NHS
Milton Keynes University Hospital
NHS Foundation Trust

Board of Directors

Public Meeting Agenda

Meeting to be held at 10.00 on Friday 4 May 2018 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 9 March 2018	Approve	Pages 3-14	Chairman
1.4	Matters Arising/ Action Log	Receive	Pages 15-16	Chairman
2. Chair and Chief Executive Strategic Updates				
2.1	Draft Minutes of the Council of Governors Meeting held on 20 March 2018	Receive	Pages 17-24	Chairman
2.2	Membership and Engagement Strategy	Approve	Pages 25-30	Chairman
2.3	Chairman's Report	Receive and Discuss	Verbal	Chairman
2.4	Chief Executive's Report	Receive and discuss	Pages 31-34	Chief Executive
2.5	Sustainability and Transformation Partnership	Note	Verbal	Chief Executive
3. Quality				
3.1	Patient Story	Receive and Discuss	Verbal	Director of Patient Care & Chief Nurse
3.2	Mortality update report	Discuss and Note	Pages 35-42	Medical Director
3.3	Nursing Staffing Update • Birthrate Plus analysis	Receive and Discuss	Pages 43-50	Director of Patient Care & Chief Nurse
3.4	Patient Experience Strategy Update	Receive and Discuss	Verbal	Director of Patient Care and Chief Nurse
4. Performance and Finance				
4.1	Performance report Month 12 • Proposal for 2018/19 dashboard	Receive and Discuss	Pages 51-68	Deputy Chief Executive
4.2	Finance update report Month 12	Receive and Discuss	Pages 69-78	Director of Finance
4.3	Workforce update report Month 12	Receive and Discuss	Pages 79-84	Director of Workforce

Item No.	Title	Purpose	Type and Ref.	Lead
5. Assurance and Statutory Items				
5.1	Freedom to Speak Up Board update	Receive and Discuss	Pages 85-92	Freedom to Speak Up Guardians
5.2	Board Assurance Framework	Receive and Discuss	Pages 93-104	Director of Corporate Affairs
5.3	(Summary Report) Finance and Investment Committee – 6 April 2018	Note	Pages 105-106	Chair of Committee
5.4	(Summary Report) Audit Committee – 22 March 2018	Note	Pages 107-110	Acting Chair of Committee
5.5	(Summary Report) Quality and Clinical Risk Committee – 22 March 2018	Note	Pages 111-114	Chair of Committee
6. Administration and closing				
6.1	Questions from Members of the Public	Receive and Respond	Verbal	Chair
6.2	Motion to Close the Meeting	Receive	Verbal	Chair
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."*	Chair

Milton Keynes University Hospital NHS Foundation Trust

BOARD OF DIRECTORS MEETING

Minutes of the Board of Directors meeting held in PUBLIC on Friday 9 March 2018 in the Board Room, Witan Gate House, 500-600 Witan Gate, Milton Keynes MK9 1ES

Present:

Simon Lloyd	Chairman
Joe Harrison	Chief Executive
John Blakesley	Deputy Chief Executive
Andrew Blakeman	Non-executive Director (Chair of Quality and Clinical Risk Committee)
John Clapham	Non-executive Director (University of Buckingham representative)
Parmjit Dhanda	Non-executive Director
Ogechi Emeadi	Director of Workforce
Robert Green	Non-executive Director (Chair of Audit Committee)
Mike Keech	Director of Finance
Lisa Knight	Director of Patient Care and Chief Nurse
Helen Smart	Non-executive Director
Tony Nolan	Non-executive Director (Chair of Workforce and Development Assurance Committee)
Ian Reckless	Medical Director
Heidi Travis	Non-executive Director

In Attendance:

Kate Burke	Director of Corporate Services
Caroline Hutton	Director of Clinical Services
Julie Wakefield	
Ade Kadiri	Company Secretary

2018/03/01	**Welcome**
1.1	The Acting Chairman welcomed all present to the meeting, and in particular, the three new non-executive directors.
2018/03/02	**Apologies**
2.1	There were no apologies for this meeting.
2018/03/03	**Declarations of interest**
3.1	John Clapham declared that he is an employee and representative on the Board of the University of Buckingham.

2018/03/04	**Minutes of the meeting held on 5 January 2018**
4.1	The minutes of the public Board meeting held on 5 January 2018 were accepted as an accurate record.
2018/03/05	**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>349 Health & Safety update</u> On today's agenda. Closed. <u>352 Nursing Staffing update</u> The Chief Nurse stated that Birthrate Plus had been due to report their findings in February, but had not done so, and have not yet given a date when it would be ready. It would appear that they are experiencing increased workloads as a result of the new guidance. To remain open.
2018/03/06	**Draft Minutes of the Council of Governors' Meeting held on 23 January 2018**
6.1	The draft minutes of the Council of Governors' meeting held on 23 January 2018 were received and noted.
2017/03/07	**Chairman's Report**
7.1	The Chairman recounted that the Trust had in recent weeks had visits from the Leader of the Opposition, the Secretary of State for Health and Social Care, and the Duke of Kent. The Secretary of State's visit had gone very well. The Chief Nurse and Medical Director had given excellent presentations showing how far the Trust has come. The opening of the Academic Centre by the Duke of Kent had also gone well – it is an excellent building and the Trust is looking forward to having use of it.
7.2	The Chairman announced that he had attended a meeting with the leader and the chairs from within the BLMK footprint. Items for discussion had included an interesting piece around the use of medical equipment in the community with a view to limiting the need for visits to GP surgeries and hospitals, the impending challenge of GDPR, and the discussion of a document entitled Partnering for Prosperity, which had indicated that 1million new homes are to be built in the corridor between Oxford, Milton Keynes and Cambridge, but yet made no mention of health or the healthcare challenges that such development would introduce. The Chairman also noted that the question whether to appoint a single Accountable Officer for all of the CCGs or retain one for each is still under review.
7.3	The hospital charity had been nominated for an award at the MK Business Awards, and although it did not win, it was heartening that the charity has been recognised within the local community. **Resolved**: The Board **noted** the Chairman's report.

2018/03/08	**Chief Executive's Report**
8.1	The Chief Executive made the point that the hospital is under immense pressure, with the current situation being more difficult than it had been in January. Winter is clearly not yet over, and this will be reflected in the overall numbers. There had also been difficulties in accessing the site in the last few days as a result of the snow.
8.2	Andrew Blakeman questioned whether, in the circumstances, the hospital remains safe. The Chief Executive indicated that all staff are doing all they can to ensure that it is as safe as it can be. However, he acknowledged that the Trust is pushing at the boundaries in terms of where and how patients are cared for. Mr Blakeman remarked that there must come a point where the Trust could no longer guarantee safety, and asked what would happen then. The Chief Executive observed that in the last six months, the Trust had moved from Operational Pressures Escalation Level (OPEL) 1 to 4, which is the highest escalation level, indicating that some patients may need to be looked after elsewhere. The Medical Director acknowledged that the Trust is not currently providing patients with the sort of experience they should be entitled to expect, and that elective patients are having difficulty getting care, but he is content that the hospital is safe. He also made the point that there had been no increase in the sort of serious incidents that would indicate intolerable pressure, such as pressure sores. It was noted, however, that unless changes are made to the way that the hospital functions, or extra capacity becomes available next year, a similar position would lead to serious difficulties.
8.3	The Chief Nurse informed the Board that there are extremes of care that the Trust had not yet resorted to, including the cessation of all elective care in order to keep the Emergency Department safe. The Director of Clinical Services reminded the Board of the planning session that had been held in December during which management of the escalation process had been considered. That planning has helped the Trust manage relatively well through this period. It was noted that despite the focus on winter pressures, June is in fact the Trust's busiest month. The Deputy Chief Executive made the point that historically, the hospital has never quite returned to normal following winter, and that escalation areas are never shut. The Trust will not be able to generate any extra capacity for some time, and as such something would need to change next winter.
8.4	Overall, the number of delayed transfers has reduced from previous years, and there has been a good response to the immediate pressures. The challenge is for the whole of the local system to achieve the national target of 3% for delayed discharges.
8.5	In response to a question about NHS Improvement's visit in March, it was noted that this is a follow up from last year, and the aim is to validate the Trust's RTT processes by assessing a number of exemplar and weaker services. It is expected that they will see some improvements, but that there is more work to do in some areas.
8.6	The Chairman indicated that as part of Apprenticeship Week, he had handed out certificates to some of the Trust's apprentices. He noted that some potential apprentices are put off by the requirement for 20% off the job training and that this

	is a common issue across sectors. There is also a lack of standards coming through in some areas. Nevertheless, the Trust is doing some good work with the University of Buckingham. **Resolved**: The Board **noted** the Chief Executive's Report.
2018/03/09	**Sustainability and Transformation Partnership**
9.1	The Chief Executive presented this update, informing the Board that STPs are to be renamed Integrated Care Systems (ICS). He expressed disappointment that the Luton & Dunstable/Bedford merger had been delayed, as a result of doubts about the availability of capital funding.
9.2	With regard to the financial positions of the different parts of the system, the Chief Executive confirmed that there is an understanding between MKUH and MKCCG about the risks around the year end position, but the Bedfordshire and Luton system is not in the same position. He reminded the Board that last year, the Trust had received some "bonus" funding for exceeding its control total – it is unlikely that the Trust would be able to access such funding this year as a result of the difficulties in other parts of the system. Conversations are to be held with the centre about this.
9.3	In 2018/19, there is an expectation that in order to become an ICS all organisations would sign up to an integrated control total. However, there is little confidence that other parts of the system would be able to deliver on their control totals, and as such the Trust will not sign up to be part of the ICS.
9.4	Conversations are ongoing with Oxford University Hospitals FT and Bucks Healthcare NHS Trust about partnership opportunities with a view to securing cost reductions. **Resolved**: The Board **noted** the Sustainability and Transformation Partnership update.
2018/03/10	**Patient's Story**
10.1	The Chief Nurse read the patient's story which had been retrieved from social media, and related to care that the patient in question had received in October 2017. The patient had suffered a fractured wrist, and her account related to her experiences in the Emergency Department and Day Surgery Unit. In summary, her experience in the Emergency Department was good, but she had found surgery more frustrating, particularly as she had unexpectedly to stay overnight in Day Surgery. Her complaints included a lack of suitable food and failure to provide information about her care to her partner.
10.2	It was acknowledged that this story highlighted the sorts of things that happen when a service or hospital is under pressure. The Chief Nurse confirmed that the Day Surgery unit is working through the issues raised, but they do not yet have a solution. In response to a question about the range of feedback that is received, the Chief Nurse stated that the Trust receives good feedback through the Friends and Family Test, receiving around 5,000 comments a month. Issues raised in complaints

	and the Patient Survey are mainly around communications, food and cleanliness. Helen Smart made the point that the story revealed that there is much to be proud about in the care provided – there is much to be learnt from both complaints and compliments, and she raised a question about the steps taken to ensure that the balance is right. The Chief Nurse indicated that the patient experience report highlights both, and that any individual members of staff who are named positively by patients or relatives receive personal letters from the Chief Executive. Joe Harrison also informed the Board of the launch of Greatix, a research backed methodology whereby staff put forward their colleagues for great thigs that they had done. This is about to be rolled out across the organisation.
10.3	Andrew Blakeman asked about the Trust's stance on visitors, and in response the Chief Nurse made the point that this is difficult as it is a Day Surgery unit, although it was acknowledged that the Trust enables patients to be escorted, as most patients need to be taken home. With regard to the concern about the lack of information that was provided to the patient's partner, the Chief Nurse made the point that he may not have been recorded as her next of kin. In any event, staff are generally reluctant to give patient related information over the telephone. **Resolved**: The Board resolved to **note** the Patient's Story.
2018/03/11	**Mortality update report**
11.1	The Medical Director provided this regular monthly update. He confirmed that on the Hospital Standardised Mortality Rate (HSMR) measure, the number of deaths at the Trust is lower than expected, while on the Summary Hospital-level Mortality Indicator (SHMI), it is as expected at 1.00 (in the 12 month period to June 2017). Within HSMR, there is one outlier – 'other lower respiratory diseases'. It was confirmed that this has been investigated, and there is no cause for concern.
11.2	It was noted that in November 2017 the Trust had published quarterly data, quantitative and qualitative, relating to deaths in the hospital in line with National Quality Board guidance. The proposal to introduce the medical examiner role to the Trust is to be considered at the Quality and Clinical Risk Committee meeting later in the month. The Board gave consideration to the frequency and length of the mortality reports that it receives, considering the detailed nature of QCRC scrutiny in this area, and it was agreed that shorter papers could be received and on a quarterly basis.
11.3	Parmjit Dhanda raised a question about the cost implications of the medical examiner role. The Medical Director confirmed that there would be no extra costs to the Trust (although there would be an opportunity cost), explaining that completion of the requisite cremation forms attracts a fee, and the proposal is to appoint a group of medical examiners to carry out this task, among other things. It was confirmed that this is a positive move, giving the Trust another opportunity to consider issues around quality. **Resolved**: The Board resolved to **note** the mortality update report.
2018/03/12	**Nursing Staffing Report**

12.1	The Chief Nurse presented the routine update on nurse staffing. She drew the Board's attention to the significant drop in the number of care hours per patient day, noting that this reflected the requirement to staff escalation areas as a result of the current pressures on the hospital.
12.2	The Chief Nurse also indicated that the state of nursing and midwifery staffing is becoming a matter of some concern. Up to now, the number of nurses that this Trust trains had risen annually. However, in March last year, the Trust had been expecting 35 adult nurses, but got only 15. This mirrors the national picture, particularly in relation to the more mature students who traditionally enter the profession in March. It would appear that many such candidates may have been put off coming into the profession by the withdrawal of the bursary. Many of the national leaders are concerned about this trend, but no cogent solution is yet emerging.
12.3	A possible solution is to train nursing associates and attract nurse apprentices. However, the Chief Nurse made the point that nursing associates cost £20k each to train, with no additional funding provided, and only 2 or 3 universities are currently supporting nursing apprenticeships. It was also noted that the Nursing and Midwifery Council (NMC) had indicated that nursing associates would not be able to give medication. The Chief Nurse confirmed that there will be gaps in the Trust's staffing. Separately, a meeting is to be held with the University of Northampton around the quality of their training.
12.4	Parmjit Dhanda questioned whether the Trust should consider running another international recruitment drive, but this time on a larger scale. The Chief Nurse indicated that this option is still under active consideration, although she noted that the NMC is holding firm on its English language test requirement. In this regard, work is being done with a university in the United States with a view to recruiting nurses from that country who would not be required to take the test. There are also opportunities for them to study in the UK that they would not necessarily be able to afford in the US. The Chief Executive added that a national programme is being launched involving a number of different opportunities that the Trust will seek to take advantage of. By way of context, it is estimated that globally, there is a 17 million shortfall in healthcare personnel, and the question was raised at the Chief Nurses' conference whether the UK has the right to take nurses from other parts of the world.
12.5	The Board had a discussion about the appropriateness of the nursing ratios and the proportion of time that nurses may be spending on activities that do not require their level of expertise. The Chief Nurse explained that the ratios that the Trust is working to are based on work that had been done by Kings College – there is some flexibility in the system, but the sense is that 1:8 is about right. It was agreed that a paper would be brought to the May meeting setting out the approach that the Trust will take to the appointment of nurses as well as allied health professionals, including occupational therapists and physiotherapists. **Action: Director of Patient Care & Chief Nurse/Director of Workforce**
12.6	Bob Green asked about steps that are being taken to reduce staff turnover. The Director of Workforce mentioned some of the factors that impact on retention here, including Milton Keynes' proximity to London and other cities, and the flexibility that

	may be available elsewhere. The point was made, however, that MKUH is the employer of choice for 98% of the students trained locally. The Chief Executive referenced the ongoing debate about the pressures on the NHS, and he expressed the view that the current workforce challenges would ultimately lead to service changes within the system. **Resolved**: The Board resolved to **note** the nursing staffing report.
2018/03/13	**Seven day services**
13.1	The Medical Director introduced this paper, informing the Board that the QCRC would be scrutinising this topic more closely. He stated that Sir Bruce Keogh, the then NHS Medical Director, had in 2013 introduced 10 standards for seven day services in hospitals. These standards are consistent with the position of the Academy of Medical Royal Colleges on consultant-delivered acute care, and include four priority standards. It is expected that 100% of these standards would be met by April 2020, and 50% by April 2018 (although it is unclear what 50% actually means in this context). The four priority standards are: • Time to first consultant review • Access to diagnostic tests • Access to consultant-directed interventions • Ongoing review by consultant twice daily for high dependency patients, daily for others.
13.2	The report articulated the gaps between these standards and the Trust's current performance, how this will be closed, and the cost (roughly £500k). It was noted that no additional funding has been made available for the implementation of these standards, and the Trust would therefore need to make some investment decisions. It was acknowledged that some of the standards will have a more positive impact on clinical quality than others - the standard assumption is that seeing consultants helps secure safe care, but this is not always the case, and the point was made that increasing the level of nursing care could in fact be more beneficial. However, the Trust will be assessed against delivery of these standards.
13.3	It was acknowledged that patients do not receive the same level of professional input at weekends, but the issue is about enabling professional groups other than consultants to take more responsibility. Andrew Blakeman remarked that implementation of the standards could lead to an improvement in patient experience, and the Chief Executive agreed, but made the point that the Trust needs to take more account of the role of technology and possibly work collaboratively with other organisations in delivering these standards. He referenced the funding that the Trust is receiving as a fast follower to the Global Digital Exemplar programme, and indicated that the quicker this can be deployed in areas such as this, the better. **Resolved**: The Board resolved to **note** the update on seven day services.
2018/03/14	**Performance Report Month 10**

14.1	The Deputy Chief Executive introduced the Month 10 Performance Report. He reiterated that the hospital is under significant pressure, as is the case in hospitals across the country. Performance against the 92% RTT 18 week target continues to fall and the figure for admitted pathways is now at 65%. The large number of cancelations over winter is beginning to affect the number of patients waiting over 52 weeks, which currently stands at 18. The Medical Director confirmed that he had reviewed all of the patients in this position, and he did not consider that any of them had suffered any clinical detriment as a result of the delay.
14.2	With regard to ambulance handover delays, Tony Nolan asked why this ever takes more than 30 minutes. The Director of Clinical Services indicated when a hospital is under pressure the Emergency Department becomes clogged up and is unable to take more patients. Typically, in such circumstances, the ambulance crews would wait with the patients until they can be seen.
14.3	Andrew Blakeman questioned the significance of the incident rate measure, in response to which the point was made that the general preference is that hospitals report a high number of low harm incidents. MKUH has always been a relatively 'low reporter', and work is ongoing to understand why thus is the case.
14.4	The Deputy Chief Executive stated that the end of the financial year is a good time to make changes to this report and asked that any suggestions that Board members may have should be communicated either to him or the Trust Secretary.
14.5	The Chief Executive announced that patients are now able to manage their appointments online. The system has gone live in orthopaedics which accounts for 10% of elective care.
14.6	The Medical Director notified the Board that the Trust had recently reported a Never Event. This related to a patient who had been looked after at the local hospice. The patient was receiving methadone subcutaneously, which is unusual, and while at the hospital, this was erroneously administered orally. No harm was caused to the patient, and it was noted that there would be much learning for all those involved.
14.7	In response to a question as to what the Trust could be doing differently, the Deputy Chief Executive indicated that improving the transition of care from the hospital to other providers would be key. The Director of Clinical Services added that the lack of community beds across Milton Keynes is a challenge.
14.8	By way of context, the Chief Executive indicated that the Trust remains within the top quartile nationally on A&E performance, cancer waiting times, diagnostics and financial performance, but he stressed that there is more that the Trust needs to do. Andrew Blakeman also added that the Board must not lose sight of the fact that the patient experience is not what is could be, despite the generally positive qualitative feedback. **Resolved**: The Board **noted** the Month 8 Performance Report.
2018/03/15	**Finance Update Report Month 10**
15.1	The Director of Finance presented the Month 10 position. He set out the national

	picture, indicating that the acute sector is forecasting a £1.9bn deficit, £900m worse than plan. There has also been a significant deterioration in performance, meaning that NHS Improvement is holding just short of £800m in unearned STF monies.
15.2	MKUH is reporting that at month 6, there is a £174k adverse variance against the control total. The operational pressures have led to a significant increase in emergency admissions (£676k positive variance in month). However, this has been achieved at the cost of elective performance and impacts on staffing – pay costs are overspent in month. Non-pay costs are also adverse to plan, in part due to high cost drugs and changes in the valuation methodology for business rates.
15.3	The Trust has achieved all of its STF in the year to date, but there are two current risk areas: • In Q3, the Trust believed that it had met the requirement, but NHS Improvement took a different view particularly with regard to primary care streaming. The Trust has lodged an appeal. The funding is worth £600k. • Q4 performance so far is below 95%, and it is highly unlikely that the Trust will be able to achieve that level for the quarter. This will create a cash pressure, but does not affect the core finance target.
15.4	The Director of Finance presented the good news that the Trust will now receive its capital loan to fund eCare. This also resolves the Trust's cash risk. There are a number of other projects for which the Trust is reliant on Department of Health funding. As this has not appeared in year, those projects will slip into the next financial year.
15.5	It was acknowledged that there is a challenge from commissioners with regard to payment for some of the Trust's activity, particularly in relation to so-called "procedures of limited clinical value". Similar disputes elsewhere in the country have gone against providers, and the Trust is taking appropriate action to limit its exposure. **Resolved**: The Board **noted** the Month 10 Finance update report.
2018/03/16	**Corporate Workforce Information Monthly Report**
16.1	The Director of Workforce introduced this report, indicating that it is the first time it is being presented. She made reference to the sickness absence rate. The rate had been 4.2%, and the target is 4.0%. The Trust is an outlier in this area, and work is underway to understand why and what can be done about it. There continue to be issues around reporting, with reasons for absence not recorded in many cases. The recently published staff survey indicates that the Trust is among the top 20% of Trusts around health and wellbeing, but this is not being reflected, as many staff say that they feel under pressure to come to work when they are unwell.
16.2	86% of staff have had their appraisals – the Trust has not met the 90% target in the last 2 years. Many staff complain that they do not receive appraisals, and that even when they do, the quality is often poor. It was noted that there is to be a focus on addressing this. In response to a question whether there are any members of staff

	who have never been appraised, it was noted that there are some who reporting not having had one in a long time.
16.3	The Chief Executive welcomed the presentation of this report to the Board, and enquired as to where the Trust is deriving learning from others. The Director of Workforce indicated that the Trust participates in regional and national HR networks, and the Chief Nurse added that MKUH is signed up for the NHS Improvement retention programme.
16.4	Parmjit Dhanda and Heidi Travis were both complimentary of the steps being taken to ensure staff health and wellbeing.
2018/03/17	**Board Assurance Framework**
17.1	The Director of Corporate Affairs presented the latest iteration of the Board Assurance Framework. She indicated that quite a lot of work had been done over the last reporting period on updating both the structure and content of the BAF, and it had already been discussed in detail at some of the Committee meetings. The question was raised, in the context of the discussion on workforce, whether the BAF accurately reflects the risks in this area, and it was suggested that both the Workforce and Development Assurance and Quality and Clinical Risk Committees should discuss this.
17.2	It was suggested that a key be incorporated into the summary of risks, and it was agreed that work is to be done to update the 5x5 matrix. The Director of Corporate Affairs informed the Board that internal audit had commented positively on the improvements made, and that the area that needs strengthening is assurance. The Director of Finance confirmed that there had been a helpful discussion at the Finance and Investment Committee. **Resolved**: The Board **noted** the Board Assurance Framework.
2018/03/18	**Trust readiness for the General Data Protection Regulation**
18.1	The Director of Corporate Affairs provided a verbal update on the Trust's readiness for the introduction of GDPR, reminding the Board that it comes into effect on 25 May. The Trust has in train a significant programme of work to ensure compliance, noting that this will be a much tougher regulatory framework than the current Data Protection Act.
18.2	There is a requirement for all areas of the Trust to carry out data flow mapping exercises, but to date there has been only 50% compliance – this would need to be stepped up. The concept of privacy by design is to gain a higher profile, and privacy impact assessments will need to be stronger. The Director of Finance noted that there will be significant fines for non-compliance. In response to a question from the Chief Nurse about the possibility of barriers to legitimate data sharing for clinical purposes, the Director of Corporate Affairs confirmed that GDPR will not obstruct this, and that a number of policies to facilitate such sharing will be taken to Management Board for approval.

18.3	The Board was informed that the Information Commissioner's Office is currently investigating an information governance breach by a previous Trust employee. No update has yet been received, and the Trust would need to consider the impact that this would have in the event that the organisation itself is found to have been in breach. **Resolved**: The Board **noted** the update on the Trust's readiness for the introduction of the GDPR
2018/03/19	**Health and Safety update**
19.1	The Director of Corporate Affairs presented this update, focusing on work being done in response to risks brought to light by the Grenfell Tower fire. The Chief Executive noted that there is no Board Committee with formal oversight of risks that are not of a clinical nature (such as estates), and the question was raised whether the Audit Committee should have a role in this. Bob Green made the point that health and safety is normally the first item on most organisations' Board agendas. It was agreed that it should come to the Board on a regular basis, but that consideration is to be given to the creation of a dedicated risk committee. **Resolved**: The Board **noted** the health and safety update.
2018/03/20	**Board Committee Summary Reports**
	The Board noted the contents of the summary reports of recent Board Committee meetings as follows: • Quality and Clinical Risk Committee meeting held on 30 January 2018 – the Committee Chair indicated that there appears to be no clear plan for the achievement of excellence on patients' experience, and it is not clear that the Trust knows what it wants to do. • Finance and Investment Committee meeting held on 5 February 2018 • Workforce and Development Assurance Committee held on 5 February 2018 • Charitable Funds Committee meeting held on 5 February 2018.
2018/03/21	**Questions from Members of the Public**
21.1	A member of the Council of Governors in attendance raised a question as to why, considering that the Trust is not in a position to sign up to a joint control total with the rest of the STP, and there is no legislative framework, there is only one STP related risk on the BAF. In response the Chief Executive confirmed that the STP is a standing Board agenda item, and is a central plank in the Trust's strategic thinking. That said, the Trust has a specific focus on building close working relationships with key partners within Milton Keynes in order to achieve real benefits for the local population. The Trust is clear that it will not jeopardise the financial sustainability of the MK system and will therefore not sign up to a BLMK wide control total until there is confidence that the whole system is able to deliver it. With regard to the Integration Board, he confirmed that having all the senior leaders of the health and social care system within MK in one place has been very positive.

2018/03/22	Any other business
22.1	The Chairman announced that Northampton General Hospital is seeking to appoint a non-executive director who has a clinical background.
22.2	The Chief Nurse announced that one of the Trust's midwives, Kate Laszlo, has won the Midwife of the Year award for the Midlands. She was nominated by a lady that she had looked after. The Board recorded their congratulations to Ms Laszlo.

	All					**Action log – All items**				
	Public/ Private	**Action item**	**Mtg date**	**Agenda item**		**Action**	**Owner**	**Due date**	**Status**	**Comments/Update**
Board of Directors	Public	352	5 Jan 2018	11.1	Nursing Staffing Update	The Birthrate Plus analysis of the Trust's midwifery workforce needs is to be presented at the March Board meeting	Lisa Knight	4 May 2018	Open	To be deferred as Birthrate Plus have not yet produced their analysis
Board of Directors	Public	353	5 Jan 2018	12.2	Approach to Safety Checklists within the Trust	The process of completing the safety checklists in theatres is to be reviewed at the Quality and Clinical Risk Committee and an update is to be presented at the Board in six months' time	Ian Reckless	6 Jul 2018	Open	
Board of Directors	Public	354	2 Feb 2018 (private)	10.7	Research and Development Strategy	A Board update on research and development activity is to be presented at the July meeting	Ian Reckless	6 Jul 2018	Open	
Board of Directors	Public	355	9 Mar 2018	12.5	Nursing Staffing Update	A paper setting out the approach that the Trust will take in recruiting nurses and allied health professionals is to be presented at the May meeting	Lisa Knight/ Ogechi Emeadi	4 May 2018	Open	

Milton Keynes University Hospital NHS Foundation Trust

MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST COUNCIL OF GOVERNORS' MEETING

DRAFT minutes of a meeting of the Council of Governors' of the Milton Keynes University Hospital NHS Foundation Trust, held in public at 5.00pm on Tuesday the 20 March 2018, in room 6 of the Education Centre at Milton Keynes University Hospital, Milton Keynes

Present:
Simon Lloyd - Chairman

Public Constituency Members:
William Butler (WB)
Alan Hastings (AH)
Alan Hancock (Aha)
Robert Johnson Taylor (RJT)
Akin Soetan (AS)
Peter Skingley (PS)
Liz Wogan (LW)

Appointed Members:
Andrew Buckley (AB) - Milton Keynes Council

Staff Constituency Members:
John Ekpa (JE)
Keith Marfleet (KM)
Lesley Sutton (LS)

In Attendance:

Executive Directors
John Blakesley(JB) - Deputy Chief Executive
Mike Keech (MK) - Director of Finance
Ian Reckless (IR) - Medical Director

Non Executive Directors
Bob Green(BG)
John Clapham (JC)
Tony Nolan(TN)
Helen Smart (HS)
Heidi Travis (HT)

Adewale Kadiri (AK) - Company Secretary
Carol Duffy (CD) - Governor and Membership Manager

1.	**WELCOME & ANNOUNCEMENTS**
	The Chairman extended a warm welcome to everyone present at the meeting and welcomed newly appointed Governor, Akin Soetan and Non- Executive Directors John Clapham, Heidi Travis and Helen Smart to their first meeting of the Council of Governors.
1.1	**APOLOGIES**
	Apologies for absence were received from Amanda Anderson, Andrew Blakeman, Parmjit Dhanda, Kate Jarman, Amanda Jopson, Douglas Campbell, Ogechi Emeadi, Paul Griffiths, Joe Harrison, Caroline Hutton, Clare Hill, Carolyn Peirson, Maxine Taffetani, Clare Walton, Matt Webb, Kim Weston, Jill Wilkinson, Marc Yerrell
1.2	**DECLARATIONS OF INTEREST**
	There were no new declarations of interest received and no interests received in relation to any other open items on the agenda.
1.3	**MINUTES**
(a)	**Minutes from the Council of Governors meeting held on the 23 January 2018.** The draft minutes of the meeting held on the 23 January 2018 were considered. **<u>Resolved:</u> That the draft minutes of the meeting held on the 23 January 2018 be agreed as a correct record of the meeting.** .
(b)	**MATTERS ARISING / ACTION LOG**
	Action Log There were no outstanding action log items. **<u>Resolved:</u> That the action log as updated at the meeting was received.**
2	**CHAIRMAN AND CHIEF EXECUTIVE REPORTS**
(a)	**Chairman's Report**
	The Chairman reported that the Trust had in recent weeks had visits from the Leader of the Opposition, the Secretary of State for Health and Social Care, and the Duke of Kent. The Secretary of State's visit had gone very well. The Chief Nurse and Medical Director had given excellent presentations showing how far the Trust has come. The opening of the Academic Centre by the Duke of Kent had also gone well – it is an excellent building and the Trust is looking forward to having use of it The Chairman informed the Governors that he had attended a meeting with the leader and the chairs from within the BLMK footprint. Items for discussion had included an interesting piece around the use of medical equipment in the community with a view to limiting the need for visits to GP surgeries and hospitals, the impending challenge of GDPR, and the discussion of a document entitled Partnering for Prosperity, which had indicated that 1million new homes are to be built in the corridor between Oxford, Milton Keynes and Cambridge, but yet made no mention of health or the healthcare challenges that such development would introduce. The Chairman also noted that the

	question whether to appoint a single Accountable Officer for all of the CCGs or retain one for each is still under review. The hospital charity had been nominated for an award at the MK Business Awards, and although it did not win, it was heartening that the charity has been recognised within the local community. It was the last formal meeting of the Lead Governor Liz Wogan and the Chairman and Governors thanked Liz, who in her time as a Governor had been a dedicated advocate for the patients and the public. Liz was as a member of the quality and clinical risk committee and keenly involved in the fifteen steps challenge. The Chairman added that her contribution at the Council of Governor Meetings was always welcomed and valued. The Chairman reminded that the process for the election of the Lead Governor position was to commence, with the deadline for submission of nominations by the 14th May. The election process for the Lead Governor was approved at the Council of Governors meeting held in January 2018. If there are any further questions these can be directed to the Governor and Membership Manager. **Resolved: That the Chairman's report be received and accepted.**
(b)	**Chief Executives Report,**
	The Deputy Chief Executive drew the Council of Governors attention to the written summary, of the outcome of discussions at the February 2018 Management Board. In response to a question from Public Governor Alan Hancock regarding the increasing number of patients awaiting an outpatient appointment who are not on RTT pathways., The Medical Director reported that in response to targets for services to significantly reduce the number of such patients by 31st March 2018, good progress has been made overall, but there are still some problem areas. **Resolved: That the Chief Executive's report be received and accepted.**
3.	**Sustainability and Transformation Partnerships (STP)**
	The Deputy Chief Executive provided a verbal update and the following was highlighted:- • STPs are to be renamed Integrated Care Systems (ICS). • With regard to the financial positions of the different parts of the system, there is an understanding between MKUH and MKCCG about the risks around the year end position, but the Bedfordshire and Luton system is not in the same position. • The Luton & Dunstable/Bedford merger had been delayed as a result of doubts about the availability of capital funding. • Last year, the Trust had received some "bonus" funding for exceeding its control total – it is unlikely that the Trust would be able to access such funding this year as a result of the difficulties in other parts of the system. Conversations are to be held with the centre about this. • In 2018/19, there is an expectation that in order to become an ICS all

	organisations would sign up to an integrated control total. However, there is little confidence that other parts of the system would be able to deliver on their control totals, and as such the Trust will not sign up to be part of the ICS. • Conversations are ongoing with Oxford University Hospitals FT and Bucks Healthcare NHS Trust about partnership opportunities with a view to securing cost reductions. **<u>Resolved:</u> That the Sustainability and Transformation Partnership update be received.**
3.1	**Update on Estate Development**
	The Deputy Chief Executive provided a verbal update and the following was highlighted:- • The multi storey car park build, was a week behind, this was due to recent inclement weather. • The Governance process was in place to commence the Cancer Centre build in July. **<u>Resolved:</u> That the Update on Estate Development be received.**
3.2	**PLACE (Patient Led Assessment of the Care Environment)** A presentation on the PLACE was given by the Deputy Chief Executive and the following was highlighted:- • PLACE assessments are carried out over one day, by teams comprising of hospital clinical and non-clinical staff, and external volunteers (e.g. from local groups e.g. Healthwatch and Governors). • The assessment follows a national tool for NHS England and results from each team are uploaded to a national database for analysis and comparison. • Ward areas are allocated to sets of assessors on the day of the inspections and are blind to the visit. Certain areas have to be assessed every year, all others are rotated. • The assessment was held on 5th May 2017, with the national comparators having recently become available. • PLACE was carried out on the following areas:- o Ward 1, Ward 7, Ward 9, Ward 15 o Ward 18, Ward 19, Ward 20, Ward 22 o Maternity Delivery and ED o Physiotherapy, EPAU,Day Surgery o Eye Clinic, o And in the following general areas: Chapel, Corridors o Public Toilets, Outside areas and Main entrance • The assessment covers 8 key areas: Cleanliness, Food, Organisation food (e.g. time of delivery), Ward food, Privacy, dignity and wellbeing • Condition, appearance and maintenance, Dementia (Third year of being assessed), Disability (Second year of being assessed). • The 2017 Assessment Scores show that:- o The trust scored 97.01% for cleanliness a drop was expected as in 2016 cleanliness scored very highly (99%). o In the new standards MKUH continues to score significantly above the

	national average, with Dementia at 80.47% for 2017 and Disability 85.49% o This year's food related PLACE scores show a drop in organisation year on year and against the national average in 2 out of the 3 standards. • An action plan for improvement focussing on the areas where the trust is an outlier is to be presented to the next Board Meeting. **Resolved: That PLACE (Patient Led Assessment of the Care Environment) Presentation be received.**
4.1	**Summary Report from the Finance and Investment Committee**
	The written summary report for the Finance and Investment Committee Meeting held on the 5th February 2018 was considered. In response to a question from Public Governor Alan Hancock, The Director of Finance reported that it was very likely, that that progress would be made for the aseptic suite in the next financial year. **Resolved: That the Summary Report from the Finance and Investment Committee be noted**
4.2	**Summary Report from the Workforce and Development Assurance Committee**
	Tony Nolan, Non- Executive Director and Chairman of the Workforce and Development Assurance Committee, presented the summary report for the meeting held on the 5 February 2018. The following was highlighted:- • Results from the Picker NHS national staff survey 2017, show that that Trust remains 'middle of the pack' nationally. • There is disappointment that that the results were not better, considering the efforts that management had put into engagement during the course of the year. • Much work has been undertaken with regard to agency controls, usage and management processes. The team are to be congratulated. In response to a question from Public Governor Alan Hancock, Tony Nolan the Chairman of the Committee reported that a detailed action plan was to be presented at the next committee meeting on various ideas and ways to improve Picker results. One idea being considered was the set up of staff focus groups. In response to a question from Public Governor Liz Wogan, Tony Nolan the Chairman of the Committee confirmed that the staff survey was completely anonymised with no way of tracking who completed the form. **Resolved: That the Summary Report from the Workforce and Development Assurance Committee be noted.**
4.3	**Summary Report from the Quality and Clinical Risk Committee**

	The written summary report for the Quality and Clinical Risk Committee Meeting held on the 30th January 2018 was considered. **<u>Resolved:</u> That the Summary Report from the Quality and Clinical Risk Committee be noted**
4.4	**Summary Report from the Charitable Funds Committee**
	Bob Green Non- Executive Director, Chairman of the Charitable Funds Committee presented the summary report for the meeting held on the 5 February 2018 and highlighted the following:- • The Fundraising Practice update had reported that significant senior engagement activity with key players, both corporate and individual within the Milton Keynes area is ongoing. • There is much interest in the Cancer Centre project among some of the City's household names and some firm promises of support have been received. **<u>Resolved:</u> That the Summary Report from the Charitable Funds Committee be received.**
5.1	**Healthwatch Milton Keynes Update**
	The written report for the Healthwatch Milton Keynes Update was considered. **<u>Resolved:</u> That the Healthwatch Milton Keynes Update be noted**
5.2	**Engagement Group Update**
	The written report for the Engagement Group Update was considered. **<u>Resolved:</u> That the Engagement Group Update be noted**
6.	**Integrated Performance Report Month 10**
	The Deputy Chief Executive introduced the Month 10 Performance Report. He reported that the hospital is under significant pressure, as is the case in hospitals across the country. Performance against the 92% RTT 18 week target continues to fall and the figure for admitted pathways is now at 65%. The large number of cancelations over winter is beginning to affect the number of patients waiting over 52 weeks, which currently stands at 18. The Medical Director confirmed that he had reviewed all of the patients in this position, and he did not consider that any of them had suffered any clinical detriment as a result of the delay. **<u>Resolved:</u> That the Integrated Performance Report Month 10 be received**
6.1	**Finance Report Month 10**
	The Director of Finance presented the Month 10 position. He set out the national picture, indicating that the acute sector is forecasting a £1.9bn deficit, £900m worse than plan. There has also been a significant deterioration in performance, meaning that NHS Improvement is holding just short of £800m in unearned STF monies.

	The Trust has achieved all of its STF in the year to date, but there are two current risk areas: • In Q3, the Trust believed that it had met the requirement, but NHS Improvement took a different view particularly with regard to primary care streaming. The Trust has lodged an appeal. The funding is worth £600k. • Q4 performance so far is below 95%, and it is highly unlikely that the Trust will be able to achieve that level for the quarter. This will create a cash pressure, but does not affect the core finance target. The Director of Finance presented the good news that the Trust will now receive its capital loan to fund eCare. This also resolves the Trust's cash risk. There are a number of other projects for which the Trust is reliant on Department of Health funding. As this has not appeared in year, those projects will slip into the next financial year. It was acknowledged that there is a challenge from commissioners with regard to payment for some of the Trust's activity, particularly in relation to so-called "procedures of limited clinical value". Similar disputes elsewhere in the country have gone against providers, and the Trust is taking appropriate action to limit its exposure. **Resolved: That the Finance Report Month 10 be received.**
7.1	**Annual Report and Accounts 2017/18 Timetable**
	The Annual Report and Accounts 2017/18 Timetable was presented for consideration by the Council of Governors. **Resolved**: **That the Annual Report and Accounts 2017/18 Timetable be noted**
7.2	**Membership and Engagement Strategy**
	The Chairman presented the Membership and Engagement Strategy that has been developed by the Engagement Group following best practice guidelines:- • The strategy has three specific objectives:- o Build and maintain membership numbers to meet/exceed annual plan targets ensuring the membership is representative of the population of the trust serves. o Regular and effective communication with members o Engage with members and encourage their involvement • Next Steps are that the membership and engagement strategy be recommended to the Board for approval. • That an action plan to deliver the strategy will be developed with the Governors through the Engagement Group.

	<u>Resolved:</u> That the Membership and Engagement Strategy be approved
7.3	**Motions and Questions from Council of Governors**
	There was none
7.4	**Annual Work plan**
	The Annual Work Plan was considered and any items pertaining to this meeting are to be added. **<u>Resolved:</u> That the Annual Work Plan be noted.**
7.5	**Any other Business** There was none
7.7	**Date and Time of next meeting** The date of the next meeting of the Council of Governors is on the 22nd May at 9.30am in room 6 at the Education Centre.
7.8	**RESOLUTION TO EXCLUDE THE PRESS AND PUBLIC** **<u>Resolved:</u> that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted.**

Carol Duffy
Governor and Membership Manager
13 April 2018

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Board of Directors	Date: 4 May 2018
Report title:	Membership and Engagement Strategy Cover	Agenda item: 2.2
Lead director Report author	Name: Simon Lloyd Name: Carol Duffy	Title: Chairman Title: Governor and Membership Manager
FoI status:	Public	

Report summary	To consider the Membership and Engagement Strategy and recommend approval of the strategy.			
Purpose *(tick one box only)*	Information ☐	Approval	To note ☐	Decision x
Recommendation	That the Trust Board be recommended to approve the Membership and Engagement Strategy.			

Strategic objectives links	Objective 10: Develop as a good corporate citizen
Board Assurance Framework links	
CQC regulations	
Identified risks and risk management actions	
Resource implications	
Legal implications including equality and diversity assessment	

Report history	Engagement Group 14 February, Council of Governors 20 March 2018
Next steps	Council of Governors Implementation
Appendices	Membership and Engagement Strategy

BACKGROUND

1. The membership and engagement strategy has been developed using good practice by the Governors.
2. The strategy has three specific objectives:
    a. Build and maintain membership numbers to meet / exceed annual plan targets ensuring the membership is representative of the population the Trust serves.
    b. Regular and effective communication with members
    c. Engage with members and encourage their involvement

3. The Council of Governors is asked to recommend to the Trust Board the approval of the strategy. An action plan to deliver the strategy will be developed with the Governors through the Engagement Group.

Milton Keynes University Hospital NHS Foundation Trust

Membership and Engagement Strategy
Action Plan 2018 – 2020

Public and Staff Governors are elected to carry out their role by the Members or staff therefore, Governors are accountable to Members and the staff. The Governors, therefore at all times link the community and staff and the Trust by ensuring that the Trust is rooted in its community, owned by its community and responds to its community's needs.

Milton Keynes University Trust NHS Foundation Trust (the Trust) Membership and Engagement Strategy (the Strategy) has three Objectives (the Objectives), namely:

Objective 1
Build and maintain membership to numbers to meet/exceed annual plan targets ensuring the membership is representative of the population the Trust serves.
The Trust's aim is to recruit and steadily increase membership, ensuring that it is fully representative of the population of Milton Keynes

Objective 2
Regular and effective communication with members
The Trust is committed to maintaining a two-way dialogue with its Membership. This will encourage Members to give their views and influence developments within the Trust

Objective 3
Engage with Members and encourage their involvement
The Trust's aim is to ensure that the Membership has an opportunity to get involved with the Trust and through this engagement, help to shape the services it provides.

Each Objective includes Key Sub-objectives (Sub-objectives), which are shown overleaf, together with the Actions to Achieve the Objectives/ Sub-objectives (Actions)

Objective 1

Build and maintain membership to numbers to meet/exceed annual plan targets ensuring the membership is representative of the population the Trust serves.
The Trust's aim is to recruit and steadily increase membership, ensuring that it is fully representative of the population of Milton Keynes.
Key sub-objectives include:-

- Meet the annual membership targets as identified in the trust's Annual Plan.
- Maintain an accurate membership database which meets regulatory requirements and can aide membership development.
- Encourage membership across the public constituencies
- Ensure the membership reflects the diversity of the population the trust serves.

ACTION	DETAIL	BY	WHEN
Assistance to Governors in presentation methods to encourage involvement in recruitment activities	Presentation training as required Develop standard presentation material	Governor and Membership Manager (GMM)/Chair Engagement Group (CEG)	Year 1
Regular, targeted recruitment drives in the Hospital and at internal and external events and locations	▪ Annual Members Meeting: Engagement Group sub-committee to be formed to consider: • Location • Order of agenda • Agenda items, e.g. recruitment drive, entertainment, speaker. • Governor involvement on the night	CEG/GMM Sub- committee and All Governors	Years 1, 2 and 3
	▪ MKUHFT CoG Meet the Members Events – Currently two per year ▪ Healthwatch AGM ▪ Healthwatch Event ▪ Clinical Commissioning Group Events ▪ Set up a stand run by Governors at various locations within MKUHFT on a rota system for short time periods, e.g. Main Entrance, Eaglestone Restaurant, car park. Results to be monitored	GMM/CEG/All Governors	Years 1, 2 and 3
Effective use of membership recruitment material	Material to be monitored Targeted campaigns by Public Governors in their constituencies, Staff Governors in their work areas and Appointed Governors in their areas, with monitoring of results, e.g.: GP Surgeries (through Practice Managers, Patient Participation Groups, Flu Clinics) Local (Parish) Councils, Parish Noticeboards.	GMM/All Governors All Governors	Ongoing
Make the Members/Governors webpage more visible	• Give the Members' webpage high priority when accessing the Trust's website • Staff Governors' page on the Trust's Intranet • Have a prominent '*Become a Member of the Hospital*' note on the front page of the MKUHFT website • Use of Twitter, Facebook, Instagram • Widen the distribution of the CEO's Weekly Message to Members • Set up a sub-group to keep the webpages up to date	GMM/Communications Dept CEG/GMM	Ongoing

Review recruitment material and Membership Application Forms	Ensure they are kept up to date, cover the changes taking place at MKUHFT, are brief and relevant, encompass modern communication systems, etc.	GMM/CEG	Years 1, 2 and 3
Set up a sub-group of Governors to develop strategies to identify and address under-representation groups	• Establish a listing of groups • Work with organisations, which are involved with the Groups • Develop specific recruitment material with organisations, as required	CEG/GMM All Governors GMM	Ongoing

Objective 2

Regular and effective communication with members

The Trust is committed to maintaining a two-way dialogue with its Membership. This will encourage Members to give their views and influence developments within the Trust

Key sub-objectives include:-

- To promote the work of the Trust and its Governors
- To identify opportunities for two-way communications between Members and Governors
- To ensure communications, encourage engagement with the Members

ACTION	DETAIL	BY	WHEN
Promote the work of the Trust and the Governors and stress the need for Two-Way Communications	• At every opportunity tell the patients and public '*We are here. Please contact us*', in any and every form • Increase the use of e-mail, the Internet, Mobile phones, Twitter, Facebook, Instagram • Issue Newsletter • Emphasise the work of the Governors in the Annual Review • Give the Members webpage high priority when accessing the Hospital's website • Staff Governors' page on the Trust's Intranet • Have a prominent '*Become a Member of the Hospital*' note on the front page of the MKUHFT website • Widen the distribution to Members of the CEO's Weekly Message • Encourage the local media to report the good news about the Hospital • Encourage the local media to keep readers up to date with the changes that are taking place in the Hospital • Set up a sub-group to keep the webpages up to date	All Governors GMM/Communications Dept Executive Executive CEG/GMM	Ongoing
Ensure Staff Members are aware of the role of Governors, particularly their elected Governors	• Engagement of Staff Members by engagement undertaken by their elected Governors who represent them • Promote opportunities for Staff Members to meet Staff Governors at events and through common areas of the Trust, e.g. ward notice boards, a stand at the Eaglestone Restaurant	Staff Governors GMM/Staff Governors	Ongoing/As required

	• Regular e-mail from the Lead Governor • Events in specific Wards and other areas	Lead Governor	
Encourage Members to make their experiences, compliments, ideas, concerns, improvements, comments known	Through • Their elected Governor • PALS • Family and Friends Test • MKUHFT website • The Lead Governor	All Governors	Ongoing
Establish any requirements for Governor/Trust information to be in different languages, formats	Review comments from Governors, patients, public, etc., for such a requirement and respond as necessary	All Governors	As required

Objective 3

Engage with Members and encourage their involvement

The Trust's aim is to ensure that the Membership has an opportunity to get involved with the Trust and through this engagement, help to shape the services it provides.

Key sub-objectives include:-

- To ensure the views of the Members are understood
- To Identify opportunities for Members and Governors to be involved in the Trust
- To encourage more Members to stand for election to the Council of Governors

ACTION	DETAIL	BY	WHEN
Increase awareness of the opportunities for Members to take part in Hospital reviews, visits	Through newsletters, e-mail, social media, Trust website, inform Members of the need for them to be involved in such as 15 Steps, PLACE (Patient Led Assessments of the Care Environment) reviews, Family and Friends Tests. Training will be given and they will be accompanied by an experienced leader	GMM/CEG/Communications Dept	Ongoing
Election to the Council of Governors	Ensure all communication systems are used to inform Members of any forthcoming elections	GMM	As required
Encourage Governors to help out with any of the Actions under the three Objectives keeping in mind they will receive any help they may need	Ask all Governors to: • Consider where they could help with any of the Actions • Notify the Governor and Membership Manager of where they could help and when • Advise the Governor and Membership Manager of any assistance or information they may require to carry out any of the actions	All Governors	Early in Year 1

Meeting title	Board of Directors	Date: 4 May 2018
Report title:	Chief Executive's Report of the Management Board meeting held on 18 April 2018	Agenda item: 2.4
Report author	Name: Joe Harrison	Title: Chief Executive
FoI status:	Public document	

Report summary				
Purpose *(tick one box only)*	Information [x]	Approval [ ]	To note [ ]	Decision [ ]
Recommendation	The Board is asked to note the update from the Chief Executive summarising the outcome of discussions at the April Management Board meeting.			

Strategic objectives links	All
Board Assurance Framework links	None
CQC regulations	None
Identified risks and risk management actions	None
Resource implications	None
Legal implications including equality and diversity assessment	None

Report history	
Next steps	
Appendices	None

Chief Executive's Report - key points arising from the Management Board meeting on 18 April 2018

1. **Matters arising**

- 'Procedures of limited clinical value (POLCV)' – Policies for dealing with funding requests for procedures on this list have now been drafted in conjunction with MKCCG.
- Preparations for the next Patient Led Assessment of the Care Environment (PLACE) are underway – a working group has been set up and an action plan agreed. It was acknowledged that floors across the hospital are cleaner.

2. **Chief Executive's update**

- Positive feedback has been received from Professor Ted Baker, the CQC's Chief Inspector of Hospitals, who recently visited the Trust. He was particularly impressed by some of the more junior clinical staff that he met, and by the Trust's escalation processes.

3. **eCARE update**

- The vast majority of frontline staff have now been trained, and the Trust is taking the opportunity afforded by the delay to go live to lay on extra sessions. Steps are to be taken to reach specific groups of staff including locums and agency staff, student nurses and community staff.
- A large cohort of students will be arriving at the Trust in 8 weeks' time and arrangements will also need to ensure that they are trained.

4. **Event in the Tent**

- Dates for this year's event have been confirmed as 8 to 10 May. The programme, which has now been shared with staff, includes more external speakers than last year – their biographies will also be provided.

5. **Corporate Workforce Report**

- The key messages are around the growth in the number of staff in post and the fact that the reasons for the majority of episodes of sickness absence are still not being declared. Long term sickness absence is being managed appropriately, but there are concerns about the level of short term absences across the Trust.
- The take up of statutory and mandatory training remains good at 90%.

- **Board Assurance Framework**
- The Trust is making progress in ensuring that investment decisions are linked to the BAF.

6. **Risk Management upwards report**

- The number of overdue incidents reported on the Datix system is very high and it would be important to reduce this in the lead up to the eCARE go live date.
- The importance of ensuring that all policies are up to date was emphasised, not least because it is expected that a CQC inspection will take place during the course of this calendar year.

7. Information Governance Annual Report 2017/18

- The Trust achieved a Level 2 rating (satisfactory) against the NHSI digital IG toolkit in 2017/18.
- The GDPR comes into force just after eCARE go live. A further plenary session is to be arranged.
- Every trust that took part in a CQC assessment of cyber security arrangements failed. All staff will now be required to have longer passwords, but in return the frequency with which they will need to be changed will be reduced.

8. Health and Safety update

- *Reported to Trust Board in Health and Safety Report (March 2018)*

9. Other business

- The outcome of the outpatient administrative structure review has been announced. The changes will be phased n to accommodate training.
- The Trust's "non-RTT" backlog (patients waiting for treatments not covered by the Referral to Treatment 18 week target) has been reduced by half, with those who have been waiting over 6 months seeing the largest reductions, but there are still 6000 patients waiting, including 1500 in the 6 month or over category. All specialities are being challenged to prioritise the clearance of this backlog of patients.
- The Trust has accepted the #End PJ Paralysis national 70 day challenge to help reduce the deconditioning of frailer patients while in hospital. Data on how the hospital is doing will be captured nationally and broken down by ward.
- The Emergency Department 95% target has now been met for the last 3 weeks, and in the last 2 weeks, no day surgery has been cancelled and a full elective caseload has been undertaken
- The new multi-story car park will be opening shortly.

Meeting title	**Public Board**	**Date: 04 May 2018**
Report title:	**Mortality update report**	**Agenda item: 3.2**
Lead director **Report author** **Sponsor(s)**	**Dr Ian Reckless** **Dr James Bursell**	**Medical Director** **Associate Medical Director**
FoI status:	**Publicly disclosable**	

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

Strategic objectives links	Improve patient safety
Board Assurance Framework links	
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	This is a regular paper at Trust Board
Next steps	To note
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 review group (MRG). In addition, it reports upon the qualitative review work undertaken within services to examine the care provided by the Trust to patients who have died (through the mortality and morbidity (M&M) meeting framework), including the assessment of 'avoidability'.

Definitions

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

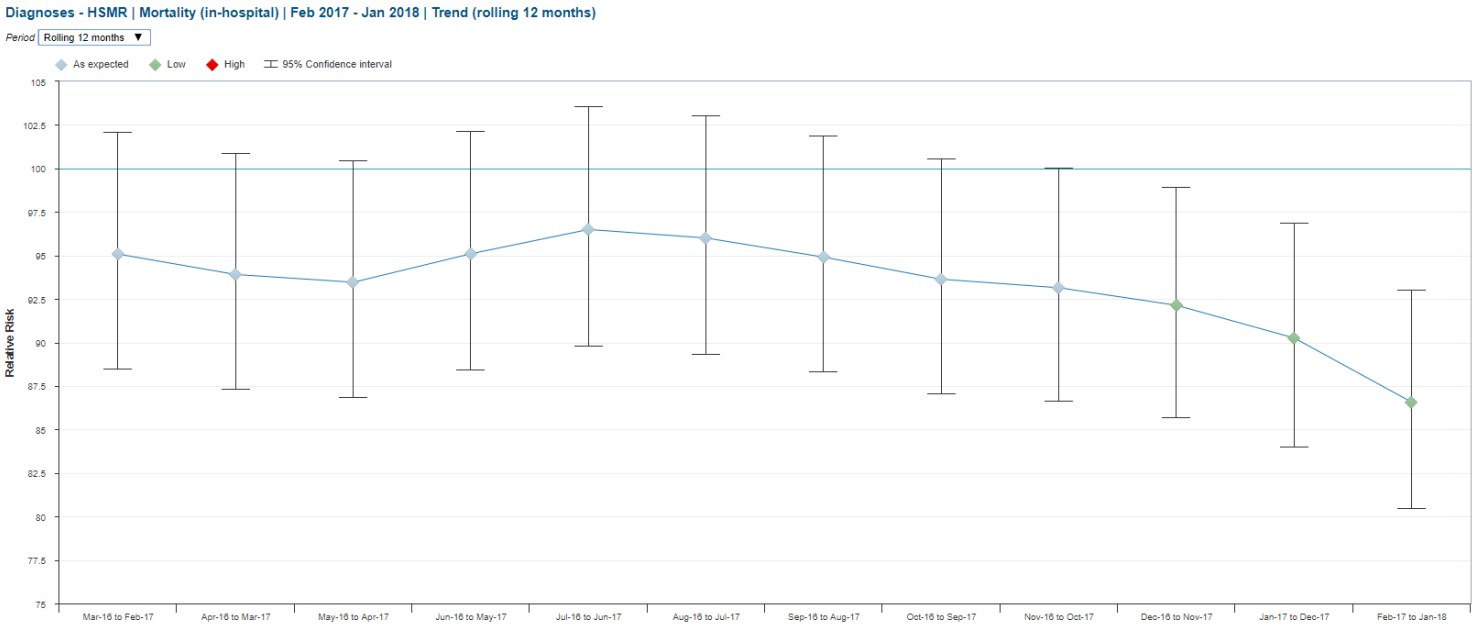
Data period: February 2017 – January 2018

Key Highlights:

- HSMR relative risk for 12 month period = **86.6** 'lower than expected' range
- Crude mortality rate within HSMR basket = **3.1%** (MKUH local acute peer group rate = 3.8%, national crude rate 3.9%)
- **1 significant outlier** was identified within the HSMR basket for this period – 'other perinatal conditions'.

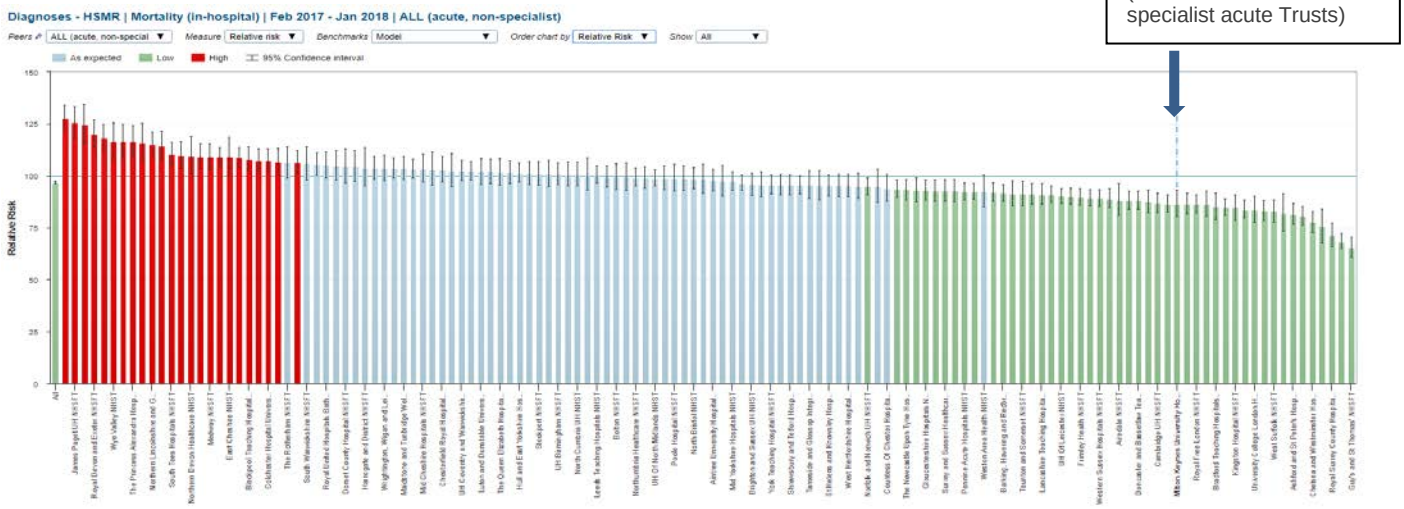
The Trust currently ranks 2nd (2nd lowest HSMR relative risk value) against its MKUH peer group and 19th lowest (best) against 136 national peers. The Trust is one of only 3 Trusts from 21 within the peer group with an HSMR which is statistically 'lower than expected'.

Trust level HSMR monthly performance Trend rolling 12 months (February 2017 – January 2018)



HSMR position vs. national acute peers: February 2017 – January 2018

HSMR = 86.6 'lower than expected'
(19th lowest out of 136 non specialist acute Trusts)



HSMR relative risk = 86.6 'lower than expected' (19th lowest out of 136 non-specialist acute). 1st lowest ranking indicates the trust with the lowest (best) HSMR relative risk.

SHMI

Data period: October 2016 – September 2017 (most up to date data available)

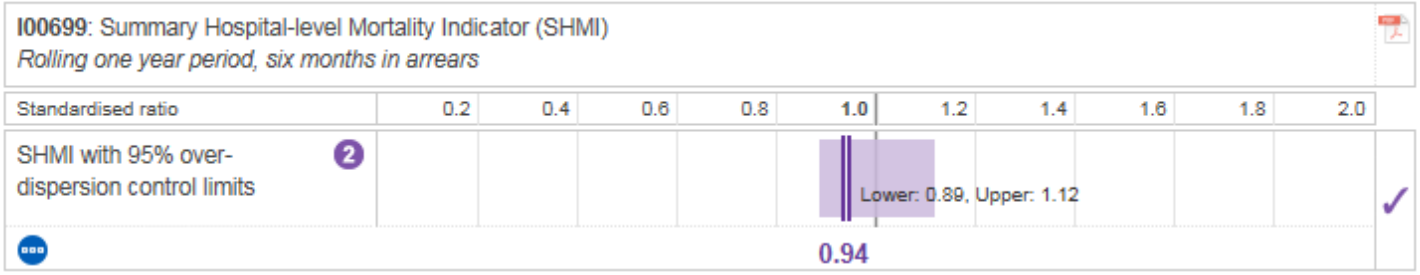
The Summary Hospital-level Mortality Indicator (SHMI), which includes out of hospital deaths occurring within 30 days of discharge, is measured by the Health and Social Care Information Centre (HSCIC). The SHMI relative risk is the ratio between the actual number of patients who die following treatment 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:

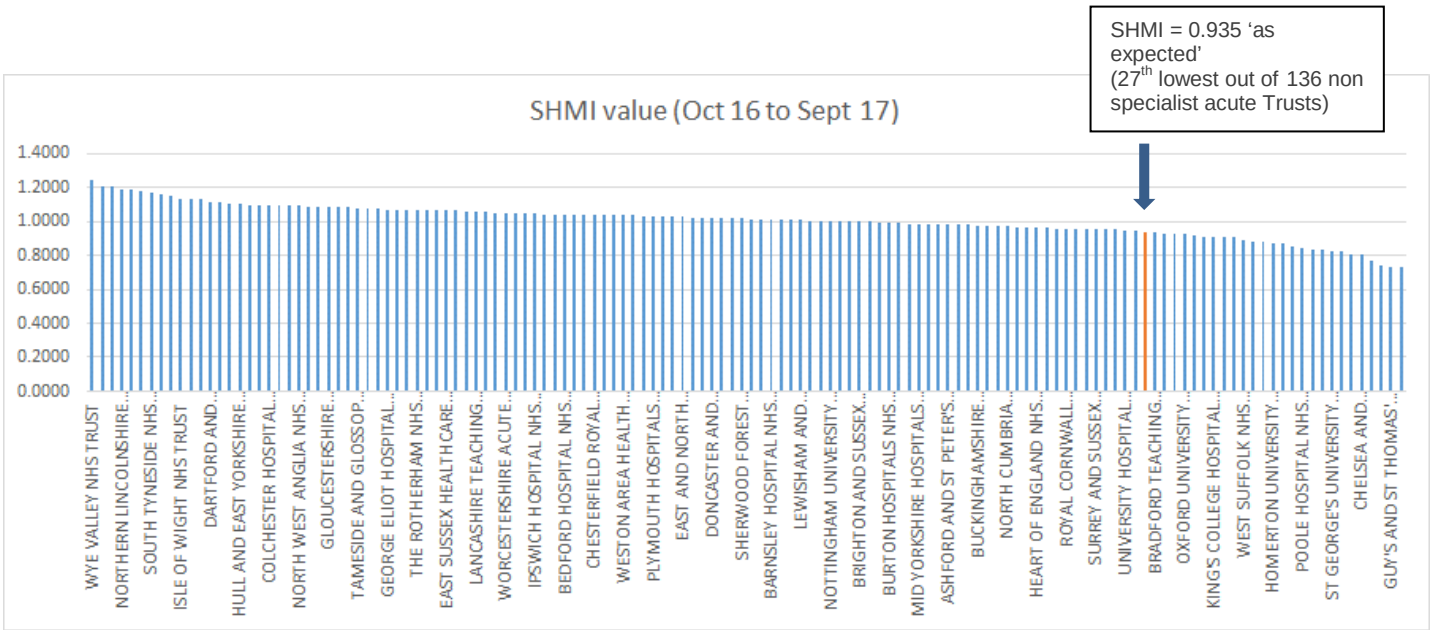
The latest SHMI published in March 2017 by HSCIC for the rolling 12 months to September 2017 = **0.935** '**as expected'** range.

The Trust ranked 27th in SHMI performers among the 136 non-specialist acute trusts in England (ranking 1 = lowest or 'best' SHMI) on 12 month data to September 2017. The Trust previously ranked 66th on 12 month data to March 2017 and 90th in SHMI on 12 month data to September 2016.

Summary Hospital-level Mortality Indicator (SHMI) • October 2016 - September 2017



SHMI position vs. national acute peers: October 2016 – September 2017



Investigations of Deaths

The data for Q1, Q2, Q3 and provisional Q4 are illustrated in the graph below outlining the number of deaths within the Trust that have:

1. Been 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 assessment 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. The data was accurate as of 24th April. 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.

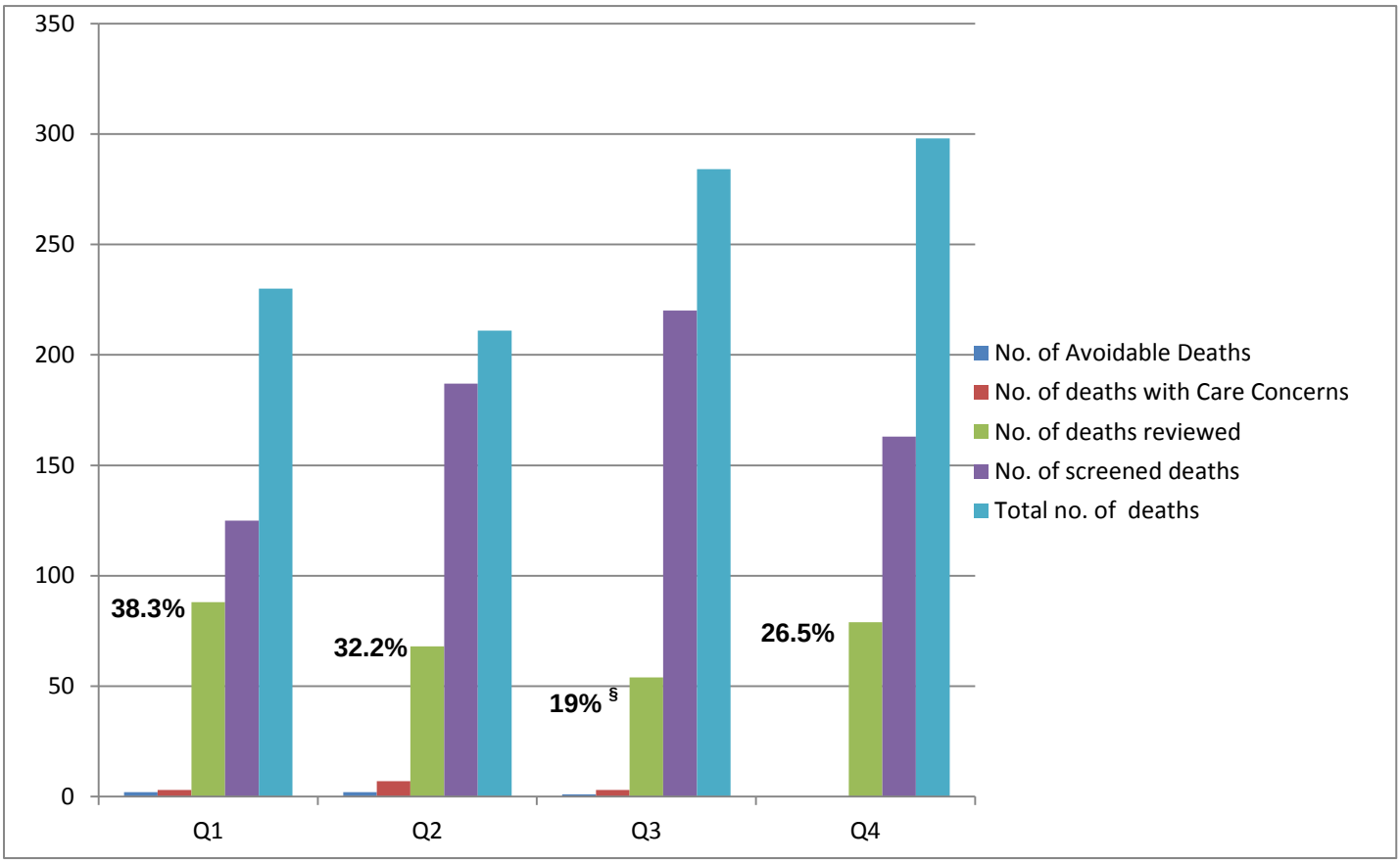
3. Judged as potentially 'avoidable' – using the current system of classification within the Trust this includes 'suboptimal care where different management MIGHT have changed outcome and 'suboptimal care where different management WOULD have changed outcome'

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'.

As the Trust adopts the RCP methodology of SJRs, the classification of deaths and 'avoidability' will change.

	Q1	Q2	Q3	Q4
No. of deaths	**230**	**211**	**284**	**298**
No. of deaths assessed by responsible consultant (% of total)	**54%**	**89%**	**77%**	**55***
No. of reviews (% of total)	**88 (38.2%)**	**63 (29.9%)**	**54 (19%)**	**79 (26.5%)***
No. of deaths with Care Quality concerns (%)	**3 (1.3%)**	**7 (3.3%)**	**3 (1.1%)**	**0***
No. of potentially avoidable deaths (%)	**2 (0.8%)**	**2 (0.5%)**	**1 (0.5%)**	**0***

* Q4 data are provisional and are still subject to further modification (as formal review processes occur within the Trust's clinical divisions).



§ In Q3, 19% of all deaths in the Trust were formally reviewed. This is fewer than the Trust's aim that 25% of all deaths undergo a formal review process. This figure is explained by the cancellation of M&M meetings due to winter pressures and also due to a vacancy in the position of Clinical Governance Facilitator for the Medicine Division. This position has now been filled and work is underway to review those deaths designated as requiring formal review as per Trust policy.

Qualitative information on deaths (whilst maintaining patient anonymity)

Cases not previously published at Public Board meetings

Q2 Avoidable deaths or deaths where suboptimal care where different management MIGHT have changed outcome care

A pregnant woman was booked under consultant care as considered as requiring Saving Babies Lives Care Bundle Pathway with serial growth scans. At a 22 week consultant appointment the pregnancy was determined as being low risk with a plan that the level of ongoing care would be downgraded to midwifery led care if the growth scan was normal at 32 weeks. Normal 32 week growths scan although no fundal height measured. At 34 weeks, scan repeated with a fundal height measurement < 10^{th} centile and a formal growth scan was requested. During growth scan at 35 weeks fetal heart was noted to be pulsating but then stopped during the scan. Appropriate action taken by sonographer but Intrauterine Death recorded.

Serious Incident Review Group Recommendations;

a. Audit of smoking cessation advice being delivered by midwives
b. Audit to review compliance of medical staff with Saving Babies Lives Care Bundle Pathway
c. Audit of community midwifery staff notes
d. Midwives to be reminded of escalation if guidance not being followed
e. Community midwives – reminded of process of using serial growth scans rather than fundal height measurements

Q3 Avoidable deaths – 1 death previously published at January Public Board meeting

Q3 deaths – Care Quality concerns that would not have changed outcome

1. Concerns from family regarding poor pain management in palliative patient and poor communication. Discussion at M&M meeting also recognised insertion of nasogastric tube might have assisted symptom control.
2. Learning Disability death – suboptimal prescribing of medication to reduce agitation. Prescription not related to death. Doctor subsequently undertook further training in palliative care prescribing.
3. Delay in ordering CT scan on admission discussed as departmental M&M meeting.
4. Poor documentation in initial clerking notes.

Meeting title	Board Of Directors	**Date:** May 4th 2018
Report title:	Nursing Staffing Report	**Agenda item: 3.3**
Lead director **Report author Sponsor(s)**	**Name:** Lisa Knight **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	Appendix A,B

Board of Directors Report on Nursing and Midwifery staffing levels
Amalgamated report for January 2018 and February 2018

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 our monthly staffing data to 'UNIFY' and to update The Trust Board on our 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	14046	4.2	2.9	7.2
March	14545	4.2	3.1	7.3

Hospital Monthly Average Fill Rates for October and November 2017

Month	RN/RM Day % Fill Rate	HCA/MCA Day % Fill Rate	RN/RM Night % Fill Rate	HCA/MCA Night % Fill Rate
February	83.8%	109.9%	99.1%	138.4%
March	76.9%	107.4%	95.2%	135.5%

We have seen a slight drop in fill rates in RN/RM Day in March due E-Care training.

A Ward by Ward breakdown of fill rates for the two months has been included in the Appendix B.

3. Recruitment

Our estimated vacancies in March 2018 are:

67wte Band 5 residual and 17 wte (whole time equivalent) Health Care Support worker (HCSW) vacancies in Medicine, most of these are on the elderly care wards. Medicine has a rolling advert and has agreed a recruitment plan for 2018.

24.7 wte band 5 and 15 wte HCSW residual vacancies in Surgery – Surgery continues to recruit on a rolling advert. Theatre staff with experience at Band 6 level continues to be an area hard to recruit to with 12 wte vacancies and critical care is reviewing its skill mix as it is currently has 7 wte Band 6 vacancies

13 wte band 5/6 residual vacancies in Maternity.

10 wte band 5 residual vacancies in Paediatrics

4. Maternity Birth Rate Plus

Birthrate Plus (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units for a significant number of years.

It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings, and have been endorsed by the RCM and RCOG. Birthrate Plus is the only recognised national tool for calculating midwifery staffing levels.

An individual service will produce a casemix based on clinical indicators of the wellbeing of the mother and infant throughout labour and delivery. Each of the indicators has a weighted score designed to reflect the different processes of labour and delivery and the degree to which these deviate from obstetric normality. Five different categories are created - the lower the score the more normal are the processes of labour and delivery. Other categories classify women admitted to the delivery suite for other reasons than for labour and delivery.

In addition, BR+ determines the staffing required for antenatal inpatient and outpatient services, postnatal care of women and babies in hospital and community care of the local population birthing in either the local hospital or neighbouring ones.

The Case mix at Milton Keynes
The main factor in the Birthrate Plus results is the casemix based on 3 months' data from August to October 2017 collected from a review of scanned maternity records using the BR+ classification; data was then validated by the BR+ Team to ensure the data quality was 100%. See Appendix A for case mix definitions.

Milton Keynes Hospital
Cat I
Cat II
Cat III
Cat IV
Cat V

Delivery Suite Casemix
7.1%
18.2%
17.7%
27.4%
29.6%

Of the 48 maternity units in England who have undertaken a BR+ assessment in 2015 to 2017, the average % of women in Categories IV & V is 54% ranging from 41 to 69%. Milton Keynes at 57% is in the average bracket.

Midwife Ratios
The ratios below are based on the BR+® dataset, national standards with the BR+ methodology and local factors, such as % uplift for annual, sick & study leave, case mix of women birthing in hospital, provision of outpatient/day unit services and total number of women having community care irrespective of place of birth.

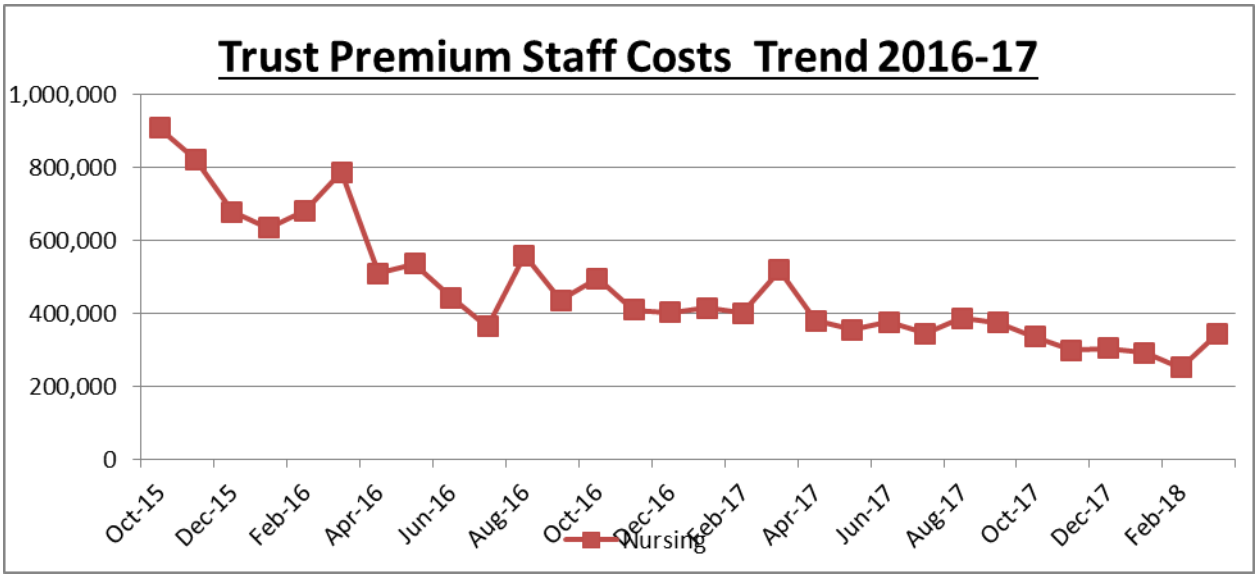
Ratios:

- Home births — 35 births to 1 wte midwife
- Delivery Suite births (all hospital care) — 36 births to 1 wte midwife
- Ante & Postnatal Community care only — 96 cases to 1 wte midwife
- Overall ratio for all births — 26 births to 1 wte midwife

Note: The overall ratio for Milton Keynes University Hospital of 26 births to 1wte equates to the often-cited ratio of 28 or 29.5 births to 1 wte.

Conclusions
The Birthrate plus assessment has concluded that the existing midwifery establishment is correct for the current casemix, however an increase in maternity support staff (Maternity Care Assistants) by 3.3 WTE is suggested.

5. Controlling Premium Cost



Agency nursing expenditure continued to stabilise in February with a slight increase in March due to backfill for E-Care.

6. NHSI Retention programme

NHS Improvement (NHSI) has launched a new major programme to improve staff retention in trusts across England and bring down the leaver rates in the NHS by 2020. Milton Keynes University is in cohort 3

The programme will highlight why there has been an increase in the amount of staff leaving and will provide support, so we can hold on to this expertise and experience. Staff

It will bring together support from the NHS's national partners to ensure a system-wide approach to securing and sustaining the future NHS workforce.

The retention programme includes an intensive support package. Over the next 90 days, NHSI will be visiting MKUH and offering direct support to analyse our staff turnover and design a bespoke improvement plan targeting the drives of why staff leave.

Appendix A

Method for Classifying Birthrate Plus® Categories by Scoring Clinical Factors in the Process and Outcome of Labour and Delivery
There are five [5] categories for mothers who have given birth during their time in the delivery suite [Categories I – V).

CATEGORY I Score = 6

This is the most normal and healthy outcome possible. A woman is defined as Category I [lowest level of dependency] if:
The woman's pregnancy is of 37 weeks gestation or more, she is in labour for 8 hours or less; she achieves a normal delivery with an intact perineum; her baby has an Apgar score of 8+; and weighs more than 2.5kg; and she does not require or receive any further treatment and/or monitoring.

CATEGORY II Score = 7 – 9

This is also a normal outcome, very similar to Category I, but usually with the perineal tear [score 2], or a length of labour of more than 8 hours [score 2]. IV Infusion [score 2] may also fall into this category if no other intervention. However, if more than one of these events happens, then the mother and baby outcome would be in Category III.

CATEGORY III Score = 10 – 13

Moderate risk/need such as Induction of Labour with syntocinon, instrumental deliveries will fall into this category, as may continuous fetal monitoring. Women having an instrumental delivery with an epidural, and/or syntocinon may become a Category IV.

CATEGORY IV Score = 14 –18

More complicated cases affecting mother and/or baby will be in this category, such as elective caesarean section; pre-term births; low Apgar and birth weight. Women having epidural for pain relief and a normal delivery will also be Category IV, as will those having a straightforward instrumental delivery.

CATEGORY V Score = 19 or more

This score is reached when the mother and/or baby require a very high degree of support or intervention, such as, emergency section, associated medical problem such as diabetes, stillbirth or multiple pregnancy, as well as unexpected intensive care needs post-delivery. Some women who require emergency anaesthetic for retained placenta or suture of third degree tear may be in this category.

Category X women are those who are admitted to the delivery suite, but after assessment/monitoring are found not to be in labour or to need any intervention. These women are either sent home or transferred to the antenatal ward for observation.

Categories A1 & A2 women are those who require some intervention such as intravenous infusion and/or monitoring, e.g. antepartum haemorrhage, pre-eclampsia or premature labour. Such women often spend considerable time on delivery suite before being transferred to the antenatal ward or to another maternity unit with neonatal facilities. However, some women with moderate risk/needs will go home following assessment and treatment.

Category R women are re-admitted after delivery as postnatal cases, often requiring medical care.
Inductions of labour with prostins are recorded, as are escorted transfers to another maternity unit and the non-viable pregnancies.

Fill rates for Nursing, Midwifery and Care Staff February 2018

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
MAU Ward 1	79.8%	130.6%	98.7%	156.8%	756	4.2	2.7	6.9
MAU Ward 2	86.2%	123.1%	106.5%	174.9%	744	3.2	3.5	6.7
Ward 3	79.7%	107.6%	111.6%	120.2%	750	3.1	3.9	7.0
Ward 5	77.9%	96.6%	112.3%	99.5%	599	5.6	1.2	6.8
DoCC	83.2%	60.0%	86.7%	-	177	25.0	1.0	26.0
Ward 7	78.3%	93.4%	102.4%	116.2%	696	3.2	3.8	7.0
Ward 8	74.2%	86.7%	97.6%	133.9%	687	3.1	2.8	5.9
Ward 9	82.9%	94.6%	95.5%	89.3%	541	5.0	1.2	6.2
Ward 10	95.5%	91.1%	100.0%	-	319	4.3	2.0	6.3
Ward 14	81.7%	125.5%	97.6%	151.8%	658	2.9	3.9	6.8
Ward 15	87.8%	110.0%	96.7%	162.4%	807	3.3	2.9	6.2
Ward 16	84.7%	93.4%	95.5%	110.8%	829	3.1	2.2	5.3
Ward 17	82.1%	92.1%	100.9%	132.1%	701	4.0	2.3	6.3
Ward 18	81.5%	109.3%	98.8%	145.1%	785	2.9	4.0	6.9
Ward 19	71.8%	106.3%	101.1%	126.2%	859	2.5	3.4	5.9
Ward 20	77.0%	125.7%	100.0%	132.1%	740	3.4	3.1	6.5
Ward 21	80.6%	121.0%	101.2%	148.2%	673	3.4	2.9	6.2
Ward 22	85.4%	102.8%	100.6%	125.0%	597	3.8	2.7	6.5
Ward 23	80.0%	159.1%	101.5%	175.1%	1061	3.1	4.5	7.6
Ward 24	89.5%	131.4%	92.4%	-	442	4.4	2.0	6.4
Labour Ward	102.0%	75.4%	96.9%	0.0%	217	23.0	1.5	24.5
NNU	101.6%	78.9%	100.7%	89.4%	408	8.7	1.4	10.1

Fill rates for Nursing, Midwifery and Care Staff March 2018

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
MAU Ward 1	82.6%	142.8%	97.6%	169.3%	837	4.2	3.0	7.2
MAU Ward 2	80.0%	114.1%	99.4%	156.5%	815	3.0	3.2	6.2
Ward 3	76.6%	90.2%	104.1%	105.2%	869	2.8	3.2	6.0
Ward 5	77.3%	107.4%	110.6%	91.2%	678	5.5	1.2	6.7
DoCC	9.9%	51.1%	56.7%	-	209	8.1	0.8	8.9
Ward 7	77.8%	105.3%	103.3%	129.9%	779	3.2	4.2	7.4
Ward 8	75.7%	103.1%	100.0%	143.0%	760	3.2	3.2	6.4
Ward 9	91.9%	95.2%	85.0%	90.3%	518	5.6	1.4	7.0
Ward 10	94.4%	98.4%	93.5%	-	295	5.0	2.6	7.7
Ward 14	84.9%	95.1%	96.8%	109.6%	730	3.0	3.1	6.1
Ward 15	84.2%	111.9%	95.9%	148.4%				
Ward 16	80.9%	99.1%	95.2%	124.5%	890	3.1	2.5	5.6
Ward 17	77.7%	102.5%	99.2%	122.6%	785	3.8	2.3	6.1
Ward 18	81.6%	91.0%	98.0%	126.9%	870	2.9	3.4	6.3
Ward 19	71.4%	103.7%	99.1%	138.9%	952	2.4	3.5	5.9
Ward 20	71.5%	122.9%	98.0%	124.6%	838	3.1	2.9	6.0
Ward 21	79.6%	147.9%	97.8%	162.9%	741	3.3	3.3	6.7
Ward 22	86.6%	141.3%	101.1%	164.2%	682	3.7	3.5	7.3
Ward 23	77.7%	129.5%	99.2%	149.2%	1183	3.0	3.8	6.7
Ward 24	88.1%	96.0%	97.2%	-	507	4.4	1.3	5.7
Labour Ward	99.5%	66.1%	95.9%	90.3%	398	13.6	1.5	15.1
NNU	93.8%	95.4%	105.7%	74.5%	209	17.9	3.3	21.3

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Trust Board	Date: 4 May 2018
Report title:	Performance Report indicators for 2017/18 (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 2017/18			
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 2018)

1.0 Summary

This report summarises performance in March 2018.

The Trust continues to be dominated by non-elective demand with the lagging indicators continue to show the hospital under stress. Inpatient occupancy worsened marginally (by 0.6%) to 98.9%. Stranded patients and DTOCs were broadly similar to previous months.

This operational pressure directly affects the Trust's ability to meet the emergency access standard in A&E and we achieved 88.6% albeit against a national backdrop of England only achieving 84.6% placing the Trust at 28th up from 33rd out of 137 and well into the top quartile.

On the elective side the RTT target was not achieved in month at 84.6% down from (87.9% last month). In February the England performance was 87.5% with MKUH being 101st out of 157 Trusts. Of continued concern is the numbers of breaches over 52 weeks as this will ensure that we are seen as an outlier (January data show the Trust at 133rd out of 137).

2.0 Sustainability and Transformation Fund (STF)

Performance Improvement Trajectories

March 2018 performance against the Service Development and Improvement Plans (SDIP):

ID	Indicator	DQ Assurance	Target 17-18	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
4.1	ED 4 hour target (includes UCS)		95%	95.0%	91.0%	88.6%	✗	▲	✗
4.2	RTT Incomplete Pathways <18 weeks		92%	92.0%		84.6%	✗	▼	
4.9	62 day standard (Quarterly)		85%	85%		87.1%	✓	▼	

ED performance for March 2018 was 1 percentage point better than in February 2018. 88.6% of patients were seen within 4 hours in ED compared to 87.6% in February 2018. This was however lower than both the 95% national target and the Trust NHS Improvement trajectory is (93.8%). Comparing the financial year performance to March with the same period in 2016/17, ED performance (91%) in 2017/18 dropped by 0.1 percentage point. National A&E performance in March 2018 was 84.6%, which was the lowest since the data collection began.

At the end of March 2018, the referral to treatment (RTT) national operating standard of 92% for incomplete pathways was not achieved. Aggregate performance at 84.6% was the lowest in over four years. Comparing the financial year performance with the same period in 2016/17, RTT performance (84.6%) in 2017/18 dropped by 7.9 percentage points. Nationally, the Trust's RTT performance was lower than the combined NHS England performance for RTT in February 2018, which was 87.9%. The national performance for March 2018 is yet to be published.

The 85% Cancer 62 day standard was achieved in Quarter 3 of 2017/18, closing at 87.1%, which was also above the NHS Improvement trajectory (85.1%). The performance also compared favourably to the national performance in March 2018 (83%) which has breached for the last sixteen quarters in a row. Indications are that the 85% target is set to be delivered by the Trust for Quarter four.

3.0 Urgent and Emergency Care

Urgent and emergency care continued to be busy in March 2018 with prolonged increased acuity and demand.

ID	Indicator	DQ Assurance	Target 17-18	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
2.4	Cancelled Ops - On Day		1.0%	1.0%	1.2%	2.3%	✗	▼	✗
3.2	Ward Discharges by Midday		30%	30%	22.2%	20.3%	✗	▲	✗
3.4	30 day readmissions		6.4%	6.4%	8.2%	8.8%	✗	▼	✗
3.9	Ambulance Handovers >30 mins (%)		5%	5%	6.2%	7.8%	✗	▼	✗
4.1	ED 4 hour target (includes UCS)		95%	95.0%	91.0%	88.6%	✗	▲	✗

Cancelled Operations on the Day

In March 2018, the number of operations cancelled on the day for non-clinical reasons continued to be significantly high (57). This was the most reported in a calendar month since October 2015 (56) and represented 2.3% of all planned elective operations. 35 (61.4%) of these cancelled operations were attributed to bed availability and 10 (17.5%) were attributed to consultant availability. The remaining twelve were attributed to a variety of reasons, including administration errors and timing.

Comparing the financial year performance with the same period in 2016/17, the performance (0.8%) in 2017/18 dropped by 1.5 percentage points. The national performance for March 2018 is yet to be released by NHS England.

Readmissions

MKUH had a challenging month in terms of readmission rates with performance at 8.8% in March 2018. This was an increase of 1.4 percentage points from the previous month and was the highest reported in over four years.

At a divisional level, the readmission rate for Women and Children (5.2%) and Medicine (13.6%) increased compared to February 2018. Surgery (4.9%) maintained the same level of performance as the previous month. Comparing the financial year performance with the same period in 2016/17, the performance (8.2%) in 2017/18 increased by 1 percentage point.

Delayed Transfers of Care (DTOC)

The Trust reported an increase in DTOC patients, from 39 in February to 41 at midnight on the last Thursday of March 2018. This was however, an improvement when compared to the same period last year (March 2017) when there were 51 DTOCs reported.

The number of bed days lost due to DTOCs decreased from 1225 in February 2018 to 1156. The high volume undoubtedly has an impact on the day-to-day acute bed capacity and patient flow, most notably to the medical bed base.

Ambulance Handovers

The percentage of ambulance handovers that took longer than 30 minutes continued above the 5% tolerance in March 2018 (7.8%) and was higher than the previous month (7.5%). The Trust most recently achieved the 5% threshold in October 2017. The number of handovers reported to have taken longer than 60 minutes also increased during March 2018.

4.0 Elective Pathways

ID	Indicator	DQ Assurance	Target 17-18	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
3.1	Overnight bed occupancy rate		93%	93%	98.3%	98.9%	✗	▼	✗
3.5	Follow Up Ratio		1.50	1.50	1.53	1.49	✓	▲	✗
4.2	RTT Incomplete Pathways <18 weeks		92%	92.0%		84.6%	✗	▼	
5.6	Outpatient DNA Rate		5%	5%	6.1%	6.3%	✗	▼	✗

Overnight Bed Occupancy

The Trust bed occupancy continued above the 93% internal threshold and increased to 98.9% in March 2018, which was the highest reported since October 2017. 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 2018, the follow up ratio improved from 1.53 in February 2018 to 1.49 follow up attendances for every new attendance seen, which was within the threshold. This is the first time the Trust achieved the 5% threshold since M2 (May 2017).

RTT Incomplete Pathways

Meeting the RTT national standard and NHS Improvement trajectory represents a huge challenge for the Trust. Performance fell significantly due to high occupancy levels and a large volume of cancelled elective operations. The Trust reported 20 patients at the end of March who had a waiting time of 52 weeks or more. The majority of these patients (13) were in Trauma & Orthopaedics, two were in ENT and one each in Urology, Neurology, Ophthalmology, Vascular Surgery and Gynaecology. The RTT National standard (92%) was most recently achieved by the Trust in October 2017.

Diagnostic Waits <6 weeks

Nationally, the operational standard of less than 1% of patients waiting six weeks or longer was not achieved in February 2018. The national performance for March 2018 is planned to be published by NHS England in May 2018.

The current Trust position for March 2018 suggests that performance has reduced to 98.3% following achievement in February 2018. However, this is currently an unvalidated position and all breaches are with the CSUs for final validation.

Outpatient DNA Rate

The outpatient DNA rate (6.3%) in March 2018 increased by 0.5 percentage points from 5.8% against the 5% threshold. Comparing this to the 2016/17 performance (5.6%), the DNA rate for 2017/18 increased to 6.1% indicating 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

Mortality

There was a marked improvement in the 12-month rolling SHMI and HSMR figures in Month 12. For Women and Children, there is one outlying diagnosis group (other perinatal conditions) attracting significantly higher than expected deaths.

Midwife to Birth Ratio

The Midwife to Birth Ratio (25) improved significantly in March 2018 and was the lowest reported in over four years. This could be because of the fewer births in the Trust in March 2018.

Infection Control

E-coli cases are known to be increasing nationally and MKUH reported three cases in March 2018 (Wards 14, 19 and 20). There were no CDIs or MRSAs reported by the Trust in Month 12. Comparing

the financial year performance with the same period in 2016/17, the number of CDIs and MRSAs increased by three and two respectively in 2017/18.

Pressure Ulcers

For the first time in 2017/18, the pressure ulcer rate (1.53) was above the internal tolerance (0.86). The number of pressure ulcers reported by the Trust increased significantly to 23, which is the highest reported in 2017/18; majority of these were in Surgery.

ENDS

Performance Report 2017/18
March 2018 (M12)

Milton Keynes University Hospital NHS Foundation Trust

OBJECTIVE 1 - PATIENT SAFETY

ID	Indicator	DQ Assurance	Target 17-18	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
1.1	Mortality - (HSMR)		100	100		89.7	✓	▲		
1.2	Mortality - (SHMI) - Quarterly		1	1		0.94	✓	▲		
1.3	Never Events		0	0	4	0	✓	▲	✗	
1.4	Clostridium Difficile		20	20	13	0	✓	▲	✓	
1.5	MRSA bacteraemia		0	0	3	0	✓	▬	✗	
1.6	Pressure Ulcers Grade 2, 3 or 4 (per 1,000 bed days)		0.86	0.86	0.59	1.53	✗	▼	✓	
1.7	Falls with harm (per 1,000 bed days)		0.19	0.19	0.12	0.13	✓	▼	✓	
1.8	WHO Surgical Safety Checklist		100%	100%	100%	100%	✓	▬	✓	
1.9	Midwife : Birth Ratio		30	30	29	25	✓	▲	✓	
1.10	Incident Rate (per 1,000 bed days)		40	40	31.80	27.82	✗	▼	✗	
1.11	Duty of Candour Breaches (Quarterly)		0	0	1	0	✓	▲	✗	
1.12	E-Coli				29	3		▼		

OBJECTIVE 2 - PATIENT EXPERIENCE

ID	Indicator	DQ Assurance	Target 17-18	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%	93.5%	92%	✗	▲	✗	
2.2	RED Complaints Received		10	10	1	0	✓	▬	✓	
2.3	Complaints response in agreed time		90%	90%	87.1%	87.5%	✗	▼	✗	
2.4	Cancelled Ops - On Day		1.0%	1.0%	1.2%	2.3%	✗	▼	✗	
2.5	Over 75s Ward Moves at Night		2,000	2000	2,813	213	✗	▼	✗	
2.6	Mixed Sex Breaches		0	0	4	0	✓	▬	✗	

OBJECTIVE 3 - CLINICAL EFFECTIVENESS

ID	Indicator	DQ Assurance	Target 17-18	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%	98.3%	98.9%	✗	▼	✗	
3.2	Ward Discharges by Midday		30%	30%	22.2%	20.3%	✗	▲	✗	
3.3	Weekend Discharges		70%	70%	68.9%	68.1%	✗	▲	✗	
3.4	30 day readmissions		6.4%	6.4%	8.2%	8.8%	✗	▼	✗	
3.5	Follow Up Ratio		1.50	1.50	1.53	1.49	✓	▲	✗	
3.6.1	Number of Stranded Patients (LOS>=7 Days)		188	188		247	✗	▲		
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)		84	84		107	✗	▼		
3.7	Delayed Transfers of Care		25	25		41	✗	▼		
3.8	Discharges from PDU (%)		16%	16%	14.2%	16.5%	✓	▼	✗	
3.9	Ambulance Handovers >30 mins (%)		5%	5%	6.2%	7.8%	✗	▼	✗	

OBJECTIVE 4 - KEY TARGETS

ID	Indicator	DQ Assurance	Target 17-18	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)		95%	95.0%	91.0%	88.6%	✗	▲	✗	
4.2	RTT Incomplete Pathways <18 weeks		92%	92.0%		84.6%	✗	▼		
4.3	RTT Patients Waiting Over 18 Weeks		911	911		2080	✗	▼		
4.4	RTT Total Open Pathways		11,388	11,388		13,511	✗	▼		
4.5	RTT Patients waiting over 52 weeks			0		20	✗	▼		
4.6	Diagnostic Waits <6 weeks		99%	99%		98.9%	✗	▼		
4.7	All 2 week wait all cancers (Quarterly)		93%	93%		95.6%	✓	▬		
4.8	31 days Diagnosis to Treatment (Quarterly)		96%	96%		100.0%	✓	▬		
4.9	62 day standard (Quarterly)		85%	85%		87.1%	✓	▼		

OBJECTIVE 5 - SUSTAINABILITY

ID	Indicator	DQ Assurance	Target 17-18	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	61,464	5,068	✗	▼	✓	
5.2	A&E Attendances		89,338	89,338	87,740	7,208	✗	▲	✗	
5.3	Elective Spells (PBR)		26,522	26,522	24,444	1,803	✗	▼	✗	
5.4	Non-Elective Spells (PBR)		32,365	32,365	34,184	2,901	✓	▲	✓	
5.5	OP Attendances / Procs (Total)		377,608	377,608	353,662	28,520	✗	▼	✗	
5.6	Outpatient DNA Rate		5%	5%	6.1%	6.3%	✗	▼	✗	

OBJECTIVE 7 - FINANCIAL PERFORMANCE

ID	Indicator	DQ Assurance	Target 17-18	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
7.1	Income £'000		223,967	223,967	223,794	20,105	✓	▲	✗	
7.2	Pay £'000		(158,813)	(158,813)	(159,438)	(13,836)	✗	▼	✗	
7.3	Non-pay £'000		(67,625)	(67,625)	(71,672)	(5,898)	✗	▼	✗	
7.4	Non-operating costs £'000		(12,954)	(12,954)	(12,588)	(1,109)	✗	▲	✓	
7.5	I&E Total £'000		(15,426)	(15,426)	(19,904)	(739)	✗	▲	✗	
7.6	Cash Balance £'000		2,504	2,504		2,507	✓	▼		
7.7	Savings Delivered £'000		10,500	10,500	8,998	2,367	✓	▲	✗	
7.8	Capital Expenditure £'000		(28,389)	(28,389)	(16,885)	(5,106)	✓	▼	✓	

OBJECTIVE 8 - WORKFORCE PERFORMANCE

ID	Indicator	DQ Assurance	Target 17-18	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
8.1	Staff Vacancies % of establishment		14%	14%		11.9%	✓	▼		
8.2	Agency Expenditure %		10%	10%	7.2%	6.3%	✓	▼	✓	
8.3	Staff sickness - % of days lost		4%	4%		4.1%	✗	▬		
8.4	Appraisals		90%	90%		84.0%	✗	▼		
8.5	Statutory Mandatory training		90%	90%		89.0%	✗	▼		
8.6	Substantive Staff Turnover		14%	14%		11.9%	✓	▲		
8.7	FFT Response Rate Staff (Quarterly)		18%	18%	20.4%	19.8%	✓	▼	✓	

OBJECTIVES - OTHER

ID	Indicator	DQ Assurance	Target 17-18	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		50	✗	▲		
O.2	Rebooked cancelled OPs - 28 day rule		95%	95%	68.4%	58.2%	✗	▼	✗	
O.3	Maternity Bookings <13 weeks		90%	90%	87.8%	86.0%	✗	▼	✗	
O.4	Overdue Datix Incidents >1 month		0	0		149	✗	▼		
O.5	Serious Incidents		58	58	50	7	✗	▼	✓	
O.6	Dementia Measures Met		3	3		3	✓	▬		
O.7	Energy Consumption (GJ)		200,684	200,684	242,112	22,170	✗	▼	✗	
O.8	Completed Job Plans (Consultants)		90%	90%		90%	✓	▬		

Key: Monthly/Quarterly Change

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

YTD Position

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

Data Quality Assurance Definitions

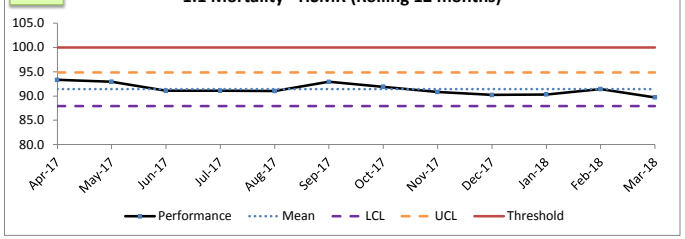
Rating	Data Quality Assurance
Green	Satisfactory and independently audited (indicator represents an accurate reflection of performance)
Amber	Acceptable levels of assurance but minor areas for improvement identified and potentially independently audited * /No Independent Assurance
Red	Unsatisfactory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

Milton Keynes University Hospital NHS Foundation Trust

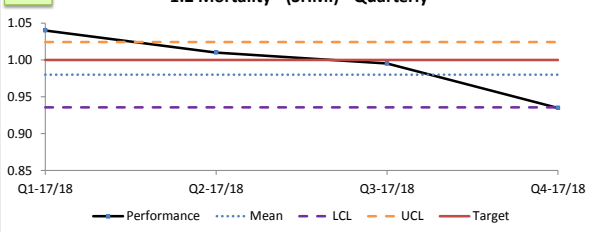
SD=3

1.1 Mortality - HSMR (Rolling 12 months)

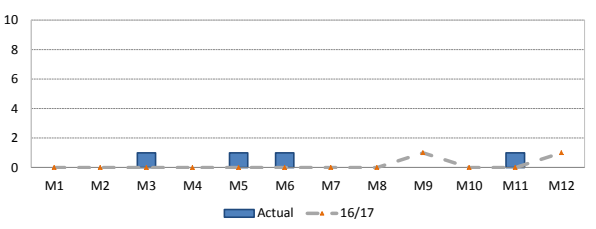


SD=3

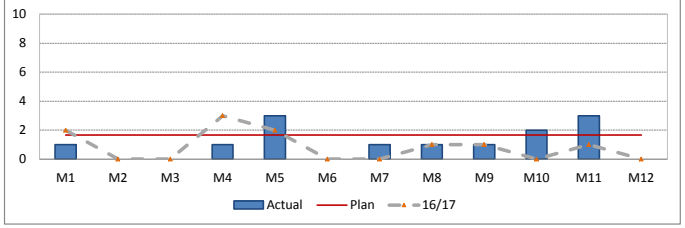
1.2 Mortality - (SHMI) - Quarterly



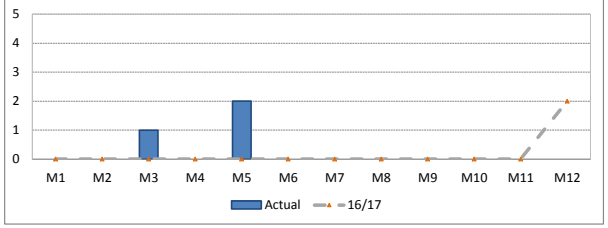
1.3 - Never events



1.4 - C.Diff Infections

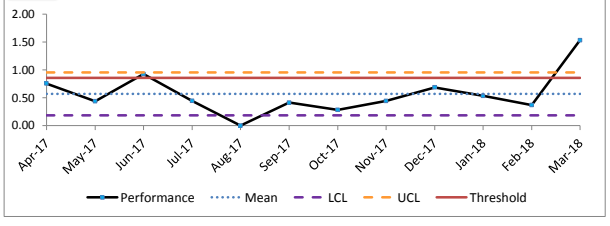


1.5 - MRSA Bacteraemia



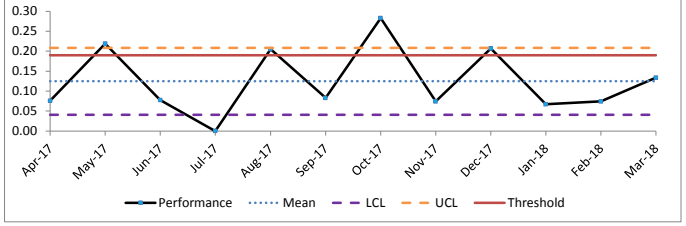
SD=1

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

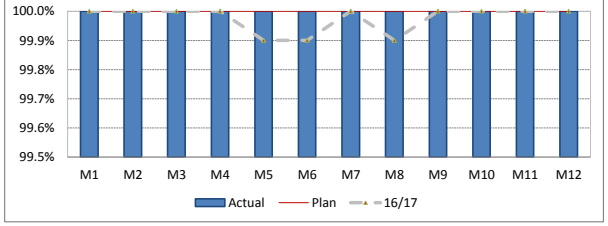


SD=1

1.7 - Inpatient falls causing harm



1.8 - WHO Surgical Safety Checklist



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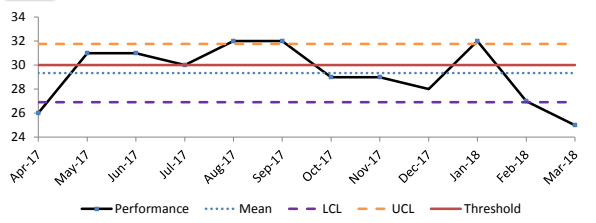
1.9 - Midwife to Birth Ratio



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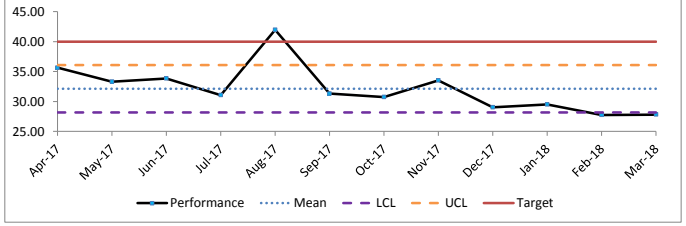
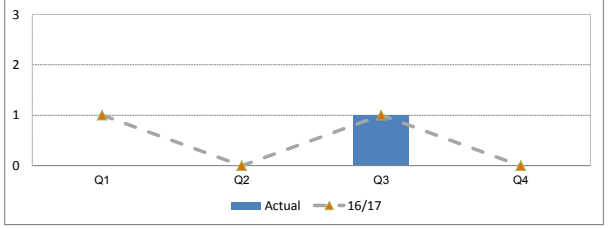
1.10 - Incident Rate (per 1,000 bed days)



1.11- Duty of Candour Breaches



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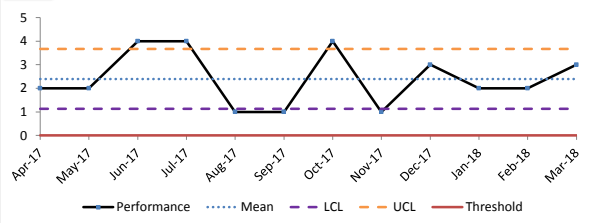
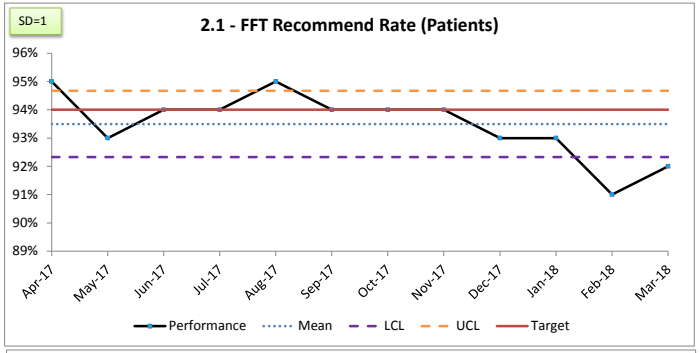
1.12 - E-Coli

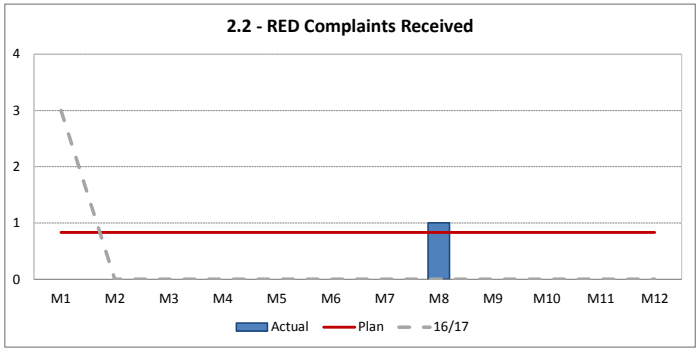


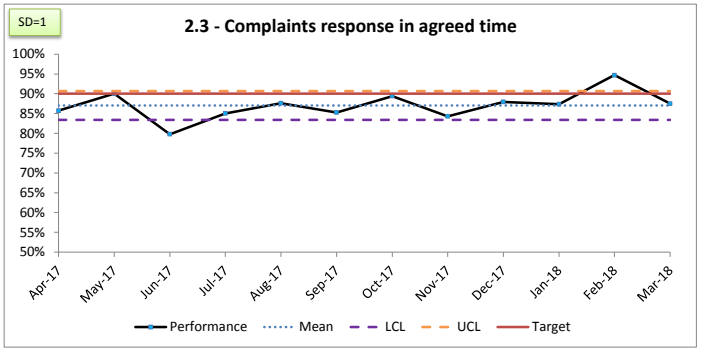
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

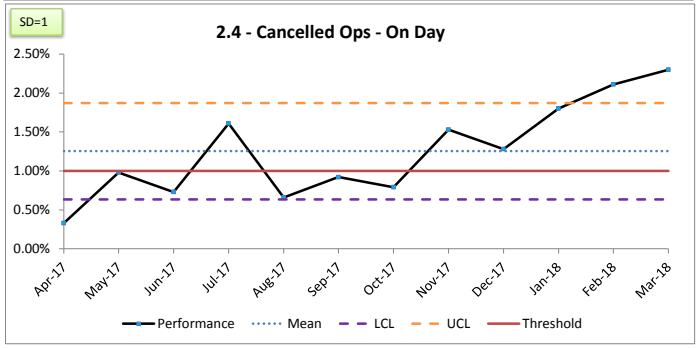
- Performance activity on a rolling 12 months/quarterly
- Average on a rolling 12 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

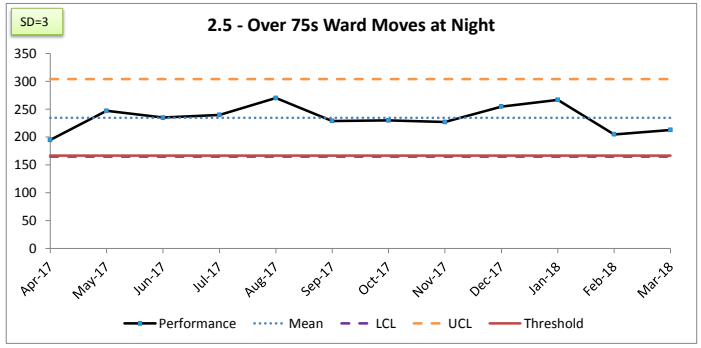
OBJECTIVE 2 - PATIENT EXPERIENCE

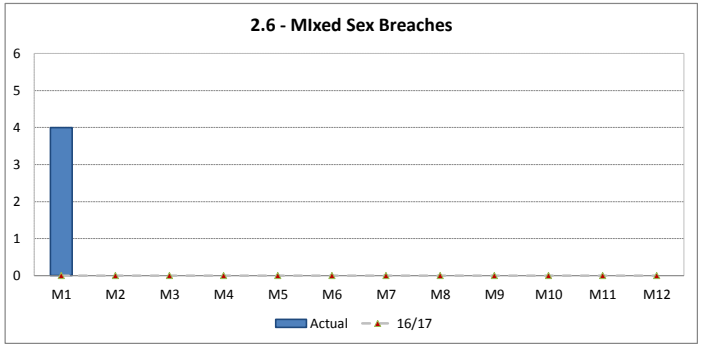












If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

- Performance activity on a rolling 12 months/quarterly
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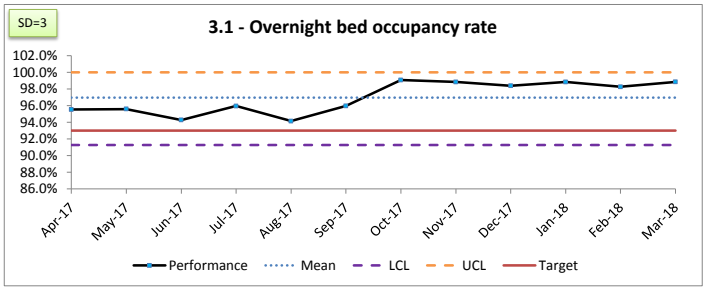
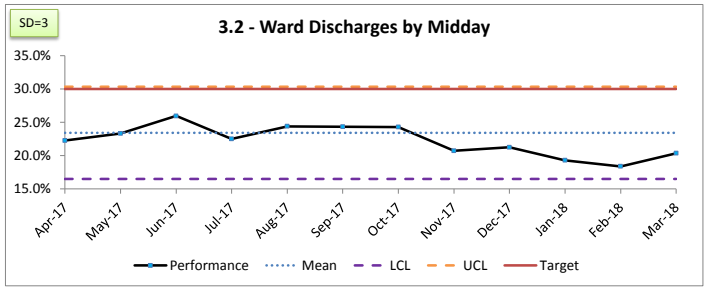
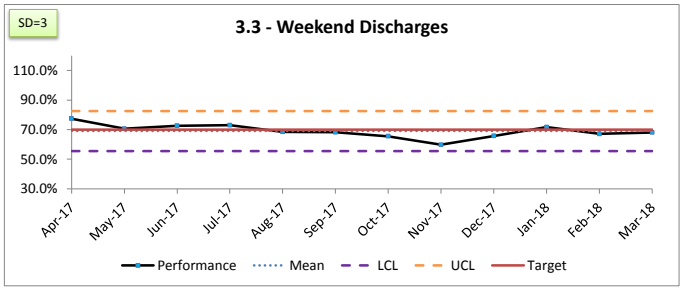
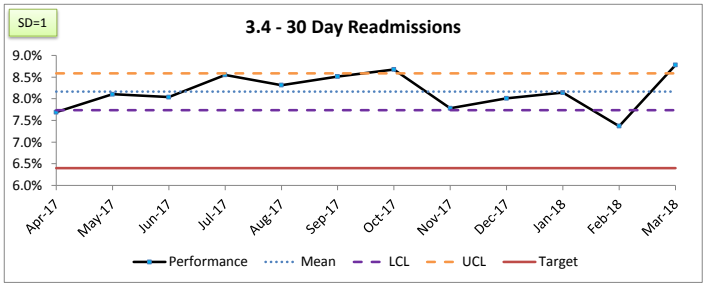
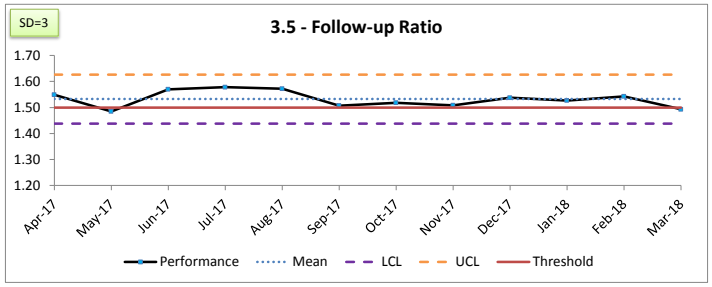
OBJECTIVE 3 - CLINICAL EFFECTIVENESS

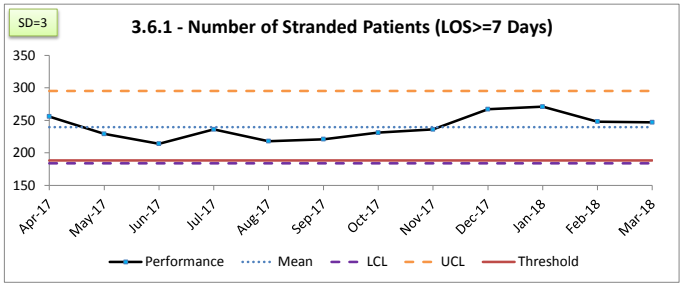


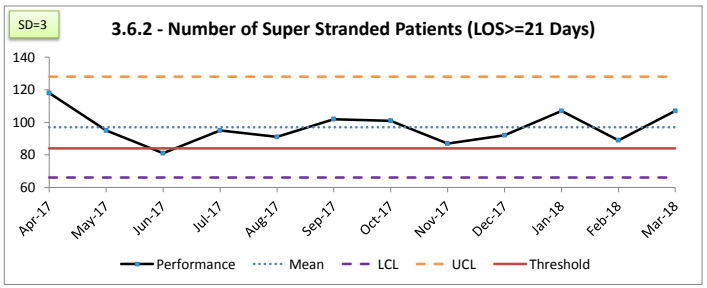


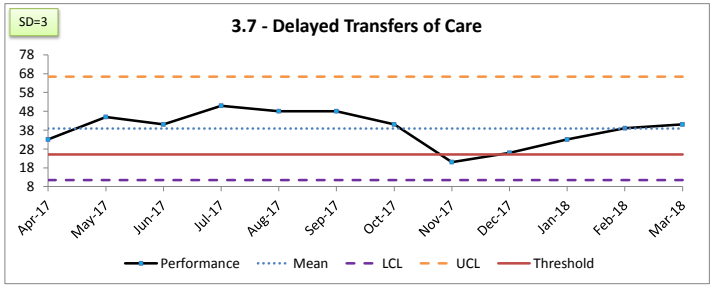


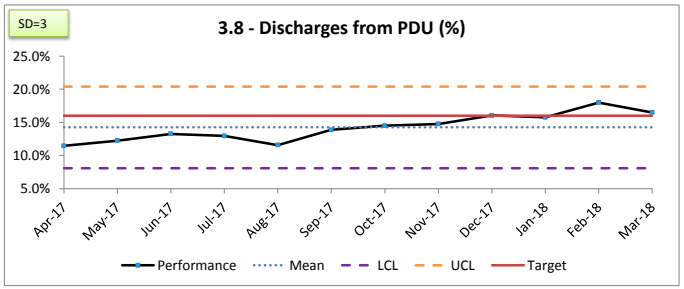


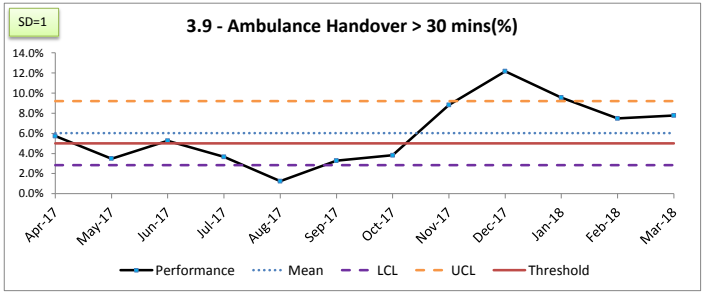












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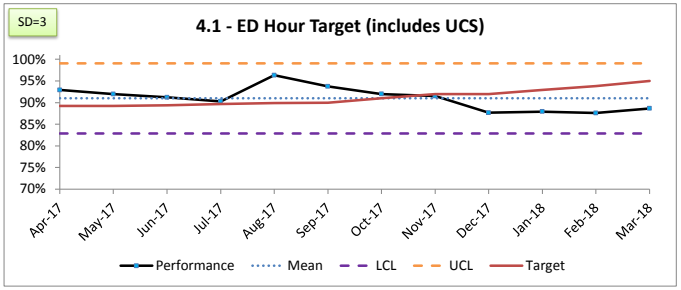
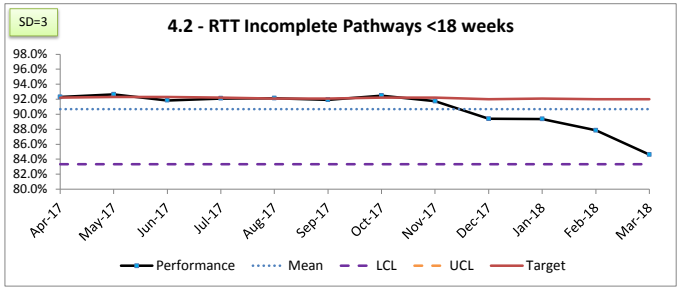
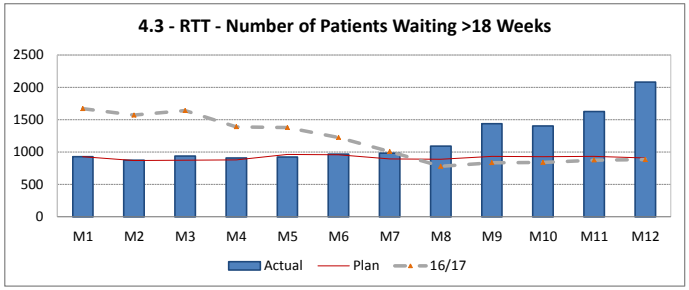
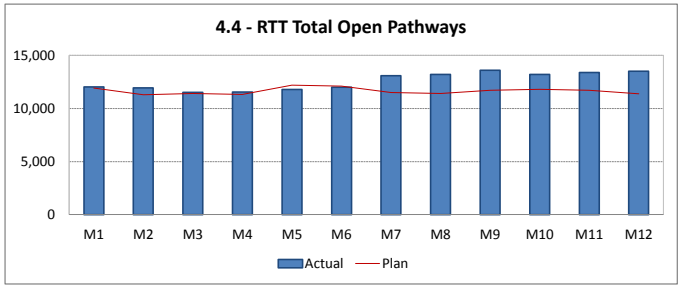
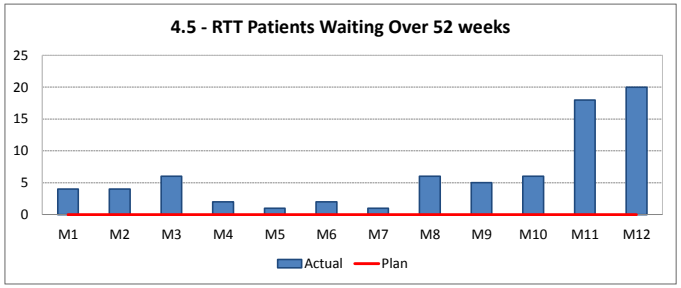
OBJECTIVE 4 - KEY TARGETS

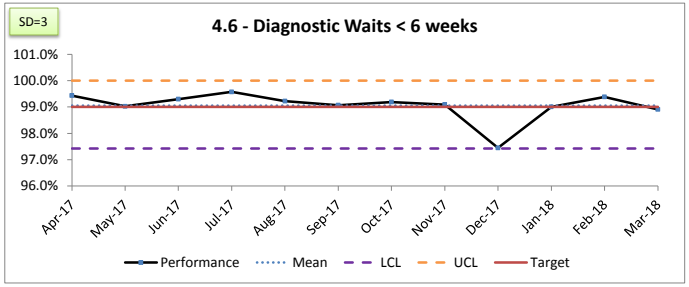


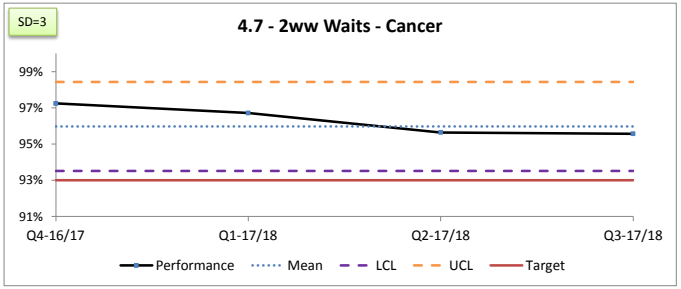


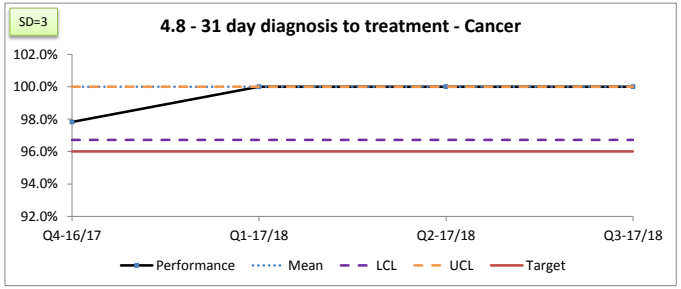


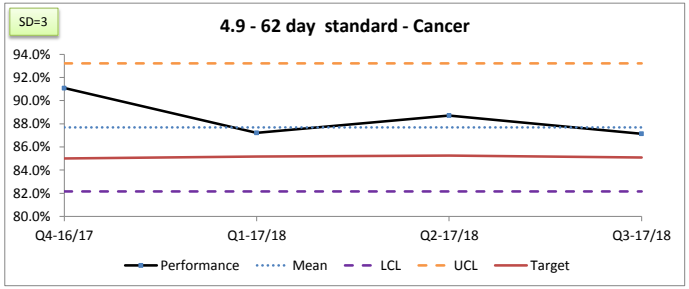












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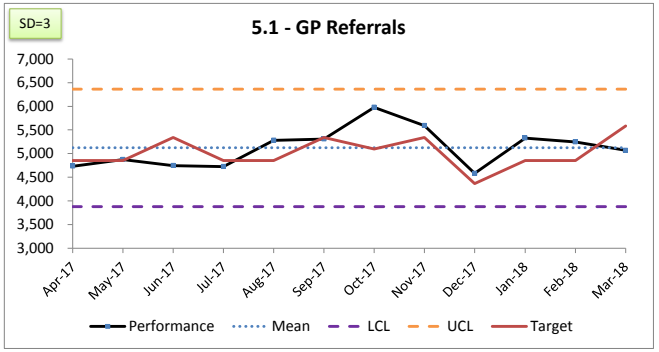

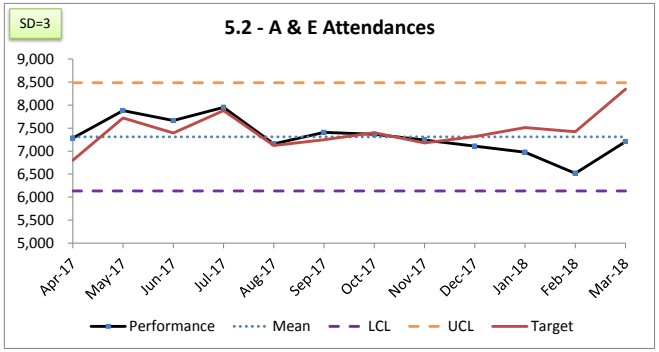

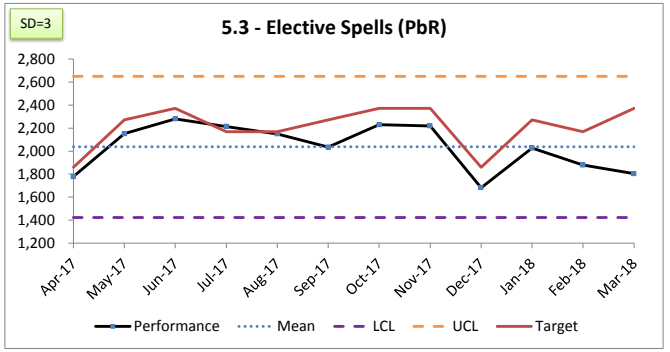

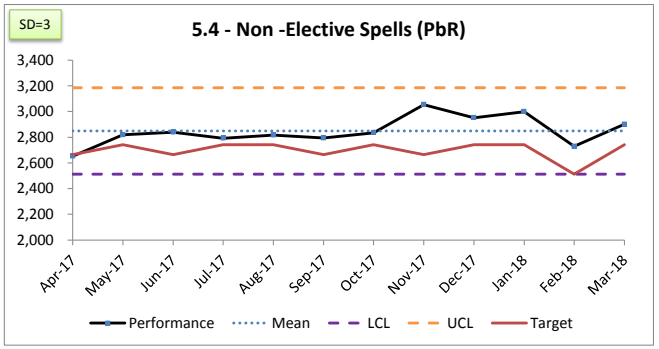

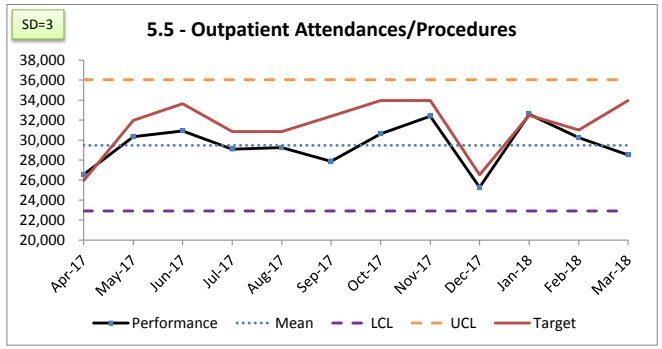

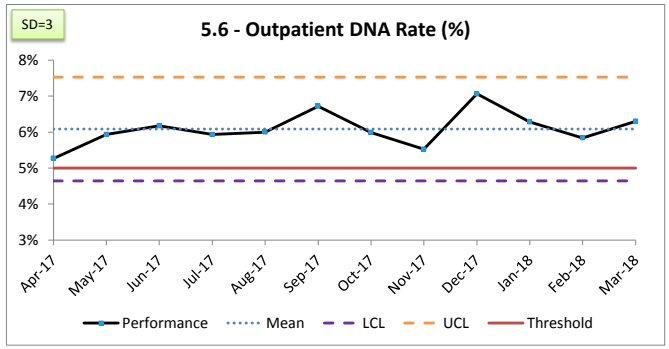

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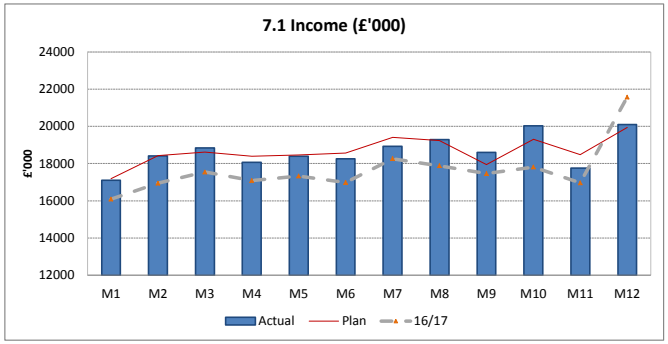
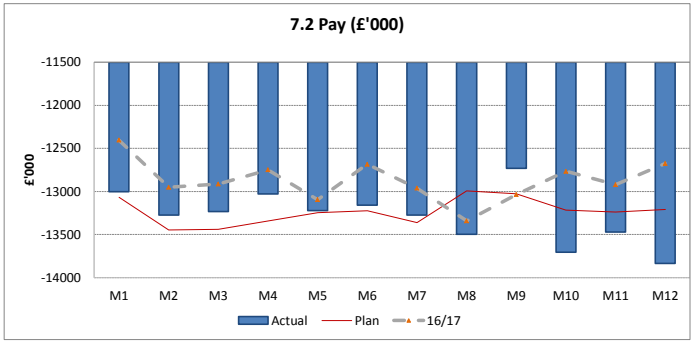
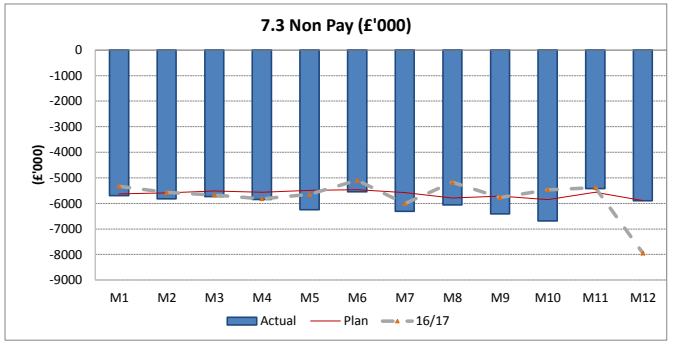
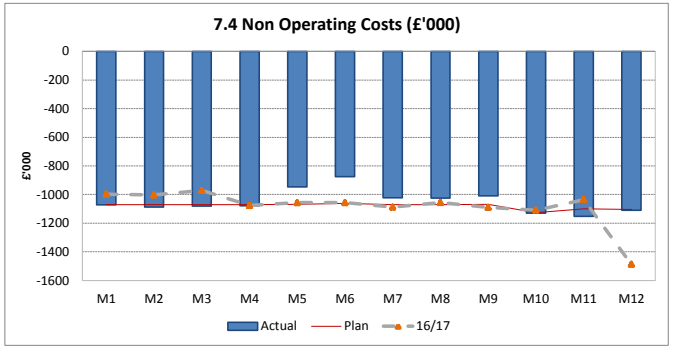
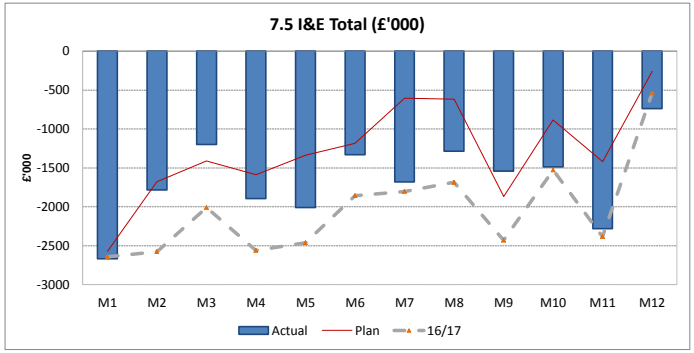
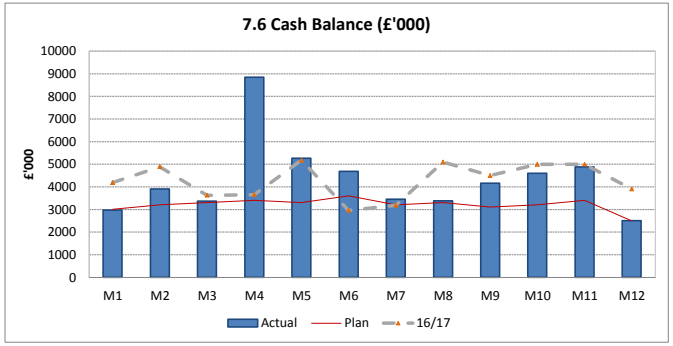

7.1 Income (£'000)
£'000
24000
22000
20000
18000
16000
14000
12000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
16/17

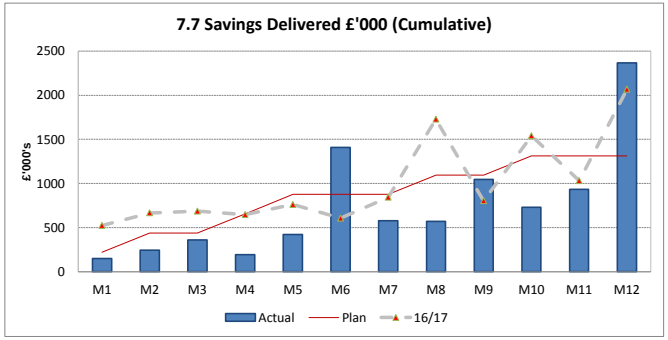

7.2 Pay (£'000)
£'000
-11500
-12000
-12500
-13000
-13500
-14000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
16/17

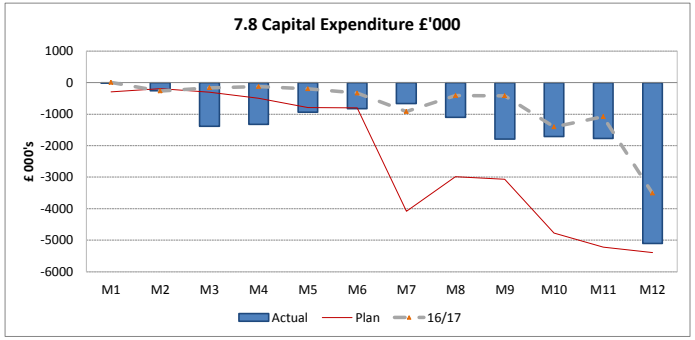

7.3 Non Pay (£'000)
(£'000)
0
-1000
-2000
-3000
-4000
-5000
-6000
-7000
-8000
-9000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
16/17


7.4 Non Operating Costs (£'000)
£'000
0
-200
-400
-600
-800
-1000
-1200
-1400
-1600
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
16/17

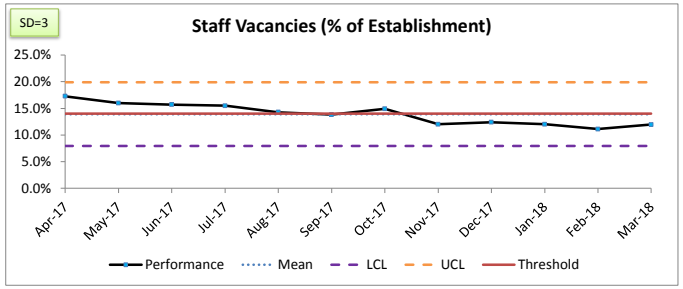

7.5 I&E Total (£'000)
£'000
0
-500
-1000
-1500
-2000
-2500
-3000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
16/17

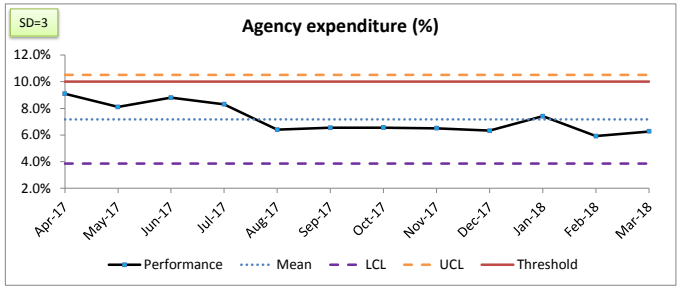

7.6 Cash Balance (£'000)
£'000
10000
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
16/17

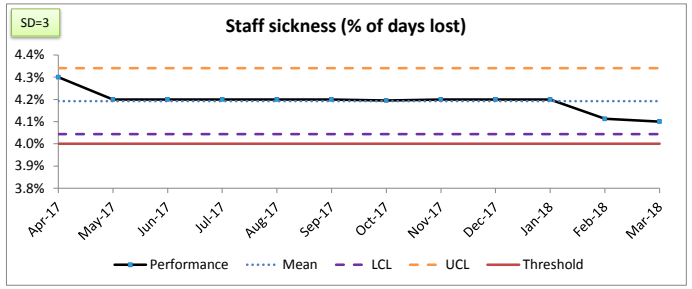

7.7 Savings Delivered £'000 (Cumulative)
£'000's
2500
2000
1500
1000
500
0
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
16/17

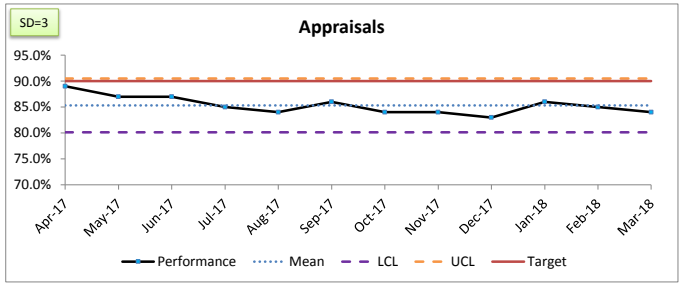

7.8 Capital Expenditure £'000
£'000's
1000
0
-1000
-2000
-3000
-4000
-5000
-6000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
16/17

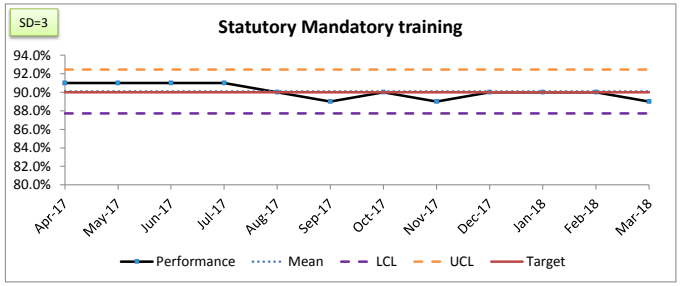
OBJECTIVE 8 - WORKFORCE PERFORMANCE

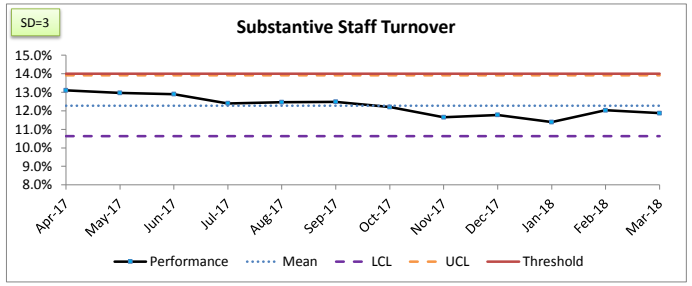


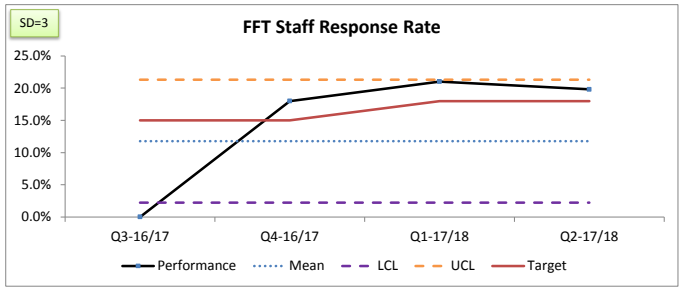












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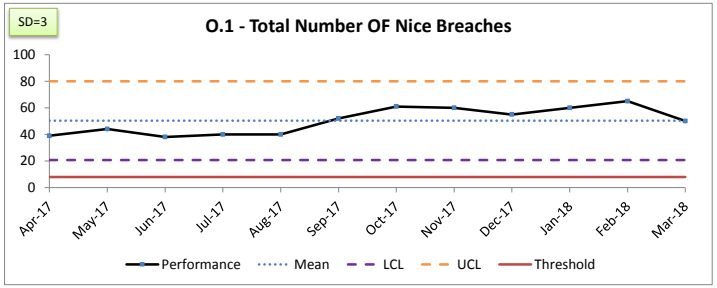

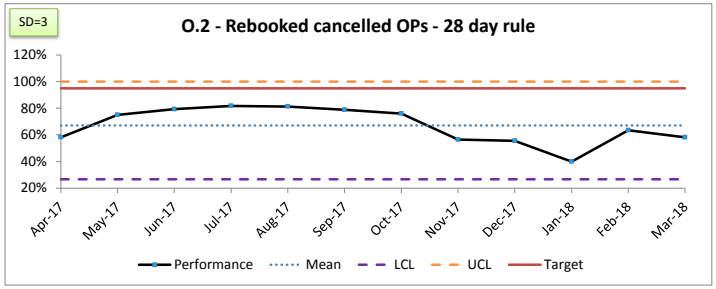

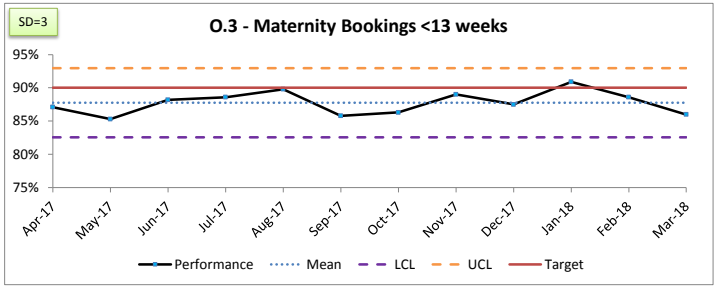

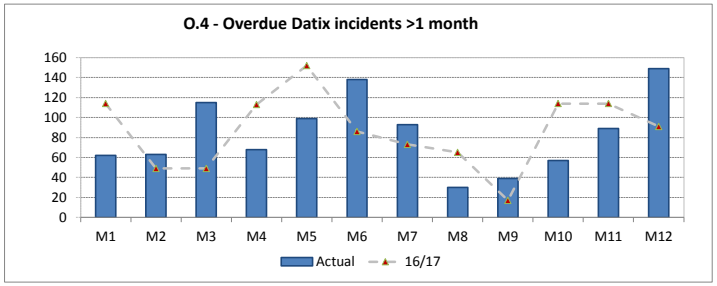

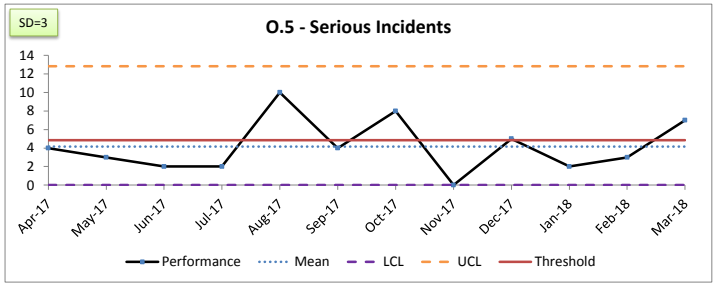

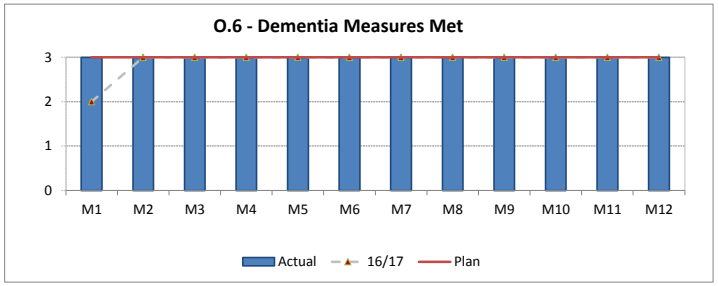

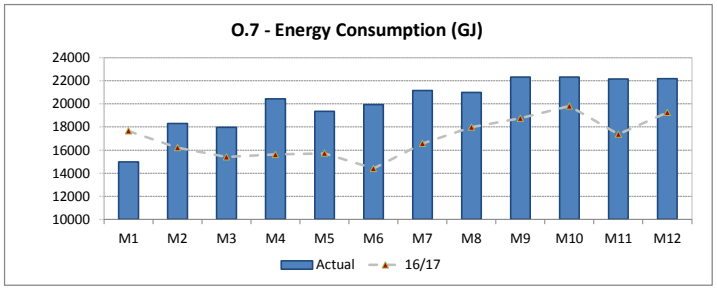

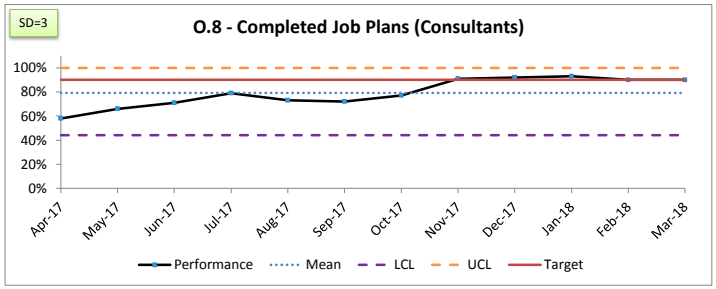

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			2016/17		2017/18		2018/19				
OBJECTIVE 1 - PATIENT SAFETY		**Source**	**Plan**	**Outturn**	**Plan**	**Outturn**	**Plan**	**Outturn**	**Comments (2018/19)**	**Status**	**Comments**
1.1	Mortality (HSMR)	National Benchmark	100	89.5	100	91.4	100		100 (national benchmark)		
1.2	Mortality (SHMI)	National Benchmark	100	104.7	100	99.54	100		100 (national benchmark)		
1.3	Never Events	National Contract	0	2	0	4	0		0 (zero tolerance)		
1.4a	Clostridium Difficile	National Contract	39	10	22	13	20		Reduce 17/18 plan by 1. Proposal to report as 'rate per 100000 bed days'? (Please see 1.4b below)		25/04/2018: Confirmed by Angela Legate.
1.4b	Clostridium Difficile - Rate per 100,000 bed days	National Contract	-	6.1	-	7.6	11.75		Based on 18/19 plan		27/04/2018: Revised figures based on 18/19 plan
1.5a	MRSA bacteraemia avoidable	National Contract	0	2	0	3	0		0 (zero tolerance).Proposal to report as 'rate per 100000 bed days'? (Please see 1.5b below)		25/04/2018: Confirmed by Angela Legate.
1.5b	MRSA bacteraemia- Rate per 100,000 bed days	National Contract	-	1.2	-	1.92	0		0 (zero tolerance)		25/04/2018: Confirmed by Angela Legate.
1.6	Pressure Ulcers Grade 2, 3 or 4 (per 1,000 bed days)	Clinical Quality	16	15	0.86	0.61	0.6?		Based on 17/18 outturn (0.56)		25/04/2018:Awaiting response from Lisa Knight.
1.7	Falls with harm (per 1,000 bed days)	Internal	16	17	0.19	0.12	0.12 / 0.19?		Based on 17/18 outturn (0.12)		25/04/2018:Awaiting response from Lisa Knight.
1.8	WHO Surgical Safety Checklist	Quality Schedule	100%	100%	100%	100%	100%		100% (same as 17/18 plan)		
1.9	Midwife : Birth ratio	RCOG	30	31	30	30	30?		~~29.5 (based on recent Birthplus evidence as per RCM document)~~		18/04/2018: Confirmed 30 with Jean Aldous and Julie Cooper
1.10	Incident Rate (per 1,000 bed days)	NRLS	0	0	40	31.9	40		Based on achieving NRLS median (same as 17/18 plan)		
1.11	Duty of Candour breaches	Quality Schedule	0	0	0	0	0		0 (zero tolerance)		
1.12a	E-Coli	Tbc	-	-	-	29	26		Reduce given 17/18 M11 outturn. Proposal to report as 'rate per 100000 bed days'? (Please see 1.12b below)		25/04/2018: Confirmed by Angela Legate.
1.12b	E-Coli - Rate per 100,000 bed days	Tbc	-	-	-	17.04	15.34?		Based on 18/19 plan		27/04/2018: Revised figures based on 18/19 plan
OBJECTIVE 2 - PATIENT EXPERIENCE		**Source**	**Plan**	**Outturn**	**Plan**				**Comments**	**Status**	
2.1	FFT - Recommend Rate (Patients)	Internal	92%	94.0%	94%	93.6%	94%		Same as 17/18		
2.2	RED Complaints Received	Internal	12	3	10	2	8		Reduction of 2 from 17/18 outturn		
2.3	Complaints response in agreed time	Quality Schedule	90%	80%	90%	87%	90%		Same as 17/18 plan		
2.4	Cancelled Ops - On Day	Internal	1.0%	0.8%	1.0%	1.2%	1.0%		Same as 17/18 plan		
2.5	Over 75s Ward Moves at night	Internal	1704	2226	2000	2835	2554		10% reduction on 17/18 outturn		
2.6	Mixed Sex Breaches	Internal	0	0	0	4	0		0 (zero tolerance)		
OBJECTIVE 3 - CLINICAL EFFECTIVENESS		**Source**	**Plan**	**Outturn**	**Plan**				**Comments**	**Status**	
3.1	Overnight bed occupancy rate	Internal	90%	93.9%	93%	96.8%	93%		17/18 is 97%; this seems to be unrealistic.Proposing same as last year 93%		
3.2	Ward Discharges before Midday	Internal	30%	24.6%	30%	22%	30%		30% (same as 17/18 plan)		
3.3	Weekend Discharges	Internal	60%	72.9%	70%	69.1%	70%		70% (based on 17/18 outturn)		
3.4	30 day readmissions (All)	Internal	6.4%	7.2%	6.4%	8.1%	6.4%?		To review with contracts		Check local contract ; Yvonne to confirm
3.5	New to Follow Up Ratio	Quality Schedule	1.5	1.5	1.5	1.54	1.5		1.5 (same as 17/18 plan) - Need to check the Activity Plan		Awaiting Activity Plan (Darren ?)
3.6.1	Number of Stranded Patients (LOS>=7 Days)	Internal	-	198	188	239	227		5% reduction on 17/18 outturn		
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)	Internal	-	89	84	96	91		5% reduction on 17/18 outturn		
3.7	Delayed Transfer of Care	Internal	25	51	25	39	25		25 (same as 17/18 plan)		
3.8	Number of Discharges from PDU	Internal	15%	15.2%	16%	14%	16%		16% (same as 17/18 plan ; it was increased last year to utilise capacity)		
3.9	Ambulance Handovers >30 mins (%)	Internal	5%	6%	5%	5.9%	5%		5% (same as 17/18 plan)		
OBJECTIVE 4 - KEY TARGETS		**Source**	**Plan**	**Outturn**	**Plan**				**Comments**	**Status**	
4.1	ED 4 hour target (includes WIC)	NHSI	95%	92.1%	95%	87.6%			To phase as per local trajectory ?		Confirm local trajectory
4.2	RTT- Incomplete pathways < 18 weeks	NHSI	92%	92.5%	92%	87.9%	90.1%		Phased as per local trajectory		
4.3	RTT- Patients Waiting Over 18 weeks	NHSI	1140	883	911	1626	1287		Phased as per local trajectory		
4.6	RTT- Open pathways	NHSI	15225	11830	11388	13384	11712		Phased as per local trajectory		
4.7	RTT- Patients waiting over 52 weeks	NHSI	0	5	0	18	12		Phased as per local trajectory		
4.8	Diagnostic Waits < 6weeks	NHSI	99%	99.6%	99%	99.4%			Phase as per local trajectory		Phase as per local trajectory
4.9	All 2 week wait all cancers %	NHS Constitution	93%	95.3%	93%	95.6%	93%		As per national standard		
4.10	Diagnosis to 1st Treatment (all cancers) - 31 days %	NHS Constitution	96%	99.2%	96%	100.0%	96%		As per national standard		
4.11	Referral to Treatment (Standard) 62 day %	NHSI	85%	86.0%	85%	87.1%			Phase as per local trajectory		
OBJECTIVE 5 - SUSTAINABILITY		**Source**	**Plan**	**Outturn**	**Plan**				**Comments**	**Status**	
5.1	GP Referrals Received	SLA Activity Plan	53905	60189	60189	61464	61,935		Provided by Finance - 27/04/2018		17/18 outturn figures updated to include M12
5.2	A&E Attendances	SLA Activity Plan	85092	86744	89338	87740	89,606		Provided by Finance - 27/04/2018		17/18 outturn figures updated to include M12
5.3	Elective Spells (PBR)	SLA Activity Plan	23923	25480	26522	24444	30,803		Provided by Finance - 27/04/2018		17/18 outturn figures updated to include M12
5.4	Non elective spells	SLA Activity Plan	32043	32293	32365	34184	32,289		Provided by Finance - 27/04/2018		17/18 outturn figures updated to include M12
5.5	OP Attendances / Procs (Total)	SLA Activity Plan	356828	358045	377608	353662	364,847		Provided by Finance - 27/04/2018		17/18 outturn figures updated to include M12
5.6	Outpatient DNA rate	Internal	5%	5.6%	5%	6.1%	5%		5% (same as 17/18 plan)		17/18 outturn figures updated to include M12
5.7	Number of babies delivered	Tbc	-	-	-	3759					27/04/2018: 17/18 outturn from Obstetrics Dashboard
5.8	Number of antenatal bookings	Tbc	-	-	-	4403					27/04/2018: 17/18 outturn from Obstetrics Dashboard

			2016/17		2017/18		2018/19				
OBJECTIVE 7 - FINANCIAL PERFORMANCE		**Source**	**Plan**	**Outturn**	**Plan**				**Comments**	**Status**	
7.1	Income £'000	Financial Plan	204,198	211,950	223,967	223,794	238,802		Provided by Finance - 27/04/2018		17/18 outturn figures updated to include M12
7.2	Pay £'000	Financial Plan	(156,152)	(154,505)	(158,813)	(159,438)	(161,048)		Provided by Finance - 27/04/2018		17/18 outturn figures updated to include M12
7.3	Non-pay £'000	Financial Plan	(61,067)	(68,891)	(67,625)	(71,672)	(72,791)		Provided by Finance - 27/04/2018		17/18 outturn figures updated to include M12
7.4	Non-operating costs £'000	Financial Plan	(12,557)	(13,029)	(12,954)	(12,588)	(12,893)		Provided by Finance - 27/04/2018		17/18 outturn figures updated to include M12
7.5	I&E Total £'000	Financial Plan	(25,578)	(24,475)	(15,426)	(19,904)	(7,930)		Provided by Finance - 27/04/2018		17/18 outturn figures updated to include M12
7.6	Cash Balance £'000	Financial Plan	2,503	3,906	2,504	2,507	2,500		Provided by Finance - 27/04/2018		17/18 outturn figures updated to include M12
7.7	Savings Delivered £'000	Financial Plan	11,800	11,900	10,500	8,998	10,130		Provided by Finance - 27/04/2018		17/18 outturn figures updated to include M12
7.8	Capital Expenditure £'000	Financial Plan	(27,304)	(8,813)	(28,389)	(16,885)	29,673		Provided by Finance - 27/04/2018		17/18 outturn figures updated to include M12
OBJECTIVE 8 - WORKFORCE PERFORMANCE		**Source**	**Plan**	**Outturn**	**Plan**				**Comments**	**Status**	
8.1	Staff Vacancies % of establishment	Human Resources	10.0%	15.2%	14%	11%	12%		Provided by HR - 27/04/2018		27/04/2018: Confirmed by Paul Sukhu
8.2	Agency Expenditure %	Human Resources	15.2%	11.5%	10%	6%	8%		Provided by HR - 27/04/2018		27/04/2018: Confirmed by Paul Sukhu
8.3	Staff sickness - % of days lost	Human Resources	4.0%	4.3%	4.0%	4.1%	4.0%		Provided by HR - 27/04/2018		27/04/2018: Confirmed by Paul Sukhu
8.4	Appraisals	Human Resources	90.0%	88.0%	90.0%	85.0%	90.0%		Provided by HR - 27/04/2018		27/04/2018: Confirmed by Paul Sukhu
8.5	Statutory Mandatory training	Human Resources	90.0%	92.0%	90.0%	90.0%	90.0%		Provided by HR - 27/04/2018		27/04/2018: Confirmed by Paul Sukhu
8.6	Substantive Staff Turnover	Human Resources	14.0%	13.4%	14%	12%	12%		Provided by HR - 27/04/2018		27/04/2018: Confirmed by Paul Sukhu
8.7	FFT - Response Rate (Staff)	Internal	15.0%	17.5%	18%	20%	15%		Provided by HR - 27/04/2018		27/04/2018: Confirmed by Paul Sukhu
OTHER OBJECTIVES		**Source**	**Plan**	**Outturn**	**Plan**				**Comments**	**Status**	
O.1	Total Number of NICE Breaches	Internal	8	38	8	65	8		Same as last year - confirmed by Tina Worth		
O.2	Rebooked cancelled OPs - 28 Day rule %	NICE Guidance	95.0%	87.4%	95.0%	67.8%	95.0%		95% (same as 17/18 plan)		
O.3	Maternity Bookings < 13 weeks %	National	90%	88.7%	90%	88%	90%		90% (same as 17/18 plan); ~~'Maternity Bookings < 10 weeks' suggested.~~		18/04/2018: Confirmed 90% with Jean Aldous and Julie Cooper
O.4	Overdue Datix Incidents > 1 month	National	0	91	0	149	0		0 - confirmed by Tina Worth		
O.5	Serious Incidents	National	76	65	58	5	45		10% reduction on 17/18 outturn- confirmed by Tina Worth		
O.6	Number of Dementia Measures met	National	3	3	3	3	3		3 (same as 17/18 plan)		No longer a CQUIN but part of standard contract.
O.7	Energy Consumption (GJ)	National	206608	204780	200684	239937	235138 ?		98% of 17/18 outturn (+ extrapolated M12);Targets to consider increase in heated areas ?		Tracy-West Mills proposed using KwH instead of GJ as units.
O.8	Completed Job Plans (Consultants)	Medical Director	90.0%	54.0%	90.0%	90.0%	90.0%		Exclude exemption of staff joined in last 3 months ?		16/04/2018 : Andrew Kerr (MDO) proposed an exclusion for this metric (cc: Ian Reckless)

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Public Board	Date: 4 May 2018
Report title:	**Finance Paper Month 12 2017-18**	**Agenda item: 4.2**
Lead director **Report authors**	Mike Keech Daphne Thomas Christopher 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 2018)**			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** X	**Decision** ☐
Recommendation	Public 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 2018

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 Board that actions are in place to address any areas where the Trust's financial performance would adversely affect next financial year.

EXECUTIVE SUMMARY

2. *Income and expenditure* – the Trust's position for March 2018 was £2.8m surplus which is £3.1m favourable to plan and £3.6m favourable to the control total in month (incl. core STF and incentive STF). For the full year the Trust will report a deficit of £16.1m against a control total of £-18.8m, this includes £3.6m of STF incentive funding and £0.3m of STF relating to prior year. Excluding STF the Trust reported a positive variance against control total of £261k for the year.

3. *Cash and capital position* – the cash balance as at the end of March 2018 was £2.5m, which was in line with the plan. The Trust has spent £16.7m on capital year to date of which £4.8m relates to EPR (funded via a capital loan).

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 £2.4m were delivered in month against an identified plan of £2.7m. Overall for the year £9m of plans were delivered and validated against a £10.5m 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	16,994	17,508	513	194,663	196,077	1,414
Other Revenue	1,634	2,001	367	18,309	21,109	2,800
Total Income	18,628	19,509	880	212,972	217,186	4,214
Pay	(13,252)	(13,836)	(584)	(159,120)	(159,437)	(317)
Non Pay	(5,886)	(5,898)	(12)	(67,625)	(71,706)	(4,081)
Total Operational Expend	(19,138)	(19,734)	(597)	(226,745)	(231,143)	(4,398)
EBITDA	(509)	(226)	284	(13,773)	(13,958)	(185)
Financing & Non-Op. Costs	(1,053)	(1,054)	(2)	(12,359)	(11,930)	429
CT Rounding	0	0	0	(17)	0	17
Control Total Deficit (excl. STF)	**(1,562)**	**(1,280)**	**282**	**(26,149)**	**(25,888)**	**261**
Adjustments excl. from control total:						
Performance STF	256	0	(256)	2,276	1,508	(768)
Financial STF	596	596	0	5,025	5,025	0
Incentive STF	0	3,561	3,561	0	3,561	3,561
Control Total Deficit (incl. STF)	**(710)**	**2,877**	**3,587**	**(18,848)**	**(15,794)**	**3,054**
Donated income	500	0	(500)	4,000	75	(3,925)
Donated asset depreciation	(50)	(55)	(5)	(595)	(659)	(64)
CT Rounding	0	0	0	17	0	(17)
Prior Year STF	281	281	0	281	281	0
Reported deficit	**21**	**3,103**	**3,082**	**(15,145)**	**(16,097)**	**(952)**

Monthly and year to date review

7. The Trust reported a surplus in month 12 of £3,103k which is £3,082k favourable against a planned deficit of £21k and £282k against the control total (excluding STF). For the full year, the Trust's reported position is £261k positive to the control total (excluding STF).

8. The Trust did not achieve the required 95% performance on the 4-hour A&E target in order to secure the Q4 performance STF (£768k); however this was more than offset by STF incentive funding of £3,561k (comprising £261k pound for pound incentive funding, £2,347k general distribution and £953k bonus STF). The Trust also received £281k additional STF funding

relating to 2016/17. After STF funding, the Trust is reporting a deficit of £-16.1m against a control total of £-18.8m. The Trust's reported deficit has improved by £5m compared to a deficit of £-21.1m in 2016/17 (£-31.8m in 2015/16).

9. **Operationally** March continued to be a challenging month with higher than expected levels of urgent and emergency activity leading to pressure on elective capacity. However, the overall net effect was a positive impact on income against Plan for the month.

10. **Income** was above plan in month, high levels of non-elective income was combined with the receipt of additional STF funding.

11. **Operational costs** in March are adverse to plan by £597k and adverse £4,398k for the year. The YTD variance is mainly related to non pay costs.

12. **Pay costs** are £584k higher than budget in Month 12 and £317k adverse for the year. Positive variances on agency and locum costs were offset by higher substantive and bank expenditure. The Trust remained favourably under its agency ceiling for the month and year to date.

13. **Non pay** costs were £12k adverse to plan in month and £4,081k YTD. Higher then planned expenditure has been incurred to support higher than planned activity levels including high costs drugs, one-off costs relating to unbudgeted increases in rates and undelivered budgeted cost savings.

    The in-month position has benefitted from the release of a prior year provision against HMRC

14. **Non-operational** costs are £7k negative in month and £365k positive YTD (due to lower than budgeted interest costs).

    Further analysis of the costs can be found in Appendix 1 - Statement of Comprehensive Income & Expenditure

COST SAVINGS

15. In Month 12, £2,367k was delivered against an identified plan of £2,658k. For the year £8,998k has been delivered against a budgeted target of £10,500k leaving a variance of £1,502k. The Trust has managed to deliver its control total position despite the shortfall in the transformation programme; this is in part due to £900k of winter pressures funding received in year.

CASH AND CAPITAL

16. The cash balance at the end of March 2018 was £2.5m, which was in line with the plan. The details of the Trust's current loans are shown below. The Trust was notified by DH that the revenue loan, due for repayment in March 2018, is now due for repayment in March 2019. The Trust has drawn down all of its revenue allocation.

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

- Non-Current Assets are above plan by £1.2m; however this includes the impact of an increase in the revaluation of plant and buildings of £8.1m which has offset the reduction in planned strategic capital.

- Current assets are above plan by £9.4m. The main variances relate to receivables of £8.9m which includes the £3.6m STF Bonus and Incentive Funding and inventories £0.5m above plan.

- Current liabilities are below plan by £35.1m. This is being driven by the re-categorisation of part of the DH loan from non-current to current borrowings £31m, trade and other creditors £5.3m above plan offset by deferred income £0.3m and provisions £0.5m

- Non-Current Liabilities are below plan by £42m. This is due to the re-categorisation of part of the DH loan from non-current to current borrowings £31m, with the remainder relating to the planned loans for strategic capital not received from NHSI and external sources.

- Taxpayers equity is £17.5m above plan, PDC accounts for £3.0m which relates to DH funding for additional capital schemes. The revaluation reserve is £13.8m above plan, £5.7m relates to the previous year increase in the revaluation reserve not known when the plan was submitted and the 2018/19 increase in revaluation of £8.1m for 2017/18.

18. The Trust has spent a total of £16.8m on capital for 2018/19 of which £4.8m relates to EPR, £1.8m Global Digital Exemplar schemes, £1m Primary Care Streaming, £0.1m Wi-Fi, £3.8m other strategic projects and £5.2m on business as usual schemes.

RISK REGISTER

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

a) Continued DH cash funding is insufficient to meet the planned requirements of the organisation.

Funding to cover the planned financial deficit in 2017/18 is subject to approval by DH on a monthly basis. The overall funding risk has reduced for the 2017-18 financial year due to confirmation of the various funding stream noted above but remains a significant risk in the new financial year.

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

The Trust had a challenging target of £10.5m to deliver for the 2017-18 financial year. At month 12 did not meet the full target, but was able to meet its control total through non-recurrent means.

The risk against delivering financial efficiency will continue into 2018/19

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

The Trust has an annual agency ceiling of £15.12m in 2017-18 which is in line with the level included in the financial plan. Agency spend was significantly below the ceiling set by NHSI at £11.5m

d) The Trust is unable to access £7.3m of Sustainability & Transformation Funding.

In order to receive the full amount of Sustainability and Transformation funding in 2017-18, the Trust needed to achieve its financial control total (linked to 70% of funding), and meet performance standards in respect of urgent and emergency care (linked to 30% of funding). The targets are measured on a quarterly basis. The Trust met its requirements for quarter 1, 2 and 3 but was unable to meet the performance target for Q4 as noted above. However, this was more than offset by the additional funding earned through the incentive scheme.

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. 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 risk to recoverability.

RECOMMENDATIONS TO THE BOARD

20. The Trust Public Board is asked to note the financial position of the Trust as at 31 March 2018 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 2018

	March 2018			12 months to March 2018			Full year
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME							
Outpatients	3,785	3,382	(403)	42,277	40,147	(2,130)	42,277
Elective admissions	2,638	1,897	(741)	29,654	26,320	(3,334)	29,654
Emergency admissions	4,753	5,745	992	56,021	62,643	6,621	56,021
Emergency adm's marginal rate (MRET)	(112)	(409)	(297)	(1,314)	(3,040)	(1,727)	(1,314)
Readmissions Penalty	(103)	(778)	(675)	(1,208)	(3,353)	(2,145)	(1,208)
A&E	1,207	1,027	(179)	12,919	12,648	(272)	12,919
Maternity	1,921	1,518	(403)	22,825	21,396	(1,430)	22,825
Critical Care & Neonatal	578	537	(41)	6,814	6,122	(692)	6,814
Excess bed days	0	0	0	0	0	0	0
Imaging	375	403	29	4,171	4,314	143	4,171
Direct access Pathology	400	385	(15)	4,801	4,514	(287)	4,801
Non Tariff Drugs (high cost/individual drugs)	1,035	1,264	229	12,190	15,289	3,099	12,190
Other	517	2,536	2,019	5,512	9,078	3,565	5,512
Clinical Income	**16,994**	**17,508**	**512**	**194,663**	**196,077**	**1,414**	**194,663**
Non-Patient Income	**3,267**	**6,439**	**3,171**	**29,891**	**31,558**	**1,668**	**29,891**
TOTAL INCOME	**20,261**	**23,946**	**3,684**	**224,554**	**227,635**	**3,081**	**224,554**
EXPENDITURE							
Total Pay	**(13,252)**	**(13,836)**	**(584)**	**(159,120)**	**(159,437)**	**(317)**	**(159,120)**
Non Pay	(4,851)	(4,634)	216	(55,435)	(56,417)	(982)	(55,435)
Non Tariff Drugs (high cost/individual drugs)	(1,035)	(1,264)	(229)	(12,190)	(15,289)	(3,099)	(12,190)
Non Pay	**(5,886)**	**(5,898)**	**(12)**	**(67,625)**	**(71,706)**	**(4,081)**	**(67,625)**
TOTAL EXPENDITURE	**(19,138)**	**(19,734)**	**(597)**	**(226,745)**	**(231,143)**	**(4,398)**	**(226,745)**
EBITDA*	**1,124**	**4,211**	**3,087**	**(2,191)**	**(3,508)**	**(1,316)**	**(2,191)**
Depreciation and non-operating costs	(966)	(844)	122	(11,308)	(10,817)	491	(11,308)
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**158**	**3,367**	**3,209**	**(13,499)**	**(14,326)**	**(826)**	**(13,498)**
Public Dividends Payable	(137)	(266)	(129)	(1,646)	(1,772)	(126)	(1,646)
OPERATING DEFICIT AFTER DIVIDENDS	**21**	**3,102**	**3,082**	**(15,145)**	**(16,098)**	**(952)**	**(15,145)**
Adjustments to reach control total							
Deferred Income	(500)	0	500	(4,000)	-75	3,925	(4,000)
Donated Assets Depreciation	50	55	5	595	659	64	595
Control Total Rounding	0	0	0	-17	0	17	-17
Prior Year STF	-281	-281	0	-281	-281	0	-281
CONTROL TOTAL DEFECIT	**(710)**	**2,876**	**3,587**	**(18,848)**	**(15,795)**	**3,054**	**(18,848)**

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

Milton Keynes Hospital NHS Foundation Trust
Statement of Cash Flow
As at 31st March 2018

	Unaudited Mth12 2017-18 £000	Mth 11 2017-18 £000	In Month Movement £000
Cash flows from operating activities			
Operating (deficit) from continuing operations	(16,106)	(15,772)	(334)
Operating surplus/(deficit) of discontinued operations			
Operating (deficit)	**(16,106)**	**(15,772)**	**(334)**
Non-cash income and expense:			
Depreciation and amortisation	9,038	8,335	703
(Gain)/Loss on disposal	(28)	(28)	-
(Increase)/Decrease in Trade and Other Receivables	2	1,074	(1,072)
(Increase)/Decrease in Inventories	(213)	(19)	(194)
Increase/(Decrease) in Trade and Other Payables	566	526	40
Increase/(Decrease) in Other Liabilities	12	325	(313)
Increase/(Decrease) in Provisions	(1,458)	(1,178)	(280)
Other movements in operating cash flows	2	(2)	4
NET CASH GENERATED FROM OPERATIONS	**(8,185)**	**(6,739)**	**(1,446)**
Cash flows from investing activities			
Interest received	19	16	3
Purchase of Property, Plant and Equipment, Intangibles	(15,085)	(8,570)	(6,515)
Net cash generated (used in) investing activities	**(15,066)**	**(8,554)**	**(6,512)**
Cash flows from financing activities			
Public dividend capital received	2,997	995	2,002
Loans received from Department of Health	23,625	18,825	4,800
Loans repaid to Department of Health	(954)	(859)	(95)
Capital element of finance lease rental payments	(309)	(146)	(163)
Interest paid	(1,449)	(1,326)	(123)
Interest element of finance lease	(322)	(301)	(21)
PDC Dividend paid	(1,735)	(913)	(822)
Net cash generated from/(used in) financing activities	**21,853**	**16,275**	**5,579**
Increase/(decrease) in cash and cash equivalents	**(1,398)**	**982**	(2,380)
Opening Cash and Cash equivalents	**3,906**	**3,906**	
Cash and Cash equivalents at start of period for new FTs			
Cash and Cash equivalents changes due to transfers by absorption			
Closing Cash and Cash equivalents	**2,508**	**4,888**	**(2,380)**

Appendix 3

Milton Keynes Hospital NHS Foundation Trust
Statement of Financial Position as at 31st March 2018

	Audited Mar-17	Mar-18 FY17 Plan	Mar-18 FY17 Actual (Unaudited)	In Mth Mvmt	YTD Mvmt	% Variance
Assets Non-Current						
Tangible Assets	160.4	169.8	172.3	2.5	11.9	7.4%
Intangible Assets	5.7	11.0	9.5	(1.5)	3.8	66.0%
Other Assets	0.3	0.3	0.4	0.1	0.1	47.3%
Total Non Current Assets	**166.4**	**181.1**	**182.2**	**1.1**	**15.8**	**9.5%**
Assets Current						
Inventory	3.0	2.8	3.3	0.5	0.3	8.4%
NHS Receivables	16.6	12.8	13.3	0.5	(3.3)	(19.9%)
Other Receivables	3.2	1.5	6.4	4.9	3.2	100.8%
Cash	3.9	2.5	2.5	0.0	(1.4)	-35.8%
Total Current Assets	**26.7**	**19.6**	**25.5**	**5.9**	**(1.2)**	**-4.6%**
Liabilities Current						
Interest -bearing borrowings	(32.3)	(1.8)	(32.4)	(30.6)	(0.1)	0.3%
Deferred Income	(1.6)	(1.9)	(1.6)	0.3	0.0	(1.5%)
Provisions	(3.1)	(1.9)	(1.4)	0.5	1.7	-54.6%
Trade & other Creditors (incl NHS)	(26.2)	(23.0)	(28.2)	(5.2)	(2.0)	7.7%
Total Current Liabilities	**(63.2)**	**(28.6)**	**(63.6)**	**(35.0)**	**(0.4)**	0.7%
Net current assets	**(36.5)**	**(9.0)**	**(38.2)**	**(29.2)**	**(1.6)**	**4.5%**
Liabilities Non-Current						
Long-term Interest bearing borrowings	(61.1)	(125.9)	(83.6)	42.3	(22.5)	36.9%
Provisions for liabilities and charges	(0.9)	(0.8)	(1.1)	(0.3)	(0.2)	23.0%
Total non-current liabilities	**(62.0)**	**(126.7)**	**(84.7)**	**42.0**	**(22.7)**	36.7%
Total Assets Employed	**67.9**	**45.4**	**59.4**	**14.0**	**(8.5)**	**(12.6%)**
Taxpayers Equity						
Public Dividend Capital (PDC)	96.1	96.2	99.1	2.9	3.0	3.1%
Revaluation Reserve	70.6	64.9	78.7	13.8	8.0	11.4%
I&E Reserve	(98.8)	(115.7)	(118.4)	(2.7)	(19.6)	19.8%
Total Taxpayers Equity	**67.9**	**45.4**	**59.4**	**14.0**	**(8.5)**	**(12.6%)**

Meeting title	**Trust Board**	**Date: 04 May 2018**
Report title:	**Workforce report**	**Agenda item: 4.3**
Lead director **Report author**	**Name: Ogechi Emeadi** **Name: Paul Sukhu**	**Title: Director of workforce** **Title: Deputy director of workforce**
FoI status:	**Public**	

Report summary	This report provides a summary of key workforce key performance indicators for the full year ending 31 March 2018 (Month 12). N.B. due to the timing of this report; finance and sickness absence sections have not been updated from the M11 position as the data is not yet available.			
Purpose *(tick one box only)*	**Information** x	**Approval**	**To note** x	**Decision**
Recommendation				

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 - IF we are unable to recruit sufficient numbers of qualified nurses THEN we may be unable to provide staffing levels as we would wish LEADING TO reduction in patient experience and clinical risk. 1608 - IF there is inability for employees to undergo a well-structured appraisal THEN they will not have a development plan and a review of their performance LEADING TO the inability to meet CCG Target which is 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 for 2015-2016 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 - Management Board, 18 April 2018
Next steps	
Appendices	

Workforce report – Month 12

1. Purpose of the Report

1.1. This report provides a summary of key workforce key performance indicators for the full year ending 31 March 2018 (Month 12).

2. Staff in post

2.1. The Trust's staff in post by whole time equivalent (WTE) was 3027.5 as at 31 March, which is an increase of 127.7 WTE since March 2017.

2.2. The Trust's headcount is 3505, an increase of 137 since March 2017.

2.3. The largest increases in staff in post since March 2017 have been in professional, scientific and technical, medical and dental staff groups.

3. Temporary staffing

3.1. The temporary staff usage (bank + agency) for the year was 5964.3 WTE, which was 14.7% of total WTE staff employed.

3.2. Agency staff usage was 4.7% of the total WTE staff employed for the year but was 7.6% of the total annual staff expenditure, predominantly driven by medical and dental agency locums.

3.3. The Trust target for Agency Staff Expenditure for 2017/2018 is 10.0%.

4. Sickness absence

4.1. The sickness absence rate (12 months to 31 March 2018) for the Trust is above the trust target of 4.0% at 4.13% (1.82% short term and 2.31% long term).

4.2. Overall the trust's sickness absence levels have been lower than the same period for the last two financial years since October 2017.

4.3. The top 3 stated reasons for absence by staff group are common to most acute NHS trusts. Steps are being taken to address under-reporting of sickness absence in the medical and dental profession.

4.4. A reviewed sickness, absence and attendance policy has been approved at Workforce Board in April 2018. This will help the trust to manage its levels of sickness absence down further, following implementation and training. It will also help to increase visibility of reasons for sickness absence through improved reporting. Over 30% of sickness absence is for reasons 'unknown/undeclared'.

4.5. More detail on sickness absence is reported and discussed at divisional executive performance reviews (monthly) and workforce and development assurance committee (quarterly).

5. Turnover

5.1. The permanent staff turnover rate by month for the year April 2017 to March 2018 (annual turnover rate of 12.03%; Trust Target – 14.00%) and the previous year to 31st March 2017 (annual turnover rate of 13.63%.

5.2. Overall, the trust's leaver turnover rate has been lower in 2017/18 than it was in 2016/17. This is due to a number of interventions that the trust has undertaken, as reported at workforce and development assurance committee e.g. onboarding and exit questionnaires, staff engagement and staff support activities.

5.3. There is a national focus on retention and the trust is in Cohort 3 of the Retention Direct Support Programme with NHS Improvement, which launched on 05 April 2018.

5.4. The programme is being led locally by the associate chief nurse and the deputy director of workforce. The work itself will be undertaken by the Recruitment and Retention workforce transformation task and finish group. Updates will be provided via one or more of: Workforce Transformation Strategy Programme Board, Workforce Board and/or Nursing and Midwifery Board as appropriate.

6. Statutory and mandatory training

6.1. Statutory and mandatory training compliance as at the end of March 2018 was 89% against the trust target of 90%.

6.2. 89% is a slight deterioration from 90% achieved in January and February 2018; this reflects the organisation-wide focus and commitment to eCARE (electronic patient record) training.

Training Compliance by Division	
Core Clinical	93%
Corporate Services	93%
Medicines Unplanned Care	87%
Surgical Planned Care	88%
Women's and Children's	89%
Trust Total Compliance	**89%**

7. Appraisal compliance

7.1. Appraisal compliance as at the end of March 2018 was 84% against the trust target of 90%.

7.2. Compliance has deteriorated from 86% since January 2018; it is anticipated that the trust level will increase further, following the implementation of eCARE and its associated training.

Appraisal Completion by Division	
Core Clinical	95%
Corporate Services	81%
Medicines Unplanned Care	81%
Surgical Planned Care	73%
Women's and Children's	84%
Total Trust	**84%**

8. Workforce Key Performance Indicators – 2018/19

8.1. Following discussion at Workforce Board, the thresholds for the trust's Key Performance Indicators (KPIs) for 2018/19 have been reviewed and amended as follows:

KPI	2017/18	2018/19	Variance
Staff vacancies % of establishment	14%	12%	-2%
Agency expenditure %	10%	8%	-2%
Staff sickness - % of days lost	4%	4%	=
Appraisals	90%	90%	=
Statutory & mandatory training	90%	90%	=
Substantive staff turnover	14%	12%	-2%
Staff FFT response rate (quarterly)	15%	15%	=

9. Recommendations

9.1. Trust Board is asked to note the Workforce report, in particular:

- The change in core workforce KPIs for 2018/19 and
- The

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Board of Directors**	**Date: 4 May 2018**
Report title:	**Freedom to Speak Up Annual Report 2017/18**	**Agenda item: 5.1**
Lead director **Report author** **Sponsor(s)**	**Name:** **Name: Nicky Burns-Muir** **Name: Adewale Kadiri** **Name: Joe Harrison**	**Title:** **Title: Deputy Chief Nurse** **Title: Company Secretary** **Title: Chief Executive**
FoI status:		

Report summary	The Freedom to Speak Up Guardian is a relatively new role within the NHS that was set up as a recommendation from Sir Robert Francis' report that was published in 2015 following his investigation into what went wrong at Mid-Staffordshire NHS Foundation Trust. All Trusts are required to have a Guardian in place to support members of staff who wish to raise concerns, but may feel unable to do so. Guardians are required to report to the Board at least annually on their activities. Nicky Burns-Muir and Ade Kadiri have been appointed as MKUH guardians and this is their first annual report.						
Purpose *(tick one box only)*	**Information**		**Approval**	x	**To note**	x	**Decision**
Recommendation	**That the timetable for the appointment of the Chairman be noted**						

Strategic objectives links	**Objective 7 Become well governed and financially viable**
Board Assurance Framework links	
CQC regulations	
Identified risks and risk management actions	
Resource implications	
Legal implications including equality and diversity assessment	

Report history	
Next steps	
Appendices	

Freedom to Speak Up Guardian Annual Report 2017/18

Executive Summary

This is the annual report to the Trust Board on Freedom to Speak Up in the Trust for the 12 months April 2017 to March 2018. The Freedom to Speak Up Guardian is a relatively new role across the NHS and was a recommendation of the Freedom to Speak Up Review by Sir Robert Francis that was published in 2015. The Freedom to Speak Up Guardian for MKUH came into post in April 2017. The role of the Freedom to Speak Up Guardian is to provide independent and confidential support to staff that want to raise concerns and promote a culture in which staff feel safe to raise those concerns. Over the past 12 months 28 staff contacted the Guardian with concerns. Most concerns were resolved locally: a small number progressed to formal whistleblowing investigations. In addition, other activities have been undertaken to raise awareness of Freedom to Speak Up and to encourage cultural change in the Trust.

This is an annual report. This report has not been presented to any committees or groups in the Trust.

Background to Freedom to Speak Up

Sir Robert Francis, in his Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry (2013), described the experiences of nurses and doctors who raised whistleblowing concerns about the poor care of some patients at Stafford Hospital. As a result, he was asked to conduct a further review into whistleblowing in the NHS. 'Freedom to Speak Up – an independent review into creating an open and honest reporting culture in the NHS' was published in 2015. The report identified a need for culture change, improved handling of cases, measures to support good practice, particular measures for vulnerable groups, and extending the legal protection. Sir Robert Francis identified 20 principles that addressed these themes. In particular, he recommended that all trusts should have a Freedom to Speak Up Guardian to 'act in a genuinely independent capacity' and support staff to raise concerns.

In 2016-17 it became a contractual requirement for all NHS provider trusts to have a Freedom to Speak Up Guardian. By the end of the financial year, all trusts in England had made appointments although not all Guardians were in post. Trusts were also expected to adopt a model NHS whistleblowing/raising concerns policy.

The National Guardian's Office is an independent, non-statutory body with the remit to lead cultural change in the NHS so that speaking up becomes business as usual. The office is not a regulator, but is sponsored by the CQC, NHS England and NHS Improvement.

The National Guardian's Office supports the National Guardian for the NHS Dr. Henrietta Hughes, in providing leadership, training and advice for Freedom to Speak Up Guardians

based in all NHS Trusts. Dr Hughes and her office also provides challenge and learning and support to the healthcare system as a whole by reviewing trust's speaking up culture and the handling of concerns where they have not followed good practice. Dr Hughes' role was a key recommendation from Sir Robert Francis' Freedom to Speak Up Review in response to the Mid- Staffordshire scandal.

http://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_Executive-summary.pdf

The Role of the Freedom to Speak Up Guardian

It is recommended that The Freedom to Speak Up Guardian is not part of the management structure of the Trust and is able to act independently in response to the concerns being raised. The Guardian reports directly to the Chief Executive, and this gives them access to the executive directors of the Trust. There are two key elements to the role:

- To give independent, safe and confidential advice and support to members of staff who wish to raise concerns that have an impact on patient safety and experience. This is not just for permanent staff members but is also available for temporary or agency staff, trainees or students, volunteers and trust governors. Support from the Guardian is not available to carers and patients as they can raise concerns through the complaints and PALS service.
- To promote a culture where members of staff feel safe to raise concerns and do not fear adverse repercussions as consequence

At MKUH Nicky Burns-Muir Deputy Chief Nurse was appointed as the FTSU Guardian in April 2017 and undertook the role within her portfolio to establish the service and scope the ongoing requirements and infrastructure required to meet the role. More recently Adewale Kadiri the Company Secretary was appointed as a second FTSU Guardian to support the service and provide staff with an option of who to speak up to. The guardian role reports directly to the Chief Executive Officer so they are aware of patient safety issues and gain an insight into concerns that have been raised across the organisation. There is a generic email freedomtospeakup@mkuh.nhs.uk for staff to contact the Guardians.

Freedom to Speak Up activities in the Trust

The FTSU information submitted for MKUH :

Quarter	Organisation	No of Cases	No. of Anonymous	Element of patient safety	Element of bullying and	Detriment experienced by speaking

					harassment	up
Q1	MKUH	No Data	No Data	No Data	No Data	No Data
Q2	MKUH	10	10	4	6	1
Q3	MKUH	6	6	2	5	0
Q4	MKUH	12	9	5	3	1
Total		28	25 (90%)	11(40%)	14(50%)	2(7%)

Table 1. Submission data for 2017/18 to National Guardians Office

*No data submitted in Q1 as FTSU Guardian was on Annual Leave during the two week submission period.

- The majority of staff who spoke up wished to remain anonymous for a variety of reasons including impact on career; bullying behaviour increasing; concerned about reference for new job; being exposed and ostracised in the team; fear that nothing will be done.
- Staff who have contacted the guardian are predominately nurses both registered and healthcare assistants, clerical and administration, and managers. In the year there were no concerns raised by midwives and medical staff.
- Staff contacted the Guardian by e-mail or telephone but a number were direct contacts as a result of awareness across the organisation.

The majority of issues raised with the guardian were not formally investigated and therefore the categorisation of the issue of concern was based on the account given by the staff member and not formally substantiated. The issues fall into the following categories:

- Patient Safety
- Demand and patient complexity
- Bullying and harassment
- Service re-organisation
- Management Style and communication
- Signposting individuals

The discussions with the Guardian would often lead to the individual developing strategies to address their concerns with their managers or making changes to their own practice. Their concerns about being identified or possible repercussions meant that for some the Guardian was only able to feedback or address their concerns in a general way.

Changing the Culture

Raising awareness: Freedom to Speak Up is an important part of the patient safety agenda and staff need to know that they can safely raise concerns and how to do so. All new staff are given information about freedom to Speak Up as part of corporate induction and presentations have been given to student nurses and medical students. A further

programme is required to raise awareness including development of website, the guardians visiting teams and attending meetings to deliver short presentations to promote FTSU. The FTSU Guardians will be part of the equality and diversity group within the Trust.

Staff Development: Unregistered care staff can often find it harder to raise concerns but spend most time in direct contact with our patients. There is a need to develop opportunities to engage with professional groups and within leadership development training to empower staff to feel confident about speaking up and also preparing managers to receive feedback from their staff when they have concerns.

Influencing cultural change: There needs to be continued collaborative working with HR to develop a campaign to raise awareness about bullying and harassment and how to address and combat this behaviour.

National and Regional Developments

The National Guardian, Dr Henrietta Hughes, came into post in October 2016 and has been developing her role and the work of the National Guardian's Office. Training has been provided for new Guardians and guidance has been issued on recording information, case reviews and Freedom to Speak Up and CQC assessments of Trusts. Nationally there have been four annual conferences, the most recent of which took place in March 2018, and was attended by Ade Kadiri. Speakers included Jeremy Hunt, the Secretary of State for Health and Social Care, and Matthew Bromiley of the Clinical Human Factors Group.

From April 2017, the National Guardian's Office started collecting data quarterly on the work of the Guardians which it publishes. This includes a satisfaction question that Guardians are requested to ask all staff that contact them.

MKUH sits within both the East Midlands and Thames Valley Wessex regional guardians' network and there are quarterly meetings where support for guardians is given and it is an opportunity to share learning and good practice.

Plans for 2018 – 19

- Development of a survey for staff who contact the guardian to anonymously feedback on 'given their experience would they contact the guardian again?' the results of which will be collated quarterly. The survey will also contain questions about equality which will enable a picture of the type of staff contacting the guardian to build up. As the quarterly collections of data by the NGO develop, they may enable some benchmarking with similar Trust to be undertaken.
- The addition of questions on the leaver's questionnaire about awareness of the FTSU Guardians and whether they had used the service.
- To develop an effective system of responding to and monitoring the outcomes of concerns

- To participate in the development of the role of the Freedom to Speak Up Guardian and the Office of the National Guardian.
- Evaluation of the effectiveness of the Freedom to Speak Up Guardian role in the Trust.

Recommendation

To review the Trust's long term approach to the role and consider whether as an organisation we require a dedicated FTSU Guardian role which has been actioned across the network with other Trusts who have appointed individuals to undertake the FTSU role independently ranging from 2 days to full time. Addition to time spent supporting staff they proactively promote speaking up in a range of programmes that increase the awareness in all areas and staff groups across the organisation. They have also been working collaboratively with HR colleagues to raise the profile of identifying and addressing bulling and harassment in the workplace. Currently this is has not been possible to facilitate within MKUH as the guardian role has been added to existing roles and consequently there are time constraints. As a Trust we should also consider having a nominated NED as a FTSU Guardian to support the process and champion at board level which would bring us in line with the regional network approach

The Trust Board is asked to note the contents of the annual report by the Freedom to Speak Up Guardians.

Nicky Burns-Muir, FTSU Guardian

Adewale Kadiri, FTSU Guardian

Board Assurance Framework 2018/19

Exec Lead	Risk Ref	Objective	Committee	Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance				Residual risk rating	Progress since last report	Further mitigation/assurances	Completion date	Target risk score
						Consequence v Likelihood		Level 1 Operational (management)	Level 2 Oversight functions (Committees)	L3 Independent	Overall					
CH	1-1	SO1	Quality & Clinical Risk	Strategic failure to manage demand for emergency care	Lack of demand management by the local health economy Inadequate primary care provision/ capacity Inadequate community care provision/ capacity Inadequate social care provision/ capacity	4x4=16	Working with partners to manage peak demand periods (e.g expediting discharge; using full community/ social care capacity)	Strategic planning at trust-wide and service level Strategic planning within local health economy (CCG, CNWL, GP Federation)	Regular strategic planning withing the system - include Emergency Care Delivery Board Regular reporting to Management Board; Committees and Trust Board on strategic planning	System-wide Emergency Care Delivery Board Regular NHSI oversight (PRMs) External scruitny through Transformation Board, Health and Wellbeing Board and Health Overview and Scrutiny Committee Part of ICS (STP) priority programme on acute care	Good	3x4=12	Executive strategy session 23/03/17	System-wide strategic plan		2x5=10
CH	1-2	SO1	Quality & Clinical Risk	Tactical failure to manage demand for emergency care	Annual emergency and elective capacity planning inadequate or inaccurate Daily flow/ site managmement plans inadequate or ineffectual Poor clinical/ operational relationships impacting on patient flow through the organisation Poor operational/ managerial relationships impacting on escalation Ineffective engagement with stakeholders to support patient flow day-to-day	4x4=16	Introduction of ED streaming Working with UCC to manage demand Implementation of national flow improvement programmes - Red2Green; 100% Challenge; EndPJParalysis; SAFER Strong clinical and operational leadership and ownership; good team working Clear escalation and well-known and understood flow management and escalation plans Positive relationships with stakeholders through daily working and medium-term planning	Daily operational oversight Medium-term planning at service-level Daily and short/ medium-term planning with local health economy partners to support flow and right care/ right place	Regular strategic planning withing the system - include Emergency Care Delivery Board Regular reporting to Management Board; Committees and Trust Board on strategic planning	System-wide Emergency Care Delivery Board Regular NHSI oversight (PRMs) External scruitny through Transformation Board, Health and Wellbeing Board and Health Overview and Scrutiny Committee Part of ICS (STP) priority programme on acute care	Good	3x4=12	Daily management	Continue the implementation of ED streaming Continue the roll out of Red2Green and SAFER across the hospital in order to improve flow through the hospital. Continue to work with external partners to help to reduce ED attendances and reduce delayed discharges		
CH	1-3	SO1	Quality & Clinical Risk	Ability to maintain patient safety during periods of overwhelming demand	Significantly higher than usual numbers of patients through the ED Significantly higher acuity of patients through the ED Major incident/ pandemic	5x4=20	Clinically and operationally agreed escalation plan Adherence to national OPEL escalation management system Clinically risk assessed escalation areas available	Daily operational management command structure in place to manage emergency and elective activity safely Clinical site team 24/7 SMOC and EOC 24/7 Daily patient safety huddle	Daily reporting to clinical, oeprational and executive management Daily sit-rep reporting to regulatory and commissioning bodies Twice-monthly oversight at Management Board (formal reporting)	Daily sit-rep reporting and review by external bodies (CCG, NHSI, NHSE)	Good	4x4=16	Daily management	Continue to clinically review escalation plans in line with demand to ensure patient safety is no compromised		
IR	1-4	SO1	Quality & Clinical Risk	Failure to appropriately embed learning and preventative measures following Serious Incidents	Failure to appropriately report, invesitgate and learn from incidents and complaints	5x3=15	All SIs and action plans processed through the Serious Incident Review Group Actions including learning distribution tracked through SIRG Core component of all Clinical Improvement Group Meetings Lessons communicated via Trust-wide channels Debriefing embedded in specialties and corporately Training and skills programme annually Cultural work (inc Greatix and FTSU Guardians	Incident reports and action plans Performance information on incident numbers Emerging or existing trends analysed and reported Repeat incidents analysed and reported - particularly for failure to learn	Serious Incident Review Group Oversight at Clinical Quality Board Oversight at Quality and Clinical Risk Committee	CCG satisfaction with RCA reporting Stakeholder involvement with RCA/SI investigation Internal Audit review of SI process	Satisfactory	5x2=10				4x2=8

IR	1-5	SO1	Quality & Clinical Risk	Failure to recognise and respond to the deteriorating patient	Non compliance with the NEWS protocols; failure to appropriately escalate NEWS scores or failure to clinically assess patients outside protocols (i.e. 'hands on, eyes on' patients who are ill but not triggering on NEWS)	4x3=12	National NEWS protocol in place Level 1 pathway in place	Performance is reported to the Clinical Quality Board and is regularly audited Serious Incident Review Group process where issues around deteriorating patient identified eCare implementation supports early earning systems Standardised mortality review process to identify issues and learning	Serious Incident Review Group Oversight at Clinical Quality Board Oversight at Quality and Clinical Risk Committee	Coronial review of deaths	Satisfactory	3x3=9				4x2=8
CH	1-6	SO1	Quality & Clinical Risk	Failure to manage clinical risks throughout the implementation of eCARE (particularly refers to eCARE go-live)	Clinical risks are underestimated or not identified prior to and during the implementation of eCARE	4x4=16	Risk and hazard logging and tracking system in place (Cerner and Trust) Clinical safety lead in place with clinical safety sign-off process part of the go-live gateway Clinical Advisory Group in place to reivew all decisions	Clinical Advisory Group in place - key decision-making body for clinical/ operational risks and issues Clinical safety lead in place - decision making alongside Medical Director and Director of Nursing	Oversight at Health Informatics Programme Board Oversight at Management Board Oversight at Trust Board		Satisfactory	4x3=12				

LK	2-1	SO2	Quality & Clinical Risk	Failure to provide an appropriate patient experience	Despite largely positve feedback that is received via social media and through the Friends and Family Test, the Trust has scored relatively poorly in most of the annual patient surveys. There are also a number of recurring themes from complaints, including poor communication, unsatisfactory food, and patients being unable to have a proper say in their care	4x4=16	Risk and incident reporting awareness campaign ongoing Risk and incident training programme in place Integrated Datix system Embedded governance and assurance teams to provide more resource, internal challenge and audit. Lesson of the week shared through the weekly CEO message, supported by divisional publications, briefings and plenary. Appointment of Picker to manage FFT responses and capture more qualitative feedback from patients Appointment of patient experience manager; clinical leads Launch of hellomynameis across the Trust Implementation of new complaints system, and raising the profile of complaint handling across the divisions Receipt of patient stories at the Trust Board Production and monitoring of action plans followjng annual patient surveys Real time feedback provided as appropriate to issues and comment on social media	Oversight at Risk and Compliance Board and Serious Incident Review Group	Oversight at Quality and Clinical Risk Committee and at the Quality and Clinical Risk Committee – reports include details of themes from complaints and evidence that learning is taking place		Poor	4x4=16		Feedback from various patient surveys – inpatient, maternity, ED and children's.		3x3=9
KB/IR	3-1	SO3	Risk	Lack of assessment against and compliance with best evidence based clinical practice through clinical audit	Insufficient resource to introduce or embed process and lack of engagement by clinicians	3x4=12	Forward audit plan agreed and published annually Clinical audit leads in place with new (2018) job descriptions and agreed time within job plans Clinical governance leads and audit support in place to support audit leads in CSUs/ divisions Audit assessment process in place - supported and monitored by clinical governance leads and central audit support team New clinical governance structure (2018) in place to improve oversight and escalation of audit	Oversight and scrutiny at Clinical Effectiveness Board; Risk and Compliance Board and Clinical Quality Board Internal compliance monitoring and reporting monthly Reporting to CIGs and divisional management meetings	Oversight at the Quality and Clinical Risk Committee and the Audit Committee	External audi (KPMG) reivew in 2017/18 which identified areas for improvement. On forward audit plan for external audit review in 2018/19.	Satisfactory	3x4=12				2x3=6
KB/IR	3-2	SO3	Quality & Clinical Risk	Lack of assessment against and compliance with NICE guidance	The Trust has a significant backlog of NICE guidelines	3x4=12	Monthly assessments of compliance against published NICE baseline assessments Process in place to manage baseline assessments with relevant clinical lead - supported by clinical governance leads Independent review by compliance and audit lead Requires clinical engagement and ownership	Oversight and scrutiny at Clinical Effectiveness Board; Risk and Compliance Board and Clinical Quality Board Internal compliance monitoring and reporting monthly Reporting to CIGs and divisional management meetings	Oversight at the Quality and Clinical Risk Committee		Satisfactory	3x4=12				3x2=6

CH	4-1	SO4	Executive Management	Failure to meet the 4 hour emergency access standard	The Trust is unable to meet the target to see 95% of patients attending A&E within 4 hours	4x5=20	Operational plans in place to cope with prolonged surges in demand Cancelling of non urgent elective operations New elective surgical ward open to reduce liklihood of above control Opening of escalation beds Working with partners for social, community and primary care	Divisional and Trust performance reports Rates of discharge; DTOC	A&E Delivery Board	Ongoing NHSI review of key indicators Internal audit work on data quality Quality Report testing of key indicators by external auditors	Satisfactory	4x4=16				3x2=6
CH	4-2	SO4	Executive Management	Failure to meet the key elective access standards - RTT 18 weeks, non-RTT and cancer 62 days	The Trust is unable to meet the 18 week RTT and 62 day cancewr targets, and unable to reduce its non-RTT backlog as required	4x3=12	Regular PTL meetings Work on improving administrative pathways Work with tertiary providers on breach allocations RTT and non-RTT action plans	Divisional and Trust performance reports Management Board scrutiny and oversight of RTT and non-RTT action plans	Finance and Investment Committee scrutiny of financial and operational performance Quality and Clinical Risk Committee oversight	NHSI regional information on performance against key access targets	Satisfactory	4x3=12				3x3=9
JB	4-3	SO4	Audit	Failure to ensure adequate data quality leading to patient harm, reputational risk and regulatory failure	Data quality governance and processes are not robust	4x4=16	Robust governance around data quality processes including executive ownership Audit work by data quality team	Oversight of progress against action plans by Data Quality Compliance Board	Standing agenda item at the Audit Committee	Outcome of Internal audit assessment of data quality Outcome of External Audit Quality Report testing Outcome of NHSI review	Satisfactory	4x3=12				3x3=9
JB	5-1	SO5	Audit	Failure to adequately safeguard against major IT system failure (deliberate attack)	Weakneses in cyber security leave the trust vulnerable to cyber attack	3x3=9	Investment in better quality systems GDE investment NHS Digital audits and penetration tests	Results of penetration and phishing tests	Audit Committee review of cyber security	Performance against NHS Digital standards	Good	5x2=10				3x2=6
JB	5-2	SO5	Finance & Investment	Failure to adequately safeguard against major IT system failure (inability to invest in appropriate support systems/infrastructure)	Lack of suitable and timely investment leaves the Trust vulnerable to cyber attack	3x3=9	2 dedicated cyber security posts funded through GDE All Trust PCs less than 4 years old Robust public wifi network EPR investment	Robust capital prioritisation process overseen by Managment Board	Oversight of IT investment strategy and decision making by the Finance and Investment Committee	External oversight of uses of the GDE funding	Good	4x2=8				3x2=6
CH	5-3	SO5	Executive management	Failure to successfully deploy EPR in a way that diminishes disruption	That the roll out of EPR disrupts clinical and operational services	5x3=15	Robust programme management, including executive oversight Involvement and engagement of all operational and clinical staff Good undertsanding of risks at go live and either accepting or planning for them Understanding the phasing of the programme and the specific operational challenges at each phase	Oversight by the Health Informatics Programme Board chaired by the Chief Executive and attended by all Executives. This Board reports to Management Board, and in turn, Trust Board	Regular updates to the Finance and Investment Committee Updates to the Trust Board Council of Governors, and shortly to the Trust membership		Satisfactory	4x3=12				4x2=8
CH	5-4	SO5	Executive Management	Failure to maximise the benefits of EPR	That the Trust does not derive all of the benefits in terms of efficiency and productivity from the EPR system as had been anticipated in the business cases	4x3=12	Under review									3x2=6

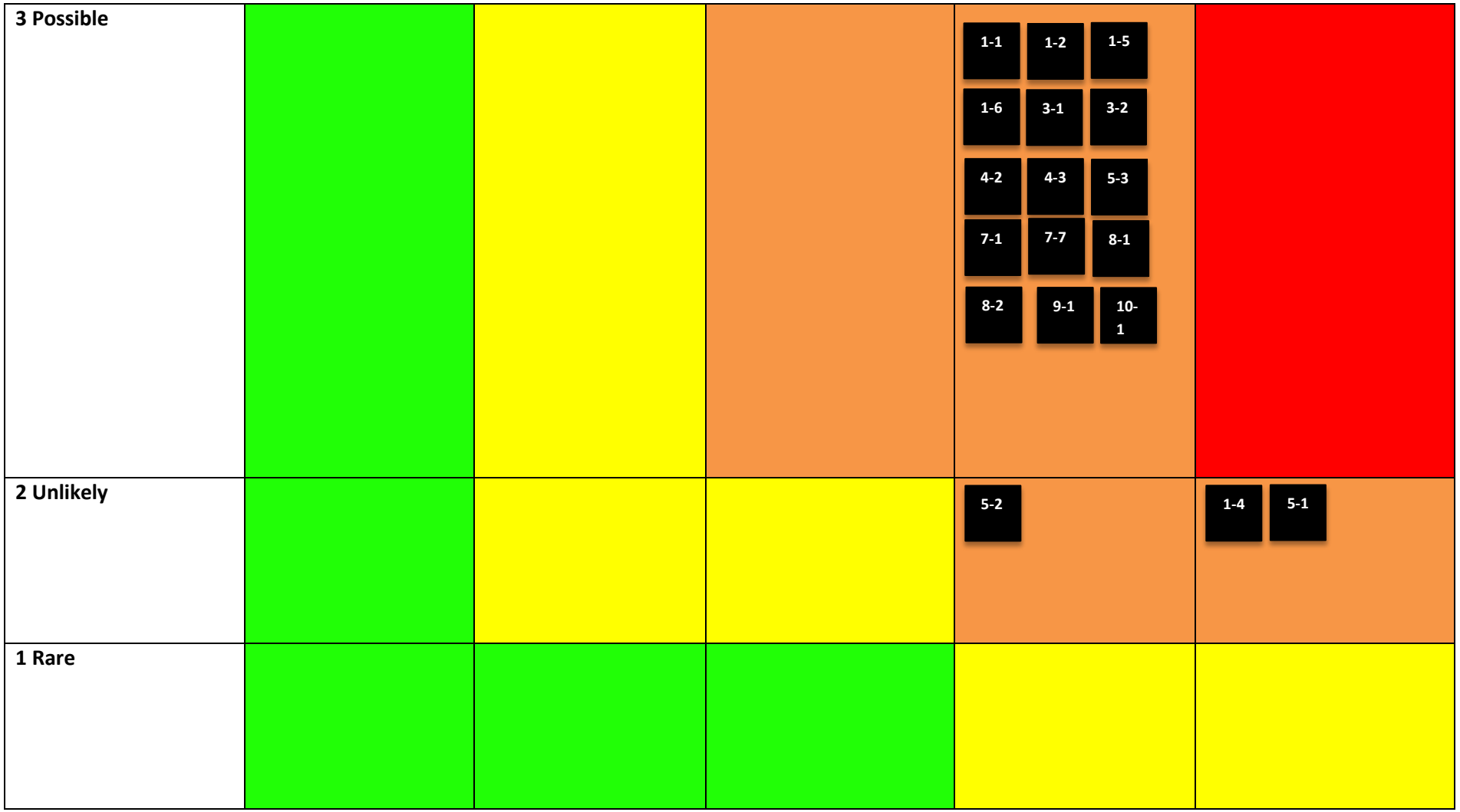
MK	7-1	SO7	Finance & Investment	Inability to keep to affordable levels of agency and locum staffing	Inability to recruit to difficult to recruit to posts (across disciplines but particularly in medicine) Short notice sickness absence Poor planning around activity peaks Poor rostering of annual leave/ other leave requirements Increased requirement for enhanced observation levels of care National price caps mean that in a range of areas the Trust has little prospect of full compliance in short term future.	5x4=20	Weekly vacancy control panel review agency requests. Control of staffing costs identified as a key transformation work stream Bank rates and enhancements Capacity planning Robust rostering and leave planning Escalation policy in place to sign-off breach of agency rates Fort-nightly executive led agency reduction group meeting with aim of delivering reduction in both quantity and cost of agency used. Agency cap breaches are reported to Divisions and the FIC .	Transformation plans with tracked delivery. Oversight at the Vacancy Control Panel. Action plan reviews at fortnightly Executive Director Meetings Divisional deep dive sessions Monthly reports to Workfoirce Board and then to Management Board	Performance reported to the F&I Committee Oversight by the Workforce and Development Assurance Committee	Internal audit assessment on the use of medical locums NHSI performance review meetings NHSI agency weekly returns	Good	4x3=12	The Agency spend up to mth 11 is £10.6, in mth £0.8m . The Trust's Y/E ceiling is £15.15m. The trust is below the target future months run-rate of £2.7m and is performing better than its agency plan year to date.	More robust and comprehensive capacity planning. Consistent approach to rostering and leave planning across the trust.	Current and ongoing	4x3=12
	7-2	SO7	Finance & Investment	Timing and release of capital and revenue funding for 2017/18		5x5=25	Ongoing dialogue with NHSI regarding status of cash commitment from the DH. Revenue funding for July has been approval by the DoH in the form of an uncommitted term loan. Revenue plan submitted in line with 2017/18 control total of £18.8m deficit. The Trust is reaching its limit of being re-profiling its Capital Expenditure for 2017-18 until it receives Strategic capital funding approval. Currently only funds of emergency nature are being released by the Trust.	Capital Expenditure is reviewed at the monthly capital control group and management board	Updates reported to the F&I Committee and Trust Board on a monthly basis	The Trust discusses the position at its monthly PRM calls with NHSI	Good	4x4=16	The Trust has received confirmation of the EPR capital funding for 17/18, 18/19 and 19/20. The Trust has also received confirmation that the revenue support loan due for repayment in March 2018 will be extended to March 2019. The Trust will continue to seek approval for funding of other capital schemes in 2018/19 in line with it's annual plan, and for clarity over what will happen with its revenue support loan due now for repayment in March 2019 (as the Trust has not reasonable prospect of repaying the loan).		Current and ongoing	3x2=6
MK	7-3	SO7	Finance & Investment	Inability to achieve the required levels of financial efficiency within the Transformation Programme	Increased unplanned activity Inability to identify sufficient savings schemes, or to achieve the expected levels of savings Inability to deliver identified schemes	5x4=20	Tracker in place to identify and track savings and ensure they are delivering against plan Savings measured against trust finance ledger to ensure they are robust and consistent with overall financial reporting All savings RAG rated to ensure objectivity	Fortnightly CIP review meetings between with the Director of Service Development, DoF, divisional managers and project managers Recovery plans requested for off-track schemes Savings plan for 17/18 financial year not yet fully identified.	Monthly CEO chaired Transformation Board oversight, providing leadership and scrutiny of programme delivery		Satisfactory	4x4=16	Savings of £6.6m up to mth 11 against a full year target of £10.5m	Further saving schemes to be identified to deliver maximum savings in 2017/18 and full year effect benefits in to 2018/19.	Current and ongoing	3x3=9

	7-4	SO7	Finance & Investment	Disagreement with main commissioner over the level of performance that they are prepared to fund	MKCCG has included £4m of QUIP schemes within its contract with the trust for 2017-18. Historically this has not delivered Over performance is not payable until up to four months after the activity undertaken, putting pressure on cash flows CCG financial position is such that ability to hold their financial plan will be challenging if over-performance continues at a similar level to 2016-17.	5x4=20	Clearly defined quarterly reconciliation process of contract payments made with close monitoring of the payment for over performance invoices. Escalation of issues to NHSI for intervention where required.	Twice monthly meetings with MKCCG, attended by the DoF and the Deputy CEO to discuss contractual and actual levels of activity	Updates reported to the F&I Committee and Trust Board on a monthly basis		Satisfactory	4x4=16	The Trust has held a number of meetings with MKCCG to understand the contract challenges in respect of the 2017/18 contract. The Trust is chasing all commisioners for payment of overperformance amounts.	The Trust to continue to work closely with the CCG on demand management solutions.	Current and ongoing	3x3=9
MK	7-5	SO7	Finance & Investment	The Trust is unable to access £7.3m of Sustainability & Transformation Funding	That Trust does not meet the performance targets in relation to the A&E 4 hour standards and cancer treatment and therefore does not qualify for STF	5x5=25	In order to receive the full amount of £7.3m of S&T funding in FY 2017-18, the Trust needs to achieve its financial control total (ie 70% of the funding) and its A&E performance trajectory (30% of the funding). The Trust has agreed a control total of £18.8m deficit and its performance trajectory with NHSI and is forecasting to achieve its control total	Financial performance and A&E performance is reviewed at the Executive Director meetings.	F&I committee reviews the monthly financial performance against the control total and receives updates in respect of the A&E performance a monthly basis. The Trust Board reviews A&E performance as well as financial performance on a monthly basis		Satisfactory	4x4=16	The Trust has met its mth 11 Finance control total and achieved Q3 A&E target. The Q4 A&E performance requirement is unlikely to be met, but this does not effect acehivement of the Trust's control total	The Trust will continue to closely monitor its performance against the financial and activity targets	Current and ongoing	3x4=12
MK	7-6	SO7	Finance and Investment	The Trust fails to utilise available capital funding according to strategic and clinical priorities	That the process of prioritising projects oin which the Trust's limited capital funds should be spent does not properly align with its broader strategic priorities	3x4=12	CBIG forum including clinical, corporate and executive representation Capital prioritisation programme	Management Board processes		Internal audit oversight of capital programme	Satisfactory	Scoring under review				
LK	7-7	SO7	Board of Directors	Failures in compliance leading to regulatory intervention (CQC)	That the Trust fails to meet the CQC's fundamental standards and receives a critical report foollowing an inspection	4x4=16	Compliance assessments embedded in divisions and CSUs (through CIGs and compliance reporting) Divisions undertaken Well Led Assessment in quarter three 2017/18 Trust commissioned GGI to prepare for corporate Well Led Assessment review process Corporate governance structure updated to further strengthen quality and compliance oversight and reporting - effective quarter one 2018/19	Oversight through CIGs Oversight at Risk and Compliance Board Oversight at Nursing and Midwifery Board Oversight at Clinical Quality Board Oversight at Management Board	Regular engagement with the local CQC relationship manager Oversight at Quality and Clinical Risk Committee Trust Board engagement in GGI review	Well Led peer review exercise to be held with kingston Hospital Commissioned GGI to undertake Well Led Assessment preparatory review	Satisfactory	4x3=12				3x2=6
OE	8-1	SO8	Workforce	Inability to recruit to critical vacancies	National shortages of appropriately qualified staff in some clinical roles, particularly at consultant level Competition from surrounding hospitals Buoyant locum market National drive to increase nursing numbers leaving market shortfall (demand outstrips supply)	4x4=16	Participation in local and regional job fairs Targeted overseas recruitment activity Apprenticeships and work experience opportunities Exploration and use of new roles to help bridge particular gaps Use of recruitment and retention premia as necessary Use of the Trac recruitment tool Use of a system to recruit pre-qualification students Use of enhanced adverts, wsocial media and recruitment days Rollout of a dedicated workforce website	Vacancy control panel Divisional deep dive sessions Monthly reports to Mangement Board Workfoce Board oversight Use of workfoce planning templates Outcomes from the recruitment and retention task and finish group Workforce transformation reports	Quarterly reports to the Workforce and Development Assurance Committee	NHSI Model Hospital benchmarking Staff survey results	Satisfactory	4x3=12				3x2=6

OE	8-2	SO8	Workforce	Inability to retain staff employed in critical posts	Poor working and management envinroment, lack of progression or development opportunities make it difficult to retain key staff	4x4=16	Variety of organisational change/staff engagement acitivities, e.g. Event in the Tent Schwartz Rounds and coaching collaboratives Recruitment and retention premia We Care programme Onboarding and exit strategies/reporting Staff survey Learning and development programmes Health and wellbeing initiatives, including P2P and Care First Staff friends and family results/action plans Links to the University of Buckingham Staff recognition - staff awards, long service awards, GEM Leadership development and talent	Monthly reports to Workforce Board and Managment Board Workforce transformation reports	Reports to Workforce and Development Assurance Committees and the Finance and Investment Committee	NHSI Model Hopsital benchmarking, Staff survey results	Satisfactory	4x3=12				3x2=6
KJ	9-1	SO9	Finance & Investment	Failure to achieve the required level of investment (including appeal funds) to fund the Cancer Centre	Lack of suitable and timely engagement with key players within the city and wider area during the private phase of the appeal, and an inability to enthuse and gain the support of potential donors more broadly, means that the Charity is unable to achieve the required level of charitable contribution to the project	4x3=12	Fundraising strategy and plan in place Financial forecasts under very regular scrutiny Experienced consultancy engaged to support existing senior and experienced fundraising staff Tactical plan for private and public appeal phase developed and implemented	Regular reporting to Committee Operational oversight	Oversight at Charitable Funds Committee	Appeal Leadership Committee	Satisfactory	4x3=12				3x2=6
JH	10-1	SO10	Board of Directors	Inability to progress the Milton Keynes Accountable Care System and wider ACS/STP programme	Lack of effective collaboration among all the key local partners means that the goal of a comprehensive and integrated place based health and social care solution within MK is not realised	4x3=12	Chief Executive and Executive team engagement both at ICS and MK Place levels. MK Place leaders chairing 3 of the 5 ICS priority workstreams	Direct MKUH senior invokvement in decision making. Regular CEO progress updates to Management Board	Standing agenda item at the Trust Board		Satisfactory	4x3=12				3x2=6

Board Assurance Framework Heat Map April 2018

The heat map reflects residual scores. The map for April depicts clustering of risk in the major/ likely or possible category. These scores will be given particular scrutiny in the April to May review round to assess whether they can be mitigated further.


3 Possible
1-1
1-2
1-5
1-6
3-1
3-2
4-2
4-3
5-3
7-1
7-7
8-1
8-2
9-1
10-1
2 Unlikely
5-2
1-4
5-1
1 Rare

Strategic Objective	Risk Ref	Committee	Risk Description	Proximity	Risk Score (consequence v likelihood)		
					Jan-18	Apr-18	Jun-18
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	
SO1: Patient Safety	1-2	Quality and Clinical Risk	Tactical failure to manage demand for emergency care		Not on BAF	(4x3) = 12	
SO1: Patient Safety	1-3	Quality and Clinical Risk	Ability to maintain patient safety during periods of overwhelming demand		(4x5) = 20	(4x4) = 16	
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	
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	
SO1: Patient Safety	1-6	Quality and Clinical Risk	Failure to manage clinical risks through the implementation of eCARE (go-live)		Not on BAF	(4x3) = 12	
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	
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	
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	
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	
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	
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	

SO5: Sustainability	5-1	Finance	Failure to adequately safeguard against major IT system failure (deliberate attack)	Next 3 to 6 months	(3x3) = 9	(5x2) = 10	
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	
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	
SO5: Sustainability	5-4	Management Board	Failure to maximise the benefits of EPR	Next 3 to 6 months	(4x3) = 12	Reassessment required	
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	
SO7: Finance and Governance	7-2	Finance	Timing and release of capital and revenue funding	Next 12 months	(5x5) = 25	(4x4) = 16	
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	
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	
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	
SO7: Finance and Governance	7-6	Finance	The Trust fails to utilise available capital funding according to strategic and clinical priorities	Next 12 months	(3x4) = 12	Reassessment required	
SO7: Finance and Governance	7-7	Finance	Failures in compliance leading to regulatory intervention (CQC)	Next 12 months	(4x3) = 12	(4x3) = 12	
SO8: Workforce	8-1	Workforce	Inability to recruit to critical vacancies	Next 3 to 6 months	(4x4) = 16	(4x3) = 12	
SO8: Workforce	8-2	Workforce	Inability to retain staff employed in critical positions	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	
SO10: Corporate Citizen	9-1	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	

SO10: Corporate Citizen	10-1	Board	Inability to progress the Milton Keynes Accountable Care System and wider ACS/STP programme	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	

Milton Keynes University Hospital NHS Foundation Trust

MEETING OF THE FINANCE AND INVESTMENT COMMITTEE HELD ON 6 April 2018

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

- There were no matters approved by the Committee.

Matters referred to the Board for final approval:

- There were no matters that were referred to the Board for final approval.

Other matters considered at the meeting:

1. Performance Dashboard:

The Committee noted:

I. The metrics that are presented at each meeting are to be reviewed for 2018/19

2. Finance Report:

The Committee noted that:

I. Two local variations t the two year contract with the CCG had been agreed.
II. Although capital spend is currently reported as being behind plan, it was confirmed that there was no risk of any capital being lost.
III. The income position around year end is to be clarified later today, but the Trust did not wish to be too aggressive in recovering income this year.

3. Agency update

Spend was back to normal levels in February compared to what it was in January. It is anticipated that the spend for the year will be £11.5m leaving the Trust in a good position to meet the ceiling of £11.4m in 2018/19. However the risks around escalation areas, which now remain open for most of the year, were noted. The possible impact of the decision to reduce bank rates will also be kept under review.

4. Reference costs

This will be the final year of reference costs, with all trusts moving towards patient level costing. This new system will provide more detailed information which will better assist the Trust in making investment decisions. The data in this report indicated that MKUH sits in the middle of the pack of comparable organisations within its peer group. While there are no financial implications to the Trust's position, the information does help regulators to assess how efficient organisations are.

5. Transformation Programme Month 11 update

The following points were highlighted:

I. The Trust is behind target in the year to date partly due to issues around length of stay and theatre efficiency
II. Although £8.1m worth of schemes have so far been identified for 2018/19, this value falls to £4.1m in terms of the expectation of delivery. Nevertheless, this is a much better position compared to the same time last year
III. The CQUIN target is expected to be met
IV. The focus of the 2018/19 Transformation Programme will change, with the team becoming more of a delivery unit, rather than a support resource
V. There will be a focus on securing the significant anticipated benefits from the implementation of the eCARE system.

6. Timeline for strategic capital projects

The year to date position is that £7.7m has been spent on strategic projects, and £3.3m on projects considered to be part of business as usual. The year-end position is likely to be just shy of the £17.7m that had been forecast. Next year, the biggest items are likely to be the Cancer Centre and the various estate replacement projects.

In response to a question about Oxford University Hospitals' proposal to build a radiotherapy centre on site, it was noted that this is predicated on them being paid above national tariff in recognition of this investment, which is unlikely.

7. Other Business

There was no other business.

8. Risks highlighted during meeting for consideration to CRR/BAF

No new risks were highlighted.

Audit Committee Summary Report

1. Introduction

The Audit Committee met on 22 March 2018. A summary of the key matters discussed is provided for the Board:

2. Matters Arising and Action Log

The Director of Finance indicated, in relation to the possibility of cross defaults as a result of the fact that the Department of Health loan had not been rolled over, that there are no such risks.

Data Quality

The Deputy Chief Executive explained that there is a significant programme of work being done to address the issues around data quality, and the internal auditors confirmed that there is now good governance oversight of the processes.

The Board itself has oversight of the actions that have arisen out of the NHS Improvement investigation into whistle-blower concerns raised about the way RTT stops and starts have been managed. A report on how these actions are being taken forward this will be presented to this Committee by the Data Compliance Board.

3. Counter Fraud

The self-review too, which is now a forward looking document, was presented, the aim of which is to measure the effectiveness of actions being taken. The Trust is assessing itself as green overall.

4. Update in data security

The Head of IT presented on cyber security and raised the following points:

- The Trust has a network of around 3000 PCs and 2000 IP phones
- It is on a migration path towards Windows 10, but in the meantime is working proactively with Microsoft around security
- Significant resilience has been built into the infrastructure, and this is being upgraded as older kit is replaced
- The possibility of the eCARE system going down is acknowledged but robust continuity planning has been done. The system is very secure and can only be accessed through the use of smartcards
- The Trust has at least one old system that it linked to Windows XP, but this is business critical and would take up to 1 year to re-procure
- All the Trust's PCs are fitted with state of the art anti-virus software, and an additional more powerful tool has been acquired to protect the network.
- As part of the outcome of work with NHS Digital it has been decided that passwords are to be lengthened.

5. External Audit

Interim planning has been completed and there are no emerging issues. Testing around the Quality Report indicators, which will again be RTT and A&E has commenced. It is expected that the Trust will once again be qualified, but it is likely that the number oif exceptions would have decreased.

Overall, operationally, not much appears to have changed from last year.

6. Internal Audit

The Internal Auditor presented this update indicating that the work programme has broadly been completed:

- It was confirmed that there has been a marked improvement in relation to data quality, particularly with the creation of the Data Quality Compliance Board which has helped to secure engagement from senior clinicians.
- There has also been an improvement in the Board Assurance Framework as part of a more active engagement with risk management.
- The clinical audit review was awarded a rating of partial assurance. Although the work is being done, it was not being monitored for quality of progress and there was no evidence of learning being derived from the programme. These issues are now being addressed and a remedial plan is in place to address the main problems of governance and ownership.
- The capital governance review is also likely to be rated as providing partial assurance.
- It was noted in relation to the waiver process that there is a need for more governance around the larger projects.

7. Financial Controller Report

This report to the Committee indicated that during the period in question:

- Write offs amounted to £61k but with a £25k impact.
- Losses for the period amounted to £7k, £6k of which related to pharmacy stock write offs.
- There were 2 significant credit notes both of which related to administrative errors.
- There were 3 tender waivers in the period, 2 of which related to the timing of procuring endoscopy equipment.

8. Board Assurance Framework

It was acknowledged that some gaps remain and that further work would need to be done with the executives to address these. It was also agreed that further attention will be given to whether the controls and assurances as set pout are correct.

9. Going Concern review paper

3 options had been set out around the going concern assessment, with the preferred option referencing the added complication of the Department of Health loan. A form of words would need to be found in the event that this is not resolved by the time of reporting.

10. GDPR action plan

There are still some risk areas around data mapping and asset ownership, and it was noted that there is a need for a culture shift in thus area as many staff have little understanding of the changes that this new regulation will bring. The Trust is part of an information governance network, and overall it is on track. It was agreed that this issue needs to be reflected on the BAF.

11. Timetables for the annual report and the accounts

The audited accounts are to be signed off by this Committee on 22 May, and then the Board pm 25 May, after which the final submission to NHS Improvement will take place on 29 May.

12. Minutes from Board Committees

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

- Finance and Investment Committee meetings on 5 February (approved) and 5 March 2018 (draft)
- Quality and Clinical Risk Committee meeting on 30 January 2018 (draft)
- Charitable Funds Committee on 5 February 2018 (draft)
- Workforce and Development Assurance Committee meeting on 5 February 2018 (draft)

13. Risks highlighted in the meeting for consideration to CRR/BAF

- Cyber security
- Data quality (improving)
- Clinical audit and capital governance (rated partial assurance by internal audit)
- GDPR

14. Items for Escalation to the Board

None

15. Any other business

None

16. 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

Quality and Clinical Risk Committee Summary Report

1. Introduction

The Quality and Clinical Risk Committee met on 22 March 2018.

2. Key matters

The following items were presented to the Committee:

Action log (highlights)

- The indicators on the quality dashboard are reviewed by the Deputy CEO on an annual basis – the importance of ensuring that they remain useful was emphasised.
- There is a sense that the quarterly patient experience report focuses on complaints rather than patient experience. The Committee is impatient to see improvements in this area. The new Patient Experience Strategy is being finalised and will be presented at this report in June.

Quarterly highlight report

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

- The hospital is very busy and has been at OPEL (Operational Pressures Escalation Level) 4 on two occasions this quarter. There is some anxiety over next year's plans as there is no further provision available for escalation.
- eCARE goes live over the weekend of 14-15 April 2018 and areas of concern are the stability and design of the system and keeping implementation on track.
- The increased number of safeguarding cases is believed to be due to better recognition and improving collaborative working with external partners.

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

- Some formatting issues remain to be resolved on the spreadsheet.
- The Committee Chair indicated that he would like to focus on a few risks at a time at each meeting.
- Risk 1-1 is to be split into 3 components to reflect strategic failure, tactical failure and staying safe when overwhelmed.
- It was agreed that the risks around eCARE go live and implementation would be reflected on the BAF

Exception report for the Quality Dashboard

- The Never Event highlighted on the dashboard related to a medication incident.
- Although delays in ambulance handover are high, only a small number involve very long delays and processes are in place to ensure patient safety.

Mortality update

- The Trust's mortality rate, as measured by the HSMR and SHMI continues to be lower than or within the expected range.
- There are 3 outlying diagnoses, but there are no obvious concerns in relation to any of them.
- The role of the medical examiner is to be introduced as part of National Quality Board recommendations.

Quarterly Serious Incident Report

- There were 6 Serious Incidents in the quarter one of which was a Never Event.
- There are fewer SIs this year than last, but there is no room for complacency.

- In terms of reporting, although there is confidence that the Trust appropriately reports all incidents where harm is caused, it is known to be a low reporter of low harm incidents.
- A peer review was recently undertaken with the Princess Alexandra Hospital. This showed that MKUH reports and investigates more incidents, but the PAH classifies incidents differently.

Quarterly Patient Experience Report

- There had been 316 complaints recorded during the quarter, 232 of which had been raised informally via PALS.
- The Committee Chair acknowledged that the report demonstrates that the Trust has a good complaints policy, but he made the point that this does not reflect the broader picture around patient experience.

Early draft of the 2017/18 Quality Report

- It was acknowledged that this report may not pass the plain English test, but its format and much of its content is mandated.
- It was noted that the Gold Standards Framework, which is one of the chosen priorities had never been discussed at this Committee, and there were also questions whether outpatients is one of the hospital's top priorities.
- It was agreed that for the future, the choice of priorities would be discussed with this Committee.

Paediatric Picker survey action plan update

- On the issue of noise, the Chair questioned whether nurse alarms are suppressed at night. It was noted that they can be turned down slightly.
- The children's ward is very busy and is constrained by its environment.
- On the issue of pain management, pan audits are carried out and these indicate that management is better in planned care than in response to emergencies. The Trust also has play therapists who sit with and provide support to patients, although funding can be an issue – the Committee was of the view that this should be a top priority for patient experience.
- The Henry Allen Trust has been supportive of the children's ward in terms of funding artwork, and are in the process of helping to convert one of the Trust's in-call houses into a residence where families might stay while their child is in hospital.

Quarterly report on clinical audit

- The Associate Medical Director came into post in February 2018, with clinical audit forming part of his remit. Hitherto the role of clinical audit lead was neither recognised nor well supported within the CSUs and divisions. A more prescriptive job description is now being devised and strengthened governance arrangements being put into place.
- The AMD is also reviewing why some of the Trust's audits were less successful than others, and the choice of audits that the Trust will participate in going forward is also under review.
- Additional resources will be made available to enable clinicians to participate in audit as required
- It was noted, however, that it may be some years before significant progress in this area would be recognised.

Compliance with processes for assessing performance against NICE guidance

- Completing baseline assessments continues to be a problem which appears to be getting worse. This is partly due to the exponential growth in the number of new guidelines
- The risk is low on the basis that not all of the guidance is relevant to this Trust
- A report highlighting the Trust's "must dos" is to be brought back to the next meeting.

7 Day Services

By 2020, it is expected that patients will have access to the certain services on a 7 day basis, based on 4 priority targets that have been set. A business case is being presented to Management Board in terms of the additional cost that this will mean for the Trust.

GIRFT litigation costs in surgical specialities

- The Committee noted this report breaking down the Trust's litigation costs by surgical specialities and benchmarking them against those of other organisations.
- In some specialities such as general surgery, gynaecology and T&O, the Trust is in the middle in the pack while in others such as ENT, it is considerably lower.
- The Divisional Director for Surgery is to report to Management Board on each of the specialities.

Divisional Focus – Core Clinical

- Imaging ids the biggest area within the Division in terms of procurement and expenditure. The Trust is one of only five providers to have gained ISAS accreditation
- The Trust is giving some strategic thought to the future of MRI provision, noting the need to secure additional capacity
- The new pathology standards for United Kingdom Accreditation Service (UKAS) are costly to undertake but worthwhile. The Trust recently renewed its HTA (Human Tissue Authority) licence.
- Pharmacy is sited in a poor part of the estate which is affecting day to day activity with the regular breakdown of the pharmacy robot caused by repeated leaks in the building. Capital funding has been approved for relocation and building of a new aseptic suite.
- The Division's top concerns are:
    - Limitations in terms of location of departments within the estate.
    - The challenge of keeping staff engaged in light of the uncertainty over the Pathology Network which will provide a more collaborative arrangement with Oxford.
    - Recruitment within Pharmacy and Psychology along with other support services.
    - The increased demand on diagnostic services linked to increased capacity issues in the hospital
- The division's role in patient experience in terms of food, environment, cleanliness and TTOs was acknowledged, as well as the impact Therapies have on length of stay with regard to patient flow.

3. Items for Escalation to the Board

- Following presentation to Board in June, the Patient Experience Strategy will be reviewed at the next Quality and Clinical Risk Committee
- Affirmation that the Trust is now attracting high quality staff
- Significant pressures in the hospital and growing anxiety regarding the organisation's ability to manage capacity next winter.
- Concerns around eCARE
- Measures being introduced to address the clinical audit concerns raised in the KPMG report

4. 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 and the specific items escalated for the Board's attention.