8,833
Other Revenue	1,573	1,818	245	12,950	14,655	1,705	19,169	22,361	3,192
Total Income	27,266	29,880	2,614	216,371	224,014	7,643	326,993	339,018	12,025
Pay	(17,212)	(18,811)	(1,599)	(140,597)	(148,368)	(7,771)	(208,343)	(220,229)	(11,886)
Non Pay	(8,134)	(8,893)	(758)	(66,530)	(66,792)	(262)	(98,408)	(98,547)	(139)
Total Operational Expenditure	(25,346)	(27,703)	(2,357)	(207,127)	(215,160)	(8,033)	(306,751)	(318,776)	(12,025)
EBITDA	1,920	2,177	257	9,244	8,854	(390)	20,242	20,242	0
Financing & Non-Op. Costs	(1,806)	(1,719)	87	(13,261)	(12,836)	425	(20,242)	(20,242)	0
Control Total Deficit (excl. top ups)	**114**	**457**	**344**	**(4,018)**	**(3,983)**	**35**	**0**	**0**	**0**
Control Total Deficit (incl. top ups)	**114**	**457**	**344**	**(4,018)**	**(3,983)**	**35**	**0**	**0**	**0**
Donated Income	10	0	(10)	5,060	5,010	(50)	5,171	5,171	0
Depreciation	(48)	(48)	0	(372)	(381)	(9)	(563)	(563)	0
Impairments & Rounding	0	0	0	(1)	0	1	1	1	0
Reported deficit/surplus	**76**	**409**	**334**	**669**	**646**	**(23)**	**4,609**	**4,609**	**0**

3. Clinical Income
Clinical income shows a favourable variance of £2.4m which is due to overperformance on out-of-area PbR contracts (Bucks and Northants), and the planned release of deferred income from the prior year.

4. Other Income
Other income shows a favourable variance of £0.2m. Higher than planned income for staff recharges and overseas recruitment was received in month.

5. Pay
Pay spend is above plan with the payment of enhanced bank rates to fill vacant shifts as well as the unbudgeted element of the pay award. This is mostly offset by additional clinical income. Further detail is included in Appendices 1 and 4.

6. Non-Pay
Non pay is above plan due to increased spend on drugs and clinical consumables. Further detail is included in Appendices 1 and 5.

7. Non-Operating Expenditure
Non-operating expenditure is lower than plan in-month due to interest received.

Key message
For the month of November 2022, the position on a Control Total basis is a £0.5m surplus, which is slightly better than plan. This is due to an increase in deferred income to offset an increase in spend on temporary staffing and clinical consumables.

FINANCIAL PERFORMANCE - OVERVIEW YTD

8. **Summary Year to Date**

Cumulative financial performance (April-November) on a Control Total basis is a deficit of £4m. This is better than plan by £0.03m. Overspends on pay costs are offset by increased clinical income.

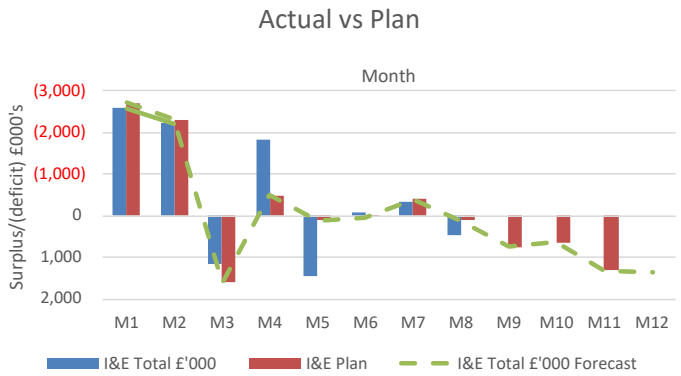
9. Clinical Income YTD
Clinical income shows a favourable variance of £5.9m which is due to overperformance on the remaining PbR contracts and revenue received for the wage award (paid in September). Further detail is included in Appendix 1.

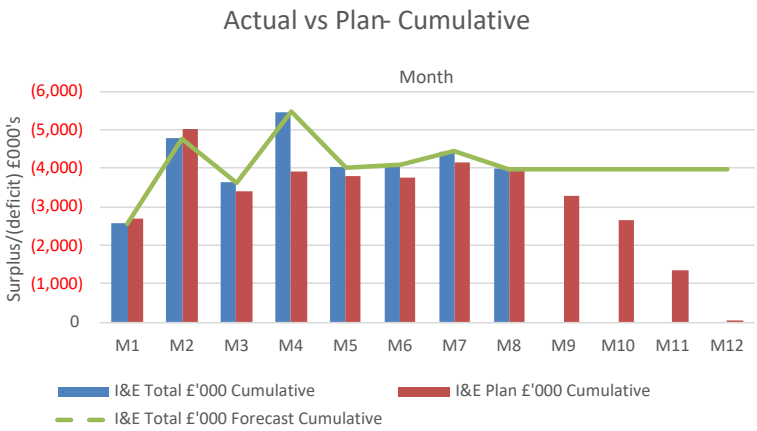
10. Other Income YTD
Other income shows a favourable variance of £1.7m. This is due to favourable variances against the R&D, education, and training and covid testing income.

11. Pay YTD
Pay spend is above plan by £7.8m YTD due mainly to the payment of the wage award. The impact of this is offset by increased clinical income. Spend on temporary staffing costs is also going up with to enhanced rates increasing uptake in clinical areas. Further detail is included in Appendices 1 & 4.

12. Non-Pay YTD
Non pay is above plan due to expenditure on clinical supplies and establishment expenses relating to activity and inflationary pressures. Further detail is included in Appendices 1 & 5.

13. Non-Operating Expenditure YTD
Non-operating expenditure is lower than plan YTD due to interest received.





Key message
Up to November 2022, the position on a Control Total basis is a deficit of £4m. This is slightly better than plan. Overspends on pay are partially offset by increased clinical income.

It should be noted that the plan in the second half of the year moves from a deficit to a breakeven position indicating an expected reduction in run-rate.

ACTIVITY PERFORMANCE & ERF

14. The Trust has recognised 100% of the expected ERF income available for the month on the basis that this will not be subject to clawback from NHS England. This is expected to continue in the second half of the financial year. The revised budget includes full achievement of the £7.6m of ERF allocated to MKUH which requires achievement of 104% of activity versus 2019-20 baselines.

15. Activity vs Plan (as per CIVICA)

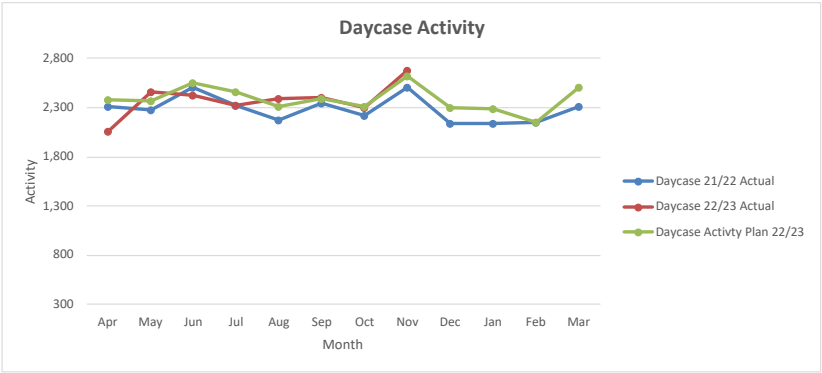
Day case activity-
Day cases have increased since Month 7, remaining in line with the 22/23 plan and 21/22 actuals. Day cases are running at 99.1% of 19/20 actuals against a target of 104%.

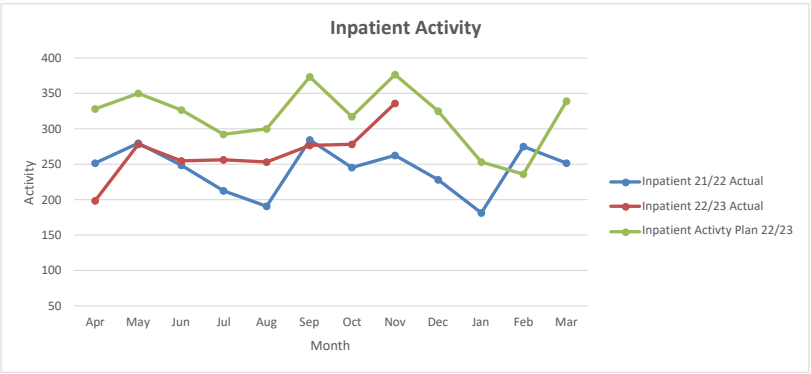
Elective Inpatient Activity-
Inpatient activity has increased since Month 7 and remain down against the 22/23 plan but above the 21/22 actuals. Electives are running at 88.5% of 19/20 actuals against a target of 104%.

Outpatient Activity-
Outpatient activity has increased since Month 7 and remains up against the 21/22 actuals and is also now above 22/23 plan. New appointments are 113% of 19/20 actuals against a target of 104%.

Non-Elective Spells-
Non elective activity has increased since Month 7 and is much higher than the 22/23 plan and 21/22 actual due to the inclusion of the Maple Centre Activity.

A&E activity-
A&E activity has decreased since Month 7 and remains marginally above 21/22 activity and 22/23 plan.





Key message
Inpatient elective activity increased in November. ERF activity has been recorded at 100% to month 8 following guidance from NHS England that any underperformance will not be subject to clawback. New outpatient appointments are ahead of the 104% target, but electives and day cases are behind the 104% target.

EFFICIENCY SAVINGS

16. The efficiency target is £5.6m to November 2022 and the schemes that have been signed off are delivering £3m. The remainder of the efficiency target is being achieved through managing the incremental cost of operational pressures bringing total efficiencies to £5.6m.

17. Trust 'Better Value' Programme has identified circa £8.6 (up to Month 8) from schemes against the total plan level of £12m. The pipeline of schemes has undergone a significant review with £1.5m of potential schemes removed. This has been offset by recognising additional income from our remaining PbR contracts at Bucks and Northants which are expected to contribute £2.2m of additional revenue in FY 2022-23.

Division	Target	Risk Adjusted Plan PYE	Recurrent	Non-recurrent	% of target
	£000's	£000's	£000's	£000's	%
Medicine	3,399	2,612	2,323	290	77%
Surgery	2,709	1,344	1,234	110	50%
W&C	1,451	1,401	277	1,124	97%
Core Clinical	2,716	1,680	730	950	62%
Corporate	1,629	1,515	513	1,001	93%
Central Ops	103	0			0%
Latest position	12,007	8,552	5,077	3,475	71%

18. It should be noted that the phasing of the required savings increases during the second half of the financial year. This is shown in the graph below:

Key message
YTD the Trust has delivered its £5.6m efficiency requirement. This has been achieved through transactional savings schemes and managing the cost of operations within available resources. Work is progressing through the Trust 'Better Values' programme to identify schemes in line with the efficiency target for 2022/23. The planned savings requirement increases significantly in the second half of the financial year (70% of the target is in the second half).

CAPITAL - OVERVIEW YTD

19. The YTD spend on capital after accounting for donated assets and derecognised assets is £9.7m, which is broadly in line with Trust's revised capital plan (excluding national funding). There is £1.7m relating to derecognition of various assets following an internal review.

20. The Trust's ICS CDEL allocation is £15.9m and there is further approved national funding of £2.1m as detailed below. An increase in mth by £0.31m. As the Trust does not expect to receive any additional NHP funding in year and the funding for the impact of the new leases will be held centrally it has revised its CDEL forecast to £17.99m. MKUH are also not likely to be receive any addition funding from the BLMK IT Integrated Care Board (ICB) which wasn't within its capital plan. However, the Trust is awaiting national approval of £3.52m for IT frontline digitalisation, CDC £1.1m and £1.3m for various bids associated with Cancer funding.

21. The full breakdown of all funding and sources of application is shown in the table below.

	ICS Approved CDEL Allocation 2022/23	National CDEL Allocation 2022/23		
Scheme Subcategory	**Internally Funded**	**Planned**	**Approved**	**Awaiting National Approval**
	£m	£m	£m	£m
Depreciation	15.04			
Self Funded	0.86			
PDC Funded				
New Hospital Programme		1.94	1.23	
Endoscopy		0.14	0.14	
Digital Diagnostic Funding - Pathology			0.32	
Digital Diagnostic Funding - Imaging			0.39	
New Lease impact (IFRS16)		0.00		
IT - frontline Digilisation				1.09
CDC - Lloyds Court & Whitehouse Park				1.12
Cancer bids				1.32
Sub Total CDEL	**15.90**	**2.08**	**2.08**	**3.52**
CDEL Allocation Approved	**17.99**			
Total Planned CDEL	**17.97**			

Capital Item	**YTD Plan up to end of Nov 22 £m**	**Actual up to end of Nov 22 £m**	**PO & Pre-commitments up to end of Nov 22**	**YTD Variance to YTD Plan £m**	**Status**
Pre-commitments					
CBIG	2.25	0.75	0.93	-1.50	
Strategic	4.19	5.73	4.49	1.54	
Slippage from Pre-commitments		0.17			
Total Pre-commitments	**6.44**	**6.65**	**5.42**	**0.03**	
Scheme Allocations For 22/23 schemes					
CBIG including IT and Contingency	2.51	2.21	1.42	-0.29	
Strategic Radiotherapy	0.02	0.01	0.01	-0.00	
Strategic Contingency	0.00			0.00	
Funded from Strategic Contingency				0.00	
Asbestos Removal for flat roofs	0.00	0.16	0.16	0.16	
Additional costs for Whitehouse	0.00	0.00	0.04	0.00	
EV Chargers	0.00	0.00	0.04	0.00	
Escalation Beds & Mattresses	0.00	-	0.08	0.00	
Boiler Adaptation	0.00	-	-	0.00	
Total Proposed Scheme Allocations	**2.53**	**2.38**	**1.64**	**- 0.14**	
Total Pre-commitments and Scheme Allocations (ICS CDEL Allocation)	**8.97**	**9.03**	**7.06**	**0.06**	
Nationally approved schemes					
NHP	0.62	0.63	1.11	0.01	
Endoscopy	0.00	0.00	0.00	0.00	
Digital Diagnostic Funding - Imaging	0.00	0.00	0.07	0.00	
Digital Diagnostic Funding -Pathology	0.00	0.00	0.00	0.00	
Total Nationally approved schemes	0.62	0.63	1.18	0.01	
CDEL Approved capital plan	**9.59**	**9.66**	**8.24**	**0.07**	
New Leases Impact under IFRS 16 - held centrally	0.01	0.00	0.00	-0.01	
NHP - external fees	0.00	0.00	0.00	0.00	
Submitted CDEL capital plan	**9.60**	**9.66**	**8.24**	**0.06**	
Donated Assets (excluded from CDEL)					
Maple Centre	3.40	0.00	5.00	-3.40	
Pathlake	0.00	0.00	0.00	0.00	
Staff Rooms	0.03	0.00	0.00	-0.03	
Total Donated Assets	**3.44**	**0.00**	**5.00**	**-3.44**	
Awaiting Approval					
IT - frontline Digilisation	0.00	0.00	0.00	0.00	
CDC - Lloyds Court & Whitehouse Park	0.00	0.00	0.00	0.00	
Cancer bids	0.00	0.00	0.00	0.00	
Total awaiting approval	**0.00**	**0.00**	**0.00**	**0.00**	

Key message
Capital expenditure is broadly on plan up to November. The Trust is forecasting full year spend in-line with plan and will need to closely manage business-as-usual scheme costs and strategic capital expenditure on strategic schemes (Radiotherapy) to deliver the plan.

CASH

22. Summary of Cash Flow

The cash balance at the end of November was £39.4m, this was £1.4m lower than the planned figure of £40.8m and a decrease on last month's figure of £41.4m. (see opposite).
See appendices 6-8 for the cashflow detail.

23. Cash arrangements 2022/23

The Trust will receive block funding for FY23 which will include an uplift for growth plus any additional incentive funding linked to activity delivery and funding for high-cost drugs on a pass-through basis.

24. Better Payment Practice

The Trust has fallen below the national target of 95% of all bills paid within the target timeframe in terms of value and volume. This is mainly due to the repatriation of SBS AP services, and the ongoing issues with agency invoicing. Both issues are being addressed and action plans are in progress to resolve them. This metric will continue to be monitored in accordance with national guidance and best practice

Better payment practice code	Actual M8 YTD Number	Actual M8 YTD £'000	Actual M7 YTD Number	Actual M7 YTD £'000
Non NHS				
Total bills paid in the year	47,018	124,728	41,910	111,823
Total bills paid within target	41,217	114,533	36,921	102,698
Percentage of bills paid within target	**87.7%**	**91.8%**	**88.1%**	**91.8%**
NHS				
Total bills paid in the year	1,292	4,895	1,099	4,397
Total bills paid within target	988	3,198	830	2,889
Percentage of bills paid within target	**76.5%**	**65.3%**	**75.5%**	**65.7%**
Total				
Total bills paid in the year	**48,310**	**129,622**	**43,009**	**116,220**
Total bills paid within target	**42,205**	**117,730**	**37,751**	**105,588**
Percentage of bills paid within target	**87.4%**	**90.8%**	**87.8%**	**90.9%**

Key message

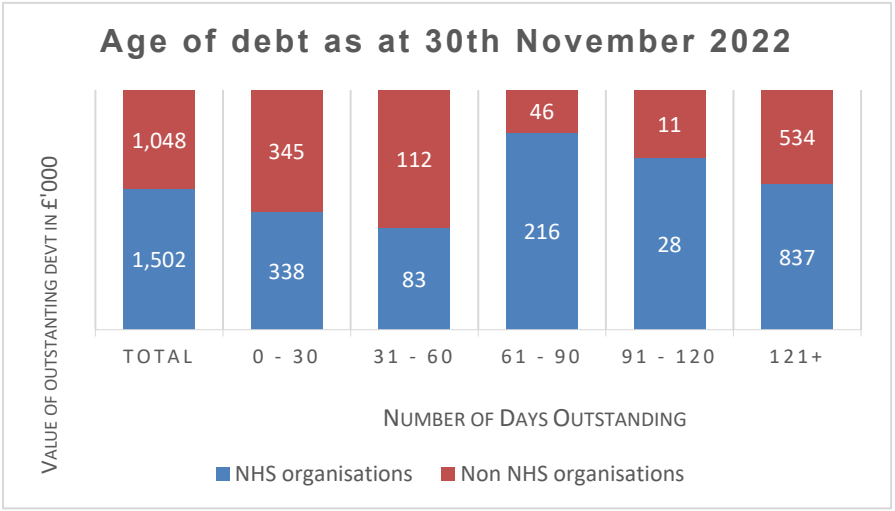
Cash is below plan by £1.4m, and the Trust has fallen below the 95% target for BPPC, mainly due to issues experience by SBS during their repatriation of AP services, and ongoing agency invoicing issues. Management is working to rectify payment performance to levels required.

BALANCE SHEET

25. Statement of Financial Position

The statement of financial position is set out in Appendix 9. The key movements include:

- Non-Current Assets have increased from March 22 by £14m; this is mainly driven by the inclusion of Right of Use assets related to the adoption of IFRS 16 1 April 2022 and capital purchases in year offset by in year depreciation.
- Current assets have decreased by £10m, this is mainly due to the decrease in cash £18.6m offset by an increase in receivables (£8.6m).
- Current liabilities have decreased by £9.1m, this is mainly due to the decrease in Trade Payables £4m and deferred income £5.3m offset by the inclusion of Right of Use assets related to the adoption of IFRS 16 1 April 2022 (£0.5m)
- Non-Current Liabilities have increased from March 22 by £12m, this is due to the inclusion of Right of Use assets (£12m) related to the adoption of IFRS 16 1 April 2022.

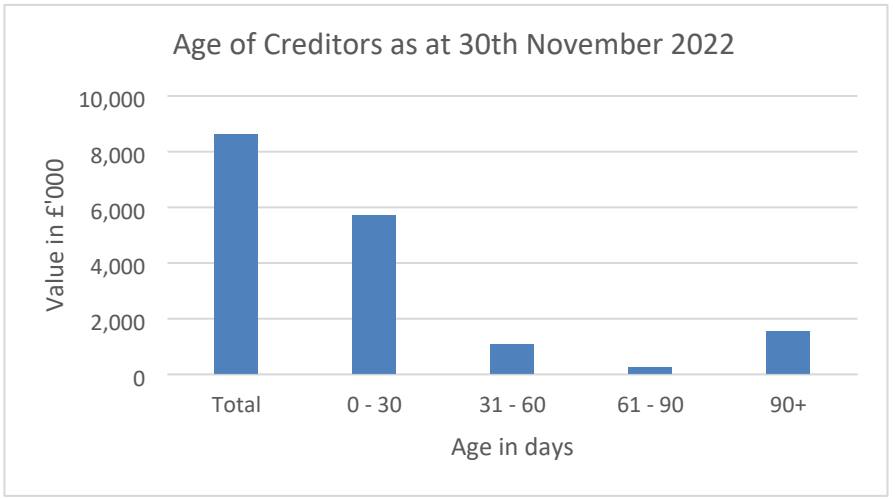


26. Aged debt

- The debtors position as of 30th November is £2.6m, which is a decrease of £0.1m from the October'22 position. Of this total £1.4m is over 121 days old, the detail is shown in Appendix 10.
- The three largest NHS debtors are Bedford Hospitals NHS Foundation Trust £0.07m for salary recharges, NHS England £0.3m relating to midwifery and non-contract recharges and University Hospitals Southampton NHS Foundation Trust £0.1m relating to salary recharges. The largest non-NHS debtors include £0.1m for overseas patients, £0.8m with Northamptonshire council for sexual health, £0.8m with University of Buckinghamshire Ltd for utilities recharges. Further details of the aged debtors are shown in Appendix 11.

27. Creditors

- The creditor's position is £8.6m, which is a decrease of £2.0m from the October'22 position. Of this £2.9m is over 30 days, with £2.1m approved for payment. The breakdown of creditors is shown in Appendix 12.



Key message

Main movements on the statement of financial position related to the inclusion of Right of Use Assets related to the adoption of IFRS 16 1 April 22 and decrease in cash; debtors are like the prior month but there is an aged debtor of over 121 days of £1.2m that is being closely monitored

RECOMMENDATIONS TO BOARD

28. Trust Board is asked to note the financial position of the Trust as of 30th November and the proposed actions and risks therein.

APPENDICIES

Appendix 1

Statement of Comprehensive Income
For the period ending 30th November 2022

	FY23	M8 CUMULATIVE			M8			PRIOR MONTH	
	Annual Budget	Budget	Actual	Variance	Budget	Actual	Variance	M7 Actual	Change
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME									
Outpatients	49,690	33,812	32,406	(1,406)	4,103	4,350	247	4,094 ▲	255
Elective admissions	33,324	22,894	19,307	(3,587)	3,204	3,103	(101)	2,291 ▲	812
Emergency admissions	81,933	54,490	59,114	4,624	7,208	11,350	4,142	6,939 ▲	4,411
Emergency adm's marginal rate (MRET)	0	0	0	0	0	0	0	0 ▲	0
Readmissions Penalty	0	0	0	0	0	0	0	0 ▲	0
A&E	19,076	13,150	13,063	(88)	1,592	1,621	29	1,696 ▼	(75)
Other Admissions	2,926	5,983	12,492	6,508	2,729	10,607	7,878	943 ▲	9,663
Maternity	24,851	12,764	1,097	(11,667)	(426)	(8,885)	(8,459)	1,001 ▼	(9,887)
Critical Care & Neonatal	7,141	4,861	4,221	(640)	533	587	53	588 ▼	(1)
Imaging	6,309	4,330	4,581	251	557	617	61	600 ▲	17
Direct access Pathology	4,724	3,153	3,472	318	465	522	116	413 ▲	109
Non Tariff Drugs and Devices (high cost/individual drugs)	21,299	14,224	14,546	321	1,752	1,931	179	1,865 ▲	66
Other (inc. home visits and best practice tariffs)	6,148	4,111	15,653	11,542	513	3,759	3,246	46 ▲	3,714
CQUINS	0	0	0	0	0	0	0	0 ▼	(0)
Contract Risk Provision - General challenge & CIP offset	0	0	0	0	0	0	0	0 ▼	(0)
National Block/Top up	50,403	29,650	29,408	(242)	3,522	(1,499)	(5,021)	5,611 ▼	(7,110)
MK(CCG Block ad)	0	0	0	0	0	0	0	0 ▲	0
Clinical Income	**307,824**	**201,421**	**209,359**	**5,938**	**25,693**	**28,062**	**2,370**	**26,088** ▲	**1,974**
Non-Patient Income	19,169	12,950	14,655	1,705	1,573	1,818	245	2,164 ▼	(347)
PSF Income	0	0	(0)	(0)	0	0	0	0 ▲	0
Donations	5,171	5,060	5,010	(50)	10	0	(10)	0 ▲	0
Non-Patient Income	**24,340**	**18,010**	**19,665**	**1,655**	**1,583**	**1,818**	**235**	**2,164** ▼	**(347)**
TOTAL INCOME	**332,164**	**221,431**	**229,024**	**7,593**	**27,276**	**29,880**	**2,604**	**28,252** ▲	**1,628**
EXPENDITURE									
Pay - Substantive	(189,757)	(127,595)	(122,308)	5,288	(15,810)	(15,334)	477	(15,314) ▼	(20)
Pay - Bank	(9,194)	(6,516)	(13,609)	(7,072)	(677)	(1,772)	(1,095)	(1,901) ▲	128
Pay - Locum	(3,168)	(2,113)	(3,124)	(1,011)	(280)	(426)	(146)	(396) ▼	(30)
Pay - Agency	(5,555)	(3,912)	(8,748)	(4,836)	(391)	(1,198)	(807)	(1,263) ▲	65
Pay - Other	(758)	(512)	(580)	(68)	(63)	(81)	(18)	(73) ▼	(8)
Pay CIP	41	27	0	(27)	3	0	(3)	0 ▲	0
Vacancy Factor	69	46	0	(46)	6	0	(6)	0 ▲	0
Pay	**(208,343)**	**(140,597)**	**(148,368)**	**(7,771)**	**(17,212)**	**(18,815)**	**(1,599)**	**(18,946)** ▲	**135**
Non Pay	(77,110)	(52,306)	(52,246)	60	(6,382)	(6,962)	(579)	(6,145) ▼	(817)
Non Tariff Drugs (high cost/individual drugs)	(21,299)	(14,224)	(14,546)	(321)	(1,752)	(1,931)	(179)	(1,865) ▼	(66)
Non Pay	**(98,409)**	**(66,530)**	**(66,792)**	**(262)**	**(8,134)**	**(8,893)**	**(758)**	**(8,009)** ▼	**(883)**
TOTAL EXPENDITURE	**(306,752)**	**(207,127)**	**(215,160)**	**(8,033)**	**(25,346)**	**(27,709)**	**(2,357)**	**(26,955)** ▼	**(748)**
EARNINGS BEFORE INTEREST, TAXATION, DEPRECIATION AND AMORTISATION (EBITDA)	**25,412**	**14,304**	**13,864**	**(440)**	**1,930**	**2,177**	**247**	**1,298** ▲	**879**
Interest Receivable	0	0	437	437	0	89	89	75 ▲	14
Interest Payable	(338)	(225)	(250)	(25)	(28)	(31)	(3)	(41) ▲	10
Depreciation, Impairments & Profit/Loss on Asset Disposal	(14,474)	(9,415)	(9,402)	13	(1,326)	(1,325)	0	(1,220) ▼	(105)
Donated Asset Depreciation	(563)	(372)	(381)	(8)	(48)	(48)	0	(48) ▲	0
Profit/Loss on Asset Disposal & Impairments	0	0	0	0	0	0	0	0 ▲	0
DEL Impairments	0	0	0	0	0	0	0	0 ▲	0
AME Impairments	0	0	0	0	0	0	0	0 ▲	0
Unwinding of Discounts	0	0	0	0	0	0	0	0 ▲	0
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**10,037**	**4,291**	**4,268**	**(23)**	**528**	**862**	**334**	**64** ▲	**798**
Dividends Payable	(5,429)	(3,621)	(3,621)	0	(455)	(455)	0	(455) ▲	0
OPERATING SURPLUS/(DEFICIT) AFTER DIVIDENDS	**4,608**	**669**	**646**	**(23)**	**76**	**409**	**334**	**(389)** ▲	**798**

Appendix 2

Statement of Cash Flow
As of 30th November 2022

	Audited Mth12 2021-22 £000	Mth 8 £000	Mth 7 £000	In Month Movement £000
Cash flows from operating activities				
Operating (deficit) from continuing operations	2,699	4,080	3,275	805
Operating (deficit)	**2,699**	**4,080**	**3,275**	**805**
Non-cash income and expense:				
Depreciation and amortisation	11,278	9,783	8,410	1,373
Impairments	715	0	0	0
(Gain)/Loss on disposal	(48)	0	0	0
(Increase)/Decrease in Trade and Other Receivables	9,003	(8,665)	(7,227)	(1,438)
(Increase)/Decrease in Inventories	(375)	(12)	(13)	1
Increase/(Decrease) in Trade and Other Payables	14,788	(6,055)	(7,616)	1,561
Increase/(Decrease) in Other Liabilities	5,945	(5,267)	(2,348)	(2,919)
Increase/(Decrease) in Provisions	(338)	(38)	(34)	(4)
NHS Charitable Funds	(561)	(5,010)	0	(5,010)
Other movements in operating cash flows	(1)	(4)	(2)	(2)
NET CASH GENERATED FROM OPERATIONS	**43,105**	**(11,188)**	**(5,555)**	**(5,633)**
Cash flows from investing activities				
Interest received	36	437	348	89
Purchase of intangible assets	(4,160)	(766)	(1,228)	462
Purchase of Property, Plant and Equipment, Intangibles	(37,974)	(10,122)	(7,932)	(2,190)
Net cash generated (used in) investing activities	**(44,598)**	**(10,451)**	**(8,812)**	**(1,639)**
Cash flows from financing activities				
Public dividend capital received	15,273	500	200	300
Capital element of finance lease rental payments	(201)	(169)	(158)	(11)
Interest element of finance lease	(267)	(250)	(219)	(31)
PDC Dividend paid	(4,663)	(2,045)	(2,045)	0
Receipt of cash donations to purchase capital assets	561	5,010	0	5,010
Cash flows from (used in) other financing activities	0	0	0	0
Net cash generated from/(used in) financing activities	**10,703**	**3,046**	**(2,222)**	**5,268**
Increase/(decrease) in cash and cash equivalents	**9,210**	**(18,593)**	**(16,589)**	(2,004)
Opening Cash and Cash equivalents	**48,765**	**57,975**	**57,975**	
Closing Cash and Cash equivalents	**57,975**	**39,382**	**41,386**	**(2,004)**

Appendix 3

Statement of Financial Position as of 30th November 2022

	Audited Mar-22	Nov-22 YTD Actual	YTD Mvmt	% Variance
Assets Non-Current				
Tangible Assets	189.6	193.2	3.6	2.0%
Intangible Assets	22.3	20.1	(2.2)	(10.1%)
ROU Assets	0.0	12.6	12.6	100.0%
Other Assets	1.0	1.0	0.0	1.3%
Total Non Current Assets	**212.9**	**226.9**	**14.0**	**6.3%**
Assets Current				
Inventory	4.1	4.1	0.0	0.0%
NHS Receivables	3.5	5.9	2.4	57.1%
Other Receivables	7.2	13.4	6.2	95.4%
Cash	58.0	39.4	(18.6)	(40.4%)
Total Current Assets	**72.8**	**62.8**	**(10.0)**	**(16.5%)**
Liabilities Current				
Interest -bearing borrowings	(0.2)	(0.7)	(0.5)	32.0%
Deferred Income	(19.4)	(14.1)	5.3	(27.0%)
Provisions	(2.4)	(2.4)	0.0	0.0%
Trade & other Creditors (incl NHS)	(60.4)	(56.1)	4.3	(8.3%)
Total Current Liabilities	**(82.4)**	**(73.3)**	**9.1**	**(12.1%)**
Net current assets	**(9.6)**	**(10.5)**	**(0.9)**	**6.2%**
Liabilities Non-Current				
Long-term Interest bearing borrowings	(5.4)	(17.4)	(12.0)	90.8%
Deferred Income	(1.5)	(1.5)	0.0	100.0%
Provisions for liabilities and charges	(1.8)	(1.8)	0.0	0.0%
Total non-current liabilities	**(8.7)**	**(20.7)**	**(12.0)**	**79.9%**
Total Assets Employed	**194.6**	**195.7**	**(5.8)**	**(3.0%)**
Taxpayers Equity				
Public Dividend Capital (PDC)	275.1	275.6	0.5	0.2%
Revaluation Reserve	52.6	52.6	(0.0)	(0.1%)
Financial assets at FV through OCI reserve	(2.3)	(2.3)	0.0	0.0%
I&E Reserve	(130.8)	(130.2)	0.6	(0.4%)
Total Taxpayers Equity	**194.6**	**195.7**	**(5.1)**	**(2.7%)**

GLOSSARY OF TERMS

Abbreviation	Full name	Explanation
A/L	Annual Leave	Impact of staff annual leave
BAU	Business as usual	In the context of capital expenditure, this is the replacement of existing capital assets on a like for like basis.
BPP	Better payment practice	This requires all NHS Organisations to achieve a public sector payment standard for valid invoices to be paid within 30 days of their receipt or the receipt of the goods or services – the target for this is 95%
CBIG	Clinical Board Investment Group	Capital approval meeting overseeing small scale capital schemes including equipment replacement and building work.
CDEL	Capital Departmental Expenditure Limit	Trusts maximum amount of capital expenditure available to be spent for the current year set by Regional NHS team and reviewed every financial year.
CIP	Cost Improvement Programme	Scheme designed to improve efficiency or reduce expenditure
COVID	COVID-19	Costs associated with COVID-19 virus
E&T	Education & Training	
ERF	Elective Recovery Fund	Additional non recurrent funding linked to recovery
HCD	High Cost/Individual Drugs	
NHP	New Hospital Programme	National capital funding for major hospital redevelopments
PDC	Public Dividend Capital	A form of long-term government finance which was initially provided to NHS trusts when they were first formed to enable them to purchase the Trust's assets from the Secretary of State. Public dividend capital (PDC) represents the Department of Health's (DH's) equity interest in defined public assets across the NHS.
R&D	Research & Development	
YTD	Year to date	Cumulative costs for the year
Other frequently used abbreviations		
Accelerator	Accelerator Funding	Additional funding linked to recovery
Block	Block value	Block income value linked to 19/20 values
Top-up	Top up Funding	Additional block income linked to 19/20 values
Covid	COVID Funding	Additional block funding to cover incremental COIVD-19 expenditure
Maple Centre	Maple Centre	The initial project name for the Maple Centre was the Pathway Unit - a 23hr ambulatory care facility currently under construction

Meeting Title	**Board Report**	**Date: January 2023**
Report Title	**Workforce Report – Month 8**	**Agenda Item Number: 20**
Lead Director	Danielle Petch, Director of Workforce	
Report Author	Louise Clayton, Deputy Director of Workforce	

Introduction	Standing Agenda Item		
Key Messages to Note	This report provides a summary of workforce Key Performance Indicators for the previous 12 months up to 30 November 2022 (Month 8) and relevant Workforce and Organisational Development updates to Trust Board.		
Recommendation *(Tick the relevant box(es))*	**For Information** [x]	**For Approval** [ ]	**For Review** [ ]

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	Employ the best people to care for you

Report History	
Next Steps	JCNC & TEC
Appendices/Attachments	See Appendix 1: Bank and Agency Fill Rate

1. Purpose of the report

1.1. This report provides a summary of workforce Key Performance Indicators as at 30 November 2022 (Month 8), covering the preceding 13 months.

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

Indicator	Measure	Target	11/2021	12/2021	01/2022	02/2022	03/2022	04/2022	05/2022	06/2022	07/2022	08/2022	09/2022	10/2022	11/2022
Staff in post (as at report date)	Actual WTE		3347.7	3349.0	3390.5	3410.0	3414.4	3418.4	3418.8	3417.5	3445.6	3437.0	3458.0	3467.9	**3507.1**
	Headcount		3827	3830	3878	3904	3900	3902	3904	3901	3930	3917	3946	3956	**4001**
Establishment *(as per ESR)*	WTE		3725.7	3718.1	3722.9	3727.6	3716.9	3723.9	3839.8	3842.5	3840.8	3837.0	3881.4	3887.9	3892.8
	%, Vacancy Rate - Trust Total	**10.0%**	10.1%	9.9%	8.9%	8.5%	8.1%	8.2%	11.0%	11.1%	10.3%	10.4%	10.9%	10.8%	9.9%
	%, Vacancy Rate - Add Prof Scientific and Technical							23.0%	33.9%	33.2%	35.2%	32.4%	31.3%	33.7%	32.2%
	%, Vacancy Rate - Additional Clinical Services *(Includes **HCA**s)*							12.9%	2.9%	4.0%	4.3%	3.3%	10.1%	10.7%	11.2%
	%, Vacancy Rate - Administrative and Clerical							4.6%	8.8%	8.6%	8.5%	8.4%	8.1%	8.8%	7.6%
	%, Vacancy Rate - Allied Health Professionals							11.0%	18.7%	19.5%	20.2%	18.8%	18.9%	17.8%	16.7%
	%, Vacancy Rate - Estates and Ancillary							10.8%	13.9%	14.4%	14.3%	12.9%	11.5%	10.4%	9.0%
	%, Vacancy Rate - Healthcare Scientists							2.6%	3.5%	0.6%	0.8%	0.0%	0.0%	0.7%	0.0%
	%, Vacancy Rate - Medical and Dental							3.3%	4.9%	3.3%	0.0%	2.8%	0.0%	0.0%	0.0%
	%, Vacancy Rate - Nursing and Midwifery Registered							6.2%	15.3%	16.0%	15.5%	15.3%	15.3%	14.6%	12.8%
Staff Costs (12 months) *(as per finance data)*	%, Temp Staff Cost (%, £)		12.3%	12.5%	12.7%	12.9%	13.1%	13.4%	13.7%	14.0%	14.3%	14.5%	14.8%	15.1%	**15.3%**
	%, Temp Staff Usage (%, WTE)		12.8%	12.9%	13.0%	13.1%	13.2%	13.5%	13.7%	13.8%	14.0%	14.1%	14.2%	14.4%	**14.4%**
Absence (12 months)	%, 12 month Absence Rate	5.5%	5.0%	5.0%	5.0%	5.1%	5.3%	5.4%	5.4%	5.5%	5.6%	5.5%	5.4%	**5.3%**	*5.3%*
	- %, 12 month Absence Rate - Long Term		*3.0%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*	*2.9%*	*2.9%*	*2.8%*	**2.6%**	*2.6%*
	- %, 12 month Absence Rate - Short Term		*2.0%*	*2.0%*	*2.0%*	*2.1%*	*2.3%*	*2.4%*	*2.4%*	*2.5%*	*2.7%*	*2.6%*	*2.6%*	**2.7%**	*2.7%*
	%,In month Absence Rate - Total	4.0%	5.5%	6.0%	6.3%	5.4%	5.6%	5.0%	4.3%	4.4%	5.6%	4.1%	4.2%	**5.0%**	*4.7%*
	- %, In month Absence Rate - Long Term	*2.0%*	*3.3%*	*3.3%*	*3.0%*	*2.8%*	*2.5%*	*2.3%*	*2.6%*	*2.6%*	*2.6%*	*2.5%*	*2.3%*	**2.3%**	*2.5%*
	- %, In month Absence Rate - Short Term	*2.0%*	*2.3%*	*2.7%*	*3.3%*	*2.6%*	*3.1%*	*2.7%*	*1.7%*	*1.8%*	*3.0%*	*1.6%*	*1.9%*	**2.7%**	*2.2%*
	- %, In month Absence Rate - COVID-19 Sickness Absence		0.6%	1.2%	2.3%	1.6%	2.2%	1.5%	0.5%	0.7%	1.7%	0.6%	0.4%	**0.9%**	*0.5%*
Starters, Leavers and T/O rate (12 months)	WTE, Starters		347.1	362.3	390.3	376.5	382.0	409.1	427.3	433.9	447.8	492.1	505.8	517.4	**543.0**
	Headcount, Starters		395	411	441	428	431	459	481	490	507	550	570	587	**613**
	WTE, Leavers		241.5	254.8	277.9	296.9	329.4	364.6	380.6	400.1	417.1	449.4	469.0	504.7	**506.0**
	Headcount, Leavers		289	304	332	357	395	435	456	480	500	542	562	604	**605**
	%, Leaver Turnover Rate	9%	8.3%	8.8%	9.5%	10.2%	11.2%	12.3%	12.9%	13.6%	14.2%	15.3%	15.8%	16.9%	**16.9%**
	%, Stability Index		85.2%	85.9%	85.5%	85.3%	84.8%	83.7%	82.9%	82.7%	82.8%	82.5%	82.6%	82.7%	**82.2%**
Statutory/Mandatory Training	%, Compliance	90%	96%	96%	95%	94%	94%	94%	94%	95%	95%	95%	92%	93%	**93%**
Appraisals	%, Compliance	90%	91%	91%	91%	90%	92%	90%	90%	88%	89%	90%	91%	92%	**92%**
Time to Hire (days)	General Recruitment	35	56	52	72	65	72	58	52	65	59	64	56	54	**53**
	Medical Recruitment (excl Deanery)	35	65	43	52	49	68	47	79	63	89	72	73	63	**80**
Employee relations	Number of open disciplinary cases		10	9	10	7	9	4	4	9	13	14	15	22	**26**

2.1. The table in appendix 1 shows the bank and agency **fill rate**. Fill rate for night duty is still higher than for days across both nursing and HCSW **see Appendix 1**.

2.2. The Trust's **vacancy rate has fallen** for this first time in 2022/23 and is now **9.9%** with improvements across all staff groups. There are now over 4000 substantive staff in post in the Trust, which is the highest it has been, with an additional 174 staff in post compared to the same period in the previous year.

2.3. **Staff absence** has started to increase as expected as we enter winter and experience increased viral infections such as flu with 4.7% absence, of which 0.5% is due to Covid.

2.4. The **stability index figure** (defined as *proportion of staff in post at end of period who were in post at beginning of period)* has started to stabilise and has had no significant change in a 3-month period, currently at 82.2%. **Staff turnover** remains at 16.9% which is in line with other NHS employers in the ICS. However, this has doubled in the last 12 months and so the Workforce team have formed the **Turnover and Retention Group** to address this increase.

2.5. **Time to hire** continues to reduce slowly (down to 53 days in month) and the current pressures on the recruitment team to fill newly established posts and meet the high number of vacant posts each month is having a significant impact on this target.

2.6. The number of **open disciplinary cases** has risen in month, as has the number of employees suspended due to allegations of gross misconduct. A detailed Employee Relations case report is produced monthly to JCNC and on a quarterly basis for Workforce Board.

2.7. **Statutory and mandatory training** compliance is at 93% and **appraisals** compliance at 92%. Divisions are addressing any underperformance against these KPIs locally and are asked to create recovery plans against target.

2.8. There are **107 nursing vacancies** across the Trust, a reduction of 31 from the previous month. The last cohort of 14 international nurses from Phase 1 started in M9. The team have now started interviewing for Phase 2 of the International Recruitment Programme to recruit an additional 100 nurses. The 1st cohort of Phase 2 is expected to arrive in late January/early February. Regional monies have been awarded to the Trust for this second phase.

2.9. There are **114 HCSW vacancies** (B2 and B3) across the Trust. The Recruitment Team are working closely with the Divisions to arrange recruitment events to fill these posts as soon as possible.

3. Continuous Improvement, Transformation and Innovation

3.1. The team have advertised for the **Work Any Hours campaign** for a pool of substantive staff who will work their choice of hours on an 'allocate on arrival' arrangement. There are 8 nurses and 21 HCAs in shortlisting with a planned interview date for January.

3.2. The HR Business Partnering Team have been working closely with the catering manager to increase the **food provision for staff** during the Winter. From M9 there will be free breakfast cereals, bread and spreads for toast available in the staff hub and at Witan Gate. There will also be Live cooking demonstrations and recipe-posting for staff to cook low-cost meals. From M10 on Sundays a roast dinner will be available in the canteen for staff and their families at a cost of £3.50 per plate.

4. Culture and Staff Engagement

4.1. The MK Way Leaders Induction will launch in January. This will be for every newly promoted and new employee that has management responsibilities as part of their role. The induction will follow directly on from the general induction and will be held once a month, service managers that have had new recruits in the last 12 months are also being contacted to ask them to book their employees onto the induction so that there will be a mix of current and new employees into the Trust. The Lead with Values session will be on day 1 which will introduce our new leaders to the **Behaviours Framework** as well as how to carry out appreciative feedback, behaviour, and role modelling of the values.

5. Current Affairs & Hot Topics

5.1. The **new payroll provider** is in place from 1st January 2023. Along with an improved service, including longer opening hours for our employees. Our workforce should not notice any impact on how they are paid and the HR Services team have been working closely with the new provider for a smooth transition.

5.2. The Christmas Loyalty Incentive Scheme closed in December and over a 1000 staff benefited from payments before Christmas. Due to an administration error a small number of people who didn't qualify were mis-paid the loyalty bonus and the Trust will be offering repayment plans to those impacted.

5.3. MKUH has been shortlisted for the 'This is Us' Diversity and Inclusion awards for the Changemaker and Employee Resource Group Categories. The Trust's entry focussed on some of the initiatives the ED&I team have focussed on such as the Cultural Inclusion, Breaking the Bread Strategy for Diwali and Romanian Celebration Days, the Bold, Loud and Proud Project, and the supportive Preceptorship Programme. The ceremony will take place on 12th January.

6. Recommendations

Members are asked to note the report.

Appendix 1 – Fill Rate

	Day		Night	
	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)
Total	**73%**	**82%**	**95%**	**102%**
A & E	94%	75%	99%	79%
AMU	72%	96%	101%	127%
DOCC	80%	84%	95%	-
MAU 2	79%	84%	99%	118%
NNU	61%	69%	77%	100%
Phoenix Unit	84%	80%	91%	101%
Ward 10	0%	0%	0%	0%
Ward 15	92%	89%	110%	116%
Ward 16	63%	86%	71%	127%
Ward 17	68%	100%	104%	116%
Ward 18	76%	89%	106%	117%
Ward 19	87%	77%	102%	124%
Ward 20	71%	101%	107%	116%
Ward 21	72%	101%	97%	87%
Ward 22	70%	95%	100%	99%
Ward 23	77%	89%	109%	104%
Ward 24	84%	72%	100%	88%
Ward 3	70%	95%	101%	113%
Ward 5	70%	50%	106%	82%
Ward 7	78%	113%	107%	122%
Ward 8	89%	63%	118%	98%
Ward 9	57%	69%	66%	76%
Ward 25	76%	78%	126%	110%
Ward 4	62%	45%	93%	66%
Ward 12 (Escalation)	66%	39%	77%	65%
Ward 3a	53%	77%	68%	74%
Ward 2b (Escalation)	42%	10%	86%	17%

Meeting Title	**Trust Board**	**Date: 12th January 2023**
Report Title	**Risk Register Report**	**Agenda Item Number: 23**
Lead Director	***Kate Jarman, Director of Corporate Affairs***	
Report Author	***Paul Ewers, Risk Manager***	

Introduction	***The report provides an analysis of all risks on the Risk Register, as of 03 January 2023.***		
Key Messages to Note	***This the first Risk Register Report in this format. Please take note of the trends and information provided in the report. Please also provide feedback on the new report format, including anything else you'd like to see included.***		
Recommendation ***(Tick the relevant box(es))***	**For Information** ☐	**For Approval** ☐	**For Review** √

Strategic Objectives Links ***(Please delete the objectives that are not relevant to the report)***	***Objective 1: Keeping you safe in our hospital*** ***Objective 2: Improving your experience of care*** ***Objective 3: Ensuring you get the most effective treatment*** ***Objective 4: Giving you access to timely care*** ***Objective 7: Spending money well on the care you receive*** ***Objective 8: Employ the best people to care for you*** ***Objective 10: Innovating and investing in the future of your hospital***

Report History	***Trust Executive Committee, January 2023***
Next Steps	
Appendices/Attachments	***Appendix: Corporate Risk Register***

1. INTRODUCTION

This report shows the risk profile of the Trust, the aim of providing the Committee with assurance that the Risk Management process is being effectively managed and highlighting key areas of concern.

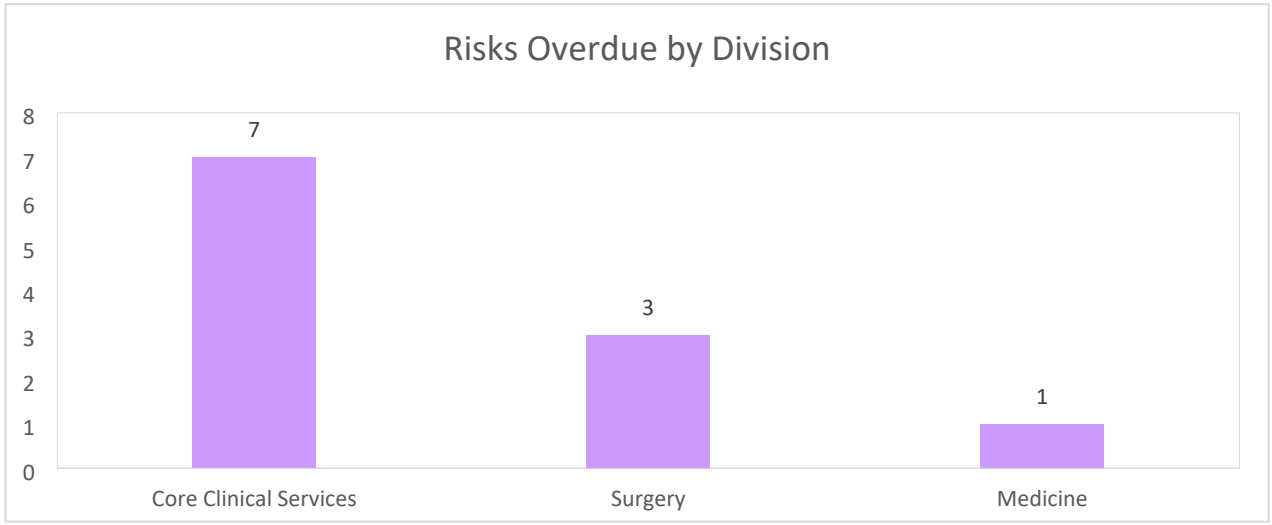
2. RISK PROFILE

2.1 Overdue Risks

At the time of reporting, there are 11 risks out of 250 risks (4%), that are overdue their review date.

2.1.2 Risks Overdue Review > 1 month = 0

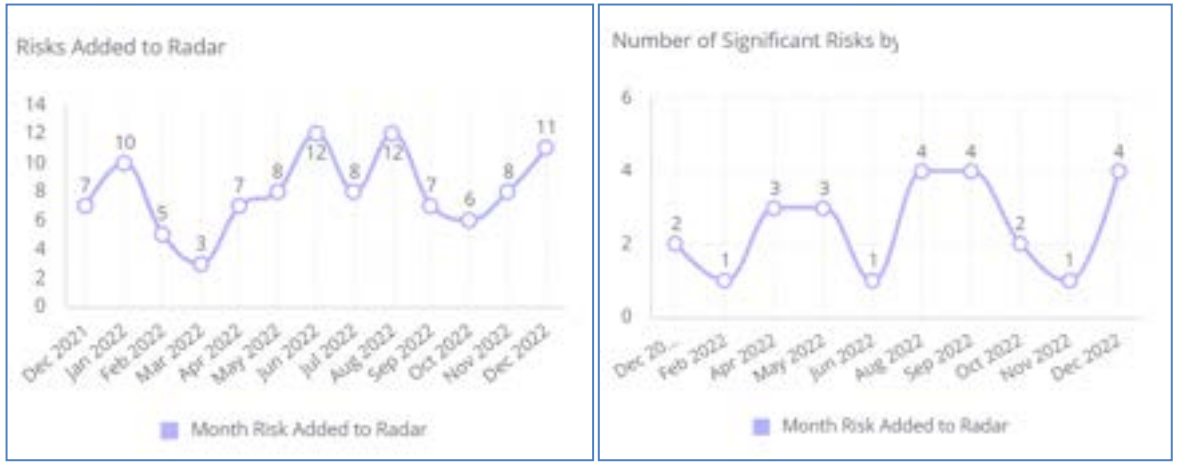
2.1.2 Overdue Risks by Division = 11 (reduction of 6 from last report)



There are currently 11 risks that are overdue their review date. A risk report is sent out every Monday morning by the Risk Manager advising Risk Owners of any risks that are overdue and also any that are pending review during the week. The report provides a summary of the number of overdue by Risk Owner and also specific details of which risks are overdue. The report is copied in to the Divisional Triumvirates and Corporate Heads of Department as applicable. This is to support the timely review of risk.

In addition to the Risk Manager's report, Radar sends automatic email notification of overdue risks to any Risk Owner, and this is copied in to their Line Manager. Risk Owners will also be able to see any overdue tasks (including risks and incidents) on their homepage as soon as they log into Radar.

2.2 New Risks



There were a total 11 new risks added to Radar during December 2022 (up to 21/12/22), of these there were four where the Current Risk Scoring was 15 or more.

2.2.1 Significant (15+) risks added to Radar during November = 4

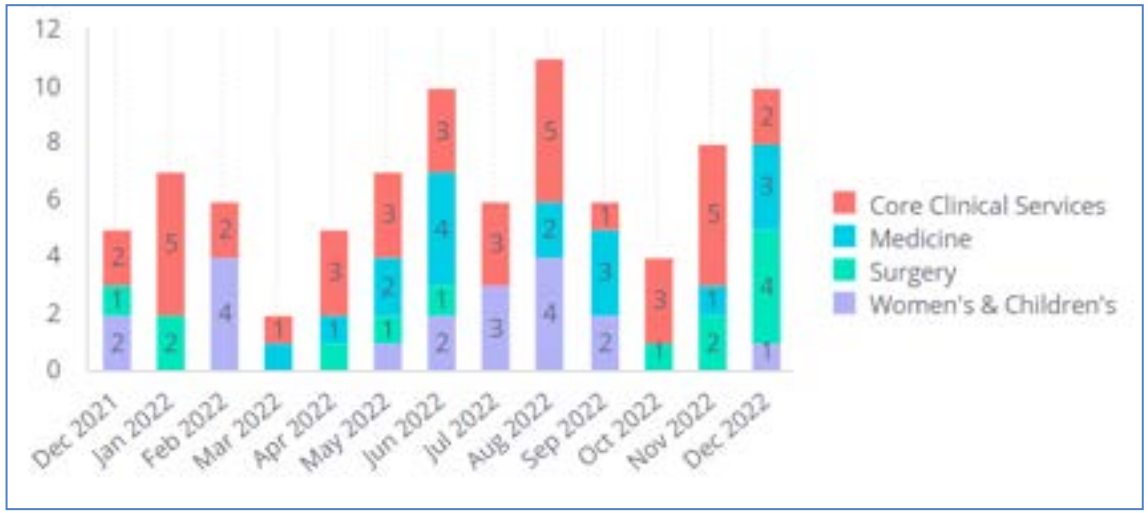
RSK-402 IF there is a lack of Orthopaedic Therapy staff to provide rehabilitation, discharge planning and equipment to patients in the trauma and elective orthopaedic pathways. THEN fractured NOF patients may not be able to be offered mobilisation daily and have regular physiotherapy reviews; elective Orthopaedic patients may not be seen twice a day.
Risk Register: Therapies CSU Risk Register / Core Clinical Division **Risk Owner:** Adam Baddeley
Current Risk Score: 15 (Consequence 3, Likelihood 5)

RSK-403 IF Pharmacy's Kelsius Temperature Monitoring System is unable to connect to the hospital network THEN the system cannot alert Pharmacy if any temperatures are out of range
Risk Register: Pharmacy CSU Risk Register / Core Clinical Division **Risk Owner:** Alan Dutta-Plummer
Current Risk Score: 16 (Consequence 4, Likelihood 4)

RSK-406 IF there is a global shortage of electronic components THEN this can impact the lead times for delivery of medical equipment
Risk Register: Estates **Risk Owner:** Ayca Ahmed
Current Risk Score: 15 (Consequence 5, Likelihood 3)

RSK-411 IF child protection medical assessments continue to be undertaken with current workforce arrangements within the Paediatric Assessment unit (PAU) as part of the current consultant and junior doctor and nursing workload. THEN there will be issues regarding the current workflow and clinical risk within a busy acute/emergency area.
Risk Register: Child's Health **Risk Owner:** Keya Ali
Current Risk Score: 20 (Consequence 5, Likelihood 4)

2.2.2 New Risks by Division



2.3 Closed Risks

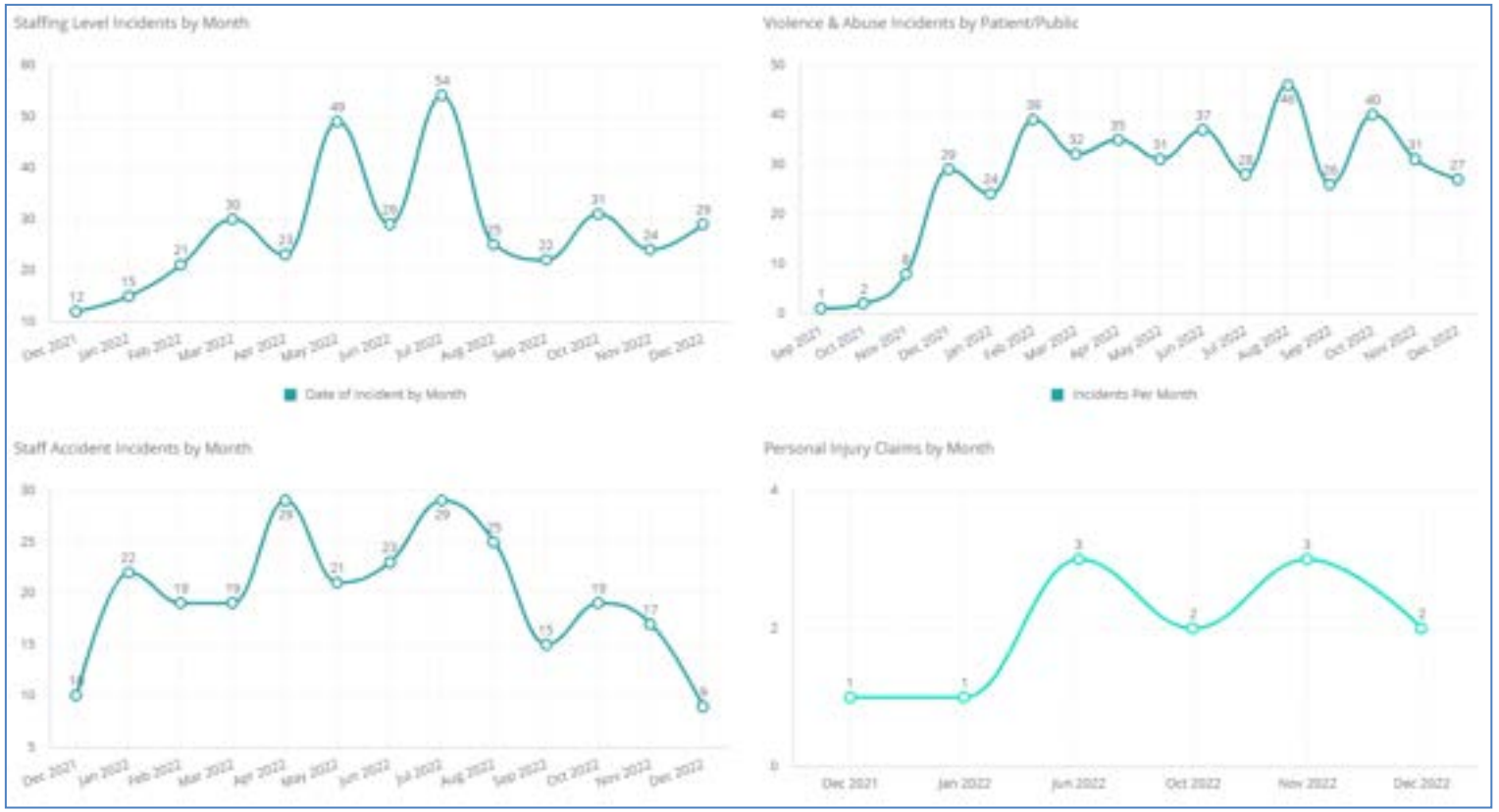
There was a total 1 risk closed during December 2022:

RSK-015 IF there are ligature point areas in Ward 1 in various areas of the department THEN patients may use ligature points to self-harm
Risk Register: Emergency Medicine CSU Risk Register / Medicine Division **Risk Owner:** Laki Yassan
Current Risk Score: 15 (Consequence 3, Likelihood 5)
Reason for Closure: This risk is no longer applicable due to ward moving to Maple Unit. Risk Assessment being completed by Laki Yassin and Marion Fowler for Ward 2A. Ward 1 will need to complete a department H&S Risk Assessment for it's new location. Depending on the outcome of these Risk Assessments, they may be added to the Risk Register in due course.

3. Key Risk Indicators

The aim of the Key Risk Indicators is to give the Committee a proactive view of activity that could affect the achievement of the Trusts Strategic Objectives, through aggregation of intelligence from incidents, complaints, claims/litigation, compliments, and safety alerts. The below is an example of Key Risk Indicators that could be used to provide the Committee with aggregated data to monitor Trust Objectives.

Objective: Improve Workforce Effectiveness



Staff Level Incidents: The data from Radar shows that there is an average of 28 staffing level incidents reported on the system each month. So far in December (21st December), there have been 29 staffing level incidents reported. This is likely to increase by the end of the month.
Violence & Abuse Incidents: The average number of violence and abuse (by patients/public) reported each month is 33. So far there have been 27 incidents reported, again this is likely to increase by month end.
Staff Accidents: The number of staff accidents has reduced over the last 3-4 months. There have been 9 staff accident incidents reported this month. Although we are only two-thirds through the month, this is significantly lower than the average of 19 incidents per month.
Personal Injury Claims: The number of personal injury claims per month is very minimal, with none being raised on Radar between February and September 2022. The last 3 months have seen either 2 or 3 personal injury claims raised. Whilst these numbers are low, they do reflect a slight increase compared to the monthly average per month this year (n=1).

The slight increases identified above (or potential increase by the end of the month) could be explained by the increased operational pressures during December, and the increased footfall of patients/public attending the hospital. It is recommended that this data, along with data in relation to retention/recruitment of staff and activity data (e.g. the number of patient's attending ED, wards etc), should be monitored to help identify whether this continues and to support the identification of any risks that could prevent the Trust's effective use/wellbeing of the workforce.

4. RECOMMENDATION

The Board is asked to review and discuss this paper.

Meeting Title	**Trust Board of Directors**	**Date: January 2023**
Report Title	**Declarations of Interests – 2022/23**	**Agenda Item Number: 26**
Lead Director	Kate Jarman, Director of Corporate Affairs	
Report Author	Kwame Mensa-Bonsu, Trust Secretary	

Introduction	This is to provide the Trust Board with an update on the returns submitted for 2022/23.		
Key Messages to Note	1. All members of the Trust Board of Directors submitted their declarations of interest. 2. The Trust Secretariat will, also take steps to ensure that all staff are better informed on how to report offers of gifts and hospitality, whether accepted or not. This is an area which requires significant improvement.		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Review** x

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	*N/A*

Report History	*N/A*
Next Steps	Trust Board Meeting in Public, January 2023
Appendices/Attachments	a. A summary of Trust Board members' current register of interests for 2022/23 (**Appendix 1**). b. A summary of the register of interests of decision-making staff for 2022/23 (**Appendix 2**). c. A summary of the Hospitality and Gifts register for 2022/23 (**Appendix 3**).

DECLARATIONS OF INTERESTS REPORT

1. Introduction

The purpose of the report is to provide the Audit Committee with an update on the returns submitted for 2022/23.

2. Background

In line with the Trust's Conflicts of Interest, Hospitality, Gifts, Donations and Sponsorship Policy, all 'decision making staff' (defined as AfC band 8A and above, staff involved in contracting and procurement, and all consultant medical staff), Non-Executive Directors and members of the Council of Governors were asked in July 2022 to submit their declarations of interests for 2022/23.

For this declarations exercise, an online solution was introduced with a particular focus on improving the rate of returns for the Trust's Consultants and to ensure the improvement is sustained, steps will be taken to keep improving the solution's questionnaire.

3. Update on 2022/23 Returns

For 2022/23, 152 (71%) out 215 Trust Consultants submitted their declarations of interests, from the 158 (80%) out of 198 Trust Consultants who did so in 2021/22. 18 of the 215 Consultants provided details of their other interests, while the rest provided 'nil' returns as their submissions. It must be noted that this remains a significant improvement on the 39 (22%) out of the 178 Trust Consultants who participated in the 2020/21 exercise.

138 (65%) out of 214 Band 8A+ staff submitted their declarations in 2022/23, from the 148 (74%) out of 201 Band 8A+ staff who submitted their declarations in 2021/22. This also remains a significant improvement on the 73 (36%) who submitted their declarations for the 2020/21 exercise.

Of the 21 members of the Procurement Staff, 17 submitted their 2022/23 declarations.

All members of the Trust Board of Directors submitted their declarations of interest.

4. Plans for 2023

The Trust Secretariat will continue to work towards ensuring all relevant staff submit their declarations of interest, and that they provide the full details.

The Trust Secretariat will, also take steps to ensure that all staff are better informed on how to report offers of gifts and hospitality, whether accepted or not. This is an area which requires significant improvement.

5. Recommendation

The Committee is asked to:

- **Note** the report and the appended registers.

Milton Keynes University Hospital NHS Foundation Trust

APPENDIX 1: BOARD OF DIRECTORS – DECLARATIONS OF INTERESTS 2022/23

Director	Role	Do you, your spouse, partner of family member hold or have any of the following: • A directorship of a company? • Any interest or position in any firm, company, business or organisation (including charitable or voluntary) which does or might have a trading or commercial relationship with the Foundation Trust? • Any interest in an organisation providing health and social care to the NHS?	Do you or your spouse, partner or family member have a position of authority in a charity or voluntary organisation in the field of health and social care?	Do you, your spouse, partner or family member have any connection with an organisation, entity or company considering entering into a financial arrangement with the Foundation Trust, including but not limited to lenders or banks?	Dates during which the interests were held	Action taken to manage any potential conflict *[Board and Committee agendas are proactively and continuously scrutinised to ensure that Board members are not exposed to potential conflicts and at every Board and Committee meeting, members are asked to declare any conflicts that they may have]*
Ian Reckless	Medical Director	Yes – Director, JTER Trading Ltd (retail and property services) Director, ADMK (wholly owned subsidiary of MKUH NHS Foundation Trust)	No	No	July 2019 to date	

		Spouse is employed as a Consultant Anaesthetist in the NHS in the region Non-Executive Director, Royal Orthopaedic Hospital NHS Foundation Trust			November 2022 to date	
Professor Joe Harrison	Chief Executive Officer	Yes – Council Member – National Association of Primary Care Member of TenX Advisory Board Member of NHS Employers Policy Board Trustee of NHS Confederation Vice-Chair of NHS Employers Policy Board Keele University Lecturer Advisor to Alphasights Advistor to M3 Global Research Advisor to Silverlight Advisor to Stepcare	No	No	July 2019 to date	

		Spouse is the Prime Minister's Expert Advisor for NHS Transformation and Social Care. Ruth Harrison – Director at Durrow Limited.				
Dr Luke James	Non-Executive Director (till September 2022)	Yes – Striatum Consulting Limited Medical Director for Bupa Global and UK Insurance – part of the Market Unit which includes Bupa Clinics Bupa Care homes and Bupa Dental businesses. However, Luke is not involved in executive or commercial aspects of these Director / Board Member of Bupa Trustees Limited	No	No	April 2020 to September 2022	
Terry Whittle	Director of Finance	Nil	No	No	To date	
John Blakesley	Deputy CEO	Yes – Director of ADMK Limited, wholly owned subsidiary of the Trust	No	No	July 2019 to date	
Danielle Petch	Director of Workforce	Yes – Company Secretary, S4 Software Solutions Limited	No	No	To date	

		Husband is Management Director, S4 Software Solutions Limited				
Andrew Blakeman	Non-Executive Director (till March 2022)	Yes – Director of Stryde International Ltd, a subsidiary of BP PLC	No	No	To date	
Haider Husain	Non-Executive Director	Yes- Director & CEO of Paracat Ltd Director & COO of Healthinnova Limited British Standards Institute (BSI) Committee member – Healthcare Organisation Management Associate Non-Executive Director, Medicines and Healthcare products Regulatory Agency Board Bucks. Oxfordshire & Berkshire West ICB Dementia Carers Count	No	No	Feb 2018 to date March 2019 to date Apr 2019 to date September 2020 to date July 2022 to date June 2021 to date	
Kate Jarman	Director of Corporate	Yes –	No	No	Nov 2020 to date	

	Affairs	Faculty Member of the Good Governance Institute Board Member – Milton Keynes Urgent Care Centre Member of the Labour Party Member of Women's Equality Party Trustee – Milton Keynes Arts for Health Trustee				
Professor James Tooley	Non-Executive Director (till September 2022)	Yes – Director – The Education Partnership (UK) Ltd Director – Apollo Buckingham Health Science Campus (ABHSC) Ltd Director – University of Buckingham Medical School of the North (UBMSN), Crewe University			2000 to present 2020 to present 2020 to present	
Alison Davis	Hospital Chair	Nil			To date	
Jacqueline Collier	Director of Transformation & Partnerships (till July 2022)	Yes – Husband is a partner in PA Consulting.			To date	
Helen Smart	Non-Executive	Nil			To date	

	Director (till July 2022)					
Nicky Burns-Muir	Director of Patient Care and Chief Nurse (till September 2022)	Nil			To date	
Heidi Travis	Non-Executive Director	Nil			To date	
Emma Livesley	Director of Operations	Nil			To date	
Nicky McLeod	Non-Executive Director (January 2022)	Nil			To date	
Beverley May Messinger	Non-Executive Director	Yes – Non-Executive Director - Your Housing Group, Warrington Non-Executive Director - Government Actuary Department Spouse is employed at the Estates Department of an NHS provider			April 2022 to date	
Gary	Non-Executive	Non-Executive Director, MLL			April 2022 to	

Marven	Director	Telecom			date	

Milton Keynes University Hospital NHS Foundation Trust

2022/23 Hospitality Register and Declaration of Gifts and Hospitality

DATE VISIT/GIFT ETC	DESCRIPTION OF HOSPITALITY/GIFT RECEIVED INCLUDING LOCATION IF RELEVENT	SUPPLIER OR DONATOR OF THE GIFT/HOSPITALITY, NAME OF COMPANY AND BUSINESS ACTIVITY	TITLE OF MEMBER OF STAFF RECEIVING THE HOSPITALITY OR GIFT	VALUE OF HOSPITALITY OR GIFT
30/06/22	Honorarium taken to deliver a lecture for GPs and PNs	Abbott Laboratories	Malik Asif Humayun	Not specified
24/08/22	Dinner	CMR Surgical	Joe Harrison	Not specified

Role	Date of submission	Description of Interest	Relevant dates		Comments
			From	To	
Consultant Paediatrician	27/07/2022	Deputy Clinical Director East Of England NHSEngland Children and Young Persons Transformation team	Feb 2022	Present	1.5 PAs. When involved in discussions and decision making around potential funding requests or service changes in the region or ICS that may affect Milton Keynes Hospital Paediatric Department or me personally I declare an interest and when appropriate do not engage in the relevant aspect of any such discussions or decisions.
Consultant Cardiologist	27/07/2022	Organiser and speaker at the Stress echocardiography Interpretation course sponsored by TomTec GmbH Germany	July 2022	June 2022	Weekends and evenings – out of hours
Consultant radiologist	27/07/2022	Director at vitalscan Ltd.	January 2022	Ongoing	6 hours per week. Not involved in any commissioning or decision making for trust
Consultant	28/07/2022	Medic at Silverstone Race track			Working on weekends at my spare time- Not linked to hospital work about 100 hours a year.
Consultant in Palliative Medicine	03/08/2022	As part of my Trust employment, I work mainly for Willen Hospice (independent charity). At the hospice, I work	2021	Ongoing	6 PAs/week; University of

		clinically as Consultant in Palliative Medicine which includes being a member of the senior management team. I also hold a contract for my position as Cancer Care Block Lead (Honorary Senior Clinical lecturer) at University of Buckingham Medical School.			Buckingham 2 PAs/week (MKUH 3 PAs/week)
Consultant cardiologist	05/08/2022	Attendance at multidisciplinary meeting at Whaddon Community Cardiovascular Service to advise on care of NHS patients; Honorary contract for NHS cardiology work at Oxford University Hospitals; Unpaid Editor for Cochrane Heart Group	June 2022		3 hours for Whaddon MDT; 1 day a week work at OUH; A few hours per year as Cochrane editor.
Locum Consultant	08/08/2022	Have done Speakers educational meetings for Pharma outside NHS working hours.			Infrequent.

Consultant Anaesthetist	08/08/2022	Private Practice at Spire Harpenden Hospital, BMI Saxon Clinic, Blakelands Hospital MK, Cherwell Hospital Banbury	06/09/2020	Ongoing	1 Saturday a month at Spire Harpenden, 2 sessions a week approximately at either Blakelands or Saxon. Recently received privileges at Cherwell. Not done any sessions there. All private commitments are done after my NHS commitments are fulfilled on the rota.
Consultant and Clinical Lead	07/09/2022	I undertake private practice in a similar role. This is in part also undertaking work in relation to insourcing in the Trust as part of an LLP. This is not undertaken during Trust time.		Ongoing	6-12hrs I keep these activities separate and am open about possible conflicts and work to mitigate them. I do not discuss private practice with NHS patients and follow the MD advice from previous years. I do not make decisions about the use of insourcing.
Consultant Orthopaedic surgeon	07/09/2022	Private Practice at Saxon Clinic in Milton Keynes- work carried out fully documented in job plan			1 day a week
Consultant Orthopaedic Surgeon	08/09/2022	In addition to my NHS job, I work in private practice at the Saxon Clinic and The Portland Hospital. I gained approval from my CSU and medical director for each post. The work does not clash or affect my NHS commitments. This work has been added to my job plan.			

Consultant	09/09/2022	Outside employment for Thames Valley Air Ambulance Outside employment (bank only) for East Midlands Ambulance Service NHS Trust		Ongoing	One day per week As agreed on joining trust. Ensure EWTD compliance with shift working. Variable as bank only- average 18-30 hours/month Ensure compliance with EWTD regarding shift work
Consultant	25/09/22	Clinical Director - Newmedica Northampton, Blakelands Hospital - Consultant	March 2022 August 2021	Ongoing Ongoing	42 days a year

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Board of Directors**	**Date: 12 January 2023**
Report title:	**Use of Trust Seal**	**Agenda item: 25**
Lead director **Report author Sponsor(s)**	**Name: Kate Jarman** **Name: Julia Price**	**Title: Director of Corporate Affairs** **Title: Senior Corporate Governor Officer**
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 note the use of the Trust Seal since March 2022						

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 entries in the Trust seal register which have occurred since the last full meeting of the Board.

2. Context

Since the last Trust Board, the Trust Seal has been executed as follows:

4 November 2022 - Deed of Easement for gas infrastructure

Meeting Title	**Trust Board Meeting In Public**	**Date: 28/12/2022**
Report Title	**Audit Committee Summary Report of the meeting held on 26/09/22**	**Agenda Item Number: 26.1**
Chair	*Gary Marven-Chair*	
Report Author	**Gary Marven-Chair**	

Key Messages to Note

1. **Matters approved by the Committee/Recommended for Trust Board approval**
   Approved the internal audit tracking protocol
   Approved the financial controllers report, specifically write offs of £19k
   Approved terms of reference of the financial sustainability checklist
   Approved the changes to the Financial instructions and standing orders proposed by TW
   Approved Audit committee terms of reference

2. **Items identified for escalation to Trust Board**
   Consultant job planning issues as raised by internal auditors, issues which are perennial to the NHS not just MK.
   Trusts position on the internal audit assessment in comparison to last year, a decline, but still a positive result.
   The level of value for money waivers, which continue to be high and whilst justified in the current climate run the risk of issues if a supplier fails to deliver for whatever reason and also make value for money justifications harder.
   The high number of significant risks that are red and have been static for several months.

3. **Summary of matters considered at the meeting**
   External Auditors value for money report
   Internal audit progress report and findings
   Healthcare benchmarking of internal audit findings
   Counter fraud report
   Financial sustainability check list
   Financial controllers report
   Standing Financial instructions and Standing orders
   BAF
   Significant risk register

4. **Highlights of Board Assurance Framework Review**
   An extensive discussion took place around potential improvements in the format of both the BAF and significant risk register which will be incorporated into a separate Board session planned for September.

5. **Risks/concerns (Current or Emerging) identified**
   High level of risk in a number of areas principally driven by staffing levels-ongoing
   Impact of potential strike action

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	*1. Keeping you safe in our hospital* *2. Improving your experience of care* *3. Ensuring you get the most effective treatment*

	4. *Giving you access to timely care* 5. *Working with partners in MK to improve everyone's health and care* 6. *Increasing access to clinical research and trials* 7. *Spending money well on the care you receive* 8. *Employ the best people to care for you* 9. *Expanding and improving your environment* 10. *Innovating and investing in the future of your hospital*

Meeting Title	Trust Board	**Date:** January 2023
Report Title	Summary Report for Finance and Investment Committee held on 04 October 2022	**Agenda Item Number: 26.2**
Chair	Heidi Travis, Non-Executive Director	
Report Author	Kwame Mensa-Bonsu, Trust Secretary	

Key Messages to Note

1. Matters recommended for Trust Board approval

- The Maple Centre Business Case
- The International Nursing Business Case

2. Items identified for escalation to the Board

- International Nursing Business Case (Revenue)
- Maple Centre Business Case (Revenue)

3. Summary of matters considered at the meeting

- The Trust's operational and financial performance for August 2022
- An update on capital programme expenditure for 2022/23
- The proposal for a Community Diagnostic Centre
- A Cognitive Contract Management Pilot – this was related to a contract management platform that enabled organisations to analyse and manage their contracts using Artificial Intelligence (AI) quickly and accurately. The Trust had agreed to pilot the AI system with KPMG as an associate for four to six weeks at no cost.

4. Highlights of Board Assurance Framework Review

The Board Assurance Framework was comprehensively reviewed. There were no highlights to report.

5. Risks/concerns (Current or Emerging) identified

There were no risks or concerns identified.

Strategic Objectives Links	7 Spending money well on the care you receive 9 Expanding and improving your environment 10 Innovating and investing in the future of your hospital

Meeting Title	Trust Board	**Date:** January 2023
Report Title	Summary Report for Finance and Investment Committee held on 01 November 2022	**Agenda Item Number: 26.3**
Chair	Heidi Travis, Non-Executive Director	
Report Author	Kwame Mensa-Bonsu, Trust Secretary	

Key Messages to Note

1. Matters recommended for Trust Board approval

- Capital Bids for the Community Diagnostic Centre (CDC)
- Contract Renewal for GENMED Pathology Contract

2. Items identified for escalation to the Board

- Contract Renewal for GENMED Pathology
- Community Diagnostic Centre capital bids
- Workforce issues, particularly in reference to the industrial action

3. Summary of matters considered at the meeting

- Draft Financial Forecast Month 6
- The Trust's operational and financial performance for September 2022
- An update on capital programme expenditure for 2022/23

4. Highlights of Board Assurance Framework Review

The Board Assurance Framework was comprehensively reviewed. There were no highlights to report.

5. Risks/concerns (Current or Emerging) identified

There were no risks or concerns identified.

Strategic Objectives Links	7. Spending money well on the care you receive 8. Expanding and improving your environmentInnovating and investing in the future of your hospital

Meeting Title	Trust Board Meeting in Public	**Date:** 12 January 2023
Report Title	Trust Executive Committee	**Agenda Item Number:** 26.4
Chair	Joe Harrison, Chief Executive Officer	
Report Author	Kwame Mensa-Bonsu, Trust Secretary	

Key Messages to Note

Matters approved by the Committee

A. Business Cases

i. Cardiac Rhythm Management Database Business Case
ii. Replacement Printers Business Case
iii. Variation to Cardiac Monitors Replacement (Space labs) – Business Case for additional capital
iv. Hard Landscaping of the area outside the Staff Hub – Business Case to be fully funded by charitable funds.
v. Introduction of a Percutaneous Coronary Intervention (PCI) Service – Business Case for additional capital
vi. The Committee also supported a business case which would fund the establishment of a Multiple Sclerosis Service in the Trust. This was subject to further discussion and sign-off by the Executive Team

B. Policies

i. Lone Working Policy
ii. Self or Parent/Carer Administration of Medicine for Babies, Children and Young People Policy
iii. Fresh Frozen Plasma (FFP) and Cryoprecipitate Indication Guideline
iv. Platelet Indication Guidelines
v. Blood Transfusion Policy
vi. Foundation Trust Standing Financial Instructions Policy
vii. Debt Management Policy
viii. Counter Fraud Policy
ix. Treasury Management Policy
x. Handover Guidelines for Hospital at Night (H@N) Meeting
xi. Pay Progression Policy and Procedure
xii. Annual Leave (Non-Medical/Dental Employees) Policy and Procedure

Summary of matters considered at the meeting

- The Maple Centre has been handed over to the Trust and would be operationalised on 31 October 2022
- CQC Preparedness Highlight Report and Divisional CQC Well-Led Assessments
- Patient Safety Executive Director's Update – (i) Patient Safety Board (PSB) would meet on the third Wednesday of each month, with a small core agenda and other topics explored quarterly; (ii)The Maternity Assurance Group (MAG) formed in August 2022 would report directly to the Trust Board and ensure that Board-level maternity and neonatal safety champions could understand key challenges; (iii) There would be preparation in the Trust to transition from traditional incident management to Patient Safety Incident Response Framework (PSIRF).
- Deep Tissue Injuries (DTI) and Thematic Review Update

- Financial, operational and workforce performance data in August 2022
- Divisional risk management and the significant risk register
- Research and Development 2021/22 Annual Report – The recruitment to the National Institute for Health and Care Research (NIHR) portfolio studies remained healthy at the Trust during the peak of the pandemic. Research and Development activities had expanded into general surgery, including robotics.
- Workforce – A recruitment fair was held in Milton Keynes Town Centre, which was well attended, and there were a lot of leads, including in difficult to recruit areas like Pharmacy.

Highlights of Board Assurance Framework Review

The BAF was due a review at Trust Board Seminar in October 2022.

Risks/concerns (Current or Emerging) identified

None

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	*1. Keeping you safe in our hospital* *2. Improving your experience of care* *3. Ensuring you get the most effective treatment* *4. Giving you access to timely care* *5. Working with partners in MK to improve everyone's health and care* *6. Increasing access to clinical research and trials* *7. Spending money well on the care you receive* *8. Employing the best people to care for you* *9. Expanding and improving your environment* *10. Innovating and investing in the future of your hospital*

Meeting Title	Trust Board Meeting in Public	**Date:** 12 January 2023
Report Title	Trust Executive Committee	**Agenda Item Number:** 26.5
Chair	Joe Harrison, Chief Executive Officer	
Report Author	Kwame Mensa-Bonsu, Trust Secretary	

Key Messages to Note

Matters approved by the Committee

A. Business Cases

i. One Band 7 for 18 months to support an automation programme to digitalise key HR forms and processes. The case would be funded from non-recurrent funding.
ii. Palliative Care Consultant business cases for a 10PA's of which 8 PA's will be funded by Willen Hospice and 2PA's will be part of the Trust's recurrent funding, graded "A", subject to further financial discussion and sign-off by the Executive Team.
iii. Additional Specialist Registrar in Oncology graded “A", subject to further financial discussion and sign-off by the Executive Team.
iv. A CT Imaging Assistant to increase the CT capacity by 20% (approx. five scans a day), resulting in an additional 1,800 scans a year.
v. For the replacement of 4 of the 12 Electrosurgery Units – Diathermy
vi. For the replacement of ENT Navigation System, subject to further discussion with IT
vii. For the acquisition of a radiofrequency generator
viii. For the acquisition of a VAC Biopsy machine

B. Policies

i. Performing Venepuncture and the Insertion and Management of Peripheral Intravenous Catheters (Cannulas)
ii. Guidelines for Adults and Adolescents aged 16-18 years with (suspected /confirmed) Eating Disorders.
iii. Use of FP10HP and Outpatient Prescriptions Policy V1.8 19-10-2022
iv. Parking Policy and Procedure

Summary of matters considered at the meeting

- The Maple Centre was operationalised on 31 October 2022
- CQC Preparedness Highlight Report and Divisional CQC Well-Led Assessments
- Workforce – The Trust Board had approved the additional recruitment of 100 international nurses. After some delays with sponsorship certificates, the final cohort of nurses from the first recruitment round was expected to arrive in December 2022
- Patient Safety Executive Director’s Update – The Patient Safety team at Milton Keynes University Hospital (MKUH) had been Highly Commended for Patient Safety Pilot Project of the Year at the HSJ Patient Safety Awards 2022. The Support and Action Following Events (SAFE) pilot project was highly recommended by the HSJ judging panel.
- Patient Experience Executive Director’s Update - Complaints services had been severely understaffed, resulting in significant delays in complaints response. Actions had been undertaken to bring stability to the team to strengthen the team's resilience.

- Deep Tissue Injuries (DTI) and Thematic Review Update
- Financial, operational and workforce performance data in September 2022
- Divisional risk management and the significant risk register

Highlights of Board Assurance Framework Review

The BAF was due a review at Trust Board Seminar in November 2022.

Risks/concerns (Current or Emerging) identified

None

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	*1. Keeping you safe in our hospital* *2. Improving your experience of care* *3. Ensuring you get the most effective treatment* *4. Giving you access to timely care* *5. Working with partners in MK to improve everyone's health and care* *6. Increasing access to clinical research and trials* *7. Spending money well on the care you receive* *8. Employing the best people to care for you* *9. Expanding and improving your environment* *10. Innovating and investing in the future of your hospital*

Meeting Title	**Trust Board**	**Date: 12 January 2023**
Report Title	**Workforce and Development Assurance Committee Summary Report**	**Agenda Item Number: 26.6**
Chair	*Alison Davis, Trust Chair*	
Report Author	*Moira Mawuru, Interim Committee Secretary*	

Key Messages to Note

1. Matters approved by the Committee/Recommended for Trust Board approval

a. Workforce and Development Self-Evaluation Report

2. Items identified for escalation to Trust Board

a. Staffing challenges in core areas as winter approached

3. Summary of matters considered at the meeting on 20 October 2022.

a. The Committee noted the issues raised in the 2021/22 GMC National Training Surveys, of which a robust action plan for improvements was being developed.
b. The Committee noted the various initiatives to support staff with the rising cost of living, such as collaborating with Catering Services to educate staff on how to cook good value, nutritious meals, offering affordable options in the canteen such as the "£2 healthy meal deal'. From a financial standpoint, there was also an incentive to receive a Blue Light card upon completing the staff survey and collaboration with a local charity providing money and debt management services.
c. The Committee received the 'Comparisons with other organisations on their approach towards appraisals in response to a Board Action raised in May 2022.
d. The Committee received a 'Deep dive into midwifery establishment over the last five years' in response to a Board Action raised in Aug 2022.
e. The Committee discussed the areas with high turnover, such as Pharmacy and the general challenges in the recruitment market at present.
f. The Committee was pleased to hear the Workforce objective in respect of reducing Employee relations cases had been achieved.
g. The Committee received the latest WRES and WDES reports and the updates about the neurodiversity awareness campaign, the networks and the planned learning disability internships.

4. Highlights of Board Assurance Framework Review

5. Risks/concerns (Current or Emerging) identified

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	*1. Keeping you safe in our hospital* *2. Improving your experience of care* *3. Ensuring you get the most effective treatment* *4. Giving you access to timely care* *5. Working with partners in MK to improve everyone's health and care* *6. Spending money well on the care you receive* *7. Employ the best people to care for you*

	8. *Expanding and improving your environment* 9. *Innovating and investing in the future of your hospital*

Milton Keynes University Hospital NHS Foundation Trust

CHARITABLE FUNDS COMMITTEE TERMS OF REFERENCE

1. Constitution

1.1 The Trust Board hereby resolves to establish a Committee of the Trust Board to be known as the Charitable Funds Committee (known as 'the Committee'). The Committee is a non-executive chaired committee and as such has no delegated authority other than that specified.

1.2 The Committee is established under Standing Order 5 of Annex 7 of the Trust's Constitution.

2. Delegated Authority

2.1 The Committee has the following delegated authority:

2.1.1 The authority to require any officer to attend a meeting and provide information and/ or explanation as required by the Committee

2.1.2 The authority to take decisions on matters relevant to the Committee

2.1.3 The authority to establish sub-committees and the terms of reference of those sub-committees

2.2 The Committee has the authority to commit charitable fund resources. The Committee supports the fundraising activities of the Hospital Charity on behalf of the NHS Trust. The Hospital Charity is a charitable trust and the corporate trustee is the NHS Foundation Trust. All Board members act as trustees of the Charity.

3. Accountability

- The Charitable Funds Committee is a committee of the Trust Board. A minute of each meeting will be taken and approved by the subsequent meeting.

- Following each meeting, the Chair of the Committee will provide a written report to the next available meeting of the Trust Board meeting in public, drawing the Board's attention to any issues requiring disclosure or Board approval.

- The Chair of the Committee shall provide written reports to the Audit Committee, highlighting matters which provided information and assurance around risk management and internal control systems across the organisation.

- The Chair of the Committee will, based on the Trust Secretariat's schedule, provide written reports to the Council of Governors

- The Committee will annually review its own effectiveness and report the results of that review in an annual report to the Trust Board.

4. Duties of the Charitable Funds Committee

The Charitable Funds Committee is charged by the Board to:

i) support, guide and encourage the fundraising activities of the Trust;
ii) monitor charitable and fundraising income;
iii) oversee the administration, investment and financial systems relating to all charitable funds held by the hospital charity;
iv) develop policies for fundraising and for the use of funds;
v) ensure compliance with all relevant Charity Commission regulations, and other relevant items of guidance and best practice;
vi) review the work of other committees within the organisation, whose work can provide relevant assurance to the Charitable Funds Committee's own scope of work;
vii) consider any funding request above the Directorate Fund level, or outside the scope of these funds, which is made to the Charitable Funds Committee. These must have been through the relevant standard Trust approvals processes for either Capital or Revenue (See Appendix One).
viii) consider and approve any urgent requests in advance of any formal meeting, on an exceptional basis through the approval of the named executive director and the committee chair.
ix) oversee and advise on the running of major fundraising campaigns.

5. Membership, Attendance and Quorum

5.1 Membership

The Membership of the Charitable Funds Committee shall be as follows:

- A Non-Executive Director will be appointed by the Chair of the Board of Directors to Chair the Charitable Funds Committee.
- One Non-Executive Director who may be an associate Non-Executive Director
- Director of Corporate Affairs
- A named representative from the Finance Directorate
- A named Governor from the Council of Governors.

The Chief Executive and the Chair of the Trust Board of Directors will be ex-officio members of the Committee, but their attendance will not count towards quorum.

Other Non-Executive Directors of the Trust, including associate Non-Executive Directors may substitute for members of the Charitable Funds Committee in their absence. Such directors will count towards the achievement of a quorum.

An external individual may be appointed as a member of the Committee with the consent of the Board.

The Secretary of the Committee will be the Trust Secretary.

The meeting is deemed **quorate** when one Non-Executive Director, the named representative from the Finance Directorate and the named Governor from the Council of Governors is present.

6. Attendance

6.1 The following posts shall be invited to routinely attend meetings of the Charitable Funds Committee in full or in part but shall neither be a member nor have voting rights.

- Head of Charity
- A representative from the Finance Directorate
- Trust Secretary
- Invited representatives from the clinical directorates

7. Responsibilities of Members and Attendees

7.1 Members or attendees of the Committee have a responsibility to:

7.1.1 Attend at least 75% of meetings
7.1.2 Identify agenda items for consideration by the Chair at least 14 days before the meeting
7.1.3 Submit papers, as required, by the published deadline (7 days before the meeting) on the approved template
7.1.4 If unable to attend, send apologies to the Trust Secretary and where appropriate seek the approval of the Chair to send a deputy
7.1.5 Maintain confidentiality, when confidential matters are discussed within the Committee.
7.1.6 Declare any conflicts of interest or potential conflicts of interest at the start of each meeting in accordance with Milton Keynes University Hospital NHS Foundation Trust policy, even if such a declaration has already been made.

8. Meetings and Conduct of Business

8.1 Frequency

The Committee will meet four times a year on a quarterly basis and at least 14 days prior to the Trust Board to allow a committee report to be submitted.

8.2 Calling Meetings

Meetings of the Charitable Funds Committee are subject to the same procedures as specified in Standing Order 3 of Annex 8 of the Constitution for the Board of Directors. A meeting may be called by the Secretary of the Committee or the Chair of the Committee or the other Non-Executive Director Member of the Committee.

8.3 Agenda

The Committee will at least annually review these terms of reference. The agenda for meetings will be circulated to all Board members who have requested to receive papers. Full papers will be sent to members of the Committee at least 5 clear days before the meeting.

Version Control

Version	Date	Author	Comments	Status
0.1	December 2008	Wayne Preston	Considered by Charitable Funds Committee and approved for Board	Draft
1.0	January 2009	James Bufford	Approved by Board	Approved
1.1	March 2010	Maria Wogan	Minor amendments recommended to Board 24.03.10	For approval
1.2	March 10	Maria Wogan	Annual Review by the Board	Approved
1.3	April 2012	Michelle Evans-Riches	Review of Committee Structure By Finance and Investment Committee	For approval
1.4	September 2012	Michelle Evans-Riches	Implement changes from Charitable Funds Committee 27 September 2012	For approval
2	August 2013	Michelle Evans-Riches	Annual Review and changes to Committee Structure	For approval
2.1	November 2013	Jonathan Dunk	Updated to reflect new charitable funds approval guidance	For approval
3	June 2014	Michelle Evans-Riches	Review following changes to Terms of Reference template	For approval
4	October 2017	Ade Kadiri	Annual Review	For approval
5	February 2019	Ade Kadiri	Annual review and changes to the procedure for bid applications	For approval
6	October 2019	Ade Kadiri	Annual review (continued) including replacement of the charitable order form	For approval
7	November 2020	Julia Price	Annual review by Trust board	Approved
8	Aug 2021	Kwame Mensa-Bonsu	Annual Review	Draft
8.1	27 Aug 2021	Haider Husain	Review & mark-up of draft	Draft
9	10 September 2021	Kwame Mensa-Bonsu	Review Completed	Draft
10	November 2021	Kwame Mensa-Bonsu	Annual Review by the Board	Approved
11	January 2023	Kwame Mensa-Bonsu	Annual Review by the Board	Approved

Milton Keynes University Hospital NHS Foundation Trust

Trust Executive Committee

Terms of Reference

Summary

The Trust Executive Committee comprises the Executive Directors, who meet informally twice weekly. Each month the Trust Executive Committee meets formally, with an extended membership to include clinical divisional management and other senior clinical or professional service leads (as specified in the terms of reference). The Trust Executive Committee meetings are chaired by the Chief Executive.

The formal monthly business meeting provides scrutiny and oversight across clinical quality, operational and financial performance; as well as compliance and governance reporting; approval of business cases, investment plans etc (in accordance with the terms of reference).

During major incidents, the Trust Executive Committee may meet more frequently as Gold Command (as determined by the nature and duration of the incident).

Meetings and Conduct of Business

The Board hereby resolves to establish an Executive Committee of the Board to be known as the **Trust Executive Committee (TEC)**. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board meetings.

The TEC is responsible for overseeing the effective operational management of the Trust including the fulfilment of statutory and regulatory requirements; the monitoring of clinical standards and targets; the delivery of high-quality patient centred care; the monitoring of financial performance; and the monitoring of corporate/ business data and information pursuant to the effective running of the organisation.

The TEC is the designated senior operational leadership and decision-making body of the Trust and is chaired by the Chief Executive.

The TEC is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee of the Trust and all employees are directed to cooperate with any request made by the Board.

The TEC is authorised by the Trust Board to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

Purpose

The TEC is the primary executive decision-making body of the Trust with responsibility for:

- Providing effective operational leadership of the Trust
- Ensuring the Trust delivers safe, high quality and cost-effective services,
- Ensuring the objectives and key performance indicators in annual and operational plans are delivered
- Ensuring statutory and regulatory compliance is met

Membership

Core Membership

- Chief Executive (Chair)
- The Executive Directors
- The Divisional Triumvirate (Divisional Director, Associate Director of Operations, and Divisional Chief Nurse or Head of Midwifery or Lead Allied Health Professional)

Attendance for Agenda-Specific Items

Senior management staff will be expected to attend TEC for agenda-specific items. The Company Secretary, in planning the meeting agenda with the CEO, will inform staff of the requirement to attend.

Members of the TEC are expected to attend all meetings in person. If they are on annual or sick leave, members may send nominated deputies. The meeting secretary should be notified of the attendance of deputies at least 24 hours in advance of the meeting.

The Chief Executive will nominate a member of the TEC to Chair the meeting in his/her absence.

Frequency and Type of Meeting

The TEC comprises the Executive Directors, who meet informally twice weekly, which may become Gold and therefore a formal minuted meeting in times of emergency/crisis.
Once a month the Trust Executive Committee meets formally, with an extended membership to include clinical divisional management and other senior clinical or professional service leads as required.

The meeting will focus on corporate/ Trust-wide reporting and accountability. This requires corporate groups to present upward reports on the exercising of their delegated accountabilities. The meeting will also receive the minutes and items of escalation or for approval from the Management and Performance Board.

The reporting structure is available on the intranet.

Quorum

The meeting is quorate when at least three Executive Directors and (at the monthly formal TEC) two Divisional Directors are present.

Principles

The following principles will underpin the work of the TEC:

The TEC will:

- Lead by example by embodying the Trust's values in its work
- Act as an inclusive team, exploiting each other's strengths, demonstrating strong corporate commitment and trust
- Work to transparent and clear priorities
- Have a bias to action
- Have strong and effective communications
- Share information from TEC meetings with the wider organisation as appropriate, respecting the need to maintain confidentiality when required. This includes communicating upwards and downwards in the organisation and consulting colleagues prior to meetings as appropriate.
- Provide papers and presentations for the meeting in accordance with the agreed deadlines and in the required format

Duties

- To ensure the Trust provides safe, high quality care and use resources efficiently and effectively.

- To promote and protect the safety of patients and the quality of their experience.

- To value staff and promote and safeguard their welfare enabling the Trust to secure maximum value from its staff resources.

- To ensure the Trust has strong relationships within the local health economy and with local stakeholders and is recognised as a trusted and valued part of the local health community. Including:

- Listening to and learning from feedback from patients and stakeholders and agreeing action as appropriate

- To ensure appropriate engagement with stakeholders and report on the outcome of engagement activity

- To provide direct input to issues and decisions to be presented to the Trust Board for approval, as appropriate.

- To contribute to the Trust's strategic and annual business plans for approval by the Board.

- To consider and approve business cases and proposals for the appropriate deployment of the Trust's capital and revenue resources in accordance with the Standing Financial Instructions

- To review corporate and operational performance against the business plan objectives and key performance indicators and agree actions to improve delivery and performance as appropriate.

- To ensure the Trust operates in a cost effective manner, working within agreed budgets and to review performance against the Trust's budget including: delivery against Cost Improvement and Transformation Programme Plans; expenditure against forecast

- To support the Chief Executive in exercising their lead management responsibility for risk management, the internal control environment and the implementation of the Trust's quality governance assurance framework, risk management strategy and policy.

- In conjunction with delegated clinical governance groups, to review any lessons learned from patient feedback, external reviews and Major and Serious Incidents, to recommend amendments to the Trust's policies, procedures and practices as a result of this learning and to close the loop ensuring that these recommendations are implemented throughout the Trust.

- To exercise effective oversight of the Trust's arrangements for ensuring compliance with its statutory and regulatory obligations, including performance targets under the NHS Constitution

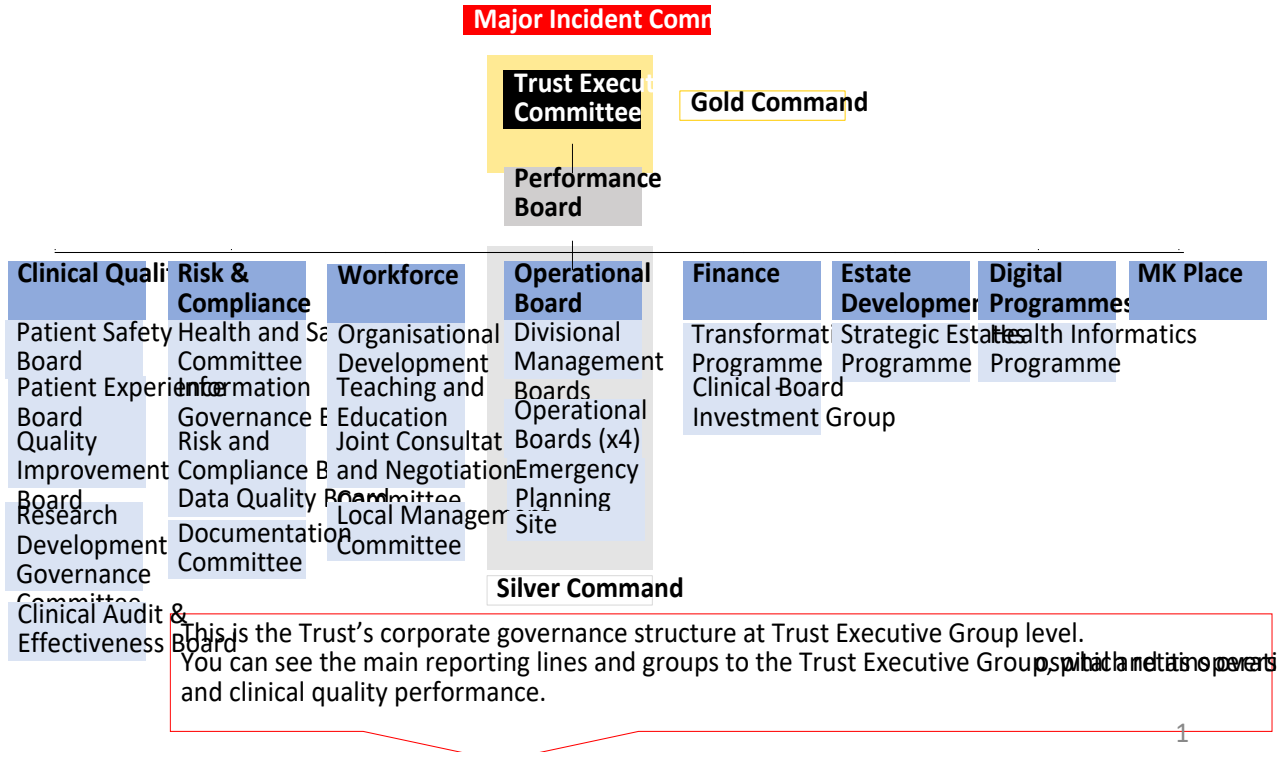
- To enable the Trust to operate with an awareness of relevant national and international guidance and best practice.

- To approve Trust policies and strategies in accordance with agreed procedures.

Sub-Groups

The TEC will be responsible for ensuring that adequate management arrangements are in place to ensure that the Trust provides safe and high-quality services to its patients.

The groups reporting to TEC are contained within the corporate governance structure, available on the Trust intranet. These include all main operational committees and boards.



Upward Reporting

The TEC will provide a monthly summary report to the Trust Board or appropriate Board Committee.

Communication from TEC

The Company Secretary will liaise with the Communications Team regarding communications for staff following TEC TEG meetings as appropriate.

Administration of TEG

The Company Secretary will be responsible for providing support for TEC meetings, including:

- Issuing agendas and papers
- Producing minutes & maintaining the action log
- Providing a report template
- Producing a work-plan for the year

The minutes of the TEC will be reported to the next TEC meeting for approval and it will be maintained and updated by the meeting secretary. Actions for people not present at the meeting will be communicated directly to them within a maximum of one week from the meeting.

Version control

Version	Date	Author	Comments	Status
1.0	28.04.10	Maria Wogan Trust Secretary	First draft endorsed by Board	Endorsed
1.1	26.01.11	Maria Wogan Trust Secretary	Revised draft endorsed by Board of Directors	Endorsed
2.0	Sept 2011	Geoff Stokes	Annual review by the Board taking into account comments from internal audit report	Approved
2.1	May 2012	Michelle Evans-Riches	Revised reporting lines	Approved
3.0	Sep 2013	Michelle Evans-riches	Annual Review and changes to reporting lines	
4.0	Oct 2017	Ade Kadiri	Revised Terms of Reference approved	Approved
4.1	March 2018	Kate Jarman	Terms of Reference reviewed to reflect move to two meetings a month	Approved
4.2	February 2020	Kate Jarman	Terms of Reference reviewed to reflect move to splitting CMB and Divisional Management Board – making DMB a sub-group of CMB	Approved
4.3	June 2020	Kate Jarman	Terms of Reference reviewed to reflect creation of TEG (replacing Corporate Management Board)	Approved
4.4	Oct 2021	Kwame Mensa-Bonsu	Annual Review and updated senior leader role titles	Approved
4.5	December 2022	Kwame Mensa-Bonsu	Annual Review	

Trust Board Meeting in Public

Forward Agenda Planner

Standing Items

Standing Business Items	Standing Trust Board Meeting In Public Items
Apologies	Patient Story
Meeting Quorate	Nursing Workforce Update
Declaration of Interests	Mortality Update
Minutes of the previous meeting	Performance Report
Action Tracker	Finance Report
Escalation items for Board attention	Workforce Report
AOB	Board Assurance Framework
Forward Agenda Planner	Trust Seal
	Summary Reports from Board Committees
	Significant Risk Register Report
	Serious Incident Report
	Patient Experience Report
	Maternity Assurance Group Update

Additional Agenda Items

Month	Assurance Reports/Items
January	Objectives Update
	Antimicrobial Stewardship - Annual Report
	Declaration of Interests Report
	Green Plan Update
	Maternity Patient Survey 2022 interim report
	Infection Prevention and Control Annual Report
March	
May	Freedom to Speak Up Guardian Annual Report
	Quality Priorities
	Mortality Update
July	Annual Claims Report
	Falls Annual Report
	Pressure Ulcers Annual Report
	Safeguarding Annual Report

	Green Plan Update
September	Research & Development Annual Report
	Emergency Preparedness, Resilience and Response Annual Report
	Annual Complaints Report
	Annual Patient Experience Report
November	CNST Maternity Incentive Scheme and Board Assurance Framework Sign Off
	Update on quality priorities (electives, diagnostics, emergency care and outpatients)
	Freedom to Speak Up Guardian Report
	Accountability and support for theatre productivity
	Mortality Update

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NHS
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University Hospital
NHS Foundation Trust

Board Meeting in Public
12 January 2023

Appendices

- **17.2 Board Scorecard**
- **24.1 Corporate Risk Register**

Board Performance Report 2022/23
November 2022 (M08)

NHS Milton Keynes University Hospital NHS Foundation Trust

OBJECTIVE 1 - PATIENT SAFETY										
ID	Indicator	DQ Assurance	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
1.1	Mortality - (HSMR) ★		100.8	100.8		108.5	✗	▲		
1.2	Mortality - (SHMI)		100.0	100.0		102.7	✗	▲		
1.3	Never Events		0	0	1	0	✓	▬	✗	
1.4	Clostridium Difficile		10	<7	14	2	✗	▲	✗	
1.5	MRSA bacteraemia (avoidable)		0	0	2	0	✓	▬	✗	
1.6	Falls with harm (per 1,000 bed days)		0.12	0.12	0.13	0.14	✗	▲	✗	
1.7b	Midwife to birth ratio (Actual for Month)					30		▲		
1.8	Incident Rate (per 1,000 bed days)		50	50	46.68	49.67	✗	▲	✗	
1.9	Duty of Candour Breaches (Quarterly)		0	0	0	0	✓	▬	✓	
1.10	E-Coli		15	10	15	1	✓	▬	✗	
1.11	MSSA		8	<6	13	2	✗	▬	✗	
1.12	VTE Assessment		95%	95%	95.9%	96.6%	✓	▬	✓	
1.14	Klebsiella Spp bacteraemia		15	10	10	3	✗	▼	✓	
1.15	P.aeruginosa bacteraemia		10	<7	4	2	✗	▼	✓	

OBJECTIVE 2 - PATIENT EXPERIENCE										
ID	Indicator	DQ Assurance	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.2	RED Complaints Received		0	0	0	0	✓	▬	✓	
2.3	Complaints response in agreed time		90%	90%	95.7%	87.6%	✗	▼	✓	
2.4	Cancelled Ops - On Day		1%	1%	1.32%	0.96%	✓	▲	✗	
2.5	Over 75s Ward Moves at Night		1,500	1,000	1,065	146	✗	▼	✗	
2.6	Mixed Sex Breaches		0	0	0	0	✓	▬	✓	

OBJECTIVE 3 - CLINICAL EFFECTIVENESS										
ID	Indicator	DQ Assurance	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
3.1	Overnight bed occupancy rate		93%	93%	90.0%	90.3%	✓	▲	✓	
3.2	Ward Discharges by Midday		25%	25%	14.6%	13.7%	✗	▲	✗	
3.3	Weekend Discharges		63%	63%	61.2%	58.2%	✗	▼	✗	
3.4	30 day readmissions		7%	7%	6.9%	6.3%	✓	▲	✓	
3.5	Patients not meeting Criteria to Reside		TBC			61	Not Available	▲		
3.6a	Number of Stranded Patients (LOS>=7 Days)		184			258	✗	▲		
3.6b	Number of Super Stranded Patients (LOS>=21 Days)		50			110	✗	▲		
3.7	Delayed Transfers of Care		25			30	✗	▲		
3.8	Discharges from PDU (%)		12.5%	12.5%	9.3%	8.5%	✗	▼	✗	
3.9a	Ambulance Handovers <30 mins (%)		95%	95%	82.1%	74.9%	✗	▼	✗	
3.9b	Ambulance Handovers <60 mins (%)		100%	100%	97.2%	95.5%	✗	▼	✗	

ID	Indicator	DQ Assurance	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1a	ED 4 hour target (includes UCS)		90%	90%	80.9%	78.9%	✗	▼	✗	
4.1b	Total time in ED no more than 8 hours (Admitted)		100%	100%	47.2%	38.7%	✗	▲	✗	
4.2	RTT Incomplete Pathways <18 weeks		70%	70%		48.6%	✗	▼		
4.4	RTT Total Open Pathways		33,998	34,111		38,968	✗	▲		
4.5a	RTT Patients waiting over 52 weeks (Total)		0	230		2444	✗	▼		
4.5b	RTT Patients waiting over 52 weeks (Non-admitted)		0	TBC		1848	Not Available	▲		
4.6	Diagnostic Waits <6 weeks		90%	90%		84.0%	✗	▲		
4.7	All 2 week wait all cancers (Quarterly)		93%	93%		73.1%	✗	▼		
4.8	31 days Diagnosis to Treatment (Quarterly)		96%	96%		96.1%	✓	▼		
4.9	62 day standard (Quarterly)		85%	85%		66.0%	✗	▲		

OBJECTIVE 5 - SUSTAINABILITY										
ID	Indicator	DQ Assurance	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
5.1	GP Referrals Received		Not Available		57,120	5,997	Not Available	▼	Not Available	
5.2	A&E Attendances		104,759	71,703	68,551	8,686	✗	▲	✓	
5.3	Elective Spells		25,821	17,557	16,833	2,476	✓	▲	✗	
5.4	Non-Elective Spells		34,421	23,097	20,494	3,924	✗	▼	✓	
5.5	OP Attendances / Procs (Total)		407,339	277,565	269,894	34,916	✓	▲	✗	
5.6	Outpatient DNA Rate		6%	6%	7.2%	6.6%	✗	▲	✗	
5.7	Virtual Outpatient Activity		25%	25%	16.6%	12.2%	✗	▼	✗	
5.8	Elective Spells (% of 2019/20 performance)		110%	110%	98.0%	103.6%	✗	▲	✗	
5.9	OP Attendances (% of 2019/20 performance)		104%	104%	104.3%	111.6%	✓	▲	✓	

OBJECTIVE 7 - FINANCIAL PERFORMANCE										
ID	Indicator	DQ Assurance	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
7.1	Income £'000		332,163	221,427	229,024	29,880	✓	▲	✓	
7.2	Pay £'000		(208,343)	(140,597)	(148,369)	(18,811)	✗	▲	✗	
7.3	Non-pay £'000		(98,408)	(66,543)	(66,792)	(8,893)	✗	▼	✗	
7.4	Non-operating costs £'000		(25,412)	(18,316)	(17,851)	(1,719)	✓	▼	✓	
7.5	I&E Total £'000		(0)	(4,029)	(3,988)	457	✓	▲	✓	
7.6	Cash Balance £'000			44,584		39,382	✗	▼		
7.7	Savings Delivered £'000		12,049	5,558	5,558	1,206	✓	▲	✓	
7.8	Capital Expenditure £'000		(18,288)	(9,594)	(11,325)	(2,542)	✗	▼	✗	

OBJECTIVE 8 - WORKFORCE PERFORMANCE										
ID	Indicator	DQ Assurance	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
8.1	Staff Vacancies % of establishment		10.0%	10.0%		9.9%	✓	▲		
8.2	Agency Expenditure %		5.0%	5.0%	6.0%	6.4%	✗	▲	✗	
8.3	Staff Sickness % - Days Lost (Rolling 12 months)		5.5%	5.5%		5.3%	✓	▲		
8.4a	Appraisals (excluding doctors)		90%	90%		92.0%	✓	▬		
8.4b	Doctors due appraisal in the given month who have completed that appraisal by month end	TBC				34.1%		▼		
8.4c	Doctors who have completed appraisal since 01 April 2022	TBC				45.8%		▲		
8.5	Statutory Mandatory training		90%	90%		93.0%	✓	▬		
8.6	Substantive Staff Turnover		9.0%	9.0%		16.9%	✗	▬		
8.7	Percentage of employed consultants with (at least one) fully signed off (3-stage) job plan since 01 April 2021					88.7%		▲		

OBJECTIVES - OTHER										
ID	Indicator	DQ Assurance	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
O.1	Total Number of NICE Breaches		8	8		22	✗	▼		
O.2	Rebooked cancelled OPs - 28 day rule		90%	90%	80.1%	75.5%	✗	▲	✗	
O.4	Overdue Incidents >1 month		TBC	TBC		49	Not Available	▲		
O.5	Serious Incidents		75	50	80	4	✓	▲	✗	

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
★	There was a notable increase in the value of Mortality (HSMR) in January 2022 due to the baseline being rebased. Further, from February 2022, the HSMR threshold may change on a monthly basis as we will be using the monthly peer value to compare MKUH performance against.

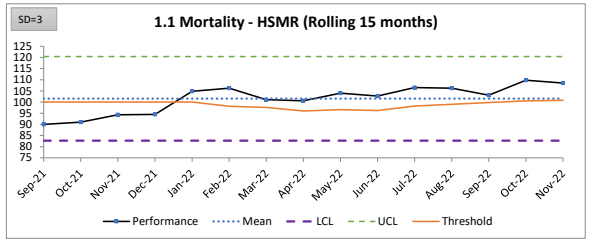
YTD Position

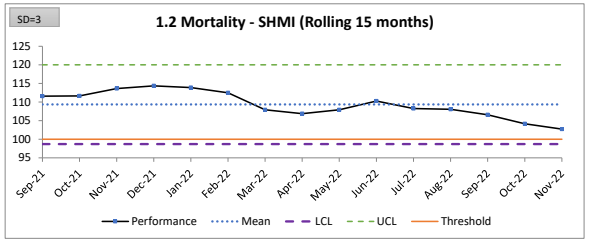
✓	Achieving YTD Target
	Within Agreed Tolerance*
✗	Not achieving YTD Target
✗	Annual Target breached

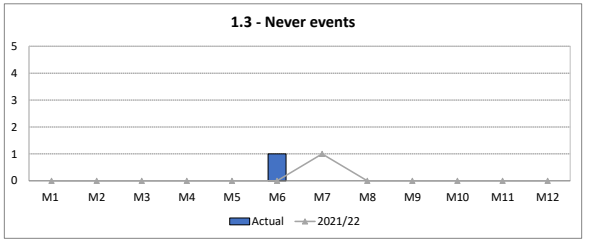
Data Quality Assurance Definitions

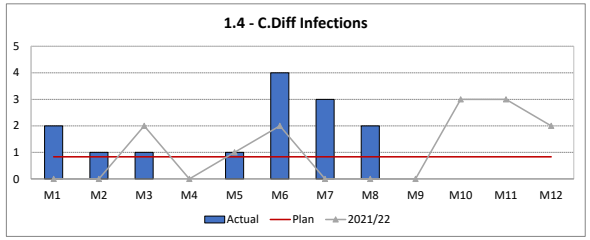
Rating	Data Quality Assurance
Green	Satisfactory and independently audited (indicator represents an accurate reflection of performance)
Amber	Acceptable levels of assurance but minor areas for improvement identified and potentially independently audited * /No Independent Assurance
Red	Unsatisfactory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

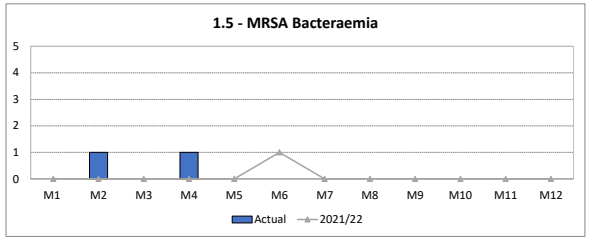
* Independently Audited – refers to an independent audit undertaken by either the Internal Auditor, External Auditors or the Data Quality Audit team.

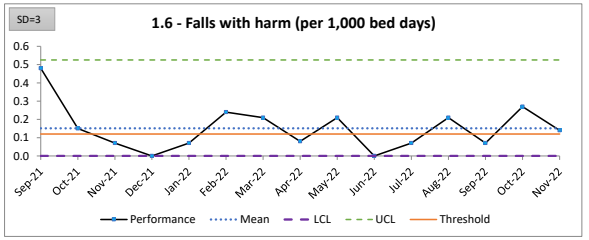


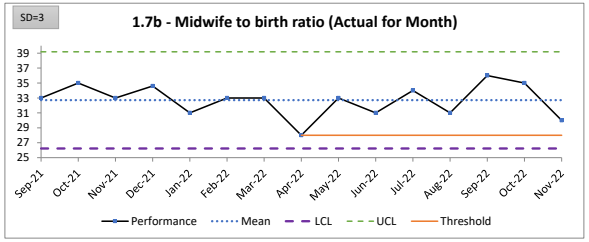


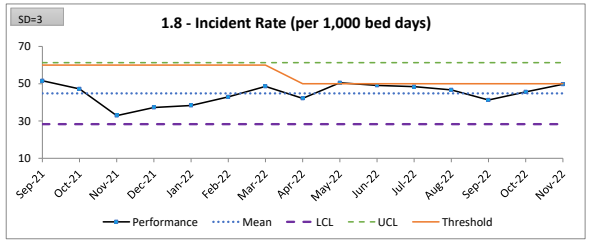


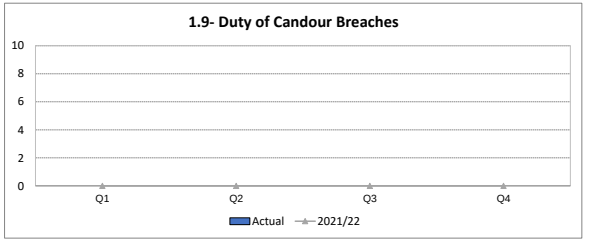


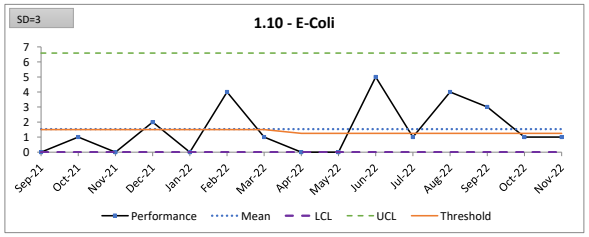


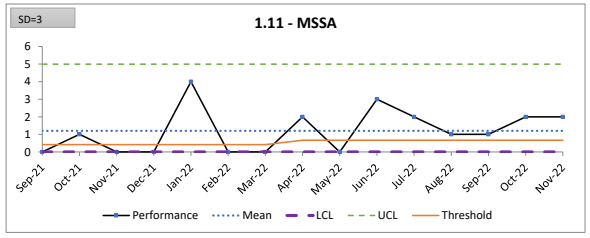


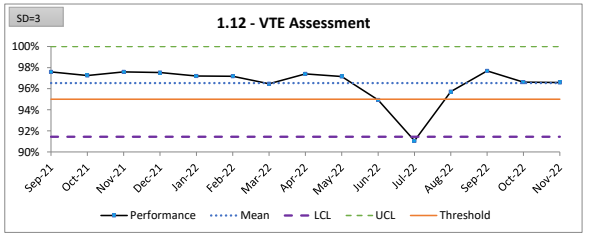


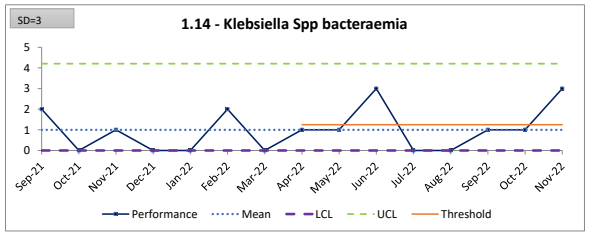


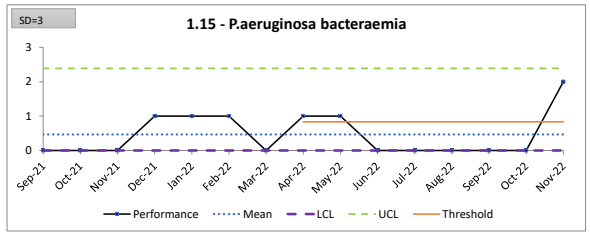












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- Average on a rolling 15 months/quarterly
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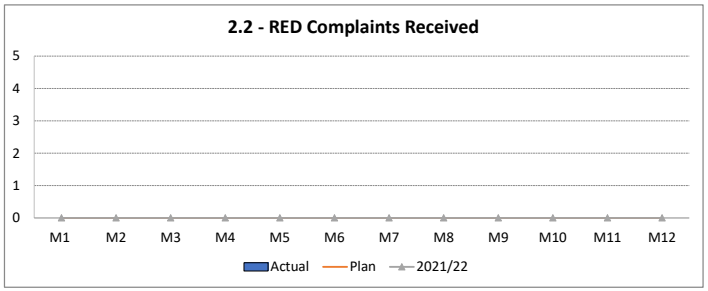
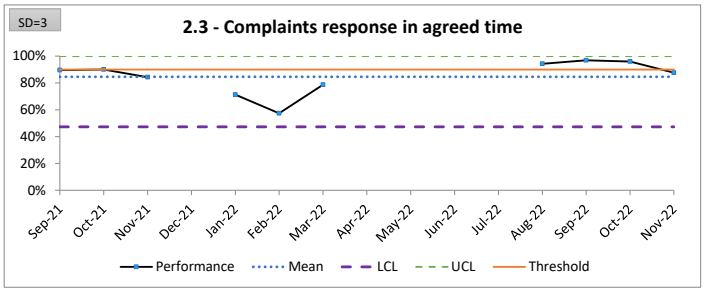
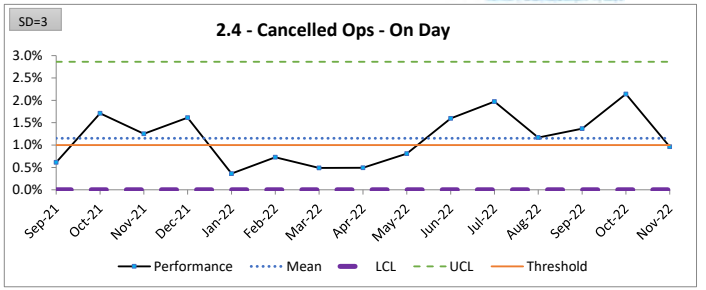
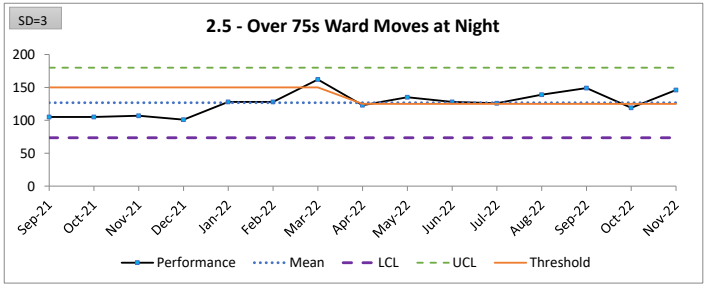
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

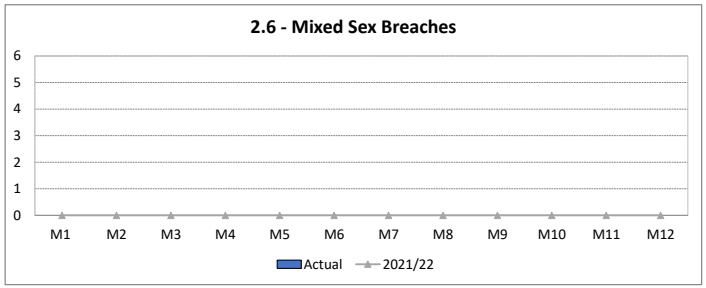
OBJECTIVE 2 - PATIENT EXPERIENCE











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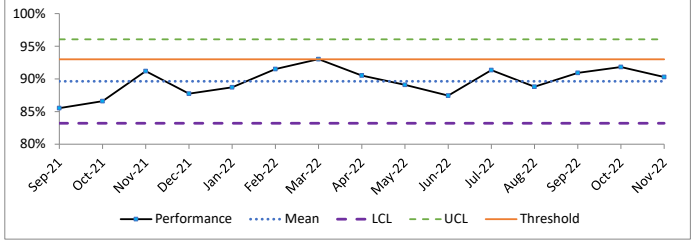
OBJECTIVE 3 - CLINICAL EFFECTIVENESS

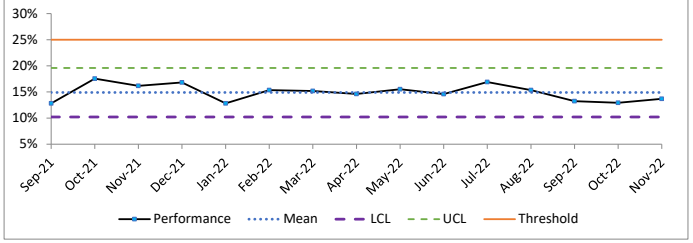
SD=3

3.1 - Overnight bed occupancy rate



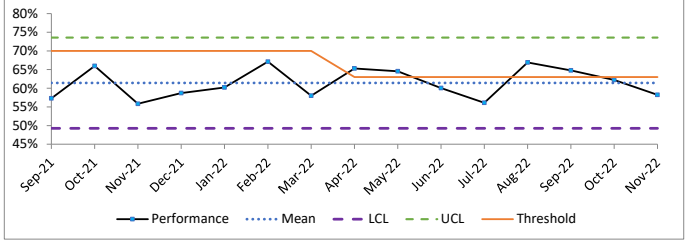
SD=3

3.2 - Ward Discharges by Midday



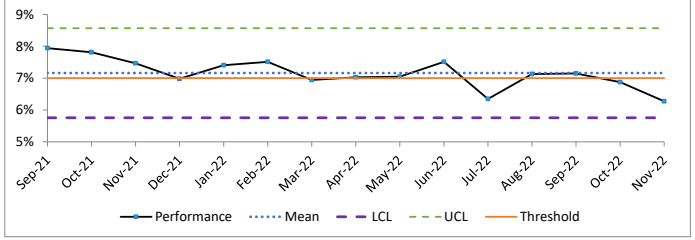
SD=3

3.3 - Weekend Discharges



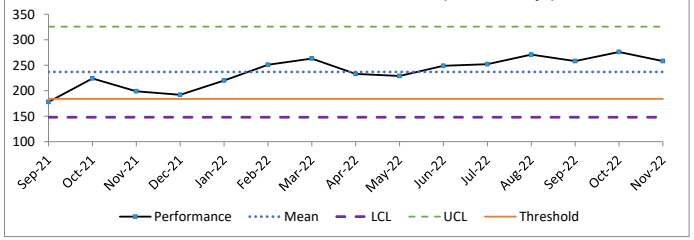
SD=3

3.4 - 30 Day Readmissions



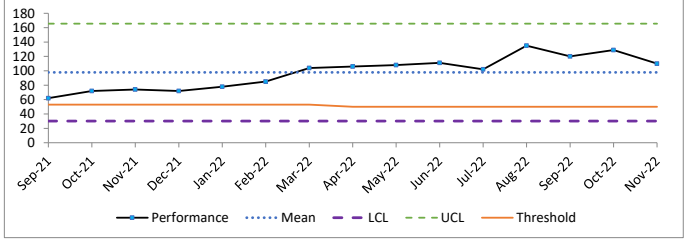
SD=3

3.6a Number of Stranded Patients (LOS>=7 Days)



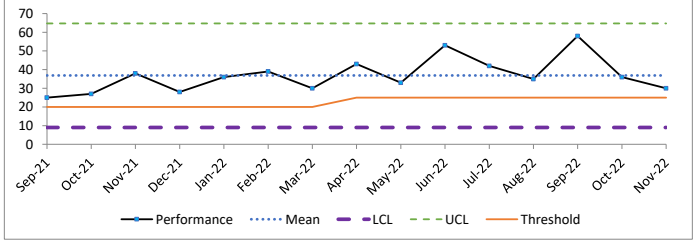
SD=3

3.6b Number of Super Stranded Patients (LOS>=21 Days)



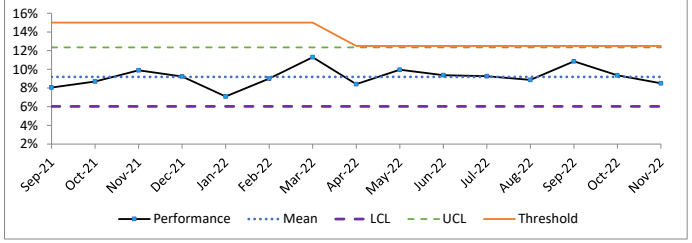
SD=3

3.7 - Delayed Transfers of Care



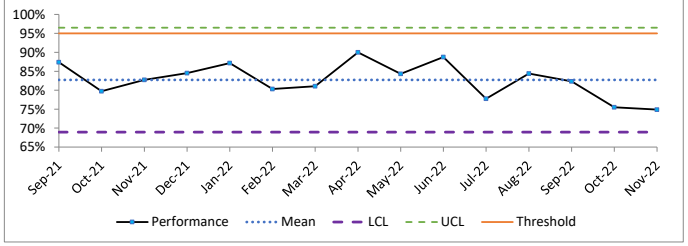
SD=3

3.8 - Discharges from PDU (%)



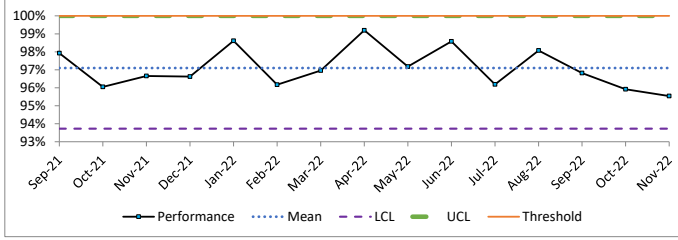
SD=3

3.9a - Ambulance Handover < 30 mins(%)



SD=3

3.9b - Ambulance Handover < 60 mins(%)



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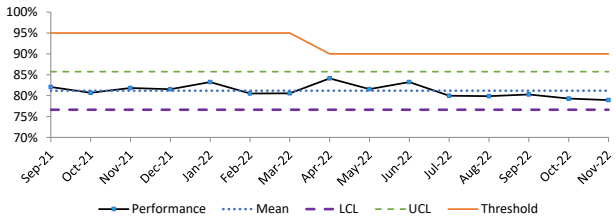
OBJECTIVE 4 - KEY TARGETS

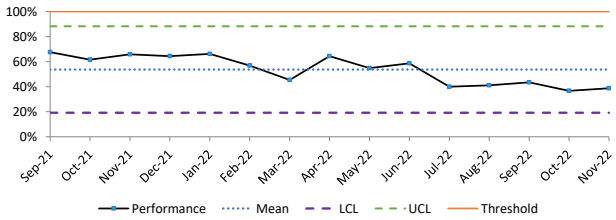
SD=3

4.1a - ED Hour Target (includes UCS)



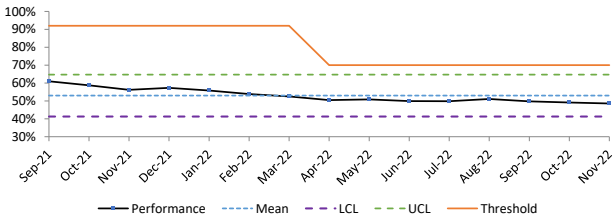
SD=3

4.1b - Total time in ED no more than 8 hours (Admitted)

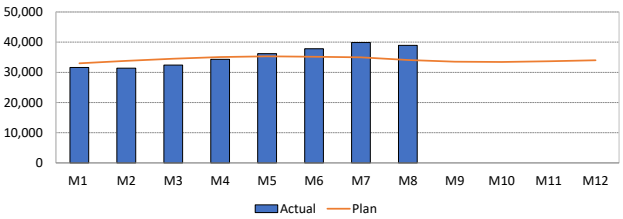


SD=3

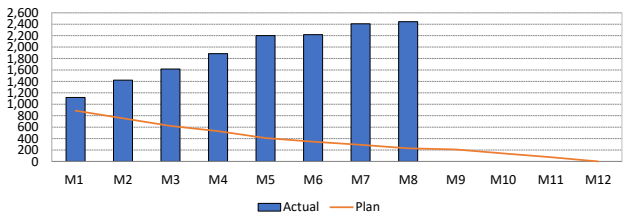
4.2 - RTT Incomplete Pathways <18 weeks



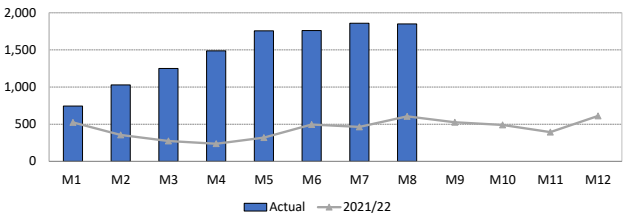
4.4 - RTT Total Open Pathways



4.5a - RTT Patients Waiting Over 52 weeks (Total)

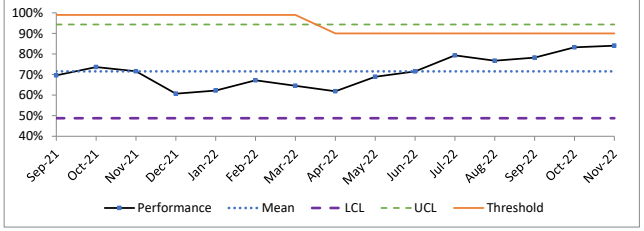


4.5b - RTT Patients Waiting Over 52 weeks (Non-Admitted)



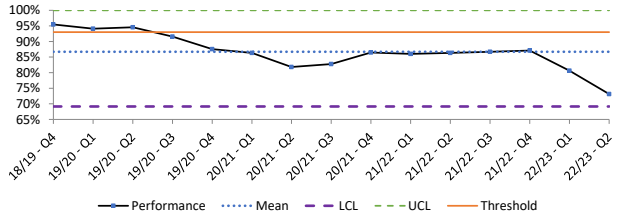
SD=3

4.6 - Diagnostic Waits < 6 weeks



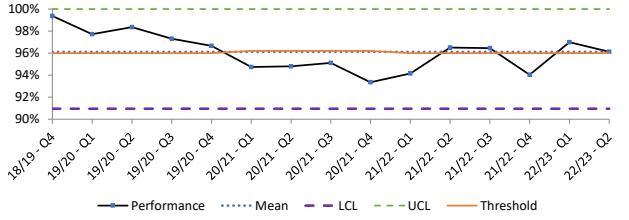
SD=3

4.7 - 2 Week Wait - Cancer



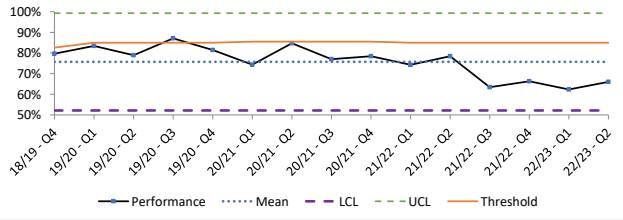
SD=3

4.8 - 31 day diagnosis to treatment - Cancer



SD=3

4.9 - 62 day standard - Cancer



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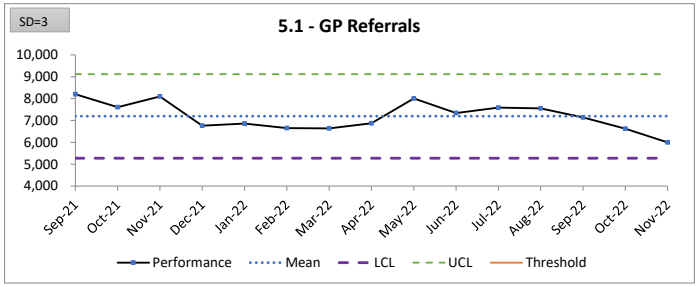
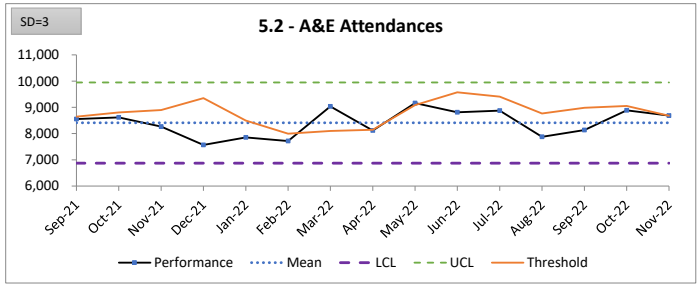
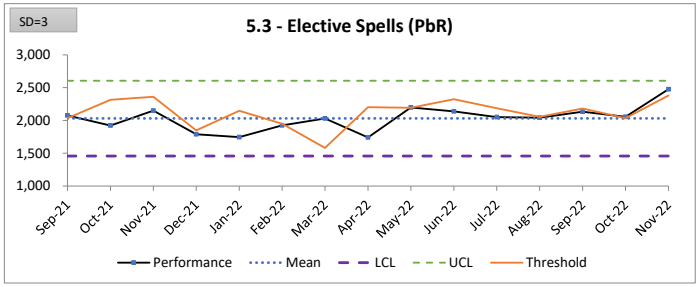
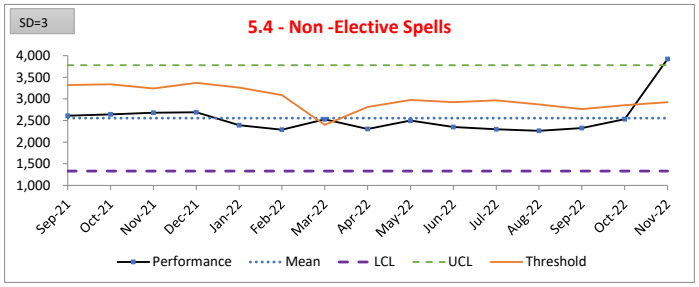
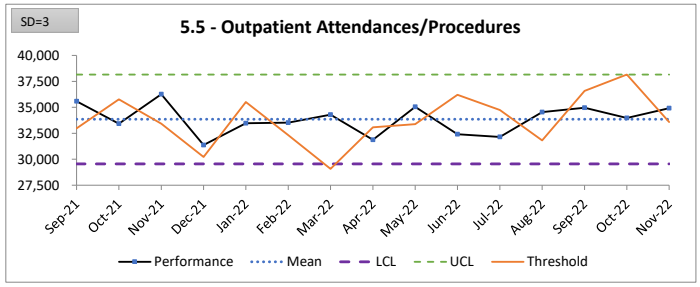
OBJECTIVE 5 - SUSTAINABILITY

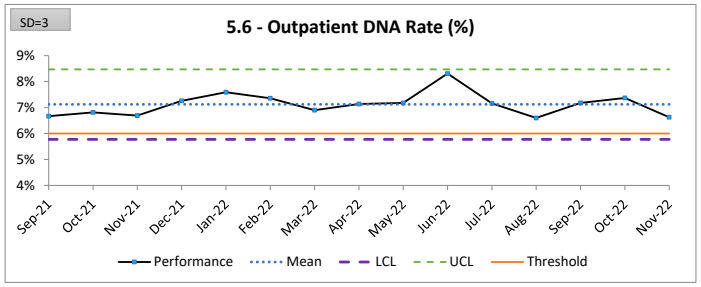












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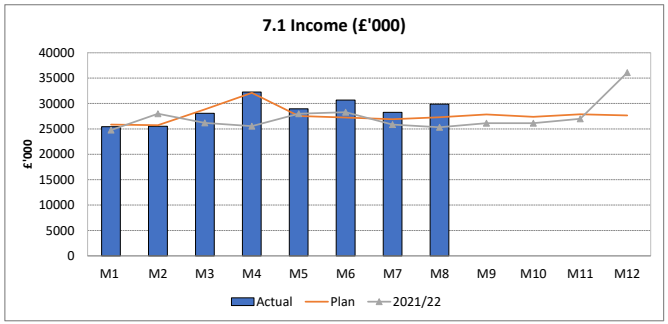
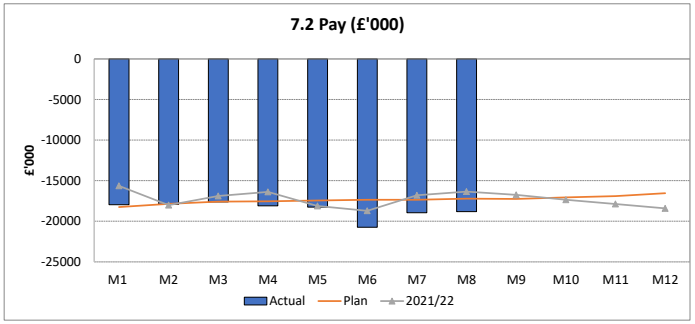
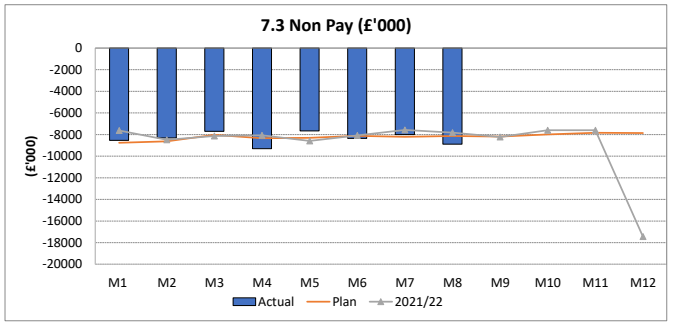
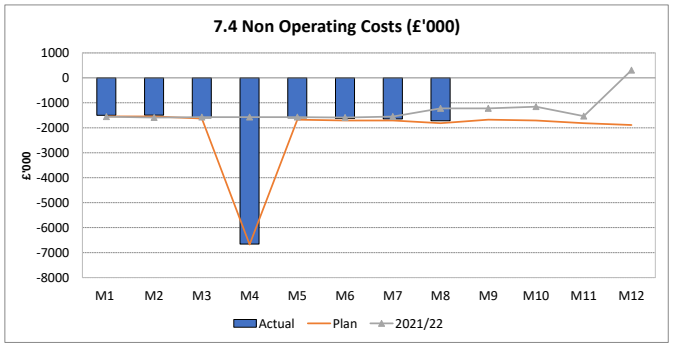
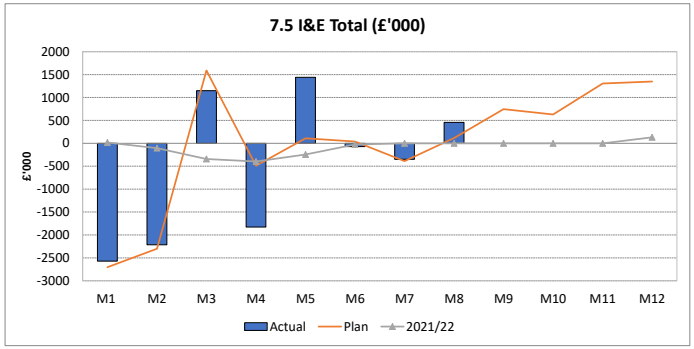
OBJECTIVE 7 - FINANCIAL PERFORMANCE

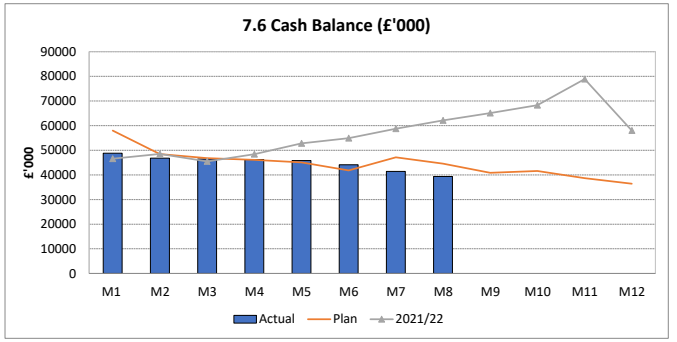


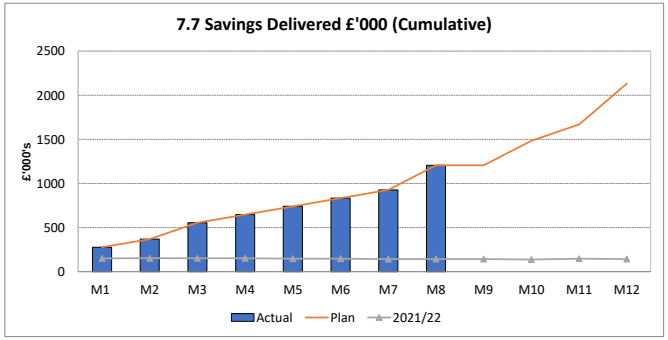


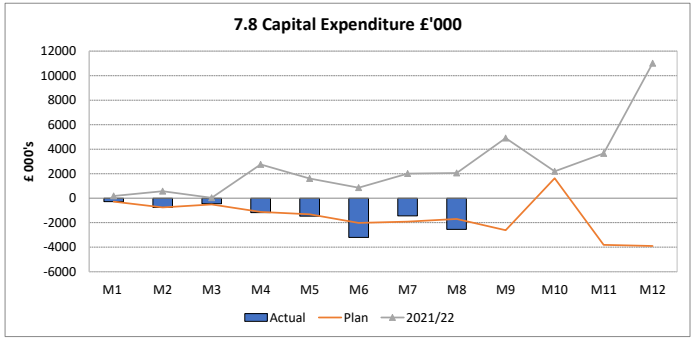




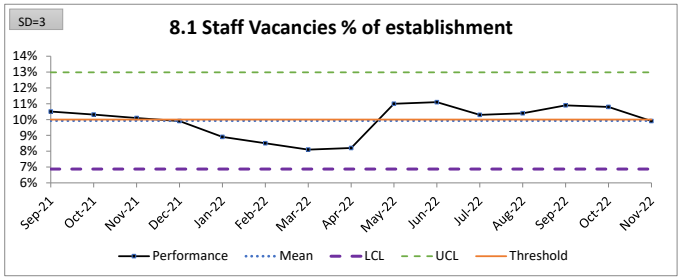


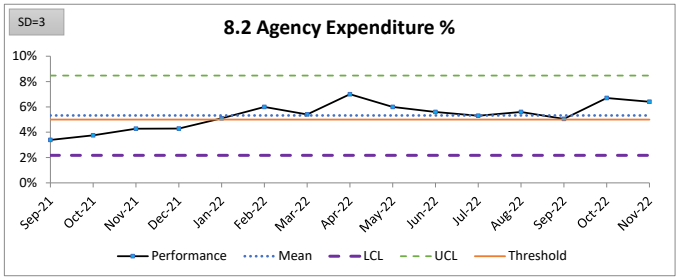


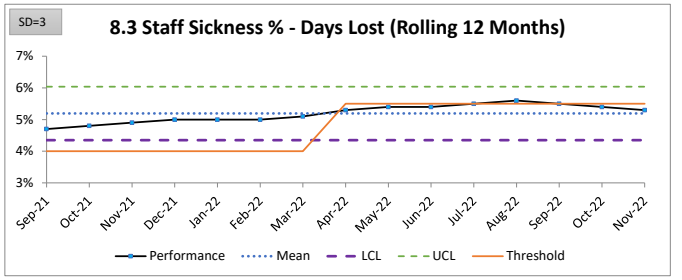


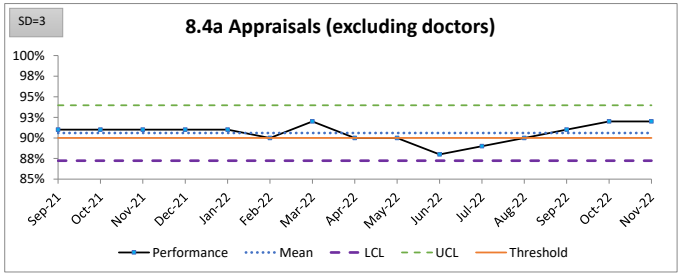


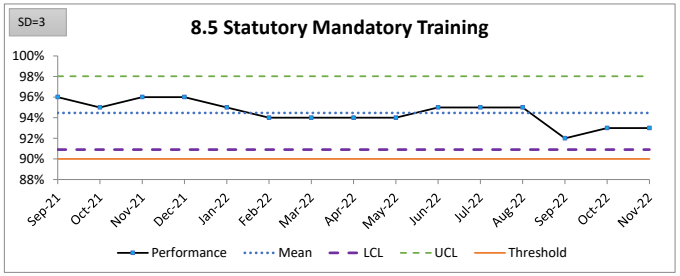
OBJECTIVE 8 - WORKFORCE PERFORMANCE

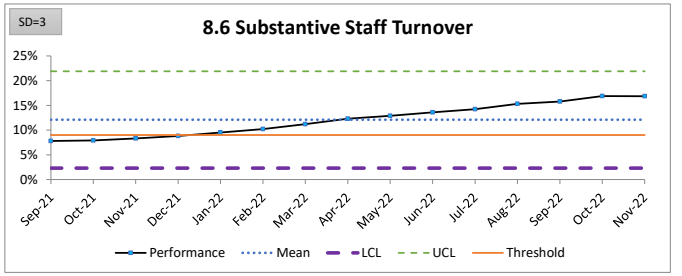






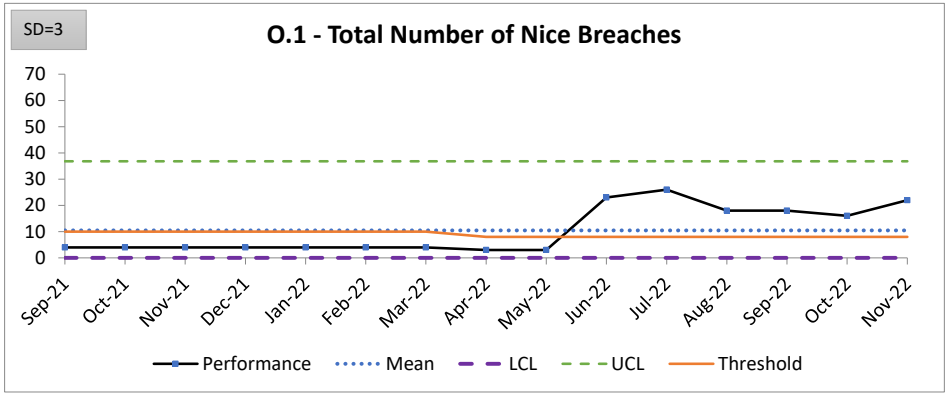


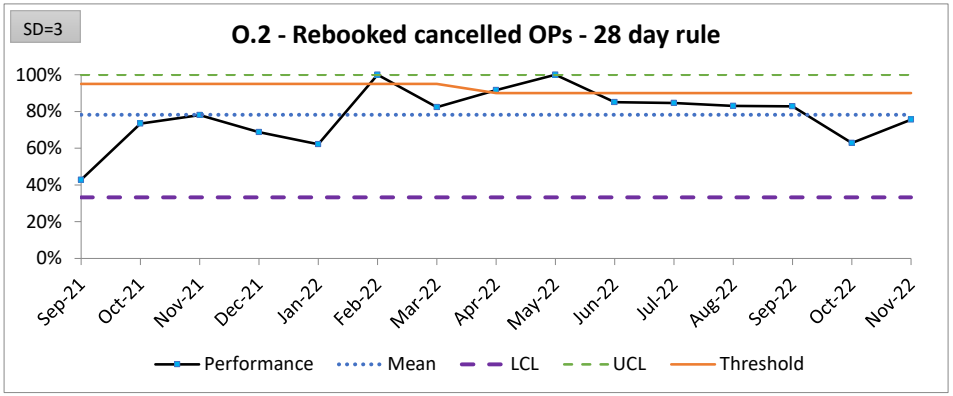


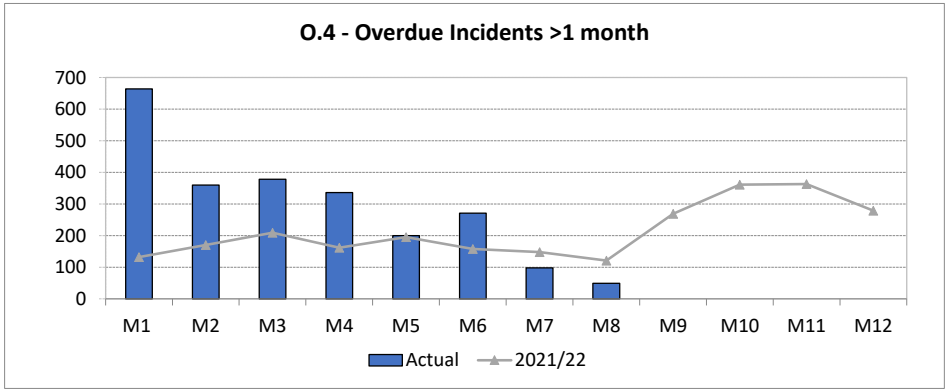


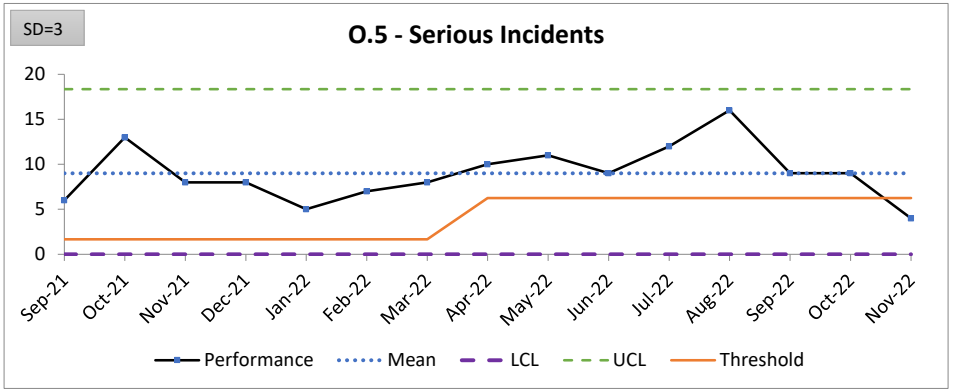
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

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









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

Reference	Description	Impact of risk	Scope	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-035	IF there is a high turnover of staff due to: work pressure, not having the opportunity to work at the top of their licence, lack of capacity for development, lack of capacity for supervision / support. Also difficulty in recruiting. Loss of staff to primary care which offers more attractive working hours. THEN there will be insufficient staff in pharmacy to meet demands of the organisation and ensure patient safety in the use of medicines.	LEADING TO: 1. increased length of stay due to TTO delay 2. increase in prescribing errors not corrected 3. increase in dispensing errors 4. increase in missed doses 5. failure to meet legal requirements for safe and secure use of medicines 6. harm to the patients 7. adverse impact on mental health of Pharmacy staff All resulting in adverse patient outcomes. Lack of financial control on medicines expenditure Breach of CQC regulations	Organisation	Helen Chadwick	30-Sep-2022	31-Dec-2022	Planned	20	20	6	Actively recruiting staff (30-Sep-2022)	Business Case for additional staff(05-Apr-2022), Temporary role realignment towards patient facing roles(05-Apr-2022), Use of Agency Staff(05-Apr-2022), Prioritisation of wards(28-Jun-2022)	Low	Treat	Business Case has been submitted, due for review Q1 2022/23
RSK-158	IF the escalation beds are open across the medical and surgical divisions THEN the additional patients that will need to be seen will put additional demand on the Inpatient Therapy Services to manage and support patient flow during periods of significant pressure. In particular the provision of OT services.	LEADING TO: Increased demand on occupational therapy and physiotherapy staff. Patients are likely to decondition if the demand is too high for the therapy staff to manage. Staff morale will reduce as they will not be providing the appropriate level of assessment and treatment to their patients. Length of stay may increase as patients will not be seen in line with care plans due to prioritising discharges. Delays to the ordering of equipment which can impact on discharge. High volume of patients not being seen daily, only new assessments, discharges and acute chests being reviewed. Most patients only being seen twice a week for rehabilitation which will not maintain the patient's level of function.	Organisation	Adam Baddeley	28-Nov-2022	06-Jan-2023	Planned	16	20	6	Closure or Reduction in Escalation Beds (23-Nov-2022)	Therapy staff attend board rounds and work with the MDT to determine priority patients. The skills mix and workforce is reviewed twice weekly between Occupational Therapy and Physiotherapy to determine cover for the base wards. To work closely with community services to raise awareness and to increase discharge opportunities i.e. in reaching Therapies working with Long stay Tuesday initiative Therapies supporting new discharge pathway/process in the Trust Over recruitment of PT and OT band 5's Locum cover for vacant posts. Daily attendance at 10.30 system wide discharge call. Inpatient Therapy Service participation in MADE events. Review of staffing model across inpatient medical and frailty wards.(12-Nov-2021)	Low	Treat	Risk reviewed at Therapies CIG - No change to risk
RSK-159	IF patients referred to the Occupational Therapy and Physiotherapy inpatient services covering medical and surgical wards are not being seen in a timely manner THEN there will be a delay in these patients being assessed, treated and discharged.	LEADING TO deconditioning of vulnerable/complex patients requiring a short period of therapy; increased length of stay; potential readmission, increased demand for packages of care requiring double handed provision. patient experience and long term quality of life will also be impacted as patients are being discharged as more dependent on care.	Organisation	Adam Baddeley	28-Nov-2022	06-Jan-2023	Planned	20	20	6	Review of Governance Structure (18-Oct-2022), Review Model of Care (28-Nov-2022), Review Equity Tool - Safe Staffing (28-Nov-2022), Review Workforce Model and Structure (28-Nov-2022), Recruitment and Retention of staff (18-Oct-2022)	Daily prioritisation of patients cross covering and review of skill mix locum cover x1 OT and x1 PT in place Ward book for escalation wards setup and band 7 reviews the caseload on the ward daily Monday- Friday and requests the most urgent are reviewed. Recruitment process ongoing but vacancies have reduced slightly. Over recruitment of band 5 OT and PT roles. Non-recurrent funding application for increase in therapy assistants over winter months.(12-Nov-2021), Education and Training of staff(19-Apr-2022)	Low	Treat	Risk reviewed at Therapies CIG - No change to risk
RSK-248	IF the core IT network fails (due to its age) THEN at least half of the IT network (if not all of it) will fail and IT will stop working for all devices,	LEADING TO an inability to access key systems such as eCARE, imaging, pathology, HSDU, plus many more	Organisation	Craig York	07-Sep-2022	31-Jan-2023	Planned	20	20	5	Replacement procured, implementation planned (16-Feb-2022)		Low	Treat	Risk likelihood increased due to recent WiFi issues believed to be linked to lack of CORE replacement.
RSK-341	IF there is a delay with imaging reporting for CT and MRI for patients on cancer pathways THEN there could be a delay with diagnosis and the commencement of treatment	LEADING TO potential increase in the required treatment, potential poorer prognosis for patient, poor patient experience, increase in complaints and litigation cases.	Organisation	Paula Robinson	06-Sep-2022	21-Feb-2023	Planned	20	20	8	2x Specialist Doctors appointed on a fixed-term basis to uplift internal reporting capacity (14-Jun-2022), Specialist Radiology to be recruited to uplift reporting capacity, Explore alternative outsourcing for some specialist areas (e.g. lung), Imaging Business Case for substantive Radiologists and Radiographers	PTL tracking to escalate to imaging leads(18-May-2022), Agency Locum Consultant appointed 2 days a week to uplift internal reporting capacity(14-Jun-2022), Temporary reduction in double reporting for Quality Assurance to increase real-time scan reporting(14-Jun-2022), Current Radiologists doing 30% over standard reporting levels(14-Jun-2022)	Low	Treat	Risk reviewed by Claire McGillycuddy. No change to risk - review again February 2023
RSK-001	IF all known incidents, accidents and near misses are not reported on the Trust's incident reporting system (Radar); THEN the Trust will be unable to robustly investigate all incidents and near-misses within the required timescales;	LEADING TO an inability to learn from incidents, accidents and near-misses, an inability to stop potentially preventable incidents occurring, potential failure to comply with Duty of Candour legislation requiring the Trust to report all known incidents where the severity was moderate or higher, potential under reporting to the Learning from Patient Safety Events (LfPSE) system, and potential failure to meet Trust Key Performance	Organisation	Tina Worth	24-Oct-2022	31-Dec-2022	Planned	20	16	12	Staff competence and confidence with Radar reporting, with improved reporting rate, reduction in inaccurate reports on system and/or failure of incidents being reported (24-Oct-2022)	Incident Reporting Policy(06-Sep-2021), Incident Reporting Mandatory/Induction Training(06-Sep-2021), Incident Reporting Training Guide and adhoc training as required. Radar to provide on site & bespoke training IT drop in hub to be set up 2 days a week for staff drop ins(06-Sep-2021), Datix Incident Investigation Training sessions(06-Sep-2021), Daily review of incidents by Risk Management Team to identify potential Serious Incidents and appropriate escalation(06-Sep-2021), Serious Incident Review Group (SIRG) ensure quality of Serious Incident Investigations(06-Sep-2021), SIRG ensure appropriate reporting of Serious Incidents to Commissioners(06-Sep-2021), Standard Operating Procedure re Risk & Governance Team supporting the closure of incident investigations during unprecedented demand on service(06-Sep-2021), Implementation of new Risk Management Software to make incidents easier to report and improve engagement with staff(06-Sep-2021)	Low	Treat	Risk unchanged.

Reference	Description	Impact of risk	Scope	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-036	If there is no capacity in the Pharmacy Team THEN there is a risk that Pharmacy and Medicines Policies and Procedures may not be reviewed and updated in a timely manner, nor new policies developed	Leading to: Potential for Policies & Procedures to be out of date Potential for staff to follow out of date Policies & Procedures Failure to meet CQC requirements Lack of guidance for staff Potential harm to patients	Organisation	Helen Chadwick	19-Dec-2022	31-Mar-2023	Planned	16	16	6	Recruitment of staff (28-Sep-2022)	Use of remote bank staff to update policies(28-Sep-2021), Business Case for additional Pharmacy staff(19-Apr-2022)	Low	Treat	Risk reviewed by Jill McDonald: The control of the pharmacy related risk remains dependent on staff recruitment. We are out to advert across all grades of pharmacist at present with some success however a number of posts will need readvertised. I do not expect the current recruitment to have a major impact for at least 3 months. Claire McGillycuddy requested review date is in 4 months
RSK-115	IF annual and quarterly test reports for Autoclaves and Washer Disinfectors used for critical processes are not being received in a timely manner from the Estates department and there is no Authorised Person (D) to maintain the day to day operational aspects of the role THEN the Trust will be unable to prove control, monitoring and validation of the sterilisation process as a control measure. Both units are reviewed only 1 day per month - a bulk of this time is spent checking records and the other aspects of the role do not get the sufficient time required to review and follow up.	LEADING TO possible loss of ISO 13485 accreditation due to non-compliance to national standards. Inconsistent checks or lack of scheduled tests for the steam plant also increase the risk.	Organisation	Mark Brown	21-Sep-2022	30-Dec-2022	Planned	20	16	9	A meeting took place in January with estates managers, where HSDU were seeking assurance that the service would be covered. Estates have agreed to look for a plan to mitigate the risk and to keep HSDU fully informed. HSDU have informed the AE(D), so he is now aware that the site will not have any day to day operational AP(D) cover. (10-Jun-2022)	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 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.(29-Oct-2021)	Low	Treat	Reviewed by Mark Brown, no change to current risk rating
RSK-126	IF cot spacing in the Neonatal Unit does not comply with BAPM guidance or the latest PHE guidance for COVID-19 (the Unit is seeking to increase both total cot spacing and cot numbers by 4 HDU/ITU cots in line with Network 5 year projections of acuity and demand, and spacing in line with National Recommendations) THEN there will be overcrowding and insufficient space in the Neonatal Unit, exacerbated by need for social distancing due to COVID-19. The milk kitchen was condemned due to this	LEADING TO an inability to meet patient needs or network requirements. We will now also be unable to meet PHE recommendations for social distancing This may result in a removal of Level 2 status if we continue to have insufficient space to adequately fulfil our Network responsibilities and deliver care in line with national requirements. This may also impact on our ability to protect babies and their families during COVID	Organisation	Zuzanna Gawlowski	20-Dec-2022	20-Mar-2023	Planned	25	16	9	Business Case for Refurnishing Milk Kitchen and Sluice	Reconfiguration of cots to create more space and extra cots and capacity, though this still does not meet PHE or national standards(04-Nov-2021), Parents asked to leave NNU during interventional procedures, ward rounds etc. Restricted visiting during COVID(04-Nov-2021), Added to capital plan(04-Nov-2021), Feasibility study completed(04-Nov-2021)	Low	Treat	Risk reviewed by triumvirate ,No change to risk or risk scoring
RSK-134	If the future NHS funding regime is not sufficient to cover the costs of the Trust THEN the Trust will be unable to meet its financial performance obligations or achieve financial sustainability and there may be an increase in operational expenditure in order to manage elective recovery	LEADING TO increase in efficiency requirement from NHS funding regime to support DHSC budget affordability.	Organisation	Karan Hotchkin	14-Dec-2022	16-Jan-2023	Planned	20	16	8	The current funding has now been clarified .The trust will work with BLMK system partners during the year to review overall BLMK performance, The risk for the current year can be managed but the underlying position going forward is uncertain due to lack of clarity on the medium term funding post March 2023	Cost and volume contracts replaced with block contracts (set nationally) for clinical income(04-Nov-2021), Top-up payments available where COVID-19 leads to additional costs over and above block sum amounts (until end of March 2022)(04-Nov-2021), Budgets to be reset for FY22 based on financial regime; financial controls and oversight to be reintroduced to manage financial performance(04-Nov-2021), Cost efficiency programme to be reset to target focus on areas of greatest opportunity to deliver(04-Nov-2021)	High	Treat	Risk transferred from Datix
RSK-142	IF there is insufficient capacity and ongoing unsustainable demand for dietetic input for Paediatric patients (both inpatient and outpatient) . IF Home Enterally Fed Paediatrics patients continue to be seen our outpatient structure which is not adequate to meet their demands and needs (rather than the community contract). This means that these high risk groups of Children and Young People are not accessing the necessary specialist nutritional support at the appropriate time in their development THEN staff may be unable to cover a service that has not been serviced correctly, and the paediatric team cannot provide a full dietetic service to children and young people in the Milton Keynes area	LEADING TO patient care and patient safety may be at risk, vulnerable children may become nutritionally compromised, the service may be unable to assess and advise new patients and review existing patients in a timely manner, and there may be an impact on patients nutritional status and longer term dietary management on what is a very vulnerable group of patients. The majority of our caseload is infants or tube fed infants and children where there nutrition and growth is a priority.	Organisation	Elizabeth Pryke	25-Nov-2022	31-Jan-2023	Planned	15	16	3		Existing staff are working some additional hours but this remains insufficient to meet the needs of the service(04-Nov-2021)	Low	Treat	Increasing caseload of patients on HEF's, becoming more complex and therefore clinics are needing to be overbooked to accommodate patients' safe care. Contacted Beccy White (Head of Comm & Transformation, BLMK ICB) to discuss lack of commissioned service.
RSK-202	IF Transformation delivery is not adequately resourced and prioritised and/or schemes are unrealistic and not well planned THEN There is a risk that the Trust is unable to achieve the required efficiency improvements through the transformation programme	LEADING TO the Trust potentially not delivering its financial targets leading to TO potential cash shortfall and non-delivery of its key targets	Organisation	Karan Hotchkin	14-Dec-2022	16-Jan-2023	Planned	20	16	9	Divisional CIP review meetings in place attended by the DoF, divisional managers and finance business partner. There are no cross-cutting transformation schemes yet identified and savings of around £8m have been identified against the £12m target. Whilst this shortfall can be mitigated this year, the risk is around the underlying financial position.	Divisional CIP review meetings in place attended by the DoF, divisional managers and finance business partners(23-Nov-2021), Cross-cutting transformation schemes are being worked up(23-Nov-2021), Savings plan for 21/22 financial year not yet fully identified(23-Nov-2021)	Medium	Treat	Risk transferred from Datix
RSK-305	If there is insufficient strategic capital funding available THEN the Trust will be unable to invest in the site to maintain pace with the growth of the Milton Keynes population's demand for hospital services	LEADING To financial loss and reputational damage	Organisation	Karan Hotchkin	14-Dec-2022	16-Jan-2023	Planned	16	16	9	Trust is discussing this with the regional Capital Team and with the ICB capital allocations for 23/24. 22/23 allocations are manageable	The trust has a process to target investment of available capital finance to manage risk and safety across the hospital(06-Dec-2021)	Medium	Treat	Risk was approved by Finance and Investment committee on 30/12/2021

Reference	Description	Impact of risk	Scope	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-203	IF the are negative impacts on the supply chain following the rising fuel costs and the conflict in Ukraine THEN there is a risk that the supply of key clinical products may be disrupted	LEADING TO some unavailabilty of clinical products, delays to deliveries and services may be disrupted or reduce resulting in impact on patient care	Organisation	Lisa Johnston	14-Dec-2022	16-Jan-2023	Planned	16	15	6		Trust's top suppliers have been reviewed and issues with supply under constant review(23-Nov-2021), Procurement business partners use the NHS Spend Comparison Site and local knowledge supported by the clinical procurement nurse to source alternative products(23-Nov-2021), Clinical Procurement nurse to join the NHSI/E Supply Resilience Forum(15-Aug-2022), Clinical Procurement nurse is part of the NHSI/E Supply Resilience Forum created in August 2022.Trust's top suppliers have been reviewed and issues with supply under constant review, Procurement business partners use the NHS Spend Comparison Site and local knowledge supported by the clinical procurement nurse to source alternative products(16-Nov-2022)	Medium	Treat	Still ongoing risk
RSK-250	IF staff across MKUH continue to use eCARE in the same way, that the volumes of requests made to the IT Department remain at their current rate, and the volume of change and project work continues at the current volume THEN the IT Department will become less responsive and a range of functions within eCARE will continue to be left without action	LEADING TO increased clinical risk, increased risk to performance of eCARE, potential disruption to staff, and delays in the deliver or projects and realising their benefits	Organisation	Craig York	07-Sep-2022	31-Jan-2023	Planned	15	15	3	Prioritisation of workload is in place to cover the most impacting of issues or projects, however this only reduces the potential impact slightly		Low	Treat	Volume of work is increasing month on month without additional staff to support.
RSK-002	IF recommendations and actions from audit are not evidenced, monitored and completed in the Trust; THEN required changes to practice may not implemented and we may not be meeting best practice criteria;	LEADING TO potential impact on the top 3 Trust objectives (patient Safety, Clinical Effectiveness, Patient Experience), potential poor quality of service and associated impact on resources and potential CQC concerns re audit activity and learning from national audits	Organisation	Tina Worth	20-Dec-2022	31-Dec-2022	Planned	15	12	3	Scheduled implementation of Radar audit module (07-Dec-2022)	Audit report templates available to identify audit action plans(06-Sep-2021), Monitoring via Clinical Audit & Effectiveness Committee (CAEB)(06-Sep-2021), Terms of Reference (ToR) for Clinical Audit & Effectiveness Board revised to include quality improvement, GIRFT etc(06-Sep-2021), Escalation/exception reporting to Management Board(06-Sep-2021), Refresh of SharePoint data base to assist with data capture, with Level 1 audit a priority(06-Sep-2021), Structure review - Staff realignment to support audit agenda(06-Sep-2021), Pilot of new governance approach to reports/CIG meetings(06-Sep-2021)	Low	Treat	Risk unchanged. Awaiting audit module on radar QI lead supporting audit however resilience on clinical sharing of information/presentations
RSK-003	IF existing Radar governance system does not support meeting Trust/legal/stakeholder requirements and are unsupported by the Trust IT department or an external IT provider; THEN the Trust is unable to meet statutory and mandatory Good Governance requirements and accreditations;	LEADING TO potential delays in care, inappropriate/incorrect/sub-optimal treatment; potential increase in incidents, complaints and claims; reduced CQC rating and potential enforcement actions	Organisation	Tina Worth	24-Oct-2022	31-Dec-2022	Planned	25	12	4	Implementation of Radar Documentation Module (20-Oct-2022), Implementation of Radar Audit Module (07-Dec-2022)	SharePoint and Q-Pulse in place(06-Sep-2021), Scheduled implementation of new system Radar(06-Sep-2021)	Low	Treat	Risk unchanged
RSK-008	IF the Trust does not have an appropriate system to record mortality and morbidity data; THEN the Trust will not be able to record and/or provide accurate reports for governance or the Trust Board	LEADING TO non-compliance with the National Mortality & Morbidity 'Learning from Death' Framework	Organisation	Nikolaos Makris	24-Oct-2022	31-Dec-2022	Planned	15	12	6		Governance Team putting forward deaths for Structured Judgement Reviews (SJRs) based on previously agreed clinical criteria e.g. sepsis related(06-Sep-2021), Learning from Deaths policy as a tool to indicate required processes and cases that require review(06-Sep-2021), Implementation of the new system - CORs(06-Sep-2021), M&M review meetings on a regular basis with all required SJRs completed(01-Apr-2022)	Medium	Treat	Risk reassigned to Associate Medical Director responsible for M&M
RSK-016	IF there is a lack of flow in the organisation THEN there may be an unsafe environment for patients	LEADING TO a potentially impact on bed space capacity, ambulance queues, missed Emergency Access Targets and overcrowding into ED/radiology corridors creating Health & Safety hazard and continued pressure, leading to poor patient care/treatment and delays in discharge/transfer and the potential for an increase of incidents being reported regarding assessment/care/treatment, and or significant number of patients with a high acuity/ dependency being cared for in areas that are not suitable for safe care	Organisation	Mahamayago dage Dias	09-Nov-2022	31-Dec-2022	Pending	25	12	9	Recruitment drive for more nurses/HCA's ongoing. Active management of Nursing/Consultant and Registrar gaps in rota daily to ensure filled. (06-Jun-2022), Walking majors and resus reconfigured. Expanded Cubicle space in Majors - extra 10 spaces, increased capacity using Acorn Suite., Internal escalation policy in place. CSU lead developing trust escalation criteria to alert trust leads to problems sooner - diverting patients to; Ambulatory care, Since Covid pandemic, phasing plan in place with red and green zones within ED., Escalation plan for ED to mitigate patient pressures	EPIC consultant in place to aid flow within department and speed up decision making(22-Sep-2021), RAT-ing process and specialty referrals having a RAG system developed to prioritise sickest patients to be assessed.(22-Sep-2021)	Low	Treat	Risk reviewed at ED CSU. Risk Assessment being updated.
RSK-093	IF there is insufficient staffing within the dietetics department in paediatrics THEN they will be unable to assess and advise new patients and review existing patients in a timely manner.	LEADING TO an impact on patients nutritional status and longer term dietary management on what is a very vulnerable group of patients. The majority of our caseload is infants or tube fed infants and children where there nutrition and growth is a priority	Organisation	Elizabeth Pryke	25-Nov-2022	31-Jan-2023	Planned	16	12	8		1. Dietetic manager has been given approval to source a band 6 experienced locum paediatric dietitian to provide cover.(22-Oct-2021), 2. As a back up plan, a band 5 basic grade dietitian is also being sourced from the locum agency, with the expectation that senior dietetic staff can cover the complex paediatric cases.(22-Oct-2021), 2 new starters to join the team in the next few weeks will start to increase paediatric dietetic provision - to review waiting list once new starters in post(19-Apr-2022), Paediatric Dietetic Assistant Practitioner appointed - to start on 9.5.22, after induction will help to reduce risk(29-Apr-2022)	Low	Treat	Locum paediatric dietitian started, doing virtual clinics - 3 days / week. In January team should be nearly fully staffed as B7 returns from mat leave.

Reference	Description	Impact of risk	Scope	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-211	IF infection / colonisation with pseudomonas aeruginosa from contaminated water occurs within the Cancer Centre THEN there is a risk of infection and complications this could cause to immuno-suppressed cancer patients. Mitigations in place to avoid risk to patients and staff in Cancer Centre	LEADING TO susceptible patients within augmented care units such as Ward 25 and chemotherapy Suite potentially coming to harm	Organisation	Angela Legate	25-Oct-2022	30-Dec-2022	Planned	16	12	8		For direct contact with patients water where testing has shown absence of P.aeruginosa(23-Nov-2021), For direct contact with patients water supplied through a point of use (POU) filter(23-Nov-2021), For direct contact with patients sterile water (for wound washing if required)(23-Nov-2021), Signs at all taps alerting people to refrain from drinking or brushing teeth with water(23-Nov-2021), Bottled water available(23-Nov-2021), Correct installation and commissioning of water systems in line with HTM 04-01 is adhered to. Schematic drawings are available for water systems(23-Nov-2021), Flushing of water outlets is carried out daily and documented (07:00 – 09:00 HCA)(23-Nov-2021), Plans for sampling and microbiological testing of water is in place(23-Nov-2021)	Low	Treat	Risk reviewed by Angie Legate. No change to risk, review again in 2 months
RSK-230	IF a major incident was to occur requiring the trust to respond above service levels THEN there could be an impact to normal service. Eg/elective and inpatient care.	LEADING TO changes in routine working processes and procedures across the Trust for the duration of the major incident response and recovery phases.	Organisation	Adam Biggs	07-Nov-2022	07-May-2023	Planned	16	12	8		Major incident response plan (IRP)(25-Nov-2021), Action Cards have been removed from the Major Incident Response Plan and are held as a separate annex(25-Nov-2021), CBRN arrangements outlined within the IRP(25-Nov-2021), Mass casualty response outlined within the IRP(25-Nov-2021), Regional casualty dispersal process in place(25-Nov-2021), Local resilience Forum working group meetings attended, with tactical and strategic levels represented by CCG and NHSE&I(25-Nov-2021), Training and Exercise programme in place to ensure the Trust meets national best practice and statutory obligations(25-Nov-2021), EPRR annual work plan in place and agreed with Accountable Emergency Officer (AEO) that is scrutinised and reviewed through the Emergency Planning Steering Committee on a quarterly basis attended by senior and key staff(25-Nov-2021), Annual NHSE&I EPRR Core Standards review conducted by BLMK CCG to ensure MKUH is meeting its statutory obligations, with internal report sent to Managing Board and Trust Public Board for sign-off(25-Nov-2021)	Low	Treat	No change to current risk as this will remain an open risk
RSK-232	IF there is an extreme prolonged weather conditions (heat/cold) THEN there is potential for wards/departments to be unable to maintain/provide effective service provision at required standards during prolonged extreme weather conditions	LEADING TO Service disruption/delays, Staff health & wellbeing, Patient safety, Adverse media publicity Breaches of Health & Safety at Work Act, Management of Health & Safety at Work Regulations, Workplace Health, Safety & Welfare Regulations	Organisation	Adam Biggs	07-Nov-2022	16-Apr-2023	Planned	12	12	12		Business continuity plans in some areas(25-Nov-2021), Heat wave plan(25-Nov-2021), Extreme weather policy(25-Nov-2021), Cold Weather Plan(25-Nov-2021)	Low	Tolerate	No change to risk rating
RSK-254	If Nursing staff accidently select the incorrect prescription chart within eCARE THEN patients could receive medication which is prescribed for another patient.	LEADING TO potential harm to patients	Organisation	Craig York	07-Sep-2022	31-Jan-2023	Planned	12	12	9		eCARE alert if mismatch between wrist band & electronic drug chart. Correct workflow taught in eCARE training. Monthly scanning compliance report(26-Nov-2021)	Low	Treat	No progress made on mitigations since last review.
RSK-256	IF the current server version for the Pathology ICE system is outdated. THEN the server is vulnerable, and a potential Cyber attack target.	LEADING TO negative impact on patient care. Should the system fail completely, with no further support offered from CliniSys.	Organisation	Craig York	14-Sep-2022	31-Jan-2023	Planned	15	12	2	Testing under way with Pathology, Test issues raised and resolution activity taking place	Hardware migrated(26-Nov-2021)	Medium	Treat	Upgrade has not taken place yet. The project to complete the upgrade is starting up shortly.
RSK-259	If the Clinical Engineering and Medical Equipment Library Teams are unable to access the Medical Equipment Asset Management Database THEN they will not be able record PPMs, repairs, loans, report on assets for training logs and associated tasks and provide KPI reports in compliance with MHRA standards and as per the CQC guidelines – Regulation 15 Premises and Equipment. and be compliant	LEADING TO potential impact to clinical safety	Organisation	Ayca Ahmed	14-Dec-2022	31-Mar-2023	Planned	16	12	4	Full implementation of the new database (20-Oct-2022)	IT provided access to remote desktop to connect to the server directly(29-Nov-2021), Business Case approved, out to mini competition to market for alternative asset database(29-Nov-2021), Draeger (CE) has access to the FMFirst database(29-Nov-2021)	Low	Treat	Reviewed by Medical Devices Manager, no change to risk rating.

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RSK-262	IF the Trust Fire Dampers are not surveyed and remedial works funded THEN remedial work not being completed	LEADING TO the travel of fire between compartments causing risk to life, greater damage to the estate, poor public image and subsequent interventions from the Fire Brigade with potential enforcement notices.	Organisation	Michael Stark	21-Sep-2022	30-Dec-2022	Planned	20	12	8	Changed Theatre 5 Damper, remaining 6 faults to be replaced 2022/2023	A combination of fire door maintenance, fire alarm system, compartmentation inspections and remedials, fire damper inspections and remedials, automatically closing fire doors, emergency lighting, fire extinguishers and other elements of the fire strategy mitigates the reliance on any one component of fire safety(29-Nov-2021), Mandatory fire training(29-Nov-2021), Fire wardens(29-Nov-2021), Authorised Engineer (AE)appointed March 2020(29-Nov-2021), Annual inspections(29-Nov-2021), Funded annual remedial programme(29-Nov-2021), Site wide Damper annual audit, risk based approach to any remedials(29-Nov-2021), £10K of repair work ordered and new inspection(29-Nov-2021)	Low	Treat	No changes to current risk rating
RSK-263	IF the Trust Fire Compartmentation are not surveyed and remedial works funded THEN remedial work not being completed	LEADING TO the travel of fire between compartments causing risk to life, greater damage to the estate, poor public image and subsequent interventions from the Fire Brigade with potential enforcement notices	Organisation	Michael Stark	01-Jul-2022	30-Dec-2022	Planned	20	12	8	Outstanding items for last survey to be prioritised on risk basis	fire door maintenance, fire alarm system, compartmentation inspections and remedials, fire damper inspections and remedials, automatically closing fire doors, emergency lighting, fire extinguishers and other elements of the fire strategy mitigates the reliance on any one component of fire safety(29-Nov-2021), Mandatory fire training(29-Nov-2021), Fire wardens(29-Nov-2021), Annual Capital bids rolling program(29-Nov-2021), Annual audit regime in place(29-Nov-2021), Authorised Engineer (AE)appointment made March 2020(29-Nov-2021), Annual audit in place(29-Nov-2021), Annual Remedial programme in place, risk based priority(29-Nov-2021), Identified remedials were completed Jan 2021(29-Nov-2021), 21/22 programme approved at May 2021 Trust Exec Group(29-Nov-2021), Audit completed June 2021, included all plant room spaces(29-Nov-2021), 20% of Hospital streets audited annually on a rolling program(29-Nov-2021), Works identified including 140 fire doors to be fitted on electrical cupboards. Prioritisation on risk basis, Order for £10K placed with Nene Valley(29-Nov-2021)	Low	Treat	Reviewed risk owner and updated.
RSK-264	IF the Trust Fire Doors are not regularly surveyed and remedial works funded THEN remedial work not being completed	LEADING TO the travel of fire between compartments causing risk to life, greater damage to the estate, poor public image and subsequent interventions from the Fire Brigade with potential enforcement notices.	Organisation	Michael Stark	05-May-2022	29-Mar-2023	Planned	20	12	8		A combination of fire door maintenance, fire alarm system, compartmentation inspections and remedials, fire damper inspections and remedials, automatically closing fire doors, emergency lighting, fire extinguishers and other elements of the fire strategy mitigates the reliance on any one component of fire safety(29-Nov-2021), Mandatory fire training(29-Nov-2021), Fire wardens(29-Nov-2021), A new audit and prioritization has been established for 2019 onwards, with prioritised areas as discussed at Management Board July 2019(29-Nov-2021), Plant Room Doors surveyed(29-Nov-2021), Guaranteed Capital agreed brought service in house January 2020(29-Nov-2021), Authorised Engineer (AE)appointed March 2020(29-Nov-2021), Many Fire Doors have been replaced since Jan 2020 as part of the prioritisation programme(29-Nov-2021), Rolling programme with backlog to overcome issues(29-Nov-2021), 21/22 programme approved at May 2021 Trust Exec Group(29-Nov-2021), Reviews options for new AE, out to tender(29-Nov-2021)	Low	Treat	Reviewed risk owner and updated.

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RSK-265	IF there is local power failure and failure of emergency lights, due to age of existing fittings and lack of previous investment THEN there may be a failure to protect persons allowing a safe evacuation of the area	LEADING TO poor patient experience and safety, non-compliance with regulation, loss of reputation	Organisation	Mark Brown	21-Sep-2022	30-Dec-2022	Planned	20	12	8		Future investment requirements identified by PPM , reactive maintenance and Estates Specialist Officer(30-Nov-2021), PPM checks in place with regular testing by direct labour(30-Nov-2021), Rolling program of capital investment(30-Nov-2021), Rolling PPM program PPM 3 hour E-light testing program in place(30-Nov-2021), List of known remedials to be completed and prioritised(30-Nov-2021)	Low	Treat	No changes to current risk rating
RSK-266	IF the Trust are unable to take up the New Hospital Plan THEN The Trust would have to fund all future developments from either internally generated funding defined for backlog investment or borrow the money	LEADING TO the Trust being unable to meet the needs of the future MK population with regard to the size and quality of the estate	Organisation	Rebecca Grindley	05-May-2022	29-Mar-2023	Planned	16	12	8	Funding for Outline Business Case (OBC) agreed in Jan '22. Due for completion by March 2023.	Seed funding approved by DHSC to support the development of a Strategic Outline Case (SOC)(30-Nov-2021), SOC has been formally completed(30-Nov-2021), Regular monthly meetings on a formal basis with NHSE/I and DHSC(30-Nov-2021), Regular dialogue taking place with NHSE/I Strategic Estates Advisor(30-Nov-2021), Regular dialogue taking place at Board level(30-Nov-2021), Monthly reporting structure in place with NHSE/I(30-Nov-2021), Programme Board chaired by CEO set-up with agreed ToR(30-Nov-2021), Wider engagement with MK Council(30-Nov-2021), Wider engagement with senior colleagues in the Trust commenced(30-Nov-2021), Engagement with CCG undertaken(30-Nov-2021), SOC Submitted to NHSEI, OBC to be progressed in quarter 4(30-Nov-2021)	Medium	Treat	Reviewed risk owner and updated.
RSK-269	IF the Trust fails to comply fully with current DoH HTM 04-01 Parts A&B, Addendum relating to Water Systems and HTM 00 as identified in the Water Risk assessment THEN The Trust will be unable to provide assurance of a fully compliant water safety system	LEADING TO Increased risk to patients and staff, loss of reputation, financial loss to the Trust.	Organisation	Michael Stark	21-Sep-2022	30-Dec-2022	Planned	16	12	8		A Water Services Management Group operates quarterly, with agreed membership and agenda items(30-Nov-2021), Audit document and action plan has been circulated to the Group for discussion and progression at the next meeting(30-Nov-2021), Independent contractor commissioned to regularly test water outlets. Controls and testing regimes in place(30-Nov-2021), Review and Water Services Management Group membership includes independent contractor and Authorising Engineer(30-Nov-2021), Whole site risk assessments are current and risk reviewed at each meeting(30-Nov-2021), Risk assessment undertaken of augmented care areas(30-Nov-2021), House keepers are flushing water out lets in clinical areas and return flushing sheets to estates, Hotel Services Audit manager to track progress and compliance(30-Nov-2021), Tender awarded to Evolution, 2 year contract commenced 1st July 2019. extended for 6 months. New tender to be drafted(30-Nov-2021), Phase 1 and Cancer Centre risk assessments completed(30-Nov-2021), Phase 2 Risk Assessment completed June 2021, actions underway(30-Nov-2021), Audit and Risk assessments for outlying buildings planned 2022(30-Nov-2021)	Low	Treat	No changes to current risk rating
RSK-274	IF the Trust worn flooring is not replaced THEN there is a risk of failure of flooring	LEADING TO trip hazard & infection control issues	Organisation	Paul Sherratt	21-Sep-2022	30-Dec-2022	Planned	15	12	6	3 year + 1 +1 . contract awarded. Annual audit of Common areas, corridors and circulation, includes repairs	Capital bid to be placed annually(30-Nov-2021), Ward 6 and Ward 1 full floor replacement completed(30-Nov-2021), Business Case written, funded 21/22(30-Nov-2021), Adhoc floor repairs made with temporary taping of any failures occurring(30-Nov-2021), Going to the market for new contractor, out to tender(30-Nov-2021), Crown Industrial flooring making small repairs(30-Nov-2021)	Low	Treat	No changes to current risk rating
RSK-275	IF The Trust does not recruit suitably qualified estates personnel THEN there will be a shortfall of qualified skilled estates staff to perform Statutory Maintenance, Emergency On-Call & Day to Day reactive Breakdown requests and Appointed Persons	LEADING TO the Trust being at risk and service delivery systems will increasingly fail directly affecting clinical service and patient care	Organisation	Michael Stark	31-Oct-2022	31-Jan-2023	Planned	15	12	3	Current vacancies in Estates Services - 1 x Estates Officer Mechanical & 1 x Capital Projects (31-Oct-2022)	Agency staff option to back fill to current vacancies, whilst recruitment process continues if required(30-Nov-2021), Change paper put through to TEG for additional resources, better R&R payments and to bring 7 day working over longer hours by introducing a shift pattern which should protect the service availability, enhance remuneration closer to market rate and make on-call sessions less onerous. Approved subject to funding like date March 2022(30-Nov-2021), Validation pending on some changes to funding going through(30-Nov-2021)	Low	Treat	No changes to current risk rating

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RSK-276	If the flat roofs identified in the Langley Roof report and 6 facet survey as requiring replacement or upgrading, are not replaced THEN there is a risk of roof failure in relation to flat roofs across the Trust	LEADING TO Water ingress - Potential damage to equipment, disruption to service, damage to reputation	Organisation	Anthony Marsh	21-Sep-2022	30-Dec-2022	Planned	15	12	3	Replacement/upgrade of flat roofs identified in the 6 facet survey (24-Jun-2022)	Inspections and repairs as needed(30-Nov-2021), Updated annual 6 facet survey by Oakleaf(30-Nov-2021), Large patch repairs undertaken as emergency business cases(30-Nov-2021), 1 x Post Grad roof fully replaced 19/20(30-Nov-2021), Ward 10 - 50% of roof patch repairs completed 19/20(30-Nov-2021), 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(30-Nov-2021), Pharmacy small roof replaced September 20(30-Nov-2021), Business Case approved for 4 to 5 year rolling programme(30-Nov-2021), Community Hospital work completed July 2021(30-Nov-2021), Phase 1 and Phase 2 of the hospital works outstanding. Funding to be approved(30-Nov-2021), Funding for phase 2 included in carbon zero funds to be announced Jan 2022(30-Nov-2021)	Low	Treat	No changes to current risk rating
RSK-281	If the lift located in Outpatients (servicing levels 3, 4 of yellow zone, and Staff Health & Wellbeing) fails THEN disabled & mobility reduced/sight impaired individuals unable to access workplace or services – unable to fulfil contractual obligations. Persons entrapped in lift unable to exit. Delayed access/treatment of an individual taken ill whilst trapped. Claustrophobia, panic attacks, psychological harm, deterioration of condition	LEADING TO Reduced availability of staff, unable to carry out duties, reduced clinical input/unable to see clients (internal/external) in a timely manner – increased workload for other staff leading to increased work pressure/stress Loss of income of external clients who cannot be seen due to absence of clinician Service user dissatisfaction – complaints/reputation of service and organisation affected Adverse publicity if unavailability of service reported to local press/reputation of organisation and service affected The organisation would be in breach of statutory duties under Health & Safety At Work etc Act 1974, Equality Act 2010 – failure to provide safe access/egress/safe place of work – potentially leading to enforcement action/further interest of Health & Safety Executive Inspectorate	Organisation	Mark Brown	21-Sep-2022	30-Dec-2022	Planned	12	12	9	M&E study completed, Business Case written to install a second lifting platform in outpatients	There is an SLA is place that states that the lift will be repaired within 4 hours, normally 1-2hours(30-Nov-2021), ResQmat are on the landings on floors 3 & 4 and should be used in the event disabled persons and those with limited mobility, are unable to leave their respective floors, although staff are not trained in their use(30-Nov-2021), Call bell/telephone in lift to call for assistance(30-Nov-2021), Monthly lift inspections in place(30-Nov-2021), 6 Monthly PPM in place(30-Nov-2021), Annual insurance inspections in place(30-Nov-2021), ResQmat training video in place created by Manual Handling adviser(30-Nov-2021), Refurbishment of ward 14 lift carried out(30-Nov-2021), Ward 16 undergone H&S improvements(30-Nov-2021), On the Capital Programme(30-Nov-2021), Outpatients Business Case approved for M&E study, with any identified anticipated to be completed end of FY 2022(30-Nov-2021)	Low	Treat	No changes to current risk rating
RSK-299	IF the Summary Record of Estates 5 year and Prioritised Backlog Maintenance risk based priority programme is not fully implemented THEN plant and equipment may fail in various areas of the hospital	LEADING TO infection control, financial implications, loss of services and reputation damage	Organisation	Anthony Marsh	21-Sep-2022	30-Dec-2022	Planned	9	12	4	Ongoing reviews, identified backlog issues driving Capital Plan. Outstanding funding of Capital works required. Operational impact of significant works to be considered. (31-Oct-2022), New Hospital Programme guidance indicates funding to clear CIR backlog programme to be included as part of the project.	All areas are reviewed on a monthly basis by Estates Service Manager, or sooner if equipment/plant breakdown demands(30-Nov-2021), Business cases for plant replacement to be put forward FY21/22(30-Nov-2021), Compliance Officer reviewing to identify significant costs(30-Nov-2021), Review of recent 6 Facet Survey to identify future funding requirements e.g. Roof, Ventilation, Plant, HV, drainage(30-Nov-2021), March 2021 20% physical and remaining 80% desktop survey completed(30-Nov-2021), Annual Physical 20% of site 6 facet survey undertaken(03-Mar-2022)	Low	Treat	No changes to current risk rating
RSK-300	IF the call bell system is not replaced/upgraded THEN the call bell system could fail as parts obsolete for some systems to obtain	LEADING TO increased risk to patients and possible service disruption and poor patient experience	Organisation	Mark Brown	21-Sep-2022	30-Dec-2022	Planned	9	12	3	Ward 1 and ED call bell systems ordered from FY22/23 capital for installation this FY. Upgrade programme to be included in rolling Capital bid (14-Nov-2022)	An emergency back up system of 30 units has been purchased in the event of current system failing. There is also an additional spare unit(30-Nov-2021), Ward 4, 5 and Milton Mouse & A&E Majors were replaced in FY18/19(30-Nov-2021), ADAU replaced as emergency business case October 2019(30-Nov-2021), Endo replaced in Jan 2020(30-Nov-2021), Vizcall no longer in business, plan to replace all Vizcall systems in 20/21 - Vizcall test equipment and spares purchased for in house support(30-Nov-2021), Above the line funding for 2 x wards and ED agreed for 2021 with Ascom(30-Nov-2021)	Low	Treat	No changes to current risk rating

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RSK-364	If SBS are not able to respond to supplier and finance queries in a timely way THEN there is risk that there will be a delay in paying suppliers leading to suppliers putting the Trust on stop and not delivering key supplies	LEADING TO impact on patient care through non supply of goods	Organisation	Karan Hotchkin	14-Dec-2022	16-Jan-2023	Planned	16	12	6		On going monthly meetings with Senior SBS Client Relationship team to discuss issues and outline their plan on resolving this issue(15-Jul-2022), Additional Bank resource for Finance and Procurement staff(15-Jul-2022), Finance team reviewing supplier on stop notifications(15-Jul-2022), The Trust is meeting on a monthly basis with senior SBS client relationship team to discuss the issues and get a plan from SBS of how the situation can improve, In addition extra temporary resources are being employed to support the finance and procurement team to deal with the additional supplier queries. The Finance team are reviewing any suppliers who are providing stop notifications and arranging urgent payment if required(16-Nov-2022)	Low	Treat	
RSK-007	IF the team Fire Warden is not adequately trained or they are not present during a related emergency; THEN there would be no focal point for fire safety matters for local staff and supporting line managers on fire safety issues, and the team may not be represented in Fire Safety Committee meetings, and they will not be able to organise and assist in the fire safety regime within their local area	LEADING TO staff and other individuals visiting level 1 in Oak House potentially not being evacuate in a timely manner due to the lack of oversight. The lack of single focused oversight could cause confusion, delays in evacuation and people being left behind. This could lead to smoke inhalation, burns, death. Fire checking and prevention procedures may not be robust enough to identify potential hazards and prevent a fire from happening. Breach of statutory regulations	Organisation	Tina Worth	24-Oct-2022	31-Dec-2022	Planned	15	10	5	There was a recommendation that in light of the working from home arrangements, it might be appropriate for everyone to have the training so that there is adequate cover. (24-Oct-2022)	Fire Warden advised to work within current knowledge and skill gained through mandatory fire training(06-Sep-2021), No team member to attempt to fight fires with equipment untrained to use(06-Sep-2021), Risk assessment shared with team / Staff awareness(06-Sep-2021), Quarterly fire safety audits completed(06-Sep-2021), Good housekeeping practicalities - reiterated at team huddle(06-Sep-2021), Fire safety signage displayed -action cards and assembly points identified, clearly visible to team members and others visiting corridor(06-Sep-2021), Fire alarm system checked regularly in line with Trust policy and is audible in corridor(06-Sep-2021), Team members have undertaken and are up to date with mandatory training (compliance checked monthly)(06-Sep-2021), Team risk assessment for lone working on back of Covid changes which covers fire(06-Sep-2021), Risk & Clinical Governance Team Fire Warden to attend Fire Warden Training(06-Sep-2021), There was a suggestion that posters were put up for staff to follow when Kevin is not in.(21-Dec-2021)	Low	Treat	Risk unchanged
RSK-125	IF there is a surge of COVID-19 patients impacting on Trust ability to maintain patient care and clinical services, or loss of staff to support clinical and non-clinical services due to high levels of absence, or a loss of national stockpile in PPE or medical devices (ventilators) resulting in the Trust not receiving deliveries to preserve the safety of patients and staff THEN there is a risk of reduced 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	LEADING TO Loss of clinical and non-clinical services, risk to patient care, risk to staff wellbeing and financial impacts	Organisation	Adam Biggs	21-Nov-2022	13-Mar-2023	Planned	25	10	10		COVID-19 operational and contingency plans in place(04-Nov-2021), PPE logged daily covering delivery and current stock(04-Nov-2021)	Low	Tolerate	No current change to risk scoring with watching brief concerning current COVID surge against national guidance and comms.
RSK-163	If there are inadequate computer facilities and working environment are not adequate to support the office needs for clinical staff located on the Stroke Unit. Then there is potential for staff to suffer musculoskeletal injuries and reduced efficiency of working when writing clinical notes and reports. Reduced patient experience from receiving rehabilitation in an unsuitable environment.	Leading to staff potentially being off sick due to injury; potential financial impact; potentially reduced service for patients. Potential for patient/family complaints due to poor condition of the environment.	Organisation	Adam Baddeley	23-Nov-2022	06-Jan-2023	Planned	6	10	2	Current environment on the ward to be adapted/developed. Capital funding required. Business case has been written and submitted for review at CBIG in July 2022 (23-Nov-2022)	Assessed gym area Staff educated about correct postures Creating risk(12-Nov-2021)	Medium	Treat	Business case is out to tender.
RSK-242	IF a chemical, biological, radiological, nuclear (CBRN/HAZMAT) incident was to occur through either intentional or unintentional means THEN the Trust would require specialised response through national guidelines and expert advice	LEADING TO potential impact on Trust services and site safety to patients and staff; Possible impact on closing or disrupting ED operations, with further risk to all operations on how the Trust operate depending on the nature of the incident (e.g., Novichok incident at Salisbury)	Organisation	Adam Biggs	21-Nov-2022	22-May-2023	Planned	10	10	10			Low	Treat	Not changes to risk scoring as an open risk. Ongoing CBRN training programme being delivered as part of national guidance with plans in place.
RSK-260	IF people working at height are not correctly trained THEN there is a risk from fall from height	LEADING TO staff/contractor injuries, potential claims, non compliance with statutory regulations and loss of reputation	Organisation	Paul Sherratt	21-Sep-2022	30-Dec-2022	Planned	15	10	5		Staff training. Ladder/equipment inspections(29-Nov-2021), Written processes(29-Nov-2021), New lifting equipment purchased(29-Nov-2021), General H&S training conducted(29-Nov-2021), Cherry Picker obtained- staff trained(29-Nov-2021), RAMS from contractors reviewed by Compliance Manager(29-Nov-2021), Edge protection in place in all locations where plant or PV panels exist(29-Nov-2021), Treatment Centre now has edge protection replacing latchway system(29-Nov-2021), Trained RP in August 2021(29-Nov-2021), RP to be appointed by Alan Hambridge(29-Nov-2021)	Low	Treat	No changes to current risk rating

Reference	Description	Impact of risk	Scope	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-206	IF the Trust is unable to recruit staff of the appropriate skills and experience; there continues to be unplanned escalation facilities; There are higher than expected levels of enhanced observation nursing; and there is poor planning for peak periods / inadequate rostering for annual/other leave. THEN the Trust may be unable to keep to affordable levels of agency and locum staffing	LEADING TO Adverse financial effect of using more expensive agency staff and potential quality impact of using temporary staff	Organisation	Karan Hotchkin	14-Dec-2022	16-Jan-2023	Planned	16	9	9		Weekly vacancy control panel review agency requests(23-Nov-2021), Control of staffing costs identified as a key transformation work stream(23-Nov-2021), Capacity planning(23-Nov-2021), Robust rostering and leave planning(23-Nov-2021), Escalation policy in place to sign-off breach of agency rates(23-Nov-2021), Fort-nightly executive led agency reduction group meeting with aim of delivering reduction in both quantity and cost of agency used(23-Nov-2021), Agency cap breaches are reported to Divisions and the FIC(23-Nov-2021), Divisional understanding of how to reduce spend on temporary staffing to be developed(23-Nov-2021)	Medium	Tolerate	Risk transferred from Datix
RSK-214	IF there is insufficient nursing staffing THEN there is a risk that the number of patients requiring nutritional assistance at meal times exceeds staff availability	LEADING TO patients nutritional needs potentially not being met, impacting on poor outcomes, patient experience and length of stay	Organisation	Elizabeth Winter	18-Oct-2022	02-Jan-2023	Planned	15	9	9		Protected meal times(24-Nov-2021), Red trays/jugs(24-Nov-2021), Meal time assistants(24-Nov-2021), Dining Companions Launched May 2018(24-Nov-2021), Senior Sister highlighting patients who require assistance at daily safety huddle(24-Nov-2021)	Low	Tolerate	No change risk.
RSK-235	IF the Trust is unable to fill rotas THEN there may be insufficient medical cover	LEADING to increased clinical risk. We may not be able to easily provide sufficient clinical cover, leading to reduced service delivery, deteriorating patient experience	Organisation	Louise Clayton	31-Oct-2022	31-Jan-2023	Planned	16	9	9	Add a 'Recruitment and Retention Premia' initiative to key posts (31-Oct-2022)	Recruitment and retention premia for certain specialties(25-Nov-2021), Advanced Nurse Practitioners development and integration in progress(25-Nov-2021), New SAS grade established(25-Nov-2021), New publication for International Medical Graduates developed(25-Nov-2021), Acting Down Policy in place(25-Nov-2021), Routine/regular evidence based trends inform early recruitment activity for shortage deanery specialties (e.g. medicine, paediatrics)(25-Nov-2021)	Low	Tolerate	Risk Reviewed - No change to risk
RSK-236	IF there is inability to retain staff employed in critical posts THEN we may not be able to provide safe workforce cover	LEADING TO clinical risk. Increasing temporary staffing usage and expenditure Increased turnover Decreased stability rates Increased stress levels within trust Reduced morale	Organisation	Louise Clayton	31-Oct-2022	31-Jan-2023	Planned	16	9	9	International Recruitment ongoing to recruit 125 nurses in 2022, attraction campaign to commence in 2022 with national advertising of the Trust as employer of choice. (31-Oct-2022), Attraction Campaign to launch Autumn 2022 with programme of events and mixed media advertising through to March 2023	Variety of Organisational Development and Reward initiatives, including Event in the Tent, P2P, Schwartz Rounds, Living our Values, Annual Staff Awards and feedback from staff being acted upon(25-Nov-2021), Monitoring via staff survey feedback and local action plan based outcomes(25-Nov-2021), Health and Wellbeing promotion, education and prevention via Staff Health and Wellbeing(25-Nov-2021), Online onboarding and exit interview process in place(25-Nov-2021), Flexible working and Agile Working policies in place(25-Nov-2021), MK Managers Way in place(25-Nov-2021), Recruitment and retention premia in place, including Golden Hello for Midwives(25-Nov-2021), Enhanced social media engagement in place and ongoing(25-Nov-2021), Annual funding initiatives to upskill staff and retain them through ongoing education e.g. Chief Nurse Fellowships, PGCE and Rotary Club Bursary fund(25-Nov-2021), Refer a Friend Scheme introduced in 2022 to improve retention and recruitment.(10-May-2022)	Low	Tolerate	Risk Reviewed - Controls updated. No change to Risk Score
RSK-238	IF poor moving and handling practice happens, THEN staff and patients may get injured due to poor moving and handling	LEADING TO litigation, sickness absence and increased temporary staffing backfill. Staff and/or patient injury Subsequent reduction in staff numbers Poor reputation and publicity Potential risk of litigation and prosecution	Organisation	Louise Clayton	31-Oct-2022	31-Dec-2022	Planned	12	9	6		Currently manual handling training is carried out every three years and the Manual Handling and Ergonomics Advisor visits all departments to carry out risk assessments, offer advice and ad-hoc training as required(25-Nov-2021), Training is currently being provided ad-hoc by an external company(10-May-2022), Occupational Health are employing a MSK Physio to provide staff support post injury.(10-May-2022), The Trust is exploring bank contracts for trainers to meet demand(10-May-2022)	Low	Treat	Risk reviewed - Controls updated
RSK-258	IF the Switchboard resources cannot manage the service activity THEN this may result in poor performance	LEADING TO failure To meet KPI's and Emergency Response Units will put Patients, Staff and Visitors at risk and Communication with Users will give poor perception of the We Care action initiative	Organisation	Anthony Marsh	21-Dec-2022	30-Jun-2023	Planned	20	9	4		Re-profiled staff rotas(29-Nov-2021), Bank staff employed where possible(29-Nov-2021), IT Department implemented IVR to assist in reducing the volume of calls through the switchboard(29-Nov-2021), Contingency trained staff available to assist(29-Nov-2021), Two additional workstations/consoles created in Estates Information office and Security office to allow for remote working(29-Nov-2021), Review of staff rota profile(04-Mar-2022)	Low	Treat	No changes to current risk rating

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RSK-272	IF the Passenger Lifts are not maintained THEN there is a risk of failure of components	LEADING to malfunction. Patients or visitors could get stuck in the lift, this could potentially cause panic or delay treatment. The public image of the trust could be affected.	Organisation	Mark Brown	21-Sep-2022	30-Dec-2022	Planned	15	9	3	Luing Cowley Lift awaiting upgrades, difficult as no alternative when lift not in service, business case drafted for submission July 2022 (14-Nov-2022), AE (Authorising Engineer) to be identified. (14-Nov-2022)	Maintenance Contracts are in place(30-Nov-2021), Insurance inspections are place(30-Nov-2021), Lift modernisation inspection has been completed and 5 year plan underway since FY17/18(30-Nov-2021), Eaglestone lift upgraded and some remedial and safety upgrades during FY19-20(30-Nov-2021), W14 upgraded 2020(30-Nov-2021), Maintenance contract awarded.(30-Nov-2021)	Low	Treat	No changes to current risk rating
RSK-279	IF pedestrians in the hospital grounds walk over the verges, grassed areas, mounds, slopes, sloped/high curbs and do not stick to the designated pathways THEN Patients, visitors and staff could slip, trip or fall causing injury including fractures, sprains, strains	LEADING TO legal and enforcement action against individuals/and or the Trust leading to fines/compensation/exposure in local press leading to adverse publicity	Organisation	Michael Stark	21-Sep-2022	30-Dec-2022	Planned	12	9	6	Areas suitable to install knee high fencing identified. To be prioritised and installed in future years.	Sloping curbs painted yellow where they may be crossed(30-Nov-2021), Fencing or railings in some areas to stop access(30-Nov-2021), Rolling Paths annual program to repair paths and roads(30-Nov-2021), Grass kept cut by grounds team(30-Nov-2021), Grass kept cut by grounds team(30-Nov-2021), Keep off the Grass signage in place(30-Nov-2021)	Low	Treat	No changes to current risk rating
RSK-282	IF there is a lack of on-site appointed person for decontamination - AP (D) THEN the Trust will not be able to implement and operate the Management's safety policy and procedures relating to the engineering aspects of decontamination equipment	LEADING TO non-compliant machines – working but not correctly; machine Failures – suddenly unusable, loss of production, out-sourcing; equipment released that is not disinfected or sterile – risk to staff; equipment released that contains endotoxins – risk to patients / SSI's	Organisation	Michael Stark	21-Sep-2022	30-Dec-2022	Planned	12	9	6	An Estates Officer is to be appointed as AP(D) following training and approval. (04-Mar-2022), An external AP(D) will be needed for Endoscopy, however the AE(D) is currently covering this responsibility. Mark Brown will continue to provide estates operational management to service. All testing now undertaken by external expert contractor. (21-Nov-2022)	We are unable to employ or sub-contract and independent AP (D), the AE(D) is covering this role currently working with our internal, trained but yet to be appointed Estates Officer(30-Nov-2021), The AE(D) is coming to site once a month and spends his time validating servicing reports and giving feedback(30-Nov-2021)	Low	Treat	No changes to current risk rating
RSK-283	IF medical equipment is damaged due to misuse, inappropriate use, storage, transportation, and/or inappropriate cleaning THEN the medical equipment may be unavailable due to damage	LEADING TO delay in patient care and treatment; cost of parts; cost of repairs; purchasing replacement	Organisation	Ayca Ahmed	13-Dec-2022	31-Mar-2023	Planned	12	9	6	Training in the use of medical equipment, Auditing PPMs, Medical Devices Management policy- following processes		Low	Treat	Reviewed by Medical Devices Manager, no change to risk rating.
RSK-284	IF staff members do not adhere to the Medical Devices Management Policy THEN they may not follow the correct procurement procedures for Capital and Revenue medical equipment purchases	LEADING TO them being not fit for purpose equipment being purchase; more costly; non-standardised; lack maintenance contract; lack of training for staff; incompatible/lack of consumables and accessory; additional IT integration costs	Organisation	Ayca Ahmed	13-Dec-2022	31-Mar-2023	Planned	12	9	6	Medical Devices Group meetings are held monthly to discuss procurement		Low	Treat	Reviewed by Medical Devices Manager, no change to risk rating.
RSK-257	IF the server MKH-CRIS-01 continues to run Red Hat Linux Enterprise Version 6, Version 6 currently has 337 vulnerabilities THEN the server will be extremely vulnerable to being exploited by a third-party threat actor	LEADING TO negative impact on patient care due to lack of the service	Organisation	Craig York	14-Sep-2022	31-Jan-2023	Planned	15	8	6		The server is currently on the clinical VLAN, leading to security benefits.(26-Nov-2021), Additional support procured to mitigate the security risk(26-Nov-2021)	Low	Treat	The supplier have not made an upgrade available yet - they are still validating their system on the new version of the operating system.
RSK-285	IF footpaths and roadways are not maintained and inspected sufficiently and regularly THEN this could lead to trips and falls if not correctly maintained	LEADING TO harm to patients, staff and the general public, and damage to vehicles and other road users	Organisation	Paul Sherratt	21-Sep-2022	30-Dec-2022	Planned	12	8	4	Annual Capital bid placed on the capital program FY23 (01-Jul-2022)	Inspections and ad-hoc repairs(30-Nov-2021), Annual Audit to be completed(30-Nov-2021), Some remedial captured by capital works at Cancer Centre(30-Nov-2021), Remedial works completed. Further improvements identified and action plan developed to address on a rolling program.(04-Mar-2022)	Low	Treat	No changes to current risk rating
RSK-291	IF the existing surface water drainage system is not suitably maintained or repaired THEN the surface water drainage system could fail	LEADING TO flooding and contamination and loss of service	Organisation	Michael Stark	21-Sep-2022	30-Dec-2022	Planned	12	8	4		Reactive maintenance repairs(30-Nov-2021), A drain survey scheduled annually(30-Nov-2021), CCTV works has indicated areas of root re-growth with pipe damage to storm water pipes, works being undertaken during summer/autumn 2021(30-Nov-2021), BDP created scope for full site survey under the HIP program to identify shortfall in current data and future plan requirements. A new link is likely to be required as part of South Site development(30-Nov-2021), Road Gulley on PPM(30-Nov-2021)	Low	Treat	No changes to current risk rating
RSK-293	IF the current fuse boards are not updated to miniature circuit breakers THEN existing fuse-boards could fail	LEADING to delays in repairs/replacement resulting in possible service disruption and poor patient experience	Organisation	Mark Brown	21-Sep-2022	30-Dec-2022	Planned	12	8	4		PPM testing and repairs(30-Nov-2021), Fixed electrical testing program in place to identify any potential risks and actions required(30-Nov-2021), Replaced Circuit breakers/fuses FY 20/21(30-Nov-2021), Ongoing funded, rolling program of refurbishment(30-Nov-2021), Ward 1 completed 2021(30-Nov-2021)	Low	Treat	No changes to current risk rating
RSK-301	IF the existing foul water drainage system is not suitably maintained or repaired THEN the system could fail	LEADING TO cause flooding, contamination and loss of service	Organisation	Michael Stark	21-Sep-2022	30-Dec-2022	Planned	8	8	4		Reactive maintenance repairs(30-Nov-2021), Wards 1-5 identified as risk areas(30-Nov-2021), Some CCTV inspection has been completed(30-Nov-2021), Scope of works being reviewed for proactive maintenance(30-Nov-2021), Multiple areas descaled ongoing programme(30-Nov-2021)	Low	Treat	No changes to current risk rating

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RSK-005	IF policies, guidelines and patient information are not reviewed and amended in a timely manner; THEN staff will be working with out of date information	LEADING TO potential error in patient care, non-compliance with legislative, national requirements, potential litigation and potential loss of reputation to Trust	Organisation	Tina Worth	24-Oct-2022	31-Dec-2022	Planned	12	6	3	Implementation of Radar Document Management System to improve engagement and access to the documentation process (20-Oct-2022)	Trust Documentation Policy(06-Sep-2021), Library resource to source current references(06-Sep-2021), Governance Leads provide support to staff reviewing guidelines and policies(06-Sep-2021), Monthly trust documentation report shared with Governance Leads(06-Sep-2021), New process via Trust Documentation Committee for 'removal' of significantly breached documents(06-Sep-2021), Work plan in place to check approval of documents/links to national leaflets(06-Sep-2021)	Low	Treat	Starting to transfer documents across to new radar document module. Trust wide drive to manage overdue especially corporate documents
RSK-010	IF the Radar Risk Management System does not meet the needs to the Trust and of legal reporting requirements THEN the Trust will not have an appropriate system to manage incidents, complaints, claims, compliments, safety alerts and risks	LEADING TO an inability for the Trust to defend itself against future claims/litigation leading to potential financial penalties, improvement notices, PFD notices from HM Coroner, adverse publicity etc., an inability to evidence compliance with CQC regulations and freedom of information requests, and potential for an increase in incidents, complaints and claims due to lack of learning from incidents.	Organisation	Paul Ewers	10-Nov-2022	30-Dec-2022	Planned	20	6	6		Project Manager identified along with 3 members of staff to provide cover and support to the project where necessary(06-Sep-2021), Radar Project Plan in place(06-Sep-2021), Radar Risk Assessment in place(06-Sep-2021), Working Groups identified to support design/build of system in line with Trust's requirements(06-Sep-2021), Radar Healthcare have a dedicated Project Manager and team in place to support MKUH with implementation(06-Sep-2021), Clearly defined roles added to the Project Plan(06-Sep-2021), Escalation process in place to Exec Sponsor(06-Sep-2021), Communication Strategy Developed(06-Sep-2021)	Low	Tolerate	Risk reviewed. No change to risk. Report going to RCB w/c 14th November 2022
RSK-020	IF there are ligature point areas in ED for Adult and C&YP in all areas of department THEN ED patients may use ligature points to self harm. There has been an incident where a mental health patient used a door closer as a ligature point.	LEADING TO increased safety risk to patients, safe and adverse publicity	Organisation	Patricia Flynn	13-Oct-2022	22-Jun-2023	Planned	9	6	2	Mental Health pathway to be reviewed by the Corporate Team (23-Nov-2022), E-Care Risk Assessment Tool to be reviewed/adapted	Patients assessed and those at risk of self harming are placed in an area they can easily be observed.(22-Sep-2021), New mental health room has been ligature and risk assessed by CNWL team(22-Sep-2021), Remind all staff about keeping swipe doors closed so they don't access rooms where they are not observeble Last ligature audit was April 2019 and actioned.(22-Sep-2021), Risk Assessment of adult and C&YP areas reviewed April 2019(22-Sep-2021), Check list in place to risk asses each Adults and C&YP attending with MH/DSH issues to identify personalised action plan(22-Sep-2021), Follow up ligature RA completed as advised by H&S lead for trust Risk Assesment completed - identified need for collapsible clothes hangers in public toilets - request to estates to install and completed; x1 non-compliant cord pull also in toilet - changed(22-Sep-2021), Repeat Ligature Risk Assessment for 2020 required(22-Sep-2021), ensure all staff are aware of the new Policy - "Ligature Risk Awareness"(22-Sep-2021)	Low	Treat	discussed with safeguarding BJ.. noting a small number of identified pt with known MH issues who are high risk who are frequent attenders to ED.
RSK-038	If Covid-19 impacts NHS Trusts through reduction in availability of Pharmacy staff as a result of infections, self-isolation and redirection to assisting with vaccination programs. & therefore Trusts are purchasing more ready-to-administer injections rather than make the doses themselves. With commercial companies have also been affected by staff having to self-isolate, reducing their capacity and ability to meet the increased demand for ready-to-administer products Then a number of commercial companies that provide ready-to-administer injections of chemotherapy, will have capacity issues that might prevent doses of urgently required chemotherapy from being obtained by the Pharmacy department for issue to cancer patients	Leading to: Non-availability of ready-to-administer products may prevent patients being treated as planned. Where ready-to-administer products can be obtained from commercial companies, an extended lead time has been implemented that does not permit timely purchase of required products.	Organisation	Stephen Thomas	05-Oct-2022	31-Mar-2023	Planned	15	6	6	A number of commercial companies that provide ready-to-administer injections of chemotherapy, have capacity issues that might prevent doses of urgently required chemotherapy from being obtained by the Pharmacy department for issue to cancer patients (17-Oct-2022)		Low	Tolerate	
RSK-204	IF data sent to external agencies (such as NHS Digital, Advise Inc and tenders) from the Procurement ordering system contain patient details THEN there is a risk that a data breach may occur with reference to GDPR and Data Protection Act as the procurement department deals with large volumes of data.	LEADING TO a data breach and potential significant fine	Organisation	Lisa Johnston	14-Dec-2022	16-Jan-2023	Planned	16	6	6		All staff attend an annual mandatory training course on Information Governance(23-Nov-2021), Staff are encouraged to use catalogues which reduces the requirements for free text(23-Nov-2021), Data sent out to external agencies is checked for any patient details before submitting(23-Nov-2021)	Medium	Tolerate	Ongoing risk
RSK-205	IF there is Incorrect processing through human error or system errors on the Procurement systems THEN there is risk that there may be issues with data quality within the procurement systems	LEADING TO Incorrect ordering resulting in a lack of stock and impacting on patient safety	Organisation	Lisa Johnston	14-Dec-2022	16-Jan-2023	Planned	12	6	6		Monthly reviews on data quality and corrections(23-Nov-2021), Mechanisms are in place to learn and change processes(23-Nov-2021), Data validation activities occur on monthly basis(23-Nov-2021), A desire to put qualifying suppliers in catalogue(23-Nov-2021)	Medium	Tolerate	Risk transferred from Datix
RSK-207	IF there is major IT failure internally or from external providers THEN there is a risk that key Finance and Procurement systems are unavailable	LEADING TO 1. No Purchase to pay functions available ie no electronic requisitions, ordering, receipting or payment of invoices creating delays for delivery of goods. 2. No electronic tenders being issued. 3. No electronic raising of orders or receipting of income	Organisation	Karan Hotchkin	14-Dec-2022	16-Jan-2023	Planned	12	6	6		If its an external issue, SBS the service provider of the purchase to pay and order and invoicing has a business continuity plan in place(23-Nov-2021), If its an internal issue. The Trust has arrangements with the CCG who also use SBS to use their SBS platform(23-Nov-2021)	Medium	Tolerate	Risk transferred from Datix

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RSK-209	IF staff members falsely represent themselves, abuse their position, or fail to disclosure information for personal gain THEN the Trust/Service Users/Stakeholders may be defrauded	LEADING TO financial loss and reputational damage	Organisation	Karan Hotchkin	14-Dec-2022	16-Jan-2023	Planned	12	6	6		Anti-Fraud and Anti-Bribery Policy(23-Nov-2021), Standards of Business Conduct Policy including Q&A section(23-Nov-2021), Standing Orders(23-Nov-2021), Local Counter Fraud Specialist in place and delivery of an annual plan(23-Nov-2021), Proactive reviews also undertaken by Internal Audit(23-Nov-2021), Register of Gifts and Hospitality(23-Nov-2021), Register of Declarations(23-Nov-2021)	Medium	Tolerate	Risk transferred from Datix
RSK-216	If agreed processes for multi agency working are not appropriately managed THEN the information and shared working agreements may fail.	LEADING TO potential failures in care provision which may have a detrimental effect on patients and their families, members of staff and the Trust. The complexities of multi agency working especially within safeguarding requires sharing of information between multiple agencies and within agencies. Currently there are multiple pathways for sharing of information within and externally from the Trust. This carries a potential legal and financial cost to the Trust if not appropriately managed within agreed legal frameworks.	Organisation	Lesley-Anne Johnson	28-Nov-2022	31-Mar-2023	Planned	9	6	6		Memorandum of understanding for the MK Safeguarding adult and children's board and for the subgroups that feed into this multi agency board, of which the Trust is a signatory(24-Nov-2021), There are electronic safeguarding forms available to staff to raise safeguarding concerns to the relevant external safeguarding adult or children's teams, SABR1, MARF. MARF now go to what is known as the Multi-Agency Hub and that has POLICE, EDUCATION, HEALTH AND SOCIAL SERVICES(24-Nov-2021), The Safeguarding Leads attend MARAC AND MARM COMMITEES which are Multi-Agency(24-Nov-2021), Safeguarding has an electric promoting welfare tab on EDM to identify individuals at risk(24-Nov-2021), Safeguarding children have a sharing information electronic form to help identify to school nurses and health visitors children who have attended or may be at risk due to the child behind the adult(24-Nov-2021), Maternity services use confidential communique on the Amalga system This has been widened to include children's and also the safe storage and collection of the MARF forms(24-Nov-2021), Trust Safeguarding Committee is multi agency(24-Nov-2021), MKHFT sits on the Milton Keynes Safeguarding Adults and Children's Boards(24-Nov-2021), MKHFT has named leads for Safeguarding Adults and Children	Low	Tolerate	Risk under control. Annual Review
RSK-220	IF there are insufficient side rooms THEN it may not always be possible to isolate patients and there is a risk that patients with a highly transmissible infection are not able to be isolated in a single room	LEADING TO Potential risk of an outbreak that can affect large numbers of patients and staff, ward closures, reduced numbers of staff, loss of revenue and increased waiting times.	Organisation	Angela Legate	25-Oct-2022	27-Jan-2023	Planned	15	6	6		Public Health alerts(25-Nov-2021), ED and Assessment areas priorities use of single rooms(25-Nov-2021), Board agreement for new build to incorporate en-suite facilities(25-Nov-2021), Space Committee review re-establishment of single rooms where currently used as offices(25-Nov-2021), Daily Safety huddle captures number of patients requiring isolation against number of single rooms available(25-Nov-2021), Breaches in isolation is reported on Datix(25-Nov-2021)	Low	Tolerate	Risk reviewed by Angie Legate. Not change to risk, review again in January 2023
RSK-225	IF staff do not adhere to the Information Governance Policies THEN there is a risk that staff members may access records of family, friends and other staff members	LEADING TO potential breach in confidentiality and potential criminal prosecution under section 55 of the Data Protection Act, Negative publicity and complaints.	Organisation	Dawn Budd	10-Nov-2022	09-Jan-2023	Planned	12	6	6		Role based Access(25-Nov-2021), Audits on adhoc basis(25-Nov-2021), Information Governance Policy(25-Nov-2021), Staff Code of Conduct(25-Nov-2021), Statements in Contract(25-Nov-2021), Information Governance Mandatory Training(25-Nov-2021), Message on Screensavers, Acute User Email and CEO Weekly Newsletter(25-Nov-2021)	Medium	Tolerate	No change in risk.
RSK-229	IF there is poor quality of data input into the eCare system THEN there could be consequential impact on the data flow into the Trust data warehouse and reporting for both performance management and contracting (commissioners) data	LEADING TO Impacts all performance reporting. Impacts "Contracts" reporting leading to a loss of income for the Trust	Organisation	Ian Fabbro	07-Sep-2022	31-Jan-2023	Planned	12	6	6		Extensive list of data quality reports to identify poor data quality(25-Nov-2021), Data Quality team is in place, who undertake a compliance function to review sample records to ensure early capture of data quality issues(25-Nov-2021), Control scripts to identify data quality issues when the data is loaded into the Data Warehouse(25-Nov-2021)	Medium	Tolerate	Risk ownership transferred to Chris Wiggins. Risk to be reviewed by end of July.
RSK-247	IF the wait times for ventilated babies and children requiring transfer to a tertiary centre continue to increase due to increasing pressures across the system. THEN the children's physiotherapy and on call team will be asked to assess and treat ventilated children. The physiotherapists do not currently have the training and competencies to complete this.	LEADING TO a ventilated child requiring support with airway clearance may not receive the assessment and treatment they require whilst waiting at MKUH for transfer. This may have a negative impact on their respiratory status and clinical outcome	Organisation	Sarah Knight	14-Dec-2022	17-Jan-2023	Planned	15	6	6		Standard Operating Procedure for physiotherapy supporting intubated children(11-May-2022), Training for on call physiotherapy staff that could be responsible for treating intubated children(11-May-2022)	Low	Tolerate	14.12.22 - Standard Operating Procedure has been circulated to therapy governance for review, to be circulated to Children's Division for comments by Children's Physio Service Lead. Following this risk can be closed
RSK-252	IF eCARE does not prevent non-prescribers from prescribing medication which could then be administered to a patient THEN there could be limitations in restricting access to individual Smart Card holders permissions or individuals do not adhere to the correct workflow	LEADING TO Medications could be prescribed and administered to a patient that are not clinically required & could be contraindicated	Organisation	Craig York	07-Sep-2022	31-Jan-2023	Planned	9	6	6	Monthly audit of in place a mechanism where medications prescribed by non-physicians are audited monthly against the known list of Non-Medical Prescribers/pharmacists/Midwives. Inconsistencies will be escalated to CNIO for investigation, SOP to be produced to support monthly audit.	eCARE training of correct process -eCARE training includes advice on only performing tasks related to professional registration and job role(26-Nov-2021), Code of conduct - NMC -eCARE pop up requires staff to state who advised them to prescribe medication & how (verbally/written)(26-Nov-2021)	Low	Tolerate	No progress made since prior review

Reference	Description	Impact of risk	Scope	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-253	IF the Trust does not maintain its 4 year PC replacement cycle (including PC Monitors) THEN the IT Department will be unable to provide a secure and performant infrastructure for clinical and business applications	LEADING TO reduced level of service and functionality	Organisation	Craig York	07-Sep-2022	30-Apr-2023	Planned	12	6	6		Stock for replacement programme 2021/22 available(26-Nov-2021)	Low	Treat	Risk dropped due to additional procurement of PCs last FY.
RSK-273	If the Trust Wards and Departments fail to demonstrate their medical equipment is maintained to correct standards THEN there is a risk of the Trust not complying with CQC Regulation 15 Premises and Equipment and risk to patient care	LEADING TO non-compliance and negative impact on the reputation of the Trust	Organisation	Ayca Ahmed	14-Dec-2022	31-Mar-2023	Planned	15	6	3	Contract KPI's agreed as part of new contract (26-Sep-2022)	Robust PPM maintenance schedule in place, audits of the rolling programme(30-Nov-2021), Audits monitored at Medical Devices Committee(30-Nov-2021), Escalation process in place to respond to 'unfound items'(30-Nov-2021), September 2018 , 6 Years contract approved(30-Nov-2021), Annual review of asset base and contract base reset linked to Capital Programme(30-Nov-2021)	Medium	Treat	Reviewed by Medical Devices Manager, no change to risk rating.
RSK-217	IF patients are unable to feed orally and need an alternative feeding method to meet their nutritional needs and staff do not feel confident to pass Nasogastric Tubes (NG Tubes) due to the low patient numbers requiring them THEN there is a risk that Nasogastric (NG) Feeding Tubes are not inserted and/or positioned safety, or there is a delay in confirming that the NG Tube is not positioned correctly	LEADING TO 1) Potential for aspiration which could lead to subsequent death. 2) Poor and unreliable identification of correct placement of NGT can lead serious harm or death of a patient. This type of event is a NPSA "Never Event". 3) Patients would experience a delay in feeding. 4) If bedside documentation is not fully completed or is inaccurately completed as per NPSA recommendations.Patients may be fed inappropriately in an unsafe environment. 5) Incomplete documentation may also lead to a delay in a patient's nutritional needs being met and their discharge delayed. 6) Potential for staff to be unaware of what documentation requires completing.	Organisation	Jane Radice	12-Oct-2022	31-May-2023	Planned	15	5	5		All NPSA recommendations were acted upon in 2011 in the Trust as per NPSA requirements by the ANP for Nutrition(24-Nov-2021), Nutrition Committee overseeing this alert and is standard item on agenda from Dec 16. Clinical Medical and Nutritional ANP leading on the action plan(24-Nov-2021), Policies, protocols and bedside documentation reviewed to ensure compliance(24-Nov-2021), Ongoing programme of audit. Previous audit data presented to NMB Spring 2016(24-Nov-2021), Dietetic Amalga database identifies patients who require Nasogastric feeding(24-Nov-2021), Trust declared compliance with 2016 Nasogastric Tube Misplacement: Continuing Risk of Death or Severe Harm Patient Safety Alert (NHS/PSA/RE/2016006)(24-Nov-2021), The NG tube used by the trust was changed in 2020 to a tube that is more radiopaque and is therefore easier to interpret on X-ray(24-Nov-2021), pH strips are purchased from one supplier to avoid confusion with colour interpretation(24-Nov-2021), Two nutrition nurses available to place NG tubes if there are no trained clinical staff available(24-Nov-2021), Radiographers trained to interpret x-rays for confirmation of NG tube tip position. This speeds up reporting and avoids junior medical staff having to assess X-rays(24-Nov-2021)	Low	Tolerate	Risk reviewed at Therapies CIG - No change to risk
RSK-160	IF the existing Bag Valve Masks (BVM) look similar to the Lung Volume Recruitment (LVR) bags that the department want to introduce as a Physiotherapy treatment modality for airway clearance THEN they could be used in error during resuscitation procedures	LEADING TO patient requiring resuscitation with a BVG could have resuscitation attempted with a LVR bag and could suffer consequences of incorrect treatment initially and delay to correct treatment procedures	Organisation	Adam Baddeley	12-Oct-2022	07-Apr-2023	Planned	15	4	4		•The bag has “not for resuscitation purposes” printed on the bag by the manufacturers and also comes with a yellow “not for resuscitation purposes” tag attached to it. •There are clear differences in the two bags appearances - All staff that work in the ward environments will have completed BLS training at least so will be familiar with the BVM equipment. They will have seen and used the BVM in practice during resus training and therefore would know that it has an oxygen reservoir bag and tubing that connects to an oxygen flow meter which an LVR bag does not have. •BVM is kept in its packaging hung on the resus trolley. When an LVR bag is provided to a patient it would be kept in their bedside locker in the navy blue drawstring bag it comes from the manufacturer in. •The resus trolley is checked daily by ward staff so if the LVR bag mistakenly was put in the resus trolley by nursing staff that would be recognised. •All physio staff that would be issuing this equipment out would have specific training before being able to use with patients. •The patient would be seen daily by Physio who would recognise if the LVR bag was missing from that patients locker. •If an LVR bag was issued to a patient then the nurse involved in that patients care would be informed of the equipment being kept in the patients locker (but not expected to use the equipment with the patient) •Once the LVR is not longer being used with the patient we will ensure it is promptly removed from the bedspace and	Medium	Tolerate	Risk reviewed at Therapies CIG - No change to risk
RSK-215	IF Child Protection (CP) Medicals are not completed THEN there is potential for delay in proceedings for Child Protection and could mean the children remain in care longer than they should	LEADING TO the police and Social Services having to return to get the medicals completed, an increased risk to the child's safety and potential litigation against the Trust	Organisation	Lesley-Anne Johnson	28-Nov-2022	03-Apr-2023	Planned	9	4	4	Ongoing discussions are being held with CCG and Designated Doctor to progress an agreeable pathway	Named Doctor to review the process of booking the patients in(24-Nov-2021), Social Service made aware that the earlier we know about CP Medicals the easier it is to get them in and out(24-Nov-2021), A interim process has been agreed that SW requesting CP Medical contacts the SGC Lead who will coordinate booking through ward 4 and discuss with on call consultant(24-Nov-2021)	Low	Tolerate	No change to risk. Outside control of the Trust. Annual Review.

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RSK-223	IF there are a reduced number of isolation rooms due to the need to provide additional space for medical teams, allied health services and office space. THEN there is a risk that The Trust cannot therefore safely care for patients with high risk transmissible diseases (i.e. multi-drug resistant tuberculosis, viral hemorrhagic fever etc.)	LEADING TO the potential for staff, patient and public exposure to life threatening diseases	Organisation	Angela Legate	25-Oct-2022	27-Jan-2023	Planned	9	4	4		Patient pathway identified using current resources from the ED to recieving wards in medicine and paediatrics. Capital programme in place for single room upgrade across the hospital(25-Nov-2021), Upgrades to ED isolation facilities(25-Nov-2021), Oxford and London hospitals now able to receive a small number of high risk patients(25-Nov-2021), Ward 22 - 14 single rooms with en-suite(25-Nov-2021)	Low	Tolerate	Risk reviewed by Angie Legate. No change to risk, review again in January 2023
RSK-233	IF we are unable to recruit sufficient qualified nurses THEN we may not have safe staffing levels in wards and departments	LEADING TO potential reduction in patient experience and patient care, giving rise to clinical/safety risk.	Organisation	Louise Clayton	31-Oct-2022	31-Dec-2022	Planned	16	4	4	International Recruitment of 100 Nurses (31-Oct-2022)	Apprenticeship routes for nursing(25-Nov-2021), System in place to recruit student nurses from placements at MKUH(25-Nov-2021), Enhanced adverts, social media and recruitment open day tool kit for Divisions to use(25-Nov-2021), NHS People Plan strengthens action on education and new roles(25-Nov-2021), National NHS England recruitment publicity(25-Nov-2021)	Low	Tolerate	Risk reviewed - No change to risk
RSK-237	IF the Trust is unable to spend the full amount of the Apprenticeship Levy each month THEN money which could have been used to develop our staff will be forfeit	LEADING failure to maximise taxpayers money. The Trust may not be able to use the apprenticeship levy to fund staff education, training and development. Inability to maximise the new apprenticeship standards may impact on recruitment, retention and career development	Organisation	Louise Clayton	28-Nov-2022	28-Feb-2023	Planned	15	4	2	Review of the Nurse Apprenticeship pathway is underway with newly appointed Head of Practice Education (29-Sep-2022)	Apprenticeship Manager attends the Nursing, Midwifery and Therapies Education Forum to promote apprenticeship benefits(25-Nov-2021), NHS People Plan commitment to support apprenticeships and other key national entry routes(25-Nov-2021), There is a national tender for the radiography apprenticeships underway led by HEE(25-Nov-2021), Apprenticeship strategy approved, maximising Levy use going forwards(25-Nov-2021), Medical apprenticeship consultation ongoing(25-Nov-2021), New apprenticeships have been created for IT, Data Analyst roles and HR.(10-May-2022), Increase in advertising of apprenticeships across the Trust and through the network through widening participation.(10-May-2022)	Low	Treat	Risk reviewed - Additional controls identified. No change to risk scoring.
RSK-261	IF adequate PAT testing is not carried out in a systematic and timely manner THEN untested faulty equipment could be used	LEADING TO poor patient and staff safety and increased claims against the Trust	Organisation	Mark Brown	09-Mar-2022	29-Mar-2023	Planned	8	4	4		Visual checks carried out by user(29-Nov-2021), 100% PAT testing completed annually by contractor(29-Nov-2021)	Low	Tolerate	Reviewed by Associate Director of Estates and Estates Services Manager. Agreed no change to risk rating.
RSK-287	IF the medical vacuum pumps fails to function or becomes non-compliant with HTM requirements THEN the vacuum plant may not be available	LEADING TO Potential loss of service, reduced patient safety and substandard care.	Organisation	Michael Stark	12-May-2022	29-Mar-2023	Planned	12	4	4		PPM, schedule and reactive repairs in place as required(30-Nov-2021), Steve Goddard has been appointed Authorised Engineer and has conducted a site wide inspection. No specific issues were identified(30-Nov-2021), Phase 1 plant was replaced 2017(30-Nov-2021), Phase 2 Plant to be considered for replacement in future due to age, although no issues currently(30-Nov-2021)	Low	Tolerate	Reviewed risk owner and updated.
RSK-288	IF the medical oxygen supply fails to function or becomes non-compliant with HTM requirements THEN the oxygen plant may not be available	LEADING TO potential loss of service, reduced patient safety and substandard care	Organisation	Michael Stark	21-Sep-2022	30-Dec-2022	Planned	12	4	4		PPM Schedule, and reactive repairs as required(30-Nov-2021), Robust contingency plan is in place with liquid O2(30-Nov-2021), Steve Goddard has been appointed as Authorised Engineer(30-Nov-2021), Estates Officer has been appointed as AP(30-Nov-2021), SHJ appointed as maintenance contractor(30-Nov-2021), AP training booked for and additional estates officer and estates service manager(30-Nov-2021), VIE capacity upgrade 2021(30-Nov-2021), Draft feasibility to achieve second VIE, and conversion of site to ring main, linked to HIP programme(30-Nov-2021)	Low	Tolerate	No changes to current risk rating
RSK-294	IF staff do not carry out either informal (i.e. experience-based) or formal risk assessments before attempting a work task THEN there is a risk of personal injury to staff carrying out routine work	LEADING TO poor staff safety, injury and financial loss	Organisation	Michael Stark	12-May-2022	29-Mar-2023	Planned	12	4	4		All staff receive formal risk assessment training, and are competency assessed for their roles. Independent External Advisor contractor commissioned to review estates risk assessments and arrangements regularly.(30-Nov-2021), Risk awareness training is performed annually along with asbestos awareness training for all workshop staff as part of the H&S training package(30-Nov-2021), Training plan updated and implemented(30-Nov-2021), Facility to add Risk Assessments by task type to MICAD PPM tasks(30-Nov-2021), Weekly huddle meeting with maintenance staff to include H&S(30-Nov-2021)	Low	Tolerate	Reviewed risk owner and updated.
RSK-295	IF there is a lack of knowledge on use or poor condition of ladder THEN there is a risk of fall from height from ladders	LEADING TO risk of harm to staff, poor public image, a potential investigation by HSE	Organisation	Paul Sherratt	12-May-2022	29-Mar-2023	Planned	12	4	4		Staff issued with safe use of ladder guidance(30-Nov-2021), Ladder inspections PPM schedule in place to check(30-Nov-2021), New replacement ladders have been installed, tagged and registered(30-Nov-2021), A competent training person needs to be identified to provide continual training(30-Nov-2021), RP Appointed(30-Nov-2021)	Low	Tolerate	Reviewed risk owner and updated.

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RSK-390	IF the current Amber alert for Blood stock escalated to a Red Alert, THEN the Trust may be unable to provide required red cell components to patients in need	LEADING TO patients that do not fulfil the criteria of transfusion in a red alert situation may be denied red cell transfusions and potential shortening of the patient's life	Organisation	Jasmine Marshall Beharry	08-Dec-2022	31-Jan-2023	Planned	12	4	4		Emergency Blood Management Arrangements (EBMA): Review of elective surgery. Defer all patients who have a greater than 20% chance of requiring transfusion of 2 units or more. Communicated to stakeholder hospitals. Top up transfusion threshold moved from 80g/L to 70g/L with and request over threshold being challenged by BMS staff and possibly referred to Haem clinicians for review.(28-Oct-2022), Top up transfusion requests with an Hb higher than 70 g/L will be challenged and referred to a consultant if required(28-Oct-2022), EBMA: Consider limiting transfusion to 2 units where Hb falls below trigger levels.(28-Oct-2022), Red cells for transport currently limited to 2 units(28-Oct-2022), Clinical area required to check Hb after single unit transfusions to determine whether more units are required(28-Oct-2022), Communication has been shared with Trust directors, Silver Command, HTC members, Stakeholder hospitals and managers in medicine, surgery, W&C and Oncology.(28-Oct-2022), As part of the Massive Haemorrhage Protocol (MHP) process, the designated communicator should inform the lab to stand down.(28-Oct-2022), All requests for red cells to be reviewed by Haematology clinician.(28-Oct-2022),	Low	Treat	NHSBT has advised Trusts to remain in a pre-Amber alert status until at least January 2023