Board of Directors

Public Meeting Agenda

Meeting to be held at 10.00 am on Friday 3 May 2019 in Room 6, Postgraduate Education Centre, Milton Keynes University Hospital.

Item No.	Title	Purpose	Type and Ref.	Lead
1. Introduction and Administration				
1.1	Apologies	Receive	Verbal	Chairman
1.2	Declarations of Interest • Any new interests to declare • Any interests to declare in relation to open items on the agenda	Noting	Verbal	Chairman
1.3	Minutes of the meeting held in Public on 1 March 2019	Approve	Pages 2-14	Chairman
1.4	Matters Arising/ Action Log	Receive	Pages 15-16	Chairman
2. Chair and Chief Executive Strategic Updates				
2.2	Chairman's Report	Receive and Discuss	Verbal	Chairman
2.3	Chief Executive's Report	Receive and discuss	Verbal	Chief Executive
3. Quality				
3.1	Patient Story	Receive and Discuss	Presentation	Director of Patient Care and Chief Nurse
3.2	Nursing staffing update	Receive and Discuss	Pages 17-22	Director of Patient Care and Chief Nurse
3.3	CNST Maternity Incentive Scheme Action Plan and Position Statement	Approve	Pages 23-32	Medical Director
3.4	Mortality Update Report	Receive and Discuss	Pages 33-44	Medical Director
3.5	7 Day Services Board Assurance Report	Receive and Discuss	Pages 45-52	Medical Director
4. Performance and Finance				
4.1	Performance report Month 12	Note	Pages 53-68	Deputy Chief Executive
4.2	Finance update report Month 12	Receive and Discuss	Pages 69-76	Director of Finance
4.3	Workforce update report Month 12	Receive and Discuss	Pages 77-82	Director of Workforce
5. Assurance and Statutory Items				
5.1	Board Assurance Framework: End of Year Report (2018/19); Proposals for 2019/20	Receive and Discuss	Pages 83-92	Director of Corporate Affairs
5.2	(Summary Report) Audit Committee – 21 March 2019	Note	Pages 93-96	Chair of Committee

Item No.	Title	Purpose	Type and Ref.	Lead
5.3	(Summary Report) Finance and Investment Committee – 25 February & 1 April 2019	Note	Pages 97-98	Chair of Committee
5.4	(Summary Report) Quality and Clinical Risk Committee – 21 March 2019	Note	Pages 99-100	Chair of Committee
6. Administration and closing				
6.1	Questions from Members of the Public	Receive and Respond	Verbal	Chairman
6.2	Motion to Close the Meeting	Receive	Verbal	Chairman
6.3	Resolution to Exclude the Press and Public	Approve	The Chair to request the Board pass the following resolution to exclude the press and public and move into private session to consider private business: *"That representatives of the press and members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted."*	Chairman

Milton Keynes University Hospital NHS Foundation Trust

BOARD OF DIRECTORS MEETING

Minutes of the Board of Directors meeting held in PUBLIC on 1 March 2019 in the Conference Room, Academic Centre, Milton Keynes University Hospital

Present:

Simon Lloyd	Chairman
Joe Harrison	Chief Executive
John Blakesley	Deputy Chief Executive
Andrew Blakeman	Non-executive Director (Chair of Audit Committee)
Parmjit Dhanda	Non-executive Director (Chair of Charitable Funds Committee)
Nicky McLeod	Non-executive Director
Danielle Petch	Director of Workforce
Caroline Hutton	Director of Clinical Services
Lisa Knight	Director of Patient Care and Chief Nurse
Tony Nolan	Non-executive Director (Chair of Workforce and Development Assurance Committee)
Helen Smart	Non-executive Director (Chair of Quality & Clinical Risk Committee)
Heidi Travis	Non-Executive Director (Chair of Finance & Investment Committee

In attendance:

Kate Jarman	Director of Corporate Affairs
Ian Wilson	NExT Director
Daphne Thomas	Deputy Director of Finance
Sally Burnie	Head of Cancer Services (item 3.1)
Jaff Newton	Secretary, Milton Keynes Cancer Patient Partnership (item 3.1)
Suzan St Maur	Chair, Milton Keynes Cancer Patient Partnership (item 3.1)
Adewale Kadiri	Company Secretary

2019/03/01	**Welcome**
1.1	The Chairman welcomed all present to the meeting, including the CQC inspectors who were observing.
2019/03/02	**Apologies**
2.1	Apologies were received from Mike Keech.
2019/03/03	**Declarations of interest**
3.1	No new interests had been declared and no interests were declared in relation to the open items on the agenda.

2019/03/04	**Minutes of the meeting held on previous meeting**
4.1	The minutes of the public Board meeting held on 11 January 2019 were accepted as an accurate record.
2019/03/05	**Matters Arising/ Action Log**
5.1	There were no matters arising in addition to those included on the agenda.
5.2	The action log was reviewed in turn: <u>361 Chairman's report</u> It was confirmed that the Trust is currently working through the contracting process with the CCG. The deeper implications of the NHS Long Term Plan are to be discussed at the April Seminar. <u>362 Nursing staffing report</u> The Chief Nurse reported that she has met with the Head of Therapies, and has been in touch with local hospitals with a view to benchmarking the Trust's provision.
2019/03/06	**Chairman's Report**
6.1	The report of the Kark Review of the fit and proper test for NHS managers has been published. The Chairman reported that two of the report's recommendations have been accepted by the Secretary of State – the creation of a database of directors and the application of specific standards of conduct. This is now out for consultation. Mention was also made of the Topol review, which focused on the need to prepare healthcare workers to deliver care in the "digital future". The findings were considered to be sensible, and have no immediate implications for the Trust.
6.2	The Chairman gave feedback on a very good evening spent recently in the Pathology Department with enthusiastic colleagues talking about and demonstrating their work. He has also been out with the palliative care team and on other wards and reflected on the modesty that staff show about what they do. There is a need for the organisation to think about how it celebrates success. Heidi Travis agreed and suggested that the Board should take the opportunity of public meetings to highlight the good work that is done across the hospital. Helen Smart was impressed that at the locations she visited, staff were able not only to recite the Trust's visions and values, but also to demonstrate what these mean to them in their day to day work. The Medical Director had visited Day Surgery with Tony Nolan where they had had useful discussions about day to day processes and some frustrations. **Resolved**: The Board **noted** the Chairman's report.
2019/03/07	**Chief Executive's Report**
7.1	The Chief Executive welcomed the director of Clinical Services back to the organisation after some time away. He informed the Board that the Deputy Chief Executive and the Medical Director will continue to cover the operational portfolio

	while the Director of Clinical Services focuses on the quality improvement agenda, pulling together the different strands to this across the organisation.
7.2	The Chief Executive made reference to the relative lightness of the pack for this meeting, making the point that at this stage in year various annual reports are being prepared and contracts negotiated.
7.3	He informed the Board that he is part of the national working group on workforce, focusing on how digital developments can support the workforce. One of the themes emerging from the Topol report is that all boards are required to have a CIO to ensure that the board takes digital seriously. The Chief Executive expressed the view that this would not necessarily lead to the sort of culture change that is required. At this trust, a number of executives have an involvement with technology - the Medical Director had recently attended the HIMSS conference in the US and had been able to observe first-hand some future developments that are shortly to arrive in the UK. It was interesting to note that Microsoft are now taking a keen interest in the health sector.
7.4	Plans are underway for the 2019 Event in the Tent. This is a three day staff engagement event which will take place just after the May Bank Holiday. This year's event will focus on safety, wellbeing and innovation and inclusion. The following Friday will be International Nurses' Day.
7.5	The Trust has launched a number of staff networks including one for women and another on disability. MKUH Pride has been rolled out successfully in the ED. The Trust has been recognised across social media as being focused on flexible working – NHS Flex and NHS Happiness are being run by the Director of Corporate Affairs and others. The promotion of flexible working now acknowledged as a key part of recruitment and retention as well as health and wellbeing. NHS Happiness on the other hand is a platform to promote good practice across the NHS. There are 1.5 million followers so far.
7.6	The redesign and refurbishment of the chapel and Muslim prayer facilities are due to be completed within the next six weeks.
7.7	Sir David Behan, the Chair of Health Education England, and chair of the group looking into technology and workforce with regard to the Long Term Plan, visited the Medical School recently and he spent time with Sir Anthony Seldon. He was very impressed with Medical School and keen to see how HEE can support the Medical School. He saw the Sim Suite and heard about developments within the nursing and AHP Workforce.
7.8	The Medical Director updated the Board on the surgical robot, informing them that this technology would significantly increase the number of procedures that could be performed laparoscopically. He indicated that a number of new products are about to emerge, and the Trust is interested in exploring their possibilities. There are 2 or 3 stablished surgeons within the hospital with interests in this area. A robot was brought into the Trust for demonstration purposes last week and 200 people came to see it. It was fascinating and well received. In answer to a question from Tony Nolan as to what the robot does, the Medical Director explained that the robot should expand the range of procedures that can be moved from open to minimal

	access and reduce length of stay. It is also possible that it would enable surgeons can carry on operating for longer. He acknowledged that at this stage quality improvement opportunities provided by these devices are difficult to measure but efforts would be made to do so.
7.9	Heidi Travis expressed her support for the embedding of technological development through teams and questioned how the bigger picture is being shared. The Chief Executive referenced the organisation's continued focus on eCare and getting people used to it. He made the point that the NHS normally seeks to overlay new technology onto existing processes, while the challenge going forward is to adapt to the use of invisible technology. This includes enabling individual parts of the organisation, such as maternity, to come forward with their own apps. John Clapham enquired as to how much of this innovation has come from staff, in response to which the Chief Executive indicated that eCare has provided the platform upon which staff are being encouraged to base their apps. The Trust is providing encouragement and support, and this fit this with its strategy.
7.10	Parmjit Dhanda reported that on his visit to the pharmacy department, they raised concerns about duplication. The need for a better link on stock control was acknowledged, but it was noted that this remains an issue for all Cerner trusts. The Medical Director added that Cerner now has a better understanding of the NHS.
7.11	Andrew Blakeman referred to his visit to the pathology lab, where staff had also raised concerns about Cerner, in relation to which he made the following recommendations: 1. There is a need for clarity about what is happening and how it all fits together. Thought should be given to the production of routine written reports on the programme; 2. The Trust needs to be strict on how it measures benefit realisation – some things are better and more cheaply done by hand.
7.12	On pathology, the Deputy Chief Executive referred to the need to work closely with Oxford.
7.13	In terms of governance, the Chief Executive made reference to the Health Informatics Programme Board which he chairs. HIPB reports to Management Board and its work is also overseen by the Finance and Investment Committee. It was agreed that regular programme updates would be made to the Finance and Investment Committee. The point was made that the Trust's overall objective is to treat patients safely and effectively. It is not a technology company, but has described operational and clinical processes that technology can support **Resolved**: The Board **noted** the Chief Executive's update
2019/03/08	**Patients Stories**

8.1	The Chief Nurse introduced the first of two patient stories. The first was on the journey that cancer services in the hospital had been on since 2013. Sally Burnie, Head of Cancer Services attended to give the presentation, and she was supported by members of the Milton Keynes Cancer Patients' Partnership.
8.2	Cancer services at the hospital had stagnated, and by 2012, the Trust had the 2nd worst service in the country according to the National Cancer Patient Survey. In order to make the necessary improvements, it was important that staff were able to understand what patients were feeling and thinking. The service needed patients to work alongside staff.
8.3	A number of objectives were agreed including: • Improving the patient experience. • There was a focus on enabling patients to access care closer to home. • The Trust had been bottom in terms of patients' access to trials – aligning with Oxford allowed this to improve significantly • There is much ongoing work with regard to diagnostics. • With a view to improving the environment, work started on developing the vision of a new Cancer Centre, which is now due to open in December 2019. • Radiotherapy – this is not located on site, and as such causes difficulty. The service has worked with a private company to open up provision five minutes' drive away and this covers 70% of patients.
8.4	There is an acknowledgement that not everything is fixed yet. MKCPP attend all meetings including with the CCG steering Group to make sure that the patients' voice is heard. The Trust is also involved in learning with Harrogate hospital. The 2018 survey results has provided some reward for all the hard work - of the 54 questions asked, in only 5 are the scores below the national average.
8.5	The 5 areas requiring improvement are: • Contact with specialist nurses – the Trust has worked with the Cancer Alliance to recruit patient navigators who will pick up calls. • Communications with medical staff – how can doctors communicate better? A 2 day advanced communication course has been provided. • Acute and community working- linked with McMillan – a member of Trust staff will move into the community. • Bigger environment – development of the Cancer Centre • Access to support – there will be a wellbeing centre at the front of the Cancer Centre.
8.6	MKCPP meets regularly with the service – they speak to patients feed messages back. Some of the issues raised can be dealt with quickly, such as wi-fi or dietary needs, while for others like environment and staffing, action plans were produced and updated to ensure that the messages are not lost.
8.7	Members of the group are from different backgrounds, and they are heavily involved across the hospital, including 15 steps visits and volunteering. They have produced a comprehensive Directory of Services (now on its 3rd printing), as well as a patient journal which enables patients to detail all aspects of their care and for the service to

	pick up areas that could be improved.
8.8	The Chief Nurse indicated that this is an opportunity for the Board to say thank you to MKCPP. They have set out an example that the Trust would wish to replicate. Parmjit Dhanda enquired whether the model could be highlighted to other hospitals as an example of good practice, and it was noted that the service is doing more with others through the Cancer Alliance.
8.9	Tony Nolan acknowledged that the service had been able to bring about tangible improvements in patient experience by listening to patients and acting on what they have said. The challenge would be to instil the same level of discipline and focus across the hospital. The Chief Executive remarked that improvements in patient experience have now been recorded in cancer services, A&E and maternity where there has been a focus. He acknowledged that there is more that can and should be done.
8.10	In response to a question from Andrew Blakeman about how vulnerable patients would be able to access this complicated range of cancer treatments, the point was made that the navigators are fundamental in such cases. Much work has been done with the Learning Disabilities team and it is known that there are links between dementia and cancer and people who are on their own. There are 2 dedicated colleagues who take on these complex patients.
8.11	On radiotherapy, the Chief Executive indicated that the Board had previously decided, rightly, to uncouple radiotherapy and the Cancer Centre. The uncertainty around the on-site development by Oxford has been and remains frustrating. It is hoped that the Thames Valley Cancer Alliance will be able to help.
8.12	The question was raised whether there is another service that could benefit from a similar transformation. While it was acknowledged that care close to home and super- specialist care are sometimes difficult to reconcile, through tenacity and hard work, a good sense of teamwork can be created. Stroke could be the next service to be focused on.
8.13	The second patient story was a short video clip about the High Intensity User Programme in the Thames Valley area. The film highlighted how colleagues from across the health and social care sector and beyond have worked together to better address the needs of a small minority of vulnerable patients who are responsible for a disproportionately high number of A&E attendances. The steps being taken to support these patients who often have, mental health and other complex issues, include the creation of individual care plans and innovative funding arrangements. **Resolved**: The Board **noted** the patient stories
2019/03/09	**Nursing staffing update**
9.1	The Chief Nurse presented this routine report on nursing staffing. She reported that last month a comprehensive assessment on the use of nursing associates had been carried out following new guidance from NHS England which the Trust is following. One of the Trust's nursing associate trainees has been shortlisted for Trainee of the

	Year by the Nursing Times. There is much excitement and he is being supported.
9.2	On recruitment, the last cohort from Philippines. Last cohort did their OSCEs on Friday – there was a 100% pass rate. They will be deployed on Monday, but they may need to go back to Philippines in the first instance. This last cohort contains 25 nurses out of 120 that had been interviewed. The Chief Nurse confirmed that there had been no difficulties thus far in obtaining visas for them.
9.3	Regarding fill rates, it was noted that ward 15 is the male respiratory ward on which dependency levels can spike. It was acknowledged that there are possibly things that could be done differently.
9.4	In response to a question from Helen Smart about the 12% vacancy for healthcare support workers, the Chief Executive made the point that the Trust is better than average in this regard. It was also noted in relation to fill rates from Healthcare Assistants that staff prefer to work night shifts, hence the disparity between day and night fill rates. The Chief Nurse also confirmed that there are no staffing problems on the Neonatal unit.
9.5	The Chief Executive noted that non-executive directors have observed on their ward visits how busy nurses are, and he asked how the Board can be assured that the hospital is safe. The Chief Nurse referred to outcome measures including falls and pressure ulcers. She also made reference to her quarterly performance meetings with the ward sisters – she always asks them if they have the right number of staff and relies on them to provide the necessary oversight. **Resolved**: The Board **noted** the nursing staffing update.
2019/03/10	**Performance Report Month 10**
10.1	The Deputy Chief Executive introduced the month 10 Performance Report. He noted the approaching year-end and enquired as to the changes and improvements that the Board would want to see next year.
10.2	With regard to the current report, he made the point that • the C Difficile spike is a normal winter occurrence. • VTE assessment – this is one of the early achievements of eCare, but the Board may wish to be assured that it is happening. • There are as yet no targets for E-Coli and MSSA. These can be set for next year.
10.3	The Chief Executive noted in relation to C-Difficile that 20 is already a stretch target agreed by Board (the Trust's national target is 39). The 2019/20 target would need to be understood and communicated to the Board.
10.4	The Medical Director stated that there had been a numerical cluster of pressure ulcers (6) in different parts of the hospital with no themes emerging. A piece of work to look into this has been commissioned. It is possible that some of them may be downgraded following investigation. There may be a case for taking the outcome of

	the Serious Incident Review Group's work to the Quality and Clinical Risk Committee. Parmjit Dhanda enquired whether eCare training could have caused issues. The Chief Nurse acknowledged that this could have been the case just after go live, but staff are now 9-10 months into using eCare now. Andrew Blakeman noted that there have been a number of conversations on pressure ulcers at QCRC, and he raised the question whether the Trust should have an aspiration to reach 0 as is the case at other hospitals. There was a discussion about this – the Chief Nurse indicated that she would try to report on both current pressure ulcers and the new national standards. She warned that this could mean that the Trust is rated amber/red over this transition period.
10.5	The Deputy Chief Executive acknowledged on patient experience that complaints are not being responded to as quickly as they should. With regard to cancelled operations, on the other hand, the Trust has done well, with most patients being re-booked within 28 days. This contrasts with the position at many other hospitals.
10.6	Andrew Blakeman indicated that it is not possible to assess seasonality on the SPC charts, and in response the Deputy Chief Executive agreed to see about adding in last year's figures.
10.7	The Director of Corporate Affairs informed the Board that the Trust is experiencing problems with its Friends and Family Test provider and that these are being dealt with contractually.
10.8	The Deputy Chief Executive stated that bed occupancy is currently high, but not as high as at the same time last year. The super-stranded patients' target is 91– which is higher than it has been. The Chief Executive indicated that he has asked the Director of Clinical Services to get into these metrics as part of her quality improvement work. The Medical Director is leading on length of stay. A detailed discussion on Quality Improvement will be held at QCRC in March. The Director of Clinical Services indicated that there is a large amount of quality improvement work going on. It would be important to ensure that all of it, including the smaller projects, are captured.
10.9	Helen Smart raised a question about re-admission rates within the Medicine division. In response, the Medical Director remarked that it is difficult to know what the optimum rate is. He was clear that he was unaware of any readmission related harm. There is nothing to suggest that there are any common issues at present.
10.10	The Trust's performance against the 4 hour ED target was 87% for January, while the national position was 84.4%. The Trust is at the bottom of the top quartile for this target. On RTT, the Trust's December performance was 88.9% (England 86%). As at this morning it was 90.6%. There are 14,200 open pathways (higher than target) due largely to an increase in referrals. There are no 52 week waiters for the first time in many months (there had been 20 previously). The Chief Executive raised the question whether the Trust is content to maintain a level of performance that is better than the national average or seek to deliver against aspirational targets. He noted the improvement in on RTT- the Trust was at 84% at the start of the year and is now at 90-91% with an aspiration to deliver the 92% constitutional target. The organisation supports this. The ED team is ambitious to deliver the 95% target, but if that is not possible, they still wish to remain within the top quartile. The team is

	dissatisfied with its current performance, but the Chief Nurse observed that the department has a better balance this year than it did last year.
10.11	The Deputy Chief Executive announced that the Trust has met the 62 day cancer target for quarter 3. January had not started well mainly as a result of patients choosing to postpone their treatments over Christmas.
10.12	The number of births seems to be falling, but the number of children has gone up by a third over the last 8 years. The patient 'Did Not Attend' rate has been going up for the past few months. It would be important to understand why and address this. The Director of Corporate Services indicated that the rate is currently tracking at 7%. A new Head of Patient Access is now in post and looking into this. She is also arranging training for the bookers and schedulers.
10.13	Parmjit Dhanda commended the changes to the narrative in the report and suggested a focus on the pathways at either end of care – working more with GPs and with rehabilitation services.
10.14	The Chief Executive stressed the importance of ensuring that targets are sufficiently stretching without causing alarm to the public. Heidi Travis articulated the Trust's ambition to become an outstanding acute hospital, and the targets agreed should help to achieve this. Andrew Blakeman agreed and suggested that conversations need to be held with staff as to what it would take to get there. The targets set must be demanding but credible. **Resolved**: The Board **noted** the Month 10 Performance Report.
2019/03/11	**Finance Update Report Month 10**
11.1	The Deputy Director of Finance presented the Month position and highlighted the following points: • The overall position is positive and the trust is on track to achieve its year-end target. • However, December coding in-month made it less positive • Agency spend continues to be below budget, and the final spend will be 10% lower than the ceiling if the current trend continues • £8m of savings have been achieved YTD. The Trust is close to the £10.1m target, with £9m identified • The Trust is on track to spend its entire capital allocation • The 900k improvement to the control total has been built into the forecast.
11.2	It was noted that next year's agency target will be £11.1m (down from £11.4m this year). This year the Trust, expenditure will be £10m, but 3 years ago agency spending was £21m. The question was raised as to what an aspirational agency target should look like. The Director of Workforce agreed to consider this in conjunction with the executive team. **Action: Director of Workforce** **Resolved**: The Board **noted** the Month 10 Finance Update Report.

2019/03/12	**Workforce Report**
12.1	The Director of Workforce presented this routine report and highlighted the following points: • The Trust's turnover rate has continued to fall, and MKUH now has the lowest turnover within the patch. • Agency usage is well managed and teams are making good use of the bank • Sickness has continued to come down, and remains under 4% • Statutory and mandatory training – the Trust is now 4th in the patch. • There has been a major turnaround in appraisal completion – this has gone up to 88%, and this month it is at 90-91% (un-validated)
12.2	The Medical Director made the point that meeting the flu vaccination target felt more comfortable this year. He asked that a more granular report around take up in the various parts of the hospital be produced. The Director of Workforce agreed to produce this. **Action: Director of Workforce**
12.3	It was noted that the hospital had received 150 to 200 flu type A cases covering a wide range of age groups. Some very sic younger patients have had to be transferred to specialist units, but the focus on ensuring that older people were vaccinated has borne fruit.
12.4	The Chief Executive raised a question about the Friends and Family Test in response to which the Director of Workforce indicated that this will be picked up at the Workforce and Development Assurance Committee. **Resolved**: The Board **noted** the Workforce report
2019/03/13	**Board Assurance Framework**
13.1	The Director of Corporate Affairs introduced the Board Assurance Framework, noting that there had not been much movement around the scores. There is to be a more detailed update on the potential impact of the UK's exit from the EU, and it was noted that the scoring around this risk could fluctuate as events unfold over the next few weeks. Parmjit Dhanda acknowledged that the mitigations to this risk are most likely outside of the Trust's control.
13.2	Helen Smart questioned whether the residual score of 16 around patient experience is correct considering all of the ongoing activity and progress that has been made. Tony Nolan made the point that there has always been a lot of activity, but he would only be comfortable with the risk rating being lowered when he sees evidence of improvement. There is to be a detailed conversation on this at the Quality and Clinical Risk Committee.
13.3	On the issue of action planning, the Director of Corporate Affairs indicated that at the April Board seminar the whole BAF will be reviewed and the Board would also be asked to consider its risk appetite. The Chairman indicated that one of the key questions to be considered in April is whether the BAF accurately reflects the

	Board's view as to the risks that could prevent the Trust achieving its objectives. The Chief Executive made reference to a conversation held at the recent Finance and Investment Committee meeting on the 2019/20 finance risks. These will be challenged over the next six weeks, but it was acknowledged that the CIP related risk will once again be scored highly.
13.4	With regard to risk 1-4, the Deputy Director of Finance made reference to the learning hub which had been put in place as part of the launch of the Trust's new intranet in February to help support learning across the organisation. **Resolved**: The Board **noted** the Board Assurance Framework update
2019/03/14	**7 day services – Board assurance report**
14.1	The Medical Director presented this report, asking the Board to note the Trust's performance, gaps against standards and work in progress, in relation to 7 day services. He reminded the Board that there are 4 priority and 6 other standards. The key standards are 2 and 8. These are aspirational standards for the time being, with the requirement that these and the other priority standards are met by April 2020.
14.2	The focus for now is on the Trust's actual performance and how good it is at documenting what is being done. The daily reviews that are taking place indicate a particular challenge around electronic capture. This is a work in progress. The Chief Executive informed the Board that £1m has been invested in senior medical cover out of hours to meet these requirements. **Resolved**: The Board **noted** the assurance report on the progress being made toward providing 7 day services
2019/03/15	**Any other business**
	There was no other business

	All					Action log – All items				
	Public/ Private	**Action item**	**Mtg date**	**Agenda item**		**Action**	**Owner**	**Due date**	**Status**	**Comments/Update**
Board of Directors	Public	362	11 Jan 2019	10.7	Nursing staffing report	The Chief Nurse agreed to carry out a baseline assessment for allied health professional staff	Nicky Burns-Muir	5 July 2019	Open	The Chief Nurse has met with the Head of Therapies, and has made contact with other local hospitals with a view to benchmarking the Trust's position
Board of Directors	Public	363	1 Mar 2019	11.2	Finance Update Month 10	The Director of Workforce is to consider, in conjunction with the rest of the executive team, what an aspirational agency target should look like	Danielle Petch	3 May 2019	Open	
Board of Directors	Public	364	1 Mar 2019	12.2	Workforce Report	A more granular report on the take up of the flu vaccine in the various parts of the hospital is to be produced	Danielle Petch	3 May 2019	Open	

Meeting title	Board of Directors		**Date:** 3 May 2019		
Report title:	Nursing Staffing Report		**Agenda item: 3.2**		
Lead director **Report author Sponsor(s)**	**Name:** Nicky Burns-Muir **Name:** Matthew Sandham		**Title:** Director of Patient Care/Chief Nurse **Title:** Associate Chief Nurse		
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 and 2

Board of Directors Report on Nursing and Midwifery staffing levels Amalgamated report for February 2019 and March 2019

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.

CHPPD = hours of care delivered by Nurses and HCSW
Numbers of patients on the Ward at midnight

CHPPD	Total Patient Numbers	Registered Midwives/Nurses	Care Staff	Overall
February	13305	4.9	3.2	8.1
March	15301	4.6	3.0	7.6

Hospital Monthly Average Fill Rates for February 2019 and March 2019

Month	RN/RM Day % Fill Rate	HCA/MCA Day % Fill Rate	RN/RM Night % Fill Rate	HCA/MCA Night % Fill Rate
February	83.1%	103.6%	95.2%	129.3%
March	83.8%	102.9%	96.4%	128.4%

A Ward breakdown of fill rates for February and March 2019 is included in Appendix 1.

The CHPPD hours decreased in March this was due to a higher total number of in- patients.

Areas with notable fill rates

Neonatal Unit had a high CHPPD due to low number of babies admitted in March.

3. Safer Staffing report

The Safer Care Nursing Tool (SCNT) is an evidence-based tool that enables nurses to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that nursing establishments reflect patient needs in acuity/dependency terms.
This is one method that can be used to assist Chief Nurses to determine optimal nurse staffing levels. The SCNT was used in all wards in 2018/19 and Ward 24 were included for the first time in September 2018. The SCNT has now developed a new tool for use in paediatrics and has been utilised on Ward 5 in September 2018 and this has now been re-run in February to enable us to gain an understanding of the acuity during the winter season. The SCNT was carried out over a 20 day period as recommended and this can now be used to inform the annual staffing review for paediatrics and the findings are laid out in the chart below.

Ward	Establishment	2018 SCNT	2019 SCNT	Difference	Comments
Ward 5	39WTE	44.3WTE	45.6WTE	-6.6wte	New tool

4. Recruitment

The Associate Chief Nurse and the newly appointed Head of Human Resources System and Compliance are currently reviewing a proposal for an overseas recruitment plan.
All divisions have rolling adverts out on the NHS job site and are in the process off agreeing open days for the next financial year 2019/20.

Qualified Staff Vacancies

Division	WTE vacancies now	% vacancy now	Post recruited to	Residual WTE vacancy	Residual % vacancy
Women's & Children	24.4wte	11%	3.68	20.72wte	10%
Medicine	68.62wte	17.8%	17.5wte	51.1 wte	15%
Surgery	33.84wte	14%	11.8wte	22.04wte	11%

Total vacancy rate for qualified nurses' including new staff in post approx. **14.5%**

HealthCare Assistant Vacancies

Division	WTE vacancies now	% vacancy now	Post recruited to	Residual WTE vacancy	Residual % vacancy
Women's & Children	8wte	6%	2.14wte	5.86wte	5%
Medicine	25wte	15.7%	10wte	15wte	6%
Surgery	18wte	15%		18wte	13%

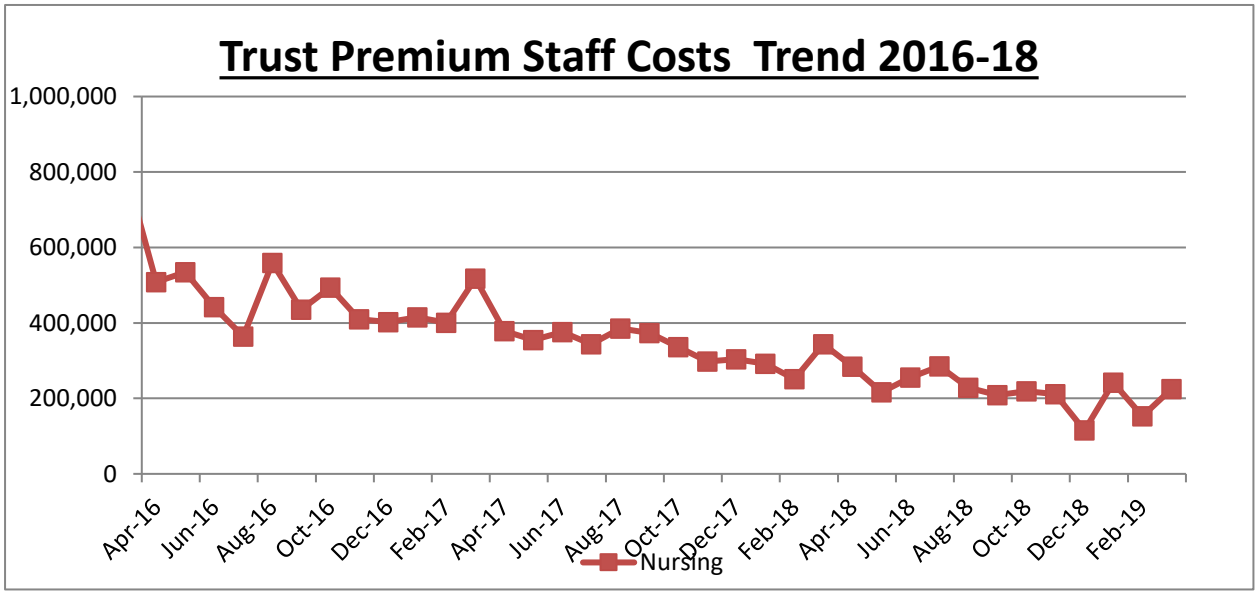
Total Trust vacancy rate for HCA's including new staff in post approx. **9%**

Please note that these figures are dynamic and so are changing on a daily basis – and recruited to posts will still be subject to leavers. The vacancies need to be validated against vacancies recorded on Electronic Staff Record (ESR) to ensure factual accuracy.

Within these figures the areas with the highest vacancy factor are – Wards 3, 15, 16 and 20. These wards will be monitored and supported by the Heads of Nursing.

5. Controlling Premium Cost

Agency nursing expenditure continues to stabilise with a small peak in March due to staff using their remaining annual leave for the financial year. This was an improvement on March 2018 and will continue to form part of our staff rota reviews.



6. Therapies update

The Therapy and Dietetic department has made a significant amount of progress in the last year appointing Dietetic Therapy Lead and establishing leads for our Inpatient and Outpatients teams following a restructure and staff consultation. This structure promotes the integration of Occupational Therapy (OT) and Physiotherapy (PT) teams through the alignment of team meetings and common working practices. In addition to this the therapy department has appointed key roles to lead its admin team to ensure that outpatient's teams are supported to optimise patient income and patient experience.

We have successfully recruited to a number of Band 5 posts who should start in June 2019 once they are registered. We are working collaboratively with Bedfordshire University to receive their first intake of OT and PT students. We are also exploring options for an Apprenticeship Physiotherapy for our assistant staff with Coventry University.

This year we are focussing on creating a clear vision and workforce strategy for Therapies in line with Trust values and strategy. This will focus on a number of key areas outlined below:-

- Development of the 'Front Door Coordinator post in ED
- Leadership training for all Band 6/7 staff
- Review of Inpatient structure and staffing requirements – reduction in Length of Stay (LOS)
- Paediatric Dietetic provision – currently in negotiation with CCG
- All clinical staff to have job plans by 2020
- To implement Health roster by 2020

Appendix 1

Fill rates for Nursing, Midwifery and Care Staff February 2019

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	77.3%	134.0%	101.0%	150.2%	675	5.6	3.1	8.7
MAU 2	93.6%	107.0%	101.2%	144.7%	759	3.5	2.9	6.4
Phoenix Unit	81.2%	92.3%	98.8%	116.0%	659	3.1	3.1	6.2
Ward 15	83.1%	151.3%	100.0%	187.5%	796	3.4	3.8	7.3
Ward 16	86.2%	88.4%	96.4%	110.7%	812	3.5	2.2	5.7
Ward 17	78.3%	105.8%	99.1%	115.9%	705	4.2	2.3	6.5
Ward 18	85.2%	115.4%	100.0%	153.4%	752	3.1	4.4	7.6
Ward 19	78.8%	101.8%	97.6%	139.3%	784	3.0	3.8	6.8
Ward 20	82.4%	141.6%	105.7%	143.9%	700	4.0	3.6	7.6
Ward 21	81.4%	96.9%	105.0%	114.3%	695	3.7	2.2	5.9
Ward 22	84.4%	85.7%	100.3%	100.0%	574	4.3	2.3	6.7
Ward 23	88.4%	103.5%	100.9%	123.5%	1023	3.8	4.1	7.9
Ward 24	86.6%	80.3%	96.4%	-	469	4.4	0.8	5.2
Ward 3	81.4%	91.4%	100.0%	114.1%	783	3.2	3.3	6.5
Ward 5	82.4%	125.8%	103.1%	160.8%	543	6.3	2.5	8.8
Ward 7	79.8%	98.2%	101.2%	135.6%	667	3.7	4.3	8.0
Ward 8	77.7%	102.7%	100.0%	123.2%	690	3.4	3.0	6.4
DOCC	91.7%	90.0%	92.9%	-	198	25.3	1.6	26.8
Labour Ward								
Ward 9	79.0%	100.0%	88.9%	100.0%	600	4.2	1.2	5.4
Ward 10	97.3%	71.4%	101.9%	-	268	5.2	2.2	7.4
NNU	49.4%	41.6%	47.3%	44.2%	153	11.4	1.9	13.3

Appendix 1

Fill rates for Nursing, Midwifery and Care Staff March 2019

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	84.0%	153.0%	97.8%	156.4%	702	5.5	3.5	9.0
MAU 2	94.7%	120.9%	106.6%	166.3%	823	3.6	3.4	7.0
Phoenix Unit	84.2%	91.3%	100.6%	125.8%	739	3.1	3.2	6.3
Ward 15	84.0%	127.6%	98.8%	177.9%	879	3.5	3.4	6.8
Ward 16	80.9%	119.8%	97.5%	161.1%	885	3.4	3.1	6.5
Ward 17	79.3%	72.7%	100.0%	117.7%	760	4.3	1.9	6.3
Ward 18	89.1%	101.4%	102.0%	130.1%	857	3.3	3.7	7.0
Ward 19	76.3%	107.9%	100.0%	154.3%	905	2.9	3.9	6.8
Ward 20	84.0%	116.6%	104.9%	120.3%	801	3.9	2.9	6.8
Ward 21	80.5%	113.8%	103.3%	141.8%	752	3.7	2.7	6.4
Ward 22	87.7%	101.5%	100.0%	114.5%	653	4.3	2.6	6.9
Ward 23	84.5%	96.7%	100.0%	104.4%	1120	3.6	3.6	7.2
Ward 24	88.2%	98.9%	95.7%	-	514	4.5	1.1	5.7
Ward 3	86.9%	95.1%	100.0%	119.4%	861	3.2	3.5	6.7
Ward 5	88.3%	102.0%	119.7%	177.4%	619	6.7	1.8	8.5
Ward 7	82.3%	94.7%	102.2%	120.4%	751	3.5	4.0	7.5
Ward 8	73.7%	93.2%	100.0%	112.9%	766	3.2	2.7	5.9
DOCC	86.6%	59.5%	87.1%	-	185	24.8	1.1	26.0
Labour Ward								
Ward 9	64.6%	133.8%	70.5%	77.4%	1248	1.7	0.5	2.2
Ward 10	73.4%	62.9%	64.5%	-	294	3.8	1.8	5.6
NNU	74.6%	90.0%	73.4%	54.8%	187	15.4	3.1	18.6

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Board of Directors	Date: 3 May 2019
Report title:	CNST Incentive Scheme Action Plan and Position Statement	Agenda item: 3.3
Lead director Report author	Name: Ian Reckless Name: Jean Aldous	Title: Medical Director Title: General Manager, Women's and Children's
FoI status:		

Report summary	The Trust was successful in benefitting from NHS Resolution's CNST maternity incentive scheme in 2018/19 which was the first year of the scheme. The scheme is now in its second year. As in year one, trusts are required to demonstrate that they have achieved all of the ten safety actions in order to benefits from the scheme. One of the requirements for year 2, under maternity safety action 3 is for the Trust to demonstrate that it has Transitional Care Services to support the Avoiding Term Admissions into neonatal Units (ATAIN) programme. To demonstrate this, it is required that boards agree an action plan to address local findings from ATAIN, and that progress against this plan has been shared with the Board. The action plan is attached.						
Purpose *(tick one box only)*	**Information**	x	**Approval**	x	**To note**	x	**Decision** x
Recommendation	The Board is asked to agree the action plan and note the progress that has already been made						

Strategic objectives links	Objective 1: Improve patient safety Objective 2: improve patient experience
Board Assurance Framework links	
CQC regulations	Regulation 12
Identified risks and risk management actions	
Resource implications	
Legal implications including equality and diversity assessment	

Report history	

Next steps	The full incentive scheme self-assessment will be presented for Board sign-off at the July meeting
Appendices	Appendix 1: Maternity incentive scheme – year two

Reducing Harm Leading to avoidable admission of full term babies into the neonatal unit

This Action plan has captured all those items identified in the survey results that have been specifically flagged by all reviews as requiring attention

Theme	Action Required	Owner(s)	Current Progress (Narrative)	Completion Date	Sources of Evidence	Assurance Board	RAG Rating
Joint Policies/Guidelines	Set up a Joint Maternity and Neonatal Liaison Group . - Review of joint Maternity / Neonatal guidelines - Standing agenda item to review of all term admissions to the neonatal unit and discuss appropriateness of each admission - All avoidable admissions are subject to datix and review.	Julie Cooper Kate Swailes Denise Campbell/Kirsty Felce	Monthly Multi-Disciplinary team meetings List of joint guidelines disseminated to Multi-Disciplinary team.	Ongoing July 2017	Minutes of meetings List of guidelines/Policies		
	Hypoglycaemia	Ross McFadden	Up dated Guideline with New national guidance. Reviewed and completed.	October 2017	Guideline uploaded onto SharePoint		
	Jaundice management of Neonate	Dr Z Gawlowski	Consultation with a Patient information Leaflet. completed	October 2018	Guideline Uploaded onto SharePoint and PIL uploaded onto SharePoint		
	Neonatal Resuscitation	Dr Z Gawlowski	Resus Council algorithm incorporated into Neonatal Resuscitation guideline..	November 2017	New guidance disseminated during PTTW NLS session and new algorithm sent to all staff attached to payslips		
	Newborn feeding Policy. Review date 05/2020	Ross McFadden	Currently in date on SharePoint		Accessible on SharePoint		
	Admission to the Neonatal Unit Guideline. Review date 11/2020	Karen Rice and C. Swailes	Currently available on SharePoint		Accessible on SharePoint		
Hypothermia	Optimum thermal environments	Lydia Stratton- Fry.	Uninterrupted Skin to Skin following all births to optimise birth temperature in recovery Joint working with theatres and recovery to establish policy an process for non separation of mother and baby.	December 2017	Message of the week. Labour ward handover.		
			Implementation of room thermometers in all rooms on Labour Ward.	December 2017	Labour ward forum.		

Theme	Action Required	Owner(s)	Current Progress (Narrative)	Completion Date	Sources of Evidence	Assurance Board	RAG Rating
			Transfer all babies to recovery in skin to skin were this is not appropriate a hot cot can be used.	December 2017			
			All babies to transfer to the postnatal ward in clean, dry towel and wearing a hat when transferring skin to skin with mother or fully dressed if transferring in a cot.	December 2017			
Saving babies lives	NHS England publication of Saving Babies Lives care bundle, designed to tackle stillbirth and early neonatal death. It brings together four elements of care that are recognised as evidence based or best practice: 1) Reduced smoking in pregnancy 2) Risk assessment and surveillance for fetal growth restriction 3) Raising awareness of reduced fetal movements 4) Effective fetal monitoring during labour	Angela Weatherley	Fetal Growth Assessment guideline. Review date: 05/2019 Fetal Monitoring Guideline. Review date: 02/2020 Reduced Fetal Movement Guideline. Review date: 07/2019 New Antenatal Care pathway. SOP Obesity in Pregnancy Guideline. Review date: 03/2019	August 2017 Ongoing Ongoing Ongoing Ongoing	Access Guidelines on SharePoint. New Telephone triage form. Staff training in GAP/GROW – compliance monitored monthly Perinatal institute study days Fresh ears and fresh eyes implemented – All maternity and Obstetric staff must undertake yearly completion of K2. Compliance checked on a monthly basis. Fresh ears and fresh eyes reported on Nursing Metrics on Labour Ward monthly. All women are offered carbon monoxide testing. Opt out referral for smoking cessation services. All women given information about reduced fetal movements. Women are risk assessed against the SBL algorithm and referred to		

Theme	Action Required	Owner(s)	Current Progress (Narrative)	Completion Date	Sources of Evidence	Assurance Board	RAG Rating
					appropriate care. All women identified at risk of SGA referred for serial growth scans in pregnancy. All babies identified as being as SGA at birth to commence Hypo Pathway. Saving babies lives information leaflet produced for staff awareness 3 hour SBL workshop incorporated into PTTW Ultrasound staff have completed Doppler training		
Maternity Improvement Board	To monitor and reduced Perinatal Mortality and Morbidity	Triumvirate members	Quarterly meetings with executive team, CCG, CQC and NHSI to monitor progress. Current Mortality rate (07/2017) = 3.8 per 1000 births compared to 7.8 per 1000 births in 2013/2014	Ongoing. Since mid 2018 this meeting no longer takes place.	Quarterly minutes of meetings and agreed action plans.		
Hypoglycaemia	Recognition, escalation and timely management	Joint Neonates and Maternity	Guidance with in Newborn feeding policy re reluctant feeder pathway to include observation and Blood sugars. With clear escalation to Paediatricians when outside normal parameters NHS Improvement Audit: Reducing harm leading to avoidable admission of full-term babies into neonatal units	Ongoing	Uninterrupted Skin to Skin following all births to optimise birth temperature. Infant Feeding Leads report statistics Newborn Feeding policy offers clear pathways for feeding. Protecting your baby from low blood glucose Patient Information leaflet now available on SharePoint Hypoglycaemia of the newborn (Postnatal ward identification and management) guideline now on sharePoint All staff to attend PTTW which includes BFI BFI 2 day training for all new staff BFI 1 day refresher course for all staff.		
Respiratory Distress Syndrome (RDS)	Recognition, escalation and timely management	Joint neonates and maternity	Antenatal corticosteroids to reduce neonatal morbidity Guideline under review	December 2017	All babies delivered by elective C/S before 39/40 are to have Steroids to aid lung maturation		

Theme	Action Required	Owner(s)	Current Progress (Narrative)	Completion Date	Sources of Evidence	Assurance Board	RAG Rating
				September 2019	Neonatal Study day to be set up		
					A full set of postnatal observations performed on baby and escalated as appropriate.		
			NHS Improvement Audit: Reducing harm leading to avoidable admission of full-term babies into neonatal units	October 2019	Audit of the number of term admissions to NNU, to include hospital numbers, gestation, date, time and mode of delivery. Level of intervention an length of stay. Assessing whether the level of intervention warranted the separation of mother and baby.		
Jaundice	Recognition, escalation and timely management	Joint neonates and maternity	Jaundice Guideline completed	Ongoing	Guideline uploaded onto SharePoint		
			Patient Information Leaflet developed	July 2017	PIL uploaded onto SharePoint		
			Transcutaneous Bilirubinometers (TCB) SOP developed	January 2019	SOP uploaded onto SharePoint		
			Implementation of TCB into Community to aid early recognition of the neonate needing further management.	January 2019	SOP uploaded onto SharePoint and training records		
Sepsis	Recognition, escalation and timely management	Joint neonates and Maternity	Pre labour Rupture of membranes at term To enable staff to care for women with pre labour rupture of membranes at term and prevention of early onset neonatal group b streptococcal infection, in line with national guidance	Ongoing	Guideline currently under review		

Maternity incentive scheme – year two

Conditions of the scheme

Ten maternity safety actions with technical guidance

Questions and answers related to the scheme

Contents

Safety action 3: Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?

Required standard	a) Pathways of care for admission into and out of transitional care have been jointly approved by maternity and neonatal teams with neonatal involvement in decision making and planning care for all babies in transitional care. b) A data recording process for transitional care is established, in order to produce commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2. c) An action plan has been agreed at Board level and with your Local Maternity Systems (LMS) and Operational Delivery Network (ODN) to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews. d) Progress with the agreed action plans has been shared with your Board and your LMS & ODN
Minimum evidential requirement for trust Board	Local policy available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: 1. There is evidence of neonatal involvement in care planning 2. Admission criteria meets a minimum of HRG XA04 but could extend beyond to BAPM transitional care framework for practice 3. There is an explicit staffing model 4. The policy is signed by maternity/neonatal clinical leads Data is available (electronic or paper based) on transitional care activity which has been recorded as per XA04 2016 NCCMDS. An audit trail providing evidence and a rationale for developing the agreed action plan to address local findings from ATAIN reviews. Evidence of an action plan to address identified and modifiable factors for admission to transitional care. Action plan has been signed off by trust Board, ODN and LMS and progress with action plan is documented within minutes of meetings at Board ODN/LMS.

Validation process	Self-certification by the trust Board and submitted to NHS Resolution using the Board declaration form
What is the relevant time period?	a) By Sunday 3 February 2019 b) By Sunday 3 February 2019 c) By Sunday10 March 2019 d) By Sunday 19 May 2019
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon.

Technical guidance for Safety action 3
Can you demonstrate that you have transitional care facilities in place and are operational to support the implementation of the ATAIN Programme?

Technical guidance	
Where can we find guidance regarding this safety action?	Helpful guidance can be found at the following websites: www.bapm.org/sites/default/files/files/TC%20Framework-20.10.17.pdf www.bapm.org/sites/default/files/files/NCCMDS.%20Neonatal%20HRGs%20and%20Reference%20Costs%20-%20A%20Guide%20for%20Clinicians%20Dec%202016.pdf
What is the suggested time period for transitional care pathways?	We would expect that all trusts should at least have pathways agreed by 31 January 2019.
What is the definition of transitional care?	Transitional care is not a place but a service and can be delivered either in a separate transitional care area, within the neonatal unit and/or in the postnatal ward setting. Principles include the need for a multidisciplinary approach between maternity and neonatal teams; an appropriately skilled and trained workforce, data collection with regards to activity, appropriate admissions as per HRGXA04 criteria and a link to community services.

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Trust Board**	**Date: 3 May 2019**
Report title:	**Mortality update report**	**Agenda item: 3.4**
Lead director **Report author** **Sponsor(s)**	**Dr Ian Reckless** **Dr Bina Parmar**	**Medical Director** **Associate Medical Director**
FoI status:	**Publically disclosable**	

Report summary				
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** X	**Decision** ☐
Recommendation				

Strategic objectives links	Improve patient safety
Board Assurance Framework links	Risk register ID reference 616
CQC outcome/ regulation links	Trust objective – patient safety **This report relates to CQC:** **Regulation 12 – Safe care & treatment** **Regulation 17 – Good governance**
Identified risks and risk management actions	Mortality data outside the expected range would be of public & regulatory body concern
Resource implications	None
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	Regular update
Appendices	N/A

Executive Summary

This paper summarises the Trust's current position in relation to mortality based on the latest Dr Foster data available and as discussed through the Trust's mortality and morbidity (M&M) meeting framework.

The Trust's current HSMR and SHMI are both statistically 'as expected'. Dr Foster, when analysing the Trust's data, previously identified an HSMR negative outlying diagnostic group of 'other perinatal conditions'. This continued to 'alert' (for statistical significance) for some months. This alert has now ceased but it should be noted (as a 12 month rolling dataset) that this may well reappear. One new HSMR negative outlier has emerged, at diagnosis level: fractured neck of femur. This follows a cluster of five deaths in November 2018 which contribute to the latest HSMR figures. Initial examination suggests no obvious cause for concern in relation to these deaths, although they await an in-depth review via established M&M processes. As for 'other perinatal deaths', given modest overall patient numbers, it is likely that this alert (based on 12 month rolling data) may now present itself from time to time over the next few months.

The Trust continues to implement National Quality Board guidance regarding Learning from Deaths. This includes quarterly publishing of qualitiative and quantative data on deaths at Trust Public Board meetings. The Trust has trained more than 20 multidisciplinary Trust staff members in the use of Royal College of Physicians (RCP) methodology for Structured Judgement Review (SJR) case note review. Changes have been made to the structure and running of Trust Mortality and Morbidity meetings to incorporate the new methodology. Changes to the Trust Mortality – Learning from Deaths policy have been made in line with regional classification terminology and classification of deaths.

A national network of medical examiners was recommended by the Shipman, Mid-Staffordshire and Morecambe Bay public inquiries. The Government has supported an initiative to have a national system of medical examiners be introduced from April 2019. Introducing Medical Examiners is a vital step in the drive to improve patient safety in the NHS. Medical Examiner pilot schemes have provided reassurance to the next of kin, identified problems with care at an early stage, ensured the right referrals to the coroner, improved accuracy of death certification and this did lead to a reduction in cases of litigation against the Trust. The Trust advertised for and appointed 8 Medical Examiners. The national meetings have encouraged that the coroner be involved and Mr Osborne accepted an invitation to be on the Interview panel. The start date for implementation will be the May 2019.

Definitions

Out of hours – Nights/weekends and bank holidays

Case mix – Type or mix of patients treated by a hospital

Morbidity – Refers to the disease state of an individual or incidence of ill health

Crude mortality – A hospital's crude mortality rate looks at the number of deaths that occur in a hospital in any given year and then compares that against the amount of people admitted for care in that hospital for the same time period. The crude mortality rate can then be set as the number of deaths for every 100 patients admitted

SMR - Standardised Mortality Rate (HSMR). A ratio of all observed deaths to expected deaths.

HSMR – Hospital Standardised Mortality Rate (HSMR). This measure only includes deaths within hospital for a restricted group of 56 diagnostic groups with high numbers of national admissions; it takes no account of the death of patients discharged to hospice care or to die at home. The HSMR algorithm involves adjustments being made to crude mortality rates in order to recognise different levels of comorbidity and ill-health for patients cared by similar hospitals.

SHMI – Summary Hospital-level Mortality Indicator (SHMI). SHMI indicates the ratio between the actual number of patients who die following treatment at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated. It includes deaths which occur in hospital and deaths which occur outside of hospital within 30 days (inclusive) of discharge.

Relative Risk – Measures the actual number of deaths against the expected number deaths. Both the SHMI and the HSMR use the ratio of actual deaths to an expected number of deaths as their statistic. HSMR multiplies the Relative Risk by 100.

- A HSMR above 100 = There are more deaths than expected
- A HSMR below 100 = There are less deaths than expected

Dr Foster

Third-party tools used to report the relative position of Milton Keynes University Hospital NHS Foundation Trust (MKUH) on national published mortality statistics. The trust recently renewed its relationship with Dr Foster Intelligence - therefore some of the graphs may look different.

HSMR

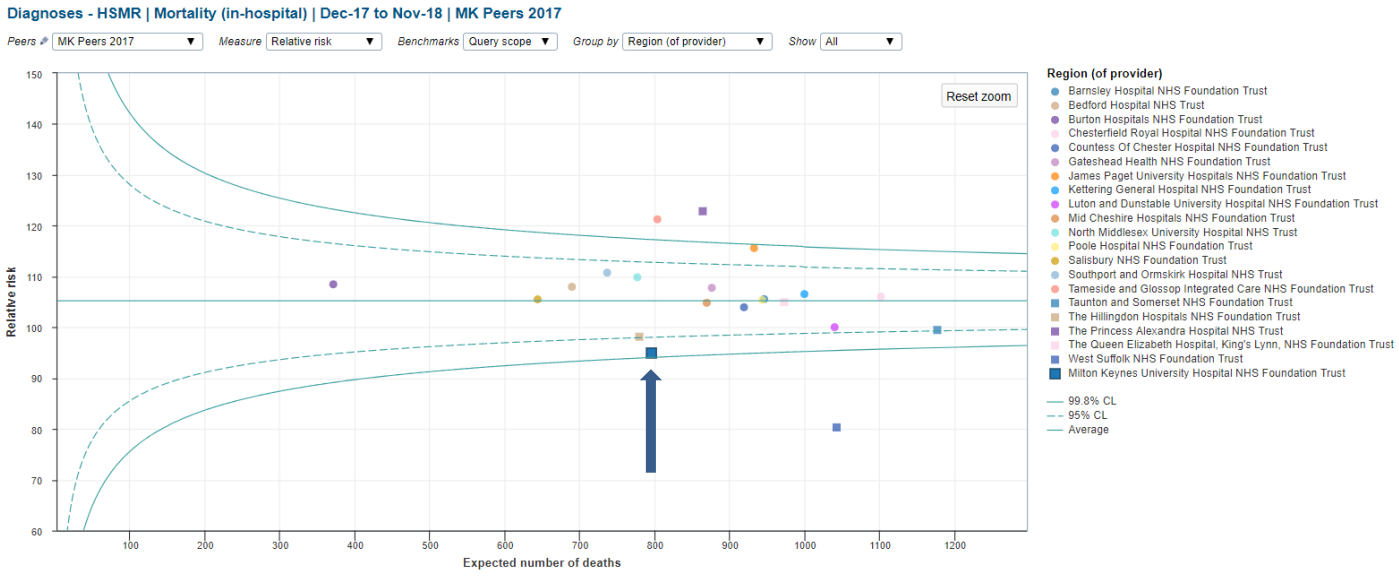
Data period: January 2018 to December 2018

Key Highlights:

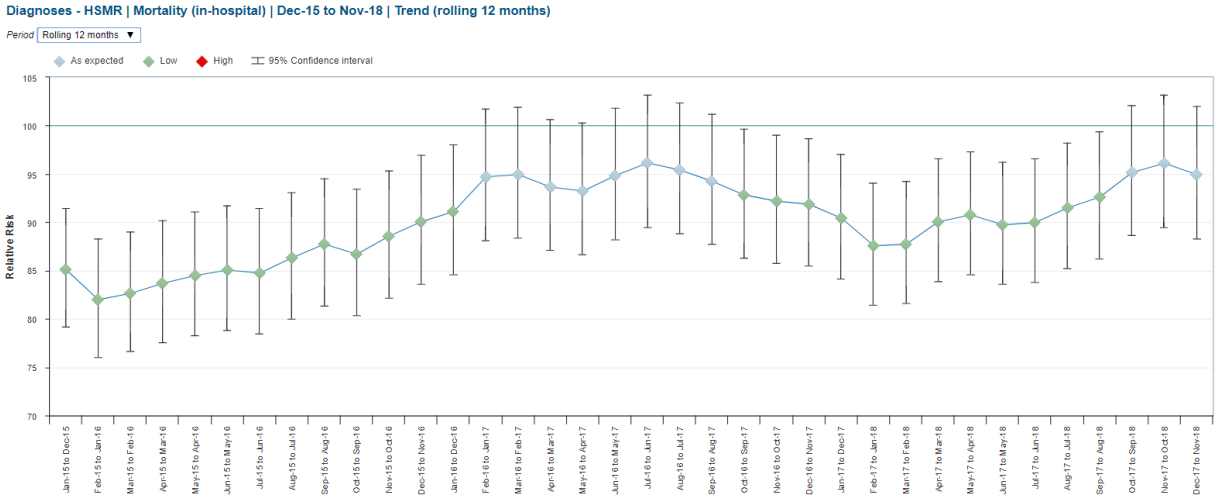
- HSMR relative risk for 12 month period = 94.9 ‘as expected’ range
- The Trust has moved to the ‘as expected’ banding from ‘lower than expected’ since the last report.
- The move in banding is noted and a watching brief will be kept. It is unlikely that this change is significant in terms of care quality: it is noted that the palliative care coding rate has fallen a little, and also that the input data now includes 5 months of coded data derived largely from electronic patient records which may have had some impact upon coding depth and other aspects.
- Crude mortality rate within HSMR basket = **3.2%** (MKUH local acute peer group rate = 3.9%)
- 1 outlier was identified within the HSMR basket for this period. Fracture neck of femur.

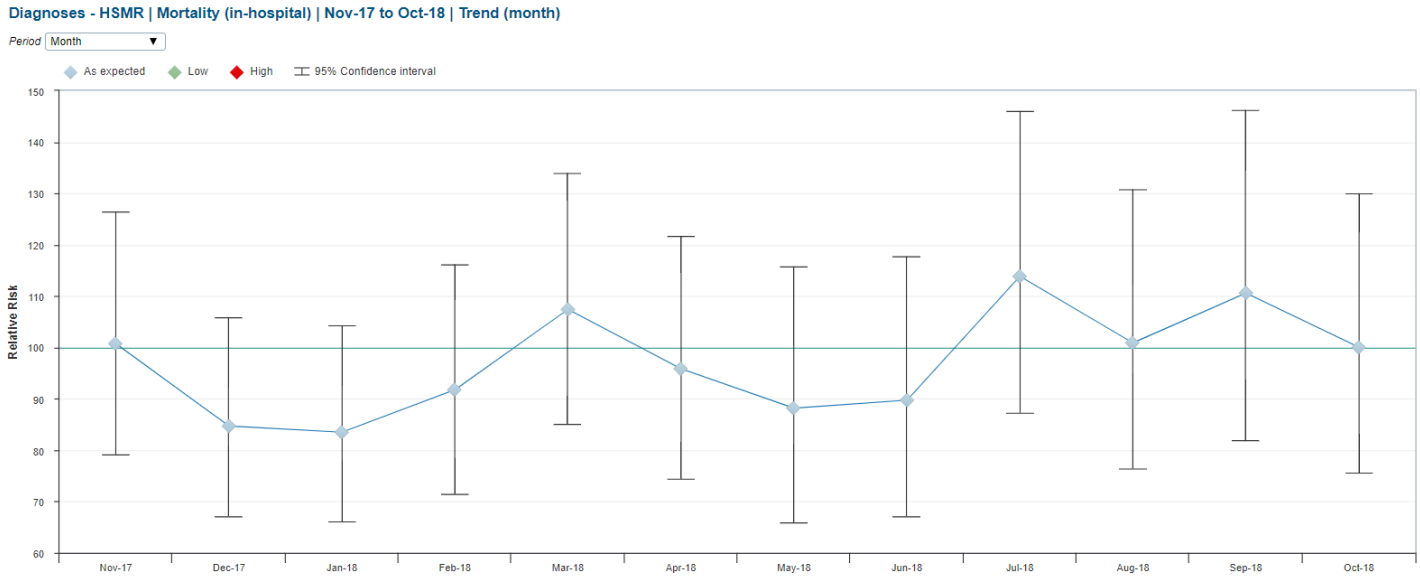
The Trust currently ranks 1st (best) against its MKUH peer group

HSMR Funnel Plot – Trust vs. MKUH peer group (Dec 2017 to Nov 2018)



Trust level HSMR monthly performance trend (Rolling 12 months) last 36 months

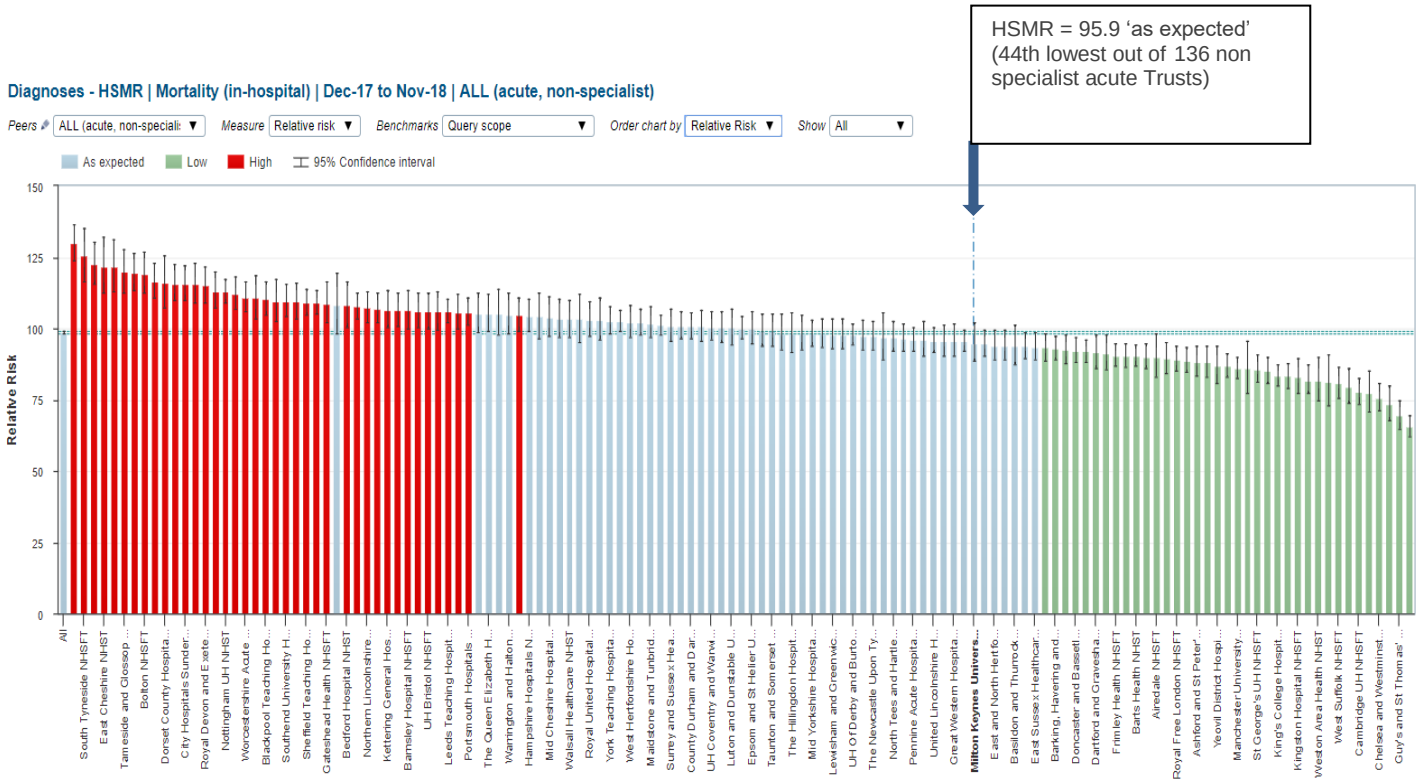




1 month lag applied to data so 12 month period Nov 17 to Oct 18.
HSMR = 95.9 'as expected'

HSMR position vs. national acute peers: December 2017 – November 2018

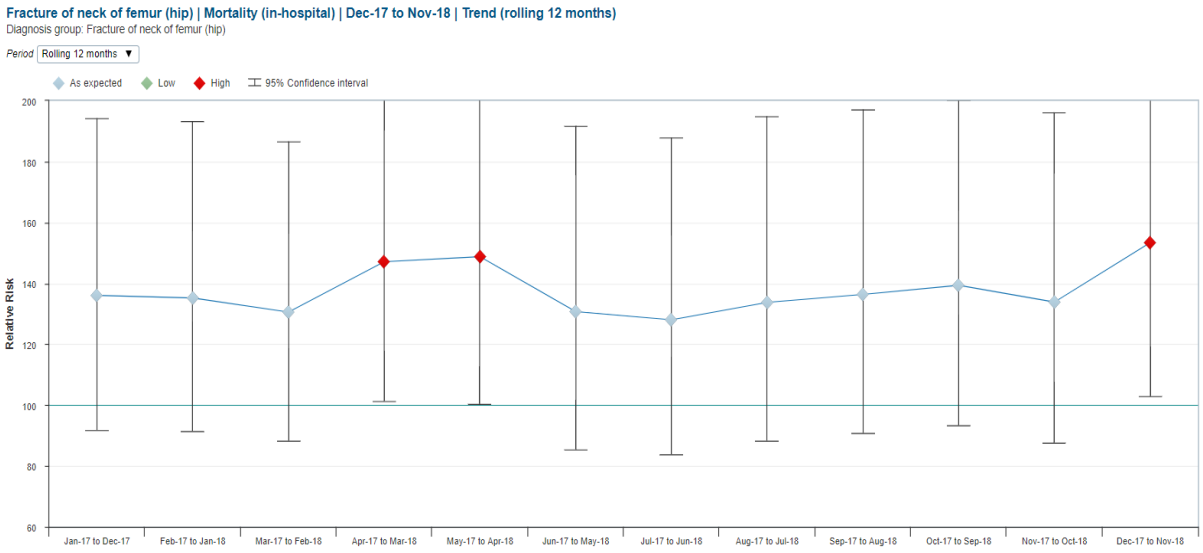
HSMR relative risk = 95.9% 'as expected' (44th lowest out of 136 non-specialist acute). 1st lowest ranking indicates the trust with the lowest (best) HSMR relative risk.



HSMR by diagnosis group:

<u>HSMR basket 'Fracture of neck of femur' – alerting in this report</u>

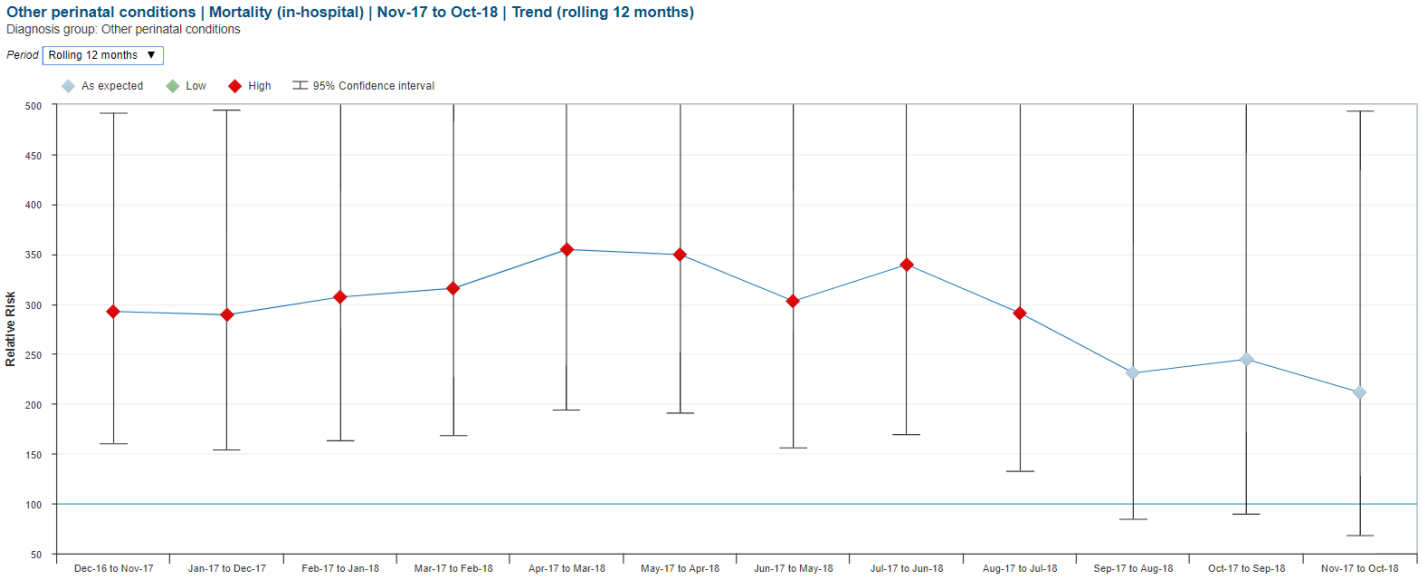
There have been 29 deaths over the last 12 months. The latest month of Nov 18 has attracted 5 deaths, which is notably higher than previous months.



HSMR by diagnosis group:

<u>HSMR basket 'Other perinatal conditions' – no longer alerting in this report</u>

This HSMR diagnostic group alerted as being a negative outlier in the March 2018 Dr Foster report that covered the period December 2016 to November 2017 and had alerted in subsequent monthly reports. This alert has been discussed at the Mortality Review Groups held in April, May, June and July. The Trust's response to the alert was outlined in the Quality and Clinical Risk Committee Board paper in September 2018. It is important to note that 'other perinatal conditions' is a non-specific diagnostic basket, and other perinatal diagnostic groups have not attracted adverse flags at MKUH.



An action from the November 2018 Mortality Review Group was to put together a working group to review any negative effect that inaccurate or imprecise coding or documentation may be having on the HSMR basket for 'other perinatal conditions'. A specific concern was that babies receiving antibiotics at birth but not subsequently demonstrated to have bacterial infection through microbiological cultures may well be termed 'well baby', whilst at other providers, the same infant might form part of the denominator for 'other perinatal conditions'.

Divisional HSMR performance for rolling year (December 2017 – November 2018)

Divisional HSMR relative risk (RR) scores have been developed by attributing deaths in the Dr Foster basket of 56 diagnostic groups to the most appropriate division. A significant caveat must be provided when the data are dis-aggregated in this way. This is intended for information / screening purposes only, rather than purporting to provide any significant assurance in any direction.

Medical Division RR = 94.0 'as expected'. There were 0 outlying diagnosis groups (significantly higher than expected deaths).

Surgical Division RR = 105.1 'as expected'. There were 1 negative outlying diagnosis group 'Fracture Neck of Femur '.

Women's and Children's Division RR = 76.1 'as expected'. There were 0 outlying diagnosis groups.

SHMI

Data period: Oct 2017 – Sep 2018 (most up to date data available)

The Summary Hospital-level Mortality Indicator (SHMI), which includes out of hospital deaths occurring within 30 days of discharge, is measured by the Health and Social Care Information Centre (HSCIC). The SHMI relative risk is the ratio between the actual number of patients who die following treatment at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated. A SHMI score below 1.00 is better than average.

Key Highlights:

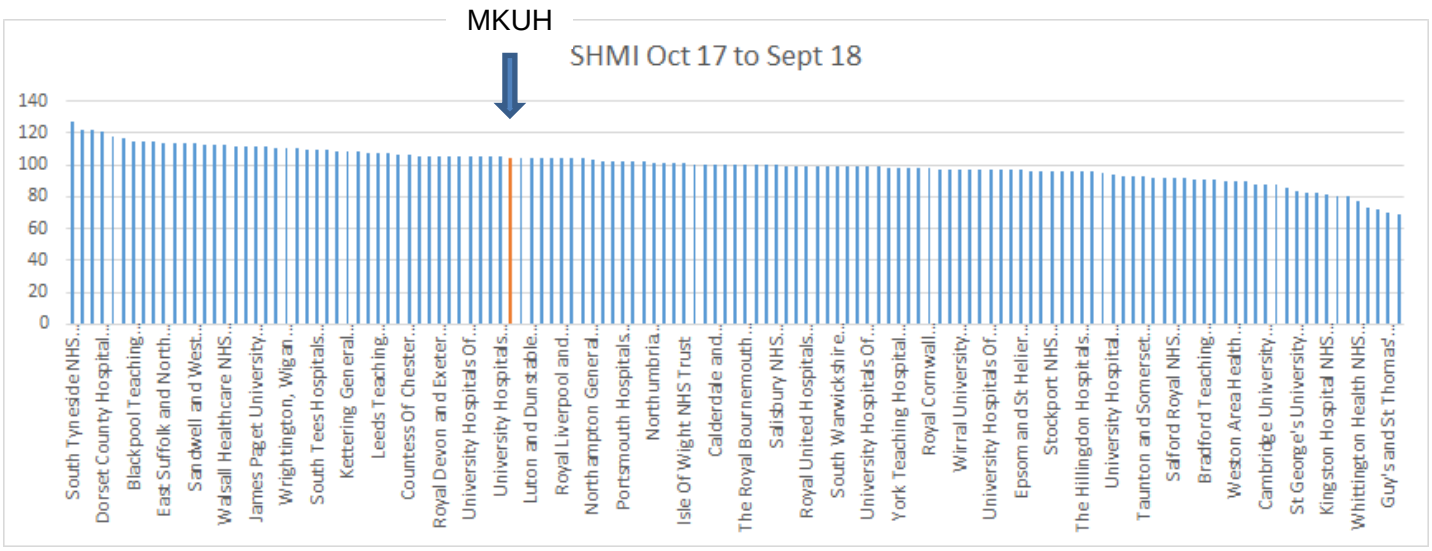
A SHMI score below 1.00 is better than average.

The latest SHMI published by HSCIC for the rolling 12 months to September 2018 is 104.66, falling in the 'as expected' range.

The Trust ranked 88th in SHMI performers among the 133 non-specialist acute trusts in England (ranking 1 = lowest or 'best' SHMI) on 12 month data to September 2018.

SHMI position vs. national acute peers: October 2017 – September 2018

MKUH position 88 out 133 (Acute non-specialist) Trusts

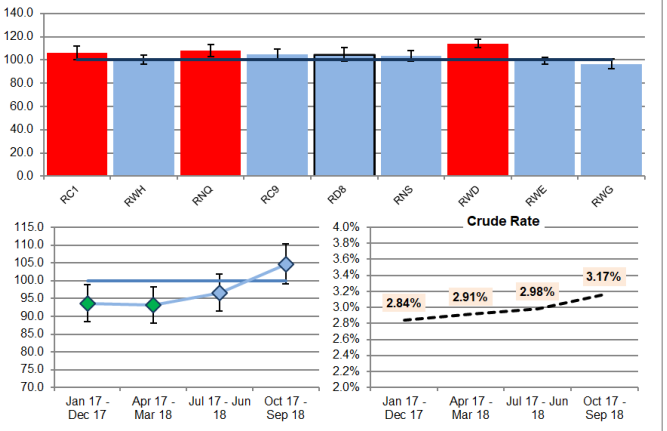


Comparison with peer Trusts

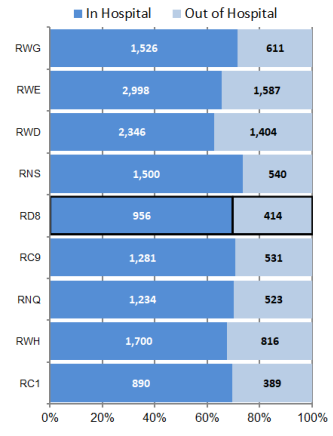
SHMI - Published (With Over Dispersion): (Oct 17 - Sep 18)

	Provider	Denominator	Obs	Exp	Obs-Exp	SHMI	Low	High
RC1	Bedford Hospital NHS Trust	36,234	1,279	1,209	70	105.78	88.48	113.01
RWH	East And North Hertfordshire NHS Trust	66,169	2,516	2,519	-3	99.90	89.10	112.23
RNQ	Kettering General Hospital NHS Foundation Trust	51,499	1,757	1,625	132	108.12	88.78	112.63
RC9	Luton And Dunstable University Hospital NHS Foundation Trust	78,597	1,812	1,732	80	104.61	88.84	112.56
RD8	Milton Keynes Hospital NHS Foundation Trust	43,279	1,370	1,309	61	104.66	88.57	112.90
RNS	Northampton General Hospital NHS Trust	69,955	2,040	1,969	71	103.62	88.94	112.44
RWD	United Lincolnshire Hospitals NHS Trust	80,117	3,750	3,288	462	114.05	89.24	112.06
RWE	University Hospitals Of Leicester NHS Trust	156,556	4,585	4,631	-46	99.01	89.37	111.89
RWG	West Hertfordshire Hospitals NHS Trust	60,766	2,137	2,215	-78	96.46	89.02	112.33
Group		643,172	21,246	20,497	749	103.66		

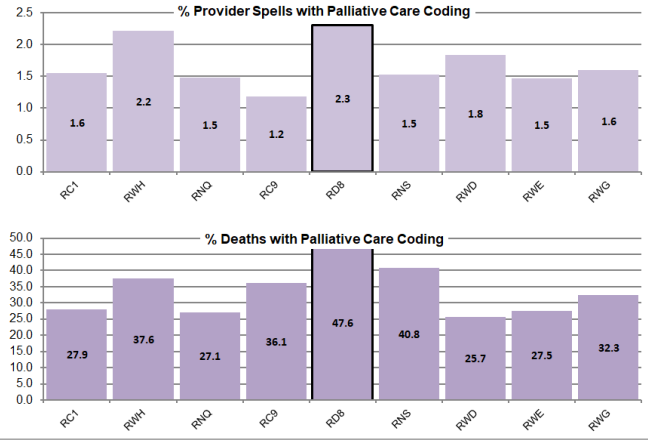
SHMI - With 95% CI: (Oct 17 - Sep 18)



Deaths: (Oct 17 - Sep 18)



% Palliative Care Coding: (Oct 17 - Sep 18)



SHMI Group - With 95% CI: (Oct 17 - Sep 18)

SHMI Group	Obs	Exp	SHMI	Low	High
(84) Oesophageal disorders	6	2	347.32	126.83	756.00
(37) Fluid and electrolyte disorders	29	17	171.49	114.83	246.30
(120) Fracture of neck of femur (hip)	40	26	152.68	109.06	207.91
(81) Cystic fibrosis, Other lower respiratory disease	14	7	193.72	105.82	325.05
(101) Urinary tract infections	56	43	130.55	98.61	169.54
(39) Deficiency and other anaemia, Acute posthaemorrhagic anaemia	14	8	179.98	98.31	302.00
(123) Joint disorders and dislocations, trauma-related, Spinal cord injury, Skull and face fractures, Other fractures, Sprains and strains	14	8	167.43	91.46	280.94
(74) Acute bronchitis	39	31	125.36	89.13	171.38

Investigations of Deaths

The data for Q4, Q3, Q2 and provisional Q3 are illustrated in the graph below outlining the number of deaths within the Trust that have:

1. Been reviewed and assessed by the consultant responsible for the patient's care with the potential for the case to be 'screened out' of further formal review. This active case record review process recognises that in many cases death in hospital will have been inevitable and appropriate. The process assists in directing collective review efforts to those cases where multi-professional review is likely to lead to learning. A subset of those cases 'screened out' is subjected to formal review at random.

2. Undergone formal review – the Trust aims for ~ 25% of all deaths to undergo a formal review process however it is recognised that this figure may not been achieved for Q3 as winter pressures can lead to cancellation of some departmental M&M meetings. It should be recognised that deaths that occur within Q4 are still undergoing the process of formal review as per the Trust Mortality policy and more complete data will be available for Q4 at the next Trust Board meeting.

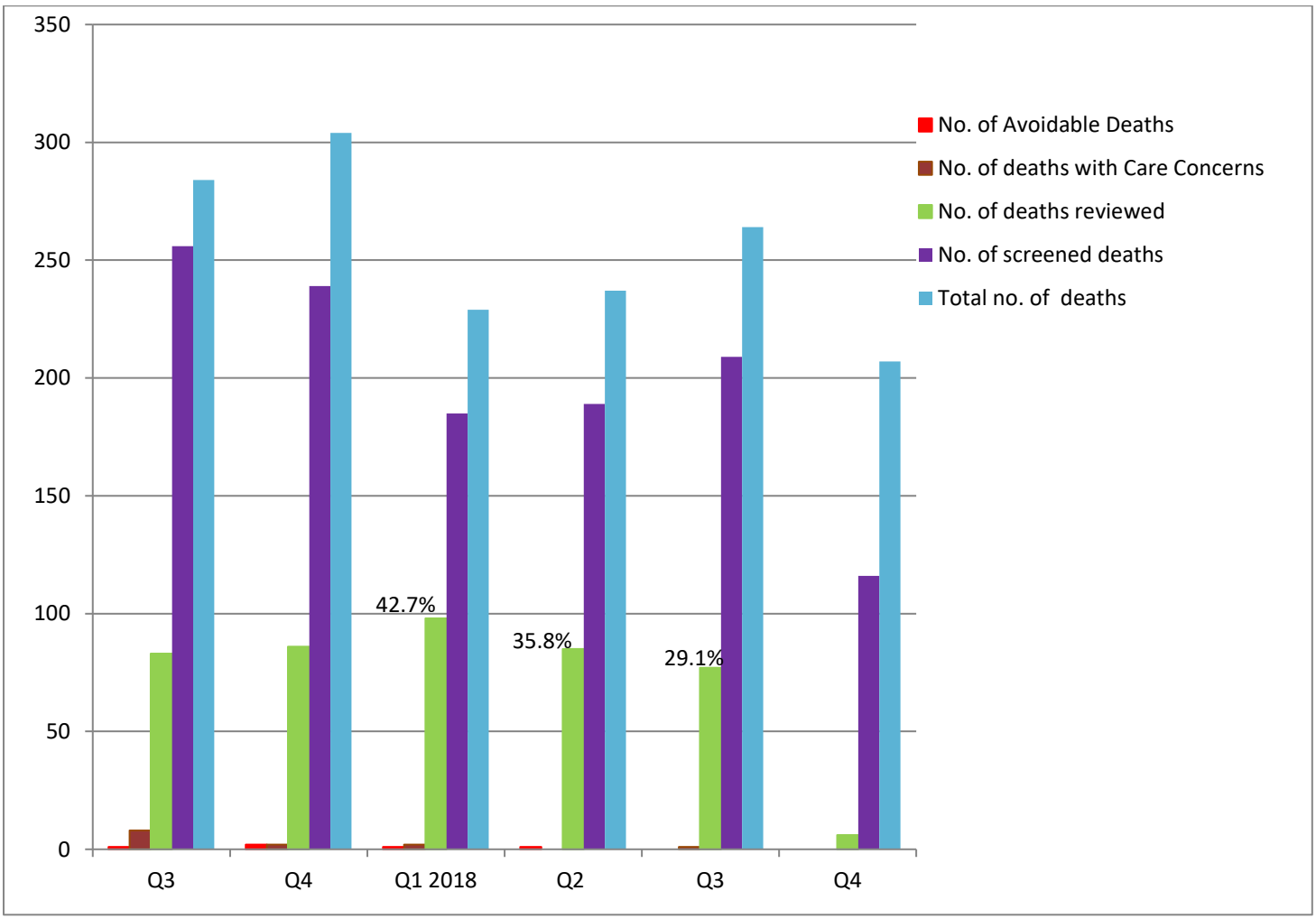
3. Judged as potentially 'avoidable' – using the current system of classification within the Trust this includes 'suboptimal care where different management MIGHT have changed outcome and 'suboptimal care where different management WOULD have changed outcome'

4. Judged as 'non-avoidable' but where there have been Care Quality concerns identified. This includes 'suboptimal care where different management WOULD NOT have changed outcome'.

2018/19	Q1	Q2	Q3	Q4
No. of deaths	**229**	**237**	**264**	**207**
No. of deaths reviewed by responsible consultant (% of total)	**185 (80.8%)**	**189(90%)**	**209(79%)**	**116* (56%)**
No. of investigations (% of total)†	**98 (42.3%)**	**85 (37.8%)**	**77 (29.1%)**	**6* (2.8%)**
No. of deaths with Care Quality concerns (%)	**2**	**1**	**1**	**0***
No. of potentially avoidable deaths (%)	**1**	**2**	**0**	**0***

† All deaths that have been investigated have been through the initial case record review process

* Q3 data are provisional and are still subject to further modification (as formal review processes occur within the Trust's clinical divisions)



Recent changes in the description and classification of deaths during the mortality review process have taken place. These minor changes mere made following discussions at Regional Network Mortality meetings led to agreement that all Trusts within the region would use the same classification method. The method (outlined below) below also includes the opportunity to recognoise excellent care.

Good or excellent care	No problems in care	Problems in care but very unlikely to have contributed to death	Problems in care but unlikely to have contributed to death	Problems in care more likely than not to have contributed to death

Meeting title	Trust Board	**Date:** 03 May 2019
Report title:	7 Day Services Update	**Agenda item: 3.5**
Lead director **Report author** **Sponsor(s)**	**Name:** Dr Ian Reckless **Name:** Elisa Scaletta	**Title:** Medical Director **Title:** Deputy Business Mngr
FoI status:	Publicly disclosable	

Report summary							
Purpose *(tick one box only)*	**Information**		**Approval**	x	**To note**	x	**Decision**	x
Recommendation	Trust Board is asked to note the data contained with the appendix to this report and authorise submission to regulators of the same during June 2019.						

Strategic objectives links	Improve patient safety
Board Assurance Framework links	▪ Improve patient safety ▪ Deliver key targets ▪ Improve clinical effectiveness
CQC regulations	NHS England delivering 7 day hospital services (10 standards)
Identified risks and risk management actions	Non-compliance with standards monitored by regulators
Resource implications	As described within the body of the paper.
Legal implications including equality and diversity assessment	

Report history	Third report to Board. Previously discussed at Clinical Quality Board, Management Board and Quality and Clinical risk Committee.
Next steps	This report provides Trust Board with progress made following the trial board assurance self-assessment submitted and results from the March 2019 audit to be approved.
Appendices	Appendix 1 - Assurance template in respect of local audit data, 18th March – 14th April 2019.

1. Purpose of the Report

Board are asked to note performance and the work in progress and Board are asked to approve the self-assessment (appendix 1)

2. Context

7 Day Services aim to ensure emergency inpatients have equivalent access to consultant input and key tests / interventions, irrespective of the day of the week.

There are 10 standards, 4 of which are termed 'priority.' NHS providers are expected to meet all 4 priority standards by April 2020. Various investments planned internally to assist in meeting standards.

The 10 standards for seven-day services are:

Standard	Definition
1	Patients involved in shared decision making
2*	**Time to first consultant review**
3	All emergency inpatients must be assessed for complex or ongoing needs within 14 hours by a multi-professional team
4	Handovers led by competent senior decision maker
5*	**Access to diagnostic tests**
6*	**Access to consultant-directed interventions**
7	Liaison mental health services to respond to referrals and provide urgent and emergency mental health care in acute hospitals with 24/7 Emergency Departments 24 hours a day, 7 days a week
8*	**Ongoing review by consultant twice daily for high dependency patients, daily for others**
9	Support services must be available seven days a week
10	Those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement

**Priority Standard*

National progress towards delivery of seven day hospital services was previously measured by bi-annual self-assessment surveys. In February 2019, as part of a trial run, progress was measured using a board assurance process, which involved completing a self-assessment template and publishing this as part of public Trust board papers. This was done at MKUH on 01 March 2019. The next template requires submission to regulators in late June (before

the next public Trust Board meeting in early July), and hence the issue is being considered today.

3. February 2019 Audit Results

The trial board assurance self-assessment was submitted to NHS England on 27th February 2019, with subsequent discussion at public Board on 1st March 2019. The data was from 120 randomly selected patients with emergency admissions followed by discharge / death in the weeks commencing 4th and 11th February (60 per week)

Priority standard 2 - The Trust achieved 73%, the target being 90% and therefore this standard was not met.

Priority standard 5 – The Trust achieved the 90% target with ongoing work to support inpatient echo capacity 7 days a week.

Priority standard 6 – The Trust did not meet the 90% target due to interventional radiology only being available on or offsite via an informal agreement. However, formalisation of interventional radiology is currently being reviewed and negotiated with Oxford as our tertiary centre.

Priority standard 8 – The Trust did not achieve the 90% target, however, work is ongoing and plans are in place to build pre-populated (auto text) templates into eCare to provide clearer documentation as to whether patient review is delegated to another member of staff. Of note the impact of eCARE (which will make a positive contribution in the medium term) is in a phase of maturation. All patients are reviewed daily by either a Consultant, Registrar, SHO or Nurse, however the documentation isn't clear as to whether the patient was delegated. The auto text should help with this.

4. March - April 2019 Audit Results

Trust	**S2 – 14 Hours**	**S8 – Daily Review**
Weekday	85%	57%
Weekend	78%	39%
Overall	83%	52%

Medicine	**S2 – 14 Hours**	**S8 – Daily Review**
Weekday	92%	60%
Weekend	86%	29%

Overall	90%	51%

Surgery	S2 – 14 Hours	S8 – Daily Review
Weekday	75%	59%
Weekend	64%	65%
Overall	72%	61%

W&C	S2 – 14 Hours	S8 – Daily Review
Weekday	61%	38%
Weekend	50%	75%
Overall	58%	45%

Although, overall, we have not achieved the 90% compliance against standard 2, due to the clearer documentation, the Trust has improved by 10% overall for standard 2 and Medicine have achieved 90% compliance against standard 2 for weekday and overall first Consultant review.

5. Recommendation

Board are asked to note performance and the work in progress and Board are asked to approve the self-assessment (appendix 1)

Elisa Scaletta

Deputy Business Manager, MDO

Ian Reckless

Medical Director

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	240 randomly selected patients with emergency admission followed by discharge / death from 18.03.2019 - 14.04.2019 There has been a big improvement since the last board assurance self-assessment was completed. Documentation is becoming clearer specifically around the first Consultant review, however this is still working progress which we believe will improve our % to over 90%. Weekday: 85% Weekend: 78% Overall: 83% (increased from 73% in February data)	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	100% compliance except for weekend echo. Some elective lists and Consultant Cardiologist onsite 7 days a week. A business case has been approved to embed inpatient echo capacity 7 days a week, however not yet available. MRI is available within 12 hours.	Echocardiography	Yes available on site	No the test is not available	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available on site	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Not Met
		Interventional Radiology	No the intervention is only available on or off site via informal arrangement	No the intervention is only available on or off site via informal arrangement	
		Interventional Endoscopy	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Emergency Surgery	Yes available on site	Yes available on site	
	Formalisation of interventional radiology is currently being reviewed and negotiated with OUH as our tertiary centre. No solution feasible via STP / ICS.	Emergency Renal Replacement Therapy	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Urgent Radiotherapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Cardiac Pacing	Yes mix of on site and off site by formal arrangement	Yes available off site via formal arrangement	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	We are building pre-populated (auto text) templates into eCare to provide clearer documentation as to whether patient review is delegated to another member of staff. Of note the impact of eCARE (which will make a positive contribution in the medium term) is in a phase of maturation. By way of illustration , it can be more difficult to ascertain whether or not a consultant was physically present at a ward round in the eCARE system than it was in paper notes. Measures are being put in place to improve this. Once Daily: Weekday 57% (similar to February data - 60%) Once Daily: Weekend 39% (a deterioration on february data - 51%) Overall: 52% We are certain that once the pre-popluated (auto text) are implemented and used, it will be very clear to see which patients have been delegated to another member of the MDT. All patients are being reviewed by a Consultant / Registrar / SHO / Nurse, however the key fields that are missing is the recorded information around the delegation of the patients.	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
S1 - Carers and families receive information about appointments and procedures, gaining consent as appropriate 7 days a week. We work to ensure patients' needs are listened to and recorded. We follow the ethos of John's Campaign which facilitates families and carers to stay with patients, supporting their care plans and decision making. We have a Trust wide 'Your Stay in Hospital' leaflet which gives a range of information to support a patient's stay. We follow the #hellomynameis campaign and elicit feedback from patients, families and carers. There is also a Length of Stay Programme which looks at 11 key areas for improvement. S3 - Daily board rounds on all clinical wards, led by the most senior clinician, which follows the 'Red2Green' approach. Monday to Friday, a Consultant is typically present. MKUH has a Rotational Operational Liaison Officer role to highlight / manage complex discharges, working alongside the MDT. S4 - There is a weekend handover meeting for medical specialties on a Friday afternoon, highlighting patients who require specific review and input over the weekend. Additional handover meetings occur if there are bank holidays that fall away from the weekend. There are also daily meetings at 21:30, 7 days a week. This is always attended by the medical teams (incoming and outgoing), the night ITU registrar, rapid response and the night nurse practitioners. At the night handover meeting all patients who are unwell are discussed, plus any outstanding patients from the day take, any outstanding tasks for inpatients and any operational issues such as staffing gaps. This meeting is typically attended by the on-call medical consultant. S7 - This is in place and provided by Central and North West London NHS Foundation Trust. S9 - There is a duty social worker, 7 days a week for emergencies. There are also the Home First Reablement Team, Home First Nursing Team and Home First Therapies Team. They work on admission avoidance 7 days a week. The Home First Reablement Team also takes discharges from A&E. There are also District Nurses 7 days a week, 24/7. S10 - The Trust has a clinical audit programme (as detailed in the annual Quality Account) and is currently reviewing the interplay between audit, transformation and quality improvement. The trust is committed to an environment of continuous quality improvement using established and proven methodologies.

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 6	No, the standard is not met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 8	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
Intra-arterial clot retrieval is currently available at OUH 08:00 to 16:00 Monday to Friday. It is not yet a 24/7 service. It is hoped that this will occur during 2019/20 and MKUH is well placed to offer all patients access to this key service via the integrated MKUH / OUH acute stroke service.

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Board of Directors	Date: 3 May 2019
Report title:	Performance Report indicators for 2018/19 (Month 12)	Agenda item: 4.1
Lead director Report author Sponsor(s)	Name: John Blakesley Name: Hitesh Patel	Title: Deputy Chief Executive Title: Associate Director of Performance and Information
FoI status:	Disclosable	

Report summary	Lists the proposed key performance metrics for the Trust for the financial year 2018/19			
Purpose *(tick one box only)*	Information [x]	Approval [ ]	To note [ ]	Decision [ ]
Recommendation				

Strategic objectives links	All Trust objectives
Board Assurance Framework links	None
CQC outcome/ regulation links	
Resource implications	None
Legal implications including equality and diversity assessment	None

Report history	None
Next steps	None
Appendices	None

Trust Performance Summary: M12 (March 2019)

1.0 Summary

The Trust in March 2019 continued to have high occupancy rates and slow discharges both before midday and at the weekends with poorer use of the discharge unit. Ambulance handover delays have remained higher than the internal target On a more positive note readmissions are lower than in recent months.

On the elective side the RTT performance continues to improve with no 52-week waiters being reported.

Mortality rates appear to be increasing for both HSMR and SHMI. There may be technical reasons for this and a review of coding depth has been commissioned.

2.0 Sustainability and Transformation Fund (STF)

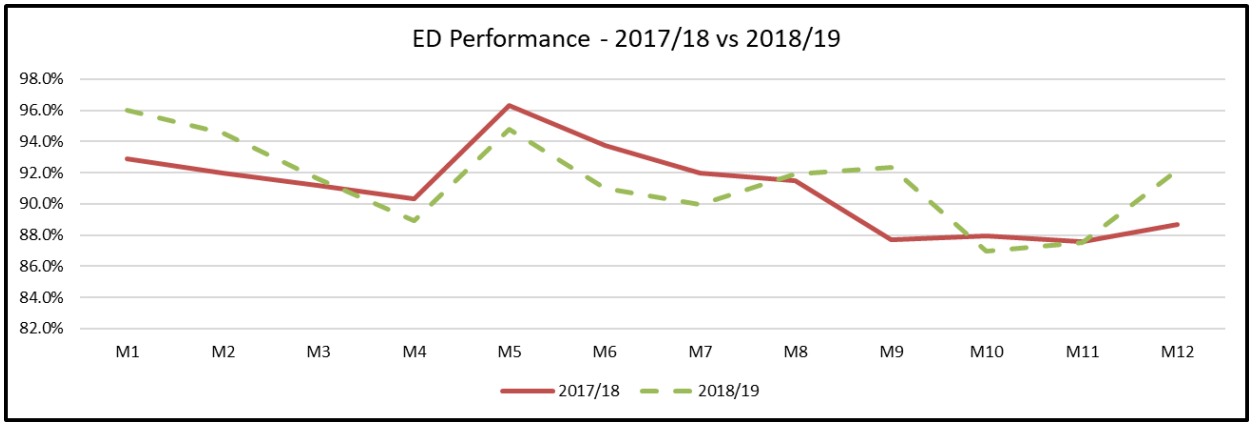
Performance Improvement Trajectories

March 2019 performance against the Service Development and Improvement Plans (SDIP):

ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
4.1	ED 4 hour target (includes UCS)		92.5%	92.5%	91.5%	92.2%	✗	▲	✗
4.2	RTT Incomplete Pathways <18 weeks		90.1%	90.1%		91.3%	✓	▲	
4.9	62 day standard (Quarterly)		82.4%	82.4%		85.1%	✓	▼	

ED performance for March 2019 improved significantly compared to February 2019. 92.2% of patients were seen within 4 hours in ED compared to 87.5% in February 2019. This was however lower than both the 95% national target and fell short of the Trust NHS Improvement trajectory (92.5%). Comparing the whole financial year performance to March with the same period in 2017/18, ED performance (91.5%) in 2018/19 improved by 0.5 percentage points. Performance was also better than the NHS England national A&E performance in March 2019, which was 86.6%.

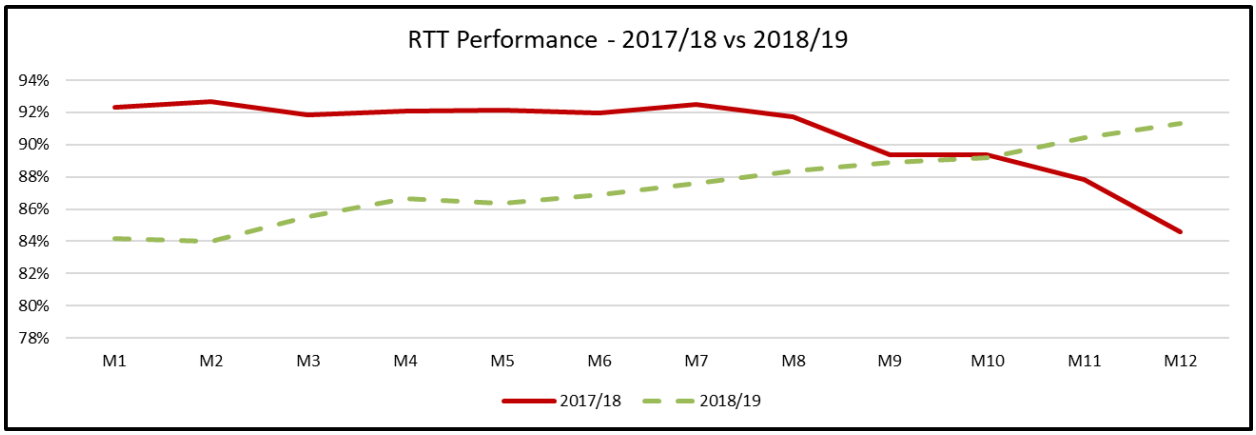
The graph below shows that the ED performance during this month (M12) compares favourably with the performance for the same period during the previous year (2017/18).



At the end of March 2019, the referral to treatment (RTT) national operating standard of 92% for incomplete pathways was not achieved. The performance was, however, above the NHS Improvement trajectory (90.1%) with an aggregate performance at 91.3%, which was also the highest reported since November 2017. Also, comparing the financial year performance with the

same period in 2017/18, RTT performance (91.3%) at the end of 2018/19 improved significantly by 6.7 percentage points. Nationally, the Trust's RTT performance was ahead of the combined NHS England performance for RTT in February 2019, which was 87%. The national performance for March 2019 is yet to be published.

The graph below shows that the RTT performance during this month (M12) compares favourably with the performance for the same period during the previous year (2017/18).



The 85% Cancer 62 day standard was achieved in Quarter 3 of 2018/19, closing at 85.1%, which was also above the NHS Improvement trajectory (82.4%). Nationally, the operational standard for 62 day waits was breached in Q3 2018/19 with a performance of 79.5%.

3.0 Urgent and Emergency Care

Urgent and emergency care continued to be busy in March 2019 with prolonged increased acuity and demand.

ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
2.4	Cancelled Ops - On Day		1.0%	1.0%	0.7%	0.8%	✓	▼	✓
3.2	Ward Discharges by Midday		30%	30%	14.9%	19.6%	✗	▲	✗
3.4	30 day readmissions		6.4%	6.4%	8.1%	7.0%	✗	▬	✗
3.9	Ambulance Handovers >30 mins (%)		5%	5%	7.7%	8.3%	✗	▲	✗
4.1	ED 4 hour target (includes UCS)		92.5%	92.5%	91.5%	92.2%	✗	▲	✗

Cancelled Operations on the Day

In March 2019, the number of operations cancelled on the day for non-clinical reasons increased from 10 in February to 19. This represented 0.8% of all planned elective operations during the month and was within the threshold (1%). Nine (47.4%) of these cancelled operations were attributed to bed availability and three (15.8%) were attributed to insufficient time. The remaining seven were attributed to a variety of reasons, including administration errors and timing.

Comparing the financial year performance with the same period in 2017/18, the performance (0.7%) in 2018/19 improved by 0.5 percentage points. The national performance for March 2019 is yet to be released by NHS England.

Readmissions

In March 2019, the 30 day emergency readmission rate (7%) for the Trust continued above the 6.4% threshold and remained the same as February 2019. At a divisional level, the readmission rate for Women and Children (4.1%) and Medicine (10.9%) increased slightly compared to February 2019, whilst the rate in Surgery decreased to 3.8%. Comparing the financial year performance with the same period in 2017/18, the performance (8.1%) in 2018/19 improved by 0.1 percentage point.

Delayed Transfers of Care (DTOC)

The number of DTOC patients (29) as at midnight on the last Thursday of March 2019 was the same as February 2019. This was an improvement when compared to the same period last year (March 2018) when there were 41 DTOCs reported.

The number of bed days lost due to DTOCs increased from 706 in February 2019 to 822. The high volume undoubtedly has an impact on day-to-day acute bed capacity and patient flow.

Ambulance Handovers

The percentage of ambulance handovers that took longer than 30 minutes continued above the 5% tolerance in March 2019 (8.3%). This was however an improvement over the previous month (11.7%). The number of handovers reported to have taken longer than 60 minutes also improved considerably during March 2019.

4.0 Elective Pathways

ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
3.1	Overnight bed occupancy rate		93%	93%	93.8%	96.3%	✗	▲	✗
3.5	Follow Up Ratio		1.50	1.50	1.58	1.53	✗	▲	✗
4.2	RTT Incomplete Pathways <18 weeks		90.1%	90.1%		91.3%	✓	▲	
5.6	Outpatient DNA Rate		5%	5%	7.5%	7.4%	✗	▲	✗

Overnight Bed Occupancy

The Trust bed occupancy continued above the 93% internal threshold at 96.3% in March 2019. Overnight bed occupancy at such high levels can increase the risk of infections and affect the timely admission of emergency and urgent care patients, as well as those booked for surgery. Constant demand for beds represents a huge challenge for the Trust.

Follow up Ratio

Planning outpatient capacity to cope with new referrals is impacted by the demand for follow ups. In March 2019, the follow up ratio improved from 1.58 in February 2019 to 1.53 follow up attendances for every new attendance seen.

RTT Incomplete Pathways

The RTT performance of the Trust has been on an upward trend since September 2018 and continued to improve in March 2019. The performance at year-end was the best reported since October 2017, which was when the Trust last achieved the RTT National standard (92%). At the end of March 2019, there were no patients reported to have been waiting more than 52 weeks.

Diagnostic Waits <6 weeks

In March 2019, the Trust continued to meet the operational standard of less than 1% of patients waiting six weeks or longer for a Diagnostic test, with a performance of 99.1%. Nationally, the operational standard of less than 1% of patients waiting six weeks or longer was not achieved in February 2019.

Comparing the financial year performance with the same period in 2017/18, the performance (99.1%) at the end of 2018/19 improved by 0.1 percentage point. The national performance for March 2019 is planned to be published by NHS England in May 2019.

Outpatient DNA Rate

The outpatient DNA rate (7.4%) in March 2019 decreased from 8% in February 2019. Comparing the financial year performance to the 2017/18 performance (6.1%), the DNA rate for 2018/19 increased significantly to 7.5% which was a drop in performance.

DNAs represent clinic capacity that cannot be otherwise utilised. All services should ensure that they adhere to the Trust Access Policy to minimise DNA rates. The Policy is frequently discussed at the weekly RTT meetings, at which all services are represented.

5.0 Patient Safety

Never Events

There were three Never Events reported by the Trust for the financial year 2018/19. The Trust reported zero never events in March 2019.

Mortality

For Month 12, the SHMI value for the Trust was in the 'as expected' banding and the HSMR showed an improvement when compared to the previous month (Month 11). For Surgery, there was one outlying diagnosis group attracting significantly higher than expected deaths (which the report from Dr.Foster suggested as "prudent to investigate").

Infection Control

MKUH reported one case of e-Coli in Ward 8 (Medicine) during March 2019. There were no CDIs or MRSAs reported by the Trust in Month 12. Comparing the financial year performance with the same period in 2017/18, the number of CDIs (15) increased by two whereas the MRSAs (1) decreased by two in 2018/19.

Pressure Ulcers

The pressure ulcer rate (0.86) was above the internal tolerance (0.6) in March 2019 and was the highest reported in 2018/19. There were 11 pressure ulcers reported by the Trust in March 2019 and the majority of these were in Medicine.

ENDS

OBJECTIVE 1 - PATIENT SAFETY										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
1.1	Mortality - (HSMR)		100	100		94.9	✓	▲		
1.2	Mortality - (SHMI) - Quarterly		1	1	0.97	1.04	✗	▼	✓	
1.3	Never Events		0	0	3	0	✓	▬	✗	
1.4	Clostridium Difficile		20	20	15	0	✓	▬	✓	
1.5	MRSA bacteraemia (avoidable)		0	0	1	0	✓	▬	✗	
1.6	Pressure Ulcers Grade 2, 3 or 4 (per 1,000 bed days)		0.6	0.6	0.62	0.86	✗	▼	✗	
1.7	Falls with harm (per 1,000 bed days)		0.15	0.15	0.12	0.16	✗	▼	✓	
1.8	WHO Surgical Safety Checklist		100%	100%	100%	100%	✓	▬	✓	
1.9	Midwife : Birth Ratio		28	28	27	25	✓	▲	✓	
1.10	Incident Rate (per 1,000 bed days)		40	40	37.73	39.36	✗	▼	✗	
1.11	Duty of Candour Breaches (Quarterly)		0	0	0	0	✓	▬	✓	
1.12	E-Coli				22	1		▼		
1.13	MSSA				15	1		▼		
1.14	VTE Assessment	Tbc	95%	95%	88.2%	96.6%	✓	▼	✗	

OBJECTIVE 2 - PATIENT EXPERIENCE										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
2.1	FFT Recommend Rate (Patients)		94%	94%	Not Available					
2.2	RED Complaints Received		8	8	0	0	✓	▬	✓	
2.3	Complaints response in agreed time		90%	90%	84.1%	92.0%	✓	▲	✗	
2.4	Cancelled Ops - On Day		1.0%	1.0%	0.7%	0.8%	✓	▼	✓	
2.5	Over 75s Ward Moves at Night		2,554	2554	2,346	158	✓	▲	✓	
2.6	Mixed Sex Breaches		0	0	0	0	✓	▬	✓	

OBJECTIVE 3 - CLINICAL EFFECTIVENESS										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
3.1	Overnight bed occupancy rate		93%	93%	93.8%	96.3%	✗	▲	✗	
3.2	Ward Discharges by Midday		30%	30%	14.9%	19.6%	✗	▲	✗	
3.3	Weekend Discharges		70%	70%	67.8%	61.3%	✗	▼	✗	
3.4	30 day readmissions		6.4%	6.4%	8.1%	7.0%	✗	▬	✗	
3.5	Follow Up Ratio		1.50	1.50	1.58	1.53	✗	▲	✗	
3.6.1	Number of Stranded Patients (LOS>=7 Days)		227	227		229	✗	▼		
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)		91	91		90	✓	▲		
3.7	Delayed Transfers of Care		25	25		29	✗	▬		
3.8	Discharges from PDU (%)		16%	16%	10.8%	9.7%	✗	▼	✗	
3.9	Ambulance Handovers >30 mins (%)		5%	5%	7.7%	8.3%	✗	▲	✗	

OBJECTIVE 4 - KEY TARGETS										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
4.1	ED 4 hour target (includes UCS)		92.5%	92.5%	91.5%	92.2%	✗	▲	✗	
4.2	RTT Incomplete Pathways <18 weeks		90.1%	90.1%		91.3%	✓	▲		
4.3	RTT Patients Waiting Over 18 Weeks		1,287	1,287		1,260	✓	▲		
4.4	RTT Total Open Pathways		12,999	12,999		14,554	✗	▼		
4.5	RTT Patients waiting over 52 weeks			10		0	✓	▬		
4.6	Diagnostic Waits <6 weeks		99%	99%		99.1%	✓	▬		
4.7	All 2 week wait all cancers (Quarterly) ✎		93%	93%		96.9%	✓	▼		
4.8	31 days Diagnosis to Treatment (Quarterly) ✎		96%	96%		99.1%	✓	▲		
4.9	62 day standard (Quarterly) ✎		82.4%	82.4%		85.1%	✓	▼		

OBJECTIVE 5 - SUSTAINABILITY										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
5.1	GP Referrals Received		60,189	60,189	61,952	5,128	✗	▼	✓	
5.2	A&E Attendances		91,290	91,290	88,041	7,712	✗	▲	✗	
5.3	Elective Spells (PBR)		25,528	25,528	25,933	2,520	✓	▲	✓	
5.4	Non-Elective Spells (PBR)		35,287	35,287	34,401	3,202	✓	▲	✗	
5.5	OP Attendances / Procs (Total)		367,859	367,859	383,036	31,780	✓	▲	✓	
5.6	Outpatient DNA Rate		5%	5%	7.5%	7.4%	✗	▲	✗	
5.7	Number of babies delivered				3592	276		▼		
5.8	Number of antenatal bookings				4080	326		▲		

OBJECTIVE 7 - FINANCIAL PERFORMANCE										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
7.1	Income £'000		240,602	240,602	244,585	20,370	✗	▲	✓	
7.2	Pay £'000		(161,048)	(161,048)	(165,854)	(14,271)	✗	▼	✗	
7.3	Non-pay £'000		(71,891)	(71,891)	(77,795)	(6,377)	✗	▼	✗	
7.4	Non-operating costs £'000		(12,893)	(12,893)	(11,808)	(407)	✓	▲	✓	
7.5	I&E Total £'000		(5,230)	(5,230)	(10,871)	(686)	✗	▲	✗	
7.6	Cash Balance £'000		2,500	2,500		6,175	✓	▼		
7.7	Savings Delivered £'000		10,130	10,130	10,819	2,001	✓	▲	✓	
7.8	Capital Expenditure £'000		29,673	29,673	15,678	6,089	✗	▼	✓	

OBJECTIVE 8 - WORKFORCE PERFORMANCE										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
8.1	Staff Vacancies % of establishment		12%	12%		8.4%	✓	▼		
8.2	Agency Expenditure %		8%	8%	5.7%	6.7%	✓	▼	✓	
8.3	Staff sickness - % of days lost		4%	4%		3.9%	✓	▬		
8.4	Appraisals		90%	90%		95.0%	✓	▲		
8.5	Statutory Mandatory training		90%	90%		93.0%	✓	▲		
8.6	Substantive Staff Turnover		12%	12%		10.7%	✓	▬		
8.7	FFT Response Rate Staff (Quarterly)		15%	15%	14.0%	14.0%	✗	▼	✗	

OBJECTIVES - OTHER										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
O.1	Total Number of NICE Breaches		8	8		47	✗	▲		
O.2	Rebooked cancelled OPs - 28 day rule		95%	95%	70.4%	80.0%	✗	▲	✗	
O.4	Overdue Datix Incidents >1 month		0	0		125	✗	▬		
O.5	Serious Incidents		45	45	68	8	✗	▬	✗	
O.8	Completed Job Plans (Consultants)		90%	90%		84%	✗	▼		

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

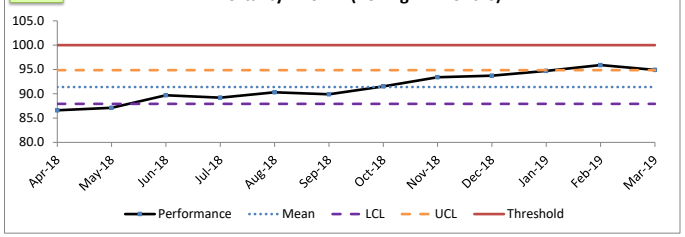
Rating	Data Quality Assurance
Green	Satisfactory and independently audited (indicator represents an accurate reflection of performance)
Amber	Acceptable levels of assurance but minor areas for improvement identified and potentially independently audited * /No Independent Assurance
Red	Unsatisfactory 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

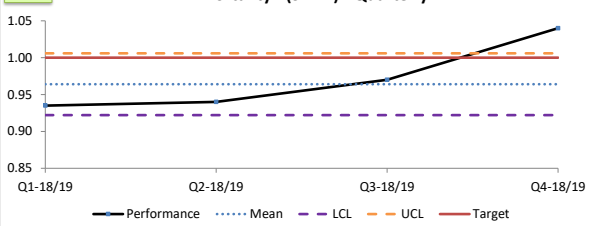
SD=3

1.1 Mortality - HSMR (Rolling 12 months)

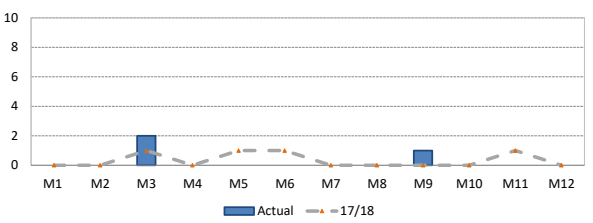


SD=3

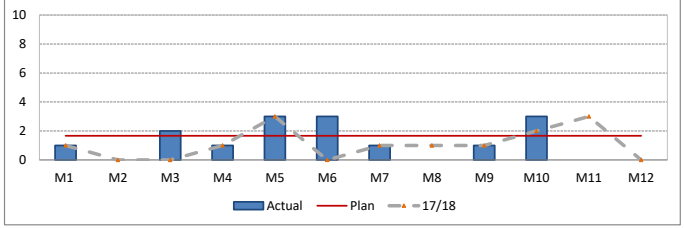
1.2 Mortality - (SHMI) - Quarterly



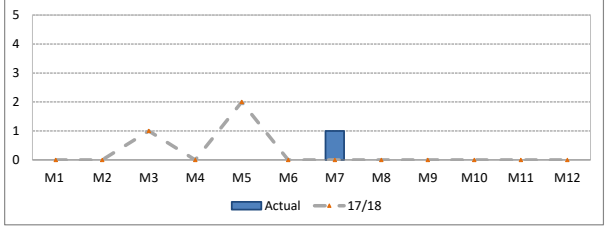
1.3 - Never events



1.4 - C.Diff Infections

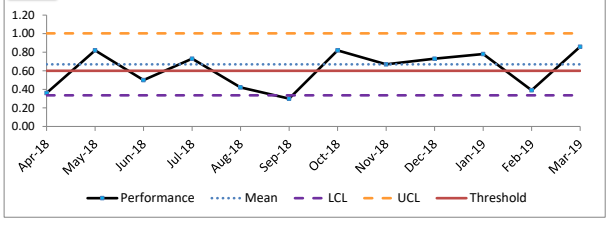


1.5 - MRSA Bacteraemia



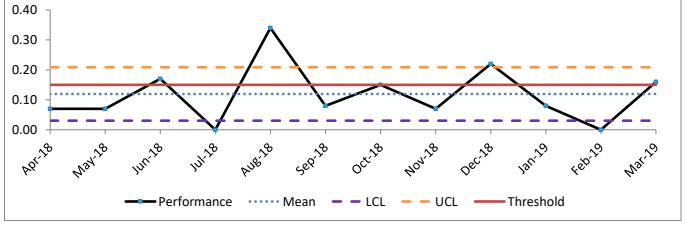
SD=1

1.6 - Pressure Ulcers Grade 2, 3 or 4 (per 1,000 bed days)

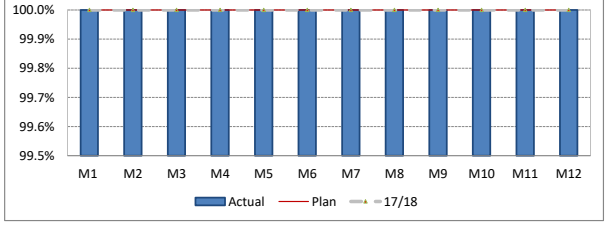


SD=1

1.7 - Inpatient falls causing harm

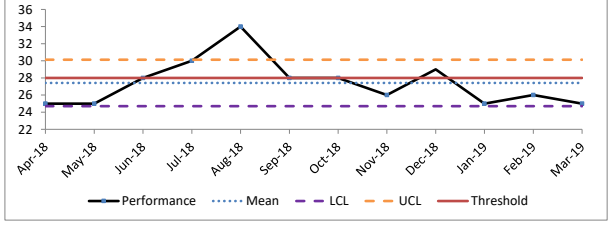


1.8 - WHO Surgical Safety Checklist



SD=1

1.9 - Midwife to Birth Ratio



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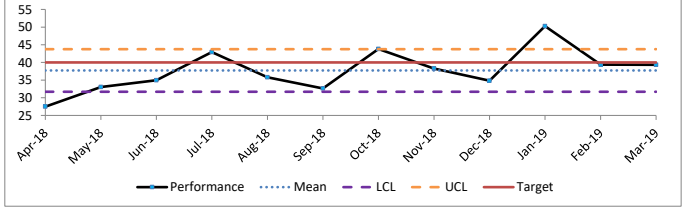
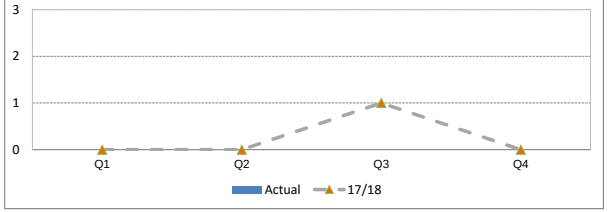
1.10 - Incident Rate (per 1,000 bed days)

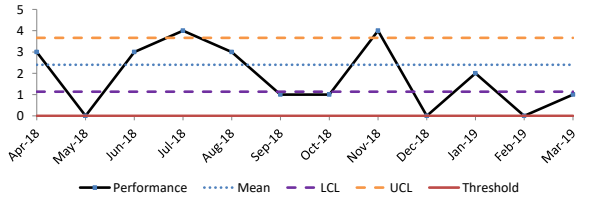


1.11- Duty of Candour Breaches



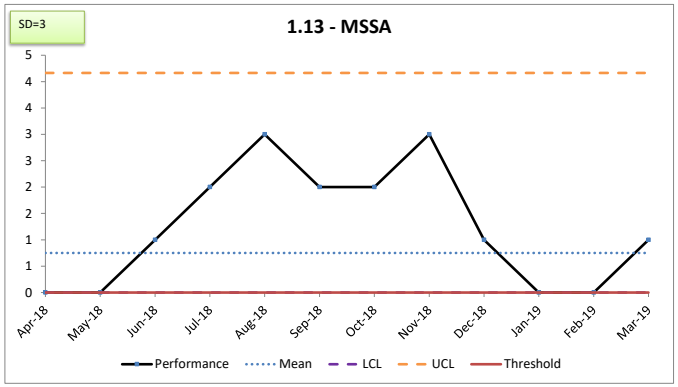
SD=1

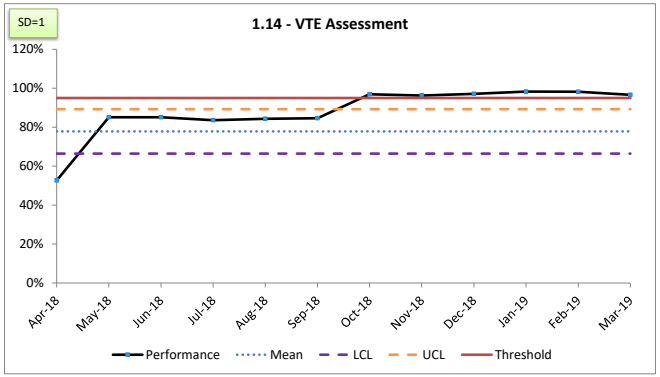
1.12 - E-Coli



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 12 months/quarterly
- Average on a rolling 12 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

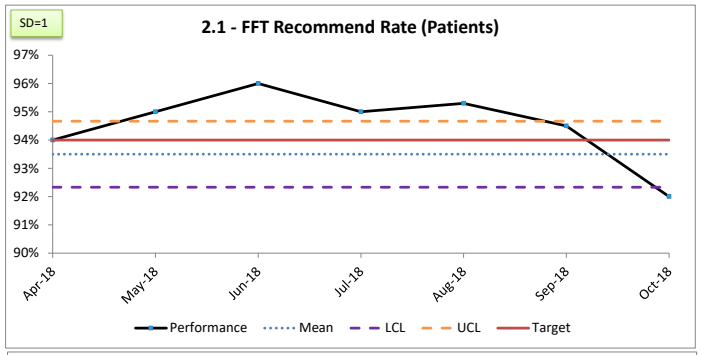


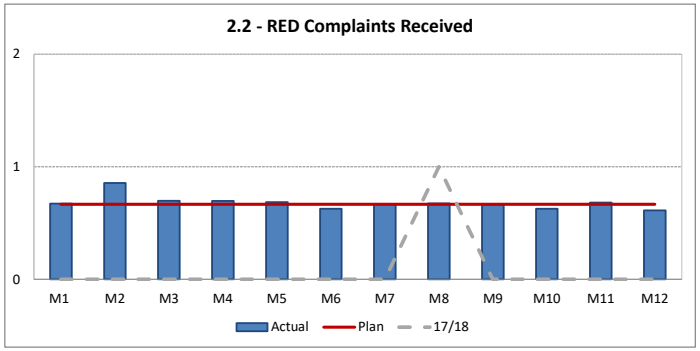


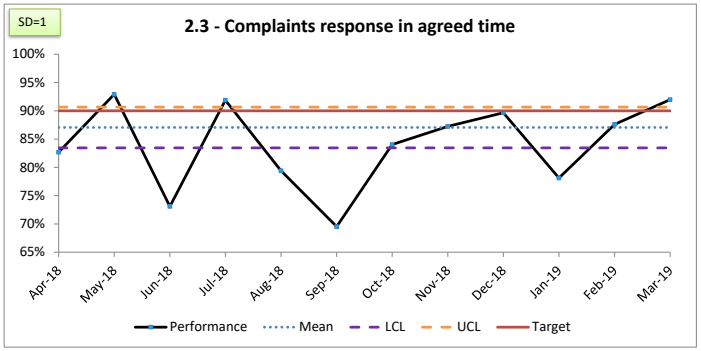
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

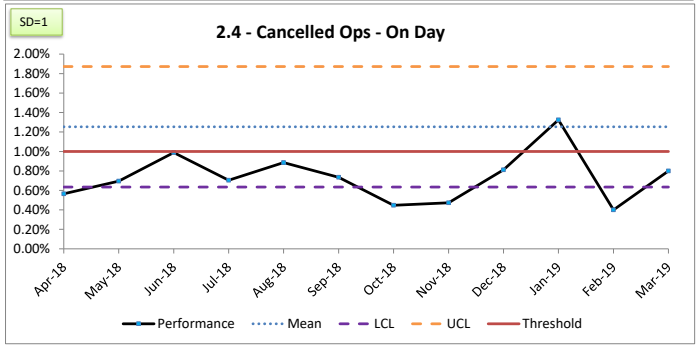
- Performance activity on a rolling 12 months/quarterly
- Average on a rolling 12 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

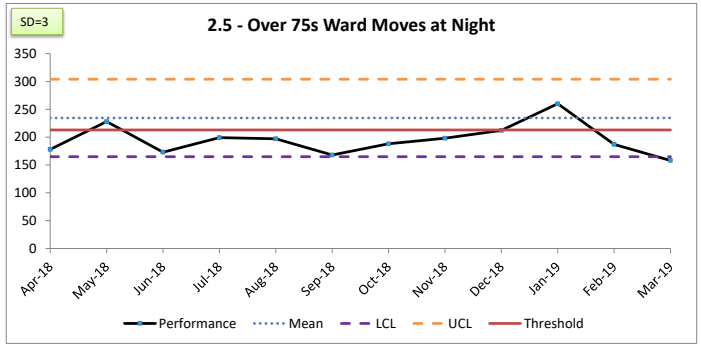
OBJECTIVE 2 - PATIENT EXPERIENCE

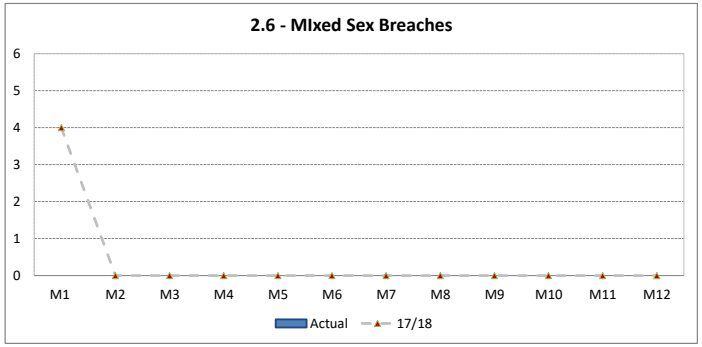








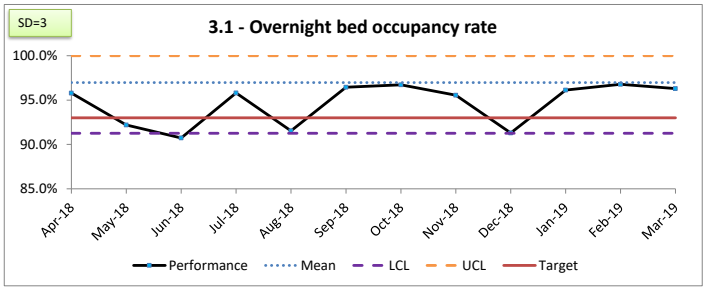


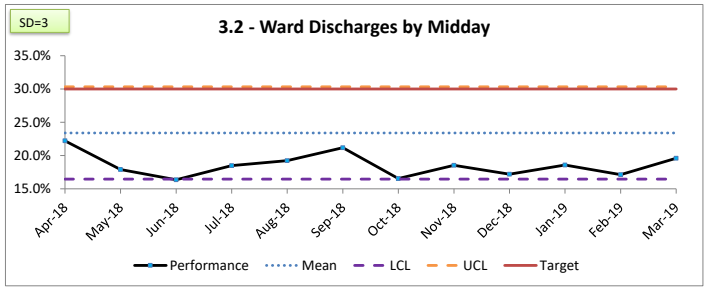


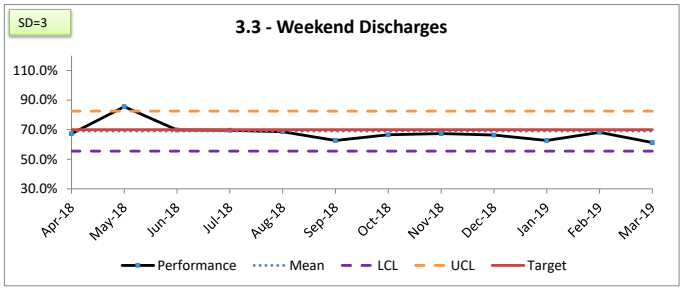
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

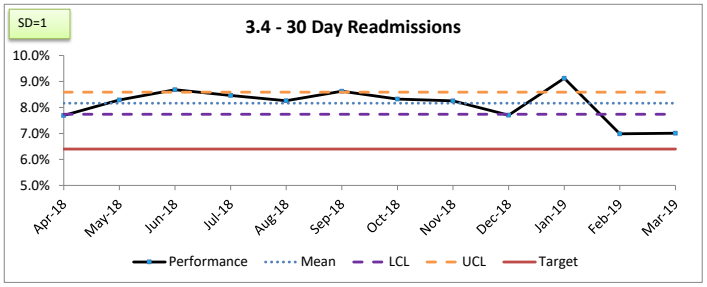
- Performance activity on a rolling 12 months/quarterly
- Average on a rolling 12 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

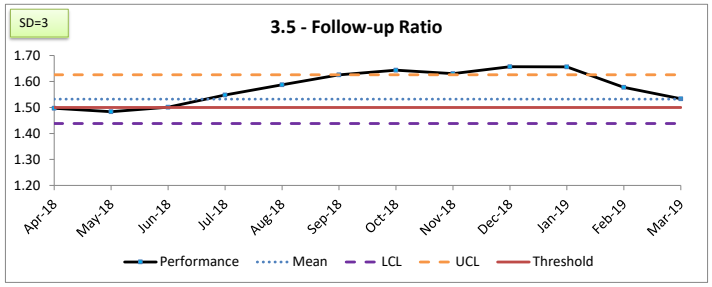
OBJECTIVE 3 - CLINICAL EFFECTIVENESS

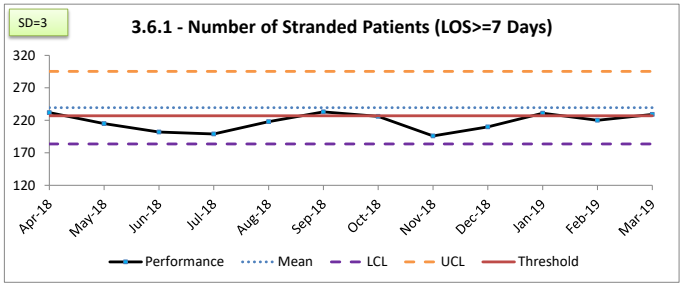


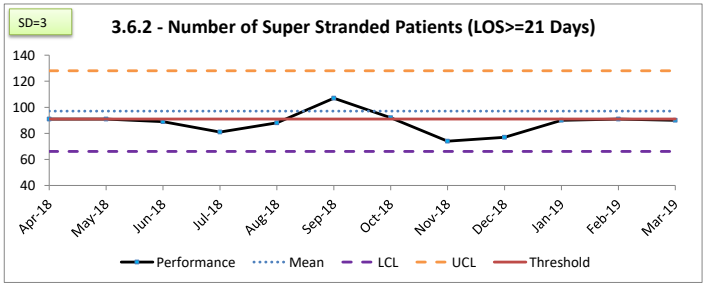


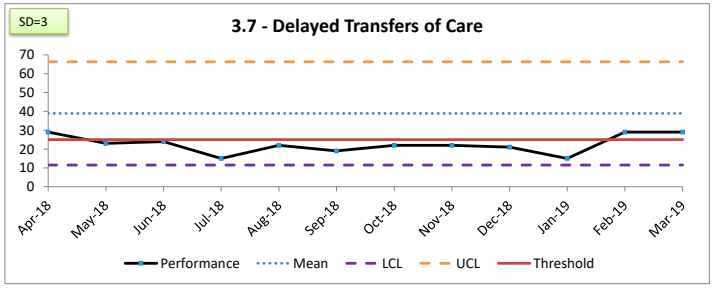


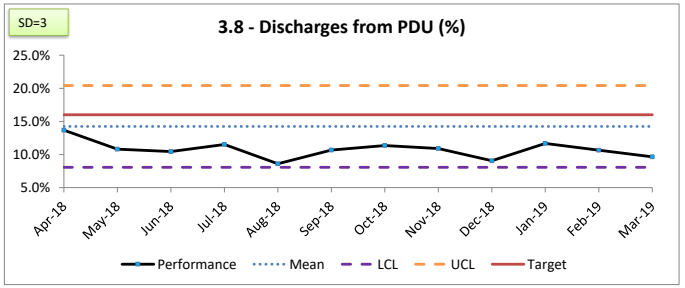


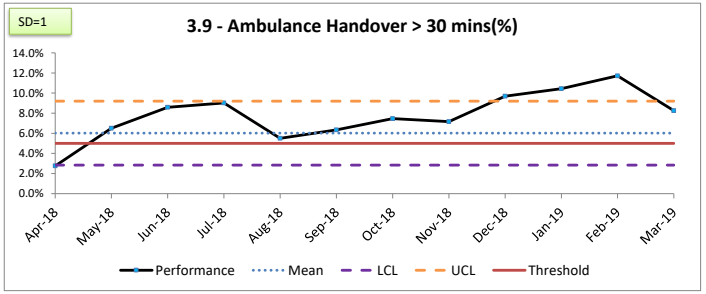












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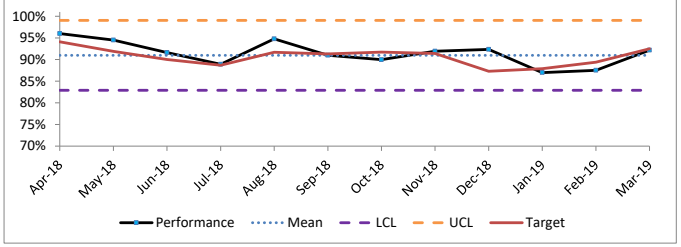
- Performance activity on a rolling 12 months/quarterly
- Average on a rolling 12 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

OBJECTIVE 4 - KEY TARGETS

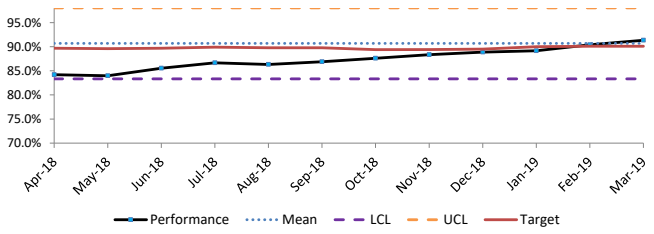
SD=3

4.1 - ED Hour Target (includes UCS)

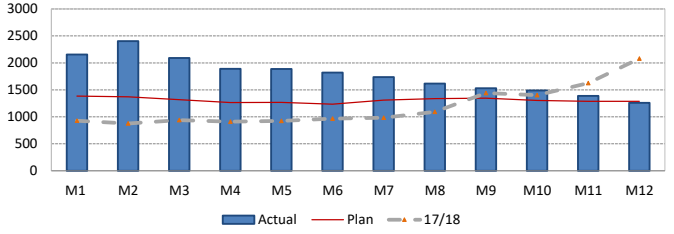


SD=3

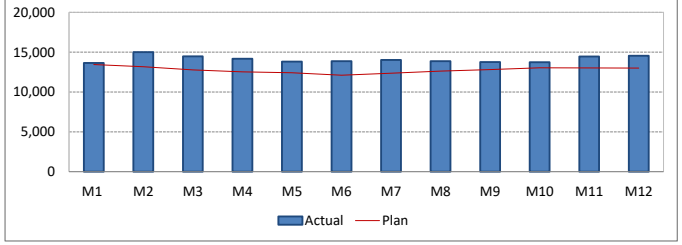
4.2 - RTT Incomplete Pathways <18 weeks



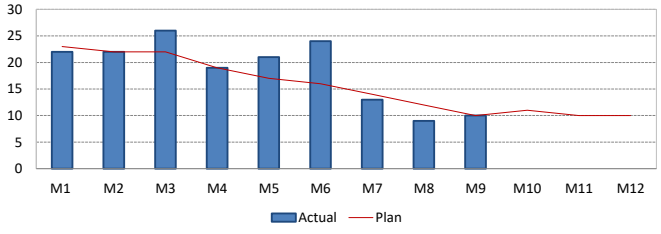
4.3 - RTT - Number of Patients Waiting >18 Weeks



4.4 - RTT Total Open Pathways

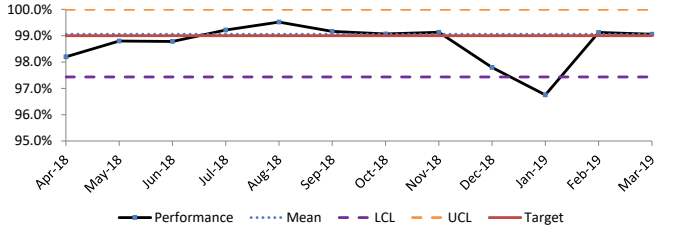


4.5 - RTT Patients Waiting Over 52 weeks



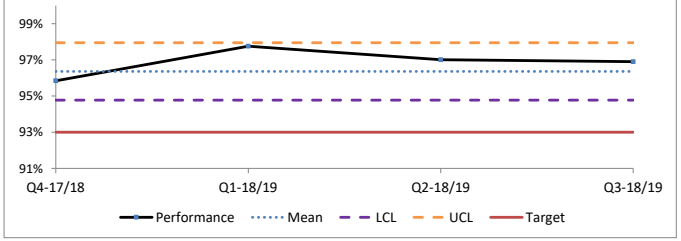
SD=3

4.6 - Diagnostic Waits < 6 weeks



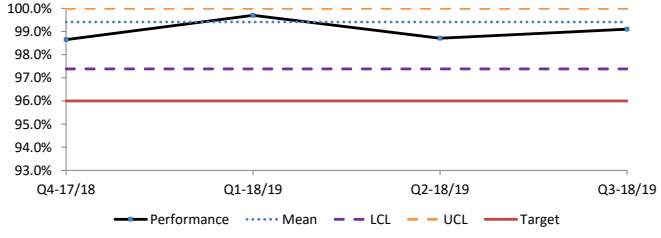
SD=3

4.7 - 2ww Waits - Cancer



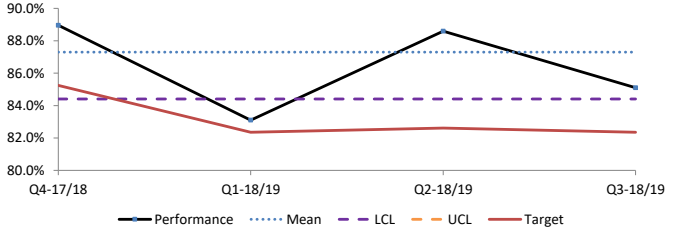
SD=3

4.8 - 31 day diagnosis to treatment - Cancer



SD=3

4.9 - 62 day standard - Cancer



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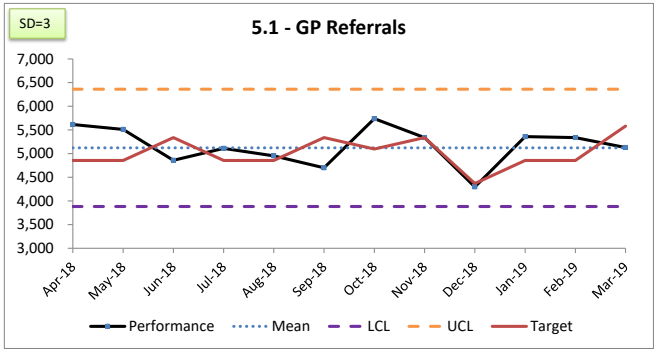
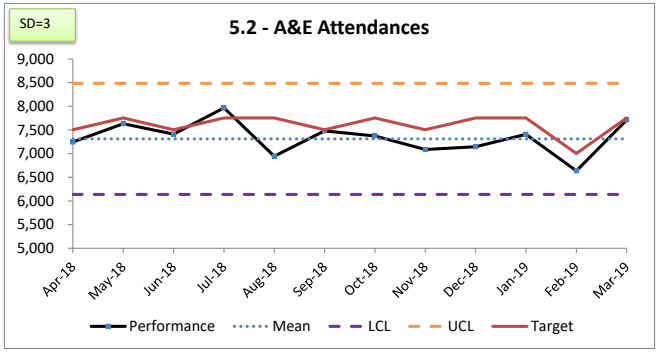
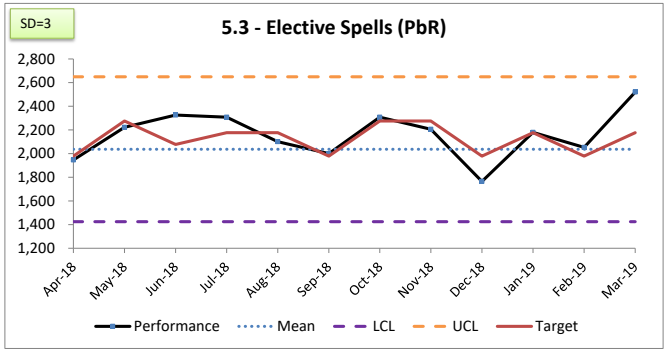
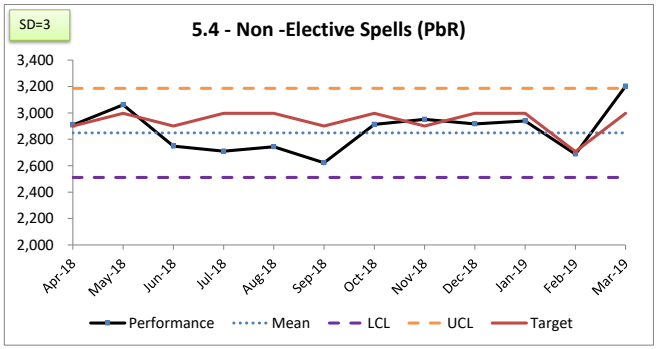
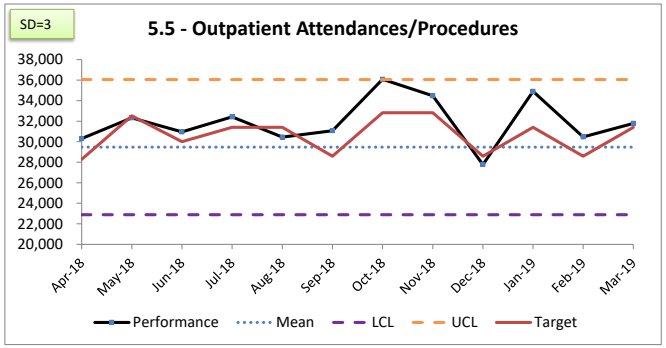
Milton Keynes University Hospital NHS Foundation Trust

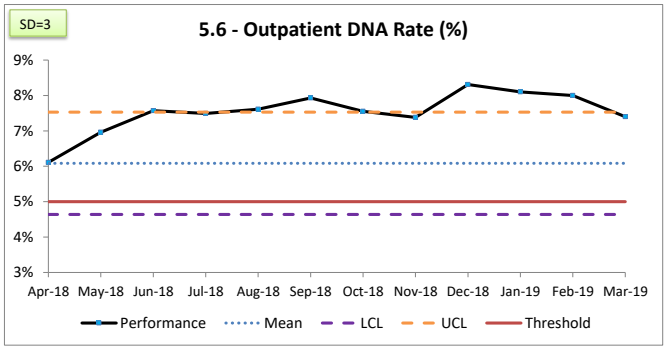


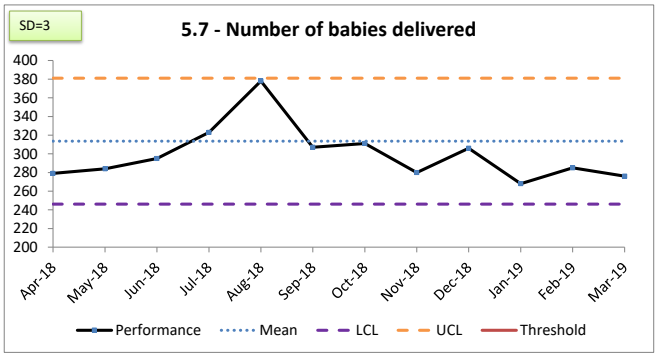


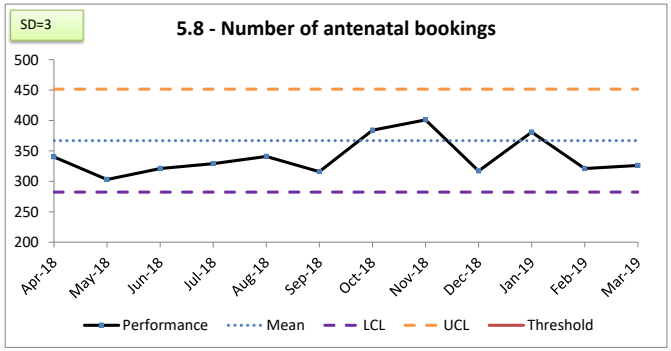












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- Average on a rolling 12 months/quarterly
- Lower Control Limit (LCL)
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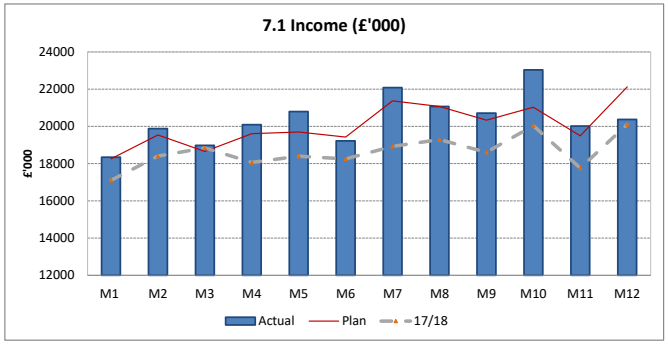
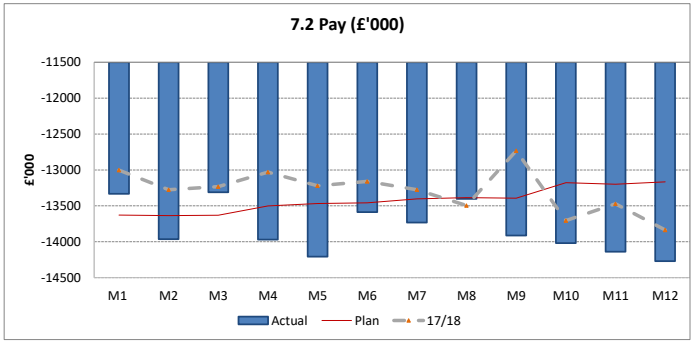
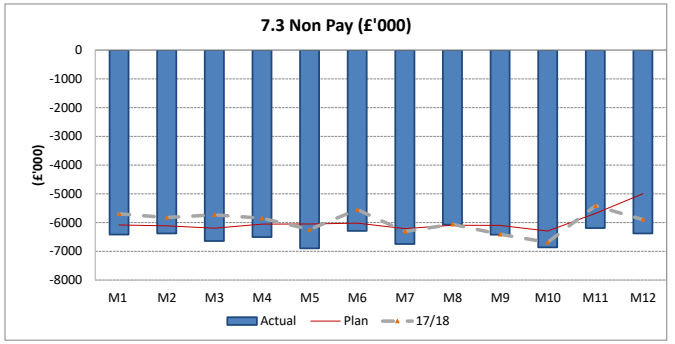
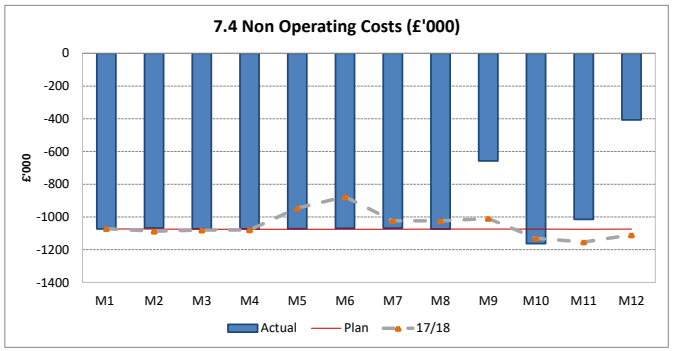
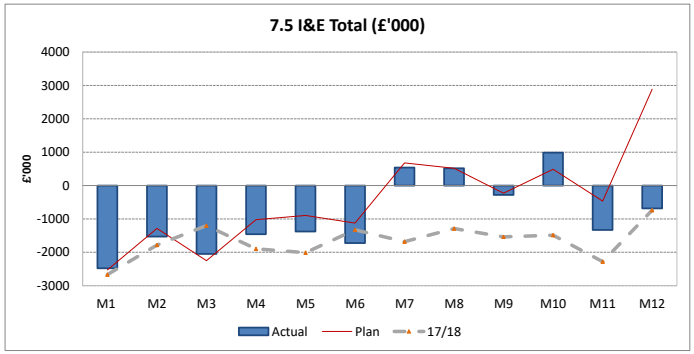
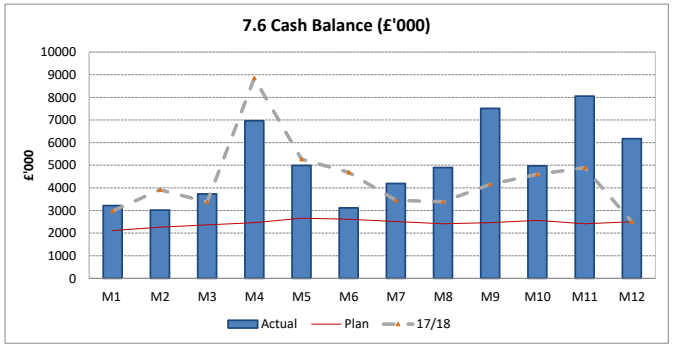

7.1 Income (£'000)
£'000
24000
22000
20000
18000
16000
14000
12000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

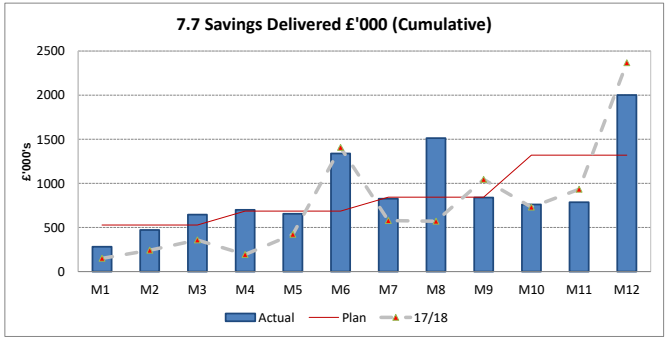

7.2 Pay (£'000)
£'000
-11500
-12000
-12500
-13000
-13500
-14000
-14500
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

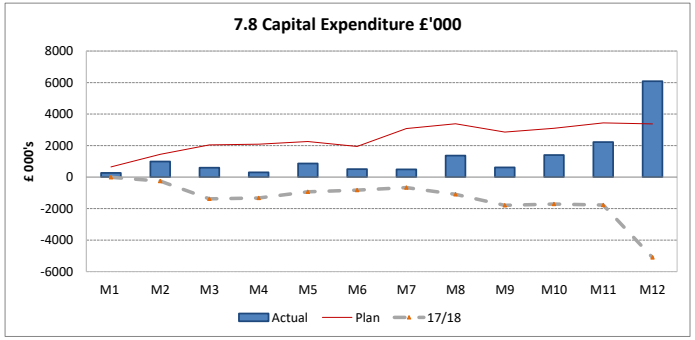

7.3 Non Pay (£'000)
(£'000)
0
-1000
-2000
-3000
-4000
-5000
-6000
-7000
-8000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18


7.4 Non Operating Costs (£'000)
£'000
0
-200
-400
-600
-800
-1000
-1200
-1400
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

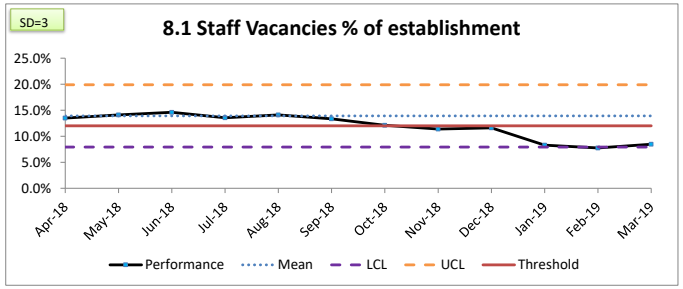

7.5 I&E Total (£'000)
£'000
4000
3000
2000
1000
0
-1000
-2000
-3000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

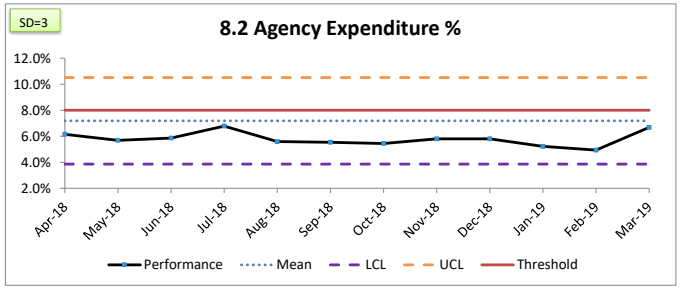

7.6 Cash Balance (£'000)
£'000
10000
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

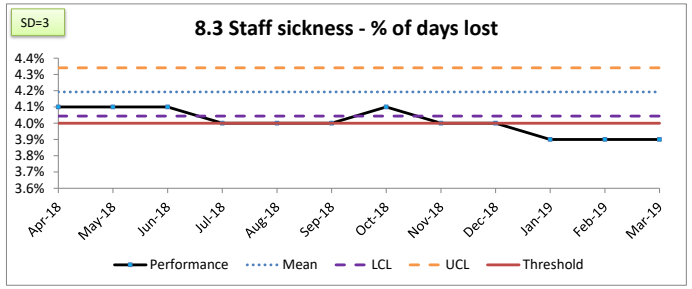

7.7 Savings Delivered £'000 (Cumulative)
£'000's
2500
2000
1500
1000
500
0
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

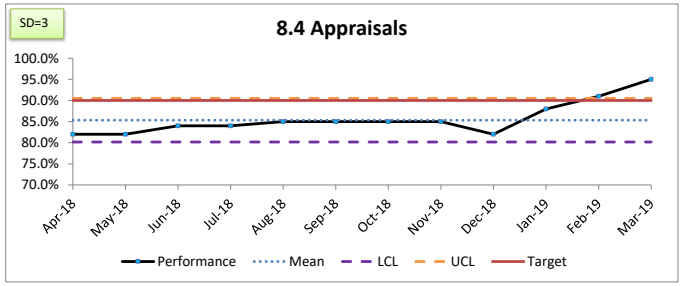

7.8 Capital Expenditure £'000
£ 000's
8000
6000
4000
2000
0
-2000
-4000
-6000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

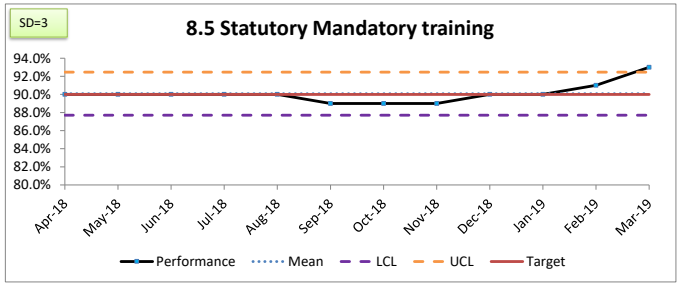
OBJECTIVE 8 - WORKFORCE PERFORMANCE

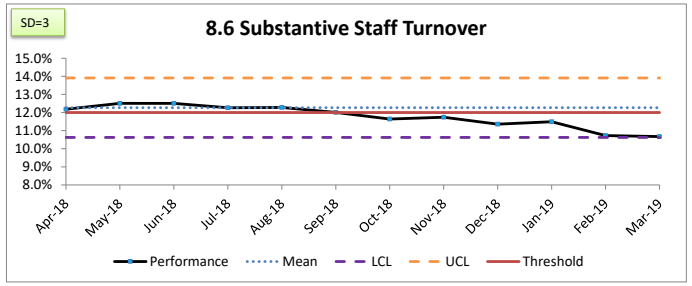


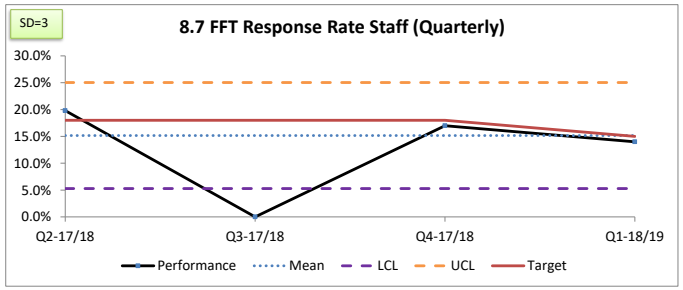












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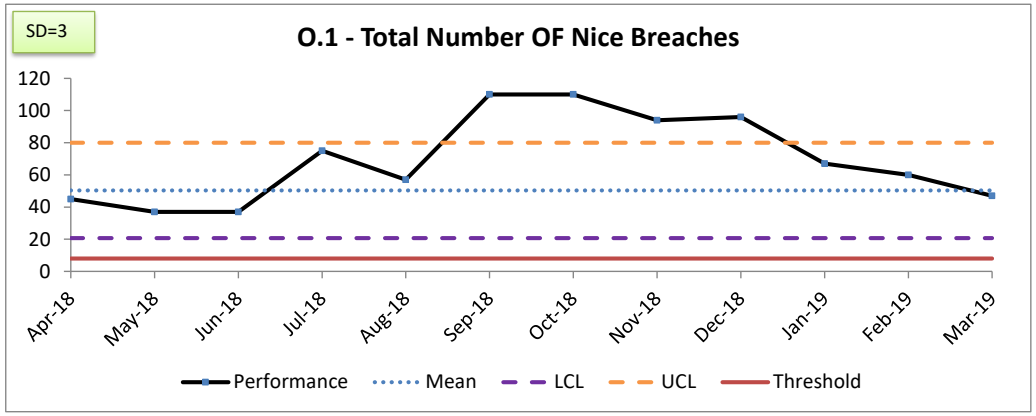

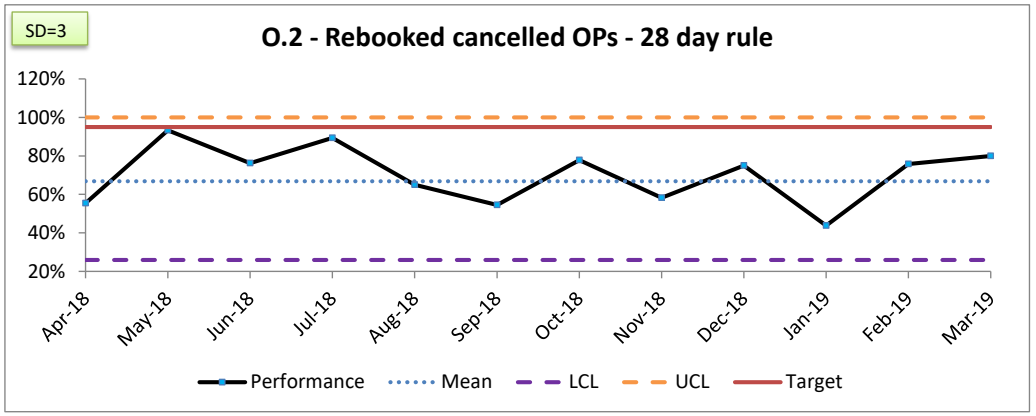

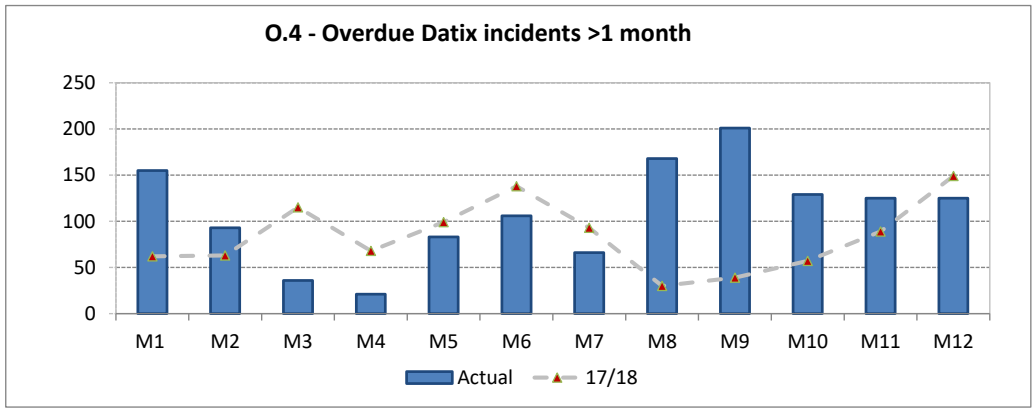

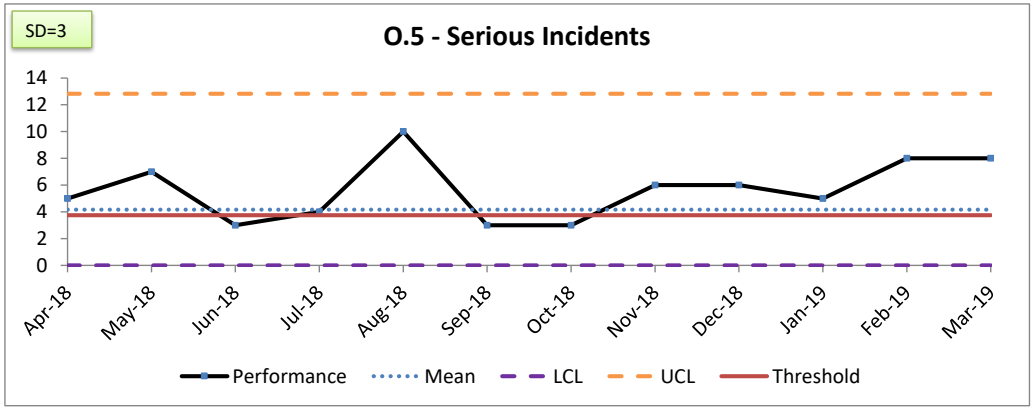

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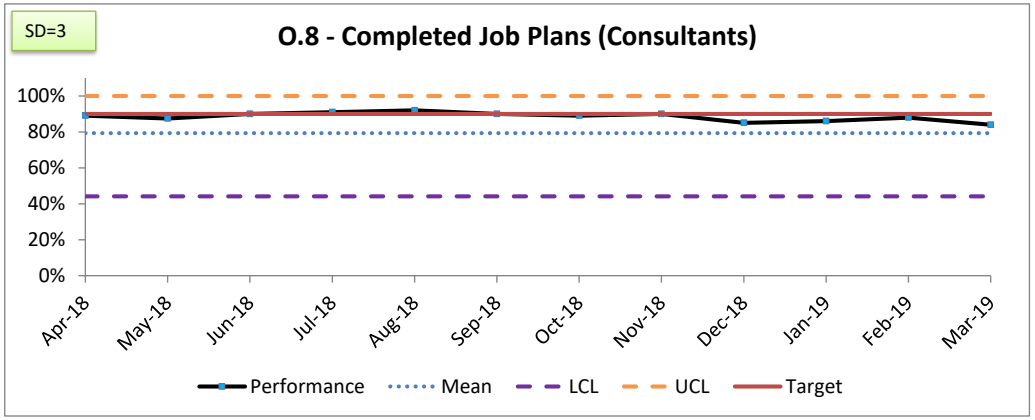


Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Public Board	Date: 3 May 2019
Report title:	**Finance Paper Month 12 2018-19**	**Agenda item: 4.2**
Lead director **Report authors**	Mike Keech Daphne Thomas Chris Panes	Director of Finance Deputy Director of Finance Head of Management Accounts
FoI status:	Private document	

Report summary	**An update on the financial position of the Trust at Month 12 (March 2019)**			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** X	**Decision** ☐
Recommendation	Trust Board to note the contents of the paper.			

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

Report history	None
Next steps	None
Appendices	1 to 3

FINANCE REPORT FOR THE MONTH TO 31st MARCH 2019

PUBLIC BOARD MEETING

PURPOSE

1. The purpose of the paper is to:

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

EXECUTIVE SUMMARY

2. *Income and expenditure* –The Trust's surplus for March 2019 was £7.3m (inclusive of £8.7m incentive PSF) which is £4.4m favourable to budget in the month and £0.3m worse than the Trust's control total (excluding PSF). For the full year, the Trust reported a deficit of £2.8m (after receipt of £9.2m core and £8.7m incentive PSF) which is £2.4m favourable to plan overall and £0.1m better on a control total basis (before PSF). The positive variance overall is driven principally by higher than plan receipt of PSF (£5.9m) offset by lower donations of £3.6m.

3. *Cash and capital position* – the cash balance as at the end of March 2019 was £6.2m, which was £3.7m above plan due to the timing of capital expenditure and receipts. The Trust has spent £15.8m on capital up to Month 12 of which £1.9m relates to eCARE, Cancer Centre £3.4m, Multi-Storey Car Park £0.3m, North site infrastructure £0.3m, UEC and GDE £1.3m and £8.6m on patient safety and clinically urgent capital expenditure.

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

5. *Cost savings* – overall savings of £2m were delivered in month against an identified plan of £1.9m and the target of £1.3m bringing the total year end savings achieved to £10.8m, an over achievement of £0.7m against the £10.1m full year target.

INCOME AND EXPENDITURE

6. The headline financial position can be summarised as follows:

All Figures in £'000	Month Plan	Month Actual	Month Var	Full Year Plan	Full Year Actual	Full Year Var
Clinical Revenue	17,038	17,736	698	200,842	206,267	5,425
Other Revenue	1,584	2,351	767	19,108	24,155	5,047
Total Income	18,622	20,087	1,465	219,950	230,422	10,472
Pay	(13,178)	(14,271)	(1,093)	(161,178)	(166,258)	(5,080)
Non Pay	(4,983)	(6,283)	(1,300)	(71,762)	(78,092)	(6,330)
Total Operational Expend	(18,161)	(20,555)	(2,394)	(232,941)	(244,350)	(11,409)
EBITDA	461	(468)	(929)	(12,990)	(13,928)	(938)
Financing & Non-Op. Costs	(1,017)	(382)	635	(12,191)	(11,140)	1,051
Control Total Deficit (excl. PSF)	**(556)**	**(850)**	**(294)**	**(25,181)**	**(25,068)**	**113**
Adjustments excl. from control total:						
PSF- Performance	359	359	(0)	3,079	3,079	0
PSF- Financial	717	717	0	6,147	6,147	0
PSF- ICS Financial	121	0	(121)	1,037	0	(1,037)
PSF- Incentive	210	7,144	6,934	1,800	8,734	6,934
Control Total Deficit (incl. PSF)	**851**	**7,369**	**6,518**	**(13,118)**	**(7,108)**	**6,010**
Donated income	2,092	10	(2,082)	8,592	5,000	(3,592)
Donated asset depreciation	(59)	(53)	6	(697)	(695)	2
Reported deficit/surplus	**2,884**	**7,326**	**4,442**	**(5,223)**	**(2,803)**	**2,420**

Note – the table above excludes a £6.7m impairment charged to operating expenses as a result of the revaluation of the Trust's estate.

Monthly and year to date review

7. The **deficit excluding Provider Sustainability Funding (PSF)** in month 12 is £850k which is £294k adverse to plan in month. For the full year the deficit excluding PSF is £25,068k which is £113k better than plan and therefore the Trust has delivered its revised financial control total for the year. Against the original control total set by NHSI, the Trust has over performed by £1,013k, thereby giving access to incentive funding (see below).

8. The Trust failed to meet the A&E performance requirements for Q4 however has met the full year target securing the full PSF funding associated with this element. The Trust has also secured £8,734k of incentive PSF income which has been added to the position. The STP performed below plan for the year and as a result the Trust has reported a negative variance of £121k (£1,037k YTD) in respect of the STP element of PSF, however this has been mitigated by the recognition of £700k of transformation funding.

9. The Trust reported a surplus in month 12 of £7,326k which is £4,442k favourable to the budget surplus of £2,884k; however the in-month variance included a negative variance of £2,082k against plan on donations and a positive variance of £6,814k on PSF income.

10. **Income (excluding PSF and donations)** is £1,464k favourable to plan in March and £10,472k favourable for the year and can be further analysed in Appendix 1.

11. **Operational costs** in March are adverse to plan by £2,422k and £11,437k for the year.

12. **Pay costs** are £1,093k adverse to budget in Month 12. The variance is a result of high substantive and bank expenditure in month partly due to the higher than budgeted pay award which is largely offset by central funding as noted above (total of £187k in the month) as well higher temporary staffing costs to support higher activity levels.

13. **Non pay costs** were £1,328k adverse to plan in month and £6,358k for the year. The in-month variances relate to outsourcing and clinical supplies costs required to deliver the higher than planned activity levels as well as various balance sheet itemovements relating to bad debt and other items.

14. **Non-operational costs** are lower than plan in month due to an adjustment to PDC and Depreciation.

COST SAVINGS

15. In Month 12, £2,001k was delivered against an identified plan of £1,860k and a target of £1,315k.

16. Overall for the year £10.8m of schemes has been delivered against the £10.1m target.

CASH AND CAPITAL

17. The cash balance at the end of March 2019 was £6.2m, which was £3.7m above plan due to the timing of receipts relating to PSF incentive funding of £1m and £0.7m relating to education and training budgets and capital spend relating to the non-strategic schemes. The Trust drew down its remaining capital funding relating to approved capital schemes.

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

- Non-current assets are below plan by £40.9m; this is mainly driven by the revision to the capital plan and the impact of the revaluation reducing assets by £27m.

- Current assets are above plan by £12.7m, this is due to cash £3.7m, receivables £8.6m and inventories £0.4m above plan.

- Current liabilities are above plan by £51.3m. This is being driven by borrowings £46.7m, Trade and Other Creditors £4.4m, provisions £0.1m and deferred income £0.1m above plan. The borrowings are above plan due to the re-categorisation in loan principal due in the next financial year from non-current borrowings, and the change in accounting standard (IFRS9) whereby accrued interest is included in the current borrowings value.

- Non-current liabilities are below plan by £55.7m. This is being driven by the timing of revenue loan funding from NHSI being different to planned and the re-categorisation of loan principal due in the next financial year moved to current liabilities.

19. The Trust has spent £15.8m on capital up to month 12 of which £1.9m relates to ECare, Cancer Centre £3.4m, Multi-Storey Car Park £0.3m, North site infrastructure £0.3m, UEC and GDE £1.3m and £8.6m on patient safety and clinically urgent capital expenditure.

RISK REGISTER

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

a) Continued Department of Health and Social Care (DHSC) cash funding is insufficient to meet the planned requirements of the organisation.

Funding to cover the ongoing funding requirements in 2019/20 is subject to approval by DHSC on a monthly basis and remains a risk in the new financial year. The Trust also requires additional capital funding in order to progress essential schemes.

b) The Trust is unable to achieve the required levels of financial efficiency within the Transformation Programme.

The Trust has achieved its target for this financial year and there will be a requirement to deliver CIP's of £8.4m in 2019-20.

c) The Trust is unable to keep to affordable levels of agency (and locum) staffing.

The Trust has an annual agency ceiling of £11.4m in 2018-19 which is in line with the level included in the financial plan. The Trust has manged to maintain its trajectory of agency expenditure over the winter period however there is still significant pressure on the Trust to maintain this level into the new financial year where the target will be £11.1m.

d) The Trust is unable to access £10.3m of Provider Sustainability Funding.

As reported earlier in the report, the Trust has successfully accessed £9.3m of the £10.3m funding from PSF relating to its original allocation as well as an additional £8.7m of incentive funds. Central DHSC funding will continue to form a significant element of the 2019-20 plan and will be contingent on achieving the Trust's financial plan so this type of risk will continue into 2019-20.

e) Main commissioner is unable to pay for the volume of activity undertaken by the Trust.

If the Trust over performs against the contract this places financial pressure on the Trust's commissioners who are more likely to challenge other areas in the contract such as the application of penalties. For 2018/19 a significant level of contract challenges has been raised by commissioners in particular with the new (more stringent) process for authorisation of Procedures of Limited Clinical Value (PoLCV) and this represents a risk to recoverability of income.

RECOMMENDATIONS TO BOARD OF DIRECTORS

21. The Trust Board is asked to note the financial position of the Trust as at 31st March 2019 and the proposed actions and risks therein.

Appendix 1

Milton Keynes Hospital NHS Foundation Trust
Statement of Comprehensive Income
For the period ending 31st March 2019

	March 2019			12 months to March 2019			Full year
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME							
Outpatients	3,612	3,854	242	42,179	43,881	1,702	42,179
Elective admissions	2,356	2,448	92	28,205	28,538	333	28,205
Emergency admissions	5,487	5,058	(429)	64,477	64,526	49	64,477
Emergency adm's marginal rate (MRET)	(279)	(146)	133	(3,287)	(4,013)	(726)	(3,287)
Readmissions Penalty	(221)	(232)	(11)	(2,594)	(2,727)	(133)	(2,594)
A&E	1,130	1,083	(47)	13,302	12,373	(929)	13,302
Maternity	1,944	1,781	(163)	22,856	20,624	(2,232)	22,856
Critical Care & Neonatal	525	383	(142)	6,181	5,970	(211)	6,181
Excess bed days	0	0	0	0	0	0	0
Imaging	425	486	61	4,831	5,153	322	4,831
Direct access Pathology	390	416	27	4,569	4,650	81	4,569
Non Tariff Drugs (high cost/individual drugs)	1,407	1,271	(136)	16,607	17,713	1,105	16,607
Other	263	1,333	1,070	3,516	9,579	6,063	3,516
Clinical Income	**17,038**	**17,736**	**698**	**200,842**	**206,267**	**5,425**	**200,842**
Non-Patient Income	**5,083**	**10,581**	**5,498**	**39,763**	**47,115**	**7,352**	**39,763**
TOTAL INCOME	**22,121**	**28,316**	**6,195**	**240,605**	**253,382**	**12,776**	**240,605**
EXPENDITURE							
Total Pay	**(13,178)**	**(14,271)**	**(1,093)**	**(161,178)**	**(166,258)**	**(5,080)**	**(161,178)**
Non Pay	(3,576)	(5,012)	(1,436)	(55,155)	(60,379)	(5,224)	(55,155)
Non Tariff Drugs (high cost/individual drugs)	(1,407)	(1,271)	136	(16,607)	(17,713)	(1,105)	(16,607)
Non Pay	**(4,983)**	**(6,283)**	**(1,300)**	**(71,762)**	**(78,092)**	**(6,330)**	**(71,762)**
TOTAL EXPENDITURE	**(18,161)**	**(20,555)**	**(2,394)**	**(232,941)**	**(244,350)**	**(11,409)**	**(232,941)**
EBITDA*	**3,960**	**7,762**	**3,802**	**7,665**	**9,032**	**1,367**	**7,665**
Depreciation and non-operating costs	(944)	(838)	106	(11,309)	(10,816)	493	(11,309)
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**3,015**	**6,924**	**3,908**	**(3,644)**	**(1,785)**	**1,860**	**(3,643)**
Public Dividends Payable	(131)	403	534	(1,579)	(1,019)	560	(1,579)
OPERATING DEFICIT AFTER DIVIDENDS	**2,884**	**7,326**	**4,442**	**(5,223)**	**(2,804)**	**2,420**	**(5,223)**
Adjustments to reach control total							
Donated Income	(2,092)	(10)	2,082	(8,592)	(5,010)	3,582	(8,592)
Donated Assets Depreciation	59	53	(6)	697	695	(2)	697
Control Total Rounding	0	0	0	0	0	0	0
PSF	(1,408)	(8,221)	(6,813)	(12,064)	(17,961)	(5,897)	(10,263)
CONTROL TOTAL DEFECIT	**(557)**	**(851)**	**(294)**	**(25,182)**	**(25,080)**	**104**	**(23,381)**

* EBITDA = Earnings before Interest, Taxation, Depreciation and Amortisation

Appendix 2

Milton Keynes Hospital NHS Foundation Trust
Statement of Cash Flow
As at 31st March 2019

	Unaudited Mth12 2018-19 £000	Mth 11 £000	In Month Movement £000
Cash flows from operating activities			
Operating (deficit) from continuing operations	(6,528)	(6,891)	363
Operating surplus/(deficit) of discontinued operations			
Operating (deficit)	**(6,528)**	**(6,891)**	**363**
Non-cash income and expense:			
Depreciation and amortisation	8,816	8,161	655
Impairments	6,743	0	6,743
(Increase)/Decrease in Trade and Other Receivables	(5,830)	(1,087)	(4,743)
(Increase)/Decrease in Inventories	(320)	(6)	(314)
Increase/(Decrease) in Trade and Other Payables	618	2,605	(1,987)
Increase/(Decrease) in Other Liabilities	69	(306)	375
Increase/(Decrease) in Provisions	(128)	(54)	(74)
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows	(5,010)	(5,009)	(1)
Other movements in operating cash flows	(4)	(4)	-
NET CASH GENERATED FROM OPERATIONS	**(1,574)**	**(2,591)**	**1,017**
Cash flows from investing activities			
Interest received	54	48	6
Purchase of intangible assets	(2,062)	(2,615)	553
Purchase of Property, Plant and Equipment, Intangibles	(13,363)	(8,009)	(5,354)
Sales of Property, Plant and Equipment	0	0	0
Net cash generated (used in) investing activities	**(15,371)**	**(10,576)**	**(4,795)**
Cash flows from financing activities			
Public dividend capital received	2,202	641	1,561
Loans received from Department of Health	18,125	16,409	1,716
Loans repaid to Department of Health	(953)	(858)	(95)
Capital element of finance lease rental payments	(146)	(140)	(6)
Interest paid	(1,669)	(1,204)	(465)
Interest element of finance lease	(307)	(281)	(26)
PDC Dividend paid	(1,649)	(860)	(789)
Receipt of cash donations to purchase capital assets	5,010	5,009	1
Cash flows from (used in) other financing activities		0	0
Net cash generated from/(used in) financing activities	**20,613**	**18,716**	**1,897**
Increase/(decrease) in cash and cash equivalents	**3,668**	**5,549**	(1,881)
Opening Cash and Cash equivalents	**2,507**	**2,507**	0
Closing Cash and Cash equivalents	**6,175**	**8,056**	**(1,881)**

Appendix 3

Milton Keynes Hospital NHS Foundation Trust
Statement of Financial Position as at 31st March 2019

	Audited Mar-18	Mar-19 YTD Plan	Mar-19 YTD Actual (unaudited)	In Mth Mvmt	YTD Mvmt	% Variance
Assets Non-Current						
Tangible Assets	171.9	188.7	147.3	(41.4)	(24.6)	(14.3%)
Intangible Assets	10.0	13.8	14.2	0.4	4.2	42.0%
Other Assets	0.4	0.4	0.5	0.1	0.1	13.1%
Total Non Current Assets	**182.3**	**202.9**	**162.0**	**(40.9)**	**(20.3)**	**(11.2%)**
Assets Current						
Inventory	3.3	3.2	3.6	0.4	0.3	9.1%
NHS Receivables	19.1	16.5	23.5	7.0	4.4	23.0%
Other Receivables	4.1	4.4	6.0	1.6	1.9	46.3%
Cash	2.5	2.5	6.2	3.7	3.7	147.3%
Total Current Assets	**29.0**	**26.6**	**39.3**	**12.7**	**10.3**	**35.5%**
Liabilities Current						
Interest -bearing borrowings	(32.3)	(33.5)	(80.2)	(46.7)	(47.9)	148.2%
Deferred Income	(1.6)	(1.6)	(1.7)	(0.1)	(0.1)	6.6%
Provisions	(1.4)	(1.4)	(1.6)	(0.2)	(0.2)	12.0%
Trade & other Creditors (incl NHS)	(28.4)	(24.5)	(28.9)	(4.4)	(0.5)	1.6%
Total Current Liabilities	**(63.7)**	**(61.0)**	**(112.3)**	**(51.3)**	**(48.6)**	76.3%
Net current assets	**(34.7)**	**(34.4)**	**(73.0)**	**(38.6)**	**(38.3)**	**110.4%**
Liabilities Non-Current						
Long-term Interest bearing borrowings	(83.6)	(108.4)	(53.0)	55.4	30.6	(36.6%)
Provisions for liabilities and charges	(1.1)	(1.1)	(0.8)	0.3	0.3	(24.8%)
Total non-current liabilities	**(84.7)**	**(109.5)**	**(53.9)**	**55.7**	**30.8**	(36.4%)
Total Assets Employed	**62.9**	**59.0**	**35.1**	**(24.0)**	**(27.8)**	**(44.2%)**
Taxpayers Equity						
Public Dividend Capital (PDC)	99.2	100.4	101.4	1.0	2.2	2.2%
Revaluation Reserve	78.7	78.7	58.3	(20.4)	(20.4)	-25.9%
I&E Reserve	(115.0)	(120.1)	(124.5)	(4.4)	(9.5)	8.3%
Total Taxpayers Equity	**62.9**	**59.0**	**35.1**	**(23.9)**	**(27.7)**	**(44.1%)**

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Trust Board**	**Date: 3 May 2019**
Report title:	**Workforce update report**	**Agenda item: 4.3**
Lead director **Report author**	**Name: Danielle Petch** **Name: Paul Sukhu**	**Title: Director of Workforce** **Title: Deputy Director of Workforce**
FoI status:		

Report summary	This report provides a summary of workforce Key Performance Indicators for the full year ending 31 March 2019 (Month 12).						
Purpose *(tick one box only)*	**Information**	x	**Approval**		**To note**	x	**Decision**
Recommendation	Trust Board is asked to note the Workforce report.						

Strategic objectives links	Objective 8 : Improve Workforce Effectiveness
Board Assurance Framework links	None
CQC outcome/ regulation links	Well Led Outcome 13 : Staffing
Identified risks and risk management actions	1606 - We may be unable to recruit sufficient qualified nurses for safe staffing in wards and departments 1608 - There is a risk that sufficient numbers of employees may not undergo an appraisal to achieve target of 90%. 1609 - IF staff are unable to remain compliant in all aspects of mandatory training linked to their job requirements THEN staff may not have the knowledge and skills required for their role LEADING potential patient/staff safety risk and inability to meet CCG compliance target of 90% 1613 - IF there is inability to retain staff employed in critical posts THEN we may not be able to provide safe workforce cover LEADING TO clinical risk.
Resource implications	
Legal implications including equality and diversity assessment	

Report history	Full monthly Corporate Workforce Information report - Executive Management Board, Divisional Accountability, April 2019
Next steps	
Appendices	None

Workforce report – Month 12, 2018/19

1. Purpose of the report

1.1. This report provides a summary of workforce Key Performance Indicators for the full year ending 31 March 2019 (Month 12).

2. Staff in post

2.1. The Trust's staff in post by whole time equivalent (WTE) was 3091.0 as at 31 March 2019; an increase of 67.2 WTE since March 2018.

2.2. The Trust's headcount is 3572, an increase of 70 since March 2018.

2.3. The largest increases of staff in post since March 2018 have been in the Additional Clinical Services and Nursing and Midwifery staff groups.

3. Vacancy rate

3.1. The Trust's overall vacancy rate is 11.5%; this has reduced from 13.1% in September 2018.

3.2. Rolling recruitment adverts are in place for Nursing and Midwifery posts within the clinical divisions, with toolkits for targeted recruitment using social media channels.

3.3. As required under the ongoing Workforce Strategy delivery plan, the teams continue to hold recruitment events/fayres and to investigate innovative means of recruitment to fill vacancies.

4. Turnover

4.1. The Trust's leaver turnover rate has been lower in 2017/18 than it was in 2016/17 and in line with its trend for Q2 to Q4 has reduced from 12.6% to 10.89% since May 2018.

4.2. Retention is a key theme in the Trust's Workforce Strategy 2018-21. Information from the newly available 2018 National Staff Survey will be utilised to undertake initiatives to further improve retention rates.

5. Temporary staffing

5.1. The temporary staff usage (bank and agency) for the rolling year-to-date was 5948.0 WTE, which was 14.3% of total WTE staff employed.

5.2. Agency staff usage was 3.7% of the total WTE staff employed for the rolling year to date but was 6.1% of the total annual staff expenditure. This is predominantly driven by high cost medical and dental agency locums and volume of nursing agency staff.

5.3. The Trust ceiling for agency staff expenditure for 2018/2019 is £11.4m. The Trust is consistently below the allocated agency expenditure ceiling.

6. Sickness absence

6.1. The sickness absence rate (N.B. 12 months to M11, 28 February 2019) has reduced further since M10, remaining below the Trust target of 4.0% at 3.95% (1.73% short term and 2.22% long term).

6.2. Overall, the Trust's sickness absence levels remain lower than the same period for the last two financial years.

6.3. Since the implementation of the new Sickness Absence and Attendance policy in December 2018, increased volumes of referrals to Staff Health and Wellbeing are being undertaken by managers and supervisors; this is also increasing activity for the Staff Health and Wellbeing Team and HR Advisory teams.

6.4. The Workforce team continues to identify sickness absence trends and hotspots, providing case management support where appropriate. Cases of intermittent and long term absence are also targeted to improve staff health and wellbeing and elicit improved attendance levels.

6.5. More detail on sickness absence is reported and discussed at Divisional Executive Management Board (Divisional Accountability – monthly), Workforce Board and Workforce and Development Assurance Committee (both quarterly).

7. Statutory and mandatory training

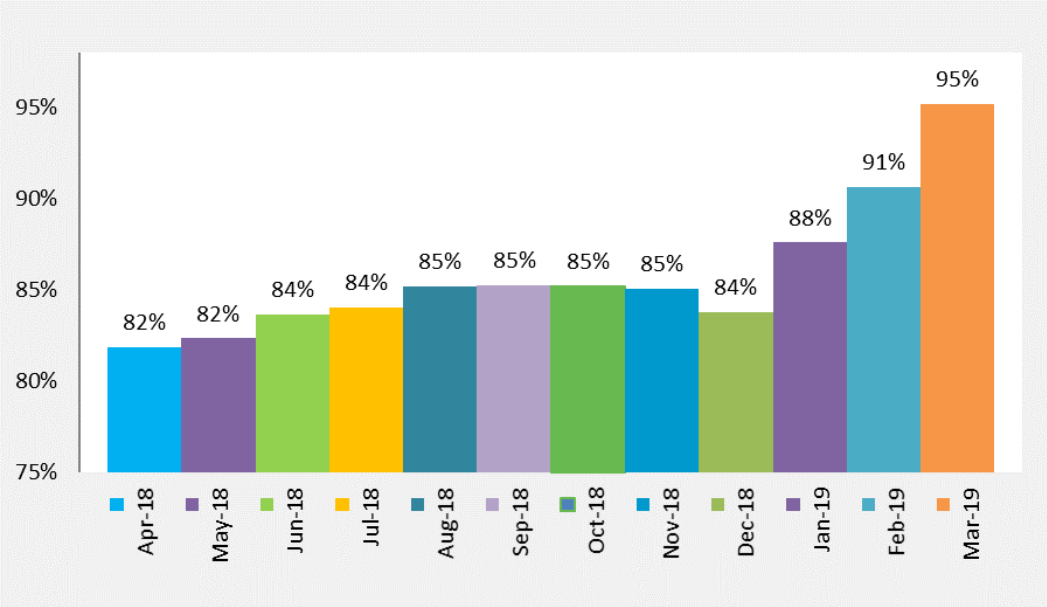
7.1. Statutory and mandatory training compliance as at 31 March 2019 was at 93% against the Trust target of 90%.

Training Compliance by Division	
Core Clinical	96%
Corporate Services	95%
Medicines Unplanned Care	92%
Surgical Planned Care	91%
Women's and Children's	94%
Trust Total Compliance	**93%**

8. Appraisal compliance

8.1. Trust-wide appraisal compliance as at 31 March 2019 is 95%, against the Trust target of 90%.

Appraisal Completion by Division	
Core Clinical	97%
Corporate Services	93%
Medicines Unplanned Care	96%
Surgical Planned Care	93%
Women's and Children's	96%
Total Trust	**95%**



9. 2018 National Staff Survey (18NSS)

9.1. The results of the 18NSS were published in February 2019. Briefings have been shared with the Executive Team, Workforce Board and Workforce Development and Assurance Committee. The detailed results have also been shared with the operational teams. The results for MKUH are very close to the national averages for all Acute Trusts.

9.2. The top 5 scores compared to average are:

1) Last experience of physical violence was reported (Ave 66% MKUH 70%)
2) I have adequate material supplies and equipment to do my work (Ave 53% MKUH 58%)
3) Organisation definitely takes positive action on health and wellbeing (Ave 28% MKUH 32%)
4) Last experience of harassment/bullying/abuse was reported (Ave 44% MKUH 49%)
5) I know who senior managers are (Ave 83% MKUH 86%)

9.3. The bottom 5 scores compared to average are:

1) In the last 3 months have not come to work when not feeling well enough to perform duties (Ave 42% MKUH 33%)
2) Don't work any additional paid hours per week for this organisation over and above contracted hours (Ave 64% MKUH 57%)
3) Receive regular updates on patient and service user feedback in my directorate /department (Ave 56% MKUH 54%)
4) Appraisal performance review – organisational values are definitely discussed (Ave 37% MKUH 31%)
5) Feedback for patients and service users is used to make informed decisions within the directorate / department (Ave 58% MKUH 54%)

9.4. The 5 most improved scores for MKUH from the 2017 to 2018 survey were:

1) staff have adequate materials, supplies and equipment to do their work;
2) harassment, bullying or abuse at work has higher rates of reporting
3) my organisation takes positive action on health and well-being
4) higher reporting of physical violence at work
5) the organisation acts on concerns raised by patients/service users

9.5. The 5 scores which have deteriorated from the 2017 to 2018 survey were:

1) training, learning or development needs not identified at staff appraisal
2) discrimination experienced with regard to ethnicity
3) working more paid hours than contracted
4) the values of the organisation were not discussed as part of the appraisal process
5) Feedback from patients/service users is not used to make informed decisions within directorates/departments

9.6. The HR teams are working closely with the operational teams to develop plans to address issues raised in the survey, both at strategic and team level. Progress against these plans will be monitored through Workforce Board and Workforce Development and Assurance Committee.

10. Recommendations

10.1. Trust Board is asked to note the Workforce report.

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Board of Directors	Date: 3 May 2019
Report title:	Board Assurance Framework – End of Year Report (2018/19); Board Assurance Framework for 2019/20	Agenda item: 5.1
Lead director Report author Sponsor(s)	Kate Burke	Director of Corporate Affairs
FoI status:	Public	

Report summary				
Purpose *(tick one box only)*	Information [x]	Approval [ ]	To note [ ]	Decision [ ]
Recommendation	That the Board notes the end of year summary and the proposal for developing the Board Assurance Framework in 2019/20			

Strategic objectives links	All
Board Assurance Framework links	All
CQC regulations	All domains
Identified risks and risk management actions	Within BAF
Resource implications	Within individual risk action plans
Legal implications including equality and diversity assessment	Pursuant to individual risks

Report history	The BAF is reported to the Board on a quarterly basis (minimum) and to every Board sub-Committee
Next steps	Board Committees
Appendices	Papers follow

Board Assurance Framework: 2018/19 End of Year Report and 2019/20 Board Assurance Framework Process

2018/19 End of Year Board Assurance Framework Management Report

The Board of Directors has set, reviewed, scrutinised and challenged the Board Assurance Framework throughout the year as part of its duty to ensure appropriate risk management and internal control. This has taken place both at the Board and at Committees of the Board, which each have delegated responsibility around risk management, with Audit Committee holding responsibility for assuring overall risk management and internal control processes on behalf of the Board.

The Board set its risk appetite in 2018/19, with the genera risk appetite statement: Milton Keynes University Hospital recognizes that its long-term sustainability depends upon the delivery of its strategic objectives and its relationships with those it serves, the wider community, and the health and social care system in which it operates (both locally and nationally).The Trust will not accept risks that materially impact on the safety (quality and outcomes) of the patients it provides care and services for. The Trust will consider risk in other categories if there is clear strategic or operational benefit. The Trust recognizes that it takes such decisions within a legal and regulatory framework.

The Trust has further reviewed its risk appetite using the Good Governance Institute risk management matrix, which segments types of risk and allows specific risk appetites to be set against each segment.

Risk appetite levels:

0 **Avoid**	**1** **Minimal (As Little As Reasonably Possible)**	**2** **Cautious**	**3** **Open**	**4** **Seek**	**5** **Mature**
Avoidance of risk and uncertainty is a key organizational objective	Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward	Willing to consider potential delivery options and choose while also providing and acceptable level of reward and value for money (VFM)	Eager to be innovative and to choose options offering potentially higher business rewards despite greater inherent risk	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness are robust

Types of risk:

Type of Risk	Definition
Financial	Risks that may adversely affect the Trust's financial position or viability
Compliance/ Regulatory	Risks that may adversely affect the Trust's ability to deliver care and services in accordance with its licence and registration and any relevant statute/ legislation/ law/ regulation
Innovation	Risks that may threaten the Trust's ability to explore innovative ways of working or delivering care/ services
Quality/ Outcomes	Risks that may threaten the day-to-day delivery of safe, high quality care and services
Reputation	Risks that may threaten public confidence in the Trust and its services or staff

The Trust's risk appetite by segment:

Type of Risk	Risk Appetite
Financial	**Open** - Willing to consider potential delivery options and choose while also providing and acceptable level of reward and VFM
Compliance/ Regulatory	**Cautious** - Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
Innovation	**Seek** - Eager to be innovative and to choose options offering potentially higher business rewards despite greater inherent risk
Quality/ Outcomes	**Minimal/ ALARP** (as low as reasonably practicable)- Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
Reputation	**Open** - Willing to consider potential delivery options and choose while also providing and acceptable level of reward and VFM

Risk management performance throughout 2018/19

The summary of risk scoring and movement is included below. Risks have moved on and off the Board Assurance Framework during the year, demonstrating the Trust's active risk management approach. The overall risk management picture is relatively static, with some scores remaining consistent throughout the year. Risk scores, controls, assurances, gaps and actions can be evidenced as being discussed in detail at Committees of the Board, with appropriate challenge around each. There is a suggestion that target scores may be set too

low for such broad strategic risk categories and reviewing these, along with revised and updated risks, will form part of the Board's Board Assurance Framework plenary in May.

The highest scoring risks at the end of 2018/19 on the Board Assurance Framework were:

2.1 Failure to provide an appropriate (good) patient experience

4.1 Failure to meet constitutional standards (emergency access)

4.2 Failure to meet constitutional standards (elective access)

7.4 Disagreement with main commissioner over the level of performance that they are prepared to fund

Strategic Objective	Risk Ref	Committee	Risk Description	Proximity	Risk Score (consequence v likelihood)								Target	Movement towards target (since Mar 2018)	Risk Appetite
					Jan-18	Apr-18	Jun-18	Aug-18	Sep-18	Dec-18	Mar-19				
SO1: Patient Safety	1-1	Quality and Clinical Risk	Strategic failure to manage demand for emergency care	Next 3 to 6 months	Not on BAF	(4x3) = 12	(4x3) = 12	(4x3) = 12	(3x4)= 12	(3x4)=12	(3X4)= 12		(4x2) = 8	Remains static	Avoid
SO1: Patient Safety	1-2	Quality and Clinical Risk	Tactical failure to manage demand for emergency care	Next 3 to 6 months	Not on BAF	(4x3) = 12	(4x3) = 12	(4x3) = 12	(3x4)= 12	(3x4)=12	(3X4)= 12		(4x2) = 8	Remains static	Avoid
SO1: Patient Safety	1-3	Quality and Clinical Risk	Ability to maintain patient safety during periods of overwhelming demand	Next 3 to 6 months	(4x5) = 20	(4x4) = 16	(4x4)= 16	(4x4)= 16	(4x4)= 16	(4x4)=16	(4X3)= 12		(4x2) = 8	Closer to target	Avoid
SO1: Patient Safety	1-4	Quality and Clinical Risk	Failure to appropriately embed learning and preventative measures following Serious Incidents	Next 3 to 6 months	(5x2) = 10	(5x2) = 10	(5x2) = 10	(5x2) = 10	(5x2)= 10	(5x2)=10	(5X2)= 10		(5x1) = 5	Closer to target	Avoid
SO1: Patient Safety	1-5	Quality and Clinical Risk	Failure to recognise and respond to the deteriorating patient	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(3x3) = 9	(5x2) = 10	(5x2)= 10	(5x2)=10	(5X2)= 10		(5x1) = 5	Remains static	Avoid
SO1: Patient Safety	1-6	Quality and Clinical Risk	Failure to manage clinical risks through the implementation of eCARE (go-live)	Next 3 to 6 months	Not on BAF	(4x3) = 12	(4x3) = 12	(4x2) = 8	(4x2)= 8	Recommend Risk Closed	Risk Closed		(4x2) = 8	Closer to target	Cautious
SO2: Patient Experience	2-1	Quality and Clinical Risk	Failure to provide an appropriate patient experience	Next 3 to 6 months	(4x4) = 16	(4x4) = 16	(4x4)= 16	(4x4)= 16	(4x4)= 16	(4x4)=16	(4x4)=16		(4x2) = 8	Remains static	Cautious

SO3: Clinical Effectiveness	3-1	Quality and Clinical Risk	Lack of assessment against and compliance with best evidence based clinical practice through clinical audit	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3) = 12	(3x4)= 12	(3x4)=12	(3X4)= 12		(4x2) = 8	Remains static	Cautious
SO3: Clinical Effectiveness	3-2	Quality and Clinical Risk	Lack of assessment against and compliance with NICE guidance	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3) = 12	(3x4)= 12	(3x4)=12	(3X4)= 12		(4x2) = 8	Remains static	Cautious
SO4: Key Targets	4-1	Management Board	Failure to meet the 4 hour emergency access standard	Next 3 to 6 months	(4x5) =20	(4x4) =16	(4x4)= 16	(4x4)= 16	(4x4)= 16	(4x4)=16	(4x4)=16		(4x2) = 8	Remains static	Cautious
SO4: Key Targets	4-2	Management Board	Failure to meet the key elective access standards - RTT 18 weeks, non-RTT and cancer 62 days	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x4) = 16	(4x4)= 16	(4x4)=16	(4x4)=16		(4x2) = 8	Remains static	Cautious
SO5: Sustainability	4-3	Audit	Failure to ensure adequate data quality leading to patient harm, reputational risk and regulatory failure	Next 3 to 6 months	(4x5) = 20	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3)= 12	(4x3)=12	(4X3)= 12		(4x2) = 8	Remains static	Cautious
SO5: Sustainability	5-1	Audit	Failure to adequately safeguard against major IT system failure (deliberate attack)	Next 3 to 6 months	(3x3) = 9	(5x2) = 10	(5x2) = 10	(5x2) = 10	(5x2)= 10	(5x2)=10	(5X2)= 10		(5x1) = 5	Remains static	Cautious
SO5: Sustainability	5-2	Finance	Failure to adequately safeguard against major IT system failure (inability to invest in appropriate support systems/infrastructure)	Next 3 to 6 months	(3x3) = 9	(4x2) = 8	(4x2) = 8	(4x2) = 8	(4x2)= 8	(4x2)=8	(4x2)=8		(4x2) = 8	Remains static	Cautious

SO5: Sustainability	5-3	Management Board	Failure to successfully deploy EPR in a way that diminishes disruption	Next 3 to 6 months	(5x3)=15	(4x3) = 12	(4x3) = 12	Recommend Risk Closed	Risk Closed	Risk Closed	Risk Closed		(4x2) = 8	Closer to target	Cautious
SO5: Sustainability	5-4	Management Board	Failure to maximise the benefits of EPR	Next 3 to 6 months	(4x3) = 12	Reassessment required	Reassment required	Reassment required	4x2=8	4x2=8	4x2=8		3x2 = 6	Remains static	Minimal
SO5: Sustainability	5-5	Management Board	Failure to maximise the benefits of the Trust's digital strategy (patient access)	Next 3 to 6 months	Not on BAF	Not on BAF	Not on BAF	(4x3) = 12	(4x3)= 12	(4x3)=12	(4X3)= 12		(4x2) = 8	Remains static	Seek
SO7: Finance and Governance	7-1	Finance	Inability to keep to affordable levels of agency and locum staffing	Next 3 to 6 months	(5x4)=20	(4x3) = 12	(5x4)=20	(4x4) = 16	(4x4)= 16	(3x4)=12	Risk Closed		(4x3) = 12	Closer to target	Open
SO7: Finance and Governance	7-2	Finance	Timing and release of capital and revenue funding	Next 12 months	(5x5) = 25	(4x4) = 16	(4x4)= 16	(4x4)= 16	(4x4)= 16	(4x4)=16	(4x3)=12		(4x3) = 12	Closer to target	Open
SO7: Finance and Governance	7-3	Finance	Inability to achieve the required levels of financial efficiency within the Transformation Programme	Next 12 months	(5x4) = 20	(4x4) = 16	(5x4) = 20	(5x4) = 20	(5x4)= 20	(4x4)=16	(4X3)= 12		(4x3) = 12	Closer to target	Seek
SO7: Finance and Governance	7-4	Finance	Disagreement with main commissioner over the level of performance that they are prepared to fund	Next 12 months	(5x4) =20	(4x4) = 16	(4x4)= 16	(4x4)= 16	(4x4)= 16	(4x4)=16	(4x4)=16		(4x3) = 12	Remains static	Seek
SO7: Finance and Governance	7-5	Finance	The Trust is unable to access £7.3m of Sustainability & Transformation Funding	Next 3 to 6 months	(5x5) = 25	(4x4) = 16	(5x4) = 20	(5x4) = 20	(5x4)= 20	(5x4)=20	(4X3)= 12		(4x3) = 12	Closer to target	Seek

SO7: Finance and Governance	7-6	Board	Failures in compliance leading to regulatory intervention (CQC)	Next 12 months	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3)= 12	(4x3)=12	(4x2)=8		(4x2) = 8	Closer to target	Cautious
SO8: Workforce	8-1	Workforce	Inability to recruit to critical vacancies	Next 3 to 6 months	(4x4) = 16	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3)= 12	(4x3)=12	(4X3)= 12		(4x2) = 8	Remains static	Seek
SO8: Workforce	8-2	Workforce	Inability to retain staff employed in critical positions	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3)= 12	(4x3)=12	(4X3)= 12		(4x2) = 8	Remains static	Seek
SO9: Estate	9-1	Finance	Insufficient capacity in the Neonatal Unit to accommodate babies requiring special care	Next 3 to 6 months	Not on BAF	Not on BAF	Not on BAF	(4x4) = 16	(4x4)= 16	(4x4)=16	(4X3)= 12		(4x2) = 8	Closer to target	Minimal
SO10: Corporate Citizen	10-1	Charitable Funds	Failure to achieve the required level of investment (including appeal funds) to fund the Cancer Centre	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3)= 12	(4x3)=12	(4x2)=8		(4x2) = 8	Remains static	Open
SO10: Corporate Citizen	10-2	Board	Inability to progress the Milton Keynes Accountable Care System and wider ACS/STP programme	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3)= 12	(4x3)=12	(4X3)= 12		(4x2) = 8	Remains static	Seek
SO10: Corporate Citizen	10-3	Board	Insufficent preparedness for disruption to workforce or supplies (including medications) following withdrawal from the European Union	Next 3 to 6 months	Not on BAF	Not on BAF	Not on BAF	Not on BAF	Not on BAF	(5x2)=10	(5X2)= 10		(5x1) = 5	Remains static	Avoid

2019/20 Board Assurance Framework Process

The Executive Team have reviewed the Board Assurance Framework risks under their risk ownership. An updated draft Board Assurance Framework is being presented in part two of the May Board meeting for input, review and agreement. The updated Board Assurance Framework will be brought back to the July public Board meeting. Committees will continue to actively assurance on those risks within their terms of reference. The Audit Committee will continue to provide scrutiny and assurance on the risk management and internal control process.

The Board reviewed its risk appetite statement during a plenary in April. Risk appetite will remain the same unless and until individual Committee recommend changes; or the Board reviews the risk appetite again (in six months' time).

Action Required

The Board is asked to note the content.

Audit Committee Summary Report

1. Introduction

The Audit Committee met on 21 March 2019. A summary of the key matters discussed is provided for the Board:

2. Counter Fraud

The Committee was notified that a recruitment review was undertaken but that this had not identified any significant issues. The Counter Fraud team has been working through National Fraud Initiative notifications, but no major risk to the Trust has been uncovered. A number of reactive reviews are ongoing.

3. Board Assurance Framework (BAF)

The Committee held a wide-ranging discussion about its role in relation to the BAF and the wider system of risk management. There was agreement that the Committee's principal role is to ensure the effectiveness of the overall process, rather than interrogate individual risks. In this regard, the Committee was assured that the Trust's risk management system is adequate, and that the BAF does help to drive the Board's agenda. However, they identified a number of areas for improvement, including a call for more timely reviews of risks, a drive for greater consistency in the way different risks are scored, and ensuring that actions are effective and timely. The Committee was keen to understand the steps that would need to be taken to transform the system from effective to among the "best in class". It was agreed that for the next meeting, an update will be provided to address the following issues:

- How often should risks be reviewed and what should be the Committee's role in this?
- What would an enhancement of the current system look like?
- How is the BAF being used to drive the Board agenda?

It was also suggested that "deep dives" be held to test the effectiveness of the system and that other risk registers might be tested to assess how well the overall system is working.

4. Data Quality

The data quality annual summary progress report was presented to the Committee. The Committee acknowledged that the Trust has been on a journey in this area, and there is now a robust structure in place, including the Data Quality Compliance Board, which is chaired by the Deputy Chief Executive. Data quality as tested by the auditors as part of the Quality Report process has steadily improved, although it was acknowledged that the number of errors recorded remains high compared to other trusts. The introduction of eCare, while positive, did temporarily slow progress, but staff are increasingly becoming more comfortable with the system, and the implementation of phase C is imminent.

The importance of accurate reporting was stressed, both from a clinical and financial perspective, and it is an area of focus for the executive team, with high priority being given to improving the effectiveness of the administrative systems that support the RTT pathways.

The Committee noted that the Trust continues to be rated in the 3rd quartile on this measure, and they stressed that they want to see more evidence of a systematic plan for improvement.

5. Investment Alternative Site Valuation

The Committee was asked to consider and approve an alternative valuation of the hospital site that would represent a change in the assumption of what it would look like. Multi-block and tower block options were considered, and the Committee accepted the former. It was noted that the valuation was subject to audit.

6. Internal audit

The Committee considered the draft Head of Internal Audit opinion, noting the auditors' view that the Trust has an adequate and effective framework for risk management, governance and internal control, but that their work had identified further enhancements to the framework to ensure that it remains adequate and effective. The internal auditors confirmed that they will be following up on all medium and high rated actions.

7. Financial Controller Report

Write-offs for the quarter amounted to £76k, £69k of which related to overseas patients, 50% of which would be a cost to the Trust.

Losses in the period amounted to £27k, £21k of which related to pharmacy and stock write offs.

In terms of credit notes over £20k, there were 2 in the period, amounting to £340k, and they related to underperformance against the NHS England contract.

There were 14 tender waivers in the period totalling £0.8m.

8. Draft Audit Committee Annual Report

The Committee noted and commented on its draft annual report, an updated version of which will be presented at the June meeting before presentation to the Board in July. The report will highlight how well the Committee assessed it had met its terms of reference during 2018/19 and identify any areas for development. The Committee recommended that similar reports be produced in respect of the other Board Committees.

9. Minutes from Board Committees

Minutes of the following Board Committee meetings were presented to the Committee for information:

- Finance and Investment Committee meetings on 17 December 2018 and 14 January and 4 February 2019 (approved)

10. Recommendation

The Board is asked to:

i) Note the report; and
ii) Consider the escalation items and any necessary actions.

Milton Keynes University Hospital NHS Foundation Trust

MEETINGS OF THE FINANCE AND INVESTMENT COMMITTEE HELD ON 25 February and 1 April 2019

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

The business case for internal alterations in the pharmacy department and replacement of the pharmacy robot was approved at the 25 February meeting.

Matters referred to the Board for final approval:

No matters were referred to the Board for final approval.

Matters considered at the meetings:

1. Performance dashboard

At the March meeting, it was noted that the high bed occupancy was indicative of the time of year, but the number of delayed transfers of care had remained low. A&E performance had been lower than in previous months but remained good in comparison to the position nationally. At the April meeting, it was noted that the readmission rate had dropped, despite continued pressure on the hospital as a result of high patient numbers.

2. Board Assurance Framework:

At the March meeting, it was noted that all of the finance related risks, with the exception of commissioner affordability were being positively managed.

3. Finance Report

I. At month 10, the Committee noted that the Trust's position was £144k better than plan in the year to date, and that it was £1m better than at the same time last year. There was some concern about the amount of debt owed, in particular, by non-NHS bodies, but they were assured that these issues had now been resolved. The Committee was also informed that the Trust is compliant with the latest regulations relating to overseas patients.

II. At month 11, the positive variance had grown to £400k in the year to date. The Committee's attention was drawn to the large negative variance across the rest of the BLMK footprint.

4. Agency update

I. Agency and locum usage remained steady over the March and April period. It was expected that by the end of the year, £9.5m would have been spent on agency staff – well below the £11.4m ceiling. The ceiling for next year will be £11.1m.

5. Timeline for strategic capital projects

I. The Committee received confirmation in March that the all of the funding for the year would be fully utilised by the end of the year.

II. The Cancer Centre remains on track for completion on 30 November 2019, and it remains on budget.

III. A full business case is to be prepared in respect of the Pathway Unit, work on which will commence in 2019/20.

6. Annual Plan

The Committee received an update on the annual planning process at their April meeting. Discussions continue with the MK CCG as to the form and structure of the contract for 2019/20. It was expected that a decision would be reached on the options by 18 April. The Committee also noted the expectation as expressed by the Department of Health and Social Care, that all provider bodies that are in deficit would return to balance by 2023/24.

Milton Keynes University Hospital NHS Foundation Trust

Quality and Clinical Risk Committee Summary Report

1. Introduction

The Quality and Clinical Risk Committee met on 21 March 2018.

2. Key matters

The following items were presented to the Committee:

Quarterly highlight report

The top issues, positive and challenging, occupying the Medical Director and the Chief Nurse's minds included:

- The CQC inspection dates had been confirmed and the logistics of hosting the team and preparing the organisation for the inspection were being worked through.
- A number of changes within the wider senior management team are taking place.
- The rate of pressure ulcers had increased in month to 1.71 per 100 bed days. The number of tissue viability nurses in the Trust has dropped from 2 posts to 0.6 WTE, and this may have had an impact on educational provision in this area. Opportunities for collaborative working with other local providers are being explored.

Clinical and Quality risks on the Board Assurance Framework (BAF)

- It was noted that a wider review of the BAF is to be undertaken at the Board seminar in April, after which this Committee will consider specific clinical risks.
- Regarding Risk 2-1 (failure to provide an appropriate patient experience), it was suggested that this might be recast to better reflect the different types of interactions that patients have with the hospital.
- There was a question whether the score for risk 1-3 (ability to maintain safety during periods of overwhelming demand) is high enough to reflect the importance of the issue.
- The need for a systematic annual review of the stability of services has been recognised.
- It was agreed that going forward, the BAF will be used more explicitly in agenda planning for this committee.
- The Medical Director and Chief Nurse both confirmed that there were no items missing from the BAF.

Exception report for Quality Dashboard

- The Trust is considering changing its Friends and Family Test provider as a result of problems it has experienced with its current provider.
- The position regarding ward moves at night is improved on what it was at the same time last year.
- The Trust is working well with the South Central Ambulance Service to address issues around ambulance handover delays.
- Although the complaints response time quoted in the report is rather low at 78.1%, a new process is now in place whereby complaints that have not been responded to within the set time limits are escalated for the direct intervention of the relevant executive director. No such interventions have been required since the process was introduced.

Mortality update

- The Committee was informed that although the Hospital Standard Mortality Ratios (HSMR) measure of mortality remains below 100, there has been an upward trend over the course of the year. If real, this may be due to changes to the availability of information to the clinical coders since the introduction of eCare. This will need to be kept under review.

- 7 medical examiners have been appointed and will take up post in May 2019. Their role will be to quality assure death certification processes within the Trust, identifying areas for learning and supporting bereaved families.
- 30 members of staff have been trained on the use of structured judgement review to review the care of patients who have died. Root Cause Analysis training is provided for the investigation of serious incidents, but specific bereavement training is not yet available.

Quarterly trust wide progress report – Serious Incidents
The Medical Director referred to a particular case which had highlighted cultural / teamworking issues within that team. These are being addressed, and the Committee was assured that in the main, teams work well together across the hospital.

Quality priorities 2019/20
The Committee was informed of the 3 priorities for 2019/20 to be addressed in the Quality Report 2018/19. These are:

- The scanning of patients for drug rounds
- Turnaround times for patient discharge medication
- Reducing the number of 'did not attends'

These priorities are consistent with the Trust's objectives, and progress against them will be measured routinely. Going forward, the quality priorities will link more directly to the Trust's Quality strategy.

A discussion about aspirational quality targets was commenced at this meeting and is to continue in June.

The Committee received and noted the early first draft of the Quality Report 2018/19.

Quarterly report on clinical audit
The Committee was informed of improvements in the quality and scope of clinical audit across the organisation. More support is being provided to audit leads and the process has been made less complicated. The link to quality improvement has also been acknowledged.

Length of stay update
The length of stay programme has been refocused and tasked with reducing length of stay for adults by 10% in 2019/20. Transport was identified as one of the biggest logistical barriers to patients getting home. It was noted that there are now good levels of collaborative working between the Trust and local partner organisations, as a result of which delayed discharges of care have reduced considerably. Improved access to community beds and therapy would help secure further improvements.

Update on the impact of the exit from the European Union
The NHS response to the risks posed by the exit is being managed regionally by Thames Valley. As at the time of the meeting, and in the run up to the original exit date of 29 March, there were no concerns about the availability of medicines, and no issues around supplies or workforce.

3. Conclusions
The committee was assured that the hospital remains safe, and commended the engaged and professional executive team.

The Board is asked to note this report.