Board of Directors
Public Meeting Agenda

Meeting to be held at 10am on Thursday 14 January 2021 remotely via Teams in line with social distancing

Item No.	Title	Purpose	Type and Ref.	Lead
1. Introduction and Administration				
1.1	Apologies	Receive	Verbal	Chairman
1.2	Declarations of Interest • Any new interests to declare • Any interests to declare in relation to open items on the agenda	Noting	Verbal	Chairman
1.3	Minutes of the meeting held in Public on 5 November 2020	Approve	Page 3	Chairman
1.4	Matters Arising	Receive	Verbal	Chairman
2. Chair and Chief Executive Strategic Updates				
2.1	Chairman's Report	Receive and Discuss	Verbal	Chairman
2.2	Chief Executive's Report	Receive and discuss	Verbal	Chief Executive
3. Quality				
3.1	Patient Story	To Note	Presentation	Director of Patient Care and Chief Nurse
3.2	Nursing staffing update	To Note	To follow	Director of Patient Care and Chief Nurse
3.3	Ockenden Report Trust Response	Receive and Discuss	Page 14 Page 62	Director of Patient Care and Chief Nurse
4. Performance and Finance				
4.1	Performance Report Month 8 Executive Summary	To Note	Page 66 To follow	Deputy Chief Executive
4.2	Finance Report Month 8	To Note	Page 74	Director of Finance
4.3	Workforce Report Month 8	To Note	To follow	Director of Workforce
5. Strategy and investment				
5.1	Winter escalation plan/Covid second wave plan update	To Note	Verbal	Director of Operations

Item No.	Title	Purpose	Type and Ref.	Lead
5.2	Estates development update	To Note	Verbal	Deputy Chief Executive
6. Assurance and Statutory items				
6.1	Significant Risk Register	To Note	Page 84	Director of Corporate Affairs
6.2	Board Assurance Framework	Receive and Discuss	To follow	Director of Corporate Affairs
6.3	(Summary Reports) Finance and Investment Committee – 2 November 2020 30 November 2020	To Note	 Page 89 Page 90	Chair of Committee
7. Administration and closing				
7.1	Questions from Members of the Public	Receive and Respond	Verbal	Chairman
7.2	Motion to Close the Meeting	Receive	Verbal	Chairman
7.3	Resolution to Exclude the Press and Public	Approve	The Chair to request the Board pass the following resolution to exclude the press and public and move into private session to consider private business: *"That representatives of the press and members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted."*	Chairman

Milton Keynes University Hospital NHS Foundation Trust

BOARD OF DIRECTORS MEETING

Draft Minutes of the Board of Directors meeting held in PUBLIC on November 5, 2020 remotely via Teams due to pandemic

Present:

Simon Lloyd (SL)	Chairman
Joe Harrison (JH)	Chief Executive
Ian Reckless (IR)	Medical Director
John Blakesley (JB)	Deputy Chief Executive
Emma Livesley (EL)	Director of Operations
Kate Jarman (KJ)	Director of Corporate Affairs
Danielle Petch (DP)	Director of Workforce
Mike Keech (MK)	Director of Finance
Nicky Burns-Muir (NBM)	Chief Nurse & Director of Patient Care
Sophia Aldridge (SA)	incoming Interim Director of Finance
Heidi Travis (HT)	Non-Executive Director (Chair of the Finance & Investment Committee
Helen Smart (HS)	Non-Executive Director (Chair of the Quality and Clinical Risk Committee)
Andrew Blakeman (AB)	Non-Executive Director (Chair of the Audit Committee)
Nicky McLeod (NMc)	Non-Executive Director (Chair of the Workforce Development & Assurance Committee)
Haider Husain (HH)	Non-Executive Director
John Lisle (JL)	Non-Executive Director
Luke James (LJ)	Associate Non-Executive Director

In attendance:

Alison Marlow (AM)	Trust Secretary (minutes)
Julie Goodman (JG)	Trust Lead for Complaints (item 3.1)

Other attendees

Jackie Westway (member of public)
James Nichols (member of public)
David Tooley (local democracy reporter)
Andrea Thompson (CQC representative)

1	**Welcome**
	The Chairman welcomed all present to the meeting.
1.1	**Apologies**
	No apologies were received.
1.2	**Declarations of interest**
	No new interests had been declared and no interests were declared in relation to the open items on the agenda.
1.3	**Minutes of the meeting held on September 3, 2020**
	Item 3.1 – last line to be reworded for accuracy, then the minutes of the public Board meeting held on September 3 2020 were accepted as an accurate record. There were no matters arising.
2	**Chairman and Chief Executive's Reports**
2.1	**Chairman's Report**

	The Chair noted note that the NHS has moved to level 4 as announced yesterday. AB gave an update on Chair recruitment. This is the second round of searches as the first was unsuccessful. Applications close on November 9 and we are confident we will be able to appoint. Interviews on December 11. It was Mike Keech's last meeting as DoF. The Chair reported that his successor has been appointed and an announcement would be made in due course. Sophia Aldridge will be acting DoF on Mike's departure. ICS – work was ongoing and a consultancy had been engaged to work with ICS to look at role of CCG in terms of strategic commissioning. They had spoken to various stakeholders. The Chair said he would keep the board updated on developments. **Resolved**: The Board **noted** the Chairman's Report **Chief Executive's Report** The CEO referred the Board to the printed report in the papers but went on to highlight key items. With Level 4 being reinstated, he said things were moving very fast indeed and that Daily Gold and Silver Command meetings had been reinstated. NBM said that the Trust was seeing an increasing number of Covid positive patients. At beginning there was more space in the organisation but now with winter it was more challenging. She said all side rooms were being used and pathways were being looked at. Because of how viral loading works, it was possible for a patient to have a negative swab and then five days later be positive She said any positive swabs were followed by a RCA. Reviews were done on a daily basis. IR explained that patients suspected or already positive came in on a red pathway through ED. If needed they go to ICU or W2 where there was a lower density of patients, pending the return of swabs. When the results were back they were moved to appropriate areas. He said the numbers were going up but that he was cautiously optimistic about the MK picture and also the red pathway and assessment pathway which could both flexed up/down according to numbers. EL said that during the quieter period in the summer they took the opportunity to do estates work. This weekend ICU would be repatriated to the newly refurbished W6, Day Surgery will move back to its own area and W22 would be back in use for additional Covid capacity. Work on W14 was concluding and that would bring another 24 beds back into use. JH explained that NBM had developed an in-house visiting app that complied with track and trace. Guidance was being reviewed on a daily basis, but he stressed that the Trust supported end of life visiting and John's campaign. All requests for visits had to be approved by Gold, monitored by matrons and senior leaders on ward. He said the challenge was around making sure patients remain connected but maintaining safety for staff and patients. He said when the Trust did the Ross Kemp documentary they were challenged about not allowing visitors and stressed that new measures meant visiting now could be considered, within safety measures as outlined.

	JH stressed that the work the Trust was doing with partners to manage MK as a place was excellent and that working relationships with the council, mental health colleagues etc were strong. HT asked if cases doubled in the next 10 days would the hospital be able to cope and EL said yes, there was resilience for that. IR said there was external temptation to see wave two as another wave one, but he stressed this was quite different and there was more data. The Trust wanted to keep electives running as far as possible. He said there was much more clarity regarding a super-surge, which for the hospital, would mean transferring patients to planned space at Papworth. AB asked for reassurance on oxygen supplies and PPE. JH said there was sufficient stock of PPE. IR said they were keeping a close eye on oxygen. He said that. CPAP masks have a higher draw on oxygen than intubated patients. Yesterday using 35-40% of available oxygen. There had also been a delivery of non-invasive ventilators, which are better in terms of reduced leakage. NBM said ensuring the Trust had suitably skilled staff was key. There had been a comprehensive training programme for staff who work in those areas. Staff who worked in intensive care at the peak were skilled up if required. HS thanked JH for his report and paid tribute to the executive team on the work they continued to do on staff welfare, demonstrated by the recruitment and retention of staff. She expressed concerns about the welfare of directors. JH said that one of benefits of being the second isolation site from Wuhan and the intensity of those two weeks as a team was the recognition that directors took time off when appropriate and used the overall infrastructure of the system. SL asked if Nosocomial could be reported at forthcoming Boards. JH – commented that it was pleasing to report to Board how well recent training events have been received. KJ explained about the staff engagement event - Virtual Event in Tent – with the focus on rest, recovery and resilience. This replaced the normal marquee event. 600 staff a day logged into various sessions, which were available afterwards as recordings. The Trust was now looking to develop a virtual wellbeing platform particularly for remote workers, following feedback, to help support staff going into winter. JH said Duty of Care/Candour work was going on and that a detailed report would be brought back to Board when available. He said it was genuinely innovative and groundbreaking work with families who might be involved with Complaints. The Apple Health option went live and was very positively received. JH said that nationally, through his work at NHSX, they were looking at how to roll this out across all Cerner sites. Black History Month was celebrated with a huge number of virtual events. JH also spent valuable time with our BAME network, being clear about our commitment to support.

	Through DP, the Trust was looking at the work it has been doing on Brexit. DP attended a webinar with national leads for Brexit and an update will be brought to Board when ready. IR explained there had been a never event where the wrong shape of synthetic plastic bearing was inserted into a knee. He said the consequences were minor but the patient required a second operation to correct this. This never event will be discussed at the next Quality and Clinical Risk Committee, and a report brought to Board in January. **Resolved: The Board noted the Chief Executive's Report**
3	**Quality**
3.1	**Patient Story** Julie Goodman gave a comprehensive presentation of the work done to ensure patients maintained contact with relatives during the first wave and outlined steps that would continue if a second wave were to occur. She also included details of the work done to support busy staff (eg, Staff Hub, groceries available in restaurant and Friends shop). Among the initiatives to continue were Letters to Loved Ones, bag drop off, welfare checks, and a bigger Staff Hub A matron role would also be integrated into Patient Experience. SL thanked JG for the presentation and the good work continuing. AB said it was a very comprehensive suite of actions and asked if similar was happening elsewhere. NBM said many trusts had taken on board some of our actions. She said some Trusts had been more successful recruiting younger volunteers and that was something MK was going to look at, especially with so many young people having deferred university. AB asked if there was a central location where this kind of work could be shared. NBM referred to Fab Change Week, and also said that networking had become stronger. IR said the Ross Kemp documentary had helped, and JG referred to a patient who had since died who featured on the film. His relatives now cherished the footage. **Resolved:** The Board thanked Julie Goodman for her presentation.
3.2	**7-Day Services Update** IR said 7 Day Services and monitoring were suspended during the pandemic. He said there were 10 NHSE standards which were aspirational. The Trust was making steady progress towards that, and were performing above average and likely to hit 3 of 4 priority standards. He said the Trust hadn't stopped monitoring but expected there to be more scrutiny on it when NHSE starts it up again next year.
3.3	**Nursing Staffing Update** The report was taken as read. NBM explained that rates in August often appeared lower due to holidays and less beds open. She highlighted the success with recruitment and said that many students who worked here during the pandemic had gone on to take Band 5 posts here. The Workforce matron has developed a 5-step programme with HR which is working well. Therapies assistants are being introduced with a broader remit. Surgery has attracted a number of experienced staff. During Covid, people have re-thought travelling to further sites and been attracted by our staff benefits and

	also the preceptorship programme which is extended to two years. A Band 6 programme has also been developed. She said there was a need to work on the HCA workforce and encourage bank workers to transition to substantive roles. She said check and challenge meetings were held regularly to ensure staffing is correctly managed. There was good engagement from senior nurses and matrons around rotas. NBM reported the good news that a number of staff had received Thames Valley health awards. Investment in senior nursing was approved at Trust Executive Group. Each ward would now have a Band 6 nurse 24/7 to improve safety and patient experience outcomes. There were now six chief nurse fellows undertaking leadership courses. A learning disabilities nurse had joined the team and was already making a huge impact for patients with additional needs. NBM said that there were a significant number of patients with mental health concerns and there was a need to build understanding of managing them in an acute setting. SL said this was all very positive. Mike Keech asked about the 75% staffing in some wards, particularly W19 and W21. NBM explained that this was due to escalation beds on W19 and therefore added another HCA to support. This was why the fill rate looks reduced. W21 appeared as half staffing but that wass because only half the ward was open, yet the data monitored it as a full ward. JL commented on the good report. He asked if there was an easy way to find out if staff were working more than 37.5 hours. DP said the rostering system had comprehensive working time rules embedded within it, which would give a warning if close to a limit. She also said staff were encouraged to take leave when they could. The Trust recognised people might not be able to take all leave, so they would be able to sell back or carry over, HH said he had the opportunity to visit the hospital last month regarding mental health and saw first hand the great work going on. HS said the report was impressive. She asked how challenging it would be to staff W22. NBM said that each year it was always have a challenge opening an escalation ward, but that during the pandemic the Trust had learned to gather people quite quickly. The Trust had already identified a senior sister doing a maternity cover and she was going to run W22 for winter. W14 staff wanted to work together again and that will be accommodated. She said it was always a challenge, depending on the acuity and complexity of patients but that it was vital to look at safer care and staffing on a regular basis.
3.4	**Mortality Report** The report was taken as read. IR made two points – that the SHMI is statistically high at moment and that the qualitative aspect and the identification or not of care quality concerns. He was confident there was no care quality concern and believed the high SHMI related to data. Every single death was reviewed by a medical examiner.

	He believed the SHMI increase was mostly driven by electronic patient records where it was more difficult to capture comorbidities. Previously a patient would have been coded under general medicine and remained thus for their stay, but now if a patient goes from ED to cardiology the information is recorded differently. NMc said there was a lot of information in the data around mortality. She had been pleased to meet with Dr Parmar, lead medical examiner. She stressed it was not just about data but about the human element in that every death is reviewed by a human, who has vital conversations with the relatives. At the end of the visit she felt more confident that everything was being reviewed and looking behind data. IR agreed but stressed the Trust wanted to want to understand our SHMI position and the work going on particularly with other sites with EPR. He said that medical examiners did a great amount for relatives and assurance, but that the work they were putting in at the moment wasn't as good in terms of feeding back into the organisation. He hoped that would improve.. He also commented that out of 289 deaths there was only one care quality concern. He said that more care quality concerns needed to be identified and from 2021 they would be encouraging colleagues to raise care quality concerns. LJ asked if the Structured Judgement Review was a fixed national process or could it be adjusted to local needs. IR said it was a standardised process but wanted it to be less of a tick-box exercise. He said they knew that when cases are reviewed by independent clinicians review you do find care quality concerns in 5-10% of cases.
3.5	**Staff health and wellbeing update** The paper was taken as read. DP outlined the huge amount of support to staff, including over 9000 outbound calls to staff (especially those alone at home), also food parcels and the creation of a staff hub. The Trust also participated in two research studies – one for asymptomatic staff and one for antibody testing. The Trust engaged with BAME colleagues throughout the pandemic which affected these colleagues in a different way. Changes were made to the risk assessment process. MKUH was one of the first Trusts to do risk assessments for everyone – with 1100 risk assessments for the clinically vulnerable reviewed by a panel. After first surge/shield the Trust recognised that many struggled to come into the workplace so we formed support circles, peer support and reassurance. The Trust had put a lot of effort into being supportive. The Flexible and Carers Leave policy was changed so that so that staff had a variety of leave options. As travel corridors were introduced, it devised a process to allow staff to go on holiday if they wanted to, along with plans if quarantine was needed on return. This was especially valuable for colleagues who wouldn't normally work from home. They could use paid leave, work the hours back or as a final resort take unpaid leave. DP said the Trust worked really hard with partners across region to stock our bank and used fast track recruitment for staff and volunteers. The NHS People Plan – MKUH featured quite heavily in this. DP thanked KJ for her work with NHS Flex. She stressed the Trust was in a good position as it had implemented a lot of the recommendations already. Updates would be brought back to Board.

	JH asked how the Board could be sure that by fast tracking there hadn't been any shortcuts. DP said national tools were used, including fast track DBS and utlisation of factual references via the national HR system. They were also able to rely on information from professional bodies. MK commented on the helpful summary re clinically extremely vulnerable. He asked about the impact of new guidance. DP said her team had already reviewed the 48 staff who came into the extremely clinical vulnerable category. These staff are working from home, or if not possible, alternative tasks sought. She did comment that many of those who shielded first time felt guilty and liked to be given tasks to ensure they still felt useful and relevant.
3.6	**Membership Engagement** The report was taken as read. KJ explained it would go to the Council of Governors as membership engagement was part of their remit. The Trust was looking to do more engagement as membership was static and in fact had slightly declined over the last couple of years. The aim was to encourage governors to get more engagement from their communities. .AB asked how it would be resourced. KJ said Julia Price would lead the work alongside the Communications team. SL said it was a very good paper and also said it was important to encourage governors to feed into operational areas as they had done in the past as it was very useful to have that input.
3.7	**Engaging with Users – Maternity Voices Partnership** NBM showed a brief animation demonstrating how a BLMK working partnership had benefited women through listening to their views. She said it was helpful to evidence that engagement can have good results..
4.	**Strategy**
4.1.	The Strategic Outline Case presentation was given to support the paper in the pack, which was taken as read. JB reminded the Board that it was the SOC for the redevelopment of the hospital in line with the HIP programme of £200m to develop the hospital. He stressed that MKUH were in the programme due to the growth of the town and its projected future growth rather than because buildings were falling into disrepair. The SOC had received approval in principle from the CCG. The Finance and Investment Committee studied it and made some requests for changes, which have been actioned. JB said it was probably the most important strategic project that the hospital will have for the next five years or so. JB said that the hospital has been growing at a third of an inpatient ward every year. A variety of ways of measuring growth had been used. In MK there are an average of 2.5 people per household compared to the national average of 2.2 and it estimated that the population will be approx. 469k by 2050. JB said there had been robust conversation with NHSI and regional estates teams and the CCG to make sure they understand the consequences of population growth and that it's in line with their expectations. This is absolutely in line with their forecast. SA referenced affordability, saying the Trust had been transparent with the national team so when you looked at financial position you would see one big hit in 2026 and the organisation would recover quite quickly, which wouldn't

	ordinarily be the case. MK added that it was typical for a new building to be impaired at beginning of use but that was a technical accounting piece. HT asked what would happen to vacated spaces on site? JB said some of the space would be repurposed into general wards and in the short term this may be done to reduce the density of the wards. HH asked how it would support the digital strategy. JB said that HIP2 was predicated on achieving certain national goals such as off-site construction. NHSX published the digital footprint for the HIP programme. He emphasised that 'digital' did not just mean electronic records but also clever tech regarding things such as heating, cooling, blinds. The Trust was looking at the whole range of technology from cleaning systems to patient experience. **Outcome: The Strategic Outline Case for the HIP2 Programme was approved by the Board.**
4.2	**Winter Escalation Plan/Covid second wave plan** EL said the clear message this time was that NHS systems are open for business and the local population is responding to that. A health cell meets regularly. She said that 30% of outpatient activity was taking place virtually. Services are still being moved. Last week the Maple Unit was emptied to make way for the Pathway Unit. This meant thousands of appointments were rebooked – thank you to everyone who made this happen. Moves this weekend would lead to more elective activity. The Trust was still using the independent sector as planned until end of December. The 52 week (52WW) breach position remained low in comparison to other organisations. More equipment had been ordered, especially for ENT. The other backlog was in T&O services. Attendances in ED were still fluctuating (220 average in 24 hours whereas used to be 270). The challenge was the use of two different pathways, red and green zones. The RAU (Respiratory Assessment Unit) could be resinstated if needed to allow for expansion of the ED footprint of ED. EL said she didn't want to underestimate the challenge of staff managing two separate departments within one, but that ED performance was still to be commended and still in top quartile nationally. Everyone entering ED was swabbed. Winter escalation challenges were very different and there were joint plans with BLMK ICS and the region. There was still recovery to maintain, a second surge and Brexit to be managed in addition to normal winter pressures. The assurance was there and there were good plans in place, but workforce remained one of the biggest concerns. JH said that regarding 52WW, the national figure at the end of August was 110k so the Trust plans to bring down its long waiters were doing very well in a challenging national context. AB said in terms of benchmarking, due to the unequal nature of the pandemic it would be more interesting to know how the Trust compared to closer hospitals. JH said that it appeared that the position was going to steadily worsen so the Trust was keen to keep elective pathways going. JB added that the East of England region had recovered very well compared to other regions.

5.	**Performance and Finance**
5.1	**Performance Report M6** This was taken as read. EL said it was worth noting that there was work still to be done on long Length of Stay patients. **The Performance report was received, discussed and noted.**
5.2	**Finance Report M6** The report was taken as read. MK said that in M6 the Trust was operating under fixed lump sum and two additional top ups. In terms of month 6 break even position, the Trust claimed an additional £444k in respect of Covid costs, compared to £1.2m at peak. He said the second half financial regime would retain a block contract sum, with additional funding for inflationary pressures. The change was that whereas previously the Covid top up was variable it would now be fixed at a system level. MK said the increased number of Covid cases would lead to additional costs and the risk was that it was as yet unclear if the financial regime would continue. AB asked if it mattered if the Trust couldn't quite balance the books in these unusual times. JH said that the Trust had hit its financial control totals for the last 7 years and as a consequence of that it was seen as a high performing organisation and allowed head room to get involved in innovation. He said it was important for financial controls to continue to avoid regulatory intervention. MK added that it would depend on how the Trust was performing relative to others. At a local level want to be using taxpayer money wisely and to minimise cost implication while keeping patients and staff safe. JH said it was important for the Board to note that the Trust had areas of spend that could be curtailed to buy some financial support to maintain patient safety. SL thanked MK for an excellent report.
5.3	**Workforce Report M6** The report was taken as read. DP said the Trust was doing well on statutory mandatory training and appraisals/vacancies. The Health and Wellbeing strategy had been agreed, and would go to the Trust Executive Group. KJ is handling a large piece of work on QI and learning that is going well. Flu jabs and staff survey work is going well, with staff who have their jabs being given the survey at the same time, which should lead to increased update. There were a large number of applicants for the Leadership and Inclusion Council which will act as a critical friend to the Board. The selection process is underway. Inclusion leadership council. Critical friend to the Board. Large no of applicants for roles and selection process underway. JL asked if flu jabs could be made mandatory. JH said he would expect the unions to challenge a local mandate but that the Trust would continue to pressure the national bodies. IR said mandating flu jabs was not the sort of thing the Trust could do solo.
6,	**Assurance and Statutory items**

6.1	**Significant Risk Register Report** KJ presented the report which was taken as read. She said the Audit Committee last month discussed proposed changes to risk management framework, with benchmarking with local auditors. There is currently one SRR which is all high scoring risks (summary on report including risk profiling). The Audit Committeee considered the Risk Register in full as did QCRC. She said the Trust was also making changes to the risk management governance structure – with more focused work on divisional risk. She said the proposal was not yet approved, but was presented to the Board for information. . JH said he found the report far more helpful. KJ said the Trust was working with its internal auditors RSM to benchmark/ risk processes subject to internal audit every year. JH asked for a brief view of process of moving risks on to the BAF? KJ said that not all risks needed be on the BAF, as some are on the Significant Risk Register and others managed at a corporate level. AB said it was about ensuring that the Trust was crystal clear about the purpose of all the different stages. He said it wasn't a difference of goals but of agreeing a common language. HT said it was good that the Board spent a lot of time talking about risk. She said it would be good moving forward if the Board could talk through again how each risk steps up and down. SL asked for further comments to be fed directly to KJ.
6.2	**Board Assurance Framework** KJ said most items on the BAF had been discussed at committee level. She proposed the inclusion of new risks: 1. Risks around HIP2 in terms of estate objective and to be brought back through the next round of committees. 2. Use of health information like Apple and Sensyne and the opportunist risk appetite for such developments. AB said he liked the new format and that changes should be acknowledged individually. He said it would be useful to have a summary of changes made since last time.
6.3	**Update to the Terms of Reference of the Board and its Committees** Minor changes had been made to some of the Terms of Reference of the Board and its Committees. KJ asked for any minor amendments to be taken off line. **Outcome: The Board approved the updates.**
6.4	**Board Register of Interests** KJ said the report was an update and the full list was available on the Trust website.
6.5 - 6.9	**Summary Reports** These were noted by the Board.
6.10	**Use of Trust Seal** This was noted by the Board.
7	**Closing Administration**
7.1.	**Questions from Members of the Public** There were no questions
	AOB

	• JH said a new non-executive director representing the University of Buckingham had been appointed and approved by the Governors. He said it was very positive to have a senior member of staff coming on to our Board. • The Maple unit has been closed off and demolition started. • SL formally recorded the Board and hospital's thanks and appreciation for the truly excellent job MK had done as Director of Finance. He said he was a consummate finance professional, who brought leadership to the organisation, with character, sense of humour and as a good team player. He said the Trust's loss was Addenbrookes' gain. MK thanked the Board and said he had spent an enjoyable four and a half years here. The meeting closed at 12.50pm

OCKENDEN REPORT

Emerging Findings and Recommendations
from the Independent Review of

MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

Our First Report following 250 Clinical Reviews

10 December 2020

Return to an Address of the
Honourable the House of Commons
dated 10 December 2020 for

Emerging Findings and Recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust

Our First Report following 250 Clinical Reviews

HC 1081

Ordered by the House of Commons to be printed on 10 December 2020

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Letter to the Secretary of State for Health and Social Care from Donna Ockenden

10 December 2020

Dear Secretary of State

I publish this emerging findings report at a time when the NHS is facing further challenging months ahead as a result of the Covid 19 pandemic. We are all aware that frontline NHS staff have, day after day, risen to these challenges, demonstrating their commitment to providing excellent care in what are often seen and described as the most difficult of circumstances.

Whilst this year, especially, has been about the pride our country has quite rightly in our NHS, this independent maternity review is about those families who have suffered harm as a result of their NHS care at a time when they had planned for a joyous event. Families have told us of their experiences of pregnancies ending with stillbirth, newborn brain damage and the deaths of both babies and mothers. These families have shared with us their accounts of the overwhelming pain and sadness that never leaves them.

We have met face to face with families who have suffered as a result of the loss of brothers and sisters or, from a young age, have also been carers to profoundly disabled siblings. We have met many parents where there have been breakdowns in relationships as a result of the strain of caring for a severely disabled child, the grief after the death of a baby or resultant complications following childbirth.

Following the review of 250 cases we want to bring to your attention actions which we believe need to be urgently implemented to improve the safety of maternity services at The Shrewsbury and Telford Hospital NHS Trust as well as learning that we recommend be shared and acted on by maternity services across England.

Your predecessor, the former Secretary of State Jeremy Hunt, requested an *'independent review of the quality of investigations and implementation of their recommendations of a number of alleged avoidable neonatal and maternal deaths, and harm at The Shrewsbury and Telford NHS Trust'*. When I started work as chair of this review, 23 cases had been identified after considerable efforts by the parents of Kate Stanton Davies and Pippa Griffiths who both died just after their births in 2009 and 2016, respectively. Since the review commenced, the number of families who have directly contacted my team, together with cases provided by the Trust for review, has now reached 1,862. When the review is completed, this is likely to be the largest number of clinical reviews conducted as part of an inquiry relating to a single service in the history of the NHS.

Understandably, examining the details of 1,862 cases is taking time and we continue to face many challenges which are out of our control, including adapting to new ways of working during the COVID19 pandemic.

Due to the significant increase in numbers, I was asked by the Minister of State for Mental Health, Suicide Prevention and Patient Safety to do my utmost to enable initial learning for The Shrewsbury and Telford Hospital NHS Trust and the wider NHS in this calendar year. Therefore, I publish this first emerging first report arising from the 250 cases reviewed to date. The number of cases considered so far include the original cohort of 23 cases.

My team and I have also held conversations with more than 800 families who have raised serious concerns about their care. These are in addition to the 250 cases considered in this

report and have also informed our findings in this report. We would like to pay tribute to all the families who have approached us to share their experiences.

We have identified a number of important themes which we believe must be shared across all maternity services as a matter of urgency. Therefore, with the full support of the Department of Health and Social Care and NHS England and Improvement we are sharing emerging findings and themes, have formed **Local Actions for Learning** and make early recommendations which we see as **Immediate and Essential Actions**. We appeal for these to be implemented at The Shrewsbury and Telford Hospital NHS Trust as soon as practically possible and recommend these for thorough consideration within all maternity units across England.

Secretary of State, through our work to date we have recognised a need for critical oversight of patient safety in maternity units. This oversight must be strengthened by increasing partnerships across trusts within local networks of neighbouring trusts. Neighbouring trusts and their maternity services **must** work together with immediate effect to ensure that local investigations into all serious incidents declared within their maternity services are subject to external oversight by trusts working together. This is essential to ensure that effective learning and impactful change to improve patient safety in maternity services can take effect using a system wide approach and in a timely manner.

We have no doubt that, had a similar structure of partnership working been in place, The Shrewsbury and Telford Hospital NHS Trust would have been alerted much earlier for the need to scrutinise its governance processes and learn from its serious incidents.

For this structure to be effective we have identified the need to give increased authority and accountability to Local Maternity Systems (LMS) to ensure safety and quality in the maternity services they represent. They must have knowledge of all serious maternity incidents within their LMS with input to and oversight of these investigations and their resultant outcomes and recommendations. Of significance is that we are convinced that an LMS cannot function effectively when limited to one maternity service only. We also consider it imperative that family voices are strongly and effectively represented in each LMS through the Maternity Voices Partnerships.

This is just one of seven **Immediate and Essential Actions** we outline in this first report. We will add to and strengthen these recommendations in our final report following completion of this review as per the terms of reference. We are certain that these **Local Actions for Learning** and **Immediate and Essential Actions** will improve safety in the maternity service at The Shrewsbury and Telford Hospital NHS Trust and across all maternity services in England provided that implementation is approached with urgency and determination.

Thank you Secretary of State for your ongoing support.

Yours sincerely,

Donna Ockenden
Chair of the Independent Maternity Review

Acknowledgements

This first report and the work that will follow owes its origins to Kate Stanton Davies and her parents Rhiannon Davies and Richard Stanton and to Pippa Griffiths and her parents Kayleigh and Colin Griffiths.

Kate's death in 2009 and Pippa's death in 2016 were avoidable. Their parents' unrelenting commitment to ensuring their daughters' lives were not lost in vain continues to be remarkable. In a void described by the families as 'incomprehensible pain', they undertook their own investigations to highlight the deaths of their newborn daughters, and to insist upon meaningful change in maternity services that would save other lives.

Rhiannon, Richard, Kayleigh and Colin persisted in their call for an independent review of maternity services at The Shrewsbury and Telford Hospital NHS Trust; through their tenacity and efforts this review was instigated.

We remain indebted to all the families contributing to this maternity review. Their experiences continue to shape the learning which will transform maternity care for the better. Finally, we convey our sincere gratitude to the many families who tried to raise serious concerns about maternity care and safety at the Trust who have told us they were not listened to.

Why This Report is Important

Serious complications and deaths resulting from maternity care have an everlasting impact on families and loved ones.

The families who have contributed to this review want answers to understand the events surrounding their maternity experiences, and their voices to be heard, to prevent recurrence as much as possible. They are concerned by the perception that clinical teams have failed to learn lessons from serious events in the past.

The learning of lessons and embedding of meaningful change at The Shrewsbury and Telford Hospital NHS Trust and in maternity care overall is essential both for families involved in this review and those who will access maternity services in the future.

After reviewing 250 cases and listening to many more families, this first report identifies themes and recommendations for immediate action and change, both at The Shrewsbury and Telford Hospital NHS Trust and across every maternity service in England.

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Explanation of Maternity specific terminology used in this report

Throughout the text this report sometimes uses terms and words that may be unfamiliar to some readers. Although use of these are kept to a minimum, on occasions they are essential because this is a report about maternity services. These terms and words are highlighted in ***bold italics*** at the first use with further explanations for them found in the Glossary at the end of this report.

Chapter 1

Introduction

1.1 In the summer of 2017, following a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at The Shrewsbury and Telford Hospital NHS Trust, the former Secretary of State for Health and Social Care, Jeremy Hunt, instructed NHS Improvement to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust.

1.2 The first terms of reference in 2017 were written for a review comprising 23 families. They were amended in November 2019 to encompass a much larger number of families. The current terms of reference can be found in Appendix 1.

1.3 Since the commencement of this review many more families have directly approached the review team, voicing similar concerns to those raised by the original cohort of 23 families. Intermittent publicity regarding the work of the review led to a continual increase in families wanting their stories and voices to be heard and their questions and concerns answered. Between June 2018 and the summer of 2020 a further 900 families directly contacted the review team raising concerns about the maternity care and treatment they had received at the Trust. These included a number of maternal and baby deaths and many cases where babies suffered brain damage possibly as a result of events that took place around the time of their birth.

1.4 In addition, The Shrewsbury and Telford Hospital NHS Trust , supported by NHS Improvement and NHS England, undertook its own two-stage review of electronic and paper records of cases of ***stillbirth, neonatal death, hypoxic ischaemic encephalopathy (HIE grades 2 and 3)*** and ***maternal deaths.*** Through these reviews, known as the 'Open Book', which first occurred in October 2018 as an electronic review and then in July 2020 with paper records included, the review team were notified by NHS Improvement and subsequently the Trust of over 750 cases of poor outcomes across these 4 categories in the period 2000 to the end of 2018. The review team were first able to make contact with these families in April and July 2020.

1.5 Direct contact from families together with the Trust's referrals led to us reporting in July 2020 that the review numbers had increased to encompass 1,862 families. We are aware that a number of families made multiple attempts, sometimes over many years to raise concerns with the Trust, but at this stage we are unable to say whether all of the poor outcomes reported to us occurred as a result of poor care.

1.6 It is likely that, when completed, this review of 1,862 families will be the largest number of clinical reviews undertaken relating to a single service, as part of an inquiry, in the history of the NHS. The majority of cases are from the years 2000 to 2019. However, where families contacted us directly with concerns preceding the year 2000, we agreed to review those cases where records exist as per the revised terms of reference. Throughout the review, the care and treatment provided and the quality of any internal reviews, investigations and learning undertaken by the Trust will be considered with reference to the guidance and standards of the day by experienced clinicians who were in clinical practice at the time.

1.7 It is important that we explore the experiences of staff working in the maternity units at The Shrewsbury and Telford Hospital NHS Trust. To do this we will scrutinise staff surveys where available and are working towards a process to hearing from staff directly. In addition we aim to examine past and current governance procedures within maternity services at the Trust that are applicable for the core period of this review.

1.8 To carry out a review of this size and to give each case the attention it deserves will take some time. It is important that expert clinicians lead the process, ensuring that each case is considered carefully and consistently using a standardised methodology. With the review now at 1,862 families, we anticipate a publication date for the second and final report in 2021.

1.9 To date, the review team have already identified emerging themes that should be addressed by the Trust and the wider maternity community across England as soon as possible. Therefore we have decided to publish this first report of important emerging themes and findings, **Local Actions for Learning** and **Immediate and Essential Actions** for the Trust and the wider maternity system in advance of the completion of the final report, with the full support of NHS England and Improvement, the Department of Health and Social Care and the Secretary of State for Health and Social Care.

1.10 For this first report 250 cases were investigated which are drawn from the entire period of the review and include the original cohort of 23 families. We also refer to in depth conversations and contact with a further 800 families, but we are mindful that these cases have not yet been subject to systematic and independent review by our team.

1.11 Our first objective in publishing these emerging themes and findings and their corresponding **Local Actions for Learning** is to support the improvement work currently underway in the maternity services at the Trust. A second objective is to ensure that these emerging themes and findings, **Local Actions for Learning** and **Immediate and Essential Actions** are carefully considered by all maternity services in England. We strongly believe we have identified a need for structural changes which, if implemented nationwide with our recommendations will reduce cases of harm to mothers and babies.

1.12 It is important to note that we would not have been able to identify these objectives without carefully considering the voices of families which underpin this report.

1.13 Over the years, many important recommendations from previous national maternity reviews[1] [2] [3] and local investigations which might have made a significant difference to the safety of mothers and babies receiving care at the Trust have either not been implemented or the implementation has failed to create the intended effect of improving maternity care. From this review of 250 cases we can confirm that we have identified missed opportunities to learn in order to prevent serious harm to mothers and babies. However, we are unable to comment any further on any individual family cases until the full review of all cases is completed.

1.14 Having listened to families we state that there must be an end to investigations, reviews and reports that do not lead to lasting meaningful change. This is our call to action. We expect to see real change and improved safety in maternity services as a result of

1 Northwick Park (2008) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1557922/ https://www2.harrow.gov.uk/documents/s30776/Maternity%20Review%20Report.pdf

2 Morecambe Bay (2015) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf

3 Saving Babies Lives (2019) https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/

findings from these 250 case reviews and our resultant **Local Actions for Learning** and **Immediate and Essential Actions** whilst we continue to work towards completion of the full and final report.

1.15 Furthermore, we recommend that the **Immediate and Essential Actions** which we have identified should also inform the decision-making of those who lead maternity services at local, regional and national levels.

1.16 Everyone has a part to play. The Shrewsbury and Telford Hospital NHS Trust Board and local commissioners must urgently focus on expediting implementation of the **Local Actions for Learning** and **Immediate and Essential Actions** outlined within this first report. This will ensure that consistently safe maternity care is provided to its local population.

1.17 The NHS England and Improvement regional improvement team must ensure that they give appropriate support and oversight to the Trust. Regulators and professional bodies including the **Care Quality Commission**, The Royal College of Obstetricians and Gynaecologists, The Royal College of Midwives, The Royal College of Anaesthetists and The Royal College of Paediatrics and Child Health must strengthen their collective efforts to work collaboratively to ensure rapid action and implementation of these **Local Actions for Learning** and **Immediate and Essential Actions** in order that they translate into safer maternity care across England. To do nothing is not an option.

1.18 Repeatedly, families have told us of two key wishes. Firstly, they want questions answered in order that they understand what happened during their maternity care. Secondly, they want the system to learn, so as to ensure that any identified failings from their care are not repeated at the Trust or occur at any other maternity service in England. The scale of this review has reinforced their perceptions that their cases were not thoroughly investigated and that there may have been missed opportunities for learning and change and thereby a failure to prevent future harm.

1.19 We owe it to the 1,862 families who are contributing to this review to bring about rapid, positive and sustainable change across the maternity service at The Shrewsbury and Telford Hospital NHS Trust. Implementation of the recommendations from this first report and the final report in 2021 will be their legacy.

Chapter 2:

How we approached this Review

What kind of clinical incident is this review considering?

2.1 This independent maternity review is focusing on all reported cases of maternal and neonatal harm between the years 2000 and 2019. These include cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE) (grades 2 and 3) and other severe complications in mothers and newborn babies.

2.2 In addition, a small number of earlier cases have emerged where families have raised significant concerns with the review team. These are being reviewed by the independent team wherever medical records are available from which it may then be possible to answer family questions. These earlier cases are those proactively reported to us by families, rather than systematically provided to us by the Trust. In all likelihood these are not the actual number of events. The earlier cases which occurred in the years immediately prior to 2000 are of importance to this review to establish whether there is evidence of embedded learning in subsequent cases.

2.3 The total number of families to be included in the final review and report is 1,862. The original plan was to publish one complete report, when the reviews of all the cases had been completed. However, as numbers of affected families continued to grow, in July 2020 it was agreed with the Minister of State for Mental Health, Suicide Prevention and Patient Safety, that early learning from the review of cases so far be shared with the Trust and the wider maternity services this calendar year. This has led us to publish this first report whilst our work continues towards completion of the remaining cases.

Methodology

2.4 For this first report the care that 250 mothers and their babies received has been reviewed as fully as possible on the evidence available. All clinical reviews have been undertaken by a team of independent expert clinicians. All review team members work outside the Trust and region and have no current or previous association with the Trust.

2.5 All reviews have been undertaken to date with benchmarking and consideration of the standards of care, policies and practice that would have been considered acceptable at the time the incident or concern occurred. The review team have had access to a range of local and national policies and guidance whilst undertaking their work. All the team members reviewing each case are experienced in clinical practice at the time the issue or incident of concern occurred.

2.6 The review team comprises obstetricians, midwives and neonatologists working collaboratively. Where specialist advice is required, for example in obstetric anaesthesia, maternal medicine, or other medical specialities such as adult cardiology or neurology, appropriate clinicians are available in the review team.

Listening to family voices

2.7 Family voices have been heard by the review team, either through face to face individual interviews held in Shrewsbury in a non-NHS location or via telephone or a

videoconferencing platform. Interviews are recorded electronically and typed up using a transcribing service of which a copy of the transcript is then shared with the family. There is a comprehensive support service available to all families in the review following initial assessment with a trained professional. The review team works in collaboration with SANDS, Child Bereavement UK and Bereavement Training International in offering this service. From early 2021 this will be extended to include support from the Midlands Partnership NHS Foundation Trust.

Listening to the views and voices of staff working at the Trust

2.8 Arrangements are under way to ensure that staff voices of current and former employees within the maternity and neonatal services at the Trust will be heard and carefully considered. We will review the information already available about staff views over the years from a number of sources, including staff surveys undertaken by the Care Quality Commission, the ***'Mat Neo' Collaborative***[4] and the NHS annual staff survey[5]. Following analysis of this information we will offer both former and current employees of the Trust the opportunity to speak with members of the review team in confidence.

Review of the Trust's maternity governance processes

2.9 The maternity review team has received a large volume of governance documentation from the Trust that is of importance and is of relevance to the review. It is now believed that the Trust have provided us with all the governance documentation that they have available that refers to the main time period under review. Findings following consideration of this documentation will be included in our final report.

2.10 For the governance documentation considered so far for this report the review team have found inconsistent governance processes for the reporting, investigation, learning and implementation of maternity-wide changes.

2.11 To date, the review team have also found inconsistent multiprofessional engagement with the investigations of maternity serious incidents at the Trust. There is evidence that when cases were reviewed the process was sometimes cursory. In some serious incident reports the findings and conclusions failed to identify the underlying failings in maternity care. The review team has also seen correspondence and documentation which often focussed on blaming the mothers rather than considering objectively the systems, structures and processes underpinning maternity services at the Trust.

2.12 Further, whilst the action plans and recommendations that the review team have seen so far provide some limited evidence of feedback to staff, we have found clear examples of failure to learn lessons and implement changes in practice. This is notable in the selection of, or advice around, place of birth for mothers, the management of labour overall, the injudicious use of oxytocin, the failure to escalate concerns in care to senior levels when problems became apparent, with continuing errors in the assessment of fetal wellbeing.

2.13 This indicates that opportunities for valuable learning to improve care and the prevention of similar occurrences in the future were lost. The frequency with which particular issues have re-occurred, even within the limited group of cases reviewed so far, is entirely consistent with that conclusion. In the sections below we have provided anonymised

4 https://www.england.nhs.uk/mat-transformation/maternal-and-neonatal-safety-collaborative/

5 From 2003 to 2019 and provided by the Trust to the review team 10.11.20

vignettes of some of the mothers' and babies' stories; these are illustrative of the types of incidents which have occurred, and which might have been avoided had lessons been learned from previous events and changes in practice been implemented accordingly.

2.14 Within the 250 cases reviewed to date, we have also found that a number of the earlier cases of significant concern were not investigated at the time, although this appears to improve over the period under review. The Trust underwent external review and scrutiny by the CQC in 2015, 2018 and 2020[6], and by The Royal College of Obstetricians and Gynaecologists (RCOG)[7] in 2017. However, even within this later timeframe, there is evidence that some serious incidents were not investigated using a systematic and multiprofessional approach, and evidence is lacking that lessons were learned and applied in practice to improve care.

6 https://www.cqc.org.uk/sites/default/files/new_reports/AAAA3868.pdf CQC report 2015

7 https://www.rcog.org.uk/en/news/statement-regarding-an-invited-review-by-royal-college-of-obstetricians-and-gynaecologists-rcog-into-maternity-services-at-shrewsbury-and-telford-hospital-nhs-Trust/

Chapter 3

Trust Board oversight and External Reviews

3.1 As we have progressed with this review a number of apparent themes have emerged in the 250 cases and family interviews considered to date. These themes will be further scrutinised as we review the remaining cases, but the following are noted by the maternity review team at this early stage:

Turnover of Executive leadership at The Shrewsbury and Telford Hospital NHS Trust impacting organisational knowledge and memory

3.2 We understand from documents supplied to us by the Trust that there have been ten Chief Executive Officers (CEOs) from 2000 to early 2020, with eight in post between 2010 and the current day. Four of those eight were employed as interim CEOs[8]. Since 2000 there have been ten Executive Board Chairs. There has also been considerable Board level turnover amongst both Executive and Non-Executive Directors since the year 2000.

3.3 We have concluded that, it is probable that this lack of continuity at Board level has resulted in a loss of organisational memory. As new CEOs started at the Trust there was a tendency, until at least 2019, to regard problems at the Trust as *'historical'* or as a *'legacy'* from previous years. Indeed, one of the groups of cases of potentially significant concern submitted to the review team by the Trust, ranging from between 1998 and 2017 and therefore, includes some relatively recent cases, was titled *'The Legacy'* cohort by the Trust.

What the Care Quality Commission (CQC) said about the Trust

CQC Reports

3.4 The CQC reports in 2015[9], 2018[10] and 2020[11] vary considerably. We note that the two later reports are critical of leadership at the Trust. The 2015 CQC report graded the maternity and gynaecology services *'good'* across all five domains of safe, effective, caring, responsive and well led, with an overall rating of *'good'*. (CQC 2015, page 21). Oswestry, Ludlow and Bridgnorth Midwifery Led Units (MLUs) were also rated *'good'* across all 5 domains. The 2015 report noted that *'The Trust had recently opened the new Shropshire Women and Children's Centre at the Princess Royal [hospital] site. This had seen all consultant led maternity services and inpatient paediatrics move across from the Royal Shrewsbury [hospital] site. We found that this had had a positive impact on these services.'* (CQC 2015, page 2)

The CQC reports in 2018 and 2020

3.5 We note that in the 2018 and 2020 reports the Trust's overall rating of the domain *'well led'* was *'inadequate'*. The 2020 report states that there is a lack of stability in the Executive team. Overall, the CQC told the Trust they must *'ensure that there are effective governance systems and processes in place to effectively assess, monitor and improve the quality and safety of services'.* (CQC 2020, page 6).

8 'Who's Who at the Trust – internal document – received by the review team 9th September 2020

9 https://www.cqc.org.uk/sites/default/files/new_reports/AAAA3868.pdf CQC report January 2015

10 https://www.cqc.org.uk/provider/RXW CQC report 29th November 2018

11 https://www.cqc.org.uk/provider/RXW CQC report January 2020

3.6 In respect of maternity services at the Princess Royal Hospital, the CQC advised that the Trust must:

- *Ensure staff complete mandatory training, including training on safeguarding of vulnerable children and adults*
- *Ensure high risk women are reviewed in the appropriate environment by the correct member of staff*
- *Ensure grading of incidents reflects the level of harm, to make sure the duty of candour is carried out as soon as reasonably practical*
- *Ensure all women receive one to one care when in established labour*
(CQC 2020, page 8)

The review team will further consider these CQC reports of the maternity service and the Trust's responses to them in its final report.

MBRRACE (Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries)

Overview of MBRRACE reports: perinatal mortality rates at the Trust 2013-2017

3.7 Stillbirths, neonatal deaths and perinatal mortality rates for the UK are published by MBRRACE-UK in Perinatal Mortality Surveillance Reports[12]. These reports publish stabilised and adjusted mortality rates to adjust for chance variation due to small numbers and for key factors known to increase the risk of perinatal mortality such as mother's age, socio-economic deprivation, baby's ethnicity, baby's sex, multiple births and gestational age at birth (for neonatal deaths only).

3.8 MBRRACE issues individual reports to NHS Trusts indicating the local perinatal mortality rates. These Trust-specific reports recommend that Trusts should review existing records regarding the deaths to ensure any avoidable factors have been identified and appropriate changes to care have been implemented.

3.9 MBRRACE reports show that for the years 2013-2016 stabilised and adjusted extended perinatal mortality rates at The Shrewsbury and Telford Hospital NHS Trust were up to or more than 10% higher than comparable UK NHS Trusts. For the year 2017 stabilised and adjusted extended perinatal mortality rates at The Shrewsbury and Telford Hospital NHS Trust were reported as up to 5% higher or up to 5% lower than the UK average (suggesting roughly comparable rates with other UK Trusts). Perinatal mortality rates for 2018 were not published at the time of writing this report.

Clinical Commissioning Group (CCG) oversight of the Trust

3.10 There are two CCGs in the local area, Telford and Wrekin CCG and Shropshire CCG. They were formally established in April 2013 and from 2019 have engaged in *'bringing their decision-making processes closer together'*[13].

12 https://www.npeu.ox.ac.uk/mbrrace-uk/reports

13 https://www.healthwatchtelfordandwrekin.co.uk/news/new-board-members-join-shropshire-ccg-and-telford-and-wrekin-ccg/

3.11 The Maternity review team will have the opportunity to consider a range of maternity specific documentation from the two CCGs. As commissioners, the interactions with the Trust and the CCGs and the ***Primary Care Trusts (PCTs)*** before them, will provide valuable insight into the local external oversight the Trust's maternity services received during the timespan of the maternity review.

3.12 We note that during the inaugural Telford and Wrekin CCG Board meeting in April 2013[14] there appeared to have been some concerns raised about maternity services at the Trust, leading to the CCG intending to write to the Trust *'with regards to concerns with Midwifery numbers.'* (page 4).

3.13 In June 2013 the Telford and Wrekin CCG Quality and Safety report[15] describes that, following concerns raised by both CCGs, a 'Risk Summit' led by the NHS England Area Team had been held in May 2013. Concerns specific to maternity services were: *'Maternity services model and the number of SIs reported (in particular 1 high profile case and coroner's inquest and a 2nd SI...'* (page 5). In July 2013 a CCG led review of maternity services at the Trust[16] was commenced with the stated *'Lack of improvement in maternity services'* recorded as a 'risk' as follows:

'Risk 3 - Lack of Improvement in Maternity Services
External review of maternity services across the local health economy has now formally commenced and will report to Boards by September 2013.' (page 4)

3.14 The resulting report[17] published jointly by both CCGs in October 2013 will be considered more fully in the final report, as will further documentation received from the CCGs.

The role of the Local Supervisory Authority and statutory supervision of midwives at the Trust

3.15 Prior to its demise in 2017 the purpose of statutory supervision of midwives was to protect the public by ensuring a safe standard of midwifery practice through enhanced quality and safety.

3.16 As a consequence of family complaints there were a number of independent reviews commissioned into the quality of supervisory investigations undertaken by supervisors of midwives at the Trust. The review team will continue to consider all available supervisory governance documentation relating to any individual cases in this maternity review.

14 See Telford and Wrekin CCG, Minutes of Governing Board Meeting 090413 –page 4
https://www.telfordccg.nhs.uk/who-we-are/publications/ccg-governance-board/governance-board-papers/2013/may-3/444-03-ccg-board-minutes-9th-april-2013-v1/file

15 https://www.telfordccg.nhs.uk/who-we-are/publications/ccg-governance-board/governance-board-papers/2013/june-3/542-10-5-twccg-board-quality-and-safety-june-2013-report/file

16 https://www.telfordccg.nhs.uk/who-we-are/publications/ccg-governance-board/governance-board-papers/2013/july-3/585-11-3-ccg-board-quality-and-safety-report-9th-july-2013/file

17 https://shropshireccg.nhs.uk/media/1197/maternity-services-review-msr-report-281013.pdf

Review of Maternity Services 2007- 2017

3.17 In June 2017 the Trust conducted an internal review of maternity services[18]. It considered the history of maternity services between 2007 and 2017, focussing on issues of patient safety, learning, and engagement with bereaved parents. The report concluded that '*all patient safety actions should be in one plan against a framework that makes sense to the staff that run the service.*' The report further stated that the service must '*create a coordinated approach to the maternity safety improvement plan*' and that '*safety in maternity is protected by the efforts of the staff and supported by leaders.*' (2017, page 28.)

18 https://www.sath.nhs.uk/wp-content/uploads/2019/12/170629-06-Safety-of-Maternity-Services-2007-17-final-version-June-17.pdf

Chapter 4

Multidisciplinary Review: Our findings following review of 250 cases

Midwifery and Obstetric issues identified in the review of 250 cases at the Trust

The roles of midwives and obstetricians in the multidisciplinary maternity team

4.1 Midwives and obstetricians work closely together providing maternity care. Midwives are specialists in the provision of normal pregnancy care throughout the pregnancy pathway. Obstetricians are the lead clinicians providing care for complex pregnancies and births in an obstetric unit working in collaboration with midwives and other health care professionals including obstetric anaesthetists. The following is a reflection of emerging themes identified from the 250 cases reviewed to date by the independent review team.

4.2 The midwifery and obstetric issues identified from these cases are merged for the purposes of this report, which recognises the close working relationship that is required between midwives and obstetricians for the benefit of mothers and babies within their collective care.

Compassion and kindness

4.3 One of the most disappointing and deeply worrying themes that has emerged is the reported lack of kindness and compassion from some members of the maternity team at the Trust. Healthcare professionals are in a privileged position caring for women and their families at a pivotal time in their lives. Many of the cases reviewed have tragic outcomes where kindness and compassion is even more essential. The fact that this has found to be lacking on many occasions is unacceptable and deeply concerning.

4.4 Evidence for this theme was found in the women's medical records, in documentation provided by the Trust and families, in letters sent to families by the Trust and from through the families' voices heard through the interviews with the review team. Inappropriate language had been used at times causing distress. There have been cases where women were blamed for their loss and this further compounded their grief. There have also been cases where women and their families raised concerns about their care and were dismissed or not listened to at all.

4.5 *Follow up letter sent after discharge which states: 'If you would like to come and have a chat with me about the death of your baby…' There were no words of condolences or sympathy within the body of the letter. (2001)*

4.6 *A woman was in agony but told that it was 'nothing'; staff were dismissive and made her feel 'pathetic'. This was further compounded by the obstetrician using flippant and abrupt language and calling her 'lazy' at one point. (2011)*

4.7 *A woman was in great pain after delivery and left screaming for hours before it was identified that there were problems that needed intervention. The attitude of some of the midwives also made the situation worse. (2013)*

4.8 There are several examples from the cases reviewed to date indicating that minimal learning has occurred and that this lack of compassion and kindness has persisted. There are some examples of midwives and doctors who have made a huge difference to the women and families due to the care they provided and kindness they showed. However, kind and compassionate care is something that every woman, baby and family deserve and should expect from all midwives, doctors and members of the maternity team.

Place of birth: Assessment of risk

4.9 At the booking appointment all women should have a risk assessment to decide on the most appropriate place of birth. This can be at home, a midwifery led unit or an obstetric-led unit. Once the decision on place of birth has been made, there should be a risk assessment at each antenatal appointment to ensure the decision remains appropriate. In many cases reviewed there appears to have been little or no discussion and limited evidence of joint decision making and informed consent concerning place of birth. There is evidence from interviews with women and their families, that it was not explained to them in case of a complication during childbirth, what the anticipated transfer time to the obstetric-led unit might be.

4.10 *A woman was considered appropriate for birth in a remote stand-alone birth centre despite developing known risk factors in the weeks leading up to her delivery. There were then errors in the fetal monitoring in labour. After birth the baby was not monitored appropriately despite clear warning signs, and was transferred, too late, to a specialist unit where the baby died. (2009)*

4.11 *A woman who laboured at the birth centre was not adequately monitored as 'the unit was busy'. When problems were eventually identified in labour there was a delay in transferring the mother to the labour ward, where her baby was delivered in a very poor condition having suffered a brain injury. The baby subsequently died. (2016)*

4.12 *A woman who delivered in a stand alone birth centre suffered a catastrophic haemorrhage requiring transfer to the consultant unit, where she died. Her family stated that there had not been an explanation of the risks of birth in a midwifery led unit, nor information on the need for transfer if complications arose. (2017)*

Clinical care and competency: management of the complex woman

4.13 At the point of registration a midwife will have achieved competency in the required academic and clinical subject areas and therefore qualify for entry to the Nursing and Midwifery Council register. In a significant number of cases the review team found evidence that the clinical care and decision making of the midwives did not demonstrate the appropriate level of competence, with consequences for the mothers and babies in their care. One aspect is failure to recognise deviation from the norm and so failure to escalate appropriately.

4.14 In some cases the review team has found evidence of poor consultant oversight of mothers with high-risk pregnancies; they either remained under midwifery-led care or were managed by obstetricians in training without appropriate and timely escalation.

4.15 *A woman in the early third trimester of her pregnancy was admitted to the antenatal ward with severe pre-eclampsia, characterised by new onset hypertension and proteinuria. Shortly after her discharge home she had an eclamptic seizure and was taken to a neighbouring unit, where she delivered. (2011)*

4.16 *A woman developed severe high blood pressure and was managed on the labour ward. There was a delay in treating her high blood pressure and, following delivery, there was a further delay in seeking senior clinical advice. She subsequently died in another hospital. (2011)*

4.17 *A pregnant woman who was known to have large uterine fibroids had midwifery led care and was not referred to an obstetrician as her condition should have required. There were errors in the interpretation of the baby's growth and an obstetric opinion or ultrasound scan was not obtained. The baby was delivered around ten weeks early, was growth restricted and died the same day from a severe hypoxic birth injury. (2016)*

Escalation of concerns

4.18 In the cases reviewed so far, concerns regarding escalation have evolved as an overarching theme. The cases show repeated failures to escalate for further opinion and review. This is a key element of the role of the midwife and an integral part of safe practice. There is also evidence that when concerns were escalated they were not then acted upon appropriately or escalated further to the appropriate level. This may indicate a lack of multidisciplinary communication and collaboration and/or senior clinical supervision, both of which are key to providing safe care.

4.19 The reviewers found a significant number of instances both of failure to recognise and escalate the management of deteriorating mothers by midwives to obstetricians, and by obstetricians in training to consultants. From the 250 cases reviewed to date these problems appear to continue across the review period, suggesting a failure to learn from other previous serious incidents which had resulted in stillborn or severely brain damaged babies.

4.20 *A woman was induced for raised blood pressure at 37 weeks. The fetal heart rate was normal on arrival on labour ward. After artificial rupture of the membranes there was a failure by the midwife to record the fetal heart rate or escalate any concern and the baby was subsequently stillborn. The family did not feel that they were involved in the investigation and did not receive an apology. (2015)*

4.21 *A woman who was admitted with contractions and early signs of infection late in her second trimester of pregnancy was seen by a junior doctor and discharged without higher level assessment. Her management was not subsequently discussed with a senior colleague. Several hours later she was re-admitted and delivered a premature baby. (2015)*

Management of labour: monitoring of fetal wellbeing, use of oxytocin

4.22 Fetal heart rate (FHR) monitoring is an essential component of the safe management of labour. When labour is managed in a midwife-led setting the FHR is monitored using intermittent auscultation (IA). On the labour ward setting the FHR is usually monitored continuously with the ***cardiotocograph*** (CTG). The review team found significant problems with the conduct of intermittent auscultation and in the interpretation of CTG traces.

4.23 Oxytocin is an intravenous infusion commonly used in obstetric labour wards to increase the frequency, strength and length of uterine contractions. There are guidelines for its use and it should be used carefully and reduced or discontinued in the presence of excessive uterine contractions or fetal heart rate concerns. Appropriate risk assessment should be carried out before oxytocin use in the first stage of labour, and again before use in the second stage of labour.

4.24 Long labour exacerbated by use of oxytocin can result in an obstructed labour leading to fetal distress and also difficult caesarean delivery because the fetal head is deeply in the pelvis. Long labours can also increase the risks of infection and excessive haemorrhage after birth. The review team noted many examples where oxytocin was used injudiciously; these cases occurred across the time period of the 250 cases reviewed, which suggests a failure to learn from previous cases where the outcome was poor.

4.25 *A woman who had a previous caesarean section was induced and had a long labour using oxytocin. The baby's head was in the occiput posterior position and this made the delivery by caesarean section difficult. The mother said afterwards that she had the impression that the Trust were trying to keep the caesarean section rate low. (2000)*

4.26 *A mother, admitted in labour with a breech presentation, had inappropriate use of oxytocin for her long labour with CTG concerns. Standard obstetric teaching is to avoid the use of oxytocin in breech labour and especially in this case, where there was the added complication of FHR abnormalities. Her baby was born in very poor condition and died a few days later. (2006)*

4.27 *A woman presented in labour at 39 weeks. There were CTG abnormalities in labour, which were not escalated. Oxytocin was used despite an abnormal CTG. The baby was delivered normally but developed a hypoxic brain injury and cerebral palsy. (2006)*

4.28 *A woman had a prolonged labour at a birth centre despite earlier concerns over abnormal CTG tracings during the antenatal period. She was transferred to the labour ward but her baby was stillborn shortly afterwards. Despite the failure to adequately monitor both the mother and the baby there was no investigation or learning. The mother and father did not receive an apology. (2007)*

4.29 *A woman was in labour and there were fetal heart rate concerns. Despite the abnormal CTG oxytocin use was continued throughout the labour. At the caesarean section there was evidence that there had been an obstructed labour. The baby suffered from hypoxic brain injury and died some months after birth. (2009)*

4.30 *A woman had oxytocin commenced in the later stage of delivery with CTG abnormalities. There was a ventouse delivery and the baby was delivered in poor condition and developed a hypoxic brain injury. (2010)*

4.31 *A woman who had a previous caesarean section was in active labour. Despite FHR abnormalities, oxytocin was commenced and was continued despite evidence of deterioration of the baby's condition. The baby was born in poor condition and died a few months later. A case review was undertaken but it failed to identity or address the errors in the management of the mother's labour thus leading to a complete failure to learn lessons or change clinical practice in future. (2014)*

4.32 *A woman had a previous caesarean section followed by a normal delivery. The following pregnancy she was induced at term. Oxytocin was used in the presence of CTG*

abnormalities and there was excessive uterine action (hyper stimulation). There was also a failure to monitor the fetal heart during siting of epidural. An emergency caesarean section was performed and the baby was delivered in a poor condition. The investigation did not address the management of labour and CTG interpretation or the injudicious use of oxytocin. (2014)

4.33 *A woman was admitted in normal labour. There were CTG abnormalities in the second stage, which were not recognised and later it was also not recognised that the maternal heart rate was being recorded rather than the fetal heart. The baby was born in poor condition, developed hypoxic brain injury, and died several months later. (2015)*

4.34 *A woman had a failed ventouse delivery and emergency caesarean section in a previous pregnancy. In the next pregnancy the baby was found to be macrosomic (large) on scan at 36 weeks. The woman was admitted in labour and despite requests for a caesarean section she was persuaded to attempt a vaginal birth. This was complicated by a pathological CTG in labour with inappropriate use of oxytocin and shoulder dystocia. The baby died a few days later from hypoxic brain injury and complications of the shoulder dystocia. The family were dissatisfied with the investigation. The investig*ation failed to acknowledge omissions in care, which prevented future learning. (2015)

4.35 *A woman who laboured at the birth centre was not adequately monitored as 'the unit was busy'. When problems were eventually identified in labour there was a delay in transferring the mother to the labour ward, where her baby was delivered in very poor condition and hypoxic ischaemic encephalopathy (HIE) was later confirmed. The baby subsequently died. The family were critical of the ensuing investigation, and correspondence with the Trust, and said during a meeting with the Review Chair that they had been 'put off, fobbed off and had obstacles put in our way'. (2016)*

Traumatic birth

4.36 Some cases involving long labour with injudicious use of oxytocin resulted in women becoming fully dilated and consequently being assessed for instrumental vaginal delivery. The review team found evidence in a number of cases of repeated attempts at vaginal delivery with forceps, sometimes using excessive force; all with traumatic consequences. There was clear evidence that the operating obstetricians were not following established local or national guidelines for safe operative delivery.

4.37 *A woman laboured and had repeated attempts at forceps delivery. The baby sustained multiple skull fractures and subsequently died. (2007)*

4.38 *A woman who was known to have a big baby was refused her request for a caesarean section and encouraged to labour. She had a forceps delivery and the baby had* **shoulder dystocia** *with a resulting fractured* ***humerus****. In her letter to the Trust afterwards the mother wrote that she felt her request for a caesarean section was refused because the Trust wanted to keep their caesarean section rates low. There was no incident form or investigation. (2012)*

4.39 *A baby died following a traumatic forceps delivery. There were repeated attempts by two doctors to deliver the baby with forceps. (2013)*

4.40 *A woman had repeated attempts to deliver the baby using forceps. The baby was found to have skull fractures after birth and subsequently developed cerebral palsy. There was no investigation. The family were very dissatisfied with the Trust's response to their concerns. (2017)*

4.41 The reviews of these and other cases indicate that efforts to ensure a vaginal delivery either should not have been attempted or should have been abandoned and the baby delivered by caesarean section. Some of these deliveries were undertaken by consultant obstetricians, which was particularly concerning.

Caesarean section rates at The Shrewsbury and Telford Hospital NHS Trust

4.42 Caesarean section rates have risen in the UK over the two decades of this review. It is notable that for this period the caesarean section rate at The Shrewsbury and Telford Hospital NHS Trust has consistently been 8%-12% below the England average and those of its neighbouring units (Table 1). Over the years this has been positively reported in the local press with it widely known in the local community.

Table 1. Comparison of Caesarean section rates between The Shrewsbury and Telford Hospital NHS Trust, neighbouring Hospital Trusts, and the rates in England.

	The Shrewsbury and Telford Hospitals NHS Trust	University Hospitals of North Midlands NHST	Royal Wolverhampton Hospitals Trust	NHS Hospitals England
2006-2007	11.8%	24.3%	25.5%	24.2%
2007-2008	15.5%	23.5%	26.1%	24.6%
2008-2009	16.8%	24.1%	25.0%	24.6%
2009-2010	15.8%	25.6%	24.9%	24.8%
2010-2011	No data	-	-	-
2011-2012	14.9%	26.3%	25.9%	24.4%
2012-2013	16.3%	25.4%	25.4%	24.8%
2013-2014	16.3%	27.6%	27.9%	26.2%
2014-2015	16.3%	26.0%	28.0%	26.5%
2015-2016	19.5%	29.0%	28.2%	27.1%
2016-2017	20.8%	29.8%	26.6%	27.3%
2017-2018	21.0%	30.0%	28.0%	29.0%

(Data from NHS Maternity Statistics NHS Digital)

4.43 The review team came across many cases where women said that they had been aware The Shrewsbury and Telford Hospital NHS Trust wished to keep caesarean section rates low. A typical quote during interviews was that *'they didn't like to do caesarean sections'*. The review team observed that women who accessed the Trust's maternity service appeared to have little or no freedom to express a preference for caesarean section or exercise any choice on their mode of delivery.

4.44 The review team have the clear impression that there was a culture within The Shrewsbury and Telford Hospital NHS Trust to keep caesarean section rates low, because this was perceived as the essence of good maternity care in the unit. Whereas it is not possible to correlate this culture with overall poor obstetric outcomes, the previous vignettes show that in some individual cases earlier recourse to a caesarean delivery would have avoided death and injury.

Overall there did not seem to be a consideration of whether this culture contributed to unnecessary harm.

Bereavement care

4.45 It is well known that the provision of support following a bereavement makes a significant difference to the family and how supported they feel. The quality of bereavement care can have a significant effect on the wellbeing of parents and their families in the time immediately following the loss and in the longer term.

4.46 The Stillbirth and Neonatal Death Society (SANDS)[19] states that high quality bereavement care involves a recognition of parenthood using sensitive and effective communication, whilst enabling informed choice in all aspects of care and decision making. This may be decision making with regards to delivery, seeing their baby, funerals and post mortem, to name a few aspects. Midwives and obstetricians need to have an awareness of these key issues and also an awareness of the grief and trauma that families may be going through. Compassion and kindness in care and communication by midwives, obstetricians and all members of the maternity team parents may encounter is essential. Such compassion can have a positive and long lasting influence on the experience families have at this time.

4.47 Whilst there is some limited evidence that parents were supported to spend time with their baby after death and to create memories from the very limited time they were able to spend together, there is also little evidence of follow up support being provided as would be expected and recommended. There are several instances where the bereavement care was either inadequate or non-existent, which had a negative impact on the wellbeing of the parents and their overall experiences.

4.48 Not only was bereavement care poor in a number of the 250 cases reviewed to date, there are also examples of completely inappropriate comments made to some family members after the loss of their baby. There are several examples where mothers say that they were made to feel responsible by Trust staff for the loss of their babies.

4.49 *One mother complained about the consultant obstetrician's attitude when seen on the neonatal ward. She described the consultant as being rude and completely dismissive of the family's concerns. She also complained about postnatal care saying that the staff were not aware of the issues and she had to keep explaining distressing details at every shift change. There was no investigation or learning. (2009*)

4.50 *A woman whose baby died after a particularly traumatic delivery was seen by the consultant afterwards. The consultant was described as having 'no compassion or understanding of the trauma experienced'. (2013)*

4.51 *The family had received limited bereavement support on Day 17 after birth. The family found this unhelpful and unprofessional. …….bereavement care was lacking to the point of being completely inadequate. The Trust's bereavement service should have made contact much sooner. There is no record that any follow up support and advice was given. (2016)*

4.52 *A mother experienced a neonatal death at 17 hours of age. She and her partner described the bereavement service 'as offering no support, lacking in compassion and actually making it so many times worse'. (2016)*

19 https://nbcpathway.org.uk/about-nbcp/national-bereavement-care-pathway-background-project

4.53 *A woman had an apparently uncomplicated homebirth. Later the same day and overnight she repeatedly rang the midwifery unit to say that she was concerned that the baby wasn't feeding properly. She was reassured but the baby collapsed and died the next day. The family felt they had to 'push for an investigation' and that the Trust did not listen to them. They believed that the bereavement care they received was inadequate. (2016)*

LOCAL ACTIONS FOR LEARNING: MATERNITY CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- **4.54** A thorough risk assessment must take place at the booking appointment and at every antenatal appointment to ensure that the plan of care remains appropriate.

- **4.55** All members of the maternity team must provide women with accurate and contemporaneous evidence-based information as per national guidance. This will ensure women can participate equally in all decision making processes and make informed choices about their care. Women's choices following a shared decision making process must be respected.

- **4.56** The maternity service at The Shrewsbury and Telford Hospital NHS Trust must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of fetal monitoring. Both colleagues must have sufficient time and resource in order to carry out their duties.

- **4.57** These leads must ensure that the service is compliant with the recommendations of Saving Babies Lives Care Bundle 2[20] (2019) and subsequent national guidelines. This additionally must include regional peer reviewed learning and assessment. These auditable recommendations must be considered by the Trust Board and as part of continued on-going oversight that has to be provided regionally by the Local Maternity System (LMS) and Clinical Commissioning Group.

- **4.58** Staff must use NICE Guidance (2017)[21] on fetal monitoring for the management of all pregnancies and births in all settings. Any deviations from this guidance must be documented, agreed within a multidisciplinary framework and made available for audit and monitoring.

- **4.59** The maternity department clinical governance structure and team must be appropriately resourced so that investigations of all cases with adverse outcomes take place in a timely manner.

- **4.60** The maternity department clinical governance structure must include a multidisciplinary team structure, trust risk representation, clear auditable systems of identification and review of cases of potential harm, adverse

20 https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/

21 https://www.nice.org.uk/guidance/cg190

outcomes and serious incidents in line with the NHS England Serious Incident Framework 2015[22].

- **4.61** Consultant obstetricians must be directly involved and lead in the management of all complex pregnancies and labour.

- **4.62** There must be a minimum of twice daily consultant-led ward rounds and night shift of each 24 hour period. The ward round must include the labour ward coordinator and must be multidisciplinary. In addition the labour ward should have regular safety huddles and multidisciplinary handovers and in-situ simulation training[23].

- **4.63** Complex cases in both the antenatal and postnatal wards need to be identified for consultant obstetric review on a daily basis.

- **4.64** The use of oxytocin to induce and/or augment labour must adhere to national guidelines and include appropriate and continued risk assessment in both first and second stage labour. Continuous CTG monitoring is mandatory if oxytocin infusion is used in labour and must continue throughout any additional procedure in labour.

- **4.65** The maternity service must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of bereavement care within maternity services at the Trust.

- **4.66** The Lead Midwife and Lead Obstetrician must adopt and implement the National Bereavement Care Pathway.

Maternal Deaths

4.67 Between the years 2000 and 2019, there were 13 maternal deaths at The Shrewsbury and Telford Hospital NHS Trust. The review team were also contacted by two families who had experienced the death of their mothers whilst under maternity care at the Trust before 2000. These will be reviewed if clinical records become available.

4.68 The review team identified recurrent themes in the care of some mothers who died, which present opportunities for important learning from the initial evaluation of these occurrences.

4.69 In the cases reviewed from 2000 onwards there appears to have been a lack of antenatal multidisciplinary team planning for women with significant pre-existing comorbidities and/or other medical risk factors. Whilst the women appear to have been correctly identified as 'high risk' at booking, the review team were unable to identify the lead clinician with overall responsibility for the care of the woman in the majority of cases. Whilst pathways seem to have existed for referral to other medical specialities, once referred for specialist care, the resultant assessments were frequently conducted by junior doctors. There appear to have been no joint clinics and multidisciplinary care planning for antenatal monitoring, labour, delivery or postnatal care.

22 https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

23 https://www.hsib.org.uk/documents/261/HSIB_Delays_to_intrapartum_intervention_once_fetal_compromise_is_suspected_Report.pdf

4.70 In some cases there was poor completion of the ***maternal early warning score (MEWS)*** which might have prompted escalation if completed appropriately, and there was frequently a failure to recognise the deteriorating patient. High risk and significantly sick women on the delivery suite were reviewed by junior medical staff without involvement of consultant obstetricians or consultant obstetric anaesthetists for lengthy time periods. There were delays in initiating appropriate investigations and treatment which also led to delayed escalation. These delays impacted on timely transfers to a higher level facility such as high dependency or intensive care.

4.71 The review team is further concerned about the rigour and quality of investigations after serious incidents such as a maternal death. In some cases no investigation was initiated. Some cases were investigated internally by a small governance team, no learning appears to have been identified and the cases were subsequently closed with it deemed that no further action was required. A number of investigations lacked visibility and input from the wider multidisciplinary team, resulting in missed opportunities for important learning.

LOCAL ACTIONS FOR LEARNING: MATERNAL DEATHS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- **4.72** The Trust must develop clear Standard Operational Procedures (SOP) for junior obstetric staff and midwives on when to involve the consultant obstetrician. There must be clear pathways for escalation to consultant obstetricians 24 hours a day, 7 days a week. Adherence to the SOP must be audited on an annual basis.

- **4.73** Women with pre-existing medical co-morbidities must be seen in a timely manner by a multidisciplinary specialist team and an individual management plan formulated in agreement with the mother to be. This must include a pathway for referral to a specialist maternal medicine centre for consultation and/or continuation of care at an early stage of the pregnancy.

- **4.74** There must be a named consultant with demonstrated expertise with overall responsibility for the care of high risk women during pregnancy, labour and birth and the post-natal period.

Obstetric Anaesthesia

4.75 Obstetric anaesthetists are an integral part of the labour ward team. Over 60 % of all women entering the labour ward require anaesthetic interventions, and many more are assessed by an obstetric anaesthetist in the antenatal or postnatal period[24]. The Royal College of Anaesthetists (RCoA) and the Obstetric Anaesthetist Association (OAA) have issued clear guidance for staffing on the labour ward which includes a duty anaesthetist available for maternity services 24 hours a day and appropriate consultant cover for emergency and elective work[25].

24 RCoA Guidelines for the Provision of Anaesthesia Services (GPAS); Chapter 9: Guidelines for the Provision of Anaesthesia Services for an Obstetric Population 2020 "Raising the Standards", RCoA Quality Improvement Compendium, 4th Edition, May 2020, page 241-268; www.rcoa.ac.uk

25 OAA/AABGI Guidelines for Obstetric Anaesthesia Services 2013

4.76 The number of women requiring advanced levels of medical and anaesthetic care from maternity services has risen over the last 20 years, due to a number of factors including increasing levels of maternal obesity and its associated co-morbidities such as Type 2 diabetes, high blood pressure and cardiac disease. More women conceive with pre-existing medical problems and/or are delaying motherhood until they are older and may therefore have developed more underlying medical conditions[26].

4.77 The trend towards an older obstetric population with increasing morbidities and significant levels of maternal obesity means obstetric anaesthetists are increasingly required to take on the role of peri-partum physician dealing with the management of these underlying medical conditions in labour and in acute settings, as well as providing their traditional services such as pain relief in labour and anaesthesia for operative delivery or immediate surgery postpartum. The support of a consultant anaesthetist on the labour ward is crucial, in addition to consultant anaesthetist availability 'around the clock', as maternity is a 24 hours a day and 7 days a week service.

4.78 In considering the cases for this first report, the review team have identified several areas of concern relating to obstetric anaesthesia practice. The reviewers found a tendency towards simple task focus, e.g. siting an epidural, or administering anaesthesia, without a holistic assessment of the patient and appreciation of the wider clinical picture.

Poor obstetric anaesthesia practice

4.79 *A woman with severe and rapidly progressive pre-eclampsia and uncontrolled blood pressure (BP) was taken to theatre for an emergency caesarean section. The labour ward team failed to control her blood pressure and the duty anaesthetist compounded the issue when inducing general anaesthesia without administration of any drugs to attenuate the potential BP rise during intubation. This failure exposed the woman to an increased risk of cerebrovascular accident (CVA) or a stroke. (2011)*

4.80 *A woman requested epidural analgesia in labour. She had frequent contractions and felt the urge to push, although diagnosed as being in the first stage of labour. There were significant concerns about fetal wellbeing on the basis of the cardiotocograph (CTG). Despite this, the CTG was discontinued for a significant time to site the epidural. When the CTG was recommenced immediately after siting of the epidural, the fetal heart rate was difficult to obtain and an emergency caesarean section was indicated. The anaesthetist did not seek clarification on the CTG and possible urgency of delivery before siting the epidural. The baby was born in poor condition, requiring neonatal resuscitation. (2014)*

Lack of escalation to, and involvement of, senior anaesthetists

4.81 We also found several examples of lack of senior involvement from the consultant anaesthetists on call. Even in periods of high workload there was limited support by the consultant anaesthetist responsible for the delivery suite out-of-hours. Complex obstetric complications, for example severe sepsis or pre-eclampsia, or women with significant pre-existing underlying co-morbidities, were treated by very junior staff for extended periods of time even when the complexity of work clearly required senior input. There were some cases where there was an evident delay in escalating to the

26 Knight M et al on behalf of MBRRACE-UK. Saving Lives, Improving Mother's Care- Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013 – 2015. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2017

consultant anaesthetist on call. However, when requested by junior doctors, we also found instances where the consultant anaesthetist failed to attend in a timely manner.

4.82 *A woman who had an epidural for pain relief in childbirth developed a significant headache and unspecific neurological symptoms after birth. She was seen over several days by a junior doctor. Only one review was documented in the notes. There was a significant delay requesting further diagnostic tests and involving the consultant anaesthetist. Subsequent imaging showed significant pathology that should have been detected earlier. The delay put the woman at significant risk for further complications. (2012)*

Limited consultant anaesthetist representation in incident investigation and multidisciplinary team meetings after significant incidents

4.83 The review team found instances of maternal deaths or cases of severe complications, where the obstetric anaesthesia team was requested by the obstetric risk management team to 'perform their own incident investigation' and not participate in any wider investigation or contribute recommendations to prevent such occurrences in future. Sometimes only junior anaesthetic staff attended initial root cause analysis meetings or obstetric anaesthetists were not represented at all in investigation panels or team meetings. This undermines the concept of multidisciplinary team working and indicates to the external review team that obstetric anaesthetists were not perceived as an integral part of the maternity team.

4.84 As late as 2016 the review team saw serious incident investigations without input from obstetric anaesthetists or relevant other sub-specialities. The lack of a well-functioning multidisciplinary team represented a significant weakness in the structure of the Trust's maternity services with a significant impact on wider learning from adverse events and ultimately a detrimental impact on patient safety.

LOCAL ACTIONS FOR LEARNING: OBSTETRIC ANAESTHESIA

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- **4.85** Obstetric anaesthetists are an integral part of the maternity team and must be considered as such. The maternity and anaesthetic service must ensure that obstetric anaesthetists are completely integrated into the maternity multidisciplinary team and must ensure attendance and active participation in relevant team meetings, audits, Serious Incident reviews, regular ward rounds and multidisciplinary training.

- **4.86** Obstetric anaesthetists must be proactive and make positive contributions to team learning and the improvement of clinical standards. Where there is apparent disengagement from the maternity service the obstetric anaesthetists themselves must insist they are involved and not remain on the periphery, as the review team have observed in a number of cases reviewed.

- **4.87** Obstetric anaesthetists and departments of anaesthesia must regularly review their current clinical guidelines to ensure they meet best practice standards in line with the national and local guidelines published by the RCoA and the OAA.

Adherence to these by all obstetric anaesthetic staff working on labour ward and elsewhere, must be regularly audited. Any changes to clinical guidelines must be communicated and necessary training be provided to the midwifery and obstetric teams.

- **4.88** Obstetric anaesthesia services at the Trust must develop or review the existing guidelines for escalation to the consultant on-call. This must include specific guidance for consultant attendance. Consultant anaesthetists covering labour ward or the wider maternity services must have sufficient clinical expertise and be easily contactable for all staff on delivery suite. The guidelines must be in keeping with national guidelines and ratified by the Anaesthetic and Obstetric Service with support from the Trust executive.

- **4.89** The service must use current quality improvement methodology to audit and improve clinical performance of obstetric anaesthesia services in line with the recently published RCoA 2020 'Guidelines for Provision of Anaesthetic Services', section 7 'Obstetric Practice' [27].

- **4.90** The Trust must ensure appropriately trained and appropriately senior/ experienced anaesthetic staff participate in maternal incident investigations and that there is dissemination of learning from adverse events.

- **4.91** The service must ensure mandatory and regular participation for all anaesthetic staff working on labour ward and the maternity services in multidisciplinary team training for frequent obstetric emergencies.

Neonatology

4.92 From our review of patient clinical records in 250 cases to date, for most babies the quality of neonatal care at the Trust appears to have been satisfactory or good and at times excellent. The period 2000 - 2019 includes the time when services across England and Wales were moving from a situation where many units delivered intensive care to one where all units became part of networks within which certain units were designated intensive care units and others were not.

4.93 Prior to 2006, the neonatal unit at the Royal Shrewsbury Hospital regularly delivered neonatal intensive care, as was appropriate at that time. From 2009 the unit was designated as a Local Neonatal Unit (LNU). LNUs are not expected to deliver ongoing neonatal intensive care. It appears that there was a period between 2006 and 2011 when the local network was transitioning from one model of neonatal care to another.

4.94 We have found a small number of cases where the neonatal care was substandard. However, these were very much the exception and we have to date found no evidence of systemic poor practice or lack of care in the neonatal service.

4.95 It appears from the majority of the 250 medical records reviewed to date that involvement of the consultant neonatologists in the provision of neonatal care and in communication with parents was of a very high quality. The medical records invariably record that the consultants were physically present for much of the working day, and often at night, and that they gave priority to communication with parents.

27 http://www.csen.com/GPAS.pdf

4.96 Review of the medical records show that advanced neonatal nurse practitioners (ANNPs) played an important role in the management of sick or premature infants at delivery, on the neonatal unit and on the postnatal ward. It appears that their practice has been sound and likely to have contributed to the maintenance of good standards of neonatal practice within the Trust.

LOCAL ACTIONS FOR LEARNING: NEONATAL SERVICE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their neonatal services.

- **4.97** Medical and nursing notes must be combined; where they are kept separately there is the potential for important information not to be shared between all members of the clinical team. Daily clinical records, particularly for patients receiving intensive care, must be recorded using a structured format to ensure all important issues are addressed.

- **4.98** There must be clearly documented early consultation with a neonatal intensive care unit (often referred to as tertiary units) for all babies born on a local neonatal unit who require intensive care.

- **4.99** The neonatal unit should not undertake even short term intensive care, (except while awaiting a neonatal transfer service), if they cannot make arrangements for 24 hour on-site, immediate availability at either tier 2, (a registrar grade doctor with training in neonatology or an advanced neonatal nurse practitioner) or tier 3, (a neonatal consultant), with sole duties on the neonatal unit.

- **4.100** There was some evidence of outdated neonatal practice at The Shrewsbury and Telford Hospital NHS Trust. Consultant neonatologists and ANNPs must have the opportunity of regular observational attachments at another neonatal intensive care unit.

Chapter 5

Immediate and Essential Actions to Improve Care and Safety in Maternity Services

We include these **Immediate and Essential Actions** because the Minister of State for Mental Health, Suicide Prevention and Patient Safety has expressly asked us, as part of this first report, to make recommendations which will help to improve safety in maternity services across England. We are aware that to date, there has been a mixed approach to implementing change from national safety reports and reviews into maternity services triggered by concerns relating to safety, such as this review.

Recommendations are of limited use if they are not implemented; indeed, had earlier recommendations been followed at The Shrewsbury and Telford Hospital NHS Trust some of the adverse outcomes we are investigating might not have occurred. Relying on the strength of our collective clinical experience we have named our conclusions as **Immediate and Essential Actions** – i.e. these are things which we say must be implemented now if not already done so.

As a team of clinicians we are engaged in practice across eleven Trusts in London and the South East and South West of England. In addition to clinical practice, our current roles, or those we have held in the recent past include midwifery, clinical and divisional director roles, consultant midwives, leads for governance, labour ward coordinators, clinical matrons and educational leads. Many of us have been active in leading and supporting regional and national maternity safety initiatives and have published their expertise in maternal and child health on a national and international level[28].

Many of our **Immediate and Essential Actions** are not newly developed; they are largely formed from recommendations made in previous reports and publications, to which we have referred below. We have formed our 'musts' from recurrent themes we have identified from investigating the selected 250 cases of concern referred to in this first report, with the objective being to positively impact safety in all maternity services across England.

28 http://www.ockendenmaternityreview.org.uk/

1: ENHANCED SAFETY	
Essential Action **Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks.** **Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.**	• Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months. • External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. • LMS must be given greater responsibility, accountability and responsibility so that they can ensure the maternity services they represent provide safe services for all who access them. • An LMS cannot function as one maternity service only. • The LMS Chair must hold CCG Board level membership so that they can directly represent their local maternity services which will include giving assurances regarding the maternity safety agenda. • All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months.

2: LISTENING TO WOMEN AND FAMILIES

Essential Action

Maternity services must ensure that women and their families are listened to with their voices heard.

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

3: STAFF TRAINING AND WORKING TOGETHER

Essential Action

Staff who work together must train together.

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

4: MANAGING COMPLEX PREGNANCY	
Essential Action There must be robust pathways in place for managing women with complex pregnancies Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.	• Women with complex pregnancies must have a named consultant lead. • Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team. • The development of maternal medicine specialist centres as a regional hub and spoke model must be an urgent national priority to allow early discussion of complex maternity cases with expert clinicians. • This must also include regional integration of maternal mental health services.

5: RISK ASSESSMENT THROUGHOUT PREGNANCY	
Essential Action Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.	• All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional. • Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

6: MONITORING FETAL WELLBEING	
Essential Action **All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.**	• The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: - Improving the practice of monitoring fetal wellbeing - Consolidating existing knowledge of monitoring fetal wellbeing - Keeping abreast of developments in the field - Raising the profile of fetal wellbeing monitoring - Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported - Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. • The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. They should also lead on he review of cases of adverse outcome involving poor FHR interpretation and practice. • The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

7: INFORMED CONSENT	
Essential Action **All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.**	• All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care • Women must be enabled to participate equally in all decision making processes and to make informed choices about their care. • Women's choices following a shared and informed decision making process must be respected.

Our Ongoing Work

I am grateful to my Independent Review Team who continue to support me with this review. We have taken these initial steps, through the publication of this first report, towards making a significant difference in helping to improve safety in maternity services. This review of 250 cases at the Trust can now impact positively on the maternity care provision for women and their families in Shropshire with the Trust working with their commissioners to ensure this happens.

As our work continues, we implore maternity services across England to also carefully consider this first report, and to make ambitious plans to ensure timely implementation of these **Local Actions for Learning** and **Immediate and Essential Actions** takes place.

Donna Ockenden

Appendix 1: Terms of Reference

Revised Terms of Reference - November 2019

1. This document sets out the revised Terms of Reference for the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust, which was commissioned in 2017 by the Secretary of State for Health. These updated Terms of Reference reflect changes to the scope of the review.

2. The original Terms of Reference set out an 'independent review of the quality of investigations and implementation of their recommendations, relating to a number of alleged avoidable neonatal and maternal deaths, and cases of avoidable maternity and new born harm at Shrewsbury and Telford Hospital (the Trust). The review will be led by NHS Improvement and will cover incidents raised with the Secretary of State in a letter dated 6 December 2016 requesting an independent inquiry.' Terms of Reference, May 2017.

3. Following the original launch of the review, more families have come forward with concerns about the care they received at the Trust. NHS Improvement commissioned an Open Book review of Trust records which also identified additional cases for review. These two factors have led to an extension to the scope of the original independent review as outlined in the original Terms of Reference.

Background

4. The Independent Review was established following a number of serious clinical incidents, beginning with the death of a new born baby in 2009; an incident which was not managed, investigated or acknowledged appropriately by the Trust at the time. From 2009 to 2014 a number of further investigations and reviews (internal and external) were undertaken to confirm whether:

    a. appropriate investigations were conducted; and

    b. the assurance processes relating to investigations in the maternity service were adequate.

Governance

5. The review was commissioned by the Secretary of State for Health.

6. The NHS Senior Responsible Officer for the review is the National Medical Director of NHS Improvement and NHS England who will periodically update the Department of Health and Social Care on progress.

7. The review will continue to be led by independent Chair, Donna Ockenden and the final report will be presented to the Department of Health and Social Care.

8. The Chair will be supported by the Review Team, a multidisciplinary clinical team of independent external reviewers.

Revised scope

9. The review will now include all cases which have been identified since the original review was established. Cases where families have contacted various bodies with concerns regarding their own experiences since the commencement of the original review will also have oversight from the clinical review team undertaking the Secretary of State commissioned review. This is in addition to cases identified in the 'Open Book' review. Any reports from previously commissioned reviews will also be submitted to the Chair of the review to ensure consistency and record any recommendations and lessons learnt for sharing more widely. The processes applied to the Trust case review and the associated governance process will also be review

Review approach

10. The multidisciplinary Review Team will:

a. Review the quality of the investigations and subsequent reports into the identified cohort of incidents;

b. Identify whether the investigations appropriately addressed the relevant concerns and issues from those incidents;

c. Establish if recommendations were accepted and appropriate actions implemented within the timescales identified in the associated action plan;

d. Consider how the parents, patients and families of patients were engaged with during these investigations;

e. Reserve the right to undertake a second-stage review of primary cases should the considerations above justify such action following agreement with the National Medical Director of NHS Improvement and NHS England; and

f. The review team will present cases internally, and on an as required basis seek further external advice

11. If the Review Team identifies any material concerns that need further immediate investigation or review, the National Medical Director of NHS Improvement and NHS England must be notified immediately.

12. All relevant case notes and other information will be passed by the Trust to the Chair and the Review Team and will be treated confidentially by them. Every effort will be made to contact families to let them know whether their case forms part of the review and to ask how they wish to be engaged, if at all. In the interests of conducting a comprehensive review and maximising the clinical learning, it is necessary for the Chair and Review Team to consider all cases within the scope of the review but no patient or family member will be identified by name in the final published report unless they have consented to this.

13. Directions to the Review Team:

a. Did the Trust have in place, at the time of each incident, mechanisms for the governance and oversight of maternity incidents? Does the Trust have this now?

b. Were incidents and investigations reported and conducted in line with national and Trust policies, that were relevant at the time?

c. Is there any evidence of learning from any of the identified incidents and the subsequent investigations?

d. Were families involved in the investigation in an appropriate and sympathetic way?

Key Principles

14. The review will be expected to:

a. Engage widely, openly and transparently with all relevant parties participating in the review process;

b. Be respectful when dealing with individuals who have been impacted by the incidents being investigated;

c. Adopt an evidence-based approach;

d. Acknowledge the importance of inter-professional cooperation in achieving good outcomes for women and babies;

e. Consider links to national policy and best practice in relation to midwifery, maternity, neonatal and obstetric care and investigation management that were relevant at the time; and

f. Consider the challenge of implementing proposals, including the workforce.

g. Handle data and information with care and in accordance with good information governance practice

15. For families who have contacted the Chair of the Secretary of State commissioned Independent Review directly, and whose cases were originally investigated by the Trust, the investigations of these cases will be reviewed. The review process will consider the investigations and associated action plans from each incident investigation to ensure these appropriately addressed the relevant concerns and were implemented by the Trust at the time.

16. All cases will be reviewed in relation to Trust policy and national guidance that was relevant at the time.

17. In 2018 NHS Improvement commissioned an ‘Open Book’ review of Trust records. Shrewsbury and Telford Hospital NHS Trust was requested to ‘open its books’ in relation to specific maternity data held by the organisation from 1 January 1998, when national incident reporting on the Strategic Executive Information System (STEIS) began, to 27 September 2018. The scope included patients from England and Wales (Powys).

18. The purpose of the review was to determine as far as reasonably practical with the available data, the number of cases and associated incident reporting and investigation practices over the time period in relation to:

a. Maternal deaths

b. Stillbirths

c. Neonatal deaths

d. Babies diagnosed with hypoxic ischemic encephalopathy (Grade 2 & 3)

19. This has identified over 300 cases which don't appear to overlap with many other cases known to the review team. The independent review will now consider how to incorporate these cases, and any others which arise through the investigation, into its scope to assess whether their outcomes were the result of failings.

Resources

20. Resource requirements will be agreed between the Chair of the review, NHS Improvement and NHS England and the Department of Health and Social Care to ensure the review is adequately supported.

Timeframe

21. The overall timeline will be agreed between the Chair of the review, NHS Improvement and NHS England and Department of Health and Social Care, in light of the extended scope of the review.

22. The final review report and proposals should be available within one month of the review being completed.

Appendix 2: Glossary

Definitions and Medical and Midwifery terms used throughout this Report

Glossary of terms used

Birthing centre	A birth centre staffed by midwives, they may be 'stand alone', (some distance from a Consultant led unit) or alongside- often in the same building/ on the same floor as a Consultant led unit
Cardiotocograph (CTG)	A technical means of recording the fetal heart rate and the uterine contractions during pregnancy and labour
Care Quality Commission (CQC)	An executive non-departmental public body of the Department of Health and Social Care of the United Kingdom. It was established in 2009 to regulate and inspect health and social care services in England
Clinical Commissioning Groups (CCG)	Groups of general practices (GPs) which come together in each area to commission the best services for their patients and population
Consultant obstetric unit	A place to give birth staffed by obstetricians, midwives and anesthetists. They have a neonatal unit staffed by neonatologists and nurses
Executive Director	A member of a board of directors who also has managerial responsibilities
Extended perinatal death	A stillbirth or neonatal death
Fibroids	A benign tumour of muscular and fibrous tissue which develops in the wall of the uterus
Forceps	An instrument shaped like a pair of large spoons which are applied to the baby's head in order to guide the baby out of the birth canal
HSIB	The Healthcare Safety Investigation Branch. They investigate incidents that meet the Each baby Counts criteria and their defined criteria for maternal deaths https://www.hsib.org.uk/maternity/what-we-investigate/

Hypoxic ischaemic encephalopathy (HIE)	A newborn brain injury caused by oxygen deprivation to the brain. Graded into HIE grades 1-3 depending on severity
Humerus	The long bone in the arm
Intermittent auscultation (IA)	The technique of listening to and counting the fetal heart rate (FHR) for short periods during active labour
Local Maternity System (LMS)	The Local Maternity Systems are the mechanism through which it is expected that a Sustainability and Transformation Partnership (STP) will collaboratively transform maternity services with a focus on delivering high quality, safe and sustainable maternity services and improved outcomes for women and their families. The LMS's are overseen by the Maternity Transformation Board
Maternal Death	Defined as the death of a woman while pregnant or within 42 days of termination of pregnancy
Maternity Voices Partnerships (MVP)	A team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care
MatNeo collaborative	The maternity and neonatal safety collaborative is a programme to support improvement in the quality and safety of maternity and neonatal units across England
MEWS or MEOWS	An early warning score or guide used by medical services to quickly determine the degree of illness of a patient. It is based on the vital signs. The MEOWS is a 'Modified Early Obstetric Warning System'
MBRRACE-UK	(Mothers and Babies: Reducing Risk though Audits and Confidential Enquiries across the UK) – a national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths
Neonate	Refers to an infant in the first 28 days after birth
Neonatal death	An infant who dies in the first 28 days of life - Early neonatal death – a liveborn baby who died before 7 completed days after birth - Late neonatal death – a liveborn baby who died after 7 completed days but before 28 completed days after birth
Non Executive Director (NED)	A board member without responsibilities for daily management or operations of the organisation

Nursing and Midwifery Council (NMC)	The nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland
Occipito posterior position	Common malpresentation in labour, which can be associated with a prolonged labour
Oxytocin	A hormone commonly used in obstetric practice to increase uterine activity
Perinatal death	A stillbirth or early neonatal death
Pre-eclampsia	A disease of high blood pressure, proteinuria and organ dysfunction occurring in pregnancy
Primary Care Trust or PCT	were part of the National Health Service in England from 2001 to 2013. PCTs were responsible for commissioning primary, community and secondary health services from providers. Primary care trusts were abolished on 31 March 2013 as part of the Health and Social Care Act 2012, with their work taken over by Clinical Commissioning Groups or CCGs.
Shrewsbury and Telford Hospital NHS Trust or the Trust	
Stillbirth	A stillbirth is the death of a baby occurring before or during birth once a pregnancy has reached 24 weeks
Ventouse delivery	A suction cap is applied to the baby's head in order to deliver the baby through the birth canal

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21st December 2020

Ockenden Review of Maternity Services

This letter provides assurance that Milton Keynes University NHS Foundation Trust (MKUH) are implementing all 12 urgent clinical priorities and included is a brief outline of progress and evidence. The full comprehensive action plan is under development and will be submitted for the 15th January 2021 deadline.
MKUH works collaboratively within Bedford Luton and Milton Keynes (BLMK) Local Maternity and Neonatal System (LMNS) proactively on the agenda for maternity services.

Immediate Actions

1) **Enhanced Safety**

a) A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly

Discussions are underway within LMNS to develop a maternity quality and safety model which will strengthen the oversight of maternity and neonatal quality and safety at board level. The LMNS plan to take a more formal role in maternity and neonatal quality, transformation, and quality improvement. Regional oversight will come in the form of an identified committee which has specific responsibility for perinatal quality involving the Regional Chief Midwife and Regional Lead Obstetrician.

b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB.

All serious incidents (SI's) and HSIB investigations are presented and discussed at the weekly multidisciplinary Trust's Serious Incident Review Group Chaired by the Medical Director and Chief Nurse and then monitored through departmental governance meetings and quarterly Quality and Clinical Risk Committee.

SIs are shared with Milton Keynes CCG as per the SI Framework (2015). These are then discussed and reviewed by members of the BLMK LMNS, when the final report is submitted to Anne Murray, SRO for the LMNS (BLMK Chief Nurse) and the Quality Lead

for Maternity Services.
Quarterly multi professional SI review panels have been initiated within the LMNS to provide discussion, identify themes, and share learning across BLMK Maternity services.

To strengthen the current process a monthly SI report will be and shared at Trust Board including maternity SIs.

2) **Listening to Women and their Families**

a) *Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services*

MK MVP have been working collaboratively with maternity stakeholders in Milton Keynes for over 10 years and are considered an integral part of the maternity service development programme. MK MVP are fundamentally embedded as independent members of the LMNS ensuring that service user voices drive, support, and challenge current developments in local maternity care. Attached is a letter from MK MVP offering their support and evidence to contribute towards this requirement.

The MVP have collaborated in the development of:
a) Personal care plans for women
b) Development to expand the current perinatal mental health offer to expand perinatal services across the LMNS.
c) Support women's experiences throughout the current pandemic.

Healthwatch Enter and View have undertaken planned visits and survey to engage with women and families to explore their overall experience of care received when delivering their baby under the care of MKUH.

We have a Birth Afterthoughts service supporting listening to women's feedback and experiences and using the themes to inform quality improvement projects.

b) *In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Further guidance will be shared shortly.*

MKUH Board Maternity Safety Champions are the Medical Director and Chief Nurse. Trust discussions on the appointment of a NED lead are underway with the Chairman and Chief Nurse by reviewing the newly produced role descriptor to ensure the most appropriate NED is identified.

3) **Staff Training and working together**

a) *Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.*

Currently, there are twice daily consultant led ward rounds and a virtual teleconference takes place at 22:00 daily which is recorded with auditable outcomes.

b) *The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented, In the meantime we are seeking assurance that a MDT training schedule is in place.*

Multidisciplinary training has been fully implemented and is evidenced by monthly PROMPT training, and regular skills and drills in the clinical environment. In 2020 there was a CTG masterclass facilitated for the MDT with a recognised expert in this field. The multidisciplinary team also undertake K2 CTG training and Gap/Grow training annually.

c) *Confirmation that funding allocated for maternity staff training is ringfenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety.*

We can confirm the funding for maternity staff training is ringfenced for staff. Whilst the refund is not specifically used only for maternity safety there are no barrier to support or financial investment to drive quality improvement projects and initiatives.

4) **Managing complex pregnancy**

a) *All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.*

There is a named lead consultant for fetal medicine and maternal medicine A review and gap analysis of the current antenatal pathway will be undertaken to implement consultant led pathway with a named consultant for all complex pregnancies.

b) *Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres*

MKUH sits within the East of England and has tertiary pathways to Oxford University Hospital which is our regional maternal medicine specialist centre where the local maternal medicine lead consultant refers patients as required.

5) **Risk Assessment throughout pregnancy**

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

All women receive a formal risk assessment at their booking appointment to determine the appropriate pathway. This now needs to be standardised within our electronic patient record eCare to ensure this can be audited and provide assurance on quality.

Implementation of personalised care plans will be finalised within the LMNS.

6) Monitoring Fetal Wellbeing

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

All elements of the Saving Babies Lives Care Bundle have been implemented. Currently, element 4 has an identified senior midwifery lead. There is a dedicated labour ward consultant, and their roles and responsibilities will be reviewed to ensure this element is included. An audit programme is planned to include all 5 elements of the Saving Babies Lives Care Bundle.

7) Informed Consent

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

MKUH have an approved Trust Consent Policy in place. A task and finish group is being developed to specifically address consent during labour to enhance the policy. Implementation of personalised care plans for all women when approved at LMNS alongside a risk assessment at each booking will provide documentary evidence of informed consent and women's preferences.
We will ensure all maternity care pathways are available on the Trust website in an accessible format for all.

Review of current education and training for all clinicians to reinforce the specific aspect of informed consent to enable and promote families to participate equally in all decision making.

At MKUH we are dedicated to improving maternity safety and experiences and outcomes for women and their families and welcome the insights and recommendations within the report.

Yours Sincerely

Joe Harrison, CEO
Milton Keynes University Hospital
NHS Trust

Anne Murray
Chief Nurse
BLMK Commissioning
Collaborative

OBJECTIVE 1 - PATIENT SAFETY									
ID	Indicator	Target 20-21	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
1.1	Mortality - (HSMR)	100	100		94.7	✓	▲		
1.2	Mortality - (SHMI)	100	100		116.0	✗	▲		
1.3	Never Events	0	0	1	0	✓	▲	✗	
1.4	Clostridium Difficile	15	<10	2	0	✓	▲	✓	
1.5	MRSA bacteraemia (avoidable)	0	0	1	1	✗	▼	✗	
1.6	Falls with harm (per 1,000 bed days)	0.12	0.12	0.26	0.40	✗	▼	✗	
1.7	Midwife : Birth Ratio	28	28	28	31	✗	▼	✗	
1.8	Incident Rate (per 1,000 bed days)	40	40	74.87	66.08	✓	▼	✓	
1.9	Duty of Candour Breaches (Quarterly)	0	0	0	0	✓	▬	✓	
1.10	E-Coli	20	<14	14	0	✓	▲		
1.11	MSSA	8	<6	8	1	✓	▼	✓	
1.12	VTE Assessment	95%	95%	97.9%	97.9%	✓	▲	✓	

OBJECTIVE 2 - PATIENT EXPERIENCE									
ID	Indicator	Target 20-21	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.2	RED Complaints Received			0	0		▬		
2.3	Complaints response in agreed time	90%	90%	91.6%	88.6%	✗	▼	✓	
2.4	Cancelled Ops - On Day	1.0%	1.0%	0.10%	0.04%	✓	▲	✓	
2.5	Over 75s Ward Moves at Night	2,000	1,333	570	117	✓	▼	✓	
2.6	Mixed Sex Breaches	0	0	5	0	✓	▲	✗	

OBJECTIVE 3 - CLINICAL EFFECTIVENESS									
ID	Indicator	Target 20-21	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
3.1	Overnight bed occupancy rate	93%	93%	73.1%	84.2%	✓	▲	✓	
3.2	Ward Discharges by Midday	27%	27%	20.6%	21.7%	✗	▲	✗	
3.3	Weekend Discharges	70%	70%	65.2%	64.3%	✗	▼	✗	
3.4	30 day readmissions			8.7%	7.8%		▼		
3.5	Follow Up Ratio	1.50	1.50	1.74	1.40	✓	▲	✗	
3.6.1	Number of Stranded Patients (LOS>=7 Days)	198	198		144	✓	▲		
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)	53	53		58	✗	▲		
3.7	Delayed Transfers of Care	25	25		11	✓	▲		
3.8	Discharges from PDU (%)	15%	15%	8.9%	8.7%	✗	▬	✗	
3.9	Ambulance Handovers >30 mins (%)	5%	5%	3.2%	5.7%	✗	▼	✓	

OBJECTIVE 4 - KEY TARGETS									
ID	Indicator	Target 20-21	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1	ED 4 hour target (includes UCS)	90.0%	90.0%	96.4%	92.2%	✓	▼	✓	
4.2	RTT Incomplete Pathways <18 weeks	79.0%	71.0%		58.0%	✗	▲		
4.4	RTT Total Open Pathways	18,878	20,466		24,752	✗	▲		
4.5	RTT Patients waiting over 52 weeks		0		343	✗	▲		
4.6	Diagnostic Waits <6 weeks	99%	99%		82.0%	✗	▲		
4.7	All 2 week wait all cancers (Quarterly)	93.0%	93.0%		81.8%	✗	▼		
4.8	31 days Diagnosis to Treatment (Quarterly)	96.2%	96.2%		94.8%	✗	▲		
4.9	62 day standard (Quarterly)	85.5%	85.5%		84.6%	✗	▲		

OBJECTIVE 5 - SUSTAINABILITY									
ID	Indicator	Target 20-21	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
5.1	GP Referrals Received	Not Available		33,967	4,447	Not Available	▲	Not Available	
5.2	A&E Attendances			48,936	6,388		▲		
5.3	Elective Spells (PBR)			9,815	1,927		▼		
5.4	Non-Elective Spells (PBR)			15,318	2,191		▼		
5.5	OP Attendances / Procs (Total)			190,262	29,614		▲		
5.6	Outpatient DNA Rate			6.1%	6.8%		▬		

OBJECTIVE 7 - FINANCIAL PERFORMANCE									
ID	Indicator	Target 20-21	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
7.1	Income £'000	Not Available		189,569	24,542	Not Available	▲	Not Available	
7.2	Pay £'000			(125,528)	(16,483)		▼		
7.3	Non-pay £'000			(54,508)	(7,421)		▲		
7.4	Non-operating costs £'000			(10,792)	(1,286)		▲		
7.5	I&E Total £'000			(1,258)	(647)		▼		
7.6	Cash Balance £'000				50,228		▲		
7.7	Savings Delivered £'000			1,247	150		▼		
7.8	Capital Expenditure £'000			5,367	1,316		▼		

OBJECTIVE 8 - WORKFORCE PERFORMANCE									
ID	Indicator	Target 20-21	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
8.1	Staff Vacancies % of establishment	10%	10%		10.9%	✗	▬		
8.2	Agency Expenditure %	4.1%	4.1%	2.8%	3.6%	✓	▼	✓	
8.3	Staff Sickness % - Days Lost (Rolling 12 months)	4%	4%		4.6%	✗	▼		
8.3b	Staff Sickness % - Days Lost (Monthly - Including Covid-19)	4%	4%	4.4%	4.1%	✗	▼	✗	
8.3c	Staff Sickness % - Days Lost (Monthly - Excluding Covid-19)	4%	4%	3.9%	3.9%	✓	▼	✓	
8.4	Appraisals	90%	90%		91.0%	✓	▼		
8.5	Statutory Mandatory training	90%	90%		95.0%	✓	▲		
8.6	Substantive Staff Turnover	10%	10%		8.5%	✓	▬		

OBJECTIVES - OTHER									
ID	Indicator	Target 20-21	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
O.1	Total Number of NICE Breaches	10	10		33	✗	▬		
O.2	Rebooked cancelled OPs - 28 day rule	95%	95%	70.0%	0.0%	✗	▼	✗	
O.4	Overdue Datix Incidents >1 month	0	0		64	✗	▼		
O.5	Serious Incidents	45	<30	61	10	✗	▲	✗	
O.8	Completed Job Plans (Consultants)	90%	90%		87%	✗	▲		

Key: Monthly/Quarterly Change

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

YTD Position

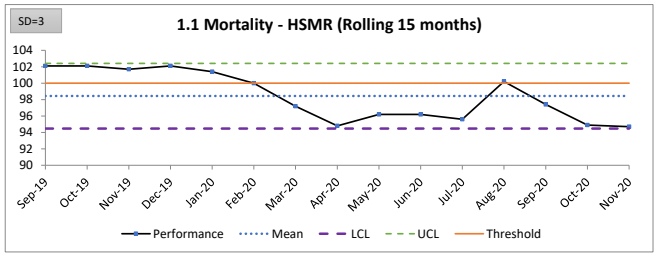
✓	Achieving YTD Target
	Within Agreed Tolerance*
✗	Not achieving YTD Target
✗	Annual Target breached

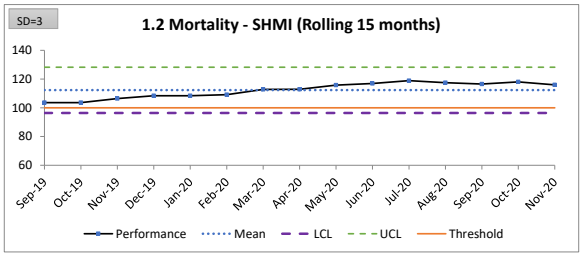
Data Quality Assurance Definitions

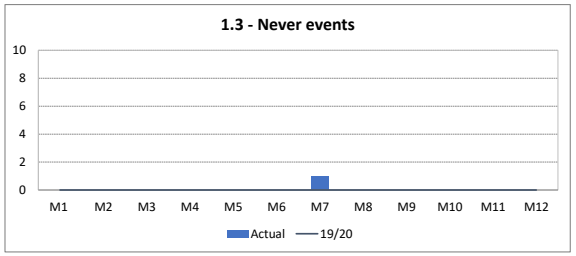
Rating	Data Quality Assurance
Green	Satisfactory and independently audited (indicator represents an accurate reflection of performance)
Amber	Acceptable levels of assurance but minor areas for improvement identified and potentially independently audited * /No Independent Assurance
Red	Unsatisfactory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

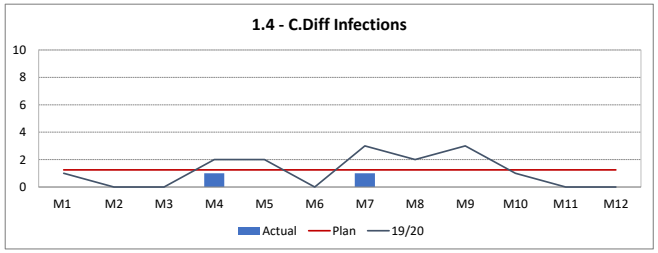
* Independently Audited – refers to an independent audit undertaken by either the Internal Auditor, External Auditors or the Data Quality Audit team.

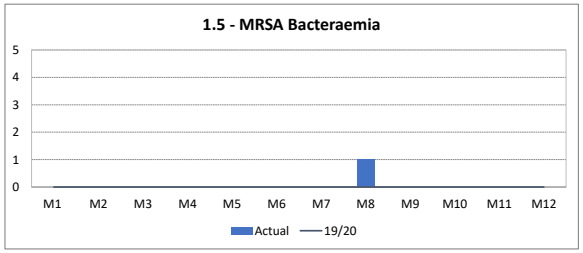
Date Produced: 11/12/2020

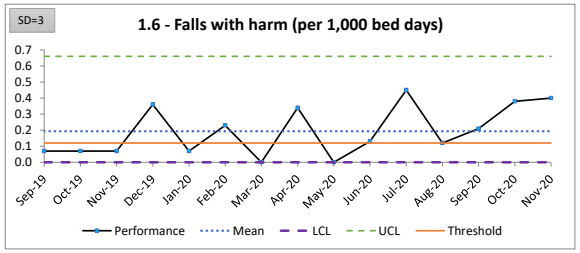


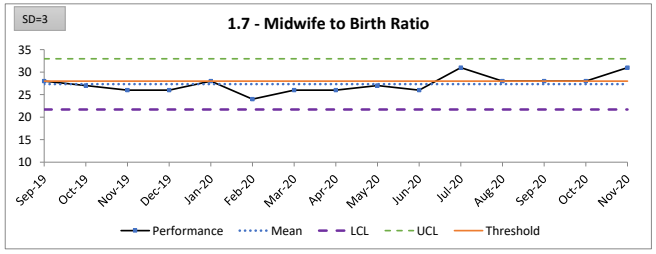


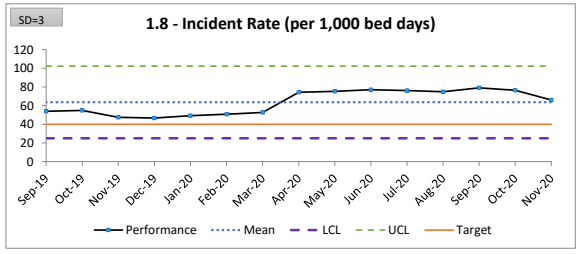


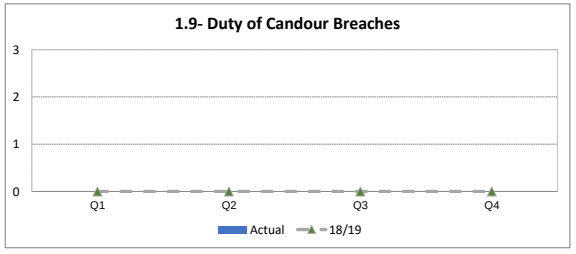


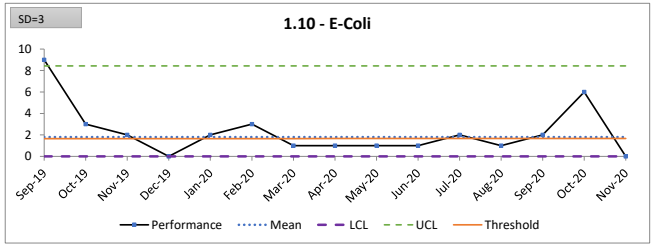


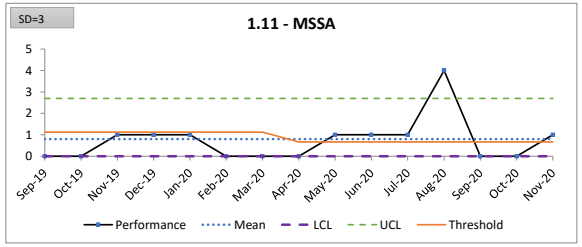


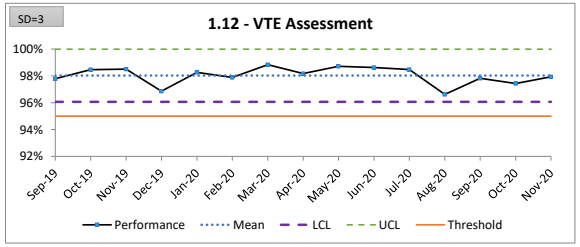












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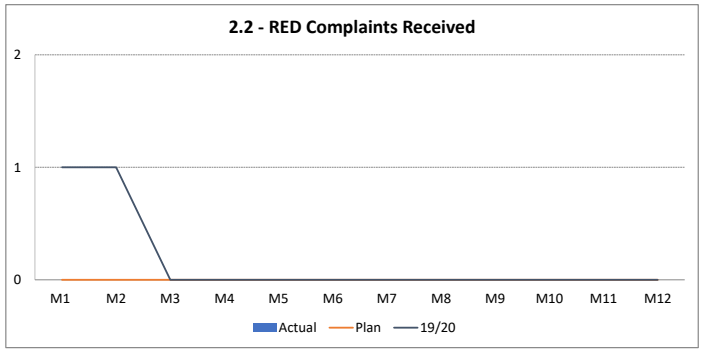
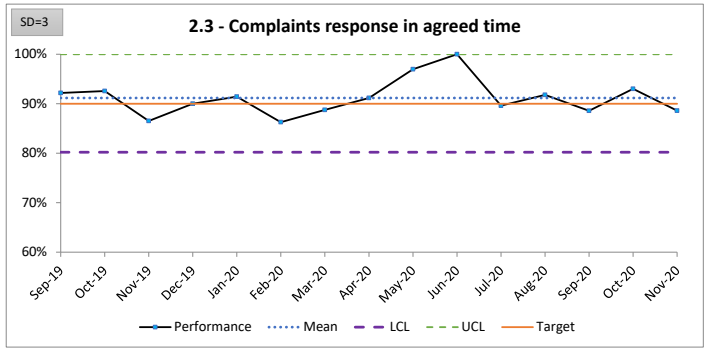
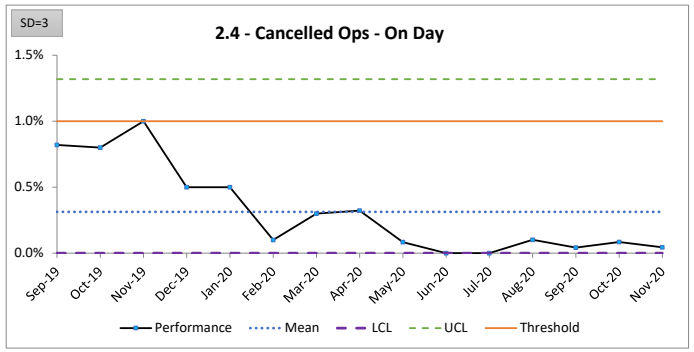
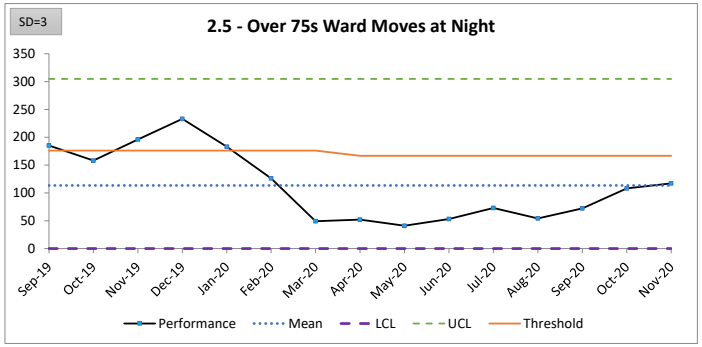
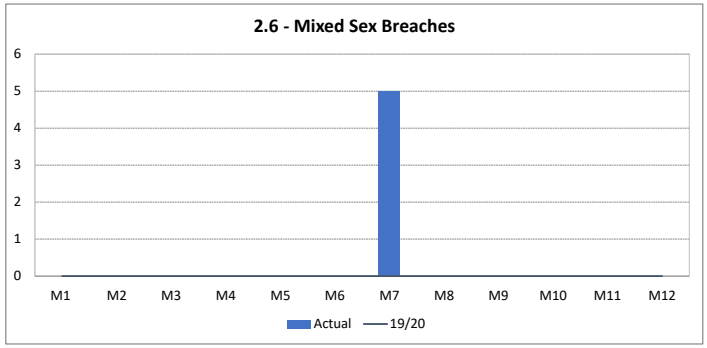
OBJECTIVE 2 - PATIENT EXPERIENCE











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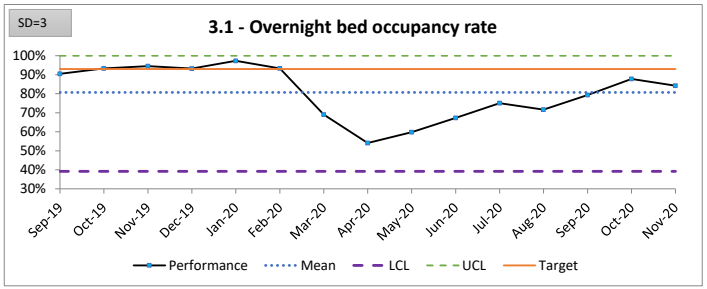
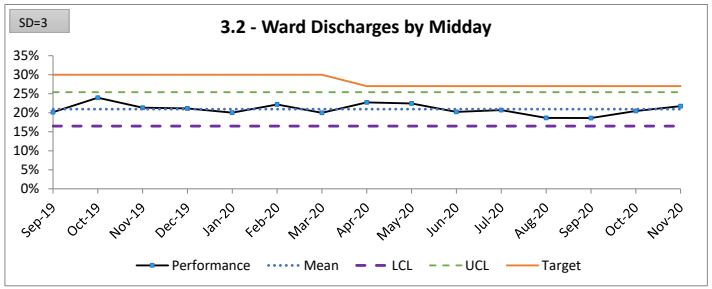
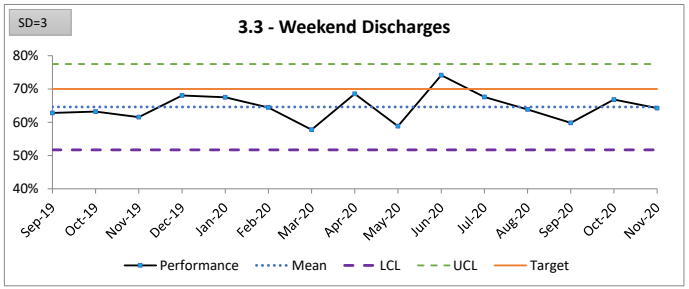
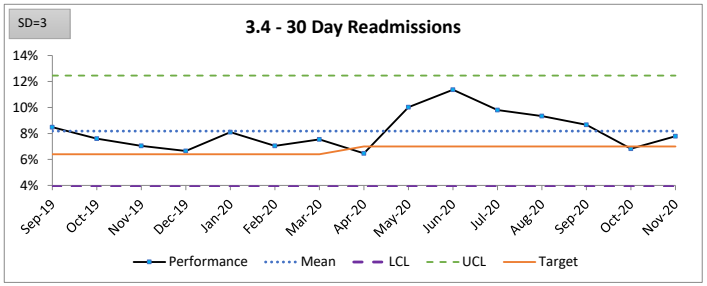
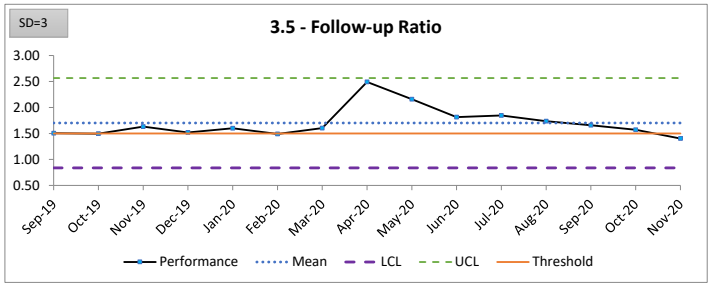
OBJECTIVE 3 - CLINICAL EFFECTIVENESS

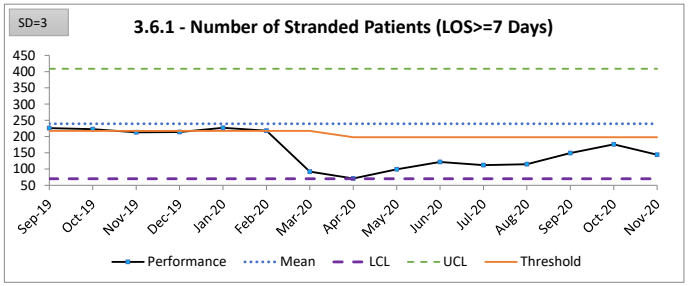


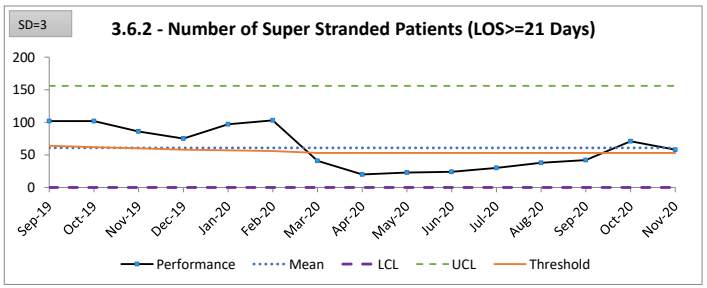


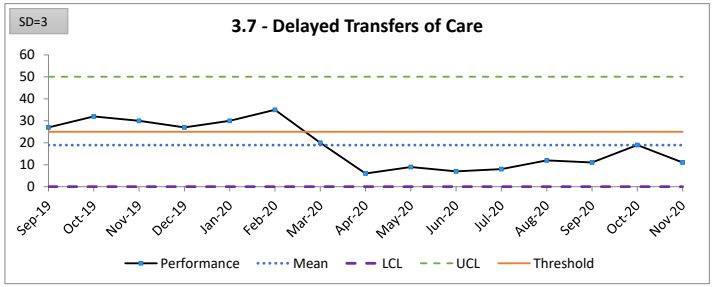


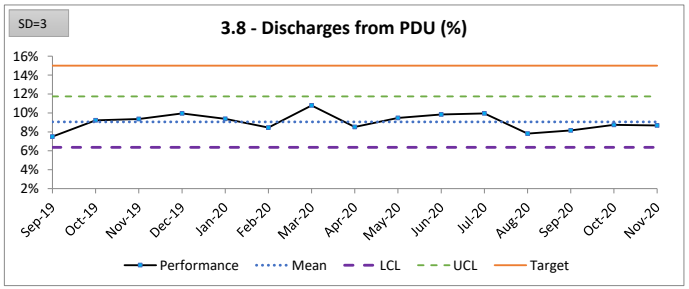


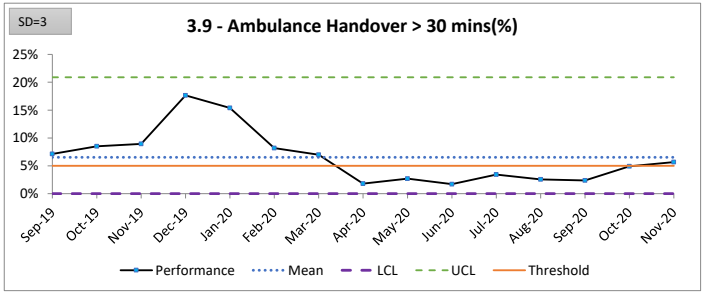












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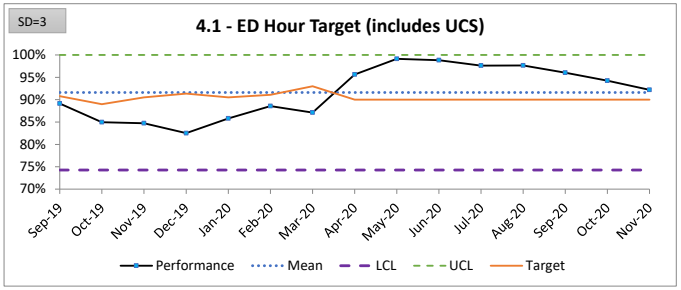
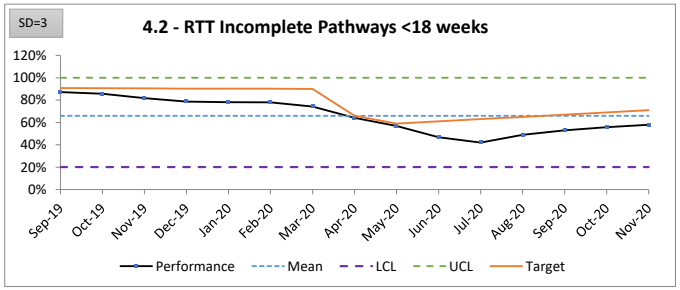
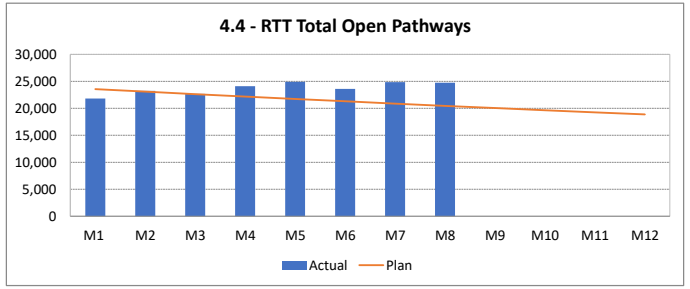
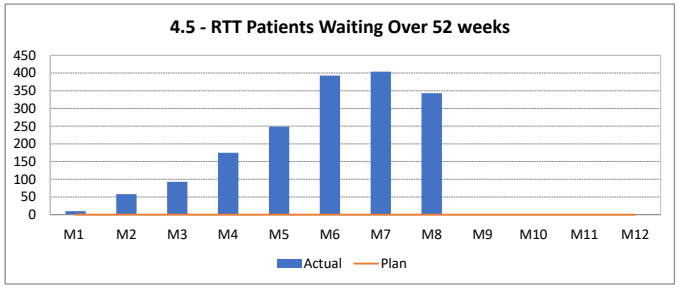
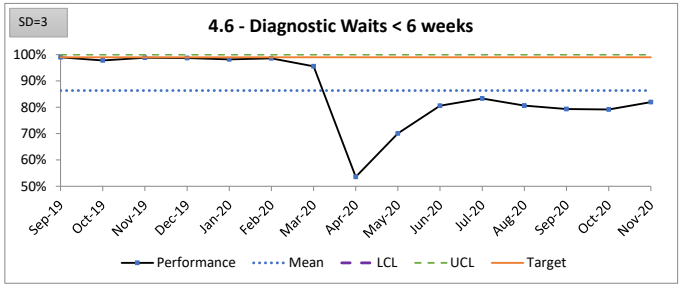
OBJECTIVE 4 - KEY TARGETS

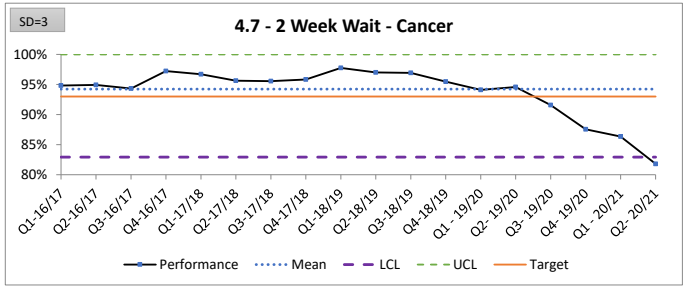


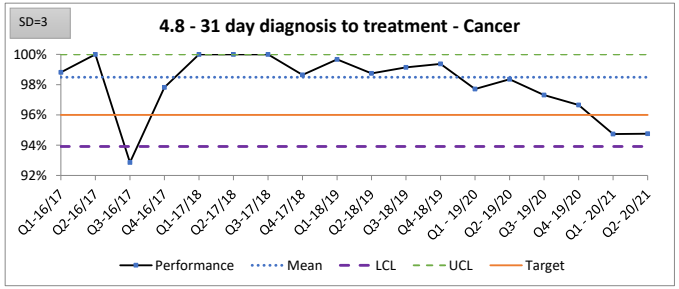


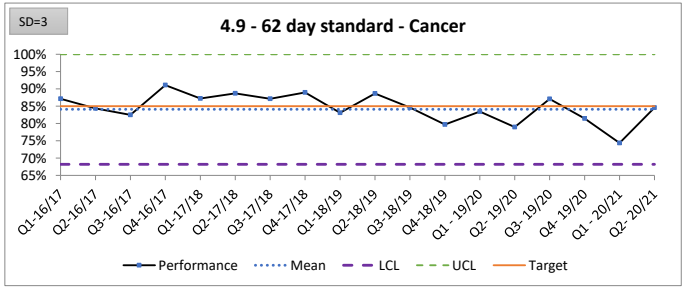












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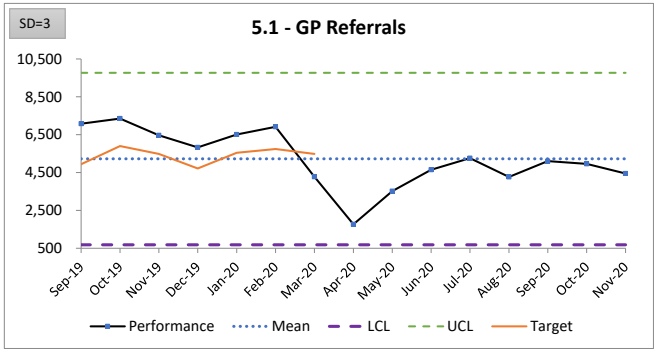
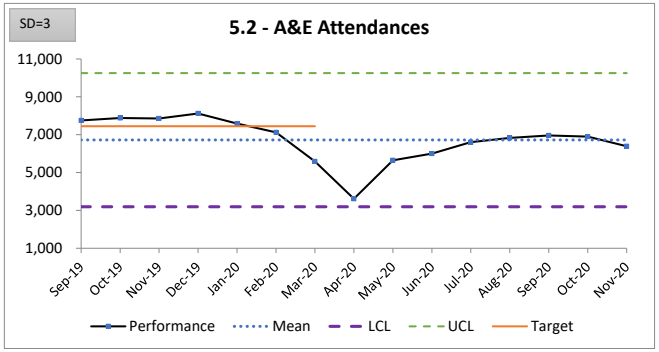
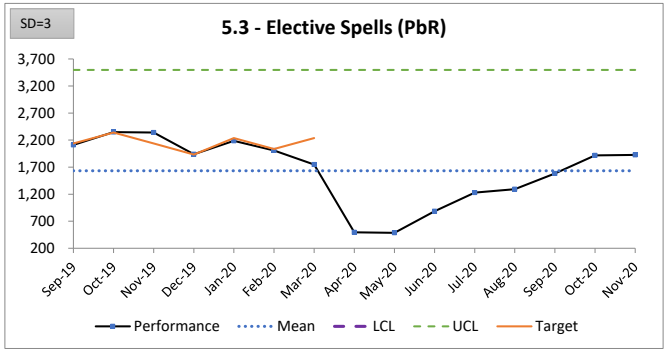
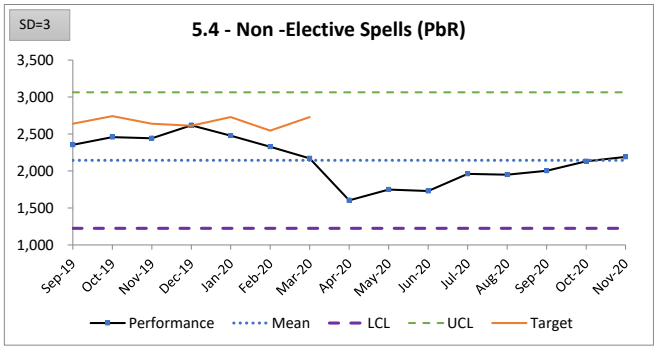
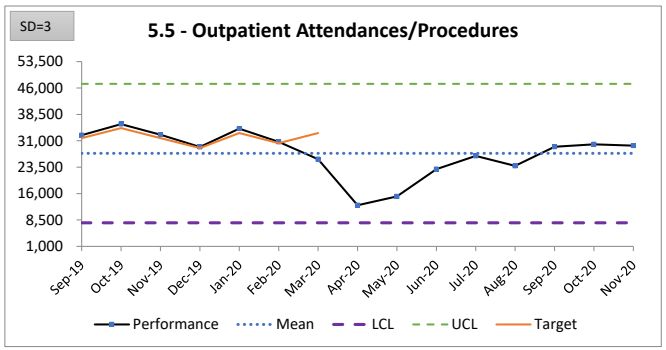
Milton Keynes University Hospital NHS Foundation Trust

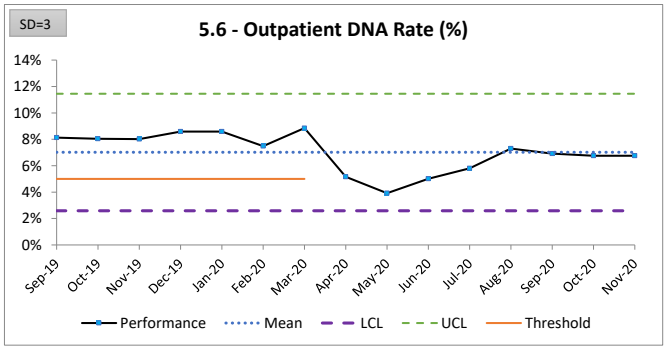












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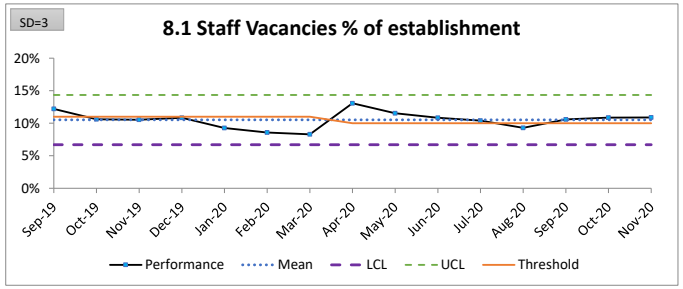
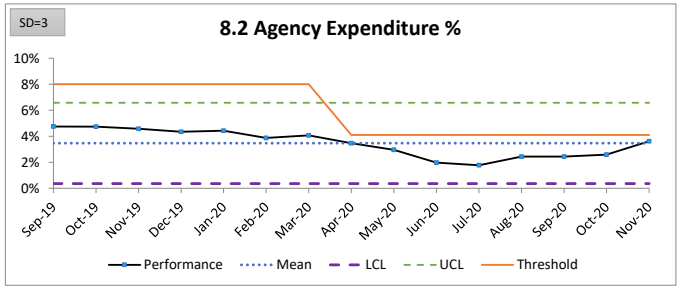
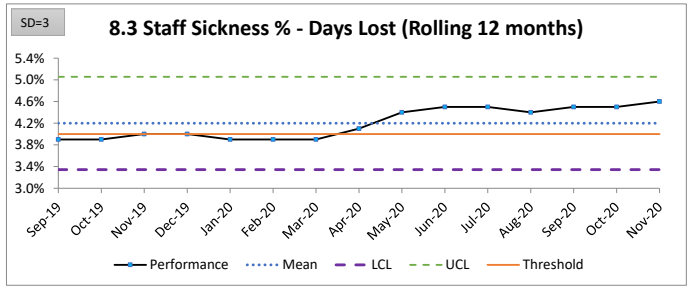
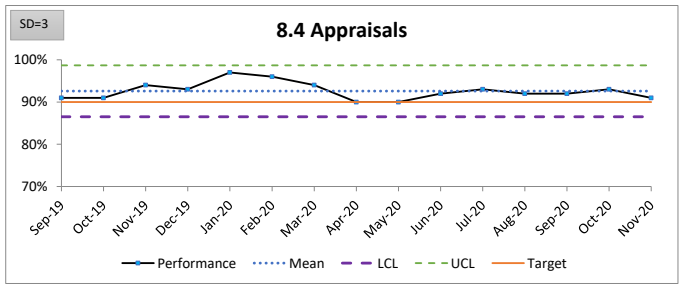
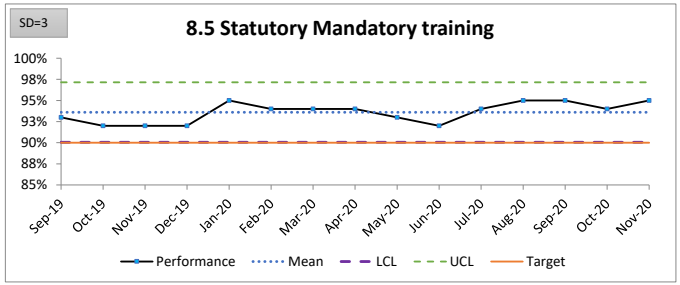
OBJECTIVE 8 - WORKFORCE PERFORMANCE

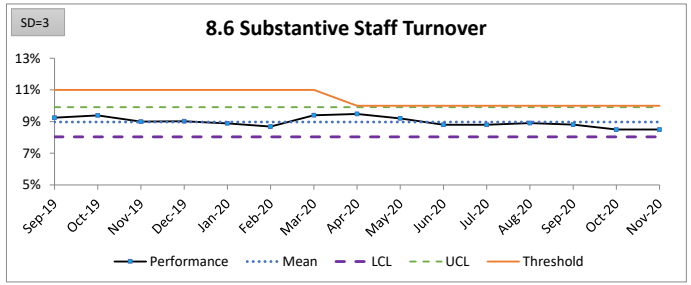






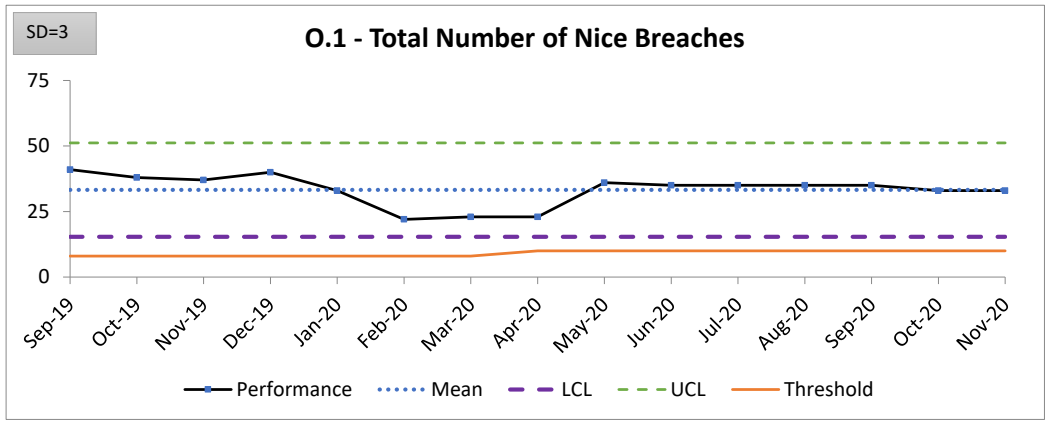


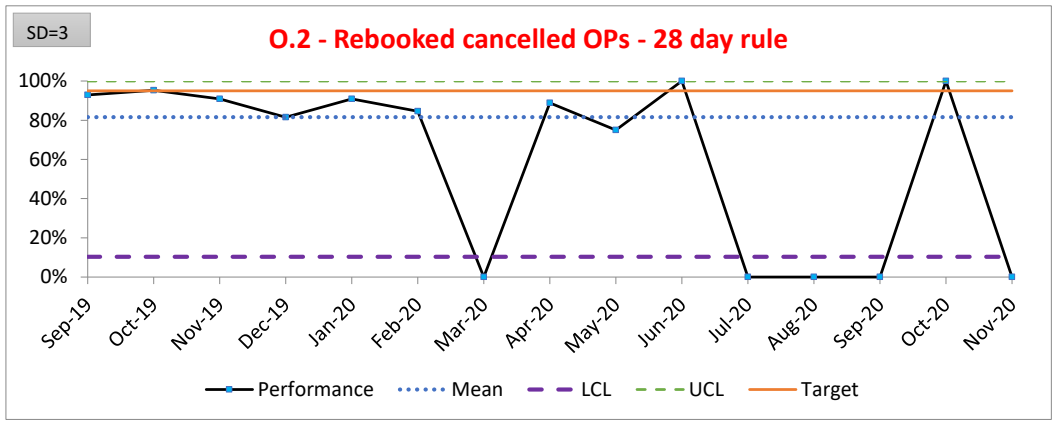


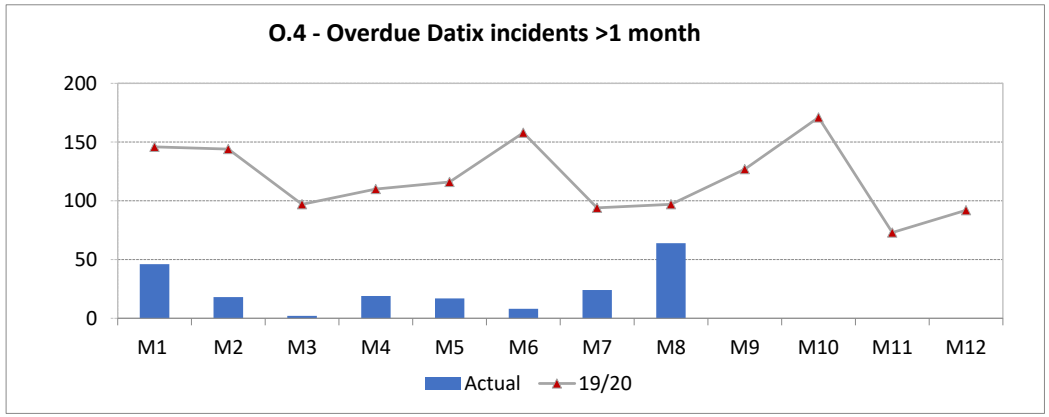


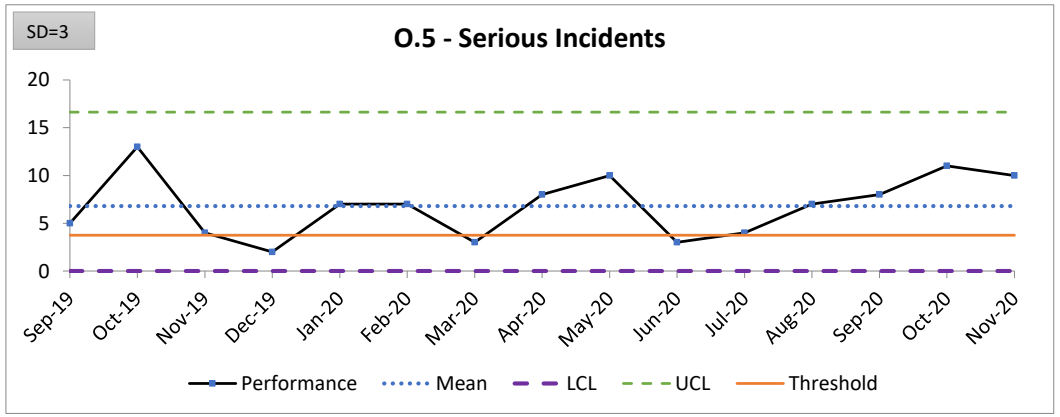
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

- 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









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Performance activity on a rolling 15 months/quarterly
Average on a rolling 15 months/quarterly
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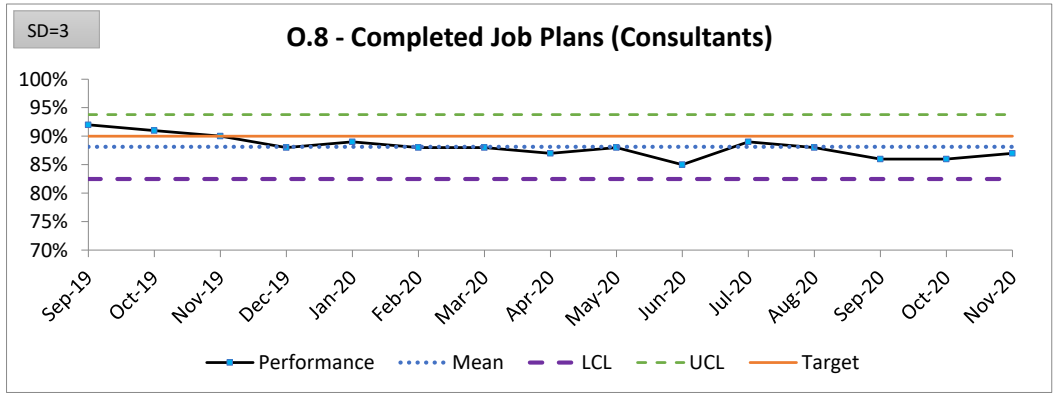

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Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Public Board Meeting	Date: 14 January 2021
Report title:	**Finance Paper Month 8 2020-21**	**Agenda item: 4.2**
Lead director **Report authors**	Sophia Aldridge Chris Panes	Director of Finance Head of Management Accounts
FoI status:	Private document	

Report summary	**An update on the financial position of the Trust at Month 8 (November 2020)**			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** X	**Decision** ☐
Recommendation	Trust Board to note the contents of the paper.			

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

Report history	None
Next steps	None
Appendices	1 to 3

FINANCE REPORT FOR THE MONTH TO 31st NOVEMBER 2020

PUBLIC BOARD MEETING

PURPOSE

1. The purpose of the paper is to:

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

EXECUTIVE SUMMARY

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

3. *Income and expenditure* –Against the revised plan and funding arrangement the Trust has reported a negative variance of £10k against (£57k positive YTD) a planned deficit of £567k (£780k YTD) for November 2020. Within this position the Trust has claimed an additional £0.9m (£6.4m YTD) of income directly related to the COVID-19 outbreak (against which the Trust is able to evidence an additional £6.5m of costs relating to covid).

   After the revised block funding arrangement, the Trust has overerperformed against its original planned deficit for month 8 (after Financial Recovery Funding) by £1.3m (£3.4m overperformed YTD).

4. Cash and capital position – the cash balance as at the end of November 2020 was £50.2m, which was £5.1m above the revised plan.

   The Trust has spent £5.4m on capital up to month 8 which relates to £1.2m HIP 2 and £4.2m patient safety and clinically urgent capital expenditure.

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

6. *Cost savings* – Work on tracking and delivering schemes has resumed following a temporary suspenson due to COVID. The Trust has submitted its financial plan which includes a target of £5m for CIP delivery by year end. As of at M8 £1.8m of schemes have been identified and added to the trust tracker with a delivery of £1.2m YTD. Divisions have renewed focus on cost improvement plans and are working to identify the remaining £3.2m .

INCOME AND EXPENDITURE

7. As part of its revised planning submission (draft resubmitted on 18th November 2020), the Trust has completed a revised financial forecast based on the revised funding arrangement. In its reporting to NHSI, the Trust is required to report against this plan/forecast going forward. However, in order for the Trust to get a better understanding of the Trust's cost base and how this has been impact by covid, the Trust is also monitoring performance against a planned position that would meet the original financial control total (excluding the regional 0.5% additional efficiency requirement). The tables below summarises performance against the revised plan and the Trust's original plan. For the purposes of the report, the narrative discusses performance against the Trust's original plan and the revised forecast plan.

Revised Forecast Plan:

All Figures in £'000	Month 8			Month 8 YTD			Full Year		
	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var
Clinical Revenue	18,546	18,709	163	146,308	146,613	305	220,494	220,494	0
Other Revenue	1,340	1,497	157	10,362	10,622	260	15,762	15,762	0
Total Income	19,886	20,206	320	156,670	157,236	566	236,256	236,256	0
Pay	(16,472)	(16,471)	1	(126,196)	(125,444)	752	(192,395)	(192,395)	0
Non Pay	(7,141)	(7,433)	(292)	(53,355)	(54,590)	(1,235)	(82,197)	(82,197)	0
Total Operational Expend	(23,613)	(23,903)	(290)	(179,551)	(180,034)	(483)	(274,592)	(274,592)	0
EBITDA	(3,727)	(3,697)	30	(22,881)	(22,799)	82	(38,336)	(38,336)	0
Financing & Non-Op. Costs	(1,178)	(1,216)	(38)	(10,220)	(10,246)	(26)	(14,931)	(14,931)	0
Control Total Deficit (excl. top up)	**(4,905)**	**(4,913)**	**(8)**	**(33,101)**	**(33,044)**	**57**	**(53,267)**	**(53,267)**	**0**
Adjustments excl. from control total:									
FRF	0	0	0	0	0	0	0	0	0
MRET	0	0	0	0	0	0	0	0	0
National Block	0	0	0	0	0	0	0	0	0
National Top up	3,413	3,411	(2)	25,871	25,871	0	39,523	39,523	0
COVID Top up	925	925	0	6,449	6,449	0	10,150	10,150	0
Control Total Deficit (incl. top up)	**(567)**	**(577)**	**(10)**	**(781)**	**(724)**	**57**	**(3,594)**	**(3,594)**	**0**
Donated income	0	0	0	14	14	0	14	14	0
Donated asset depreciation	(68)	(70)	(2)	(543)	(545)	(2)	(815)	(815)	0
Impairments & Rounding	0	0	0	0	0	0	0	0	0
Reported deficit/surplus	**(635)**	**(647)**	**(12)**	**(1,310)**	**(1,255)**	**55**	**(4,395)**	**(4,395)**	**0**

Performance against original internal 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	Full Year Plan	Full Year Forecast	Full Year Var
Clinical Revenue	19,320	17,194	(2,126)	155,595	118,846	(36,749)	233,455	233,455	0
Other Revenue	1,608	1,497	(111)	12,971	11,340	(1,630)	19,295	19,295	0
Total Income	20,928	18,691	(2,237)	168,566	130,187	(38,379)	252,749	252,749	0
Pay	(15,047)	(16,483)	(1,435)	(120,336)	(125,528)	(5,192)	(180,692)	(180,692)	0
Non Pay	(6,831)	(7,421)	(590)	(54,830)	(54,506)	324	(82,026)	(82,026)	0
Total Operational Expend	(21,878)	(23,903)	(2,025)	(175,166)	(180,034)	(4,868)	(262,718)	(262,718)	0
EBITDA	(950)	(5,212)	(4,262)	(6,600)	(49,848)	(43,247)	(9,969)	(9,969)	0
Financing & Non-Op. Costs	(1,192)	(1,216)	(24)	(9,530)	(10,246)	(715)	(14,299)	(14,299)	0
Control Total Deficit (excl. PSF)	**(2,142)**	**(6,428)**	**(4,286)**	**(16,130)**	**(60,093)**	**(43,963)**	**(24,268)**	**(24,268)**	**0**
Adjustments excl. from control total:									
FRF	0	0	0	9,892	0	(9,892)	19,788	19,788	0
MRET	269	0	(269)	2,152	0	(2,152)	3,238	3,238	0
National Block	0	1,515	1,515	0	27,767	27,767	0	0	0
National Top up	0	3,411	3,411	0	25,154	25,154	0	0	0
COVID Top up	0	925	925	0	6,448	6,448	0	0	0
Control Total Deficit (incl. PSF)	**(1,873)**	**(577)**	**1,296**	**(4,086)**	**(724)**	**3,362**	**(1,242)**	**(1,242)**	**0**
Donated income	0	0	0	0	14	14	1,000	1,000	0
Donated asset depreciation	(68)	(70)	(2)	(544)	(545)	(1)	(816)	(816)	0
Impairments & Rounding	0	0	0	0	0	0	0	0	0
Reported deficit/surplus	**(1,941)**	**(647)**	**1,294**	**(4,630)**	**(1,255)**	**3,375**	**(1,058)**	**(1,058)**	**0**

Monthly and year to date review

8. The **deficit excluding central funding (top up) and donated income** in month 8 is £6,428k which is £4,286k adverse to the Trust's original plan; this is due to a combination of:
    - The national block contract income being lower than clinical income assumed in the internal plan (and agreed as part of the heads of terms with Milton Keynes CCG);
    - Lower non-clinical income streams due to lower activity volumes (e.g. parking income);
    - The impact of covid on the Trust's cost base.

    However, on a control total basis after the block payment and top up income the Trust has reported a £577k deficit position for the month and YTD which is £10k adverse to the revised plan position and £57k favourable YTD.

    Included within this position is £6,483k YTD of direct covid costs (excluding loss of non-clinical income which is outside the scope of provider claims) against which the Trust expects to receive an additional £925k (£6,449k YTD) top-up.

    The impact of the elective incentive scheme has not been reported in month, the impact of which will be adjusted in future months when baselines and coded data is available.

9. **On a payment by results basis, income (excluding block, top up and donations effect)** against the original plan is £2,237k adverse in November and £38,379k YTD with significant reductions in non-elective activity and low levels of activity following suspension of non-urgent elective activity earlier in the year (clinical income is £2,126k adverse to plan in month and £36,749k YTD).

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

   Against the revised trust plan/forecast income is £320k favourable in month and £566k year to date

10. **Operational costs** in November are adverse to the original plan by £2,025 in month and £4,868k YTD. Against the revised plan/forecast operational costs are adverse by £290k in month & £483k YTD

11. **Pay costs** are £1,435k adverse to budget in Month 8 and £5,192k YTD against the original plan. Against the revised plan pay costs are £1k favourable in month and £752k favourable YTD. High costs against substantive, bank and agency include direct covid related costs due to changes in rotas, additional hours and cover of sickness/self-isolation. Continuing high costs are seen as the trust has implemented additional sessions as part of activity recovery plans, however costs are lower then expected in the revised plan due to lower then expected escalation and covid costs. Underlying agency remains low, however has increased in month in response to the second wave of COVID and increased numbers of staff isolating.

12. **Non-pay costs** were £590k adverse to the original plan in month and £324k favourable YTD. Against the revised plan non pay reported a £292k adverse variance in month and £1,235k YTD.

13. **Non-operational costs** are £26k adverse in month and £716k adverse YTD, this is a result of increase in PDC costs offset by additional income

    Further analysis of the costs can be found in appendix 1

COST SAVINGS

14. Work on tracking and delivering schemes has resumed following a temporary suspenson due to COVID. The Trust has submitted its financial plan which includes a target of £5m for CIP delivery by year end. As of at M8 £1.8m of schemes have been identified and added to the trust tracker with a delivery of £1.3m YTD. Divisions have renewed focus on cost improvement plans and are working to identify the remaining £3.2m.

CASH AND CAPITAL

15. The cash balance at the end of November 2020 was £50.2m, which was £5.1m above the revised plan.

16. On 2 April 2020, the Secretary of State for Health and Social Care, announced that over £13bn of debt will be written off as part of a major financial reset for NHS providers. As a result, the Trust's Department of Health and Social Care interim revenue support and capital

loans (totalling £130.8m as at 31 March 2020) was repaid in September 2020 and replaced with Public Dividend Capital for which there is no repayment obligation.

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

- Non-Current Assets are below plan by £0.4m; this is driven by timing of capital projects.
- Current assets are below plan by £5.8m, this is due to receivables £10.9m below plan. Offset by cash £5.1m above plan.
- Current liabilities are above plan by £4.5m. This is being driven by deferred income £8.4m below plan offset by Trade and Other Creditors £3.9m above plan.
- Non-Current Liabilities are on plan.

The Trust has spent £5.4m on capital up to month 8 which relates to £1.2m HIP 2 and £4.2m patient safety and clinically urgent capital expenditure.

The key performance indicators have been met with the exception of, capital spend and creditor days.

RISK REGISTER

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

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

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

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

PBR contracts have been replaced with block contracts (set nationally until September) and top-up payments available where covid-19 leads to costs over block amounts. Trust is in constant dialogue with NHSI/E regarding funding post July.

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

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

RECOMMENDATIONS TO BOARD

19. The Trust Board is asked to note the financial position of the Trust as at 30th November and the proposed actions and risks therein.

Appendix 1

Milton Keynes Hospital NHS Foundation Trust
Statement of Comprehensive Income
For the period ending 30th November 2020

	November 2020			Year to Date			Full year
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME							
Outpatients	4,229	3,620	(609)	34,209	23,021	(11,188)	51,328
Elective admissions	2,439	2,221	(218)	19,277	11,086	(8,191)	29,148
Emergency admissions	6,097	5,136	(961)	49,387	38,069	(11,319)	73,776
Emergency adm's marginal rate (MRET)	(268)	(260)	7	(2,168)	(2,109)	59	(3,238)
Readmissions Penalty	0	0	0	0	0	0	0
A&E	1,247	1,075	(172)	10,404	8,329	(2,076)	15,489
Other Admissions	257	174	(83)	2,085	1,382	(703)	3,114
Maternity	1,760	1,834	74	14,113	14,033	(80)	21,186
Critical Care & Neonatal	543	478	(65)	4,400	3,961	(439)	6,572
Excess bed days	0	0	0	0	0	0	0
Imaging	485	422	(63)	3,835	2,610	(1,226)	5,799
Direct access Pathology	417	357	(61)	3,298	2,360	(938)	4,987
Non Tariff Drugs (high cost/individual drugs)	1,619	1,560	(59)	12,796	12,052	(743)	19,348
Other	494	578	83	3,958	4,054	(550)	5,946
National Block Top Up	0	1,515	1,515	0	27,766	27,766	0
Clinical Income	**19,320**	**18,709**	**(611)**	**155,595**	**146,613**	**(8,982)**	**233,455**
Non-Patient Income	**1,877**	**5,833**	**3,956**	**25,015**	**42,956**	**17,942**	**43,321**
TOTAL INCOME	**21,197**	**24,542**	**3,345**	**180,610**	**189,570**	**8,960**	**276,775**
EXPENDITURE							
Total Pay	**(15,047)**	**(16,483)**	**(1,435)**	**(120,336)**	**(125,528)**	**(5,192)**	**(180,692)**
Non Pay	(5,212)	(5,861)	(649)	(42,034)	(42,454)	(420)	(62,678)
Non Tariff Drugs (high cost/individual drugs)	(1,619)	(1,560)	59	(12,796)	(12,052)	743	(19,348)
Non Pay	**(6,831)**	**(7,421)**	**(590)**	**(54,830)**	**(54,506)**	**324**	**(82,026)**
TOTAL EXPENDITURE	**(21,878)**	**(23,903)**	**(2,025)**	**(175,166)**	**(180,034)**	**(4,868)**	**(262,718)**
EBITDA*	**(681)**	**639**	**1,320**	**5,444**	**9,535**	**4,092**	**14,057**
Depreciation and non-operating costs	(1,000)	(1,056)	(56)	(7,994)	(8,156)	(161)	(11,995)
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**(1,681)**	**(417)**	**1,264**	**(2,550)**	**1,379**	**3,930**	**2,063**
Public Dividends Payable	(260)	(230)	30	(2,080)	(2,635)	(555)	(3,120)
OPERATING DEFICIT AFTER DIVIDENDS	**(1,941)**	**(647)**	**1,294**	**(4,630)**	**(1,255)**	**3,376**	**(1,058)**
Adjustments to reach control total							
Donated Income	0	0	0	0	(14)	(14)	(1,000)
Donated Assets Depreciation	68	70	2	544	545	1	816
Control Total Rounding	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0
PSF/FRF/MRET	(269)	0	269	(12,046)	0	12,046	(23,026)
CONTROL TOTAL DEFICIT	**(2,142)**	**(577)**	**1,565**	**(16,132)**	**(723)**	**15,410**	**(24,268)**

Appendix 2

Milton Keynes Hospital NHS Foundation Trust
Statement of Cash Flow
As at 30th November 2020

	Mth 8 £000	Mth 7 £000	In Month Movement £000
Cash flows from operating activities			
Operating (deficit) from continuing operations	1,562	1,959	(397)
Operating surplus/(deficit) of discontinued operations			
Operating (deficit)	**1,562**	**1,959**	**(397)**
Non-cash income and expense:			
Depreciation and amortisation	7,973	6,939	1,034
(Increase)/Decrease in Trade and Other Receivables	5,512	(7,607)	13,119
(Increase)/Decrease in Inventories	(9)	(9)	0
Increase/(Decrease) in Trade and Other Payables	10,511	6,517	3,994
Increase/(Decrease) in Other Liabilities	16,457	26,854	(10,397)
Increase/(Decrease) in Provisions	(163)	(158)	(5)
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows	(14)	(14)	0
Other movements in operating cash flows	(1)	(3)	2
NET CASH GENERATED FROM OPERATIONS	**41,828**	**34,478**	**7,350**
Cash flows from investing activities			
Interest received	4	4	0
Purchase of intangible assets	(4,075)	(3,989)	(86)
Purchase of Property, Plant and Equipment, Intangibles	(2,778)	(2,377)	(401)
Sales of Property, Plant and Equipment			
Net cash generated (used in) investing activities	**(6,849)**	**(6,362)**	**(487)**
Cash flows from financing activities			
Public dividend capital received	132504	132504	0
Loans repaid to Department of Health	(130,852)	(130,852)	0
Capital element of finance lease rental payments	(147)	(124)	(23)
Interest paid	(273)	(273)	0
Interest element of finance lease	(187)	(164)	(23)
PDC Dividend paid	(2,096)	0	(2,096)
Receipt of cash donations to purchase capital assets	14	14	0
Net cash generated from/(used in) financing activities	**(1,037)**	**1,105**	**(2,142)**
Increase/(decrease) in cash and cash equivalents	**33,942**	**29,221**	4,721
Opening Cash and Cash equivalents	**16,286**	**16,286**	
Closing Cash and Cash equivalents	**50,228**	**45,507**	**4,721**

Appendix 3

Milton Keynes Hospital NHS Foundation Trust
Statement of Financial Position as at 30th November 2020

	Audited Mar-20	Nov-20 YTD Plan	Nov-20 YTD Actual	In Mth Mvmt	YTD Mvmt	% Variance
Assets Non-Current						
Tangible Assets	143.2	141.9	141.5	(0.4)	(1.7)	(1.2%)
Intangible Assets	16.1	15.0	15.0	0.0	(1.1)	(6.8%)
Other Assets	0.9	0.9	0.9	0.0	0.0	0.0%
Total Non Current Assets	**160.2**	**157.8**	**157.4**	**(0.4)**	**(2.8)**	**(1.7%)**
Assets Current						
Inventory	3.4	3.4	3.4	0.0	0.0	0.0%
NHS Receivables	18.7	18.0	8.5	(9.5)	(10.2)	(54.5%)
Other Receivables	6.9	13.0	11.6	(1.4)	4.7	68.1%
Cash	16.3	45.1	50.2	5.1	33.9	208.0%
Total Current Assets	**45.3**	**79.5**	**73.7**	**(5.8)**	**28.4**	**62.7%**
Liabilities Current						
Interest -bearing borrowings	(131.3)	(0.1)	(0.1)	0.0	131.2	-99.9%
Deferred Income	(2.3)	(27.1)	(18.7)	8.4	(16.4)	713.0%
Provisions	(1.5)	(1.3)	(1.3)	0.0	0.2	-13.3%
Trade & other Creditors (incl NHS)	(38.9)	(44.4)	(48.3)	(3.9)	(9.4)	24.2%
Total Current Liabilities	**(174.0)**	**(72.9)**	**(68.4)**	**4.5**	**105.6**	(60.7%)
Net current assets	**(128.7)**	**6.6**	**5.3**	**(1.3)**	**134.0**	**(104.1%)**
Liabilities Non-Current						
Long-term Interest bearing borrowings	(5.8)	(5.8)	(5.8)	0.0	0.0	0.0%
Provisions for liabilities and charges	(1.6)	(1.6)	(1.6)	0.0	0.0	0.0%
Total non-current liabilities	**(7.4)**	**(7.4)**	**(7.4)**	**0.0**	**0.0**	0.0%
Total Assets Employed	**24.1**	**157.0**	**155.3**	**(2.0)**	**131.2**	**545.0%**
Taxpayers Equity						
Public Dividend Capital (PDC)	105.3	239.5	237.8	(1.7)	132.5	125.8%
Revaluation Reserve	48.4	48.4	48.4	0.0	0.0	0.0%
I&E Reserve	(129.6)	(130.9)	(130.9)	0.0	(1.3)	1.0%
Total Taxpayers Equity	**24.1**	**157.0**	**155.3**	**(1.7)**	**131.2**	**544.4%**

Significant (16+) Risks

ID	BAF	Exec Owner	Risk Owner	Division	Specialty	Description	Cause	Impact	C	L	Initial Risk Rating	Initial Risk Level	Controls in Place	Assurance on Controls	C	L	Current Risk Rating	Current Risk Level	Gaps in Controls	C	L	Target Risk Rating	Target Risk Level	Treatment Category	Action Plan Summary	Date Last Reviewed	Trend	Trend Rationale	Review Due?
2570	9-1	Director of Clinical Services	Gawlowski, Dr Zuzanna	Women's & Children's Health - Children's Health	Neonatal	Overcrowding and insufficient space in the Neonatal Unit, exacerbated by need for social distancing due to COVID-19	Cot spacing 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.	Without the increase in cot numbers and corresponding cot spacing we will be unable 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	5	5	25	High / Significant Risk	1. Reconfiguration of cots to create more space and extra cots and capacity, though this still does not meet PHE or national standards 2. Parents asked to leave NNU during interventional procedures, ward rounds etc. Restricted visiting during COVID 3. Added to capital plan 4. Feasibility study completed	1. NNU Feasibility study in progress awaiting decision of the Board as to whether to proceed with major reconfiguaration and increased cots to meet TVN demand. 2.Planning for a specific W&C build is being discussed	5	4	20	High / Significant Risk	1. Outline business case for NNU rebuild has been developed by Trust and estates department and submitted to CCG/STP partners for consideration. Awaiting final decisions	3	3	9	Moderate / Unacceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	Approval of business case	08/04/2020	No Change	No change	31/01/2021
2796		Director of Clinical Services	Chadwick, Ms Helen	Core Clinical & Support Services - Pharmacy	Pharmacy	The risk is there will be insuffient staff in pharmacy to meet demands of the organisation and ensure patient safety in the use of medicines.	High turnover of staff due to work pressure and not having the opportunity to work at the top of their licence. Also difficulty in recruiting particuarly to 8a posts.	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 Breach of CQC regulations	4	5	20	High / Significant Risk	Actively recruiting, listening events with staff, identifying quick wins from staff to reduce turnover, implementing 1-1 system to support staff, reviewing work activities of 8a's and above to identify what could stop for a period of time.	Morale remains low, turn over remains high.	4	5	20	High / Significant Risk	Use of senior staff to support not viable long term.	2	3	6	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	Bc to execes	21/08/2020	No Change	turnover remains Reduced pressure c19	21/08/2020
2920		Director of Clinical Services	Biggs, Adam	Operations	Emergency Planning	The risk of capabilities in responding to a Novel Coronavirus (COVID-19) impacting on patient care within clinical and non-clinical services, with the inability to maintain safety for staff and patients due to national pressures on supplies and infrastructure.	Surge of COVID-19 patients impacting on Trust ability to maintain patient care and clinical services. Loss of staff to support clinical and non-clinical services due to high levels of absence. 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.	Loss of clinical and non-clinical services Financial impacts Risk to patient care Risk to staff wellbeing	5	5	25	High / Significant Risk	COVID-19 operational and contingency plans in place reviewed through Silver and Gold command structure, with meeting recorded through action logs PPE logged daily covering delivery and current stock		5	4	20	High / Significant Risk	Trust has no control over national stockpile of PPE and medical devices required for response. This is monitored and reported daily.	5	3	15	High / Significant Risk	TREAT - above tolerable level - appropriate cost-effective control required		21/10/2020	No Change	National oversight	09/11/2020
2955	N/A	Director of Patient Care / Chief Nurse	Cooper, Ms Julie	Women's & Children's Health - Women's Health	Obstetrics & Maternity	Poor patient experience, inability of Trust to provide maternity care locally for some women (during times of peak demand on service, delays in clinical care) and potential increased readmission rate due to reduced length of stay	Location of gynaecology patients on Ward 10 resulting in the loss of 13 obstetric beds	Delays in clinical care (inductions, pain relief etc) at times of heavy demand while beds sourced & potential need to divert to neighbouring maternity units when unable to accommodate women.	5	5	25	High / Significant Risk	Daily huddle & bed state reviews Escalation process Review of obstetric clinical pathways	LOS data Incident reporting rate on readmissions - deep dive analysis currently ongoing	4	5	20	High / Significant Risk	None	3	3	9	Moderate / Unacceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required		15/12/2020	No Change	ongoing risk	15/12/2020
3025		Deputy CEO	York, Craig	IT	Information Technology	Removal of IT links to Primary Care and the Community	MK CCG has migrated IT Providers to HBLICT, during this transition they have removed access from Acute staff who previously had access.	Staff groups effected are Community Midwives and MK Integrated Diabetes Service Team. Although repeatedly requesting reinstatement of the service, HBL have now confirmed they will only rollback for an extremely limited time. MKUH believes this continued disruption is affecting the patient care they provide.	4	5	20	High / Significant Risk	HBL have confirmed they will only rollback for an extremely limited time.		4	5	20	High / Significant Risk	Staff groups effected are Community Midwives and MK Integrated Diabetes Service Team. Although repeatedly requesting reinstatement of the service, HBL have now confirmed they will only rollback for an extremely limited time.	1	5	5	Low / Acceptable Risk	TOLERATE - at lowest practicable/ cost-effective level		03/11/2020	No Change	New risk	13/11/2020

Significant (16+) Risks

ID	BAF	Exec Owner	Risk Owner	Division	Specialty	Description	Cause	Impact	C	L	Initial Risk Rating	Initial Risk Level	Controls in Place	Assurance on Controls	C	L	Current Risk Rating	Current Risk Level	Gaps in Controls	C	L	Target Risk Rating	Target Risk Level	Treatment Category	Action Plan Summary	Date Last Reviewed	Trend	Trend Rationale	Review Due?
3029		Director of Clinical Services	Burns, Ms Samantha	Surgical - Head & Neck	Ophthalmology	Insufficient experienced schedulers/patient pathway co-ordinators to support Ophthalmology Service	vacancies following restructure and staff do not have the necessary knowledge and skills required to support this very specialist area	- Potential increase in delays, loss of income, lack of continuity to patient pathways, decreased activity and increased complaints. - potential removal of patients from waiting lists - loss of clinical validation of screening programme patients being actioned - staff with no formal training affecting staff morale.	4	5	20	High / Significant Risk	1. Preventative & mitigating controls - review of patients who had been revalidated - plan to discuss issues with patient access team	- Reporting and monitoring of incidents reported or when lack of support is escalated to PPCs or Ops Manager.	4	4	16	High / Significant Risk	- Admin errors are occuring - letters sent to wrong patients, clinics over/under booked - part time staff in post insufficient to meet service needs.	4	1	4	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	recruitment of admin staffing	16/11/2020	No Change	new risk	29/01/2021
2972				Women's & Children's Health - Children's Health	Children's Services	Following PCPCH guidance, and health issues the Registrar's rota is potentially impacted by the need to ensure some Registrars do not attend COVID risk areas- and only work in NNU. This reduces the ability to support busy shifts across the unit and potentially delays the acute pathway flow	COVID and individual Doctors Health assessments in relation to COVID, in line with RCPCH guidance	Increase waiting times for acutely unwell children to be seen by a registrar as some registrars are unable to work across all areas as required This could impact on ED, PAU, patient flow and patient safety	4	4	16	High / Significant Risk	Consultants will offer back up out of hours, when possible as 2 Consultants are also COVID high risk.		4	4	16	High / Significant Risk											
2929		Director of Clinical Services	Philpott, Ms Katy	Women's & Children's Health - Children's Health	Children's Services	Ward 5 store rooms unfit for purpose, unsafe storage of equipment and consumables could result in significant harm to staff and delays in access equipment and consumables resulting in delay in care provision	Risk has occurred due to inefficient and ineffective storage facilities	If staff injured due to unsafe storage - I have been advised by litigation that costs could be immense	4	4	16	High / Significant Risk	Tidy daily- it does not improve the situation for any significant amount of time	Assurances to be confirmed	4	4	16	High / Significant Risk	TBC	4	4	16	High / Significant Risk	TREAT - above tolerable level - appropriate cost-effective control required		14/07/2020	Increased	New Risk	30/11/2020
2953	N/A		Cooper, Ms Julie	Women's & Children's Health - Women's Health	Obstetrics & Maternity	Pregnant women with their increased risk (in addition to known Covid risk) not being vaccinated for flu leaving them more open to contracting flu	Unavailability of flu vaccines	Increased rate of pregnant women getting the flu. Changes in the immune system, heart, and lungs during pregnancy make pregnant women (and women up to two weeks postpartum) more prone to severe illness from flu, including illness resulting in hospitalisation. Flu also may be harmful for a pregnant woman's developing baby.	4	4	16	High / Significant Risk	None - possible supply from PHE & Immunisation midwife available for vaccination programme (but reliant on availability)		4	4	16	High / Significant Risk	Vaccine supply	4	3	12	Moderate / Unacceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required					
2954	N/A		Swailes, Mrs Catherine	Women's & Children's Health - Children's Health	Children's Services	Children & young people (2 - 16 year olds)not being vaccinated for flu leaving them more open to contracting flu	Unavailability of flu vaccines (nasal)	Increased rate of children, especially those with other complex conditions getting the flu, leading to increased hospital admission rate over whelming service	4	4	16	High / Significant Risk	None - reliant on vaccine availability. Nurse available for vaccination service Mon - Thursday (15hrs)		4	4	16	High / Significant Risk		4	3	12	Moderate / Unacceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required					
2423		Director of Clinical Services	Chadwick, Ms Helen	Core Clinical & Support Services - Pharmacy	Pharmacy	There is a risk that Pharmacy Policies and Procedures may not be reviewed and updated in a timely manner	Lack of appropriate staff (Specialty Pharmacist) available. No dedicatated post and no capaity in others.	Potential for Policies & Procedures to be out of date Potential for staff to follow out of date Policies & Procedures	4	4	16	High / Significant Risk	Development of eCare Try to release staff to review policies	Policies remain out of date	4	4	16	High / Significant Risk	Unable to release staff with patient facing roles prioritised	2	2	4	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	BC for resource	21/08/2020	No Change	Current Out of Date Policies.	25/09/2020

Significant (16+) Risks

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2791		Director of Clinical Services	Orr, Mrs Julie	Operations	Patient Discharge	Risk that patient discharges will significantly be delayed, especially those requiring complex coordination of the discharge process	The Discharge Coordinators (Registered Nurses B6 level) are currently severely short staffed due to vacancies and sudden long term sickness, with an additional Discharge Coordinator due to have major surgery leading to additional long term sickness. The Discharge Team currently consists of 5 wte B6 Registered Nurses. At present there are 3wte in post however 2wte are on long term sick leave.	Increased length of stay (LOS) for complex discharges, leading to a potential for an increase in hospital acquired infections, de-conditioning Potential to affect the stranded and super stranded patient numbers and a failure achieve National target set for 2019-20, with associated impact on ED performance Increased delayed transfers of care (DToC) Poor patient experience due to the delays in discharge/discharge planning and referrals Other services capacity not being fully utilised due to delays in internal assessments Need for the Head of Clinical Services & Trust Lead for Discharge to take on some of the functions impacting on their daily roles significantly Increased workload & stress level for the remaining Discharge Coordinators in post Reduction in mandatory training compliance due to inability to release staff	4	5	20	High / Significant Risk	Covering a small number of shifts with former Discharge Coordinator carrying out bank shifts, when available. Offered bank shift to train an Agency Nurse who has shown an interest in the role. Recruited in to one vacancy and interviewing in to Bucks Coordinator role on 2/8/19. Reviewed role and delegated minor responsibilities to Rotational Operations Liaison Officers. Support requested from key nursing areas who have the skills to support a number of aspects relating to the role & discharge process- awaiting confirmation	Review of Datix incidents figures Superstranded patirnt data	4	4	16	High / Significant Risk	Additional funding to over recruit 1 WTE to for a 6 month period to cover the long term sickness	3	3	9	Moderate / Unacceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required		28/08/2019	No Change	New Risk	30/11/2019
940	7-3	Director of Finance	Keech, Michael	Finance	Financial Management	There is a risk that the Trust has insufficient resources (financial or otherwise) or has insufficient physical capacity in order to clear the waiting list backlogs that occurred as a result of the COVID-19 pandemic, leading to delays in patients receiving treatment and a potential long-term financial pressure for the Trust through a requirement to deliver higher levels of activity each financial year.	"The COVID-19 pandemic led to the delay or cancellation of procedures and clinics which resulted in an increase in the size of the waiting list (at the Trust and across the NHS more broadly). On-going measures in response to COVID-19 (such as social distancing measures) have the potential to reduce the available physical capacity at the Trust."	Negative impact on Trust cash-flow and ability to meet financial obligations	4	5	20	High / Significant Risk	"1. Monitoring of the Trust's waiting list through divisional meetings, executive performance meetings, and Trust board sub-committees (including the Finance and Investment Committee); 2. Recovery plans developed in accordance with guidance issued by NHS England and NHS Improvement, including financial forecast to assess the impact of increasing activity alongside COVID-19 measures. 3. Financial incentive scheme in place to provide additional funding for performing activity in excess of baseline levels set by regulators 4. Capital and revenue bids submitted to regulators in order to provide additional finance resource to create additional capacity to increase activity volumes at the Trust."	1. Clearly defined monitoring of the monthly activity performance with divisions. 2. Escalation of issues to senior managers within the Trust. 4.Updates reported to the F&I Committee and Trust Board on a monthly basis.	4	4	16	High / Significant Risk	The Trust has only limited control over the allocation of additional financial resources to support its recovery plans.	3	3	9	Moderate / Unacceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	Maintain dialogue with CCG re Contract Raise risk of dispute over interpretation of Contract with Monitor	09/11/2020	Increased	Increased	09/12/2020

Significant (16+) Risks

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940	7-3	Director of Finance	Keech, Michael	Finance	Financial Management	There is a risk that the Trust has insufficient resources (financial or otherwise) or has insufficient physical capacity in order to clear the waiting list backlogs that occurred as a result of the COVID-19 pandemic, leading to delays in patients receiving treatment and a potential long-term financial pressure for the Trust through a requirement to deliver higher levels of activity each financial year.	"The COVID-19 pandemic led to the delay or cancellation of procedures and clinics which resulted in an increase in the size of the waiting list (at the Trust and across the NHS more broadly). On-going measures in response to COVID-19 (such as social distancing measures) have the potential to reduce the available physical capacity at the Trust."	Negative impact on Trust cash-flow and ability to meet financial obligations	4	5	20	High / Significant Risk	"1. Monitoring of the Trust's waiting list through divisional meetings, executive performance meetings, and Trust board sub-committees (including the Finance and Investment Committee); 2. Recovery plans developed in accordance with guidance issued by NHS England and NHS Improvement, including financial forecast to assess the impact of increasing activity alongside COVID-19 measures. 3. Financial incentive scheme in place to provide additional funding for performing activity in excess of baseline levels set by regulators 4. Capital and revenue bids submitted to regulators in order to provide additional finance resource to create additional capacity to increase activity volumes at the Trust."	1. Clearly defined monitoring of the monthly activity performance with divisions. 2. Escalation of issues to senior managers within the Trust. 4.Updates reported to the F&I Committee and Trust Board on a monthly basis.	4	4	16	High / Significant Risk	The Trust has only limited control over the allocation of additional financial resources to support its recovery plans.	3	3	9	Moderate / Unacceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	Maintain dialogue with CCG re Contract Raise risk of dispute over interpretation of Contract with Monitor	09/11/2020	Increased	Increased	09/12/2020
1472	1-4	Director of Corporate Affairs	Ewers, Mr Paul	Corporate Affairs	Risk Management	There is a risk that not all known incidents, accidents and near misses are reported onto Trust Incident Reporting System (Datix) and that they will not be robustly investigated within the required timescales	Failure to comply with the Incident Reporting Policy; Poor incident reporting culture; Lack of understanding of the necessity and importance of reporting incidents; Lack of incentives to report incidents due to lack of feedback or poor quality investigation outcomes; Lack of consequences for failing to report; Lack of consequences for poor quality investigations; Lack of computer access to report incidents; Conflicting priorities and lack of time to report; Perceived difficulty in completing the online incident reporting form	The Trust will not have a complete list of incidents occurring in the Trust; Inability to learn from incidents, accidents and near-misses; Inability to stop potentially preventable incidents occurring; Potential failure to comply with Duty of Candour legislation requiring the Trust to report all known incidents where the severity was moderate or higher; Potential under reporting to the National Reporting & Learning System (NRLS); Potential failure to meet Trust Key Performance	4	5	20	High / Significant Risk	1. Incident Reporting Policy 2. Incident Reporting Mandatory/Induction Training 3. Incident Reporting Training Guide and adhoc training as required 4. Datix Incident Investigation Training sessions 5. Daily review of incidents by Risk Management Team to identify potential Serious Incidents and appropriate escalation 6. Serious Incident Review Group (SIRG) ensure quality of Serious Incident Investigations 7. SIRG ensure appropriate reporting of Serious Incidents to Commissioners 8. Staff able to have automatic feedback following investigation approval 9. Incident Reporting Awareness Campaign - September 2017	1. Risk Management Dashboard monitoring trends 2. Weekly overdue incident reporting 3. Routine and exception reports to Risk & Compliance Board 4. Weekly Compliance Report to Executive Team 5. Incident reporting rate and overdue incidents monitored through Trust KPIs 6. Regular reporting to Divisions through Clinical Governance reports 7. Divisional Dashboards to monitor trends 8. Bi-monthly National Reporting & Learning System reports 9. Serious Incident Review Group upward reports 10. Monitoring of Serious Incident Investigations by MKCCG 11. Escalation to Patient Safety Board for scrutiny	4	4	16	High / Significant Risk	1. Lack of a high incident reporting culture 2. Lack of robust investigations for non-Serious Incidents 3. Lack of feedback to reporters/staff following incident investigations 4. Staff lack access to a computer to report incidents 5. Staff lack time during shift to report incidents 6. More intuitive incident reporting system - procurement scoping exercise on going for Datix Cloud/new system	4	3	12	Moderate / Unacceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	Comms Initiative being developed to coincide with launch of simpler incident reporting form and enhanced Incident reporting training at Induction/Mandatory Training - Complete Quality Improvement Project to be undertaken - Ongoing through Learning From Incidents Focus Group Recruitment of two new band 7 facilitators - complete Launch the 'SHARE' Incident Reporting Campaign with Comms Team - Complete Letter re-iterating the importance of incident reporting to be sent from CEO via wage slips - Decision made not to undertake - Complete Incident Reporting	24/12/2020	No Change	No change since last review	28/02/2021
1681		Director of Clinical Services	Barton-Young, Mr Phillip	Surgical - Surgery	General Surgery	There will be increased demand for Endoscopy sessions	1. QMCW 2WW referrals are steadily increasing year on year specifically at high season (Easter, Summer and Christmas. This in turn is increasing the Endoscopy sessions that need to run (Colonoscopy, OGD etc)	- Possibility of missing cancer diagnosis, delay for other patient appointments and poor patient experience.	4	4	16	High / Significant Risk	1. Preventive controls - Ongoing monitoring - currently managing own demand. - Regular review of clinic slots - especially colorectal clinics. - Consultant running 1 extra list - Team considering outsourcing or extra sessions. - Employing additional Locums which is a risk in its self - Running additional endoscopy sessions either with locums or substantive staff with a huge financial consquence	- Ongoing monitoring of clinic slots by operational manager - Ongoing monitoring of reported incidents where patient care has been compromised 21/10/2020 team consider this is still an issue. 06/04/2020 no reported incidents where patient care has been compromised due to demand.	4	4	16	High / Significant Risk	- Occasional times when endoscopy session not available due to alternative work commitments. - Inexperienced and insufficient staffing leading to delays	4	2	8	Moderate / Unacceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	Recruitment of substantive surgeon Development of training programme to re-skill	21/10/2020	No Change	ongoing risk	29/01/2021

Significant (16+) Risks

ID	BAF	Exec Owner	Risk Owner	Division	Specialty	Description	Cause	Impact	C	L	Initial Risk Rating	Initial Risk Level	Controls in Place	Assurance on Controls	C	L	Current Risk Rating	Current Risk Level	Gaps in Controls	C	L	Target Risk Rating	Target Risk Level	Treatment Category	Action Plan Summary	Date Last Reviewed	Trend	Trend Rationale	Review Due?
2055		Director of Corporate Affairs	Stamp, Mr Jamie	Core Clinical & Support Services - Clinical Support Services	Dietetics	The risk is that the trust is failing in its statutory legal duty under the Health & Safety at Work etc. Act 1974, Management of Health & Safety at Work Regulations 1999, Workplace (Health, Safety & Welfare) Regulations 1992 and Display Screen Equipment Regulations 1992 to provide a safe and well maintained place of work including welfare facilities for staff	Health and Safety lead for the Trust has confirmed that the maximum number of staff by law would be 11 staff, this is exceeeded on a regular basis as staff are unable to write their notes on the wards due to a lack of WOWs.	1. Physical and mental wellbeing concerns in relation to staff welfare with potential for sickness absence and potential litigation claims 2. Multiple breaches of statutory and regulatory duties leading to interest from the Health & Safety Executive 3.Enforcement action including formal notices; potential criminal prosecution resulting in fines and/or imprisonment dependent upon the action pursued; loss of Trust reputation; adverse publicity	4	4	16	High / Significant Risk	Due to the number of staff within the area, some staff have to work from home (rota basis) Mobile air conditioning units distributed. Plumbed in water cooler in situ. . A request for screens has been submitted to support social distancing requirements		4	4	16	High / Significant Risk	The portacabins continues to provide insufficient space for the staff using this base, this has been further compromised by the social distancing requirements for COVID-19.	2	3	6	Low / Acceptable Risk	TOLERATE - at lowest practicable/ cost-effective level	Risk to be reviewed by the Trust when office staff move to into MK Centre resolve short term issues - drinking water / flooring / window latches / changing facilities / secure path Upkeep of the portacabin including drinking water facilities, flooring and windown seals	13/10/2020	No Change	No change	15/12/2020
2182		Director of Clinical Services	KK2	Surgical - Anaesthetics & Theatres	Emergency Theatres	Theatre staff will not be available out of hours to staff phase 1 activity across obstetrics and emergency lists if elective lists overrun 1) currently theatres cannot mix emergency and elective patients - previously 23% of emergency cases were addressed in gaps in elective cases 2) Issues are also at 6pm as cannot combine recovery areas, these also have to be kept separate.	1. Case load in theatres and recovery - late finishers, complex cases, over running of theatre lists. Additional causes: 1) currently theatres cannot mix emergency and elective patients - previously 23% of emergency cases were addressed in gaps in elective cases Covid-19 IPC measures have intensified risk. 2) Issues are also at 6pm as cannot combine recovery areas, these also have to be kept separate.	- Frequent stopping of the emergency list in the evening. - Potential delay in emergency list activity (excluding life and limb surgery).	4	4	16	High / Significant Risk	1. Preventative controls - agreement with Divisional Director of Operations for Surgery to staffing of late shift - Theatre 1 (elective PM) now vacant and staffing used for emergency, surgical and theatres skills permitting. - Review of staffing rota - extended to 7pm. - Staff are requested to stay longer for urgent cases 1. Mitigating controls - Discussion with Phase 1 to prioriitise lists including obstetrics - Requests for planned over runs to be made early - Team are progressing with plan to implement 3 booked sessions per list which may address robotic surgery or predictable over runs but will not address unpredictable causes of over runs. This will also need to be addressed in job planning.	- Monitoring of reported Datix incidents and complaints.	4	4	16	High / Significant Risk	- Issue of over running lists persists especially after 6pm - 8pm where anaesthetist could be working alone. - Skill mix for staff in theatre 1 may not have skills for specific emergencies. - Major operations ending at same time increases the number of patients in recovery - Overlap of recovery time and inability to move patient to the ward areas occur	4	2	8	Moderate / Unacceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	review of staffing rota Continued monitoring of capacity issues	18/11/2020	No Change	reviewed risk	29/01/2021

Agenda item 6.3
Public Board 14.01.21

Meeting of the Finance and Investment Committee held on 2 November 2020

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

Matters referred to the Board for final approval:

Estates Strategic Outline case. An abridged version of this was presented and the full case was to be submitted to the Board later in the month. A central national team had been established to oversee the HIP programme and was expected to have a big influence on designs and timing. Th construction of the new Women's & Children's Hospital would free up space for more medical wards which are expected to be required in future years. Milton Keynes' ambition to reach carbon neutrality would be achieved in part through the construction and design processes and an ambition to generate electricity on site.

The Committee recommended the Strategic Outline Case to the Board.

Matters considered at the meeting:

- With regard to the Performance Dashboard M6, there are discrepancies between activity undertaken and coded activity. The Interim Director of Finance will discuss this with the Deputy CEO and feedback at the next meeting.
- With regard to the Finance Report M6 the Interim Director of Finance advised that the probability of failing to achieve CIP (Cost Improvement Programme) targets is recognised nationally and additional Treasury funding for the NHS is expected to be directly related to CIPs.
- Internal discussions on next year's budget and objectives are taking place and assumptions behind the plan will be brought to the next meeting. The regional Director of Finance has advised that he expects block payments to continue to October 2021 after which funding may be received at ICS level.
- IFRS16 Impact paper – The Interim Director of Finance explained that expected changes from April 2021 have been deferred for a year in light of the impacts of the pandemic. Business case processes and templates continue to be reviewed in preparation.

Milton Keynes University Hospital NHS Foundation Trust

Agenda item 6.3
Public Board 14.01.21

Meeting of the Finance and Investment Committee held on 30 November 2020

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

- **Roofing and Solar Panels Business Case**
  The Interim Director of Finance explained that the hospital is an ideal site for solar panels in view of the flat roofs across the estate. £1.6m funding has been received for areas requiring critical maintenance and a five-year programme of works is being drawn up. The Business Case was approved by the Committee.
- **Patient Catering**
  In a deviation from normal practice, procurement was progressed in conjunction with the business case, but no contractual commitments made. It was confirmed that senior clinicians and governors have been involved in the selection process, but it was acknowledged that there had not been enough oversight of the scheme at committee level. The Interim Director of Finance confirmed that the latest analysis on NHS food provision had been taken into account. She explained that the option to change to a fresh food model had been under review but that the costs were prohibitive as a complete refit of the catering department would have been required. In addition, the urgency to improve the standard of food provision meant that this was not a feasible option at the moment but that the proposed model might be considered as a stepping stone towards that model. The direct award was noted. The Business Case was approved by the Committee.

Matters reported at the meeting:

- Regarding the M7 Performance Dashboard, the Interim Director of Finance advised that there had been no notification in respect of baselines or whether incentive payments for recovering the position could be expected.
- Regarding the M7 Performance Dashboard, there were discrepancies between activity undertaken and coded activity. The Interim Director of Finance will discuss this with the Deputy CEO and feedback at the next meeting of the Committee.
- Regarding the M7 Finance Report, the Interim Director of Finance advised that the probability of failing to achieve CIP targets was recognised nationally and additional Treasury funding for the NHS was expected to be directly related to CIPs (Cost Improvement Programmes).
- Internal discussions on next year's budget and objectives were taking place and assumptions behind the plan would be brought to the next meeting
- IFRS16 impact paper – the Interim Director of Finance said that expected changes from April 2021 had been deferred a year in the light of the impact of the pandemic. Business case processes and templates continue to be reviewed in preparation.