Bundle Trust Board Meeting in Public 3 July 2025

1.1 10:00 - Agenda
Item 0 Agenda Board Meeting in Public - 03.07.25

1.2 10:00 - Apologies
Chair
Item 1 Placeholder Apologies

2 10:01 - Declarations of Interest
Chair
Item 2 Placeholder Declarations of Interest

3 10:02 - Staff Story
Chief Nursing Officer
Item 3 Placeholder Staff Story

4 10:22 - Minutes of the Last Meeting
Chair
Item 4 Draft Minutes Trust Board Meeting in Public 01.05.2025 HT

5 10:24 - Matters Arising and Action Log
Chair
Item 5 Board Action Log

6 10:26 - Chair's report
Chair
Item 6 Chair's Report

7 10:31 - Chief Executive's Report
Chief Executive
Item 7 Chief Executive's Report
Item 7.1 BLMK ICB Update

8 10:46 - Patient Safety Update
Chief Medical Officer/Chief Corporate Services Officer
Item 8 Trust Board July 2025 PSIRF Cover page
Item 8.1 PSIRF bimonthly report April-May 2025
Item 8.2 A One-Year Review of PSIRF Implementation final
Item 8.3 Inquest Update

9 10:56 - Maternity Assurance Group Update
Chief Nursing Officer
Item 9 Placeholder Maternity Assurance Group Update

10 11:01 - Patient Experience Report
Chief Corporate Services Officer
Item 10 Patient Experience Annual Report 2024-25

Item 10.1 Patient and Family Experience Report Q4 2024-25

11 11:11 - Performance Report
Chief Operating Officer – Planned Care
Item 11 2024-25 Executive Summary M02 Coversheet
Item 11.1 2024-25 Executive Summary M02
Item 11.2 2025-26 Board Scorecard M02

12 11:26 - Finance Report
Chief Finance Officer
Item 12 Finance Report Month 2

13 11:36 - People and Culture Report
Chief People Officer
Item 13 People and Culture Report M2

14 11:41 - Anti-Racism Programme Launch
Chief People Officer
Item 14 Anti-Racism Programme Launch

15 11:46 - Green Plan Update
Chief Finance Officer
Item 15 ICS Green Plan 2025 FINAL
Item 15.1 The DRAFT BLMK ICS Green Plan 2025 v10.1

16 11:51 - Falls Annual Report
Chief Nursing Officer
Item 16. Annual Inpatient Falls Report -Public Board July 2025
Item 16.1 Annual Inpatient Falls Report 2024 2025

17 11:56 - Nursing Workforce Update
Chief Nursing Officer
Item 17 Nursing Workforce Update Coversheet
Item 17.1 Safer Staffing Report Submission July 2025

18 12:01 - Risk Management Report
Chief Corporate Services Officer
Item 18 Risk Management Report

19 12:06 - Board Assurance Framework
Chief Corporate Services Officer
Item 19 BAF Report - June 2025
Item 19.1 Risk Appetite Report - July 2025

20 12:11 - Board Committees Assurance Reports
Chairs of Board Committees
Item 20.1 Committee Assurance Report - Audit and Risk Committee

Item 20.2 Committee Assurance Report - Charitable Funds Committee
Item 20.3 Committee Assurance Report - Finance and Investment Committee
Item 20.4 Committee Assurance Report - Quality and Clinical Risk Committee

21 12:16 - Forward Agenda Planner
Chair
Item 21 Trust Board in Public Forward Plan 2025-26

22 12:20 - Questions from Members of the Public
Chair

23 12:25 - Resolution to Exclude the Press and Public
The chair to request the Board pass the following resolution to exclude the press and public and move into private session to consider private business:
"That representatives of the press and members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted."

24 Next Meeting in Public: Thursday, 04 September 2025

TRUST BOARD MEETING IN PUBLIC

Thursday 03 July 2025, 10:00 -12:30 hours
Conference Room at the Academic Centre and via MS Teams

AGENDA

Item No.	Timing	Title	Purpose	Lead	Paper
Introduction and Administration					
1	10:00	Apologies	Note	Chair	Verbal
2		Declarations of Interest • Any new interests to declare • Any interests to declare in relation to open items on the agenda • 2025/26 Register of Interests – Board of Directors - Register of Interests - Milton Keynes University Hospital (mkuh.nhs.uk)	Note	Chair	Verbal
3		Staff Story	Discuss	Chief Nursing Officer	Presentation
4		Minutes of the Trust Board meeting held in public on 01 May 2025	Approve	Chair	Paper
5		Matters Arising and Action Log	Note	Chair	Paper
Chair and Chief Executive Updates					
6	10:20	Chair's Report	Note	Chair	Paper
7	10:25	Chief Executive's Report • Strategy • BLMK ICB Update	Discuss Note	Chief Executive	Paper Paper
Patient Safety					
8	10:35	Patient Safety Update Inquest Update	Discuss Note	Chief Medical Officer/Chief Corporate Services Officer Chief Corporate Services Officer	Paper Paper

Item No.	Timing	Title	Purpose	Lead	Paper
Patient Experience					
9	10:45	Maternity Assurance Group Update	Discuss	Chief Nursing Officer	Paper
10	10:50	Patient Experience Report	Discuss	Chief Corporate Services Officer	Paper
Performance					
11	10:55	Performance Report	Discuss	Chief Operating Officer – Planned Care	Paper
Break 11:00 (10 mins)					
Finance					
12	11:10	Finance Report	Discuss	Chief Finance Officer	Paper
People and Culture					
13	11:20	People and Culture Report	Discuss	Chief People Officer	Paper
14	11:30	Anti-Racism Programme Launch	Discuss	Chief People Officer	Paper
Assurance and Statutory Items					
15	11:35	Green Plan Update	Note	Chief Finance Officer	Paper
16	11:40	Falls Annual Report	Discuss	Chief Nursing Officer	Paper
17	11:45	Nursing Workforce Update	Discuss	Chief Nursing Officer	Paper
18	11:50	Risk Management Report • Corporate Risk Register	Note	Chief Corporate Services Officer	Paper Supplementary Shelf
19	11:55	Board Assurance Framework • Risk Appetite	Discuss Approve	Chief Corporate Services Officer	Paper Paper
20	12:05	Board Committees Assurance Reports • Audit & Risk Committee • Charitable Funds Committee	Note	Chairs of Board Committees	Paper

Item No.	Timing	Title	Purpose	Lead	Paper
		• Finance & Investment Committee • Quality & Clinical Risk Committee			
Administration and Closing					
21	12:10	Forward Agenda Planner	Information	Chair	Paper
22	12:15	Questions from Members of the Public	Discuss	Chair	Verbal
23	12:20	Motion to Close the Meeting	Approve	Chair	Verbal
24		Resolution to Exclude the Press and Public The Chair to request the Board pass the following resolution to exclude the press and public and /move into private session to consider private business: "That representatives of the press and members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted."	Approve	Chair	
12:30		Close			
Next Meeting in Public: Thursday, 04 September 2025					

Quoracy: This meeting shall be deemed quorate with not less than 3 voting Executive Directors (one of whom must be the Chief Executive or acting Chief Executive) and 3 voting Non-Executive Directors (one of whom must be the Chair or Deputy Chair).

	Members	
1	Heidi Travis	Non-Executive Director - Chair
2	Joe Harrison	Executive Director- Chief Executive Officer
3	Gary Marven	Non-Executive Director
4	Haider Husain	Non-Executive Director
5	Piers Ricketts	Non-Executive Director
6	Mark Versallion	Non-Executive Director
7	Sarah Whiteman	Non-Executive Director

8	Precious Zumbika	Non-Executive Director
9	Ganesh Baliah	Non-Executive Director
10	Ian Reckless	Executive Director - Deputy Chief Executive
11	John Blakesley	Executive Director
12	Fay Gordon	Executive Director
13	Helen Beck	Executive Director
14	Catherine Wills	Executive Director
15	Fiona Hoskins	Executive Director
16	Kate Jarman	Executive Director
17	Jonathan Dunk	Executive Director

TRUST BOARD IN PUBLIC

Academic Centre/Teams

Thursday, 3 July 2025

Agenda Item 1:
Apologies

Heidi Travis
Chair

Note

TheMKWay

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

TRUST BOARD IN PUBLIC

Academic Centre/Teams

Thursday, 3 July 2025

Agenda Item 2:
Declarations of Interest

Heidi Travis
Chair

Note

TheMKWay

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

TRUST BOARD IN PUBLIC

Academic Centre/Teams

Thursday, 3 July 2025

Agenda Item 3:
Staff Story

Fiona Hoskins
Chief Nursing Officer

Presentation/Discuss

TheMKWay

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

Minutes of the Trust Board of Directors Meeting in Public held on Thursday, 1 May 2025 at 10.00 hours in the Academic Centre, Milton Keynes University Hospital Campus and via Teams

Present:

Heidi Travis (Chair)	Trust Chair	(HT)
Joe Harrison	Chief Executive	(JH)
Dr Ian Reckless	Chief Medical Officer	(IR)
Kate Jarman	Chief Corporate Services Officer	(KJ)
Mark Versallion	Non-Executive Director	(MV)
Haider Husain	Non-Executive Director	(HH)
Gary Marven	Non-Executive Director	(GM)
Precious Zumbika	Non-Executive Director	(PZ)
Prof Ganesh Baliah	Non-Executive Director	(GB)
Piers Ricketts	Non-Executive Director	(PR)
Sarah Whiteman	Non-Executive Director	(SW)
Fiona Hoskins	Chief Nursing Officer	(FH)
Helen Beck	Chief Operating Officer – Planned Care	(HB)
Fay Gordon	Chief Operating Officer – Unplanned Care	(FG)
Jonathan Dunk	Chief Finance Officer	(JD)
Catherine Wills	Chief People Officer	(CW)

In Attendance:

Helen Smith	Clinical Director of Pharmacy	(HS)
Marsha Jones	Deputy Chief Nursing Officer	(MJ)
Matthew Burnett	Staff Governor	(MB)
Amechi Ejoh	Staff Governor	(AE)
David Cattigan	Staff Governor	(DC)
Ian Oswald	Public Governor	(IO)
Paul Ewers	Risk Manager	(PE)
Nadia Slatch	Parent	(NS)
Sarah Knight	Lead Paediatric Physio	(SK)
Charlie Nunn	Divisional Chief Nurse, Women and Children	(CN)
Oluwakemi Olayiwola	Trust Secretary	(OO)
Timi Achom	Assistant Trust Secretary	(TA)

1 Welcome and Apologies

1.1 The Chair welcomed all Board members in attendance and recognised those attending virtually. The Chair also recognised the Governors who were in attendance over Teams.

1.2 There were apologies John Blakesley, Chief Strategic Development Officer and Cllr Ansar Hussain, Milton Keynes Council Representative.

2 Declarations of interest

2.1 There were no declarations of interest in relation to the agenda items. The Board was reminded to update their declarations as necessary throughout the year.

3 Patient Story

3.1 FH introduced NS, Ryyan's mother, to discuss their family's experience caring for their son, who had a complex respiratory condition requiring frequent hospital admissions. NS described the impact of repeated stays over 16 admissions in the past year on family life, schooling, and outdoor activities that

Ryyan participated in. She pointed out current gaps in home-based care, including the lack of community respiratory physiotherapy and advanced oxygen delivery systems, which resulted in prolonged inpatient stays.

3.2 SK presented the idea of establishing a Community Respiratory Physiotherapy Post, based on recommendations and research, to assist in managing children with complex respiratory needs and decreasing hospital admissions. The Board acknowledged the potential for a Community Respiratory Physiotherapy service and a paediatric virtual ward to reduce admissions and enhance quality of life.

3.3 FH referenced national consensus guidance and early adopter sites where rapid-response teams and virtual wards had delivered significant bed-day savings, reduced emergency attendances and provided families with a step-up/step-down model of care.

3.4 In response to MV's question regarding what currently prevented earlier discharge. NS explained that high-flow humidified oxygen therapy and twice-daily chest physiotherapy could not be replicated safely at home without specialist training and equipment.

3.5 KJ highlighted areas on the ward for sensory stimulation, helping children like Ryyan to enjoy outdoor experiences indoors, reducing anxiety and improving wellbeing. IR supported virtual wards, confirming efforts to adapt the model for children and proposing a multi-disciplinary group to advance this.

3.6 The Board expressed gratitude to NS for her openness and bravery in sharing a personal story and acknowledged the team's dedication to enhancing patient and family care.

4 Minutes of the Trust Board Meeting in Public held on 6 March 2025

4.1 The minutes of meeting held on 6 March 2025 were **reviewed** and **approved** by the Board subject to the following addition to the minutes:

Item 15 Workforce Report: *IR brought the Board's attention to the issue of mandatory training for registrants in relation to sepsis, in the context of the recent conclusion of the national review of statutory and mandatory training (which had been silent on this specific subject, focusing largely on 'passporting' of 12 specific training items between employers). He advocated that appropriate sepsis training should now be mandated within the Trust and there was support from Board for the Executive to progress implementation.*

5 Matters Arising and action log

5.1 Action 40
FH explained the development of a career pathway tool for healthcare support workers, outlining the different pathways within nursing and the educational requirements for advancement. She also highlighted the Trust's efforts to expand the apprenticeship nursing program to grow the number of registered nurses within the organisation. Closed

6 Chair's Report

6.1 HT provided a brief update, highlighting the ongoing efforts to improve patient care and operational efficiency. She also acknowledged the hard work of the finance team in achieving a small surplus for the year. It was noted that this was HT's inaugural meeting since her official appointment as Trust Chair.

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

7 Chief Executive's Report

7.1 JH reported on the Trust's performance over the winter period. He highlighted innovative flow-management approaches enabled by new senior operational oversight from HB and FG which

had maintained high elective and emergency throughput, including weekend working. As a result, the Trust treated approximately 34 percent more patients in 2024-25 than in 2019-20, ranking highest in the East of England for volume of activity against pre-COVID baselines. He noted appropriate use of private-sector capacity to reduce waiting lists but confirmed that premium-rate outsourcing would be scaled back in 2025-26 to reflect improved internal capacity.

7.2 JH highlighted the recently concluded jury inquest into the death of Brian Ringrose. KJ confirmed the Trust accepted the coroner's findings of fact and was liaising with the coroner's office to identify and implement any further learning. JH emphasised that, although the case dated back four years under different service arrangements, the Trust remained committed to continuous improvement in patient management and safety.

7.3 MV asked for more detail on innovative approaches to managing flow. JH explained that, alongside stringent budget controls, the Trust implemented:

- Enhanced cross-sector coordination across primary, community and social care.
- Rapid-response pathways to divert suitable patients to virtual or step-down care.
- Twice-daily senior operational reviews to optimise bed utilisation.

These measures had driven both elective recovery and improved emergency department flow.

7.4 In light of recent high-profile cyber-attacks in the sector, HH enquired who on the Board was responsible for technology governance and how regularly the Board received cyber-incident intelligence. JH confirmed that John Blakesley Chief Strategic Development Officer led on technology matters and reported through him as part of the Executives and the Audit and Risk Committee. He noted new cybersecurity "fences" approved for 2025-26 and emphasised the Trust's ongoing software-update programme, supported by Microsoft. He acknowledged that no system was impervious and welcomed proposals for enhanced reporting on attack volumes, typologies and recovery-plan preparedness.

7.5 *Bedfordshire, Luton and Milton Keynes Integrated Care Board (BLMK ICB) update*

7.5.1 The Board reviewed the BLMK ICB report, which summarised key discussions from the ICB Board meeting held on 21 March 2025. Key points included governance updates, strategic priorities, and financial planning for the upcoming year.

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

8 Patient Safety Update

8.1 IR provided an update on the one-year implementation of the Patient Safety Incident Response Framework (PSIRF) across the Trust, which was introduced on 01 May 2024. He highlighted that PSIRF had implemented and integrated new systems and processes to improve incident management and learning, including a daily Trust-wide triage process and weekly directorate-level patient safety huddles. These mechanisms had been well established and continued to evolve.

8.2 A key highlight was the upward trend in incident reporting, which was viewed positively as it reflected a culture of openness and vigilance around safety concerns. IR also outlined current thematic investigations, including one focused on deteriorating surgical patients with complex conditions, which had prompted wide-ranging discussions around surgical decision-making and access to specialist care.

8.3 During the discussion:

- HT queried the triage process. IR clarified that the patient safety team was increasingly centralising follow-up responsibility post-triage to reduce the burden on local services and streamline communication.
- PR raised questions regarding clusters of incidents. IR confirmed the existence of an active cluster investigation, particularly in maternity services, some of which involved external

oversight. He emphasised that while the process was lengthy, it was critical for capturing meaningful learning.

- GB questioned overdue workflows. IR acknowledged previous resourcing challenges, particularly in maternity, but shared that work was underway to review capacity and compare with peer organisations to improve turnaround.
- GM sought clarity on how thematic patient safety issues were being measured and whether improvements were visible. IR responded that, although clear metrics were still developing across the system, qualitative indicators such as increased reporting and staff engagement suggested positive momentum. He acknowledged the challenge of quantifying improvement and noted that this was a national issue across NHS England.

IR concluded by noting that the patient safety team would produce an annual report detailing safety themes, trends, successes, and areas for future focus. This report would support continuous learning and strategic improvement across the Trust.

8.4 The Board **noted** the Patient Safety Update

9 **Maternity Assurance Group (MAG) Update**

9.1 FH provided an update from the Maternity Assurance Group (MAG), covering key areas of maternity performance, risk, and assurance. She noted that safety actions and key metrics were under close monitoring, particularly in the context of the Maternity Incentive Scheme (MIS) and ongoing improvement work.

9.2 In response to questions about communication-related complaints, FH noted recurring issues around discharge information and postnatal care, with improvements seen due to targeted work since last summer.

9.3 The Board **noted** the Maternity Assurance Group Update

10 Annual Patient Experience Report

10.1 KJ explained that the patient experience platform aggregated real-time data from various sources, including online feedback, the Friends and Family Test (FFT), complaints, PLACE audits, and community engagement. The platform provided:

- Star ratings.
- Peer benchmarking against regional Trusts.
- Dynamic, constantly updated data feeds.
- Insights that supported inspections and broader quality improvement work.

10.2 The central Patient Experience Team, though small, supported access to and usage of data across all wards and departments. Leaders and teams were encouraged to use the platform to identify trends and initiate quality improvement projects. The team cross-referenced patient feedback with incident reports and other quality metrics to identify areas for improvement.

10.3 HH raised concerns about Ward 12, which had shown a notable drop in patient satisfaction scores in recent months. He questioned whether teams like Ward 12 and pharmacy actively used this data, and if there was a formal process for using the data to drive improvement. KJ confirmed that a mix of central oversight and local responsibility existed. Teams had access to the platform and were encouraged to use it. Trending issues were identified and followed up centrally, but wards were also expected to act locally.

10.4 JH raised a key point around demographic balance, asking if the data was adjusted or considered in light of population characteristics. He noted that younger patients tended to report lower satisfaction and inquired if this skew was accounted for. KJ acknowledged the demographic nuances and stated that teams did consider such factors when analysing trends.

10.5 The Complaints team regularly analysed data and supported triangulation across sources. Community engagement efforts had been award-winning and helped connect the hospital with underserved populations. PLACE audits, which focused on cleanliness, nutrition, and other factors, were included as part of the experience monitoring.

10.6 The patient experience platform was viewed as a valuable tool for continuous service improvement, but there was an ongoing effort to ensure data was used meaningfully at all levels from frontline staff to executive teams. There was strong interest in refining the process to make better use of insights, particularly in areas with declining performance.

10.7 The Board **noted** the New Hospital Programme (NHP) Update

11 Performance Report Month 12

11.1 FG provided an update on performance metrics, specifically focusing on the 4-hour and 12-hour discharge targets. Despite challenges during the winter period, she noted that the team had performed better than most across the country. As of the previous week, the team was ranked second nationally for performance. FG highlighted the dual focus on improving both admissions and discharge processes to reduce patient time in the department and maintain high standards of care. She acknowledged the quieter period during Easter but emphasised that the team continued to prioritise quality and efficiency.

11.2 FG reiterated that sustainable improvement was key and stressed the importance of focusing on patient care for the right reasons, not simply to meet performance metrics. She outlined the ongoing Urgent and Emergency Care (UEC) programme, which included multiple work streams aimed at improving discharge processes. Key initiatives included discharge before midday, enhanced ward rounds, and refining discharge criteria. She emphasised the critical role of involving clinicians and senior nurses to ensure these improvements were embedded and sustainable.

11.3 There was discussion on the significance of team engagement and culture. FG noted a sense of ownership and commitment within the team, describing them as motivated by a collective goal to enhance outcomes. She emphasised the necessity for curiosity, continuous questioning, and ongoing dialogue to maintain behaviour and culture change.

11.4 During the discussion, PR asked about the potential benefits of earlier discharges. FG stated that discharging patients earlier could reduce system pressure significantly. GB and HT asked questions related to ensuring quality and how improvements are maintained within the team. FG responded by reinforcing the importance of clinical involvement and focusing on long-term impact over short-term targets.

11.5 The Board **noted** the Performance Report

12 Finance Report Month 12

12.1 JD presented the Finance Report, noted a £136,000 surplus for the financial year. This final position had been submitted nationally and underwent an external audit review, which was expected to last 3 to 4 weeks from April 28. He acknowledged that despite the surplus, significant financial challenges remained.

12.2 Looking ahead, JD emphasised the scale of the task for 2025–2026, which included delivering a £24 million Cost Improvement Programme (CIP). He stressed that this would be critical in addressing ongoing financial pressures and ensuring long-term sustainability. Despite the challenges, he encouraged the team to celebrate the breakeven position and acknowledged the collective effort across the organisation that made it possible. He also noted that achieving financial balance opened up opportunities for additional revenue support from regulators, making it even more vital to continue prioritising financial discipline and collaboration.

12.3 HT commended the finance team and the wider organisation for their collective efforts in delivering the financial outcome. PR also praised the result, describing it as a "significant accomplishment," and queried whether a reconciliation process was in place. JD confirmed that such a process was indeed established and operational.

12.4 The Board **noted** the Finance Report

13 People and Culture Committee Report

13.1 CW presented the People and Culture Committee Report, highlighting key areas of focus including sickness absence, workforce technologies, international recruitment, mandatory training, and safe staffing. There had been a notable reduction in sickness absence, which was attributed to targeted efforts by teams and the implementation of tools such as Impact and Loom apps. These technologies improved access to rosters and occupational health services, streamlining support and communication.

13.2 She addressed ongoing challenges related to Home Office sponsorship for international recruits, noting the importance of local and national collaboration to manage allocations and ensure compliance. Positive developments in mandatory training were also reported, particularly the adoption of a national MOU covering 12 core training areas to standardise requirements.

13.3 The Board **noted** the People and Culture Committee Report

14 Nursing Workforce Update

14.1 FH provided an overview of the Nursing and Midwifery staffing for February 2025. It was noted that safe staffing had remained a key priority, with the Safer Nursing Care Tool being used to assess patient care needs. Her report indicated that nine areas had shown utilisation above recommended levels, though trends had been improving. Red flag reporting rates had remained low, with no incidents of patient harm recorded. However, work had been underway to improve staff understanding of when and how to escalate concerns and to ensure mitigation efforts were better captured.

14.2 FH emphasised the need for robust workforce data to inform staffing models. Establishment reviews were updated using insights from temporary staffing usage and acuity tools, with early work underway to develop flexible staffing models tailored to high-demand areas.

14.3 The Board **noted** the Nursing Workforce Update

15 Declaration of Interests Report Annual Report

15.1 KJ presented the Register of Interests and associated Action Plans, noting that the declaration process had been automated. This improvement was designed to streamline submissions and ensure accuracy and efficiency. KJ highlighted the focus on increasing compliance, particularly in areas with historically lower response rates such as among consultants.

15.2 The report, compiled by the Trust Secretariat team, was submitted for noting and approval for publication. KJ emphasised ongoing efforts to address low-intensity declaration areas and confirmed continued monitoring throughout the year to enhance transparency.

15.3 The Board **noted** and **approved** publication of the updated Register of Interests.

16 Risk Management Report

16.1 KJ presented the Risk Management Report, highlighting ongoing efforts to manage long-term, high-scoring risks. A deep dive into risks persisting for over five years was discussed, with a proposal for further review at a future Board seminar. The Audit and Risk Committee may be asked to examine selected long-term risks in more detail to provide additional assurance.

16.2 It was agreed that the Risk Appetite Statement and its implementation would be revisited at a future Board seminar.

The Board approved the escalation of the following risks to the Corporate Risk Register:

- **RSK-638** – POCT Poccellerator Informatics System
- **RSK-645** – CPAP Service

16.3 The Board **noted** the Risk Management Report

17 Board Assurance Framework (BAF)

17.1 KJ provided an overview of key updates from the BAF report.

- A new strategic risk related to **poor data quality** was under assessment and would be added to the BAF once the review was completed.
- A risk concerning **widening health inequalities** was discussed. The Board agreed that further work was needed to appropriately define the scope of MKUH's influence, with further discussion to take place at Board level.

17.2 The Board **noted** the Board Assurance Framework.

18 Board Committees Assurance Reports

18.1 The Audit & Risk Committee Assurance Report

18.1.1 The Audit & Risk Committee Assurance Report provided an update on the committee's activities since the last Trust Board meeting held in public on 6 March 2025. The committee met on 17 March 2025 and 14 April 2025, making several key decisions and noting important updates. These included the Annual Accounts Timetable, the Audit Plan 2024/25, the External Audit Findings Improvement Action Plan, and the inclusion of MK Urgent Care Services Ltd (MKUCS) investment income in the Trust's 2024/25 annual accounts. The committee also reviewed the Draft Going Concern Review, Internal Audit Progress Report, and the Financial Controller's Report. Additionally, the committee noted the Risk Management Framework and the Declaration of Interest Annual Report. No items were escalated to the Board for further discussion.

18.2 The Charitable Funds Committee Assurance Report

18.2.1 The Charitable Funds Committee Report provided an update on the committee's activities since the last public Trust Board meeting on 6 March 2025. The committee met on 22 January 2025 and discussed several key issues, including the departure of the Individual Giving Marketing Lead, the closure of the Radiotherapy Wellbeing Appeal, and the future partnership with Friends of MK. The committee also reviewed the funding position of Arts for Health MK and the impact of the removal of the Individual Giving Fundraising Lead role. The report highlighted significant fundraising activities and engagement growth on the charity's website and social media.

18.3 The People & Culture Committee Assurance Report

18.3.1 The People and Culture Committee met on 17 April 2025, chaired by PZ. The committee discussed the Board Assurance Framework and Risk Register, focusing on risk controls and targets. They noted the appointment of an inclusion lead to develop a dashboard for monitoring the inclusion strategy. The Freedom to Speak Up report highlighted the appointment of a new post to ensure open communication. The Workforce Strategy included values-based recruitment training and the implementation of the Loop app for booking shifts. The Safe Staffing Report noted a reduction in vacancies but highlighted challenges in meeting patient needs and staff burnout. The committee was assured by the discussions and decisions made.

18.3.1 The Board **noted** the Board Committees Assurance Reports

19 Annual Review of Committee Effectiveness

19.1 KJ presented the Annual Review of Committee Effectiveness, highlighting the significant work done by the committees, good membership and attendance, and the ongoing review and assessment cycle.

19.2 The Annual Review of Effectiveness Report for the Audit & Risk Committee

19.2.1 The Annual Review of Effectiveness for the Audit & Risk Committee (ARC) for the financial year 2024/25 provided an update on the committee's activities and effectiveness. The ARC, chaired by MV since June 2024, had fulfilled its roles and responsibilities in accordance with its Terms of Reference. The committee had overseen the Trust's governance, risk management, and internal control systems, ensuring the integrity of financial statements and monitoring internal and external audits. An evaluation conducted in May 2024 indicated a need for improvement in focusing on key risks and challenging substantive matters. The committee met formally four times, with additional meetings for the Annual Report and Accounts governance process.

19.3 The Annual Review of Effectiveness Report Quality & Clinical Risk Committee

19.3.1 The Annual Review of Effectiveness Report for the Quality & Clinical Risk Committee (QCRC) provided an update on the activities of the committee for the financial year 2024/25. It highlighted the committee's adherence to its Terms of Reference, the evaluation of its effectiveness, and the review of its activities. The report included details on membership, meeting attendance, and the committee's oversight of the Board Assurance Framework and Corporate Risk register. It also outlined the committee's role in monitoring and improving the safety and quality of care, patient experience, and the implementation of proposed actions for improvement.

19.4 The Board **noted** the Board Committees Assurance Report

20 Use of Corporate Seal

20.1 The report outlined the schedule for the use of the Corporate Seal detailing a contract between Milton Keynes University Hospital NHS Foundation Trust and Fiva Landscapes Ltd for professional landscape architecture services related to a new hospital and a refurbished Day Surgery Unit.

21 Forward Agenda Planner

21.2 The Board reviewed the Forward Plan and noted that there were no items captured for discussion at the July Board.

22 Questions from Members of the Public

22.1 There were no questions from the public

23 Any Other Business

23.1 None

The meeting closed at 11:55AM

Updated:01.05.25

NHS
Milton Keynes University Hospital
NHS Foundation Trust

Trust Board Action Log

Action No.	Date added to log	Agenda Item No.	Subject	Action	Owner	Completion Date	Update	Status Open/ Closed
41	06-Mar-25	9	New Hospital Programme (NHP) Update	A new master plan for the site will be presented to the Board in the coming months, outlining how the new development will integrate with the existing hospital infrastructure.	JB	04-Sep-25		**Open**
42	06-Mar-25	20	Use of Corporate Seal	JB and KJ to review the current use of the corporate seal and explore potential improvements, including the feasibility of an electronic alternative	KJ	TBC		**Open**
43	01-May-25	16	Risk Management Report	Schedule a deep dive at a future Board seminar into long-standing risks (over five years), including review of selected risks by the Audit and Risk Committee; revisit the Risk Appetite Statement and its implementation.	KJ	02-Oct-25	**Risk Appetite Statement - On the July Public Board Agenda** Deep Dive: Long-Standing Risks - On the October 2025 Board Seminar Agenda	**Open**

Meeting Title	**TRUST BOARD PUBLIC**	**Date: 3rd July 2025**
Report Title	**Chair's Update**	**Agenda Item Number: 6**
Lead Director	**Heidi Travis**, Chair	
Report Author	**Heidi Travis**, Chair	

Introduction	This report is a standing agenda item		
Key Messages to Note	This report informs the Board of key points arising from the Council of Governors and members' discussions and the Chair's and Non-Executive Directors most significant activities since the last Trust Board held in public. The Board is invited to NOTE the report		
Recommendation *(Tick the relevant box(es))*	**For Information** [x]	**For Approval** [ ]	**For Assurance** [ ]

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

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

1. Introduction

1.1 This report aims at updating the Board on the Chair's main activities, Non-Executive Directors (NEDs) ward visits, Governors' visits and discussions as well as systems and place collaborations as part of the MKUH Board's commitment to transparency and accountability. The report further informs the Board of key points arising from the Council of Governors' discussions and the Chair's and Non-Executive Directors most significant activities since the last Trust Board held in public.

1.2 The Board is invited to NOTE the report.

2. Chair's Update

2.1 At the Board Seminar on 5th June, Board members focused on the Annual strategy review with various aspects of current year challenges and longer term strategic plans given consideration. In addition, we reviewed the BLMK ICS 10 year Green Plan which was approved by Board. Finally, we considered and gave feedback on the new proposed Integrated performance report and think this will continue to develop robust assurance for the Board on delivery of the strategic plan.

2.2 On 28th April participated in the Chairs and Chief Executives East of England provider event. Discussed performance and plans for delivering the challenging targets this year. Contributed to the discussion on future structure of the ICBs in East of England.

2.3 On 23rd May attended the Joint Board and Healthcare Partnership seminar. Discussed key matters in service provision for cancer services, and community and mental health across the wider BLMK ICS.

2.4 Attended the MKUH Inclusion and Leadership Council with Chair leads from the Trust networks. The CPO Updated on the reports and continuing work that is happening at the Trust building on from the Roger Kline and Yvonne Coghill work 24/25.

Council of Governors Update

2.5 Governor Engagement

The Governor Engagement Committee (a formal sub-committee of the Council of Governors). had a very positive first meeting on 30th April. Discussion took place on structuring of support for Governors in engaging communities, with a positive discussion about the Annual Members Meeting in 2025 which the Governors are very keen to support.

The MKUH 'Hospital in the Community' health event at King's Community Centre in Wolverton took place on Tuesday 13 May, 10am-2pm. It was very well attended and highlights how good conversation and advice in the community with members of the MKUH team can really support people with their health and wider needs.

2.6 Governors Open Forum

The Governors Open Forum took place on 4th June. The Meeting was attended by Michael Bracey CEO and Victoria Collins from MK Council. Governors enjoyed a productive discussion on the positive relationship and activity that happens due to collaboration between MKUH and MK Council

3. Other Engagements

Over the past two months, the Chair continued to participate in regular one-to-one meetings with Non-Executive Directors and Chaired interview panels for various roles, alongside our medical and non-medical colleagues. Additionally, attended Board Committees and engaged in the following activities:

3.1 7th May attended the Oak Wards topping out ceremony with colleagues from across the Trust and Mk region.

3.2 Met with the Quality Improvement team and attended presentations later in the month by colleagues who are delivering projects across the Trust. Their passion for excellence and commitment was very inspiring.

3.3 With Joe Harrisson CEO attended basic life support training delivered by Lesley Whitesmith, Trust Senior Practitioner for resuscitation.

3.4 Spent time talking with volunteer Jeff Drake on hospital radio which supports patients and colleagues across the Trust with good conversation and music.

3.5 Visited several departments including the Mortuary, Pathology, and the Palliative care team and time with Anna O'Neill the Trust patient safety lead.

3.6 Alongside executive colleagues hosted one of several anti -racism sessions to discuss the importance of us all playing our part.

4. Recommendation

The Board is invited to NOTE the report.

Meeting Title	**TRUST BOARD PUBLIC**	**Date: 3 July 2025**
Report Title	**Chief Executive's Update**	**Agenda Item Number: 7**
Lead Director	Joe Harrison, Chief Executive	
Report Author	Joe Harrison, Chief Executive	

Introduction	This report is a standing agenda item		
Key Messages to Note	This report informs the Board of key points arising from the Chief Executive's most significant activities since the last Trust Board held in public. The Board is invited to NOTE the report		
Recommendation *(Tick the relevant box(es))*	**For Information** [x]	**For Approval** [ ]	**For Assurance** [ ]

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

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

1. Introduction

1.1 This report aims to update the Board on the Chief Executive's activities as part of the MKUH Board's commitment to transparency and accountability.

1.2 The Board is invited to NOTE the report.

2. Chief Executive's Update

2.1 Performance

Over the past 12 months, we have made significant progress in reducing the longest waits as well as the number of patients on our waiting list.

By accelerating change and equipping our teams as best as we can with smart ways of working, new technology, good facilities and a supportive place of employment, I am confident that we will continue to get closer towards the achievement of national targets.

2.2 Strategy

With significant changes to the NHS and MKUH underway, and the continued growth of our city, the Trust strategy has been revised to reflect our new world. It reinforces our number one priority – to provide safe, values-led patient care.

The strategy acknowledges the importance of having a supported team of people who work, first and foremost, to serve patients. It focusses on improving today's delivery and being fit for the future. We intend to launch the final strategy to all stakeholders this September.

2.3 Anti-Racism Programme

Preventing and tackling racism, and all forms of inequality, is everyone's responsibility. This is why the Anti-Racism Programme has been launched across our entire Trust.

This programme is based on the insights and recommendations from the Kline and Coghill reports, the findings of our National Staff Survey (NSS), and feedback from over 200 colleagues.

All colleagues now have access to the full Kline and Coghill reports, their recommendations and our action plan. We are proactively engaging colleagues across the Trust through our staff networks, leadership, communications channels and workshops to embed the Anti-Racism Programme fully.

This is not a one-off campaign; it is a continual effort to make MKUH fairer and more equal for everyone.

2.4 Development

There has been continued progress to enhance our infrastructure and capacity. In May, we marked the topping-out of Oak Wards and, next week, we will open the new multi-storey car park. The Eye Clinic is now settled into its new home at the Community Diagnostic Centre we operate in central Milton Keynes. The Radiotherapy Centre was officially opened on Monday with attendance from OUH, NHSE, our local MPs, MKCC partners, contractor and BLMK among others.

2.5 CQC Children and Young People's Survey

The Care Quality Commission (CQC) published the 2024 Children and Young People survey results on 22 May 2025. The survey gathered responses from the parents and carers of 232 patients, aged 0 to 15 years, who received care at Milton Keynes University Hospital (MKUH) between August and December 2024.

Overall, the results were in line with national averages. Young patients reported having access to a clean, age-appropriate hospital setting where they are treated with dignity, respect, kindness, and compassion. They expressed confidence and trust in the staff, felt their pain was well-managed, and were satisfied with most facilities. Additionally, parents and carers appreciated being able to stay with their children as long as needed.

There are some areas that can be improved, and MKUH is formulating a plan to address them.

2.6 Critical Infrastructure Risk Funding

It was announced that MKUH is to benefit from £4.9m of critical infrastructure risk funding. Our intention is to use this to refurbish three of our older theatres where we will install new ventilation and convert one theatre into an Ultra Clean Ventilation (UCV) theatre. UCV theatres are suitable for all types of surgery but particularly beneficial for trauma and orthopaedics.

We also plan to replace a number of single-glazed windows with efficient double glazing, primarily in Phase 1 of the hospital.

Finally, we will re-roof a small area above the Phase 2 theatres.

2.7 TeamMKUH Awards

In the current financial climate, we had to think carefully about hosting our annual awards. We decided to go ahead because we are a people business, and recognising the tremendous efforts of the people we employ is truly important to us.

The event was delivered on a much-reduced budget and supported with donated prizes for our winners. I would like to congratulate all of those who were nominated - around 1,000 members of TeamMKUH - and our shortlisted nominees and winners.

2.8 Filming and sharing without consent

Both nationally and locally, there is a growing trend to film NHS colleagues and share arising content on social media without consent. To safeguard the dignity, privacy and wellbeing of patients, visitors and colleagues, we have a policy in place that prohibits this behaviour. To reinforce that policy, we have stepped up site-wide messaging.

3. Recommendation

The Board is invited to NOTE the report.

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date 3 July 2025

ICB Executive Lead: Maria Wogan, Chief of Strategy and Assurance, and MK Link Director, Bedfordshire, Luton and Milton Keynes (BLMK) ICB

ICB Partner Member: Joe Harrison Chief Executive, Milton Keynes University Hospital NHS Foundation Trust

BLMK Health and Care Partnership Member: Heidi Travis, Acting Chair, Milton Keynes University Hospital NHS Foundation Trust

Report Author: Maria Wogan

Report to the: Board of Directors, Milton Keynes University Hospital NHS Foundation Trust

Bedfordshire, Luton and Milton Keynes Integrated Care Board (ICB) and Health and Care Partnership update

1.0 Executive Summary

1.1 This report summarises key items of business from the Board of the BLMK ICB and the BLMK Health and Care Partnership arising recent meetings.

2.0 Recommendations

2.1 The Board of Directors is asked to **note** this report.

3.0 Key Implications

Resourcing	✓
Equality / Health Inequalities	✓
Engagement	✓
Green Plan Commitments	✓

4.0 Report

4.1 Bedfordshire, Luton and Milton Keynes Integrated Care Board Update

The Board last met on 27 March 2025, and a report of this meeting was presented to the April meeting of the Board of Directors. The next meeting of the Board of the ICB will be held on 27 June 2025.

Board papers and a link to join the meeting is available here a week before the meeting.

4.2 Joint Seminar of the Board of the ICB and the BLMK Health and Care Partnership 23 May 2025

Introduction – Councillor Martin Towler, Co-chair of the Bedfordshire, Luton and Milton Keynes Health and Care Partnership and Portfolio Holder for Health at Bedford Borough Council welcomed everyone to the meeting and introduced Robin Porter, the new Chair of NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board. The Chair set out his commitment to serving the people and communities in the area.

Mount Vernon Cancer Centre Programme – Jessamy Kinghorn, Head of Partnership and Engagement at NHS England and Kathy Nelson, Deputy Programme Director for the Mount Vernon Cancer Centre Programme Team introduced the latest developments on Mount Vernon Cancer Centre. Members heard about plans to move cancer care from Mount Vernon in Hillington to Watford General Hospital and build satellite radiotherapy suites in one of two locations – either at the Luton and Dunstable Hospital or the Lister Hospital to provide care closer to home.

Outline timescales for a formal consultation were shared, together with the outcome on important work that had been undertaken to review the impact of proposals and what this would mean for residents, especially those who experience significant health inequalities. Members fed back that person centred care was important and that residents should have the right to choose where they access cancer care.

The Partnership agreed to develop a position statement on the preferred option ahead of the formal consultation and shared their concerns about the availability of capital funding which could affect timely and appropriate transfer of care.

Infrastructure Strategy – Nikki Barnes, Associate Director of System and ICB Estates, shared the Infrastructure Plan for Bedfordshire, Luton and Milton Keynes and set out the ICB's vision to grow capacity in estate and increase productivity to support new models of care, and ensure the area is better able to meet the significant population growth and demographic changes that are expected in the next 15 years.

Laura Church, Chief Executive of Bedford Borough Council, explained that nationally important infrastructure plans including Universal Studios and an expanded Luton Airport require a bold vision for Bedfordshire, Luton and Milton Keynes.

Members heard that the ICB proposes to develop seven priority workstreams including i) fit for purpose hospitals, ii) the establishment of community diagnostic centres to support planned care, iii) the establishment of primary care neighbourhoods, iv) support for the growth of pharmacy, optometry and dentistry, v) care closer to home, vi) the green agenda and vii) digital strategy.

Members welcomed proposals, recognising the important role this would play in helping residents to become healthier and wealthier by 2040 and asked that the ICB is clear on the gap in capital funding, to support further conversations at national and regional level.

Community and Mental Health Services – Kathy Nelson, Programme Director and Penny Harris, Strategic Consultant introduced proposals to re-imagine and co-design Community and Mental Health Services in Bedfordshire, Luton and Milton Keynes. Members heard that the two-year programme was designed to ensure services met the needs of residents, were better able to manage increasing demand associated with a growing and ageing population and considered the three changes set out in the Darzi

Review - to prevent poor health, move care out of hospital into the community and move from analogue towards digital solutions.

Members reflected the need to engage residents and VCSE partners in discussions, in addition to NHS providers and primary care as no single provider would be able to achieve the ICB's aim for more integrated, person-centred and preventative care. They agreed that the population needed to be engaged and empowered more in self-care by taking a less medicalised approach, and that the possibility for pooled budgets, and neighbourhood led interventions should be enhanced through this programme. It was agreed that data should drive modelling to ensure services meet population needs.

Successfully delivered, members agreed that this would be part of the left shift needed to move the NHS towards the recommendations in the Darzi Review. Feedback from the session would be reflected in the case for change and would inform development of a set of principles to underpin the business case and procurement approach.

Transition of the Integrated Care Boards – Robin Porter, Chair of the ICB explained to Members that following a national directive to reduce running costs of the ICB by 50% by October 2025, proposals were being developed to cluster and eventually merge Bedfordshire, Luton and Milton Keyes Integrated Care Board(ICB) with Hertfordshire and West Essex ICB (with West Essex joining an Essex ICB) and Cambridgeshire and Peterborough ICB.

Members heard that timescales were being agreed – but it was likely that formal mergers would take place by 1 April 2026, or April 2027 following local government reform. The Chair explained that while national figures showed that BLMK had been £158m underfunded in previous years, all ICBs are required to achieve a running cost of £18.76 per head of population.

Felicity Cox, Chief Executive of Bedfordshire, Luton and Milton Keynes Integrated Care Board announced her decision, taken with other ICB CEOs and NHS England, to become the lead Chief Executive for the ICB reconfiguration work. She confirmed that she intends to step down from this transition role, when the designate Chief Executive for the new organisation is appointed. She will continue as the CEO of BLMK ICB during this time.

Members thanked Felicity for her service to BLMK residents and agreed that robust and ambitious place teams should be integral to the new organisation, to retain the strengths and relationships developed in BLMK over many years. It was also agreed that further conversations were required to ensure the area received its fair allocation of resources for residents and that this should not be lost within the new geography. A position statement based on the feedback received would be drafted and shared with the Members.

If you have any queries regarding this summary, then please contact blmkicb.corporatesec@nhs.net

4.3 Next Steps

None

List of appendices

None

Background reading

None

Meeting Title	Trust Board Meeting in Public	Date	03 July 2025
Report Title	Patient Safety Update		
Lead Director	Dr Ian Reckless, Chief Medical Officer		
Report Authors	Anna O'Neill, Patient Safety Specialist, Head of Patient Safety and Learning Anna Costello, Patient Safety Specialist, Patient Safety Doctor		

Introduction	These papers provide the Trust Board with a detailed overview of patient safety activity between **01 April and 31 May 2025** as well as a **12-month review** of the Patient Safety Incident Response Framework (PSIRF) implementation following Trustwide transition on 01 May 2024. Papers include: 1. Report: PSIRF Bimonthly Update (April-May 2025) 2. Report: Transforming Patient Safety: A One-Year Review of PSIRF Implementation
Key Messages to Note	1. The implementation of PSIRF has significantly improved incident reporting, staff engagement, and patient-centred care, with notable achievements in faster incident resolution and a shift towards systems thinking. However, challenges remain in aligning PSIRF with existing processes, providing timely responses for more complex incidents and evidencing safer practice changes. 2. A thorough internal audit of PSIRF implementation has been conducted by RSM UK Risk Assurance Services. Recommended actions are: a. Patient Safety Board Terms of Reference to be updated to reflect PSRIF operations b. Patient Safety Team to alert teams to their overdue patient safety actions. c. Develop an options appraisal for patient safety training (local and national) and monitor compliance of said training. d. To ensure patient safety incidents are investigated and workflows completed according to locally agreed KPIs. 3. Incident reporting rates (all incidents and patient safety incidents) remain above pre-PSIRF levels with a 48% increase since 2023. 4. The number of overdue incidents is decreasing with significant reductions seen in acute and emergency medicine. Women's health has the largest number, with 43% of open incidents currently overdue, accounting for 25% of all overdue incidents. 5. The patient safety team are working with relevant teams to commence a new role of Patient Safety Learning Lead with an interest in Maternity and Gynaecology to help support patient safety activity. 6. Since the previous Trust Board, 3 incidents have been allocated a level 1 local patient safety incident investigation (PSII). Of note, only one of these is described in the attached bimonthly report (covering periods of April-May25) because the other 2 were approved for PSII in June. One of these incidents met

	a local criterion for PSII (delayed diagnosis). However, the other 2 did not meet a local or national safety priority but the patient safety incident review group and lead clinicians felt there was significant MDT learning opportunity to warrant a PSII. 7. Deteriorating surgical inpatients remains a safety concern with 3 PSIIs ongoing or completed over the past 2 months. Next step agreed is for the surgery triumvirate to bring together all actions and learning from PSII's undertaken and provide an update on actions to be taken to make wider divisional improvements. 8. Staff feedback indicates a positive shift in safety culture. 9. The patient safety team continue to offer and support innovative, collaborative ways of learning and improving from patient safety incidents.		
Recommendation	[x] For Information	[ ] For Approval	[ ] For Review

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	1. Keeping you safe in our hospital 2. Improving your experience of care 3. Ensuring you get the most effective treatment 4. Giving you access to timely care
Report History	Last report shared at Trust Board on 01 May 2025.
Next Steps	

PSIRG Bimonthly Report April-May 2025

Executive Summary

The Patient Safety Incident Response Framework (PSIRF) was launched across Milton Keynes University Hospital (MKUH) on 01 May 2024, following a period of limited piloting. A brief background on PSIRF and its implementation at MKUH is detailed in **Appendix 1.**

Data within this paper covers the period **01 April 2025 to 31 May 2025**. Much of this information has been shared in other forums within the Trust and is shared today for information and feedback from the committee members.

Key points:

1. PSIRF at MKUH reached its first-year milestone on 1st May 2025. A special PSIRF annual report has been developed and shared here in addition to this bimonthly report. The purpose is to review the implementation of PSIRF in terms of key findings, challenges, achievements, and recommendations for the upcoming year.
2. The internal auditors conducted a review of PSIRF implementation at MKUH in March, concluding 'reasonable assurance' and suggesting four low/medium actions. The full report is included in the pack.
3. A PSIRF one year celebration event was held in the tent on 15th May with a selection of interactive activities to engage staff, showcase some of the new PSIRF approaches and capture feedback on the first year of PSIRF. A summary of the event is included in the pack and in **Appendix 2**.
4. A PSIRF action plan (included in pack) has been created based on feedback from the one-year review, the internal auditors report and the staff feedback at the celebration event. Six key areas of improvement have been identified each with SMART actions to build on the success of year one.
5. One incident reported in the time frame has been allocated a level 1 local patient safety incident investigation (PSII). Whilst this event didn't meet a local safety priority the patient safety incident review group and lead clinician felt there was significant MDT learning opportunity.
6. Approximately 449 incidents have 'overdue workflows' associated with them. This is a 15% reduction over the past 2 months (from 529 in March). Whilst recognising that timelines for these workflows are internally set, the nature and distribution of these delays is described in this paper and the management of overdue workflows is one of the areas for improvement for 2025/26.

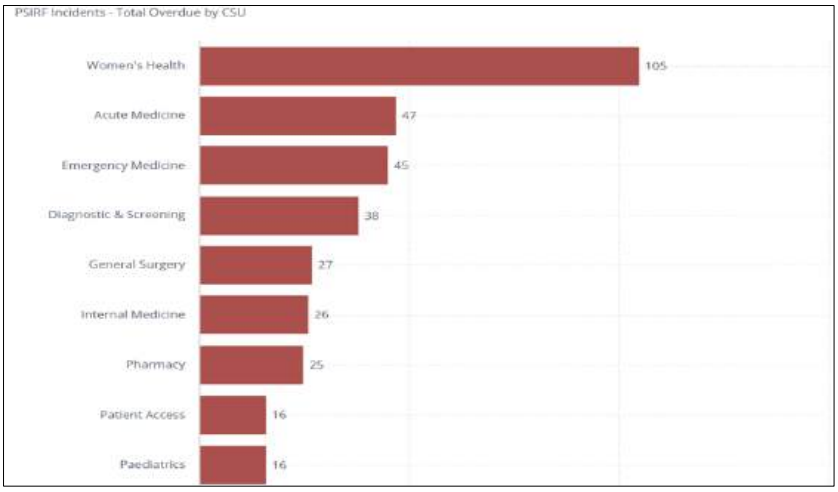
Main Report

Reporting Period (01 April 2025 – 31 May 2025)

Key Data

The total number of incidents reported[1] between 01 April 2025 and 31 May 2025 was 2294. This is rate has remained stable over the past 4 months and is also reflected in the number of patient safety incidents reported (see graph below). Both sets of data remain significantly above pre-PSIRF levels, suggestive of a positive reporting culture.

- The number of incidents with overdue workflows is currently 449, a 15% decrease over the past 2 months. **It is important to note that there are no national KPIs for PSIRF other than guidance that PSIIs should be completed within 3-6 months.** The KPIs agreed are to provide assurance that progress is being made and learning and action occurs within a timely manner. The overdue incidents are discussed at PSIRG each week and the patient safety team are continuing to support divisions to clear their backlogs. Women's health has the largest number of overdue incidents (43% of open incidents currently have overdue workflows), whilst both acute and emergency have almost halved their overdues over the past 2 months.



[1] Incidents reported through the RADAR system include both patient safety (typically two thirds) and non-patient safety (typically a third) events.

Responding to incidents in a timely way is one of the key areas for improvement for year 2 and actions have been put in place to address this backlog. Whilst these overdues exist, it is worth acknowledging that since PSIRF was introduced, the time taken to respond and close incidents has reduced by 29%.

The two Radar workflows contributing to the largest number of overdue incidents are the rapid reviews and the local safety huddles (described here as 'local triage').

1. Rapid reviews are required for incidents allocated as 'Level 4 – more information needed'. The process for level 4 more information includes:

   i. Identified at initial Trustwide triage that further information is required in order for an informed decision to be made regarding learning response level.
   ii. Local teams (division or CSU) are asked to clarify details and gather further information about the event (as supported by the rapid review form). The expectation is that this is completed ahead of the next weekly local safety huddle.
   iii. If more work or time is required to gather the necessary information, it remains on their local task list and therefore will appear as overdue when it exceeds the agreed KPI of 15 working days (currently 248 rapid reviews are overdue and awaiting completion).
   iv. Once more information is gathered and the rapid review form complete, the local team will either close the incident, convert it to a level 2 or 3, or ask for consideration of a Level 1 investigation (PSII). All potential PSIIs are discussed at PSIRG on a weekly basis.

2. As described above, the rapid review form needs to be completed ahead of the local safety huddle and therefore is having a knock effect on the number of overdue local safety huddles (currently described as local triage). All CSUs now have established weekly MDT meetings to review their incidents and rapid reviews. This will reduce the current local triage backlog of 232.

3. It has been recognised that there is no local safety huddle for patient safety incidents sitting within the corporate division, Examples include the patient discharge unit, patient access and the discharge team. A proposal was made to have a fortnightly huddle with rostered representation from estates, patient access and operations, supported by the patient safety team, however it is recognised that the individual services are too different, and separate huddles are likely to be more effective. The patient safety team are awaiting feedback from the leads of these services as to how these huddles can be introduced.

Level 1 Patient Safety Incident Investigations (including local PSIIs)

Since 01 April 2025, there has been one local level 1 PSII identified (INC-36577), two PSIIs are ongoing and two PSIIs have been completed, quality assured and approved at PSIRG. See table below for further details:

INC No.	Date declared at PSIRG	Level 1 type	Safety Priority (National & Local)	Description	Progress update
30615 /30590	01-Dec-24	PSII	National Priority: Never Event	Misplaced Nasogastric Tube	PSII and inquest completed
32451	17-Jan-25	PSII	Local Priority: Deteriorating Surgical Patient	Deteriorating surgical patient ward 20	PSII completed
32366	23-Jan-25	PSII	Local Priority: Deteriorating Surgical Patient	Deteriorating medical patient requiring surgical input ward 22	Ongoing - PSII report and QA tool completed. For PSIRG approval 05-Jun-25
34808	20-Mar-25	PSII	Local Priority: Deteriorating Surgical Patient	Urology patient. Unexpected cardiac arrest associated with abnormal electrolytes and drug complications	Ongoing – initial learning event held with urology team, pharmacy and representation from the orthogeriatricians. Next steps: Learning event with resident urology doctors and ward 21 nurses to hear their perspective on what happened, the safety culture, and specifically, escalation, speaking up and monitoring medically complex patients.
36577	22-May-25	PSII	None	Delay in emergency care treatment of a child involved in a road traffic accident.	Learning response lead and engagement lead allocated. Initial engagement commenced.

Themes from reported incidents

Potential themes identified from reported patient safety incidents are actively tracked by the team. An identified theme may lead to specific actions (for example, co-ordination of an MDT meeting to discuss and improve understanding) which may not have been warranted based on a single incident. Identified themes may also assist in the identification of training needs and patient safety priorities for future years. The table below describes themes which are continuing or newly emerging since 01 April 2025.

Category	Source	Plan / next steps
Deterioration of Surgical Inpatients	Incidents	A further PSII has been completed and 2 further are ongoing within this local priority. A recent incident that was considered for PSII was declined at PSIRG on the basis that learning and actions have already been identified. Next step agreed is for the surgery triumvirate to bring together all actions and learning from PSII's undertaken within surgery and provide an update on actions to be taken to make wider divisional improvements.
Discharge Medications	Incidents	3 QIPs addressing the 3 main workstreams (prescribing, pharmacy/dispensary, nursing) are now underway each with a clinical lead and QI coach. Oversight and assurance will likely be through Patient Safety Board via the new Medication Safety and Improvement Group.
Violence and aggression towards staff	Incidents	Being managed under Health & Safety.

Learning from Patient Safety Incidents

Learning is identified at all stages of the PSIRF process:

1. Daily triage meeting when all patient safety incidents are discussed by experts representing each hospital department.
2. Locally at weekly safety huddles (local triage).
3. Weekly PSIRG meeting where learning is identified and shared.
4. Level 1 & 2 learning events.
5. Mortality and Morbidity (M&M) meetings.
6. Monthly Learning Forums.

Key learning is recorded on Radar and together with case studies, are shared via the 'Spotlight on Safety' (SOS) message each week, published on the patient safety intranet page and shared on the 'MKUH Patient Safety Hub' MS Teams site.

The monthly patient safety learning forums are continuing - drop-in face-to-face sessions for staff to come and hear about patient safety themes, share their experiences and learn from topic experts. The topics chosen for each forum are based on current safety themes, Trust safety priorities and recent learning from PSIIs. The plan from summer 2025 is to triangulate intelligence and learning from other sources including complaints, litigation, inquests and safeguarding. The two most recent forums were held in April and May with focus on 'Sepsis and Antimicrobials' (Trust Safety Priority) and 'Right Patient, Right Care: Mastering ID and Safety Checklists' (Learning from a never event and ongoing theme). See ***Appendix 3*** for summaries of each forum. Upcoming forums will focus on:

- The Power of Now: Immediate Learning with Hot Debrief Tools
- Mastering Surgical Care for Medically Complex Patients

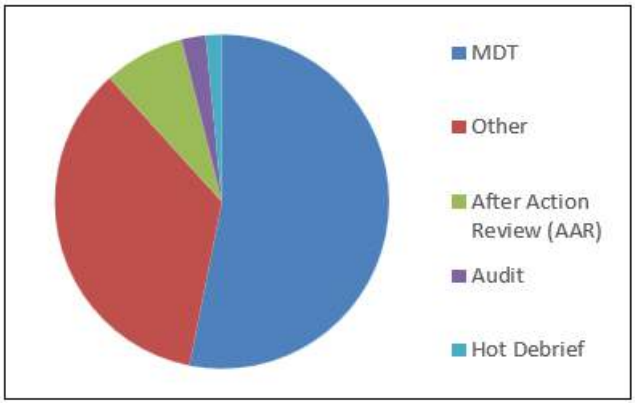
The patient safety team continues to capture learning using the M&M meeting outcome form. This is a simple Microsoft form that encourages the M&M group to identify examples of care excellence, key learning and potential quality improvement and audit opportunities. An

outcome summary is developed monthly and shared across all CSUs and learning platforms for Trust wide learning. See ***Appendix 4*** for the latest summary of outcomes.

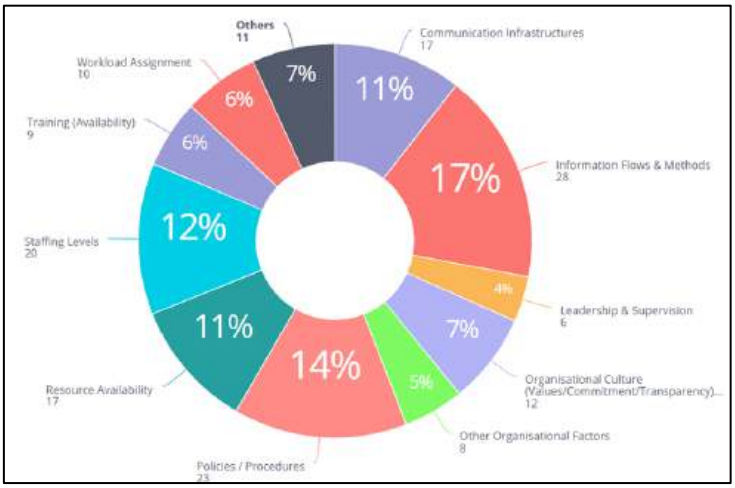
Level 2 Learning Events

Data

Between 01 April and 31 May 2025, 56 level 2 learning events have been completed, and the chart below shows the proportion of different learning response types held.



The chart below shows the key system factors contributing to our incidents and errors since the PSIRF launch in May 2024 with 'Information flows & methods' remaining the largest contributing factor; themes include the documentation of care handovers and escalation, IT system interactions and the use of outreach/specialist teams to bridge the gap between clinical teams and improve the sharing of information with patient and families. Other commonly identified contributing factors are 'Staffing Levels' (for example, the disparity between 'in hours' and 'out of hours' staffing provision, staff working in unfamiliar areas, provision of non-MKUH clinical teams to support MKUH services) and 'Policies & Procedures' (for example, accessibility of policy documents, policies requiring further clarity and updates).



As can be seen from the contributory factors chart above, we still need to improve the recording of 'contributory factors' following completion of learning events. Whilst it is improving, the more contributory factors recorded, the better our understanding of what is causing our incidents and our ability to make systemic change. Upon further exploration, this

disparity between number of learning events held and contributory factors listed can be accounted for by:

- Many MDT learning events are thematic in nature and explore multiple incidents during one event. This means that whilst several incidents were reviewed, the contributory factors are only added once onto Radar.
- Other level 2 learning event types don't currently have specific templates on Radar and therefore the systemic factors are not being captured. This is a piece of work is planned for this year, with specialist departments such as maternity and infection, prevent and control (IPC) to design specific learning outcome forms on Radar where needed. Conversations with the IPC team have already commenced.
- Not all level 2 learning response types currently include a SEIPS analysis, such as audits and M&M reviews.

A further 86 learning events are planned over the coming 2 months. 65 are currently overdue in accordance with the local KPI of within 60 days. It is important to recognise that learning events must be facilitated at a time and place that suits the people involved both logistically and emotionally. This requires detailed planning and scheduling to ensure that the right people are able to attend. PSIRF training is continuing to up-skill the ward / department teams to facilitate timely learning events such as hot debriefs and after-action reviews. This should reduce the number of delayed learning events and hence the overdue incidents. MDTs are excellent for high quality thematic learning. Reviewing multiple incidents at one MDT learning event is beneficial in terms of time and expertise but can be more challenging to arrange which can impact the overdue incidents list.

Staff feedback

During the **PSIRF one year celebration event**, staff were invited to share their experiences of PSIRF so far (full details in **Appendix 2**). Below are some quotes and the key positive sentiments of the feedback captured:

"Emphasises fair & just culture. Not always people, often processes need work!"

"Brilliant - has made safety a positive, welcoming constructive space - looking after and understanding staff whilst improving things for patients."

"Best thing is seeing learning events taking place & having outcomes to incidents that has a positive outcome to team/patient/trust"

"The MDT involvement & expert collaboration in a constructive, non-judgemental setting!"

"Bridges differences in the hierarchy"

- Staff appreciate PSIRF's systems-based approach, its emphasis on patient and family engagement, and the promotion of a supportive, blame-free culture.
- The patient safety team is seen as approachable and helpful.
- PSIRF is valued for fostering engagement, openness, and a positive, no-blame culture. Staff appreciate the focus on learning from incidents to prevent recurrence and the use

of proportionate responses. Strong data collection, inclusive learning opportunities, and multi-disciplinary team involvement are also seen as key strengths.

Staff also fed back areas they would like to see improve in relation to learning events and engagement:

- There is a call for better dissemination of learning from events and improved visibility of incidents within the clinical areas, particularly level 4 closes.
- Clearer oversight of the back log of learning responses and what needs actioning.
- Respondents emphasised the importance of supporting staff attendance at learning events during working hours.

Learning event feedback forms have been developed with a variety of feedback methods including satisfaction scales and open questions. These are to collate initial feedback from staff following a learning event and then 3 months post learning event.

1. **Initial feedback form** (0-7 days post learning event)

   Visual inquiry images (***Appendix 5***) are also provided as a well-established appreciative inquiry tool used at MKUH to help explore people's feelings and thoughts about a specific experience. So far staff completing the initial feedback form have rated learning events as either 'good' or 'excellent' and the most commonly chosen image is the hand holding image below. Words used to describe how the learning event felt are illustrated in the word cloud.

2. **3-month post learning event** feedback form

   This has been developed to evaluate the impact of learning events. Questions have been designed to explore how people are feeling about the incident now, whether any positive change has occurred, both personally and in terms of safety culture within their area and whether any safety actions have been completed. So far 80% of staff surveyed have felt that the learning event and the actions generated as a result, have met the intended objective and the majority having seen positive difference in patient safety as a result of the learning event (see graph below).

Closing the Loop

A 10-week pilot is to start in June with the introduction of a structured, 15-minute learning and improvement update at the weekly Patient Safety Incident Review Group (PSIRG) meeting. This initiative aims to enhance communication, share learning, integrate other governance workstreams and support continuous improvement by providing a regular platform for projects and departments to present progress and highlight challenges. A proposal was approved at PSIRG on 29th May, and an example schedule of updates has been shared:

QIP / Department	Updates due (PSIRG date)		
Pressure Damage	12/06/2025	23/10/2025	05/03/2025
Inpatient Falls	19/06/2025	30/10/2025	12/03/2025
Dysphagia	26/06/2025	06/11/2025	19/03/2025
Sepsis	03/07/2025	13/11/2025	26/03/2025
Maternity - MOH & ATTAIN	10/07/2025	20/11/2025	02/04/2025
AVAILABLE FOR ADHOC UPDATES	17/07/2025	27/11/2025	09/04/2025
Obstetric USS Service	24/07/2025	04/12/2025	16/04/2025
Safeguarding	31/07/2025	11/12/2025	23/04/2025
Inpatient Diabetes	07/08/2025	18/12/2025	30/04/2025
Discharge Medications - all 3 QIPs	14/08/2025	25/12/2025	07/05/2025
Maternity - Discharge & VTE	21/08/2025	01/01/2026	14/05/2025
AVAILABLE FOR ADHOC UPDATES	28/08/2025	08/01/2026	21/05/2025
Communication	04/09/2025	15/01/2026	28/05/2025
LocSSIPs	11/09/2025	22/01/2026	04/06/2025
IPC	18/09/2025	29/01/2026	11/06/2025
Therapies	25/09/2025	05/02/2026	18/06/2025
Pharmacy	02/10/2025	12/02/2026	25/06/2025
Histopathology	09/10/2025	19/02/2026	02/07/2025
AVAILABLE FOR ADHOC UPDATES	16/10/2025	26/02/2026	09/07/2025

Appendices

Appendix 1 – PSIRF Background

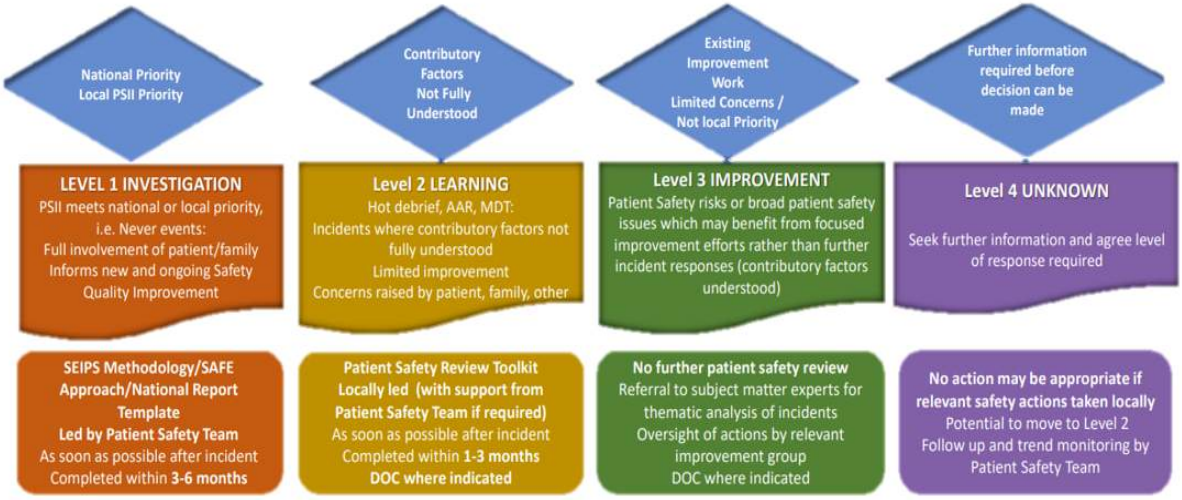
PSIRF represents a significant shift in the way the NHS responds to patient safety incidents. It supports Trusts to focus their resource and time into reviewing patient safety incidents where there is an opportunity to learn and to avoid repetition. This requires a considered and proportionate approach to the triage and response to patient safety incidents.

The introduction of PSIRF is a major step to improving patient safety management and is greatly support MKUH to embed the key principles of a patient safety culture which include:

- Using a system-focused approach to learning (The SEIPS model B1465-SEIPS-quick-reference-and-work-system-explorer-v1-FINAL.pdf)
- Focusing on continuous learning and improvement
- Promoting supportive, psychologically safe teamwork
- Enabling and empowering speaking up by all

Patient safety incidents reported at MKUH (through our RADAR software system) are reviewed in a 2-stage process; a daily Trust wide triage panel and weekly locally led patient safety huddles (local triage). The two stages allow for both Trust wide and local oversight and learning.

Trust wide triage includes a broad membership with representation from all key clinical areas (including patient safety, corporate nursing, medical, pharmacy, maternity, paediatrics, radiology, pathology, safeguarding). Trust wide triage occurs every working morning such that all incidents should be considered by triage within 72 hours of being reported – usually within 24 hours. Of note, relevant leaders are informed of the incident at the time of reporting through an email cascade appropriate to the geographical area / category of incident. The local patient safety huddles (sometimes described as 'local triage') are smaller groups and include representatives from patient safety, operations, medical and nursing at either divisional or clinical directorate / clinical service unit (CSU) level. Both panels are responsible for appropriately grading all patient safety incidents using the 4 MKUH response levels:



Incidents that meet the criteria for one of the four Trust's safety priorities are automatically assigned as a potential level 1 patient safety incident investigation (PSII). A front sheet is completed by an appropriate clinician and the cases are discussed at PSIRG within 7 days for either approval as a PSII or a decision for an alternative response.

A key role of a local patient safety huddle (local triage) is to review any level 4 incidents (which require further information over and above that included in the original incident report) and determine an appropriate learning response. In such cases, a rapid review form is completed by the ward/department - this ideally occurs within 7 days of the incident being discussed at daily Trust wide triage. The questions in the form are based on the following national criteria:

i. potential for learning in terms of:
   - enhanced knowledge and understanding
   - improved efficiency and effectiveness
   - opportunity for influence on wider systems improvement

ii. actual and potential impact of outcome of the incident (harm to people, service quality, service quality, public confidence, products, funds, etc.)

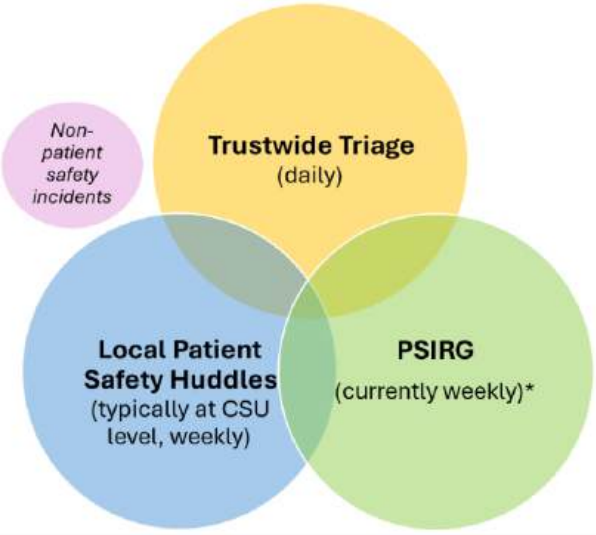
iii. likelihood of recurrence (including scale, scope and spread)

Based on the rapid review findings, the members of the local patient safety huddle (local triage) agree to either close the incident on Radar or assign a level 1 or 2 response. For level 1 and 2 responses a learning event will be suggested. Broadly these events have replaced local investigations, 72-hour reports and root cause analysis (RCA).

The Trust wide triage panel formally reports to the Patient Safety Incident Review Group (PSIRG), weekly, and the Patient Safety Board monthly, for oversight. In addition, a daily update is sent to members of the executive group for their information.

Other processes exist for the review of non-patient safety incidents or for patient safety incidents where robust improvement strategies are already in place. Any complaints which may have a significant patient safety component are discussed at Trust wide triage.

Key groups driving triage, understanding andmanagement of reported patient safety incidents



* The frequency and format of PSIRG (patient safety incident response group) will be kept under review as the transition away from historic processes completes and as we optimise our focus on learning.

Outcomes (learning and actions) from learning events are shared in several different forums including local safety huddles, team newsletters, in 'Spotlight on Safety' in the CEO newsletter as well as at the Trust wide learning forums such as PSIRG. Additional forums for sharing learning such as podcasts, drop-in learning forums and simulation are being developed and introduced.

Appendix 2 – One Year of PSIRF: A Celebration and Review

One Year of PSIRF: A Celebration & Review

Activities

Table Top Exercise

This was a fun, interactive activity designed to highlight the challenges around capacity and patient flow in the Emergency Department (ED), with a particular focus on the impact of staffing levels. This is an example of how we can learn from incidents that have a focus on flow or process within a specific area.

Line Dancing

To mark one year of PSIRF, we did a line dancing activity - a fun way to reflect on how coordination and clear systems support patient safety.

The SEIPS model shows how people, tasks, tools, environment, and organisation must work together. Like line dancing, success depends on:

Clear steps (tasks), A safe space (environment), Knowing your role (person), Cues and rhythm (tools), Teamwork (organisation)

If one part is off, the whole routine falters - just like in healthcare. Aligned systems lead to safer care.

Perspective Game

Demonstrated the PSIRF principle "we are all experts of our own experience" through the 'Perspective Game'. In this activity, participants stand in a circle around an object placed at the centre. Each person describes what they can see from their unique viewpoint, revealing different aspects of the same item at the same time depending on their angle. This effectively illustrates the principle by showing how varied perspectives are all valid and coontribute to a fuller understanding of an event.

Education

Facts & Figures

Since the launch of PSIRF the average time to investigate & close an incident has decreased by 29%

PSIRF promotes proportionate responses and does not require spending time & resources on investigations that offer no learning.

Since the PSIRF Launch the variety of incident reports has increased by 19%

Since the PSIRF Launch the reporting culture has improved. 22% more staff report & the number of reports has increased by 48%.

PSIRF takes a systems-based, no-blame approach; rather than attributing incidents to human error, it focuses on learning & improving the system.

Engagement matters: PSIRF promotes compassionate involvement of patients, families, and staff.

Under PSIRF, we choose our own local priorities and decide how best to focus our time and resources to support meaningful learning and improvement.

Not every incident requires a formal investigation; alternative learning responses are encouraged.

A slideshow was shared with staff showcasing learning within Patient Safety through M&Ms, learning events & learning forums.

Evaluation

IMPROVEMENTS FOR PSIRF

Feedback highlights a need for improvements to Radar, with concerns around its usability, speed, and the accessibility of dashboards. Perhaps related to the accessibility & functionality of dashboards there were requests for improved CSU & divisional reports. There is a call for better dissemination of learning from events and improved visibility of incidents within the clinical areas, particularly level 4 closes. Additionally, respondents emphasised the importance of strengthening both staff and patient engagement. Many reports pointed to a lack of alignment between PSIRF and related processes, such as legal, safeguarding, and IPC, indicating a need for better integration.

Stand Out Feedback:

Sense check what's being escalated as sometimes the focus doesn't reflect the feel in the clinical area.
Make the dashboard more user friendly on Radar.
Clearer oversight of the back log and what needs actioning.
Review MDT process, really challenging for clinical staff - they often attend on their day off.

BEST OF PSIRF

PSIRF is valued for fostering engagement, openness, and a positive, no-blame culture. Staff appreciate the focus on learning from incidents to prevent recurrence and the use of proportionate responses. Strong data collection, inclusive learning opportunities, and multi-disciplinary team involvement are also seen as key strengths.

Stand Out Feedback:

Emphasises fair & just culture. Not always people, often processes need work!
Best thing is seeing learning events taking place and having outcomes to incidents that has a positive outcome to team/patient/Trust.
The MDT involvement & expert collaboration in a constructive, non-judgemental setting!
Bridges differences in the hierarchy.

EXPERIENCE OF PSIRF

Staff appreciate PSIRF's systems-based approach, its emphasis on patient and family engagement, and the promotion of a supportive, blame-free culture. The team is seen as approachable and helpful. However, some find the volume of data generated from incident reports to be overwhelming.

Stand Out Feedback:

Brilliant - has made safety a positive, welcoming constructive space - looking after and understanding staff whilst improving things for patients.
Friendly, supportive, excellent.

Appendix 3 – Patient Safety Learning Forum Summaries

LEARNING FORUM: **SEPSIS**

ATTENDEES

- 2 Practice Development Nurses
- 1 ED Nurse
- 6 Members of the Patient Safety Team
- 1 Anaesthetist
- 5 Members of the Quality Improvement Team
- 2 Members of the Pharmacy Team
- 1 Member of the Point of Care Team
- Senior Nurse & HCA from Ward 14
- Senior Nurse from Ward 1

WHY WE'RE HERE?

Patient Safety | Equipment Awareness | Better Care

We are here to strengthen how we identify and manage sepsis, prevent infections, and improve patient outcomes. By working together, communicating clearly, and empowering both staff & patients, we can deliver safer, faster & more effective care.

WHAT GOES WRONG?

- Sepsis signs are missed - especially in patients who don't "fit the pattern."
- Important samples (like blood cultures) aren't always taken before antibiotics.
- Communication gaps mean opportunities for early action are lost.
- Infection control slips - caused by time pressure, outdated setups, or complacency.

WHAT WAS FOUND?

- Only 55% of suspected sepsis patients had blood cultures taken, well below our 90% target.
- Processes and training had not kept up with best practice.
- Staff and even patients could see when infection control steps weren't followed properly.
- The word "sepsis" was often used without enough explanation, causing fear or confusion.

WHAT'S CHANGING?

- Sepsis Champions now lead early recognition on wards.
- Patients are encouraged to ask: "Could this be sepsis?"
- Focus on taking samples early, before antibiotics whenever possible.
- Simpler language to support teamwork & patient understanding.
- Stronger focus on recording actions clearly to protect patient safety.

KEY LEARNING: BUILDING SAFER CARE TOGETHER

Clinical judgement plays a vital role: recognising changes early often means looking beyond the numbers.
Taking blood cultures as soon as sepsis is suspected helps guide the best possible treatment.
Clear, simple communication with patients and colleagues supports faster, safer care for everyone.
Respectfully raising concerns about practice strengthens our teamwork and improves patient safety.

IDEAS FOR IMPROVEMENT

- More training on spotting and managing sepsis.
- Speak up campaigns for staff and patients.
- Environmental upgrades like better bin and sink placements.
- Regular feedback on sepsis care and sampling rates.
- Celebrate good practice.

WHAT'S NEXT?

- Expand Sepsis Champions across more wards.
- Update trust-wide sepsis guidance and make it easy to access.
- Push community awareness so signs are caught earlier outside hospitals too.
- Aim for 90% compliance on blood cultures - and keep going beyond!

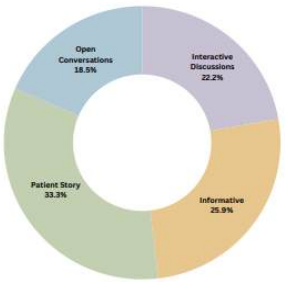
FINAL THOUGHTS - WHAT YOU CAN DO?

Notice: Pay attention to early signs of deterioration, look at the patient, not just the numbers.
Ask: Could this be sepsis? Have we taken all the right samples?
Check: Are blood cultures taken before antibiotics? Has everything been documented?
Speak up: If something feels wrong, question it, small concerns can save lives.
Communicate: Use clear, simple language with patients and colleagues. it helps everyone act faster.

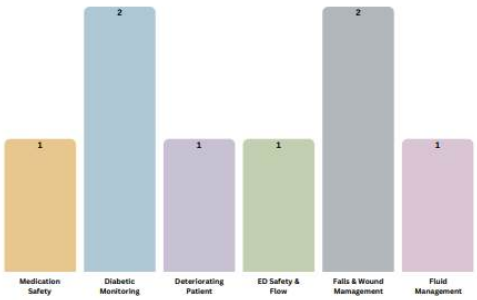
Staff Feedback

★ ★ ★ ★ ☆

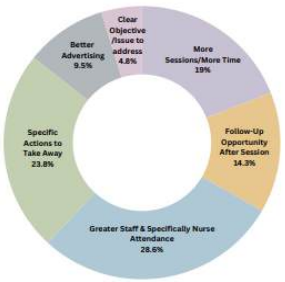
What did you enjoy about the session?



What other topics would you like to see regarding patient safety and incidents?



How could the session be improved?



LEARNING FORUM

Right Patient, Right Care, Mastering ID & Safety Checklists

ATTENDEES

- Four members of Patient Safety
- One Student Nurse
- One Point of Care Team Coordinator
- Three Matrons
- One Charge Nurse
- One Practice Educator
- One Consultant

WHY WE'RE HERE?

Patient Safety | Positive ID | Better Systems

A dedicated space to reflect on recent identification errors and explore how we can master ID and safety checklists to deliver safer, more reliable care.

WHAT WENT WRONG?

Procedures performed on wrong patients due to incorrect patient identification.

WHAT WE FOUND?

- Over-reliance on verbal ID in noisy, busy settings
- Patients responding to first names only, leading to misidentification
- Lack of awareness or familiarity with new LocSSIPs
- Patients hesitate to speak up believing Staff know best
- Staff often tell the patient their name instead of asking, creating confirmation bias

WHAT'S CHANGED?

- Posters promoting "Permission to Speak Up"
- Reinforcement: Ask for name, don't state it
- LocSSIPs audit & accessibility improvements on eCARE

IMPROVEMENT IDEAS

- Electronic displays in waiting rooms for better patient name confirmation
- Separate waiting areas for different procedures & Standardised appointment slots
- Make checklists easy to find, easy to use, and meaningful
- Encourage habitualisation of the right practice

KEY LEARNING: Routine Practice isn't always Best Practice

Familiar routines can feel safe, but that doesn't mean they are.

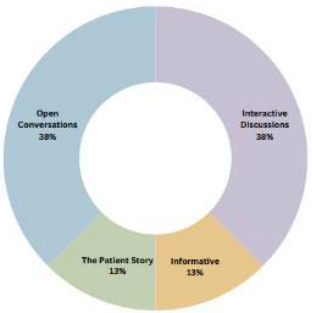
Pausing to reflect and question everyday habits is essential to stop poor practice from becoming accepted practice.
If you routinely skip asking for positive patient identification, is that really efficiency — or just an unsafe shortcut?
Always follow SOPs and LocSSIPs to embed safety into every step and ensure consistent best practice.

FINAL THOUGHTS - WHAT YOU CAN DO?

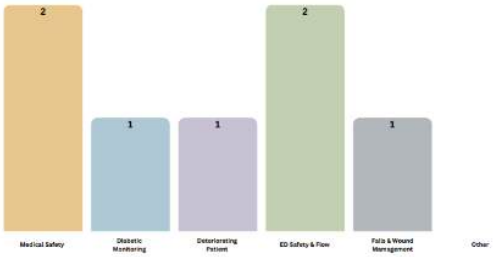
Ask: Always ask patients to state their identity never assume or tell them.
Check: Confirm identity at every stage of care. Double-checking protects patients, not paperwork.
Notice: Hesitation, silence, or confusion can be subtle signs that something isn't right.
Create space: Encourage questions from patients and colleagues — make it safe to speak up.
Reflect: Just because it's routine doesn't mean it's safe. Small habits can lead to big consequences.

Staff Feedback

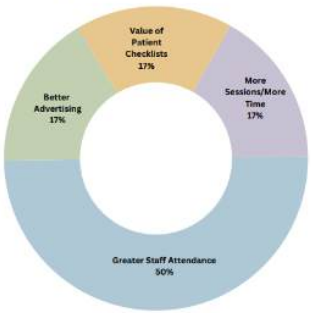
What did you enjoy about the session?



What other topics would you like to see regarding patient safety and incidents?



How could the session be improved?



Appendix 4 – M&M outcomes summary April/May 2025

Appendix 5 – Visual Inquiry Images

6. Choose an image that best portrays how being part of the learning event/workshop/training made YOU feel? *

◯ Option 2

◯ Option 3

◯ Option 4

◯ Option 1

◯ Option 5

◯ Option 6

◯ Option 7

◯ Option 8

Report Title: Transforming Patient Safety: A One-Year Review of PSIRF Implementation

Author: Anna O'Neill – Head of Patient Safety and Learning

Date: April 2025

Executive Summary

The implementation of the Patient Safety Incident Response Framework (PSIRF) at Milton Keynes University Hospital (MKUH) has driven a significant cultural shift towards openness, shared learning, systems thinking, and patient-centred care.

Key achievements include:

- A 48% increase in incident reporting, particularly in low- and no-harm categories, indicating growing psychological safety and staff confidence.
- 29% faster incident completion and closure times, enabling more timely and proportionate learning.
- Broader staff engagement, with increased diversity in both the types of incidents reported and the roles involved in reporting.
- Clear leadership commitment through daily Multidisciplinary Team (MDT) triage panels, local huddles, and widespread participation in learning events.
- Embedding of SEIPS systems thinking into incident reviews, moving away from individual blame.
- Involvement of patients and families in learning processes, reflecting a deepening culture of transparency and compassion.

There have been some specific challenges, all of which have been felt most acutely within maternity services:

- Reconciliation of the PSIRF approach with other processes which previously had an interface with clinical risk and root cause analysis, for example coronial and litigation processes.
- Simultaneous management of external processes and expectations (for example, investigations led by MNSI or regional quality assurance systems for screening programmes within NHS England).
- Difficulties in providing a timely response in respect of a reported incident, particularly where more information (level 4) is required or a multi-professional learning event is needed.

To sustain and build upon the positive momentum, whilst tackling the specific challenges, the following recommendations are proposed:

- Continued support and capacity-building to embed and expand cultural change across the Trust, including within the patient safety team.

- Training and coaching for staff to lead hot debriefs and learning events at ward level, enhancing the timeliness of learning.
- Appointment of a dedicated Patient Safety and Learning Lead for Maternity and Gynaecology to strengthen safety processes in the department (23 month fixed term).
- Review of the various processes engaged when a patient's care is considered by HM Coroner, and how these interface with one another (PSIRF, Medical Examiner, SJR, Clinical Governance, Complaints, Litigation).
- Review of patient safety priorities through a refreshed PSIRF plan in Autumn 2025 (18 months post-transition) to identify new focus areas.
- Ensuring safety actions are SMART, with support from the Quality Improvement (QI) team to evidence sustainable system change.
- Innovative learning approaches, including launching the Trust's first patient safety podcast to spotlight key topics and share insights through guest speakers.

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1. Introduction

1.1 *Background and Context*

The PSIRF is a strategic approach introduced by NHS England to improve the way healthcare organisations respond to patient safety incidents. It was introduced Trust wide at MKUH on 01 May 2024 following an 11-month pilot period in a selection of wards/departments. Its purpose is to create a more responsive, learning-focused environment that prioritises patient safety and continuous improvement. PSIRF emphasises the following key goals:

1. **Improved Incident Response**: It aims to provide a more flexible and tailored approach, ensuring that the response to incidents is proportionate.
2. **Learning from Incidents**: The framework encourages organisations to identify the systemic causes of incidents, promote a culture of openness, and actively learn from mistakes to prevent recurrence.
3. **Enhanced Patient Safety Culture**: PSIRF focuses on building a culture where staff are supported in reporting incidents and encouraged to engage in continuous safety improvements without fear of blame.
4. **Collaboration and Transparency**: It advocates for open communication with patients, families, and staff about incidents, improving transparency and trust in the safety processes.
5. **Systematic Improvement**: PSIRF aims to create a continuous cycle of safety improvement by ensuring that lessons learned from incidents lead to actionable changes in practice and policy.

The purpose of this report is to provide a review of the implementation of PSIRF in terms of key findings, challenges, achievements, and recommendations for the upcoming year.

1.2 *Objectives of the Review*

- **Assess the Implementation**: Evaluate how effectively the PSIRF framework has been introduced to MKUH and whether the key goals of PSIRF have been achieved.

- **Identify Successes and Challenges**: Highlight key areas of success and the challenges faced during the first year.
- **Provide Recommendations**: Offer actionable recommendations for the continued and improved implementation of PSIRF at MKUH.

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2. Data Collection and Review Process

The review period includes data across three 11-month time periods to allow for comparison between:

- *Pre-PSIRF*: 1 July 2022 – 1 June 2023
- *During PSIRF Implementation*: 1 June 2023 – 1 May 2024
- *Post-PSIRF*: 1 May 2024 – 1 April 2025

Data sources include the Radar incident reporting system (pre-and post-PSIRF), feedback forms (learning events, forums) and the PSIRF 6-month review (Appendix 1). Please note a 12-month celebration/review is planned for May 2025 and a summary of this will be provided in addition to this report.

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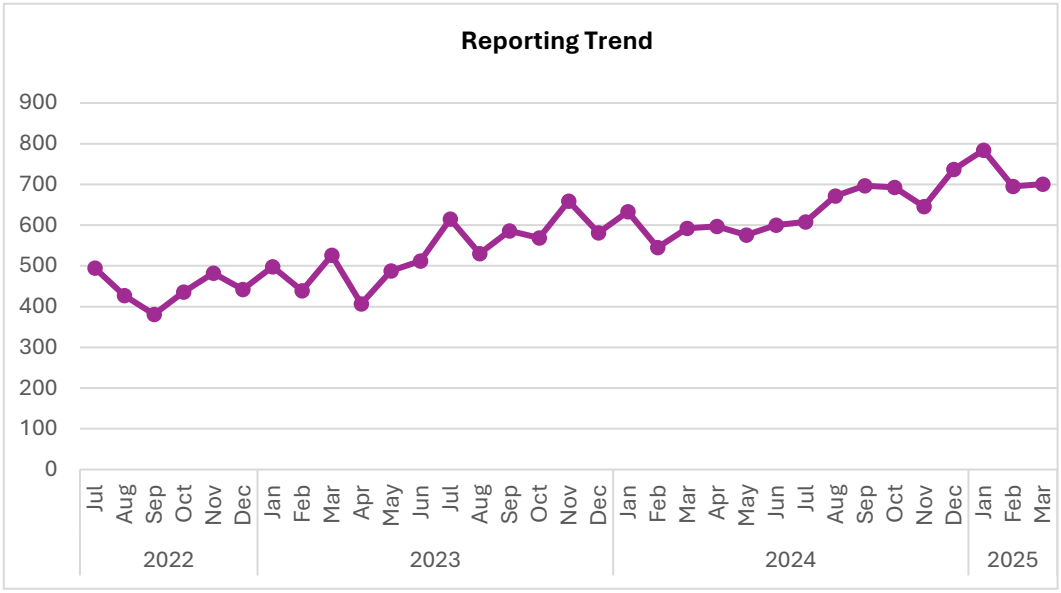
3. Key Findings

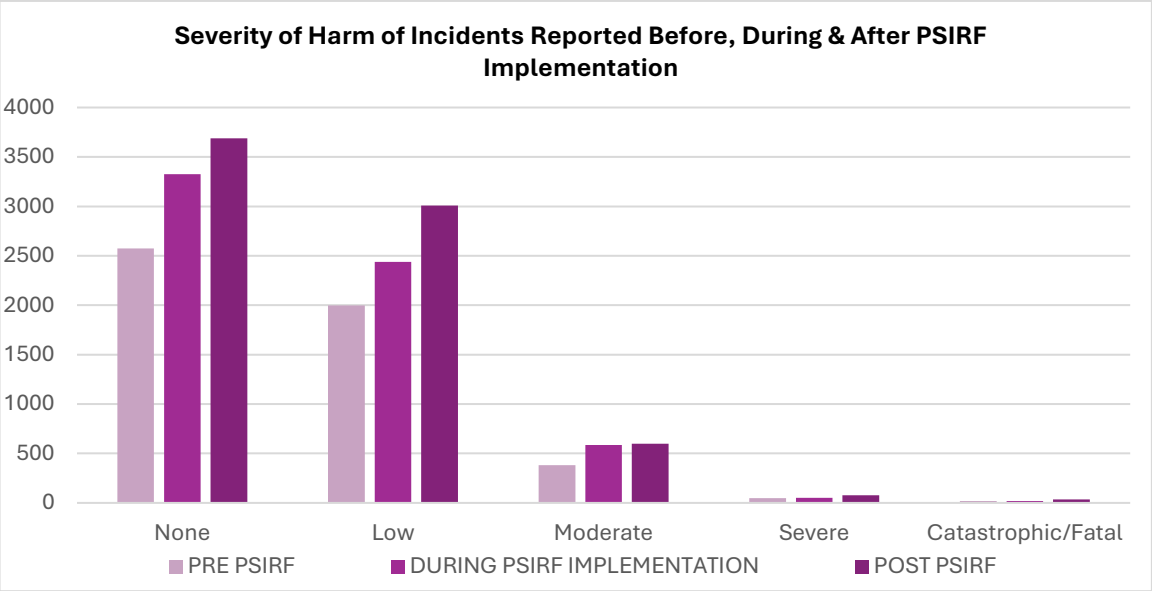
3.1 Progress achieved

- *Incident Reporting Trends*

The overall number of incident reports has increased by 48%, indicating a growing culture of transparency and learning.



There has been a significant increase in the reporting of low- and no-harm incidents, with 2154 additional cases recorded. Meanwhile, the proportion of severe incidents has remained stable at approximately 1%, and catastrophic incidents remain at <1%.
This trend is positive as it reflects an improved awareness and willingness to report less severe incidents, fostering a proactive approach to patient safety.

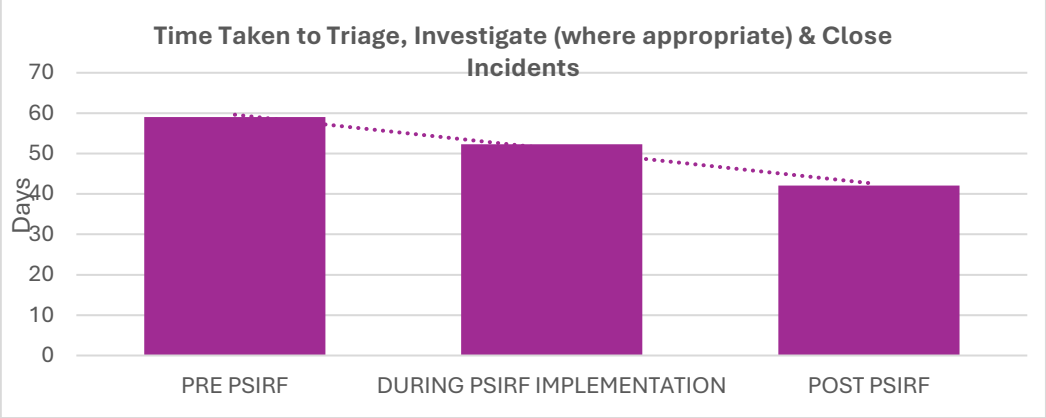


The implementation of PSIRF has led to a broader and more representative range of reported incidents. Before PSIRF, the top 10 categories accounted for 74% of all reported incidents, Since PSIRF, this has reduced to 69%, reflecting a shift towards more diverse reporting. A similar picture is evident in subcategories reporting with the top 10 subcategories representing 45% of the data rather than 54%. This suggests that staff feel more encouraged and empowered to report a wider spectrum of incidents, leading to a deeper understanding of patient safety challenges. The chart below compares the top 10 subcategories pre and post PSIRF:

Subcategory	Pre-PSIRF	Post-PSIRF
Medication	✓	✓
Insufficient Staffing	✓	✓
Other Injury	✓	✓
Lost Balance	✓	
Communication Failure	✓	✓
Individualised Patient Care Not Provided	✓	
Fall from Chair	✓	
Discharge Inappropriate	✓	✓
Breach of Confidentiality - Inappropriate Access	✓	
Care Failure - Sub Optimal Care		✓
Care Delay - Sub Optimal Care		✓
Fall on Level Ground		✓
Non Adherence to Trust Policy - Clinical		✓

- *Timeliness of Response*

  The implementation of PSIRF has significantly improved the efficiency of incident completion and closure. Before PSIRF, the average time to complete a review and close an incident was 59 days, which has now reduced to 42 days - a 29% decrease (see graph below).



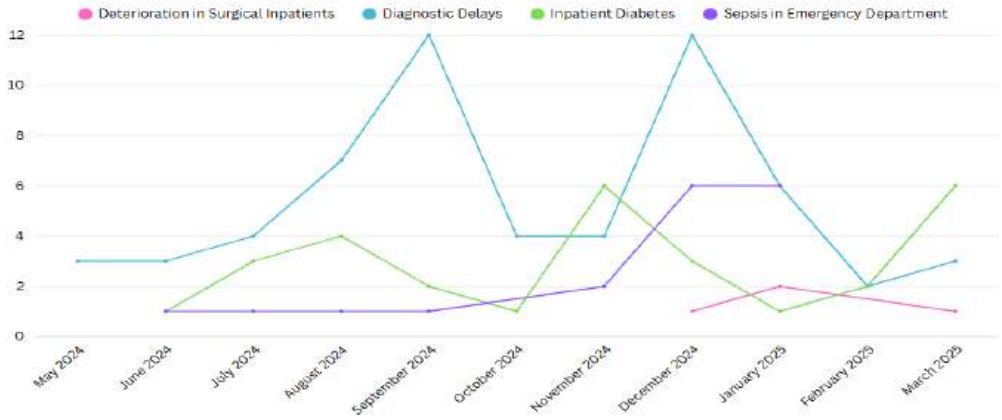
This reduction allows for quicker learning and action, enabling patient safety measures to be implemented more promptly. It also supports greater staff engagement, as incidents are addressed more efficiently, fostering transparency and trust in the reporting process. Additionally, shorter completion and closure times improve operational efficiency, reducing administrative workload and supporting more proactive risk management. These changes reflect a shift towards a more responsive and learning-focused safety culture.

- *Trust Patient Safety Priorities*

Prior to the transition to PSIRF, the patient safety incident response plan was developed and approved in October 2023 including the identification of 4 patient safety priorities. Each patient safety priority was identified using analysis and themes from 25 data sources between 2021-2023. The 4 priorities are (see Appendix 2 for further details including the rationale):

- Sepsis in the Emergency Department
- Surgical Inpatients (delay, or failure, to recognise the deteriorating surgical patient)
- Diagnostic Delays
- Inpatient Diabetes

Since May 2024, there have been 114 incidents related to the priorities with the majority (47%) occurring within the 'diagnostic delays' category. The chart below shows the number of incidents reported per month.



48% were allocated a level 1 (full PSII investigation) or a level 2 learning event which resulted in 36 separate learning opportunities to explore the contributory factors and help redesign our systems and processes reacting to our safety priority areas. Key learning themes include:

Patient-Centered Care:

- Patients are considered experts of their own disease and should be respected and listened to.
- Clear communication and involvement of patients and families in care decisions are crucial for maintaining trust and ensuring effective treatment.

Communication and Coordination:

- Timely, clear, and consistent communication between medical, nursing, and specialty teams is essential for patient safety.
- Effective communication tools (e.g., SBAR) and shared responsibility for escalation are necessary for good care.
- Improved dialogue, handovers, and documentation are required to ensure the seamless transfer and management of patients.

Workforce and Resource Management:

- Adequate staffing and skilled workforce are necessary to manage patient deterioration effectively, especially during high-demand periods.
- The impact of burnout on staff morale and patient care must be addressed, with attention to mental health support and resource allocation.
- Training, upskilling, and adequate resourcing of biomedical scientists and consultants are needed to improve workflows and reduce reliance on consultants.

Systemic and Structural Improvements:

- Improvements in digital systems (e.g., integration of patient tracking lists and appointment booking) are needed to reduce errors and enhance efficiency.
- There is need for standardised referral processes, triage timeframes, and governance surrounding the booking and scheduling systems to improve patient flow and reduce delays.
- Review of physical space, storage, and the layout of care environments to minimise unnecessary patient moves, especially for septic patients.

Clinical and Operational Processes:

- Clear clinical pathways and protocols, such as sepsis management and NEWS scoring, are vital for timely and effective care.
- There should be continuous monitoring and escalation of concerns based on clinical history, vital signs, and patient condition.
- Regular and thorough documentation is necessary to track patient status, manage referrals, and ensure that appropriate treatments are administered.

Training and Governance:

- Proper resourcing and structured training are necessary to maintain high standards in training, auditing, and laboratory operations.
- Clear governance around roles and responsibilities, including those of Patient Pathway Coordinators, is necessary for streamlined processes and accountability.

Patient Safety and Quality of Care:

- There should be a high index of suspicion for complex cases, particularly among vulnerable populations (e.g., elderly, immunocompromised).

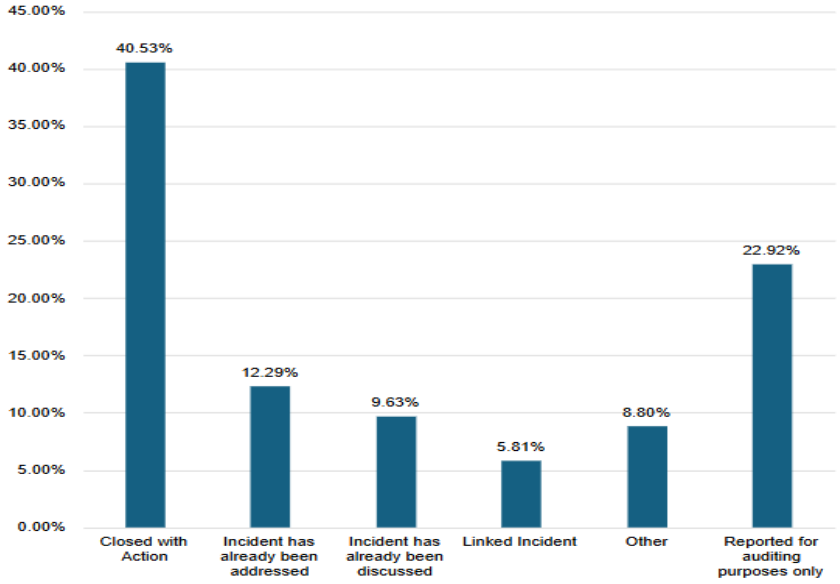
- Consistent use of clinical protocols and critical safety checks are vital to prevent errors, especially in high-risk areas like medication safety, referral delays, and escalation protocols.

- *Emerging Themes*

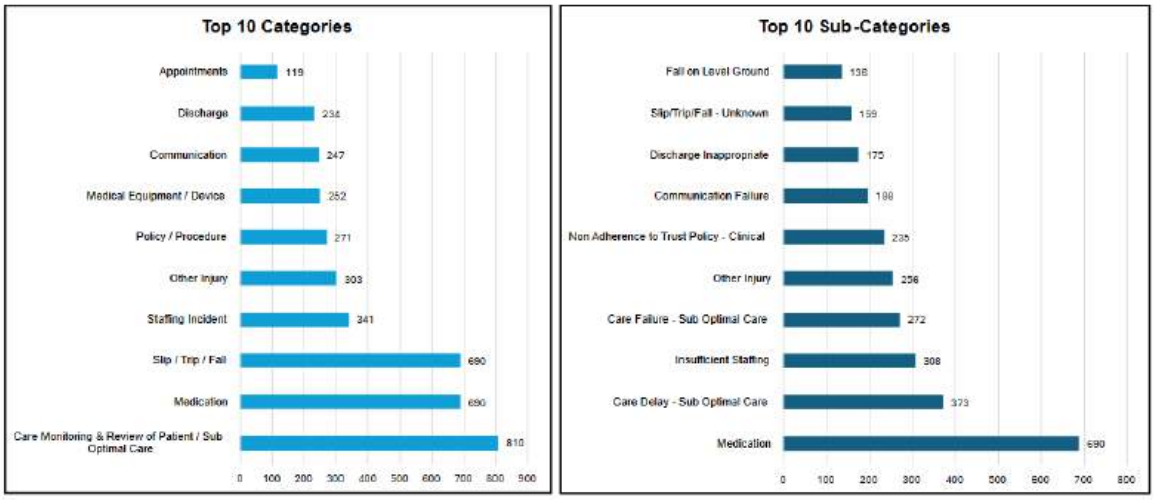
Over the past year, since the launch of PSIRF, other safety themes have emerged which have prompted action. See table below for details:

Category	**Action taken / next steps**
Management of Dysphagia in Adults	Registered QI project 18.12.2024
Capacity in Obstetric Ultrasound	Registered QI project 28.11.2024
Discharge Medications	Registered QI projects (April 2024) (3 QIPs identified to address the 3 key workstreams (prescribing, dispensing, administration). To be linked to ongoing discharge summary QIP.
Management of Controlled Drugs (CDs)	A benchmarking exercise and gap analysis of regulatory responsibilities and clinical management of opioids is being finalised, with recommendations for the Prescribing & Medicines Governance Committee. The medication safety team is prioritising training and CD audits, with ward-based audits to be rolled out soon.
Emergency Department (ED) – poor patient experience, care delays, poor staff experience leading to incivility, delays in documentation of speciality reviews impacting patient flow, violence and aggression towards staff.	• Escalated to triumvirate • MDT Level 2 learning event completed January 2025 re: documentation delays. Awaiting actions to be agreed. • ED and SCAS (South Central Ambulance Service) regular meeting for sharing incident themes • Plenary session held in Feb 2025 on incivility • Sepsis observation work and tabletop exercise completed Jan 2025 to support sepsis QIP and care delays
Use of Checklists for Invasive Procedures (LocSSIPs) including consent and Positive Patient Identification (PPID)	QI project being scoped

Recent analysis of the 5449 incidents which have been closed at the point of initial or local huddle (triage) has also highlighted themes, some of which are part of ongoing work and some which may inform future areas of learning focus and improvement. It is reassuring to know that we are not missing anything through these closures and where needed, can take a proactive approach to preventing future incidents. The reasons for closure are shown in the chart below:



The top 10 categories and subcategories of incidents closed are shown in the charts below.



Within the medication subcategory, the most common medication types were controlled drugs and discharge medications both of which are already part of ongoing work.

The care delay and care failure subcategories cover a broad variety of incidents. This has promoted the creation of an MDT working group to review the subcategories within the 'care monitoring and review of patient/ suboptimal care' category to support analysis and identification of actionable themes.

The reporting of insufficient staffing is being encouraged for auditing purposes and are closed at initial triage with the approval of the senior nursing team and evidence that appropriate escalation and mitigation have occurred.

'Other injury' is a common and somewhat unhelpful sub-category. On closer inspection these are predominantly skin tears and minor skin injuries, such as abrasions. Skin tear has now been added as a subcategory.

- *Sharing Learning*

The **M&M outcome form** was introduced in May 2024. This simple Microsoft form encourages M&M groups to identify examples of care excellence, key learning and potential quality

improvement (QI)/audit opportunities. Any QI or audit opportunities are shared with the QI team to be taken forwards. Since May 2024, 55 M&M outcomes forms have been submitted across specialities in both medicine and surgery, identifying 20 QI/audit ideas, 48 examples of excellence and 53 learning points. Monthly summary posters (Appendix 3 for an example) are developed and shared in various forums for Trust wide learning. Themes include:

Care Excellence (What we're doing well)

- Timely antibiotic administration for patients with sepsis in the ED and acute medicine
- Clear communication with families
- Early escalation planning and palliative care involvement
- Good documentation of clinical and family discussions
- Appropriate MDT involvement in complex cases

Learning Points

- Earlier recognition and management of sepsis for inpatients
- Clearer documentation and discussion of ceilings of care
- Reducing delays in investigations and referrals
- Improved clinical documentation, particularly during handovers and discharge
- Better discharge planning and booking of follow-up appointments
- Safer transitions of care between specialties and wards
- Timely reassessment and appropriate escalation for deteriorating patients
- Encouraging thorough face-to-face clinical examination and reassessment
- Consistent use of national clinical guidelines and tools
- Strategic planning for complex or end-of-life care patients

Since May 2024 the Patient Safety Team have posted 82 patient safety learning points in the **Spotlight on Safety (SOS)** section of the weekly #TeamMKUH Round Up newsletter. Since December 2024 these articles have also been shared on the Patient Safety Hub, an MS Teams group that includes all MKUH Trust ward managers, matrons and a selection of clinical and governance leads. Key themes include (for further information see Appendix 4):

The new monthly **patient safety learning forums** offer drop-in face-to-face sessions for staff to come and hear about patient safety themes, share their experiences and learn from topic experts. The topics chosen for each forum is based on current safety themes, Trust safety priorities and recent learning from PSIIs. The plan from April 2025 is to triangulate intelligence and learning from other sources including complaints, litigation, inquests and safeguarding. Topics covered so far include inpatient diabetes (Trust safety priority), point of care testing (PSII 2024) and sepsis and antimicrobials. See Appendix 5 for an example summary. Upcoming forums will focus on:

- Right Patient, Right Care: Mastering ID & Safety Checklists - May
- The Power of Now: Immediate Learning with Hot Debrief Tools - June
- Mastering Surgical Care for Medically Complex Patients - July

- *Safety Actions and Systemic Learning*

Since May 2024, 363 actions have been generated and added to Radar as a result of a patient safety incident. A weekly meeting is held with the patient safety and QI team to cross reference these actions with existing action plans linked to audits, QI projects and GIRFT (Get It Right First Time). So far 60% of actions have been completed with a further 143 in progress or planned. 16% are overdue and are being monitored through CIG meetings.

With the new systems approach to exploring why incidents occur and the addition of the Systems Engineering Initiative for Patient Safety (SEIPS) framework in Radar, it has been possible to identify which systems factors are contributing to our incidents. Not only does this shifts attention from individual blame to understanding our systems and processes, it will also enable us to proactively identify and fix weak points within our system that we know are a risk. The word cloud below shows the systems factors identified from incidents since May 2024:

Data so far has highlighted that Information flows & methods' is the largest contributing factor; themes include the documentation of care handovers and escalation, IT system interactions both within MKUH and across the region and ambiguous processes for the transfer of patients and patient information between departments.

- *Staff Awareness and Engagement*:

In preparation for PSIRF, 282 staff members (75% of staff who were originally nominated as having patient safety responsibility within their role) attended the full day of face-to-face **training** (sessions A and B) with MDT representation from all 4 divisions – surgery, medicine, core clinical and women and children's. Feedback showed that over 92% attendees thought the course had improved their confidence in managing patient safety incidents (Appendix 6 for a full summary of PSIRF training).

The full day course continues to run face- to-face every quarter to enable new starters and those in new roles to access the training. The plan is to offer the course content in bitesize eLearning modules with the option of accessing drop-in practical workshops.

A wider range of healthcare professionals are now engaged in incident **reporting.** Before PSIRF, the top 10 reporters contributed 11% of all reports. Post-PSIRF, this figure has decreased to 8%, indicating a more evenly distributed reporting culture across individuals and teams.

Since May 2024, 365 members of staff have **attended a learning event**, such as an MDT, after action review or tabletop exercise. Prior to PSIRF this data wasn't captured as learning events weren't held. In the previous serious incident framework, 72-hour reports and root cause analysis (RCAs) were generally completed by an individual with minimal input from those directly involved with the patient at the time of the incident.

Learning event feedback forms have been developed with a variety of feedback methods including satisfaction scales and open questions. These are to collate initial feedback from staff following a learning event and then 3 months post learning event. So far staff completing the initial feedback form have rated learning events as either 'good' or 'excellent' and images chosen to describe how the learning events felt for them include:



Below are some quotes from staff explaining why these images were chosen and what they felt was good about the session:

"It's like helping everyone and supporting each other"

"The ladder symbolises growth, progress, and a step-by-step journey in learning. It somehow reflects how the event helped me advance my knowledge and skills in diabetes care, moving toward a higher level of understanding and competence."

"Steps to take to make a difference to practice"

"Everyone was given the opportunity to speak without prejudice and we were encouraged to speak freely. It was a relaxed and informative session"

"A safe space and not a blame game"

"Session was really proactive towards change, encouraged new ideas and opened my eye to reality, acknowledging that we do not work in a perfect world but can do simple things to improve"

"It worked well as we were able to talk about things openly and honestly and came out with some useful actions"

"I felt safe discussing how I felt"

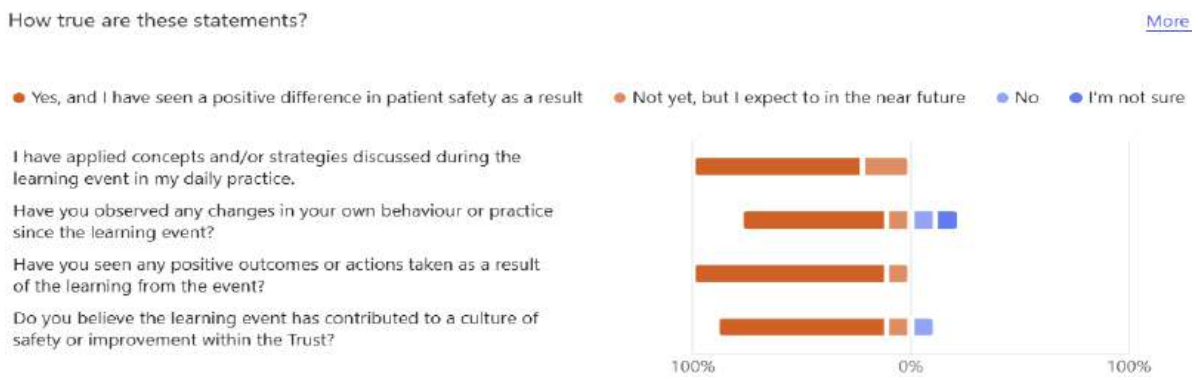
"I felt listened to"

The 3-month review has been developed to evaluate the impact of learning events. Questions have been designed to explore how people are feeling about the incident 3-months on, whether any positive change has occurred, both personally and in terms of safety culture within their area and whether any safety actions have been completed. Below are some examples of feedback gained so far:

"I am pleased that this was reported and that actions identified at the learning event and taken since appear to have reduced similar incidents."

"While it was a difficult incident and caused a lot of reflection, I am much more comfortable with my actions and reassured once I heard the experiences and opinions of my colleagues."

"It's a learning experience; I am now always on the lookout on how to avoid such circumstances and it has helped me to guide my juniors."



One of the core principles of PSIRF is the **engagement and involvement of patients and families** in patient safety investigations and learning. Since PSIRF was introduced, engagement leads have been allocated for each investigation to ensure that a compassionate and patient /family led approach is used. Incorporating patient stories at the heart of a patient safety investigation has shown to humanise the process and ensure that the real impact on individuals is understood. These stories have provided invaluable insights into the emotional, physical, and psychological experiences of patients, helping to highlight gaps in care and areas for improvement. For patients, knowing their experiences are being heard has been both empowering and validating, as it shows their voices matter in shaping the safety and quality of care at MKUH. Feedback has shown that it has helped to foster trust and transparency, giving patients a sense that their concerns have been taken seriously and contributed to positive change.

The daily MDT triage panel provides a mechanism for continuous **oversight,** enables the early identification of patient safety concerns, and supports the development of a culture of learning and improvement throughout the Trust. Benefits include:

Centralised Review:
The daily panel ensures that all patient safety incidents are consistently reviewed by a team of diverse healthcare professionals, allowing for better coordination, prioritisation, and action on issues that may otherwise go unnoticed in individual departments.

Enhanced Communication:
Bringing together different disciplines improves communication across teams. This fosters a shared understanding of incidents and enables a collaborative approach to problem-solving.

Early Identification of Trends:
With daily reviews, patterns and recurring issues can be quickly identified, supporting a more proactive approach to addressing systemic issues before they escalate.

Improved Patient Safety Culture:
Regular, timely and structured review of incidents demonstrates a commitment and provides assurance to patient safety to those reporting incidents.

Systemic Learning:
The MDT panel provides a structured space for reflection and learning on each incident. Themes that emerge are shared via SOS and help to inform improvement initiatives and learning opportunities.

A daily summary of the triage meeting is shared with the executive group and other key stakeholders. This summary provides details of incidents numbers, incidents graded as moderate harm or above, noteworthy cases and any emerging themes or significant safety issues. The decision of what to escalate in the summary is agreed by the panel each day.

The local safety huddles (local triage groups) that run regularly within each division or CSU provide effective oversight of patient safety issues by promoting local ownership, linking incidents to the risk assessment process, and ensuring a comprehensive understanding of safety concerns from multiple perspectives.

3.2 Challenges Encountered

The introduction of PSIRF has been challenging due to the cultural shift from blame to learning, resource constraints like staffing and training, and the complexity of integrating PSIRF with existing systems. Additionally, there is significant crossover with other regulatory and assurance processes, which can create confusion, duplication of effort, and resistance to change. There has been some understandable hesitation in adopting the PSIRF approach, as it represents a significant shift from established practices.

Whilst there has been positive collaboration with teams such as safeguarding and paediatrics, other teams are still adjusting to the new mindset and processes, and aligning this framework with existing systems and responsibilities continues to be a work in progress. A new **maternity and gynaecology** patient safety and learning lead has been recruited to support PSIRF delivery and learning in maternity and gynaecology. A full process mapping exercise is planned to capture all existing incident review processes within maternity, with the intention to redesign for better alignment and efficiency. This will include dedicated workflows on Radar.

Securing **QI leads and sponsors** for projects has proven difficult, often due to competing priorities and limited capacity. Evidencing tangible improvement following incident responses remains a complex task, particularly when outcomes are not immediately measurable.

Balancing the needs of staff support and meaningful learning with the statutory requirements and timelines of the coroner—especially in the context of **inquests**—adds an additional layer of complexity. A process is being developed that ensures both processes can work in parallel.

Aligning the **complaints** process with PSIRF has also been a challenge, with overlaps and gaps in responsibilities that can hinder a cohesive response. In collaboration with the complaints team, a co-designed process has been developed to ensure complaints are triaged and managed via the most suitable and proportionate route. This includes discussing some complaints at the daily triage meeting and agreeing the most suitable route for learning and meeting the needs of the complainant.

Whilst it is important to note that there are no national KPIs for PSIRF other than guidance that PSIIs should be completed within 3-6 months, there remains a number of incidents with overdue Radar workflows. This is based on locally agreed KPIs which were introduced to provide assurance that progress is being made and learning and action occurs within a timely manner. Having been approved and added to the Radar workflows in November 2024, the number of incidents with overdue workflows is monitored daily and discussed weekly at PSIRG. The two workflows contributing to the largest number of overdue incidents are the rapid reviews (level 4 more information) and the local safety huddles (local triage). Specific causes of these delays have been identified and there is ongoing work to address these and support divisions.

Finally, the logistics of enabling staff to attend **learning events**, while managing ongoing clinical demands, continue to pose a significant barrier to embedding PSIRF effectively into routine practice. Debrief training will be rolled out, and staff will be coached and supported to run their own learning events, promoting a more sustainable, locally owned approach to learning.

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4. Summary

This report highlights how PSIRF has driven a positive shift in safety culture at MKUH, fostering openness, shared learning, systems thinking, and patient-centred care. A 48% increase in incident reporting, especially in low- and no-harm categories, indicates that staff feel safe and confident in contributing to learning and improving patient safety. The growing diversity in incident types and reporting roles reflects broader engagement and shared responsibility for safety, while a 29% faster incident review completion and closure time highlights a focus on proportionate, timely learning and action. The daily MDT triage panel and local huddles demonstrate leadership commitment to embedding PSIRF principles. With 365 staff attending learning events and new methods of sharing learning, the culture of continuous improvement is strengthened. Embedding SEIPS into incident reviews marks a shift from individual blame to systems thinking, and the inclusion of patients and families in the learning process signifies a cultural shift towards transparency, partnership, and compassion.

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5. Recommendations for the coming year

To continue building on the progress achieved in the first year of PSIRF implementation, the following recommendations have been made:

- **Sustain Organisational Commitment**: Maintain momentum through continued leadership support, capacity-building, and collaboration with key stakeholders. This includes future proofing the patient safety team through national training programmes and identification of additional patient safety specialists.
- **Empower Local Learning**: Provide targeted training and coaching to enable staff to independently lead hot debriefs and other learning activities within their own wards and departments. This will enhance the timeliness and relevance of learning responses.
- **Enhance Departmental Integration**: Undertake process mapping and ensure alignment of regulatory and safety frameworks within specialist areas, including maternity, legal, infection control, and complaints, to support cohesive and effective incident response. This includes the appointment of a dedicated Patient Safety and Learning Lead for Maternity and Gynaecology to enhance safety oversight and learning processes within the maternity department.
- **Review and Refresh Safety Priorities**: Conduct a strategic review of the PSIRF plan in Autumn 2025 (18 months post-implementation) to assess current patient safety priorities and identify new areas of focus based on emerging insights and trends.

- **Ensure Measurable Safety Improvements**: Embed the use of SMART (Specific, Measurable, Achievable, Relevant, Time-bound) safety actions. Collaborate with the QI team to help clinical teams demonstrate and evidence meaningful system change following QI initiatives.
- **Innovate Learning and Communication**: Continue to explore creative and engaging methods for sharing learning across the organisation. Planned initiatives include the launch of the Trust's first **patient safety podcast**, featuring key safety themes and guest speakers to further promote a positive safety culture.

Appendix 1 – PSIRF 6-month review

Appendix 2 – Trust patient Safety Priorities

Area of focus	Description	Rationale (based on data 2021-2023)
Sepsis in the Emergency Department	Delay, or failure, to recognise and manage any adult patient presenting to the Emergency Department with signs of sepsis.	Increase in number of sepsis related incidents. Recommendations from coronial processes. Failure to recognise sepsis features in the top 3 claims. Sepsis features commonly and increasingly in the thematic learning from the serious incident review group (SIRG). ED triage and streaming feature high on the risk register for medicine.
Surgical Inpatients	Delay, or failure, to recognise the deteriorating surgical patient resulting in: • Change of lead speciality team • Unexpected further surgery • Unplanned admission to ICU • Death Adult patients under surgical specialities or inpatients on wards 20, 21, 23 or 24.	Patients reported not being heard when sharing concerns. Increase in incidents relating to deteriorating clinical condition for surgical patients. In the last 2 years, sub optimal care for deteriorating patients has featured highly in the most commonly occurring serious incidents. Conversations with staff and patients have highlighted care concerns for those residing on surgical wards. Feedback from coronial processes have highlighted the need to review escalation processes, and support of junior colleagues when caring for deteriorating patients in surgical areas. Recognising, and escalation of, deteriorating patients and the contributing human factors feature commonly in the thematic learning from SIRG. Common issues from claims include 'care below standards', 'inadequate assessments' and 'supervision of colleagues' which all contribute to our ability to recognise and care for deteriorating patients.
Diagnostic Delays	Incidents relating to diagnosis, specifically delay or failure to follow up on abnormal scan/test results resulting in: • Unexpected progression or worsening of disease • Delay in surgical intervention Need for additional tests or procedures.	Delays in imaging reporting for patients with cancer features highly on the risk register for the core clinical division. The core clinical risk register features 'Demand and access to MRI/CT scans' as a high-risk area. A top theme from patient complaints includes 'fast access to scans' and 'delayed treatment in surgery'. Delayed diagnostics and screening incidents feature in the top 10 of serious incidents in the last 2 years. Across all incidents delayed appointments and follow ups with results features in the top 10. Common thematic learning from the serious incident review group includes timely review of test results. The number one reason for a claim against MKUH is delay in diagnosis. Treatment delay is a common issue across all claims against MKUH.

Inpatient Diabetes	Incidents relating to the prescribing and administration of insulin resulting in a patient's blood glucose of >20 mmol/l (on two consecutive readings) or < 4 mmol/l. Adult patient under acute medical care (ED, Ward 1, 2)	Drug incidents relating to insulin feature in the top 10 serious incidents. Increase number of insulin related incidents, Diabetic Ketoacidosis (DKA) and the management of hypoglycaemia reviewed at the serious incident review group. Thematic learning from the serious incident review group has frequently featured checking and administration of high-risk medications. The surgical risk register features the need for more support with diabetes care during pre-assessment.

Appendix 3 – M&M Outcomes Summary (example)

KEY LEARNING

SPECIALIST SENIOR INVOLVEMENT:
ENSURE SPECIALIST CONSULTANTS, SUCH AS UROLOGISTS AND NEUROLOGISTS ARE INVOLVED IN MDT HANDOVERS & ESCALATIONS OF CARE, PARTICULARLY AROUND PROGNOSIS, DNACPR & CEILING OF CARE. ENSURE THESE DISCUSSIONS ARE SHARED WITH THE PATIENT/FAMILY & CLEARLY DOCUMENTED.

PERFORATION MANAGEMENT:
PROMPTLY RECOGNISE & MANAGE BLADDER PERFORATIONS DURING TURBT (TRANS URETHRAL RESECTION OF BLADDER TUMOUR), WITH CAREFUL MONITORING FOR COMPLICATIONS.

TIMELY REFERRALS & ESCALATION:
USE DIRECT CONTACT (BLEEP) FOR EMERGENCY REFERRALS, NOT ONLINE REFERRALS.
IF THE NEXT TIER OF ESCALTION HAS FAILED (E.G. REGISTRAR UNAVAILABLE), CONTACT THE ONCALL CONSULTANT FOR ADVICE.

SEPSIS MANAGEMENT IN VULNERABLE PATIENTS:
CONSIDER COLD SEPSIS AS A DIFFERENTIAL DIAGNOSIS IN ACUTELY UNWELL PATIENTS, EVEN IN THE ABSENCE OF FEVER. MAINTAIN A HIGH INDEX OF SUSPICION, PARTICULARLY IN ELDERLY OR IMMUNOCOMPROMISED PATIENTS. ENSURE CLEAR DOCUMENTATION OF CARE PLANS & INVOLVE FAMILIES IN DISCUSSIONS FOR FRAIL ELDERLY PATIENTS WITH SEPSIS.

JOINT INJURY ASSESSMENT & REFERRALS:
ALWAYS EXAMINE & DOCUMENT THE JOINTS ABOVE & BELOW THE SITE OF INJURY. IN CASES WHERE KNEE INJURIES CANNOT BE FULLY ASSESSED DUE TO PAIN OR SWELLING, ENSURE REFERRAL TO THE VIRTUAL FRACTURE CLINIC (VFC) FOR FURTHER EVALUATION TO RULE OUT LIGAMENTOUS INJURIES. ENSURE VFC REFERRALS ARE MADE BEFORE THE PATIENT LEAVES THE DEPARTMENT & ENSURE THE VFC SLIP IS HANDED TO THE PATIENT / PARENT.

PAEDIATRIC DISCHARGE PROCESS:
PATIENTS UNDER 1 YEAR MUST BE DISCUSSED WITH THE PAEDIATRIC REGISTRAR OR EPIC BEFORE DISCHARGE AS PER THE CHILDRENS ED POLICY.

VON WILLEBRAND DISEASE (VWD):
PATIENTS WITH VWD PRESENTING TO ED WITH BLEEDING AND/OR TRAUMA (EVEN MINOR) SHOULD BE DISCUSSED WITH HAEMATOLOGY OR THEIR RESPECTIVE SPECIALIST CENTRE. MANAGEMENT MUST FOLLOW THE RECOMMENDED PATHWAY.

VENOUS THROMBOEMBOLISM (VTE) PROPHYLAXIS:
LOWER LIMB IMMOBILISATION REQUIRES PROPHYLACTIC DALTEPARIN, WHEREAS A PATIENT WITH SUSPECTED DVT SHOULD BE PRESCRIBED TREATMENT-DOSE DALTEPARIN.

RADIOLOGY PATIENT SAFETY:
ENSURE PATIENT SAFETY ASSESSMENTS ARE COMPLETED BEFORE TRANSFERRING CONFUSED PATIENTS FOR IMAGING. ASSESS THE NEED FOR AN ESCORT BEFORE LEAVING THE ED.

SAFEGUARDING & MENTAL CAPACITY:
ASSESS MENTAL CAPACITY IN VULNERABLE POPULATIONS & ENSURE SAFEGUARDING PROTOCOLS ARE FOLLOWED & STAFF ARE AWARE OF THESE, ESPECIALLY FOR SELF-DISCHARGE SITUATIONS AND WHEN OUTSIDE REGULAR WORKING HOURS (OOH).

TESTICULAR TORSION:
RECOGNISE SYMPTOMS EARLY & USE TWIST SCORE & ULTRASOUND FOR PROPER DIAGNOSIS & TREATMENT

M&M OUTCOME FORM

Appendix 4 – SOS message themes

Communication and Handover Safety
- Effective Communication and Consent
- Closed-loop communication (e.g. SBAR, NEWS2, CUS)
- Radar Reporting and Updating
- Copying and Pasting in Notes – risk of omitting critical information
- Speaking Up and Graded Assertiveness
- Confidential Conversations and Overheard Risks
- Human Factors Training

Medication Safety
- CD Drugs Handling
- Dossett Box Accuracy (Virtual Ward Risk)
- Missed TTO Pharmacy Validation
- Medication Visibility on eCare
- Tranquilisation Policy
- MAR Charts

Clinical Procedures and Equipment Safety
- Routine Catheter Care
- NG Tube CXR Guidance
- Sepsis Management
- VTE Prophylaxis
- Insulin Pen Usage
- Neuro Observations and Glasgow Coma Scale
- Slide Sheets and Patient Transfers (Mortuary, HDU)
- Blood Bottle Labelling
- Old Medication Patch Removal

Documentation Accuracy
- Discharge Summaries and TTOs
- DNACPR Status Documentation
- "If You've Taken the Time to Care, Take the Time to Document"

Patient Identification and Consent
- Positive Patient ID (PPID)
- Stop, Check, and Protect
- MRI Referrals – Proxy Consent Forms
- Correct Weight on eCare

Governance, Policy, and Incident Reporting
- Duty of Candour and New Template Letters
- IG Breaches
- Incident Reporting Culture
- Falls Prevention and DoLS Assessments

Escalation and Deterioration Recognition
- NEWS2 and Deteriorating Patient Protocols
- Timely Escalation (Escalation NEWS2, SBAR, CUS)
- Code Victor Policy

Training, Forums, and Communication Channels
- PSIRF Training and Forum Updates
- Advertising the Patient Safety Hub

- Patient Safety Learning Forum an M&M outcome summaries share

Values, Culture, and Advocacy

- Trust Values – Responsibility, Civility, and Visibility
- Celebrating Clinical Excellence
- Staff Health and Wellbeing
- Listening Without Bias and Holistic Patient Review
- Patient-Centred Care – “Listening to the Experts”

Appendix 5 – Learning Forum Summary (example)

LEARNING FORUM
POINT OF CARE DEVICES

ATTENDEES

- Four members of the Patient Safety Team
- Three members of the Point of Care Team
- Nurses from Ward 3, Ward 8 and Ward 24
- Three Practice Development Nurses
- One Practice Education Facilitator
- Two members of the Children's Community Team
- One ED Nurse
- One Student Nurse
- One Consultant Anaesthetist

WHY WE'RE HERE?

Patient Safety | Equipment Awareness | Better Care

A safe space to talk about real incidents and how we can improve our use of Point of Care (POC) devices. Small faults can have big impacts.

WHAT WENT WRONG?

- Unexpected high HbA1c results in well-managed diabetic patients.
- Discrepancies between lab and device readings.
- Device was outdated and not properly maintained.

Impact: Stress, unnecessary visits, misdiagnosis, and damaged trust.

WHAT WE FOUND?

- Unclear ownership of devices and maintenance.
- Training gaps and confusion over interpreting results.
- Invisible equipment lifespan tracking.

WHAT'S CHANGED?

- Faulty devices removed.
- New SOPs and governance.
- Training improvements and device replacements underway.

KEY LEARNING: EMPOWERING STAFF

Staff should feel confident to question readings and escalate concerns. It's not just about using a device-it's about understanding what the results mean.

"You don't know what you don't know-so let's make it easy to ask questions."

IDEAS FOR IMPROVEMENT

- Have clear governance: Make sure there's a named person or team responsible for each device.
- Link barcodes to training: Staff can only use machines if they're trained and scanned in.
- Do yearly refreshers or equipment days for departments.
- Use discretionary spend forms as a checkpoint to flag maintenance needs.
- Make it easier to find SOPs—especially during night shifts!
- Create a device inventory per ward to track what's in use and what needs servicing.
- Make maintenance status visible on the device—like a MOT sticker.

WHAT'S NEXT?

- Building a new linked pathology system (target: 2026) to help reduce transcription errors and improve visibility.
- Encouraging more wards to assign POC 'super users' to lead training and checks.

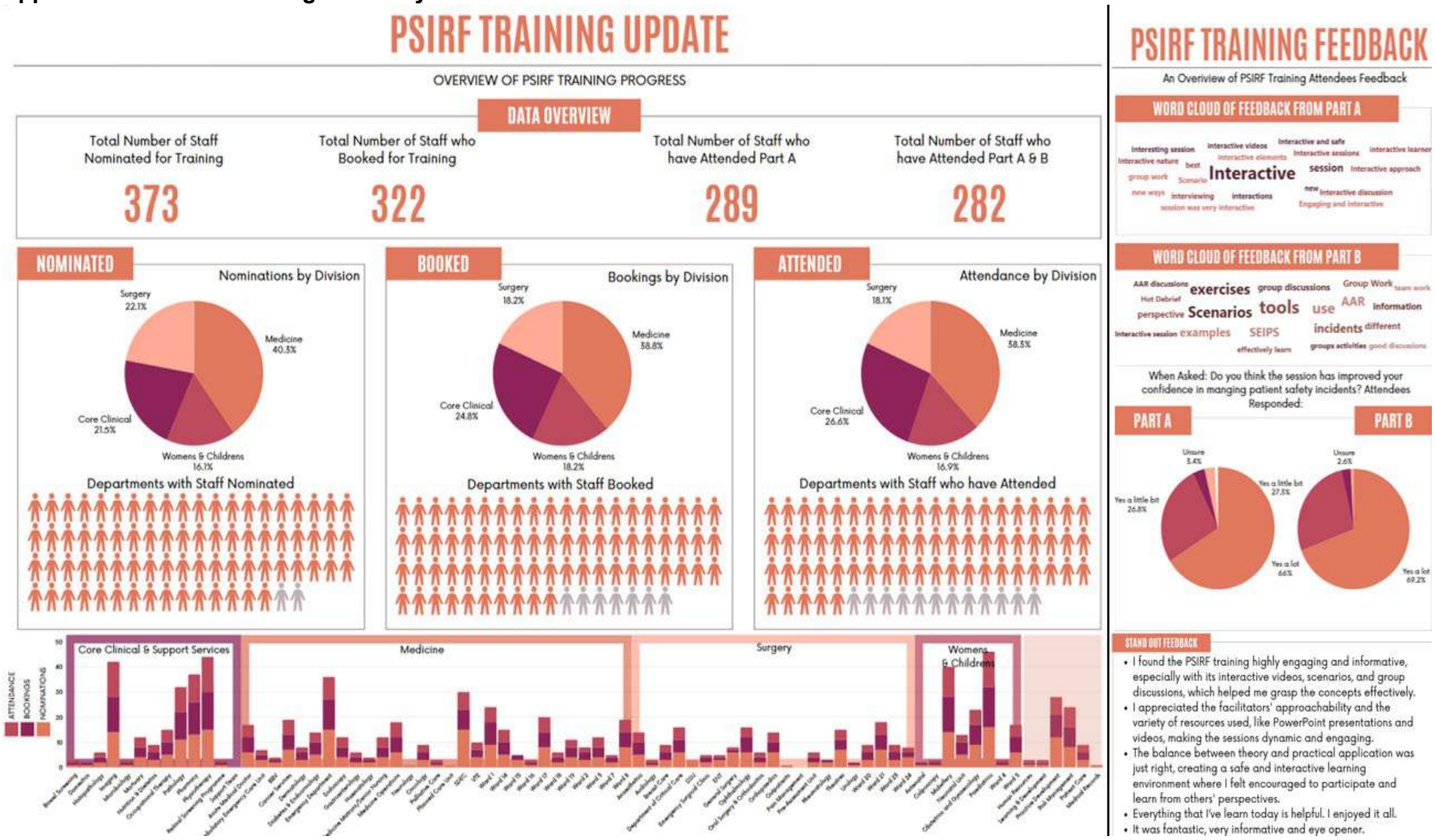
FINAL THOUGHTS - WHAT YOU CAN DO?

Ask: Who manages our devices?
Check: Is this machine up-to-date?
Speak up: Do the results make sense?

Be curious, not complacent: If a device feels off, question it.
Don't assume someone else is checking – ask your ward manager or point of care team.
Proper maintenance and training could prevent stress, misdiagnosis, and serious harm.
A machine might look fine but still give wrong results if it's past its life expectancy or hasn't been tested.

Staff Feedback

Appendix 6 – PSIRF Training Summary



Meeting Title	**TRUST BOARD (PUBLIC)**	**Date: 3 July 2025**
Report Title	**Edward Cassin inquest and Preventing Future Death (PFD) report**	**Agenda Item Number: 8**
Lead Director	*Kate Jarman, Chief Corporate Services Officer*	
Report Author	*Tina Worth, Head of Patient Safety and Legal Services*	

Introduction	*This paper provides an update on the current status/future actions following the inquest into the late Edward Cassin and the Trust's receipt of the PFD report*		
Key Messages to Note	The inquest was heard on 13 February 2025, with the receipt of the PFD on 18 June 2025 The Trust response is due by 12 August and remains under review in collaboration with the ICB Evidence submitted for the inquest and given in evidence did not reassure HM Coroner in relation to: • The collaborative working between the acute Trust and Speech and Language Therapies (service commissioned by the ICB) • Staff training and understanding in clinical practice in relation to dysphagia management		
Recommendation *(Tick the relevant box(es))*	**For Information** [x]	**For Approval** [ ]	**For Assurance** [x]

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

Report History	*The inquest and pending PFD were previously presented at Patient Safety Incident Review Group (PSIRG) and Patient Safety Board*
Next Steps	*This report will further be presented at the above groups again to include the PFD and at Trust Executive Committee and Quality and Clinical Risk Committee*
Appendices/Attachments	*Appendix 1 PFD report* *Appendix 2 Dr Pulford's report*

Section 2: Glossary of Acronyms

	Acronyms	
	PFD	Preventing Future Death Report
	ICB	Integrated Care Board
	SLT	Speech and Language Therapy
	DOLS	Deprivation of Liberty Safeguard
	MCA	Mental Capacity Act
	LeDeR	Learning from lives and deaths – People with a learning disability and autistic people

Section 3: Executive Summary

This report looks to summarise the work undertaken by the Trust both in advance of the inquest and has currently ongoing in relation to dysphagia management.

Coroners have a duty to issue a Prevention of Future Deaths Notice (PFD or Regulation 28 report) to any person or organisation where, in the opinion of the coroner, action should be taken to prevent future deaths. A response is required within 56 days.

This inquest related to a gentleman with learning difficulties and known dysphagia who developed an aspiration pneumonia following the administration of food specifically excluded by Dietetic Services, with food/ medication being found in his mouth. Evidence in court raised concerns for HM Coroner in relation to staff training and understanding of dysphagia and the apparent silo working between acute hospital staff and community staff in Speech & Language Therapy Services (SALT is provided by Central and North West London NHS Foundation Trust), as outlined in the PFD report.

The Board is asked to note the PFD report and assurance on ongoing quality improvement work, with the Trust's PFD response to follow at the next meeting.

Section 4

1. Background

This was recognised as a sensitive and high-profile inquest with assurances on actions following Mr Cassin's sad death sought from the Care Quality Commission and through the LeDer review process. Choking and aspiration has been recognised as a significant cause of non-accidental death in older people and other vulnerable risk groups.

At inquest, evidence was heard from both nursing and medical staff, as well as from Dietetics and SALT, detailing the care provided to Mr Cassin; the local and national guidance to support this; and the recommendation and action in place following the Mr Cassin's death.

Prior to the inquest a root cause analysis investigation was undertaken to identify key learning for the Trust and actions were taken including:

- Mandatory Oliver McGowan training for patients with Learning Disabilities being completed by all registered nursing staff by April 2024.
- All staff in Trust to have choking training in face-to-face training sessions.
- Collaboration with Central Northwest London for development of the 'Feeding at Risk' guidelines with Speech and Language team

The feeding at risk guideline was subsequently approved and made available to staff on the Trust's intranet, with modified diet guides/ signage for the clinical areas and was widely communicated and shared. A copy was forwarded to HM Coroner.

Compliance on staff training was also provided, with choking with a scenario included in Basic Life Support (BLS) training, which is part of the MKUH statutory and mandatory training programme.

This inquest formed part of a small number of deaths where choking or aspiration was a factor, This was identified by the Trust with an independent report commissioned from Dr Pulford, Consultant in General and Geriatric Medicine at Oxford University Hospitals. This was commissioned to review policy and practice concerning the care of inpatients at MKUH with vulnerabilities relating to swallowing.

Dr Pulford noted that choking has been recognised as a significant cause of non-accidental death in older people and other vulnerable risk groups and that adults with learning disabilities may have maladaptive eating strategies that carry a higher risk of asphyxiation and aspiration. The Trust was not seen as a significant outlier.

Her report detailed key recommendations of:

1. The recognition of eating, drinking and swallowing issues is part of many clinical professionals' responsibilities. The Trust should clarify by whom and how this should be documented in a timely manner in (i) clinical notes and (ii) ward area / patient bed space. Each clinical area must have an agreed location to provide this information, so it is visible and available to staff, families, carers, and patients.
2. The Trust should ensure appropriate feeding plans are documented for patients with an identified risk, and that there is a robust mechanism to share these and with patient, family, and any relevant care providers when a client is admitted to or discharged between different settings, either within or between care providers.
3. The Trust should monitor SLT referrals, numbers and quality and response times to establish if there is a need for more staff training and /or more SLT staffing.
4. The Trust should continue ongoing reporting and monitoring of aspiration and asphyxiation incidents and consider whether this could be a future Trust Quality Priority.
5. The Trust should ensure that MCA and DOLS assessments are consistently undertaken and documented when there is concern about an inpatient's ability to understand or consent to care.

The deaths identified, Dr Pulford's review and related Radar incidents fed into a quality improvement project on dysphagia management with multi-disciplinary team stakeholder involvement which remains live and ongoing. This has the aim of improved patient experience, safer feeding and drinking and reduced harm to patients, and Improved staff understanding for SALT referrals and dysphagia management.

A meeting is scheduled for the week commencing 30 June 2025 with the Chief Nurse, Head of Patient Safety and Legal Services and the Clinical Director, Milton Keynes Community Health Services to discuss the PFD.

2. Impact of recommendation(s) on Trust's Strategic Objectives

The Trust has a legislative requirement to respond to HM Coroner with the response detailing action taken or proposed to be taken, with agreed timescales or an explanation on why no action is proposed.

PFDs are publicly available on the internet and are seen as safety triggers for organisations.

3. Finance, Risk and Resource Implication

The inquest had related media publicity which will possibly continue with the publication of the PDF and LeDer interest.

From a risk perspective the Trust will need to demonstrate robust actions pertaining to the PFD and be in a position to audit ongoing compliance to mitigate the risk.

The Trust will follow usual processes relating to clinical negligence claims management as appropriate.

4. Action/ Recommendations

The Board is invited to note this report and await the Trust's PFD response in due course.

Section 5: Appendix

Appendix 1 PFD report

Reg 28 Report - After Inquest CASSIN E J 28

Appendix 2 Dr Pulford's report

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TheMKWay

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

TRUST BOARD IN PUBLIC

Academic Centre/Teams

Thursday, 3 July 2025

Agenda Item 9:
Maternity Assurance Group Update

Fiona Hoskins
Chief Nursing Officer

Discuss

Meeting Title	**TRUST BOARD (PUBLIC)**	**Date: 3 July 2025**
Report Title	**Annual Patient and Family Experience Report 2024/2025**	**Agenda Item Number: 10**
Lead Director	*Kate Jarman, Chief Corporate Services Officer*	
Report Author	*Julie Goodman, Head of Patient and Family Experience*	

Introduction	Assurance Report.		
Key Messages to Note	*This report provides an overview of patient experience, engagement and feedback across the Trust and actions taken to improve patient and family experience.*		
Recommendation	**For Information** [x]	**For Approval** [ ]	**For Review** [ ]

Strategic Objectives Links	*1. Keeping you safe in our hospital* *2. Improving your experience of care* *3. Ensuring you get the most effective treatment* *4. Giving you access to timely care* *10. Innovating and investing in the future of your hospital*

Report History	Patient and Family Experience Board Quality and Risk Committee
Next Steps	Trust Executive Committee
Appendices/Attachments	Report follows

1. Introduction and purpose

This report details the Trust's overall position regarding patient and family experience feedback, engagement activity and the achievements of the Patient and Family Experience team for 2024/25.

2. Achievements of the Patient and Family Experience team in 2024/25

Patient Experience Platform (PEP) Health

With the increase in the amount of free text comments received through the Family and Friends Test (FTT) route it was recognised that theming the feedback inhouse was complex. Analysis that could be shared with the divisions and individual areas to assist them in understanding what patients thought about their experience, and what mattered most to them, was required.

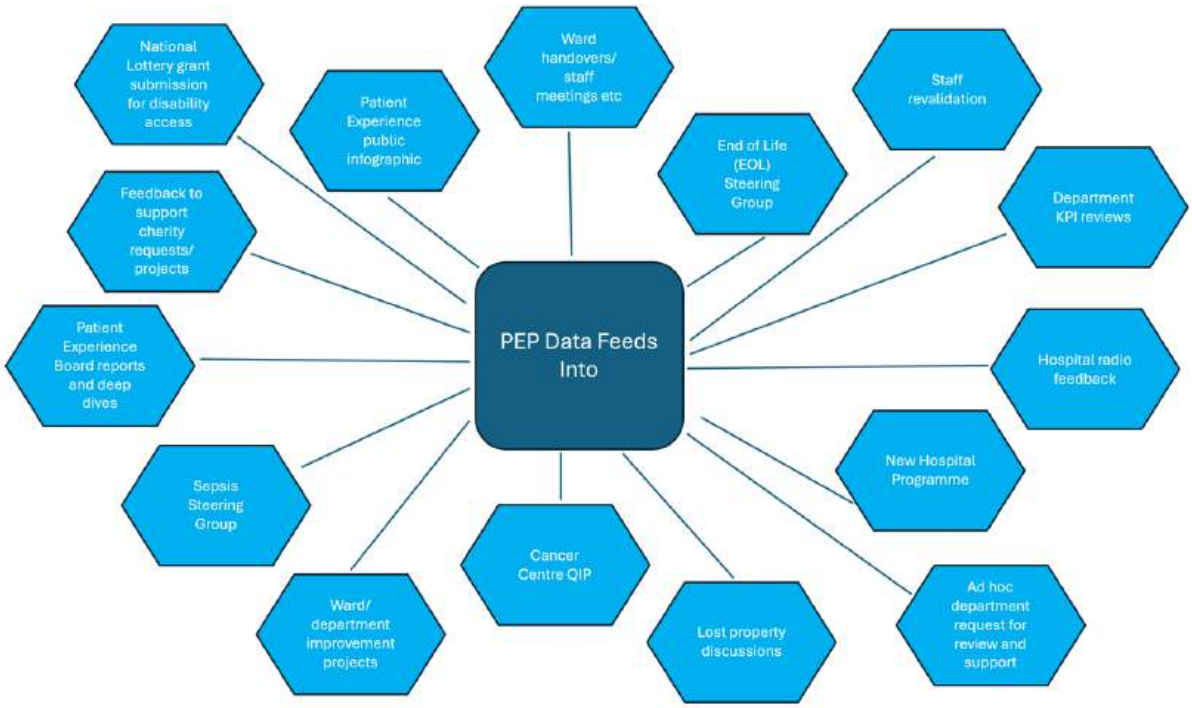
PEP Health collect all free text comments from patient feedback received through the FFT route, and online review sites such as the NHS website and Google reviews, and the hospital's social media accounts and more recently from compliments received by the Trust.

PEP Health use their unique software package to theme the comments into eight quality domains. The comments and themes are available on a dashboard and can be filtered by date, theme, and division or individual service. The platform therefore offers the Trust a unique insight into patient experience and what matters to our patients and families. PEP Health were able to record historical data from our inhouse FFT database to allow for comparative analysis.

PEP enables staff to access their patients' feedback by area, compare against other areas, hospitals, and thoroughly analyse the data. Information from the dashboard is shared in reports to the Trust Board, divisional governance groups, divisional meetings, and at the Patient and Family Experience Board to demonstrate how the dashboard is used to enhance and improve services and also allows for the celebration of positive comments.

The team continue to promote the use of PEP to ensure staff are engaging with the platform. This includes supporting the staff on wards, and ensuring staff are triangulating the data on PEP along with other feedback mechanisms available for any reports they are writing or projects they are undertaking.

Some examples of where PEP data is feeding into can be seen below.



The next stage will be to triangulate the data received from FFT, PEP, compliments, PALS and Complaints and Tendable to form a patient experience strategy.

The team have been collecting feedback from staff to showcase the vast benefits of the dashboard and the various ways the data is used. Examples of this include:

'PEP is integral to our department being able to accurately monitor, report, and act upon feedback from patients and their families. This data is presented in our departmental and divisional meetings.

If we no longer had access to PEP or a similar digital platform that allowed the tracking of patient experience data, then we would be unable to report and act upon the themes that our patients and their families identify across FFT, social media, etc. This would have a negative impact upon the experience of our patients and their families.' **Administrator in Children's Services**

'Been regularly pulling data from it. We've found the patient feedback resource to be incredibly valuable for gathering qualitative insights. The ability to search for keywords has been particularly helpful, making this data indispensable for the following purposes:

- Building an Evidence Base: Patient feedback has supported changes to processes, business cases, floor plans, environmental adjustments, transformation projects, service reviews, and equipment purchases (e.g., Wayfinding).
- Post-Project Evaluations: Reviewing patient feedback has been vital for assessing outcomes. For example, it was used after completing the Maple Centre to gather insights for both SDEC and Ward 1.
- Theme and Trend Analysis: It's straightforward to search for recurring themes or keywords, even across several years of data and multiple services.
- Creating Patient Stories: Feedback has been instrumental in developing compelling patient stories and capturing their experiences.

- Comprehensive Insights: The inclusion of feedback from multiple platforms (e.g., FFT, Google) ensures a well-rounded perspective.

Currently, we're utilising PEP data as part of the New Hospital Programme, beginning with Maternity.' **Workforce Lead – New Hospital Programme**

'I have personally found the access you've provided for PEP to be completely transformative. I have incorporated a lot of patients' experiences into training sessions and also include positive feedback from patients being treated across the trust with sepsis/severe infection in the trust and ED's sepsis newsletters (attached). The feedback from patient experiences also helps identify some real key themes in limitations of staff knowledge and practices that has allowed me to reorganise sepsis training to alleviate knowledge gaps whilst maintaining more of a focus on sepsis and infection management in the context of the patient experience.' **Practice Development Nurse, Lead for Sepsis and Deteriorating Patients**

Please see below the executive summary for 2024/25

Patient experience report:

Milton Keynes University Hospital NHS Foundation Trust

PEP Health
Patient Experience Platform

Report for: **1 April 2025**

About this report:
This report is based on external (public comments) and internally-collected patient feedback which has been analysed and scored by PEP Health.

About PEP Health:
PEP Health uses cutting-edge machine-learning technology to give healthcare trusts actionable insights they need to have an impact on patient experiences. Our empirically-proven platform provides real-time insights about patients' experience of care from large volumes of patient comments.

External data

Scores based on public comments (e.g. Facebook, Google, Twitter, NHS.uk). Star ratings are out of 5.

Overall moving averages

Milton Keynes University Hospital NHS Fo...
2.9 ★ ↓0.3 over the last year

National average for England
3.4 ★ →NC over the last year

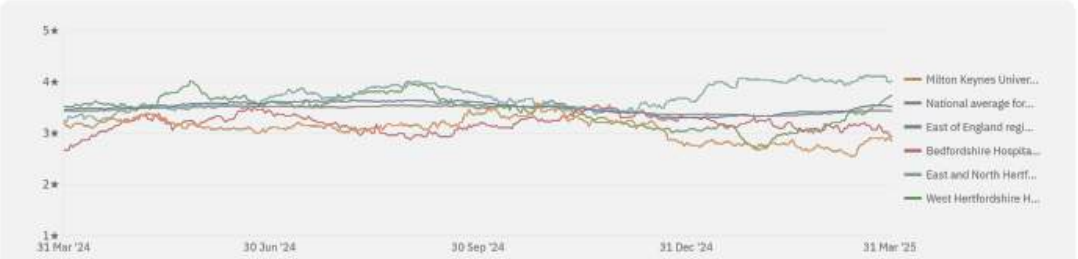
East of England region
3.5 ★ ↑0.1 over the last year

Bedfordshire Hospitals NHS Foundation Tr...
2.9 ★ ↑0.3 over the last year

East and North Hertfordshire NHS Trust
4.0 ★ ↑0.8 over the last year

West Hertfordshire Hospitals NHS Trust
3.7 ★ ↑0.2 over the last year

Averages over the last 12 months:



Rankings

Current national ranking
In the top 90%

Current regional ranking
In the top 100%

Rankings over the last 12 months:

Nationally:

East of England region:

Internal data

Scores based on internal comments (e.g. FFT). Star ratings are out of 5.

Current **overall** moving average: **4.6** ★ →NC over the last year

Care domain averages for trust

Fast access **3.5** ★ →NC over the last year	Effective treatment **4.2** ★ →NC over the last year	Continuity of care **3.0** ★ ↓0.4 over the last year
Communication & involvement **3.8** ★ ↑0.1 over the last year	Emotional support **4.2** ★ →NC over the last year	Physical needs **2.9** ★ ↓0.3 over the last year

Overall moving averages by division

Core Clinical & Support Services **4.7** ★ ↓0.1 over the last year	Surgery **4.6** ★ →NC over the last year	Women's & Children's Health **4.5** ★ →NC over the last year
Medicine **4.6** ★ →NC over the last year		

Overall moving averages by ward/team

Highest rated wards & teams:

Infectious Diseases	**5.0** ★ ↑0.1
Stoma Clinic	**5.0** ★ ↑0.1
Pals	**5.0** ★ →NC
Blakelands Hospital	**5.0** ★
Ophthalmology	**5.0** ★

Lowest rated wards & teams:

Pharmacy	**3.8** ★ ↓0.8
Emergency Department - Adult	**4.0** ★ ↑0.1
Ward 2B	**4.1** ★ ↓0.1
Treatment Centre	**4.2** ★ ↓0.3
Ward 19 (Medicine)	**4.3** ★ ↑0.1

Largest positive change:

Ward 12	**4.7** ★ ↑1.2
Ambulatory Emergency Care Unit (AECU)	**4.8** ★ ↑0.4
Hepatology	**4.8** ★ ↑0.3
Vascular Clinic	**4.8** ★ ↑0.3
Ward 8 (Gastroenterology)	**4.7** ★ ↑0.2

Largest negative change:

Pharmacy	**3.8** ★ ↓0.8
Discharge lounge	**4.5** ★ ↓0.4
Phlebotomy	**4.5** ★ ↓0.3
Treatment Centre	**4.2** ★ ↓0.3
Orthotics	**4.3** ★ ↓0.3

Changes shown are over the last year

The contract with PEP Health was renewed for two years in 2023 and a business case will be submitted later this year to extend the contract further.

Patient Experience Week – week commencing 29th April 2024

The team organised a host of events to celebrate this year's national Patient Experience Week.

Their theme this year was Patient Experience Team 'Goes on Tour'. The team felt it was important to leave the hospital and go to the patients/families in the community to listen to their experiences and share how they can feedback to the hospital and how they can get involved in the hospital with our community engagement work.

The team visited the MS Society Support Group, MK College and Shenley Wood Village. There were lots of conversations and lots of constructive feedback which gave a valuable insight into the experiences of our patients.

The week ended with the Band in the Van coming to the marquee to entertain our patients. This is the start of further work with the Charity to think outside the box on how we can make the experience of inpatients more meaningful. There have been meetings with MK College to look at involving students in some possible health and beauty treatments, courtyard maintenance and music/drama leading up to College in the Community Day in April 2025.

Engagement

The Patient Experience team and the Membership and Engagement Manager have worked collaboratively exploring opportunities to engage with the community. The Trust is taking positive steps to ensure engagement takes place with patients, families, and community support groups to ensure the voice of all groups in the community is heard when changes and improvements to services are being planned. The views of our patients and families should be considered from the onset to the completion of any improvement or service design work.

A few examples of the engagement work are detailed below:

- **Endoscopy Patient Focus Group**

The team supported the Endoscopy team with their annual patient satisfaction audit, which asks patients to share their experiences through their entire journey in the Endoscopy Department. An event was also held one evening with the Endoscopy team and members of the local Crohn's and Colitis support group. This involved a walkthrough of the department, review of the survey, and ended with a focus group to give the group an opportunity to share their experiences to date and for staff to reflect on this.

- **Cancer Centre Quality Improvement Project (QIP)**

The purpose of this QIP is to enhance the patient experience within the Cancer Centre.

The group includes a patient representative to ensure the patient voice is heard.

At present the group is focussed on the initial part of the patient's journey into the Cancer Centre, including the arrangement of appointments and the waiting area in the centre. Initial comments from the PEP dashboard were gathered to review feedback from patients. A patient survey was undertaken, along with a survey for the medical staff to look at delays in clinics. The results will be analysed to inform the improvements needed.

- **MK Mosques**

The team attended a meeting with Trust staff and representatives from three of the city's mosques. There was an excellent exchange of views, ideas and suggestions for future engagement. Engagement between local mosques and the hospital supports:

- The health of the Muslim communities which includes information provision around the services provided by the hospital and the opportunities available for improving and maintaining health in areas such as screening, organ donation and research and development. Accessing these services for the Muslim population is lower than other populations, and the team would like to explore why this is and understand how access can be supported.
- The patient experience of Muslim patients and visitors at the hospital to ensure that the needs of individuals are met either as patients or at home waiting for appointments, receiving letters and updates, using the hospital website, prayer facilities, diet availability at the hospital, how general information is provided, and bereavement guidance.
- Establishing channels for Muslim voices in our communities to ensure the hospital is listening to the views of the Muslim communities in a way that is comfortable.
- Promoting contact and trust with the Muslim communities to ensure the communities are confident that their voices are being heard and are positively influencing services at MKUH.

- **Carers MK**

CarersMK

The team continue to support Carers MK to build links with staff who are working with or supporting an unpaid carer to ensure they are aware of the benefits of a referral to Carers MK, for support. Supportive work will be ongoing with the Patient and Family Experience team working alongside Carers MK to put in place a Carers Strategy and Carers Passport. The Head of Patient and Family Experience is supporting as the Trust's honorary Trust contract with the Adult Carers Support Worker/Hospital Support Worker.

- **Kings Community Centre Food Bank**

As part of the Thank you Roadshow in November 2024 the Patient Experience team spent an afternoon with Andy Forbes, Hospital Governor, at Kings Community Centre Food Bank. They learnt about all the wonderful services they offer and met some really interesting people. This has led to a contact who is now presenting a show for the Hospital Radio and

discussions are in progress around a larger event in Wolverton in May 2025 which will showcase the work of a number of hospital teams.

Engagement Group Activity

The team have a group of patient representatives and are working to increase the numbers and diversity of members. It is so important that we listen to what our patients, families and carers think about the services we provide. All NHS organisations have a legal duty to involve and consult the public about the running of local health services. Patients should be listened to, and staff should make changes and improvements relevant to what they hear.

The team also has links with Healthwatch MK, learning disability and autism groups, and other community groups that are happy to provide their expert opinion. Examples of what they have been involved in this year include:

- Annual PLACE audit
- Reviewing a survey to assess the support required by patients waiting for the Pain Management Programme
- Reviewing a 'Different Ways of Dying' video put together by a Consultant in Palliative Care
- Supporting Cancer Centre QIP
- Reviewing various Paediatric PILS

Work with the Hospital Charity

Milton Keynes Hospital Charity

The team continues to work with the Charity on various projects and incentives to improve patient experience. This includes continued support on the purchase of items for the patient experience resource trolley.

Other support/collaborations during this year included:

- The team supported with the implementation of 'My Thank You' initiative.
- Looking at possible grants to financially support patient experience projects.
- Funding for an infant feeding corner in the main entrance following feedback via the PALS team.
- Christmas event planning.
- Provided content for the annual Charity impact report.
- College in Community Day.

SignLive Update

SignLive

The team continue to work with patients and staff to support SignLive, which provides online British Sign Language (BSL) video interpreting services, available 24/7. This allows deaf and hard of hearing patients to communicate with anyone, at any time using a simple app.

The team attended the staff awards where the SignLive Project won the category for the Best Use of Charitable Funds.

The contract with SignLive, previously supported by the hospital Charity, was renewed with the support of the Trust. A business case will be submitted later this year to ensure this valuable service can continue.

'An absolutely a fantastic piece of equipment without which the patient would not have known the plan and doctors would have struggled to communicate with the patient so 5 stars from Ward 16.'

Patient Clothing Supply Project

As a result of feedback from the team's engagement with Age UK, and discussions at the Patient and Family Experience Board, the team are continuing to work on a project to ensure there is an adequate supply of clothing for patients who may not have suitable clothing to wear in hospital or upon their discharge.

This project is two-fold:

- Making sure patients are suitably dressed whilst in hospital. This is essential for initiatives such as #endpjparalysis and for participating in therapy and functional assessments. Being dressed as they would be in their own home is proven to shorten the length of stay and helps maintain the patient's dignity.

- Making sure patients are suitably dressed to go home. Age UK raised concerns about patients being taken home in just a hospital gown, red socks, and a blanket around their shoulders. This feedback has also been received through complaints received.

There are two linen trolleys and boxes on wards to ensure each area have their own supply.

The Charity has provided valuable contacts in the community and the team have held various clothing sales to ensure the project continues.

PLACE Audit

The team supported Hotel Services with the annual PLACE Audit on the 17th October 2024. The team recruited patient representatives and received some very positive feedback.

One patient representative advised, “Thank you for the opportunity to be involved in the PLACE audit today. I found it very interesting and the food tasting session was amazing.’

Disability Advisory Group (DAG)

A member of the team attends the DAG quarterly meeting. Members of this group feed back issues to stakeholders in Milton Keynes such as Milton Keynes Council, the Park’s Trust, transport companies and many more. There is now representation from the hospital to allow members to feedback their experiences of using hospital services. This also allows the hospital to form relationships with members of the group who can then get involved in hospital projects. For example, a member of the DAG attended the hospital to undertake a journey through our MSCP to look at disabled parking. This was also attended by the Patient Experience Lead, Membership and Engagement Manager, and Security and Car Park Manager. It was positive to explore positive solutions which are being looked at further.

Ward Assurance Support

The team have supported the Lead Nurse for Quality and Ward Assurance with the ward rounds. This involves visiting various wards and completing the patient experience audit on Tendable. It gives an opportunity for discussion with patients and staff to provide assurance that patients are having a positive experience and staff feel supported and are aware of feedback mechanisms in the Trust and how to access their feedback and direct their patients accordingly.

New Hospital Programme

The team were contacted by the Communications and Engagement Lead for the programme to ask for support in obtaining the views of as many patients as possible to the following question:

‘At MKUH we are developing our hospital site to ensure we can meet the future healthcare needs of the Milton Keynes community. Thinking about your most recent hospital experience, what is the one thing you think we should consider as part of these developments that would improve your hospital care? ‘

The majority of feedback for FFT comes through our SMS text option. It was therefore agreed to add the above question to the text messages sent. This is an optional question for patients. A large amount of feedback has been received, and this is shared with the Project team monthly.

Sexual Safety

In January 2024, Milton Keynes Hospital signed up to NHS England’s ‘Sexual Safety in Healthcare – Organisational Charter’. NHS England » Sexual safety in healthcare – organisational charter.

As signatories to this charter, the Trust have committed to a zero-tolerance approached to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce in particular, but also patients.

This project is split into a variety of workstreams. The Patient Experience Lead is leading the patient safety workstream. This workstream will look at information provided to patients, how

incidents can be reported, how patients can be supported, and setting a sexual safety charter.

It is vital that the patient's voice is involved throughout this process, and this is being supported by a Patient Safety Partner.

Thank You Roadshow

As part of our commitment to ensure the patient voice is centre, the team held a 3-day 'Thank You Roadshow' in November 2024. This was to gather feedback around what is most important to patients and families when they attend hospital, and also to highlight some of the changes that the team and other staff have made as a result of patient feedback.

The team spoke to many patients in outpatients, inpatients, and the community. The data is being analysed and will help form the Patient Experience and Engagement strategy.

Compliment Project

All written compliments are acknowledged and shared with individual staff and their managers. During this year, as above, the PEP Health dashboard has been developed to capture the comments from compliments, and these are themed in the same way as the Friends and Family Test comments.

Each month a 'compliment of the month' regarding an individual and a team is chosen by the Patient and Family Experience team. The individual receives either a personal card or a team certificate from the Chief Nurse thanking them for their contribution.

The theme of the 'compliment of the month' project is stars and consequently the card and certificate are star based. The card/certificate is presented to the winners by a member of staff from the Patient and Family Experience team who dresses as a gold star, pictures are then shared in the CEO newsletter. The members of staff and teams receiving 'compliment of the month' are detailed in the Patient and Family Experience quarterly reports.



The winners this year were:

Month	Winner 1	Winner 2
April 2024	Kevin Kibuuka, Learning Disabilities Nurse	Ward 3
May 2024	Emily Howard, HCA Ward 7	Dermatology

June 2024	Debbie Bitmead, Outpatient Receptionist and Scheduler	Ward 7
July 2024	Charlotte Charles, Ward 9	Bereavement Team
August 2024	Georgie Orr, Information Governance	Angiogram
September 2024	Samantha Alder, HCA Ward 1	EPAU
October 2024	Raana Bibi, Speciality Doctor in Gynaecology and Obstetrics	Aimee Monicon, Consultant Anaesthetist
November 2024	Lesley Willis, ED Receptionist	Paediatric ED
December 2024	Dr Sani Magaji, Locum Doctor in Orthopaedics	IBD
January 2025	Sorrell Dickson, Paediatric Play Assistant	Switchboard
February 2025	Jose Gomez-Lopez, ED Doctor	Recovery Team
March 2025	Neil Trew-Smith, Pharmacy	Haematology

3. Patient Experience data

Friends and Family Test (FFT)

The table below details a comparison of the number of FFT responses received across the Trust for each quarter 2023/24.

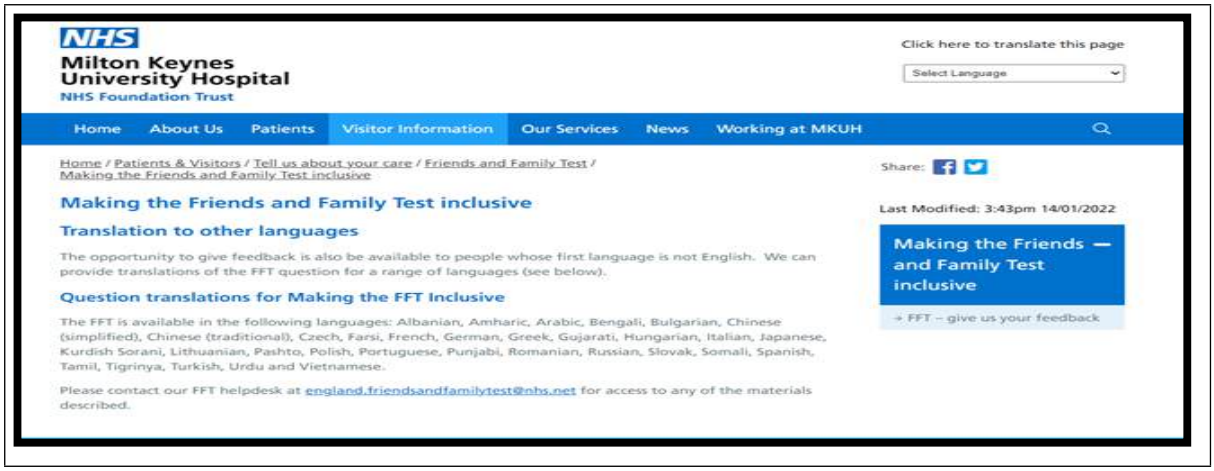
Q1 2023/24	**Q2 2023/24**	**Q3 2023/24**	**Q4 2023/24**	**TOTAL NUMBER RESPONSES FOR 2023/24**
14784	14926	16926	22387	**69023**
Q1 2024/25	**Q2 2024/25**	**Q3 2024/25**	**Q4 2024/25**	**TOTAL NUMBER RESPONSES FOR 2024/25**
22720	20093	19851	21872	**84536**

During 2024/25, 91.6% of patients on average rated the Trust's services as very good or good.

FFT- Ethnicity

From the 84536 respondees to the FFT,and where an ethnic origin was stated, 80% of respondees described themselves as being White British. This is compared to 77.7% for the previous year.

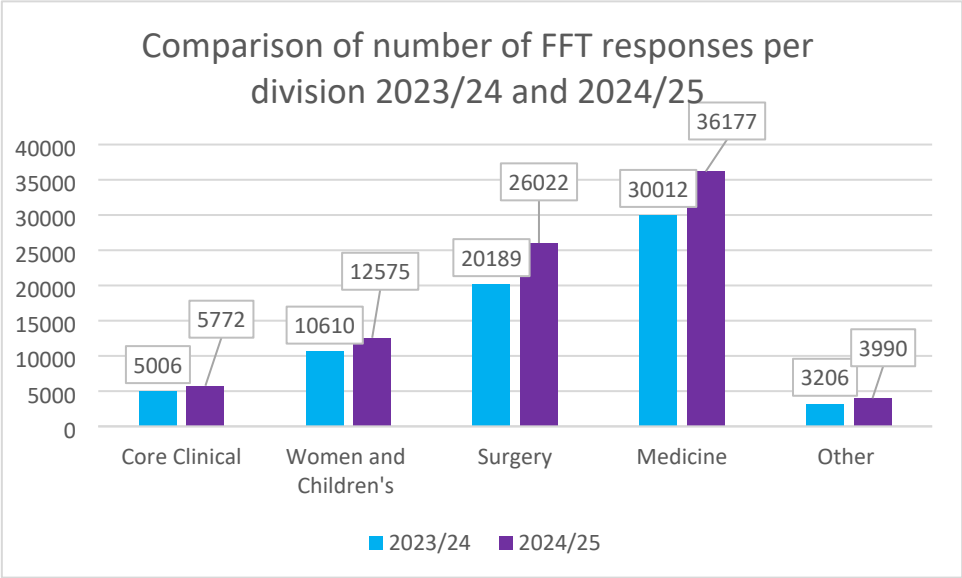
The 'Tell Us About Your Care' website pages have been improved with regard to providing information on how to get the FFT form in a different language, if required.



The Patient Experience team have also been engaging with various community groups to ensure all patients are able to provide feedback in a way that is suitable for them.

Divisonal FFT responses

The chart below details the number of FFT responses per divison for 2023/24 when compared to 2024/25.

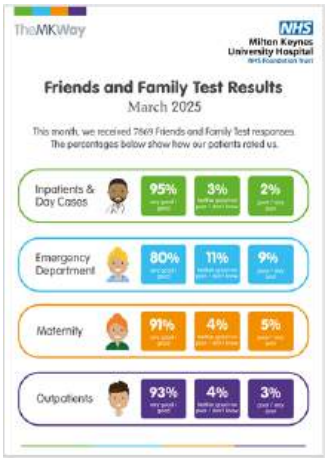


Communication of FFT results

In addition to staff having access to all feedback received via the Patient Experience Platform (PEP), as demonstrated below, posters are created by the Patient and Family Engagement team, monthly, detailing how each area has been rated by their patients regarding the FFT categories of:

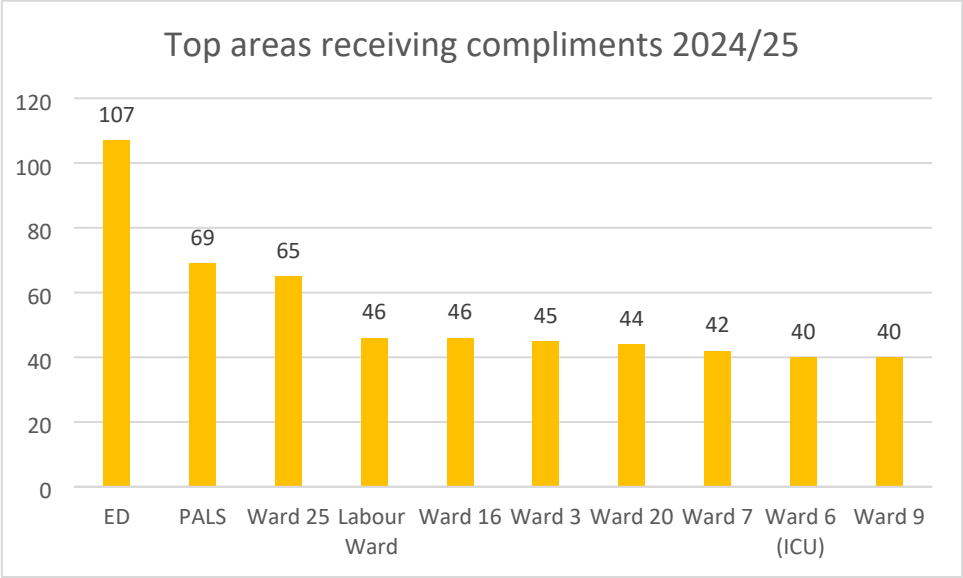
'*Very Good, Good, Neither Good nor Poor, Poor and Very Poor*'

Posters are displayed on all ward areas and some other departments, as below:



Compliments

During 2024/25, the Trust received 1298 compliments, compared to 1272 during 2023/24. The top areas receiving compliments are detailed in the graph below.



4. National Surveys

Maternity 2024

This survey was sent to women who gave birth in February/March 2024. The fieldwork took place between April and June 2024. The final CQC published results in November 2024. Maternity Services have an action plan in place in response to findings; this is monitored through the Patient and Family Experience Board.

Maternity 2025

This survey will be sent to women who gave birth in February/March 2025. Fieldwork is currently being undertaken and there is a robust communication plan in place to work to increase engagement.

Adult Inpatient 2024

The survey will be sent to patients who have at least a one-night stay in November 2024. The fieldwork will take place between January and April 2025 with the CQC published results expected in August 2025. There is a communication plan in place to work to increase engagement.

Urgent and Emergency Care 2024

This survey was sent to those adults attending the Emergency Department in February 2024. The final CQC published results were made available in November 2024.

Children and Young People 2024

This survey was sent to the parents/guardians of children and young people during the spring of 2024. The fieldwork took place between July and October 2024 and the final CQC results were published in March 2025. Work is being undertaken to ensure a robust action plan is in place.

5. Governance and Learning

Patient and Family Experience Board

The Patient and Family Experience Board meet bimonthly with key staff from across the organisation and patient representation. The Board focuses on improving patient experience by considering all feedback, learning, and governance in relation to patient experience.

The Patient and Family Experience Board has been established to provide oversight and scrutiny of the Trust's patient experience objectives.

The structure of the Board changed in February 2023, and a set agenda is now in place. The divisions and departments complete standard templates to report their current activity, planned activity, and risks in relation to patient experience and how patient feedback is being used to improve patient experience. All divisions present a deep dive report every quarter.

6. Conclusion

There is much to celebrate during this year with the improvements that have been made regarding the amount of valuable feedback gained from our patients and their families and the different pathways our patients can use to provide their feedback. The information on the PEP Health platform has helped enhance learning and outcome from feedback across the Trust. Staff are now able to see their area's feedback on an almost 'live' basis and take action/share learning accordingly in as near to real time as possible.

The projects as referenced in the body of this report have been highly successful and have heled to improve the experience of our patients and their families across the Trust.

Meeting Title	**TRUST BOARD (PUBLIC)**	**Date: 3 July 2025**
Report Title	**Trust-wide Report – Q4 2024/25 Patient and Family Experience Report**	**Agenda Item Number: 10**
Lead Director	Kate Jarman, Chief Corporate Services Officer	
Report Author	Julie Goodman, Head of Patient and Family Experience	

Introduction	Assurance Report		
Key Messages to Note	*This report provides a quarterly overview of patient experience, engagement and feedback across the Trust and actions taken to improve patient and family experience.*		
Recommendation *(Tick the relevant box(es))*	**For Information** [x]	**For Approval** [ ]	**For Review** [ ]

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	*1. Keeping you safe in our hospital* *2. Improving your experience of care* *3. Ensuring you get the most effective treatment.* *4. Giving you access to timely care* *10. Innovating and investing in the future of your hospital*

Report History	Quarterly reports
Next Steps	Quarterly reporting detailing analysis and trends in patient experience feedback
Appendices/Attachments	Report

1. Introduction and purpose

This report details the Trust's overall position regarding patient and family experience feedback and engagement activity for Q4 2024/25.

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

2. Achievements of the Patient and Family Experience team

Engagement

The Membership and Engagement Manager and the Patient and Family Experience team have worked collaboratively exploring opportunities to engage with the community. The Trust is taking positive steps to ensure engagement takes place with patients, families, and community support groups to ensure the voice of all community groups is heard when changes and improvements to services are being planned. The views of our patients and families should be considered from the onset to the completion of any improvement or service design work.

This quarter the team have been involved in many activities including the following:

- Planning for Hospital in the Community Day in Wolverton
- Supported Carers MK at an online Dementia Event
- Taken part in a talk at the Parkinson's Support Group
- Taken part in a talk at the Hard of Hearing Group
- Supported Carers MK at Great Linford Carers Support Group
- Supported a mental health patient to be involved in the new hospital planning focus group
- Supported the planning for the College in the Community Day

Engagement Group Activity

The team are working to increase the numbers and diversity of the patient engagement group. It is important that the Trust listens to what our patients, families and carers think about the services we provide. All NHS organisations have a legal duty to involve and consult the public about the running of local health services. Patients should be listened to, and staff should make changes and improvements where relevant as a result of the feedback received.

The team also has links with Healthwatch MK, learning disability and autism groups, and other community groups who provide their expert opinion. This quarter the team have been involved in:

- Reviewing the Advanced Care Planning posters
- Reviewing the Diabetes and Surgery Leaflet
- Reviewing an easy read FFT form

Imaging Feedback

The team have been working with the Imaging IT Systems Lead and the Information team to increase the amount of feedback received. Imaging patients who fit certain criteria will now be sent a text message to encourage them to complete the Friends and Family Test (FFT). On first review, the response rate has more than doubled which will enable the Imaging team to gain an insight into what matters to their patients to enable improvement to be made.

Communication QIP

The team are working with the QI team on a Communication QIP. This is following the Trust's priority to reduce complaints related to communication and the contributory factors to the breakdown in communication that occurs. The project outline was presented at the Patient and Family Experience Board in March 2025, including objectives and goals and the proposed approach.

Private Patients

The team are supporting the Private Patients Officer and Contracting team to ensure the Trust is compliant with submitting this feedback to the Competition Market Authority (CMA). The plan is to work with 'I Want Good Care' who will submit this data. The Patient and Family Experience team will share links with relevant patients once the system is up and running.

Inpatient Action Plan

An initial draft of the Inpatient Action Plan for the 2023 survey was submitted to the Patient and Family Experience Board in March 2025. The importance of moving this forward has been shared, and input is needed from various departments to focus the priorities.

PEP – Staff Feedback and Business Case

The team have been collecting feedback from staff to showcase the vast benefits of the dashboard and the various ways the data is used. Examples of this include:

'PEP is integral to our department being able to accurately monitor, report, and act upon feedback from patients and their families. This data is presented in our departmental and divisional meetings.

If we no longer had access to PEP or a similar digital platform that allowed the tracking of patient experience data, then we would be unable to report and act upon the themes that our patients and their families identify across FFT, social media, etc.

This would have a negative impact upon the experience of our patients and their families.' **Administrator in Children's Services**

'Been regularly pulling data from it. We've found the patient feedback resource to be incredibly valuable for gathering qualitative insights. The ability to search for keywords has been particularly helpful, making this data indispensable for the following purposes:

- Building an Evidence Base: Patient feedback has supported changes to processes, business cases, floor plans, environmental adjustments, transformation projects, service reviews, and equipment purchases (e.g., Wayfinding).
- Post-Project Evaluations: Reviewing patient feedback has been vital for assessing outcomes. For example, it was used after completing the Maple Centre to gather insights for both SDEC and Ward 1.
- Theme and Trend Analysis: It's straightforward to search for recurring themes or keywords, even across several years of data and multiple services.
- Creating Patient Stories: Feedback has been instrumental in developing compelling patient stories and capturing their experiences.
- Comprehensive Insights: The inclusion of feedback from multiple platforms (e.g., FFT, Google) ensures a well-rounded perspective.

Currently, we're utilising PEP data as part of the New Hospital Programme, beginning with Maternity.' **Workforce Lead – New Hospital Programme**

'I have personally found the access you've provided for PEP to be completely transformative. I have incorporated a lot of patients' experiences into training sessions and also include positive feedback from patients being treated across the trust with sepsis/severe infection in the trust and ED's sepsis newsletters (attached). The feedback from patient experiences also helps identify some real key themes in limitations of staff knowledge and practices that has allowed me to reorganise sepsis training to alleviate knowledge gaps whilst maintaining more of a focus on sepsis and infection management in the context of the patient experience.' **Practice Development Nurse, Lead for Sepsis and Deteriorating Patients**

PEP are also producing a short feedback form to share with users. This will help form part of the business case, which PEP are also supporting with.

Deaf Awareness Training

A meeting was held with the Library and E-Learning Services Manager to continue planning a deaf awareness training package. This was following feedback from staff and service users. This will be a bespoke e-learning package and training will be around basic awareness, interaction with patients, communication for appointments etc, what resources we already have and how to access these. This will be in conjunction with the Head of Audiology and Milton Keynes Sensory Services.

Planning for Patient Experience Week

The theme of Patient Experience Week 2025 is 'Building the Foundations of Experience'. This takes place during the week commencing the 28th April 2025 The focus will be showcasing the work undertaken by the team leading to recruiting more volunteers to support the various projects/incentives.

Work with the Hospital Charity

The team continues to work with the Charity on various projects and incentives to improve patient experience. This includes continued support on the purchase of items for the patient experience resource trolley.

Other support/collaborations during this quarter included:

- Support for the clothing project.
- Support for the resource trolley
- Planning for College in the Community Day which will take place on the 2nd April 2025. This will include basic beauty treatments for patients/staff, singing/performance in the main entrance for Christmas, baked goods for staff, media students capturing the events etc.

Newsletter and infographic link

Q4's information can be found on the links below:

Infographic

https://www.facebook.com/share/p/15sQHDi2JF/?mibextid=wwXIfr

Newsletter

Still to do

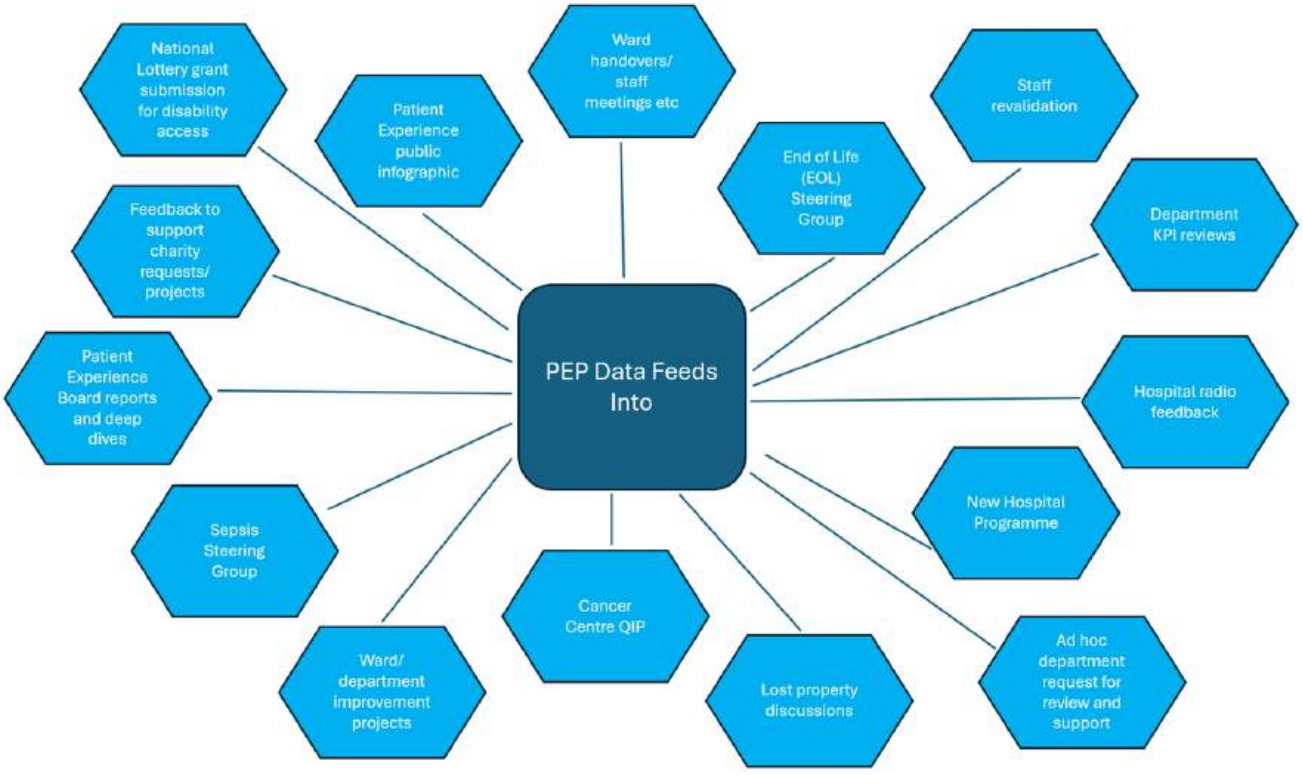
PEP (Patient Experience Platform) Dashboard Update

The data from PEP is showcased in the Integrated Quality Governance Report.

PEP enables staff to access their patients' feedback by area, compare against other areas, hospitals, and thoroughly analyse the data. Information from the dashboard is shared in reports to the Trust Board, divisional governance groups, divisional meetings and at the Patient and Family Experience Board to demonstrate how the dashboard is used to enhance and improve services and also allows for the celebration of positive comments.

The team continue to promote the use of PEP to ensure staff are engaging with the platform. This includes supporting the PEP champions and staff on wards, and ensuring staff are triangulating the data on PEP along with other feedback mechanisms available for any reports they are writing or projects they are undertaking.

Some examples of where PEP data is feeding into can be seen below.



3. Compliments

The data from compliments is shown in the Integrated Quality Governance Report.

Compliment of the month

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

MONTH	INDIVIDUAL COMPLIMENT	TEAM COMPLIMENT
January 2025	**Sorrell Dickson, Paediatric Play Specialist** 'My daughter recently stayed on Ward 5 and found being admitted to hospital for the first time and all of the tests she had very scary. She needed to have another blood test and got very upset and refused it 3 times. Sorrell (a member of the play team) spoke to her explaining how it was OK to cry, but that she had it in her to be really brave, and explained how important the test was in such a compassionate and child friendly way. My daughter then allowed the doctor to carry out the test, which wouldn't have been possible without Sorrell. Throughout her stay Sorrell helped provide activities for my daughter to do - from colouring to playdoh, which made all the difference to her stay, bringing her joy at a difficult time. My daughter even said she hoped to stay in hospital until Monday so she could see Sorrell again! I hope Sorrell knows how incredible she is at her role and what a genuinely compassionate and wonderful person she is. Thank you for everything.'	**Switchboard** 'Last Friday a young person that I work with was taken to hospital at about 3.30 am When he called me at 9.30 from the hospital in great distress and who's phone died as we were speaking. I started to try to locate him. The switchboard was extremely helpful even though he could not be located on the system and directed me to try the Campbell Centre. It took nearly 2 hours to get the phone answered at the Campbell centre and I was told he was not there. I then called back to Switchboard to ask how I could find out which hospital he may have been taken too if MKHU was too busy. I was transferred through to A & E reception then to the charge nurse where it became known that he was discharged at about 5 am so had not been handed over and presumably was still sitting in a room. She went to locate him, and he was able to make contact with me a short while later. The switchboard operator I spoke to on both occasions was extremely polite, with the right amount of empathy and support. She was very knowledgeable and reassured me she wanted to help. I know compliments are few and far between, but I do commend her for going over and above to try to assist me in locating this young person and her professionalism'.
February 2025	**Jose Gomez-Lopez, ED Doctor** 'Dear Sir/Madam, Re: Commendation to Dr. Gomez-Lopez, Jose Of A&E, Milton Keynes Hospital in name of XXXX Refers I am the undersigned and being one of your patients for years as I am in my 70s. I used to be a volunteer to serve all friends and neighbours in order to kill my time for the past years. Very unfortunately, I fell down from a tree whilst cutting a rotten branch for my neighbour sometime in February 2023 and was later rushed to A&E of MK hospital	**Recovery Team** 'I'd like to say a big thank you to everyone who looked after me so well when I was in Milton Keynes University Hospital last week for a mastectomy and suffered an adverse reaction to the general anaesthetic. I received excellent care in Recovery and later on Ward 24 but I'd particularly like to thank Recovery nurses, Holly and Debbie, who stayed on after their shifts had ended to look after me. I was in Recovery for several hours while the team worked to bring me round and to stop the non-epileptic seizures I was having. They really went above and beyond the call of duty to keep me

	where I was treated by a doctor on duty and was told my 3 rib cages were cracked and he also found my right thumb nail was in dark black colours but this wasn't done by this accident as it came for years. The doctor advised that it might be a kind of SKIN CANCER. I then applied to have treated by DERMATOLOGY where my right thumb nail plate was removed for biopsy test on 18/02/2023. The first new nail growing on it was very slow and took almost a year. Somehow another nail also found growing under the first nail about 4 months ago and so caused the edge of my thumb becoming swollen with abscess. During the period, I had reported to my GP for treatment with the following prescriptions 1) Ciprofloxacin 2) Itraconacillin 3) Flucloxacillin capsules & 4) Fucidin 20mg/g cream 5) Daktarin 15g All the above medications were tried but yet without any improvement and the symptoms still got worst. I had tried to book for several appointments again, but none could get through as all were fully booked. Under such circumstance, I had no other ways but just reported to URGENT CARE UNIT of MK hospital where the doctor only referred me back to my GP without any medication but recommended me to have an Xay arranged by my GP instead. I finally walked into A&E on 01/02/2025 where I was treated by Dr. Jose He is a very outstanding and Very professional doctor. His service attitude is very excellent. He is knowledgeable, skilled in craftsmanship and kind to others. An asset of A&E indeed. I am very enjoyable of his surgery on me, and he is the only one best doctor within my living in the UK over 25 years and that is why I would like to highly commend him accordingly. Be honest, a number of doctors today in some counties under the NHS are very sloppy to their patients and do their job not seriously unless the patients go to the private. Anyhow, thank you very much for reading my	safe and comfortable and to bring me round. Thank you so much.'

	story and please convey my best regard and commendation to this Dr. Jose and many thanks for his treatment on me. God bless all. One of your patients.'	
March 2025	**Neil Trew-Smith, Pharmacy Technician Section Manager** 'Neil was exceptionally helpful when we came to retrieve Dad\'s prescription out of hours. He was really happy to help with information, guidance on how to engage with the GP and local pharmacy, as well as providing ongoing support if needed. Made a potentially complex issue really straightforward. Thank you!'	**Haematology** 'My husband had an appointment this morning in haematology at 11am. He's been there for a year now since the wonderful dr hildyard did his last appointment in feb 2024. She was a blessing. Fantastic. Since then we've had a young lady consultant who is up against it with us because dr hildyard set such a hugely high standard! Poor woman! My husband has taken the paperwork, so I don't know her name. Although we've lost going to the cancer centre now for his appointments, this lady has been wonderful at haematology. She's been helpful and efficient. I feel bad that we keep asking her if a new consultant has been appointed yet so that he can return to the cancer centre. But she takes it on the chin. I hope she doesn't think we don't like her because we do. She's so lovely. Please tell her! I'd also like to thank the receptionist today at haematology who was efficient and helpful with all the patients. The student phlebotomist was also very good indeed. My husband commented to her supervisor and to the lady herself. All round, although it's sad to have cancer and even sadder, not to be in the cancer centre, haematology this morning was a good place to be because of the 3 lovely staff members'

Further data from compliments is shown in the Integrated Quality Governance Report.

4. Patient Experience data

Friends and Family Test (FFT)

The data from FFT is shown in the Integrated Quality Governance Report.

5. **Surveys – National CQC mandated surveys**

Maternity 2024

This survey was sent to women who gave birth in February/March 2024. The fieldwork took place between April and June 2024. The final CQC published results will be available in November 2024. Maternity Services have an action plan in place in response to findings; this is monitored through the Patient and Family Experience Board.

Maternity 2025

This survey will be sent to women who gave birth in February/March 2025. Fieldwork is currently being undertaken and there is a robust communication plan in place to work to increase engagement.

Adult inpatient 2023

The survey looked at the experience of adult inpatients who stayed at least 1 night during November 2023. The fieldwork took place between January and April 2024. The CQC results were published late August, and a Trust action plan is in progress and will lead to some quality improvement work in areas of concern.

Adult inpatient 2024

The survey will be sent to patients who have at least a one-night stay in November 2024. The fieldwork is taking place between January and April 2025 with the CQC published results expected in August 2025. There is a communication plan in place to work to increase engagement.

Urgent and Emergency Care 2024

This survey was sent to those adults attending the Emergency Department in February 2024. The final CQC published results were made available in November 2024.

Children and Young People 2024

This survey was sent to the parents/guardians of children and young people during the spring of 2024. The fieldwork took place between July and October 2024 and the final CQC results were published in March 2025. Work is being undertaken to ensure a robust action plan is in place.

6. **Conclusion and upcoming events/future plans**

The team have continued embedding existing projects and supported other areas in the gaining of feedback for projects and initiatives. Work is ongoing to ensure staff access the PEP dashboard and are aware of all the feedback that can be accessed on the platform, along with triangulating this with all other avenues of feedback available.

The team continues to focus on engaging with patients and families in the hospital and in the community.

What to expect – Q1 2025/26

- Continue work on the national survey actions plans
- Patient Experience Week
- Further planning for the joint Engagement and Experience Strategy
- Work on supporting Carers MK and their work plan
- College in the Community Day
- Hospital Community Day in Wolverton
- Work on supporting the Imaging team to increase feedback
- Launching feedback mechanism for private surgical patients
- Supporting the Dementia Nurse to get patient stories to share during Dementia Awareness Week
- Work on PEP Health business case and staff feedback
- Presenting at the community Hard of Hearing Event with Head of Audiology and Membership and Engagement Manager
- New easy read FFT forms are being produced with the support of the Communications team. These will then be shared with relevant patient groups for feedback
- Further work MK College and the charity to look at working together on further 'College in the Community' incentives
- Patient Experience Administrator recruitment
- Further recruitment of Patient and Family Experience volunteers to ensure the team supports as many patients and families as possible
- Events to raise further funding for the clothing project
- Support with gaining feedback for Birth Reflections
- Attending Governors Engagement Committee
- Attending Picker Workshop for Inpatient 2024 survey

Meeting Title	Trust Board Meeting (Public)	Date: 3 July 2025
Report Title	2025-26 Executive Summary M02	Agenda Item Number: 11
Lead Director	John Blakesley, Deputy CEO	
Report Author	Information Team	

Introduction	Purpose of the report: Standing Agenda Item
Key Messages to Note	**Emergency Department:** - There were 8,401 ED attendances in May 2025, a decrease of 127 attendances compared to April 2025. - The percentage of attendances admitted, transferred, or discharged within 4 hours was 76.0%, a deterioration in performance compared to 80.3% in April 2025. - 89.1% of ambulance handovers took less than 30 minutes in May 2025 and 99.7% took less than 60 minutes. **Outpatient Transformation:** - There were 31,884 outpatient attendances in May 2025. - 12.2% of these appointments were attended virtually and 5.3% of patients did not attend. **Elective Recovery:** - At the end of May 2025, 32,111 patients were on an open RTT pathway: 126 patients were waiting more than 65 weeks. 10 patients were waiting over 78 weeks. - At the end of May 2025, 7,136 patients were waiting for a diagnostic test. Of these, 67.4% were waiting less than 6 weeks. **Inpatients:** - Overnight bed occupancy in adult G&A beds was 88.6% in May 2025. - A considerable proportion of beds were unavailable due to: o 91 patients not meeting the criteria to reside. o 93 super stranded patients (length of stay 21 days or more). **Human Resources:** - In May 2025: o Substantive staff turnover was 12.1%. o Agency expenditure remained below the threshold of 5%, at 2.5%. o Appraisals achieved 90% and mandatory training 94%. **Patient Safety:** - In May 2025, the following infections were reported: o E-Coli: 3 o C.Diff: 5 o MSSA: 2 o Klebsiella Spp bacteraemia: 0 o P.aeruginosa bacteraemia: 0 o MRSA bacteraemia: 0

Recommendation *(Tick the relevant box(es))*	For Information ☐	For Approval ☐	For Assurance ☐

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

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

TheMKWay

NHS
Milton Keynes University Hospital
NHS Foundation Trust

Trust Performance Summary: M02 (May 2025)

1.0 Summary

This report summarises performance against key performance indicators and provides an update on actions to sustain or improve upon Trust and system-wide performance.

This commentary is intended only to highlight areas of performance that have changed or are in some way noteworthy. It is important to highlight that some local transitional or phased targets have been agreed to measure progress in recovering performance. It should however also be noted that NHS Constitutional Targets remain, as highlighted in the table below:

Indicator Description	Transitional Target	Constitutional Target
ED 4 hour target (includes UCS)	74.2%	95%
RTT Incomplete Pathways <18 weeks	48.1%	92%
RTT Patients waiting over 65 weeks	0	0
Diagnostic Waits <6 weeks	95%	99%

Monthly trajectories are in place to ensure that they are reasonable and reflect a realistic level of recovery for the Trust to achieve.

2.0 Operational Performance Targets

May 2025 performance against transitional targets and recovery trajectories:

Indicator	Threshold 2025-26	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
ED 4 hour target (includes UCS)	74.2%	74.2%	78.1%	76.0%	✓	▼	✓	
RTT Incomplete Pathways <18 weeks	53.6%	48.1%		49.1%	✓	▲		
RTT Patients waiting over 65 weeks (Total)	0	0		126	×	▼		
Diagnostic Waits <6 weeks	95.0%	95.0%		67.4%	×	▲		
62 day standard (Quarterly)	72.1%	69.7%		58.8%	×	▼		

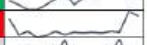
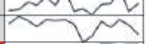
The percentage of ED attendances that were admitted, transferred, or discharged within four hours was 76.0%, a deterioration in performance compared to 80.3% in April 2025. This was above the national performance of 75.4% and puts us fourth in the MKUH peer group (see Appendix 1).

The volume of open RTT pathways was 32,111; an increase of 338 compared to April 2025. Of this total, 126 patients had waited more than 65 weeks for treatment. The Trust has robust recovery plans in place to support an improvement in RTT performance and to reduce patient waiting times. The cancellation of non-urgent elective activity and treatment for patients on an incomplete RTT pathway is also being proactively managed.

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

In Q4 2024/25, the 62-day standard performance (from receipt of an urgent GP referral for suspected cancer to first treatment) was 58.8% against a national target of 85%, a deterioration from 59.1% in the previous quarter. The percentage of patients to begin cancer treatment within 31 days of a decision to treat decreased from 96.2% to 96.0%, which equalled the national target of 96.0%. The 28 Day Faster Diagnosis performance was 73.6%, down from 75.1% in the previous quarter.

3.0 Urgent and Emergency Care

Indicator	Threshold 2025-26	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Cancelled Ops - On Day	1%	1%	0.72%	0.77%	✓	▼	✓	
Ward Discharges by Midday	25%	25%	22.5%	22.0%	×	▼	×	
Patients not meeting Criteria to Reside	50			91	×	▼		
Number of Super Stranded Patients (LOS>=21 Days)	50			93	×	▲		
Ambulance Handovers <60 mins (%)	100%	100%	99.7%	99.7%	×	▬	×	

Cancelled Operations on the Day

In May 2025, 20 operations were cancelled on the day for non-clinical reasons. The biggest contributors to this number were lists overrunning due to complexity of procedures and emergency admissions.

Patients not Meeting Criteria to Reside

The number of inpatients not meeting the criteria to reside at the end of May 2025 was 91 against a threshold of 50. This was a deterioration compared to the figure of 74 reported at the end of April 2025.

Length of Stay (Stranded and Super Stranded Patients)

The number of super stranded patients (e.g. length of stay of 21 days or more) at the end of the month was 93, an improvement compared to 111 in April 2025.

Ambulance Handovers

In May 2025, the percentage of ambulance handovers to the Emergency Department taking less than 30 minutes was 89.1%. This was deterioration in performance compared to 92.3% in the previous month.

The percentage of ambulance handovers to the Emergency Department taking less than 60 minutes was 99.7%, the same as the previous month.

4.0 Elective Pathways

Indicator	Threshold 2025-26	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Overnight Bed Occupancy - Adult G&A	95.7%	96.5%	88.6%	88.6%	✓	▼	✓	
RTT Incomplete Pathways <18 weeks	53.6%	48.1%		49.1%	✓	▲		
RTT Total Open Pathways (inluding ASIs)	30,958	32,020		32,111	✗	▼		
Diagnostic Waits <6 weeks	95.0%	95.0%		67.4%	✗	▲		

Overnight Bed Occupancy

Overnight bed occupancy was 88.6% in May 2025, below the threshold of 96.5%.

RTT Incomplete Pathways

The Trust's RTT 18 week performance at the end of May 2025 was 49.1% and the number of patients waiting over 65 weeks was 126. Total RTT open pathways was 32,111.

Diagnostic Waits <6 weeks

At the end of May 2025, performance was 67.4%, an improvement from 67.0% last month.

5.0 Patient Safety

Infection Control

In May 2025 the following infections were reported:

Infection	Number of Infections
C.Diff	5
E-Coli	3
MSSA	2
Klebsiella Spp bacteraemia	0
P. aeruginosa bacteraemia	0
MRSA bacteraemia	0

ENDS

Appendix 1: ED Performance - Peer Group Comparison

Several other NHS Acute Trusts have historically been considered as peers of MKUH. Their ED performance compared to MKUH over the past three-months can be found below:

March 2025 to May 2025 ED Performance Ranking

MKUH Peer Group Comparison - ED Performance	Mar-25	Apr-25	May-25
Homerton Healthcare NHS Foundation Trust	82.8%	82.0%	82.5%
Buckinghamshire Healthcare NHS Trust	78.9%	79.5%	77.6%
The Hillingdon Hospitals NHS Foundation Trust	75.8%	74.8%	77.0%
Milton Keynes University Hospital NHS Foundation Trust	74.5%	80.3%	76.0%
Oxford University Hospitals NHS Foundation Trust	68.4%	93.1%	75.8%
Mersey and West Lancashire Teaching Hospital (Formerly Southport and Ormskirk)	74.3%	74.6%	74.4%
Barnsley Hospital NHS Foundation Trust	80.2%	67.1%	71.9%
Northampton General Hospital NHS Trust	65.8%	66.0%	66.4%
The Princess Alexandra Hospital NHS Trust	69.4%	68.1%	64.8%
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	60.1%	61.3%	62.3%
Mid Cheshire Hospitals NHS Foundation Trust	59.8%	59.7%	57.5%

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Milton Keynes University Hospital NHS Foundation Trust

OBJECTIVE 1 - PATIENT SAFETY									
Indicator	DQ Assurance	Threshold 2025-26	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Mortality - (HSMR) ★		100.0	100.0		102.9	✗	–		
Mortality - (SHMI)		100.0	100.0		97.8	✓	▲		
Never Events		0	0	0	0	✓	–	✓	
Clostridium Difficile		47	<8	5	5	✗	▼	✓	
MRSA bacteraemia (avoidable)		0	0	0	0	✓	–	✓	
Falls with harm (per 1,000 bed days)		0.12	0.12	0.11	0.07	✓	▲	✓	
Incident Rate (per 1,000 bed days)		60	60	67.99	67.05	✓	▼	✓	
Duty of Candour Breaches (Quarterly)		0	0	0	0	✓	▲	✓	
E-Coli		57	<10	5	3	✓	▼	✓	
MSSA		17	<3	2	2	✗	▼	✓	
VTE Assessment		95%	95%	95.2%	95.2%	✓	▲	✓	
Klebsiella Spp bacteraemia		17	<3	2	0	✓	▲	✓	
P.aeruginosa bacteraemia		10	<2	0	0	✓	–	✓	

OBJECTIVE 2 - PATIENT EXPERIENCE									
Indicator	DQ Assurance	Threshold 2025-26	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
RED Complaints Received		0	0	0	0	✓	–	✓	
Cancelled Ops - On Day		1%	1%	0.7%	0.8%	✓	▼	✓	
Over 75s Ward Moves at Night		1,500	250	239	88	✓	▲	✓	

OBJECTIVE 3 - CLINICAL EFFECTIVENESS									
Indicator	DQ Assurance	Threshold 2025-26	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Overnight Bed Occupancy - Adult G&A		95.7%	96.5%	88.6%	88.6%	✓	▼	✓	
Ward Discharges by Midday		25%	25%	22.5%	22.0%	✗	▼	✗	
Weekend Discharges		63%	63%	80.1%	81.9%	✓	▲	✓	
Patients not meeting Criteria to Reside		50			91	✗	▼		
Number of Stranded Patients (LOS>=7 Days)		184			242	✗	▲		
Number of Super Stranded Patients (LOS>=21 Days)		50			93	✗	▲		
Discharges from PDU (%)		12.5%	12.5%	19.0%	19.5%	✓	▲	✓	
Ambulance Handovers <30 mins (%)		95%	95%	90.7%	89.1%	✗	▼	✗	
Ambulance Handovers <60 mins (%)		100%	100%	99.7%	99.7%	✗	–	✗	

OBJECTIVE 4 - KEY TARGETS									
Indicator	DQ Assurance	Threshold 2025-26	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
ED 4 hour target (includes UCS)		74.4%	74.2%	78.1%	76.0%	✓	▼	✓	
Total time in ED no more than 12 hours		93%	93%	95.0%	94.0%	✓	▼	✓	
Triage within 15 Minutes		90%	90%	71.9%	69.8%	✗	▼	✗	
RTT Incomplete Pathways <18 weeks		60.0%	48.1%		49.1%	✓	▲		
RTT Total Open Pathways (inluding ASIs)		30,958	32,020		32,111	✗	▼		
RTT Patients waiting over 65 weeks (Total)		0	0		126	✗	▼		
Diagnostic Waits <6 weeks		95.0%	95.0%		67.4%	✗	▲		
31 days Diagnosis to Treatment (Quarterly) ✎		96.4%	96.1%		96.0%	✗	▼		
62 day standard (Quarterly) ✎		72.1%	69.7%		58.8%	✗	▼		
28 Day Faster Diagnosis (Quarterly) ✎		77.9%	76.3%		73.6%	✗	▼		

OBJECTIVE 5 - SUSTAINABILITY									
Indicator	DQ Assurance	Threshold 2025-26	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Total Referrals Received		Not Available		32,423	15,721	Not Available	▼	Not Available	
Total ASIs		0	0		1,288	✗	▼		
Total RTT Non-Admitted Open Pathways					27,518		▼		
Total RTT Admitted Open Pathways					4,593		▼		
A&E Attendances		110,777	18,399	16,929	8,401	✓	▲	✓	
Elective Spells		31,128	4,908	4,413	2,174	✗	▼		
Non-Elective Spells		29,167	4,543	5,173	2,502	✗	▲	✗	
OP Attendances / Procs (Total)		489,844	77,359	67,619	31,884	✗	▼		
Outpatient DNA Rate		5%	5%	6.7%	5.3%	✗	▲	✗	
Virtual Outpatient Activity		25%	25%	12.9%	12.2%	✗	▼	✗	

OBJECTIVE 7 - FINANCIAL PERFORMANCE									
Indicator	DQ Assurance	Threshold 2025-26	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Income £'000		429,253	71,542	70,868	35,546	✗	▲	✗	
Pay £'000		(270,317)	(46,495)	(46,349)	(23,049)	✓	▲	✓	
Non-pay £'000		(131,649)	(22,527)	(23,074)	(11,537)	✗	–	✗	
Non-operating costs £'000		(27,287)	(4,462)	(4,235)	(2,121)	✓	▼	✓	
I&E Total £'000		0	(1,941)	(2,790)	(1,161)	✗	▲	✗	
Cash Balance £'000			12,845		16,324	✓	▼		
Savings Delivered £'000		23,816	2,373	1,662	968	✗	▲	✗	
Capital Expenditure £'000		(69,099)	(5,014)	(5,531)	(3,840)	✗	▼	✗	
Elective Spells (% of 2019/20 performance)		130%	130%	123.2%	110.3%	✗	▼	✗	
OP Attendances (% of 2019/20 performance)		130%	130%	120.9%	111.7%	✗	▼	✗	

OBJECTIVE 8 - WORKFORCE PERFORMANCE									
Indicator	DQ Assurance	Threshold 2025-26	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Staff Vacancies % of establishment		7.5%	7.5%		5.2%	✓	▲		
Agency Expenditure %		5.0%	5.0%	2.7%	2.5%	✓	▲	✓	
Staff Sickness % - Days Lost (Rolling 12 months) ✎		5.0%	5.0%		5.0%	✓	–		
Appraisals (excluding doctors)		90%	90%		90.0%	✓	–		
Statutory Mandatory training		90%	90%		94.0%	✓	–		
Substantive Staff Turnover		12.5%	12.5%		12.1%	✓	▲		

OBJECTIVES - OTHER									
Indicator	DQ Assurance	Threshold 2025-26	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Total Number of NICE Breaches		8	8		19	✗	▼		
Rebooked cancelled OPs - 28 day rule		90%	90%	86.4%	100.0%	✓	▲	✗	
Patient Safety Incidents (Reported)		9967	1662	1915	961	✓	▲	✓	
Patient Safety Incidents which resulted in moderate harm or above		1874	313	382	207	✗	▼	✗	

Key: Monthly/Quarterly Change

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

YTD Position

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

Data Quality Assurance Definitions

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

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

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Meeting Title	**Public Board**	**Date: 3 July 2025**
Report Title	**Finance Paper Month 2 2025-26**	**Agenda Item Number: 12**
Lead Director	**Jonathan Dunk**	**Chief Finance Officer**
Report Authors	**Sue Fox** **Cheryl Williams**	**Head of Financial Management** **Head of Financial Control and Capital**

Introduction	This report provides an update on the financial position of the Trust at Month 2 (May 2025).
Key Messages to Note	The Trust is reporting a **£2.8m deficit** on a Control Total basis to the end of May, which is **£0.8m adverse to plan**. The in-month position is a deficit of £1.2m, which is £0.3m adverse to plan. This in month actual deficit reflects a reduction from M1 position, where a loss of £1.7m was reported. The year-to-date adverse variance to plan is primarily driven by: • Lower than expected clinical income • Higher non-pay costs, including drugs • Under-delivery of the Cost Improvement Programme (CIP) as compared to phasing in the plan. ***Key Financial Drivers*** **Income Performance** • Elective Recovery Fund (ERF) activity was at 124% of pre-Covid baseline levels, exceeding the national target of 106%. This generated £2.2m of ERF income, which is above the national benchmark but below the internal plan of £2.9m. • Community Diagnostic Centre (CDC) income was £0.7m below plan, mainly due to delays in the ophthalmology service transfer. Although partially offset by lower costs, this resulted in a net adverse impact of £0.04m. **Expenditure Pressures** • Although notice was given on several high-cost capacity arrangements, many continued into April due to contractual obligations, including the use of modular theatres and outsourcing. These arrangements concluded as scheduled in May. The Trust is now developing its plan to meet the RTT (Referral to Treatment) target, which will involve the

procurement of targeted additional resources. These will undergo a rigorous value-for-money assessment to ensure they effectively support RTT delivery and contribute to generating additional ERF (Elective Recovery Fund) income.

- Drug expenditure exceeded the planned budget by £0.5m. £0.3m was due to additional High-Cost Drugs (HCD) costs, offset by additional income from Specialised Commissioning. The remaining £0.2m contributed to overall deficit.

Cost Improvement Programme (CIP)

- The Trust has a 6% savings target (£23.8m) for the year.
- £1.7m has been delivered to date, against a £2.4m year-to-date plan.
- Full development of all CIP plans is expected by end of June 2025, with a focus on accelerating delivery.
- At this stage the full CIP requirement is forecast to be delivered.

Key Issues to Resolve

The following key areas are being prioritised in the short term, to strengthen the Trust's financial position:

- Ongoing work is being carried out to optimise the alignment between income, activities, and the specific resources required to meet the enhanced RTT target of 60%. This includes ensuring a shared understanding of these priorities across the Trust and with commissioners.
- Recovery plan for the Community Diagnostic Centre to achieve its activity plan for 2025/26 taking into account the various delays relating to one of the site start-ups and hard to recruit clinical staff across a number of specialties.
- Agreement on contracts and plans is progressing well with the majority of commissioners; with any issues being escalated with the BLMK ICB and East of England regional team.
- Full identification of the actions and plans to deliver the efficiency programme and recover any phasing slippage.
- Actions and plans being implemented to deliver the bank and agency reduction targets at ward and department level.

Recommendation *Tick the relevant box(es)*	**For Information** ☐	**For Approval** ☐	**For Assurance** [x]

Strategic Objectives Links	7. *Spending money well on the care you receive* 10. *Innovating and investing in the future of your hospital*

Report history	None
Next steps	To note the contents of this report.
Appendices	Attached - Appendices 1-3 (Supplementary Shelf)

FINANCE REPORT FOR THE MONTH TO 31st MAY 2025

PUBLIC BOARD

CONTENTS

TheMKWay

NHS
Milton Keynes University Hospital
NHS Foundation Trust

EXECUTIVE SUMMARY

Measures

Ref	All Figures in £'000	In Month Plan	In Month Actual	In Month Var	YTD Plan	YTD Actual	YTD Var	Full Year Plan	Full Year Forecast	Full Year Var	RAG
1	Clinical Revenue	33,722	33,342	(381)	67,444	66,392	(1,052)	404,682	404,682	-	
2	Other Revenue	2,019	2,204	185	4,037	4,475	438	35,852	35,852	-	
3	Pay	(23,099)	(23,049)	49	(46,495)	(46,349)	145	(270,317)	(270,317)	-	
4	Non Pay	(11,288)	(11,537)	(249)	(22,527)	(23,074)	(547)	(131,649)	(131,649)	-	
5	Financing & Non-Ops	(2,271)	(2,190)	81	(4,542)	(4,374)	168	(27,767)	(27,767)	-	
6	Surplus/(Deficit)	(917)	(1,231)	(314)	(2,082)	(2,930)	(848)	10,801	10,801	-	
7	Control Total Surplus/(Deficit)	(847)	(1,161)	(314)	(1,942)	(2,790)	(848)	-	-	-	
	Memos										
8	High Cost Drugs	(2,344)	(2,609)	(265)	(4,650)	(4,996)	(346)	(27,849)	(27,849)	-	
9	Financial Efficiency	1,334	968	(366)	2,374	1,662	(712)	23,816	23,816	-	
10	Cash	12,845	16,324	3,479	12,845	16,324	3,479	7,021	7,021	-	
11	Capital Plan - CDEL (excluding donated)	(2,687)	(3,840)	(1,153)	(5,014)	(5,531)	(517)	(69,099)	(70,599)	(1,500)	

Key messages

The Trust is reporting a deficit position of £2.8m (on a Control Total basis) to the end of May 2025. This is adverse to plan by £0.8m. The in-month position is a deficit of £1.2m which is £0.3m adverse to plan.

At month 2 the Trust is behind its savings plan by £0.7m.

ERF performance is currently above the 106% target, with estimated income showing £2.2m above the national target as at M02. However, this is £0.7m below internal plan.

The capital expenditure programme is £0.5m above plan YTD and £1.5m above the full-year forecast.

(1 & 2.) Revenue – Clinical revenue for Integrated Care Board (ICB), NHS England (NHSE) contracts, and variable (non-ICB income) is below plan, due to Elective Recovery Fund (ERF) and CDC (Community Diagnostic Centre) under performance. Other revenue is above plan due principally to income received for education and training and funding from the local authority for therapies and frailty posts (offset by pay costs).

(3. & 4.) Operating expenses – Pay costs are lower than plan and agency expenditure has reduced again in May. Bank expenditure has also reduced with enhanced controls applied across nursing wards and escalation areas remaining closed in the month. Non-pay is overspent with an overspend on drugs (partly offset by income for high-cost drugs), and clinical outsourcing.

(7.) Control Total Deficit - The Trust is reporting a deficit position to the end of May.

(9.) Financial Efficiency – £1.7m delivered against an annual target of £23.8m. Plans are expected to be fully developed by the end of June 2025.

(10.) Cash – Cash balance is £16.3m, equivalent to 15 days cash to cover operating expenses.

(11.) Capital – Capital expenditure is currently £0.5m above the year-to-date plan and £1.5m above the full-year forecast. The full-year forecast variance reflects the additional Public Dividend Capital (PDC) funding allocated to the Trust under the New Hospital Programme (NHP).

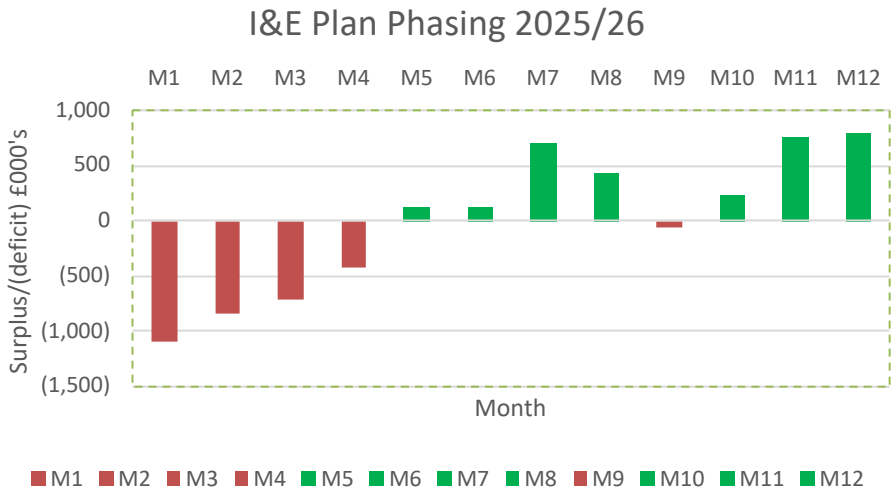
FORECAST

2. Forecast

At this early stage in the financial year, the forecast is expected to be on plan at breakeven. The phasing of the plan is illustrated below for information. A deficit position is expected in the first 4 months of the year whilst savings schemes are embedded and this switches to a surplus position from month 5 (August 2025).

To achieve the planned breakeven position by year end, the following actions are required:

- Control of temporary staffing spend (bank and agency use)
- Achievement of required savings target by each division.



Key message
The overall plan for the year is breakeven and this is phased to deliver a deficit in the first 4 months of the year. Achievement of the plan will depend heavily on the required savings being realised.

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CASH

3. Summary of Cash Flow

The cash balance at the end of May was £16.3m, £3.5m ahead of the planned figure of £12.8m. This positive variance was mostly driven by a delay in the receipt and payment of capital invoices. The May cash balance is a £0.2m decrease on last month's figure of £16.5m. (See FY26 forecast opposite).

See Appendices 2 for further cashflow detail.

4. Cash arrangements 2025/26

The Trust will continue to receive block funding for FY25 which includes an uplift for growth plus any additional incentive funding linked to activity delivery and funding for high-cost drugs on a pass-through basis.

5. Better Payment Practice

The Trust has fallen below the national target of 95% of all bills paid within the target timeframe in terms of value and volume. This is due to ongoing issues with agency invoicing and NHS approvals. BPPC has declined slightly from prior month, for both NHS and non-NHS. This metric will continue to be monitored in accordance with national guidance and best practice.

Better payment practice code	Actual M2 YTD Number	Actual M2 YTD £'000	Actual M1 YTD Number	Actual M1 YTD £'000
Non NHS				
Total bills paid in the year	10,368	43,676	5,591	28,581
Total bills paid within target	7,077	36,914	4,058	24,632
Percentage of bills paid within target	**68.3%**	**84.5%**	**72.6%**	**86.2%**
NHS				
Total bills paid in the year	346	2,680	222	1,685
Total bills paid within target	324	2,191	208	1,253
Percentage of bills paid within target	**93.6%**	**81.7%**	**93.7%**	**74.4%**
Total				
Total bills paid in the year	**10,714**	**46,356**	**5,813**	**30,265**
Total bills paid within target	**7,401**	**39,105**	**4,266**	**25,885**
Percentage of bills paid within target	**69.1%**	**84.4%**	**73.4%**	**85.5%**

Key message

Cash at the end of May was £3.5m ahead of plan, due to timing of the payment of capital invoices. There was a month-on-month decrease of £0.2m from April.

YTD BPPC performance has declined slightly in May. This metric will continue to be monitored in accordance with national guidance and best practice.

BALANCE SHEET

6. Statement of Financial Position

The statement of financial position is set out in Appendix 3. The key YTD movements include:

- Non-Current Assets have increased from March 25 by £2.8m; this is mainly driven by a £2.8m increase in tangible assets (additions).
- Current assets have decreased by £12.7m; this is mainly driven by a decrease in cash of £12.3m and a decrease in NHS receivables of £0.6m.
- Current liabilities have decreased by £7.7m; this is mainly due to a £8.7m decrease in trade payables, offset by an increase of £1.3m for deferred income.
- Non-Current Liabilities have increased from March 25 by £0.7m; this is due to the Right of Use assets, related to IFRS 16.

7. Aged debt

- The debtors position as of May 25 is £3.6m, which is an increase of £0.8m from the prior month. Of this total £0.6m is over 121 days old.

8. Creditors

- The creditors position as of May 25 is £6.6m, which is a decrease of £1.0m from the prior month. £1.8m is over 30 days of ageing with £0.6m approved for payment.

Key message

Main movements in year on the statement of financial position are the reduction in cash of £12.3m, reflecting a decrease in supplier payables of £8.7m and an increase in tangible assets of £2.8m.

RECOMMENDATIONS TO BOARD

9. The Trust Board is asked to note the financial position of the Trust as of 31st May 2025 and the proposed actions and risks therein.

Meeting Title	**Trust Board in Public**	**Date: 3 July 2025**
Report Title	**Executive Director Update - Workforce**	**Agenda Item Number: 13**
Lead Director	*Catherine Wills, Chief People Officer*	
Report Author	*Louise Clayton, Deputy Chief People Officer*	

Introduction	*Standing Agenda Item* *This report provides a summary of workforce Key Performance Indicators for the previous 12 months up to 31 May (M2) 2025/26 and relevant People and Culture updates*		
Key Messages to Note	*Points to note in the report for the members of the Board:* • *Temporary Staffing spend and usage continues to reduce incrementally. This remains an area of focus as we continue to seek to reduce reliance on temporary staff and work towards a more sustainable and stable workforce, balanced against operational need.* • *Absence has started to see an improvement in month and is now down to 4.2% for month 2. Investment in increasing the capacity of Occupational Health through the right-sizing business case approved in M2 will start to have an impact on this in Q3 once recruitment to the posts is complete.* • *The team continue to develop and promote training videos for staff to support them with completion of changes directly onto ESR (Employee staff Record) will have a positive impact on this.* • *The NHS Pay Award is due to be paid into August salaries and pay deadlines for payroll and rostering submissions will be brought forwards.*		
Recommendation	**For Information** √	**For Approval** ☐	**For Assurance** ☐

Strategic Objectives Links	*8. Employ and retain the best people to care for you*

Report History	*This is the first version of this report*
Next Steps	*This report will be presented at JCNC and TEC in July 2025*
Appendices/Attachments	*None*

1. Purpose of the report

1.1. This report provides a summary of workforce Key Performance Indicators as at 31 May 2025 (Month 2), covering the preceding 13 months.

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

Indicator	Measure	Target	05/2024	06/2024	07/2024	08/2024	09/2024	10/2024	11/2024	12/2024	01/2025	02/2025	03/2025	04/2025	05/2025
Staff in post *(as at report date)*	Actual WTE		3880.6	3879.2	3913.0	3873.3	3875.2	3885.2	3909.6	3924.3	3935.0	3950.0	4002.4	3983.0	**3994.5**
	Headcount		4415	4412	4449	4408	4406	4414	4439	4454	4466	4478	4528	4516	**4532**
Establishment *(as per ESR)*	WTE		4144.0	4156.7	4162.7	4159.1	4170.8	4187.0	4196.1	4199.2	4207.9	4209.4	4212.5	4207.1	**4218.7**
	%, Vacancy Rate - Trust Total	**7.5%**	6.4%	6.7%	6.0%	6.9%	7.1%	7.2%	6.8%	6.5%	6.5%	6.2%	5.0%	5.3%	**5.3%**
	%, Vacancy Rate - Add Prof Scientific and Technical		21.4%	22.2%	23.0%	23.8%	23.8%	23.9%	23.5%	25.6%	23.0%	20.8%	17.1%	17.5%	**17.0%**
	%, Vacancy Rate - Additional Clinical Services *(Includes **HCA**s)*		15.5%	14.7%	14.4%	16.7%	19.1%	18.8%	18.4%	16.6%	16.6%	16.1%	13.0%	13.3%	**13.4%**
	%, Vacancy Rate - Administrative and Clerical		2.9%	3.1%	2.8%	4.5%	3.9%	3.3%	3.6%	4.2%	4.5%	4.7%	3.7%	3.9%	**3.9%**
	%, Vacancy Rate - Allied Health Professionals		17.0%	18.6%	18.0%	16.0%	14.9%	16.5%	15.0%	14.0%	13.6%	13.2%	10.8%	11.8%	**11.6%**
	%, Vacancy Rate - Estates and Ancillary		8.7%	8.2%	7.7%	6.6%	7.0%	7.9%	8.2%	8.5%	7.5%	7.5%	6.8%	5.2%	**5.2%**
	%, Vacancy Rate - Healthcare Scientists		5.2%	5.0%	2.6%	1.9%	1.6%	0.0%	1.1%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0%**
	%, Vacancy Rate - Medical and Dental		2.1%	3.0%	-0.5%	1.2%	1.6%	0.9%	0.3%	0.2%	0.4%	0.0%	0.1%	0.9%	**0.9%**
	%, Vacancy Rate - Nursing and Midwifery Registered		0.8%	1.5%	1.5%	2.0%	1.7%	2.4%	1.6%	1.5%	1.6%	1.5%	0.9%	1.5%	**1.5%**
Staff Costs (12 months) *(as per finance data)*	%, Temp Staff Cost (%, £)	**5.0%**	11.7%	11.7%	11.7%	11.8%	11.8%	11.6%	11.5%	11.4%	11.3%	11.1%	11.0%	10.8%	**10.6%**
	%, Temp Staff Usage (%, WTE)		12.0%	11.9%	11.9%	11.8%	11.8%	11.7%	11.6%	11.5%	11.4%	11.4%	11.2%	11.2%	**11.1%**
Absence (12 months)	%, 12 month Absence Rate	**5.0%**	4.8%	4.8%	4.8%	4.9%	4.9%	4.9%	4.9%	4.9%	4.9%	5.0%	5.0%	**5.0%**	*4.9%*
	- %, 12 month Absence Rate - Long Term		*2.6%*	*2.6%*	*2.6%*	*2.6%*	*2.7%*	*2.6%*	*2.6%*	*2.6%*	*2.6%*	*2.6%*	*2.6%*	***2.7%***	*2.7%*
	- %, 12 month Absence Rate - Short Term		*2.2%*	*2.2%*	*2.3%*	*2.3%*	*2.2%*	*2.3%*	*2.3%*	*2.3%*	*2.3%*	*2.3%*	*2.4%*	***2.3%***	*2.2%*
	%,In month Absence Rate - Total		4.4%	4.3%	4.9%	4.9%	4.8%	5.1%	5.2%	5.6%	5.6%	5.3%	4.7%	**4.4%**	*4.2%*
	- %, In month Absence Rate - Long Term		*2.4%*	*2.4%*	*2.7%*	*2.8%*	*2.7%*	*2.5%*	*2.9%*	*2.8%*	*3.0%*	*2.9%*	*2.8%*	***2.6%***	*2.2%*
	- %, In month Absence Rate - Short Term		*2.0%*	*2.0%*	*2.2%*	*2.1%*	*2.1%*	*2.6%*	*2.3%*	*2.8%*	*2.6%*	*2.4%*	*1.9%*	***1.8%***	*2.0%*
Starters, Leavers and T/O rate (12 months)	WTE, Starters (In-month)		43.8	43.0	36.1	25.4	26.5	31.8	46.3	36.3	37.0	27.4	70.6	19.2	**35.2**
	Headcount, Starters (In-month)		51	49	45	28	29	37	50	40	45	32	77	21	**40**
	WTE, Leavers (In-month)		34.5	39.3	36.0	55.1	39.5	29.9	27.5	24.0	34.7	21.8	30.1	26.1	**29.3**
	Headcount, Leavers (In-month)		39	49	41	64	51	35	32	32	43	29	40	33	**35**
	%, Leaver Turnover Rate (12 months)	**12.5%**	13.1%	13.1%	12.5%	13.3%	13.1%	13.3%	13.1%	12.9%	12.7%	12.6%	12.6%	12.2%	**12.1%**
Statutory/Mandatory Training	%, Compliance	**90.0%**	96%	95%	94%	95%	95%	95%	95%	95%	95%	95%	94%	94%	**94%**
	Moving and Handling - Level 1 - 3 Years		94.0%	94.0%	93.0%	93.0%	93.0%	93.0%	93.0%	92.0%	92.0%	92.0%	92.0%	92.0%	**92.0%**
	Moving and Handling - Level 2 - 3 Years		94.0%	94.0%	94.0%	94.0%	93.0%	92.0%	92.0%	93.0%	92.0%	92.0%	90.0%	90.0%	**90.0%**
Appraisals	%, Compliance	**90%**	92%	91%	91%	90%	93%	93%	94%	92%	92%	92%	91%	90%	**90%**
Time to Hire (days)	General Recruitment	**35**	54	48	44	51	51	42	43	46	51	48	44	45	**48**
	Medical Recruitment (excl Deanery)	**35**	76	51	54	68	86	65	40	36	56	75	46	63	**131**
Employee relations	Number of open disciplinary cases		20	12	18	12	17	18	18	15	18	17	26	28	**28**
Number of payroll payments to all staff *(inc. Doctors in Training)* **for all payrolls processed**	*Number of Overpayments in monthly period*			10	19	27	30	11	41	39	33	45	17	27	**38**
	Number of Underpayments in monthly period			177	181	70	81	23	37	144	58	93	85	76	**74**
	Percentage of Payroll errors			4.2%	4.4%	2.1%	2.4%	0.7%	1.7%	4.1%	2.0%	3.0%	2.2%	2.2%	2.4%

2.1. **Temporary staffing cost** has **reduced** slightly (down to 10.6%) and is now the lowest it has been for 13 months. Usage as a % of WTE still remains high. Areas with high bank usage remain under review.

2.2. The Trust's **headcount has increased in month** and there are now 4532 employees in post with an increase in WTE to 3994.5. The **vacancy rate remains unchanged**, despite an increase in establishment in month. There has been no significant change in vacancy rate down to staff group level.

2.3. **Staff absence is at 4.9%** for the 12-month period and in-month has **reduced by over 1%** in 3 months, now reporting at 4.2%. Additional temporary Occupational Health resource has resulted in the support of more management referrals and the Employee Relations Team and Occupational Health and the HR Business Partners (HRBPs) have been working with managers to provide increased education around absence management.

2.4. **Staff turnover has improved and is down to 12.1%.** Retention projects in areas of high turnover continue and the HRBPs are carrying out bespoke pieces of work where turnover is high. This could also be attributed to a current feeling of instability and job security within the wider NHS and neighbouring NHS providers announcing redundancies.

2.5. **Time to hire is at 48 days** for general recruitment**.** Medicine Division were an outlier in month with an average time to hire of 78 days. Shortlisting and Candidate Selection by the Division took an average of 34 days. The time to hire for medical recruitment is particularly high due to low numbers of new starters and a hire that took a significant amount of time in Women's and Children's due to issues securing the appropriate visa.

2.6. The number of **open disciplinary cases** is 28. A detailed Employee Relations case report is produced monthly to Joint Consultative and Negotiating Committee (JCNC) and case length continues to fall.

2.7. **Statutory and mandatory training** compliance is at 94% and **appraisal** compliance is at 90%.

2.8. **Pay impacting errors** in M2 **are at 2.4%** following interventions for improved communications with managers on the completion of pay-impacting forms on ESR.

3. Continuous Improvement, Transformation and Innovation

3.1. The **Resourcing Group** continues to present granular bank and agency usage data to the Divisions to support them in targeted approach to temporary staffing spend. Governance arrangements for embedding these changes to practice are underway.

3.2. The Staff Health and Wellbeing and HR Teams are creating a toolkit to **better support managers in making adjustments** for their employees that have specific needs for their working environment due to a disability or health condition. The toolkit will include clear instructions on equipment, procurement, and examples of adjustments that could be considered to support quicker decision making. A training session on reasonable adjustments is also being developed as part of the toolkit.

3.3. The **Employee Passport** is currently being redeveloped with a view to improving completion and portability. The passport helps staff who have specific requirements at work, either due to a disability, long-term health condition, or caring responsibilities, to share their needs and adjustments that have been previously agreed as they move role or change line managers in the Trust. This will be launched in Q2.

3.4. As part of the work to reduce pay-impacting errors, the HR team have started to create **a suite of training videos** for managers, taking them through how to make changes on ESR through Manager's Self Service.

4. Culture and Staff Engagement

4.1. The Team are currently preparing the **Annual ED&I Report** and associated action plans, This report will include our WRES, WDES and Gender Pay Gap data and set out our plans for improvements that have been voiced during the Anti-Racism events held by the Executive Team. The WRES and WDES data is currently available on the Trust internet.

4.2. Progress on the Anti Racism Programme is presented in a separate update to board.

5. Current Affairs & Hot Topics

5.1. There is a current focus on ensuring that our rosters are compliant with the **Working Time Directive**. Restrictions are in place to prevent shifts from being booked that do not allow from the appropriate rest breaks as well as the required daily and weekly rest. Where managers are changing rosters retrospectively in order to bypass these restrictions, escalation to the senior divisional leadership team will be made.

5.2. The Trust's **Sexual Safety at Work** policy has now been launched alongside toolkits and comms, to support a safer working environment. A suite of training will follow, for both managers and employees, to embed a safe and professional working environment. Bystander training is a key part of this and our leadership teams are asked to role model interventions, not just when they witness sexual misconduct, but where they see any behaviour that falls outside of the Trust Values and behaviours framework.

5.3. The **new job profiles for job matching** and evaluation have now been released by the national team and are available on the NHS Employers Website. An evaluation group has been set up to review Nursing and Midwifery jobs against these new profiles to ensure fairness of pay.

5.4. The **NHS 2025/26 Pay award** is confirmed and the new pay rates and backpay to 1st April will be reflected in August salaries. Weekly paid staff will notice the new pay rates being applied from 28th July in their pay through August. As processing times in August will be longer, Payroll and rostering deadlines will be moved earlier to allow for this.

6. Recommendations

6.1. Members are asked to note the report.

Meeting Title	**Public Board**	**Date: 3 July 2025**
Report Title	**Anti Racism Programme**	**Agenda Item Number: 14**
Lead Director	**Catherine Wills, CPO**	
Report Author	Catherine Wills, CPO	

Introduction	To provide the Board with an update on the progress made with the Anti Racism Programme launch.		
Key Messages to Note	Launch events took place throughout May and included: - A 25% increase in attendance at Town Hall - Over 100 people attending face to face sessions - Over 200 visits to the online interactive summary report (appendix A)		
Recommendation *(Tick the relevant box(es))*	**For Information** [x]	**For Approval** [ ]	**For Review** [ ]
Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	Employ and retain the best people to care for you		
Report History	This is the first submission of this report		
Next Steps	Ongoing monitoring of this programme will happen through the People and Culture Committee		
Appendices/Attachments	Appendix A: Anti Racism Programme Summary Report (Supplementary Shelf)		

1. Executive Summary

1.1. Through May and June Anti Racism Programme sessions were scheduled for discussion on the report and were hosted by a variety of executives across this period.

1.2. The following events took place:

Date	Event
14th May	Trust Executive Committee
14th May	Inclusion Leadership Council
15th May	Joint Negotiating Committee (JCNC)
21st May	Town Hall (25% increase up on usual attendance)
22nd May	Leadership Forum
28th May	Academic Centre – open session (40+ attendees)
29th May	Academic Centre – open session (60+ attendees)
12th June	Medical Advisory Committee
12th June	Womens Network

1.3. The full report was formally launched online on 21st May following Town Hall.

1.4. This was accompanied by a summary interactive online booklet, which is available in **Appendix A** and to date has received over 200 interactions.

2. Next Steps

2.1 Our Trust wide Inclusion Lead commenced in post on the 9th June, and has quickly picked up the momentum of the Anti Racism Programme as a priority area of work.

2.2 Over the coming months the Anti Racism Programme initial actions will be subsumed into an overarching Anti Racism Strategy, the development of which will be led throughout the summer including further engagement sessions by the Inclusion lead.

2.3 The expectation is that we will launch an Anti Racism Strategy that has been co developed with key stakeholders in the organisation in the Autumn

2.4 Ongoing monitoring against the KPIs of that strategy and initial anti racism actions will be overseen by the **People and Culture Committee**.

Meeting Title	**Trust Board (Public)**	**Date: 3 July 2025**
Report Title	**BLMK & MKUH Green Plan 2025-2028**	**Agenda Item Number: 15**
Lead Director	Jonathan Dunk, Chief Finance Officer	
Report Authors/Editors	Benjamin Ayuba - Senior Improvement Lead Saima Whatley – Head of Transformation	

Introduction	The Trust is required to agree a new three-year green plan for the period 2025-2028, following the conclusion of the term of the previous plan. As agreed with Trust Board, the MKUH Green Plan 2025-28 will largely mirror the BLMK ICS Green Plan 2025–28. This ensuring a consistency of approach, deliverables and metrics across the system, whilst still allowing opportunity for local flexibility where appropriate. The plan sets key targets across 11 focus areas. There are 82 newly identified schemes for 2025-2028, with approximately 47% delivered in Year 1. For context MKUH has achieved 80% of the key targets we set in the 2021–24 plan. MKUH continues to target Net Zero (NZ) by 2030 for Scope 1 and 2 emissions, ahead of the NHS targets of 2040-45 for direct and indirect emissions.		
Key Messages to Note	Key points to note: • Updated guidance – The National NHSE sustainability guidance was published in February 2025 and updated in May 2025. It provides the key actions for NHS organisations 2025–28 Green Plans. • BLMK ICS Green Plan 2025-28: has been developed with input from all key stakeholders. The Finance and Investment Committee has agreed to progress the plan to Trust Board. • Integrated Approach: The ICS Green Plan will serve as an overarching framework, linking together various health providers in BLMK while facilitating shared learning and collaboration. • The MKUH Green Plan: The plan has been developed in alignment with NHS Guidance and ICS Green Plan. The plan includes regional and system-wide initiatives, which is supported by leadership from the ICB and MKUH. The plan is outlined in the appendices and provides a breakdown of the initiatives, targets and measures to track progress over the next 3 years. • Identification of leads in the green group to support the delivery of two focus areas; Net Zero Clinical Transformation and Travel and Transport.		
Recommendation	**For Information** ☐	**For Approval** x	**For Assurance** x

Strategic Objectives Links	1. *Keeping you safe in our hospital* 2. *Improving your experience of care*

	3. *Working with partners in MK to improve everyone's health and care* 4. *Spending money well on the care you receive* 5. *Expanding and improving your environment* 6. *Innovating and investing in the future of your hospital*

Report History	This plan has been reviewed and agreed by the Finance and Investment Committee. Due to the requirement to agree this ahead of ICB formal approvals and national submission, the ICS Green Plan, along with MKUH additional deliverables, was approved privately at June Board Seminar. As such it is on agenda today for formal approval in public only.
Next Steps	Approve BLMK ICS Green Plan Approve initiatives for MKUH Green Plan
Appendices/Attachments	*N/A*

Glossary of Acronyms

	Acronyms	
	NZ	Net Zero
	BC	Business case

Contents

Executive Summary

Background

This report provides an update on the MKUH Green Plan (2025-2028). A draft plan has been developed that aligns with National guidance and the Bedford, Luton, and Milton Keynes Integrated Care Board (BLMK ICS). The plan will continue the Trust progress towards achieving national sustainability targets (2025-2045), with a focus on achieving Net Zero (NZ) by 2030.

The BLMK-wide Green Plan (2025-2028) has been developed and sent to partner organisations for review and approval. The system-wide Green Plan for 2025, sets out a unified vision to support People, Places, and Planet. Underpinned by a commitment to strong leadership, storytelling, and removing barriers to action, the programme is branded BLMK CARES, focusing on four key areas:

1. **Culture** – Fostering a supportive environment for climate action through informed leadership, governance, communication, and capability-building.
2. **Climate Adaptation** – Enhancing infrastructure and community resilience, supporting biodiversity, and optimising transport and supply chains.
3. **Resource Consciousness** – Promoting circular economy principles through the "5Rs" (Reduce, Reuse, Reprocess, Renewable, Recycle), sustainable procurement, and waste minimisation.
4. **Environmentally Sustainable Healthcare** – Embedding prevention, healthy lifestyles, service redesign, and adoption of low-carbon innovations into health and care delivery.

At MKUH, the green plan has been developed to build on the initiatives that were delivered in 2021-2024. Due to the Trust's efficiency programme, some initiatives were not delivered and will be transferred to the MKUH Green Plan 2025-2028. The plan has been developed to account for National Guidance, the BLMK Green Plan 2025, and local initiatives that will support achieving Net Zero by 2030. To support the MKUH Green Plan, the MKUH Green Group has been reinstated to drive both local and system-wide sustainability initiatives.

Key Enablers:

- Staff Education – Embedding sustainability training.
- Innovation & Trials – Testing and scaling sustainable healthcare solutions.
- Data & Monitoring – Developing dashboards to track progress.
- Environmental Impact Assessments – Supporting informed decision-making.
- Sustainability Networks – Engaging staff and the wider community in sustainability efforts.

MKUH's sustainability strategy follows a 'dual approach'

- Meeting the 2030 Net Zero target for Scope 1 and 2 emissions.
- Collaborating with ICS partners to achieve the wider system-wide Net Zero goal by 2040.

Key MKUH initiatives for carbon reduction:

- Reintroducing Green Champions to drive initiatives

- Transitioning to cleaner fuels, facilities, and fleet operations.
- Expanding Patient Initiated Follow-Up (PIFU) to reduce travel.
- Salix-funded decarbonisation projects (e.g., HVAC, LED lighting, energy-efficient buildings).
- Decommissioning high-carbon footprint medical gases (e.g., nitrous oxide).
- Improving waste management and sustainable procurement.

Next Steps for MKUH (2025-2028):

1. Sign-up to the ICS Green Plan 2025
2. Approve the MKUH Green Plan 2025-2028
3. Communications and engagement plan

The MKUH Transformation Team will continue driving sustainability initiatives, focusing on carbon baselining, energy efficiency, and waste reduction to meet the 2030 targets.

Impact of Recommendations on Trust's Strategic Objectives

- The proposed Integrated Green Plan will be for the NHSE target for NZ.
- The proposed national guidance and the BLMK plan will support MKUH's Net Zero Emissions target for 2030, although it aligns with the broader NHS carbon emissions reduction targets of 2040 and 2045.
- Resources will need to be allocated to identify key areas for emissions reduction, implement necessary changes, and track carbon emissions.
- The green plan initiatives will be reviewed in line with the Trust efficiency targets to ensure that the green initiatives support the Trusts Efficiency targets.

Finance, Risk and Resource Implication

- **Baseline:** Meeting MKUH's carbon net zero target by 2030 will be a significant challenge. It is therefore likely that MKUH will need to enlist some external expertise to provide a baseline of where we are now versus NZ achievement and advise as to what key areas to focus during the delivery of the 2025-2028 plan. A tracking and monitoring tool will also be required to measure carbon emissions versus plan, with a contingency plan to stay on target
- **Funding**: Key initiatives in estates and facilities/medicines require funding to be delivered e.g., Decommission piped nitrous oxide gas and replacing these with cylinders on anaesthetic machines. External funding from NHS England will be bid for by the leads but some investment from MKUH may be required to meet all the initiatives.

***NB**: Any additional funding requirements will be identified and a business case developed for approval. There will be a cost versus benefits and funding streams to support the plan and how this aligns with the overall efficiency / productivity plan for the organisation.*

- **Resource:** There is limited staff to complete reviews and support all the plans that we are aiming to deliver. Additional support will be needed from staff to support. Green champions will be reinstated to support the delivery of the green initiatives. Protected time may be required to ensure green champions can support the initiatives being delivered in 2025-2028.
- **Clinical engagement/Leadership:** Clinical leadership will be required to support the Net Zero Clinical transformation focus area and other key schemes e.g., Procurement. A lead will be identified with the CMO and a clear plan for engaging

clinical staff will be developed and included in the engagement strategy for the Green Plan.

Action/ Recommendations

The Board is asked to note and approve the direction of travel for the MKUH Green Plan and the proposed integrated BLMK / key stakeholders' approach / plan

- Sign-up to the ICS Green Plan 2025
- Approve the MKUH 2025-2028 Green Plan

MKUH Green Plan (2025-2028)

NHS Guidance

In 2020, the NHS was the world's first health system to commit to net zero emissions. After the success of the 2021-2024 Green Plan, new NHS guidance requires all Integrated Care Boards (ICBs) and trusts to refresh and submit updated green plans by 31 July 2025. These plans, spanning a minimum of three years, aim to cut emissions, improve health outcomes, and reduce inequalities while delivering high-quality care.

The updated Green Plans will consider the role of the local system including the ICB and other local providers. The new NHS guidance requires the Trusts to identify measurable, locally relevant actions across nine key focus areas: leadership, workforce, net zero clinical transformation, estates, digital transformation, medicines, travel and transport, procurement and supply chain, food and nutrition and adaptation.

Bedford, Luton, and Milton Keynes (BLMK) ICS Plan

The BLMK Integrated Care System (ICS) has developed a refreshed system-wide Green Plan for 2025, setting out a unified vision to support *People, Places, and Planet*. Underpinned by a commitment to strong leadership, storytelling, and removing barriers to action, the programme is branded **BLMK CARES**, focusing on four key areas: *Culture, Climate adaptation, resource consciousness, and environmentally sustainable healthcare*

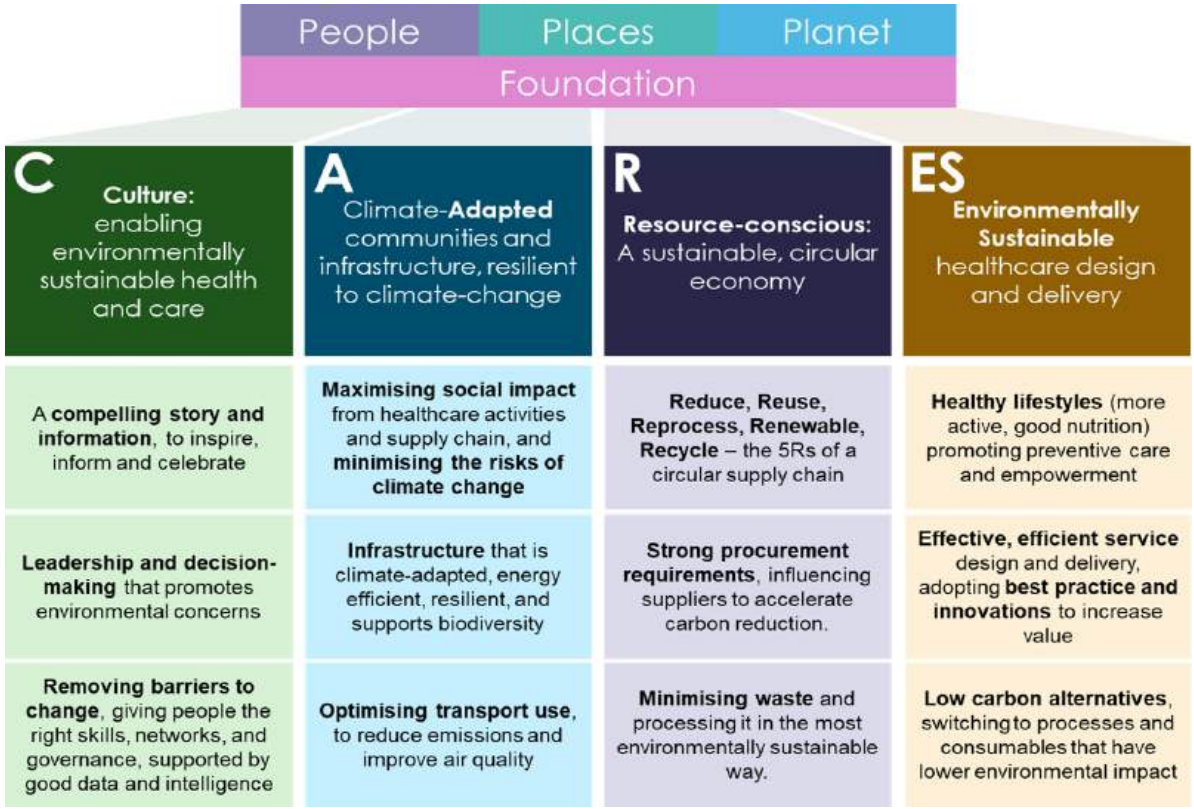


Figure 1 BLMK Programme Areas

The plan sets out the following carbon reduction targets:

- **NHS Carbon Footprint (CF)**: Net zero by 2040 (aspirational target 2035), with an 80% reduction by 2032 (aspiration: 2028). This requires >7.5% annual emissions reduction to 2032.
- **NHS Carbon Footprint Plus (CF+)**: Net zero by 2045 (aspiration: 2040), with an 80% reduction by 2039 (aspiration: 2036), requiring ~6% annual emissions reduction to 2039. All NHS providers in BLMK are expected to meet these targets.

The MKUH Green Plan will be developed to meet the identified targets against the programme areas set out in the BLMK Green Plan 2025.

MKUH Green Plan (2025-2028)

In line with NHS guidance, the MKUH Green Plan has been developed through engagement with key stakeholders leading across the nine national focus and a trust initiative focused on our role as an anchor organisation in the area.

MKUH remains committed to exceeding the national Net Zero target of 2040, setting an internal ambition to achieve Net Zero by 2030. Led by the MKUH Green Group, and informed by the NHS focus areas, the Trust has developed a comprehensive three-year plan to drive local sustainability initiatives and measure progress.

The 10 focus areas for the MKUH Green Plan are described below, showing the key initiatives delivered in MKUH 2021-2024 plan and the plan for delivery in 2025 – 2028 plan set against the national guidelines and the BLMK Green Plan 2025. For a full breakdown of the initiatives achieved in 2021-2024 and the targets for 2025-2028 see appendix 1 and 2 respectively.

*NB: * denotes initiatives that are being brought forward from the 2021-2024 Green plan into 2025-2028.*

Leadership

For the 2021-2024 Green Plan, MKUH followed NHS guidelines and:

- ✓ Appointed a dedicated Executive Lead—the Director of Finance
- ✓ Set up a Green Group comprising dedicated leads across each focus area was established to support implementation of the 2021–2024 sustainability goals.

For the 2025 – 2028 Green Plan, MKUH will further strengthen leadership and strategic oversight using the *Culture* programme area, including:

Culture

- Appointing a Clinical Lead to oversee the Net Zero Clinical Transformation workstream
- Refreshing key policies and strategies, including the Infrastructure and Digital Strategies, to ensure alignment with the updated objectives of the MKUH Green Plan

Workforce

For the 2021–2024 Green Plan, MKUH completed the following workforce initiatives:

- ✓ Implementation of an agile and home working model, with policy approval in October 2023
- ✓ Establishment of a Space Committee focused on optimising estate utilisation
- ✓ Provided flexible Estate task-based accommodation to a high environmental standard on and off site – Pines Suite and Witan Gate
- ✓ Specified courtyards have been introduced across the site enhancing wellbeing by encouraging patients, visitors and staff to interact with nature.

For 2025–2028, the Workforce will continue top progress sustainable workforce initiative using the *Culture* programme area, including

Culture

- Enhancing staff carbon literacy through regular communications such as features in the staff newsletter and intranet, promotion of NHS Greener resources, and support for green events*

- Redeploy Green Champions, supporting the ICS target that at least 2.5% of staff develop enhanced sustainability knowledge*
- Deliver training to staff using Sustainability leaders who will be trained through the IEMA-accredited sustainability course – funded and supported by the ICS

Net zero clinical transformation

For the 2021–2024 Green Plan, MKUH successfully delivered the following initiatives under the previous sustainable models of care focus area. Key achievements included:

- ✓ Implementation of Same Day Emergency Care (SDEC) pathways via the new Maple Centre, helping to reduce avoidable admissions
- ✓ Running 'Super surgery days' for Paediatrics, consolidating other services in the Trust to support the management of delivery.
- ✓ Refurbishment of the Milton Mouse Paediatric Unit, increasing capacity and enhancing the patient care environment
- ✓ Developed community care services which are based offsite, which reduces emissions by reducing the need to travel to the hospital e.g., Lloyds Court and Whitehouse surgery.

For 2025–2028, the Trust will continue to progress this work through the *Net Zero Clinical* in two programme areas, *Transformation* workstream in the *Environmentally sustainable*, including:

Environmentally sustainable

- Expanding the uptake of Patient-Initiated Follow-Up (PIFU) to 5% of outpatient activity—placing MKUH in the top national quartile—while maintaining appropriate clinical governance around activation rates
- Implementing clinical Quality Improvement (QI) projects, with sustainability at the heart of the projects, targeting measurable reductions in carbon emissions alongside gains in patient outcomes, service efficiency, and health equity

Digital

For the 2021–2024 Green Plan period, MKUH successfully delivered the following key initiatives.

- ✓ MyCare Platform: Enabled digital access to patient letters, significantly reducing paper use and postal-related emissions
- ✓ Remote Working Support: Expanded access to Microsoft Teams and supporting IT infrastructure, helping to reduce travel and associated carbon emissions
- ✓ Smart Buildings: Introduced empathic building management systems in the Pines Suite to optimise environmental controls and energy efficiency

For the 2025–2028, Green Plan, will continue to deliver sustainable digital initiatives in two key programme areas: *resource consciousness*, and *environmental sustainability*, including.

Resource Consciousness

- Introducing responsible IT recycling in compliance with Waste Electrical and Electronic Equipment (WEEE) regulations
- Donating redundant IT equipment to charitable organisations to reduce landfill waste and carbon emissions

Environmental Sustainability

- Migrating from on-premises servers to cloud-based hosting to reduce energy consumption

- Implementing energy-saving measures, such as power management schemes for laptops and PCs
- Reviewing and replacing backup power devices with energy-efficient alternatives
- Replacing Workstations on Wheels (WoWs) with lower-energy models to reduce bedside care emissions

Medicines

For the 2021-2024 Green plan, MKUH delivered the following initiatives

- ✓ Decommissioned the use of Desflurane—a high-impact anaesthetic gas—achieving the national phase-out target ahead of schedule

For 2025-2028, MKUH will continue to advance its work on sustainable medicines across three programme areas *culture, environmental sustainability and resource consciousness.*

Culture

- Develop a Greener Pharmacy Plan, aligned with Royal Pharmaceutical Society (RPS) guidance
- Educate staff and patients on sustainable pharmaceutical practices, including appropriate inhaler use and disposal*

Environmental Sustainability

- Ongoing collaboration with BLMK Integrated Care Board (ICB) to support the transition to lower-carbon inhalers, particularly alternatives to pressurised Metered-Dose Inhalers (pMDIs)*

Resource Consciousness

- Explore recycling options for medicine containers and packaging
- Expand the use of electronic communications in pharmacies to reduce reliance on printed materials

Travel and Transport

For the 2021-2024, MKUH delivered the following travel and transport initiatives, including.

- ✓ Installation of electric vehicle (EV) chargers in staff and public car parks, with free charging available for staff.
- ✓ Launch of a NextBike station with 20 bikes at the hospital's main entrance for use by staff and patients.
- ✓ offered VIVUP app to staff for employee benefits, including Salary sacrifice Car lease scheme, Salary sacrifice bike scheme

For 2025–2028, MKUH will continue to deliver its green initiative for travel and transport in the *climate-adapted programme area, including*

Climate Adapted

- Optimising Staff and Commuter Transport: Promoting a shift to lower-carbon transport modes to reduce emissions and improve local air quality.
- Reducing Fleet and Business Travel Emissions: Exploring opportunities to decarbonise fleet operations and improve the sustainability of patient transport, collection, and delivery services.
- All new fleet vehicles (owned or leased, excluding dual-crewed ambulances (DCAs)) to be zero- emission vehicles (ZEV) from 2030 and all new DCA fleet to be net zero from 2035.

Estates and facilities

The Estates and Facilities team has made strong progress in delivering against the 2021–2024 Green Plan, with key achievements including:

- ✓ Installation of 600 additional solar panels, increasing the Trust's on-site renewable energy generation
- ✓ Exploration of High Temperature Incineration (HTI) for clinical waste disposal, a method currently used to generate energy at Princess Alexandra Hospital

As part of the 2025–2028 Green Plan, MKUH will continue to deliver its sustainable estates and facilities initiatives in three programme areas: *Culture*, *Climate Adaptation*, and *Environmental Sustainability*, including

Culture

- Energy manager training will be delivered to help managers to review and optimise energy settings and controls, with the objective of reducing overall energy consumption.

Resource consciousness

- Connecting the hospital to the District Heat Network to decarbonise heat supply
- Upgrading and replacing key infrastructure to reduce operational emissions e.g., Low temperature radiators, and changes to plumbing and controls

Environmentally Sustainable

- Phasing out heavy oils and backup fuels currently used for heating and hot water
- Installing low-carbon equipment such as condensing boilers to improve energy efficiency

Supply Chain and Procurement

For the 2021–2024, MKUH delivered the following initiatives key initiatives in the supply and procurement focus area, including:

- ✓ Ensuring all suppliers with contracts over £5 million have submitted a Carbon Reduction Plan
- ✓ Replaced all bedframes and mattresses with energy-efficient models, reducing electricity use
- ✓ Procured reusable cold sticks to replace aerosol-based chemicals for sensory testing following spinal, epidural, or local anaesthesia

For the 2025–2028, MKUH will continue to deliver sustainable supply chain and procurement practices, using three programme areas *Culture, Climate adapted* and *resource-conscious*, including:

Culture

- Train divisional stakeholders on the legal and policy requirements to utilise sustainable suppliers where possible when reviewing contracts and completing tender exercises
- Introduce sustainability labelling on products to raise awareness among staff and patients

Climate Adapted

- Partner with other organisations to leverage collective purchasing power for more sustainable products and to offset potential cost implications

Resource consciousness

- Review products with multiple suppliers and work to rationalise to reduce number and frequency of deliveries to the trust, reducing the associated emissions*
- Reducing or eliminating single-use items where safe, reusable alternatives are available

Food and Nutrition

For the 2021–2024 Green Plan, MKUH made significant progress in the food and nutrition, including.

- ✓ Maintaining inpatient food waste at 2%
- ✓ Replaced all gas ovens with electric models, contributing to reduced carbon emissions
- ✓ Introduced digital tablets to replace printed menus, saving the equivalent of approximately 47 trees per year
- ✓ Removed single use plastic cutlery in the restaurant and replaced with wooden cutlery. The Trust will save disposal of approx. 230000 individual spoons, forks and knives per year, with a financial saving of £4,200 per year
- ✓ Partnered with Guardians of Grub Initiative to continually monitor food waste

As part of the 2025–2028 Green Plan, MKUH will continue to drive progress through three core programme areas, *culture, resource consciousness and environmentally sustainable, including*:

Culture

- Introduction of new policies to support food waste reduction
- Educate and raise awareness for staff and patients on sustainable food choices & “Food Fit” plant-based options

Resource consciousness

- Implement reuse and recycling practices in food production areas

Environmentally sustainable

- Review the patient snack menu to introduce lower carbon, low calorie or higher-protein alternatives
- Launching further initiatives to reduce emissions from the food supply chain—from farm to hospital

Adaptation

During the 2021–2024 period, MKUH implemented several key initiatives in line NHS guidance including:

- ✓ Completion of a climate adaptation risk assessment and development of a corresponding action plan.
- ✓ Development of an Adverse Weather and Health Policy, which outlines the Trust’s response to national health weather alerts and aligns with national planning frameworks.

In 2025-2028, MKUH will continue to progress its plans to ensure sustainable and adaptable practices in the *culture* programme area, including.

Culture

- Developing an updated adaptation plan, fully aligned with the Trust’s Green Plan.

Our role as an anchor organisation

The concept of ‘anchor institutions’ refers to large organisations deeply connected to their local areas, using their assets and resources to support the well-being of surrounding

communities. As one of the main employers in Milton Keynes and a key supporter of local health and welfare, we are committed to embracing this role by.

- Collaborating closely with local partners
- Purchasing more locally
- Green suggestion boxes for all who come to MKUH (2024)
- Continue with colleague engagement, events, using the intranet page and newsletters show casing completed projects.
- Continued and ongoing communications across MKUH, MK and sharing ideas across East of England network.
- Weekly opportunity to engage with the Executive team and share your ideas in an online Town Hall event.
- To develop an accurate process and system for measuring the carbon score across all eleven focus areas and aligned to risk assessment and plans and counting down to 2030 (with a requirement for mitigation, monitoring, and resourcing).
- Aim to integrate the green plan with quality and efficiency plans and business case completion/ criteria.
- Engage with our local partners, ICS, peers and explore other opportunities and share data to make improvements.

Communications and staff engagement

A critical component in the successful delivery of the Green Plan 2025–2028 is meaningful engagement with both staff and the wider Milton Keynes community. Continued collaboration with the established Green Committee will play a key role in shaping and driving sustainability initiatives across the Trust and beyond.

NB: A full communications and engagement plan will be developed and shared.

Ongoing engagement activities will include the following:

Staff Engagement:

- Regular updates via the Trust's social media channels and website
- A staff-wide survey to gather suggestions, ideas, and feedback
- The creation of a dedicated Microsoft Teams channel for staff interested in sustainability
- Partnership working with MK Hospital Charity to enhance community outreach and integration

Patient and Public Engagement:

- Regular updates via the Trust's social media channels and website
- Community-focused sustainability events
- Sharing progress on the Green Plan at the Annual Members' Meeting
- Development of a Greener NHS case study to highlight key programmes and raise awareness
- Distribution of a 'Green' newsletter, including clear communication on the measurable impact of sustainable behaviours on carbon emissions

Governance

For the 2025–2028 period, governance of the Green Plan delivery will be maintained through a structured framework to ensure continued progress and accountability:

- The Executive Lead, supported by the Green Group, will remain responsible for driving the sustainability agenda across MKUH in line with NHS guidance.

- The Green Group will convene regularly every eight weeks to review progress, discuss risks, and oversee delivery of key initiatives.
- A new reporting structure will be implemented to systematically review initiatives and monitor progress against Trust, ICS, and NHS targets.

In addition, external reporting requirements will be managed in coordination with the ICS and NHS England, including:

- Submission of quarterly progress reports to NHS England
- Bi-annual meetings with the ICS, accompanied by formal reporting
- An annual progress report to NHS England, incorporating narrative updates on achievements, milestone delivery, risk management, and quantitative assessments against defined targets.

Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

People, Places, Planet

BLMK CARES

The ICS Green Plan 2025

Draft Foreword and Executive Summary

Since the first Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care System (ICS) Green Plan was published in 2022, BLMK partners have made exciting progress towards net zero. We have helped patients switch to inhalers that emit fewer greenhouse gas emissions, we have installed more-efficient heating and energy systems, we have reduced patient and staff travel, and we have started to create a "green" movement within healthcare. These changes will reduce emissions we can control by over 14% (equivalent to driving around the Earth 1,200 times).

Our own health is intimately linked to that of the environment – we are not separate from nature, and the impacts of climate change on our lives and our health will increase inexorably. The need for healthcare is increasing as our populations age, and our lives are increasingly energy-hungry. We are facing a rising demand for resources and, with it, an increasing burden on ecosystems and the knock-on impacts on our health. To break this cycle between climate change and health impacts, we must become a sustainable health and care system, preventing ill health, empowering people to look after themselves better, and moving towards effective, efficient, low-carbon care.

This refreshed BLMK ICS Green Plan marks a shift in our previous approach, setting out a holistic vision to support People, Places and Planet underpinned by a strong Foundation. Through coproduction with partner organisations and residents, we have put together a programme of activities, demonstrating that **BLMK CARES**: together we will create a **Culture** that supports action on climate change, help communities to **Adapt** to climate change, be more conscious of the **Resources** we use, and deliver **Environmentally Sustainable** health and care.

We will increase awareness and reduce the barriers needed to act, embedding sustainability principles in all we do. We will help people prepare for climate change impacts, adapting our built environment to be more energy efficient and resilient, while supporting nature recovery. We will use fewer resources and create less waste by reusing more and recycling what we can. And we will reduce emissions to net zero by 2045 through shifting to preventative, digitally-enabled and lower-carbon care, closer to home.

With every single one of us working together, constantly challenging each other to do more to reduce our shared environmental impacts, the effects on our health, our communities, the places we live, and our whole planet will be immense. By acting with the environment in mind, we will not only prevent environmental emergencies, but also reinforce delivery of our core mission to improve the health and the lives of our patients, our populations, and our families, and support social and economic growth alongside our anchor partners.

Because great healthcare ***is*** sustainable healthcare.

We invite you to join us on this journey together, to see the world around us as another way to keep us healthy and happy, to see ourselves as part of the ecosystem, and to join the green movement to a brighter, more-hopeful future.

[Placeholder for signature]

Dean Westcott
Chief Finance Officer, BLMK ICB
SRO for the BLMK ICS Green Plan

[Placeholder for signature]

Vineeta Manchanda
Non-Executive Member & Audit Chair BLMK ICB
Non-Executive Green Champion, BLMK ICB

The BLMK ICS Green Plan 2025

Introduction

"As a result of climate change and wider impacts on the environment and biodiversity, there is a risk that the health of the population, health inequity, and the ability to deliver services will be negatively affected resulting in worsening health, inequalities, access to healthcare, and additional pressures on health services."

Box 1: BLMK ICB Board Assurance Framework risk 7: Climate Change: Health Inequality and Healthcare Service Impacts from Climate Change and Environmental Degradation, and Risk of Not Achieving Net Zero

Our overarching ambition as the Bedfordshire, Luton and Milton Keynes (BLMK) Health and Care Partnership (HCP) is to **increase the number of years** people spend **in good health** and **reduce the gap** between the **healthiest and least healthy** in our community.

This means moving to a Sustainable Health and Care system – one which, by its nature, addresses all the wider determinants of health to improve population health outcomes, and support the ecosystems in which we all live to thrive.

What and Who is the Green Plan for?

This BLMK Integrated Care System (ICS) Green Plan is for all organisations and individuals involved in designing, delivering and accessing health and care services, and has many purposes:

- Sets the vision from 2025 onwards for our ICS for a sustainable health and care system, as part of the HCP "Growth" priority, to help support local social and economic development.
- Acts as the Green Plan for the BLMK Integrated Care Board (ICB) and its two hosted acute Trusts[i], meeting the statutory requirement to have a refreshed board-approved Green Plan by July 2025, and regulatory requirements. While the ICS Green Plan is structured differently to the Green Plan guidance, it meets the requirements of that document.
- Acts as the Carbon Reduction Plan (CRP) for primary care organisations in BLMK, as per CRP guidance, setting out relevant activities for those organisations to undertake.
- Provides direction for other NHS healthcare organisations creating their own Green Plans.
- Details our best idea yet of the activities we need to undertake, including at a health and care system level, to address climate change and environmental degradation.
- Seeks to inspire the reader to find out more and take their own actions, whether they are a public sector employee, a supplier or contractor, someone that is accessing health and care services, or a member of our broader community of partner organisations and residents.

The Green Plan is also accompanied by a detailed Delivery Plan (Annex), a set of initial activities covering the next 3 years, by which the ICB and the two acute Trusts[i] will be held to account and measured, working alongside other partner organisations to deliver.

The Green Plan has been developed by engagement with NHS (primary and secondary care), local authority, Voluntary, Community and Social Enterprise (VCSE), and residents, including:

- Three years' of progress against the previous ICS Green Plan (2022-2025).
- Learning, sharing and collaborating across partner organisations and other ICSs.
- Dedicated sessions with sustainability leads in NHS and local authority organisations.
- A Health and Care Partnership (HCP) seminar to shape the ICS Green Plan (see below).

[i] Milton Keynes University Hospital and Bedfordshire Hospitals Foundation Trust (consisting of the Luton and Dunstable Hospital and Bedford Hospital).

Leading for a Sustainable Health and Care System

Following 6 months of engagement with sustainability leads and other stakeholders in primary and secondary care, on 15 November 2024, 87 leaders in the climate conversation from across BLMK joined a seminar with local youth councillors, to discuss how climate change impacts health and the burning platform to change the future for generations to come. After keynote speeches, delegates discussed five challenging topics to generate 71 distinct recommendations for inclusion in the ICS Green Plan (see Appendix), covering ideas from outreach activities with schools and providing healthier food at hospital sites, to sharing resources and increasing Green Social Prescribing rates. It is these recommendations that have shaped the refreshed Green Plan.

Signatories to The BLMK ICS Green Plan

The BLMK Green Plan has been endorsed as a system plan by the following organisations, who recognise and support the BLMK system vision, and commit to working together to achieve the aims for the BLMK ICS and its residents.

BLMK ICB on behalf of all members of the ICS **Chair / CEO and/or SRO for the ICS Green Plan**	
Bedfordshire Hospitals NHS Foundation Trust, who also intend to adopt the document as their Trust Green Plan **Chair / CEO and/or SRO for the Trust Green Plan**	Milton Keynes University Hospitals NHS Foundation Trust, who also intend to adopt the document as their Trust Green Plan **Chair / CEO and/or SRO for the Trust Green Plan**
Cambridgeshire Community Services NHS Trust **Chair / CEO and/or SRO for the Trust Green Plan**	Central and North West London NHS Foundation Trust **Chair / CEO and/or SRO for the Trust Green Plan**
East of England Ambulance Service NHS trust **Chair / CEO and/or SRO for the Trust Green Plan**	East London Foundation Trust **Chair / CEO and/or SRO for the Trust Green Plan**
South Central Ambulance Services NHS Trust **Chair / CEO and/or SRO for the Trust Green Plan**	
Bedfordshire and Milton Keynes Public Health Service **Director of Public Health**	Luton Public Health Service **Director of Public Health**
Bedford Borough Council	Central Bedfordshire Council
Luton Borough Council	Milton Keynes City Council

[PLACEHOLDER – signatures to be updated / added as they are obtained.]

Section 1: Our Vision: Improving health and wellbeing in harmony with the environment

We, the partners of the BLMK HCP want to improve the health and wellbeing of our communities by living in harmony with the environment – reducing our impact on it and using sustainable ways to improve health. To do this, we have set out three "we will" statements to support our vision:

People: We will improve health and wellbeing, reduce health inequalities, and work to help our communities adapt to climate change and protect themselves from the health impacts of environmental degradation.

Places: We will care for our surroundings, improving the built environment, supporting the regeneration of the natural environment, and reduce pollution from health and care services.

Planet: We will reduce healthcare-associated greenhouse gas emissions, achieving "net zero" across the health and care system by 2045 or earlier, and reducing the contribution of healthcare to climate change.

Figure 1: The BLMK ICS Green Plan vision

The impact ICS partners hope to have:

People (P_1)	Places (P_2)	Planet (P_3)
People will be living healthier lives, with fewer health inequalities, being more active, and adopting healthier food choices. Communities, organisations and services will be resilient to the impacts of a changed climate, adapting the way they live and work and using sustainable and nature-based solutions.	Our health and care buildings and other infrastructure will be more sustainable, supporting better wellbeing, and minimising environmental damage from delivering service. Health and care organisations will contribute to enhancing the natural world, recovery of nature and biodiversity net gain.	NHS organisations in BLMK will be net zero by 2040 or earlier, for emissions that can be controlled, influencing partners and suppliers to achieve net zero by 2045 for all other emissions. Care pathways will be shifted to more-preventative models, using digital methods and care closer to home within the community to reduce the need for higher-intensity healthcare services.
A Strong Foundation (F)		
Environmental sustainability will be built into the way services are designed and delivered, so that we create the right conditions for sustainable healthcare to thrive. Everyone working in health and care will understand the impact of their work on the environment, and how to lead and make changes to be more environmentally sustainable.		

Section 2: Environment, Climate, Health, and Healthcare

Our health is inextricably linked to the health of the environment and the planet. This is why the climate and nature crises are a health crisis: climate change and environmental degradation exacerbate existing health conditions, create new health challenges, worsen population health, drive health inequalities, and, through extreme weather events, result in harm and disruption to day-to-day healthcare provision, particularly for the most vulnerable (Figure 2).

Figure 2: The impacts of climate change within BLMK and further afield (see BLMK ICS Green Plan Health Impact Assessment for references)

This is driving a higher use of health and care resources, resulting in greenhouse gas emissions (roughly 4% of the UK's total emissions), waste and pollution, leading to an accelerating deterioration of the ecosystems on which we depend. Figure 3 demonstrates a simplified version of this "vicious cycle"; to break it, our society must reduce the impact on the environment, including through health and care services.

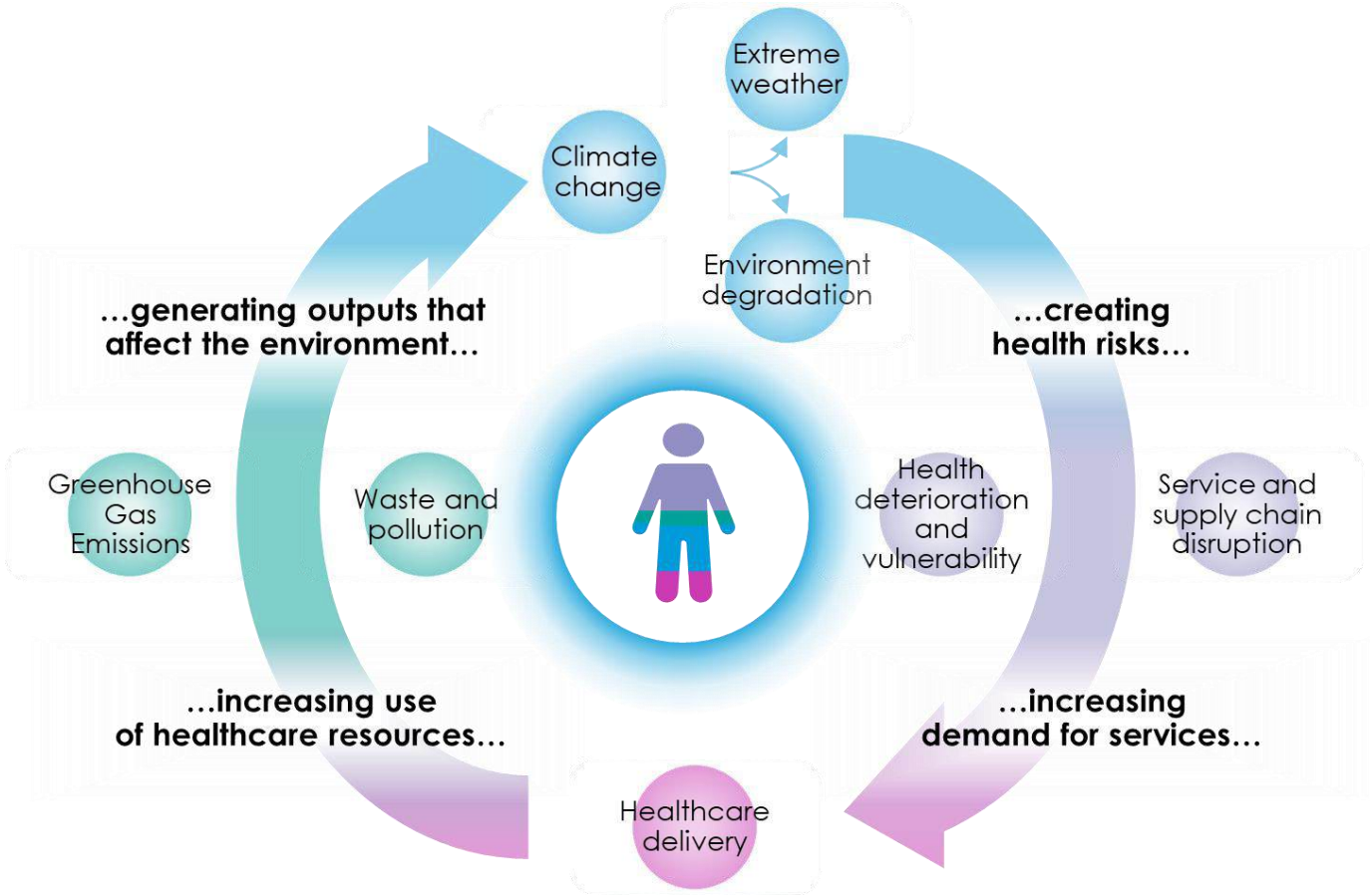


Figure 3: The link between environment and health

Due to its significant risks to health and health inequalities, the BLMK ICB has listed climate change as one of its key risks on its Board Assurance Framework (Box 1).

Great Healthcare *is* Sustainable Healthcare

A recent study[ii] has demonstrated that beyond a particular level (~400 kgCO_2e per head of population[iii]), more carbon emissions do not necessarily mean better health outcomes; even without the large changes required for net zero, it is possible to reduce emissions without compromising quality of care.

Climate-resilient and environmentally sustainable health care systems are ones that anticipate, respond to and adapt to climate-related stresses, minimising negative impacts on people, and using opportunities to restore the environment (WHO), and follow principles for doing so:

1. increasing preventative action to stop people getting ill.
2. empowering those with health issues or disabilities to live the fullest life possible.
3. delivering effective, efficient, productive, and well-managed services, minimising waste.
4. shifting to ways of doing things that reduce emissions.

[ii] Romanello et al. (2024) *The Lancet*, **404**(10465), 1847-1896

[iii] BLMK appears to be close to this level but is likely higher, as the carbon emissions in Figure 2 do not include those for community, mental health, ambulance or other care services – work is ongoing to understand the full footprint.

Each of these elements is reflected in the longer-term aims of an ICS (to improve outcomes, tackle inequalities, enhance productivity and value for money, and support social and economic development), and in the three transformational shifts (treatment to prevention, acute to community, analogue to digital) that will be fundamental to the NHS 10-Year Health Plan. Thus, for BLMK ICS to deliver great healthcare, it must at its core be environmentally sustainable.

A Note on Greenhouse Gases in the NHS

Emissions are categorised as being Scopes 1, 2 or 3 in the international Greenhouse Gas (GHG) Protocol covering the seven GHGs in the Kyoto Protocol:

- **Scope 1**: direct emissions resulting from owned or controlled sources.
- **Scope 2**: indirect emissions from the generation of purchased energy.
- **Scope 3**: other indirect emissions that occur in the supply chain (upstream or downstream).

GHGs are compared by their "global warming potential" (GWP) or emissions factor – the equivalent amount of carbon dioxide (gCO_2e) that has the same global warming effect. A kilogram of a GHG with a GWP of 100 has the same atmospheric heating effect as 100 $kgCO_2e$.

NHS England has defined the NHS Carbon Footprint (NHS CF) as Scopes 1 and 2, and a few Scope 3 categories items (inhalers and anaesthetic gases) – those that the NHS can directly control. The totality of NHS emissions is called the NHS Carbon Footprint Plus (NHS CF+) and include the remaining Scope 3 emissions that the NHS can only influence.

Carbon footprinting the NHS in BLMK takes into account the two acute Trusts, and an estimated contribution for the ICB and primary care (Figure 4), totalling nearly 325 $ktCO_2e$ in 2019/20 (Figure 2). Elements of this have been re-measured since, and progress has been made (see below), but the proportions remain roughly equivalent. The ICB and the two acute Trusts will be held to account for delivery against the BLMK ICS Green Plan emissions reduction targets.

BLMK community, mental health and ambulance NHS Trusts are held to account for emissions reductions (even those generated in BLMK) through their "host" ICSs. Similarly, local authorities have their own net-zero goals monitored separately. These organisations are still important to the delivery of the BLMK ICS Green Plan, and will be involved in supporting various activities, where relevant (see Section 4: Governance).

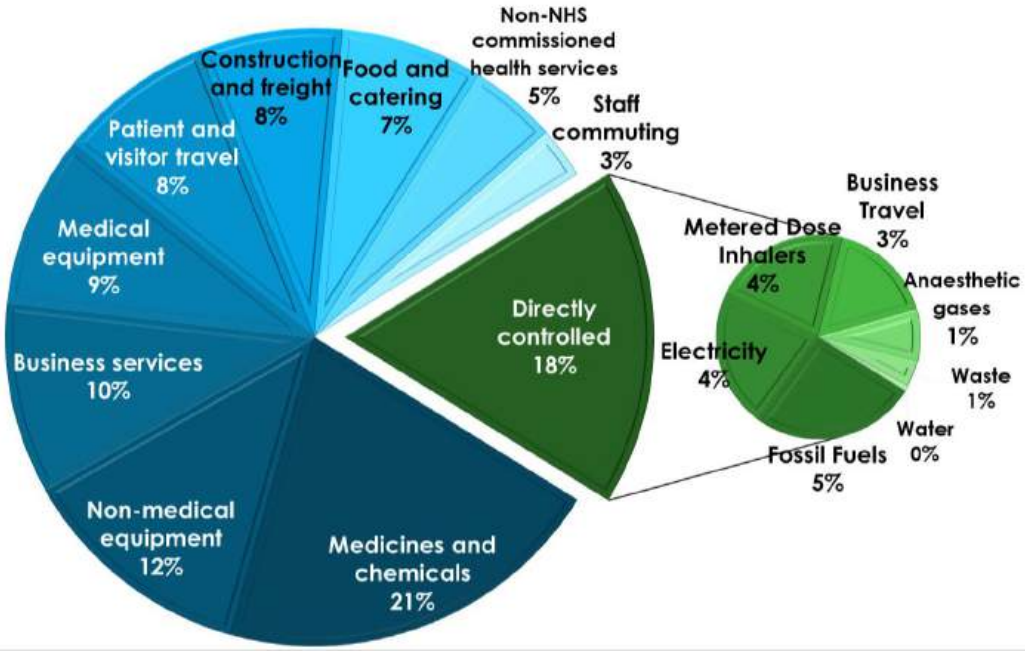


Figure 4: BLMK NHS Carbon Footprint 2019/20 (for the ICB, primary care and the two acute trusts)

The current state

Our System Challenges

BLMK is one of the fastest growing areas in the country, driving ever increasing demand for housing, employment, healthcare, and other infrastructure and services. The opportunities to the local economy from these developments will likely have a beneficial impact on the health and wellbeing of local residents. However, not only does this bring challenges to healthcare service delivery (addressed in other ICS strategies, such as the *BLMK Health Services Strategy*), growth in demand for healthcare will increase services' contribution to climate change, environmental degradation (Figure 2) and subsequent health and healthcare challenges (Figure 3).

We want to support a thriving population and a growing local economy; it is therefore necessary to counter-act the increase in emissions whilst looking to improve population health.

Progress against our first ICS Green Plan (2022-2025)

Our first ICS Green Plan has driven some progress since 2022, most notably:

1. **Emissions:** reductions of at least 14.5% (8.3 $ktCO_2e$) of our directly-controllable emissions.
2. **Anaesthetic gases:** Eliminating the use of the anaesthetic gas with the highest global warming potential and reducing nitrous oxide emissions by 27%.
3. **Inhalers:** Emissions from asthma inhalers have dropped by ~42%, and BLMK's performance is improving quicker than the national average.
4. **Waste**: at acute sites, waste has reduced by 10% overall, and food waste in some places has dropped to less than 2%.
5. **Energy efficiency:** installation of renewable and other energy systems at our main hospitals, including securing additional capital funding for various works.
6. **Circular economy:** A walking aid return and reuse scheme at MKUH has saved £2,500. More than 600 ICB office assets have been reused by a hospital, schools and VCSE.
7. **Travel and transport:** trialling of e-bikes for staff members and public transport subsidies encouraged 300 hospital staff to leave their cars at home.
8. **Workforce education:** More than 60 staff members from the ICB, Trusts, public health teams, and primary care have undertaken forms of enhanced sustainability training.
9. **Governance and decision-making:** As well as convening partners to collaborate and oversee progress, the ICB has introduced an Environmental and Social Impact Assessment (EaSIA) tool to understand the likely impact of service changes.
10. **Innovation:** Testing different approaches to support residents at risk of fuel poverty and cold homes, resulting in an improved patient experience, installation of energy efficiency measures, and a reduction in healthcare use.

More examples are available via the BLMK ICB environmental sustainability webpages. The first BLMK ICS Green Plan did not set specific goals, focusing instead on creating the initial call to action – the refreshed Green Plan builds beyond this, setting "SMART[iv]" ambitions.

BLMK partners' priorities

BLMK partners are already committed to improving their impact on the environment, through organisational actions such as declaring a climate emergency and setting net zero goals. The ICS Green Plan is complementary to this, setting out the way the system will operate together in the future, with environmental concerns addressed in all its work, and partnerships formed with all partners, public sector or otherwise, to support mass action on areas of commonality.

Supporting local authorities' priorities

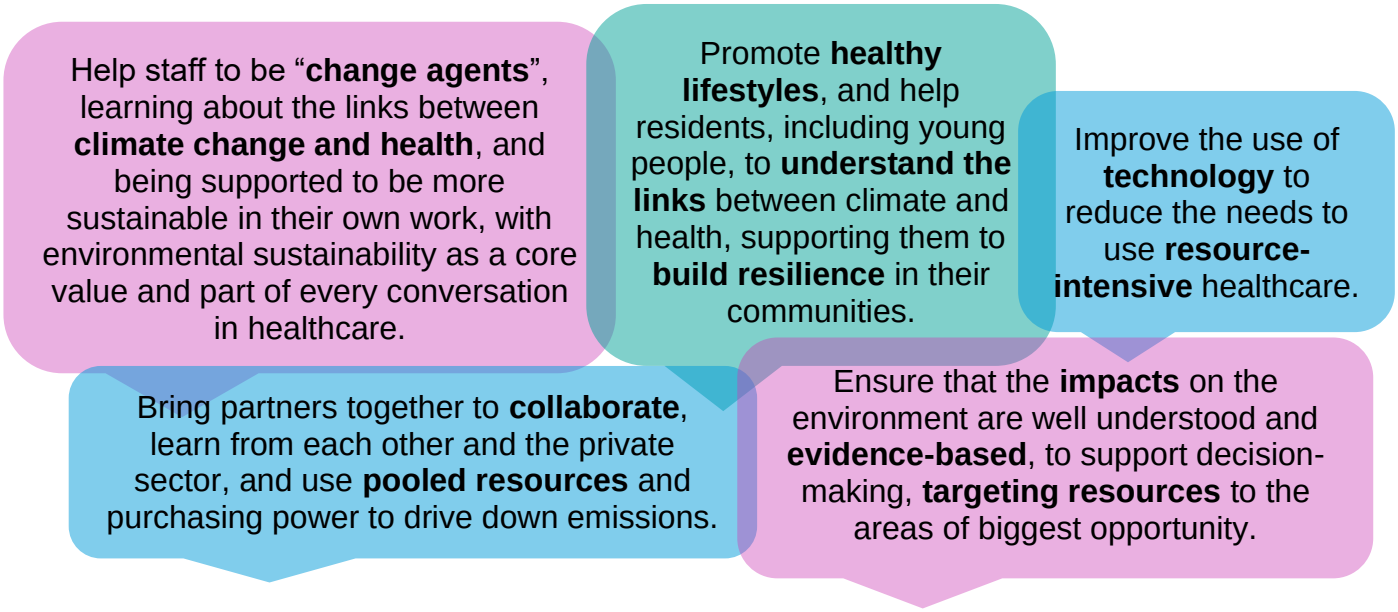
Aside from working with other ICS partners on environmental improvement, the ICB and NHS Trusts are statutory partners for local developments. This means working with and advising other

[iv] Specific, Measurable, Achievable, Relevant and Time-bound

organisations and responding to consultations on developments requiring planning consent. The ICB undertakes this duty considering all four purposes of an ICS and the views of all system partners. This might mean attempting to balance positive and negative impacts on all the direct impacts and wider determinants of health and health services, in order to obtain the highest possible benefit to the health and wellbeing of the residents within BLMK.

What BLMK partners and residents have said is important

At the Leading for a Sustainable Health and Care System seminar in November 2024, and through other engagement, people from NHS organisations, local authorities, VCSE, and residents including local youth council members, recommended that the refreshed ICS Green Plan should:



What have we learned from our first Green Plan?

Despite our progress, the evidence and our own experience have highlighted:

- Increasing healthcare demand and activity is driving greater use of resources, counteracting efforts to reduce absolute emissions. For example, the emissions reduction from virtual outpatient appointments has been dwarfed by the overall growth in outpatient activity. Attempting to achieve the best health outcomes may also have a similar effect. This means progress with emissions reduction is not always linear.
- Environmental sustainability is still often seen by many staff as an "additional extra", so effort is required to find ways to build it into existing work and ambitions.
- That said, some staff are pioneers, driving improvements in their own areas of work (for example food waste, e-bikes, medical equipment) without being mandated to do so – they and others should be celebrated and encouraged to do more.
- Data is not always readily available to measure an accurate carbon footprint, progress in health outcomes, or "triple-bottom-line" impacts (environmental, social and financial).
- There are many existing, proven case studies from within the system and elsewhere that could be easily spread across BLMK (for example reducing unnecessary cannula use).
- Whilst many activities will save money in the long term, money is not always available here and now to make "invest to save" choices, or we may not have a full idea of the full impact on health, environment or social factors to demonstrate value for money.
- The influence of BLMK over the supply chain is variable, despite the large purchasing power of the NHS as a whole. This is due to there being small markets for some, high-value or novel items, and that the majority of consumables are procured via NHS Supply Chain.
- Similarly, there are some policy measures that will be required at a national level, outside the direct influence of the ICS, such as regulations requiring compliance from suppliers.
- Even if we implemented all known emissions-reduction measures, there is likely to be a gap to net-zero. This will require innovations that are still in development.

- The BLMK carbon footprint and NHS guidance suggest the biggest opportunities are in medicines, supply chain, and travel (Figure 4). However, the areas that are most easily addressed are direct emissions from anaesthetics, waste, inhalers, estates decarbonisation, energy and food (Appendix 2: Opportunity analysis).
- The *BLMK ICS Green Plan 2022-25 Health Impact Assessment* highlighted the main health benefits of sustainability actions to be in a) Air pollution, by reducing travel by private vehicle; b) Activity levels, by shifting to active modes of transport and more exercise; c) Food and nutrition, by encouraging uptake of lower-carbon, healthier diets; d) Adaptation and resilience to extreme weather, through artificial and natural solutions.
- Comparison with peers (Appendix 2: Opportunity analysis) suggests an opportunity of >30 $ktCO_2e$ vs. the 2019/20 baseline, solely by moving to median, top quartile or top decile performance (depending on the emissions source) – whilst 9 $ktCO_2e$ has already been achieved, national policy and action (e.g. grid decarbonisation) will enhance this.

Section 3: BLMK CARES: The Green Plan

Our progress so far, what BLMK partners and residents say is important, and the remaining challenges tell us that, for our ICS Green Plan 2025, we need to go further than before.

More than delivering net zero services

"People, Places and Planet" is about a different mind-set, that the best possible health for all, and the highest value healthcare, can **only** be achieved by living in harmony with our environment. In developing this ICS Green Plan, colleagues, partners, VCSEs and members of the public identified a number of recommendations. Mapping these to the principles of a sustainable health and care system, we have developed a broad programme to support this Green Plan. These "SMART[iv]" activities address one or more of the vision statements, People, Places and Planet, and the Foundation. So, they have been grouped into four main programme areas that are most likely to be delivered together: BLMK **CARES** (Figure 5), mapped to the vision (Figure 6).

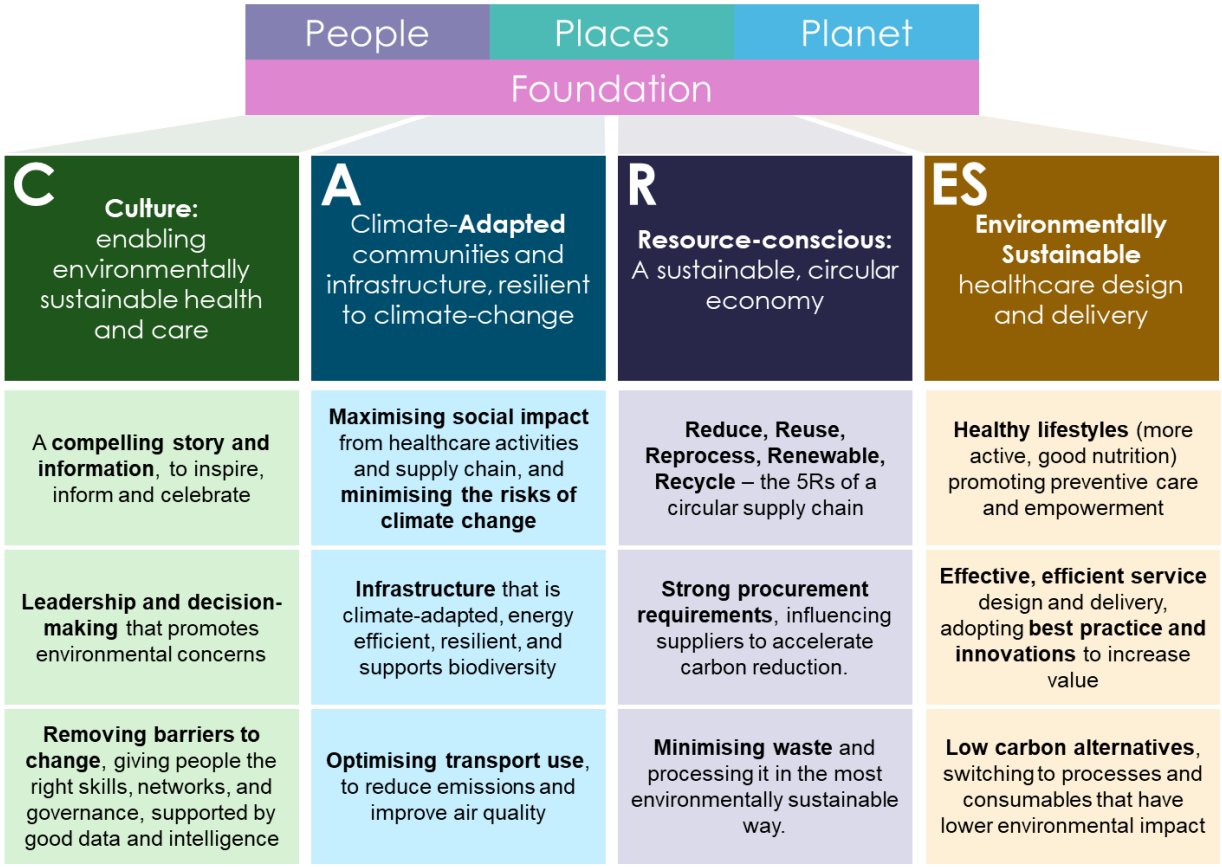


Figure 5: People, Places, Planet: BLMK CARES – The ICS Green Plan

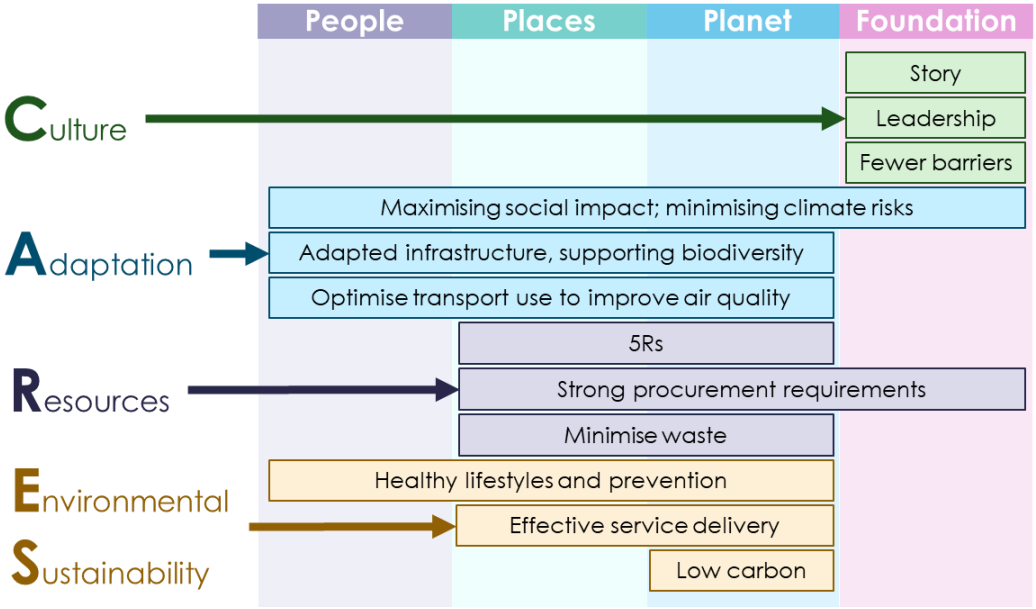


Figure 6: BLMK CARES: mapping the Green Plan activities to the vision.

Reducing NHS emissions faster than ever, to meet the national targets

The BLMK Health and Care System will be net zero by 2040 for NHS Carbon Footprint (CF) emissions, with an aspiration to do so by 2035:

- Some NHS Trusts may achieve this earlier; all will achieve it by 2040, including an 80% reduction in emissions[v] by 2032 (with an aspiration to do so by 2028[vi]).
- CF emissions will need to reduce by >7.5% of our current emissions in each year to 2032[vii].

The BLMK Health and Care System will be net zero by 2045, for NHS Carbon Footprint Plus (CF+) emissions that the NHS can only influence, requiring:

- an 80% reduction in emissions[v] by 2039 (with an aspiration to do so by 2036[vi]).
- CF+ emissions to reduce by ~6% of our current emissions in each year to 2039[vii].
- All organisations delivering NHS services in BLMK to reach net zero by 2045.

Addressing Population Health

As with all system strategies, the ultimate purpose of the ICS Green Plan is to address population health outcomes. specifically healthy life expectancy, and inequalities in life expectancy. Figure 7 demonstrates schematically how the main activities described in the Green Plan map against the wider determinants of health (socio-economic, health behaviours, physical environment, and health and care delivery), and then in turn how they link to each of the five ICS strategy priorities, Start Well, Live Well, Age Well, Growth and Reducing Inequalities.

Implementing the BLMK ICS Green Plan should avoid the deaths of at least 30 people internationally every year by reducing emissions over the next three years, 60 or more by meeting the 2032 national emissions targets, and 300 or more by reaching net zero. It is difficult to attribute morbidity and mortality directly. However, according to the Health Impact Assessment of the 2022 BLMK Green Plan, actions in the Delivery Plan should further reduce illness and deaths through reduced air pollution, more physical activity and better diets, and less waste entering biosystems.

[v] relative to the 1990 baseline
[vi] Equivalent to a ~47% reduction against the 2019/20 NHS CF and ~73% against NHS CF+
[vii] Assumes a ~5% reduction for CF, and no reduction for CF+ during 19/20 - 24/25, and 2% annual growth in activity.

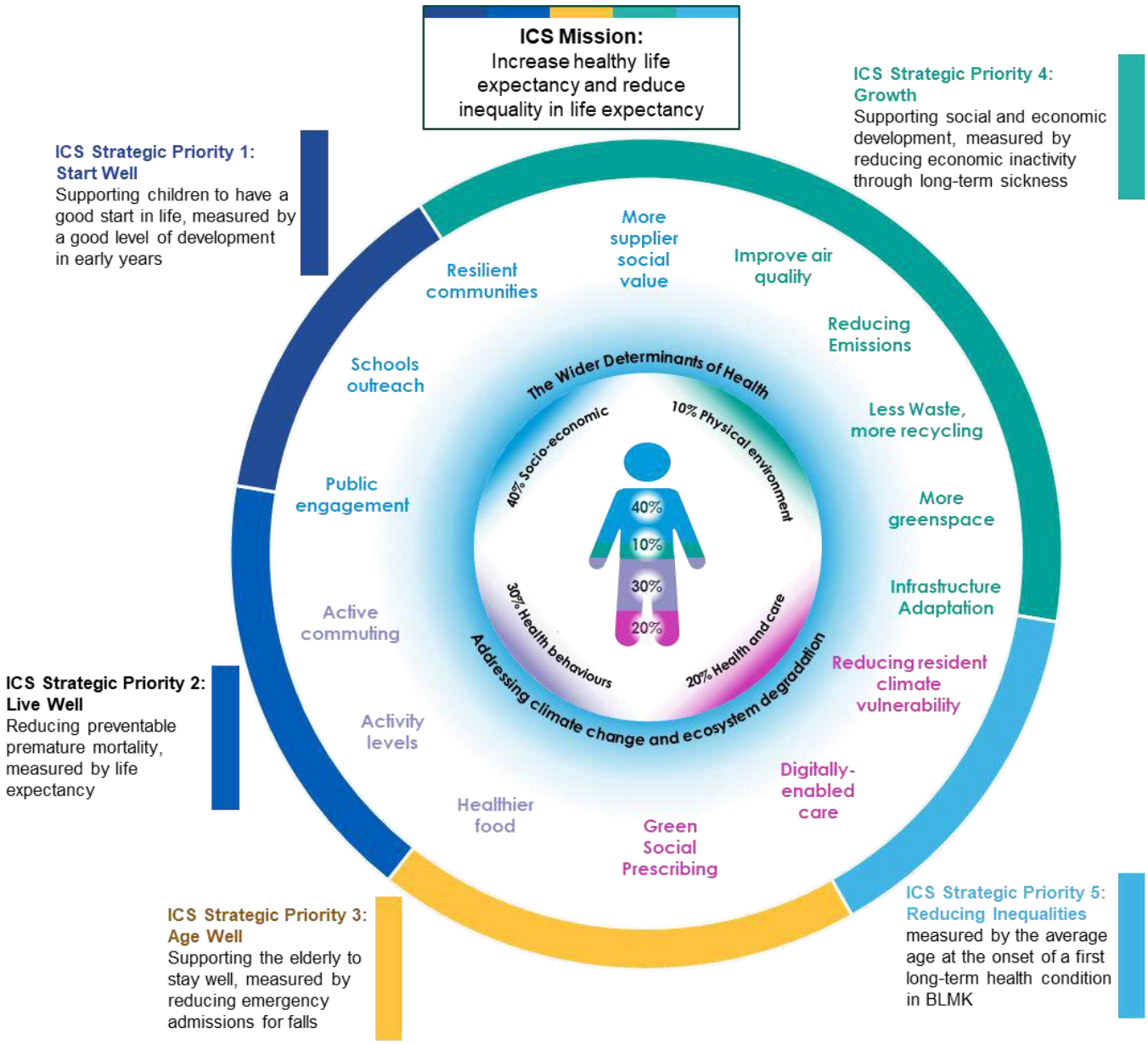


Figure 7: Mapping ICS Green Plan activities to ICS Priorities and Population Health Outcomes

Delivering the ICS Green Plan

The programme of activities for delivering the ICS Green Plan is set out in the following pages.

Further detail is contained in a "Delivery Plan" in the Annex, including how activities align to the Green Plan guidance. Some activities have quantifiable targets, others will need further work and the calculation of baselines. The partners of the ICS will work together to implement the Delivery Plan, continuously learning about what works and what we have not previously considered. This continuous improvement approach means we are always learning and changing our approach to become even more environmentally sustainable.

The ICS Green Plan itself will become the standard for BLMK, not just for 2025-2028, but beyond. The intent is not to fundamentally re-write the entire Green Plan after 2028, but to refresh the activities in the Delivery Plan underpinning it, based on new evidence that comes to light.

The acute Trusts will use this Green Plan as their own, adopting and supporting activities and creating additional local actions aligned to the plan as required.

C

Culture enabling environmentally sustainable health and care

A supportive culture encourages ownership and action from all, and can be nurtured with a compelling and motivating narrative, removing barriers to change (e.g. providing skills and data analysis), and leaders role-modelling and making decisions with sustainability in mind. During 2022-2025, partners created green champion networks, held seminars and celebrations with hundreds of people, communicated by newsletters and videos, supported awareness days, and trained more than 60 people in specialist sustainability knowledge and skills. The aim for 2025 onwards is to go further, embedding sustainability in more of the business and culture of health and care to create even more of movement.

Activities to achieve the aim		Led by	By when	Measured by…	Lowers CO_2e
C1	A compelling story and information				
A	By 2028, 95% of staff polled will state they have an increased awareness and commitment to change (relative to 2025/26 baseline)				
Communicate with staff **monthly** and residents **at least quarterly**, and outreach together to schools, VCSEs and SMEs **at least quarterly**, initially through existing channels managed by LAs, to increase knowledge of the links between health and climate, and promote action.		**ICB and Trusts**	Sep 2025 (ongoing)	Awareness rating in surveys. # of outreach events.	
C2	Leadership Planning and Decision-making				
A	From Apr 2025, all major service changes within the NHS in BLMK will address environmental and social impacts				
All ICS services changes, and all new and refreshed policies and strategies (e.g. Joint Forward Plan, Infrastructure Strategy, Digital Strategy, Primary Care Prevention Delivery Plan) will assess for environmental and social impact (initially qualitative, aiming to quantify impacts in carbon terms from Apr 2026 onwards). Trusts will do likewise by April 2026.		**ICB**	Apr 2025 (ongoing)	# of service changes with a social and environmental impact assessment.	
Accountability for delivery of the ICS Green Plan will be embedded within ICB functions. This will include setting objectives with ICB directorates and workstreams, ensuring oversight forums (e.g. the Health and Care Professional Leadership Group) review environmental impacts, and training executive and non-executive members in sustainable healthcare principles.		**ICB**	Sep 2025 (ongoing)		
C3	Removing barriers to change				
A	We will collaborate to maximise the sustainability resource available to the ICS to increase the pace of change, supporting 100% of the workforce to become sufficiently sustainability-literate according to their role to deliver change locally.				
Provide the right skills and knowledge for the right job, with:					
a) system sustainability teams working in a single matrix to co-deliver projects			Apr 2026		

Activities to achieve the aim	Led by	By when	Measured by…	Lowers CO_2e
b) developing at least 2.5% (and aiming for >3%) of the workforce with enhanced sustainability knowledge (champions, local leaders, experts, green project team members and others[viii]).	**ICB; Trusts**	Mar 2028	# of staff identified as champions, leaders or sustainability leads	
c) creating system clinical sustainability leadership of >1 wte (across various organisations).		Apr 2027		
d) 100% of staff receiving a basic level of knowledge and skills **appropriate to their role**[ix] (through organisational values, at recruitment, induction, formal learning, and objective-setting).		Apr 2026 (ongoing)		
e) providing guidance and ideas to organisations to address regulatory requirements (e.g. CQC)		Dec 2025		
Focusing on Green Plan initiatives that have a rapid and easily-delivered financial, productivity or quality return, supporting the "three shifts", including:	**ICB; Trusts**	From now	Financial and carbon savings made through sustainability initiatives	
a) collaborating on identifying and bidding for external funding		From now		
b) considering the creation of a BLMK "Green Fund", reinvesting a proportion of financial savings made through sustainability initiatives in further green projects		Apr 2026 (ongoing)		
Creating self-sustaining expertise through:	**ICB and Trusts**		# of staff trained in sustainability. Attendance at network events.	
a) A "Green-Skills Faculty" – experts from ICS partners delivering sustainability training		Jan 2026		
b) incorporating "SusQI" concepts into the BLMK "Quality Improvement" faculty and tools		From now		
c) BLMK-wide sustainability networks (including clinical) meeting **at least quarterly**		From now		
B	Measure progress in "triple-bottom-line" (environmental, social, and financial) impacts, identifying gaps in achieving net zero ambitions.			
Measure our direct carbon emissions **at least annually**[x], projecting forward known reductions to identify the likely system gap to achieving net zero within the required timeframes.	**ICB; Trusts**	Mar 2026	Delivery of milestones and products.	
Report **annually** on progress against BLMK emissions, and address any NHS reporting requirements (e.g. Task-Force on Climate-Related Financial Disclosures). This will support working towards full triple-bottom-line and health-impact reporting	**ICB; Trusts**	Apr 2026 (ongoing)		
Support local authorities and public health functions in incorporating the impact of environmental impacts on health within Local Plan health needs assessments.	**ICB**	From now		

[viii] This will include sustainability leads, green plan theme leads, managers and directors overseeing environmental sustainability objectives, teams working on implementing green pathway best practice (e.g. GreenED), those taking enhanced sustainability training, and green network attendees. See Delivery Plan for rationale.
[ix] from simple awareness through to sustainability expert, depending on the role.
[x] Emissions from controllable sources ("NHS Carbon Footprint") are calculated annually by NHS England.

A Adapted communities and infrastructure, resilient to climate change

Even if all countries were successful with their net zero ambitions, average summer temperatures in BLMK could be 5.5°C higher by 2070. We cannot rely on climate change being halted so we must adapt our behaviours, processes and buildings to a different climate. During 2022-2025 BLMK partners began the process of creating adaptation plans, understanding the likely health impact of climate change and our ICS Green Plan, risk assessing and projecting future impacts of climate change, decarbonising buildings, and testing ways to reduce travel emissions. For 2025 onwards we will ensure these things are taken forward, working with emergency planning teams, public health, adaptation leads, commissioners and service transformation leads to embed aims in dedicated plans to meet national goals and make services more resilient.

Activities to achieve the aim		Led by	By when	Measured by…	Lowers CO_2e
A1	Maximising social impact and minimising climate risks for communities and organisations				
A	Improve the level of climate adaptation planning across organisations and communities				
Committing least 0.5%[xi] of their annual sustainability resource (expertise or volunteer time) to support communities and community groups/organisations to adapt to climate change, supporting at least one community/group by March 2028.		**ICB and Trusts**	Mar 2028	# of adaptation plans in place. Sustainability team time spent supporting local communities	
All NHS Trusts will have Adaptation plans in place, separate from business continuity plans, linked to Emergency Planning functions, based on a local risk-assessment of climate risks to service delivery, monitored annually, and refreshed at least every 3 years.		**Trusts**	Dec 2025		
Identify local market capacity to provide goods and services for "addressable lines[xii]", then set a future aim to increase the amount spent in the local economy, and reduce transport emissions.		**ICB, LAs, Trusts**	Mar 2027	Amount of local spend.	
A2	Infrastructure: healthy and climate-adapted design, supporting biodiversity				
A	Reduce emissions from built healthcare environment in line with net zero goals and building standards				
All NHS Trusts operating within BLMK will improve efficiency and reduce emissions, including:					
a) Creation and implementation of best practice decarbonisation plans, incorporating national guidance (including the NHS Estates Net Zero Strategy, and Biodiversity Net Gain), ensuring all new refurbished buildings plan to meet Net Zero Building Standards		**Trusts and NHSPS**	Mar 2026	Emissions from energy / heating by source.	✓

[xi] Approximately 1 day per year for each full-time-equivalent post.
[xii] Addressable spend is that where organisations could change to other suppliers; this will exclude consumables procured by centralised bodies such as NHS Supply Chain.

Activities to achieve the aim	Led by	By when	Measured by…	Lowers CO_2e
b) An assessment of the evidence base (e.g. studies by Greater South-East Net Zero Energy Hub) to identify opportunities to increase the use of heat networks, solar energy, heat pumps, insulation, passive heating and cooling, water saving devices, and building management	**ICB with Trusts**	Mar 2026	LED coverage. Water use	
c) an increase in LED coverage by >10% per year, aiming for 100% coverage by 2028.	**Trusts**	Dec 2028		✓
The ICB, with ICS healthcare partners, will map healthcare organisation greenspace, identifying opportunities to improve quality of the greenspace and tree cover.	**ICB**	Mar 2026	Healthcare greenspace area	
A3	Optimise transport use to reduce emissions and improve air quality			
A	NHS Trusts will aim to reduce commuting emissions by 50% by 2033 (as per the national Travel and Transport strategy)			
The ICS partners will develop a sustainable (place-based) travel strategy for BLMK linked to, or covered by, local authority Local Transport Plans.	**ICB; LAs**	Dec 2026	Local and on-site air quality (where feasible).	
ICS partners will use the Clean Air Framework to work towards becoming a 'Clean Air System'	**ICB**	Mar 2026		
Help 20% of staff currently commuting by sole-occupied internal combustion engine vehicles to shift to lower carbon forms of transport (e.g. public or active modes) through awareness of the Sustainable Travel Hierarchy, and promoting / incentivising alternatives (for example public transport discounts, car-sharing, salary-sacrifice).	**Trusts**	From now	% of staff commuting by transport mode	✓
All vehicles on salary sacrifice schemes to be electric or zero-emission vehicles[xiii].	**NHS**	Dec 2026		✓
B	Reduce emissions from fleet and business travel (non-ambulance NHS fleet to be net zero by 2035, 50% of total ambulance fleet to be net zero by 2036, and all fleet to be net zero by 2040.)			
All new fleet vehicles (owned or leased, excluding dual-crewed ambulances (DCAs)) to be zero-emission vehicles (ZEV) from 2030 and all new DCA fleet to be net zero from 2035.	**Ambulance Trusts**	Dec 2030 and 2035	% of fleet that is ZEV	✓
All Trusts will improve fleet management and use, including **exploring opportunities** to:	**Trusts; ICB**		Business / fleet travel distance and emissions by vehicle type	✓
a) improve efficiency of patient transport, collection and delivery services (pathology, supplies)		Mar 2028		
b) use e-bikes for community visits in urban areas, where feasible		Sep 2026		

[xiii] with agreement with staff side representatives, and in line with NHS England's Travel and Transport plan.

R

Resource-consciousness: a sustainable circular economy

At least 60% of healthcare carbon emissions come from the supply chain. Waste – the product of a process that is no longer valuable to society – is created during production, transport, and use of consumables, and its disposal pollutes our environment. This means we must be more resource-conscious, moving from a "linear economy" (where products are used and then thrown away) to a "circular economy" (where materials are used again and again, without throwing anything away) by using less, reusing and recycling more, and shifting to renewables. During 2022-2025, partners made many low-carbon switches, started dedicated programmes to appropriately reuse equipment, and reduced waste emissions. For 2025 onwards we will broaden this to include more product lines and accelerate the drives to improve value in the supply chain.

Activities to achieve the aim		Led by	By when	Measured by…	Lowers CO_2e
R1	5 Rs of procurement: Reduce, Reuse, Reprocess, Renewable, Recycle				
A	Reduce use of consumables through process and behaviour change				
Reducing nitrous oxide (N_2O) use (including N_2O / oxygen mix) by 50% using the N_2O toolkit.		**Trusts**	Mar 2028	N_2O volume.	✓
Initiating or accelerating clinically-appropriate personal protective equipment (gloves, masks, aprons, or other PPE)-reduction improvement projects in 2025/26, aiming to reduce glove usage from these tests by 10% by Sep 2026, scaling and spreading during 2026-2028		**NHS**	Mar 2026	Reduction in PPE use (by project)	✓
B	Reduce use of consumables by increasing reuse of existing items				
All NHS Trusts issuing walking aids will participate in a system-wide or trust-specific Walking Aid Return and Reuse scheme by March 2026, with a 60% return rate by 2028.		**Trusts**	Mar 2028	# of single-use items used (by project). Carbon and cost savings.	✓
Implementing a system-wide office asset reuse scheme.		**ICB**	Sep 2025		✓
Implement best practice in reusable alternatives to single-use consumables (including tourniquets, pulse oximeters, cool sticks, sharps bins, meal sets, theatre gowns and caps).		**Trusts**	Mar 2027		✓
C	Reduce use of consumables by switching to re-processable alternatives				
Scale and spread best practice in medical device reprocessing schemes		**Trusts**	From now	Device # / cost	✓
D	Move to products made with renewables and recyclables				
Through agreement *via* the BLMK Procurement Participation Group, review and test best-practice approaches to "choice-editing[xiv]" to remove or deprioritise less-sustainable items.		**ICB with Trusts**	Mar 2027 (ongoing)	# of items removed	✓
E	Reduce waste emissions by recycling more				

[xiv] removing or deprioritising less-sustainable consumables from purchasing systems, where there is no additional clinical or significant financial value.

Activities to achieve the aim	Led by	By when	Measured by…	Lowers CO_2e
Reduce valuable materials entering inappropriate waste streams, including through waste segregation at source, implementing the Simpler Recycling reforms for non-clinical waste and identifying ways to improve recycling rates (including inhalers and blister packs).	**All ICS partners**	From now	Recycling rates, by waste type.	✓
R2	Strong procurement requirements and influence			
A	NHS organisations to increase the sustainability of the supply chain			
Increase the value of supplier social value (SV) commitments supporting Sustainable Procurement Practices outcome in the UK Social Value Model (from a 2025/26 baseline)	**ICB and Trusts**	Mar 2026 (ongoing)	Value of supplier SV	
Ensure all suppliers meet the NHS Net Zero supplier roadmap, including:			# and % of suppliers completing Evergreen assessments, and average maturity level	
a) ensuring adherence to the Carbon Reduction Plan requirements	**All**	From now		✓
b) embed narrative within procurement processes and contracts (including non-scored questions about current level), to encourage progress against the Evergreen Assessment.	**ICB with Trusts**	Sep 2025 (ongoing)		
c) engage the top 10 suppliers with addressable spend[xii] and emissions, and a representative sample of smaller suppliers not currently using Evergreen, to understand the barriers and limitations of the Evergreen Assessment, and encourage progress.		Dec 2026		
R3	Minimise waste			
A	Reduce waste-related emissions to top-quartile amongst system peers			
NHS Trusts will have 0% domestic waste to landfill	**Trusts**	Mar 2028	Waste volumes	✓
Reduce food waste from food provided to patients by 50% across providers (baseline required), aiming for <2% on acute healthcare sites, through digital meal ordering, awareness campaigns, and on-site composting where appropriate.	**Trusts**	Mar 2027	Waste quantities	✓
ICS partners will reduce medicines emissions by action on overprescribing, polypharmacy, disease control, education campaigns for different audiences (e.g. patients, VCSE, doctors, nurses), alternatives (e.g. social prescribing), recycling schemes (e.g. inhalers, blister packs), better adherence to medication regimes (including by working with VCSE), and eliminating the use of medicines of low clinical value[xv]. The ICB will support developing baselines for programmes and projects to understand and maximise the environmental benefit.	**Trusts and Primary Care**	Mar 2028	Medicines volumes, waste and cost (by project)	✓

[xv] Activities relating to these have been captured in the 2025/26 Prescribing Incentive Scheme

ES

Environmentally Sustainable health and care design and delivery

A system can be more sustainable if it: a) **prevents** illness or exacerbation of existing conditions, and **empowers people** to look after themselves, to improve care quality and reduce demand for high-resource services; b) is highly **efficient and effective**, with lean healthcare services, ensuring best value care is provided, with lower levels of waste (in all forms – time, resource, money, duplication, rectifying mistakes, and physical waste) and c) Uses **low-carbon resources**, with lower emissions, from more-sustainable, more ethical, and less-polluting sources. During 2022-2025, BLMK partners reduced inhaler emissions, made low-carbon switches and started to impact-assess decisions. For 2025 onwards we will embed an understanding of the environmental impact in all our decisions, driving efficiency through implemented best practice and innovations and reach median or higher quartile performance relative to our peers.

Activities to achieve the aim	Led by	By when	Measured by…	Lowers CO_2e
ES1 Healthy lifestyles, preventative healthcare, and self-empowerment				
A Supporting residents and patients to look after their own conditions				
Implement the Primary Care Prevention Delivery Plan and measure the environmental benefit.	**ICB; Public Health; Primary Care**	From now	Reduction in emissions and healthcare use (by project). Patient wellbeing.	✓
Provide better health support for those vulnerable to impacts of climate change, using data and identifying best practice models to test out in BLMK. Milestones to include identifying priority cohorts (Sep 2026) and agreeing an approach (Apr 2027).		Mar 2028		✓
Increasing number of patients with a “patient-initiated follow-up” (PIFU) to 5% (top quartile), whilst maintaining or minimising activation rates.	**Trusts**	Mar 2027		✓
B Increased uptake of low-carbon food at hospital sites				
Encourage staff and patients to choose more lower-carbon meals on-site, aiming for 10% increase in uptake (through best practice such as “Plants-First”, on-site campaigns on the health and environmental benefits, incentives, digital meal ordering and seasonal menus.)	**Trusts**	Mar 2027	Uptake of lower-carbon meals. Cost per meal.	✓
C Reduce use of higher carbon medications				
Develop a plan to increase Green Social Prescribing (GSP), based on understanding the baseline and a benefits analysis, setting a future aim to increase GSP rates.	**ICB with LAs**	Mar 2027	GSP rates. Medicines use.	✓
Primary care inhaler emissions per Short-Acting Beta Agonist (SABA) inhaler will reduce from 18 $kgCO_2e$ in March 2025 across all inhaler prescribers, through:	**Trusts and Primary Care**	Mar 2026 (15$kgCO_2e$); Mar 2028 (12$kgCO_2e$)	Inhaler prescriptions and associated emissions.	✓
a) optimising respiratory care in line with NICE asthma and chronic obstructive pulmonary disease clinical guidance				
b) shifts to lower-carbon pressurised Metered-Dose Inhalers (pMDIs) and alternatives, exploring bulk switches of low-risk patients.				✓

Activities to achieve the aim	Led by	By when	Measured by…	Lowers CO_2e
c) better disease control, including the use of "MART"[xvi] inhalers				✓
ES2	Effective, efficient and financially sustainable health and care service delivery, adopting best practice to increase value			
A	Best Practice in Sustainable Health and Care to reduce emissions associated with operational service delivery			
Best practice healthcare in BLMK, highlighting short- and long-term financial return on investment as well as environmental, social and health benefits, through:	**ICB (with Trusts and Primary Care)**			
a) continuous review and adoption of best practice interventions from BLMK and outside, developing with Health Innovation East an innovations pipeline for trial in BLMK		From now	# of interventions adopted. Cost.	✓
b) adopting guidance for Infection Prevention and Control, outlining opportunities to reduce carbon while maintaining or improving infection control rates.		Mar 2026		
c) ensure energy and equipment is only used when required (including safely powering-down equipment overnight, such as Heating Ventilation and Air Control (HVAC) systems, anaesthetic scavenging, and PCs, and improving ventilation and indoor air purification).	**Trusts; Primary Care**	From now	Reduction in energy use and emissions	✓
d) implementation of GIRFT Greener bladder cancer care, the Green Theatre Checklist, GreenED, Net zero mental health care and other similar guidance	**Trusts**	From now	Emissions (by project)	✓
e) increasing clinically-appropriate virtual consultations (VCs), aiming for peer median rates.	**Trusts**	Mar 2027	VC rates.	✓
The ICB will work with primary care networks (PCNs) to identify local sustainability initiatives that will reduce emissions, save money, and improve patient and staff experience, incl. reducing consumables, energy use, building efficiency, medicines use and waste, and proactive care for patients vulnerable to climate change.[xvii]	**ICB with PCNs and NHSPS**	From now	# GP practices engaged. Carbon and cost.	✓
B	Care pathway transformation			
All pathways undergoing transformation will use sustainable healthcare principles and set targets to reduce environmental impact and greenhouse gases emissions as a core objective of the work (commencing with transformation priorities in the BLMK Health Services Strategy.)	**ICB**	Sep 2025 (ongoing)	# projects with environmental objectives.	
The ICB will ensure the ICS Digital Strategy (which incorporates the What Good Looks Like framework) will deliver a carbon benefit, baselining the Information and Communications Technology footprint in line with Sustainable Technology Advice and Reporting guidance.	**ICB**	Mar 2026	Emissions and waste reduction (by project)	
Existing and future digital programmes will measure the carbon and water use and other environmental impacts of digital technologies as projects are enacted.	**ICB**	From now		✓

[xvi] Maintenance And Reliever Therapy; see https://www.asthmaandlung.org.uk/symptoms-tests-treatments/treatments/mart [Accessed 5 March 2025].
[xvii] This will form a Primary Care Green Plan, a recommendation supported by the BLMK Primary Care Delivery Group in October 2024

Activities to achieve the aim	Led by	By when	Measured by…	Lowers CO_2e
ES3 Use low-carbon alternatives to reduce emissions				
Many low-carbon alternatives are referenced in other sections. ICS partners will continually explore and assess other low-carbon alternatives for adoption within BLMK, including:	**Trusts; Primary Care**	March 2026	Carbon and cost savings	✓
a) Pre-operative paracetamol – shift from intravenous to oral				
b) Alcohol-based hand rubs in place of traditional scrub solutions				
c) On-site composting / food waste to energy				

Phasing our activities

Given the current challenges facing the health and care sector in England, the UK and the world (socially, economically, and politically), and the increasing demand for healthcare, implementation of the Green Plan will not be linear. Initial focus will be on areas that have fewer barriers relative to the size of the opportunity, particularly those that contribute to addressing other risks to service delivery: quality, activity and finances.

Appendix 2: Opportunity analysis outlines the biggest opportunities and an estimation of the relative effort. Each initiative will require a detailed understanding of the costs of implementation (financial or otherwise) prior to commencing work. Opportunities outlined so far only achieve part of what is required (33% of emissions we can directly control, and only 9% of the total Carbon Footprint Plus) – further efforts will be required to calculate the impact of initiatives such as the move to reusable consumables, and to identify further opportunities.

"What can and should I do?"

Even if you are not directly involved in delivering **BLMK CARES**, you can help us achieve net zero, whether a patient or resident, a member of staff, or one of the broader system partners, by following the "Reduce, Reuse, Recycle" mantra. Here are some things you can try:

- Talk to your friends and your colleagues: ask yourselves if you really need to do an activity, or if there's a more sustainable way to do it. What can you stop doing or do without; what could be switched off; and is the way you've always done something the only way?
- Ask your healthcare professional if there are environmentally sustainable treatment methods with the same clinical outcomes; talk to your doctor about your medication and any you have stored at home; ask about whether you can see your doctor virtually if appropriate. Your views and choices matter for your care, as well as the environment.
- Use medicines as directed; try not to stockpile (talk to your healthcare professional if you are worried about supply); take waste medicines to the pharmacy for safe disposal (some high-street pharmacies accept empty blister packs too).
- Try to be more sustainable and healthier with your choices – walk or cycle if only travelling a manageable distance; take public transport if you can; join a group that will increase your social connections and activity levels; consider plant-based foods more often.
- Finally, be proud of what you do achieve.

Section 4: Governance

Figure 8 outlines how Green Plan progress will be governed; the ICB Board has overall accountability for delivery, reporting to the BLMK Health and Care Partnership.

The ICS Green Plan Leadership Group[xviii] is the main forum for oversight; chaired by the ICB Non-Executive Green Champion, it will consist of ICB executive and senior leads (including but not restricted to the Senior Responsible Officer for the ICS Green Plan, chief finance officer, chief medical officer, and accountable emergency officer), sustainability leads from Trusts and local authorities, and directors and theme-leads responsible for key workstreams[xix].

All boards and leadership functions are responsible for supporting delivery of the Green Plan goals alongside their other objectives; the Green Plan activities are expected to support delivery of healthcare's quality, inequality, financial and social objectives and thus will complement and contribute to the ICS priorities.

Additional oversight will be provided by embedding environmental sustainability impact within ICS and ICB functions, including the Health and Care Professional Leadership Group (previously Clinical Senate) and approval processes for healthcare policies, strategies and change projects.

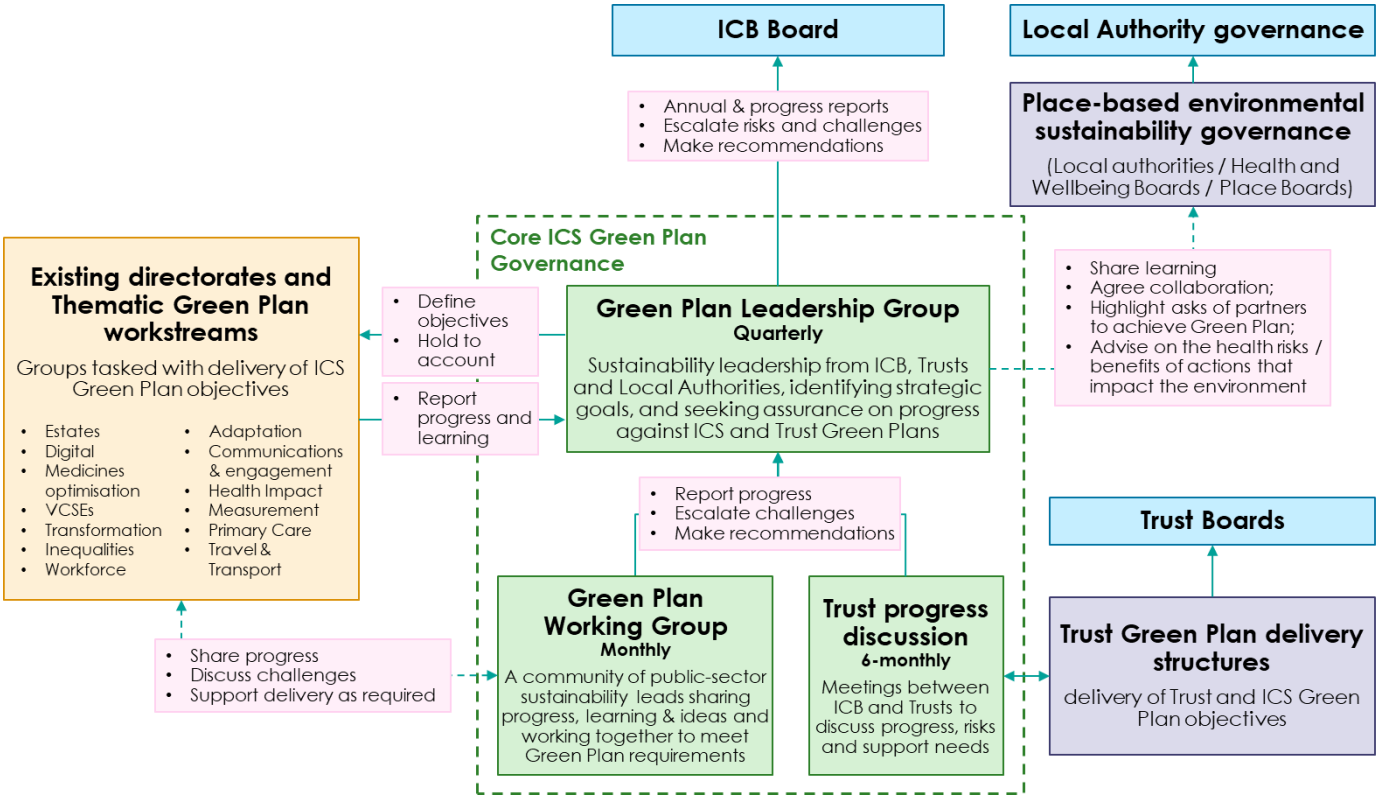


Figure 8: ICS Green Plan governance

How we will measure success of the Green Plan

Progress will be monitored by the ICB sustainability team, using metrics gathered from a variety of sources. Quarterly reports will be made to the Green Plan Leadership Group, and an Annual Report, in line with the requirements of the Taskforce for Climate-Related Financial Disclosures, to the ICB Board.

Each item in the Green Plan and supporting Delivery Plan (Annex) has an associated set of measures. Where possible, actions will be measured in terms of emissions, but proxy measures may be used where emissions are not impacted, where there is a direct correlation between metric

[xviii] a refreshed version of the current Environmental Sustainability System Leadership Group
[xix] including estates, supply chain and procurement, medicines optimisation, adaptation and business intelligence

and emissions, or where the data is difficult to obtain. Table 1 outlines various Process measures (things counted to show action is being taken), Outcome measures (demonstrating the impact being achieved), and Balance measures (to monitor unintended consequences), along with an Aim for each metric.

Aims will evolve over time, overseen by the Green Plan Leadership Group, based on what is achieved and continuous learning.

The Green Plan will be measured by:			**Type**	**Unit**	**Aim[xx]**
Carbon footprint	Total (CF and CF+)		Outcome	$ktCO_2e$	↓ by 22%[xxi] (77 $ktCO_2e$) by 2028
	Per head of population		Outcome	CO_2e per person	↓ below 400 tCO_2e[xxii]
Anaesthetic gases	Volume used by type		Process	litres	↓ by 50% of N_2O use
	Emissions		Outcome	tCO_2e	
Inhalers (by inhaler type)	Items prescribed (by type)		Process	Number	n/a
	Emissions (also per inhaler, by type)		Outcome	$kgCO_2e$ (total and per inhaler)	↓ to 12 $kgCO_2e$ per inhaler
Sustainable Procurement	Social Value	Committed	Process	£ or time	↑[xxii]
		Delivered	Outcome		↑[xxii]
	Walking aid returns		Outcome	Number, and tCO_2e saved	↑ to 60% return rate
Fleet Zero Emissions Vehicles (ZEVs)	Vehicle type		Process	Number of ZEVs	↑ to 100% by 2030
	Emissions		Outcome	$kgCO_2e$ (also per mile)	↓ to 0 by 2035 (non-DCA)
Energy	Energy efficient activities		Process	e.g. LED coverage; heat pumps installed	↑[xxiii]
	Energy used		Outcome	kWh	n/a
	Emissions		Outcome	tCO_2e	↓ by 27.5%
Waste	Disposal (by route)		Process	tonnes	n/a
	Food waste		Process		↓ to 2% (patient meals)
Water	Use		Process or Outcome	litres per patient	↓[xxii]
Skills	Staff trained in sustainability		Process	Number	↑[xxii]
Finance for sustainability	New funding attracted		Process	£	↑[xxii]
	Funding spent on sustainability actions		Balance		n/a
	Return on investment		Outcome		Positive

Table 1: BLMK ICS Green Plan 2025 metrics

[xx] by 2028 unless stated; baseline 2019/20 unless stated otherwise.
[xxi] based on national target as described in the section on emissions-reductions, above, and relative to 2019/20 baseline, factoring in 14.5% reductions in directly-controllable emissions already achieved and annual growth of 2% year on year.
[xxii] baseline / aim to be further developed.
[xxiii] various initiatives

All ICS partners have differing roles to play in delivering this ICS Green Plan:

The ICB and the two acute Trusts will be held to account for delivery of the Green Plan and underpinning Delivery Plan actions, with wider partners supporting as set out below.

The ICB will oversee delivery of the ICS Green Plan and:

- Ensure there is always a board-level Senior Responsible Officer (SRO) (currently the Chief Finance Officer) to oversee the ICS Green Plan, and a clinical lead to oversee net zero clinical transformation.
- Provide system leadership and direction to other organisations, engaging system partners.
- Leading delivery of some collaborative projects, and support other partners, including primary care, to deliver against sustainability aims.
- Embed sustainability requirements within all system planning, commissioning and delivery functions, and seek assurance from others delivering improvements (monitoring through the provider contracts, including the NHS Standard Contract service condition 18).
- Coordinate some of the cross-system and cross-sector networking, sharing and collaboration, including through themed working groups.
- Oversee delivery via the existing ICS Green Plan Leadership Group (chaired by the ICB Non-Executive Green Champion).

The two acute Trusts hosted directly by the ICS (MKUH and BHFT) will:

- Use the ICS Green Plan and associated Delivery Plan to guide delivery of local actions, adapting to the local context where required.
- Ensure delivery of local Green Plan activities, overseen by the Trust's Green Plan SRO, meeting national targets, and reporting to the ICB on progress twice annually.
- Actively engage with ICS Green Plan activities, identifying clinical leaders to oversee net zero clinical transformations.

The other NHS Trusts that provide services within BLMK will:

- Develop and deliver their own Trust Green Plans, using the ICS Green Plan as a steer, overseen by the Trust's Green Plan SRO.
- Actively engage with system Green Plan activities.
- Share progress against their own Trust Green Plans to help with learning and collaboration, including a 6-monthly update to the Green Plan Leadership Group.

This includes Cambridgeshire Community Services, Central and North West London Foundation Trust, East London Foundation Trust, East of England Ambulance Service Trust, and South Central Ambulance Service.

Public Health teams will:

- Provide expertise in population health improvement initiatives.
- Provide expertise in the latest evidence base.
- Collaborate on specific projects (for example reductions in inequalities and vulnerabilities).
- Support residents to become more climate-resilient through healthier lifestyles.

Local authorities will:

- Undertake actions that support delivery of the ICS Green Plan, where required, and continue work to improve population health.
- Share expertise and knowledge and actively engage with collaborative work (such as air quality, green space, environmental awareness and community resilience).

Primary Care (GPs, Pharmacy, Optometry and Dental) will:

- Continue to collaborate on developing and progressing a local Primary Care Green Plan.
- Openly engage with the ICB to support achievement of system aims.

Supply Chain and private providers (incl. VCSE providers) will be expected to:

- Consider undertaking the voluntary Evergreen Assessment.
- Provide and progress Carbon Reduction Plans as required.
- Openly engage with the ICB to support achievement of system aims.

VCSE will be encouraged to:

- Consider their own role in improving health and wellbeing in harmony with the environment.
- Contribute to system decision-making supporting the environmental sustainability vision, through the BLMK VCSE Strategy Group

ICS partners will work with Members of the Public to:

- Help the ICB and Trusts understand how to make the ICS Green Plan more impactful.
- Coproduce specific activities (e.g. climate-resilient communities).
- Support residents to reduce their own impact across all wider determinants of health.
- Support the ICB to regularly engage with local resident groups and representatives, including our youth councillors.

Section 5: Further information

If you would like to find out more about the ICS Green Plan, including a glossary of the terms used in this document, or you have a suggestion for activities to help make BLMK a more-sustainable health and care system, please visit the BLMK HCP environmental sustainability webpages or email blmkicb.sustainability@nhs.net.

May 2025

Annex

Delivering The BLMK ICS Green Plan 2025

This Delivery Plan sets out the detailed activities that will be undertaken to deliver the Bedfordshire, Luton and Milton Keynes (BLMK) vision of a sustainable health and care system (Figure 5). It complements and should be viewed alongside the main BLMK Integrated Care System (ICS) Green Plan 2025. Actions are based on broad engagement and build on the recommendations from a system-wide seminar held in November 2024. It is also the set of activities against which the Integrated Care Board (ICB) and the two "hosted", acute Trusts will be held to account, *via* their Green Plan Senior Responsible Officers (SROs[xxiv]), and incorporates all items from the Green Plan Guidance. A large print version can be made available on request.

In this section, a key is used to indicate which vision statement is supported by the action:

Supporting the Vision statements: P_1 = People | P_2 = Places | P_3 = Planet | = enables vision | = delivers against vision

Organisation (RASCI): **R** = Responsible (does the doing) | **A** = Accountable (Held to account for delivery) | **S** = Supporting (Helps Responsible or Accountable organisation) | **C** = Consulted (Provides advice / expert input) | I = Informed (notified of changes)

Other: Primary care = 1° care, and refers to General Practice, Pharmacy, Optometry, and Dentistry.

Activities to achieve the aim		ICB	Acutes	Other Trusts	LAs	Primary care	Date	Supports vision			Measured by…	Greener NHS Theme	Main emissions category	Likely financial impact	Accountable lead (role)
								P_1	P_2	P_3					
Culture enabling environmentally sustainable health and care															
C1	A compelling story and information														
A	By 2028, 95% of staff polled will state they have an increased awareness and commitment to change (relative to 2025/26 baseline)														
/i	Refresh the communications and engagement plan and commence delivery, mutually amplifying messages across partner communications teams.	**A**	**S**	**S**	**S**	**C**	Sep-25				% rating on sustainability awareness on staff surveys	1. Workforce and Leadership	None direct	None	Sustainability and Growth (ICB CFO)
/ii	Create online resources to support staff, partners and residents to be more sustainable.	**A**	**R**	**R**	**S**	**S**	Dec-25				% rating on sustainability awareness on staff surveys	1. Workforce and Leadership	None direct	None	Sustainability and Growth (ICB CFO)
/iii	Communicate with staff monthly and residents quarterly on the link between health and environmental sustainability, emphasising the immediate positive benefits and celebrate progress.	**A**	**R**	**R**	**S**	**C**	Sep-25				% rating on sustainability awareness on staff surveys	1. Workforce and Leadership	None direct	None	Comms and Engagement (ICB Chief of Strategy and Transformation)

[xxiv] In the case of the ICB and two acute hospitals, these are currently the Chief Finance Officers (CFOs).

Activities to achieve the aim		ICB	Acutes	Other Trusts	LAs	Primary care	Date	Supports vision			Measured by…	Greener NHS Theme	Main emissions category	Likely financial impact	Accountable lead (role)
								P_1	P_2	P_3					
/iv	Work collaboratively with local authorities (LAs) and Voluntary, Community and Social Enterprise (VCSE) to outreach together to other organisations (schools, VCSEs, SMEs) at least quarterly, initially through existing channels managed by LAs, to: a) increase knowledge of the links between health and climate, and support a higher level of activation, so that individuals take more action on climate and health. b) seek views on how environmental sustainability should be incorporated into policies and decisions.	**A**	**S**	**S**	**C**		Sep-25				# of people / organisations reached	1. Workforce and Leadership	None direct	None	Sustainability and Growth (ICB CFO)
C2	Leadership Planning and Decision-making														
A	From Apr 2026, all major service changes within the NHS in BLMK will assess for environmental and social impact														
/i	Use environmental impact assessment tools to aid decision-making, ensuring the likely impacts of decisions on the environment are always considered (initially qualitative, aiming to quantify impacts in carbon terms from Apr 2027 onwards), including within other evaluative and oversight forums such as the BLMK Health and Care Professional Leadership Group.	**A**	**A**	**A**	**C**		Apr-26				# of documents including a social and environmental impact assessment.	10. Governance	None direct	None	PMO (ICB Chief of Strategy and Transformation)
/ii	All key ICS strategies, policies and priority programmes being refreshed to reflect environmental impacts, receiving approval from the ICS Green Plan System Leadership Group, particularly Health Services Strategy, Joint Forward Plan, Infrastructure Strategy, Integrated Neighbourhood Working, Digital, Primary Care Prevention Delivery Plan, and population health and inequalities work.	**A**					Apr-25				# documents including a social and environmental impact assessment	10. Governance	None direct	None	ICB Chief of Strategy and Transformation
/iii	Train all senior NHS executives and non-executives to understand the environmental impacts of their decisions.	**A**	**A**	**A**			Mar-26				# execs and non-execs trained	1. Workforce and Leadership	None direct	None	Sustainability and Growth (ICB CFO)
/iv	To ensure accountability for delivery, set ICS Green Plan objectives with ICB directorates and workstreams, refreshing annually, specifically estates, procurement/supply chain/contracting, medicines optimisation, adaptation/emergency planning, workforce, digital, and transformation, with quarterly updates provided to the ICS Green Plan Leadership Group	**A**					Sep-25				activity delivered	1. Workforce and Leadership	None direct	None	Sustainability and Growth (ICB CFO)
C3	Removing barriers to change														
A	We will collaborate to maximise the sustainability resource available to the ICS to increase the pace of change, supporting the workforce to become sustainability literate, with sustainability champions and leaders, creating a movement of skilled and enthusiastic staff delivering projects locally														
/i	Link sustainability teams in a matrix, across NHS organisations as a minimum, to maximise the resource available, sharing activities such as horizon scanning for funding opportunities,	**A**	**A**	**R**	**S**		Apr-26				activity delivered	1. Workforce and Leadership	None direct	None	ICB and Trust Green Plan SROs

Key: = enables vision = delivers against vision. **R** = Responsible **A** = Accountable **S** = Supporting **C** = Consulted **I** = Informed

Activities to achieve the aim		ICB	Acutes	Other Trusts	LAs	Primary care	Date	Supports vision			Measured by…	Greener NHS Theme	Main emissions category	Likely financial impact	Accountable lead (role)
								P_1	P_2	P_3					
	supporting each other to apply for external funding (e.g. PSDS), and moving towards co-delivering similar projects.														
/ii	Consider creation of a BLMK "Green Fund", if financially viable, taking at least 10% of any financial savings made through sustainability initiatives to invest in additional green projects that are likely to generate further savings.	**A**	**A**	**C**			Apr-26				Savings reinvested	10. Governance	None direct	None	ICB and Trust CFOs
/iii	The ICB and primary care partners (including NHS Property Services) will co-develop a Green Plan for primary care, providing a menu of achievable actions and projects for practices to select from to reduce their own environmental impacts, and supporting them to identify external funding opportunities. This will also include working with other organisations to support patient empowerment (e.g. collaborating with leisure centres).	**A**				**R**	Dec-25				activity delivered	10. Governance	None direct	None	Primary Care (ICB Chief Medical Officer)
/iv	Inclusion of sustainability principles and ideas in support for organisations to address regulatory requirements (e.g. CQC)	**A**			**I**	**I**	Dec-25				activity delivered	10. Governance	None direct	None	Governance (ICB Chief of Strategy and Transformation)
/v	All healthcare organisations will ensure 100% of their staff have received an appropriate level of knowledge and skills in environmental sustainability and health, including basic information for all staff (for example, organisational values, at recruitment, induction, formal training where appropriate, and role-specific actionable tips).	**A**	**A**	**A**		**R**	Mar-28				# staff reached	1. Workforce and Leadership	None direct	None	Sustainability and Growth (ICB CFO)
/vi	Creation of system clinical sustainability roles (e.g. clinical leads, clinical fellows, hybrid roles), aiming for at least 1 full-time equivalent system clinical expertise in sustainability (likely spread across organisations and roles)	**A**	**R**	**R**			Apr-26				clinical wte with sustainability as specific responsibility	2. Net zero clinical transformation	None direct	None	ICB Chief Medical Officer
/vii	Create clinical and multi-disciplinary sustainability working group(s), or ensure sufficient clinical sustainability oversight, for pathway reconfiguration.	**A**	**A**	**A**		**S**	Mar-27				clinical wte with sustainability as specific responsibility	2. Net zero clinical transformation	None direct	None	ICB Chief Medical Officer
/viii	Develop at least 2.5%[xxv] (aiming for >3%) of the health and care workforce with enhanced sustainability knowledge, including green champions, theme leads, sustainability experts, those working on implementing green projects, those responsible for green objectives, green network attendees, and others with an enhanced sustainability skillset, for example in Finance, Estates and Procurement (~500 people in BLMK).	**A**	**R**	**R**		**S**	Mar-28				% of staff with enhanced sustainability knowledge / role	1. Workforce and Leadership	None direct	None	Sustainability and Growth (ICB CFO)

[xxv] Based on identifying a greater proportion of staff that could be classed as "early adopters" in E. Rogers' "Diffusion of Innovations" (1962).

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Activities to achieve the aim		ICB	Acutes	Other Trusts	LAs	Primary care	Date	Supports vision			Measured by…	Greener NHS Theme	Main emissions category	Likely financial impact	Accountable lead (role)
								P_1	P_2	P_3					
/ix	Incorporating sustainability concepts and skills into the emerging BLMK "Quality Improvement" faculty.	**A**					Jan-26				# QI projects with sustainability measures	1. Workforce and Leadership	None direct	None	Quality Improvement (ICB Chief Nursing Officer)
/x	Create a BLMK "Green-Skills Faculty" – a virtual group of sustainability experts from each BLMK healthcare partner delivering training in health and environmental awareness (potentially in collaboration with other anchor organisations, where appropriate).	**A**	**R**	**R**	**C**	**I**	Dec-26				# staff trained internally	1. Workforce and Leadership	None direct	None	Sustainability and Growth (ICB CFO)
/xi	Convene BLMK-wide sustainability networks (including clinical) at least quarterly, to support staff to share ideas, celebrate successes and learn skills (including taking up existing core training offers via GreenerNHS).	**A**	**R**	**R**	**C**	**C**	Dec-26				# people attending	1. Workforce and Leadership	None direct	None	Sustainability and Growth (ICB CFO)
B	Measure progress in the "triple-bottom-line" (environmental, social and financial) and identify gaps in achieving net zero ambitions.														
/i	The ICB and NHS Trusts, supported by existing BLMK data and intelligence functions, will measure our direct carbon footprints (Scopes 1 and 2[1]).	**A**	**A**	**A**			Mar-26				carbon footprint	10. Governance	None direct	None	Sustainability and Growth (ICB CFO)
/ii	Report annually on local progress against Scopes 1 and 2 for BLMK emissions, and address any NHS reporting requirements (e.g. Task-Force on Climate-Related Financial Disclosures (TCFD).	**A**	**A**	**A**			Apr-26				activity delivered	10. Governance	None direct	None	Sustainability and Growth (ICB CFO)
/iii	Understand the likely system gap between known impacts of sustainability work, and our Scope 1 and 2 net-zero targets (2032 and 2040) and develop a plan to close them.	**A**	**A**	**A**			Mar-26				activity delivered	10. Governance	None direct	None	Sustainability and Growth (ICB CFO)
/iv	Understand the likely system gap between known impacts of sustainability work and our Scope 3 net zero targets (2039 and 2045) and develop a plan to close them.	**A**	**A**	**A**	**C**	**C**	Sep-27				activity delivered	10. Governance	None direct	None	Sustainability and Growth (ICB CFO)
/v	Identify expertise in triple-bottom-line reporting within private and public sector, to learn from.	**A**	**S**	**S**	**S**		Dec-26				# of people trained in carbon footprinting	1. Workforce and Leadership	None direct	None	Sustainability and Growth (ICB CFO)
/vi	Generate local evidence of the current and projected impact of initiatives in the "triple-bottom-line" (environmental, social, and governance/financial impacts) as well as health terms.	**A**	**A**	**A**			Mar-26				# case studies	10. Governance	None direct	None	Sustainability and Growth (ICB CFO)
/vii	Create a dashboard to measure progress against sustainability initiatives in environmental and health impact terms (and the links between them), including to assist with measuring the impact of preventative activities.	**A**			**C**		Dec-26				activity delivered	10. Governance	None direct	None	Business Intelligence (ICB CFO)
/viii	Support local authorities and public health functions in incorporating the impact of environmental impacts on health within Local Plan health needs assessments.	**C**			**A**		Mar-28				activity delivered	1. Workforce and Leadership	None direct	None	Public Health Directors
/ix	Work towards a "triple-bottom-line" annual reporting model.	**A**	**A**	**A**			Mar-29				activity delivered	10. Governance	None direct	None	Finance (CFOs)

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Activities to achieve the aim	ICB	Acutes	Other Trusts	LAs	Primary care	Date	Supports vision			Measured by…	Greener NHS Theme	Main emissions category	Likely financial impact	Accountable lead (role)
							P1	P2	P3					
Adapted communities and infrastructure, resilient to climate change														
A1	Maximising social impact and minimising the risks of climate change for communities													
A	Improve the level of climate adaptation planning across organisations and communities													
/i	Local authority and NHS partners will work together to support communities and community groups/organisations to improve their resilience to climate change through adaptation, identifying an approach by March 2027	**A**			**A**		Mar-27			activity delivered	9. Adaptation	None direct	None	Sustainability and Growth (ICB CFO)
/ii	Support at least one community to create and test an approach to community adaptation.	**A**			**A**		Mar-28			positive community feedback	9. Adaptation	Other	Cost pressure	Sustainability and Growth (ICB CFO)
/iii	All providers and commissioners of NHS-funded services will work with local partners, particularly those involved in emergency response, to risk assess, prepare for and mitigate the impacts of climate change, and identify interdependencies, including: a) business continuity plans reflecting climate risks and planning to respond during adverse weather events. b) Trusts completing the Climate-Change Risk Assessment (or equivalent) c) separate and complementary organisational and system Adaptation plans to address the way services are delivered, considering physical, natural, behavioural and operational factors, monitored annually, and refreshed every 3 years as a minimum.	**A**	**A**	**A**	**S**	**C**	Dec-25			# adaptation plans in place	9. Adaptation	None direct	None	Emergency Preparedness Resilience and Response, EPRR (ICB Chief of Staff; Trust EPRR directors)
/iv	All directorates within the ICB will assess for climate change-related risks, and develop adaptation initiatives as part of their service development plans.	**A**					Apr-26			# risk assessments undertaken	9. Adaptation			EPRR (ICB Chief of Staff)
B	Measure and increase local social impact of public sector anchor organisations with respect to the environment													
/i	ICS partners will map and identify local market capacity to provide goods and services for “addressable lines” (i.e.. those that are not procured through a centralised regional or national body, for example food and catering), aiming to increase the amount spent in the local economy, and reduce transport emissions.	**A**	**R**	**R**	**S**	**C**	Mar-27			£ spent locally	7. Supply Chain and Procurement	Consumables and equipment	None	Commissioning and Contracting (ICB CFO)
/ii	All ICS health anchor organisations will commit at least 0.5% of their annual sustainability resource to provide expertise and/or volunteer time to support VCSEs to consider their own environmental sustainability activities.	**A**	**A**	**R**			Apr-26			£ (or equivalent value) delivered locally	1. Workforce and Leadership	None direct	None	ICB and Trust Green Plan SROs
A2	Infrastructure: healthy and climate-adapted design, improving biodiversity													
A	Reduce emissions from built healthcare environment in line with net zero goals (80% by 2032; 100% by 2040), focusing on energy efficiency measures, replacing fossil fuel heating systems, and increasing renewable and low-carbon energy use.													

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	Activities to achieve the aim	ICB	Acutes	Other Trusts	LAs	Primary care	Date	Supports vision			Measured by…	Greener NHS Theme	Main emissions category	Likely financial impact	Accountable lead (role)
								P_1	P_2	P_3					
/i	All NHS Trusts operating within BLMK will create / update best practice decarbonisation plans to achieve emissions reductions in line with net zero targets, incorporating national guidance (including the NHS Estates Net Zero Strategy ("Making every kWh count"), Net Zero Building Standards and Biodiversity Net Gain), and focusing on: a) replacing all fossil fuel-based primary heating systems by 2032 b) increasing the use of lower-carbon and renewable energy, including reference to Local Area Energy Plans c) improving building efficiency d) identifying and bidding for external funding sources		**A**	**A**			Mar-26				carbon emissions	6. Estates & Facilities	None direct	None	Trust Estates Directors
/ii	All new buildings will plan to meet the standards expected in the NHS England Net Zero Building Standards.		**A**	**A**			Apr-25				# new buildings with by BREEAM rating	6. Estates & Facilities	Power, heating and lighting	Cost pressure	Trust Estates Directors
/iii	The ICB will work with acute Trusts and Primary Care to respond to the evidence base (e.g. studies by Greater South-East Net Zero Energy Hub and the BLMK Green Plan Health Impact Assessment) to identify specific opportunities to increase the use of heat networks, solar energy, heat pumps, insulation, passive heating and cooling, water saving devices, and building management	**A**	**S**			**S**	Dec-25				activity delivered	6. Estates & Facilities	None direct	None	Trust Estates Directors
/iv	NHS Trusts will increase LED coverage by at least 10% per year, aiming for 100% coverage by 2028, for buildings where they are responsible for the estate.		**A**	**A**			Dec-28				LED coverage	6. Estates & Facilities	Power, heating and lighting	High (£50k+)	Trust Estates Directors
B	A higher quality natural environment on healthcare estate, contributing to nature recovery.														
/i	The ICB, with ICS healthcare partners, will map healthcare organisation greenspace, identifying opportunities and an action plan to improve quality of the greenspace and tree cover, and to support (where feasible) the Local Nature Recovery Strategies covering Bedfordshire and Buckinghamshire as relevant.	**A**	**S**	**S**	**C**	**S**	Mar-26				activity delivered	6. Estates & Facilities	None direct	None	Trust Estates Directors
A3	Optimise transport use to reduce emissions and improve air quality														
A	NHS Trusts will aim to reduce commuting emissions by 50% by 2033 (as per the national Travel and Transport strategy), including supporting 20% of staff currently commuting by sole-occupier vehicles to shift to lower-carbon transport														
/i	The ICS partners will develop a sustainable (place-based) travel strategy for BLMK, including an assessment of infrastructure requirements (e.g. EV charging, active travel, public transport) for patients, staff and the public, based on an assessment of the main healthcare-related travel routes. This will link to, or be covered by, local authority Local Transport Plans and Local Walking and Cycling Implementation Plans.	**A**	**S**	**S**	**S**	**C**	Dec-26				activity delivered	5. Travel & Transport	None direct	None	Sustainability and Growth (ICB CFO)

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Activities to achieve the aim		ICB	Acutes	Other Trusts	LAs	Primary care	Date	Supports vision			Measured by…	Greener NHS Theme	Main emissions category	Likely financial impact	Accountable lead (role)
								P1	P2	P3					
/ii	ICS partners will assess current maturity against the ICS Clean Air Framework tool, developing an action plan to work towards the system becomes a 'Clean Air Champion'.	**A**	**R**	**R**	**S**	**S**	Mar-26				activity delivered	5. Travel & Transport	None direct	None	Sustainability and Growth (ICB CFO)
/iii	Building staff awareness of the Sustainable Travel Hierarchy, communicating across primary and secondary care organisations at least annually.	**A**	**A**	**A**			Apr-25				staff commuting method	5. Travel & Transport	Travel and Transport	None	Workforce and OD Directors
/iv	Promote car-sharing and the benefits to staff at least annually.	**A**	**A**	**A**			Apr-25				staff commuting method	5. Travel & Transport	Travel and Transport	None	Workforce and OD Directors
/v	Assess the case for introducing car-sharing schemes.	**S**	**A**	**A**			Sep-26				activity delivered	5. Travel & Transport	None direct	None	Workforce and OD Directors
/vi	Promote public transport discounts for NHS staff at least quarterly.	**A**	**A**	**A**			Apr-25				staff commuting method	5. Travel & Transport	Travel and Transport	Cost pressure	Workforce and OD Directors
/vii	Submit to NHS England annual fleet data and staff and public travel survey information, reporting and publishing findings		**A**	**A**			Jun-25 ongoing				activity delivered	5. Travel & Transport	None direct	None	Estates Directors
/viii	Review staff use of on-site parking and implement best practice incentives and disincentives.		**A**	**A**			Sep-26				staff commuting method	5. Travel & Transport	Travel and Transport	None	Workforce and OD Directors
/ix	All vehicles on salary sacrifice schemes to be electric or zero-emission vehicles (on approval from Staff Side representatives).	**A**	**A**	**A**			Dec-26				# vehicles leased by type	5. Travel & Transport	Travel and Transport	None	Workforce and OD Directors
/x	Map key secondary healthcare commuter routes against transport infrastructure availability, working closely with transport authorities and providers, to maximise funding and infrastructure opportunities to support "modal shift" to active travel, public and zero-emission transport.	**S**	**A**	**A**	**S**		Sep-26				staff commuting method	5. Travel & Transport	Travel and Transport	None	Workforce and OD Directors
/xi	Review best balance of working from home and on-site work, considering any technology required, and calculating carbon opportunity and staff productivity as part of the impact analysis.	**A**	**A**	**A**			Dec-26				staff commuting method	5. Travel & Transport	Travel and Transport	None	Workforce and OD Directors
B	Reduce emissions from fleet and business travel (with all non-ambulance NHS fleet to be net zero by 2035, 50% of the total ambulance fleet to be net zero by 2036, and all fleet to be net zero by 2040.)														
/i	All new fleet vehicles (owned or leased, excluding dual-crewed ambulances) to be zero-emission vehicles (ZEV), in accordance with the NHS Travel & Transport Strategy 2023.		**A**	**A**			Dec-27				# fleet by type	5. Travel & Transport	Travel and Transport	High (£50k+)	Estate Directors
/ii	All new dual-crewed ambulance fleet to be net zero, in accordance with the NHS Travel & Transport Strategy 2023.			**A**			Dec-30				# fleet by type	5. Travel & Transport	Travel and Transport	High (£50k+)	Estate Directors
/iii	All Trusts will improve fleet management and use, including exploring opportunities to improve efficiency of collection and delivery services (pathology, supplies)		**A**	**A**			Dec-30				Fleet and business miles	5. Travel & Transport	Travel and Transport	Low (£0k-10k)	Estate Directors

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Activities to achieve the aim		ICB	Acutes	Other Trusts	LAs	Primary care	Date	Supports vision			Measured by…	Greener NHS Theme	Main emissions category	Likely financial impact	Accountable lead (role)
								P_1	P_2	P_3					
/iv	BLMK ICB will work with primary care and community providers to explore opportunities for e-bike use for community visits in urban areas, producing an opportunity analysis.	**A**		**S**		**C**	Sep-26				Business miles by mode	5. Travel & Transport	Travel and Transport	None	Sustainability and Growth (ICB CFO)
/v	All ICS partner organisations will explore opportunities to improve efficiency of patient transport services, including Non-emergency Patient Transport Services (NEPTS) and volunteer services, to identify ways to achieve the goal of all NEPTS vehicles to be ZEV by 2035.	**A**	**C**	**R**	**R**	**C**	Dec-30				Business miles by mode	5. Travel & Transport	Travel and Transport	None	Commissioning and Contracting (ICB CFO)
Resource-consciousness: a sustainable circular economy															
R1	5 Rs of procurement: Reduce, Reuse, Reprocess, Renewable, Recycle														
A	Reduce use of consumables through process and behaviour change														
/i	All NHS Trusts operating in BLMK will reduce nitrous oxide (N_2O) use and waste (including N_2O / oxygen mix) by 50% using the updated NHS England N_2O toolkit.		**A**	**A**			Mar-28				Volume of N_2O and emissions	4. Medicines	Anaesthetic gases	High (£50k+)	Estates Directors
/ii	The ICB and NHS Trusts will identify selected health and care services (delivered or commissioned by NHS and local authorities, incl. primary care organisations, and care homes) across BLMK and initiate clinically-appropriate personal protective equipment (PPE)-reduction improvement projects in 2025/26, aiming to reduce glove usage from the tests by 10% by Sep 2026, scaling and spreading during 2026-2028	**A**	**A**	**A**	**S**	**R**	Mar-26				PPE reduction (by project)	4. Medicines	Consumables and equipment	High (£50k+)	Infection Prevention and Control director (Chief Nursing Officer)
/iii	Rationalise fluid giving sets and warming devices in Theatres		**A**				Mar-27				Plastic waste	7. Supply Chain and Procurement	Consumables and equipment	High (£50k+)	Directors responsible for theatre services
B	Reduce use of consumables by increasing reuse of existing items														
/i	All NHS Trusts issuing walking aids will participate in a system-wide or trust-specific Walking Aid Return and Reuse scheme, supported by other ICS partners	**S**	**A**		**S**		Mar-26				Walking aid returns and reuse rates	7. Supply Chain and Procurement	Consumables and equipment	Medium (£10k-50k)	Trust Green Plan SROs
/ii	All NHS Trust / system-wide Walking Aid Return and Reuse schemes will achieve a >40% return rate (3-month rolling average)		**A**				Mar-27				Walking aid returns and reuse rates	7. Supply Chain and Procurement	Consumables and equipment	Medium (£10k-50k)	Trust Green Plan SROs
/iii	All NHS Trust / system-wide Walking Aid Return and Reuse schemes will achieve a >60% return rate (3-month rolling average)		**A**				Mar-28				Walking aid returns and reuse rates	7. Supply Chain and Procurement	Consumables and equipment	Medium (£10k-50k)	Trust Green Plan SROs
/iv	The ICB will implement a system-wide office asset reuse scheme by the end of 2025/26, working to involve all public sector organisations by March 2028 (if demonstrated to be beneficial).	**A**	**S**	**S**	**S**	**I**	Sep-25				Office assets shared and cost / emissions avoided	7. Supply Chain and Procurement	Consumables and equipment	High (£50k+)	Estates Director (ICB CFO)
/v	All NHS Trusts to have implemented best practice in reusable alternatives to single-use consumables (including tourniquets, pulse oximeters, cool sticks, sharps bins, meal sets, theatre	**S**	**A**	**A**			Dec-28				Single use equipment volumes and emissions	7. Supply Chain and Procurement	Consumables and equipment	Medium (£10k-50k)	Procurement Directors

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Activities to achieve the aim		ICB	Acutes	Other Trusts	LAs	Primary care	Date	Supports vision			Measured by…	Greener NHS Theme	Main emissions category	Likely financial impact	Accountable lead (role)
								P_1	P_2	P_3					
	gowns and caps, anaesthetic masks, vaginal specula, suture kits, wound wraps) by Dec 2028														
/vi	Assess the need to increase and/or centralise sterilisation services to accommodate an increased volume of reusable equipment requiring cleaning.	**S**	**A**				Mar-28				activity delivered	7. Supply Chain and Procurement	Consumables and equipment	Cost pressure	Estates Directors
C	Reduce use of consumables by switching to re-processable alternatives														
/i	All NHS Trusts to implement best practice in medical device reprocessing schemes, and to scale and spread schemes across BLMK, commencing in 2025/26	**S**	**A**	**A**			Dec-25				Single use equipment volumes and emissions	7. Supply Chain and Procurement	Consumables and equipment	Medium (£10k-50k)	Trust Green Plan SROs
D	Reduce use of less-sustainable items and move to products made with renewables and recyclables														
/i	The ICB will implement best practice in “choice-editing”, promoting sustainable options and removing or deprioritise less-sustainable consumables where there is no additional clinical or significant financial value, including by working with NHS Supply Chain	**A**	**R**	**R**		**C**	Mar-26				Single use equipment volumes and emissions	7. Supply Chain and Procurement	Consumables and equipment	None	Commissioning and Contracting (ICB CFO)
E	Reduce waste emissions by recycling more														
/i	Reduce valuable materials entering waste streams, including achieving waste segregation at source (20:20:60), working with local authorities to improve recycling rates, and exploring initiatives to recycle inhalers and blister packs.	**S**	**A**	**A**	**S**	**A**	Mar-28				Recycling rates, volumes and segregation ratios	6. Estates & Facilities	General Waste	Low (£0k-10k)	Estates Directors
/ii	Primary Care practices will implement the UK government Simpler Recycling reforms for non-clinical waste, separating dry recyclables, food waste and "black bin" waste.	**S**				**A**	Apr-25				# practices implementing processes to abide by regulation	6. Estates & Facilities	General Waste	Potential cost pressure	PCN Directors
R2	Strong procurement requirements and influence														
A	NHS organisations to increase the supply chain social value linked to sustainability delivered within BLMK														
/i	Baseline recent and existing social value commitments from NHS suppliers, and agree a goal across NHS Trusts to increase.	**A**	**A**	**A**			Mar-26				£ (or equivalent value) delivered locally	7. Supply Chain and Procurement	None direct	None	Directors of Procurement / Commissioning and Contracting
/ii	Include 10% minimum weighting for Social Value (SV) within all tenders, including a minimum 5% weighting for the Sustainable Procurement Practices outcome in the UK Government Social Value Model.	**A**	**A**	**A**			Apr-25				activity delivered	7. Supply Chain and Procurement	Suppliers and commissioned / sub-contracted services	None	Directors of Procurement / Commissioning and Contracting
/iii	Measure supply chain social value commitments and achievements relating to Sustainable Procurement Practices, reporting annually to the board.	**A**	**A**	**A**			Mar-26 ongoing				£ (or equivalent value)	7. Supply Chain and Procurement	None direct	None	Directors of Procurement /

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Activities to achieve the aim		ICB	Acutes	Other Trusts	LAs	Primary care	Date	Supports vision			Measured by…	Greener NHS Theme	Main emissions category	Likely financial impact	Accountable lead (role)
								P1	P2	P3					
											delivered locally				Commissioning and Contracting
/iv	Create a Social Value priorities and measurement model, linked to and sensitive to place priorities. [d]	**A**	**C**	**C**	**C**		Dec-25				activity delivered	7. Supply Chain and Procurement	None direct	None	Directors of Procurement / Commissioning and Contracting
/v	ICB and NHS trusts to adopt BLMK Social Value priorities and measurement model [d]	**A**	**A**	**A**			Apr-26				activity delivered	7. Supply Chain and Procurement	None direct	None	Directors of Procurement / Commissioning and Contracting
B	Ensure suppliers are progressing net-zero activities and sustainability maturity														
/i	Ensure all suppliers meet NHS England's Carbon Reduction Plan guidance. [d]	**A**	**A**	**A**			Apr-25 ongoing				supplier emissions	7. Supply Chain and Procurement	Suppliers and commissioned / sub-contracted services	None	Directors of Procurement / Commissioning and Contracting
/ii	All NHS organisations will embed narrative within procurement processes and contracts (including asking non-scored questions about current maturity levels), to encourage completion of the voluntary Evergreen Assessment, and progress with efforts reported through Evergreen to move towards higher levels of maturity. [d]	**A**	**A**	**A**			Sep-25 ongoing				activity delivered	7. Supply Chain and Procurement	None direct	None	Directors of Procurement / Commissioning and Contracting
/iii	The BLMK Procurement Participation Group (PPG) will: a) Baseline the current proportion of suppliers with an Evergreen Assessment, and their average maturity level [d] b) Set aims for 2026/27 to increase: [i] the proportion of BLMK suppliers using Evergreen [d] [ii] the average Evergreen maturity level. [d]	**A**	**R**	**R**			Jun-26				# suppliers using Evergreen, and maturity level	7. Supply Chain and Procurement	Suppliers and commissioned / sub-contracted services	None	Directors of Procurement / Commissioning and Contracting
/iv	Work with a representative sample of smaller suppliers not currently using Evergreen to understand the barriers and limitations. [d]	**A**	**R**	**R**	**S**		Dec-26				activity delivered	7. Supply Chain and Procurement	None direct	None	Directors of Procurement / Commissioning and Contracting
/v	Share learning between NHS-, LA- and Public Health-commissioned services (e.g. sexual health, drug & alcohol and pharmacy needs assessment), and collaborate on shared goals to influence suppliers and reduce consumable use	**A**	**A**	**A**	**A**		Apr-25 ongoing				activity delivered	7. Supply Chain and Procurement	None direct	None	Directors of Procurement / Commissioning and Contracting
R3	Minimise waste														
A	Reduce waste-related emissions to top-quartile amongst system peers (from bottom of second quartile)														
/i	NHS Trusts will have 0% domestic waste to landfill by reducing waste production (see 5Rs), separating waste at source, increasing recycling rates, and incinerating all other waste for energy.		**A**	**A**			Mar-28 ongoing				Waste volumes and disposal route	6. Estates & Facilities	General Waste	None	Estates Directors

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Activities to achieve the aim		ICB	Acutes	Other Trusts	LAs	Primary care	Date	Supports vision			Measured by…	Greener NHS Theme	Main emissions category	Likely financial impact	Accountable lead (role)
								P1	P2	P3					
/ii	NHS Trusts will aim to reduce food waste from food provided to patients as much as possible, aiming for <2% on all healthcare sites, including through digital meal ordering, awareness campaigns, and on-site composting where appropriate. This will be measured through ERIC returns.		**A**	**A**			Mar-27				Waste volumes and disposal route	8. Food and Nutrition	General Waste	Low (£0k-10k)	Estates Directors
B	Reduce medicines emissions by acting on inappropriate use and waste														
/i	ICS partners will aim to reduce medicines emissions in line with identified national medicines optimisation opportunities, including action on: • overprescribing (e.g. appliance service (stoma, incontinence) • polypharmacy (e.g. Care home Structured Medicine Reviews). • disease control (e.g. hypertension protocol) • education campaigns (either local, system-wide or national) for different audiences (patients, VCSE, doctors, nurses) (e.g. Pharmacy First) • alternatives (e.g. social prescribing). • better adherence to medication regimes, including by working with VCSE. • eliminating the use of medicines of low clinical value (e.g. bath preparations, glucosamine) • optimising ordering and delivery (e.g. dressing) • recycling schemes (e.g. inhalers, blister packs, insulin pens) Successful pilot projects to be scaled across BLMK	**A**	**A**	**A**		**A**	Mar-28				Medicines use (volumes, spend and emissions)	4. Medicines	Medicines and chemicals	High (£50k+)	Medicines Optimisation (ICB Chief Medical Officer)
/ii	The ICB will support providers and medicines optimisation teams to develop sustainability baselines and objectives for medicines optimisation programmes and projects to understand and maximise the environmental benefit, with an aim to set emissions-reduction objectives of at least 10% within each project (subject to project baseline and agreed scope).	**A**	**R**	**R**		**R**	Sep-25 ongoing				Emissions	4. Medicines	Medicines and chemicals	None	Sustainability and Growth (ICB CFO)
Environmentally Sustainable health and care design and delivery															
ES1	Healthy lifestyles, preventative healthcare, and self-empowerment														
A	Supporting residents and patients with self-care and self-directed recovery, to empower them to look after their own conditions														
/i	ICS healthcare, public health, local authorities and VCSE partners will review best practice in providing better health support for those vulnerable to impacts of climate change, identifying opportunities to test out in BLMK. [d]	**A**	**S**	**S**	**A**	**S**	Mar-26				activity delivered	2. Net zero clinical transformation	Other	None	Sustainability and Growth (ICB CFO) and Directors of Public Health
/ii	ICS healthcare, public health, local authorities and VCSE partners will use data to identify public and patient cohorts vulnerable to the impacts of climate change, (including those living in social- and temporary housing, and frequent users of	**A**	**S**	**S**	**A**	**S**	Sep-26				# people supported. Healthcare usage.	2. Net zero clinical transformation	Other	None	Sustainability and Growth (ICB CFO) and

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Activities to achieve the aim		ICB	Acutes	Other Trusts	LAs	Primary care	Date	Supports vision			Measured by…	Greener NHS Theme	Main emissions category	Likely financial impact	Accountable lead (role)
								P_1	P_2	P_3					
	healthcare services), developing a plan to act proactively to reduce demand for healthcare, (e.g. through "warm homes programmes / prescribing"). [d]														Directors of Public Health
/iii	Increasing number of patients with a "patient-initiated follow-up" (PIFU) to 5% (top quartile), whilst maintaining or minimising activation rates.		**A**	**A**			Mar-27	🌱	🌱	🌱	PIFU levels and activation rates	2. Net zero clinical transformation	Travel and Transport	None	Chief Operating Officers
B	Increased uptake of low-carbon food at hospital sites														
/i	NHS Trusts will deliver more-sustainable food on-site in line with national standards for healthcare food and drink, aiming for a 10% increase in uptake, through, for example: • Approaches such as "Plants-First" and other best practice. • On-site campaigns to show the health and environmental benefits. • Incentives. • Reducing the availability of higher-carbon and less-healthy foods, including through seasonal menus.	**S**	**A**	**A**			Mar-27	🌱		🌱	% plant-based meals delivered	8. Food and Nutrition	Food	Low (£0k-10k)	Estates Directors
/ii	ICS partners will work at place to improve partnership working across food systems (including food security)	**A**			**A**		Apr-26 ongoing	🪴	🪴	🪴	activity delivered	8. Food and Nutrition	None direct	None	Sustainability and Growth (ICB CFO)
C	Reduce use of higher carbon medications														
/i	The ICB will work with partners, including VCSEs, to develop a plan to increase Green Social Prescribing (GSP), based on understanding the baseline and a benefits analysis, setting a future aim to increase GSP rates. [d]	**A**			**S**	**S**	Mar-27	🌱	🌱	🌱	GSP rates. Medicines use for cohort.	2. Net zero clinical transformation	Medicines and chemicals	Low (£0k-10k)	Primary Care (ICB Chief Medical Officer)
/ii	Optimise respiratory care in line with clinical guidelines for asthma (NICE NG245) and chronic obstructive pulmonary disease (NICE NG115), such as: • shifts to lower-carbon pressurised Metered-Dose Inhalers (pMDIs) and low-carbon alternatives, including supporting patient choice and exploring bulk switches of low-risk patients, aiming for average of 15kgCO2e by March 2026 and 12kgCO2e by March 2028. • Better disease control, including inhaler use and adherence, and the use of "MART" inhalers, to reduce prescriptions. • Working with NHS Trusts to align prescribing and supporting patients to choose a lower carbon inhaler	**S**	**A**	**A**		**A**	Mar-26 (15 $kgCO_2e$) and Mar-28 (12 $kgCO_2e$)	🌱	🌱	🌱	Inhaler volumes and emissions	4. Medicines	Inhalers	Low (£0k-10k)	Medicines Optimisation (ICB Chief Medical Officer)
ES2	Effective, efficient service delivery, adopting best practice to increase value														
A	Best Practice in Sustainable Health and Care to reduce emissions associated with operational service delivery														
/i	The ICB and NHS Trusts will produce or adopt a single guide for Infection Prevention and Control teams, outlining opportunities to reduce carbon while maintaining or improving infection control rates. [d]	**A**	**R**	**R**		**C**	Mar-26	🪴	🪴	🪴	activity delivered	7. Supply Chain and Procurement	None direct	None	Infection Prevention and Control director (ICB Chief Nursing Officer)

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Activities to achieve the aim		ICB	Acutes	Other Trusts	LAs	Primary care	Date	Supports vision			Measured by…	Greener NHS Theme	Main emissions category	Likely financial impact	Accountable lead (role)
								P_1	P_2	P_3					
/ii	The ICB will work with ICS partners to develop a strong pipeline and process, for demand-signalling, testing, and adoption of innovations. This will include working with local academic organisations on novel research projects. [d]	**A**	**A**	**A**	**C**	**C**	Jun-26				activity delivered	1. Workforce and Leadership	None direct	None	Research and Innovation directors (incl. ICB Chief Medical Officer)
/iii	Work with Health Innovation East to **assess opportunities** for innovation to reduce the gap to net-zero, prioritising higher impact and lower resource interventions, including as a minimum assessing opportunities to further explore: **(a) Asset management:** [i] Air purification technologies [ii] Grey water [iii] Reducing water use [iv] Lighting through EtherNet [v] Automated power-off of equipment [vi] Fleet management [vii] Lifecycle assessment for procurement **(b) Medicines and pathology:** [i] Automated dispensing robots [ii] Drone collection/delivery of samples or medicines [iii] Fridge/cold-chain technologies **I Care pathways:** [i] Smart scheduling [ii] Telehealth and telemedicine	**A**	**A**	**A**	**C**	**C**	Assess oppor-tunities by Dec-26				activity delivered	1. Workforce and Leadership	Power, heating and lighting	None	Research and Innovation directors (incl. ICB Chief Medical Officer)
/iv	NHS Trusts will assess opportunities for further clinically-appropriate reductions in the emission of gaseous general anaesthesia beyond eliminating use of desflurane, creating an opportunity analysis. [d]		**A**				Sep-26				Volume of volatile anaesthetics and emissions	4. Medicines	Anaesthetic gases	None	Chief Medical Officers
/v	NHS organisations will ensure energy and equipment is only used when required, including (where applicable): • Switching off theatre Heating Ventilation and Air Control (HVAC) systems and anaesthetic scavenging systems overnight, where clinically appropriate. • Reducing the number of fridges required, and introducing enhanced cold-storage technology. • Auto-powering down PCs • Improving ventilation and air purification to avoid opening windows in winter.		**A**	**A**		**A**	Apr-25 ongoing				kWh saved and emissions	6. Estates & Facilities	Power, heating and lighting	High (£50k+)	Estates Directors
/vi	Review and reduce any unnecessary cannulation in emergency departments.		**A**				Mar-27				Single use equipment volumes and emissions	2. Net zero clinical transformation	Consumables and equipment	High (£50k+)	Directors responsible for emergency departments

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Activities to achieve the aim		ICB	Acutes	Other Trusts	LAs	Primary care	Date	Supports vision			Measured by…	Greener NHS Theme	Main emissions category	Likely financial impact	Accountable lead (role)
								P1	P2	P3					
/vii	Trusts will commence work to adopt the following best practice guidance by March 2026, so that they are applied to all relevant services by 2028: • GIRFT Greener pathway for bladder cancer care • Green Theatre Checklist • GreenED • Delivering more sustainable mental health care Trusts will also commence adoption of any other new similar best practice guidance as it is released.		**A**	**A**			Mar-28				# units implementing each best practice guide	2. Net zero clinical transformation	Consumables and equipment	Low (£0k-10k)	Service Transformation directors
/viii	Aim for peer median levels of virtual consultations (VCs), by specialty, where clinical quality and safety allows.		**A**	**A**			Mar-27				VC rates	2. Net zero clinical transformation	Travel and Transport	None	Chief Operating Officers
/ix	The ICB will work with 4 different primary care networks (or at least 1 practice within) per year, and NHS Property Services, to identify local sustainability initiatives that will reduce emissions, save money, and improve patient and staff experience, including: reducing consumable use (PPE, couch roll), minimising energy use and improving building efficiency (power down PCs overnight, boiler replacements), minimise medicines use and waste, proactive care for patients vulnerable to climate change, and developing staff expertise.	**A**				**R**	Apr-25				£, time, consumables, and emissions savings	1. Workforce and Leadership	Consumables and equipment	High (£50k+)	Sustainability and Growth (ICB CFO)
B	Care pathway transformation														
/i	All pathways undergoing transformation will adopt sustainable healthcare principles the design, setting targets to reduce environmental impact, including targeting at least 10% reduction in greenhouse gas emissions, as a core objective of the work. At system level this will commence with the programme of transformation work set out in the BLMK Health Services Strategy. Trusts will prioritise based on local need, considering the five recommended areas in the Green Plan Guidance.	**A**	**A**	**A**		**I**	Apr-27				# transformation programmes with sustainability objective	2. Net zero clinical transformation	Consumables and equipment	Low (£0k-10k)	Service Transformation directors (incl. ICB Chief of Strategy and Transformation)
/ii	The ICB will ensure the ICS Digital Strategy (which incorporates the What Good Looks Like framework) delivers a carbon benefit, baselining Information and Communications Technology (ICT) footprint in line with Sustainable Technology Advice and Reporting (STAR) guidance. This will include measuring carbon and water use and other environmental impacts of digital technologies as projects are enacted, and using the Digital Maturity Assessment to identify further opportunities.	**A**	**C**	**C**	**C**	**C**	Mar-26				Carbon emissions and water use (by project)	3. Digital	Power, heating and lighting	Cost pressure	Digital director
ES3	Use low-carbon alternatives to reduce emissions														
A	Implement best practice in low carbon alternatives														

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Activities to achieve the aim		ICB	Acutes	Other Trusts	LAs	Primary care	Date	Supports vision			Measured by…	Greener NHS Theme	Main emissions category	Likely financial impact	Accountable lead (role)
								P_1	P_2	P_3					
/i	Healthcare providers to move from pre-operative IV paracetamol to oral where clinically appropriate		**A**	**A**		**I**	Mar-27				Prescriptions of IV paracetamol	7. Supply Chain and Procurement	Medicines and chemicals	Low (£0k-10k)	Chief Medical Officer
/ii	Healthcare providers to ensure use of alcohol-based hand rubs for routine hand hygiene, including in Theatres, where clinically-appropriate to do so (that is, where liquid soap and water is not necessary), in line with Standard Infection Prevention and Control procedures		**A**	**A**		**A**	Apr-26				Use of soap / alcohol-based hand rubs.	7. Supply Chain and Procurement	Consumables and equipment	Low (£0k-10k)	Infection Prevention and Control directors
/iii	NHS Trusts to consider introducing on-site composting and/or food waste-to-energy systems, or off-site (where on-site not feasible).		**A**	**A**			Mar-28				Waste volumes and disposal route	7. Supply Chain and Procurement	Food	Low (£0k-10k)	Estates directors
	Many low-carbon alternatives are referenced under other drivers above. The ICB and ICS partners will continually explore new low-carbon alternatives and methods for increasing adoption within BLMK.														

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Appendices

Appendix 1: Recommendations from the system seminar (15 November 2024)

Recommendations from Leading for a Sustainable Health and Care System seminar		Supports vision				Main link to the Delivery Plan
		P_1	P_2	P_3	F	
Increase Carbon Literacy	Mandatory sustainability training for all staff		enables	enables	delivers	Removing barriers to change
	Tailored learning sessions for teams and roles to deliver most impact		enables	enables	delivers	
	Use proactive language i.e. “What more can you do?”				delivers	
	Include sustainability in staff objective setting		enables	enables	delivers	
	Use Green plan as engagement tool to clarify connection of health, business & climate				delivers	
Staff as change agents	Staff promote & activate sustainable behaviours		enables	enables	delivers	
	System Sustainability Champions group – incl. Primary Care		enables	enables	delivers	
	System staff Green Award		enables	enables	delivers	
	Utilise Cranfield University students for health and care projects		enables	enables	delivers	
	Clinical Fellows	enables	enables	enables	delivers	
NHS and local authorities work together as change agents	Housing and prevention	delivers	enables			Healthy lifestyles, preventative healthcare
	Local areas/ neighbourhoods	delivers	enables			
	Bring in expertise where required			enables		Data and intelligence
	Overarching plan with mix of small, medium and larger schemes	delivers	delivers	delivers		Whole plan
Corporate Values	Ensure include Social Values			delivers		Strong procurement requirements
	Values based recruitment – include sustainability				delivers	Removing barriers to change
	Sustainability & Social Impact Assessment part of business case assessment process	enables	enables	enables	delivers	Leadership and decision-making
Investment	Long-term cost perspective – shift from short term “return on investment” (RoI) to lifetime RoI			enables	delivers	Data and intelligence
	Definition of value – including both monetary and social aspects			enables	delivers	
	Grant officer role in ICB for funding opportunities		enables	enables	delivers	Adopt best practice and innovation
	Funding for sustainability projects	enables	enables	enables	delivers	Data and intelligence
	Funding and Support for VCSEs for resilience	delivers	enables			Maximising social impact
	Funding for Social Prescribing services	delivers	delivers	delivers		Healthy lifestyles, and self-empowerment

Key: enables = enables delivers = delivers

Recommendations from Leading for a Sustainable Health and Care System seminar		Supports vision				Main link to the Delivery Plan
		P_1	P_2	P_3	F	
Improved use of technology	Reduce unnecessary activity – better planning for visits, upskilling staff to take on more duties			🌱		Optimise transport use
Infrastructure	Infrastructure to enable modal shift – cycle lanes, bike racks. bus routes, bus stops, trains		🌱	🌱		
	Infrastructure – Electric vehicle fleet, solar, LEDs, insulation – reduce energy use and make savings		🌱	🌱		
	Work with large local organisations – use their ideas				🌱	Whole plan
Economies of scale – purchasing power, pooling resources for clinical leadership	Specific sustainability ambitions in tenders e.g. ownership of recycling of products			🌱		Circular Economy
	Use market force to encourage suppliers to be more sustainable			💧		
	Environmental, Social and Governance (ESG) considerations in all tenders			💧		
	Evergreen assessment for all procurements			💧		
	Look at National Institute for Health Research (NIHR) Funding for system plan				🌱	Best practice and innovation
Decision-making - Business cases to include	Carbon calculations			💧	🌱	Data and intelligence
	Environment and Social Value impact assessment output	💧	💧	💧	🌱	Leadership and decision-making
	Strengthen the environmental sustainability or green voice in our decision-making	💧	💧	💧	🌱	
	System wide approach. Tie in with cost improvement			💧	🌱	Best practice and innovation
School Engagement	Tailor the message to different generations	💧			🌱	A compelling story
	Change the message to promote the immediate positive benefits	💧			🌱	
	Create more links with young people e.g. mental health links in schools and youth clubs	💧			🌱	Leadership
	Raise the youth voice to influence politics	💧			🌱	
Business as Usual in all Health & Social Care conversations	Build the green message into general comms around promoting healthy living	💧			🌱	A compelling story
	Ensure a strong comms plan				🌱	
	Green plan to provide a description of ambition but also a clear call to action				🌱	Whole plan
Promoting Healthy Lifestyles	Youth movement – help promote healthy foods, non-processed, veggie/vegan, plant/eat/grow schemes	💧		💧		Healthy lifestyles
	Infrastructure changes e.g. Bike racks to promote active travel	💧	💧	💧		Optimise transport
	Provide public transport information when sending appointments	💧	💧	💧		
Collaboration	GPs working with VCSEs to support “frequent attenders” and reduce health inequalities	🌱		🌱		Prevention and self-empowerment

Key: 💧 = enables 🌱 = delivers

Recommendations from Leading for a Sustainable Health and Care System seminar		Supports vision				Main link to the Delivery Plan
		P_1	P_2	P_3	F	
	GP collaboration with leisure centres	🪣		🪣		Removing barriers
	Family hubs linking with and signposting to other services	🪣		🪣		Community adaptation
	Community Toolkits – knowledge/skills/experience sharing				🌱	Whole plan
	Neighbourhood teams lead the collaboration for NHS and local authorities				🌱	
	Use the skills of VCSEs and develop authentic and meaningful partnerships				🌱	
Investment	Funding and support for VCSEs to increase resilience and ensure continuity of services	🪣	🪣	🪣	🌱	Maximising social impact
Governance	ICB/LAs provide support in VCSE governance				🌱	
	Strong leadership emphasis and specific targeting to ensure action		🪣	🪣	🌱	Leadership and decision-making
Community Spaces	Increasing community spaces for interaction to reduce isolation	🌱				Community adaptation
	Condition-led tailored art/ craft/ exercise/ social sessions	🌱				Healthy lifestyles and self-empowerment
Simple and Clear Green Plan	Unified plan – Trusts, ICB and communities				🌱	Whole plan
	Alignment of goals – financial & sustainability				🌱	Data and intelligence
	Targeting the biggest impact areas		🪣	🪣	🌱	
	Powerful commitments				🌱	Whole plan
	NHS greener guidance a priority				🌱	Leadership and decision-making
	ICS to identify how to measure a baseline in each trust				🌱	Data and intelligence
	Meet regularly to network				🌱	Removing barriers
Economies of Scale	Purchasing and contracting power			🪣		Strong procurement requirements
	Pooling resources for clinical leadership				🌱	Removing barriers
	Chamber of Commerce collaboration to inform and influence suppliers				🌱	Strong procurement requirements
	Support call for a Shelf-Life Extension Program (SLEP) for tablets/capsules		🪣	🪣		Minimise waste
Action and Education for biggest impact areas	Assisting providers to calculate carbon footprints				🌱	Data and intelligence
	Community Engagement - schools, VCSEs, communities, councils - needs strong leadership emphasis and specific targeting				🌱	Community adaptation

Key: 🪣 = enables 🌱 = delivers

Appendix 2: Opportunity analysis

Table 2 sets out an estimate of the potential opportunity, by moving BLMK organisations to either meet existing national targets or to improve performance to be in line with local or national peers (either a median, or upper quartile or decile) and thus considered achievable.

Theme	**Carbon Opportunity** (vs 2019/20) **/tCO_2e**	**% of CF**	**% of CF+**	**Date to achieve reduction**	**Rationale**	**Achieved to date / tCO_2e**	**Effort to achieve the remaining opportunity**[xxvi]
Inhalers	~8,100	14%	2.5%	2028	Through level of current top ICS in England (15 $kgCO_2e$) to current best practice in BLMK (12 $kgCO_2e$)	~5,100	High – requires administration, clinical time and patient behaviour change
Medicines waste	~6,700	n/a	2%	2028	10% of medicines use	Unknown	High – requires shift in human behaviours and accurate baseline (based on volumes)
Acute energy and building efficiency	~5,300	9%	1.6%	2032	Achieving 80% reduction relative to 1990 levels in both gas and electricity.	1,783	High – external capital investment not guaranteed
Commuting	~4,300	n/a	1%	2032	50% reduction by 2033	Unknown	High – requires staff behaviour change and improved infrastructure
Food waste	~2,000	3.5%	1%	2028	2% of food emissions	~800	Medium – spread of existing initiatives to other sites
Nitrous oxide	~1,200	2%	0.4%	2028	Performance of best in East of England (~75% reduction)	~500	Medium – small amount of capital and process change
Waste to landfill	~1,000	2%	0.3%	2026	Reduction to zero	None	Low
Desflurane	~850	1.5%	0.3%	2023	Reduce desflurane use to zero	850	No further action
Consumable use	~690	n/a	0.2%	2027	Based on achievement at other hospitals	Unknown	Medium – requires ability to identify opportunities
Patient travel through virtual care	~600	n/a	0.2%	2028	Increasing PIFU use and virtual outpatient appointments to peer median	Unknown	Medium – requires clinical practice to align to care model
Walking aid reuse	~200	n/a	0.1%	2028	4,500 items annually (based on case study from peer ICS)	~35	Medium – spread to whole of BLMK required
Fleet shift to ZEV	~170	0.3%	0.1%	2032	Linear trajectory to net zero non-ambulance fleet by 2035	Unknown	Low – on track for routine replacements
TOTAL	**~31,000**	**~33%**	**~9%**				

Table 2: Carbon emission opportunity analysis for BLMK

[xxvi] Effort judged in financial or human terms (i.e. person-hours required, barriers to change, length of time for return).

Notes for appendix 2:

1. Some of these emissions reductions have already occurred since 2019/20 – see relevant table column.
2. The opportunity analysis is limited in scope:
    a. It does not reflect changes in demand due to demographics, population health or new care models implemented since 2019/20, which are estimated at cumulative rate of 2% per year.
    b. It only accounts for emissions linked to the two acute trusts for most items (excl. inhalers and medicines waste) – additional opportunities exist in primary care.
    c. National progress in emissions reductions (for example decarbonisation of the National Grid and the public uptake of electric vehicles) will contribute to reductions in the carbon footprint – to avoid the risk of double-counting, these are excluded from the opportunity analysis, but may accelerate efforts or create an additional reduction.
    d. Supplier decarbonisation will also have an impact on the embodied carbon in products and commissioned services, also not included to avoid the risk of double counting.
3. Rounding errors may mean columns do not add up perfectly.
4. See Section 2: Environment, Climate, Health, and Healthcare for definitions of NHS CF and NHS CF+.

Meeting Title	TRUST BOARD PUBLIC	Date: 3rd July 2025
Report Title	Annual Inpatient Falls Report 2024/2025	Agenda Item Number: 16
Lead Director	*Fiona Hoskins- Chief Nursing Officer*	
Report Author	*Patricia Flynn - Head of Clinical Quality* *Marsha Jones - Deputy Chief Nurse*	

Introduction	*Purpose of the report; Assurance*
Key Messages to Note	Milton Keynes University Hospital (MKUH) NHS Trust is committed to reducing inpatient falls, especially those that result in harm. Key priorities include reducing unwitnessed falls and strengthening safety measures, in alignment with the Trust's Falls Prevention Assurance Framework. These efforts are aimed at improving the overall patient experience by fostering a culture of learning and continuous improvement. In 2024/25, there has been an 8% increase in recorded falls, with 1,133 incidents reported compared to 1,041 in 2023/2024, noting that 46% of the patient profile is those at risk of falls (66-85yrs) and 13% more patients were treated as inpatients in hospital compared to 2023/2024. In the previous year, 3% of falls caused moderate harm (e.g., arm fractures) and 0.2% resulted to severe harm (e.g., fractured neck of femur, head injuries). In 2024/2025, 2% resulted in harm, though no cases of severe harm have been reported. This improvement reflects the focused work on falls. The majority (79%) of falls occurred in the Medicine Division, which has the Trust's largest number of bed base and a high proportion of frail, elderly patients. Falls have significant cost implications. For instance, a neck of femur (NOF) fracture can cost the NHS around £14,000 per case, with a national average hospital stay of 14 days. To address these challenges, the Trust will continue to build on the existing improvement strategies in collaboration with the quality improvement team and divisional staff. A focus on personalised, patient-centred care will remain central to these efforts. These strategies include: • Introduce digital tools to assess multifactorial falls risks. • Improve documentation of fall risk assessments in electronic patient records. • Provide ongoing training programs focused on falls prevention and management. • Embed falls-related learning into the patient incident response framework process. • Strengthen governance and safeguarding practises and processes at MKUH to promote transparency and accountability. • Partner with the quality improvement team and divisional staff to drive falls-reduction efforts. • Review medication management (polypharmacy) to lower fall risks

	• Explore technology solutions such as falls detection alarms.		
Recommendation	**For Information** ☐	**For Approval** x	**For Review** x

Strategic Objectives Links	*1. Keeping you safe in our hospital* *2. Improving your experience of care* *3. Ensuring you get the most effective treatment* *4. Giving you access to timely care* *5. Working with partners in MK to improve everyone's health and care* *6. Increasing access to clinical research and trials* *7. Spending money well on the care you receive* *8. Employ the best people to care for you* *9. Expanding and improving your environment* *10. Innovating and investing in the future of your hospital*

Report History	*Falls Assurance Group.* *Executive Directors.* *Trust Executive Committee*
Next Steps	*July 2025 Trust Board.*
Appendices/Attachments	*Full report follows*

	Acronyms	

Annual Inpatient Falls Report 2024/2025

Executive Summary

Milton Keynes University Hospital (MKUH) NHS Trust is committed to reducing inpatient falls, especially those that result in harm. Key priorities include reducing unwitnessed falls and strengthening safety measures, in alignment with the Trust's Falls Prevention Assurance Framework. These efforts are aimed at improving the overall patient experience by fostering a culture of learning and continuous improvement.

In 2024/25, there has been an 8% increase in recorded falls, with 1,133 incidents reported compared to 1,041 in 2023/2024, noting that 46% of the patient profile is those at risk of falls (66-85yrs) and 13% more patients were treated as inpatients in hospital compared to 2023/2024.

In the previous year, 3% of falls caused moderate harm (e.g., arm fractures) and 0.2% resulted in severe harm (e.g., fractured neck of femur, head injuries). In 2024/2025, 2% resulted in moderate harm, though no cases of severe harm have been reported. This improvement reflects the focused work on falls.

Falls have significant cost implications. For instance, a neck of femur (NOF) fracture can cost the NHS around £14,000 per case, with a national average hospital stay of 14 days.

To address these challenges, the Trust will continue to build on the existing improvement strategies in collaboration with the quality improvement team and divisional staff. A focus on personalised, patient-centred care will remain central to these efforts. These strategies include:

- Introduce digital tools to assess multifactorial falls risks.
- Improve documentation of fall risk assessments in electronic patient records.
- Provide ongoing training programs focused on falls prevention and management.
- Embed falls-related learning into the patient incident response framework process.
- Strengthen governance and safeguarding practises and processes at MKUH to promote transparency and accountability.
- Partner with the quality improvement team and divisional staff to drive falls-reduction efforts.
- Review medication management (polypharmacy) to lower fall risks.
- Explore technology solutions such as falls detection alarms.

1. Introduction

The National Institute for Health and Care Excellence (NICE) (2013) defines a fall as "an event where a person unintentionally comes to rest on the ground or a lower level" (NICE, 2013). Falls are the most reported patient safety incident and the leading cause of harm related mortality in older people (Wellstead and Morgan, 2024). Falls can lead to serious injuries, including head injuries and hip fractures, which can significantly impact an individual's health, wellbeing, and independence. In the UK, hip fractures account for £1.8 million hospital bed days and incur hospital costs amounting to £1.1 billion annually.

Inpatient falls are a significant concern, with potential outcomes including severe morbidity and, in extreme cases, mortality (Healthcare Quality Improvement Partnership, 2024). Over the past year, the NHS has reported an increase in the incidence of falls - this is also reflected in MKUH local picture of falls incidence, highlighting the need to sustain preventive strategies. By adopting a multifactorial approach to fall prevention, patient safety and outcomes will be enhanced and reduce the frequency of falls.

A fall can be multifactorial and complex. NICE (2013) recommends conducting a multifactorial risk assessment (MFRA) to comprehensively identify risk factors. This assessment is essential for developing a prevention or management plan aimed at reducing the risk of falls or recurrent falls.

At Milton Keynes University Hospital (MKUH), patient safety is of paramount importance. The Trust is committed to further build on existing falls prevention measures. All falls, irrespective of the severity of harm, are systematically reported through the Trust Radar reporting system. These are triaged by the Falls Lead outside of the Trust's daily Patient Safety Incident Review process. In instances where a fall results in moderate, severe harm or death, a 'hot debrief' is convened, and the incident findings are discussed at the weekly Patient Serious Incident Review Group (PSIRG). The purpose of the 'hot debrief' and further reviews are to evaluate whether the fall meets the criteria to be reported as a Patient Safety Incident as per the Trust guidance and to identify and disseminate learning to improve future care delivery.

The purpose of this report is to provide an annual analysis of inpatient falls at Milton Keynes University Hospital (MKUH). The report provides information on the number and location of falls, as well as the levels of harm. Despite this, there has been a shift in how harm is reported following the implementation of Patient Safety Incident Response Framework (PSIRF), following the publication of the National Patient Safety Strategy, (2019). This report summarises the work of the Trust-wide falls prevention and management programme.

2. Incidence of Inpatient Falls at MKUH

MKUH recorded 1,133 inpatient falls between April 2024 and March 2025 of which 97.8% were no or low harm events and 2% were moderate harm or above. Figure 1 below provides a breakdown of the number of inpatient falls by month, in comparison to April 2023 to March 2024, with an increase in falls reflected in the linear line. The highest number of reported falls in 2024/25 was in May, December and January whilst in 2023/2024 it was July, November and December. Awareness of patterns aids to support improvement strategies.

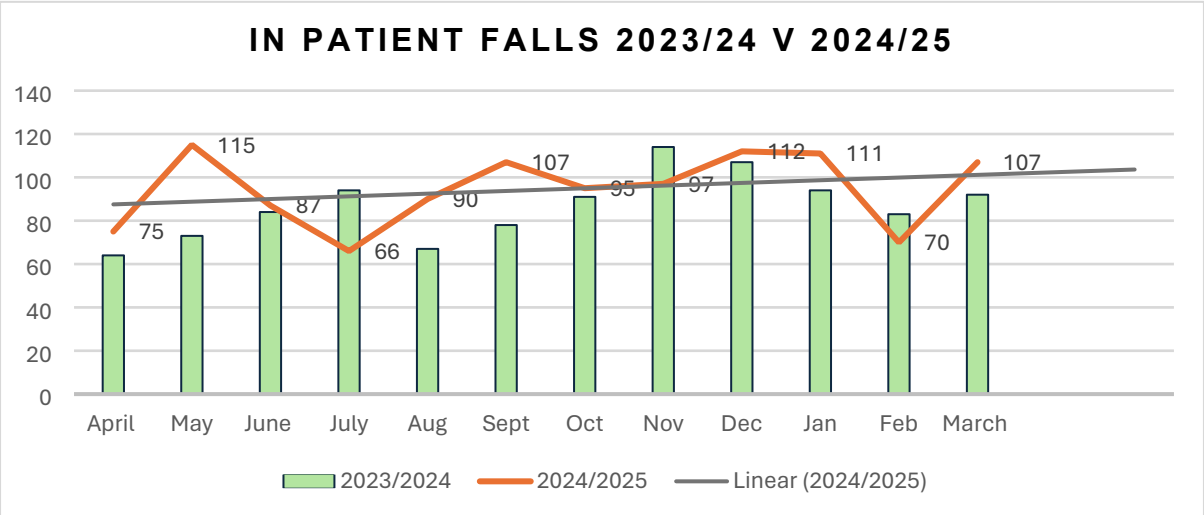


Figure 1: Inpatient falls 2023/24 vs 2024/25

Figure 2 below presents a breakdown of inpatient falls by division. It is important to note that the Medicine division reports 79% of all inpatient falls. This is attributed to its large bed base and the significant number of frailty patients who are at increased risk of falling.

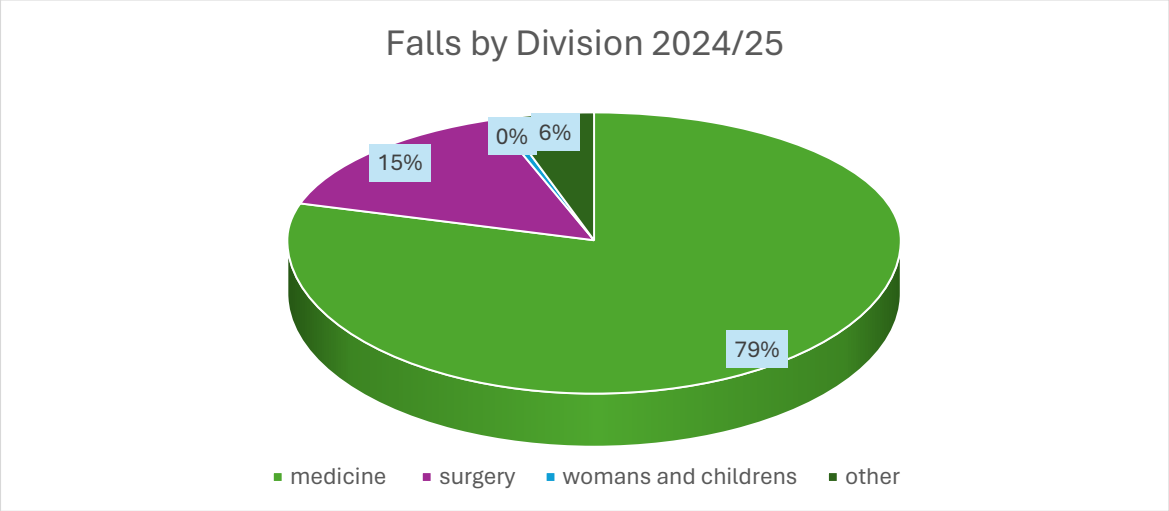


Figure 2: Falls by division 2024/2025
(N.B. The above does not reflect the recent changes of Ward 25 moving into Core Clinical Division as previously in the Medicine Division.)

Figure 3 below provides a breakdown of the number of reported inpatient falls by ward, listed in descending order. The ten wards with the highest incidence of patient falls were Ward 18 and Ward 19, both general medical wards with a focus on frailty; Ward 23, which specialises in trauma and orthopaedics; Ward 1, an acute medical unit; the Emergency Department (ED); Ward 3, frailty ward; Ward 15, respiratory ward; Ward 25, oncology and Ward 14, transitional care nurse led unit. Collectively, 10 inpatient areas accounted for 66% of all falls during the period under review. Additionally, this year saw a significant increase in falls occurring outside of ward areas such as endoscopy, x-ray, physiotherapy department and outpatients. This is reflected in Figure 3 as other.

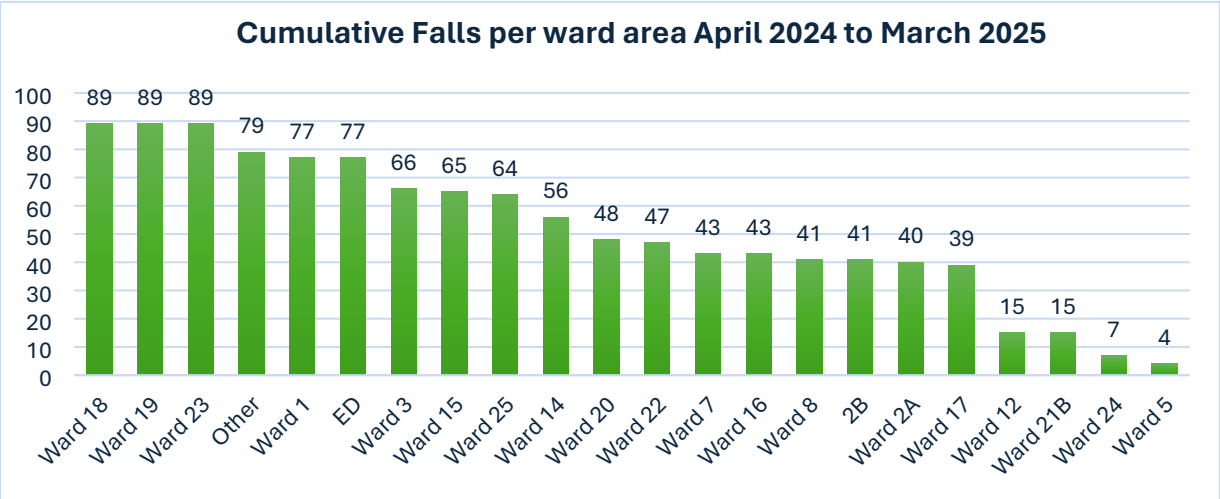


Figure 3: cumulative falls per ward area April 2024 – March 2025

To ensure equity and quality validation of the falls data, “Falls Per Bed Base" (FPBB) in ward areas were calculated (see Figure 4). Monitoring FPBB is crucial as it supports patient safety strategies tailored to the clinical environment, setting realistic goals and objectives. Additionally, understanding fall rates and their impact aids in resource allocation, ensuring patient safety remains central to fall improvement strategies.

Figure 4 below illustrates that wards 18 and 19 continued to have the highest incidence of falls. Ward 23, with a bed base of 40 beds, has been repositioned to seventh ward with the highest incidence of falls, while Ward 1 now ranks third of reported falls. Ward 20 has moved down to 13th place, and ward 22, which has moved to ninth place. Ward 12 (8 beds) shares the tenth position with the Emergency Department. It is important to note that the MKUH Emergency Department treated over 85,000 patients for 2024/25 which should also be considered. Consequently, FPBB would be inclusive of falls per patient treated, this should be considered when focusing on falls improvement strategies.

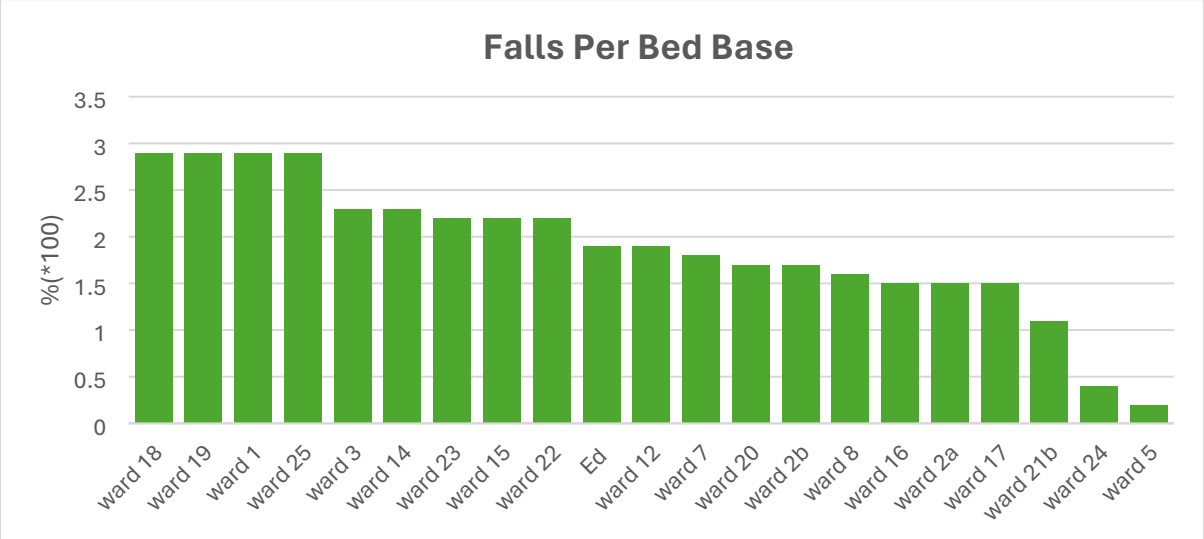


Figure 4: Falls per bed base.

The wards with the highest number of falls were frailty wards consisting of patient groups with co-morbidities leading to increased risk of falls; over 65 years old, reduced mobility/functionality, including patients with cognitive impairment with fluctuating capacity. This highlights the importance of targeted interventions that is focused on individualised patient care which will be further explored later in this report.

Figure 5 below shows a breakdown of the number of inpatient falls by category. This reporting year has evidenced a 23% improvement in categorising falls with 17% being unknown compared to the previous year's 40%.

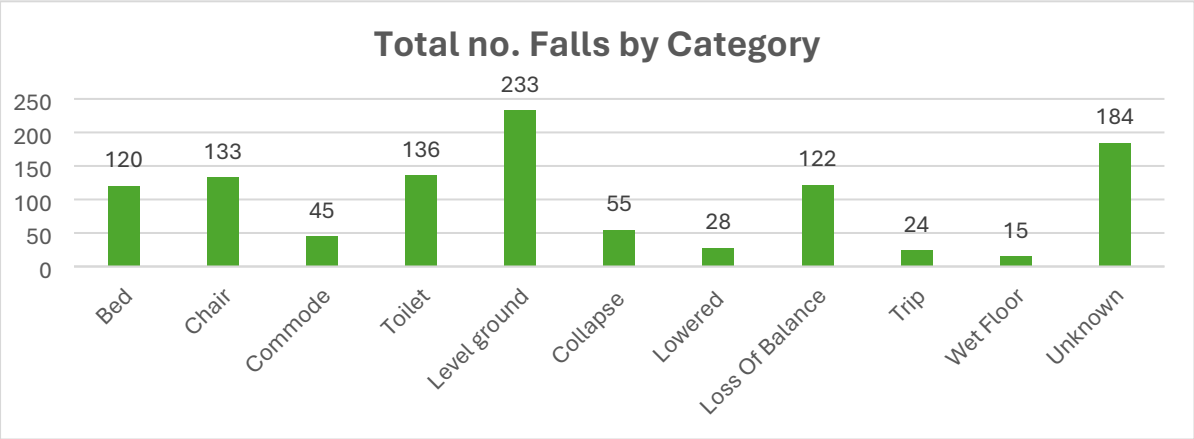


Figure 5: Total no. of falls by category. (Note: Level ground is a fall from standing a position)

Focused efforts are ongoing to reduce the number of unwitnessed falls at MKUH. This includes collaboration between the ten wards with the highest incidence of falls and the quality improvement team to advance falls prevention initiatives. In addition, the environment of toilets is being risk assessed and the necessary modifications underway.

This reporting year has observed a 3% reduction in falls with harm compared to the 2023/24 reporting year (see: Figure 6), despite an increase in the overall number of reported falls. As a result of previous manual collection of data, through data cleansing and validation, the 2023/24 data from the annual report against our clinical reporting system RADAR discrepancies were identified in the location and number of moderate harms associated with ward areas.

The Medicine division continues to report the highest number of falls with harm, reflecting the larger bed base and the higher percentage of vulnerable patient groups with complex needs.

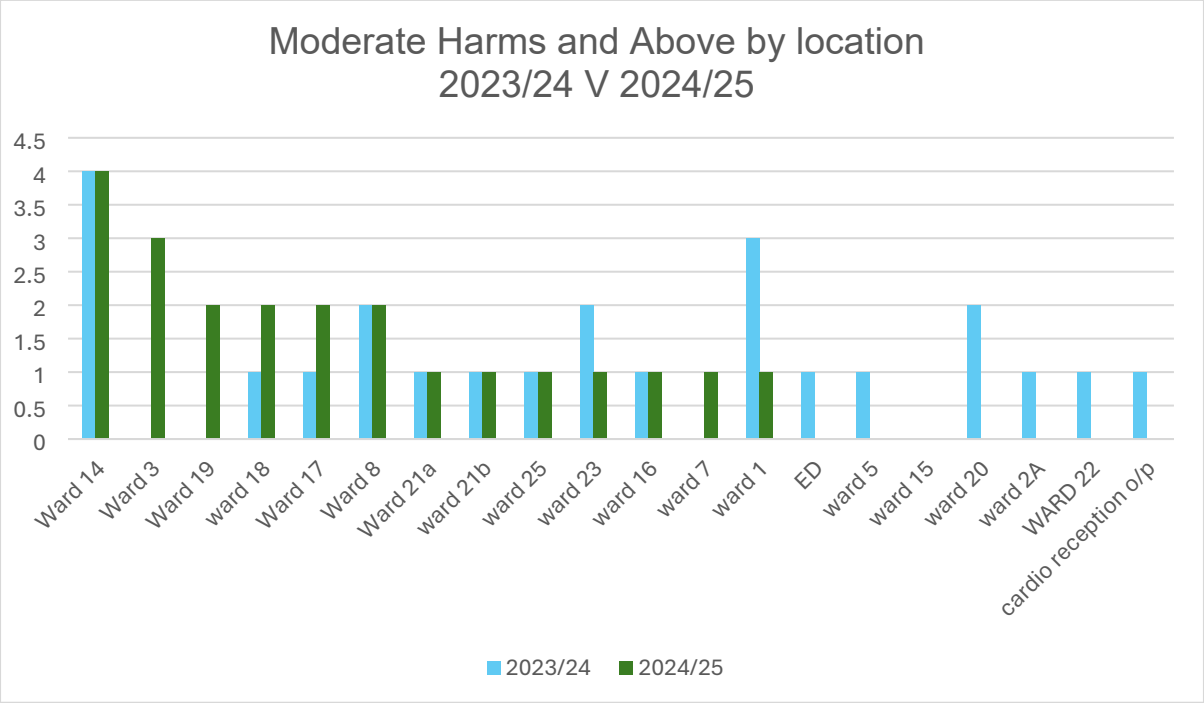


Figure 6: Location of falls with harm

3. Falls per 1000 Bed Days.

Literature from the UK indicates that the average rate of falls per 1,000 bed days was 6.3 (Morris et al., 2017). However, it is important to interpret this data with caution, as it was published 8 years ago. Future falls data and subsequent falls rates will be influenced by various factors, including population demographic changes, data accuracy and relevance, and external influences such as the impact of COVID-19 on population health. Currently, MKUH reports a rate of 6.8 falls per 1,000 bed days (see: Figure 7). The total Falls per 1000 bed days for 2023/2024 was not referenced in the previous annual report to offer a benchmark. Furthermore, MKUH has not submitted data into the national audit of inpatient falls (NAIF) database for this 2023/2024. NAIF data is transferred into the NHS model health system to enable benchmarking against peer organisations. It is also worth noting that peer organisations have not published their falls rate per 1000 bed days in their annual reports to facilitate accuracy of benchmarking. Evaluating our benchmarking process against peer organisations will be a key focus for the upcoming reporting period of 2025/26

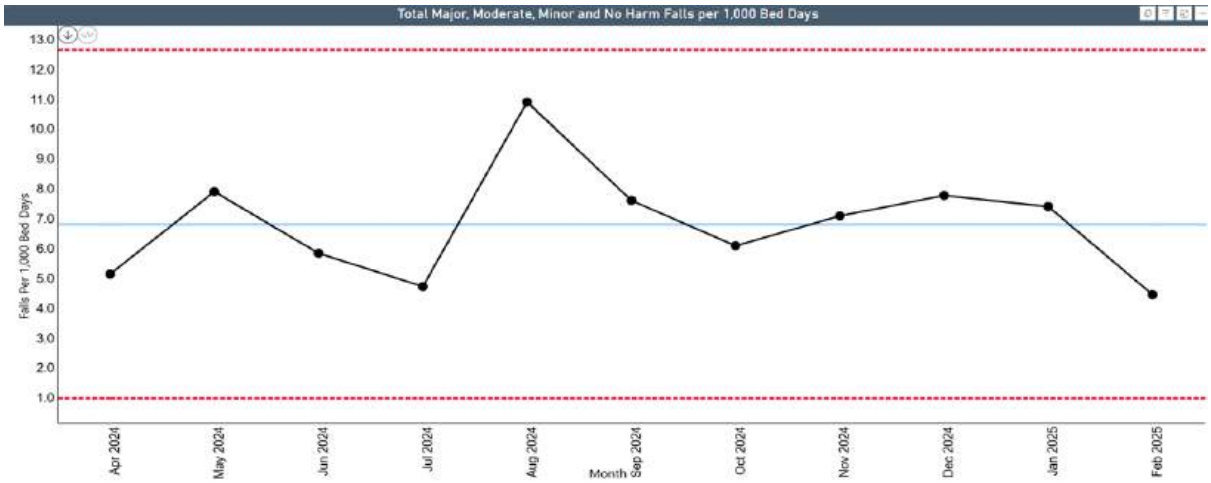
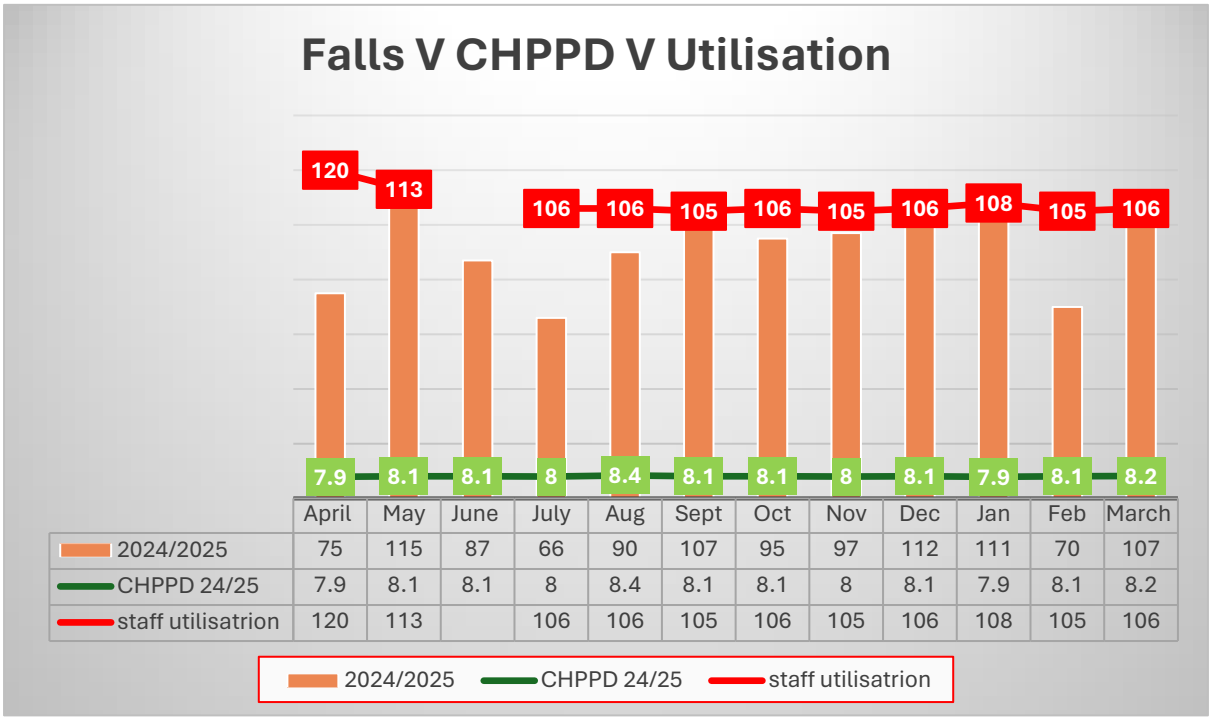


Figure 7: Total Falls per 1000 bed days

Falls Correlation Against Care Hours Per Patient Day (CHPPD) and Staff Utilisation

CHPPD and staff utilisation is captured in the safer staffing report; this data offers a comprehensive overview of staff deployment and productivity within ward areas. It assists Ward Managers, Nursing Leaders, and Corporate Executives in understanding staffing patterns. CHPPD and staff utilisation (how hard staff are working) encompasses both direct patient care and ancillary activities, such as medication preparation and record updating. It includes both temporary and permanent care staff, excluding student nurses and staff working across multiple wards. However, CHPPD and staff utilisation alone does not fully capture the total care provided or safety levels; it should be evaluated alongside quality and safety metrics. Evidence indicates that patient outcomes are significantly influenced by registered nurse staffing levels, competency levels and experience of staff, impacting mortality rates, care quality, missed care, and adverse events such as infections, pressure ulcers, and medication errors (Royal College of Nursing, 2023).

Figure 8 illustrates the average CHPPD and staff utilisation in relation to our falls data. It is crucial to recognise that staff consistently operate at 105% to 120% capacity, indicating they are frequently under pressure. The data suggests quality of care is not compromised. For example, April, despite staff utilisation was 120, this did not suggest a direct correlation with patient falls which highlights falls is multifactorial and cannot be reviewed in isolation. Other factors to be considered include competency and experience of staff.



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
2024/2025	75	115	87	66	90	107	95	97	112	111	70	107
CHPPD 24/25	7.9	8.1	8.1	8	8.4	8.1	8.1	8	8.1	7.9	8.1	8.2
staff utilisatrion	120	113		106	106	105	106	105	106	108	105	106

Figure 8: Falls V CHPPD V staff utilisation (NB: June data unavailable at the time of the report published)

Figure 9 below illustrates staff utilisation in relation to our highest falls areas per bed base. The data shows that on Ward 18, which has the highest number of falls, the workforce is operating at an average of 123% for the reporting year 2024/25. As previously stated, whilst staff utilisation impacts on patient safety but should not be viewed in isolation in developing Falls Prevention Strategies. There was no correlation for MKUH that staff utilisation impacted on patient safety and outcomes.

It is important to recognise the factors influencing falls, such as the ward environment and the number of side rooms, which affect patient visibility. For instance, Ward 25 and Ward 22 have extensive footprints with multiple side rooms, which are contributing factors to these challenges. Ward 25 and Ward 22 rank as the fourth and ninth highest areas for Falls Per Bed Base (FPBB), with staff utilisation at 96% (Ward 25) and 94% (Ward 22). The remaining six areas has staff utilisation over 109% which will need focused work. It is acknowledged that there is an ongoing workforce establishment review using an evidenced based decision tool “Safety Nursing Care Tool” (SNCT) endorsed by the National Institute for Health and Social Care Excellence (NICE) led by the Chief Nurse Officer with assurance provided to Trust Board as per the National Quality Board requirements.

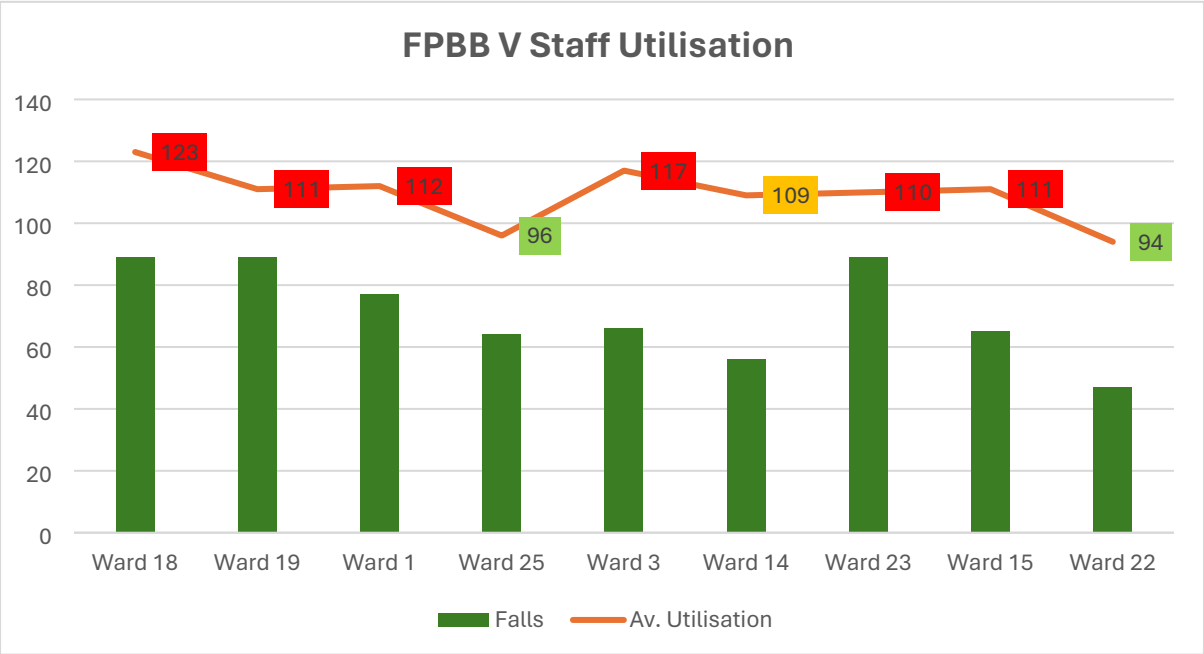


Figure 9: FPBB V Staff Utilisation

4. Patient Demographics.

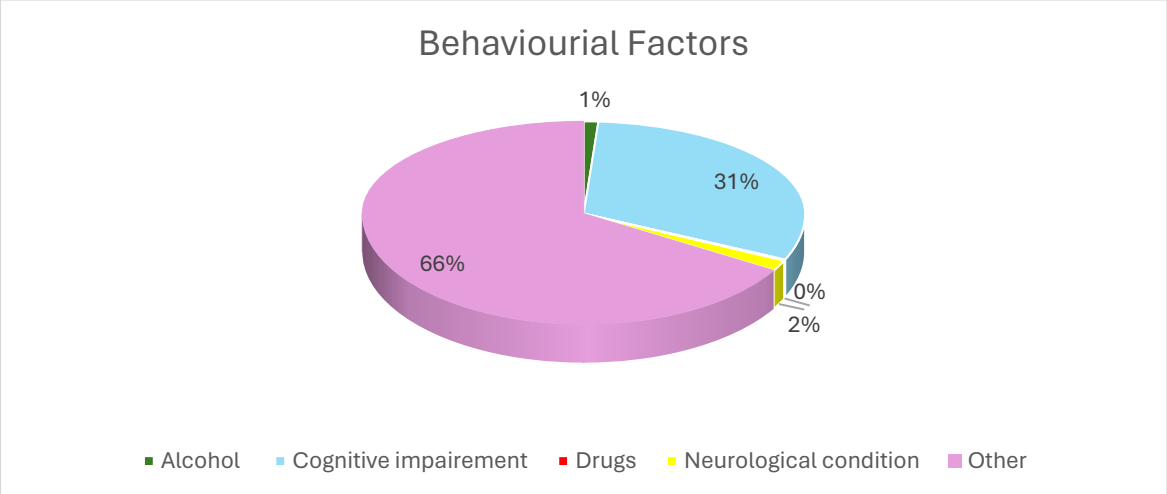


Figure 10: Behavioural factors

Currently, data is being manually collated for all inpatient falls due to the need for data cleansing in the internal incident reporting system (RADAR) to ensure accuracy. The current manual collection of data does not capture behavioural factors. Notwithstanding, Figure 10 shows the total number of falls on site generated from RADAR, indicating the predisposing factors that may have a causative effect. The predominant behavioural factor captured in the 'other' category includes frailty, mental health issues, deconditioning, etc., contributing 66%. Cognitive impairment accounts for 31% of falls related to behavioural factors.

Figure 11 illustrates that 54% of inpatient falls occur were individuals who identified as male, with a further 39% who identified as female. This is important information to appreciate when developing individualised falls prevention strategies.

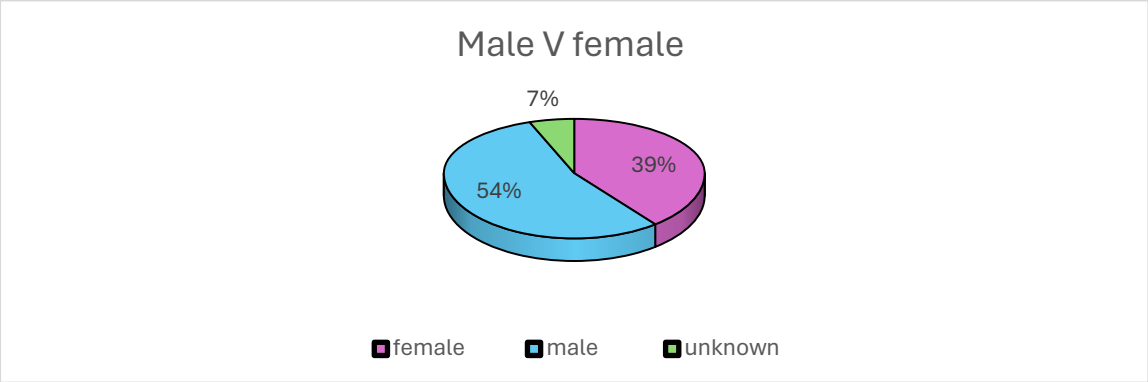


Figure 11: Gender

As revealed in Figure 12, 46% of all inpatient falls occur in adults between the age of 66-85years, 26% of in-patient falls occur in patients over 85 years with 14% occurring in adults between the ages of 46-65years.

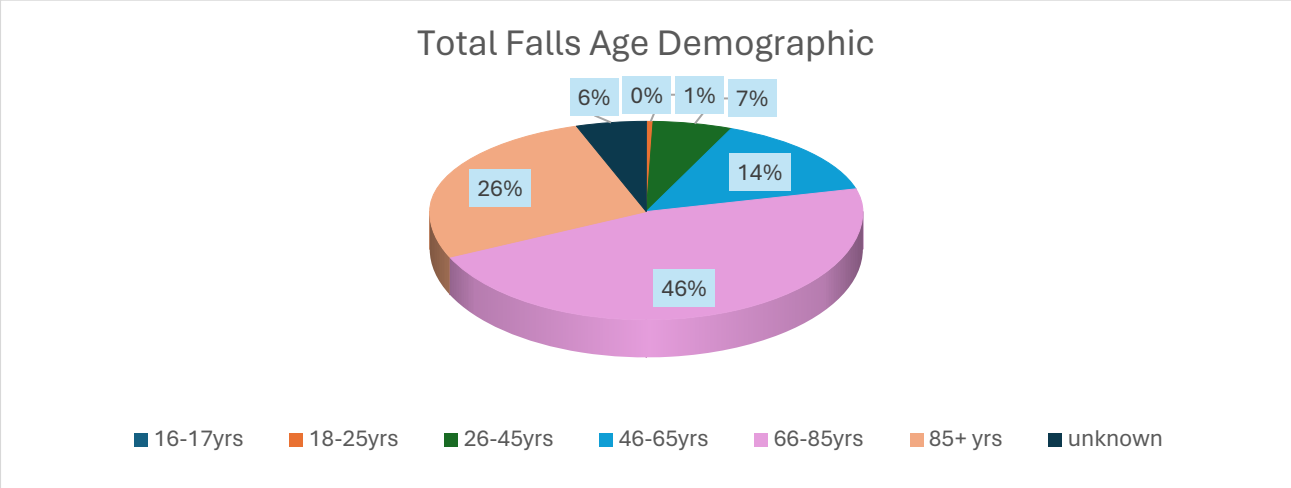


Figure 12: Age demographic of all inpatient falls.

Eighty-five percent of all patients who fell in hospital identified themselves as white, with 7% unknown and a further 3% occurring in patients who were Black, African, Caribbean and or Asian, Asian British, Pakistani, Bangladeshi or Indian (see: Figure 13). Understanding ethnicity in patients who fall is crucial because of risk variation, cultural and behavioural factors, health disparities, language and communication barriers which all support customisation of falls prevention strategies to ensure individualised patient care plans.

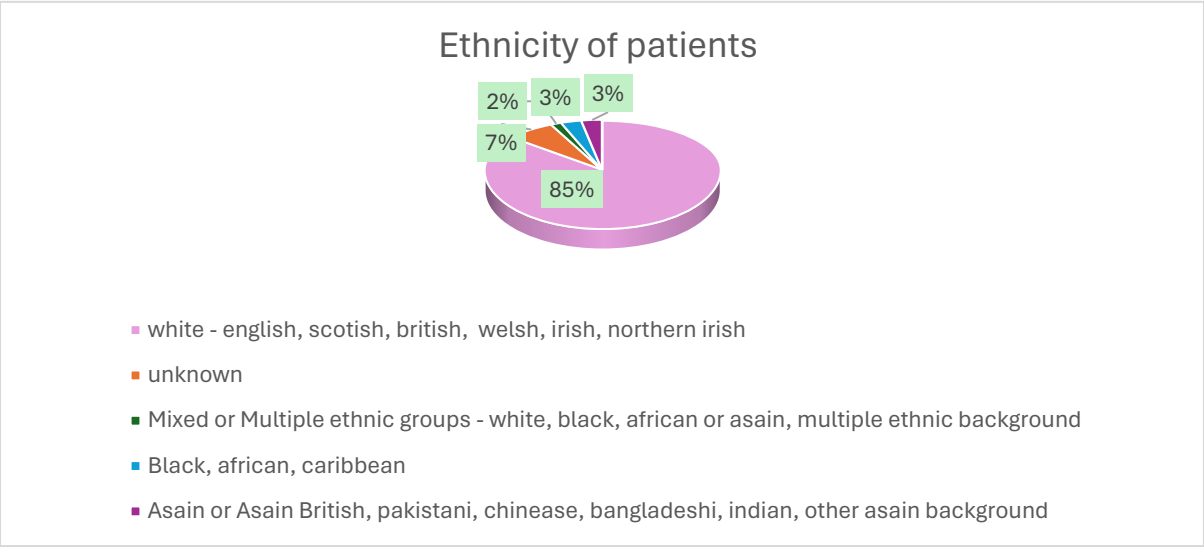


Figure 13: Ethnicity of inpatient falls

In support of the Patient Incident Response Framework, there have been two learning events focused on improving cognitive impairment management and raising awareness around falls prevention and management. It is important to acknowledge that many patients will have more than one risk factor and additional medical co-morbidities that increase their risk of falls. The aim for the reporting year 2025/2026 is to work closely with the risk management team to improve the incident reporting system, generating reports that reflect the patient demographic and contributing factors that relate to falls.

5. Analysis of Moderate Falls - Fractured Neck of Femur

Falls and fractures are prevalent and serious health concerns among older adults in England. The impact on individuals can be severe, encompassing distress, pain, injury, loss of confidence and reduced independence. Further, studies indicate that the mortality rate within one year of sustaining a fracture range from 26% to 35%, with males over 70 years with pre-existing co-morbidities at increased risk (Walter et al, 2023; Todd CJ et al 1995).

For health services, falls and fall related injuries represent a significant cost. The cost of treating a single fractured neck of femur (NOF) for the NHS on average is estimated to be around £14,000 per patient (RCP, 2018). This includes the expenses related to surgery, hospital stay, rehabilitation, and follow-up care. Public Health England (2017) estimated the total cost of fragility fractures at £4.4bn which includes £1.1bn for social care. Hip fractures account for around £2bn of this sum.

Milton Keynes University Hospital (MKUH) NHS Trust remains committed to reducing inpatient falls, particularly those that lead to injury. Reducing unwitnessed falls, ensuring adequate safeguards are in place is a key priority aligned with our falls prevention assurance framework that remains a standing priority with our vision to enhance patient experience through a culture of shared learning from incidents

All fractured neck of femurs is considered moderate harm or higher. MKUH reported 11 incidents of neck of femur fractures resulting from inpatient falls, with an associated annual cost averaging £154,000. The local average length of stay for patients with a neck of femur fracture is 20 days, compared to the national average of 14 days. An area to further understand to reduce length of stay, however other co-morbidities are likely contributing factors.

5.1 Key Learning Implemented from Moderate Incidents

The below are direct excerpts from incidents

- ***Policy and Procedure Review*:** To clarify and update policies, including those related to falls, bed rails, and enhanced observation, ensuring alignment with current practices and governance frameworks. This review will detail clear pathways and protocols for best practices. Additionally, new elements will be incorporated into the policy, such as red frames monitoring, multifactorial risk assessment, hot debriefs, and the Baywatch initiative.
  - ➔ *Baywatch* is a patient safety initiative, and a Multi-Disciplinary Team (MDT) approach, recently implemented by MKUH to reduce the risk of inpatient falls. It involves continuous supervision of patients in a bay who are at high risk of falling, particularly those who have cognitive impairment, mobility issues or recovering from surgery. Dedicated staff members are assigned to support these patients, assist them with movement, and ensure their safety. The goal is to prevent falls and improve the patient experience by providing immediate support and intervention where necessary.
- ***Patient Acuity:*** The combined acuity and dependency of all patients within a clinical area significantly affects the capacity and availability of nursing and support staff. Utilisation of SafeCare is essential to ensure precise analysis, thereby informing appropriate staffing levels and skill requirements.
- ***Ward Orientation*:** Patients should be orientated to the ward or clinical area to ensure they know the direct route to the nearest toilet. Improvement and implementation of signposting should be considered as a potential strategy to prevent falls on those with visual impairment and/or cognitive impairment.
- ***Training and Education:*** Patients and families should be given the falls prevention leaflet with a discussion on best practice to prevent falls during admission to hospital. Falls spot-checks are now being employed to identify gaps in learning and translate teaching into practice. This initiative also provides opportunities to promote falls awareness.
- ***Clinical Documentation:*** Contemporaneous documentation wherever possible will increase accuracy and improve the opportunity to identify learning.
- ***Falls Prevention**:* Ensure that there is awareness and availability of resources to promote falls prevention and minimise patient harm.
- ***Post-falls Management**:* Completion of the post falls checklist supports systemic and comprehensive management of the patient and enhances the communication within the clinical team.

6. Safeguarding:

There has been one section 42 raised by MKUH. A Section 42 Safeguarding Enquiry, under the Care Act 2014, requires local authorities to make enquiries, or cause others to do so, if they have reasonable cause to suspect that an adult in their area is experiencing, or is at risk of, abuse or neglect due to their care and support needs. The section 42 raised was due to failure to identify a fractured neck of femur following a witnessed fall, which was substantiated. Identified learning is being monitored through the divisional governance framework. Our objective for 2025/2026 is to enhance the safeguarding process for monitoring falls with harm, ensuring comprehensive oversight by the safeguarding team.

7. Adult Inpatient Metrics Falls Prevention and Management

The falls prevention and management audit tool is aligned with NICE guidance. These audits have now been implemented in all inpatient wards. The purpose of the adult inpatient metrics is to provide data for divisional and corporate oversight enabling focused ward-based action plans and effective Trust-wide improvement actions.

In August 2024, “The Falls Prevention and Management Audit” inspections decreased from 10 a month to 1 per week to manage audit burden with a focus on quality. In 2024/25 2,014 inspections relating to falls prevention and management was completed. Figure 14 presents the average score per division; Medicine scored 86.48% and Surgery 78.86%.

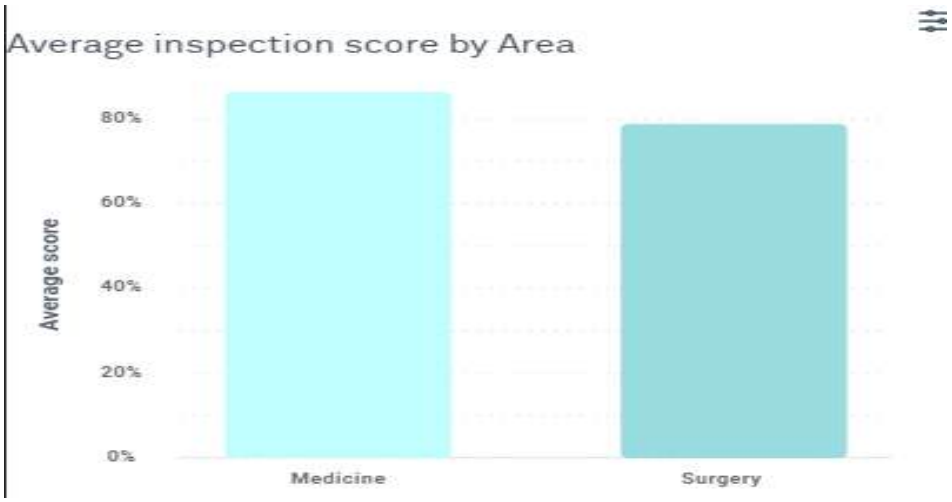


Figure 14: Average inspection score by division

Figure 15 highlights the cumulative average lowest scoring factors relating to falls prevention and management. Lying and standing blood pressure recorded within 48hrs of admission remains our lowest scoring at 47%, followed by medication review (76%), bedrails assessment (76%), post falls care plans completed at 78% and medical review for evaluation of a postural

drop at 84%. Adult inpatient metrics are monitored locally via the divisional governance framework and corporately through ward performance reviews.

Low scoring questions

Includes scoring questions that were responded to

Question	Average score
Has a Lying and Standing BP been recorded within 48 hours of admission ?	47.07%
Have the patients' medications been reviewed and evaluated for falls prevention purposes?	76.03%
Has bedside rails assessment been completed?	76.20%
If patient has fallen in the last 48 hours, was post fall care plan completed?	78.52%
Has the patient been evaluated and reviewed by the medical team when their lying and standing blood pressure indicates a postural drop?	84.62%
Has the falls care plan been initiated within 24 hours of admission/transfer?	90.98%
Has the patient been re-assessed every 7 days and/or when the condition changes?	92.42%
Has the falls risk assessment been completed within 6 hours of admission/transfer?	94.47%
Does the patient have appropriate footwear at the time of inspection?	95.68%
Is the patient's bed area clutter-free?	96.64%

Figure 15: Lowest scoring questions relating to the "falls management and prevention audit"

7.1 Ward Accreditation:

Implementing local accreditation programs improve patient outcomes, staff engagement, satisfaction, and retention, and enhances experiences at ward and unit levels. Monitoring comprehensive standards allows for accurate performance measurement and benchmarking, both internally and externally. This framework supports re-evaluating progress through documented development plans, celebrates excellence, fosters continuous improvement, and tailors support to each area's needs (Brennan & Wendt, 2021).

This strategy underpins all nursing and midwifery practices at Milton Keynes University Hospitals NHS Foundation Trust and contributes to the Trust's goal of achieving outstanding status.

A baseline assessment for Ward Accreditation in falls prevention and management yielded a cumulative score of 70%. The Medicine division scored 69%, while the Surgery division scored 72% (rounded to the nearest whole number) (see: Figure 16). Local action plans are in place to support learning and development following initial baseline assessment. All inpatient areas are preparing to be reassessed in May 2025.

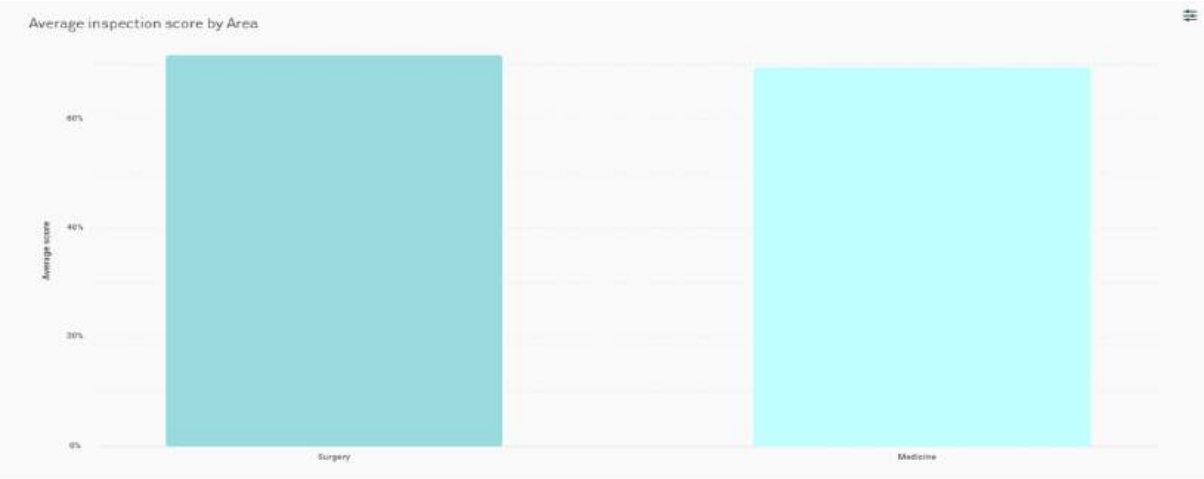


Figure 16: Average score by area; Falls prevention and management

8. Initiatives to Prevent and Reduce the Incidence of Falls

a. The ten wards with the highest reported falls have been selected as part of a fall's improvement program (See: Figure 3)

Using an MDT approach, a Systems Engineering, initiative for patient safety (SEIPS) model has been used to revisit the Falls Driver Diagram to identify the improvement work plans and strengthen the local and corporate governance of falls assurance. This is a recommended evidence-based improvement model. Each clinical setting has their specific objectives/standards that is overseen locally through the divisional governance framework which will report to the Fall's Assurance Group.

b. Falls Champion

Staff were selected in inpatient settings to become Falls Champions. A falls champion program has been developed and multi-disciplinary team led. The first phase of Falls Champion training has been delivered. The aim is to ensure ward areas are equipped with additional knowledge and skills to provide individualised patient care which directly impacts on falls prevention and reduction.

c. Multifactorial Risk Assessment (MFRA)

The MFRA is developed and aligned to NICE guidance (2013), this is in the testing phase. This acknowledges all aspects that contribute to falls, enabling accurate assessments that are in line with national recommendations to provide timely interventions.

d. Hot Debrief

A hot debrief post fall template is being developed and designed, to begin piloting in our highest reported areas for falls. This will be audited for suitability and functionality ahead of Trust wide implementation.

8.1 The Falls Lead is spearheading falls awareness and prevention through several initiatives:

- **Daily triage of high-risk falls via RADAR.**

- **Embedding spot checks into practice** to monitor compliance with falls prevention strategies and risk assessments.

- **Collaborative work with the MDT** to improve the delirium pathway at MKUH, including ongoing efforts on Ward 23.

- **Development and alignment of falls prevention** under the PSIRF process, which includes regular meetings with the Nursing Quality team, Divisional leads, and Ward Managers to identify learning from falls, supporting ongoing Quality Improvement (Q) initiatives. These efforts report directly to the Fall's Assurance Group and the Trust governance processes.

- **Training and education initiatives**: An e-learning package accessible to all staff via ESR is currently being revised. Additionally, face-to-face Falls Awareness and Management training sessions and ward-based workshops have been implemented by the Falls Prevention Lead across the Trust. MKUH offers a university-accredited frailty module for nursing staff, designed and delivered by the frailty team, focusing on preventing deconditioning to support the independence of frail patients and reduce their risk of falls.

- **Falls prevention measures**: Real-time monitoring of falls assessments and Falls Care Plans within 6 hours of admission using Business Intelligence (BI) and auditing via Tendable, reporting into the ward performance process. To comply with national guidelines and national audits, the Falls Assurance Group, relaunched in February 2025, are implementing a Multi-Factorial Risk Assessment (MFRA) tool for early identification of fall risks at the Emergency Department. This assessment is reviewed on ward admission, weekly, after inpatient falls, condition changes, or ward transfers. The same process applies to the Falls Care and Management Plan and Post Fall Care Plan on e-care. Additionally, the Lying and Standing Blood Pressure Project focuses on early identification and intervention for orthostatic hypotension, a significant fall risk factor.

- **Falls prevention policy and procedure**: The falls prevention and management policy is currently under review to ensure it reflects national and local guidance.

9. Next Steps

The Quality Improvement programme is co-designed with divisional staff. There is an ongoing focus to reduce the number of unwitnessed falls and moderate level of harm by implementing sustainable interventions.

Falls prevention remains an area of focus for 2025/26. A refreshed QI programme will aim to reduce the number of unwitnessed falls and level of harm with a focus on:

- Digitalised Multifactorial Risk Assessment Implementation.

- Review pre and post falls risk all assessment in the electronic patient records for functionality, with the aim of providing individualised patient care approach to falls prevention and management.
- Falls Prevention and Management Training.
- Continuation to align falls learning using PSIRF.
- Strengthen the governance framework with the development of the Fall's Assurance Group.
- Work closely with the QI team and the divisions of Medicine and Surgery to advance the falls QI initiatives.
- Explore Polypharmacy in line with falls prevention strategies.
- Re-commence reporting into the National Audit of Inpatient Falls (NAIF), which is part of the falls and fragility fracture audit programme.

10. Conclusion

Despite an overall increase in the number of falls across the Trust, the rate of falls resulting in harm has decreased by 3% (following data cleansing compared to previous year). Enhancements in categorising patient falls have facilitated thematic analysis, enabling an understanding of the causes, and strategic planning of interventions to reduce both the overall number of falls and the severity of harm. Notably, the highest number of falls occur in geriatric frailty wards and emergency orthopaedic ward, where patients have elevated risk factors for falls.

This paper details the incidences of reported inpatient falls for the year 2024/2025, providing an analysis of the falls, key learnings, and the falls prevention programme and next steps. Overall, the report offers comprehensive oversight of inpatient falls at MKUH and the ongoing quality improvement strategies to advance our falls prevention and management programs. Our aim in 2025/26 is to further analyse inpatient falls to ensure it is reflective of the patient's experience.

Recommendations

The Committee is asked to approve the contents of this report outlining the plan for falls prevention.

References:

1. Morris, R., & O'Riordan, S. (2017). Prevention of falls in hospital. Clinical medicine (London, England), 17(4), 360–362.

2. NHS England and NHS Improvement. (2019). *The NHS Patient Safety Strategy: Safer culture, safer systems, safer patients*. NHS England (accessed May 2025) [online] NHS England » The NHS Patient Safety Strategy

3. NICE (2013) *Falls: assessment and prevention of falls in older people*. Available at: https://www.nice.org.uk/guidance/cg161 (Accessed: 22 April 2025).

4. Wellstead, S. and Morgan, M. (2024) *Falls Prevention, Assessment, and Effective Management Policy for the Inpatient Setting*. Royal Cornwall Hospitals NHS Trust. Available at: https://doclibrary-rcht.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/CorporateClinical/FallsPreventionAssessmentAndEffectiveManagementPolicyForTheInpatientSetting.pdf (Accessed: 22 April 2025).

5. Healthcare Quality Improvement Partnership (2024) *National Audit of Inpatient Falls 2023 Annual Report*. Available at: https://www.data.gov.uk/dataset/bb9a630c-8378-4a14-87b9-943e091bf3b2/national-audit-of-inpatient-falls-2023-annual-report (Accessed: 22 April 2025).

6. Office for Health Improvement and Disparities (2022) *Falls: applying All Our Health*. Available at: https://www.gov.uk/government/publications/falls-applying-all-our-health/falls-applying-all-our-health (Accessed: 22 April 2025).

Meeting Title	**Trust Board in Public**	**Date: 3 July 2025**
Report Title	Nursing Workforce Update	**Agenda Item Number: 17**
Lead Director	*Fiona Hoskins, Chief Nursing Officer*	
Report Author	*Emma Thorne, Safe Staffing Matron*	

Introduction	This report provides an overview of the Nursing and Midwifery staffing for May 2025. The report contains a safer staffing dashboard that details Fill Rates, Care Hours Per Patient Day alongside patient outcomes for triangulation. The information presented in this report is in line with the National Quality Board (NQB, 2016) and Developing Workforce Safeguards (NHSI, 2018) requirements.		
Key Messages to Note	1. Band 5 Registered Nurses vacancies are 1.88% (9.27wte), and Healthcare Support Worker vacancies have reduced to 15.91% (73.95wte). Maternity report a -0.48wte Midwife vacancy. 2. Fill rates (against establishment) for Registered Nurses is 99% during the day and 106% at night. The HCA fill rate for the day was 105% and 117% at night. The report details the fill rate (%) against additional requirements and notes a lower fill rate for HCA's during the day to 89% and 93% at night. This suggests there are occasions where staffing levels did not meet the acuity and needs of patients. 3. 114 Red Flags were raised across Adult and Paediatric areas in May. 58 were unable to be fully mitigated. 4. Workforce utilisation suggests that there are 4 areas exceeding 110% to meet patients care needs. 5. Trust wide Care Hours per Patient Day (CHPPD) sits at 8.6 hours per day. 6. There was a decrease in agency usage for registered staff in May. There were 524 registered duties left unfilled. The Business Case associated to the June 2024 Bi-Annual establishment reviews has been approved. The Chief Nurse is currently working on a prioritisation plan and phased approach to implementation. This report has also been submitted to the CNO Committee/Group and Trust Board.		
Recommendation	**For Information** [x]	**For Approval** [ ]	**For Review** [ ]

Strategic Objectives Links	1. *Keeping you safe in our hospital* 2. *Improving your experience of care* 3. *Ensuring you get the most effective treatment* 4. *Giving you access to timely care*

	5. *Working with partners in MK to improve everyone's health and care* 6. *Increasing access to clinical research and trials* 7. *Spending money well on the care you receive* 8. *Employ the best people to care for you* 9. *Expanding and improving your environment* 10. *Innovating and investing in the future of your hospital*

Report History	*Standing Agenda Item*
Next Steps	*Standing Agenda Item*
Appendices/Attachments	*Report follows.*

Glossary

	Acronyms	
	CHPPD	Care Hours Per Patient Day
	HCA	Healthcare Assistant
	MCA	Maternity Care Assistant
	RN	Registered Nurse

NHS
Milton Keynes University Hospital
NHS Foundation Trust

Safer Staffing Report

Reporting Period: May 2025 Data

Author: Emma Thorne, Matron for Safer Staffing

Environment		Day Fill Rates						Night Fill Rates						Care Hours Per Patient Day			Workforce Utilisation		Reported Concerns				Nurse Sensitive Outcome Indicators							
Directorate	Ward	Average fill rate registered nurses/midwives (%)	Average fill rate registered nurses/midwives (%) including additional duties	% of which are Bank / Agency	Average fill rate - care staff (%)	Average fill rate - care staff (%) including additional duties inc	% of which are Bank / Agency	Average fill rate - registered nurses/ midwives (%)	Average fill rate - registered nurses/ midwives (%) including additional duties	% of which are Bank / Agency	Average fill rate care staff (%)	Average fill rate - care staff (%) including additional duties inc.	% of which are Bank / Agency	RN/RM	HCA	Overall	SafeCare Average Utilisation % May 2025	SafeCare Average Utilisation trend	No. of Red Flags raised May 2025	No of Red Flags that were unable to be mitigated	Total Number of Radars for May 2025	No.of Radars completed associated to staffing	Hospital Acquired Pressure Ulcers G2 and above May 2025	Hospital Acquired Pressure Ulcer trend	Falls with no harm/ Falls resulting in harm April 2025	Falls with no harm/ Falls resulting in harm May 2025	Medication errors May 2025	Medication error trend	Patient Expereince Rating	Friends and Family Test Response Rate
Medicine	Ward 1	100%	90%	17%	104%	88%	21%	113%	100%	13%	109%	89%	24%	5.7	3.3	9.0	109%	1%↑	10	2	26	0	2	2↑	9/0	3/0	5	0↑	4.57	50.7
Medicine	Ward 2	97%	97%	9%	105%	98%	7%	96%	96%	9%	111%	100%	17%	4.0	3.1	7.1	102%	1%↑	6	3	13	0	0	0↑	1/0	1/0	0	1↓	4.43	166.3
Medicine	Ward 3	88%	88%	16%	123%	95%	25%	100%	100%	18%	144%	100%	49%	3.8	3.0	6.8	109%	8%↓	7	5	17	0	2	1↑	6/0	1/0	2	0↑	4.3	23.9
Medicine	Ward 7	97%	97%	3%	95%	91%	9%	100%	100%	6%	105%	100%	28%	4.2	3.3	9.3*	100%	1%↓	1	1	24	0	1	1↑	2/0	3/0	1	2↓	4.76	74
Medicine	Ward 8	97%	97%	13%	136%	90%	36%	100%	100%	8%	163%	95%	51%	4.2	3.5	7.7	106%	2%↑	0	0	17	1	0	5↓	5/0	5/0	2	1↓	4.33	61.4
Medicine	Ward 14	107%	107%	4%	91%	90%	16%	106%	106%	5%	96%	96%	34%	2.1	4.2	6.2	124%	26%↑	5	3	17	0	1	1↑	8/0	7/0	4	4↑	4.41	31
Medicine	Ward 15	97%	95%	3%	106%	97%	17%	98%	97%	4%	114%	101%	23%	3.2	2.5	5.7	112%	3%↓	0	0	23	0	4	2↑	6/0	3/0	2	0↑	4.25	48.9
Medicine	Ward 16	100%	100%	17%	119%	91%	15%	100%	100%	14%	153%	99%	40%	3.3	2.9	6.2	112%	3%↓	4	2	37	0	1	3↓	4/0	8/0	2	4↓	4.58	47.6
Medicine	Ward 17	95%	95%	25%	118%	91%	31%	101%	100%	19%	140%	99%	33%	3.9	2.8	6.7	108%	1%↑	5	3	16	1	4	3↑	3/0	2/0	1	2↓	4.77	16.9
Medicine	Ward 18	115%	100%	31%	117%	89%	43%	155%	99%	53%	143%	97%	39%	3.8	4.0	7.9	108%	2%↓	5	2	52	1	1	0↑	8/0	8/0	1	1↑	3.92	20
Medicine	Ward 19	113%	99%	25%	98%	93%	64%	152%	99%	31%	104%	99%	25%	3.6	3.2	6.8	97%	2%↓	4	2	23	0	5	4↑	7/0	8/0	0	2↓	4.31	48.9
Medicine	Ward 22	92%	91%	10%	94%	93%	1%	100%	100%	26%	100%	99%	44%	3.8	3.2	7.0	106%	6%↑	0	0	7	0	0	6↓	3/0	1/0	2	0↑	4.61	67.9
Core Clinical	Ward 25	100%	97%	17%	134%	88%	45%	100%	100%	17%	177%	99%	72%	4.8	4.0	8.8	101%	13%↑	13	9	18	1	3	0↑	5/2	5/1	5	2↓	4.85	238.5
Medicine	ED	98%	98%	32%	108%	107%	63%	108%	107%	31%	123%	122%	61%				N/A	N/A	1	0	94	2	2	1↑	2/1	3/0	7	3↑	3.93	11.2
Surgery	Ward 20	98%	97%	12%	124%	90%	44%	102%	99%	26%	150%	98%	54%	3.9	2.9	6.7	94%	3%↑	3	3	24	1	1	0↑	3/0	6/0	3	0↑	4.37	55.8
Surgery	Ward 21	90%	90%	11%	118%	87%	22%	89%	89%	16%	116%	86%	47%	5.3	3.5	8.8	76%	1%↑	9	1	8	0	0	1↓	0/0	2/0	0	3↓	4.7/4.56	48.3/27
Surgery	Ward 23	94%	94%	13%	112%	97%	15%	99%	99%	6%	120%	100%	12%	3.3	3.1	6.4	108%	7%↓	6	4	38	1	2	4↓	4/0	6/0	1	1↓	4.46	50.8
Surgery	Ward 24	108%	98%	19%	101%	97%	10%	110%	99%	13%	104%	97%	45%	4.0	2.7	6.7	83%	6%↑	0	0	7	0	2	2↑	1/0	1/0	0	0	4.6	46.6
Surgery	ITU	102%	98%	8%	0%	0%	0%	101%	97%	9%	0%	0%	0%	22.3	0.0	22.3	74%	3%↑	0	0	28	0	0	2↓	0	0	2	2↓	4.9	66.7
Paediatrics	Ward 5	88%	88%	9%	103%	100%	30%	101%	91%	35%	108%	101%	57%	6.8	1.4	8.1	121%	0%↑	29	18	16	1	0	1↓	0	0	8	4↓	4.48	30
Paediatrics	NNU	91%	91%	10%	91%	91%	5%	92%	92%	12%	82%	82%	3%	20.3	6.6	26.9	72%	1%↓	1	0	10	1	0	0↑	0/0	0	2	1↓	4.94	18.2
	Total	**99%**	**96%**	**14%**	**105%**	**89%**	**25%**	**106%**	**99%**	**18%**	**117%**	**93%**	**36%**	**5.1**	**3.4**	**8.6**	**101%**	**2%↑**	**109**	**58**	**515**	**10**	**31**				**50**	**17↓**		

Areas of concern – May 2025

Area	Concern
Ward 14	124% workforce utilisation (26% increase from April), low HCA day fill rate and red patient outcomes.
Ward 15	112% Workforce utilisation, lowest CHPPD in the Trust at 5.7, red patient quality indicators.
Ward 16	112% Workforce utilisation, low HCA fill rates against additional requirement (in the day), amber and red patient outcomes.
Ward 5	121% Workforce, low RN fill rates for the day, high number of red flags. red patient outcomes including medication errors.
Ward 1	109% workforce utilisation, low fill rates, and increase In pressure ulcers and medication errors.
Ward 3	109% workforce utilisation, low RN fill rates, amber patient outcomes .

Narrative and mitigation

All wards are reviewed on a daily basis by a Matron.
Safer Staffing meetings review SafeCare data, including red flags, fill rates patient acuity and staffing available.
Matrons redeploy staff to mitigate risk where possible.
RN Staffing increased on Ward 18 at Night in response to increased acuity.

Safe Staffing Report

Milton Keynes University Hospital NHS Foundation Trust

Data

- In May, the Trust wide fill rates (planned vs Actual) against establishment for Registered Nurse was 99% during the day and 106% at night. The HCA fill rate for the day was 105% and 117% at night.
- Trust wide fill rates against additional requirement details that RN fill rates increased to 96% Day and 99% at night. Where HCA fill rates increased from 86% in April to 89% in the day and 93% at night.
- Trust wide CHPPD 8.6. Latest CHPPD data published by Model Hospital (March 2025) details 9.0 to be the national value and 8.6 to be the median CHPPD provided by peer organisations. Ward 15 has the lowest CHPPD across the Trust at 5.7. This means patients in this area received less patient contact time with a RN/HCA per day.
- Fill rates across Maternity for May was 90% .
- Agency use for Registered Nurse/Midwives decreased from 332 in March to 180 in April, and 167 in May.
- Bank RN usage 2173 in May 2025. 524 RN shifts were left unfilled, in comparison to 765 shifts remained unfilled in April.
- 114 Red Flags were raised across Adult and Paediatric areas, in comparison to 117 in April . Ward 5 (29) Ward 25 (13) Ward 1 (10) are the highest areas for reporting red flags for this reporting period.
- In Maternity 19 Red Flags were raised. Opel 4 was declared once in May.
- Trust wide workforce utilisation in May was 101% (Green RAG) which is a 2% increase from April 2025.
- 4 areas working above 110% (RED), in comparison to 6 in April.
- 13 staffing incidents were raised across the Trust pertaining to Nursing and Midwifery staffing (17 in April 2025).

Escalations

- High workforce utilisation (above 110%) in 4 areas – Ward 5, 14,15,16.
- Unable to mitigate all red flags.
- In response to the trusts operational pressures, Ward 19 exceeded its funded bed capacity on 20/31 days during this reporting period, meaning that the ward on occasions required additional staffing to support care delivery. Similarly, Ward 25 worked above its funded bed capacity (of 20 beds) on 27/31 days.
- This group are asked to review the patient outcome data for falls, medication incidents and pressure ulcers.

Exceptions

- Fill rates continue to vary from planned levels due to changes in patient acuity, dependency, enhanced care requirements and additional beds.
- During this reporting period Ward 19 continued to have additional Registered Nurse at night due to the acuity and dependency of patients.
- During the reporting period there was a high number of Enhanced Care usage Trust Wide.
- Escalation areas were predominantly closed during this reporting period.

Actions

To continue with the three times daily safer staffing meetings, to review red flags, staffing levels and implement mitigation and deployment, where possible.
To continue to work in line with the Trusts Safer Staffing and Escalation Policy.
To continue focus work on the use of bank and agency spend with the Divisional Chief Nurses.
To continue with the Enhanced Therapeutic Observations and Care workstream.

Meeting Title	TRUST BOARD (PUBLIC)	Date: 3 July 2025
Report Title	Corporate Risk Register	Agenda Item Number: 18
Lead Director	*Kate Jarman, Chief Corporate Services Officer*	
Report Author	*Paul Ewers, Senior Risk Manager*	

Introduction	The report provides an analysis of all risks on the Risk Register, as of 28th May 2025.		
Key Messages to Note	Please take note of the trends and information provided in the report. **Risk Appetite:** This is defined as the amount of risk the Trust is willing to take in pursuit of its objectives. The risk appetite will depend on the category (type) of risk.		
Recommendation	**For Information** ☐	**For Approval** ☐	**For Review** √

Category	Appetite	Definition
Financial	Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
Compliance/ Regulatory	Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
Strategic	Seek	Eager to be innovative and to choose options offering potentially higher business rewards despite greater inherent risk
Operational	Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
Reputational	Open	Willing to consider potential delivery options and choose while also providing and acceptable level of reward and value for money
Hazard	Minimal (ALARP)	Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential

Strategic Objectives Links	*Objective 1: Keeping you safe in our hospital* *Objective 2: Improving your experience of care* *Objective 3: Ensuring you get the most effective treatment* *Objective 4: Giving you access to timely care* *Objective 7: Spending money well on the care you receive* *Objective 8: Employ the best people to care for you* *Objective 10: Innovating and investing in the future of your hospital*

Report History	The Risk Report is an ongoing agenda item
Next Steps	
Appendices/Attachments	The following items can be found under item 20 in the supplementary shelf: • Appendix 1: Corporate Risk Register

Exception Reporting:

The report provides a summary of the key metrics to provide assurance that the risk management process is working as intended.

The key highlights are as follows:

1.0 Overdue Risks:

1. There has been a slight decrease in the total number of risks (n=268).
2. There are currently 60 risks (22%) that are overdue their review date. This is **an increase of 5** from the previous report.
3. 16 of the overdue risks are more than 1 month overdue

Reference	Risk Owner	CSU	Days Overdue
RSK-591	Katy Philpott	Women's Health	112
RSK-513	Katy Philpott	Women's Health	109
RSK-084	Amanda Taylor	General Surgery	102
RSK-226	Antoanela Colda	Research & Development	102
RSK-549	Julie Orr	Directorate of Patient Care	71
RSK-210	Patricia Flynn	Directorate of Patient Care	50
RSK-435	Thozama Cele	Diagnostic & Screening	47
RSK-108	Lisa Calvert	Women's Health	46
RSK-634	Shoma Banerjee	Musculoskeletal	44
RSK-232	Julie Orr	Directorate of Patient Care	43
RSK-301	Darren Grace	Estates	34
RSK-518	Rathna Begum	Diagnostic & Screening	34
RSK-642	Andrew Scott	Diagnostic & Screening	34
RSK-644	Andrew Scott	Diagnostic & Screening	34
RSK-230	Julie Orr	Directorate of Patient Care	33
RSK-418	Elaine Gilbert	Women's Health	33

4. There are 360 controls that have been identified and are in progress. This shows that when risks are identified, controls are being identified to mitigate the risk. However, of these 114 are past their expected implementation date. This is **an increase of 3**.

2.0 Risk Appetite Statements

In a Board Seminar in February 2025, the risk appetite statement was reviewed and updated. Below is the new risk appetite statement, which has been updated in the Risk Management Framework document:

Category	Appetite	Definition
Financial	Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
Compliance/ Regulatory	Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
Strategic	Seek	Eager to be innovative and to choose options offering potentially higher business rewards despite greater inherent risk
Operational	Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
Reputational	Open	Willing to consider potential delivery options and choice while also providing an acceptable level of reward and value for money
Hazard	Minimal (ALARP)	Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential

3.0 Risks on Risk Register > 5 years and Not at Target/Tolerable Level:

Unmitigated risks can result in the Trust being unnecessarily exposed to risks that could have been prevented and/or reduced the impact if they do occur. Therefore, this leaves the Trust potentially vulnerable. Mitigation of risk also increases the likelihood of the Trust achieving its goals and objectives including reducing harm to patients / staff / members of the public, providing high quality care, having efficient and effective processes and managing resources/finances effectively

There are currently 7 risks that have been on the Risk Register for more than 5 years and have not been mitigated down to the Target / Tolerable level:

Ref	Title	Risk Owner	Progress	Status
RSK-019	Violence & Abuse (V&A) in ED	Kirsty McKenzie	V&A QI project is taking place. This risk is to be updated and kept aligned with the progress of the project.	Treat – Further controls required
RSK-020	ED Ligature Points	Kirsty McKenzie	Meeting held. Ligature Policy to be updated. Recommended that a Target Risk Score of 8 is more appropriate for this risk – therefore risk to be tolerated once policy has been updated	Treat – To be changed to Tolerate once policy has been updated.
RSK-016	Lack of patient flow	Kirsty McKenzie	Ongoing risk, to be reviewed	Treat
RSK-035	High turnover of staff in Pharmacy	Helen Smith	To be reviewed	
RSK-012	Violence & Abuse within Acute Medicine	Liz Winter	V&A QI project is taking place. This risk is to be updated and kept aligned with the progress of the project.	Treat – Further controls required
RSK-135	Pathology LIMS system	Rebecca Potter	Risk to be closed when LIMS system is implemented (May 2025).	Treat – to be closed
RSK-018	ED Diabetes Patients not being assessed promptly	Liz Winter	To be Reviewed	

4.0 Risks Escalated by Division/Corporate Department:

There are 2 risks that have been identified as requiring escalation onto the Corporate Risk Register this month.

Ref	Title	Risk Owner	Rationale for escalation to Corporate Risk Register
RSK-374	IF patients on the cancer pathway wait longer than 62 days	Sally Burnie	Trustwide impact of risk and national performance metric.
RSK-657	IF the Estates COSHH Inventory and associated Risk Assessments are not maintained accurately	Darren Hutchings	Trustwide impact of risk.

5.0 Risks Escalated for Approval to Tolerate at Current Level:

There are 2 risks that are being escalated for approval to tolerate the risk at the current level.

Ref	Title	Risk Owner	Rationale for escalation to Corporate Risk Register
RSK-088	IF there is overcrowding and insufficient space in the Neonatal Unit.	Lazarus Anguvaa	The risk has been mitigated down to the current risk level (16). Remaining control relates to the new hospital build. Therefore, risk being tolerated at current level. Escalated to TEC for decision whether to tolerate at current level. *June update: Discussion took place between Fay Gordon, Charlie Nunn and Paul Ewers. Risk Assessment and controls options are being considered to reduce the risk prior to the new hospital build.*
RSK-475	IF the bevacizumab syringes from ITH Pharma are not fit for purpose	Julian Roberts	Outstanding control to switch to an alternative supplier using BD Syringes. Escalated to TEC for a decision as whether to switch to an alternative supplier or tolerate the risk at current level (9). *June Update: Risk to be reviewed by Pharmacy, Purchasing and Ophthalmology Team.*

6.0 Risks requiring further mitigation with no outstanding controls identified

There are 14 risks where further mitigation is required to reduce the risk to an acceptable level and where there are no outstanding controls identified on Radar. These need to be reviewed and the outstanding/planned controls need to be added to Radar with estimated completion dates:

Ref	Title	Risk Owner
RSK-591	If the Ultrasound service cannot meet the demands of the maternity service and the required SBLv3 scan requirements	Katy Philpott
RSK-565	IF there is insufficient staffing across all specialities in Ophthalmology	Bina Parmar
RSK-016	IF there is a lack of flow in the organisation	Kirsty McKenzie
RSK-079	IF we are unable to clear the pelvic health physiotherapy backlog	Celia Hyem-Smith
RSK-658	IF the savings required by NHSE of £650k in the Finance and Procurement teams are implemented	Daphne Thomas
RSK-455	If there is a lack of knowledge and familiarity with the use of e-prescribing within the Neonatal Unit (NNU) & Paediatric Unit, by medical and nursing staff	Lazarus Anguvaa
RSK-461	IF there is insufficient staffing in the Orthopaedic Outreach Physiotherapy	Celia Hyem-Smith
RSK-583	IF the Audiology Department do not have the facility space or equipment to provide a Vestibular Service	Jack Constable
RSK-434	IF there is insufficient capacity of outpatient appointments	Felicity Maple
RSK-499	IF the capacity to increase Echocardiogram appointments is not increased	Jose Samoes
RSK-414	IF The Dermatology Department does not have appropriately trained nursing staff to be able to provide a Phototherapy Service	Elizabeth Winter
RSK-421	IF there are shortages of medicines with minimal notice or little warning	Nicholas Beason
RSK-606	IF the requirements of the various Audit Programs within the department are not met	Jackie Palmer
RSK-473	IF the Trust does not have a working CTG flatbed scanner	Janine Young

Recommendations / Decisions to be Considered:

1. Divisions/Corporate Departments to ensure that all overdue risks to be updated by 30th June 2025 – see section 1.0 (page 2)

2. Divisions/Corporate Departments to ensure that controls are reviewed and updated as part of reviewing each risk. It is recommended that all controls are updated and either closed or their due dates extended by 30th June 2025 – see section 1.0 (page 2)

3. TEC to note the updated risk appetite statement to support decision making and identification of Target Risk Score when managing risks – see section 2.0 (page 3)

4. Approval requested for risks escalated for inclusion on Corporate Risk Register – see section 4.0 (page 4)

5. Divisions/Corporate Departments to ensure that all risks that need to be further mitigated have at least one outstanding/planned control listed on Radar – see section 6.0 (page 5)

Meeting Title	**TRUST BOARD (PUBLIC)**	**Date: 3 July 2025**
Report Title	**Board Assurance Framework**	**Agenda Item Number: 19**
Lead Director	*Kate Jarman, Chief Corporate Services Officer*	
Report Author	*Paul Ewers, Senior Risk Manager*	

Introduction	This report is to provide assurance that the Board Assurance Framework (BAF) is being effectively managed.		
Key Messages to Note	• There have only been minor review and amendments during May.		
Recommendation	**For Information** ☐	**For Approval** ☐	**For Assurance** [x]

Strategic Objectives Links	1. *Keeping you safe in our hospital* 2. *Improving your experience of care* 3. *Ensuring you get the most effective treatment* 4. *Giving you access to timely care* 5. *Working with partners in MK to improve everyone's health and care* 6. *Increasing access to clinical research and trials* 7. *Spending money well on the care you receive* 8. *Employ the best people to care for you* 9. *Expanding and improving your environment* 10. *Innovating and investing in the future of your hospital*

Report History	Regular Committee cycle
Next Steps	*N/A*
Appendices/Attachments	*N/A*

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BAF Dashboard:

Strategic Risk		Executive Lead	Inherent Risk (level of risk without controls)	Current Risk												Last Review	Target Risk (level of risk deemed tolerable)	Risk Appetite	Treatment Strategy	Assurance Rating
				Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May					
2	Insufficient capital funding to meet the needs of population we serve	Chief Financial Officer	25	20	20	20	20	20	20	20	20	20	20	15	15	May-25	10	Cautious	Treat	Negative Assurance
3	If the future NHS funding regime is not sufficient to cover the costs of the Trust, then the Trust will be unable to meet its financial performance obligations or achieve financial sustainability and financial liquidity	Chief Financial Officer	20	20	20	20	20	20	20	20	20	20	20	20	20	May-25	8	Cautious	Treat	Negative Assurance
4	Patients experience poor care or avoidable harm due to delays in planned care	Chief Operating Officer – Planned Care	25	20	20	20	20	20	20	20	20	20	20	20	20	May-25	10	Minimal (ALARP)	Treat	Inconclusive Assurance
5	Patients experience poor care or avoidable harm due to inability to manage emergency demand.	Chief Operating Officer – Unplanned Care	25	20	20	20	20	20	20	20	20	20	20	20	20	May-25	10	Minimal (ALARP)	Treat	Positive Assurance
6	System inability to provide adequate social care and mental health capacity.	Chief Operating Officer – Unplanned Care	20	20	20	20	20	20	20	20	20	20	20	20	20	May-25	8	Minimal (ALARP)	Treat	Inconclusive Assurance
8	If the pathway for patients requiring head and neck cancer services is not improved, then users of MKUH services will continue to face disjointed care, leading to unacceptably long delays for treatment and the risk of poor clinical outcomes	Chief Medical Officer	25	15	15	15	15	15	15	15	15	15	15	15	15	May-25	10	Minimal (ALARP)	Treat	Inconclusive Assurance
10	Insufficient staffing levels to maintain safety - Inability to recruit 'hard to recruit' roles	Chief People Officer	15	10	10	10	10	10	10	10	10	10	10	10		Jun-25	5	Minimal (ALARP)	Treat	Positive Assurance
11	Insufficient staffing levels to maintain safety - Inability to retain staff	Chief People Officer	15	10	10	10	10	10	10	10	10	10	10	10		Jun-25	5	Minimal (ALARP)	Treat	Positive Assurance
12	Vulnerability of Cyber Security breach	Chief Strategic Development Officer	20										16	16	16	May-25	8	Cautious	Treat	Inconclusive Assurance

13	Poor data quality impacting patient care, operational performance and Trust financial position	Chief Operating Officer – Planned Care	20											15	15	May-25	4	Cautious	Treat	Inconclusive Assurance

Longer-term Risks: Nine longer-term risks have been identified:

- Conflicting priorities between the ICS and providers
- Lack of availability of skilled staff
- Increasing turnover
- Lack of time to plan and implement long-term transformational change
- Long-term financial arrangements for the NHS
- Growing/ageing population
- A pandemic
- Continued industrial action resulting in significant disruption to service/ care provision
- Political instability and change

Risk Appetite Statement Update:

Category	Appetite	Definition
Financial	Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
Compliance/ Regulatory	Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
Strategic	Seek	Eager to be innovative and to choose options offering potentially higher business rewards despite greater inherent risk
Operational	Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
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Hazard	Minimal (ALARP)	Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential

Potential New BAF Risks:

1. The following risk was discussed at Quality & Clinical Risk Committee and it was recognised that the risk would need to be appropriate worded so that it reflects what MKUH can influence/control. The Committee decided that this needs further discussion at Board:

- Widening health inequalities

Recommendations:

1. The Trust Executive Committee are asked to review and discuss the Board Assurance Framework and have an awareness of the potential new risk to be discussed for consideration to be added to the BAF.

Meeting Title	**Trust Board in Public**	**Date: 3rd July 2025**
Report Title	**Risk Appetite**	**Agenda Item Number: 19**
Lead Director	*Kate Jarman, Chief Corporate Services Officer*	
Report Author	*Paul Ewers, Senior Risk Manager*	

Introduction	This report outlines the proposed updated Risk Appetite statement of the Trust following discussions at the Board Seminar in February 2025.		
Key Messages to Note	The Board are asked to consider and approve the new Risk Appetite Statement.		
Recommendation	**For Information** ☐	**For Approval** √	**For Review** ☐

Strategic Objectives Links	*Objective 1: Keeping you safe in our hospital* *Objective 2: Improving your experience of care* *Objective 3: Ensuring you get the most effective treatment* *Objective 4: Giving you access to timely care* *Objective 7: Spending money well on the care you receive* *Objective 8: Employ the best people to care for you* *Objective 10: Innovating and investing in the future of your hospital*

Report History	N/A
Next Steps	*N/A*
Appendices/Attachments	None

Risk Appetite Statements

Risk appetite is defined as the amount of risk the Trust is willing to take in pursuit of its objectives. It supports the balancing of patient safety, quality of services, operational efficiency, financial constraints and strategic development etc.

Risk appetite should be integrated as part of decision-making at all levels of the organisation.

In the February 2025 Board Seminar, the risk appetite statement was reviewed and updated. The following table shows the outcome of these discussions:

Category	Appetite	Definition
Financial	Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
Compliance/ Regulatory	Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
Strategic	Seek	Eager to be innovative and to choose options offering potentially higher business rewards despite greater inherent risk
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Hazard	Minimal (ALARP)	Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential

Recommendations / Decisions to be Considered:

1. The Board are asked to discuss and approve the above revised Risk Appetite statement and how risk appetite can be integrated into decision-making processes within the Trust to support the achievement of objectives, whilst balancing the various requirements and constraints the hospital faces.

Meeting Title	**TRUST BOARD (PUBLIC)**	**Date: 3 July 2025**
Report Title	Audit & Risk Committee Assurance Report	**Agenda Item Number: 20**
Committee Chair	**Mark Versallion**, Non- Executive Director & Chair of the Committee	
Report Author	**Timi Achom**, Assistant Trust Secretary	

Introduction	The purpose of the report is to provide an update to the Trust Board on the activities of the Audit & Risk Committee since the Trust Board held in public on 1 May 2025. The committee had met on one occasion since the last update to the Board: **19 May 2025**		
Key Messages to Note	The Trust Board is invited to NOTE the report.		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Assurance** [x]

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

1. Committee Discussion and Decision

Key points to note:

- The committee had met on one occasion since the last update to the Board: 19 May 2025.

The following decisions were made at the Audit and Risk Committee held on **19 May 2025**

The meeting was quorate and chaired by Mark Versallion - NED

Agenda Item	Decision Made	Comments
Draft Annual Report 2024/25	The committee **noted** the Draft Annual Report **2024/25**	The committee received the Draft Annual Report, which included key updates such as its submission to the auditors, comments and corrections being welcomed during the drafting process, and

		acknowledgments of the effort involved in compiling the report.
Annual Accounts Progress Update 2024/25	The Committee **noted** the Annual Accounts Progress Update 2024/25	A progress update was provided on the status of the external audit. It was reported that the external audit was progressing well, with no significant issues identified at this stage. It was further noted that there was effective collaboration between the financial services and audit teams, contributing to the smooth advancement of the audit process.
Draft Head of Internal Audit Opinion	The Committee **noted** the Draft Head of Internal Audit	The review of Medical Equipment Management highlighted positive outcomes, indicating improvements in oversight and process effectiveness.
Internal Audit - Progress Report	The Committee **noted** the report	An update was provided on internal audit progress. Clarification was sought regarding the efficiency of the outsourced medical equipment model. It was agreed that delaying the implementation of Integrated Care System (ICS) governance actions was a prudent approach in the current context.
Internal Audit - Audit Plan 2025/26	The Committee **approved** the Internal Audit - Audit Plan 2025/26	The proposed Internal Audit Plan for 2025/26 was reviewed. A query was raised concerning the alignment of the planned Health and Safety audit. Concerns were also noted regarding the Trust's ongoing cybersecurity posture and the need for continued monitoring and improvement.
Third Party Assurance	The Committee **noted** the report	A report was provided on third-party assurance arrangements. NHS Shared Business Services (SBS) had implemented enhanced guidance and monitoring processes to strengthen oversight and risk management in this area.
Informing the Audit Risk Assessment	The Committee **noted** the report	The Audit Risk Assessment paper was reviewed. Assurance around declarations of related party interests was queried. It was reported that approximately 50 additional responses had been received from Consultants, supporting the ongoing compliance process.

2. Assurance

As noted in comments

3. Areas for escalation to the Board for further discussion or decision from the agenda items

- Cybersecurity

4. Recommendation

- The Board are invited to NOTE the report.

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Meeting Title	**TRUST BOARD (PUBLIC)**	**Date: 3 July 2025**
Report Title	Charitable Funds Committee Report	**Agenda Item Number: 20**
Committee Chair	**Haider Husain**, Non- Executive Director & Chair of the Committee	
Report Author	**Timi Achom**, Assistant Trust Secretary	

Introduction	The purpose of the report is to provide an update to the Trust Board on the activities of the Charitable Funds Committee since the Trust Board held in public on 1 May 2025 The committee had met on one occasion since the last update to the Board: **24 April 2025**		
Key Messages to Note	The Trust Board is invited to NOTE the report.		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Assurance** [x]

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

1. Committee Discussion and Decision

The committee had met on one occasion since the last update to the Board: 24 April 2025

The following decisions were made at the Charitable Funds Committee held on **24 April 2025**

The meeting was quorate and chaired by Haider Husain - NED

Agenda Item	Decision Made	Comments
Charitable Funds Report	The committee **noted** the report.	The report highlighted fundraising activities and charitable spend. Efforts to reverse a downturn in income were noted, with new connections being built and a focus on supporter retention. Significant contributions were made by schools, corporate entities, and MKUH staff. The charity's website and social media presence saw significant engagement and growth. The departure of the Individual Giving

		Marketing Lead was discussed, and an extra-ordinary meeting was agreed to address future funding, recruitment, and retention
Finance Report	The committee **noted** the report.	The financial position of the charity as of 31 March 2025 was presented. The unrestricted reserves had fallen below the policy minimum of £50k, limiting the charity's flexibility to manage core costs and respond to discretionary funding requests. Ongoing delays in validating the release of unused restricted funds were noted to be further hindering financial flexibility. Cash reserves were forecasted to continue to decline with unrestricted balances insufficient to cover core running costs without corrective action. In order to support the charity's sustainability, the following actions were recommended: • Monitor donation trends closely and consider further fundraising initiatives. • Assess operational budgets for further cost control in light of projected cash flow pressures. • Explore temporary restrictions on discretionary spend until reserves are rebuilt. • Prioritise finalising discussions on dormant restricted funds, particularly the • VCSE grant and liaise with funders to seek permission to repurpose or release balances where appropriate. • Encourage targeted fundraising efforts and stakeholder engagement focused on replenishing the General Fund to restore operational flexibility.
Strategic View of Objectives 2025/26	The committee **noted** the Strategic Overview for 2025/26 and **approved** the Charity Fundraising Plan for 2025/26.	The Charity Fundraising Plan 2025–26 for Milton Keynes Hospital Charity was presented for approval. The plan aims to raise £360,000, focusing on community events, corporate partnerships, individual giving, and school engagement. Priorities include increasing unrestricted income, improving staff retention, and enhancing on-site branding. Strengths identified include a committed team and strong brand identity, while challenges noted were high staff turnover. The financial plan forecasts £360,000 in income against £103,600 in expenditure. Key risks such as underperformance in fundraising and staff retention have corresponding mitigation measures. Progress would be monitored quarterly.

Arts for Health MK	The committee **approved** the revised funding arrangement for two years, subject to the agreement on a formal SLA with MK Arts for Health and **supported** the annual review of the arrangement to ensure financial sustainability and continued alignment with the Charity's priorities.	It was noted that the historical funding level of £34,000 per annum was no longer sustainable. A revised funding arrangement of £15,000 per annum for two years was proposed, alongside the implementation of a Service Level Agreement (SLA) with Arts for Health MK to clearly define service expectations and distinguish the arrangement from a charitable donation. An annual review was recommended to assess financial viability and ensure ongoing alignment with Milton Keynes Hospital Charity's strategic priorities.
Friends of MK Update	The committee **noted** the update	Discussions with the Friends of MK had focussed on their physical presence on site and the potential for a merger. The current shop facility space was under review due to the need to expand restaurant capacity. Their current space lease was to move to a rolling lease, with ongoing discussions regarding a replacement unit and their role in ward rounds. It was highlighted that the merger would benefit the visibility of the MK Hospital Charity but would not generate substantial financial gains if the two were to merge, as the shop's profitability had diminished. Income revenue would however be more stable.
Re-banding of Fundraising Role	The committee **approved** the request in principle to progress the Fundraising role	Approval was sought to progress the Fundraising role from band 5 to band 6, highlighting that the member of the team had absorbed many of the responsibilities since the removal of the fixed term contract post. It was also highlighted that the fundraiser had been successful in the transformation of corporate giving into the charity. An uplift was expected to improve staff retention and enable continuity within the team.
Risks Highlighted During the Meeting for Consideration to CRR/BAF	Discussed	Diminishing restricted funds dropping below the policy minimum of 50k

2. Assurance

The Chair and Non-Executive Directors were assured that:

- As noted in comments

3. Areas for escalation to the Board for further discussion or decision from the agenda item
The following were escalated from the committee to the Trust Board: • Diminishing restricted funds dropping below the policy minimum of 50k

Recommendation
• The Board are invited to NOTE the report.

TheMKWay

NHS
Milton Keynes University Hospital
NHS Foundation Trust

Meeting Title	**TRUST BOARD (PUBLIC)**	**Date: 3 July 2025**
Report Title	Finance & Investment Committee Assurance Report	**Agenda Item Number: 20**
Committee Chair	**Gary Marven,** Non- Executive Director & Chair of the Committee	
Report Author	**Timi Achom**, Assistant Trust Secretary	

Introduction	The purpose of the report is to provide an update to the Trust Board on the activities of the Finance & Investment Committee since 1 May Board held in public. The committee had met on one occasion: on **27 May 2025**		
Key Messages to Note	The Trust Board is invited to NOTE the report		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Assurance** X

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	1. *Spending money well on the care you receive* 2. *Employ the best people to care for you* 3. *Expanding and improving your environment* 4. *Innovating and investing in the future of your hospital*

1. Committee Discussions and Decisions

The Committee had met on one occasion since the last update to the Board on 1 May 2025: 27 May 2025

The following decisions were made at the meeting held on **27 May 2025**

Agenda Item	Decision Made	Comments
Financial Performance	The committee **noted** the report	The Trust reported a £1.6m deficit on a Control Total basis at the end of April, which was £0.5m adverse to plan. The variance was driven by lower-than-expected clinical income, higher non-pay costs, and under-delivery of the Cost Improvement Programme (CIP). Elective Recovery Fund (ERF) activity was at 132% of pre-Covid baseline levels, generating £1.1m in ERF income.
Efficiency Report	The committee **noted** the report	£14m in budgeted efficiencies and £6.3m in reductions to bank and agency spend totalling £20.2m had been identified, leaving a gap of £3.6m.
Capital Report	The committee noted the proposed capital plan for 2025/26	The total proposed capital plan for 2025/26, including donations and grants of £11.6m, was £69.1m. The Trust proposed Capital Departmental Expenditure Limit (CDEL) was £57.5m due to the exclusion of donations.

Cash	The committee **noted** the cash management requirements for 2025/26	The April Closing Balance was £16.5 million, which was £1.5m below plan. The expected closing cash position was £13m, assuming full delivery of savings and a 2.8% pay award from September.
Integrated Performance Report	The committee **noted** the report	The Trust achieved a position of 48.3% for the end of May 2025 relating to the 18-week target. The percentage of patients over 52-weeks on the Patient Treatment List (PTL) stood at 5.9%. The percentage of first outpatient appointments delivered in under 18-weeks was recorded at 49.7%.
Green Plan	The committee **supported** the escalation of the BLMK ICS Green Plan and MKUH Green Plan initiatives to the Trust Board for approval	The local Green Plan mirrored the system plan, developed in partnership with the wider system. The focus remained on delivering net zero for type one and two emissions earlier than the national requirements, targeting 2030.
Board Assurance Framework Capital Risk Change	The committee **noted** the changes to the Board Assurance Framework Capital Risks	The risk score for insufficient capital funding was reduced from a rating of 20 to a current risk rating of 15
NHP Update	The committee **supported** the recommendation to Trust Board to continue with the current delivery plans without a Memorandum of Understanding for Q1 funding of £1.2m, to the end of August	The procurement had commenced for the retender of the design team. Formal approval and the MOU associated with Q1 programme fees were awaited

2. Assurance

The Chair and Non-Executive Directors were assured that:

- As noted in comments

3. Areas for escalation to the Board for further discussion or decision from the agenda item

The following items have been recommended to be escalated to the Trust Board for further discussions and approvals:

- BLMK ICS Green Plan for approval
- NHP Design Work at a cost of £1.2m to the end of August for approval

5. Recommendation

The Board are invited to note the Finance and Investment Committee Assurance report.

TheMKWay

NHS
Milton Keynes University Hospital
NHS Foundation Trust

Meeting Title	**TRUST BOARD (PUBLIC)**	**Date: 3 July 2025**
Report Title	Quality and Clinical Risk Committee	**Agenda Item Number: 20**
Committee Chair	**Prof. Ganesh Baliah**, Non- Executive Director	
Report Author	**Timi Achom**, Assistant Trust Secretary	

Introduction	The purpose of the report is to provide an update to the Trust Board on the activities of the Quality and Clinical Risk Committee since the Trust Board held in public on 1 May 2025. The committee had met on one occasion since the last update to the Board: **2 June 2025**		
Key Messages to Note	The Trust Board is invited to NOTE the report.		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Assurance** x

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	1. *Keeping you safe in our hospital* 2. *Improving your experience of care* 3. *Ensuring you get the most effective treatment* 4. *Giving you access to timely care* 5. *Employ the best people to care for you* 6. *Expanding and improving your environment* 7. *Innovating and investing in the future of your hospital*

1. Committee Discussion and Decision

The committee had met on 2 June 2025

The following decisions were made at the Quality and Clinical Risk Committee held on **2 June 2025**

The meeting was quorate and chaired by Prof. Ganesh Baliah - NED

Agenda Item	Decision Made	Comments
Patient Safety	The committee **noted** the report and medication safety case study for ICU.	Discussions focused on patient safety incident reporting, quality improvement projects, and medication safety in the ICU. The PSIRF update and a medication safety case study were noted.
Integrated Quality Governance Report	The committee **noted** the report.	The report provided updates on quality improvement activities, inquests, claims, complaints, and PALS.

Clinical Quality Risks on the Board Assurance Framework	The committee **noted** the report.	Nine risks were listed against the Trust's strategic objectives. The committee discussed the implications of these risks and the measures in place to mitigate them.
Board Assurance Framework Review and Discussion	The committee **noted** the report.	Discussion centered on existing risks and the need for a dynamic and responsive Board Assurance Framework (BAF) to address emerging challenges.
Quarterly Mortality Update	The committee **noted** the report.	Update included metrics such as SHMI and HSMR, and efforts to improve the mortality review process. The committee acknowledged the importance of these metrics in monitoring and improving patient outcomes.
Quarterly Highlight Report from the Chief Medical Officer and Chief Nursing Officer	The committee **noted** the report.	The report covered updates on coronial cases, the ophthalmology department move, mental health patient care, and corporate nursing team priorities. The committee appreciated the detailed insights provided.
Quality Dashboard	The committee **noted** the report.	The dashboard provided updates on formal complaint response times, patient discharge processes, and the movement of patients over 75 years old. The committee noted the importance of these metrics in ensuring quality care.
Safeguarding Update	The committee **noted** the report.	The update included changes in the safeguarding team, results from a dementia care audit, and improvements in discharge planning. The committee supported the initiative to include safeguarding training in Trust Inductions.
Summary Highlight Report & Minutes of the Complaints & PALS	The committee **noted** the report.	The report provided updates on formal and informal complaints, learning from complaints, and trends. The committee discussed the importance of addressing these complaints to improve patient experience.
Annual Complaints Report	The committee **noted** the report.	The report included updates on formal complaints, PALS efficiency, and the restructuring of the complaints process. The committee acknowledged the efforts to streamline the complaints process.
Annual Patient Experience Report	The committee **noted** the report.	The report highlighted positive work by various teams to engage with the community and improve patient experience.
CNST Declaration Update	The committee **noted** the report.	The update covered actions related to the maternity incentive scheme and the impact of the removal of ring-

		fenced funding. The committee discussed the implications of these changes.
Antimicrobial Stewardship – Annual Report	The committee **noted** the report.	The report provided updates on antibiotic use, stewardship activities, and governance challenges. The committee emphasized the importance of antimicrobial stewardship in ensuring patient safety.
Quality Accounts 2024/25	Approved	Approved the escalation of the draft Quality Accounts to the Trust Board.
Committee Evaluation Report	The committee **noted** the report.	The report included feedback on committee performance and areas for improvement. The committee discussed ways to enhance their effectiveness.

2. Assurance

The Chair and Non-Executive Directors were assured that:

- As noted in comments

3. Areas for escalation to the Board for further discussion or decision from the agenda items

- Draft Quality Accounts 2024/25

4. Recommendation

- The Board are invited to NOTE the report.

Milton Keynes University Hospital NHS Foundation Trust

TRUST BOARD MEETING IN PUBLIC

Forward Plan 2025-26

	Agenda Item	Lead	Purpose	Frequency Paper(P)/Verbal (V)	Seminar 03/04/2025	Formal 01/05/2025	Seminar 05/06/2025	Formal 03/07/2025	Formal 04/09/2025	Seminar 02/10/2025	Formal 06/11/2025	Seminar 04/12/2025	Formal 08/01/2025	Seminar 05/02/2026	Formal 05/03/2026
1	Apologies	Chair	Receive	Standing Item (V)		■		■	■		■		■		■
2	Meeting Quorate	Chair	Note	Standing Item (V)		■		■	■		■		■		■
3	Declaration of Interests	Chair	Note	Standing Item (V)		■		■	■		■		■		■
4	Minutes of the previous meeting	Chair	Approve	Standing Item (P)		■		■	■		■		■		■
5	Action Tracker	Chair	Note	Standing Item (P)		■		■	■		■		■		■
6	Chair's Report	Chair	Information	Standing Item (V)		■		■	■		■		■		■
7	Chief Executive's Report	Chief Executive	Assurance Discuss	Standing Item (V)		■		■	■		■		■		■
8	Patient Story/Staff Story	Chief Nursing Officer	Assurance Discuss	Standing Item (P)		■		■	■		■		■		■
9	Nursing Workforce Update	Chief Nursing Officer	Assurance Discuss	Standing Item (P)		■		■	■		■		■		■
10	Performance Report	Chief Operating Officer	Assurance Discuss	Standing Item (P)		■		■	■		■		■		■
11	Finance Report	Chief Finance Officer	Assurance Discuss	Standing Item (P)		■		■	■		■		■		■
12	Workforce Report (-IPR?)	Chief People Officer	Assurance Discuss	Standing Item (P)		■		■	■		■		■		■
13	Patient Safety Update (-IPR)	Officer/Chief Corporate Services Officer	Assurance Discuss	Standing Item (P)		■		■	■		■		■		■
14	Objectives Update	Chief Executive	Assurance Discuss	(P)									■		
15	Equality, Diversity & inclusion (ED&I) Update	Chief People Officer	Assurance Discuss	(P)					■						
16	and Board Assurance Framework Sign Off	Chief Nursing Officer	Assurance Discuss	(P)									■		
17	Progress update – 2025/26 Quality Priorities	Chief Corporate Services Officer	Assurance Discuss	(P)									■		
18	Declaration of Interests Report	Chief Corporate Services Officer	Assurance Receive and Discuss	Annually (P)		■									
19	Maternity Patient Survey 2024 interim report	Chief Nursing Officer	Assurance Discuss	(P)		■									
20	Annual Claims Report	Chief Medical Officer	Assurance Discuss	Annually (P)		■									
21	Falls Annual Report	Chief Nursing Officer	Assurance Discuss	Annually (P)		■									
22	Freedom to Speak Up Guardian Report	Chief People Officer	Assurance Discuss	(P)				■					■		
23	Pressure Ulcers Annual Report	Chief Nursing Officer	Assurance Discuss	Annually (P)				■							

24	Green Plan Update	Chief Finance Officer	Assurance Discuss	(P)											
25	Green Plan Update (C/F from July 2025)	Chief Finance Officer	Assurance Discuss	(P)											
27	Mortality Update	Chief Medical Officer	Assurance Discuss	(P)											
28	Safeguarding Annual Report	Chief Nursing Officer	Assurance Discuss	Annually (P)											
29	Research & Development Annual Report	Chief Medical Officer	Assurance Note	Annually (P)											
30	Emergency Preparedness, Resilience and Response Annual Report	Chief Operating Officer	Assurance Note	(P)											
31	Annual Complaints Report	Chief Corporate Services Officer	Assurance Discuss	Annually (P)											
32	Annual Patient Experience Report	Chief Corporate Services Officer	Assurance Discuss	Annually (P)											
33	Patient Safety Incident Response Framework, PSIRF – Policy and Plan	Chief Medical Officer	Assurance Discuss	(P)											
34	Antimicrobial Stewardship - Annual Report	Chief Medical Officer	Assurance Discuss	Annually (P)											
35	Infection Prevention and Control Annual Report	Chief Nursing Officer	Assurance Discuss	(P)											
36	Patient Experience Report	Chief Corporate Services Officer	Assurance Discuss	Standing Item (P)											
37	Maternity Assurance Group Update	Chief Nursing Officer	Assurance Discuss	Standing Item (P)											
38	Summary Reports from Board Committees	Chairs of Board Committees	Assurance Information	Standing Item (P)											
39	Update to the Terms of Reference of the Board and its Committees	Chief Corporate Services Officer	Assurance Approve	Annually (P)											
40	Significant Risk Register Report	Chief Corporate Services Officer	Assurance Discuss	Quarterly											
41	Board Assurance Framework	Chief Corporate Services Officer	Assurance Discuss	Standing Item (P)											
42	Trust Seal	Chief Corporate Services Officer	As required	(P)											
43	Forward Agenda Planner	Chair	Administration and Closing Information	Standing Item (P)											
44	Questions from Members of the Public	Chair	Administration and Closing Receive and Respond	Standing Item (V)											
45	Motion To Close The Meeting	Chair	Administration and Closing Receive	Standing Item (V)											
46	Resolution to Exclude the Press and Public	Chair	Administration and Closing Approve	Standing Item (V)											
	SEMINAR SCHEDULE														
	Annual Risk Seminar	Chief Corporate Services	Risk Management												
	Board Assurance Framework (BAF) Review	Chief Corporate Services	Assurance												
	Collaborative partnership/s—with whom and for what services. Future plans	Chief Executive	Assurance												
	The Trust role around, and contribution to, population health management/Place	Chief Executive	Assurance												
	Annual Objectives Review	Chief Executive	Assurance												
	Annual Strategy Review	Chief Executive	Assurance												
	Strategic links with community groups/organisations/ businesses	Chief Executive	Assurance												

	Board Informal meeting & Dinner	All	Informal												
	The Trust's representations on the BLMK ICB and ICP, and the implications thereof	Chief Executive	Assurance												