Bundle Trust Board Meeting in Public 3 March 2022

0 10:00 - Agenda
Chair
1. Agenda Board Meeting in Public - 03.03.22 v 2.docx

1 10:05 - Apologies
Chair

2 10:05 - Declarations of Interest
Chair

3 10:05 - Previous Minutes of the Meeting
Chair
3. Minutes Trust Board Meeting in Public 13.01.22 AD Approved.docx

4 10:05 - Matters Arising
Chair
4. Board Action Log 13.01.22.pdf

5 10:05 - Chair's Report
Chair
5. Chair's Report.docx

6 10:10 - Chief Executive's Report
Chief Executive - Verbal

7 10:20 - Patient Story
Director of Patient Care and Chief Nurse - Presentation To Follow

8 10:30 - Serious Incident and Learning Report
Director of Corporate Affairs/ Medical Director
8. Serious Incident and Learning Report for Trust Board March 2022.doc

9 10:35 - Ockendon Assurance Report
Director of Patient Care and Chief Nurse
9. Ockenden Immediate and Essential Safety Actions Public Board Update March 2022.docx
9.1 Ockenden Assessment and Assurance Tool Public Board Report March 2022.docx

10 10:40 - Morecambe Bay Assessment Report
Director of Patient Care and Chief Nurse
10. Morecambe Bay Trust Level Recommendation Review Public Board March 2022.docx

11 10:45 - Maternity Self-Assessment
Director of Patient Care and Chief Nurse
11. Maternity Self Assessment Tool Action Plan Private and Public Board March 2022.docx
11.1 Maternity Self Assessment Tool Private and Public Board March 2022.docx

12 10:55 - Patient Experience Report - Maternity Unit
Director of Patient Care and Chief Nurse
12. Maternity Patient Experience Paper Public Board March 2022.docx
12.1 Maternity Patient Experience Live Action Plan - Public Board March 2022.pdf

13 11:05 - Nursing Staff Update
Director of Patient Care and Chief Nurse
13. Nursing Staffing Report March 2022 V1.docx

14 11:10 - Maternity Staffing Overview Report
Director of Patient Care and Chief Nurse
14. Maternity Staffing Overview Public Board Report March 2022.docx
14.1 Maternity Staffing Overview Appendix 1 Risk Reduction Action Plan Supernumerary Status.docx
14.2 Maternity Staffing Overview Appendix 2 Risk Reduction Action Plan Care in Established Labour.docx

15 11:15 - Workforce Report

Director of Workforce

15. Trust Board Workforce Report M10 202122.docx

16 11:25 - Equality, Diversity and Inclusion Progress Update

Director of Workforce

16. EDI Progress Update Feb22.pptx

16.1 11:55 - Break

17 12:05 - Performance Report

Director of Operations

17. 2021-22 Executive Summary M10 Coversheet.docx

17.1 2021-22 Executive Summary M10.docx

17.2 2021-22 Board Scorecard M10.pdf

18 12:10 - Finance Report

Director of Finance

18. Finance Report M10 Public Board v 1.pdf

19 12:15 - Significant Risk Register

Director of Corporate Affairs

19. Risk Report February 2022.docx

19.1 Significant Risk Register - as at 24th February 2022.pdf

20 12:20 - Board Assurance Framework

Director of Corporate Affairs

20. Board Assurance Framework March 2022.docx

21 12:25 - Summary Reports

Chair

21.1 FIC Summary Report 11 January 2022.docx

21.2 FIC Summary Report 01 February 2022.docx

21.3 Charitable Funds Committee Summary Report - January 2022 Meeting.docx

21.4 WDAC Summary Report -27 January 2022 Meeting.docx

21.5 TEC Summary Report 12 January 2022.docx

21.6 TEC Summary Report 09 February 2022.docx

22 12:30 - Use of Trust Seal

Director of Corporate Affairs

22. Use of Trust Seal Mar 2022.docx

23 12:30 - Forward Agenda Planner

Chair

23. Trust Board Meeting In Public Forward Agenda Planner v 2.docx

24 12:30 - Questions from Members of the Public

Chair

25 12:30 - Motions To Close The Meeting

Chair

26 12:30 - 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."

27 12:30 - Date of Next Meeting

Next Meeting in Public: Thursday, 05 May 2022

Agenda for the Board of Directors' Meeting in Public

Meeting to be held at 10.00 am on Thursday 03 March 2022
in the Conference Room at the Academic Centre

Item No.	Timing	Title	Purpose	Lead	Paper
Introduction and Administration					
1	10.00	Apologies	Receive	Chair	Verbal
2		Declarations of Interest • Any new interests to declare • Any interests to declare in relation to open items on the agenda	Information	Chair	Verbal
3		Minutes of the Trust Board meeting in held in public on 13 January 2022	Approve	Chair	Attached
4		Matters Arising	Note	Chair	Attached
Chair and Chief Executive Updates					
5	10.05	Chair's Report	Information	Chair	Attached
6	10.10	Chief Executive's Report - Overview of Activity and Developments	Receive and Discuss	Chief Executive	Verbal
Effectiveness of Care					
7	10.20	Patient Story – Meaningful Activities	Receive and Discuss	Director of Patient Care and Chief Nurse	Presentation (To Follow)
Patient Safety					
8	10.30	Serious Incident and Learning Report	Receive and Discuss	Director of Corporate Affairs/ Medical Director	Attached
9	10.35	Ockenden Assurance Report	Receive and Discuss	Director of Patient Care and Chief Nurse	Attached
10	10.40	Morecambe Bay Assessment Report	Receive and Discuss	Director of Patient Care and Chief Nurse	Attached

Item No.	Timing	Title	Purpose	Lead	Paper
11	10.45	Maternity Self-Assessment	Receive and Discuss	Director of Patient Care and Chief Nurse	Attached
Patient Experience					
12	10.55	Patient Experience Report – Maternity Unit	Receive and Discuss	Director of Patient Care and Chief Nurse	Attached
Workforce					
13	11.05	Nursing Staff Update	Receive and Discuss	Director of Patient Care and Chief Nurse	Attached
14	11.10	Maternity Staffing Overview Report	Receive and Discuss	Director of Patient Care and Chief Nurse	Attached
15	11.15	Workforce Report Month 10	Receive and Discuss	Director of Workforce	Attached
16	11.20	Equality, Diversity and Inclusion Progress Update	Receive and Discuss	Director of Workforce	Attached
Break – 11.50					
Performance and Finance					
17	12.00	Performance Report Month 10	Receive and Discuss	Chief Operations Officer	Attached
18	12.05	Finance Report Month 10	Receive and Discuss	Director of Finance	Attached
Assurance and Statutory Items					
19	12.10	Significant Risk Register	Receive and Discuss	Director of Corporate Affairs	Attached
20	12.15	Board Assurance Framework	Receive and Discuss	Director of Corporate Affairs	Attached
21	12.20	(Summary Reports) Board Committees • Finance & Investment Committee 11/01/2022 and 01/02/2022 • Charitable Funds Committee 27/01/22	Assurance and Information	Chairs of Board Committees	Attached

Item No.	Timing	Title	Purpose	Lead	Paper
		• Workforce and Development Assurance Committee 20/01/2022 • Trust Executive Committee 12/01/2022 and 09/02/2022			
22		Use of Trust Seal	Noting	Director of Corporate Affairs	Attached
Administration and Closing					
23	12.25	Forward Agenda Planner	Information	Chair	Attached
24		Questions from Members of the Public	Receive and Respond	Chair	Verbal
25		Motion To Close The Meeting	Receive	Chair	Verbal
26		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, 05 May 2022					

Milton Keynes University Hospital NHS Foundation Trust

BOARD OF DIRECTORS MEETING

Minutes of the Trust Board of Directors Meeting in Public held on Thursday, 13 January 2022 at 10.00 hours via Teams

Present:		
Alison Davis	Chair	(AD)
Professor Joe Harrison	Chief Executive	(JH)
Andrew Blakeman	Senior Independent Director/Non-Executive Director	(AB)
Heidi Travis	Non-Executive Director	(HT)
Dr Luke James	Non-Executive Director	(LJ)
Haider Husain	Non-Executive Director	(HH)
John Blakesley	Deputy Chief Executive	(JB)
Dr Ian Reckless	Medical Director & Deputy Chief Executive	(IR)
Terry Whittle	Director of Finance	(TW)
Danielle Petch	Director of Workforce	(DP)
Nicky Burns-Muir	Director of Patient Care and Chief Nurse	(NBM)
Emma Livesley	Director of Operations	(EL)

In Attendance:		
Kate Jarman	Director of Corporate Affairs	(KJ)
Jackie Collier	Director of Transformation & Partnerships	(JC)
Alice Fiancet	Communications Specialist	(AF)
Kwame Mensa-Bonsu	Trust Secretary	(KMB)
Julia Price	Senior Corporate Governance Officer (Minutes)	(JP)

1 Welcome and Apologies

1.1 AD welcomed all present to the meeting. She advised that the hospital's non-urgent meetings had been cancelled to enable executive colleagues to focus on operational matters and that this would therefore be a focused meeting.

There were apologies from Nicky McLeod (Non-Executive Director), Helen Smart (Non-Executive Director) and Professor James Tooley (Non-Executive Director).

2 Declarations of interest

2.1 There were no declarations of interest.

3 Minutes of the Trust Board Meeting in Public held on 4 November 2021 and Matters Arising

3.1 The minutes of the Trust Board Seminar held on 4 November 2021 were reviewed and **approved** by the Board with one amendment regarding the attendance of TW which he would discuss outside the meeting with KMB.

3.2 Regarding the action under Item 8.5 in respect of the Trust's compliance with the Human Tissue Authority's regulatory guidance on Mortuaries, KJ advised that the Trust's detailed operational return would be reported through the Quality and Clinical Risk Committee who would confirm assurance that the standards were being met.

4 Chair's Report

4.1 AD presented a written report which included the following highlights.

a) The appointment of Babs Lisgarten to the role of Lead Governor for the Trust.

b) AD had held introductory meetings with the new Governors appointed in November 2021.

c) Having met with the Mayor of Milton Keynes in December, Councillor Mohammed Kahn, AD passed on his thanks to all staff for the incredible work they were doing, especially during the height of the pandemic.

d) AD was forging links with the MK Business Leaders Partnership, continuing the involvement by the previous Chair, Simon Lloyd.

e) During Interfaith Week in November, AD had attended a meeting at the Hospital Chaplaincy with representatives from schools whose pupils had provided reflections on what faith meant to them. Interestingly, one of the key themes was kindness, which was also a theme in the cultural development work by staff at MKUH.

f) AD chaired an interview panel for the successful appointment of consultants for Cellular Pathology and was also involved in the recruitment process for the appointment of the Non- Executive Directors to the Integrated Care Board (ICB). The ICB would not become substantive under legislation until July 2022 as the original date of April 2022 had been delayed due to the continuing pressures of, and focus on, the pandemic.

g) AD had spoken with several prospective candidates for the two Non-Executive Director posts at MKUH due to become vacant between February and March 2022.

h) The national Race Equality Code was launched on 01 December 2021, which provided a framework to enable organisations to address inequity at senior levels. Details could be found at theracecode.org

4.2 AD advised that she had met with the Governors to review the Hospital Constitution, which would shortly be circulated to the relevant committees.

4.3 The Inclusion Leadership Council (ILC) had held a very focused meeting earlier in the week and AD highlighted the importance of moving forward with that agenda.

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

5 Chief Executive's Report

5.1 JH invited IR to provide an update on the current COVID situation. IR gave a presentation and reported that at the present time, there were 74 patients in the hospital with a recent positive COVID swab and who were widely distributed across the hospital. Patients with a positive swab within the last 14 days were predominantly congregated appropriately in Ward 22, Ward 8, ICU and Ward 2. IR explained that there were good reasons for those not in these areas to be managed elsewhere in the hospital and he confirmed that enhanced infection prevention and control measures were in place. IR advised that these numbers were around 2-3 times higher than three weeks prior but that numbers appeared to be stabilising. He added that the majority of deaths from COVID were incidental rather than the cause of death, and while any death was difficult and challenging for families, the number of deaths was relatively modest in the current fourth wave.

5.2 The number of nosocomial infections, that is, infections contracted in hospital, was less pronounced now than in previous waves where outbreaks had involved up to eight patients. Cases were now involving one or two patients and could generally be traced back to a patient admitted with a negative swab but who would then have a positive swab a few days later.

5.3 IR explained that the case mix in the fourth wave was very different with relatively few deaths and few ICU admissions, and with COVID an incidental finding in a high proportion of patients. The main

concerns for the hospital related to high emergency admissions over winter, high levels of staff absence in the hospital due directly or indirectly to COVID and staff absence in the community where many facilities were closed to new admissions. This meant that more patients were residing in hospital instead of in the community where their care needs could be better met.

5.4 All of the various scenarios described by the NHS for planning purposes were showing demand for beds outstripping capacity. To date, the hospital was tracking below all the trajectories set out in the scenarios but given the very high numbers in the community and the 10-14 day lag in terms of hospitalisation, IR advised that it was too early for any complacency.

5.5 In response to a query from LJ, IR reported that while the anticipated pressures on paediatrics, raised as a concern last summer, were not as bad as had been planned for, there were concerns over the return to school.

5.7 JH invited JB to provide an update on progress with the New Hospital Programme. JB reminded the Board that a year ago the strategic case for the new women and children's hospital and surgical facilities was completed and submitted formally in February 2021. Permission to continue with the projects was delayed due to restructuring of the national programme team. JB was pleased to report that the Trust had now been asked to move to the next stage which was to prepare an outline business case. Sufficient money had been provided for 2021-22 and there was a commitment to secure funding for 2022-23 as well as funding for an internal team and preparation of the bid which would be completed by the end of March 2023. JH commented that this was very good news for the women and children's hospital and the elective capacity that was so clearly required to meet capacity demands in line with the growth of Milton Keynes.

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

6 Patient Story

6.1 In view of the pressures within the hospital, the patient story was postponed to the next Board Meeting in Public in March.

7 **Incident Learning and Quality Improvement Report**

7.1 KJ explained that the paper described the summary of incidents from the last reporting period, and that investigations into nosocomial deaths continued to involve families. IR reminded the Board that the numbers of patients with definite or probable nosocomial COVID who subsequently died were presented to Board in July 2021. Of those patients, some had died of COVID and some had died with COVID incidentally. There had been 92 patients with nosocomial COVID of whom 31 had sadly died. By the end of November, a further three patients with hospital acquired COVID and two patients with probable nosocomial COVID had also died. Clearly the death of any patient who acquires an infection in the organisation was a matter of huge regret and as previously discussed, infection prevention and control measures remained in place. The Trust continued to advocate staff vaccination and regular staff testing. Both of these areas were under continual review.

7.2 KJ highlighted the trends within the report, one of which related to deep tissue injuries (pressure ulcers and sores). A lot of work was taking place led by the Chief Nurse for Medicine, around understanding any themes, trends and commonalities across different wards, with re-audits taking place to identify any further preventative measures that should be implemented. Additionally, with regard to medication incidents, prescribing of the antibiotic, Gentamicin, within Maternity had been reviewed following a cluster of incidents some time ago. A re-audit had been undertaken of the learning and action plans to review what had worked well and which areas required further work. The results were recently presented to the Serious Incident Review Group.

7.3 As previously reported to the Board, the organisation's incident and risk reporting system had moved from Datix to Radar, in addition to which, the Trust had become the first in the country to adopt the new NHS England Learning From Patient Safety Events form, which would ultimately be rolled out to all

Trusts. The form was being piloted on behalf of NHS England and the organisation was able to ensure it was as helpful as possible both for NHS England and for staff completing it. The most difficult phase was being experienced involving both the roll out of the new system and the new form requiring changes to working practices. Training was ongoing and teething issues were being addressed, to ensure as smooth a transition as possible.

7.4 There had been a deliberate pause to quality improvement works over the winter period due to organisational capacity. Recruitment to two new roles was taking place for a head of quality improvement and a quality improvement manager. The remainder of the paper described the approach to quality improvement training with the development for staff over the coming year to embed quality improvement work within the organisation. A proposal would be presented to Quality & Clinical Risk Committee in due course.

7.5 KJ clarified that the report was for noting and not for approval as indicated on the front sheet.

Action: KMB to arrange a meeting for a more detailed discussion on monitoring and tracking pressure injuries with interested Non-Executive Directors.

7.6 AD thanked KJ for the report, particularly for the helpful explanation of acronyms. She looked forward to the feedback from the planned quality improvement work.

The Board **noted** the Incident Learning and Quality Improvement Report.

8 Nursing Staff Update

8.1 NBM highlighted the following items from the report.

a) The challenges in recruiting Band 5 and 6 nurses over the last few months which, following the commencement of the international recruitment campaign in January, would be mitigated by the first 16 nurses arriving at the end of the month.

b) Several new employees formed part of the cohort of 18 training associates working in Theatres and Paediatrics.

c) Around 18 months ago, the Trust committed to ensuring all student nurses from Northampton University would be offered posts and discussions would be held in March and April with students due to qualify.

d) Following an external review, it was clear that standardisation in the use of the Safer Nursing Care tool amongst ward staff was necessary.

e) Agency usage had increased over the last month as a result of the staffing challenges where nursing teams had been unable to take annual leave over the Christmas period unless specifically requested. Many senior staff and those in advanced practice roles had supported the organisation as needed and delivery of safe care across the organisation was monitored daily. However, the situation was very challenging.

f) Alongside many other professional groups, the Trust supported the very quick turnaround to support the vaccinator programme and assisted in competency assessing and signing off 60 people in a short space of time as competent vaccinators.

g) In January, the BAME Chief Nurse Fellows commenced on the programme and would be undertaking a number of Trust-wide improvement projects.

h) The new Deputy Chief Nurse, Andrea Piggott, took up her role in December having previously worked at BLMK CCG. It was anticipated that she would bring a different lens to the organisation and would support the development of the BLMK partnership across the system.

8.2 Commenting on the extraordinary colleague support within the organisation, AD thanked everyone for their hard work.

The Board **noted** the Nursing Staff Update

9 Workforce Report Month 08

9.1 DP highlighted key points from the report as follows.

a) Staffing had been adversely affected by COVID sickness and isolation and on one day, 350 people had been absent. This had since reduced to 250 members of staff. COVID support measures such as the COVID helpline had been reinstated and onsite testing had also recommenced.

b) Statutory training and appraisal compliance remained within target.

c) The staff survey return rate had reduced to 42% but was higher than the comparator figure supplied by the survey provider. DP explained that the NHS predominantly used two survey providers, and the data from both would be collated nationally later in the year which would then be shared with the Board.

d) The Inclusion Leadership Council, made up of representatives from the networks, had met and were working on shared projects, developing good inter-relationships and providing feedback to Executives.

e) The Trust provided support in establishing the local vaccine centre where some staff took the opportunity to have their first jab.

f) Under the new condition of employment law coming into force on 1 April 2022, people wishing to work in healthcare would need to be vaccinated with two approved vaccines. National guidance was imminent, and DP advised that the HR department were working hard to establish the vaccine status of all staff. Discussions were ongoing with those yet to come forward for their first vaccination.

The Board **noted** the Month 08 Workforce report.

10 Performance Report Month 08

10.1 EL advised that the report reflected the position in November 2021 which was no longer current. She took the opportunity to provide more detail on the work being done around discharging patients from the hospital. At the beginning of January, a national letter was received requesting that the number of non-criteria to reside patients was reduced by 50% by the end of January compared to a baseline taken from 13 December 2021. EL explained that non-criteria to reside patients were those patients previously described as medically safe for discharge who did not require an acute bed and who could be more appropriately treated elsewhere. The criteria to reside was comprised of four main categories:

- The physiology of a patient
- A patient having medical therapy
- Recovery
- Function.

EL advised that on 13 December 2021, the local healthcare system was working really well and there were 69 inpatients with no criteria to reside, meaning a reduction of 35 patients would be required by the end of January. Regrettably since then, due to increasing numbers of COVID patients and staff absence the number had increased to 90 at the present time, 10% of whom had been in hospital for more than 21 days. The main reasons for that, in line with other areas across the country, were increased infection rates across the community and the closure of several community beds. In addition, interactions for out of area referrals were often complex. EL explained that the biggest challenge was

access to recuperation and care home beds. Across Milton Keynes, 22 care homes were currently closed with very limited ability to source others outside the community given the pressures across the country. Meetings with system partners were being held up to three times a day, working through issues and sourcing appropriate locations for the 90 patients to be discharged to. An update on the position would be provided at the next Board meeting.

10.2 AD thanked EL for the sobering report and wished her and system partners success in overcoming the challenges.

The Board **noted** the Month 08 Performance Report.

11 Finance Paper Month 08

11.1 TW advised that the report covered the period from April to November 2021, highlighting the following key points:

a) The Trust had reported a cumulative deficit of £1.1m for the eight-month period and continued to forecast that position to the end of the financial year. The position was also replicated across the Bedford, Luton and Milton Keynes Integrated Care System (BLMK ICS) with £158k surplus reported across the system. An in-depth exercise with regional colleagues for Quarter 3 would be taking place for the Month 09 report.

b) From a cash perspective, the organisation was well placed with £62m.

c) The capital forecast up to year end was showing a breach of the capital limit of around £7m and the Trust continued to work closely with regional and system partners to manage that position during the final quarter of the year.

11.2 AD thanked TW for the report and advised that the position had been fully discussed at the Finance and Investment Committee earlier in the week.

The Board **noted** the Month 08 Finance report.

12 Hospital Charity Accounts 2020/21

12.1 TW advised that the accounts were being presented for noting and had been reviewed in depth at the Charitable Funds Committee, chaired by HH who, together with an independent examiner, had signed them off. In summary, the Hospital Charity received £680k through a mixture of grants and donations while expenditure equated to £540k. There was a balance of around £460k at the end of the year, £300k of which was in RBS investment portfolio and around £176k was being held as cash.

The Board **noted** the Hospital Charity Accounts 2020/21.

13 Antimicrobial Stewardship Annual Report 2020/21

13.1 IR expressed his pride in the report which had previously been presented at Quality & Clinical Risk Committee. In response to a query from AD over whether the use of the WHO access category medicines was mandated, IR explained that it was recommended.

The Board **noted** the Antimicrobial Stewardship Annual Report for 2020/21

14 Enhancing Board Oversight: A New Approach to Non-Executive Director Champion Roles

14.1 KJ reported that NHS England had provided a helpful guide with a view to consolidating the non-executive champion roles in the face of a growing list of required and encouraged roles. The new guidance set out how to distribute the roles and how to absorb them into committee work. The paper presented made recommendations on how this could be achieved, requiring changes to some reporting

lines. For example, Health and Safety Committee which currently reported to the Audit Committee would report to the Quality & Clinical Risk Committee. It also made recommendations on the regulatory or statutory roles such as the maternity, wellbeing, Freedom To Speak Up, doctors' disciplinary champions and security management. KJ advised that AD was in the process of discussing those roles with Non-Executive Directors. KJ was confident that there was a good spread of the roles which would be covered within the Committees' Terms of Reference.

14.2 Thanking KJ for the paper, AD commented that there had been concern over overlaps with the non-executives' assurance role and other commitments within the hospital.

14.3 HH added his thanks to KJ for providing clarity on how Non-Executive Directors could successfully fulfil their role. However, he queried the security management role which was not referenced in the paper and KJ responded that there were some clear responsibilities within the statutory health and safety framework around security management at board level and that it was taking some time to review these but that they would be shared with the Board in due course.

The Board **approved** the actions for implementation of the approach to Non-Executive Director Champion Roles

15 Declarations of Interest Report

15.1 KJ reported that significant work had been undertaken to improve compliance with declarations of interest as part of an audit within the internal audit programme. Other work was also continuing around the declaration of gifts and hospitality to ensure transparency.

The Board **noted** the Declarations of Interest Report

16 Significant Risk Register

16.1 KJ presented the detailed spreadsheet and summary report highlighting the risk movements which had been discussed at the Trust Executive Committee the previous day. She explained that this was a dynamic document, changing on a daily basis, with a heavy burden of highly scored risks at the present time and the Trust was working to reduce the top risk scores through available mitigations and controls. KJ advised that the register was presented for transparency from a Public Board perspective.

16.2 AD commented that the register was a good reflection of the general pressures within the hospital.

The Board **noted** the Significant Risk Register.

17 Board Assurance Framework (BAF)

17.1 KJ advised that there had been no significant changes to the BAF and she reminded the Board that it was a dynamic document, under continuous review by KMB with executives on a monthly basis. The annual internal review of risk and risk management was due imminently and the internal auditors would be focusing particularly on BAF development and how it was presented. This would be factored into the board development plans for the year.

The Board **noted** the BAF Update.

18.1 Summary Report for the Finance and Investment Committee Meeting – 02 November 2021

The Board **noted** the report.

18.2 Summary Report for the Finance and Investment Committee Meeting – 29 November 2021

The Board **noted** the report.

18.3 Summary Report for the Audit Committee – 13 December 2021

The Board **noted** the report.

18.4 Summary Report Quality and Clinical Risk Committee – 13 December 2021

The Board **noted** the report.

19 Use of Trust Seal

The Board **noted** the Use of Trust Seal

20 Forward Agenda Planner

The Board **noted** the Forward Agenda Planner.

21 Questions from Members of the Public

There were no questions from the public.

22 Any Other Business

22.1 As this was her last Public Board, AD extended the Board's thanks to Nicky McLeod for her contributions to the organisation as her term of office was coming to an end. Recruitment for her replacement was in progress.

23 The meeting closed at 10:48.

Updated : 24/02/22

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
1	13-Jan-22	7.5	Incident learning and quality improvement report	A meeting to be scheduled for KJ, NBM and HH and HS to discuss monitoring and tracking of deep tissue injuries	KMB	03-Mar-22	Meeting arranged for 05 March 2022	Open

Chair's report

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

1. The recruitment process for two new Non-Executive Directors has now concluded and preferred candidates identified. Arrangements are under way for a Council of Governors meeting later in March for approval so that we will commence the new financial year with full Board membership.
   I would like to thank everyone involved in the process leading to the interviews and all those who took part in the stakeholder groups on the day—despite the severe weather!
   It is worth noting that there were nearly 40 applicants for the posts and it was heartening to see the strength of feeling for the NHS and MKUH in particular.

2. I took part in a Consultant interview panel in January for an Oncoplastic Breast Surgeon and once again we have been able to appoint an excellent candidate.

3. A visit the Cellular Pathology Department was fascinating and very informative. A service not always in the limelight, the team provide vital support to clinicians in the hospital and to the wider community, including the Coroner. Like so many of our services during the pandemic, they rose to the challenge of a huge increase in demand for their work.

4. I took part in the second round of interviews for Integrated Care System (ICS) Non-Executives in January. Three appointments have been made and the process is under way for the appointment of Executives and other Board members.
   For further information about the ICS the link is BLMK (blmkpartnership.co.uk)
   The White Paper to enable the establishment of Integrated Care Boards and other drivers for integration and collaborative working is going through Parliamentary process and can be viewed through this link Integration and innovation: working together to improve health and social care for all (HTML version) - GOV.UK (www.gov.uk)

5. To find out more about the MKUH sustainability and 'green' measures we have in place, I visited Cawleys in Luton; one of our local partners dealing with waste and resource management. The focus on recycling, repurposing and reducing landfill, working with other businesses to ensure all possible use was made of waste was inspiring.

6. I met with Ian Revell and Ranjit Singh at the MK Community Foundation to learn more about their work. They have supported many organisations by ensuring funding provided by businesses, grants and charities goes to those most in need.
   For more information Milton Keynes Community Foundation | Local charities (mkcommunityfoundation.co.uk)

7. Work continues with Governors identifying ways to engage with members and increase membership. Discussions are also under way to strengthen the relationship between Governors and NEDs.
   It is anticipated that the review of the Trust Constitution will be finalised at the end of February and presented to the Council of Governors in March.

8. Regional meetings I have attended have focused largely on elective recovery; Covid responses and levels of infection; progression of the White Paper to establish ICBs; collaboration between organisations and the creation of formal collaboratives; Equality, Diversity and Inclusion initiatives and commitment of organisations to both staff and communities from diverse backgrounds.

Milton Keynes Hospital NHS
NHS Foundation Trust

Meeting title	Trust Board (public)	3 March 2022
Report title:	**Serious Incident and Learning Report**	Agenda item: 8
Lead director **Report author** **Sponsor(s)**	Dr Ian Reckless Kate Jarman Tina Worth	Medical Director Director of Corporate Affairs Head of Risk & Clinical Governance
FoI status:	Public document	

Report summary	This report provides a monthly overview of Risk Management processes/systems in relation to serious incidents in the Trust.			
Purpose *(tick one box only)*	**Information** ☐	**Approval** X	**To note** ☐	**Decision** ☐
Recommendation	The Group is asked to note the contents of the report			

Strategic objectives links	Refer to main objective and link to others 1. Improve Patient Safety 3. Improve Clinical Effectiveness 4. Deliver Key Targets 7. Become Well-Governed and Financially Viable
Board Assurance Framework links	Lack of learning from incidents is a key risk identified on the BAF
CQC outcome/ regulation links	This report relates to: This report relates to CQC: Regulation 12 – Safe care & treatment Regulation 17 – Good governance Regulation 20 – Duty of Candour
Identified risks and risk management actions	Lack of learning from incidents is a key risk identified on the BAF
Resource implications	Breaches in respect of SI submission can incur a £1000 penalty fine Breaches in respect of the Duty of Candour have potential for penalty fine of £2,500 if taken forward from a legislative.
Legal implications including equality and diversity assessment	Contractual and regulatory reporting requirements.

Report history	Serious Incident Review Group
Next steps	Monthly incident/SI overarching issues reporting
Appendices	Trends in graphical format

Serious Incident Report January and February 2022

There were 10 new Serious Incidents reported in January and February 2022 (up to 24/2/22). These are summarised in the table below.

STEIS number	Category	Location	Details
2022/814	Baby sent for therapeutic cooling	Maternity	This is being investigated by the Healthcare Safety Investigation Branch. The Trust captures immediate learning and action through incident review and debriefs, with ongoing liaison with HSIB throughout the investigation process.
2022/817	Delayed diagnosis	Emergency Department (ED)	Patient had ECG which was signed noting 'poor trace and for repeat ECG'. Not identified that results consistent with ST elevation myocardial infarction (MI). Also repeat ECG requested but not done.
2022/1380	Unplanned admission to the Neonatal Unit (NNU)	Maternity	Baby born at 36 weeks in poor condition and subsequently transferred to a tertiary unit as unable to maintain blood sugar.
2022/1654	Child safeguarding	Children's Emergency Department (PED)	14-year-old girl sent home in a taxi with no confirmation of responsible adult at home.
2022/1937	Pressure ulcer	Ward 17	Deep tissue injury (DTI) to both heels
2022/2528	Treatment delay	Dermatology	Delayed follow up appointment (approximately nine weeks). Patient's condition deteriorated rapidly within that time.
2022/3054	Suboptimal care	Gastrointestinal (GI)	Sudden unexpected death of an inpatient admitted with a flare up of Crohn's Disease. Lost opportunities pre-hospital admission (nutritional) and no face-to-face consultations due to the pandemic.
2022/3056	Pressure ulcer	Ward 8	Deep tissue injury (DTI) to buttocks
2022/3651	Pressure ulcer	Theatres/Trauma and Orthopaedics (T&O)	Deep tissue injury (DTI) under plaster cast applied peri-operatively.
2022/3652	Drug error	Pharmacy	Medication error on discharge resulting in readmission.

Incident Trend Highlights:

- Maternal cardiac arrest related to epidural – evidence sought from anaesthetic lead for obstetrics on prevalence data. Maternity consent for epidural protocol to be reviewed for any further learning.

- Internal maternity safety alert on the use of interpreters in pregnancy to ensure safe and effective communications throughout the antenatal period, birth and postnatal care.

- **Trend:** Deep tissue injuries with use of Repose boots, including accurate assessment and documentation. Assurances sought on embedding of actions being taken. Harm Prevention Group focusing on new hospital pressure ulcers, especially those related to devices (including plaster casts).

- **Trend:** Medicines reconciliation with errors on admission and on discharge. Pharmacy leading emphasising the importance of medicines reconciliation at clerking to ensure critical medications are prescribed correctly.

Learning Highlights:

- Pharmacy projects on paracetamol, insulin, and clozapine medication errors, with remedial changes on eCARE and process reviews for identifying required actions.

- Sharing of learning from the Serious Incident Review Group (SIRG). New agenda item added of spotlight on safety focus to then be included in Trust wide communications

- Completion of three pilots of the SAFE team process for incident/serious incident investigation completed for medication incident involving paracetamol, patient fall and wrong site ophthalmology incident. Demonstrated additional learning separate to cause of the actual incident, patient and staff perspectives/reflections and clear actions – a case study to be reviewed at the Quality and Clinical Risk Committee.

Meeting Title	**Trust Board**	**Date: March 2022**
Report Title	**Ockenden Immediate & Essential Safety Action Update**	**Agenda Item: 9**
Lead Director	**Name: Nicky Burns-Muir**	**Title: Chief Nurse**
Report Author	**Name: Melissa Davis**	**Title: Head of Midwifery, Gynaecology & Paediatrics**

Key Highlights/ Summary	**The first Ockenden report published in December 2020, is the report of the first 250 cases investigated as part of the independent investigation into maternity services at the Shrewsbury and Telford Hospital NHS Trust.** **The second report is expected in March 2022.** **The first report contained 7 immediate and essential (IEA) actions and workforce actions.** **Contained is an update on the Ockenden report and actions which require completion to achieve full compliance with a trajectory for full compliance.** **Additionally, the maternity services assessment and assurance document which contains detail on the trust response to the immediate and essential safety actions, mapped against the CNST criteria is included within this submission.** **Currently, we are fully compliant with all the required actions within 4 of the IEA and workforce actions.** **In March 2022 we will achieve compliance with all the required actions within a further 2 of the IEA and workforce actions.** **In April 2022 we aim to be fully compliant with all the required actions within the IEA and workforce actions.**			
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Noting** √	**For Review** √

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

Report History	
Next Steps	
Appendices/Attachments	

Ockenden Immediate & Essential Safety Actions
Update - February 2022

Assessment against Ockenden Immediate and Essential Action (IEA)	
Immediate & Essential Action 1	100%
Immediate & Essential Action 2 NED oversight of maternity services	76%
Immediate & Essential Action 3 Twice daily consultant led ward rounds	61%
Immediate & Essential Action 4	100%
Immediate & Essential Action 5 Pathway for care outside of guidelines	93%
Immediate & Essential Action 6	100%
Immediate & Essential Action 7	100%
Maternity Workforce Planning & NICE 6 monthly board reviews for ALL staff, GAP Analysis	70%

Actions

IEA 1 – Fully compliant

IEA 2 – NED attendance at MVP Meetings – Invites to be sent from MVP to NED
NED undertaking walk rounds in maternity – To initiate in line with reduction in pandemic restrictions

IEA 3 – Following appointment of 2 further consultants, twice daily consultant led ward rounds will be implemented from March 2022

IEA 4 – Fully compliant

IEA 5 – Out of guidance pathway will be ratified through guidelines group in March 2022

IEA 6 – Fully compliant

IEA 7 – Fully compliant

Maternity & Workforce Planning – Maternity staffing paper submitted to board for March 2022
Updated process and pathway for the management of guidelines and GAP's, tracker introduced and trajectory for full compliance.
Compliance monitored through monthly divisional governance reporting

<u>Trajectory</u>

February 2022	**Fully compliant 4/8**
March 2022	**Fully compliant 6/8**
April 2022	**Fully compliant 8/8**

Maternity services assessment and assurance tool

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

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

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

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

Section 1

Immediate and Essential Action 1: Enhanced Safety

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

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

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

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

Link to Maternity Safety actions:

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

Link to urgent clinical priorities:

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

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?

		system and trust level?				
Maternity Clinical Governance Lead, Consultant Risk Lead, Risk Management Midwife, Bereavement Midwife, PMRT Lead Consultant, Data Midwife, MSDS IT Lead, Data Admin Support Team. Maternity Governance Report in place meeting all minimum evidence requirements and reporting mechanisms for CNST, Ockenden, Perinatal Quality Model and supports reporting mechanism to Board & BLMK	**MDT PMRT reviews with external representation, action plan in place to support continued improvement** **BLMK SI CRG monthly group with MDT review of SI/ HSIB to support shared learning and actions** **CRG groups organised to explore aspects identified for learning and deep dive** **Interrogation of dashboard data including exception reporting to identify areas for further focus** **HSIB/ SI reports and associated**	**Reporting to national functions to support collection of national themes to identify areas for improvement across entire maternity services** **SMART action plans identifying contributory factors which support actions linked to systems and processes enabling positive change** **Reporting through BLMK to review shared learning opportunities and share successful interventions across trusts, supporting increase evidence and data of outcomes**	**100% compliant with IEA 1** **100% compliant with Safety Action 1,2,10 for MIS year 3 submission, on track to achieve compliance with MIS year 4**	**Maternity Clinical Governance & QI Lead – Ongoing**	**Re-structure of governance team to build capacity and clarify responsibility and lines of accountability reporting - completed**	**N/A**

	action plans shared with staff and SMART action approach to support sustained change **BLMK Maternity Journey Group sharing and reporting on quality and safety data to identify areas for development and promote system learning** **Ongoing audit of HSIB cases to ensure referral, compliance figures demonstrated monthly on the maternity governance report**	**Collaborative improvement projects across the region including the approach to maternity triage, delivering audited improvements to safety** **Improvements in safety through application of processes following improvement projects such as the engagement in the GDM regional reference group** **Peer review of cases enabling opinions and feedback outside of the trust to ensure reduction in bias and review of alternative opportunities for improvement**				

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

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

Link to Maternity Safety actions:
Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Link to urgent clinical priorities:

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

What do we have in place currently to meet all requirements of IEA 2?	How will we evidence that we are meeting the requirements?	How do we know that these roles are effective?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?
NED appointed for	**1:1 meeting**	**NED role enables**	**Increased**	**NED – April**	**Capacity**	**Maternity**

maternity services April 2021 **Reduced opportunity for engagement due to implementations resulting from COVID** **Advocate role planned to be centrally organised outside of trusts and update awaited on regional progress** **Co-Produced patient experience action plan in place with monthly reporting through divisional governance and trust patient experience**	**between NED and MVP** **Patient experience action plan co-produced with the MVP** **MVP membership on the Maternity Improvement Group patient experience workstream** **MVP representation on guidelines & audit group** **MVP representation at labour ward forum** **MVP representation in current quality improvement workstreams** **MVP fortnightly meetings with HoM**	**further challenge of aspects around maternity quality and safety creating additional opportunity to review processes** **MVP engagement is pivotal to maternity service development enabling a collaborative approach to improvement actions through the lens of those accessing the service** **Improvements to the website, pathways of care through maternity and updates to clinical guidance are aimed to be more accessible and supportive to service users following MVP representation**	**presence of the NED at MVP forums** **Inclusion of the NED in the Maternity Improvement Group patient experience workstream**	**2022**	**within NED role**	**service updates from the Chief Nurse** **Inclusion in the senior team weekly newsletter update**

	MVP monthly meetings with Chief Nurse **Bi-monthly CNST meetings between exec safety champions and frontline safety champions** **MVP representation on interview panels for midwifery recruitment** **“The Big Conversation” launched in collaboration with the MVP to gain further feedback of experiences following CQC maternity survey** **Antenatal Classes co-produced with MVP to secede content** **MVP supported re-implementation of peer support staff**	**Continued collection and reporting of patient experience data to triangulate improvements recognised further to implementation**				

	on the postnatal ward **MVP representation on the communications working group to review and update the maternity website** **MVP involvement in the review of the birth preferences paperwork**					

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

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

Link to Maternity Safety actions:

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

Link to urgent clinical priorities:

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

What do we have in place currently to meet all requirements of IEA 3?	What are our monitoring mechanisms?	Where will compliance with these requirements be reported?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?
Practice Development Midwife team, Consultant Midwives, Consultant	**Monthly monitoring of training compliance reported through internal**	**Divisional governance mechanisms Board LMNS**	**Implementation of the twice daily ward rounds once consultants in post**	**CD Guideline & Audit Midwife**	**Re-structure of governance team to build capacity and clarify responsibility**	**Increased registrar presence overnight**

Obstetric & Anaesthetic input in MDT teaching, Training Needs Analysis mapped against the core competencies **External funding cost centre organised specifically for the provision of external ring-fenced funding** **Two further consultants appointed to enable the delivery of twice daily consultant ward rounds**	**governance structures and LMNS** **Reporting includes expected and achieved rates to enable constant review and organisation of training to achieve the required trajectories** **Record of training purchased through the ring-fenced training cost centre** **Update the ward rounds SoP to document the requirement for twice daily consultant led ward rounds and include audit within the auditable criteria**		**Ensure capacity to complete audits and continuous review of tracker**		**and lines of accountability reporting - completed**	**Consultant on call and available 24/7**

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

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

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

Link to Maternity Safety Actions:

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

Link to urgent clinical priorities:

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

What do we have in place currently to meet all requirements of IEA 4?	What are our monitoring mechanisms?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Maternal medicine network in place with agreed referral criteria **Consultant specialisms in place to ensure**	**Complex pregnancy is included in the annual audit schedule for continual review**	**Audits reported within the monthly governance report and associated action plans monitored through internal**	**Organise linked consultants to CoC teams to align and support consistent processes for named consultant**	**Outpatient Matron & CSU Lead**	**Re-structure of governance team to build capacity and clarify responsibility and lines of accountability**	**Organise consultant led care for women as per current pathway pending CoC implementation plan and**

named consultant for specialist obstetric indications **General obstetrics supported across consultant body**	**Named consultant documented on eCare** **All elements of SBLCBv2 are part of the annual audit schedule to continuously monitor compliance** **SBLCBv2 action plan in place** **Reporting mechanism for SBLCBv2 as part of divisional governance structures, board and through on the BLMK highlight report**	**governance structures** **SBLCBV2 monitored through internal governance forums, reported on in governance report and through BLMK monthly highlight report**			**reporting - completed**	**agreement of model**

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

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

Link to Maternity Safety actions:

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

Link to urgent clinical priorities:

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

What do we have in place currently to meet all requirements of IEA 5?	What are our monitoring mechanisms and where are they reported?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Risk assessment tool implemented onto eCare to act as a prompt and support documentation at antenatal contacts **PCP documents developed and produced by BLMK**	**Risk assessment is included in the annual audit schedule and documented on eCare** **BLMK in collaboration with MVP audit of PCP documentation being received and**	**Audits reported within the monthly governance report and associated action plans monitored through internal governance structures**	**Review approach to the documentation of PCPs with increased focus on the conversation and options for electronic recording**	**Consultant Midwife & Outpatient Matron**	**MVP support to undertake review**	**Provision of the current PCP's** **Birth Preferences pack to be implemented 28th Feb 2022**

Consultant midwives, appointed, supporting clinical leadership, birth planning including place of birth and risk assessments, informed decision making **Updating maternity website to improve accessibility of information supporting informed choice for birth planning** **Birth preferences pack organised for delivery in the antenatal period facilitated by a discussion to support informed choice and access to information to support decision making** **Birth Rights informed choice training in progres**	**usability of the document** **Patient experience data to triangulate improvements, reported through governance report and patient experience operational group**		**Out of guidance pathway in development**	**Consultant Midwife & Consultant Obstetrician**		

Immediate and essential action 6: Monitoring Fetal Wellbeing

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

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

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

Link to Maternity Safety actions:

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

Link to urgent clinical priorities:

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

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

Fetal Surveillance Midwife, Fetal Monitoring Lead Consultant, Fetal Monitoring MDT training day, Fetal Monitoring Training included in the TNA and Core Competencies, Training figures reported monthly via internal governance procedures and externally to BLMK All elements of SBLCBv2 are part of the annual audit schedule to continuously monitor compliance SBLCBv2 action plan in place Reporting mechanism for SBLCBv2 as part of divisional governance structures, board and through on the BLMK highlight report	**Project plan to transition to physiological fetal surveillance** **Development & delivery of new in-house MDT physiological fetal surveillance training** **Fetal Surveillance Midwife and Fetal Monitoring Lead Consultant are members of the fetal monitoring regional group and engage across BLMK & Thames Valley** **Competition to design the fetal monitoring logo following transition to physiological fetal surveillance to be used on all communication relation to fetal monitoring**	**Compliant with SBLCBv2 fetal monitoring requirements** **Continued review of incident reports, case reviews, learning forums within BLMK** **Physiological fetal monitoring as an embedded practice** **Local clinical guidance to support the continued provision of physiological monitoring** **Auditable criteria set within fetal monitoring guidelines** **SMART action plans developed to support continued improvement** **Monthly exception reporting on the**	**Full implementation of physiological fetal monitoring by June 2022**	**Fetal surveillance midwife & fetal monitoring lead consultant**	**Training in physiological fetal monitoring – in place** **Organised attendance on training days**	**Transition from NICE to using principles of physiological.** **Fetal monitoring guidance in place to support practice and training plan to enable all staff to be trained by June 2022** **Fetal surveillance midwife & fetal monitoring lead consultant in post**

	Fetal monitoring board in clinical area as a communication mechanism to support shared learning **Fetal surveillance midwife supports fresh eyes reviews, involved in discussions where there is a difference of opinion in the interpretation of CTG's** **Fetal surveillance midwife & fetal monitoring lead consultant support midwifery & obstetric colleagues with individual discussions regarding CTG's** **Fetal surveillance midwife & fetal monitoring lead consultant deliver fetal monitoring**	**dashboard to identify areas for further review and actions**				

	training and deliver case review forums **Fetal surveillance midwife & fetal monitoring lead consultant attend ATAIN to review cases with fetal monitoring aspects & review fetal monitoring for SI cases where this is an identified aspect, cases taken and fed back into training for ongoing learning** **Fetal surveillance midwife undertakes audits of fetal monitoring developed action plans monitored through the governance processes**					

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

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

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

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

Link to Maternity Safety actions:

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

Link to urgent clinical priorities:

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

What do we have in place currently to meet all requirements of IEA 7?	Where and how often do we report this?	How do we know that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Birth preferences pack launching on 28th February including information provided in an accessible format to support	**Monthly patient experience update as part of governance report** **Patient experience action plan reported through**	**Triangulating against patient experience feedback to identify improvements in specific areas of feedback and**	**Review with MVP other areas for improvement in accessibility of information** **Present CoC implementation**	**MVP Chair** **HoM**	**Capacity to support completion of the guidelines & GAP's**	**Tracker in place with visibility of the outstanding guidelines & GAP's to support prioritisation**

informed decision making **Birth Rights Training organised for staff to support skills and knowledge in informed consent** **Cultural competency training currently being organised across BLMK** **MVP review of website accessibility** **MVP membership on the website communications working group supporting updates to accessible information on the maternity section of the website** **MVP membership on the guidelines group, involvement in reviewing all**	**Maternity Improvement Group and patient experience trust operational meeting** **CoC delivery reported on the monthly dashboard** **CoC implementation plan scheduled for presentation at Board March 2022**	**those where improvements are still required** **Monthly exception reporting on the dashboard to identify areas for further review and actions** **Guideline's & audit tracker in place to monitor compliance** **New process flow chart approved detailing the management of guidelines and escalation points** **Guideline compliance monitored through the maternity governance report through divisional governance structures**	**plan for agreement at Board** **Out of guidance pathway in development** **Reach 100% compliance with GAP's & guidelines in date**	**Consultant midwife & consultant obstetrician** **Guidelines & Audit Midwife**		**Plan in place to provide protected time to enable completion & improved compliance** **Reporting structure for escalation strengthened for divisional oversight**

guidelines and patient information **Consultant midwives in post supporting birth choices discussions & birth planning** **Weekly meet the midwife sessions delivered virtually by the consultant midwives** **Continued implementation of CoC**						

Section 2

MATERNITY WORKFORCE PLANNING

Link to Maternity safety standards:

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

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

What process have we undertaken?	How have we assured that our plans are robust and realistic?	How will ensure oversight of progress against our plans going forwards?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Birth Rate Plus data collection completed and awaiting final report in March 2022 Birth Rate Plus acuity app agreed and for implementation February 2022 Establishment review completed and submitted to Board	Recruitment & Retention plan in place to support recruitment to required WTE Nationally approved modelling approach used to support establishment review & CoC implementation plan	6 monthly maternity staffing paper to board Monthly recruitment & retention monitoring through governance structure within HR report Retention midwife in post, supporting monitoring	Present CoC implementation plan to board for agreed approach to implementation	HoM March 2022	Exec support for the approach to implementation of CoC	51% of women currently booked under a CoC pathway CoC rollout has prioritised women from BAME backgrounds and those residing in areas of increased deprivation

CoC implementation plan completed for Board review March 2022	**Communication & engagement with the midwifery team to support implementation**	**Dashboard monitoring of CoC compliance and impact on care provision**				

MIDWIFERY LEADERSHIP

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

GAP Analysis in place

Workforce Planning Question 4

NICE GUIDANCE RELATED TO MATERNITY

We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.

What process do we have in place currently?	Where and how often do we report this?	What assurance do we have that all of our guidelines are clinically appropriate?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

Guideline and Audit Midwife, Consultant Lead for Guidelines **Guideline trajectory in place and reported through internal governance structures to continually monitor compliance** **Guideline flow chart in place detailing the process for the continual update cycle and escalation points to support achieving trajectories**	**Monthly Governance Report**	**GAP analysis currently being completed against all guidelines to review compliance with national guidance and review any mitigations to be reported through divisional governance structures as required for closure or implementation onto the risk register**	**Reach 100% compliance with GAP's & guidelines in date**	**Guideline & Audit midwife**	**Capacity to support completion of the guidelines & GAP's**	**Tracker in place with visibility of the outstanding guidelines & GAP's to support prioritisation** **Plan in place to provide protected time to enable completion & improved compliance** **Reporting structure for escalation strengthened for divisional oversight**

Meeting Title	**Trust Board**	**Date: March 2022**
Report Title	**Morecambe Bay Review Template**	**Agenda Item: 10**
Lead Director	**Name: Nicky Burns-Muir**	**Title: Chief Nurse**
Report Author	**Name: Melissa Davis**	**Title: Head of Midwifery, Gynaecology & Paediatrics**

Key Highlights/ Summary	**Following the Morecambe Bay Investigation report released in 2015, 44 recommendations were released requiring actions to be taken by NHS providers, national and regulatory institutions.** **Contained in this report is a review of the compliance with the 18 NHS provider trust actions and the actions in place relating to areas of partial compliance.** **Compliance is achieved in 17 of the 18 trust level recommendations, the one recommendation where compliance is not fully achieved relates to the maternity service not having dedicated obstetric theatres for the sole use of the maternity service.** **Compliance with the Morecambe Bay Trust recommendations is also submitted for regional oversight and to the Local Maternity and Neonatal System**			
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Noting** √	**For Review** √

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

Report History	
Next Steps	**Monitor through divisional governance processes**

Maternity Unit:- Milton Keynes Maternity Review	**Date:- 14.02.2022**	**Completed by:- Head of Midwifery**		
Recommendations for the University Hospitals of Morecambe Bay NHS Foundation Trust for other Trusts to benchmark against.	**Linked to further reviews/regulation**	**Examples of evidence (not limited to)**	**Embedded Compliance** **Red none** **Amber partially** **Green fully**	**Actions to be embed compliance fully**
1. Is an apology given to those affected, for the avoidable damage caused and any previous failures to act. **Action: Trusts**	Duty of Candour legislation regulation 20 CQC Safe Domain	Duty of Candour Policy No outstanding DoC's DoC's monitored through SI (Serious Incident) panel and reported through the governance report DoC letters updated to ensure all required information contained Tracker in place to demonstrate and monitor compliance		
2. Review the skills, knowledge, competencies, and professional duties of care of all obstetric, paediatric, midwifery and neonatal staff, and agency, locums caring for the critically ill in anaesthetics and intensive and high dependency care, against all relevant guidance from	CNST SA8 Ockenden IEA 3 CQC Effective Domain	Mandatory Training Compliance is 90% for all groups TNA (Training Needs Analysis) in place mapped against the core competency document Monthly training figures reported through internal governance and to BLMK		

professional and regulatory bodies. **Action: Trusts**		Attendance organised to ensure MDT (Multi-Disciplinary Team)		
3. Identify opportunities to broaden staff experience in other units, including by secondment and by supernumerary practice. **Action: Trusts**	CNST SA8 CQC Well Led Domain Ockenden IEA 3	Preceptorship Programme Career conversations within PDR to identify learning and development and plan to support Individual CoC (Continuity of Carer) career conversations and opportunity to gain experience in selected specialty as part of CoC team Multiple secondment opportunities available for staff development Multiple supported training opportunities for staff development delivered across BLMK		
4. Continuing professional development of staff and link this explicitly with professional requirements including revalidation. **Action: Trusts**	CNST SA 8 Ockenden IEA 3 CQC Safe Domain	Professional development discussed through PDR Training facilitated in line with TNA and career pathway reviewed to identify further opportunities within role		
5. Promote effective MDT working, joint training sessions. **Action: Trusts**	CNST SA 8 Ockenden IEA 3 CQC Effective Domain	MDT Mandatory Training including PROMPT Fetal Surveillance training Live Skills & Drills MDT ATAIN (Avoiding Term Admissions into Neonatal), PMRT (Perinatal Mortality Review Tool), IOL (Induction of Labour) & discharge workstream MOH (Major Obstetrics Haemorrhage) review group Training being organised across BLMK		
6. Protocol for risk assessment in maternity services, setting out clearly: who should be	Ockenden IEA 5 CQC Safe Domain	Clinical risk assessment at each antenatal contact		

offered the option of high or low risk care. **Action: Trusts**		Booking risk assessment completed to assign recommended pathway of care Audits Risk assessment documentation aids in place to prompt and support documentation at each antenatal contact Audit of risk assessment completion as part of the annual audit schedule		
7. Audit the operation of maternity and paediatric services, to ensure that they follow risk assessment protocols. **Action: Trusts**	CNST SA 6 Ockenden IEA 5 CQC Effective Domain	Clinical risk assessment at each antenatal contact Booking risk assessment completed to assign recommended pathway of care Audit of case notes Risk assessment documentation aids in place to prompt and support documentation at each antenatal contact Audit of risk assessment completion as part of the annual audit schedule		
8. Identify a recruitment and retention strategy achieving a balanced and sustainable workforce with the requisite skills and experience. **Action: Trusts**	CNST SA 4 & 5 Ockenden IEA Workforce CQC Safe Domain	Recruitment & Retention plan in place including – RN's, RtP (Return to Practice), International Recruits Regional task and finish groups – HoM leads the Staff Health & Wellbeing regional T&F group, Deputy HoM sits on Retention & attrition T&F group BR+ workforce review data submitted, awaiting report, currently funded to above previous BR+ Board reviews 6 monthly of midwifery and clinical work force Flexible working policy in place CoC implementation in progress HR report included in monthly divisional governance structure		

		Staff experience action plan in place Staff voices group PMA (Professional Midwifery Advocate) team in place TRiM training in place Staff development opportunities and career conversations in place Retention midwife in place		
9. Joint working between its main hospital sites, including the development and operation of common policies, systems and standards. **Action: Trusts**	CNST SA 9 Ockenden IEA 1 & NICE CQC Effective Domain	Joint LMNS (Local Maternity & Neonatal System) projects Perinatal Quality Surveillance Framework embedded with LMNS SoP's to support Cross site governance processes including safety and learning events, monthly CRG (Clinical Reference Group) panels for identified quality & safety aspects, including monthly SI panels BLMK Maternity Journey Group reviews quality and safety aspects and perinatal quality surveillance model compliance		
10. Forge links with a partner Trust, to benefit from opportunities for learning, mentoring, secondment, staff development and sharing. **Action: Trusts**	CNST SA 8 Ockenden IEA 1 & 4 CQC Well Led Domain	Regional PDM forum Regional PMA forum Lead MW Educator meetings LMNS joint SOP (Standard Operating Procedure) External review of SI's and PMRT Fetal surveillance midwife regional forum Retention midwife regional forum Diabetes regional quality improvement project EoE MSW mapping, JD & competency review Regional EOI for the Pelvic Health fast follower		

11. Staff awareness of incident reporting, review its policy of openness and honesty. Duty of Candour compliance. **Action: Trusts**	CNST SA 8 Ockenden IEA 2 & 9 CQC Safe Domain	Mandatory training Safety Champions monthly contact with frontline staff & walk rounds Bi-monthly board safety champion & frontline safety champion meetings Safety concerns pathway Monthly safety dashboard displayed in clinical areas Implementation of safety boards in clinical areas FTSU (Freedom to Speak up) Guardian in place New incident reporting system RADAR implemented with notification directly to NHSE No outstanding DoC's DoC's monitored through SI (Serious Incident) panel and reported through the governance report DoC letters updated to ensure all required information contained Tracker in place to demonstrate and monitor compliance		
12. Review the structures, processes and staff involved in investigating incidents, RCA, learning, training. Include arrangements for staff debriefing and support following a serious incident.	CNST SA 3 Ockenden IEA 1 CQC Safe Domain	Maternity Risk Management strategy AI (Appreciative Inquiry) implemented in maternity to support with response to incidents TRiM training currently taking place within maternity for a MDT co-hort to deliver across maternity PMA team in place with plan for a lead PMA role		

		RCA training in progress with trajectory for staff to attend bespoke external training Collaborative completion of SI's with midwifery and obstetric lead Innovative approach to completion of SI's taking accounts from staff as opposed to statements, system & process approach moving away from individual factors SI & HSIB (Healthcare Safety Investigation Branch) reports, and action plans shared with all staff on accessible forum Development of action plans in a SMART format with removal of personal reflection as a specific action Implementation of safety boards to share learning Learning shared through communication elements including, weekly maternity alert, maternity monthly newsletter, weekly senior team newsletter, twice daily maternity safety huddles, team messaging groups, MK teams' group, weekly "chat with HoM" forum		
13. Review the structures, processes and staff involved in responding to complaints, and learning are the public involved. **Action: Trusts**	CNST SA 1 & 7 Ockenden IEA 2 CQC Effective Domain	Complaints policy in date PALS You said we did responses MVP co-produced patient experience action plan Maternity improvement group patient experience workstream with MVP membership All PMRT cases, SI's and HSIB reports reflect the family's voice/feedback		

14. Review arrangements for clinical leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support. **Action: Trusts**	CNST SA 8 Ockenden IEA 3 & Workforce CQC Safe Domain	Mandatory Training compliance 90% Workforce Board Papers midwifery and clinical staff – action plans in place to address required mitigation RCM (Royal College of Midwives) leadership GAP analysis in place RCOG (Royal College of Obstetricians and Gynaecologists) workforce aspects implemented into the overall 6 monthly staffing report Band 6 and Band 7 leadership development courses for all staff External leadership development for senior leaders BAME Chief Nurse clinical fellowship to support diversity in leadership posts 24-hour midwifery manager on call CoC implementation plan for review at Board March 2022 PMA's (Professional Midwifery Advocates), PDM's (Practice Development Midwives), LEL (Learning Environment Lead), Retention Midwife Re-structured Midwifery Leadership team to include Deputy HoM, Consultant Midwives, Clinical Governance Lead Portfolios re-organised to enable clear responsibility and accountability within specialist & senior teams PDR (Practice Development Reviews) including career conversations Development plans in place for all new leadership roles		

		Robust interview processes to support selection of candidates with knowledge and skills required, MDT interview panels, external regional midwifery panellist for all leadership roles, MVP representation on interview panel JD include roles and responsibilities Value based interviewing and review of processes within interviews to support candidates to demonstrate knowledge and skills for role		
15. Review of governance systems clinical governance, so that the Board has adequate assurance of the quality of safe care. **Action: Trusts**	Ockenden IEA 1 CQC Well Led Domain CNST 10 SA	Maternity Dashboard in place with accurate data reporting Risk Register updated and on monthly review schedule New governance structure in place increased and clarified reporting mechanisms, increased capacity within the governance team, re-structuring roles and responsibilities for clear lines of accountability and responsibility Increased MDT collaboration with obstetric and midwifery implementation across all governance functions New pathways and procedures in place to support compliance and oversight of governance functions Reporting mechanisms strengthened and maternity governance report updated to demonstrate all aspects aligned with perinatal quality surveillance, CNST and Ockenden reporting requirements		HoM presents to board when indicated from a maternity perspective. Current structure is Chief Nurse represents Maternity at Board Close collaboration with presentations and papers for submission

		BLMK highlight reports, CRG's, submission to BLMK Maternity Journey Group		
16. Ensure middle managers, senior managers and non-executives have the requisite clarity over roles and responsibilities in relation to quality and provide appropriate guidance and training. **Action: Trusts**	CNST SA 4,5 & 8 Ockenden IEA Workforce CQC Well Led Domain	Restructure of the midwifery leadership team – implementation of Governance Lead, Consultant Midwives, Deputy HoM. Aligned inpatient & outpatient services with clinical and operational lead Development plans in place for all new leadership roles Robust interview processes to support selection of candidates with knowledge and skills required, MDT interview panels, external regional midwifery panellist for all leadership roles, MVP representation on interview panel JD include roles and responsibilities Value based interviewing and review of processes within interviews to support candidates to demonstrate knowledge and skills for role Senior leadership team visible and available, walk rounds also take place during on call periods Safety Champions walk rounds		
17. Review access to theatres, and ability to observe and respond to all women in labour and ensuite facilities; arrangements for post-operative care of women. **Action: Trusts**	CNST SA 9 Ockenden IEA 4 & 5 CQC Safe Domain	Recovery nurses in place to support post operative care Scrub nurses in place to support provision for operative care Action plan in place to support 100% supernumerary status of labour ward co-ordinators Action plan in place to support 100% 1:1 care in established labour		Theatres not for sole use of obstetrics Added to the risk register & incidents reviewed through incident reporting and ATAIN cases

		Maternity staffing escalation procedure and midwifery staffing contingency plan		Plan for a new women's and children's hospital build including designated theatres and er-suites for each room
18. All of above should involve CCG, and where necessary, the CQC and Monitor. **Action: Trusts**	CCG assurance visits CQC regulation visits	CQC action plans in place and reported through governance structures BLMK forums in pace for reporting mechanisms to review safety & quality data Actions plans monitored governance floor to Board Feedback to staff through internal communication mechanisms Midwifery & Obstetrics Leadership team have specific responsibilities within portfolios and specialist midwives in place to support responsiveness to identified aspects		
The recommendations below were allocated to be actioned by the wider NHS and selected stakeholders we suggest reviewing how these apply at provider level				
19. Professional regulatory bodies should review the findings of this report: **Action: NMC, GMC**	None Known	To follow up		
20. National review of the provision of maternity care and paediatrics in challenging circumstances, including areas that are rural, difficult to recruit to, or isolated. This should identify the requirements to sustain safe services under	CNST 10 safety actions CQC Safe Domain	Local Assessment Better Births report LMNS implemented Maternity transformation		

these conditions: **Action: NHSE, CQC, RCOG, RCPCH, NICE**				
21. We recommend that NHS England consider the review of requirements to sustain safe provision to services difficult to recruit to or isolated is not restricted to maternity care and paediatrics: **Action: NHSE**	Ockenden IEA 1 CQC Safe Domain CNST SA 4 & 5	Regional workforce workstream Local assessment. NICE safer staffing guidelines BR+ LMNS to implement maternity transformation workstream		
22. Review of the opportunities and challenges to assist remote or smaller units in promoting services and the benefits to larger units of linking with them. **Action: HEE, RCOG, RCPCH, RCM**	Ockenden IEA 1 CQC Safe Domain CNST SA 4, 5 & 9	Local Assessment Girth visits Mergers of some Trusts LMNS to implement maternity transformation workstream		
23. Clear standards should be drawn up for incident reporting and investigation in maternity services. These should include the mandatory reporting and investigation as serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths. **Action: CQC, DOH**	Ockenden IEA 1 CQC Safe Domain CNST SA 10	Maternity Risk Management strategy in date Governance structure NHS resolution HSIB		
24. Introduction of the duty of candour for all NHS professionals. **Action: CQC, NHSE**	Ockenden IEA 3 CQC Safe Domain	CQC DOC guidance for providers DOC policy in date Audit of compliance		
25. NHS Boards to report openly the findings of any external investigation, including prompt notification of relevant external bodies such as the CQC and Monitor. **Action: DOH, CQC**	CNST SA 10 Ockenden IEA 1 CQC Safe Domain	Reports from external reviews Action Plans Evidence of notification emails		
26. Introduction of a clear national policy on whistleblowing. **Action: DOH**	CQC Well Led Domain	Whistleblowing policy in date? FTSUG policy FTSUG representatives		
27. Reinforce the duty of professional staff to report concerns about clinical services,	CNST SA 8 Ockenden IEA 1 CQC Safe Domain	WB policy Governance structure Staff training		

and patient safety issues. **Action: GMC, NMC, PSAHSC**				
28. Clear national standards should be drawn up setting out the professional duties and expectations of clinical leads at all levels Trusts should provide evidence to the CQC. **Action: CQC, NMC, GMC, NHSE**	CQC Well Led Domain Ockenden Workforce	JD's Internal leadership structure RCM leadership requirements RCOG workforce issues/role-responsibilities guidance		
29. Clear national standards should be drawn up setting out the responsibilities for clinical quality of other managers, should provide evidence to the Care Quality Commission. **Action: CQC, NHSE**	CQC Well Led Domain Ockenden Workforce	JD's Internal leadership structure RCM leadership requirements RCOG workforce issues/role-responsibilities guidance		
30. A national protocol should be drawn up setting out the duties of all Trusts and their staff in relation to inquests. To include, the avoidance of attempts to 'fend off' inquests, a mandatory requirement not to coach staff or provide 'model answers', the need to avoid collusion between staff on lines to take, and the inappropriateness of relying on coronial processes or expert opinions provided to coroners to substitute for incident investigation. **Action: NHSE, CQC**	CQC Well Led Domain	HSIB Process followed Internal legal team guidelines for staff attending coroner's court Maternity Risk Management Strategy		
31. A fundamental review of the NHS complaints system is required, with particular reference to strengthening local resolution and improving its timeliness, introducing external scrutiny of local resolution and reducing reliance on the Parliamentary and Health Service Ombudsman to intervene in unresolved complaints. **Action: DOH, NHSE, CQC**	CNST SA 7 Ockenden IEA 2 CQC Effective Domain	Complaints policy including how to contact Ombudsman in date PALS You said we did responses MVP involvement All PMRT cases, SI's and HSIB reports reflect the family's voice/feedback		
32. Local Supervising Authority system for midwives was ineffectual at detecting	CQC Well Led Domain	A-EQUIP model introduction of PMA's		

manifest. Urgent review and reform is required. **Action: DOH, NHSE, NMC**				
33. Organisations draw up a memorandum of understanding specifying roles, relationships and communication of regulation by CQC and financial and performance by Monitor. **Action: CQC, DOH, Monitor**	None Known	In place NHS Improvement performed Finance inspections alongside CQC inspections		
34. A memorandum of understanding be drawn up clearly specifying roles, responsibilities, communication and follow-up, including explicitly agreed actions where issues overlap with complaints. **Action: CQC, PHSO**	None Known	To follow up		
35. NHS England draw up a protocol that clearly sets out the responsibilities for all parts of the oversight system, including itself, in conjunction with the other relevant bodies; the starting point should be that one body, the Care Quality Commission, takes prime responsibility. **Action: CQC, NHSE, DOH, Monitor**	None Known	Local meetings CQC and NHSEI sharing intelligence Quality summits held when required		
36. DOH should review how it carries out impact assessments of new policies to identify the risks as well as the resources and time required. **Action: DOH**	None Known	HSCSC Report into Maternity Services – published June 2021		
37. An explicit protocol be drawn up setting out how such processes will be managed in future Organisational change that alters or transfers responsibilities and accountability carries significant risk, which can be mitigated only if well managed. **Action: DOH**	None Known	CQC report any concerns to NHSEI prior to a merger LMNS Board Regional Perinatal Quality Oversight Group includes all stakeholders		

38. Recording systems are reviewed and plans brought forward to improve systematic recording and tracking of perinatal deaths. This should build on the work of national audits such as MBRRACE-UK, and include the provision of comparative information to Trusts. **Action: NHSE**	Ockenden IEA 1 CQC Safe Domain CNST SA 1	PMRT Tool completed to the required standard 100%		
39. There is no mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. **Action: DOH**	Ockenden IEA 1 CQC Safe Domain CNST SA 1 & 10	PMRT Tool completed to the required standard 100% HSIB reporting 100%		
40. Given that the systematic review of deaths by medical examiners should be in place, as above, we recommend that this system be extended to stillbirths as well as neonatal deaths, thereby ensuring that appropriate recommendations are made to coroners concerning the occasional need for inquests in individual cases, including deaths following neonatal transfer. **Action: DOH**	Ockenden IEA 1 CQC Safe Domain	Risk Management Strategy Policy for review of deaths Does this include all stillbirths		Requires national policy change
41. Systematic guidance drawn up setting out an appropriate framework for external reviews and professional responsibilities in undertaking them. **Action: Academy of Medical Royal Colleges, RCN, RCM**	Ockenden IEA 1 CQC Safe Domain	GIRTH visits CQC core service framework NHSEI self-assessment framework		
42. All external reviews of suspected service failures be registered with the CQC and Monitor, and that the CQC develops a system to collate learning from reviews and disseminate it to other Trusts. **Action: CQC, Monitor**	Ockenden IEA 1 CQC Safe Domain	MMSP Programme National HSIB Report CQC maternity reports		

43. The importance of putting quality first is re-emphasised and local arrangements reviewed to identify any need for personal or organisational development, including amongst clinical leadership in commissioning organisations. **Action: NHSE, DOH**	National NHSEI team ICS	CQC report any concerns to NHSEI prior to a merger LMNS Board Regional Perinatal Quality Oversight Group includes all stakeholders		
44. Establish a proper framework, on which future investigations could be promptly established. This would include setting out the arrangements necessary to access to documents, clarifying responsibilities of current and former health service staff to cooperate. **Action: DOH**	National NHSEI team ICS	Information Governance Policy IG training SLT support for staff before, during and after external investigations.		

Meeting Title	**Trust Board**	**Date: March 2022**
Report Title	**Maternity Self-Assessment Tool**	**Agenda Item: 11**
Lead Director	**Name: Nicky Burns-Muir**	**Title: Chief Nurse**
Report Author	**Name: Melissa Davis**	**Title: Head of Midwifery, Gynaecology & Paediatrics**

Key Highlights/ Summary	**The maternity self-assessment document is s tool which enables maternity service providers to assess operational service delivery enables compliance with national, regulatory, or best practice requirements.** **The tool is routinely updated as further national policy or recommendations are set and was recently updated to include the immediate and essential actions following the Ockenden report.** **The assessment will support the organisation of the maternity safety plan and continue to inform the development of this dynamic plan.** **Enclosed within the report is the completed maternity self-assessment document and the action plan detailing the planned actions for areas of current non or partial compliance.**			
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Noting** √	**For Review** √

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

Report History	

Next Steps	N/A
Appendices/Attachments	1. Maternity Self-Assessment Tool Action Plan 2. Maternity Self-Assessment Tool

Title:	Maternity Self-Assessment Tool Action Plan	**DATE:**	March 2022
Action Plan Lead	*Name:* Melissa Davis – Head of Midwifery, Gynaecology & Paediatrics		

Recommendation	**Actions Comments/**	**Date to achieve** **Person responsible**	**Change stage** Not Compliant Partially Compliant – plan to be agreed Partially Compliant – plan on track
Director of Midwifery in post	Head of midwifery in post Chief nurse executive lead for maternity services		
Head of Midwifery band 8D / 9	Head of Midwifery band 8C		
Clinical Director allocated 3 PA's	Clinical Director PA's recently increased from 1 PA to 2 PA's Review allocation of total PA's across the consultant group in maternity to review any required re-allocation	Divisional Director April 2022	

Adequate senior operational support to enable high quality service delivery	Associate Director of Ops in place & Deputy Associate Director of Ops appointed No ops manager for women's, review of requirement for additional ops support	Director of Ops April 2022	
Standalone maternity specific vision & strategy	Maternity strategy currently in development mapped against regional, national, maternity transformation & 10-year plan	Head of Midwifery May 2022	
Non-Exec Director working in line with the role descriptor Maternity & Neonatal safety champion meetings with the NED Engagement with the Maternity Voices Partnership Check & challenge around maternity services at each trust board	Review maternity forums for increased interaction with the NED to support check & challenge of maternity services MVP including NED in the invitation list for the MVP meetings Review of maternity data submitted to each trust board	Head of Midwifery Chief Nurse April 2022	
Quality reviews including 15 steps walk rounds	Paused walk rounds due to COVID 19 To re-implement patient experience led walk rounds once restrictions are reduced	Outpatient Matron – Patient Experience Lead May 2022	
Register of attendance at audit afternoons, quality improvement workstreams, debriefs	Formal registers not kept for these aspects, review administration support to support completion & storage of registers	Maternity Clinical Governance & Quality	

		Improvement Lead April 2022	
Guideline to support clinical de-brief process	TRiM training in progress, 8 staff trained, further 16 MDT attending training TRiM guideline implementation following completion of co-hort training	Maternity Clinical Governance & Quality Improvement Lead May 2022	
Focus on behavioural standards through monthly directorate meetings	Professional Midwifery Advocate team implementing staff experience & wellbeing paper based on Care, Collaborate, Communicate, Contribute Presentation through monthly CSU meeting	Professional Midwifery Advocate Team May 2022	
Standalone maternity specific risk strategy	Maternity specific risk strategy currently in development mapped alongside the BAF	Head of Midwifery Maternity Clinical Governance & Quality Improvement Lead May 2022	

Trust communication strategy in place	Trust communication strategy developed & submitted for ratification March 2022	Communication Lead March 2022	
Maternity specification in date	Maternity specification last reviewed pre-pandemic Review of specification post-pandemic to re-set against service deliverables	Contracts Lead June 2022	
100% Guidelines & GAPs in date	New process in place for maintaining compliance with guidelines & GAPs Trajectory in place for completion of overdue guidelines and GAPs monitored through divisional governance structures	Guideline & Audit Midwife April 2022	
Dynamic maternity safety plan in place	Safety plan in draft capturing all the current safety drivers within maternity	Head of Midwifery Maternity Clinical Governance & Quality Improvement Lead April 2022	
Full implementation of A-EQUIP	Professional Midwifery Advocate team completing GAP against the A-EQUIP model to prepare an implementation paper	PMA team	

	Review of implementation of a lead PMA role to support delivery of the A-EQUIP model Further candidates selected for PMA training to increase resilience within the team	May 2022	
Full implementation of the National Bereavement Pathway	Mandatory bereavement training to be included in the midwives mandatory training from March 2022 Review options for a bereavement room on EPAU	Bereavement Midwife April 2022	
Established improvement hub	Improvement hub in place, new quality improvement lead to be appointed	Director of Corporate Affairs April 2022	
MDT handovers to include specific attendance including consultant obstetrician & anaesthetist	2 further consultant obstetricians appointed to support twice daily 7-day ward rounds Investigate opportunity for increased consistency in anaesthetic attendance at the evening handover	Clinical Director Lead Obstetric Anaesthetist March 2022	
Face to face reviews clinical reviews with the obstetric team	SMART action plans in place to support the provision of face-to-face obstetric reviews Increased to 2 registrars overnight to support increased obstetric availability	Clinical Director April 2022	

	2 further consultants appointed to increase consultant presence		
Maternity safety huddles to include specific attendance including obstetric team	Review timings of the maternity safety huddle to identify opportunities to increase obstetric team attendance	Head of Midwifery Clinical Director March 2022	
Consultant job plans meet service need for demand & capacity	2 further consultants appointed to increase governance capacity	Clinical Director March 2022	
Fetal monitoring lead consultant allocated 2-3 PA's	Fetal monitoring lead consultant allocated 1 PA Review allocation of PA's for maternity specific requirements and identify opportunities for increased PA's	Divisional Director Clinical Director April 2022	

Classification: Official

Publication approval reference: PAR807

Maternity services system learning
Maternity self-assessment tool

Version 6, 19 July 2021

Where updates have been made to the content of this document since the previous version was published (version 5, February 2020), they have been highlighted in yellow.

Introduction

This Safety Self-assessment tool has been designed for NHS maternity services and private maternity providers to allow them to self-assess whether their operational service delivery meets national standards, guidance, and regulatory requirements. Organisations can use the tool to inform the trust's maternity quality improvement and safety plan and so keep the trust board and commissioners aware of their current position.

The tool has been developed in response to national review findings, and recommendations for good safety principles within maternity services. This version of the tool has been further influenced by the findings of the Ockenden review, 7 features of safety culture and the emerging themes from services on the safety support programme and the areas CQC found to be outstanding in other maternity services across England.

Please use this tool to as a benchmark for your organisation in the core principles of good safety standards within Maternity services.

The tool

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Directorate/care group infrastructure and leadership	**Clinically-led triumvirate**	Trust and service organograms showing clinically led directorates/care groups		Organogram in place
		Equal distribution of roles and responsibilities across triumvirate to discharge directorate business such as meeting attendance and decision-making processes		Triumvirate structure in place and, weekly meetings and allocated attendance at meetings
	Director of Midwifery (DoM) in post **(current registered midwife with NMC)**	DoM job description and person specification clearly defined		No DoM HoM JD & Personal specification in place
		Agenda for change banded at 8D or 9		8C
		In post		HoM in post
	Direct line of sight to the trust board	Lines of professional accountability and line management to executive board member for each member of the triumvirate		Divisional Director managed by Medical Director; Associate Director of Ops managed by Director of Ops, HoM managed by Chief Nurse
		Clinical director to executive medical director		CD direct line of escalation to MD
		DoM to executive director of nursing		HoM – Chief Nurse
		General manager to executive chief operating officer		ADO - DO

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Maternity services standing item on trust board agenda as a minimum three-monthly Key items to report should always include: • SI Key themes report, Staffing for maternity services for all relevant professional groups • Clinical outcomes such as SB, NND HIE, ATAIN, SBLCB and CNST progress/Compliance. • Job essential training compliance • Ockendon learning actions		Quarterly minimum evidence requirement for trust board implemented into the maternity monthly governance report for clarity within the reporting structures and submission directly from divisional governance processes to board. CNST bi-monthly meetings between board level and frontline safety champions. Monthly reports submitted to management board, chaired by Exec Monthly Maternity Assurance Group chaired by Exec
		Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]		Trust board Bi-Monthly Management board report monthly, escalated to Trust Executive Group

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]		Trust board Bi-Monthly Management board report monthly, escalated to Trust Executive Group
		There should be a minimum of three PAs allocated to clinical director to execute their role		Initial allocation of 1 PA now increased to 2 PA
	Collaborative leadership at all levels in the directorate/ care group	Directorate structure and roles support triumvirate working from frontline clinical staff through to senior clinical leadership team		Re-structure of maternity senior team to support increased clarity in responsibility and accountability including escalation procedures. Safety concerns pathway and monthly safety concerns dashboard visible in clinical areas

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Adequate dedicated senior human resource partner is in place to support clinical triumvirate and wider directorate Monthly meetings with ward level leads and above to monitor recruitment, retention, sickness, vacancy and maternity leave		HRBP allocated to Women's and Children's Support with management of HR functions and production of a monthly HR report for divisional governance processes Monthly meetings with finance lead & workforce matron to review eRoster parameters & unavailability Recruitment & Retention plan in place and processes supported by resource team
		Adequate senior financial manager is in place to support clinical triumvirate and wider directorate		Finance manager in place for Women's & Children's

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Monthly meetings with all ward level leaders and above to monitor budgets, ensure updated and part of annual budget setting for each area		Cost centre alignment exercise completed to split maternity budgets into different cost centres alongside eRoster Monthly eRoster & finance meetings in place to ensure monitoring
		Adequate senior operational support to the delivery of maternity services in terms of infrastructure and systems that support high quality service delivery aligned with national pathways		Associate Director of Ops for Women's & Childrens Deputy ADO appointed No specific ops manager for Women's services

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		From governance and senior management meetings that all clinical decisions are made collaboratively by multiprofessional groups		Governance structure re-organised to ensure MDT collaboration All governance forums have representation from the MDT including external representation when required Guidelines have dual authors with Midwifery & Obstetric leads, MVP representation on the guidelines group and comments on all guidelines and patient information MDT approach to completing RCA/ SI reports with parental involvement throughout the process MDT's organised for case reviews to ensure immediate learning and collaboratively organise actions SI & HSIB SMART action plans have MDT development

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
				MDT clinical pathway workstreams in place with MVP representation Collaboration across LMNS & Mat Neo system to share learning and engage in clinical reference groups Maternity projects include MDT representation
		Forums and regular meetings scheduled with each professional group are chaired by the relevant member of the triumvirate, eg senior midwifery leadership assembly		MDT forums and staff group-based

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Leadership culture reflects the principles of the '7 Features of Safety'.		forums with agreed triumvirate chair Human factors training in place and plan for faculty to support positive safety culture Systems & processes approach to the review of incidents and development of action plans Review of safety & quality indicators through governance forums with multiple methods of dissemination and co-produced action plans Significant MDT training in place including internal formal teaching and informal teaching/ support in collaboration with the PDM team External MDT training organised to support quality improvement initiatives and

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
				identified areas of development Strong links developed across midwifery & obstetric specialisms leads promoting responsive and dynamic problem solving and actions
	Leadership development opportunities	Trust-wide leadership and development team in place		Internal & external leadership development opportunities
		Inhouse or externally supported clinical leadership development programme in place		Internal Band 6 & 7 leadership development programme Chief Nurse BAME fellowship programme NHSI external leadership programmes supported Professional Midwifery Advocate training available

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Leadership and development programme for potential future talent (talent pipeline programme)		B6 & B7 development programmes in place development programme in place Chief Nurse BAME fellowship programme Secondment and shadowing opportunities Development programmes following career conversations including, training opportunities, engagement in quality improvement projects, experience in specialisms Senior leadership talent mapping and roles implemented to support senior leadership structure and development including Deputy HoM, Consultant Midwife, Clinical Governance Lead

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Credible organisations provide bespoke leadership development for clinicians/ frontline staff and other recognised programmes, including coaching and mentorship		Leadership courses supported and developed by the trust practice development team Coaching and mentorship supported through shadowing, provision of supported projects and opportunities which stretch development, clear objectives, enabling autonomy, valuing contributions, supporting training to develop knowledge, mentorship training & updates provided, Professional midwifery advocate training, teaching qualifications, generic instructor course, external leadership, and coaching courses supported
	Accountability framework	Organisational organogram clearly defines lines of accountability, not hierarchy		Organogram in place
		Organisational vision and values in place and known by all staff		Communication, presentation on multiple formats over various platforms

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Organisation's behavioural standards framework in place: Ensure involvement of HR for advice and processes in circumstances where poor individual behaviours are leading to team dysfunction. [Perinatal Surveillance model]		Organisational values and behavioural standards framework on place MK-Way-Strategy-final2.pdf (mkuh.nhs.uk) HRBP support to manage behaviours outside of this framework and those negatively impacting on the team
	Maternity strategy, vision and values	Maternity strategy in place for a minimum of 3–5 years		Nursing & Midwifery Strategy co-developed with staff, due to be launched in March Midwifery leaders on each workstream of the strategy **maternity specific strategy in development aligned with trust strategy**
		Strategy aligned to national Maternity Transformation Programme, local maternity systems, maternity safety strategy, neonatal critical care review, National Ambition for 2025 and the maternity and children's chapter of the NHS Long Term Plan		**Maternity specific strategy in development**

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MVP, service users and all staff groups.		MVP collaboration to support co-

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services [Ockenden Assurance]		production of services Bi-Monthly meetings with HoM Monthly meetings with Chief Nurse Leadership team portfolios reviewed and re-aligned, patient experience in portfolio of leadership team member Patient experience working group of the maternity improvement group with MVP representation Co-produced patient experience action plan in place with developed with MVP and maternity patient experience lead MVP representation on guidelines group, MVP input required on all guidelines and patient information ToR updated MVP representation on clinical

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
				workstream quality improvement groups MVP representation at labour ward forum MVP representation at comms working group to re-organise the website
		Maternity strategy aligned with trust board LMNS and MVP's strategies		**Maternity specific strategy in development*
		Strategy shared with wider community, LMNS and all key stakeholders		**Maternity specific strategy in development*
	Non-executive maternity safety champion	Non-executive director appointed as one of the board level maternity safety champions and is working in line with national role descriptor		NED appointed April 2021 To strengthen links with MVP and staff engagement
		Maternity and neonatal safety champions to meet the NED and exec safety champion to attend and contribute to key directorate meetings in line with the national role descriptor		NED chairs Clinical Quality & Safety Committee which includes presentation of quarterly Perinatal Quality Surveillance data CNST meetings including board and frontline safety champions

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		All Safety champions lead quality reviews, eg 15 steps quarterly as a minimum involving MVPs, service users, commissioners and trust governors (if in place)		Paused during COVID
		Trust board meeting minutes reflect check and challenge on maternity and neonatal services from non-executive safety champion for maternity services		NED & Maternity board level safety champions attend Trust Board NED chairs Clinical Quality & Safety Committee, perinatal quality surveillance data presented though this committee
		A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMS) and MatNeoSIP Patient Safety Networks. [MIS]		Pathway developed, in place and visible to staff

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Multiprofessional team dynamics	**Multiprofessional engagement workshops**	Planned schedule of joint multiprofessional engagement sessions with chair shared between triumvirate, ie quarterly audit days, strategy development, quality improvement plans		MDT clinical workstreams to support quality improvement in identified pathways inc. IOL, Discharge, Enhanced Recovery, Diabetes MDT collaboration on improvement projects inc. BSOTS, Physiological CTG, Mat Neo Optimisation Monthly Audit afternoon MDT involvement in the development of SMART action plans following reviews inc. PMRT, SI/ HSIB, ATAIN Weekly Triumvirate meeting
		Record of attendance by professional group and individual		Provided virtually through teams, record of attendance available through review of recording
		Recorded in every staff member's electronic learning and development record		Not recorded electronically on staff record

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Multiprofessional training programme	Annual schedule of job essential maternity-specific training and education days, that meet the NHS England and NHS Improvement Core Competency framework as a minimum published and accessible for all relevant staff to see		TNA mapped against the core competency document to ensure inclusion of all required training Training trajectory alongside TNA to ensure effective delivery of training by staff % to ensure training compliance which is monitored monthly
		A clear Training Needs analysis in place that identifies the minimum hours of training required for each professional group and by grade/ seniority		TNA in place, reviewed against core competencies

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		All staff given time to undertake mandatory and job essential training as part of working hours		3% headroom allocated to training which does not cover the required increase in headroom for maternity mandatory training Time for training is allocated in addition to supporting training to be completed on bank, no training is expected to be completed in own time Junior and Middle tier have allocated sessions for training, Consultants have SPA.
		Full record of staff attendance for last three years		Training records available, maintained on database and recorded on eRoster
		Record of planned staff attendance in current year		Clear trajectory in place mapping out planned annual training attendance, reported through the monthly governance report
		Clear policy for training needs analysis in place and in date for all staff groups		TNA included in the training guideline which is in date

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Compliance monitored against training needs policy and recorded on roster system or equivalent		Database and roster recording
		Education and training compliance a standing agenda item of divisional governance and management meetings		Training reported on governance report, through divisional meetings to board Training reported through BLMK
		Through working and training together, people are aware of each other's roles, skills, and competencies (who does what, how, why and when) and can work effectively together, thus demonstrating "collective competence". [7 Steps]		Staff training requirements recognised through PDR and career conversations, monitoring safety & quality metrics through governance forums and reporting mechanisms, following incident investigations, action plans, quality improvement projects, service developments & future midwife Mapped through the TNA updated annually Revalidation discussed at each PDR to review and assess requirements for compliance
		Individual staff Training Needs Analysis (TNA) aligned to professional revalidation requirements and appraisal		

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Clearly defined appraisal and professional revalidation plan for staff	All job descriptions identify individual lines of accountability and responsibility to ensure annual appraisal and professional revalidation		Job descriptions reviewed and updated in line with review and development of role, at the point of re-advertisement, on creation of a new role All staff have an agreed line manager which is defined within the organisational structure Escalation process in place to gain support within role
		Compliance with annual appraisal for every individual		Above 90% Trust defined compliance
		Professional validation of all relevant staff supported by internal system and email alerts		Email notifications sent to line manager regarding upcoming revalidation

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Staff supported through appraisal and clearly defined set objectives to ensure they fulfil their roles and responsibilities		PDR training available, career conversations as part of the PDR, review of staff interests continued service developments to identify development and learning needs Objectives set as part of appraisal process and reviewed at subsequent appraisal, development plans in place to support staff in new roles and objectives re-defined as required
		Schedule of clinical forums published annually, eg labour ward forum, safety summit, perinatal mortality meetings, risk and governance meetings, audit meetings		Meeting schedule available

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Multiprofessional clinical forums	HR policies describe multiprofessional inclusion in all processes where applicable and appropriate, such as multiprofessional involvement in recruitment panels and focus groups		Recruitment processes involve MDT representation for posts including MVP representation, external midwifery leaders on interview panels for senior leadership roles Values based approach to interviewing with various aspects to enable candidates with different learning styles to demonstrate knowledge & skills for role Interview & application feedback provided to support development
	Multiprofessional	Organisational values-based recruitment in place		Yes

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	inclusion for recruitment and HR processes	Multiprofessional inclusion in clinical and HR investigations, complaint and compliment procedures		HR included in all HR investigations with a nominated lead investigator within or outside of division MDT approach to the completion of complaints with a named obstetric and named midwifery lead Written responses and face to face meetings undertaken as an MDT including support from complaints & governance teams as required
		Standard operating procedure provides guidance for multiprofessional debriefing sessions following clinical incidents or complaints		Once training completed TRiM guideline will be adopted

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Debriefing sessions available for all staff groups involved following a clinical incident and unusual cases in line with trust guideline and policy		De-briefs currently offered supported by Appreciative Enquiry PMA team to provide RCS One co-hort of staff have attended TRIM training and two further MDT co-horts have been organised to attend training to roll out TRIM as an approach, with a guideline in place to define situations for use, training & auditable criteria
		Schedule of attendance from multiprofessional group members available		Registers not routinely used at de-brief sessions
	Multiprofessional membership/ representation at Maternity Voices Partnership forums	Record of attendance available to demonstrate regular clinical and multiprofessional attendance.		MDT & MVP attendance at Labour Ward Forum, guidelines group, quality improvement groups
		Maternity Voice Partnership involvement in service development, Quality Improvement, recruitment and business planning through co-production and co-design		Co-Production Plan, MVP attend quality improvement project groups, MVP representation on interview panels, MVP representation on guidelines group

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Quality improvement plan (QIP) that uses the SMART principle developed and visible to all staff as well as Maternity Voice Partnership/service users		Co-produced patient experience action plan Patient experience group with MVP representation
	Collaborative multiprofessional input to service development and improvement	Roles and responsibilities in delivering the QIP clearly defined, ie senior responsible officer and delegated responsibility		Transformation team support with the production and monitoring of project plans
		Clearly defined and agreed measurable outcomes including impact for women and families as well as staff identified in the QIP		Patient experience is a deliverable of all quality improvement plans
		Identification of the source of evidence to enable provision of assurance to all key stakeholders		Monitoring data and indicators to identify areas of focus within maternity services Guidelines GAP against NICE Audits, thematic reviews, trend analysis completed to evidence areas for focus SMART action plans in place

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		The organisation has robust repository for collation of all evidence, clearly catalogued and archived that's has appropriate shared access		Teams' folders utilised to store all information with access provided as required to indicated staff groups
		Clear communication and engagement strategy for sharing with key staff groups		Engagement strategy within the CoC implementation plan Multiple forums for sharing information; weekly leadership team newsletter with monthly cycle of focus, written communication, weekly safety alert, monthly maternity newsletter, WANGA (guidelines & audit newsletter) , MK teams channel platform for access to multiple documents and information for all staff, twice daily maternity safety huddles, weekly live virtual "Chat with HoM" sessions recorded for all staff unable to attend, team & ward meetings

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		QIP aligned to national agendas, standards and national maternity dataset and national maternity quality surveillance model requirements		Improvement projects aligned to areas of identified or required focus
		Weekly/monthly scheduled multiprofessional safety incident review meetings		Weekly MDT's
	Multiprofessional approach to positive safety culture	Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS		BLMK safety learning forum, monthly CRG's, Patient Safety Network Group, Monthly Patient Safety Board

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Positive and constructive feedback communication in varying forms		Patient experience compliments shared weekly on leadership team newsletter Feedback through appraisal and career conversations to support ongoing development Compliments from women shared directly with staff Face to face & team feedback PMA RCS sessions Team meetings MDT & case review learning Greatix Individual staff cards Virtual appreciation board
		Debrief sessions for cases of unusual or good outcomes adopting safety 2 approach		De-briefs available and supported by appreciative enquiry
		Senior members of staff make sure that more junior staff have opportunities to debrief and ask questions after experiencing complex clinical situations, and that they learn from theirs and others' experience. [7 steps to safety]		Retention midwife in post supporting

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Schedule of focus for behavioural standards framework across the organisation		preceptorship midwives De-briefs offered and completed as required Follow up for staff members involved in complex cases PMA team support RCS TRiM training currently being rolled out PMA, PDM, Fetal Surveillance, Shift leads available to de-brief and support case discussion Day PMA on call 24/7 maternity manager on call
	Clearly defined behavioural standards	Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month		PMA Staff experience & wellbeing report based on the 4 C's to be implemented into governance report
		Unsafe or inappropriate behaviours are noticed and with HR support corrected in real time, so they don't become normalised. [7 steps]		HRBP aligned to division, weekly

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		All policies and procedures align with the trust's board assurance framework (BAF)		touchpoints with leadership team Behaviours which do not align with trust values & support positive safety culture are actioned & advice gained from HR as required Policies & guidelines are approved through trust documentation committee which reports to clinical board reporting to TEG reporting to board, aligning against the BAF

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Governance infrastructure and ward-to-board accountability	**System and process clearly defined and aligned with national standards**	Governance framework in place that supports and promotes proactive risk management and good governance		Governance structure organised to enable clear identification and management of risks Governance report organised to demonstrate required indicators in maternity and support robust oversight Processes and pathways in place to enable MDT approach to all aspects of governance

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Staff across services can articulate the key principles (golden thread) of learning and safety		Safety boards in clinical areas Weekly maternity alerts Weekly senior team updates Monthly maternity newsletter Audit and guidelines update All guidelines co-authored by lead midwife and lead obstetrician MK teams maternity virtual group for all staff as an information sharing platform Monthly safety concerns dashboard visible to all staff SI/HSIB reports & action plans shared with all staff Dashboard & exception reports shared with all staff Maternity governance report shared with all staff Staff involvement in safety & quality

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
				improvement projects

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Staff describe a positive, supportive, safe learning culture		New processes & approaches to governance in place PMA team in place, TRiM training implemented for full roll out Human factors training with development of human factors faculty Systems & processes approach to incidents & investigations, verbal accounts taken to understand human factors, no statements requested, individual actions not included in SMART action plans Staff engagement in development of action plans & quality improvement projects Safety boards implemented, virtual teams file with shared information for all staff, communication platforms including

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
				weekly “chat with HoM” & monthly forum to speck to board level safety champions, weekly leadership team newsletter, written communication to all staff from HoM & CD, team meetings & organised forums to raise thoughts or concerns for action Safety concerns dashboard visible & email address in place Ask HoM page on teams & “my life would be easier if...” page to raise aspects at work where changes & development would improve experience Junior doctor forums & consultant meetings Twice daily safety huddles, bleepholder role implemented to support weekday demand & capacity management of elective & non elective activity, 24/7

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
				maternity manager on call Action plans in place to support provision of B7 co-ordinator SN status Open door policy with senior leadership team, visibility & availability for guidance & support Collaborative audit of demand & capacity Planned implementation of BR+ acuity app to ease completion of red flags and support assessment of acuity for reporting Escalation procedure re-organised and specific maternity staffing business contingency plan in place Re-organised maternity structure supported increased collaboration with midwifery & obstetric leads Consultant midwives to support clinical

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
				decision making, professional voice, care plans for women out of guidance New process of guideline management with pathway & flow chart in place, collaborative review & completion of guidance between obstetric & midwifery team Autonomy encouraged & supported to increase innovation & ownership Internal & external training supported & aligned with core competencies in addition to aspects raised by staff for prioritisation to increase knowledge, skills & confidence Maternity & neonatal safety champions in place FTSU guardians Individualised approach to

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
				supporting staff, promoting development, learning & aspirations Review & challenge of language used within training and governance forums which does not support human factors Identification of aspects for improvement in the workplace based on human factors & ergonomics to support staff in their role Birth Rights informed choice training to support a shared vision to the development of care planning with women Collaborative midwifery & obstetric handovers MDT de-briefs & training Staff experience action plan Many aspects implemented recently

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
				and therefore may not be fully embedded yet to enable all staff to identify this as culture takes
		Robust maternity governance team structure, with accountability and line management to the DoM and CD with key roles identified and clearly defined links for wider support and learning to corporate governance teams		Governance Lead appointed Maternity leadership structure re-organised to ensure clear responsibility and lines of accountability Specialist roles reviewed and re-organised to ensure completion of functions aligned to role and clear oversight Collaboration with corporate governance team Key roles implemented to support delivery of quality & safety Consultant links to each governance function

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Maternity governance structure within the directorate	Maternity governance team to include as a minimum: Maternity governance lead (Current RM with the NMC) Consultant Obstetrician governance lead (Min 2PA's) Maternity risk manager (Current RM with the NMC or relevant transferable skills) Maternity clinical incident leads Audit midwife Practice development midwife Clinical educators to include leading preceptorship programme Appropriate Governance facilitator and admin support		Clinical Governance Lead Consultant Risk Lead Risk Midwife Audit & Guideline Midwife Practice Development Midwife Team Learning Education Lead Clinical governance and practice development administrator
		Roles and responsibilities for delivery of the maternity governance agenda are clearly defined for each team member		JD's in place for all team members Updated in JD's in line with responsibilities Reviewing job planning with specialist midwives

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Team capacity able to meet demand, eg risk register, and clinical investigations completed in expected timescales		RCA training organised for leadership team and risk midwife Lead midwife and obstetrician as co-authors of all SI/RCA All RCA/SI reports supported by the Clinical Governance Lead midwife SI/RCA tracker in place to maintain oversight of timescales and request extensions as required SMART action plans and completion monitored through the divisional governance structures Increased capacity in the maternity governance team, no maternity specific incident lead & all who lead on completion of reports also have other roles and responsibilities Risk Register reviewed monthly at triumvirate meeting

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		In date maternity-specific risk management strategy, as a specific standalone document clearly aligned to BAF		**Maternity specific risk strategy in development**
	Maternity-specific risk management strategy	Clearly defined in date trust wide BAF		**Maternity specific risk strategy in development**
	Clear ward-to-board framework aligned to BAF	Perinatal services quality assurance framework supported by standardised reporting requirements in place from ward to board		Reporting mechanisms in place to board and LMNS to report on perinatal quality surveillance data Clinical Quality & Safety Committee Patient Safety Board Divisional Governance Structures Management Board BLMK Maternity Journey Action Group BLMK Highlight Report BLMK Perinatal quality surveillance SoP in place

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Mechanism in place for trust-wide learning to improve communications		Acute used daily updates Weekly trust newsletter updates & Chief Exec video Spotlight on safety aspects identified at SI panel for safety newsletter Trust staff briefings Information boards and screens presenting information Board Level Safety Champion monthly meetings

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Proactive shared learning across directorate	Mechanism in place for specific maternity and neonatal learning to improve communication		Maternity & Neonatal safety meeting Mat Neo collaborative ATAIN, PMRT Regional Clinical Safety Network Forum Perinatal Regional Forum Perinatal M&M Joint quality improvement projects eg. Kaiser tool Joint service developments eg. TC
		Governance communication boards		Safety boards in place in clinical areas
		Publicly visible quality and safety board's outside each clinical area		Safety board's visible to staff & service users Screens ordered for clinical areas to share information specifically with service users

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Learning shared across local maternity system and regional networks		Clinical Reference Group Regional Clinical Safety Network Forum Perinatal Regional Forum BLMK strategic board, maternity journey action group, patient safety forums

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Engagement of external stakeholders in learning to improve, eg CCG, Strategic Clinical Network, regional Director/Heads of Midwifery groups		Attendance at regional HoM/ DoM forums CCG forums to review safety & quality indicators Collaboration with CCG in review of action plans and SI reports Collaboration with HSIB on the development, review & actions for reports MVP engagement in the review of quality & safety data Clinical Reference Group Regional Clinical Safety Network Forum Perinatal Regional Forum BLMK strategic board, maternity journey action group, patient safety forums
		Well-developed and defined trust wide communication strategy to include maternity services in place and in date. Reviewed annually as a minimum.		Communication strategy completed & being ratified through board February 2022

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Multi-agency input evident in the development of the maternity specification		Development of the specification in collaboration with CCG, contracts & income team, clinicians, service leads, stakeholders
Application of national standards and guidance	**Maternity specification in place for commissioned services**	Approved through relevant governance process		CCG & trust governance processes in place for approval
		In date and reflective of local maternity system plan		Specification last updated and agreed pre-pandemic
		Full compliance with all current 10 standards submitted		Full compliance with CNST Year 3
	Application of CNST 10 safety actions	A SMART action plan in place if not fully compliant that is appropriately financially resourced.		Full compliance with CNST year 3 and action plan in place to meet the requirements of CNST year 4

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Clear process defined and followed for progress reporting to LMS, Commissioners, regional teams and the trust board that ensures oversights and assurance before formal sign off of compliance		Monthly reporting of CNST status in trust & LMNS Submit evidence files for LMNS review & sign off Board level safety champions review evidence prior to trust board sign off Evidence submitted for trust board sign off

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Clear process for multiprofessional, development, review and ratification of all clinical guidelines		Process in place with clear pathway & flow chart demonstrating procedure for guideline review Centralised file developed for guidelines for review to be organised to increase ease in process for review and update All guidelines co-authored by midwife & obstetrician with MDT input as required MVP access to centralised guidelines file to support involvement from initial review process MVP attend guidelines group, TOR updated to reflect MVP involvement in process & MVP comment required on all guidelines and patient information leaflet GAP included for update & review

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
				alongside the guideline Guideline tracker in place to monitor ongoing compliance with review timescales Guideline compliance reported through the governance report & divisional governance structure
	Clinical guidance in date and aligned to the national standards	Scheduled clinical guidance and standards multiprofessional meetings for a rolling 12 months programme.		Monthly MDT & MVP guidelines group meetings to review & approve guidelines & GAP's Compliance reported through divisional governance structures

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		All guidance NICE complaint where appropriate for commissioned services		Pathways of care delivered with guidance alternative to NICE approved & agreed with MDT involvement, through trust governance processes with regional clinical network involvement eg. Physiological CTG Guidance GAP against NICE
		All clinical guidance and quality standards reviewed and updated in compliance with NICE		Completion of GAP at time of guideline update Process implemented for non-compliant areas to report through divisional governance structure for mitigation/ escalation Aspects of non-compliance reported on risk register as necessary 10% guidelines out of date
		All five elements implemented in line with most updated version		SBLCBv2 implemented

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Saving Babies Lives care bundle implemented	SMART action plan in place identifying gaps and actions to achieve full implementation to national standards.		SBLCBv2 ongoing action plan in place
		Trajectory for improvement to meet national ambition identified as part of maternity safety plan		Fully implemented Compliance reported monthly through divisional governance structures & LMNS Maternity Safety Plan in development
		All four key actions in place and consistently embedded		Regular audits included within annual audit schedule to continuously monitor compliance
	Application of the four key action points to reduce inequality for BAME women and families	Application of equity strategy recommendations and identified within local equity strategy		LMNS bespoke cultural competency training organised Examples of tailored communications implemented for BAME women MVP collected care experiences from BAME women to support targeted improvements Implementation of CoC prioritising women from BAME backgrounds

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		All actions implemented, embedded and sustainable		Ethnic dashboard developed to target specific improvements based on identified areas of focus
	Implementation of 7 essential learning actions from the Ockendon first report	Fetal Surveillance midwife appointed as a minimum 0.4 WTE		1 WTE in post
		Fetal surveillance consultant obstetrician lead appointed with a minimum of 2-3 PAs		1 PA allocated to fetal surveillance lead consultant
		Plan in place for implementation and roll out of A-EQUIP		Sessional PMA team in place Undertaking a GAP against the A-EQUIP model to inform the implementation plan Reviewing opportunity for lead PMA to support implementation
	A-EQUIP implemented	Clear plan for model of delivery for A-EQUIP and working in collaboration with the maternity governance team		Undertaking a GAP against the A-EQUIP model to inform the implementation plan

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Training plan for transition courses and succession plan for new professional midwifery advocate (PMA) A-EQUIP model in place and being delivered		Training currently being organised for further PMA's 1 PMA recently qualified Undertaking a GAP against the A-EQUIP model to inform the implementation plan
		Service provision and guidance aligned to national bereavement pathway and standards		GAP against bereavement pathway to identify areas for service development Bereavement room on EPAU required Bereavement training to form part of midwives mandatory training from March 2022
	Maternity bereavement services and support	Bereavement midwife in post		Yes 1 WTE

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	available	Information and support available 24/7		Yes Guidance in place to support staff Information available for women & families Bereavement midwife follows up all women & families Bereavement midwife supports staff with processes
		Environment available to women consistent with recommendations and guidance from bereavement support groups and charities		Dedicated bereavement room with en-suite
		Quality improvement leads in place		Maternity QI lead in post
	Quality improvement structure applied	Maternity Quality Improvement Plan that defines all key areas for improvement as well as proactive innovation		MIG (Maternity Improvement Group) in place Workstreams Leadership Workforce Safety & Quality Education & Training Patient Experience Operational Chaired by Director of operations with CN & MD attendence

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Recognised and approved quality improvement tools and frameworks widely used to support services		Quality improvement methodology applied to projects Staff trained in QI within maternity
		Established quality improvement hub, virtual or otherwise		QI hub in place, new trust QI lead currently being appointed
		Listening into action or similar concept implemented across the trust		Staff survey/ feedback Collaborative actions Reviewing effectiveness of interventions through staff KPI's Retention & Recruitment Patient experience, quality & safety metrics Executive oversight & intervention in areas not demonstrating assurance

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Continue to build on the work of the MatNeoSip culture survey outputs/findings.		Staff survey action plan Staff voices group PMA Team Implementation of TRiM Process for raising safety concerns 7 safety concerns dashboard HF approach to the management of incidents Leadership development
	MatNeoSip embedded in service delivery	MTP and the maternity safety strategy well defined in the local maternity system and quality improvement plan		**Maternity specific risk strategy in development** Linked to the maternity safety plan LMNS workstream plan & deliverables in place
	Maternity transformation programme (MTP) in place	Dynamic maternity safety plan in place and in date (in line with spotlight on maternity and national maternity safety strategy)		Maternity safety plan being drafted to bring together all the safety & quality requirements for clarity

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Positive safety culture across the directorate and trust	**Maternity safety improvement plan in place**	Standing agenda item on key directorate meetings and trust committees		MIG is an agenda item through divisional & trust governance forums
		FTSU guardian in post, with time dedicated to the role		In post
	Freedom to Speak Up (FTSU) guardians in post	Human factors training lead in post		Trust HF training lead in post HF champions in maternity, MDT co-hort attending intensive train the trainer HF training in March 2022 to create maternity HF faculty
	Human factors training available	Human factors training part of trust essential training requirements		HF training provided to all staff as part of the core competencies
		Human factors training a key component of clinical skills drills		Included in the delivery of simulation training & skills & drills

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Human factors a key area of focus in clinical investigations and formal complaint responses		Consideration within complaint responses Investigations based on a systems & processes not individual factor HF framework used to identify contributing factors within incidents SMART human factors based action plans developed in response to incidents
		Multi-professional handover in place as a minimum to include Board handover with representation from every professional group: • Consultant obstetrician • ST7 or equivalent • ST2/3 or equivalent • Senior clinical lead midwife • Anaesthetist And consider appropriate attendance of the following: • Senior clinical neonatal nurse • Paediatrician/neonatologist? • Relevant leads form other clinical areas eg, antenatal/postnatal ward/triage.		2 further consultants appointed to support twice daily consultant led ward rounds 7 days a week Anaesthetist attends morning MDT handover and evening when available Reviewing opportunities for increased consistency with anaesthetic attendance to evening handover

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Robust and embedded clinical handovers in all key clinical areas at every change of staff shift	Clinical face to face review with relevant lead clinicians for all high-risk women and those of concern		2 further consultants appointed to support twice daily consultant led ward rounds 7 days a week Increase to 2nd registrar for cover overnight Ward rounds include MDT clinical face to face reviews with all women in the intrapartum area Theme within investigation reports of face-to-face reviews not taking place with the obstetric team SMART action plans in place addressing identified contributing factors

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		A minimum of two safety huddles daily in all acute clinical areas to include all members of the MDT working across and in maternity services as well as the opportunity to convene an urgent huddle as part of escalation process's		Twice daily maternity safety huddles in place 7 days a week MDT included in safety huddles, improved consistency in obstetric representation is currently an action Additional huddles organised as required Maternity SIT rep shared with site team Maternity updates at site team huddles 3 times a day
	Safety huddles	Guideline or standard operating procedure describing process and frequency in place and in date		Safety huddles included in updated maternity escalation guideline for ratification Feb 2022
		Audit of compliance against above		Maternity SIT REP form completed for each huddle and sent to site team Maternity manager on call/ bleep holder attends every maternity safety huddle

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Annual schedule for Swartz rounds in place		Monthly
	Trust wide Swartz rounds	Multiprofessional attendance recorded and supported as part of working time		MDT attendance
		Broad range of specialties leading sessions		Mixture of specialties & general
		Trust-wide weekly patient safety summit led by medical director or executive chief nurse		Weekly SI panel reviewing all moderate incidents & collating learning for cascade to staff
	Trust-wide safety and learning events	Robust process for reporting back to divisions from safety summit		Patient safety newsletter
		Annual or biannual trust-wide learning to improve events or patient safety conference forum		Nursing, Midwifery & Therapies Board chaired by CN Clinical Board in Seminar & Patient Safety Board chaired by MD
		Trust board each month opened with patient story, with commitment to action and change completed in agreed timeframes		Patient story at beginning of each board in place
		In date business plan in place		Business plans in place & submitted for aspects required in order to meet safety & quality aspects

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Comprehension of business/ contingency plans impact on quality. **(ie Maternity Transformation plan, Neonatal Review, Maternity Safety plan and Local Maternity System plan)**	**Business plan in place for 12 months prospectively**	Meets annual planning guidance		Business planning organised through ops 7 finance team
		Business plan supports and drives quality improvement and safety as key priority		Business cases aligned to safety & quality deliverables
		Business plan highlights workforce needs and commits to meeting safe staffing levels across all staff groups in line with BR+ or other relevant workforce guidance for staff groups		Currently funded above previous BR+ recommendation in 2018 New BR+ report awaited in March 2022, business case to be prepared if increased midwifery establishment required CoC implementation plan for presentation to board in March 2022

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Consultant job plans in place and meet service needs in relation to capacity and demand		2 further consultants recently appointed to meet requirement for twice daily, 7-day ward rounds Allocated PA's for governance functions below the recommended amount, reduces capacity for MDT support ATAIN currently on the RR due to delays associated with MDT attendance Increase in consultants will enable an increase in the PA's available to support governance functions
		All lead obstetric roles such as: labour ward lead, audit lead, clinical governance lead and early pregnancy lead are in place and have allocated PAs in job plans		Job plans include PA's for governance & lead functions
		Business plans ensures all developments and improvements meet national standards and guidance		All business cases, developments & improvements based on quality improvement aligned with guidance & requirements

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Business plan is aligned to NHS 10-year plan, specific national initiatives and agendas.		NHS 10 year plan aligned with the maternity deliverables
		Business plans include dedicated time for clinicians leading on innovation, QI and Research		Long term plan objectives within the maternity deliverables Implementation of CoC continued reducing
		That service plans and operational delivery meets the maternity objectives of the Long Term Plan in reducing health inequalities and unwarranted variation in care. Note the Maternity and Neonatal Plans on Pages 12 & 13.		

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Meeting the requirements of Equality and Inequality & Diversity Legislation and Guidances.	**That Employment Policies and Clinical Guidances meet the publication requirements of Equity and Diversity Legislation.**	Assess service ambitions against the Midwifery 2020: Delivering expectations helpfully set out clear expectations in relation to reducing health inequalities, parts 3.1, 4.1 and 4.3 of the documents.		Midwives work in partnership with external agencies to support the provision of care for women, engaging with services to enable targeted support eg. Perinatal mental health, safeguarding, smoking cessation Implementation of the CoC model to enable seamless maternity care for women, improve outcomes, collaborate with MDT & organise appropriate referrals Public health role to support population interventions improving health eg. Increased breastfeeding rates, reduction in smoking, healthy lifestyle choices

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Refer to the guidance from the Royal College of Midwives (RCM) Stepping Up to Public Health, (2017). Utilise the Stepping up to Public Health Model, Table 10 as a template.		Booking appointment includes collection of risk factors & provision of information to support healthy pregnancy, referrals made for lifestyle factors & care pathway discussed Increased information on the maternity website & identification of further areas to access information Risk assessment as part of each antenatal appointment to review care pathway & provide information as required Consultant midwives in post MSW project to align skills & competencies with consistent JD's & clear routes for career progression ELearning available on a number of

Key lines of enquiry	Kirkup recommendation number
Leadership and development	2, 3, 4, 5, 6, 7, 10, 11, 12, 13, 14, 15, 16, 17, 18
Governance: Covers all pillars of Good governance	2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Quality Improvement: application of methodology and tools	5, 6, 9, 12, 13, 15, 16, 17, 18
National standards and Guidance: service delivery	2, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Safety Culture: no blame, proactive, open and honest approach, Psychological safety	2, 3, 4, 5, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Patient Voice: Service user involvement and engagement through co-production and co-design. MVP and wider	6, 9, 11, 12, 13, 15, 17, 18
Staff Engagement: Harvard System two leadership approach, feedback and good communication tools	2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Business Planning: aligned with LMNS plans and the National Maternity Transformation agenda, Maternity safety strategy and the Long term plan	8, 9, 10, 14, 15, 16, 17, 18

Key supporting documents and reading list

1. NHS England National Maternity review: Better Births. February 2016; https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

2. Royal College of Obstetricians and Gynaecologists Maternity Standards 2016; https://www.rcog.org.uk/globalassets/documents/guidelines/working-party-reports/maternitystandards.pdf

3. NHS England NHS Long Term Plan: January 2019; https://www.longtermplan.nhs.uk/

4. Report of the Investigation into Morecambe Bay March 2015; https://www.gov.uk/government/publications/morecambe-bay-investigation-report

5. Royal College of Midwives. Birth-rate plus tools; https://www.rcm.org.uk/media/2375/working-with-birthrate-plus.pdf

6. Royal College of Midwives State of Maternity Services 2018; https://www.rcm.org.uk/media/2373/state-of-maternity-services-report-2018-england.pdf

7. NHS England. Spotlight on Maternity: Safer Maternity care. 2016; https://www.england.nhs.uk/signuptosafety/wp-content/uploads/sites/16/2015/11/spotlight-on-maternity-guide.pdf

8. Department of Health Safer Maternity care. The National Ambition. November 2017; https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/560491/Safer_Maternity_Care_action_plan.pdf

9. NHS Resolution. Maternity Incentivisation Scheme 2019/20; https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

10. NHS staff survey. (2018); https://www.nhsstaffsurveys.com/Page/1064/Latest-Results/2018-Results/

11. Maternity Picker Survey. 2019; https://www.picker.org/wp-content/uploads/2014/10/Maternity-4-pager-for-website-ARe-V2-18122018.pdf

12. National Maternity Perinatal Audit. (NMPA) report; https://www.hqip.org.uk/resource/national-maternity-and-perinatal-audit-nmpa-clinical-report-2019/#.XdUiX2pLFPY

13. Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK. (MBRACE) report; https://www.npeu.ox.ac.uk/mbrrace-uk

14. Organisations Monthly Maternity Dashboards; https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/maternity-services-dashboard

15. Organisational Maternity and Neonatal Cultural Score Survey; https://improvement.nhs.uk/documents/5039/Measuring_safety_culture_in_matneo_services_qi_1apr.pdf

16. NHS England Saving babies lives Care bundle. V2 March 2019; https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

17. 7 Features of safety in maternity services framework; https://for-us-framework.carrd.co/

18. Ockendon Report: investigation into maternity services at Shrewsbury and |Telford NHS hospitals 2020; https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust

19. Perinatal Surveillance Model; https://www.england.nhs.uk/wp-content/uploads/2020/12/implementing-a-revised-perinatal-quality-surveillance-model.pdf

20. Maternity Incentive Scheme; https://resolution.nhs.uk/wp-content/uploads/2021/03/Maternity-Incentive-Scheme-year-3-March-2021-FINAL.pdf

Meeting Title	**Trust Board**	**Date: March 2022**
Report Title	**Patient Experience Update**	**Agenda Item: 12**
Lead Director	**Name: Nicky Burns-Muir**	**Title: Chief Nurse**
Report Author	**Name: Sophie Conneely**	**Title: Outpatient Maternity Matron – Maternity Patient Experience Lead**

Key Highlights/ Summary	**The CQC Maternity Patient Experience Survey results were released in February 2022 demonstrating some required areas of improvement specifically related to elements of postnatal experience.** **The Maternity Voices Partnership work in collaboration with the service to review and support actions aimed at improving service users' experiences of maternity care.** **This paper details the developments in the approach to responding to, actioning and reporting maternity patient experience within the division, including specific response to the planned actions aligned with the CQC maternity survey.** **The current live patient experience action plan is attached as an appendix to the paper.**			
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Noting** √	**For Review** √

Strategic Objectives Links	**Improving Patient Experience**
Board Assurance Framework (BAF)/ Risk Register Links	

Report History	
Next Steps	
Appendices/Attachments	**Patient Experience Action Plan**

Maternity Patient Experience Paper February 2022

Background

In February 2021 the CQC (Care Quality Commission) completed a Maternity Survey looking at the experiences of women who had a live birth between the 1ST and 28th February 2021.

The timing of the survey means that respondents were those who have experienced their antenatal, labour, birth and postnatal stages of their pregnancies during the pandemic conditions.

The survey was the first mixed-mode maternity survey where online responses were encouraged but postal completion also remained as an option.

Nationally, the average response rate increased from 36% in 2019 to 52% in 2021 with 89% of respondents taking part online.

Report Findings

167 Milton Keynes University Hospital NHS Foundation Trust service users responded to the survey giving a response rate of 56.42%

Our Trust results were:

Much better than most trusts for **0** questions.

Better than most trusts for **0** questions.

Somewhat better than most trusts for **0** questions.

About the same as other trusts for **41** questions.

Somewhat worse than other trusts for **3** questions – as detailed below

- *If you raised a concern during labour and birth, did you feel that it was taken seriously?*
- *During labour and birth, were you able to get a member of staff to help you when you needed it?*
- *Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?*

Worse than other trust for 5 questions – as detailed below

- *After your baby was born, did you have the opportunity to ask questions about your labour and the birth?*
- *On the day you left hospital, was your discharge delayed for any reason?*
- *Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?*
- *Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?*
- *Thinking about your stay in hospital, how clean was the hospital room or ward you were in?*

Much worse than other trusts for **1** question – as detailed below

- *If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you when you needed it?*

Current

In early 2021 we implemented the Maternity Improvement Group (MIG) with one workstream specifically focused on patient experience. This group includes MVP (Maternity Voices Partnership) in the core membership. The group objectives were to:

- Ensure that women and their families are listened to and that their voices are heard
- To embed in practice, a process for how we use the experience of our service users for learning, improvement and as the driver for implementing changes with the maternity service
- Ensure that service changes are co-designed and co-produced with service users
- To ensure equality, diversity and inclusion

This branch of the MIG, set up a task and finish (TAF) group that met bi-monthly reviewing:

- The sources of feedback
- How findings are collated, reviewed, themed and actioned
- How we could encourage an increase in responses
- How to ensure diversity, inclusivity, and accessibility.

From the TAF group a patient experience live action plan has been developed and is updated monthly as part of the Maternity Patient Experience Review Group, in collaboration with MVP and a copy of the latest version can be found attached. This monthly meeting reviews feedback from the Patient Experience Platform and other sources, these are collated, themed in line with the trust categories for triangulation. They are then reviewed, actions are suggested and documented, and an exception report is produced which is submitted for oversight as part of the monthly women's and children's CSU meeting.

The maternity senior team has also undergone a restructure. Patient Experience was added to the portfolio of the Outpatient Matron, this has further developed established relationships with and a direct link to the MVP. The MVP also meet twice monthly with the Head of Midwifery and monthly with the Chief Nurse. As part of this restructure, two consultant midwife roles were implemented, focusing on embedding birth choices clinics, birth preferences packs and rolling out informed consent training.

As well as the above, our MVP in Milton Keynes have:

- Been invited onto interview panels for midwifery roles.
- Attended the guideline review group where they have commented on guidance and patient information.

- Attended the labour ward forum as service user representation
- Collaborated with the Outpatient Matron and Outpatient Consultant Midwife in the re-design of the Maternity Website alongside a dedicated member of the communications team.
- In response to the Ockenden report contributed to the review of the required accessibility of information for services users.
- Completed independent surveys, focus on capturing the experience of BAME service users
- Supported with public health messaging and communications through their active social media accounts.

As part of a further action taken in response to the CQC 2021 survey and to gain more understanding of the data provided, the MKUH Communications department are leading 'The Big Conversation: giving birth in a pandemic'. A 12 week focus on maternity care during the pandemic which we hope will provide further qualitative data and narrative to support the quantitative data provided within the report. Service users are encouraged to share their experiences online without limit on words or characters, to enable them to share as much or as little detail as they want with the opportunity to include their name or remain anonymous.

Plan

As a result of the many implementations regarding patient experience we have several specific actions to address common themes. These are all detailed in the live action plan actioned.

For the month of March 2022 there will be the following focuses:

- **A Postnatal Pledge**
    - Our continuity of carer teams are going to collectively review how they can increase their presence on postnatal ward. The aim being to improve experience through a postnatal care with a known midwife, ensuring that care is completed in a timely manner, contributing to a reduced length of stay.
- **The introduction of Night Mode**
    - Night mode is a suggested response to the theme of increased disturbance and a noisy environment during postnatal inpatient stays. We will review the requirement to complete observations during the night, consider a change in the environment including a staff/service user agreement, the use of a lower level of lighting, a quiet approach to movement of equipment and the use of headphones/phones on silent after an agreed time.
- **Continued development of the Maternity Website**
    - Alongside the MVP, our Outpatient Midwife and Outpatient Consultant Midwife will continue to meet with the communications team in the full review and re-design of the maternity website. The focus is on increased accessibility to patient information, in multiple forms whilst ensuring that the website is user friendly, interactive, and reflective of our maternity services.

Colour Key
Community
Outpatients (ANC & ADAU & Community)
ADAU
Labour Ward
Postnatal Ward
Inpatient (Labour Ward and Ward 9)
All Areas

Theme	Subthemes	Specific Actions	Steps to achieve	Responsible	Timeframe	Evidence/Outcome/Impact	Status RAG
Admissions and Discharges	*Delay in discharges	Discharge process to be laminated for ease of use	Create document Ensure accessible to staff	Ward Manager	Oct 21 Oct 21	Document created for discharge process, Accessible via Ward 9 Teams / Laminated for use on WOWs	
		Manage expectations of discharge timeframe	To be discussed at birth planning appointment Discuss & Encourage option of early discharge from LW if meets criteria Discuss on orientation to the ward Ensure discharge timeframe is discussed as part of daily check	Community Midwife Intrapartum Midwife Midwife on PN ward MW/Obstetrician on PN ward		Midwife providing IP care reviews if meets criteria for early discharge to avoid unnecessary postnatal admission	
		Bank Shifts specifically for Discharge & NIPE	Create duties on eROSTER Send to Bank Review number of specific shifts booked Review impact of these shifts	Inpatient Matron Inpatient Matron/Ward Manager Inpatient Matron/Ward Manager Inpatient Matron/Ward Manager	Sep 21 Sep 21 Feb 22 Feb 22	Shifts created on eROSTER Shifts sent to Bank	
		Support reduction in length of stay.	Implementation of MDT workstream Review and ammend enhanced recovery guidance COFC teams to review how they can increase their presence on postnatal ward Review feeding support package within community maternity including NEST	Transformation Team MDT COFC Teams & Team Leaders Infant feeding lead	Dec 21 April 22 Mar 22 Mar 22	Commenced December 2021	
		Review NIPE process	Support midwives to complete NIPE training Completion of NIPE in environment suited to families	PDM Team NIPE Practitioners		Regular course intakes Community Midwives able to complete NIPE do so in home environment. MWs completion of NIPE on LW	
		Review medication administration	Regular TTO's to be stocked on the ward Ensure TTO's are stocked and readily available Review the process for TTO prescription & the delays Support midwives to complete prescribing course	Pharmacy Ward Manager Obstetric Team PDM Team	Dec 21 Dec 21 Mar 22	Medications for regular TTO's are available on wards Shift leaders check and order daily if low stock	
		Digital Discharges	Create content for digital discharge talk Review content for inclusiviy and accessibility e.g subtitled/multi-lingual Installation of screens for service user areas Implement process for digital discharges from the ward	MDT & Comms Comms IT Ward Manager	March	Screens on order, awaiting arrival and installation	
		Neonatal Thermoregulation action plan	*See Neonatal Thermoregulation Action Plan*	ATAIN group		Neonatal Thermregulation action plan in progress	
		Resume normal visiting hours when safe to do so	Continual review of National and Trust visiting guidance	HOM/Execs		Maternity Visiting regularly reviewed, increased to 12hrs per day on ward and reintroduced 2nd birth partner on LW	
	Visiting Times	Inform service users about visiting times	Discuss Antenatally Disseminate changes through social media platforms Discuss on orientation to the ward Improve visitor signage on ward	Community Midwives Comms Ward Midwives Comms	Feb 22 Feb 22 Feb 22 Feb 22		
	Disturbed rest during stay	Reduce disturbance overnight	Requirement of observations during the night to be reviewed Night Mode' to consider lights down at a specific time Quiet approach when moving beds is required for new admissions	Obstetric Team Ward Midwives Ward Staff			
		Reduce Noisy Environment	Design a ward/service user etiquette 'contract' for ward stay Introduce 'Night Mode' Phones on silent after certain time Use of headphones/not loudspeaker Staff to ensure noise from conversations is lowered after a specific time Staff empowered to challenge for benefit of all who are staying	MVP MVP/Ward Managers Service Users Service Users Ward Staff Midwives	March	Will be discussed at March MVP meeting	
	Ward Orientaton	Thorough orientation to Ward	Discuss expected length of stay Ward Tour on Maternity Website Hospital Bag List on Maternity Website Laminate 'contract' for ward stay	MDT Comms Outpatient Matron/Outpatient Cons MW & Comms Ward Manager	April	In plans for redesign of maternity website In plans for redesign of maternity website	
	Rushed Assessments	Thorough completion of admission assessment	Review clinically on arrival to labour ward Complete well-being assessment Review use of 'Burvill Scoring' Latent Phase workshop Discuss choice and preference based on whole findings and not just clinical assessment	MDT MDT Consultant Midwives Consultant Midwives MDT			
Appointments	Incorrect appointment details	Ensure correct appointment details are issued	All appointment letter templates to be reviewed Review process for informing service user if appointment details change Service users to be able to access portal to view all upcoming appointments and details	Operations Manager/ANC Operations Team/Women's Hub/ANC IT	Oct 21 Oct 21	Appointment letters reviewed by Operations Manager and ANC MSW Consideration for informing service users when reverted to some appointments face to face	
Clinical Treatment	Service User Involvement	Co-produce and Co-desgin guidance and service changes	MVP representation at the Guideline Review Group	Guideline & Audit Midwife/MVP	Sep 21	MVP added to TOR for quorate attendance	
		Communications	Any communications to have MVP sign off	MVP/MDT	Mar 22		
Communications	*Concerns during labour and birth not taken seriously	Informed consent	Support 'Birth Rights' training for the MDT Appoint consultant midwives	Consultant Midwives HOM	Feb 22 Oct 21	2nd training date 14/2/22 Inpatient and Outpatient Consultant Midwives appointed	
		Collaborative decision making and inclusion of service users in their care	Ensure face to face ward review are completed Appoint consultant midwives LW co-ordinator leadership course to support professional development and challenge	Lead Obstetrican HOM Chief Nurse	Feb 22 Oct 21 Dec 21	Inpatient and Outpatient Consultant Midwives appointed First training dates completed	
		Support the escalation of concerns	Update 'Meet the Team' PIL with uniforms demonstrating who's who Include escalation of concerns on Trust Website Discuss escalation of concerns during birth planning appointment Poster about how to escalate and who to in service user areas	Audit and Guidelines Midwife Outpatient Matron/Outpatient Cons MW & Comms Community Midwives Comms	Feb 22 April 22 March 22 March 22	Reviewed through Guideline Review Group In plans for redesign of maternity website In plans for implementation of birth planning appointment	
	*Not having the opportunity to ask questions about labour and birth after baby born	Post Birth Discussion/Debriefing	Discuss birth experience as part of daily review as inpatient Offer Birth Afterthoughts to all women Ensure Birth Afterthoughts leaflet is included in discharge pack Discuss Birth experience & Birth afterthoughts service at Community visits Include Birth Afterthoughts information and booking on Trust Website Details of Birth Afterthoughts in be included on information screens in service user areas Review current Birth Afterthoughts services and increase availability of appointments Continued COFC rollout to increase known team presence at birth Continued COFC rollout to increase known team providing PN care Improve service user accessibility to own records to support ability to debrief Review remote eCARE connectivity to support ability to review birth records during home visits	MDT MDT Discharging Midwives Community Midwives Outpatient Matron/Outpatient Cons MW & Comms Comms PMA team HOM/Matrons HOM/Matrons IT IT	Dec 21 Dec 21 Dec 21 April 22 April 22 Mar 22 Mar 23 Mar 23	In plans for redesign of maternity website	
	*Not being given information and explanations needed	Increase accessibility of information for service users	Information sharing videos on screens in service user areas Redesign of maternity website for increased and easier access to information Continued COFC rollout to increase known midwife to provide tailored information Reintroduction of antenatal classes Design standardised antenatal class content list Birth planning information pack to be designed Birth planning appointments to take place Weekly meet your consultant midwife sessions	Comms Outpatient Matron/Outpatient Cons MW & Comms HOM/Matrons Community Midwives Consultant Midwives Outpatient Consultant Midwife Community Midwives Consultant Midwives	April 22 April 22 Mar 23 Feb 22 Jan 22 Feb 22 Mar 22 Dec 21	In plans for redesign of maternity website Content list co-produced with MVP In plans for implementation of birth planning appointment Implemented December 2021	
Consent	Personalised Care	Personalised Care Plans	To be given at booking appointment Ensure remain stocked Ensure available in all languages at point of booking for equality Review at every contact To be evaluated To become digitalised Run listening events for maternity team views on PCPs Ensure all clinicians are trained in PCP use	Community Midwives Community Team Leaders LMNS Community Midwives LMNS LMNS LMNS LMNS	April 21 Jan 22 April 21 April 21 April 21	Reviewed as part of audit for Ockenden and added PCP update to eCARE autotext for every contact	
Facilities	*Area not clean	ADAU	Identify cleanliness audit schedule Review option for perfect ward for outpatient areas Review of the planned domestic team attendance in each area Signage for service users to alert staff if an area is not clean Urine samples not to be kept on toilet shelf	ADAU Lead Midwife Outpatient Matron Ward Manager Comms ADAU Team			
		Postnatal Ward	Identify cleanliness audit schedule Completion of perfect ward Implement environmental walkrounds Review of the planned domestic team attendance in each area Increase domestic team presence overnight Weekly walk around with Domestic Supervisor Signage for service users to alert staff if an area is not clean	Ward Manager Ward Manager/Inpatient Matron Inpatient Matron Ward Manager/Inpatient Matron Domestic Services Ward Manager/Inpatient Matron Comms	Feb 22 Jan 22 Feb 22 Feb 22 Feb 22 Mar 22	Ongoing completion, iPAD purchased for ease of completion	
Care	*Not always not able to get help when needed during labour and birth	Maternity Staffing	Monthly maternity staffing review paper Recruitment and Retention plans in place Monthly monitoring of 1-1 care in labour Implementation of the Birth Rate Plus acuity app to support clinical activity planning Implementation of Bleep Holder role Implementation of twice daily safety huddles	HOM HOM/Matrons HOM/Inpatient Matron Inpatient Matron Inpatient Matron Maternity Senior Team	Feb 22 Feb 22 May 21 March 21	Ongoing completion, submitted to Trust Board Fully recruited to MSWS and MW's (In Pipeline) Maintained at 99% and above Implemented May 2021 Established with support of Deputy Chief Nurse	
		Latent Phase of Labour Care	Review use of 'Burvill score' Review appropriate location for care - not dependent soley on dilatation Review implementation of spinning babies techniques for malposition	Consultant Midwives Consultant Midwives Consultant Midwives			
	*Not always not able to get help when needed during postnatal ward stay	Maternity Staffing	Increase staffing on the postnatal ward Recruit to vacant posts for support staff Business case for Registered Nurses to be within the staffing template on postnatal ward Continued COFC rollout to increase known team providing PN care COFC teams to review how they can increase their presence on postnatal ward Reimplement volunteers on ward to support infant feeding	Inpatient Matron Inpatient Matron HOM/Operations Team/Execs HOM/Matrons COFC Teams Inpatient Matron	Jan 22 Mar 22 Mar 23 Mar 22 Mar 22	Fully recruited to MSWS	

		Medication Administration	Review patient own meds administration Explore eCARE ability for patient own meds documentation	Ward Manager/Pharmacy IT/Ward Manager/Pharmacy	Mar 22		
		Visiting	Resume normal visiting hours when safe to do so Continual review of National and Trust visiting guidance	HOM/Execs HOM/Execs		Increased to 12 hours per day on PN ward	
Privacy and Dignity							
Staff Numbers	Staffing shortages	Maternity Staffing	Monthly maternity staffing review paper Recruitment to vacant midwifery posts Retention plans in place Recruit to 'Retention Midwife' post Support for the return to practice programme Support for the recruitment of international midwives	HOM Matrons HOM/Matrons/Retention Midwife Senior Team PDM DHOM	Sep 22 Dec 21 Jan 22 Mar 22	Ongoing completion, submitted to Trust Board Fully recruited to MW's (In Pipeline) Recruited to vacant post for 1 year secondment RTP programme underway - First RTP midwife joining COFC to complete programme and join team on qualification Underway and supported by LMNS	
Values and Behaviours	*Not always treated with kindness and understanding	Thorough exploration of experiences through multiple channels	12 Week 'BIG CONVERSATION' to explore views of maternity care during COVID19 Pandemic MVP to explore this in more detail through their established forums Completion of Appreciative Enquiry	Comms MVP MDT	April 22 April 22 April 22	Commenced W/C 7/2/22	
	*Not always able to have birth partner stay as much as wanted	Visiting Restriction	Support for birth partners to attend antenatal appointments Reimplement 2nd Birth partner Review specific requests for increased birth partner presence based on individualised need Continuous review of parent support restrictions inline with national and trust adjustments Continuous review of visiting restrictions inline with national and trust adjustments	HOM/Execs HOM/Execs HOM HOM/Execs HOM/Execs	Mar 21 Nov 21 Nov 21	Reintroduced based on national and trust advice Reintroduced Nov 21 but required review and approval through HOM from Jan 22 Supported by HOM based on individualised need	
		Theatres	Ensuring partners are not excluded during spinal procedure in theatre Ensuring partners are not excluded during spinal procedure in recovery	Theatre Lead Theatre Lead	Mar 22 Mar 22		
		Length of Hospital Stay	Identify admission avoidance stategies	MDT			
Waiting Times	Increased Waiting Times in ADAU	Reduce Waiting Times	Implement 24 hour triage (BSOTS model) Communication to staff and patients re new traige system Implement an average wait time poster	DHOM DHOM Triage Lead Midwife	June 22 June 22 June 22	Business Case being submitted	

Meeting title	Board of Directors		**Date:** March 3rd 2022	
Report title:	Nursing Staffing Report		**Agenda item: 12**	
Lead director **Report author Sponsor(s)**	**Name:** Nicky Burns-Muir **Name:** Matthew Sandham Emma Thorne		**Title:** Director of Patient Care/Chief Nurse **Title:** Associate Chief Nurse Workforce Matron	
FoI status:				
Report summary				
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [x]	**Decision** [ ]
Recommendation	That the Board receive the Nursing Staffing Report.			

Strategic objectives links	Objective 1 - Improve patient safety. Objective 2 - Improve patient care.
Board Assurance Framework links	Inadequate staffing are contributory issues for BAF risks 1.1 and 1.4.
CQC outcome/ regulation links	Outcome 13 staffing.
Identified risks and risk management actions	
Resource implications	Unfilled posts have to be covered by Bank or agency staff, with agency staff having a resource implication.
Legal implications including equality and diversity assessment	None as a result of this report.

Report history	To every Public Board
Next steps	
Appendices	Appendices 1

Board of Directors Report on Nursing and Midwifery staffing levels
Amalgamated report for December 2021 and January 2022

1. Purpose

To provide Board with: -

- An overview of Nursing and Midwifery staffing levels.
- An overview of the Nursing and Midwifery vacancies and recruitment activity.
- Update the Board on controls on nursing spend.

2. Planned versus actual staffing and CHPPD (Care Hours per Patient Day)

We continue to report monthly staffing data to 'UNIFY' and to update the Trust Board on the monthly staffing position.

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

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

CHPPD	Total Patient Numbers	Registered Midwives/Nurses	Care Staff	Overall
December	13955	4.6	2.8	7.4
January	13966	4.5	2.7	7.1

Month	**RN/RM Day % Fill Rate**	**HCA/MCA Day % Fill Rate**	**RN/RM Night % Fill Rate**	**HCA/MCA Night % Fill Rate**
December	73.6%	72.7%	99.0%	105.3%
January	69.8%	68.9%	93.3%	99.1%

- *December 2021 and January 2022 data are included in Appendix 1.*

Areas with notable fill rates

During the months of December and January the Trust saw a continued rise in attendance which has affected the CHPPD hours in the month. The Day % fill rate has improved in December but dropped in January due more staff isolating.

Are we safe ?

3. Recruitment Overview

The Tables below are the residual numbers of vacancies.

Medicine

Band	WTE Vacancy	Percentage	Turn over percentage
Band 2	22 WTE	12%	7%
Band 5&6	45 WTE	13%	6%

Medicine's Band 2's has increased, and recruitment has been planned for March.

Surgery

Band	WTE Vacancy	Percentage	Turn Over percentage
Band 2	9 WTE	5 %	6%
Band 5&6	27.2 WTE	9 %	4%

Band 5 vacancies have remained static.

Women's and Children

Band	WTE Vacancy	Percentage	Turn Over percentage
Band 2	0.28 WTE	1%	6 %
Band 5&6	27.5 WTE	10 %	7%

Paediatrics Band 5 and 6 vacancies have increased, and a recruitment plan is in place

4. Recruitment

4.1 Healthcare Assistants

The Trust continues to work closely with NHSE/I on the 'Accelerated Healthcare Support Worker Recruitment Programme'. The aim of the programme is to reduce vacancies swiftly, enhance the onboarding process (including mentorship, training, and pastoral support to candidates), deliver training to optimise safety and enable staff to be competent and safe in practice.

The focus remains to appoint into residual vacancies with individuals without experience into healthcare by the end of March 2022. With this in mind the, Trust will once again collaborate with the Princess Trust, an organisation that helps young people aged 18-30 to expand on the employment opportunities available for them.

4.2 Student Nurses

The Workforce Matron continues to work with the Learning Environment Leads to offer recruitment education workshops for Student Nurses to ensure that MKUH is their first choice to work.

As outlined previously, MKUH offers students undertaking their final 'sign off placement' with us the opportunity of pursuing employment with us as an organisation. A 2022 schedule is in place for the Workforce Matron to meet with all 3rd Year students to discuss this employment opportunity.

This initiative continues to provide a supply of newly registered nurses, familiar with our organisation three times a year. The number of Student Nurses due to qualify in 2022 is outlined below.

2022	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
BSc Adult Nursing		3		11					1	20		
BSc Children & Young People Nursing									4	7		
Bsc Midwifery				8					17			
Trainee Nurse Associates					2					7		
Nurse Associate to RN												
Total	0	3	0	19	2	0	0	0	22	34	0	0

4.3 International Nurse Recruitment

To support the Trusts current vacancies, planned hospital growth and developments the organisation embarked on an international nurse recruitment programme in November 2021, with the aim to recruit 125 nurses throughout 2022.

To date:

- 58 nurses have been interviewed and offered employment with the Trust subject to satisfactory pre-employment checks.
- This recruitment programme will see nurses arrive in cohorts of 16 every 4 weeks.
- 8 International Nurses arrived in January 2022 with a second cohort scheduled to arrive on the 24th of February 2022.
- Nurses have been provided with a bespoke induction programme and 'host ward' for their first three months, (alongside 3 of their peers) to allow for training & education, supervision, and peer support while they prepare for their Objective Structured Clinical Examination (OSCE) and adjust to life in the United Kingdom.
- Interviews are being held monthly, with the next scheduled for 23rd February 2022.

Are we effective?

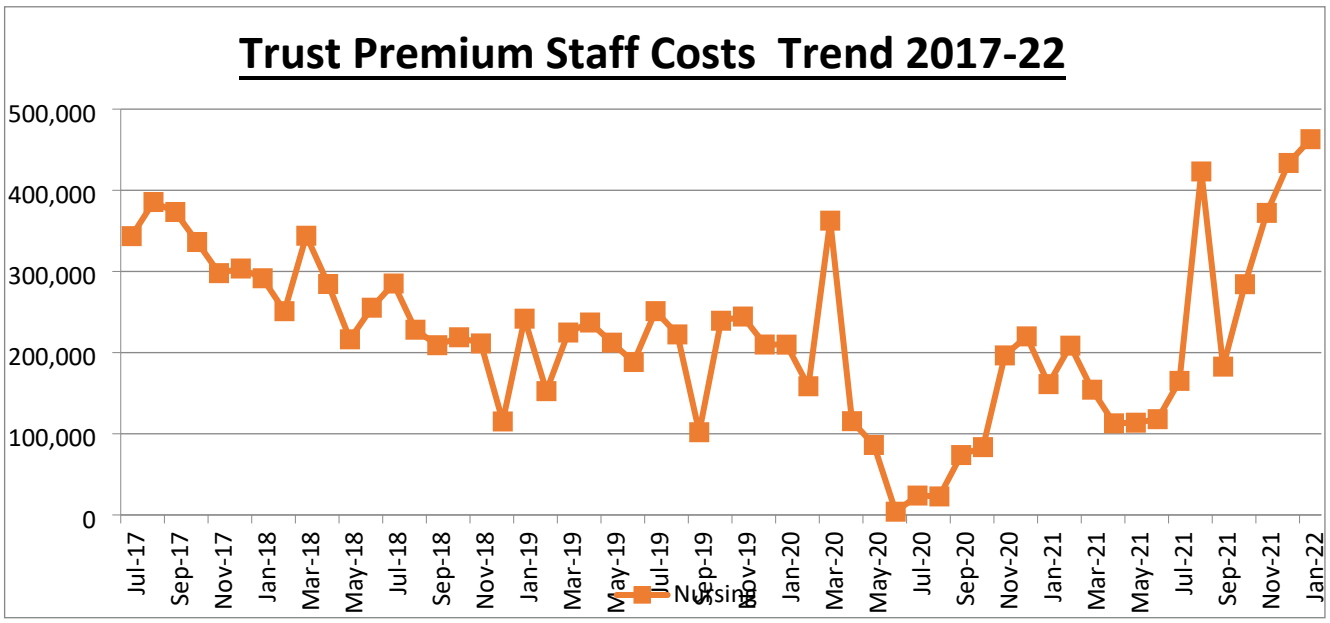
5. SafeCare Tool Update

As mentioned in previous staffing reports the SafeCare 'live system' allows organisations to compare their staffing with the actual acuity/dependency of its patients. It provides organisations with transparency and informs if staffing levels match the current demands.

This invaluable tool allows for Matrons and Senior Managers to 'see at a glance', areas with high acuity and respond to the needs of the ward/department. This tool is however focused on in-patient wards.

A module has now been developed and published by the Shelford Group for Emergency Departments. The Trusts has acquired a license for its use and the nursing workforce will be looking to implement this over the next quarter

6. Agency graph



During the period of December and January, we saw the agency cost continue to rise. This has been driven by increased bed capacity and staff isolating.

We celebrate.

Changes to the Corporate team.

We welcome Andrea Piggott in her new role as Deputy Chief nurse and Garry Copper-Stanton, Head of Practice Education.

Nursing, Midwifery and Care Staff December 2021(Appendix 1)

Ward Name	Day		Night		Care Hours Per Patient Day (CHPPD)			
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
AMU	73.6%	76.2%	97.5%	90.3%	593	6.5	2.2	8.7
ICU	72.1%	68.5%	90.9%	-	221	23.7	1.1	24.7
Ward 2	66.7%	79.0%	95.6%	106.5%	659	4.3	2.8	7.1
NNU	77.8%	61.5%	99.4%	96.8%	423	10.2	1.5	11.7
Ward 14	80.7%	86.3%	97.2%	117.8%	693	3.1	3.5	6.6
Ward 10	2.7%	73.1%	3.4%	71.0%	85	0.3	6.7	7.0
Ward 15	81.8%	82.2%	96.8%	117.7%	813	3.6	2.4	6.0
Ward 16	71.2%	75.2%	101.2%	103.7%	809	3.5	2.2	5.6
Ward 17	68.9%	77.6%	97.6%	114.5%	750	3.9	2.0	5.9
Ward 18	69.2%	79.5%	101.1%	139.1%	793	2.9	3.6	6.6
Ward 19	73.5%	79.1%	106.6%	143.9%	841	3.0	3.5	6.4
Ward 20	70.0%	77.8%	110.0%	97.8%	700	3.9	2.5	6.4
Ward 21	68.3%	72.4%	89.6%	75.8%	455	5.6	2.6	8.2
Ward 22	81.7%	58.1%	101.8%	79.5%	478	6.3	3.9	10.2
Ward 23	75.7%	87.2%	102.6%	124.2%	1106	3.2	3.7	6.9
Ward 24	64.9%	56.3%	83.9%	83.9%	421	4.6	2.8	7.4
Ward 3	85.6%	61.4%	103.2%	120.2%	734	3.8	3.2	7.0
Ward 5	93.4%	71.2%	159.5%	132.1%	489	10.2	2.2	12.4
Ward 7	74.5%	75.4%	97.8%	122.6%	643	3.8	4.1	7.9
Ward 8	83.0%	67.0%	115.3%	100.0%	575	4.7	2.8	7.5
Ward 9	66.5%	63.4%	75.8%	62.7%	1017	2.7	1.5	4.2
Ward 25	62.4%	59.5%	90.5%	68.9%	657	4.4	2.7	7.1

Nursing, Midwifery and Care Staff January 2022(Appendix 1)

Ward Name	Day		Night		Care Hours Per Patient Day (CHPPD)			
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
AMU	69.8%	71.5%	100.4%	102.6%	605	6.1	2.3	8.4
ICU	68.5%	42.9%	81.4%	-	185	25.8	0.7	26.5
Ward 2	68.0%	77.0%	107.3%	106.5%	658	4.6	2.7	7.3
NNU	77.0%	75.6%	95.3%	77.1%	365	11.6	1.7	13.2
Ward 14	71.7%	73.7%	102.2%	100.8%	731	2.8	2.8	5.6
Ward 10	-	53.8%	0.0%	45.2%	19	0.0	20.9	20.9
Ward 15	81.7%	74.2%	97.9%	103.2%	822	3.7	2.1	5.8
Ward 16	57.2%	82.3%	72.6%	113.8%	850	3.3	2.3	5.6
Ward 17	74.3%	73.5%	94.1%	104.8%	742	4.1	1.9	6.0
Ward 18	69.4%	80.3%	100.0%	139.7%	789	2.9	3.7	6.6
Ward 19	81.6%	75.3%	110.3%	115.0%	803	3.7	3.2	6.9
Ward 20	75.1%	62.3%	108.3%	93.5%	685	4.1	2.2	6.4
Ward 21	67.8%	81.6%	101.2%	96.7%	590	4.5	2.4	6.9
Ward 22	72.9%	58.4%	105.1%	90.3%	468	5.5	4.3	9.8
Ward 23	72.2%	76.6%	97.0%	98.7%	1043	3.3	3.3	6.6
Ward 24	46.5%	52.0%	84.4%	92.6%	635	3.3	2.5	5.8
Ward 3	74.3%	60.6%	110.2%	89.5%	712	3.6	2.9	6.4
Ward 5	70.4%	49.0%	122.1%	83.2%	445	8.5	1.6	10.1
Ward 7	79.2%	78.1%	98.9%	138.7%	686	3.7	4.2	7.8
Ward 8	73.2%	63.8%	114.1%	90.6%	549	4.6	2.7	7.3
Ward 9	58.8%	65.2%	65.6%	73.0%	956	2.6	1.7	4.3
Ward 25	62.1%	55.6%	89.6%	69.9%	628	4.6	2.8	7.4

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Trust Board**	**Date: March 2022**
Report Title	**Maternity Staffing Paper**	**Agenda Item: 14**
Lead Director	**Name: Nicky Burns-Muir**	**Title: Chief Nurse**
Report Author	**Name: Melissa Davis**	**Title: Head of Midwifery, Gynaecology & Paediatrics**

Key Highlights/ Summary	**Midwifery Staffing Overview Report submitted for Board Oversight to comply with Safety Action 5 of the NHS Resolutions Maternity Incentive Scheme requirement to submit a midwifery staffing paper every 6 months during the year 4 reporting period of August 2021 to June 2022.** **The staffing paper contains the minimum required information including** • **A clear breakdown of Birth Rate Plus to demonstrate how the required establishment has been calculated** • **Details of planned vs actual midwifery staffing, including evidence of mitigation/escalation for managing staffing shortfall** • **An action plan to address the findings from the tabletop exercise or Birth Rate Plus report, where deficits in staffing levels have been identified** • **The midwife to birth ratio** • **The % specialist midwives employed and those in management positions and mitigation to cover any** • **Evidence demonstrating 100% compliance with supernumerary labour ward co-ordinator status and 1:1 care in establishment with action plans for board sign off where these are not achieved** • **Attached for sign off – Action plan to support compliance with:** 1. **100% compliance with supernumerary status of the labour ward co-ordinator** 2. **100% compliance with 1:1 care in established labour**			
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Noting** √	**For Review** √

Strategic Objectives Links	**Patient Safety, Compliance with National Safety Requirements**
Board Assurance Framework (BAF)/ Risk Register Links	**Midwifery staffing is currently on the risk register at a score of 9**

Report History	
Next Steps	**To be reviewed at Trust Board and attached action plans to receive trust board sign off**
Appendices/Attachments	**Appendix 1 – Action plan to support 100% compliance with supernumerary status of the labour ward co-ordinator** **Appendix 2 – Action plan to support 100% compliance with 1:1 care in labour**

Milton Keynes University Hospital NHS Foundation Trust

MATERNITY STAFFING OVERVIEW REPORT FEBRUARY 2022

Introduction

A requirement of the NHS Resolution Maternity Incentive Scheme is the production of a paper detailing midwifery staffing to provide the board with an overview of key staffing and safety issues, every 6 months.

Birth Rate Plus is currently the only approved demand and capacity modelling tool for use in the assessment and organisation of midwifery staffing.

A Birth Rate Plus assessment was last completed for Milton Keynes maternity service in 2018 and has been the basis of the agreed organisation of maternity staffing.

Two formal establishment reviews were completed and submitted in April 2021 and August 2021 to review the impact of the transition towards continuity of carer as this model does not currently form part of the Birth Rate Plus workforce assessment.

A new Birth Rate Plus Workforce assessment is currently taking place, the data has been submitted and the report is expected, following which a further establishment review will take place to inform future workforce planning.

The review of midwifery establishment to support future workforce planning will be mapped against the continuity of carer implementation plan to support achievement of the requirement for continuity of carer to be the default pathway for women by March 2023.

Midwife to Birth ratio

The expected midwife to birth ratio at Milton Keynes is currently 1:28, which is based on the calculations following the previous Birth Rate Plus workforce report in 2018, for which a total funded clinical establishment of 142.57 WTE is required to support.
The current clinical funded establishment is 146.16 WTE which will be reviewed following the publication of the Birth Rate Plus workforce review which is currently taking place.
The midwife to birth ration is published on the monthly obstetric dashboard and over the previous 6 months, has fluctuated between 1:33 and 1:35.
August 2021 – 1:34
September 2021 – 1:33
October 2021 – 1:35
November 2021 – 1:33
December 2021 - 1:35
January 2022 – 1:31

The fluctuation has been impacted by staff unavailability, predominantly as a result of sickness absence, maternity leave and vacancy.

Planned Vs Actual Midwifery Staffing

Midwifery staffing is reviewed on a daily basis in order to identify the required staffing within all areas to manage the planned and acute activity.

Staffing is reported to the site team via organised virtual trust meetings at 08.30 and 18.30, Maternity Safety Huddles take place twice a day at 10.00 and 15.30 where a SIT REP form is completed to detail the daily staffing and activity and these reports are sent to the site team following the completion of the huddles.

A maternity escalation procedure is in place detailing planned actions to take in the event of staffing, activity or capacity concerns and challenges.
A midwifery business contingency plan was submitted for approval in January 2022 to support the management of midwifery staffing shortfalls which are unable to be mitigated by actions within the escalation procedure.

There is a maternity manager on call 24 hours a day, 365 days a year to support the continued provision of safe maternity services. A maternity bleep holder role was implemented in order to support the weekday operational management of the maternity service, specifically to enable effective organisation of planned activity against the acute service provision.

The regional maternity OPEL rating is used to support the identification of operational challenges with maternity services and is reported at all site team contacts and as part of the internal reporting mechanisms.

Red flag data is collected on a 4 hourly basis by manual collection, there is a plan in place to implement the Birth Rate Plus acuity tool in February 2022 to support the electronic collection of the data. Additionally, this will support the implementation of categories related to care requirements at incremental points to identify the required midwifery care hours needed.

Escalations pertaining to concerns about midwifery staffing levels are made at site safety meetings, through the maternity huddle, via the labour ward co-ordinator, maternity bleep holder and manager on call.

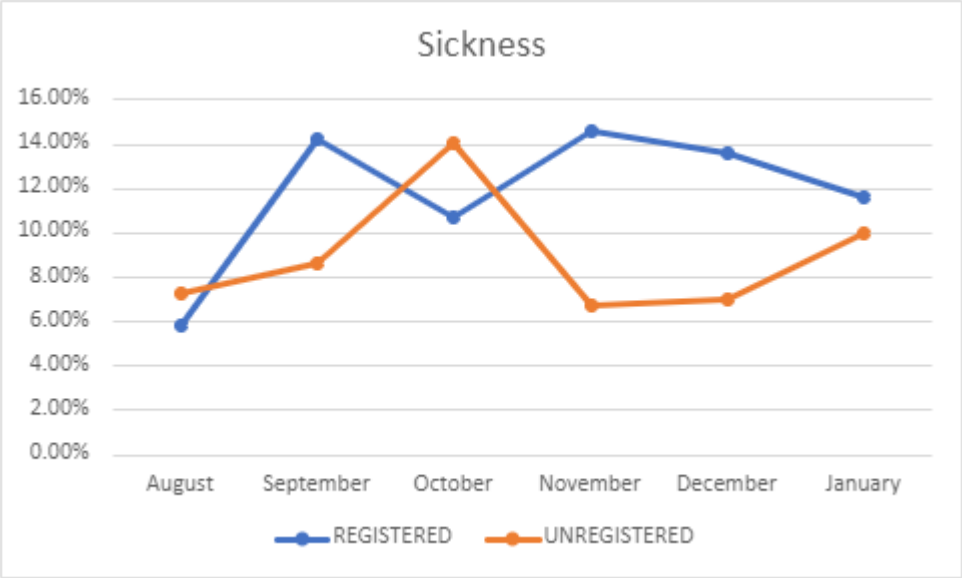
To support midwifery staffing levels a daily on call rota including specialist midwives has been organised to support the provision of acute care. The continuity of carer teams, in addition to providing daily birth cover and night on call cover for their teams, also support the provision of traditional GP based community activity and homebirths.
Registered nurses support the provision of care based in the postnatal inpatient area currently on a temporary staffing basis, a business case is due for submission to enable this to be within the shift plan for the ward.
Specific training has been identified to support the registered nurses with further skills and competencies pertinent to maternity.

Support staff are based in all maternity areas to enable effective task allocation to the most appropriate professional, this includes band 2 and band 3 maternity support workers and nursery nurses. A current mapping exercise is taking place to review skills and competencies against the newly agreed maternity support worker job descriptions which will, following a training programme, enable an increase in the skills and competencies of our support staff.

A business case for the implementation of a dedicated transitional care unit, supported by the required staffing model as set by BPAM is due to be submitted.

Unavailability

The sickness absence rate has gradually increased each month across the registered and unregistered maternity staff groups, which has reduced the overall fill rate within the maternity shift templates.



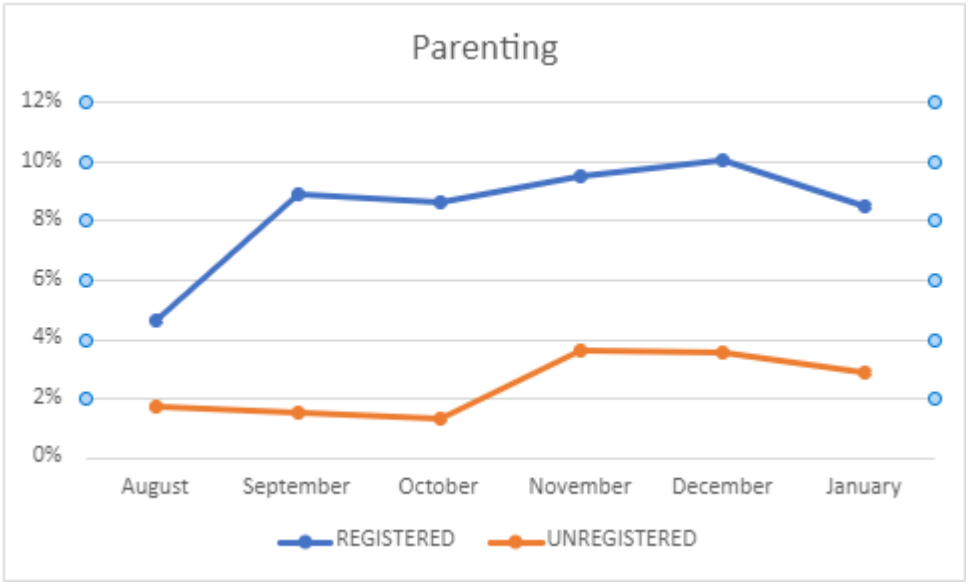
Temporary staffing shifts were made available to mitigate the staffing shortfall though this was negatively impacted by staff requiring isolation due to COVID. Additionally, staff are unable to book bank shifts for 7 days following an episode of sickness absence.

Agency midwives can book shifts at Milton Keynes and increased bank rates were agreed by the executive team to support increased uptake of temporary staffing shifts.

Look ahead of the staffing impact of unavailability takes place on a daily basis and staff are contacted to explore opportunities to change shift patterns to enable a balance of staff and skill mix across shifts.

An advert for bank only midwifery staff has been released on NHS jobs in January 2022 and it has received a positive response with interviews planned.

There are currently 11.81 WTE registered and 1.2 WTE non-registered staff on maternity leave, this has been mapped forward to review return dates and areas including an initial planned hours for return. A business case is in progress to support over recruitment to mitigate maternity leave, due to consistently increased levels.

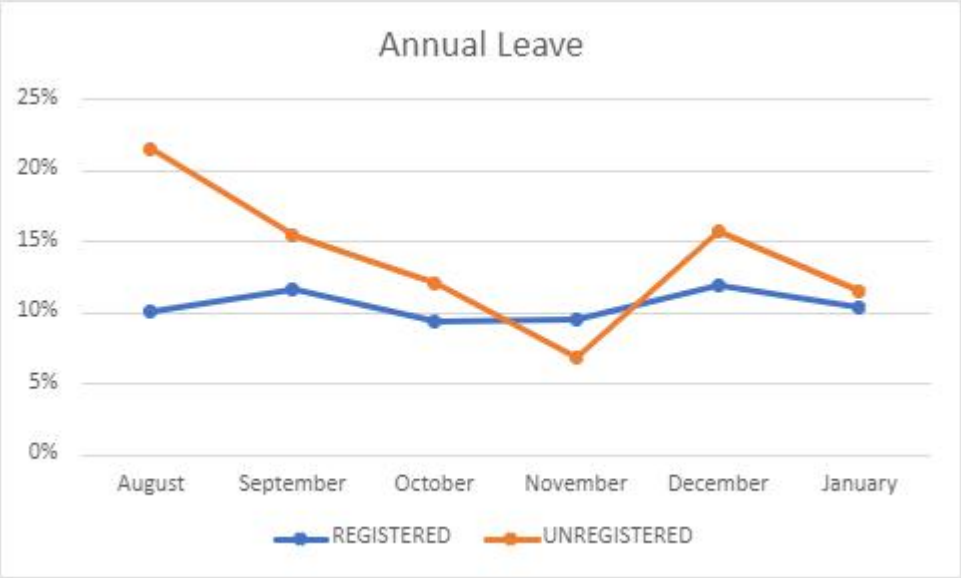


Study leave prior to January is consistently within the expected parameters, the current 22% headroom supports a 3% uplift for training and development. Due to the requirements for mandatory midwifery training, approximately a 5% uplift for is required to support the delivery of training as mapped against the core competency document. In January this was increased due to compliance with the training requirements for the implementation of physiological CTG.

The current maintenance of training within the expected parameters is partially due to the current midwifery vacancy rate, due to which, elements of staff training are supported to be completed as bank, to prioritise substantive fill rates. Additionally, the 22% headroom

applicable to inpatient staff is not applicable to those within a CoC model as their midwife to woman ratio supports the time provision for training to be accessible.

The annual leave allocation has remained consistently below the expected maximum parameter of 17% and within the current 22% headroom, 15% is attributed to annual leave uplift. Both the registered and unregistered staff groups have fallen below the minimum parameter of 11% which has the potential to negatively impact upcoming roster unavailability.



A deep dive into the allocation of annual leave is currently taking place to identify any actions required to support consistent allocation within the expected parameters.

A clear structure is in place to review the expected parameters across the eRoster, training is available for staff with aspects of eRoster management within their portfolio. Monthly trust forums to review eRoster management and support ward managers with escalation to maternity matrons and heads of department are in place.

Specialist Midwives & Management Roles

As part of the midwifery staffing model, Birth Rate Plus sets the expected % of specialist midwives and non-clinical midwifery managers to enable delivery of core functions within maternity services. The expectation is for this parameter to be between 8% and 10%, with a mitigation plan in the event that the specialist and managerial input falls below 8%.

Based on the previous Birth Rate Plus report, our specialist midwife roles equal to 10% which is within the expected parameters. We also have several externally funded specialist roles to comply with national and regional workstream deliverables. Following the submission of the recent workforce data for our updated Birth Rate Plus workforce report, this will review our updated expected compliance.

Labour Ward Co-Ordinator Supernumerary Status

In order to maintain situational awareness of the maternity unit it is a requirement that the labour ward co-ordinator has 100% supernumerary status, defined by NHS Resolutions as "having no caseload of their own during their shift".

Supernumerary compliance is reported on the regional monthly highlight reports to the Local Maternity and Neonatal System and the reporting mechanism for this is currently part of the manually collected red flag data completed every four hours. Once the Birth Rate acuity app is implemented in February 2022 this will support simplified electronic collection and reporting of this data. This will also aim to support increased consistency in data collection due to ease of completion.

Data collection for the supernumerary status is improving but this remains an incomplete data set and therefore multiple sources are triangulated to support the accuracy of the data set including red flag data, incident reports, safety concerns, SIT REP forms.

Supernumerary status was consistently reported at 100% until November 2021:
August – 100%
September – 100%
October – 100%
November - 86.7%
December - 84%
January 2022 – 89%

This may be partially explained by improved data collection and improved consistency of reporting as part of the red flags collection data, additionally the % sickness absence in November and December was significantly increased compared with previous months. This was coupled with the increased unavailability of staff due to an COVID isolation following positive lateral flow tests.

Inconsistencies were also identified in the data collection based on the interpretation of supernumerary status. An action plan to support the consistent achievement of supernumerary labour ward co-ordinator status is in appendix 1 for board sign off.

1:1 Care in Established Labour

1:1 care in established labour is reported on the obstetric dashboard with an expected parameter of 100%, excluding BBA's where this would not be possible to achieve. This has been consistently reported as 99.7% to 100%:
August 2021 – 100%
September 2021 – 99.7%
October 2021 – 99.7%
November 2021 - 100%
December 2021 – 100%
January 2022 – 99.62%

In September and October, the reduction in 1:1 care in labour was associated with cases of precipitate labour resulting in an inability to support the provision of 1:1 care during the established stage of labour. An action plan to support the consistent achievement of 1:1 care in established labour is in appendix 2 for board sign off.

Reported Red Flags

Red flag reporting in maternity is completed daily with the expected red flag triggers detailed in NICE safe staffing for maternity settings guidance. Additionally, maternity services can set their own red flags on a local basis to support focussed quality improvement.

Red flags are currently manually recorded four hourly by the labour ward co-ordinator, the written sheets are collected and scanned for electronic storage. Following the implementation of the Birth Rate Plus acuity app, this will support electronic data collection and increased consistency with completion.

Red flags raised for the period August 2021 to February 2022

The most frequent reason for raising a red flag was "Delayed or cancelled time critical activity", which was raised on almost a daily basis and raised consistently due to delays associated with induction of labour.

It is unclear from the data if cases which would fall under the red flag "delay of 2 hours or more between admission for induction and beginning of process" are also included within this capture. There are very few red flags raised for delay in the beginning of the induction process although anecdotally there is a perception that this has occurred and therefore the figures have potentially been captured above.

A working group has been organised to review the process and pathway for induction of labour and includes a review of the reasons for induction of labour to assess suitability at the point of induction.

An audit has been commenced on the inpatient antenatal area to collect data demonstrating the average delays associated with the induction of labour process and review this across the Local Maternity and Neonatal System.

Ongoing and planned inductions are reviewed as part of the service overview, at the joint midwifery obstetric handover and during the maternity safety huddle to manage activity and enable prioritisation on a clinical risk basis for the continuation of the induction of labour process.

The are currently inconsistencies in both the completion of the red flag data and the interpretation of the red flag categories. The Birth Rate Plus acuity app is due to be implemented in February 2022, which will support an electronic data capture and a simplified reporting mechanism.

A session has been scheduled for the next labour ward co-ordinators meeting to discuss and review the completion of red flag data to support improved consistency.

Obstetric Staffing

A SoP is in place defining the clinical situations for which the Consultant is required to attend which was developed in collaboration with the Consultant group.

Any circumstances where the Consultant does not attend to provide support in a clinical situation as outlined in the SoP or when requested by a doctor or midwife, will be escalated directly to the College Tutor and Clinical Director. It will also be feedback at the Junior Doctor forum or through the trainee representatives as appropriate.

The planned obstetric staffing is set as:
Long day 8.00 to 20.30, on site there are 2 registrars, 2 Senior House Officers with Consultant presence from 8.00 to 18.30 and a telephone ward round at 22.00
From the 1st March 2022 there will be consultant presence on site from 8.00 to 21.00 on weekdays and at weekends, 8.00 to 13.00 then subsequently 19.30 to 21.00 on site.
This will enable twice daily consultant led ward rounds.

Overnight from 20.30 to 8.30, on site there are 2 registrars and 1 Senior House Officer with a Consultant on call from home able to attend in 30 minutes if called in for clinical support.

Senior House Officers
In post are 10 Senior House Officers - 2 ST1, 3 GP trainees, 4 F2s, 1 trust SHO
Rota gaps are currently experienced as a result of flexible working requirements for members of the team.
Vacant shifts are offered out to bank and locum agencies are contacted; cover is not achieved for all rota gaps, which is reported via the incident reporting system.
An additional trust SHO is joining at the end of March 2022 which will reduce the rota gaps from April 2022 and an additional ST1 post has been agreed from August 2022.

Mitigations in place to support the obstetric medical staffing include Consultants covering registrar and SHO rota gaps, and registrars covering SHO rota gaps.

The registrar rota is based on 14 registrars working a 1 in 7:
There are currently 2 trust grade gaps, one registrar was appointed in October 2021 and subsequently withdrew in January 2022. The role was re-advertised and a successful candidate was offered the role in February 2022.

1 trainee gap remains until August 2022 and a long-term agency locum is being sourced to support interim cover.

To support overall obstetric medical staffing cover, movements within the rotas are organised to reduce rota gaps, therefore reducing overall risk within the service.
On occasion, if medical rota gaps are unable to be filled with bank or locum staff, movements of the substantive staff are made in order to support the service requirements and reduce risk.
Such as, a reduction to 1 registrar and 1 SHO overnight, to support movements onto day shifts to reduce rota gaps.
Incident forms are raised via RADAR for rota gaps and impacts on the service provision.

There are now 13 Consultants in post following an increase of 2 consultants in response to the immediate and essential action from the Ockenden review for twice daily consultant led ward rounds, this will be in place from the 1st March 2022.
The Consultants work to a 1:12 rota including labour ward hot weeks.

Labour ward hot weeks are 08.00 to 18.00
Emergency Gynae hot weeks are 08.00 to 13.00

Recruitment & Retention

Active recruitment to midwifery and support staff vacancies continues, including the support staff pipeline the service is currently fully recruited for support staff vacancies and we were successful in a recent national bid for funds to support retention of our support staff.

Midwifery recruitment is also in a positive position, we have engaged with a number of recruitment opportunities to support the workforce including international retention, for which we have been awarded funding across the Local Maternity and Neonatal System to appoint two international midwives.

We have developed a recruitment pipeline for Return to Practice (RtP) midwives completing the clinical element of the course within maternity, we currently have two RtP midwives who have commenced with a further RtP midwife planned to commence.

One of our provider universities has multiple intakes which supports a consistent co-hort of newly qualified midwives at multiple points during the year enabling an increased opportunity for supporting consolidation in practice and entry into the Continuity of Carer teams from qualification.

Multiple adverts have been organised to support various opportunities for midwives to join the maternity service including, bank only contracts, continuity of carer specific roles, rotational midwifery roles, in addition to specialist midwife opportunities.

Taking into consideration those offered roles in the current midwifery pipeline, the service is fully recruited to all midwifery vacancies, noting that some of these applicants are newly qualified midwives due to qualify in April 2022 and September 2022. Recruitment will continue to support a healthy midwifery pipeline, with a virtual recruitment event in the planning stage and while awaiting the updated Birth Rate Plus workforce review.

To support retention an individualised approach to the development of staff is of significant importance with opportunities for training, development and career progression. A number of staff are currently in secondment opportunities to gain experience and development, the labour ward co-ordinators are currently all enrolled on an internal leadership development course.

A co-hort of staff have been supported to attend TRiM training to enable a consistent and supportive approach for staff who have been involved in traumatic events and training is planned for a further 16 staff to enable the programme to be rolled out within maternity. Appreciative Inquiry (AI) has been implemented in maternity to support debriefs and approaches to supporting the team following incidents.

The Professional Midwifery Advocate (PMA) team offer weekly restorative clinical supervision to staff in addition to wellbeing activities within the department.

A retention midwife was recently appointed following successful allocation of national funding to support the implementation of the role with specific objectives to support retention of staff. The implementation of the Learning Education Lead has also significantly improved the experience of students and enabled a seamless transition from student to newly qualified midwife, which is recognised to be a period of increased risk of attrition.

Human factors is being prioritised within the department to support psychological safety and a "no blame" culture with a new approach to the management of investigating incidents.

Significant multidisciplinary training opportunities have been implemented to support knowledge, skills and competencies. All midwives are undertaking career conversations and the maternity support worker mapping exercise is currently taking place.

APPENDIX 1 – Included in appendix 1 is the action plan to support compliance with 100% labour ward co-ordinator supernumerary status, which requires Trust Board sign off

APPENDIX 2 – Included in appendix 2 is the action plan to support compliance with 100% 1:1 care in established labour, which required Trust Board sign off

Appendix 1 - Risk Reduction Action Plan
100% compliance with Labour Ward Co-Ordinator Supernumerary Status

Ref	Recommendation	Action Required	By whom	By when	Evidence that will confirm completion	Evidence that will demonstrate the risk has been reduced
1	Organise the shift plan to support two labour ward band 7's per shift, one identified as the co-ordinator	Ensure Band 7 establishment within the labour ward to support the provision of 2 per shift	Melissa Davis	January 2022	Maternity establishment sheet & eRoster	Improved consistency in 100% compliance with labour ward co-ordinator supernumerary status
2	Clarify the definition of supernumerary to support consistency in interpretation and reporting	Organise a session at the labour ward co-ordinators meeting to discuss the interpretation of supernumerary status	Mary Plummer	February 2022	Documentation on the red flags data collection record confirming the definition	Increased implementation of the maternity escalation procedure in the event of a reduction in % supernumerary
3	Ensure the escalation procedure documents expected actions to enable provision of labour ward co-ordinator supernumerary status	Review the escalation procedure to identify required additions to enable clarity of expected management	Mary Plummer	March 2022	Updated escalation procedure approved	Improved consistency in 100% compliance with labour ward co-ordinator supernumerary status
4	Review of staff unavailability themes and actions required to support increased midwifery staffing provision in the service	Complete a staffing unavailability action plan to identify and measure success of actions taken to increase midwifery staffing provision	Melissa Davis	March 2022	Completed action plan	Reduction in unavailability and increase in midwifery staffing supporting the compliance with 100% supernumerary status of the labour ward co-ordinator

5	Identify themes within incident reports for non-supernumerary status labour ward co-ordinator	Update this action plan with identified themes and mitigations to reduce the risk of re-occurrence	Katie Selby	Ongoing	Additions to this rolling action plan	Improved consistency in 100% compliance with labour ward co-ordinator supernumerary status
6	Implement a mechanism to review actions taken in cases where a red flag is raised for non-supernumerary status of the labour ward co-ordinator	Implement area within the data collection tool to document actions taken in response to raising a red flag for non-supernumerary status of the labour ward co-ordinator	Emma Mitchener	February 2022	Addition to the red flags data collection tool	Demonstrated consistency with expected actions to support compliance with labour ward co-ordinator supernumerary status
7	24-hour manager on call availability to enable robust escalation and oversight procedures	Maternity senior leadership team availability and contingency plan to support provision of the 24-hour manager on call	Melissa Davis	January 2022	Senior team on call rota, details of continued provision of 24-hour manager on call within maternity staffing business contingency plan	Increased implementation of the maternity escalation procedure in the event of a reduction in % supernumerary
8	Staffing escalation procedures in place to mitigate against unavailability of midwifery staff	Availability of maternity escalation procedure and maternity staffing business contingency plan detailing actions for the management of staffing shortfalls	Melissa Davis	January 2022	Documented escalation procedure and maternity staffing business contingency plan	Increased implementation of the maternity escalation procedures and business contingency planning in the event of a reduction in % supernumerary
9	Improved consistency in reporting compliance with supernumerary status of labour ward co-ordinators	Implementation of Birth Rate Plus acuity tool for electronic submission of supernumerary status of the labour ward co-ordinator	Melissa Davis	February 2022	Implementation of the Birth Rate Plus acuity app	Increased consistency in routine reporting of the supernumerary status of the labour ward co-ordinator

10	Clear divisional reporting structure for the escalation and mitigations of red flags	Reporting monthly red flags on the maternity governance report through divisional and directorate meetings	Katie Selby	February 2022	Availability of the maternity governance report with the inclusion of red flag data	Increased scrutiny of the red flags raised and multidisciplinary input into the planned actions and mitigations

Appendix 2 - Risk Reduction Action Plan
100% compliance with 1:1 Care in Established Labour

Ref	Recommendation	Action Required	By whom	By when	Evidence that will confirm completion	Evidence that will demonstrate the risk has been reduced
1	Review current staffing model in place against the recommendation from the updated Birth Rate Plus report	Identify alterations in the staffing requirements and complete an action plan for submission to Board detailing the requirements to achieve compliance with Birth Rate Plus recommendations	Melissa Davis	April 2022	Completed action plan	Improved consistency in compliance with 100% 1:1 care in established labour
2	Clarify the definition of established labour to enable consistency in reporting	Define established labour on the red flag reporting tool	Mary Plummer	February 2022	Documentation on the red flags data collection record confirming the definition	Increased consistency in reporting compliance with 1:1 care in established labour
3	Ensure the escalation procedure documents expected actions to enable provision of 1:1 care in labour	Review the escalation procedure to identify required additions to enable clarity of expected management	Mary Plummer	March 2022	Updated escalation procedure approved	Increased consistency in reporting compliance with 1:1 care in established labour

4	Review of staff unavailability themes and actions required to support increased midwifery staffing provision in the service	Complete a staffing unavailability action plan to identify and measure success of actions taken to increase midwifery staffing provision	Melissa Davis	March 2022	Completed action plan	Reduction in unavailability and increase in midwifery staffing supporting the compliance with 100% 1:1 care in established labour
5	Identify themes within incident reports for cases where 1:1 care in established labour was not provided	Update this action plan with identified themes and mitigations to reduce the risk of re-occurrence	Katie Selby	Ongoing	Additions to this rolling action plan	Improved consistency in 100% compliance with 1:1 care in established labour
6	Implement a mechanism to review actions taken in cases where a red flag is raised for 1:1 care not being provided in established labour	Implement area within the data collection tool to document actions taken in response to raising a red flag for 1:1 care not being provided in established labour	Emma Mitchener	February 2022	Addition to the red flags data collection tool	Demonstrated consistency with expected actions to support compliance with 1:1 care in established labour
7	24-hour manager on call availability to enable robust escalation and oversight procedures	Maternity senior leadership team availability and contingency plan to support provision of the 24-hour manager on call	Melissa Davis	January 2022	Senior team on call rota, details of continued provision of 24-hour manager on call within maternity staffing business contingency plan	Increased implementation of the maternity escalation procedure in the event of an inability to provide 1:1 care in established labour
8	Staffing escalation procedures in place to mitigate against unavailability of midwifery staff	Availability of maternity escalation procedure and maternity staffing business contingency plan detailing actions for the management of staffing shortfalls	Melissa Davis	January 2022	Documented escalation procedure and maternity staffing business contingency plan	Increased implementation of the maternity escalation procedures and business contingency planning in the event of a reduction in % supernumerary

9	Review current admission criteria to the antenatal inpatient area to assess suitability of admission in cases of precipitate labour precluding 1:1 care in established labour	Identify changes to admission criteria or requirement for specific admission criteria to reduce potential for precipitate progress in the ward environment	Mary Plummer	March 2022	Development or adaptation of admission criteria	Improved consistency in 100% compliance with 1:1 care in established labour
10	Triangulate against patient experience data themes related to care delays in maternity inpatient areas	Review specific patient experience themes from multiple sources to identify specific care delay concerns and include within the patient experience action plan	Sophie Conneely	March 2022	Implemented onto patient experience action plan	Improved consistency in 100% compliance with 1:1 care in established labour
11	Clear divisional reporting structure for the escalation and mitigations of red flags	Reporting monthly red flags on the maternity governance report through divisional and directorate meetings	Katie Selby	February 2022	Availability of the maternity governance report with the inclusion of red flag data	Increased scrutiny of the red flags raised and multidisciplinary input into the planned actions and mitigations

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Trust Board**	**Date: 3 March 2022**
Report Title	**Workforce Report**	**Agenda Item: 14**
Lead Director	**Name: Danielle Petch**	**Title: Director of Workforce**
Report Author	**Name: Louise Clayton**	**Title: Deputy Director of Workforce**

Key Highlights/ Summary	This report provides a summary of workforce Key Performance Indicators for the full year ending 31 January 2022 (Month 10) and relevant Workforce and Organisational Development updates to Trust Board			
Recommendation *(Tick the relevant box(es))*	**For Information** ☑	**For Approval** ☐	**For Noting** ☐	**For Review** ☐

Strategic Objectives Links	Objective 8: Investing in our people
Board Assurance Framework (BAF)/ Risk Register Links	BAF risks 19-24

Report History	
Next Steps	TEC, JCNC, WFB, March 2022
Appendices/Attachments	

1. Purpose of the report

1.1. This report provides a summary of workforce Key Performance Indicators as at 31 January (Month 10), covering the preceding 13 months.

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

Indicator	Measure	Target	01/2021	02/2021	03/2021	04/2021	05/2021	06/2021	07/2021	08/2021	09/2021	10/2021	11/2021	12/2021	01/2022
Staff in post (as at report date)	WTE		3250.0	3284.0	3311.6	3337.3	3304.1	3310.7	3328.5	3321.9	3328.6	3342.5	3347.7	3349.0	**3390.5**
	Headcount		3730	3765	3795	3826	3793	3797	3810	3799	3807	3823	3827	3830	**3878**
Establishment *(as per ESR)*	WTE		3635.5	3635.4	3635.4	3662.8	3677.7	3681.7	3675.1	3714.0	3724.7	3730.4	3725.7	3718.1	**3722.9**
	%, Vacancy Rate	10%	10.6%	9.5%	8.7%	8.9%	10.2%	10.1%	9.4%	10.6%	10.6%	10.4%	10.1%	9.9%	**8.9%**
Staff Costs (12 months) *(as per finance data)*	%, Temp Staff Cost (%, £)		11.6%	11.6%	11.6%	11.3%	11.3%	11.4%	11.6%	11.7%	11.9%	12.1%	12.3%	12.5%	**12.7%**
	%, Temp Staff Usage (%, WTE)		11.8%	11.8%	11.8%	11.7%	11.8%	12.0%	12.2%	12.4%	12.6%	12.7%	12.8%	12.9%	**13.0%**
Absence (12 months)	%, 12 month Absence Rate	4%	5.0%	5.1%	4.8%	4.5%	4.4%	4.5%	4.6%	4.7%	4.8%	5.0%	5.0%	5.0%	***5.0%***
	- %, 12 month Absence Rate - Long Term		*2.7%*	*2.8%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.8%*	*2.8%*	*2.8%*	*2.9%*	*3.0%*	*3.0%*	***3.0%***
	- %, 12 month Absence Rate - Short Term		*2.4%*	*2.3%*	*2.1%*	*1.8%*	*1.8%*	*1.8%*	*1.8%*	*1.9%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	***2.0%***
	%,In month Absence Rate - Total		6.7%	4.7%	3.6%	3.3%	4.2%	4.4%	4.6%	5.0%	5.4%	6.1%	5.5%	6.0%	***6.3%***
	- %, In month Absence Rate - Long Term		*2.9%*	*2.9%*	*2.4%*	*2.3%*	*2.9%*	*2.8%*	*3.3%*	*3.2%*	*3.0%*	*3.5%*	*3.3%*	*3.3%*	***2.9%***
	- %, In month Absence Rate - Short Term		*3.8%*	*1.8%*	*1.2%*	*1.0%*	*1.3%*	*1.6%*	*1.3%*	*1.9%*	*2.4%*	*2.5%*	*2.3%*	*2.7%*	***3.4%***
	- %, In month Absence Rate - COVID-19 Sickness Absence		3.3%	1.3%	0.5%	0.4%	0.4%	0.3%	0.5%	0.6%	0.6%	0.6%	0.6%	1.2%	***2.3%***
Starters, Leavers and T/O rate (12 months)	WTE, Starters		313.0	318.0	311.6	322.2	321.3	330.7	331.7	327.9	333.0	349.4	347.1	362.3	**390.3**
	Headcount, Starters		358	363	356	367	367	376	377	374	376	393	395	411	**441**
	WTE, Leavers		233.7	229.3	203.4	204.5	215.6	219.7	223.0	216.8	227.7	232.0	241.5	254.8	**277.9**
	Headcount, Leavers		278	273	241	244	255	259	264	258	271	276	289	304	**332**
	%, Leaver Turnover Rate	10%	8.2%	8.0%	7.1%	7.1%	7.4%	7.5%	7.7%	7.5%	7.8%	7.9%	8.3%	8.8%	**9.5%**
	%, Stability Index		87.1%	87.0%	87.8%	87.6%	87.5%	87.1%	86.6%	86.5%	86.2%	85.6%	85.2%	85.9%	**85.5%**
Statutory/Mandatory Training	%, Compliance	90%	95%	96%	97%	95%	95%	96%	96%	95%	96%	95%	96%	96%	**95%**
Appraisals	%, Compliance	90%	92%	93%	95%	95%	93%	92%	89%	90%	91%	91%	91%	91%	**91%**
Medical and Dental Appraisals	%, Compliance	90%	86%	79%	83%	97%	96%	91%	93%	94%	94%	87%	72%	85%	**79%**
Time to Hire (days)	General Recruitment	35	49	39	43	48	44	47	48	46	59	53	56	52	**72**
	Medical Recruitment (excl Deanery)	35	34	53	52	49	68	62	68	52	53	81	65	43	**52**
Employee relations	Number of open disciplinary cases		19	23	14	11	14	9	6	6	7	9	10	9	**10**

2.1. The Trust's **vacancy rate** (8.9%) is improved significantly from M9 and the Trust is reporting the highest headcount for over a year with an additional 148 (140.5 wte). The International Nurse Recruitment campaign is in progress and the first cohort of 8 arrived in M10. This was less than planned due to delays in visas and positive covid tests taken pre-flight. Feedback from the nurses has been good as they attend their bespoke induction. The next cohort arrives in M11 and 20 nurses are expected, with those delayed from cohort one joining cohort two.

2.2. Overall **staff absence** has remained at 5% with a significant proportion of that being due to the community prevalence of the Omicron Variant through M9 and M10. The Covid Helpline was re-opened during M10 to a 7-day service during to ensure that covid-absence information was up to date and employees knew when they could return to work.

2.3. The **stability index figure** (defined as *proportion of staff in post at end of period who were in post at beginning of period)* has declined slightly in-month to 85.5%. **Staff turnover** has increased, however, remains well below target. The number of leavers spiked in M10, which is a trend for the organisation post-Christmas, however this number has likely been exacerbated due to the impact of the legislation change in December which mandated vaccinations for healthcare workers.

2.4. **Time to hire** overall has increased significantly in M10, with General Recruitment being well above the KPI. In Month 10 the mandatory vaccination regulations meant that the Trust needed to secure evidence of vaccination status prior to candidates starting in post. This resulted in candidates being moved back into 'under offer' stage in order to check their status as a condition of employment before they could be moved to 'unconditional offer' and then 'start date booked'. This created a huge amount of activity for the recruitment team in addition to business as usual and the impact is likely to be evident in Time to Hire figures for the next 3 months.

2.5. The number of **open disciplinary cases** remains low, however the team are experiencing a high number of absence management cases in progress. A detailed Employee Relations case report is produced monthly to JCNC and on a quarterly basis for Workforce Board.

2.6. **Statutory and mandatory training** compliance is at 95% and **appraisals** compliance has remained at its agreed tolerance of 91% as the Trust's reporting period enters the winter period. Divisions are addressing underperformance against these KPIs locally.

3. Continuous Improvement, Transformation and Innovation

3.1. The Trust **MKUH Reservists** policy was put into practice in M10 to take volunteers from non-clinical corporate staff to attend a training session on patient care so that they can then support the clinical areas when staffing is poor during peak times. Ward gaps were identified at the morning huddle and Silver Command. The HR Team then made daily contact with volunteers to deploy them onto the wards, usually over lunchtime, to support patients, give them company, make beds, hand out food, and carry out general

tasks given to them by the ward teams. Feedback from the clinical teams has been excellent and the reservists have reported feeling welcomed and valued by the patients and ward staff.

3.2. The **Health and Wellbeing Team** are experiencing a high number of management referrals and have secured additional provision for up until the end of M12 in order to hold clinics for referral appointments. This will decrease the current waiting time and have a positive impact on returns to work for those on long term sick leave.

3.3. The **Resourcing Team** attended the MK Jobs Show in M10 in the shopping centre of Milton Keynes. This is part of the ongoing campaign to show MKUH as an employer of choice and increase recruitment marketing of the Trust.

3.4. The **Resourcing Team** are in early talks with the International Recruitment Agency to expand the current scope of international recruitment. The HRBPs are approaching their triumvirates to identify vacancies that could be recruited to from overseas.

4. Culture and Staff Engagement

4.1. The **Staff Survey** embargoed results were returned and the team are currently working through the provisional highlights for the Trust.

4.2. The staff Friends and Family Test has been replaced with the **People Pulse Survey** launched in M10, aiming to support the Trust with listening and engagement exercises, checking our employees' experiences and wellbeing at regular points throughout the year.

5. Current Affairs & Hot Topics

5.1. **Vaccination as a Condition of Deployment** (VCOD) legislation has now gone back to consultation. It is anticipated the vote will go through parliamentary passage in M11 and that VCOD will no longer be a requirement. The Trust has made the decision to halt all VCOD activity pending the outcome of this vote.

6. Recommendations

6.1. Members are asked to note and receive the Workforce Report for Month 10.

TheMKWay
CARE. COMMUNICATE.
COLLABORATE. CONTRIBUTE.

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Equality, Diversity & Inclusion Progress Update

Thomas Dunckley

Head of HR Business Partnering

Milton Keynes University Hospital NHS Foundation Trust

Purpose of Presentation

- Our Position
- Our Goals
- Our Networks
- Our Progress
- Our Future

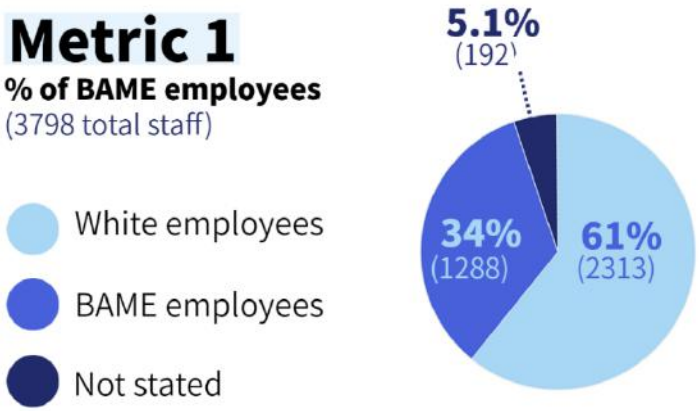
Milton Keynes University Hospital NHS Foundation Trust

Our Position

Milton Keynes University Hospital NHS Foundation Trust

WRES Metrics
(Workforce Race Equality Standard)

Metric 1
% of BAME employees
(3798 total staff)



34% of Trust employees identify as BAME in comparison with a local population of 26%

Metric 2
Likelihood of BAME Candidates Being Shortlisted

BAME candidates applying for a job at the Trust are less likely to be shortlisted than White candidates

WRES Metrics
(Workforce Race Equality Standard)

Milton Keynes University Hospital NHS Foundation Trust

Metric 3
Disciplinary Process

BAME employees are less likely to enter a disciplinary process than White employees

Metric 4
Training and Development

BAME employees are more likely to access non mandatory training than White employees

Metric 5
% of employees facing harassment, bullying or abuse from patients, relatives or the public in the last 12 months

BAME and White employees are equally as likely to face bullying, harassment, or abuse from service users

WRES Metrics
(Workforce Race Equality Standard)

Milton Keynes University Hospital NHS Foundation Trust

BAME employees experienced more harassment from colleagues than White employees in the last 12 months

BAME employees are less likely to believe the Trust offers them equal opportunity for career progression

WRES Metrics
(Workforce Race Equality Standard)

Milton Keynes University Hospital NHS Foundation Trust

Metric 8
Discrimination at Work

In the last 12 months, almost double the amount of BAME employees faced discrimination from a colleague compared to White employees

Metric 9
Board Membership

7.1% of the Trust board identify as BAME. This is much lower than the general workforce population of 34%

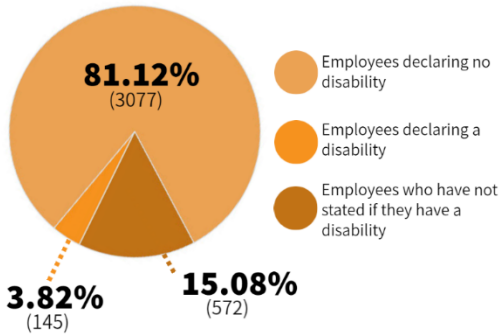
WDES Metrics

(Workforce Disability Equality Standard)

Milton Keynes University Hospital NHS Foundation Trust

Metric 1

% of Employees Declaring a Disability



3.8% of the Trust's substantive workforce have declared a disability

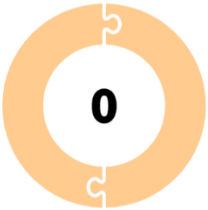
Metric 2

Likelihood of Disabled Candidates being Shortlisted

Disabled candidates are more likely to be shortlisted for Trust jobs than non-disabled candidates

Metric 3

Performance Management and Capability



No disabled employees entered a formal capability process in the last 12 months

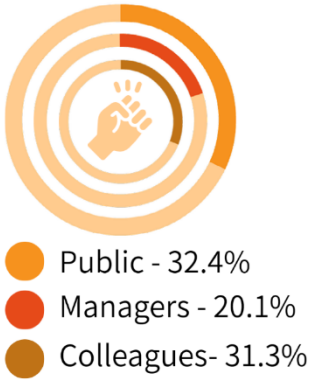
WDES Metrics

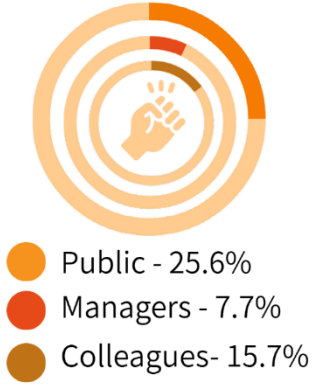
(Workforce Disability Equality Standard)

Milton Keynes University Hospital NHS Foundation Trust

Metric 4

% of Employees Facing Harassment, Bullying or Abuse in the Last 12 Months





In the last 12 months, a higher percentage of disabled employees faced harassment, bullying or abuse from service users, colleagues and managers than those without a disability

WDES Metrics

(Workforce Disability Equality Standard)

Milton Keynes University Hospital NHS Foundation Trust

Metric 5

Equal Opportunities

79.4% disabled
86.1% non disabled

Disabled employees are less likely to believe that the Trust offers them equal opportunities for career progression

Metric 6

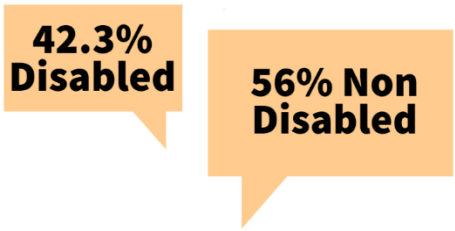
Discrimination at Work

37.7% Disabled
21.7% Non disabled

In the last 12 months, a higher % of disabled employees faced discrimination from a manager or colleague than employees without a disability

Metric 7

Feeling Valued at Work



Disabled employees are less likely to feel that the Trust values their work

WDES Metrics

(Workforce Disability Equality Standard)

Milton Keynes University Hospital NHS Foundation Trust

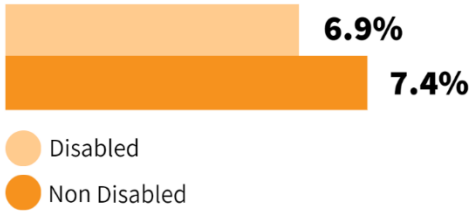
Metric 8

Reasonable Adjustments

The majority of disabled employees feel that the Trust has made appropriate reasonable adjustments for them

Metric 9

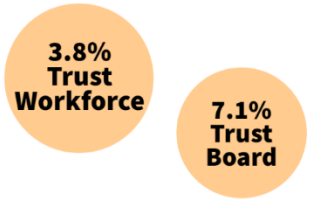
Feeling Engaged at Work



Employees with a disability are slightly less likely to feel engaged at work than employees without a disability

Metric 10

Board Representation



7.1% of the Trust's board have declared a disability, in comparison with a workforce population of 3.8%

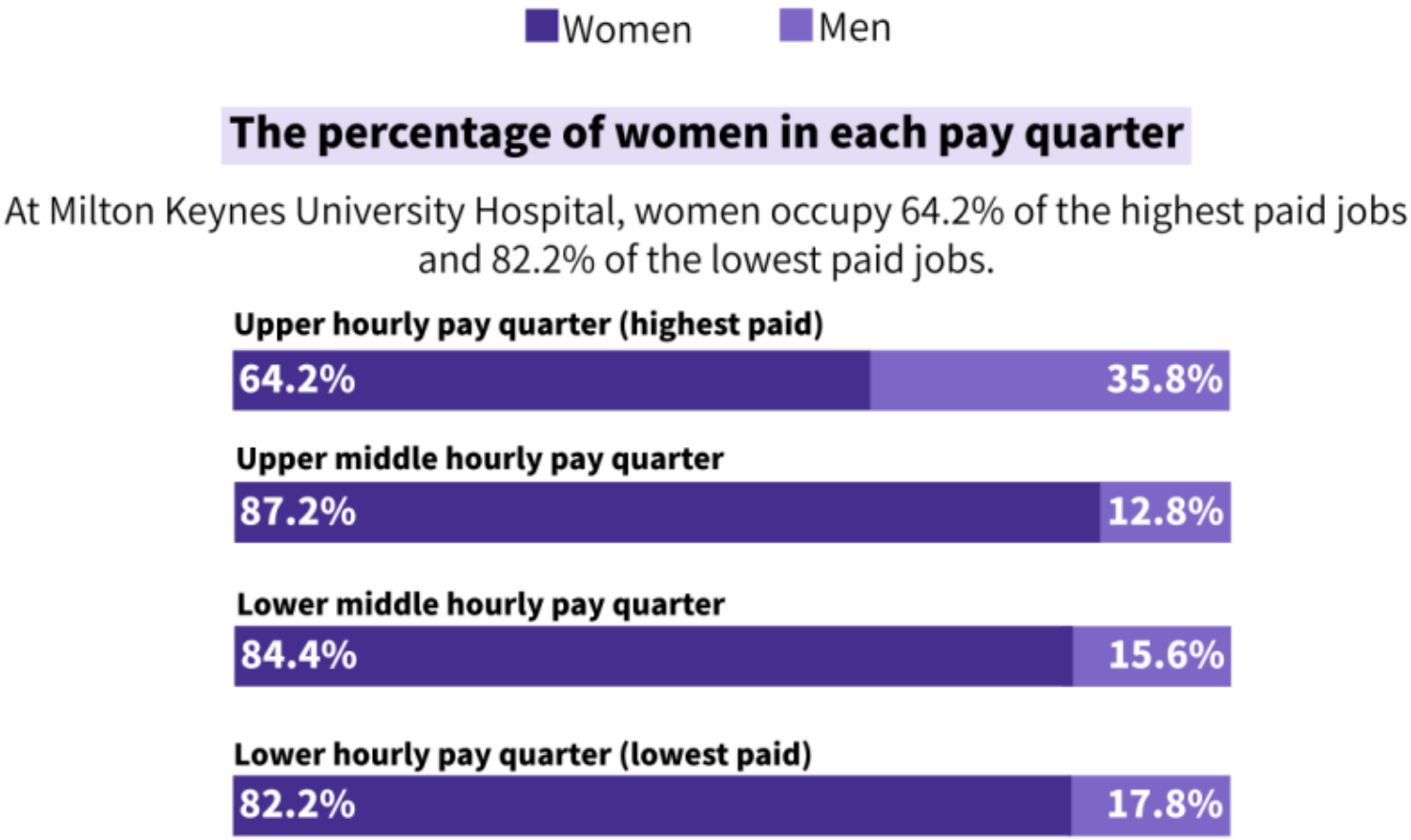
WRES/WDES Implementation

Milton Keynes University Hospital NHS Foundation Trust

- Infographics – sharing the metrics
- Engagement with networks
- Co-produced action plans
- Engagement with staff side
- Engagement with wider HR team
- Engagement with divisions

Gender Pay Gap

Milton Keynes University Hospital NHS Foundation Trust

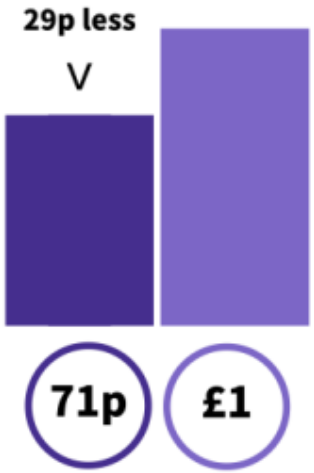


Gender Pay Gap

Milton Keynes University Hospital NHS Foundation Trust

Hourly pay gap

At MKUH, women earn 71p for every £1 that men earn when comparing hourly pay. Their median hourly pay is 28.9% lower than men's.



When comparing mean (average) hourly pay, women's mean mean hourly pay is 20% lower than men's.

Bonus pay gap

At MKUH, women earn 67p for every £1 that men earn when comparing median bonus pay. Their bonus hourly pay is 33.3% lower than men's.

When comparing mean (average) bonus pay, women's mean bonus pay is 35% lower than men's. 0.5% of women received bonus pay compared to 4.9% of men.

Key Areas for Improvement

Milton Keynes University Hospital NHS Foundation Trust

BAME employees are less likely to progress into senior roles than White employees

BAME candidates are less likely to be shortlisted than White candidates

BAME employees are more likely to be subject to bullying and harassment by colleagues than White employees

Disabled employees are more likely to be subject to bullying and harassment by colleagues or patients than non-disabled employees

Only 3.8% of Trust employees have disclosed that they have a disability

Women earn 71p for every £1 that men earn when comparing hourly pay (29p less)

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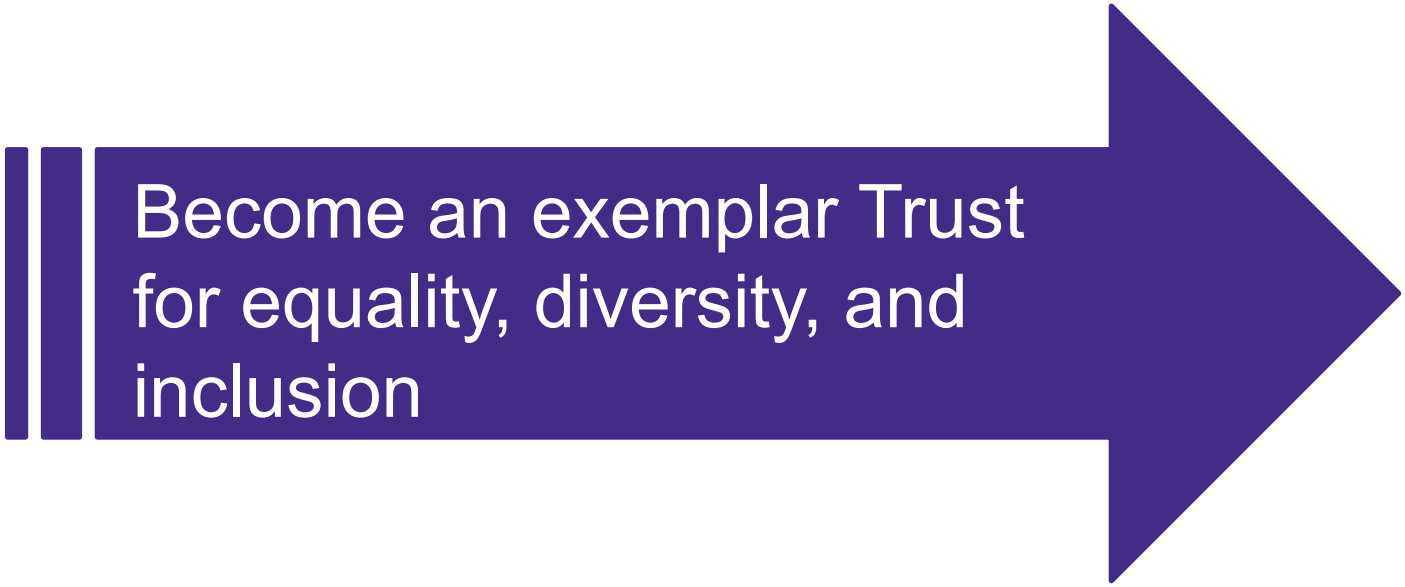
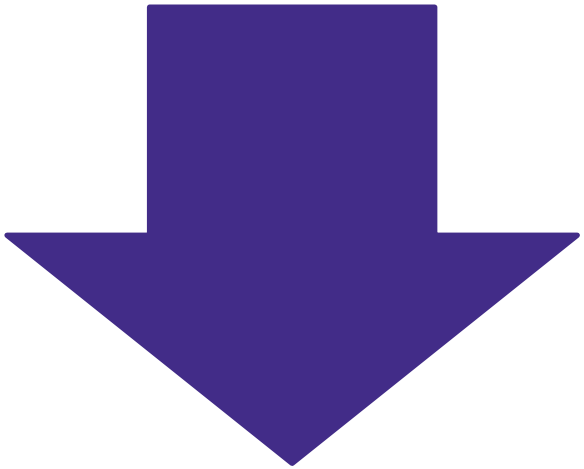
Our Goals

Our Ambition



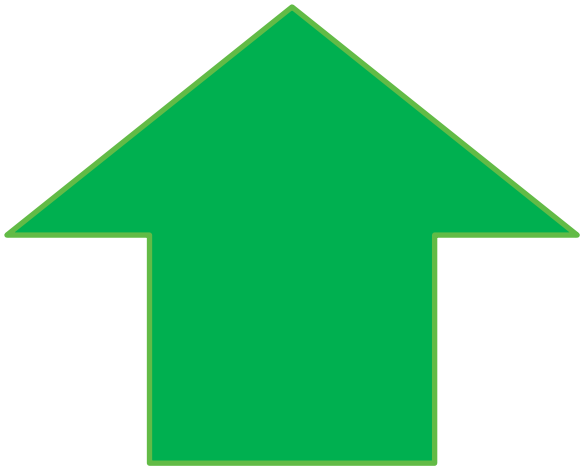
Our Objectives

Increase BAME workforce by 1% in 21/22 and a further 2% in 22/23



Increase disability workforce by 2% in 21/22 and a further 5% in 22/23

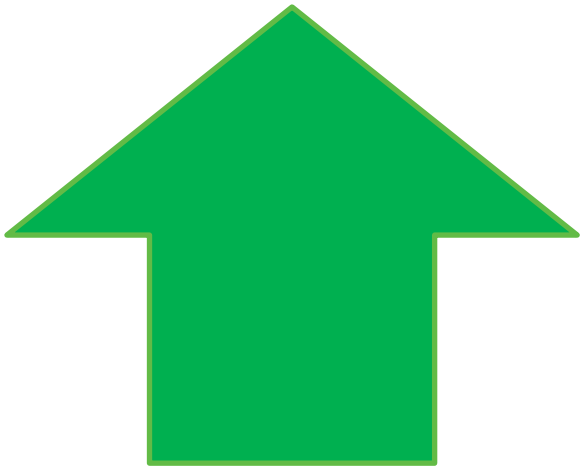
Our Aims



Increase BAME and disabled workforce in senior management roles

Increase promotion for BAME and disabled workforce through enhanced recruitment and focused talent management

Our Aims



Reduce bullying and harassment against BAME and disabled employees

Reduce the gender pay gap

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Our Networks

Staff Networks

Milton Keynes University Hospital NHS Foundation Trust

- Pride @ MKUH
- BAME
- Ability
- Women's
- Faith & Belief
- Armed Forces
- Carers
- Generational

Staff Networks

Milton Keynes University Hospital NHS Foundation Trust

Pride @ MKUH Network

- Attendance at two MK Pride events
- Roll out of badges and lanyards
- LGBTQ+ patient experience survey
- LGBTQ+ History Month 2022 events and stories campaign
- Developing a Transitioning at Work Policy and Procedure
- Supported an ED&I assessment panel at Non Executive Director interviews
- Provided advice and guidance to clinical teams to support LGBTQ+ patients
- Creation of allyship framework

BAME Network

- Black History Month 2021 events
- Supported the development of the WRES action plan
- BAME excellence stories
- Supported an ED&I assessment panel at Non Executive Director interviews
- Romanian National Day event
- Support to BAME colleagues regarding COVID-19 and vaccination awareness
- Coaching and mentoring support for BAME colleagues
- Regional and national engagement

Staff Networks

Milton Keynes University Hospital NHS Foundation Trust

Ability

- Development of disability inclusion plan and leadership plan
- Supported the development of the WDES action plan
- Commencement of AccessAble project
- Sunflower lanyard scheme
- Developed Virtual Meetings SOP
- Regional and national engagement

Women's

- Development of a Menopause Policy and Procedure
- International Women's Day 2022 inspiring stories campaign
- Signposting for menopause support (incl. webinars)
- Supported development of the Domestic Abuse Policy and Procedure

Staff Networks

Milton Keynes University Hospital NHS Foundation Trust

Faith & Belief Network

- Community outreach
- Diwali events

Armed Forces

- Working towards Veteran Aware gold status
- Paid leave for training for reservists

Staff Networks

Milton Keynes University Hospital NHS Foundation Trust

Carers Network

- Signposting for support and advice for carers

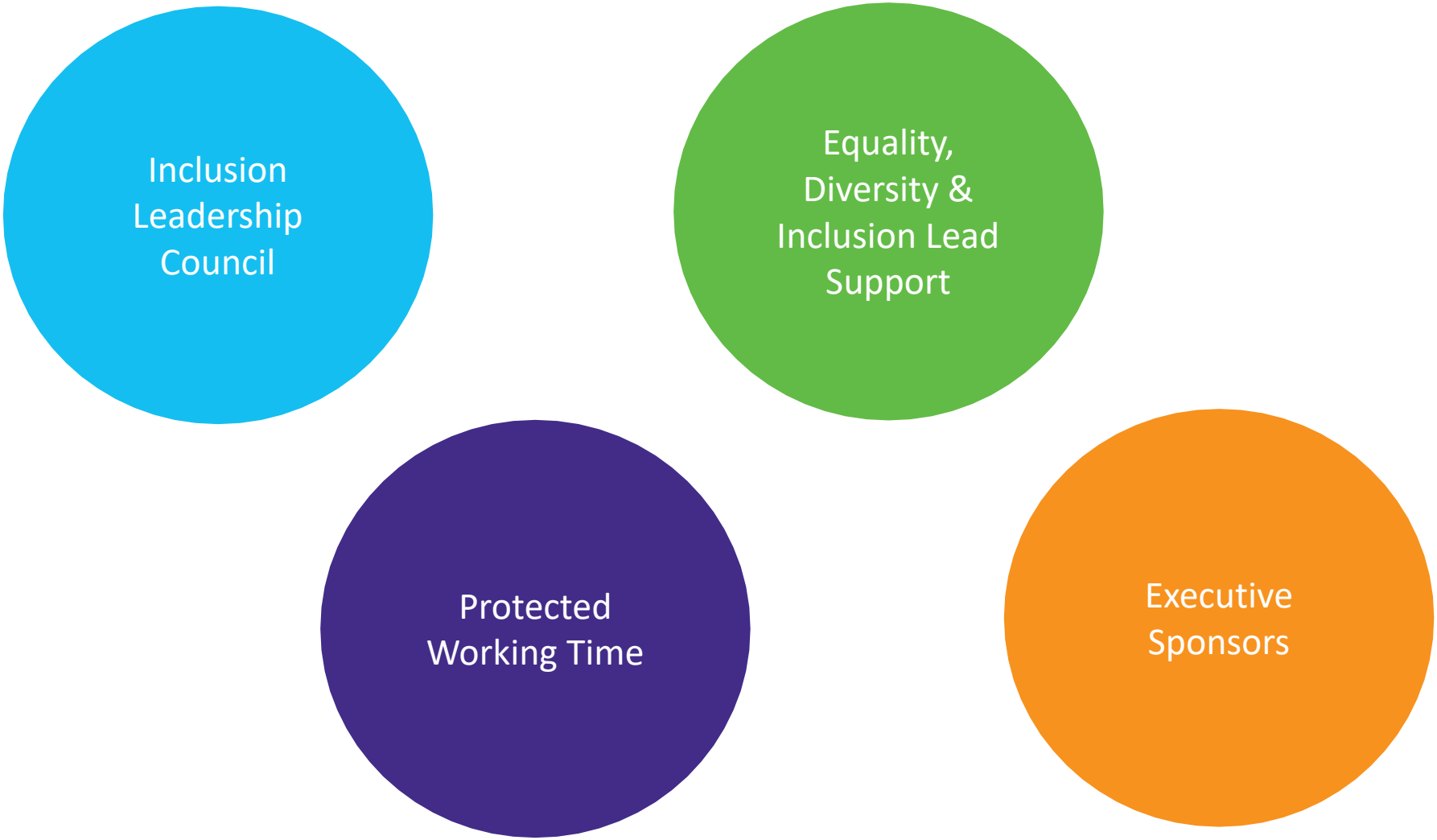
Generational Network

- Currently in development

Milton Keynes University Hospital NHS Foundation Trust

Our Commitment

To Staff Networks



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Our Progress

Milton Keynes University Hospital NHS Foundation Trust

BAME employees are less likely to progress into senior roles than White employees

BAME candidates are less likely to be shortlisted than White candidates

Talent Management Programme

Chief Nurse Fellowships

WRES Action Plan

Values Based Recruitment

CV and Interview Skills

Milton Keynes University Hospital NHS Foundation Trust

BAME employees are more likely to be subject to bullying and harassment by colleagues than White employees

Disabled employees are more likely to be subject to bullying and harassment by colleagues or patients than non-disabled employees

Above Difference Cultural Awareness

Community Outreach

Disability Inclusion Plan

Disability Confident Leadership Status

WDES Action Plan

Milton Keynes University Hospital NHS Foundation Trust

Only 3.8% of Trust employees have disclosed that they have a disability

Women earn 71p for every £1 that men earn when comparing hourly pay (29p less)

Learning Difficulty Internships

Neurodiversity Recruitment & Reasonable Adjustments Campaign

WDES Action Plan

Gender Pay Gap Data Review

Co-produced Action Plan

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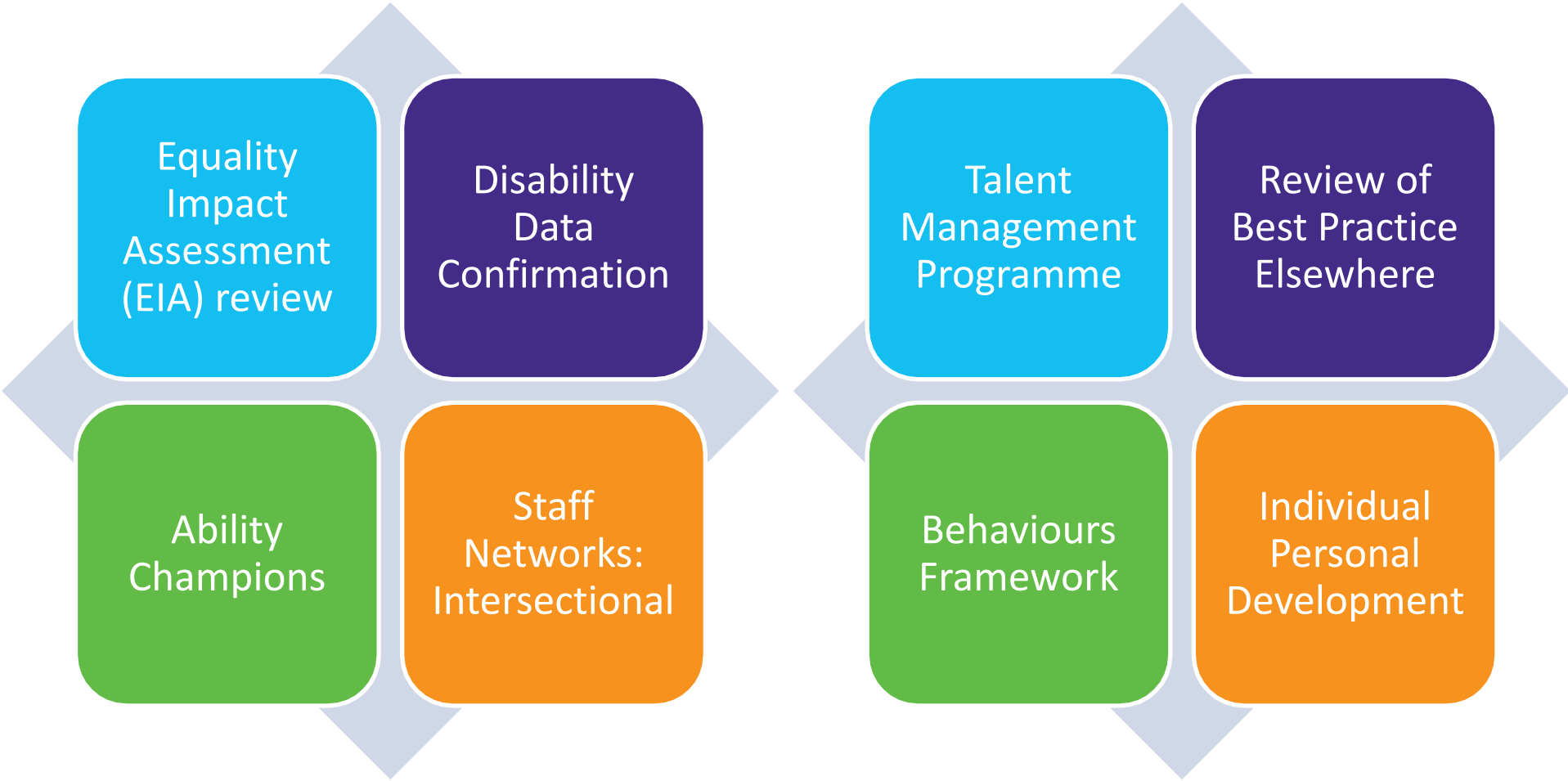
Our Future

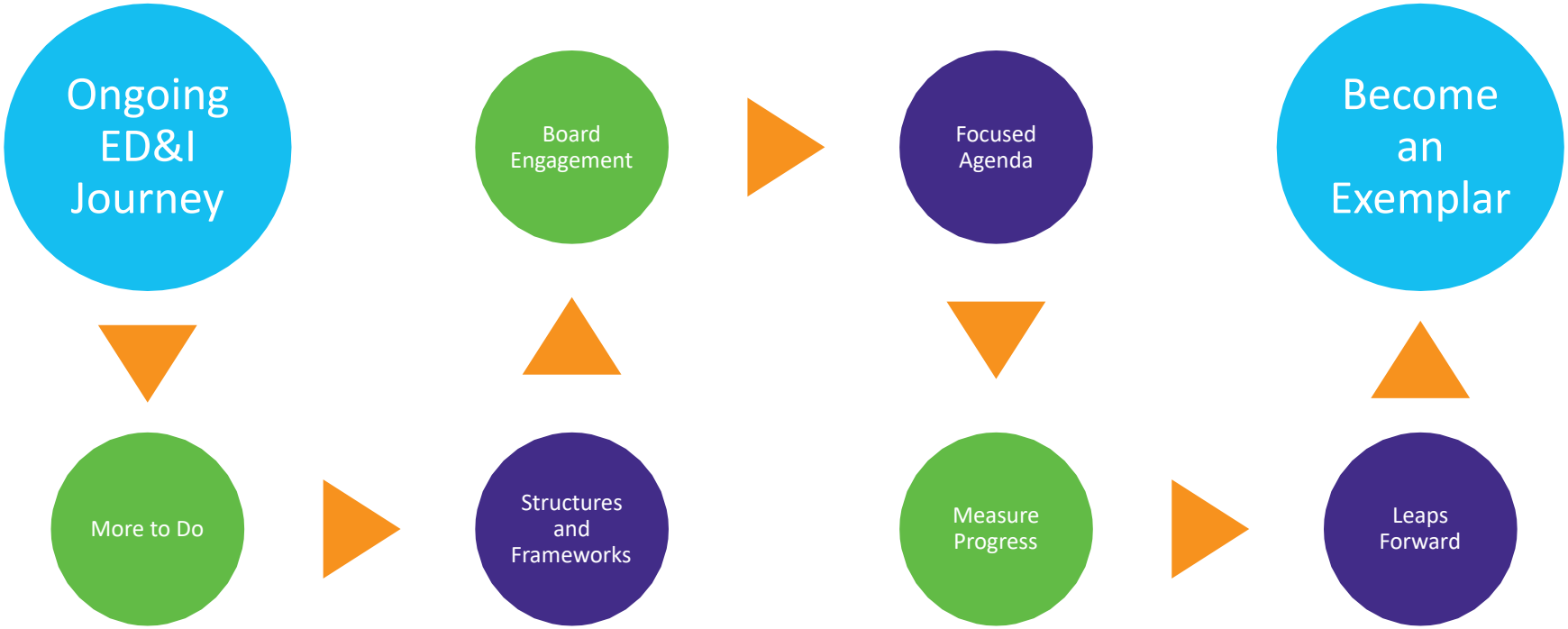
Milton Keynes University Hospital NHS Foundation Trust

Future Actions



Milton Keynes University Hospital NHS Foundation Trust

Our ED&I Journey



Any questions?

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Trust Board of Directors**	**Date: 01 March 2022**
Report Title	2021-22 Executive Summary M10	**Agenda Item: 16**
Lead Director	**Name:** John Blakesley	**Title:** Deputy CEO
Report Author	**Name:** Performance and Information Team	**Title:**

Key Highlights/ Summary	Please refer to the Executive Summary			
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Noting** ☐	**For Review** ☐

Strategic Objectives Links	Summary Sustainability and Transformation Fund Urgent and Emergency Care Elective Pathways Patient Safety
Board Assurance Framework (BAF)/ Risk Register Links	

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

Trust Performance Summary: M10 (January 2022)

1.0 Summary

This report summarises performance in January 2022 for key performance indicators and provides an update on actions to sustain or improve upon Trust and system-wide performance. This commentary is intended only to highlight areas of performance that have changed or are in some way noteworthy. It is important to highlight that the NHS Constitution Targets remain in situ and are highlighted in the table below.

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

Given the impact of COVID-19, the performance of certain key constitutional NHS targets for January 2022 have been directly impacted. To ensure that this impact is reflected, the monthly trajectories for 2021/22 are currently under review to ensure that they are reasonable and reflect a level of recovery for the Trust to achieve and have not yet been finalised.

2.0 Sustainability and Transformation Fund (STF)

Performance Improvement Trajectories

January 2022 performance against the Service Development and Improvement Plans (SDIP):

ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1	ED 4 hour target (includes UCS)		95%	95%	84.6%	83.2%	x	▲	x	
4.2	RTT Incomplete Pathways <18 weeks		92%	92%		55.8%	x	▼		
4.9	62 day standard (Quarterly)		85%	85%		62.0%	x	▼		

In January 2022 the ED performance was 83.2%; an improvement in performance when compared to 81.5% in December 2021. Further, MKUH performance was significantly higher than both the national overall performance of 74.3% and the majority of its Peer Group (see Appendix 1 for details).

The Trust's RTT Incomplete Pathways <18 weeks performance stood at 55.8% at the end of January 2022. This was a decline in performance compared to 57.3% in December 2021.

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

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

For Q3 2021/22, the Trust's provisional 62-day standard performance (from receipt of an urgent GP referral for suspected cancer to first treatment) was 62.0% against a national target of 85%.

The provisional performance of the percentage of patients who started treatment within 31 days of a decision to treat was 96.6%, above the national target of 96%. The percentage of patients who attended an outpatient appointment within two weeks of an urgent referral by their GP for suspected cancer was 86.7% against a national target of 93%.

3.0 Urgent and Emergency Care

In January 2022, two of the six key performance indicators measured in urgent and emergency care showed an improvement:

ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.4	Cancelled Ops - On Day		1%	1%	0.89%	0.36%	✓	▲	✓	
3.2	Ward Discharges by Midday		25%	25%	15.3%	12.7%	x	▼	x	
3.4	30 day readmissions		7%	7%	7.2%	7.6%	x	▼	x	
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)		53			78	x	▼		
3.9	Ambulance Handovers >30 mins (%)		5%	5%	12.2%	10.9%	x	▲	x	
4.2	RTT Incomplete Pathways <18 weeks		92%	92%		55.8%	x	▼		

Cancelled Operations on the Day

In January 2022, there were 8 operations cancelled on the day for non-clinical reasons as detailed below:

Cancellation Reason	Number of Cancellations
Insufficient Time / Lighting Issues	2
Admin Error	2
Insufficient Time	1
Equipment Issue	1
Bed Availability	1
Emergency Priority	1

Readmissions

The Trust's 30-day emergency readmission rate in January 2022 was 7.6% (please note that the readmission rate in January 2022 may include patients that were readmitted with Covid-19).

Performance showed a decline compared to the December 2021 rate of 7.0%.

Delayed Transfers of Care (DTOC)

The number of DTOC patients reported at midnight on the last Thursday of January 2022 was 36 patients: 33 in Medicine and three in Surgery.

This was a deterioration in performance when compared to the number of DTOC patients reported at midnight on the last Thursday of December 2021 (28).

Length of Stay (Stranded and Super Stranded Patients)

The number of super stranded patients (length of stay of 21 days or more) at the end of the month was 78. This was an increase compared to the 72 super stranded patients reported at the end of December 2021, and the highest volume of super stranded patients reported since February 2020.

Ambulance Handovers

In January 2022, the percentage of ambulance handovers to the Emergency Department taking more than 30 minutes was 10.9%.

This was an improvement for the third consecutive month, falling from a peak this financial year of 17.5% in October 2021.

4.0 Elective Pathways

ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
3.1	Overnight bed occupancy rate		93%	93%	88.2%	88.7%	✓	▼	✓	
3.5	Follow Up Ratio		1.5		1.29	1.29	✓	▼	✓	
4.2	RTT Incomplete Pathways <18 weeks		92%	92%		55.8%	×	▼		

Overnight Bed Occupancy

Overnight bed occupancy was 88.7% in January 2022. This was a slight decline in performance compared to the December 2021 occupancy rate of 87.7%, but remains well within the 93% threshold.

Follow up Ratio

The Trust outpatient follow up ratio in January 2022 was 1.29 which was a decline in performance when compared to the December 2021 ratio of 1.23.

RTT Incomplete Pathways

The Trust's RTT Incomplete Pathways <18 weeks at the end of January 2022 was 55.8% and the number of patients waiting more than 52 weeks without being treated was 771. These patients were in Surgery (685 patients), Medicine (54 patients), and Women and Children (32 patients).

Diagnostic Waits <6 weeks

The Trust did not meet the national standard of fewer than 1% of patients waiting six weeks or more for their diagnostic test at the end of January 2022, with performance of 62.2%.

This was a slight improvement when compared to December 2021 performance of 60.7%.

5.0 Patient Safety

Infection Control

In January 2022 there were four reported cases of MSSA, three of which were in Medicine (wards 2, 3, and 22) and 1 in Surgery (ward 20). There were also three reported cases of C.Diff, all in Medicine (wards 16, 18, and 25). There were no reported cases of MRSA or E-Coli.

ENDS

Appendix 1: ED Performance - Peer Group Comparison

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

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

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

November 2021 to January 2022 ED Performance Ranking

MKUH Peer Group Comparison - ED Performance	Nov-21	Dec-21	Jan-22
Homerton University Hospital NHS Foundation Trust	86.5%	80.1%	86.5%
Milton Keynes University Hospital NHS Foundation Trust	81.8%	81.5%	83.2%
The Hillingdon Hospitals NHS Foundation Trust	72.4%	73.0%	77.5%
Barnsley Hospital NHS Foundation Trust	62.3%	68.3%	77.4%
Southport And Ormskirk Hospital NHS Trust	79.0%	78.3%	76.0%
Buckinghamshire Healthcare NHS Trust	72.1%	73.5%	73.2%
Oxford University Hospitals NHS Foundation Trust	67.8%	70.0%	70.2%
The Princess Alexandra Hospital NHS Trust	59.6%	65.7%	69.1%
Northampton General Hospital NHS Trust	70.3%	69.0%	68.3%
North Middlesex University Hospital NHS Trust	68.7%	71.1%	67.3%
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	60.6%	56.6%	64.4%
Mid Cheshire Hospitals NHS Foundation Trust	67.4%	60.2%	60.9%
Bedfordshire Hospitals NHS Foundation Trust	-	-	-
Kettering General Hospital NHS Foundation Trust	-	-	-

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

Board Performance Report 2021/22
January 2022 (M10)

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

OBJECTIVE 1 - PATIENT SAFETY										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
1.1	Mortality - (HSMR)		100	100		104.8	✗	▼		
1.2	Mortality - (SHMI)		100	100		113.91	✗	▲		
1.3	Never Events		0	0	1	0	✓	▬	✗	
1.4	Clostridium Difficile		10	<9	8	3	✗	▼	✓	
1.5	MRSA bacteraemia (avoidable)		0	0	1	0	✓	▬	✗	
1.6	Falls with harm (per 1,000 bed days)		0.12	0.12	0.12	0.07	✓	▼	✓	
1.7a	Midwife to birth ratio (Required by Birth Rate Plus)		28	28	28	28	✓	▬	✓	
1.7b	Midwife to birth ratio (Actual for Month)					31		▲		
1.8	Incident Rate (per 1,000 bed days)		60	60	48.60	38.38	✗	▲	✗	
1.9	Duty of Candour Breaches (Quarterly)		0	0	0	0	✓	▬	✓	
1.10	E-Coli		18	15	10	0	✓	▲	✓	
1.11	MSSA		5	<5	10	4	✗	▼	✗	
1.12	VTE Assessment		95%	95%	97.6%	96.2%	✓	▼	✓	

OBJECTIVE 2 - PATIENT EXPERIENCE										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.2	RED Complaints Received				0	0		▬		
2.3	Complaints response in agreed time		90%	90%	79.1%	71.3%	✗	▼	✗	
2.4	Cancelled Ops - On Day		1%	1%	0.89%	0.36%	✓	▲	✓	
2.5	Over 75s Ward Moves at Night		1,800	1,500	1,047	125	✓	▼	✓	
2.6	Mixed Sex Breaches		0	0	0	0	✓	▬	✓	

OBJECTIVE 3 - CLINICAL EFFECTIVENESS										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
3.1	Overnight bed occupancy rate		93%	93%	88.2%	88.7%	✓	▼	✓	
3.2	Ward Discharges by Midday		25%	25%	15.3%	12.7%	✗	▼	✗	
3.3	Weekend Discharges		70%	70%	59.3%	60.0%	✗	▲	✗	
3.4	30 day readmissions		7%	7%	7.2%	7.6%	✗	▼	✗	
3.5	Follow Up Ratio		1.5		1.29	1.29	✓	▼	✓	
3.6.1	Number of Stranded Patients (LOS>=7 Days)		184			220	✗	▼		
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)		53			78	✗	▼		
3.7	Delayed Transfers of Care		20			36	✗	▼		
3.8	Discharges from PDU (%)		15%	15%	7.9%	7.0%	✗	▼	✗	
3.9	Ambulance Handovers >30 mins (%)		5%	5%	12.2%	10.9%	✗	▲	✗	

OBJECTIVE 4 - KEY TARGETS										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1	ED 4 hour target (includes UCS)		95%	95%	84.6%	83.2%	✗	▲	✗	
4.2	RTT Incomplete Pathways <18 weeks		92%	92%		55.8%	✗	▼		
4.4	RTT Total Open Pathways		33,715	32,343		33,298	✗	▼		
4.5	RTT Patients waiting over 52 weeks		1,252	1,119		771	✓	▲		
4.6	Diagnostic Waits <6 weeks		99%	99%		62.2%	✗	▲		
4.7	All 2 week wait all cancers (Quarterly)		93%	93%		86.7%	✗	▲		
4.8	31 days Diagnosis to Treatment (Quarterly)		96%	96%		96.6%	✓	▲		
4.9	62 day standard (Quarterly)		85%	85%		62.0%	✗	▼		

OBJECTIVE 5 - SUSTAINABILITY										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
5.1	GP Referrals Received		Not Available		75,890	5,669	Not Available	▼	Not Available	
5.2	A&E Attendances		103,529	87,431	83,790	7,851	✓	▼	✓	
5.3	Elective Spells (PBR)		24,474	20,941	19,899	1,758	✗	▼	✗	
5.4	Non-Elective Spells (PBR)		39,224	33,735	26,783	2,436	✓	▲	✓	
5.5	OP Attendances / Procs (Total)		392,098	330,704	336,538	32,409	✗	▲	✓	
5.6	Outpatient DNA Rate		6%	6%	6.4%	7.5%	✗	▼	✗	

OBJECTIVE 7 - FINANCIAL PERFORMANCE										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
7.1	Income £'000		316,858	264,847	264,178	26,116	✓	▼	✗	
7.2	Pay £'000		(203,273)	(170,194)	(170,997)	(17,361)	✗	▼	✗	
7.3	Non-pay £'000		(96,446)	(80,545)	(80,207)	(7,599)	✓	▲	✓	
7.4	Non-operating costs £'000		(18,239)	(15,208)	(14,615)	(1,156)	✓	▲	✓	
7.5	I&E Total £'000		(1,100)	(1,100)	(1,100)	0	✓	▬	✓	
7.6	Cash Balance £'000		25,668	32,279		68,267	✓	▲		
7.7	Savings Delivered £'000		6,850	5,728	1,468	138	✗	▼	✗	
7.8	Capital Expenditure £'000		50,799	33,927	17,165	2,197	✓	▲	✓	

OBJECTIVE 8 - WORKFORCE PERFORMANCE										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
8.1	Staff Vacancies % of establishment		10%	10%		8.9%	✓	▲		
8.2	Agency Expenditure %		5%	5%	4.0%	5.1%	✗	▼	✓	
8.3	Staff Sickness % - Days Lost (Rolling 12 months)		4%	4%		5.0%	✗	▬		
8.4	Appraisals		90%	90%		91.0%	✓	▬		
8.5	Statutory Mandatory training		90%	90%		95.0%	✓	▼		
8.6	Substantive Staff Turnover		9%	9%		9.5%	✗	▼		

OBJECTIVES - OTHER										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
O.1	Total Number of NICE Breaches		10	10		4	✓	▬		
O.2	Rebooked cancelled OPs - 28 day rule		95%	95%	73.5%	62.2%	✗	▼	✗	
O.4	Overdue Incidents >1 month		0	0		361	✗	▼		
O.5	Serious Incidents		20	<17	81	5	✗	▲	✗	
O.8	Completed Job Plans (Consultants)		90%	90%		90%	✓	▬		

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

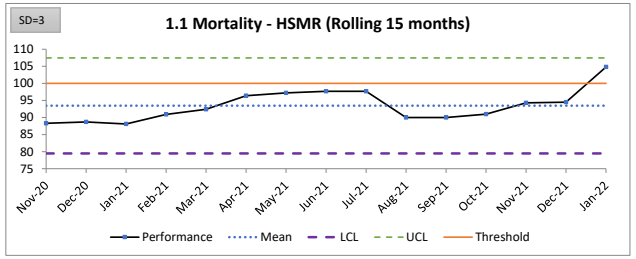
✓	Achieving YTD Target
	Within Agreed Tolerance*
✗	Not achieving YTD Target
✗	Annual Target breached

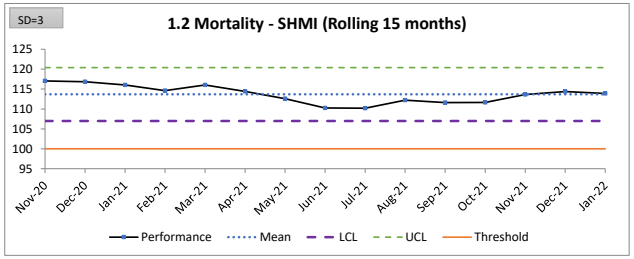
Data Quality Assurance Definitions

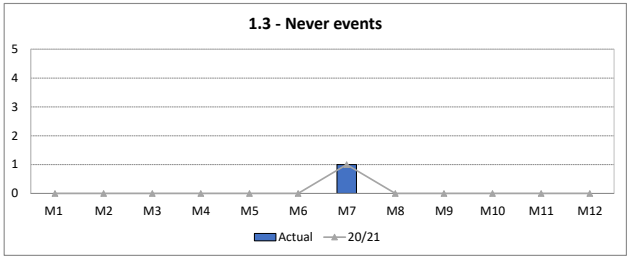
Rating	Data Quality Assurance
Green	Satisfactory and independently audited (indicator represents an accurate reflection of performance)
Amber	Acceptable levels of assurance but minor areas for improvement identified and potentially independently audited * /No Independent Assurance
Red	Unsatisfactory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

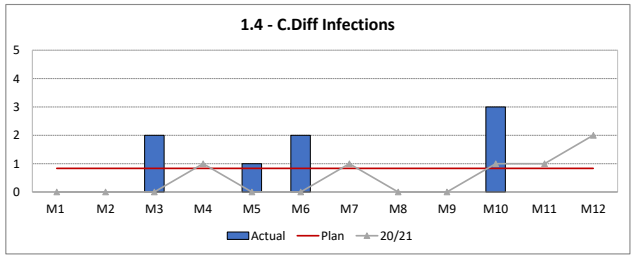
* Independently Audited – refers to an independent audit undertaken by either the Internal Auditor, External Auditors or the Data Quality Audit team.

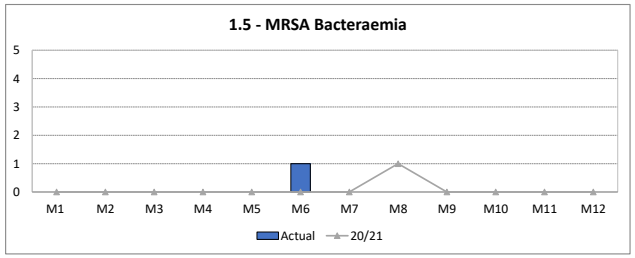
OBJECTIVE 1 - PATIENT SAFETY

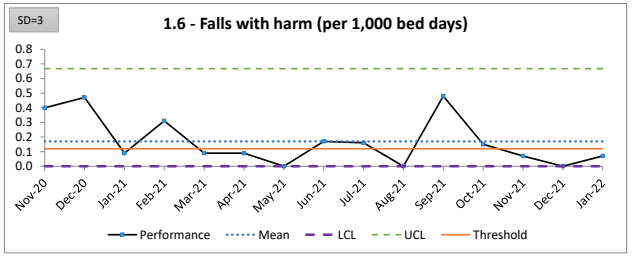


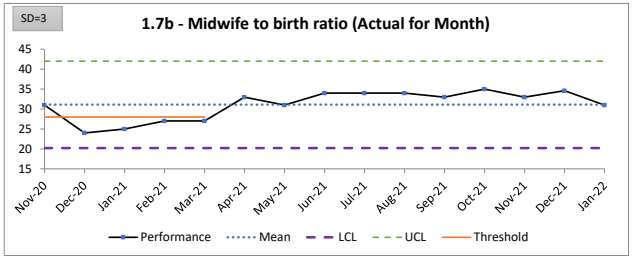


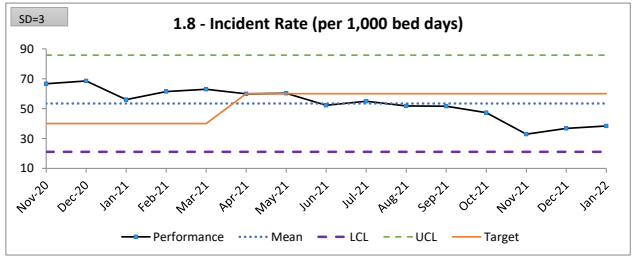


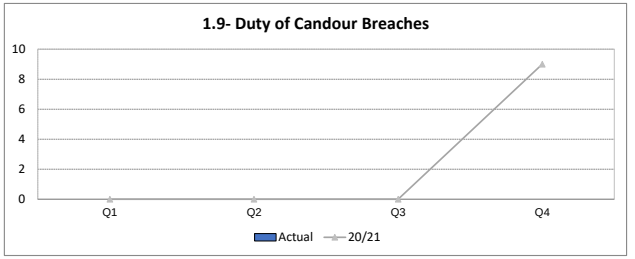


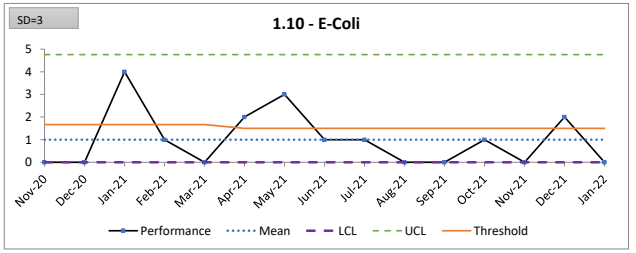


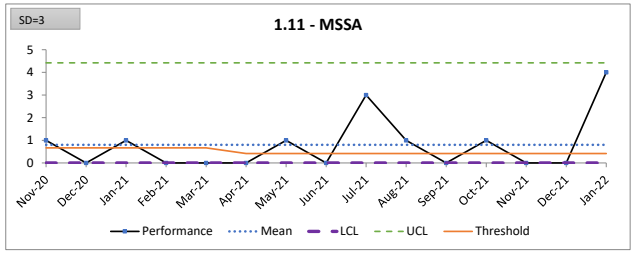


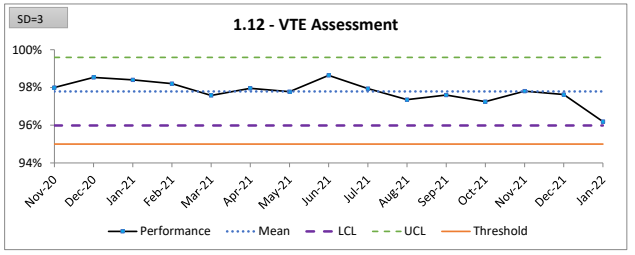












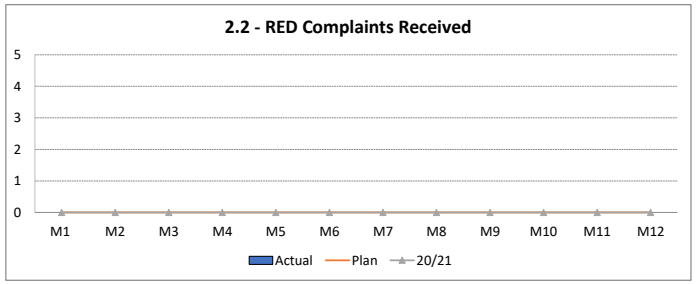
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

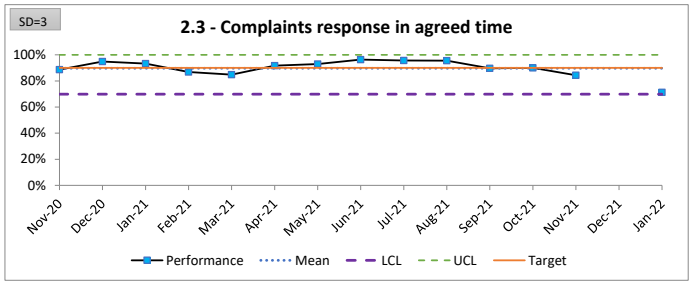
- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

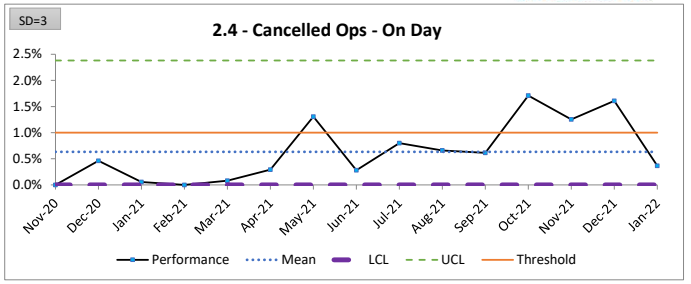
Board Performance Report 2021/22

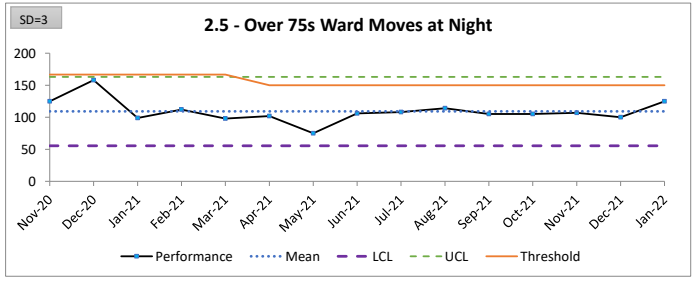
OBJECTIVE 2 - PATIENT EXPERIENCE

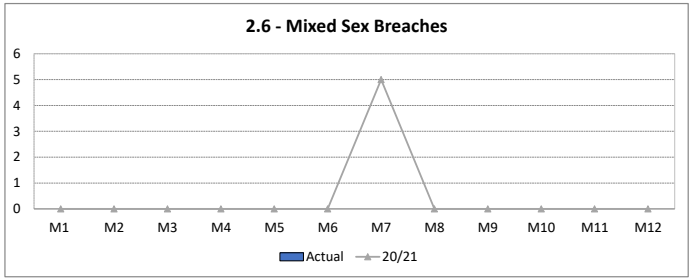
Milton Keynes University Hospital NHS Foundation Trust











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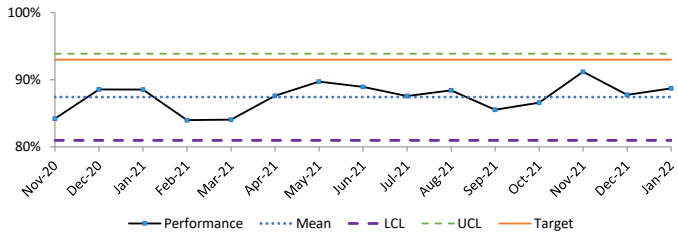
Board Performance Report 2021/22

OBJECTIVE 3 - CLINICAL EFFECTIVENESS

Milton Keynes University Hospital NHS Foundation Trust

SD=3

3.1 - Overnight bed occupancy rate



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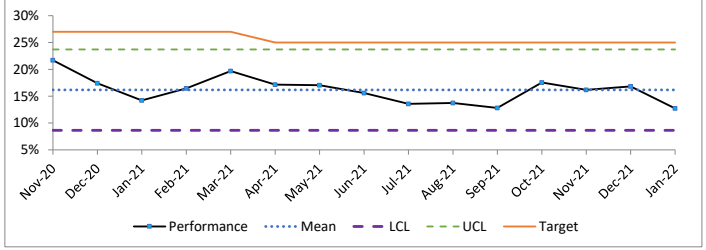
3.2 - Ward Discharges by Midday



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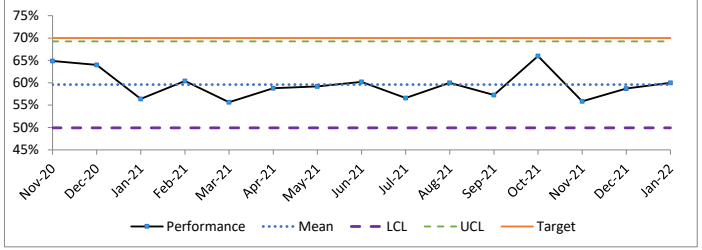
3.3 - Weekend Discharges



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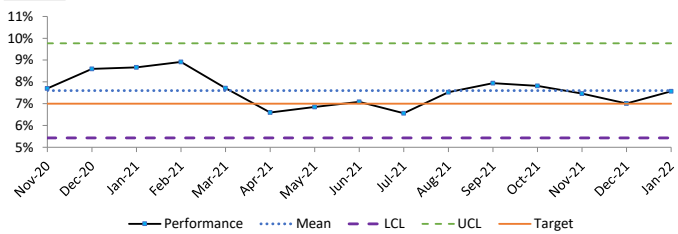
3.4 - 30 Day Readmissions



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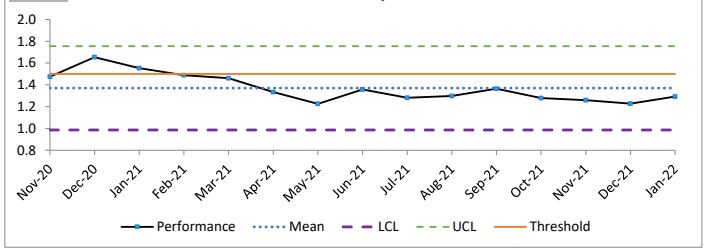
3.5 - Follow-up Ratio



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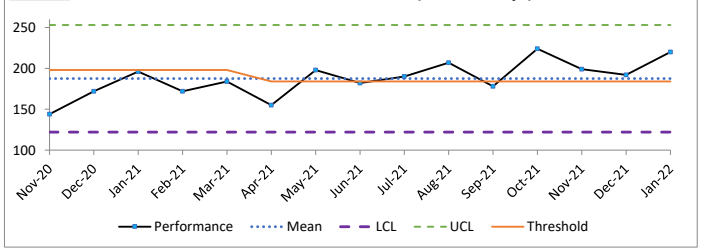
Number of Stranded Patients (LOS>=7 Days)



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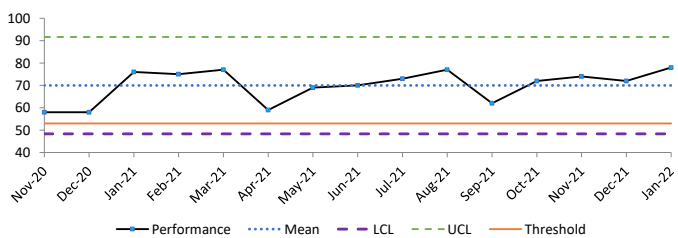
3.6.2 Number of Super Stranded Patients (LOS>=21 Days)



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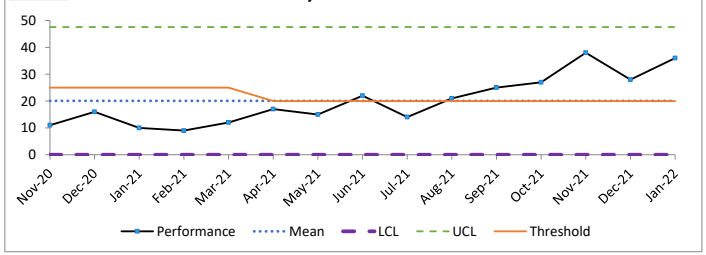
3.7 - Delayed Transfers of Care



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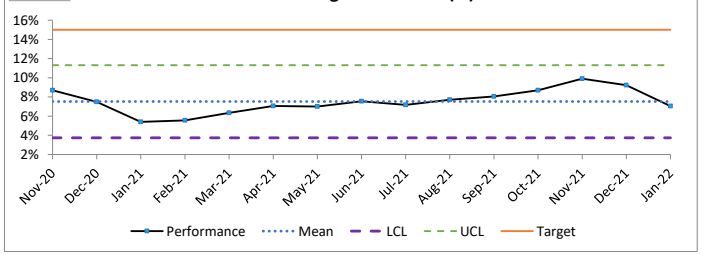
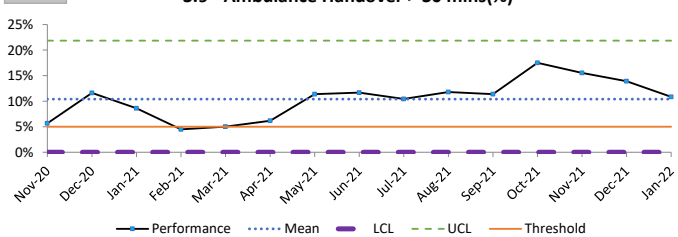
3.8 - Discharges from PDU (%)



SD=3

3.9 - Ambulance Handover > 30 mins(%)



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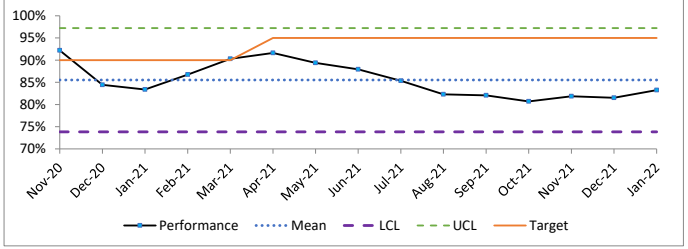
Board Performance Report 2021/22

OBJECTIVE 4 - KEY TARGETS

Milton Keynes University Hospital NHS Foundation Trust

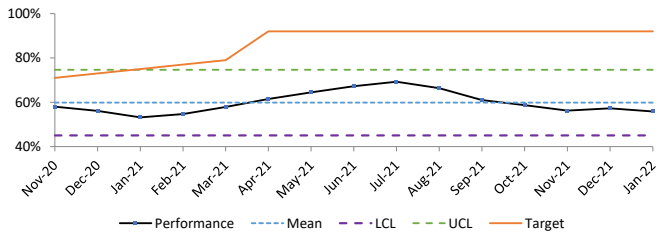
SD=3

4.1 - ED Hour Target (includes UCS)

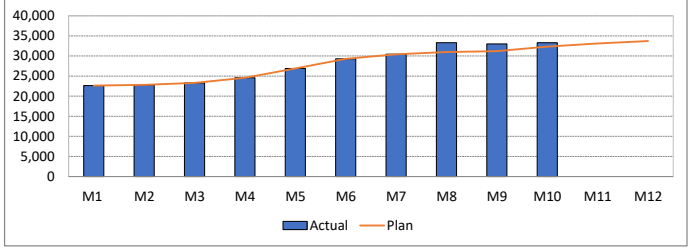


SD=3

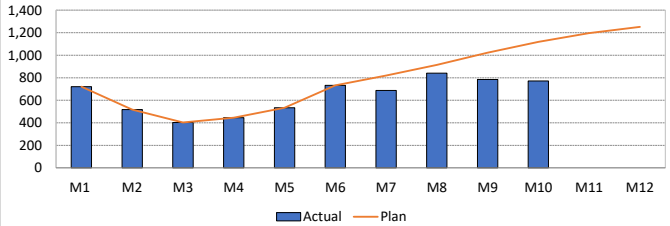
4.2 - RTT Incomplete Pathways <18 weeks



4.4 - RTT Total Open Pathways

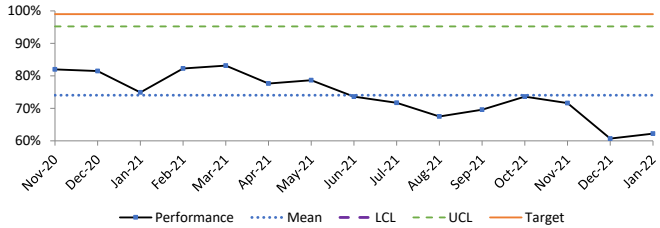


4.5 - RTT Patients Waiting Over 52 weeks



SD=3

4.6 - Diagnostic Waits < 6 weeks



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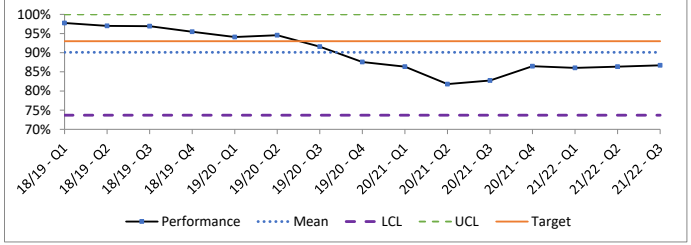
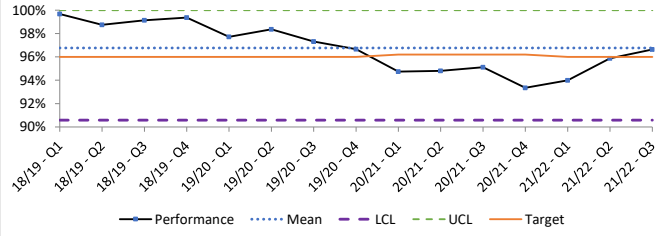
4.7 - 2 Week Wait - Cancer



SD=3

4.8 - 31 day diagnosis to treatment - Cancer



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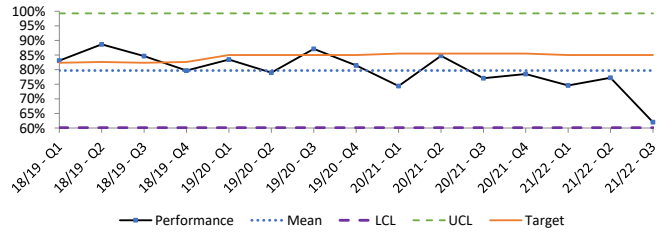
4.9 - 62 day standard - Cancer



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- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
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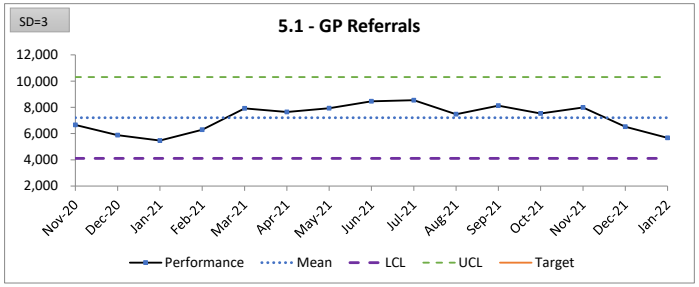
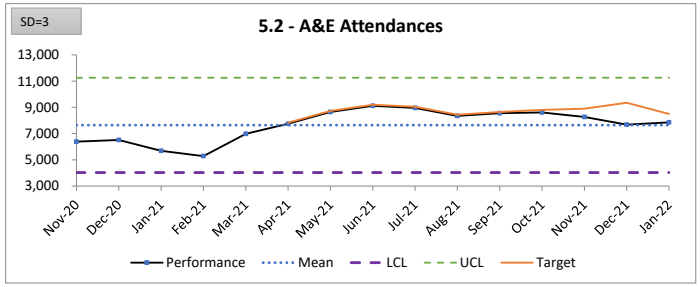
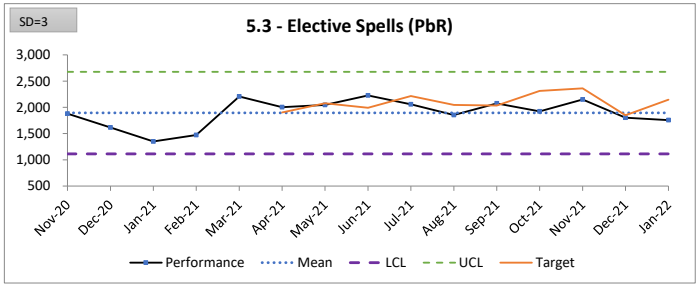
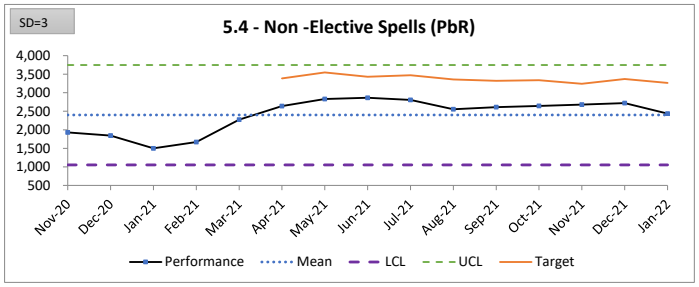
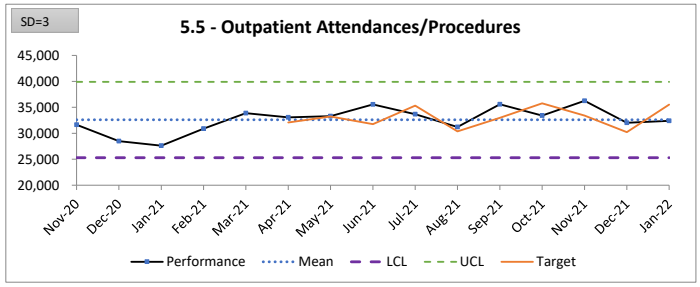
OBJECTIVE 5 - SUSTAINABILITY

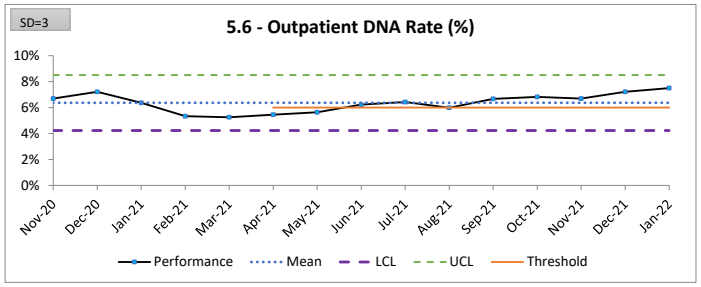












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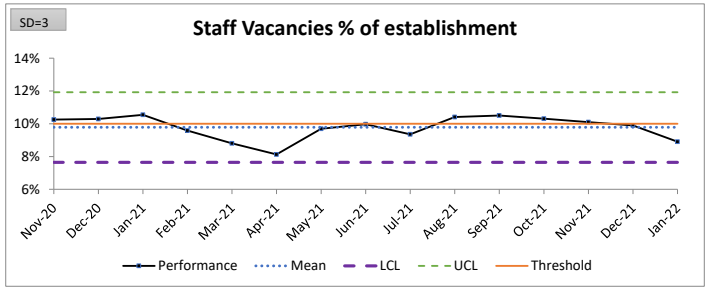
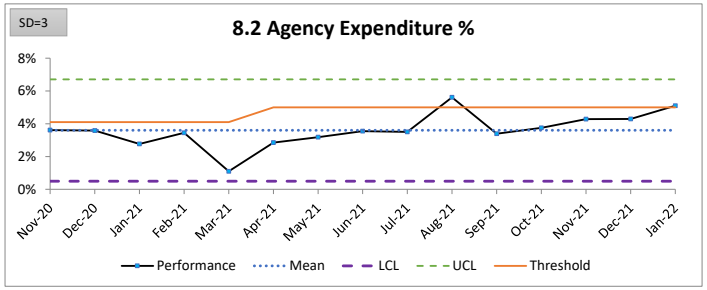
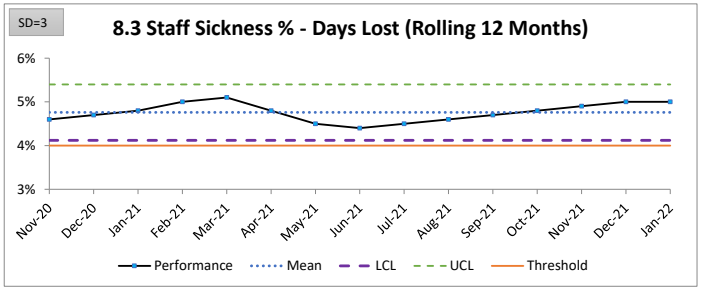
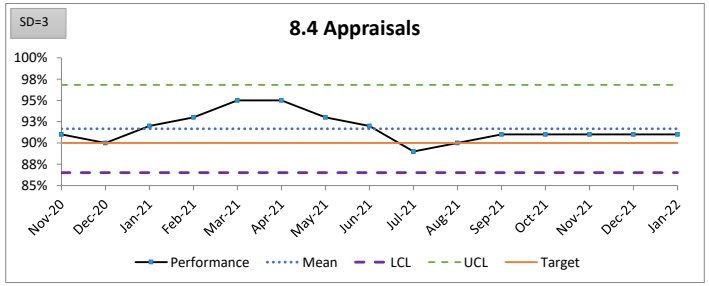
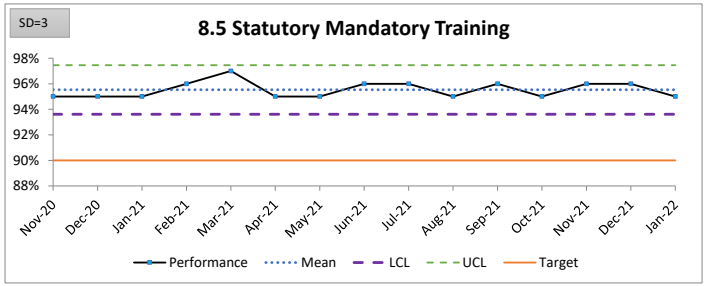
OBJECTIVE 8 - WORKFORCE PERFORMANCE

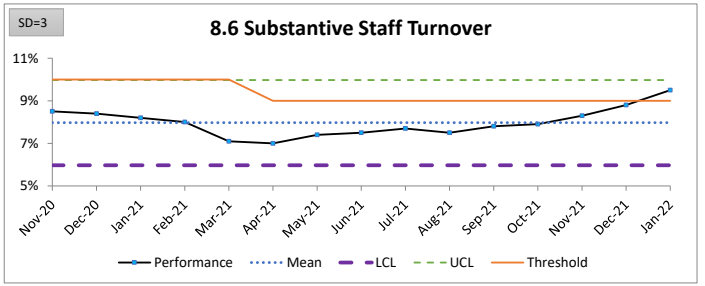












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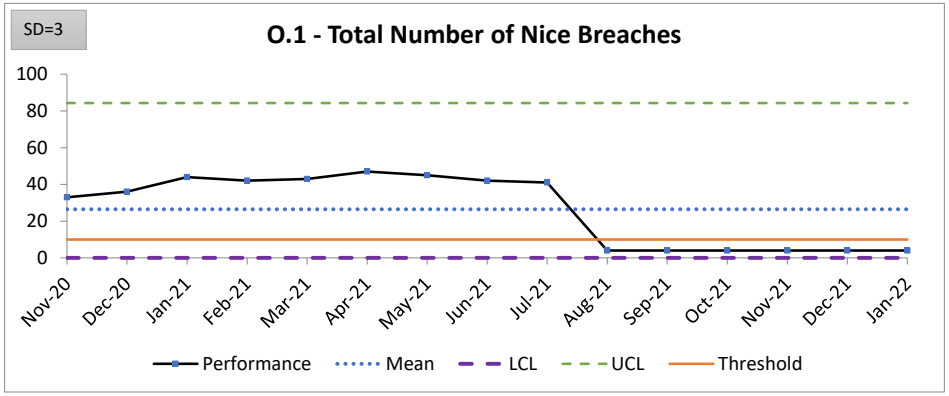

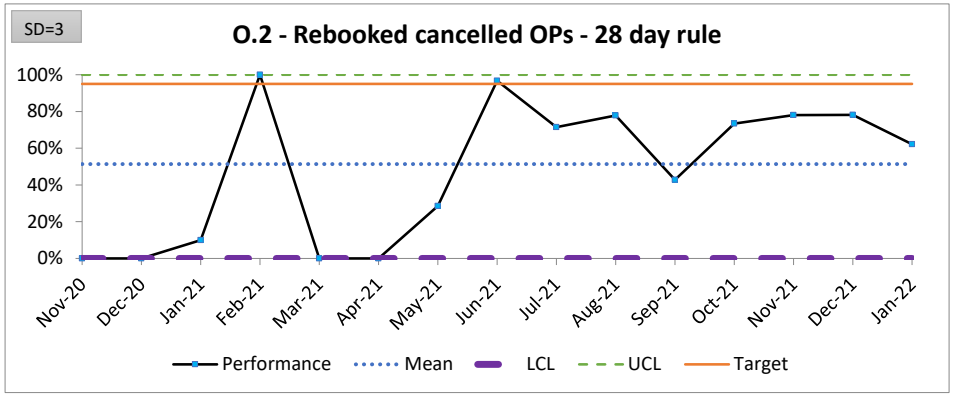

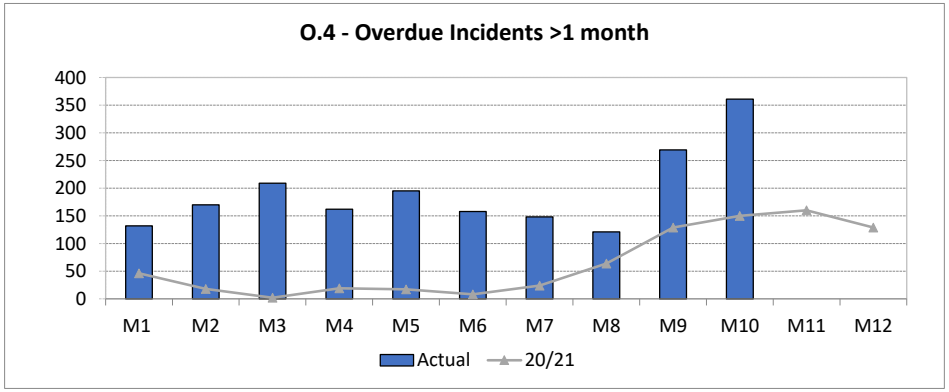

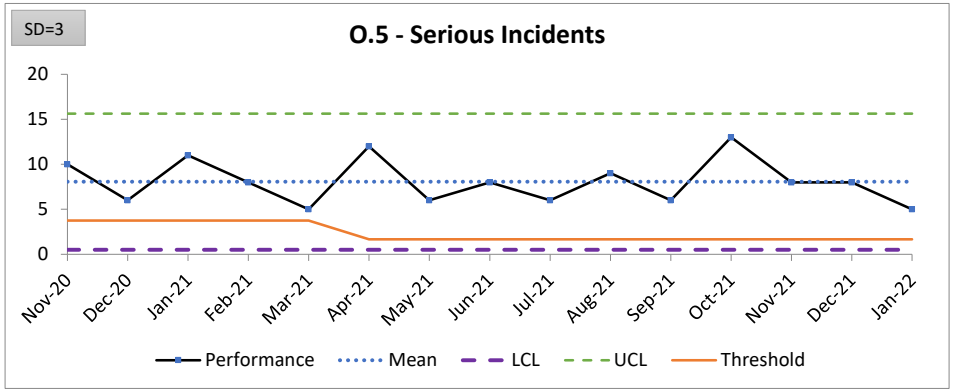

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Performance activity on a rolling 15 months/quarterly
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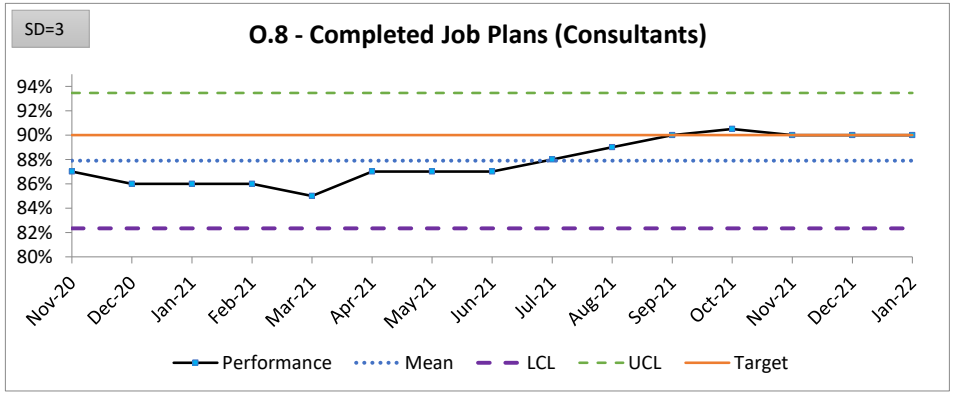


NHS
Milton Keynes
University Hospital
NHS Foundation Trust

Meeting title	**Public Board**	**Date: March 2022**
Report title:	**Finance Paper Month 10 2021-22**	**Agenda item: 18**
Lead director **Report authors**	Terry Whittle Sue Fox Cheryl Williams	Director of Finance Deputy Head of Financial Management Financial Controller
FoI status:	Private document	

Report summary	An update on the financial position of the Trust at Month 10 (January 2022)			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** x	**Decision** ☐
Recommendation	Trust Board is asked to note the financial position of the Trust as of 31st January and the proposed actions and risks therein.			

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

Report history	None
Next steps	
Appendices	Pages 13-15

FINANCE REPORT FOR THE MONTH TO 31st JANUARY 2022

TRUST BOARD

CONTENTS

EXECUTIVE SUMMARY

(1. & 2.) Revenue – Clinical revenue is paid as part of a block contract. Clinical revenue is below plan due to income for the Accelerator programme which has not been recognised (£1.3m). Non-clinical revenue is higher than plan due to additional maternity (Ockenden) funding.

(3. & 4.) Operating expenses – Pay is slightly above plan with higher temporary staffing costs. Non-pay is underspent due to lower than planned spend on elective activity (e.g., on clinical consumables).

(5.) Non-operating expenditure – non-operating expenditure is underspent due to a reduction in depreciation.

(8.) Covid expenditure– Additional direct costs attributed to Covid (e.g., swab pods and enhanced cleaning).

(10.) Financial Efficiency– Financial efficiency is being delivered by managing operating costs within our allocated funding envelope (which included a 1.1% efficiency requirement) and transactional saving schemes.

(11.) Cash – The Trust cash balance is £68.2m, equivalent to 81 days cash to cover operating expenses. Balances include £23.7m for capital schemes.

(12.) Capital – The Trust is £1.4m lower than plan excluding the New Hospital Programme (NHP). The variance is driven by timing differences on the Maple Centre scheme. The Trust is forecasting a (Capital Departmental Expenditure Limit) CDEL breach due to b/fwd. capital commitments for FY21.

(13.) Elective Recovery Fund– Higher than planned levels of ERF were recorded up to Month 10 (January). This is due to the change in the calculation against completed pathways in 2019/20.

(14.) ICS Financial Position – BLMK ICS is on plan at a breakeven position YTD.

Ref	All Figures in £'000	Month 10 YTD Plan	Month 10 YTD Actual	Month 10 YTD Var	Full Year Plan	Full Year Forecast	Full Year Var	RAG
1	Clinical Revenue	248,620	247,350	(1,270)	297,314	297,314	-	
2	Other Revenue	16,200	16,828	627	19,542	19,542	-	
3	Pay	(170,117)	(170,996)	(879)	(203,271)	(203,271)	-	
4	Non Pay	(80,604)	(80,207)	396	(96,446)	(96,446)	-	
5	Financing & Non-Ops	(15,563)	(14,676)	887	(18,634)	(18,634)	-	
6	Surplus/(Deficit)	(1,464)	(1,702)	(238)	(1,495)	(1,495)	-	
7	Control Total Surplus/(Deficit)	(1,102)	(1,102)	0	(1,102)	(1,102)	-	
8	Inc. COVID expenditure	(9,159)	(5,189)	3,970	(10,966)	(6,227)	4,739	
9	High Cost Drugs	(15,795)	(18,267)	(2,472)	(21,821)	(21,821)	-	
10	CIP Delivery	5,800	1,468	(4,332)	6,850	6,850	-	
11	Cash	32,279	68,267	35,988	25,668	39,768	14,100	
12a	Capital Plan (excluding NHP)	17,687	16,855	(832)	28,008*	34,008	6,000	
12b	Capital Plan (including NHP)	33,927	17,165	(16,762)	29,005*	35,005	6,000	
13	ERF Delivery	9,532	9,654	122	9,532	9,654	122	
14	ICS Financial Position	-	158	158	-	-	-	

Key message

The Trust is reporting a £1.1m deficit for the period April to January, this position is consistent with the plan. The Trust is forecasting a £1.1m deficit for the year-end as part of a balanced BLMK aggregate system plan. The Trust has income surety based on a block contract. Funding is adequate to cover cost pressures (e.g., premium pay costs) associated with the current operating environment.

The Trust has a robust cash position and is paying creditors promptly. The capital programme is behind plan by £1.4m excluding the NHP due to timing differences (plan phasing) in the Maple Centre scheme, this is forecast to be on plan by the end of the year. The Trust is forecasting a £6m Capital Departmental Expenditure Limit (CDEL) breach and is working with BLMK partners to mitigate this at system level.

FINANCIAL PERFORMANCE- OVERVIEW MONTH 10

2. **Summary Month 10**

For the month of January 2022, financial performance (on a Control Total basis) is a breakeven position, consistent with the plan.

All Figures in £'000	Month 10 Plan	Month 10 Actual	Month 10 Var	Month 10 YTD Plan	Month 10 YTD Actual	Month 10 YTD Var	Plan Plan	Plan Forecast	Plan Var
Clinical Revenue	19,983	20,287	303	218,079	216,809	(1,270)	244,958	244,958	0
Other Revenue	1,661	1,459	(202)	16,066	16,687	620	19,051	19,051	0
Total Income	21,644	21,746	102	234,145	233,495	(650)	264,009	264,009	0
Pay	(16,577)	(17,361)	(784)	(170,117)	(170,996)	(879)	(203,271)	(203,271)	0
Non Pay	(7,921)	(7,599)	322	(80,604)	(80,207)	396	(96,446)	(96,446)	0
Total Operational Expenditure	(24,498)	(24,959)	(461)	(250,721)	(251,203)	(482)	(299,717)	(299,717)	0
EBITDA	(2,854)	(3,213)	(360)	(16,576)	(17,708)	(1,132)	(35,708)	(35,708)	0
Financing & Non-Op. Costs	(1,509)	(1,149)	360	(15,067)	(13,935)	1,132	(17,750)	(17,750)	0
Control Total Deficit (excl. top ups)	**(4,363)**	**(4,363)**	**0**	**(31,643)**	**(31,643)**	**0**	**(53,458)**	**(53,458)**	**0**
Adjustments excl. from control total:									
National Top up	3,430	3,430	0	24,010	24,010	0	41,160	41,160	0
COVID Top up	933	933	0	6,531	6,531	0	11,196	11,196	0
Control Total Deficit (incl. top ups)	**0**	**0**	**0**	**(1,102)**	**(1,102)**	**0**	**(1,102)**	**(1,102)**	**0**
Donated income	10	7	(3)	134	141	7	491	491	0
Depreciation	(71)	(69)	2	(692)	(693)	(1)	(834)	(834)	0
Impairments & Rounding	45	0	(45)	196	(48)	(244)	(50)	(50)	0
Reported deficit/surplus	**(16)**	**(62)**	**(46)**	**(1,464)**	**(1,702)**	**(238)**	**(1,495)**	**(1,495)**	**0**

3. Clinical Income
Clinical income shows a positive variance of £0.3m which is due to additional ERF funding. This is partly offset by unrecognised accelerator funding.

4. Other Income
Other income shows a negative variance of 0.2m. This is due to reduced income related to the Medical School.

5. Pay
Pay spend is slightly above plan with additional temporary staffing costs partly offset by substantive vacancies. Further detail is included in Appendix 1.

6. Non-Pay
Non pay is below plan due partly to some one-off adjustments relating to the prior year. Further detail is included in Appendix 1.

7. Non-Operating Expenditure
Non-operating expenditure is lower than plan in-month due to a reduction in depreciation costs.

Key message
For the month of January 2022, the position on a Control Total basis is breakeven, which is on plan. Overspends in-month are offset by higher clinical income and reduced depreciation costs.

FINANCIAL PERFORMANCE- OVERVIEW YTD

8. **Summary Year to Date**

Cumulative financial performance (April to January) on a Control Total basis is a deficit of £1.1m. This is consistent with the plan. Overspends on pay related to delivery of additional elective activity, and wage awards, are now included in the H2 plan bringing the total to a breakeven position.

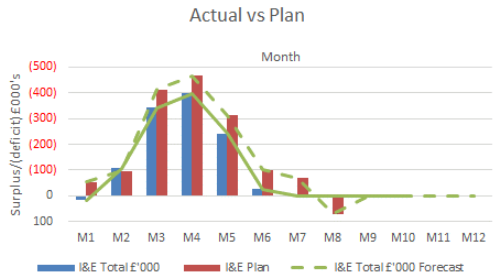
9. Clinical Income YTD
Clinical income shows a negative variance of £1.3m YTD, the Trust has recognised £9.5m related to ERF but has not recognised all the accelerator income. Further detail is included in Appendix 1.

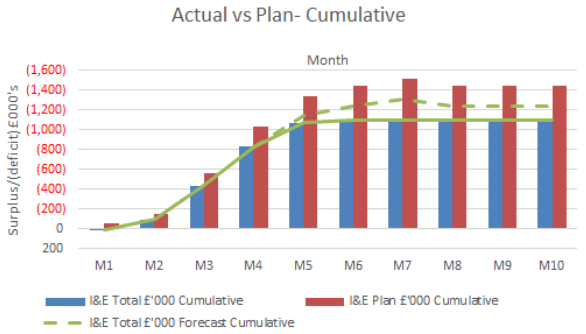
10. Other Income YTD
Other income is £0.6m above plan YTD due to receipt of additional education and training, research and development and maternity funding above planned levels.

11. Pay YTD
Pay is overspent by 0.9m YTD. £3.5m of pay expenditure has been reported as a direct result of additional activity required to deliver elective recovery and the Trust has provided a further £0.9m for the anticipated cost of recovery. Further detail is included in Appendix 1.

12. Non-Pay YTD
There is a positive variance YTD of £0.4m. £2.4m of non-pay expenditure has been reported as a direct result of additional activity to deliver elective recovery. Further detail is included in Appendix 1.

13. Non-Operating Expenditure YTD
Non-operating expenditure is £0.9m under plan YTD due to reduced depreciation charges.





Key message
Up to January 2022, the position on a Control Total basis is a deficit of £1.1m. This is in line with the plan. Overspends on pay and non-pay relate to the delivery of additional clinical activity which is offset by additional income (ERF).

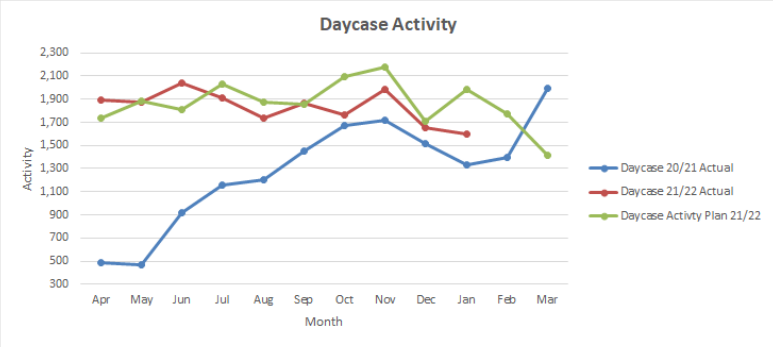
The Trust will continue to monitor operating costs to ensure expenditure incurred on additional activity is covered by ERF incentive payments.

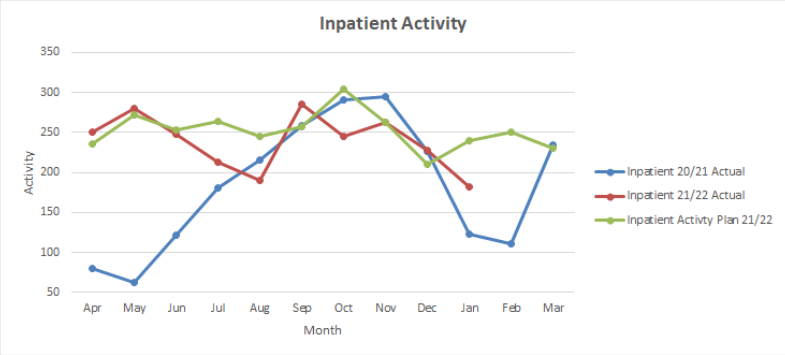
ACTIVITY PERFORMANCE & ERF

14. For the first half of the financial year activity in 2021/22 was to be measured against 2019/20 baseline, with expectations set by NHSE/I as a percentage of 2019/20 levels (adjusted for working days) starting with 70% target in April rising by 5% increments each month, with the upper threshold set at 95%. Under this guidance the Trust developed its own recovery plan in line with activity requirements of the Accelerator programme, by which the Trust planned to meet 120% of the 2019/20 baseline by July. The Trust has revised the forecast delivery downwards from July onwards to consider performance YTD and known factors limiting activity over July and August. In addition, NHSE/I revised the policy baselines from July onwards (to 95%) in response to a robust activity recovery from the NHS.
15. During the second half of the financial year the ERF payment policy has been revised with payment (to systems) contingent on the proportion of 'clock-stop' activity (set at 89% of 2019/20).

16. <u>Activity vs Plan (as per CIVICA excluding accelerator target)</u>

Day case activity- Is below plan both in month and YTD. Operational pressures and A/L have impacted performance.
Elective Inpatient Activity- Activity has reduced again this month but is in line with last year's activity but is below the 21/22 plan.
Outpatient Activity- Has increased in January compared to December but are still slightly behind plan in month.
Non-Elective Spells- Non elective activity has decreased against the previous month and is still significantly under the 21/22 plan.
A&E activity- Remains high compared to 20/21 and increased from December to January. Activity is above plan YTD.





Key message
Month 10 has seen lower levels of elective and non-elective activity but higher levels of outpatient activity. This is expected to continue in February due to Covid admissions and general winter pressures.

17. ERF position summary

NHSE/I has introduced the Elective Recovery Fund (ERF) for 2021/22. For H2 this will be focussed on completed referral to treatment (RTT) pathway activity rather than total cost weighted activity which was used in H1. The thresholds for the scheme have been recalculated so that they are on a comparable basis to the 95% threshold for the ERF in Q2.

Where systems deliver completed RTT pathway activity above the 89% threshold, additional activity will be funded at 100% of tariff between 89% and 94%, and 120% of tariff over 94%.

It must be noted that any ERF incentive payment is calculated on overall system performance and the clearance of associated ERF gateway criteria. There is no guarantee MKUH (or any single organisation within the system) will receive funds if it over performs (but the aggregate system position is not achieved).

18. The Trust achieved £7.5m of ERF over the first six months of the year. This value was £4m lower than originally planned, £3.0m is due to the change in baselines and an additional £1m is due to unplanned theatre downtime and high uptake of staff annual leave during July and August. Due to uncertainty with the RTT figures for October no additional ERF income has been assumed this month.

19. In addition to the national ERF scheme, the Trust was selected as an 'accelerator site', this attracted additional funding of £3.0m to support the Trust to meet a target of 120% of 19/20 activity by July 2021. Income is recognised in-line with the additional expenditure in the upcoming months.

Key message

Elective care activity reduced in January compared to December. Due to the change in calculation and payment of ERF and the impact on planned care recovery from the Covid-19 Omicron variant, for prudency no additional income has been assumed for the last 2 months. An additional £2m has however been recognised in M10 bringing the cumulative ERF value to £9.5m. This change was due to an update following the closure of the BLMK ERF position for activity undertaken during October.

EFFICIENCY SAVINGS

20. As of January, the Trust has reported a breakeven position to plan, included within this position is £5.8m of efficiency target. The Trust has offset the planned efficiency target by managing the incremental cost of delivering additional activity (e.g., to support recovery) within the additional funding available.

21. For the final quarter of the financial year (January to March 2022) the Trust is increasing the focus on financial efficiency through the Better Value Brighter Outcomes programme. The Trust has identified £1.5m from schemes submitted to date.

Key message
YTD the Trust has delivered its £5.8m efficiency requirement to M10. This has been achieved through transactional saving schemes and managing the cost of operations within available resources. Work is progressing through the Trust 'Better Values' programme to identify schemes in line with the efficiency target for Q4 and into 2022/23.

CAPITAL- OVERVIEW YTD

22. The YTD spend on capital (excluding donated assets and derecognised assets) is £13.12m, which is behind the Trust's capital plan (excluding the New Hospitals Programme (NHP)) by £1.44m. The strategic schemes are above plan due to schemes brought forward from prior year with no CDEL which are being offset by the timing of the costs for the Maple Centre (expected later in the year).

23. The Trust's has recently received approval for the second TIF bid relating to digital equipment (£1.92m), as well as Digital Diagnostics Capability funding for Pathology (£0.27m) and Imaging (£0.53m) and Digital workforce for echo cardiology £0.07m.

24. The Trust has received notification that it has been awarded £1.0m against its £1.8m bid for NHP funding for 21/22. The full breakdown of all funding and sources of application is shown in the table below.

	ICS Approved CDEL Allocation 2021/22			National CDEL Allocation 2021/22		
				Externally Funded		
Scheme Subcategory	**Internally Funded**	**Externally Funded Approved**		**Planned**	**Approved**	**Awaiting Approval**
	£m	£m		£m	£m	£m
Depreciation	13.6					
Self Funded	0.26					
PDC Funded						
Digital Diagnostic Equipment Replacement & Growth		0.15				
New Hospital Programme				28	0.98	
STP wave 4 (Maple Unit)				8.28	8.28	
Elective Recovery (TIF)					3.00	
Digital (TIF)					1.92	
Digital Diagnostics Capability - Pathology & Lims					0.27	
Digital Diagnostics Capability - Imaging					0.53	
Diagnostics Workforce - Echo cardiology					0.07	
Sub Total CDEL	**13.86**	**0.15**		**36.3**	**15.05**	**0.0**
CDEL Allocation Approved	**29.06**					**0.0**
Total Planned CDEL	**50.29**					

Key message
Capital expenditure is behind plan by £1.44 YTD, excluding NHP, which is due to the timing of costs for the Maple Centre. The Trust is forecasting a CDEL breach of £6m. This is being managed with BLMK partners and continued dialogue with NHSE/I regional team.

Capital Item	**YTD Plan up to end of Dec 21**	**Actual up to end of Dec 21**	**Variance YTD**	**Status**	**Comments For Forecast**
	£m	**£m**	**£m**		**Status**
CBIG Allocation	**3.98**	**4.30**	**0.32**		Slippage on schemes
Pre commitments					
Finance Leases	0.23	0.00	-0.23		Fully committed
Capitalised Staffing - IT and Estates	0.20	0.16	-0.04		Fully committed
IT equipment	0.14	0.01	-0.13		Relates to IT licenses due in Q4
Cerner Phase C	0.34	0.24	-0.10		Fully committed
LIMS (Pathology IT System)	0.02	0.06	0.04		Staffing costs not included in org plan
HR IT system	0.01	0.01	0.00		Fully committed
Mammography Installation for 2 machines	0.10	0.25	0.15		Fully committed
Breast Unit Building Works	0.20	0.01	-0.19		Fully committed
Sub Total Pre-commitments	***1.24***	***0.75***	***-0.48***		
Donated & Derecognised Assets (are excluded from CDEL)					
Baby Leo 3 incubators	0.08	0.08	0.00		Fully committed
Pathlake	0.43	0.00	-0.43		Expenditure now not expected until 22/23
COVID Donated assets	0.00	0.05	0.05		No impact on capital allocation
Derecognition of assets	0.00	-1.71	-1.71		No impact on capital allocation
Other donated assets	0.00	0.01	0.01		
Sub Total Donated & Derecognised Assets	***0.51***	***-1.58***	***-2.08***		
Strategic Schemes					
Staff Room Refurbishment	0.20	0.00	-0.20		BC approved in November
CT Scanner (prior year COVID funding)	0.53	0.00	-0.53		Now supported by TIF funding
Endoscopy (prior year COVID funding)	0.23	0.00	-0.23		Not a priority for 21/22
Xray Interventional	0.50	0.00	-0.50		Now supported by TIF funding £0.98m approved, balance to be pre-commitment
Angio Interventional	0.25	0.00	-0.25		for 22/23
Other strategic schemes allocation	0.50	1.42	0.92		
Radiotherapy	*0.00*	0.21	0.21		Scheme supported in year
South Site Infrastructure	*0.00*	1.02	1.02		Monitoring forecast
Bed replacement	*0.00*	0.00	0.00		BC approved procurement timing of order TBC
Sensyne	0.00	0.00	0.00		No confirmed CDEL
Prior year schemes not allocated CDEL					
Endoscopy Fit Out (Whitehouse)	0.00	0.00	0.00		No confirmed CDEL, BC awaiting internal approval
MRI installation	0.00	0.23	0.23		No confirmed CDEL
Flat roofs	0.00	0.00	0.00		No confirmed CDEL
HIP2 Infrastructure schemes	0.00	1.34	1.34		No confirmed CDEL
Sub Total Strategic Schemes	***1.71***	***4.22***	***2.01***		
Total ICS CDEL (excluding donated & derecog assets)	**6.42**	**7.43**	**1.01**		Above CDEL allocation
Other National Approved funding approved					
Maple Unit	7.86	5.18	-2.68		
TIF (ERF Diagnostics)	0.00	0.22	0.22		
TIF (IT Digital)	0.00	0.00	0.00		
Digital Diagnostics - Pathology	0.00	0.00	0.00		
Digital Diagnostics - Imaging	0.00	0.02	0.02		
Diagnostics workforce - Echo Cardiology	0.00	0.00	0.00		
Total Capital (excluding NHP)	**14.28**	**12.85**	**-1.44**		Forecast above CDEL approved value
New Hospital Programme (NHP)	10.64	0.28	-10.36		
Total Capital (including NHP)	**24.92**	**13.12**	**-11.80**		
Awaiting National Approval					
Unified Tech Fund					Awaiting formal approval from NHSE/I
Total Capital (including NHP)	**24.92**	**13.12**	**-11.80**		Forecast above CDEL approved value

CASH

25. Summary of Cash Flow

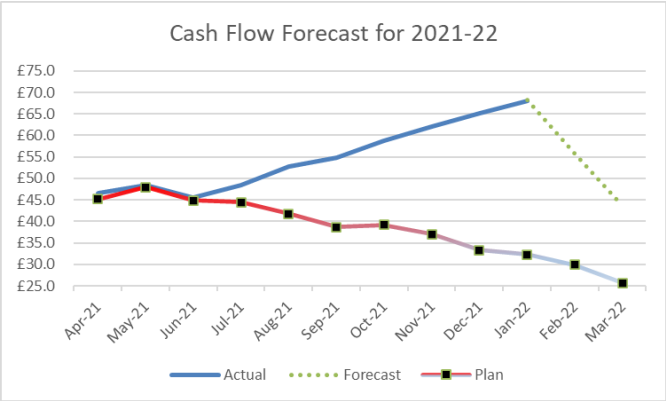
The cash balance at the end of January was £68.2m, this was £36.2m higher than the planned figure of £32m. This is an increase on last month's figure of £65m. See appendices 6-8 for the cashflow detail. The Trust is forecasting a year end cash balance of £43.8m (see opposite).

26. Cash arrangements 2021/22

The current cash funding arrangements for H2 are that the Trust is receiving monthly block payments as per its plan, plus any additional funding for high-cost drugs on a pass-through basis. The Trust received £2.7m ERF funding in January (for prior period performance).

27. Better Payment Practice Code

The Trust has fallen below the national target of 95% of all bills paid within the target timeframe. Payment performance of NHS bills require improvement, an action plan is being developed. This metric will continue to be monitored in accordance with national guidance and best practice



Better payment practice code	Actual M10 YTD Number	Actual M10 YTD £'000	Actual M9 YTD Number	Actual M9 YTD £'000
Non NHS				
Total bills paid in the year	50,548	133,754	44,445	119,327
Total bills paid within target	46,434	125,912	41,436	113,338
Percentage of bills paid within target	**91.9%**	**94.1%**	**93.2%**	**95.0%**
NHS				
Total bills paid in the year	1,637	5,149	1,490	5,038
Total bills paid within target	1,253	3,065	1,147	3,013
Percentage of bills paid within target	**76.5%**	**59.5%**	**77.0%**	**59.8%**
Total				
Total bills paid in the year	**52,185**	**138,903**	**45,935**	**124,364**
Total bills paid within target	**47,687**	**128,977**	**42,583**	**116,351**
Percentage of bills paid within target	**91.4%**	**92.9%**	**92.7%**	**93.6%**

Key message

Cash is above plan by £32m, and the Trust has fallen below the 95% target for Better Payment Practice Code (BPPC), mainly due to issues experienced by a third-party supplier during the repatriation of Accounts Payable services. This position is expected to improve, and a plan is being developed to for the NHS payment position.

BALANCE SHEET

28. Statement of Financial Position

The key movements include:

- Non-Current Assets have increased from March 21 by £5.3m; this is driven by additions in year.
- Current assets have increased by £12.3m, this is mainly due to the increase in cash £19.4m offset by a reduction in receivables (£7.1m).
- Current liabilities have increased by £14.5m, this is mainly due to the increase in Trade Payables £9.4m and Deferred Income £5.7m offset by decreases in Borrowings (£0.2m) and Provisions (£0.4m)
- There has been no change in Non-Current Liabilities in month.

29. Aged debt

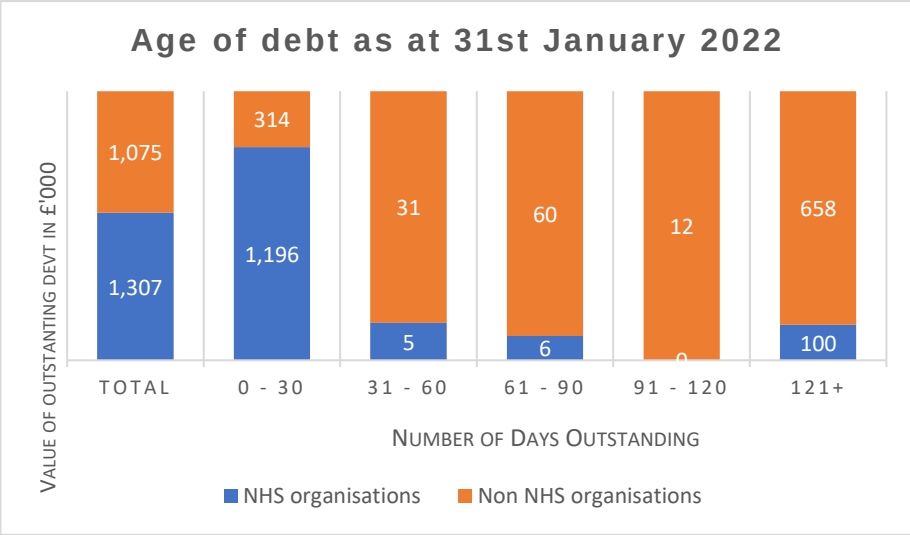
The debtors position as of 31st January is £2.4m, which is an increase of £0.4m from the November position. Of this total £0.8m is over 121 days old.

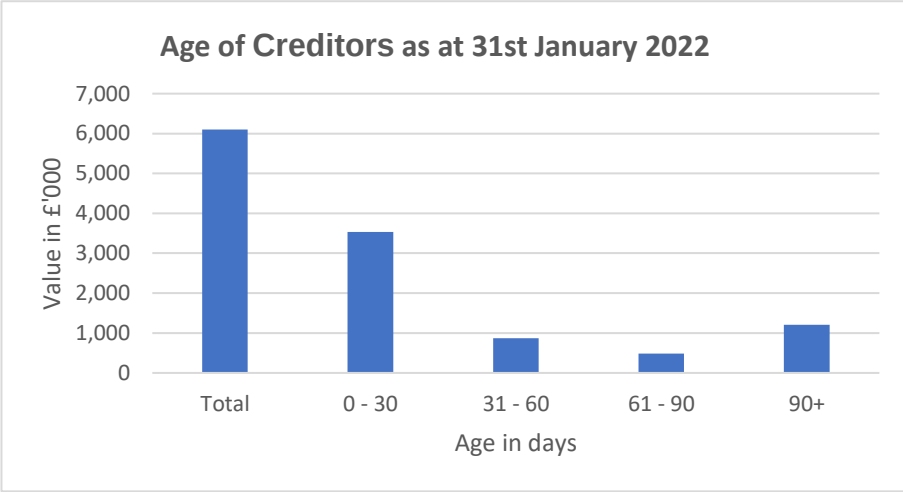
a

The three largest NHS debtors are Bedford Hospitals NHS Foundation Trust £0.03m for salary recharges, Oxford Health NHS Foundation Trust £0.1m for salary recharges and NHS England £0.07m for Diabetic Retinopathy and training recharges. The largest non-NHS debtors include £0.2m for overseas patients, £0.2m with Bedfordshire and Northamptonshire councils for sexual health, £0.1m with NHS Property Services Ltd for utilities recharges.

30. Creditors

The creditor's position as of 31st January 22 is £6.1m, which is an increase of £0.7m from the December 21 position. Of this £2.6m is over 30 days, with £1.0m approved for payment.





Key message

No significant movements on the statement of financial position; debtors are comparable to the prior month, but there is an aged debtor of over 121 days of £1.2m that is being closely monitored

RECOMMENDATIONS TO BOARD

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

APPENDICIES

Appendix 1

Statement of Comprehensive Income
For the period ending 31st January 2022

	FY22	M10 CUMULATIVE			M10			PRIOR MONTH	
	Annual Budget	Budget	Actual	Variance	Budget	Actual	Variance	M9 Actual	Change
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME									
Outpatients	53,716	45,215	47,668	2,454	4,769	4,627	(141)	3,783 ▲	844
Elective admissions	26,165	22,331	20,442	(1,890)	2,190	1,594	(597)	1,863 ▼	(269)
Emergency admissions	77,583	66,033	62,583	(3,450)	6,695	6,111	(584)	6,947 ▼	(836)
Emergency adm's marginal rate (MRET)	0	0	0	0	0	0	0	0 ▲	0
Readmissions Penalty	0	0	0	0	0	0	0	0 ▲	0
A&E	16,398	14,086	14,182	96	1,380	1,365	(15)	1,315 ▲	50
Other Admissions	2,674	2,271	1,700	(571)	219	122	(97)	159 ▼	(37)
Maternity	21,670	18,211	18,119	(92)	1,928	1,617	(310)	1,850 ▼	(233)
Critical Care & Neonatal	7,001	5,777	5,902	125	691	541	(149)	635 ▼	(93)
Imaging	5,643	4,787	4,846	58	489	535	46	464 ▲	71
Direct access Pathology	4,818	4,127	3,802	(325)	448	373	(75)	375 ▼	(2)
Non Tariff Drugs and Devices (high cost/individual drugs)	18,900	15,795	18,267	2,472	1,584	1,802	218	1,786 ▲	16
Other (inc. home visits and best practice tariffs)	6,467	5,407	14,622	9,216	551	2,547	1,996	503 ▲	2,044
CQUINS	0	0	0	0	0	0	0	0 ▲	0
Contract Risk Provision - General challenge & CIP offset	0	0	0	0	0	0	0	0 ▲	0
National Block/Top up	56,279	44,580	35,217	(9,363)	3,402	3,415	13	4,551 ▼	(1,136)
MKCCG Block adj	0	0	0	0	0	0	0	0 ▲	0
Clinical Income	**297,314**	**248,620**	**247,350**	**(1,270)**	**24,346**	**24,650**	**303**	**24,230 ▲**	**420**
Non-Patient Income	19,051	16,066	16,687	621	1,661	1,459	(202)	1,898 ▼	(439)
PSF Income	0	0	(0)	(0)	0	0	0	0 ▲	0
Donations	491	134	141	7	10	7	(3)	0 ▲	7
Non-Patient Income	**19,542**	**16,200**	**16,828**	**627**	**1,671**	**1,466**	**(205)**	**1,898 ▼**	**(432)**
TOTAL INCOME	**316,856**	**264,820**	**264,177**	**(643)**	**26,017**	**26,116**	**99**	**26,128 ▼**	**(12)**
EXPENDITURE									
Pay - Substantive	(174,597)	(144,982)	(144,564)	418	(14,905)	(14,271)	634	(13,983) ▼	(288)
Pay - Bank	(16,419)	(14,211)	(15,044)	(833)	(1,096)	(1,837)	(740)	(1,653) ▼	(184)
Pay - Locum	(4,493)	(3,958)	(3,584)	374	(231)	(295)	(64)	(335) ▲	40
Pay - Agency	(7,373)	(6,207)	(7,147)	(939)	(545)	(892)	(346)	(719) ▼	(172)
Pay - Other	0	(391)	(657)	(266)	210	(66)	(276)	(62) ▼	(4)
Pay CIP	(389)	(361)	0	361	(13)	0	13	0 ▲	0
Vacancy Factor	0	(7)	0	7	4	0	(4)	0 ▲	0
Pay	**(203,271)**	**(170,117)**	**(170,996)**	**(879)**	**(16,577)**	**(17,361)**	**(784)**	**(16,752) ▼**	**(608)**
Non Pay	(77,545)	(64,809)	(61,941)	2,869	(6,337)	(5,797)	540	(6,437) ▲	640
Non Tariff Drugs (high cost/individual drugs)	(18,900)	(15,795)	(18,267)	(2,472)	(1,584)	(1,802)	(218)	(1,786) ▼	(16)
Non Pay	**(96,446)**	**(80,604)**	**(80,207)**	**396**	**(7,921)**	**(7,599)**	**322**	**(8,222) ▲**	**623**
TOTAL EXPENDITURE	**(299,717)**	**(250,721)**	**(251,203)**	**(482)**	**(24,498)**	**(24,959)**	**(461)**	**(24,974) ▲**	**15**
EARNINGS BEFORE INTEREST, TAXATION, DEPRECIATION AND AMORTISATION (EBITDA)	**17,139**	**14,099**	**12,974**	**(1,125)**	**1,519**	**1,157**	**(363)**	**1,153 ▲**	**3**
Interest Receivable	0	2	4	2	(1)	4	5	0 ▲	4
Interest Payable	(290)	(238)	(222)	16	(26)	(22)	4	(22) ▼	(0)
Depreciation, Impairments & Profit/Loss on Asset Disposal	(12,739)	(10,615)	(9,560)	1,056	(1,062)	(710)	352	(710) ▼	(0)
Donated Asset Depreciation	(834)	(692)	(693)	(1)	(71)	(69)	2	(69) ▲	0
Profit/Loss on Asset Disposal & Impairments	(48)	(48)	(48)	(0)	0	0	0	0 ▲	0
Unwinding of discounts	0	0	0	0	0	0	0	0 ▲	0
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**3,228**	**2,508**	**2,456**	**(52)**	**360**	**360**	**0**	**352 ▲**	**8**
Dividends Payable	(4,723)	(3,972)	(4,158)	(186)	(376)	(422)	(46)	(422) ▲	0
OPERATING SURPLUS/(DEFICIT) AFTER DIVIDENDS	**(1,495)**	**(1,464)**	**(1,702)**	**(238)**	**(16)**	**(62)**	**(46)**	**(70) ▲**	**8**

Statement of Cash Flow
As of 31st January 2022

	Mth 10 £000	Mth 9 £000	In Month Movement £000
Cash flows from operating activities			
Operating (deficit) from continuing operations	2,722	2,345	(132)
Operating (deficit)	**2,722**	**2,345**	**(132)**
Non-cash income and expense:			
Depreciation and amortisation	10,252	9,473	(1,131)
(Gain)/Loss on disposal	(48)	(48)	0
(Increase)/Decrease in Trade and Other Receivables	7,119	5,316	(625)
(Increase)/Decrease in Inventories	(5)	3	1
Increase/(Decrease) in Trade and Other Payables	12,831	12,140	(4,767)
Increase/(Decrease) in Other Liabilities	5,674	3,901	1,134
Increase/(Decrease) in Provisions	(339)	(183)	4
NHS Charitable Funds	(141)	(134)	0
Other movements in operating cash flows	(4)	(4)	(1)
NET CASH GENERATED FROM OPERATIONS	**38,061**	**32,809**	**(5,517)**
Cash flows from investing activities			
Interest received	4	-	0
Purchase of intangible assets	(1,680)	(1,547)	163
Purchase of Property, Plant and Equipment, Intangibles	(19,028)	(17,150)	918
De-recognition of PPE			0
Net cash generated (used in) investing activities	**(20,704)**	**(18,697)**	**1,081**
Cash flows from financing activities			
Public dividend capital received	4,804	4,804	0
Capital element of finance lease rental payments	(166)	(150)	18
Interest element of finance lease	(222)	(200)	23
PDC Dividend paid	(2,412)	(2,412)	0
Receipt of cash donations to purchase capital assets	141	134	0
Net cash generated from/(used in) financing activities	**2,145**	**2,176**	**41**
Increase/(decrease) in cash and cash equivalents	**19,502**	**16,288**	(4,395)
Opening Cash and Cash equivalents	**48,765**	**48,765**	
Closing Cash and Cash equivalents	**68,267**	**65,053**	**(4,395)**

Appendix 3

Statement of Financial Position as of 31st January 2022

	Audited Mar-21	Jan-22 YTD Actual	YTD Mvmt	% Variance
Assets Non-Current				
Tangible Assets	169.5	177.3	7.8	4.6%
Intangible Assets	22.0	19.5	(2.5)	(11.4%)
Other Assets	1.0	1.0	0.0	0.0%
Total Non Current Assets	**192.5**	**197.8**	**5.3**	**2.8%**
Assets Current				
Inventory	3.7	3.7	0.0	0.0%
NHS Receivables	7.3	4.0	(3.3)	(45.2%)
Other Receivables	12.5	8.7	(3.8)	(30.4%)
Cash	48.8	68.2	19.4	39.8%
Total Current Assets	**72.3**	**84.6**	**12.3**	**17.0%**
Liabilities Current				
Interest -bearing borrowings	(0.2)	0.0	0.2	(100.0%)
Deferred Income	(14.9)	(20.6)	(5.7)	38.3%
Provisions	(2.9)	(2.5)	0.4	(13.8%)
Trade & other Creditors (incl NHS)	(58.5)	(67.9)	(9.4)	16.1%
Total Current Liabilities	**(76.5)**	**(91.0)**	**(14.5)**	**19.0%**
Net current assets	**(4.2)**	**(6.4)**	**(2.2)**	**52.4%**
Liabilities Non-Current				
Long-term Interest bearing borrowings	(5.6)	(5.6)	0.0	0.0%
Provisions for liabilities and charges	(1.7)	(1.7)	0.0	0.0%
Total non-current liabilities	**(7.3)**	**(7.3)**	**0.0**	**0.0%**
Total Assets Employed	**181.0**	**184.1**	**3.1**	**1.7%**
Taxpayers Equity				
Public Dividend Capital (PDC)	259.9	264.7	4.8	1.8%
Revaluation Reserve	50.1	50.1	0.0	0.0%
Financial assets at FV through OCI reserve	0.2	0.2	0.0	0.0%
I&E Reserve	(129.2)	(130.9)	(1.7)	1.3%
Total Taxpayers Equity	**181.0**	**184.1**	**3.1**	**1.7%**

GLOSSARY OF TERMS

Abbreviation	Full name	Explanation
A/L	Annual Leave	Impact of staff annual leave
BAU	Business as usual	In the context of capital expenditure, this is the replacement of existing capital assets on a like for like basis.
BPP	Better payment practice	This requires all NHS Organisations to achieve a public sector payment standard for valid invoices to be paid within 30 days of their receipt or the receipt of the goods or services – the target for this is 95%
CBIG	Clinical Board Investment Group	Capital approval meeting overseeing small scale capital schemes including equipment replacement and building work.
CDEL	Capital Departmental Expenditure Limit	Trusts maximum amount of capital expenditure available to be spent for the current year set by Regional NHS team and reviewed every financial year.
CIP	Cost Improvement Programme	Scheme designed to improve efficiency or reduce expenditure
COVID	COVID-19	Costs associated with COVID-19 virus
E&T	Education & Training	
ERF	Elective Recovery Fund	Additional non recurrent funding linked to recovery
HCD	High Cost/Individual Drugs	
NHP	New Hospital Programme	National capital funding for major hospital redevelopments
PDC	Public Dividend Capital	A form of long-term government finance which was initially provided to NHS trusts when they were first formed to enable them to purchase the Trust's assets from the Secretary of State. Public dividend capital (PDC) represents the Department of Health's (DH's) equity interest in defined public assets across the NHS.
R&D	Research & Development	
YTD	Year to date	Cumulative costs for the year
Other frequently used abbreviations		
Accelerator	Accelerator Funding	Additional funding linked to recovery
Block	Block value	Block income value linked to 19/20 values
Top-up	Top up Funding	Additional block income linked to 19/20 values
Covid	COVID Funding	Additional block funding to cover incremental COIVD-19 expenditure
Maple Centre	Maple Centre	The initial project name for the Maple Centre was the Pathway Unit - a 23hr ambulatory care facility currently under construction

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	Trust Board Meeting	**Date:** 24th February 2022
Report Title	Risk Report	**Agenda Item:**
Lead Director	**Name:** Kate Jarman	**Title:** Director of Corporate Affairs
Report Author	**Name:** Paul Ewers	**Title:** Risk Manager

Key Highlights/ Summary	*The report includes all significant risks across all Risk Registers (where the Current Risk Rating is graded as 15 or above), as of 24th February 2022.*			
Recommendation *(Tick the relevant box(es))*	**For Information** √	**For Approval** ☐	**For Noting** ☐	**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*
Board Assurance Framework (BAF)/ Risk Register Links	*Compliance Paper*

Report History	*The Risk Report is an ongoing agenda item*
Next Steps	*Public Board*
Appendices/Attachments	*Significant Risk Register – as of 24th February 2022*

Risk Report

1. INTRODUCTION

This report shows the profile of significant risks across the Trust.

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

2. RISK PROFILE – Significant Risk Register

- There are a total of 42 significant risks identified on Risk Registers across the Trust, and of these risks, 20 are overdue their review dates. The 20 overdue risks have been escalated for corporate review.

- There were 2 new significant risks added since the last paper:

  a. ***RSK-324*** *- IF there are significant nursing vacancies within the Paediatric Unit, including Maternity Leave and Long-Term Sickness - we are currently 38% of permanent staff roles unfilled- this is being partially mitigated with use of regular Agency and Bank staff. THEN there will not be sufficient/safe numbers of nursing staff to cover shifts.*
  b. ***RSK-325*** *- IF Ward 4 has no allocated paediatric pharmacist- with the change in ward function from a Paediatric Assessment Unit (PAU) to both PAU and inpatients. THEN the Ward 5 pharmacist will lack the capacity to sufficient cover both ward 4 and ward 5*

- There are 4 risks showing on Radar as controlled. This is where current risk scores for the risks are the same as their target risk scores. The controlled risks are listed below:

  a. ***RSK-112*** *- IF there is a lack of capacity THEN the Trust will not be able to undertake appropriate management of CT and MRI, within KPI and DM01 timescales*
  b. ***RSK-125*** *- IF there is a surge of COVID-19 patients impacting on Trust ability to maintain patient care and clinical services, or loss of staff to support clinical and non-clinical services due to high levels of absence, or a loss of national stockpile in PPE or medical devices (ventilators) resulting in the Trust not receiving deliveries to preserve the safety of patients and staff. THEN there is a risk of reduced capabilities in responding to a Novel Coronavirus (COVID-19) impacting on patient care within clinical and non-clinical services, with the inability to maintain safety for staff and patients due to national pressures on supplies and infrastructure*
  c. ***RSK-113*** *- IF mammography machine in BS2 fails due to its age (10 years). THEN there could be an increased amount of unplanned downtime consistent with aging equipment, a potential inability to procure replacement parts and/or delay in repair due to the replacement part needed to be shipped from Chicago*

d. ***RSK-114*** *- If there is insufficient staffing within the Paediatric Team THEN the team may not be able to provide a full dietetic service to children and young people in the Milton Keynes area*

- There are 4 risks that have been identified as uncontrolled. These are therefore recorded as significant risks with no controls in place to reduce the risk. These risks will be reviewed with the relevant risk owners to identify whether there are controls in place and if not, discuss what controls need to be developed. These uncontrolled risks are listed below:

a. ***RSK-326*** *- IF the delay in delivering the annual cancer surveillance follow-up mammograms for post - op women with breast cancer and those women in the family history risk programme continues. THEN there will be a delay in detecting recurrence in those with previous cancer and delayed early diagnosis in those with a family history.*

b. ***RSK-247*** *- IF the wait times for ventilated babies and children requiring transfer to a tertiary centre continue to increase due to increasing pressures across the system. THEN the children's physiotherapy and on call team will be asked to assess and treat ventilated children. The physiotherapists do not currently have the training and competencies to complete this.*

c. ***RSK-306*** *- IF there is a national shortage of BD vacuum biopsy needles due capacity constraints at their sterilisation facility. THEN the Trust may not be able to procure sufficient quality and the Trust needing to find alternative devices or alternative treatment plans*

d. ***RSK-310*** *- IF all maternity related incidents are not reported on the Trust incident reporting system. THEN maternity's ability to demonstrate effective governance processes and procedures, both within internal trust mechanisms and to the external stakeholders will be negatively affected*

3. CONCLUSION

The Trust Secretary and the Risk Manager are working to ensure that the Trust's Risk Framework is 'live' and always reflective of the state of the hospital. As such they are taking steps, including meetings with Executive Directors, to review the Trust's Risk Registers and Risk Strategy, and to enhance the Risk management processes in the Trust. As part of this work, the risk reports will be restructured to enhance the assurance they provide.

The Trust has recently changed the way risks are articulated to make it easier to understand what the risk relates to. Risks on all Risk Registers have been updated into the new IF, THEN, LEADING TO format. There are 3 risks remaining in the old format, which require further work before re-articulating.

4. RECOMMENDATION

The Group is asked to review and discuss this paper.

5. APPENDICES

Appendix 1 - Significant Risk Register as of 24th February 2022.

6. DEFINITIONS:

Significant Risks: Any risk where the Current risk score (the level of risk now) is graded 15 or above.
Current Risk: This is the level of risk posed at the time of the risk's last review.
Target Risk: Recognising that there is always an element of risk and that (depending on the risk) the lowest level of risk is not always the optimum (e.g. cost vs benefit), this is the level of risk that the Trust is willing to accept/tolerate.
Controlled Risk: This is where the current risk score is the same as the Target risk score. Risks should only be recorded as controlled where the risk has been managed down to an acceptable level in line with the Trust's risk appetite statement in the risk strategy.
Uncontrolled Risk: This is where the risk does not have any controls recorded. This means that, whilst the risk has been identified, there are currently no controls in place to mitigate/manage the risk.
Risk Appetite: The amount of risk the Trust is willing to take in pursuit of its objectives

Signficant Risk Register (15+ Risks)

Report Date: **24-Feb-2022**

Status Legend:
NotApplicable
Compliant
Planned
Pending
Overdue

Risk Score Legend:	
	Un scored
1 - 3	Low
4 - 7	Moderate
8 - 12	Significant
13 - 25	High

Reference	Created on	Owner	Category	Description	Impact of risk	Scope	Region	Location	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-035	28-Sep-2021	Helen Chadwick	Operational	IF there is a high turnover of staff due to: work pressure, not having the opportunity to work at the top of their licence, lack of capacity for development, lack of capacity for supervision / support. Also difficulty in recruiting particularly to 8a posts. Loss of staff to primary care which offers more attractive working hours. THEN there will be insufficient staff in pharmacy to meet demands of the organisation and ensure patient safety in the use of medicines.	LEADING TO: 1. increased length of stay due to TTO delay 2. increase in prescribing errors not corrected 3. increase in dispensing errors 4. increase in missed doses 5. failure to meet legal requirements for safe and secure use of medicines All resulting in adverse patient outcomes. Lack of financial control on medicines expenditure Breach of CQC regulations	Organisation			23-Feb-2022	28-Sep-2021	Overdue	20	20	6	Actively recruiting, listening events with staff, implementing 1-1 system to support staff, reviewing work activities of 8a's and above to identify what could stop for a period of time. Recruitment of additional Pharmacy technicians requested Aug19. Approved end of 2020. 3 appointed and in training.		Low	Treat	Gaps in controls: Use of senior staff to support not viable long term - 28/5/21 This action has resulted in further deterioration in morale and ability to make change, increased losses Maternity leave returners leaving for more flexible / family friendly working hours Last update in Datix (May 2021) noted: SIs occurring in service, Moderate Datix increased. Morale very poor. Turnover increasing. Safety concern escalated with request for additional resource. 2 extra locums agreed. Unable to fill these as pharmacist resource being taken up by vaccine hubs. Proposal for review being drafted.
RSK-079	14-Oct-2021	Celia Hyem-Smith	Operational	IF there are increased referral rates, a lack of space to deliver treatment, an inability to deliver timely treatment (rehab/maternity), and a lack of administrative resources THEN the Physiotherapy waiting lists may reach unacceptable levels	LEADING TO patient's not receiving timely treatment/intervention, patient's becoming unconditioned, continual pressure to provide appointments, a reduced patient outcomes and unnecessary waiting time for appointments. Increased staff stress and sickness, staff being unable to treat as many patients as pre Covid-19, staff having to use clinical time for admin duties	Region	Therapies		23-Feb-2022	01-May-2022	Planned	20	20	12	Approval given for locum support until the end of November 2021 (02-Feb-2022),All referrals triaged on receipt and rated as urgent, routine and non-urgent. Maintain contact with long waiters to determine if they still need our service. Packs and leaflets sent out, as appropriate (02-Feb-2022),Set slots kept for very urgent cases but does not meet needs.,12-month fixed term contract approved for 1.00 WTE, Band 6 member of staff,Request made to use the therapy treatment room on ward 14 for outpatient services. This area could remove 4 staff from the existing space and free up three clinic rooms and the need to access the gym,Plans to re-instate small group sessions allowing approx. 40 patients to be seen per week	Virtual clinic appointments have been introduced as part of the treatment pathway(14-Oct-2021),Additional areas suitable for telephone and video clinics have been identified and additional resources supplied(14-Oct-2021),Reconfiguration of department to support virtual working, enable social distancing and allowing appropriate staff to work from home(14-Oct-2021),An additional room has been refurbished for MSK. Refurbishment of two orthotics rooms has provided workspace for the WMH team.(14-Oct-2021),Separate risk assessment completed relating to under resourcing within the admin team(14-Oct-2021)	Low	Treat	Risk added to Risk Register following approval at Therapies governance meeting
RSK-088	15-Oct-2021	Zuzanna Gawlowski	Operational	IF there is overcrowding and insufficient space in the Neonatal Unit, exacerbated by need for social distancing due to COVID-19. The milk kitchen was condemned due to this. THEN we will be unable to meet patient needs or network requirements (without the increase in cot numbers and corresponding cot spacing). We will also be unable to meet PHE recommendations for social distancing	LEADING TO potential removal of Level 2 status if we continue to have insufficient space to adequately fulfil our Network responsibilities and deliver care in line with national requirements. This may also impact on our ability to protect babies and their families during COVID	Region	Paediatric Services		23-Feb-2022	22-Feb-2022	Overdue	25	20	9	Business Case for Refurnishing Milk Kitchen and Sluice	1. Reconfiguration of cots to create more space and extra cots and capacity, though this still does not meet PHE or national standards(15-Oct-2021),2. Parents asked to leave NNU during interventional procedures, ward rounds etc. Restricted visiting during COVID(15-Oct-2021),3. Added to capital plan(15-Oct-2021)	Low	Treat	Risk assessment to be carried out again by LV. Risk reviewed 19/01/22 by CGL/ ZG/CS/JP/LV-risk grading to remain at present Update required regarding newbuild. Further clarification required regarding risk being reduced.

Signficant Risk Register (15+ Risks)

Reference	Created on	Owner	Category	Description	Impact of risk	Scope	Region	Location	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-112	28-Oct-2021	Paula Robinson	Operational	IF there is a lack of capacity THEN the Trust will not be able to undertake appropriate management of CT and MRI, within KPI and DM01 timescales	LEADING TO Financial due to missed targets; Reputation due to long waiting times; Reputation and financial due to increased infection rates; Staff leaving due to poor working conditions; This is delaying patient management and causing issues with meeting the diagnostic waiting times. Inability to manage patients privacy and dignity also increased risk of infection due to overcrowding of facilities.	Region	Diagnostic & Screening		23-Feb-2022	29-Jun-2021	Overdue	20	20	20		Extended working hours and days, some scans sent off site to manage demand. Reduced appointment times to optimise service. 1.12.20 no change to risk rating services remain challenged due to lack of basic capacity made worse by Covid social distancing and cleaning issues. 1.6.21 Ongoing capacity issues, situation deteriorating as post covid activity builds up. Case approved for mobile MRI capacity which should be implemented in June Case for additional CT declined by Trust to be revisited in July 2021. IS provider approached to provide more MRI capacity(28-Oct-2021)	Low	Not Applicable	
RSK-125	04-Nov-2021	Adam Biggs	Operational	IF there is a surge of COVID-19 patients impacting on Trust ability to maintain patient care and clinical services, or loss of staff to support clinical and non-clinical services due to high levels of absence, or a loss of national stockpile in PPE or medical devices (ventilators) resulting in the Trust not receiving deliveries to preserve the safety of patients and staff THEN there is a risk of reduced capabilities in responding to a Novel Coronavirus (COVID-19) impacting on patient care within clinical and non-clinical services, with the inability to maintain safety for staff and patients due to national pressures on supplies and infrastructure	LEADING TO Loss of clinical and non-clinical services, risk to patient care, risk to staff wellbeing and financial impacts	Organisation			09-Dec-2021	07-Feb-2022	Overdue	25	20	20		COVID-19 operational and contingency plans in place(04-Nov-2021),PPE logged daily covering delivery and current stock(04-Nov-2021)	Not Applicable	Not Applicable	Trust follows national guidance on all responding mechanisms covering COVID-19 alongside its Category one responsibilities
RSK-126	04-Nov-2021	Zuzanna Gawlowski	Operational	IF cot spacing in the Neonatal Unit does not comply with BAPM guidance or the latest PHE guidance for COVID-19 (the Unit is seeking to increase both total cot spacing and cot numbers by 4 HDU/ITU cots in line with Network 5 year projections of acuity and demand, and spacing in line with National Recommendations) THEN there will be overcrowding and insufficient space in the Neonatal Unit, exacerbated by need for social distancing due to COVID-19. The milk kitchen was condemned due to this	LEADING TO an inability to meet patient needs or network requirements. We will now also be unable to meet PHE recommendations for social distancing This may result in a removal of Level 2 status if we continue to have insufficient space to adequately fulfil our Network responsibilities and deliver care in line with national requirements. This may also impact on our ability to protect babies and their families during COVID	Organisation			20-Dec-2021	18-Jan-2022	Overdue	25	20	9	Business Case for Refurnishing Milk Kitchen and Sluice	Reconfiguration of cots to create more space and extra cots and capacity, though this still does not meet PHE or national standards(04-Nov-2021),Parents asked to leave NNU during interventional procedures, ward rounds etc. Restricted visiting during COVID(04-Nov-2021),Added to capital plan(04-Nov-2021),Feasibility study completed(04-Nov-2021)	Not Applicable	Treat	Risk transferred from Datix to Radar
RSK-128	04-Nov-2021	Melissa Davis	Operational	IF there is an inability to identify/review in a timely manner any cases where there may be immediate system or process learning., or there is an inability to complete an incident report in a timely manner THEN the Trust will be unable to identify reasons for admission to the neonatal unit at term, and the proportion of admissions which are avoidable vs those which are unavoidable; there will be a negative effect on compliance with Clinical Negligence Scheme for Trusts (CNST) as ATAIN is also included within this.	LEADING TO a negative impact on the provision of Maternity / Neonatal Services, a negative impact on patient care and a negative impact on the Trust's reputation	Region	Women's Health		03-Feb-2022	18-Jan-2022	Overdue	20	20	4		ATAIN meetings still taking place when possible/quorate(04-Nov-2021),Completing incident report retrospectively(04-Nov-2021),Weekly ATAIN meetings to review current backlog of cases and ensure all current cases are reviewed weekly to ensure that there are no further backlogs of cases which would increase the risk of not capturing immediate learning(04-Nov-2021),Shadowing opportunities at other trusts to review ways in which to manage ATAIN to increase the effectiveness of the group.(04-Nov-2021),Allocation of appropriate MDT time within roles to attend ATAIN meetings(04-Nov-2021)	Not Applicable	Not Applicable	Reviews are occurring weekly Additional meetings held Backlog reduced but a number still remain This risk remains the same. To be reviewed in 1 months time.
RSK-131	04-Nov-2021	Deborah Dolling	Hazard / Health & Safety	IF the demand for CT and MRI increases and there is continued requirement to reduce scan turnaround times THEN there will be a delay in patient management, an inability to manage patients privacy and dignity, an increased risk of infection due to overcrowding of facilities, and there will be a lack of capacity for appropriate management of CT and MRI within KPI and DM01 timescales	LEADING TO financial targets being missed, negative impact on reputation due to long waiting times Reputation, and financial due to increased infection rates, and staff leaving due to poor working conditions.	Region	Diagnostic & Screening		20-Jan-2022	29-Jun-2021	Overdue	20	20	4		Extended working hours and days(04-Nov-2021),Some scans sent off site to manage demand(04-Nov-2021),Reduced appointment times to optimise service(04-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix

Source: Radar

Signficant Risk Register (15+ Risks)

Reference	Created on	Owner	Category	Description	Impact of risk	Scope	Region	Location	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-199	16-Nov-2021	Melissa Davis	Operational	IF the CTG documentation tool within eCare is not based on a human factors principles and the parameters within the CTG documentation tool on eCare do not match the parameters within the local clinical guidance THEN the mechanism for completion of the CTG assessment on eCare will not support the review of the whole clinical picture as second reviewer does not need to be in the room for the review and can activate this mechanism from a different computer.	LEADING TO negative impact on fetal morbidity and mortality resulting from a delay in recognition or escalation of an evolving clinical picture of which one element is the fetal monitoring	Region	Women's Health		23-Feb-2022	18-Jan-2022	Overdue	20	20	6		Re-introduction of sticker as CTG documentation tool alongside the entry onto eCare(16-Nov-2021),Increase of registrar presence within maternity setting. Increase in prioritisation of face-to-face reviews within the acute setting. Identification and action in place to remove the commencement of oxytocin prior to a face-to-face obstetric review.(16-Nov-2021),Review of CTG training in place as online module does not offer the optimal learning or MDT development. Project plan in place for transition to physiological CTG monitoring. Monthly reporting of training compliance through divisional governance processes.(16-Nov-2021)	Low	Treat	This risk remains unchanged Initial audit identified areas of improvement and did not meet expected levels.
RSK-326	10-Feb-2022	Deborah Noble	Operational	IF the delay in delivering the annual cancer surveillance follow-up mammograms for post - op women with breast cancer and those women in the family history risk programme continues THEN there will be a delay in detecting recurrence in those with previous cancer and delayed early diagnosis in those with a family history.	LEADING to patients receiving sub-optimal care / delay in treatment. Increased anxiety in patients and and an increased likelihood of delayed cancer diagnosis, complaints and claims.	Location		Breast Care Unit - Imaging	23-Feb-2022	11-Feb-2022	Overdue	20	20	8			Low	Treat	
RSK-001	06-Sep-2021	Tina Worth	Hazard / Health & Safety	IF all known incidents, accidents and near misses are not reported on the Trust's incident reporting system (Radar); THEN the Trust will be unable to robustly investigate all incidents and near-misses within the required timescales;	LEADING TO an inability to learn from incidents, accidents and near-misses, an inability to stop potentially preventable incidents occurring, potential failure to comply with Duty of Candour legislation requiring the Trust to report all known incidents where the severity was moderate or higher, potential under reporting to the Learning from Patient Safety Events (LfPSE) system, and potential failure to meet Trust Key Performance	Organisation			12-Jan-2022	30-Mar-2022	Planned	20	16	12		Incident Reporting Policy(06-Sep-2021),Incident Reporting Mandatory/Induction Training(06-Sep-2021),Incident Reporting Training Guide and adhoc training as required. Radar to provide on site & bespoke training IT drop in hub to be set up 2 days a week for staff drop ins(06-Sep-2021),Datix Incident Investigation Training sessions(06-Sep-2021),Daily review of incidents by Risk Management Team to identify potential Serious Incidents and appropriate escalation(06-Sep-2021),Serious Incident Review Group (SIRG) ensure quality of Serious Incident Investigations(06-Sep-2021),SIRG ensure appropriate reporting of Serious Incidents to Commissioners(06-Sep-2021),Standard Operating Procedure re Risk & Governance Team supporting the closure of incident investigations during unprecedented demand on service(06-Sep-2021),Implementation of new Risk Management Software to make incidents easier to report and improve engagement with staff(06-Sep-2021)	Low	Treat	Discussed at TEG 12/1/22- updates added re implementation of Radar
RSK-016	22-Sep-2021	Simon Nicholson	Operational	IF there is a lack of flow in the organisation THEN there may be an unsafe environment for patients	LEADING TO a potentially impact on bed space capacity, ambulance queues, missed Emergency Access Targets and overcrowding into ED/radiology corridors creating Health & Safety hazard and continued pressure, leading to poor patient care/treatment and delays in discharge/transfer and the potential for an increase of incidents being reported regarding assessment/care/treatment, and or significant number of patients with a high acuity/ dependency being cared for in areas that are not suitable for safe care	Region	Emergency Department		23-Feb-2022	12-Apr-2022	Planned	25	16	9	EPIC consultant in place to aid flow within department and speed up decision making (22-Sep-2021),Recruitment drive for more nurses/HCA's and consultants ongoing. Active management of Nursing/Consultant and Registrar gaps in rota daily to ensure filled.,RAT-ing process and medical specialty referrals having a RAG system developed to prioritise sickest patients to be assessed.,Walking majors and resus reconfigured. Expanded Cubicle space in Majors - extra 10 spaces, increased capacity using Acorn Suite.,Internal escalation policy in place. CSU lead developing trust escalation criteria to alert trust leads to problems sooner - diverting patients to; Ambulatory care,Since Covid pandemic, phasing plan in place with red and green zones within ED.,Escalation plan for ED to mitigate patient pressures		Low	Tolerate	Risk reviewed by C Rockliffe and CGL- Advised flow remains the same. Further update required from ADO.Review 1-2 months

Signficant Risk Register (15+ Risks)

Reference	Created on	Owner	Category	Description	Impact of risk	Scope	Region	Location	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-030	23-Sep-2021	Francesca Csordas	Operational	IF Olympus have not provided UK compliant guidelines for HSDU to follow, once the lithotripsy handles have been used, they cannot be reprocessed by HSDU THEN patients with large stones will not be able to have them manually crushed during ERCP procedure, this may mean patient remain compromised by stones blocking the common bile duct	LEADING TO a repeat / further procedure elsewhere or surgery resulting increased risk and morbidity to patient. Financial impact to trust	Region	Specialty Medicine		23-Feb-2022	30-Mar-2022	Planned	16	16	8	Risk potentially to be resolved because of a local SOP in place which is currently in Draft. (23-Sep-2021)		Low	Treat	SOP awaiting sign off by IPC committee and then risk and be closed
RSK-048	01-Oct-2021	Jane Adderley	Hazard / Health & Safety	IF the staff on Intensive Care Unit continue to manage complex clinical and communication needs with patients and there families following extraordinary circumstances such as the pandemic, sudden death and distressing situations without specialist psychological support THEN this will have a significant impact on the care they are able to provide and staff may be tramatised.	LEADING TO staff being unable to function at their designated role in a high stress situation. Increased risk of ill health, fatigue, anxiety and post traumatic stress disorder (PTSD symptoms)leading to potential increase in sickness. This may also impact on staff retention and staff morale.	Region	Anaesthetics & Theatres		18-Feb-2022	30-Mar-2022	Planned	20	16	8	Access to external psychological support. (03-Jan-2022)	Clear leadership and team support. Staff health and well-being initiatives. Individual stress risk assessments for staff.(01-Oct-2021)	Not Applicable	Treat	Risk not reviewed at A&T CSU meeting as meeting not quorate. CGL has recommended meeting with ICU Lead Nurse to review risk out of meeting. If unable to schedule risk will be discussed at next A&T CSU meeting in March. Therefore risk to remain at current rating and level until review can take place.
RSK-080	15-Oct-2021	Andrew James	Compliance & Regulatory	IF the pathway unit is not in place THEN moderate to severe head injury patients will not be appropriately cared for and will not be treated in accordance with NICE guidance (CG176: Head injury: assessment and early management, updated September 2019) These patients may frequently fall under the remit of the T&O Team or be nursed on a surgical ward when they should be under a neurological team.	LEADING TO Potential reduction in patient safety - T&O surgeons and nursing teams may be unaware of how to care for patients with moderate to severe head injuries especially patient who are anticoagulated. Clinicians may have to wait for an opinion from the Tertiary Centre staff training, competency and experience Serious incidents Reduced patient experience	Region	Musculoskeletal		23-Feb-2022	30-Mar-2022	Planned	12	16	8	1, 2 & 3. Preventive controls - On going discussions with Senior Medical Team - CSU Lead to escalate via trauma network - Alert process is in place for escalation within T&O & externally. - Resources available at tertiary site for advice/support	1, 2 c& 3. mitigating controls - Policy for management of head injuries has been developed - Awaiting appointment of head injury liaison Nurse - Long term plan for observation block to be built.(15-Oct-2021),GAPS: - Trust is not in line with other trauma units - Regional trauma centre advises head injury should not be managed by trauma and orthopaedics and after 24 hours the patient should be referred to neurosurgery. - Potential delay in opinion from Tertiary Centre(15-Oct-2021)	Not Applicable	Treat	Risk reviewed at T&O CIG meeting. Request for CGL to change wording to include "until the pathway unit is in place". This has been done. Risk remains at current rating and level. Review again at next meeting.
RSK-093	22-Oct-2021	Elizabeth Pryke	Operational	IF there is insufficient staffing within the dietetics department in paediatrics THEN they will be unable to assess and advise new patients and review existing patients in a timely manner.	LEADING TO an impact on patients nutritional status and longer term dietary management on what is a very vulnerable group of patients. The majority of our caseload is infants or tube fed infants and children where there nutrition and growth is a priority	Region	Therapies		22-Feb-2022	01-Dec-2021	Overdue	16	16	12		1. Dietetic manager has been given approval to source a band 6 experienced locum paediatric dietitian to provide cover.(22-Oct-2021),2. As a back up plan,a band 5 basic grade dietitian is also being sourced from the locum agency, with the expectation that senior dietetic staff can cover the complex paediatric cases.(22-Oct-2021)	Not Applicable	Not Applicable	
RSK-113	28-Oct-2021	Deborah Noble	Operational	IF mammography machine in BS2 fails due to its age (10 years). THEN there could be an increased amount of unplanned downtime consistent with aging equipment, a potential inability to procure replacement parts and/or delay in repair due to the replacement part needed to be shipped from Chicago	LEADING TO a loss of service capacity for the 2ww clinics and NHSBSP programme which give have a detrimental effect on Trust metrics.	Region	Diagnostic & Screening		23-Feb-2022	02-Apr-2022	Planned	16	16	16		Comprehensive service contract All faults reported immediately to external contractor / physicist for support. Robust QA systemin process to monitor system performance. This is reviewed weekly by medical physics.(28-Oct-2021)	Low	Tolerate	Risk has been reviewed at Breast Care Team meeting (BIG). The equipment is due for replacement in the next month. When in place the risk can be closed.

Signficant Risk Register (15+ Risks)

Reference	Created on	Owner	Category	Description	Impact of risk	Scope	Region	Location	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-115	29-Oct-2021	Marea Lawford	Compliance & Regulatory	IF annual and quarterly test reports for Autoclaves and Washer Disinfectors used for critical processes are not being received in a timely manner from the Estates department and there is no Authorised Person (D) to maintain the day to day operational aspects of the role THEN the Trust will be unable to prove control, monitoring and validation of the sterilisation process as a control measure. Both units are reviewed only 1 day per month - a bulk of this time is spent checking records and the other aspects of the role do not get the sufficient time required to review and follow up.	LEADING TO possible loss of ISO 13485 accreditation due to non-compliance to national standards.	Organisation			23-Feb-2022	01-Mar-2022	Pending	20	16	6	Estates management informed and plans in place to receive reports on time and to standard. Independent monitoring system in place monitoring machine performance. Weekly PPM carried out on machinery. An action plan has been created by estates, to include training the specialist estates officer so he can gain the recognised qualification he needs to carry out the role of the Authorised person for decontamination(AP(D)) and for additional training of the estates competent persons(CP(D) who test the decontamination equipment. (21-Jan-2022),A meeting took place in January with estates managers, where HSDU were seeking assurance that the service would be covered. Estates have agreed to look for a plan to mitigate the risk and to keep HSDU fully informed. HSDU have informed the AE(D), so he is now aware that the site will not have any day to day operational AP(D) cover. (21-Feb-2022)		Low	Treat	Due for review in 3 months time. The Estates member who was in training to be a AP9d) is leaving, so there will be less support and more likely less opportunities for handovers and day to day operational management from estates over steam issues and reports could suffer as a consequence.
RSK-127	04-Nov-2021	Karan Hotchkin	Financial	IF the Trust does not have a sufficient capital expenditure limit (CDEL) then the Trust will not be able to complete the level of planned capital investment THEN	LEADING TO Insufficient capital expenditure limit to accommodate the Trusts investment.	Organisation			07-Feb-2022	07-Mar-2022	Planned	20	16	10		The Trust is introducing enhanced in-year capital spend monitoring to proactively manage in-year underspends across other capital schemes.(04-Nov-2021),Where agreed by management (e.g., subject to risks and strategic need) underspends across other capital schemes could free-up capital expenditure limit for utilisation against bond schemes.(04-Nov-2021)	High	Treat	Risk transferred from Datix to Radar
RSK-134	04-Nov-2021	Karan Hotchkin	Financial	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 THEN there may be an increase in operational expenditure in order to manage COVID-19	LEADING TO an impact of H2 funding streams being worked through, reductions in non-NHS income streams as a direct result of COVID-19, Impaired operating productivity leading to costs for extended working days and/or outsourcing and potential for material increase in efficiency requirement from NHS funding regime to support DHSC budget affordability.	Organisation			07-Feb-2022	07-Mar-2022	Planned	20	16	8		Cost and volume contracts replaced with block contracts (set nationally) for clinical income(04-Nov-2021),Top-up payments available where COVID-19 leads to additional costs over and above block sum amounts (until end of March 2022)(04-Nov-2021),Budgets to be reset for FY22 based on financial regime; financial controls and oversight to be reintroduced to manage financial performance(04-Nov-2021),Cost efficiency programme to be reset to target focus on areas of greatest opportunity to deliver(04-Nov-2021)	High	Treat	Risk transferred from Datix
RSK-135	04-Nov-2021	Jill Beech	Operational	IF the Pathology LIMS system is no longer sufficient for the needs of the department, due to being outdated with a limited time remaining on its contract THEN the system is at risk of failure, virus infiltration and being unsupported by the supplier	LEADING TO the Pathology service being halted and contingency plans would have to be implemented. Sensitive information could lost or security of the information could be breached.	Region	Diagnostic & Screening		03-Feb-2022	30-Mar-2022	Planned	16	16	4	Low Level Design Completed	Systems manager regularly liaises with Clinysis to rectify IT failures(04-Nov-2021),Meetings with S4 to establish joint procurement take place periodically(04-Nov-2021),Project Manager role identified to lead project for MKUH(04-Nov-2021),High Level Design Completed(01-Dec-2021)	Not Applicable	Not Applicable	HLD has now been completed and signed off. LLD meetings have commenced and planning is underway to progress forward. Continued close monitoring of deadline extending for completion. PM reports monthly into Pathology meetings for regular updates. No change to risk score - to review in 3 months.
RSK-136	04-Nov-2021	Deborah Noble	Operational	IF the Mammography machine in BS2 were to fail THEN there could be delays in the machine being fixed due to reduced availability of older parts. Due to its age, there is an increased risk of vulnerability to cyber security attacks THEN there could be a period of downtime whilst the machine was fixed and there could be a delay in receiving replacement parts	LEADING TO a loss of service capacity for the 2ww clinics and NHSBSP programme, which give have a detrimental effect to patients and on Trust performance metrics	Region	Diagnostic & Screening		19-Jan-2022	30-Mar-2022	Planned	16	16	3	BC approved for turnkey works for installation of new mammography machine purchased with NHSEI monies	Comprehensive service contract(04-Nov-2021),All faults reported immediately to external contractor / physicist for support(04-Nov-2021),Robust QA systemin process to monitor system performance. This is reviewed weekly by medical physics.(04-Nov-2021)	Not Applicable	Not Applicable	BC passed for turnkey works to install new machine purchased with NHSEI monies has been approved. Agreed work schedule as follows. 24/2/22 : Manufacturer take possession of room & remove patient data 25/2/22 : Rhenus deinstall and remove system. 28/2/22 – 11/2/22 : Contractor pre installation works 12/3/22 : System delivery 14/3/22 – 18/3/22 : System installation 21/3/22 : Physics, clean etc… 28/3/22 : Apps commences

Signficant Risk Register (15+ Risks)

Reference	Created on	Owner	Category	Description	Impact of risk	Scope	Region	Location	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-138	04-Nov-2021	Jamie Stamp	Hazard / Health & Safety	IF the trust is not providing suitable accommodation for the dietetic team THEN the trust is failing in its statutory legal duty under the Health & Safety at Work etc. Act 1974, Management of Health & Safety at Work Regulations 1999, Workplace (Health, Safety & Welfare) Regulations 1992 and Display Screen Equipment Regulations 1992 to provide a safe and well maintained place of work including welfare facilities for staff	LEADAING TO physical and mental wellbeing concerns in relation to staff welfare with potential for sickness absence and potential litigation claims; Multiple breaches of statutory and regulatory duties leading to interest from the Health & Safety Executive; Enforcement action including formal notices; potential criminal prosecution resulting in fines and/or imprisonment dependent upon the action pursued; loss of Trust reputation; adverse publicity	Region	Therapies		11-Jan-2022	22-Nov-2021	Overdue	16	16	6	Upkeep of the portacabin including drinking water facilities, flooring and window seals	Due to the number of staff within the area, increased number of staff are having to work from home (rota basis), however as all the team see inpatients this is limited.(04-Nov-2021),Mobile air conditioning units distributed during summer months(04-Nov-2021),Plumbed in water cooler in situ(04-Nov-2021),Resolve short term issues - drinking water / flooring / window latches / changing facilities / secure path(04-Nov-2021)	Not Applicable	Not Applicable	Risk transferred to Radar
RSK-305	06-Dec-2021	Karan Hotchkin	Financial	If there is insufficient strategic capital funding available	then the Trust will be unable to invest in the site to maintain pace with the growth of the Milton Keynes population's demand for hospital services	Organisation			07-Feb-2022	07-Mar-2022	Planned	16	16	9	The trust has a process to target investment of available capital finance to manage risk and safety across the hospital		Medium	Treat	Risk was approved by Finance and Investment committee on 30/12/2021
RSK-015	21-Sep-2021	Laura Sutton	Hazard / Health & Safety	IF there are ligature point areas in Ward 1 in various areas of the department THEN patients may use ligature points to self-harm	LEADING TO physical injury/cuts/overdose/ill health/death to patients, and psychological impact, stress, anxiety, breakdown to staff/visitors; Absence from work; Reduced staffing through absence; Ongoing mental health impact	Organisation			23-Feb-2022	09-Mar-2022	Planned	15	15	10		See attached Risk Assessment.(21-Sep-2021)	Low	Treat	Reviewed by Laura Sutton/ Marion Fowler and Pauline Sharma. To discuss at SPEG tomorrow as grading last month was incorrect. To remain at 15 and not lowered as no change.
RSK-025	22-Sep-2021	Elizabeth Winter	Operational	IF there are vacancies of Band 5 and senior nursing skill mix 247 THEN wards could be experiencing some issues with nurse staffing levels and skill mix	LEADING TO a potential impact on patient Safety, staff wellbeing, the number of complaints received and incidents e.g. pressure ulcers reported. There is a significant cost risk incurred in relation to using agency staff, leading to increased pressure on Trust finances. Incidents may not be properly identified and raised.	Region	Internal Medicine		23-Feb-2022	31-Mar-2022	Planned	15	15	4	On-going recruitment drive		Low	Treat	Reviewed in SPEG increased level of risk.
RSK-055	01-Oct-2021	Robyn Norris	Operational	IF Theatres are unable to cover the increased demand for theatre staff in both elective and emergency/trauma theatre sessions, and are not able to manage staffing shortages across the theatre department THEN the team will be unable to meet the changes and developments in the service. Examples of the increased staffing demand below: Robotic lists x 5 days a week, COVID-19 secure pathway, increased elective activity & trauma activity & staffing the theatre procedure room.	LEADING TO less support for junior staff currently in post. The lack of experienced staff may also create issues around staff skill mix. Patient operations may be cancelled due to a lack of staff. This creates increased stress level with the clinical teams.	Region	Anaesthetics & Theatres		17-Feb-2022	30-Mar-2022	Planned	12	15	6		This risk is currently being mitigated by the use bank, approx. 80 /100 shifts of varying lengths per week. Agency staff approx. 300 hours per week. Even with the additional support from bank and agency staff we still struggle to provide staff for all sessions, this has recently led to cancelling lists. These risks are exacerbated when staff are off sick or absent for training / annual leave.(01-Oct-2021),GAPS: There are significant gaps in the theatre rota - 19 WTE posts are required to meet latest review of theatre staffing requirements.(01-Oct-2021)	Not Applicable	Treat	Risk reviewed and is ongoing therefore risk to remain at current rating and level. CGL and Ops Manager to review risk before next scheduled meeting.
RSK-076	13-Oct-2021	Jodie Bonsell	Operational	IF the Endoscopic Stack system in ENT outpatients is not linked to EPR (Cerner Millennium) then there will be a lack of visibility of patient records in a secure system.	LEADING TO Clinicians WILL BE unable to see images from a patients previous visits and compare current and previous to look for changes. Also Medical Staff will not be able to liaise with other Trusts within BLMK framework	Region	Head & Neck		20-Jan-2022	30-Mar-2022	Planned	9	15	6	Need to establish Link between systems		Not Applicable	Treat	Risk had been reviewed at last ENT CIG - risk is ongoing. Review again at next meeting.
RSK-082	15-Oct-2021	Samantha Burns	Operational	IF the trauma activity beyond existing capacity (5 cases per day on trauma list) continues to increase alongside the implemented green pathway for orthopaedic elective care patients THEN the Trauma and Orthopaedic department has lost capacity to escalate on to elective lists for trauma patients. As such with just one trauma list per day, there may be insufficient capacity to meet trauma needs.	LEADING TO insufficient trauma capacity, the department may not be able to operate on all trauma patients within the required timelines leading to poor outcomes. The Trust may be required to close to trauma or cancel all elective lists for the day in theatres 11 and theatres 12 in order to facilitate trauma patients who are not covid swabbed, isolated for 72 hours or given social distancing advice. This will lead to longer elective wait times and possible 52 week breaches. Alternatively, the Trust may be required to close to trauma due to insufficient capacity.	Region	Musculoskeletal		23-Feb-2022	30-Mar-2022	Planned	12	15	6	Divisional Director for Operations to work with T&O and Theatre teams to implement all day weekend emergency theatre lists.,Utilisation of theatre pm 1 for procedures that do not include metal work twice a week if staffing is available.	Cancellation of elective activity if required.(15-Oct-2021),GAPS: There are occasional surges in trauma cases especially at the weekend which impacts on trauma/ elective lists on Mondays.(15-Oct-2021)	Not Applicable	Treat	Risk reviewed at T&O CIG. Risk is ongoing. Awaiting directive on red/green pathways. Therefore risk to remain at current rating and level. Review again at next meeting.
RSK-090	21-Oct-2021	Jamie Stamp	Operational	IF the Trust cannot access and report on inpatient activity, capacity and demand THEN Therapy Services are unable to plan and develop services	LEADING TO poor patient experience, inability to demonstrate the effectiveness of the service and an inability to benchmark and compare data with other Trusts due to lack of data submission	Region	Therapies		11-Jan-2022	11-Jan-2022	Overdue	15	15	6	Inpatient data/ dashboard on a monthly basis to inform the effectiveness of services	Therapies Service working with the Information Team to establish where data is located by validating data entries(21-Oct-2021),Therapies Service collecting manual data to validate eCARE entries and to enable submission of benchmarking data(21-Oct-2021)	Not Applicable	Treat	Risk discussed and approved at CIG and local therapy governance meeting

Signficant Risk Register (15+ Risks)

Reference	Created on	Owner	Category	Description	Impact of risk	Scope	Region	Location	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-101	25-Oct-2021	Melissa Davis	Operational	IF the maternity service at MKUK do not have their own dedicated set of theatres. THEN Elective Caesarean work is completed the Theatre 1 during a booked morning session, Theatre 3 is set for obstetric emergencies. All Phase 1 theatres in the afternoon are used for emergency lists for the whole trust. This leaves maternity vulnerable to not having a guaranteed emergency theatre available 24hrs a day. There is only 1 theatre team on site overnight for all emergency surgery in the trust, should they be dealing with an emergency outside of obstetrics, obstetrics would have to call on call theatre team in from home increasing the risk for mother and baby	LEADING TO increased risk of poor outcome for mothers and babies if theatre delay; Psychological trauma for staff dealing with potentially avoidable poor outcome; Financial implication to the trust	Region	Women's Health		23-Feb-2022	18-Jan-2022	Overdue	15	15	6	Cannot currently mitigate		Low	Treat	Feedback was received from the sixty safety steps review to further highlight the risk of Maternity not having their own dedicated theatres and staff. This risk remains the same
RSK-114	28-Oct-2021	Jamie Stamp	Operational	If there is insufficient staffing within the Paediatric Team THEN the team may not be able to provide a full dietetic service to children and young people in the Milton Keynes area	LEADING TO Financial due to missed targets; Reputation due to long waiting times; Reputation and financial due to increased infection rates; Staff leaving due to poor working conditions; This is delaying patient management and causing issues with meeting the diagnostic waiting times. Inability to manage patients privacy and dignity also increased risk of infection due to overcrowding of facilities	Region	Therapies		22-Feb-2022	01-Nov-2021	Overdue	15	15	15		Existing staff are working some additional hours but this remains insufficient to meet the needs of the service.(28-Oct-2021)	Not Applicable	Not Applicable	
RSK-141	04-Nov-2021	Celia Hyem-Smith	Operational	IF outpatients can only review urgent patients virtually by telephone or video call due to the Covid-19 pandemic THEN there will be increasing numbers of patients being added to the physiotherapy outpatient waiting list, in addition to those on hold due to the COVID-19 pandemic, resulting in waiting times of well over 18 weeks for any type of intervention. A further increase in referrals may result from patients with post-COVID symptoms	LEADING TO litigation and/or complaints due to lack of timely treatment intervention, potentially resulting in permanent and unnecessary disability.	Region	Therapies		10-Dec-2021	30-May-2021	Overdue	15	15	6	To develop strategy for validating routine patient waiting list	Virtual management of patients - Video and telephone clinics(04-Nov-2021),Additional IT sourced to support virtual management(04-Nov-2021),Reconfiguration of department to support virtual working and enable social distancing along with staff working from home(04-Nov-2021),recovery plans are being written/in place to enable essential patients to be seen in the department of a face to face basis(04-Nov-2021),Educational material including exercise programmes and access to YouTube clips are made available to patients(04-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-142	04-Nov-2021	Jamie Stamp	Operational	IF there is insufficient capacity and ongoing unsustainable demand for dietetic input for Paediatric patients (both inpatient and outpatient) . IF Home Enterally Fed Paediatrics patients continue to be seen our outpatient structure which is not adequate to meet their demands and needs (rather than the community contract). IF the current dietetic workforce are not able to meet the Increasing referral for children with diabetes, this means that these high risk groups of Children and Young People are not accessing the necessary specialist nutritional support at the appropriate time in their development THEN staff may be unable to cover a service that has not been serviced correctly, and the paediatric team cannot provide a full dietetic service to children and young people in the Milton Keynes area	LEADING TO patient care and patient safety may be at risk, vulnerable children may become nutritionally compromised, the service may be unable to assess and advise new patients and review existing patients in a timely manner, and there may be an impact on patients nutritional status and longer term dietary management on what is a very vulnerable group of patients. The majority of our caseload is infants or tube fed infants and children where there nutrition and growth is a priority.	Region	Therapies		10-Dec-2021	01-Dec-2021	Overdue	15	15	3		Existing staff are working some additional hours but this remains insufficient to meet the needs of the service(04-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-143	04-Nov-2021	Amanda Brice	Operational	IF workload continued to increase in Pathology, requiring additional specimen storage, equipment, and staff THEN there is a risk that the available space within Cellular Pathology will not be enough to meet the demands of the service as workload continues to expand	LEADING TO an inability to retain specimens for the period of time required to meet RCPath guidance; an increased risk of formalin spillage / increased levels of formalin vapour; an increased risk to staff and to specimens because of cramped workspace e.g. Specimen reception area encroaches on cut-up area; an inability to safely operate and / or validate equipment; and insufficient space for record storage	Region	Diagnostic & Screening		16-Feb-2022	16-Mar-2022	Planned	15	15	6	Sink to be fitted and put into use in new space (09-Feb-2022)	Storage of specimens minimised. Review of work flow and processes to improve space efficiency(04-Nov-2021),Business Case has been accepted - plans to be confirmed regarding building work and expansion(04-Nov-2021),Business case required for Laboratory furnishings and layout(04-Nov-2021)	Not Applicable	Not Applicable	90k NHSi funding - 2021117DDCP - Business case reference. Continued estates work, will review monthly to track progress.

Signficant Risk Register (15+ Risks)

Reference	Created on	Owner	Category	Description	Impact of risk	Scope	Region	Location	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-158	12-Nov-2021	Adam Baddeley	Operational	If the escalation beds are opened the additional patients that will need to be seen will put additional demand on the Therapy deaprtment to manage and support patient flow during periods of significant pressure.	Increased demand on occupational therapy and physiotherapy staff Patients are likely to decondition if the demand is too high for the therapy staff to manage Staff morale will reduce as they will not be providing the appropriate level of assessment and treatment to their patients Length of stay may increase as patients will not be seen in line with care plans due to prioritising discharges	Organisation			24-Jan-2022	28-Feb-2022	Pending	16	15	12		Therapy staff attend board rounds and work with the MDT to determine priority patients. The skills mix and workforce is reviewed on a daily basis between occupational Therapy and Physiotherapy to determine cover for the base wards. To work closely with community services to raise awareness and to increase discharge opportunities i.e. in reaching Therapies working with Long stay Tuesday initiative Therapies supporting new discharge pathway/process in the Trust Over recruitment of PT and OT band 5's Increase in therapy assistant staff base. Locum cover for vacant posts.(12-Nov-2021)	Low	Treat	Risk score increased due to escalation beds remaining open leading to insufficient capacity to see all patients referred to OT and PT on a daily basis.
RSK-159	12-Nov-2021	Adam Baddeley	Operational	IF patients referred to Occupational Therapy and Physiotherapy inpatients covering medical wards are not being seen in timely manner THEN there will be a delay in these patients being treated	LEADING TO Deconditioning of vulnerable/complex patients requiring a short period of therapy; Increased length of stay; Potential readmission	Organisation			23-Feb-2022	28-Feb-2022	Pending	20	15	8		Daily prioritisation of patients cross covering and review of skill mix locum cover x1 OT and x1 PT in place Ward book for escalation wards setup and band 7 reviews the caseload on the ward daily Monday- Friday and requests the most urgent are reviewed. Recruitment process ongoing but vacancies have reduced slightly. Over recruitment of band 5 OT and PT roles. Non-recurrent funding application for increase in therapy assistants over winter months.(12-Nov-2021)	Low	Treat	Despite recruiting to a number of new staff over the summer period, a number of resignations are pending and will lead to further impacts on capacity to see all patients referred to therapy inpatients.
RSK-247	26-Nov-2021	Jamie Stamp	Operational	IF the wait times for ventilated babies and children requiring transfer to a tertiary centre continue to increase due to increasing pressures across the system. THEN the children's physiotherapy and on call team will be asked to assess and treat ventilated children. The physiotherapists do not currently have the training and competencies to complete this.	LEADING TO a ventilated child requiring support with airway clearance may not receive the assessment and treatment they require whilst waiting at MKUH for transfer. This may have a negative impact on their respiratory status and clinical outcome	Organisation			22-Feb-2022	27-Nov-2021	Overdue	15	15	6			Not Applicable	Treat	
RSK-306	06-Dec-2021	Deborah Noble	Operational	IF there is a national shortage of BD vacuum biopsy needles due capacity constraints at their sterilisation facility THEN the Trust may not be able to procure sufficient quality and the Trust needing to find alternative devices or alternative treatment plans	LEADING TO potentially increased risk of delay to treatment or potential for in patients requiring surgical procedures. For example: Patients would normally undergo a 1st line VAB for microcalcifications but due to the needle shortage would need to have a 14g core instead. Without VAC needles women with a B5a / B5b lesion who would normally undergo a VAB to potentially upgrade disease prior to surgery cannot. This increases the possibility that disease will be upgraded at surgery requiring women to undergo further surgery for clear margins. (This is a KPI.) The majority of B3 lesions that require a VAE may be delayed or proceed to a surgical excision instead	Location		Breast Care Unit - Imaging	23-Feb-2022	30-Mar-2022	Planned	15	15	4			Low	Treat	Still supply issues, receiving deliveries sporadically as stock becomes available
RSK-310	22-Dec-2021	Melissa Davis	Operational	IF all maternity related incidents are not reported on the Trust incident reporting system THEN maternity's ability to demonstrate effective governance processes and procedures, both within internal trust mechanisms and to the external stakeholders will be negatively affected	LEADING TO a potential reduction in the ability to learn from incidents and improve patient care/safety, an increase in incidents occurring, and complaints and claims being received	Region	Women's Health		23-Feb-2022	23-Dec-2021	Overdue	15	15	6			High	Treat	This risk remains the same.

Signficant Risk Register (15+ Risks)

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RSK-324	09-Feb-2022	Catherine Swailes	Hazard / Health & Safety	IF there are significant nursing vacancies within the Paediatric Unit, including Maternity Leave and Long-Term Sickness - we are currently 38% of permanent staff roles unfilled- this is being partially mitigated with use of regular Agency and Bank staff THEN there will not be sufficient/safe numbers of nursing staff to cover shifts.	LEADING TO an increased risk for children's safety due to the absence of permanent skilled staff; an increased use of agency; an increasing number of shifts that do not comply with national recommended safe staffing levels	Region	Paediatric Services		23-Feb-2022	10-Feb-2022	Overdue	15	15	9	We are using regular Paediatric Agency and Bank staff to fill gaps wherever possible, we are planning a minimum of 50% of permanent staff on each shift. We are constantly advertising and interviewing for replacement staff- we are steadily recruiting. We are effectively managing Long term sickness in accordance with Trust guidance and with the input of HR		Low	Treat	
RSK-325	09-Feb-2022	Catherine Swailes	Operational	IF Ward 4 has no allocated paediatric pharmacist- with the change in ward function from a Paediatric Assessment Unit (PAU) to both PAU and inpatients THEN the Ward 5 pharmacist will lack the capacity to sufficient cover both ward 4 and ward 5	LEADING TO potential delay, omission, or error in dispensing and administering medication	Region	Paediatric Services		23-Feb-2022	10-Feb-2022	Overdue	15	15	9	The Ward 5 Paediatric Pharmacist has been asked to see the 22-25 most complex, acute, long stay patients across the two wards to try and reduce risk		Low	Treat	

NHS
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NHS Foundation Trust

Meeting Title	Trust Board of Directors	**Date:** 23 February 2022
Report Title	Board Assurance Framework	**Agenda Item: 20**
Lead Director	**Name:** Kate Jarman	**Title:** Director of Corporate Affairs and Communication
Report Author	**Name:** Kwame Mensa-Bonsu	**Title:** Trust Secretary

Key Highlights/ Summary	Board Assurance Framework containing the principal risks against the Trust's objectives.			
Recommendation *(Tick the relevant box(es))*	**For Information** [x]	**For Approval** [ ]	**For Noting** [ ]	**For Review** [ ]

Strategic Objectives Links	All
Board Assurance Framework (BAF)/ Risk Register Links	All

Report History	Finance and Investment Committee March 2022
Next Steps	Trust Executive Committee and Board Committees March 2022
Appendices/Attachments	Board Assurance Framework

The Board Assurance Framework – Summary of Activity in February 2022

COVID-19 Risks

COVID-19 continues to present a dynamic risk environment. While the COVID-19 infections are increasing and the vaccination programme continue to make significant progress, there remains a significant and escalating risk in relation to the restoration of services due to the protracted and prolonged impact of the pandemic. This is the most significant operational and safety risk on the Board Assurance Framework.

Strategic Maternity Risks to be Reviewed to the BAF and the Risk Register by April 2022

1. Impact of Continuity of Carer Model
2. Staffing – Recruitment and Retention
3. Volume, acuity/ complexity of births

The Board Assurance Framework

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

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

Strategic Objectives

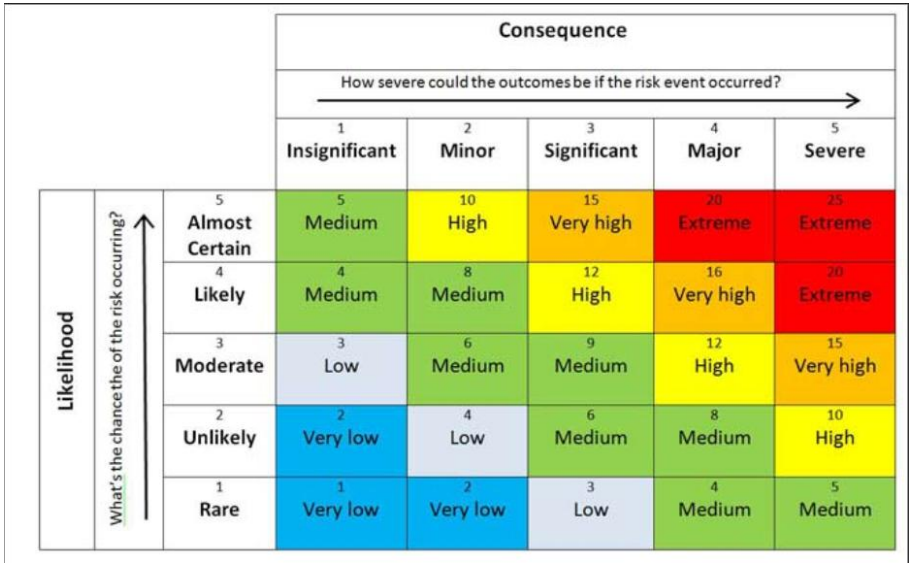
1. Keeping you safe in our hospital
2. Improving your experience of care
3. Ensuring you get the most effective treatment
4. Giving you access to timely care
5. Working with partners in MK to improve everyone's health and care
6. Increasing access to clinical research and trials
7. Spending money well 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

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

Assurance ratings:

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

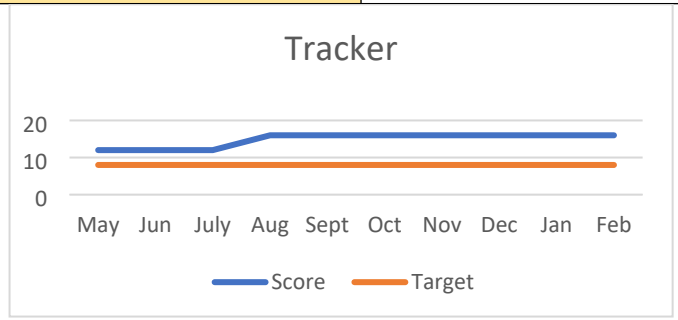
5X5 Risk Matrix:



RISK 1: If the Trust's ED does not have adequate staffing and estate capacity, and effective escalation plans, it will not be able to maintain patient safety during periods of overwhelming demand.

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If the Trust's ED does not have adequate staffing and estate capacity, and effective escalation plans, it will not be able to maintain patient safety during periods of overwhelming demand.				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Director of Operations	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	08/02/22	**Risk Rating**	16	8		



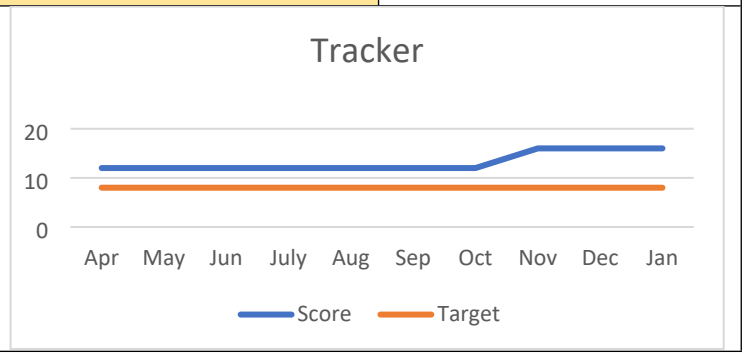
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Significant increase in activity and number of patients through the ED Significantly higher acuity of patients through the ED	Clinically and operationally agreed escalation plan Adherence to national OPEL escalation management system	ED staffing levels - vacancies in nurse staffing, higher than normal staff absences and sickness	Ongoing recruitment drive and review of staffing models and skill mix. Redeployment of staff from other areas to	Daily huddle / silver command and hospital site meetings in hours. Out of hours on call management structure.	Short term sickness or unexpected staffing levels / surges Details of Winter Plan not yet complete.	Appropriate escalation. Director of Operations oversight delivering the Winter Plan.	

Major incident/ pandemic – constraints on space and adherence to IPC measures.	Clinically risk assessed escalation areas available. Surge plans, COVID-specific SOPs and protocols have been developed. Emergency admission avoidance pathways, SDEC and ambulatory care services.	Increased volume of ambulance conveyances and handover delays. Over-crowding in waiting areas at peak times. Admission areas and flow management issues. Reduction in bed capacity / configuration issues through estates work.	the ED at critical times of need. Enhanced clinical staff numbers on current rotas Services and escalation plans under continuous review in response to shrinking pandemic numbers and related non covid pressures	ED dashboard on Trust information portal. System-wide (MK/BLMK/ICS) Partnership Board, Alliance & Weekly Health Cell. Daily system resilience report (BLMK) Regional and National reporting requirements - Daily COVID sitrep.			

RISK 2: If an effective reporting, investigation and learning loop is not established and maintained, the Trust will fail to embed learning and preventative measures following serious incidents/ Never Events.

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If an effective reporting, investigation and learning loop is not established and maintained, the Trust will fail to embed learning and preventative measures following serious incidents/ Never Events.				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Medical Director	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	17/01/22	**Risk Rating**	16	8		



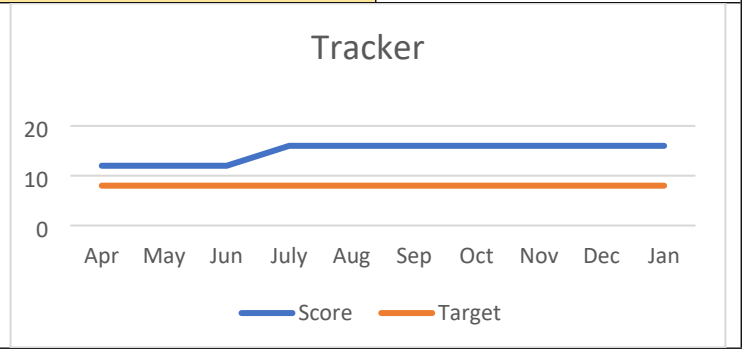
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Not appropriately reporting, investigating or learning from incidents. A lack of systematic sharing of learning from incidents.	Improvement in incident reporting rates SIRG reviews all evidence and action plans associated with Sis Actions are tracked	Establishing Learning and Improvement Board Establishing Divisional Quality Governance Boards	October 2020 - ongoing October 2020 - ongoing	NRLS data SIRG CCG Quality Team	None Currently	None Currently	

A lack of evidence that learning has been shared	Trust-wide communications in place Debriefing systems in place Training available Appreciative Inquiry training programme started (December 2020) Commencement of patient safety specialist role (April 2021)	QI/ AI strategies and processes well embedded	October 2020 – ongoing				

RISK 3: If the Trust is unable to accurately predict demand (for example, relating to the COVID-19 pandemic) and re-purpose its resources (physical, human and financial) with agility, the Trust will fail to manage clinical risk during periods of sustained or rapid change in the level or type of demand.

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If the Trust is unable to accurately predict demand (for example, relating to the COVID-19 pandemic) and re-purpose its resources (physical, human and financial) with agility, the Trust will fail to manage clinical risk during periods of sustained or rapid change in the level or type of demand.				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Medical Director	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	17/01/22	**Risk Rating**	16	8		



Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Rapid or sustained period of upheaval and change caused by the Covid-19 pandemic and need to respond and maintain	Board approved major incident plan and procedures Rigorous monitoring of capacity, performance and quality indicators	Inability to accurately predict or forecast levels of activity and risk	Ongoing dialogue with community partners	MK place-based and ICS-based planning and resilience fora Regional and national data and forecasting	Incomplete oversight of OP delays	Enhanced visibility of OPD PTL and non RTT pathways	

clinical safety and quality Risks have increased (since May 2021) in view of the combination of planned and emergency demand which exceeds pre-pandemic levels, coupled with a resurgence in COVID cases is placing the Trust under significant pressure. Number of vacant beds fewer / inpatient density higher.	Established command and control governance mechanisms Gold (Daily) Level 3/4 Incident management			COVID MARC Meeting (Data, Intelligence, Collaboration with partners)			

RISK 4: If the Trust does not carefully manage its significant digital change programme, then the delivery of clinical services may be impaired.

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If the Trust does not carefully manage its significant digital change programme, then the delivery of clinical services may be impaired						**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm	At target level – no tracker	
Executive Lead	Deputy Chief Executive	**Consequence**	4	4	**Risk Appetite**	Avoid		
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat		
Date of Review	20/01/22	**Risk Rating**	8	8				

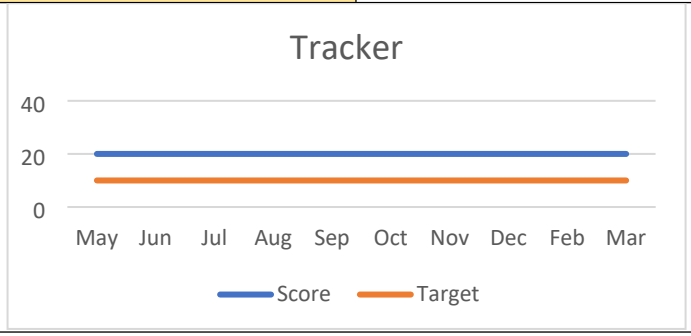
Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
Inadequate assessment of clinical risk/ impact on clinical services or practices Inadequate resourcing Inadequate training	Robust governance structures in place with programme management at all levels Clinical oversight through CAG Thorough planning and risk assessment Regular review of resourcing	None currently	Continue to maintain programme governance and keep resourcing under review	Established governance and external/ independent escalation and review process	None currently	Continued iterative testing of products post-roll out	

	Regular review of progress Risks and issues reported Track record of successful delivery of IT projects						

RISK 5: If the Trust is unable to provide capacity to match demand for elective care, (such as for cancer and screening programmes), there is a risk that this could lead to patient harm.

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If the Trust is unable to provide capacity to match demand for elective care, (such as for cancer and screening programmes), there is a risk that this could lead to patient harm.				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Director of Operations	**Consequence**	5	5	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	08/02/22	**Risk Rating**	20	10		



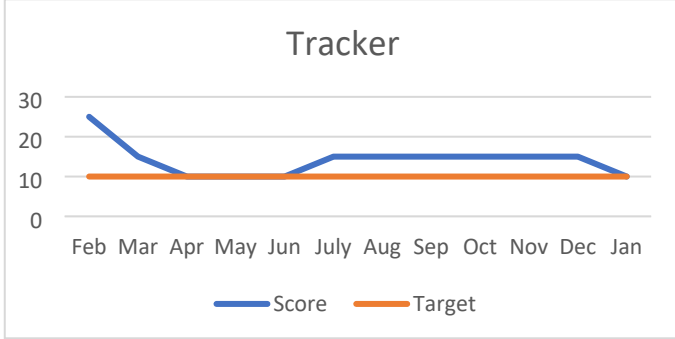
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Cessation of all routine elective care, including cancer screening and other pathways, during the peaks of the Covid-19 pandemic	Compliance with national guidance Granular understanding of demand and capacity requirements with use of national tools.	None Currently	Continue to maintain programme governance and keep resourcing under review	Established governance and external/ independent escalation and review process Regional and national monitoring.	None Currently	None Currently	

Inability to match capacity with demand	Robust oversight at Board, and sub committees. Divisional and CSU management of WL. Agreement of local standards and criteria for alternative pathway management – clinical prioritisation and validation Long-wait harm reviews Use of Independent Sector. Extension of working hours and additional WLI to compensate capacity deficits through distancing and IPC requirements. Additional capacity being sourced and services reconfigured.	Historic issue with ASI & capacity Limitations to what ISP can take. Resilience and wellbeing of staff and need for A/L and rest. Set up time for services off site.	Dedicated project resource commissioned Trust-wide and local Recovery Plans in place Reconfiguration of MKUH capacity services to best use ISP	Project reports & training programme Mutual aid options. BLMK System working.			

RISK 6: If the Trust does not establish and maintain effective capacity management processes it will be unable to cope with high demand for ITU and inpatient care during a public health crisis (or due to the Covid-19 pandemic)

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If the Trust does not establish and maintain effective capacity management processes it will be unable to cope with high demand for ITU and inpatient care during a public health crisis (or due to the Covid-19 pandemic)				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Medical Director	**Consequence**	5	5	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat
Date of Review	17/01/22	**Risk Rating**	10	10		



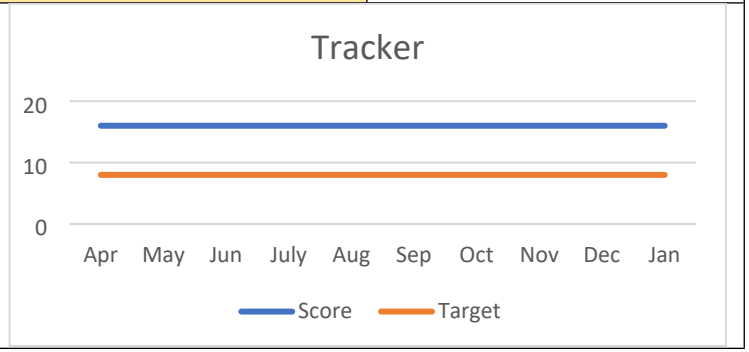
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Demand for ITU and inpatient beds exceeds capacity, including escalation capacity within the hospital and regionally. Risks have increased (since	Increased capacity across the hospital Increased capacity for ITU Clear escalation plans	Inability to accurately forecast demand	Ongoing dialogue with community partners	Tested escalation plans Active part of regional networks Clear view of CPAP support for COVID-19 patients	None currently	None currently	

May 2021) in view of the combination of planned and emergency demand which exceeds pre-pandemic levels, coupled with a resurgence in COVID cases is placing the Trust under significant pressure.	Real time visibility of regional demand/ capacity			Medical Director and Chief Nurse liaising with teams			

RISK 7: If the radiotherapy pathway provided until 2019/20 in Milton Keynes by Genesis Care (under contract with OUH) is not replaced, the access and experience of patients on clinical oncology (radiotherapy) pathways will continue to be negatively impacted.

Strategic Objective 2: Improving Patient Experience

Strategic Risk	If the radiotherapy pathway provided until 2019/20 in Milton Keynes by Genesis Care (under contract with OUH) is not replaced, the access and experience of patients on clinical oncology (radiotherapy) pathways will continue to be negatively impacted.				**Strategic Objective**	Improving Patient Experience
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Medical Director	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	17/01/22	**Risk Rating**	16	8		



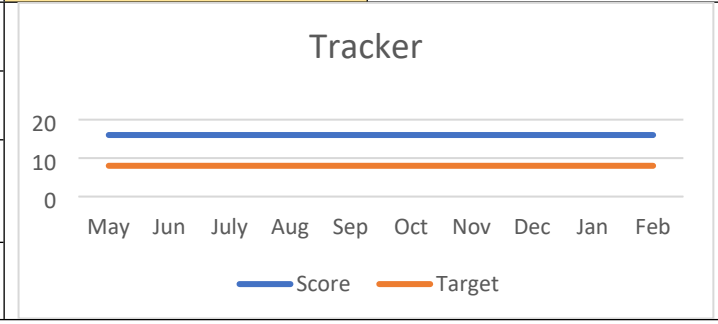
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Break down in the established relationship (subcontract) between Oxford University Hospitals and the private Genesis Care facility (Linford Wood, Milton Keynes)	Contingency for the provision of treatment to patients in Oxford and the ongoing provision of palliative and prostate radiotherapy at Linford Wood or in Northampton	Contracting and commissioning process outside the Trust's direct control or management Specific issues with the ICS CDEL limits	Continued lobbying for resolution	Minutes of established radiotherapy executive group	Lines of assurance outside the Trust's direct control Impact of ICS capital control limits	Continued work with partners	

which has provided local radiotherapy to MK residents for the last six years. This breakdown results in less choice and longer travel distances for patients requiring radiotherapy. Patients tend not to differentiate between the different NHS provider organisations. This risk materialised 16.12.2019 when the contract expired and no extension was agreed.	Promotion of agreement between OUH and Northampton General Hospital to facilitate access to facilities at Northampton for those who prefer treatment in this location. Proactive communications strategy in relation to current service delivery issues.						

RISK 8: If the Trust does not effectively work with patients and families in delivering care and positive patient experience the national patient surveys may not demonstrate improvement.

Strategic Objective 2: Improving Patient Experience

Strategic Risk	If the Trust does not effectively work with patients and families in delivering care and positive patient experience the national patient surveys may not demonstrate improvement.				**Strategic Objective**	Improving Patient Experience
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Chief Nurse	**Consequence**	4	4	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	04/02/22	**Risk Rating**	16	8		



Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Lack of appropriate intervention to improve patient experience (measured through the national surveys). Children and Young People Survey	Corporate Patient and Family Experience Team function, resources and governance arrangements in place at Trust, division and department levels, including but not limited to:	Engagement with patients for Co-production of service developments.	To develop bank of patients to engage with for involvement in wider organisational changes. **Lead:** Head of Patient and	**Annual:** PLACE surveys National Patient Experience Improvement Framework NHSI Assessment and action plan **Quarterly:** Quarterly reports with themes and	Comprehensive analysis of patient ethnic groups to ensure meeting all requirements. Link with EDI Leads.	Liaise with information dept for info on patient demographics.	

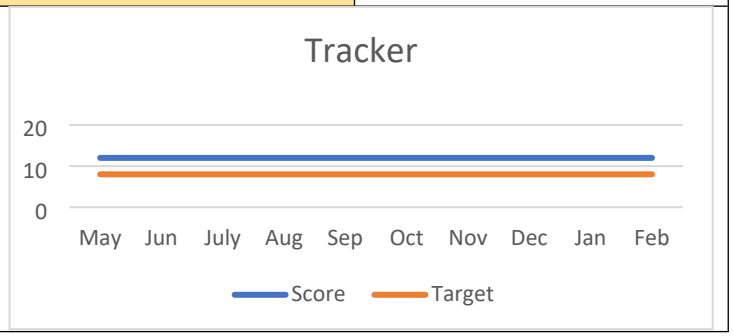
Adult Inpatient Survey Urgent and Emergency Care Survey Maternity Survey Cancer Patient Experience Survey	• Patent Experience Strategy • Learning Disabilities Strategy • Dementia Strategy • Nutrition steering group • Catering steering group • Domestic planning group • Discharge steering group • Induction training ’15 Step ’Challenge Monthly Patient Experience Board, with each quarter having a theme: 1.Governance 2. ‘Listening’ review of all feedback. 3. ‘Learning and Change’ from		Family Experience. **Timescale:** October 2021 – subject to national restrictions re COVID-19. FFT: Commencing partnership with PEP)Patient Experience Platform) who will collate and analyse all FFT/social media and other public feedback monthly and produce a report and dashboard **Timeframe:** Starts 1st November 2021	areas of for improvement. Patient experience strategy action plan progress. Perfect Ward Patient Experience Audit. **Monthly:** FFT results – thematic review. Monthly operational meeting to review and triangulate data for top themes and inform focused areas of work for next month’s activities. Department surveys **External Reviews:** Healthwatch Maternity Voices partnership (MVP)			

	feedback and co-production **Timeframe**: Starts October 2021			Cancer Patient Partnership **Website:** 'You said we did'			

RISK 9: If the Trust does not effectively work to use feedback from complaints and PALS contacts to inform learning and embed related changes patient experience will not be improved.

Strategic Objective 2: Improving Patient Experience

Strategic Risk	If the Trust does not effectively work to use feedback from complaints and PALS contacts to inform learning and embed related changes patient experience will not be improved.				**Strategic Objective**	Improving Patient Experience
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Chief Nurse	**Consequence**	4	4	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	04/02/22	**Risk Rating**	12	8		



Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Lack of appropriate intervention to improve patient experience following receipt of complaints and PALS contacts.	Corporate Patient Experience Team function, resources and governance arrangements in place at Trust, division and department levels, including but not limited to: • Patent Experience Strategy	Quality surveillance system to triangulate feedback from complaints with incidents and other quality measures across the organisation.	Current review underway for systems to link and triangulate data. Divisions to audit	**Annual:** Complaints and PALS Report **Quarterly:** Quarterly reports with themes and areas of for improvement. Patient experience strategy action plan progress.	**Patients' specific** needs supporting them to feedback: Cognitively impaired Learning Disabilities Sensory Deficit: vision, hearing, speech	Develop mechanisms for feedback for all groups. Use demographic to demonstrate complaints sources.	

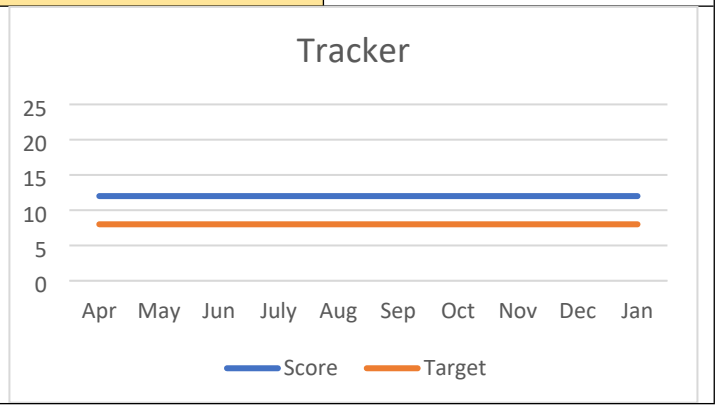
	• Learning Disabilities Strategy • Dementia Strategy • Nutrition steering group • Catering steering group • Domestic planning group • Discharge steering group • Induction training Customer service training – NHS Elect program Leadership training includes how to receive feedback from patients. Appreciative inquire approach to support complaints handling and response letters. Monthly divisional meetings with Head of Patient and Family Experience to review themes, complaints,	Audit of identified learning in divisions to ensure learning embedded.	learning from feedback and report to Patient Experience Board.	Perfect Ward Patient Experience Audit. **Monthly:** Monthly Patient Experience Board, with each quarter having a theme: 1.Governance 2. 'Listening' review of all feedback. 3. 'Learning and Change' from feedback and co-production **Timeframe**: Starts October 2021 Divisional review of learning from complaints in CIG. Complaints questionnaire for complaints re	Language difficulties Children and young people. Link with EDI leads and Trust Networks		

	associated changes, and learning.			process and experience. PALS KPIs responding to feedback in a timely manner to initiate change and learning. **Website:** 'You said we did			

RISK 10: If clinical audit requirements are not completed the Trust will fail to meet the requirements of clinical compliance regimes including NICE

Strategic Objective 3: Improving Clinical Effectiveness

Strategic Risk	If clinical audit requirements are not completed the Trust will fail to meet the requirements of clinical compliance regimes including NICE				**Strategic Objective**	Improving Clinical Effectiveness
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Director of Corporate Affairs	**Consequence**	4	4	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	18/01/22	**Risk Rating**	12	8		



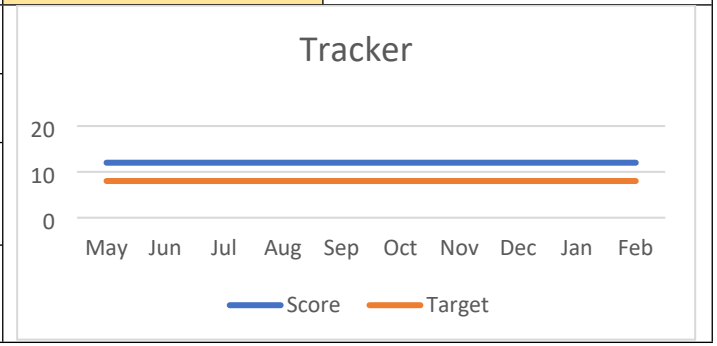
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
1. Lack of understanding/ awareness of audit requirements by clinical audit leads 2. Resources not adequate to support data collection/	1. Designated audit leads in CSUs/ divisions 2. Clinical governance and administrative support - allocated by division 3. Recruited additional clinical governance post to	1. Resource to complete audits 2. Audit policy out of date	1.Resource review currently underway 2. Audit policy has been redrafted and awaiting	Clinical Audit and Effectiveness Board External benchmarking	1.External benchmarking 2. Independent audit	Add to internal audit plan for 2021/22	

interpretation/ input 3. Audit programme poorly communicated 4. Lack of engagement in audit programme 5. Compliance expectations not understood/ overly complex	medicine to support audit function (highest volume of audits) 3. Audit programme being simplified, with increased collaboration and work through the QI programme 4. Audit compliance criteria being segmented to enable focus on compliance with data returns; opportunity for learning/ changing practice and communication/ engagement 5. Monthly review of all compliance requirements, including NICE and policies		approval by the March 2022 Audit Committee				

RISK 11: If the Trust is unable to establish robust governance around data quality processes, there is the risk that this could lead to patient harm, reputational damage and regulatory failure.

Strategic Objective 3: Improving Clinical Effectiveness

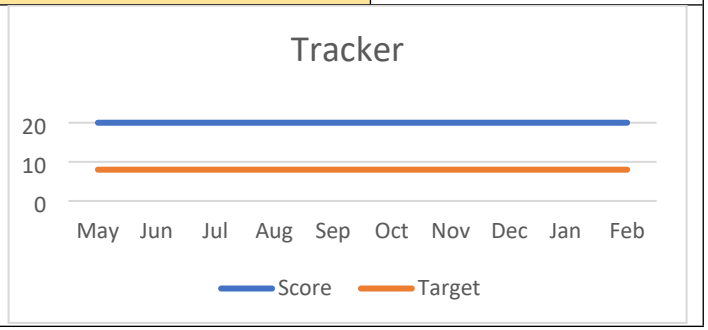
Strategic Risk	If the Trust is unable to establish robust governance around data quality processes, there is the risk that this could lead to patient harm, reputational damage and regulatory failure.				**Strategic Objective**	Improving Clinical Effectiveness
Lead Committee	Audit	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Director of Operations	**Consequence**	4	4	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	08/02/22	**Risk Rating**	12	8		



Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Failure to ensure adequate data quality leading to patient harm, reputational risk and regulatory failure because data quality processes are not robust	Robust governance around data quality processes including executive ownership Audit work by data quality team More robust data input rules leading to fewer errors	RPAS will reduce the numbers of manual input errors Better training of the administration teams leading to more consistent recording of data	RPAS scheduled in for implementation in 2022 Director of Transformation working with OP areas to improve training	Data Quality Board External benchmarking	None Currently	None Currently	

RISK 12: If the Trust does not establish and maintain effective capacity management processes it will be unable to achieve waiting time targets due to seasonal emergency pressure (or further Covid-19 surges).

Strategic Objective 4: Ensuring Access to Timely Care

Strategic Risk	If the Trust does not establish and maintain effective capacity management processes it will be unable to achieve waiting time targets due to seasonal emergency pressure (or further Covid-19 surges).				**Strategic Objective**	Ensuring Access to Timely Care	
Lead Committee	TEG	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm	
Executive Lead	Director of Operations	**Consequence**	5	5	**Risk Appetite**	Minimal	
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat	
Date of Review	08/02/22	**Risk Rating**	20	10			

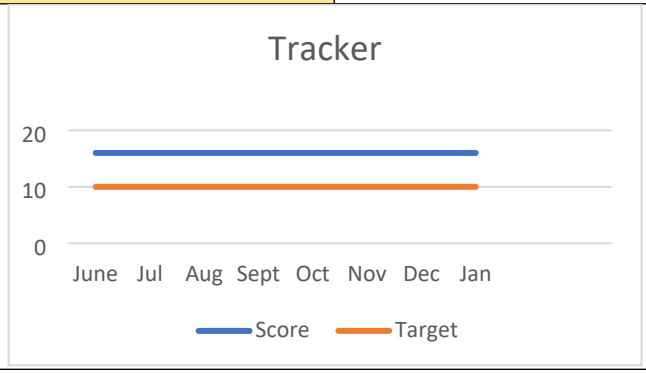
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Elective activity is suspended (locally or by national directive) to enable the Trust to cope with emergency demand or further Covid-19 surges, resulting in increasing waits for patients	Winter escalation plans to flex demand and capacity Plans to maintain urgent elective work and cancer services through periods of peak demand Agreed plans with local system	Unpredictable nature of both emergency demand and the surge nature of Covid-19 Workforce and space (in pandemic) rate limiting factors	Continued planning and daily reviews (depending on Opel and incident levels)	Emergency Care Board (external partners) Regional and national tiers of reporting and planning	None Currently	None Currently	

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

RISK 13: If the Trust does not have a sufficient capital expenditure limit (CDEL) then the Trust will not be able to complete the level of planned capital investment

Strategic Objective 10: Innovating and Investing in the future of the Trust

Strategic Risk	If the Trust does not have a sufficient capital expenditure limit (CDEL) then the Trust will not be able to complete the level of planned capital investment				**Strategic Objective**	Innovating and Investing in the future of the Trust
Lead Committee	Finance and Investment	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial
Executive Lead	Director of Finance	**Consequence**	4	5	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	20/01/22	**Risk Rating**	16	10		

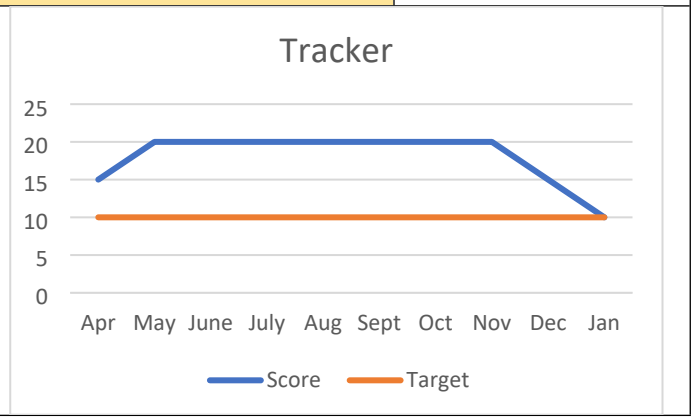


Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Following the FY21 year end audit the Trust had to adjust misstated capital expenditure of £4.5m relating to a capital bond. As a consequence, the Trust has brought forward capital	The Trust is introducing enhanced in-year capital spend monitoring to proactively manage in-year underspends across other capital schemes. Where agreed by management (e.g., subject to risks and	The Trust has limited control over the availability and reassignment of CDEL across the ICS and regional partners.	The Trust will report the capital expenditure position (MKUH and ICS) and associated risks to F&IC and regularly	Monthly capital report and BAF	CDEL reporting oversight at regional level	The Trust will engage with the NHSE/I Head of Finance for regular updates on the	

spending commitments of £4.5m into FY22 but does not have a sufficient capital expenditure limit to accommodate this investment.	strategic need) underspends across other capital schemes could free-up capital expenditure limit for utilisation against bond schemes. The Trust is engaging with NHSE/I regional colleagues and Integrated Care System partners to monitor planned capital expenditure limits (CDEL) across both ICS and regional organisations to proactively reassign available CDEL.		update the Audit Committee through the BAF			regional CDEL position	

RISK 14: If the Trust does not maintain investment in its IT infrastructure and systems, then all operational systems could be severely affected by IT failures such as infiltration by cyber criminals.

Strategic Objective 10: Innovating and Investing in the future of the Trust

Strategic Risk	If the Trust does not maintain investment in its IT infrastructure and systems, then all operational systems could be severely affected by IT failures such as infiltration by cyber criminals.				**Strategic Objective**	Innovating and Investing in the future of the Trust	
Lead Committee	Finance and Investment	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial	
Executive Lead	Deputy Chief Executive	**Consequence**	5	5	**Risk Appetite**	Minimal	
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat	
Date of Review	20/01/22	**Risk Rating**	10	10			

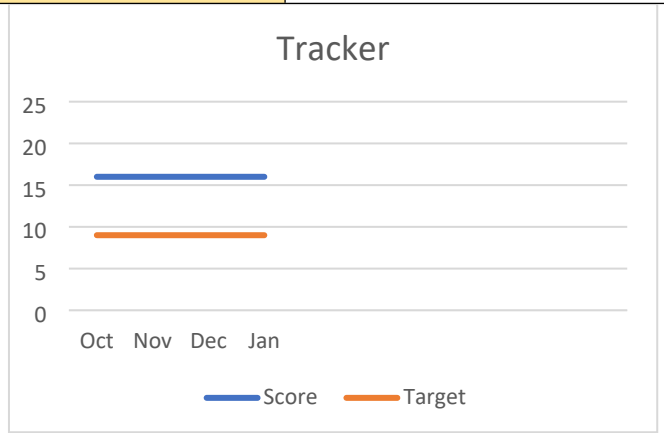
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Hardware failure due aged equipment Increasing Cyber-attacks across the world and in particular in Ireland	2 dedicated cyber security posts Good network protection from cyber security breaches such as Advanced Threat Protection (ATP) – A part of the national programmes	None identified	Continued review	External review and reporting Internal audit reports on cyber security taken with the management actions	None currently	None currently	

	to protect the cyber security of the hospital All Trust PCs less than 4 years old Purchase new hardware – not implemented yet EPR investment						

RISK 15: If there is insufficient strategic capital funding available, then the Trust will be unable to invest in the site to maintain pace with the growth of the Milton Keynes population's demand for hospital services

Strategic Objective 10: Innovating and Investing in the future of the Trust

Strategic Risk	If there is insufficient strategic capital funding available, then the Trust will be unable to invest in the site to maintain pace with the growth of the Milton Keynes population's demand for hospital services				**Strategic Objective**	Innovating and Investing in the future of the Trust
Lead Committee	Finance and Investment and Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial
Executive Lead	Director of Finance	**Consequence**	4	3	**Risk Appetite**	Cautious
Date of Assessment	02/11/21	**Likelihood**	4	3	**Risk Treatment Strategy**	Treat
Date of Review	20/01/22	**Risk Rating**	16	9		



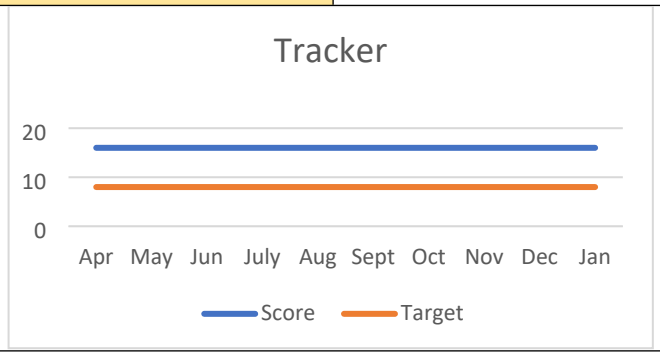
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
The current NHS capital regime does not provide adequate certainty over the availability of strategic capital finance. Consequently, it is difficult to progress development plans	The Trust has a process to target the investment of available capital finance to manage risk and safety across the hospital. The Trust is tactically responsive in pursuing central	The Trust does not directly control the allocation of strategic NHS capital finance	Continued review Close relationship management of key external partners	External New Hospital Programme review and reporting.	None Currently	None Currently	

in line with the strategic needs of the local population	NHSE/I capital programme funding to supplement the business-as-usual depreciation funded capital programme.						

RISK 16: 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.

Strategic Objective 10: Innovating and Investing in the future of the Trust

Strategic Risk	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.				**Strategic Objective**	Innovating and Investing in the future of the Trust
Lead Committee	Finance and Investment	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial
Executive Lead	Director of Finance	**Consequence**	4	4	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	20/01/22	**Risk Rating**	16	8		



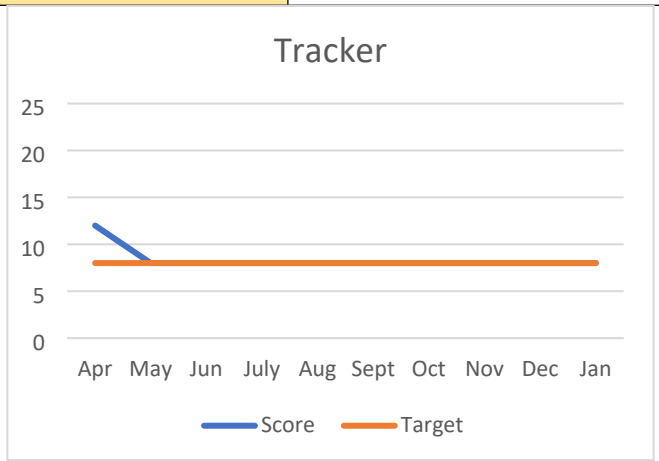
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Increase in operational expenditure in order to manage COVID-19 Reductions in non-NHS income streams as a direct result of COVID-19.	1. Cost and volume contracts replaced with block contracts (set nationally) for clinical income; 2. Top-up payments available where COVID-19 leads to additional costs over and above block sum amounts (until September 2021);	Fragmented financial regime during 2021/22, no details known for 2022/23 and beyond. Significant changes expected as NHS transitions from rounding regime heavily influenced by the	Continued review of national funding intentions to maximise time to plan organisation response. Preparation of plans at earliest opportunity	Monthly financial performance reports. Cost efficiency reporting. BLMK ICS finance performance reports.	None Currently.	None Currently.	

Impaired operating productivity leading to additional costs for extended working days and/or outsourcing. Potential for material increase in efficiency requirement from NHS funding regime to support DHSC budget affordability. Unknown funding regime beyond 2021/22 and therefore clarity on required efficiency savings for 2022/23 and beyond.	3. Budgets updated for FY22 based on prevailing finance regime (September – March 2022); financial controls and oversight to be reintroduced to manage financial performance. 4. Cost efficiency programme to be relaunched to target focus on areas of greatest opportunity.	pandemic. Trust has minimal ability to influence.	once 2022/23 national guidance is published.				

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

Strategic Objective 10: Innovating and Investing in the future of the Trust

Strategic Risk	Insufficient space in the Neonatal Unit to accommodate babies requiring special clinical care				**Strategic Objective**	Innovating and Investing in the future of the Trust
Lead Committee	Finance and Investment and Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial
Executive Lead	Deputy Chief Executive	**Consequence**	4	4	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat
Date of Review	20/01/22	**Risk Rating**	8	8		



Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
The current size of the Neonatal Unit does not meet the demands of the service. This risks high numbers of transfers of unwell babies and potential delayed repatriation of babies back to the hospital. There is a risk that if the	Reconfiguration of cots to create more space Additional cots to increase capacity Parents asked to leave NNU during interventional procedures, ward rounds, etc to	External timeframe and approval process for HIP2 funding	Continued review	External review and reporting. Whilst a technical risk the likelihood has been downgraded on the basis of actual reporting	None Currently	None Currently	

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

RISK 19: If the Trust does not retain staff then posts will be vacant resulting in workforce shortages across the hospital and/or increased temporary staffing expenditure.

Strategic Objective 8: Employing the Best People

Strategic Risk	If the Trust does not retain staff then posts will be vacant resulting in workforce shortages across the hospital or increased temporary staffing expenditure.					**Strategic Objective**	Employing the Best People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff	At target level – no tracker
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Cautious	
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat	
Date of Review	15/02/22	**Risk Rating**	8	8			

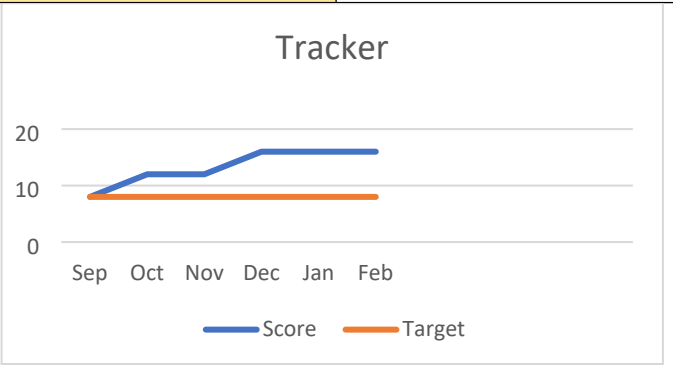
Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
Proximity to tertiary centres Lack of structured career development or opportunities for progression Benefits packages elsewhere	Variety of organisational change/staff engagement activities, e.g. Event in the Tent Schwartz Rounds and coaching collaboratives Recruitment and retention premia We Care programme Onboarding and exit strategies/reporting	None Currently	Continued review	External review and reporting Vacancy and Retention Rates	None Currently	None Currently	

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

RISK 20: If the Trust does not recruit to vacancies in the short term (0-18 months) then there will be workforce shortages across the hospital and/or increased temporary staffing expenditure.

Strategic Objective 8: Employing the Best People

Strategic Risk	If the Trust does not recruit to vacancies in the short term (0-18 months) then there will be workforce shortages across the hospital and/or increased temporary staffing expenditure.				**Strategic Objective**	Employing the Best People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	15/02/22	**Risk Rating**	16	8		



Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
National shortages of appropriately qualified staff in some clinical roles, particularly at consultant level for dermatology and acute medicine, and at middle grade level for	Active monitoring of workforce key performance indicators Targeted overseas recruitment activity Apprenticeships and work experience opportunities	None Currently	Continued review	External review and reporting Vacancy Rates	None Currently	None Currently	

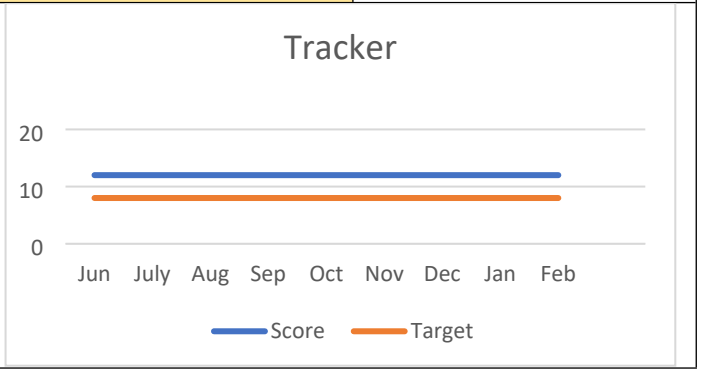
urology and trauma and orthopaedics Competition from surrounding hospitals Buoyant locum market National drive to increase nursing establishments leaving market shortfall (demand outstrips supply)	Exploration and use of new roles to help bridge particular gaps Use of recruitment and retention premia as necessary Use of the Trac recruitment tool to reduce time to hire and candidate experience Rolling programme to recruit pre-qualification students Use of enhanced adverts, social media and recruitment days Rollout of a dedicated workforce website Review of benefits offering and assessment against peers. Creation of recruitment "advertising" films Recruitment and retention focussed workforce strategy and plan to fill vacancies, develop new roles and deliver improvement to						

	working experience/ environment Targeted recruitment to reduce hard to fill vacancies						

RISK 21: If the Trust does not recruit to vacancies in the long term (19+ months) then there will be workforce shortages across the hospital and/or increased temporary staffing expenditure.

Strategic Objective 8: Employing the Best People

Strategic Risk	If the Trust does not recruit to vacancies in the long term (19+ months) then there will be workforce shortages across the hospital and/or increased temporary staffing expenditure.				**Strategic Objective**	Employing the Best People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	15/02/22	**Risk Rating**	12	8		



Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
National shortages of appropriately qualified staff in some clinical roles, particularly at consultant level Brexit may reduce overseas supply	Monitoring of uptake of placements & training programmes Targeted overseas recruitment activity Apprenticeships and work experience opportunities	None Currently	Continued review	External review and reporting Vacancy Rates	None Currently	None Currently	

Competition from surrounding hospitals Buoyant locum market National drive to increase nursing establishments leaving market shortfall (demand outstrips supply) Large percentage of workforce predicted to retire over the next decade Large growth prediction for MK - outstripping supply Buoyant private sector market creating competition for entry level roles New roles upskilling existing	Expansion and embedding of new roles across all areas Rolling programme to recruit pre-qualification students Use of enhanced adverts, social media and recruitment days Review of benefits offering and assessment against peers Development of MKUH training programmes Workforce Planning Recruitment and retention focussed workforce strategy and plan to fill vacancies, develop new roles and deliver improvement to working experience/environment International workplace plan						

senior qualified staff creating a likely gap in key roles in future (e.g. band 6 nurses) Reducing potential international supply New longer training models	Assisted EU staff to register for settled status and discussed plans to stay/leave with each to provide assurance that there will be no large-scale loss of EU staff post-Brexit						

RISK 23: If the Trust does not maintain stocks of Personal Protective Equipment (PPE) and continue implementing the enhanced infection control measures it will be unable to maintain a safe working environment during the COVID-19 pandemic

Strategic Objective 8: Employing the Best People

Strategic Risk	If the Trust does not maintain stocks of Personal Protective Equipment (PPE) and continue implementing the enhanced infection control measures it will be unable to maintain a safe working environment during the COVID-19 pandemic						**Strategic Objective**	Employing the Best People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff	At target level – no tracker	
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Avoid		
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat		
Date of Review	15/02/22	**Risk Rating**	8	8				

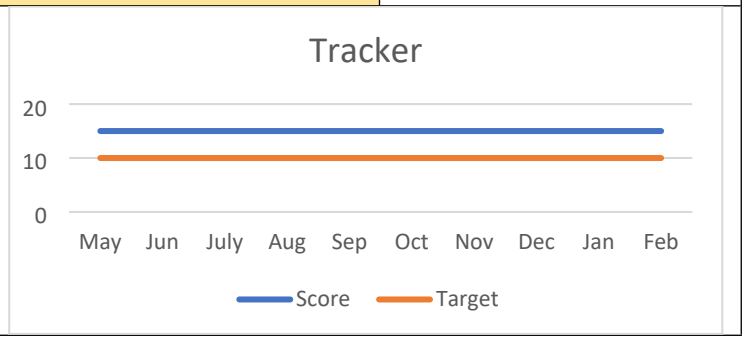
Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
Ability to maintain a safe working environment during the Covid-19 pandemic due to a lack of equipment, including PPE, or inadequate staffing numbers	Incident command structure in place Oversight on all critical stock, including PPE Immediate escalation of issues with	None currently – noted that this risk may escalate very quickly	None Currently	Completed Risk Assessments PPE Stock Level Reports Staff Test Stock Levels	None Currently	None Currently	

	immediate response through Gold/ Silver National and regional response teams in place Workforce and Workplace Risk Assessments completed and any necessary equipment or working adjustments implemented. Staff COVID-19 Self-Test and vaccine offer to all MKUH workers			Staff Vaccine Uptake Report			

RISK 24: If the Trust does not implement and progress staff health and wellbeing initiatives, there is the risk of staff burning out during or due to the COVID-19 pandemic

Strategic Objective 8: Employing the Best People

Strategic Risk	If the Trust does not implement and progress staff health and wellbeing initiatives, there is the risk of staff burning out during or due to the COVID-19 pandemic				**Strategic Objective**	Employing the Best People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff
Executive Lead	Director of Workforce	**Consequence**	5	5	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	15/02/22	**Risk Rating**	15	10		



Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Staff burnout due to high-stress working environment, conditions of lock-down, recession and other social factors	Significant staff welfare programme in place, with mental health, physical health and support and advice available Staff Hub in use Remote working wellness centre in place	Significant uncertainty about next wave of the pandemic and how it will affect staff	Continued monitoring, continued communication and engagement with staff about support systems	Regular virtual all staff events Surveys	None Currently	Package of measures to support remote workers	

	12 weeks of wellbeing focus January to March						

Milton Keynes University Hospital NHS Foundation Trust

Agenda item 21.1
Public Board 03.03.22

Meeting of the Finance and Investment Committee held on 11 January 2022

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

a. The Committee **approved** the Microsoft 365 Licensing Business Case.

Summary of matters considered at the meeting:

- Regarding the M08 Performance Dashboard, the Committee reviewed the trajectories of all key performance indicators. The Committee noted that:

  a) staff absence due to sickness and the unavailability of agency staff remained a challenge

  b) the hospital was preparing to open 'super surge' bed in anticipation of a wave of Omicron COVID-19 admissions

  c) the Trust had been ranked 15th out 160 NHS providers in terms of Emergency Department (ED) performance

- Regarding the M08 Finance Report, the Committee reviewed the trajectories of all the key income and expenditure indicators. The Committee noted that:

  a) the operating costs of the organisation had increased due to increased premium staff costing to add resilience to the workforce in the current operating climate

  b) the amount of Elective Recovery Funding (ERF) monies that the Trust qualified for would likely be impacted by Omicron and the amount of planned care work undertaken

  c) the BLMK ICS was on plan with a breakeven position year to date

- The Committee received an update on progress against the capital projects programme for 2021-22.

- The Finance and Investment Committee received an addendum to the International Nursing Recruitment Business Case which was approved in November 2021.

- The Committee received an update on the termination and transition of the Dermatology Service provision agreement with HCRG Care Group, formerly Virgin Care.

Milton Keynes University Hospital NHS Foundation Trust

Agenda item 21.2
Public Board 01.02.22

Meeting of the Finance and Investment Committee held on 30 November 2021

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

a. The Committee **approved** the Car Park and Access Road Business Case.

b. The Committee **approved** the approved the accounting treatment and the financial implications of the Imaging Centre write off.

Summary of matters considered at the meeting:

- Regarding the M09 Performance Dashboard, the Committee reviewed the trajectories of all key performance indicators. The Committee noted that:

  a. at 81.5%, with an actual YTD performance at 84.7%, the performance of the Trust Emergency Department was significantly higher than both the national overall performance of 73.3% and that of its Peer Group

  b. due to the impact of the Omicron COVID-19, the performance of certain key constitutional NHS targets for December 2021 had been negatively impacted

  c. compared to November 2021, there had been improvements on the super stranded and stranded patients

  d. there were improvements on weekend and ward discharges by midday, and on quarterly Cancer targets

  e. Diagnostics waits remained challenged due to staffing and equipment issues

- Regarding the M09 Finance Report, the Committee reviewed the trajectories of all the key income and expenditure indicators.

- The Committee received an update on progress against the capital projects programme for 2021-22.

- The Committee received a deep dive report into the Trust's financial efficiency program.

- The Committee received a report on the steps required to be terminate and transition the Dermatology Service provision from one provider to another.

Milton Keynes University Hospital NHS Foundation Trust

Agenda item 21.3
Public Board 03.03.2022

Meeting of the Charitable Funds Committee held on 27 January 2022

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee

N/A

Summary of matters considered at the meeting:

- The Committee received an update on the Q3 Financial Report of the Hospital Charity and noted that

a. the Big Give Christmas Challenge run between 30 November 2021 and 7 December 2021 and raised £8.4k against a target of £7.9k

b. a Gala Ball to raise funds in aid of the Cancer Centre is scheduled for 24 June 2022 at the MK Dons Stadium

c. various activities had been organised over Christmas to engage with the public and connect with donors

d. the Charity continues to develop relationships with local funders

- The Committee received an update from the Meaningful Activities Facilitator on their activities since October 2021. The Meaningful Activities Facilitator is funded by the Hospital Charity

Milton Keynes University Hospital NHS Foundation Trust

Agenda item 21.4
Public Board 03.03.22

Workforce & Development Assurance Committee Meeting held on 27 January 2022

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

a. N/A.

Summary of matters considered at the meeting:

HR Services and Systems (Q3) – The Committee received an update that the first cohort of international nurses from India would be joining the Trust on Monday 31 January 2022. A detailed induction and support plan was in place for their educational and pastoral needs. This is the start of an ongoing international recruitment campaign set to employ nurses into our organisation within 2022.

Organisational Development, Culture and Reward Update (Q3) - The committee noted that as of the 01 January 2022 staff flu vaccine uptake was 69.2% which was slightly lower than 85% in 2021.

Workforce Information Quarterly Report (Q3) – The Committee noted the Trusts' impressive results around recruitment, retention, turnover and the sickness levels particularly during the current difficult times.

Vacancy rates – The Committee noted that HRBPs had been working with their divisional triumvirates and heads of service to review vacancies across Divisions. It was anticipated to reduce vacancy by 1% by the end of 21/22 financial year.

NHS National Staff Survey Results- The Committee noted that NHS National Results were back but currently embargoed and that the survey had not been well completed this year due to pandemic challenges.

Staff Health and Wellbeing Annual Report – The Committee noted that the Trust would be embarking on a 'Love, MKUH' campaign focusing on gratitude, kindness, and appreciation. It would be running from February to June 2022 and culminate in staff awards ceremony. The staff awards ceremony was anticipated to take place face to face in summer 2022.

Non - Executive Director End of Term – The committee thanked Nicky McLeod for the work she had done as chair for the Workforce and Development Assurance Committee had come to an end and wished her well for the future.

The Values-Led Behaviour Framework- The committee noted that the implementation of the framework continues with 'Train the Trainer' sessions being planned for subject matter

experts in appraisal, leadership and speaking up. Sessions will then be planned and rolled out over 2022/23.

Carrying over annual leave - To ensure staff do not lose out on their annual leave, the Trust had taken the decision to remove the limit on the number of days that may be carried over to the following year. This would allow staff to determine how best to manage any remaining leave they may have

TeamMKUH Reserves – The committee noted that there was a piece of work ongoing to ensure that staff had selected a first and second preference for the clinical roles that they would be redeployed into if necessary and to completely train staff who had made selections to ensure they were ready to support and assist wards should operational pressures continue to increase.

VCOD update – The committee noted that the HR Business Partnering team had created a toolkit for managers and were currently writing a relevant policy and reviewing roles 'in scope'. Vaccine hesitancy conversations with staff members had started to make sure staff were fully informed before coming to a decision.

Milton Keynes University Hospital NHS Foundation Trust

Agenda item: 21.5
Public Board 03.03.2022

Meeting of the Trust Executive Committee held on 12 January 2022

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

1. The following capital business cases:

   a. Installation of additional ventilation in tissue processing room
   b. Enabling works for Ward 15/16 and ward moves

2. The Quality Improvement Strategy

Summary of matters considered at the meeting:

- The Committee was briefed on the preparations for a wave of Omicron COVID-19 infections and admissions.
- Staff sickness absences had declined in January 2022, compared to December 2021, notably due to staff returning from isolation and the changes to the isolation length of time.
- The Committee noted that the Patient and Experience team was shortlisted as finalist for the Patient Experience Network National Awards (PENNA).

Divisional updates:

- Medicine Division: Cancer performance remained under pressure.
- Medicine Division: Attendance rates to the Emergency Department dropped in November 2021 and December 2021.
- Core Clinical Division: Staffing challenges mainly in specialist or smaller services notably bowel screening admin team
- Surgery Division: Activity in Outpatients through November 2021 and December 2021, respectively, were at 116% and 110%.
- Surgery Division: Elective activity was at around 97.5%.

Milton Keynes University Hospital NHS Foundation Trust

Agenda item: 21.6
Public Board 03.03.2022

Meeting of the Trust Executive Committee held on 09 February 2022

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

1. The following capital business cases:

    a. Cardiac Monitors x 18, Central Stations x 2, and Consumables
    b. Monitor Replacement Program – to support more effective working practices when using core applications such as eCARE and Teams

Summary of matters considered at the meeting:

The Committee comprehensively reviewed the Strategic Priorities of the Trust in the 6 months from April 2022 to October 2022

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Board of Directors**	**Date: 13 January 2022**
Report title:	**Use of Trust Seal**	**Agenda item: 19**
Lead director **Report author** **Sponsor(s)**	**Name: Kate Jarman** **Name: Julia Price**	**Title: Director of Corporate Affairs** **Title: Senior Corporate Governor Officer**
FoI status:	**Public**	

Report summary	To inform the Board of the use of the Trust Seal.						
Purpose *(tick one box only)*	**Information**	x	**Approval**		**To note**	x	**Decision**
Recommendation	That the Board of Directors note the use of the Trust Seal since March 2021						

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

Report history	None
Next steps	None
Appendices	

Use of Trust Seal

1. Purpose of the Report

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

2. Context

Since the last Trust Board, the Trust Seal has been executed as follows:

a. 29 November 2021

Preconstruction delivery agreement – NEC Professional Services Contract

b. 23 February 2022

Lease to CNWL – Speech and Language Therapy

c. 23 February 2022

Hairdresser Lease

Trust Board Meeting in Public

Forward Agenda Planner

Standing Items

Standing Business Items	Standing Trust Board Meeting In Public Items
Apologies	Patient Story
Meeting Quorate	Nursing Staffing Update
Declaration of Interests	Mortality Update
Minutes of the previous meeting	Performance Report
Action Tracker	Finance Report
Risk highlighted during meeting for consideration to CRR/BAF	Workforce Report
Escalation items for Board attention	Board Assurance Framework
AOB	Trust Seal
Forward Agenda Planner	Summary Reports from Board Committees
	Significant Risk Register Report
	Serious Incident Report
	Equality, Diversity and Inclusion Update

Additional Agenda Items

Month	Assurance Reports/Items
January	Objectives Update
	Antimicrobial Stewardship - Annual Report
March	
May	Freedom to Speak Up Guardian Annual Report
	Quality Priorities
July	CNST Maternity Incentive Scheme – Board Assurance Statement and Sign-Off
	Guardian of Safe Working Hours Annual Report
	Medical Revalidation Annual Report
	Objectives
	Annual Complaints Report
	Annual Claims Report
	Research & Development Annual Report
	Falls Annual Report

	Pressure Ulcers Annual Report
	Safeguarding Annual Report
September	Annual Digital Review
November	Infection Prevention and Control Annual Report