Agenda for the Board of Directors' Meeting in Public

Meeting to be held on Thursday 04 November 2021
at the Conference Room in the Academic Centre from 10.00 hours

Item No.	Timing	Title	Purpose	Page No.	Lead
Introduction and Administration					
1	10.00	Apologies	Receive	Verbal	Chair
2		Declarations of Interest • Any new interests to declare • Any interests to declare in relation to open items on the agenda	Noting	Verbal	Chair
3		Minutes of the Trust Board meeting in held in public on 09 September 2021	Approve	Pg. 5	Chair
4		Matters Arising	Receive	Verbal	Chair
Chair and Chief Executive Strategic Updates					
5	10.05	Chair's Report	Receive and Discuss	Pg. 14	Chair
6	10.10	Chief Executive's Report a. CQC Update	Receive and Discuss	Verbal	Chief Executive
Quality					
7	10.20	Patient Story	Receive and Discuss	Pg. 17	Director of Patient Care and Chief Nurse
8	10.35	Serious incident & Inquest Report	Receive and Discuss	Pg. 30	Director of Corporate Affairs/ Medical Director
9	10.45	Research and Development Annual Report	Receive and Discuss	Pg. 33	Medical Director
10	10.50	Maternity Update	Receive and Discuss	Pg. 45	Director of Patient Care and Chief Nurse

Item No.	Timing	Title	Purpose	Page No.	Lead
11	11.00	Nursing Staff Update	Receive and Discuss	Pg. 51	Director of Patient Care and Chief Nurse
12	11.05	Nursing and Midwifery Strategy: 2022 - 2025	For Approval	Pg. 62	Director of Patient Care and Chief Nurse
13	11.15	Infection Prevention and Control Annual Report	Receive and Discuss	Pg. 76	Director of Patient Care and Chief Nurse
14	11.20	Complaints Annual Report	Receive and Discuss	Pg. 98	Director of Patient Care and Chief Nurse
Workforce					
15	11.25	Workforce Report Month 06	Receive and Discuss	Pg. 112	Director of Workforce
16	11.30	2020 Staff Survey Update	Receive and Discuss	Pg. 116	Director of Workforce
Performance and Finance					
17	11.35	Performance Report Month 06	Receive and Discuss	Pg. 121	Director of Operations
18	11.40	Finance Report Month 06	Receive and Discuss	Pg. 136	Director of Finance
Assurance and Statutory Items					
19	11.50	Significant Risk Register	For Information	Pg. 154	Director of Corporate Affairs
20	11.55	Board Assurance Framework	Receive and Discuss	Pg. 167	Director of Corporate Affairs
21	12.00	Terms of References a. Audit Committee b. Quality and Clinical Risk Committee	For Approval	Pg. 217	Director of Corporate Affairs

Item No.	Timing	Title	Purpose	Page No.	Lead
		c. Finance and Investment Committee d. Workforce and Development Assurance Committee e. Remuneration Committee f. Charitable Funds Committee			
22	12.03	(Summary Report) Audit Committee – a. 20 September 2021	For Information	Pg. 247	Chair of Committee
		(Summary Reports) Finance and Investment Committee – a. 07 September 2021 b. 05 October 2021	For Information	Pg. 248 Pg. 249	Chair of Committee
		(Summary Report) Charitable Funds Committee – 14 October 2021	For Information	Pg. 250	Chair of Committee
		(Summary Report) Workforce and Development Assurance Committee a. 20 October 2021	For Information	Pg. 251	Chair of Committee
		(Summary Report) Quality and Clinical Risk Committee a. 20 September 2021	For Information	Pg. 253	Chair of Committee
Administration and Closing					
23	12.05	Forward Agenda Planner	For Information	Pg. 255	Chair
24		Questions from Members of the Public	Receive and Respond	Verbal	Chair
25		Motion to Close the Meeting	Receive	Verbal	Chair
26		Resolution to Exclude the Press and Public	Approve	Resolution to Exclude the Press and Public The Chair to request the	

Item No.	Timing	Title	Purpose	Page No.	Lead
				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.	
12.10		Close			
Next Meeting: Thursday, 02 December 2021					

Milton Keynes University Hospital NHS Foundation Trust

BOARD OF DIRECTORS MEETING

Minutes of the Public Trust Board of Directors Meeting held on Thursday, 09 September 2021 at 10.00 hours via Teams

Present:

Alison Davis	Chair	(AD)
Professor Joe Harrison	Chief Executive	(JH)
Andrew Blakeman	Senior Independent Director/Non-Executive Director	(AB)
Heidi Travis	Non-Executive Director	(HT)
Helen Smart	Non-Executive Director	(HS)
Haider Husain	Non-Executive Director	(HH)
Professor James Tooley	Non-Executive Director	(JT)
Dr Luke James	Non-Executive Director	(LJ)
John Blakesley	Deputy Chief Executive	(JB)
Danielle Petch	Director of Workforce	(DP)
Nicky Burns-Muir	Director of Patient Care and Chief Nurse	(NBM)
Emma Livesley	Director of Operations	(EL)
Karan Hotchkin	Deputy Director of Finance (Attended for Terry Whittle)	(KH)

In Attendance:

Kate Jarman	Director of Corporate Affairs	(KJ)
Jackie Collier	Director of Transformation & Partnerships	(JC)
Eleanor Shield	Advanced Nurse Practitioner – Enhanced Recovery (For Item 07)	(ES)
Alice Fiancet	Communications Specialist	(AF)
Kwame Mensa-Bonsu	Trust Secretary (Minutes)	(KMB)

1 Welcome and Apologies

1.1 AD welcomed all present to the meeting. There were apologies from Nicky McLeod, Non-Executive Director; Dr Ian Reckless, Medical Director & Deputy Chief Executive; and Terry Whittle, Director of Finance.

2 Declarations of interest

2.1 HH declared that he had been appointed as a non-voting Associate Non-Executive Director of the Medicines and Healthcare products Regulatory Agency's (MHRA) Board of Directors.

3 Minutes of the meeting held on 08 July 2021

3.1 The minutes of the Private Board meeting held on 08 July 2021 were reviewed and **approved** by the Board.

4 Matters Arising

4.1 There was no Action Log.

5 Chair's Update

5.1 AD informed the Board that she visited the Woughton Parish Council in July 2021 and attended their community hub from where they provided free food supplies and other forms of support for the vulnerable and isolated in the Woughton on the Green area. AD had also spoken with Councillor Hannah O'Neill, the new chair of the Milton Keynes Urgent Care Centre, and was arranging a visit to meet with the staff as well. AD added that she and JH had also met with their counterparts at Bedfordshire Hospitals NHS

Foundation Trust, Simon Linnett and David Carter, and planned to regularly hold follow up meetings with them.

5.2 AD advised that she had taken part in training events under the 'Living Our Values Programme' and would recommend them to anyone who would like to take part as the modules promoted a completely different approach to harnessing a positive and open culture in the organisation. AD stated that she would recommend that the governors also undergo training under the 'Living Our Values Programme', as that would also be very positive for the Council of Governors.

5.3 AD stated that she had continued to engage with the Freedom to Speak Up function and noted that events under the 'Freedom to Speak Up Month' in October 2021 should be supported by all in the Trust. AD highlighted her interactions with Vanessa Holmes, the Head of Charity, to learn about the varied activities of the Hospital Charity and added that arrangements were being made through Vanessa for meetings with the many partners of the Charity. AD advised that, as part of this, she had recently met with the Buckinghamshire Freemasons who had made tremendous contributions to the Trust over the years.

5.4 AD advised that she had attended the Milton Keynes (MK) Healthwatch's 2021 AGM, which was online, and had been impressed by how much work they had managed to do during the pandemic, and the number of people they had also managed to engage with during that period. AD stated that MK Healthwatch received a significant amount of feedback from the people they engaged with and was looking forward to working closely with them and with the developing Integrated Care System (ICS).

5.5 AD noted that the September 2021 Board Development Day would provide colleagues, both new and old, with the opportunity to meet in person for the first time since March 2020, to develop their interpersonal relations.

The Board **noted** the update.

6 Chief Executive's Update

6.1 JH provided an update on the Trust's current pressures and stated that there continued to be a significant steep increase in the number of patients attending all parts of the hospital. JH advised that more than 90,000 outpatients had attended the hospital in the first five months of this year, compared to the average of 80,000 outpatient attendances over the same period in previous years. JH stated that, as the conditions under the current pressures were quite different to those experienced under the annual winter pressures, the Trust had taken steps to implement innovative patient management measures to ensure that patients were being treated safely and effectively across the whole hospital. JH noted that the increased activity was unsurprisingly having an impact on staffing, and despite enhanced rates for bank work, the already exhausted nursing staff was not readily taking up the extra bank shifts on offer.

6.2 JH advised that the informal feedback from the recent informal CQC visits to the Maternity Unit and the Critical Care Unit had been very complimentary about the staff and the work they were doing. JH noted that, as the 2 units were among the most pressured in the hospital, the informal feedback was still very assuring. The Trust was awaiting the written report on the visit from the CQC.

6.3 JH informed the Board that the Trust had implemented a new food menu and a new way of delivering and distributing food to the wards, and there was some very positive feedback from inpatients on the new initiatives. JH stated that, in a boost to the Trust's green agenda, the implementation of the initiatives has also resulted in a decline of food waste from about 18% down to 2%. JH advised that the Trust, along with other partners across the healthcare system in Milton Keynes, was actively supporting the Council to cater to the needs of the Afghan refugees who had been settled in Milton Keynes.

6.4 JH noted that the number of patients with COVID-19 continued to be higher than expected, which required the maintenance of separate pathways for patients who had 'COVID light' symptoms or had been identified with COVID-19. JH stated that this equated to an overall reduction in the capacity of the organisation during a period when there had been a significant increase in the number of patients

attending the hospital. JH advised that, despite the national shortage of blood bottes, the Trust had not run out of supplies.

6.5 JH informed the Board that the Trust completed the Phase C rollout of the e-Care system to Paediatrics, Theatres, Anaesthetics and Critical Care in September 2021. The Trust was now paperless across its whole inpatient footprint and was focused on continuing with the rollout of the system so a totally paperless hospital could be achieved.

6.6 In response to HS's query around the impact on COVID-19 on staffing, DP stated that due to an updated testing process, staff who were pinged by the track and trace system were able to return to work much more quickly than before. DP stated that this had resulted in a significant decline in the number of staff who were absent due to COVID-19 and advised that about 30 members of staff were currently isolating. JH noted that more than 90% of the staff were fully vaccinated, which was a very positive position in the NHS, and this was having a positive effect on the absence rate.

6.7 In response to another query from HS around the impact of COVID-19 on pregnant women, NBM stated that the situation had improved after work with the Milton Keynes Maternity Voices Partnership by the Head of Midwifery and her team had resulted in a significant uptake of COVID vaccinations among women. NBM noted that overall, a high number of the patients being admitted with COVID-19 were young and unvaccinated, and this was placing a lot of pressure on the Intensive Care Unit which had been split into a green pathway and a COVID pathway. NBM added that, as they were most likely to have been vaccinated in January 2021, there was a particularly urgent need to protect inpatients with complex comorbidities from being infected with COVID-19. NBM advised that, within this complex evolving situation, planning was being undertaken for the winter flu season and the expected increase in the number of COVID-19 infections in the community as a result of the country continuing to open up again.

6.8 In response to AB's query around the activities or standards that were likely be negatively impacted due to the pressures on the Trust, JH advised that under these conditions it was the most routine elective activity which were either cancelled or postponed. JH noted that, in spite of all the measures being undertaken including the running of extra clinics and weekend sessions, the total number of patients on the waiting list and the total length of time on the waiting list continued to increase. JH stated that, while reviewing the most routine clinical activities, the Trust was also looking at utilising private sector capacity, ring fenced capacity and virtual outpatient appointments. JH added that the Trust had invested in surgical robotics which had improved the efficiency and effectiveness of surgical procedures, and improved length of stay.

6.9 JH stated that, in addition to the work on the 'Health and Wellbeing' agenda, the Trust needed to take steps to not only retain staff but to also attract new talent into the organisation by providing enhanced training, education and career advancement opportunities. JH noted that the Trust believed that helping staff to freshen up old skills and develop new skills and advance into different roles would help ensure that patient experience standards were maintained even as the organisation remained under pressure.

6.10 NBM advised that the staff had also been fatigued and traumatised by the effects of the COVID-19 pandemic, and a major part of the recovery process included the provision of avenues for them to share their story. NBM added that the staff were very appreciative when directors and senior managers visited the hospital to listen to their stories and concerns. AD stated that the non-executive directors looked forward to restarting their regular visits to the hospital after the pandemic and noted that LJ had recently visited some areas of the Trust.

6.11 HH congratulated the Trust for the successful Phase C rollout of the e-Care system and stated that he looked forward to seeing the benefits of a fully paperless system.

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

7 Patient Story

7.1 ES presented the story which focussed on the experience of a patient who underwent a Versius robotically assisted Colorectal surgical procedure as part of their treatment for bowel cancer. ES advised that, apart from a short pause during the first wave of the COVID-19 pandemic, the Versius robot had been steadily utilised since it was introduced in November 2019. ES noted that as of September 2021, the Versius robot had assisted in 212 surgical cases including 89 Colorectal procedures.

7.2 ES stated that the patient had attended the hospital after being referred from the Bowel Cancer Screening Programme and met with Mr Barrie Keeler, the Colorectal Consultant Surgeon, and the Colorectal Cancer Nurse to discuss the robot assisted surgical procedure that was being proposed for them. The patient after a 2 week wait attended pre-assessment, where a thorough assessment of their medical history was conducted and was counselled by the Enhanced Recovery Nurse. The patient, after the surgical procedure, followed the Enhanced Recovery Programme and had recovered fully.

7.3 ES advised that overall, the patient felt supported, well informed, and comforted by the process prior to the robot assisted surgical procedure being conducted on them. The patient also trusted Mr Keeler and his surgical team and was satisfied with their recovery and discharge after 5 days. ES stated that the benefits of robot assisted cancer surgeries included:

a. Minimally invasive keyhole procedures.
b. Ensuring the surgical team was able to remove the cancerous growth in its entirety. The team was also able to get a better lymph node harvest, which could be examined to provide a better determination of the course of treatment required.
c. Faster recovery periods for patients.
d. The speed of recovery enabled the next phase of their treatment to commence much quicker than a non-robot assisted open procedure would have allowed.

ES stated that the patient currently was undergoing chemotherapy and was psychologically and emotionally well.

7.4 ES stated that the plan was to:

a. Develop a page dedicated to the Robot Assisted Surgical Service on the Trust's website to ensure the patients were aware before attending the hospital and were able to provide feedback on their robot assisted procedures.
b. Expand the Robot Assisted Surgical Service into other specialties such as Urology in the future.
c. Promote the Robot Assisted Surgical Service to primary care.

7.5 AD stated that, as part of her introductory visits to areas of the hospital, she was very keen to visit the Robot Assisted Surgical Service to learn more about their activities and impact on patient experience. AD added that having spent several years working in the mental health sector she noted the impact robot assisted surgeries had on both the physical health and the mental health of patients. AD noted further that this was a very good example of the mental and physical sides of health care working very well together. JH advised that, direct feedback from the Secretary of State for Health and Social Care after their recent visit to the Trust, indicated that they had been and remained very excited by the work of the Surgical Robotics Team. JH stated that, as an innovative initiative, the use of robotics to assist in surgical procedures should spread across the NHS to significantly improve upon the outcomes for patients. JH noted that the Trust was a leader in this area of robot assisted surgeries and added that members of the Robotics Team had been attracted to come and work for the hospital because of its reputation for innovative work.

7.6 In response to NMc's query around patient pushback against robot assisted surgical procedures, ES stated that the discussions with relevant consultants and nurses during a patient's first visit to the assessment clinic about how the robot worked and how long it had been used helped reassure them. KJ noted the holistic nature of the care provided to patients and the example of the multidisciplinary input from various professions, skills and talents to ensure that patients had a really great experience while in the hospital. ES, in agreement, stated that a lot of people were involved, and they had to be coordinated

as smoothly as possible. AD thanked ES for the presentation and stated that it was inspiring to see the progress being made in the robot assisted surgeries and the achievements of multidisciplinary team working.

The Board **noted** the Patient Story.

8 Nursing Staffing Report

8.1 NBM presented the report and highlighted the following:

a. Due to a recent increase in the number of band 6 junior ward sisters//charge nurses on each shift, there had a revision to the model of nursing which had resulted in the creation of more band 5 nursing posts. NBM and DP were assessing whether these vacant band 5 posts could be filled with international recruits.
b. Funding provided under of the auspices of the Ockendon Action Plan had enabled the Trust to take steps to actively recruit for 13 vacancies in the Maternity Unit.
c. The Trust had successfully recruited a number of Health Care Support Workers (HSCW) to the bank, with further recruitment activity being undertaken to recruit more. This would cover the shortfall in bank staff numbers where only 189 of the 392 HSCW registered on the bank had accepted bank shifts in the last 3 months.
d. 20 bank HSCWs had taken the opportunity to become substantive members of staff.
e. The SafeCare Tool was at the 'embedding stage' and was being utilised in the safety huddle throughout the day. The tool dynamically provided a real-time shift-by-shift view of required versus actual staffing across the Trust making it easier to be responsive to changes in demand or staff availability. NBM stated that the tool had been helpful to understand where the areas of concern were.
f. The Trust had been shortlisted for the 'Team of the Year award at the Workforce Nursing Times Workforce Awards. The Trust was shortlisted for the award because of the successful bespoke induction program which was developed for HSCWs who had never worked in healthcare.

8.2 In response to HS's query around the recruitment activity in the Maternity Unit, NBM advised that due to a shortage of readily trained midwives to recruit, the Trust had piloted having registered nurses with surgical experience on the post-natal ward. NBM noted that after some initial hesitance from the substantive midwives, they had come to realise how helpful these registered nurses were, and to accept that their presence on the post-natal ward provided significant value. NBM advised that the Head of Midwifery had been asked to conduct a review into how this pilot could be established as a permanent staffing model for the Maternity Unit. NBM stated that the Trust was also looking at the options of recruiting nursery nurses and maternity associates to provide support in the Maternity Unit and noted that there was the need to resolve the various doubts that the Royal College of Midwives had with these proposed models. NBM advised that, as part of the efforts to improve the staffing model in the Maternity Unit, the Trust had modified the way the specialist midwives worked so that they were not now involved in different areas including mental health and other clinical work. NBM stated that after some initial hesitance in the Maternity Unit, the changes had now been accepted as effective, efficient, and very necessary for the highly pressurised post-natal ward especially. NBM noted that the turnover on the post-natal ward was very high with the possibility of three or four people utilising a bed in a day.

8.3 NBM advised that, in terms of the ICS, there were discussions for models such as shared roles to ensure that the Maternity Services in the constituent NHS providers were adequately supported. NBM suggested that though a shared roles model would eventually happen, the system was not yet mature enough for it to be implemented.

The Board **noted** the Nurse Staffing report.

9 Workforce Report Month 04

9.1 DP presented the Workforce Month 04report and highlighted the following:

a. The vacancy rate had improved to 9.4% in Month 04, from 10.1% in Month 03. The recruitment team was actively taking steps to speedily complete the recruitment processes for candidates so that they could contribute to the organisation's effort to keep up with its significantly increased activity.
b. The absence rate for staff with COVID-19 infections increased slightly to 0.5% in Month 05, from 0.3% in Month 04.
c. Staff turnover increased slightly to 7.7% in Month 04, from 7.5% in Month 03.
d. The statutory and mandatory training compliance rate was at 96% in Month 04, while appraisals compliance rate was at 89% in Month 04, from 92% in Month 03.
e. The questionnaire for the 2021 Staff Survey was being finalised, and steps had been taken to ensure that all departments were provided with rich data sets to work with.
f. The first meeting for the Trust's 'Inclusion Leadership Council' had been arranged.
g. The Trust's Equality, Diversity and Inclusion (EDI) had been strengthened with the recruitment of two leads, who started in September 2021.
h. The Trust was awaiting final guidance from the Joint Committee on Vaccination and Immunisation (JCVI) on the implementation of the COVID-19 vaccine booster programme.

9.2 NMc noted the appointment of two EDI leads and stated that she looked forward to seeing their output with great expectation. AD, in agreement, stated that the appointments were very good news and added that she was looking forward to being involved in the first meeting of the 'Inclusion Leadership Council' in September 2021.

The Board **noted** the Month 04 Workforce report.

10 Performance Report Month 04

10.1 EL presented the report and noted that:

a. Emergency Department (ED) attendance also continued with its upward trend in Month 04. This upward trend impacted on the ED's performance against the 4-hour waiting target which declined from 87.9% in Month 03 to 85.4% in Month 04.
b. Ambulance handovers which were over 30 mins improved from 11.7% in Month 03, to 10.4% in Month 04.
c. COVID-19 social distancing rules, and the limited capacity of the estate, was impacting on the Trust's capacity to treat the increasing number of patients attending the hospital.
d. The need to encourage and allow fatigued staff to take holidays to rest and recuperate from the effects of the pandemic, and staffing pressures were also adding to the overall pressures on the organisation.
e. For length of stay, the number of patients who had stayed in hospital for 21 days or more after their treatment was at 73 in Month 04, from 70 in Month 03. EL advised that this was due to the difficulties associated with the discharge both into the community and other areas outside of Milton Keynes Place.
f. The 5-week loss of one of the Trust's laminar flow theatres displaced the hospital's elective capacity, which had resulted in an increased number of 'cancelled operations on the day' this month. EL advised that though the aim was always to maintain both emergency and elective activity, the pressures of the increased emergency activity had led to the cancellation of elective operations.
g. Performance against the 62-day Cancer standard declined to 78.5% in Q4 of 2020/21 from 74.6% in Q1 of 2021/22. This was due to a focus on the treatment of long waiting patients and getting through the backlog.
h. Steps were being taken to hire multiple mobile MRI units for the hospital, to significantly enhance the Trust's imaging capacity and relive the pressure on diagnostics.

10.2 In response to AD's query around patient communication and expectations management during a period of increasing intense pressure on the hospital, EL stated that the Trust tried to maintain the various lines of communication with patients. EL added that this was, however, difficult to manage around 'cancelled

elective operations on the day' as those were cancelled at very short notice and noted that even when the operations were restored quickly, this negatively affected patient experience. NBM advised that the Advanced Nurse Practitioners in Cancer, for example, tracked all the patient pathways and conducted patient welfare checks and had a helpline which was manned from 9.00am till 5.00pm from Monday to Friday. NMB noted that there were various avenues through which patients could communicate with the hospital and raise concerns or make queries.

10.3 In response LJ's query around how the Trust compared in terms of Cancer performance both within the ICS and nationally, EL stated that the Trust's performance was above those of its peers in Thames Valley. EL noted that, though the high expectations of the Board required that the Trust did better for the patients, the consistently strong performance had resulted in the Trust being asked to provide support to other Cancer centres throughout the pandemic.

10.4 NBM advised that, in terms of patient discharge, there was an emerging issue with some care homes insisting that patients were double vaccinated before they would accept them. NBM noted that the Trust were vaccinating the relevant inpatients, if they wanted it, and this limited the scope for the patients who didn't want to be vaccinated. It was noted that this was the effect of the government's requirement that all healthcare workers be fully vaccinated by November 2021. NBM stated that the Trust was in discussions with the CCG's lead for infection, prevention and control to find a resolution with the aim speeding up the discharge of relevant patients for care homes.

The Board **noted** the Month 04 Performance Report.

11 Finance Paper Month 04

11.1 KH presented the Month 04 Finance Report and noted that:

a. On a Control Total basis, the Trust reported a deficit of £397k in Month 04, which was £177k adverse to the planned deficit of £220k.
b. Overspends on Pay and Non-Pay, related to the delivery of the Elective Recovery Fund (ERF), were offset by additional clinical income. Clinical income showed a favourable variance of £449k in month with the recognition of £700k related to the ERF.
c. In terms of pay there was a negative variance to plan in June of £185k, which was due to a £245k cost related to additional ERF activity.
d. In terms of non-pay there was a negative variance in June of £598k, which was due to costs of £296k owing to additional ERF activity and £306k due to higher than planned prescribing of high-cost drugs.
e. The cash balance at the end of July 2021 was £48.4m.
f. The Capital spend year-to-date was at £3.5m, which was £1.2m. behind plan.

The Board **noted** the Month 04 Finance report.

12 Milton Keynes Radiotherapy

12.1 JH presented a report to brief the Board on development around the long-held ambition to construct a Radiotherapy Centre at Milton Keynes. The report also set out the steps which had been undertaken to prepare for the construction project including gaining the relevant regional and national support for the ambition.

12.2 JB stated that, after years of discussions, the Oxford University Hospital NHS FT (OUH), the Buckinghamshire, Oxfordshire and Berkshire West and the Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care Systems (ICS), the East of England and South-East NHS Regions and the commissioners had agreed to the Radiotherapy Centre being established in the Trust. JB advised that significant progress had been made to secure the funding streams for the construction project, and an Outline Business Case was being developed. JB added that the plan was to have an operational Radiotherapy Centre in Milton Keynes in two to three years' time.

12.3 AD noted that the progress on the proposed Centre was a very good step and would have a positive impact on the experience of patients.

The Board **noted** the progress towards the establishment of a Radiotherapy Centre in Milton Keynes.

13 Cardiology Cath Lab Upgrade

13.1 EL presented a report which noted that, as part of the aspirations to develop services and replace some of the old systems in the hospital, Medicine Division had decided to replace their 15-year-old Cardiology C-Arm Unit at a cost of £950k. EL advised that a new unit would significantly reduce radiation doses, which would be of benefit to the patients and enhance their experience and a business case to support its procurement was being developed.

13.2 JH advised that the steps being taken to develop a Radiotherapy Centre and improve the Cardiology Service was being done with the support of OUH, which had a world-class reputation for Cardiology, and added that the Trust was utilising the relationship to develop and grow the appropriate services locally until the hospital could stand on its own feet. JH stated that OUH, as part of that support, would provide robust governance oversight for the proposed Radiotherapy Centre's services.

13.3 EL advised that the Medicine Division was seeking the approval of the Trust Board to delegate approval of a final business case for the replacement of the Cardiology C-Arm Unit to the Chair of the Finance and Investment Committee.

The Board **approved** the delegation of approval of the final business case for the replacement of the Cardiology C-Arm Unit to the Chair of the Finance and Investment Committee.

14 Significant Risk Register

14.1 KJ presented the Significant Risk Register report and advised that the change of the Trust's risk and incident management systems to a new provider was progressing. KJ stated that this change would have a positive impact on the reporting of incidents and risk.

14.1 In response to the AB's query around the Trust's overall exposure to elderly equipment, JH advised that the Trust was in a unique position where the governance arrangements around the capital allocation process had Dr Ian Reckless as Medical Director being the Chair of the relevant committee. JH stated that these governance arrangements ensured that capital allocation in the Trust was conducted through the lens of the clinical risk associated with elderly or broken equipment. JH added that the Finance Team had also over the years developed the appropriate asset registers which helped provide an overview of the lifecycles of all the equipment in the Trust. JH added that there was a budgeted contingency fund which was utilised to replace or repair unexpected breakdowns. JH, in conclusion, stated that the Divisional Leads had from years of practice learnt to utilise the Trust Risk Register and relevant asset register to highlight and reference their aged equipment to progress getting them repaired or replaced.

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

15 Board Assurance Framework (BAF)

15.1 KJ presented the BAF and noted that it had undergone its regular and monthly review but there were no significant changes to the document.

15.2 In response to HH's query around the risk to the cyber security profile of the Trust, JB advised that the risk score had been increased in July 2021 due to a significantly increased hostile external activity. JB stated that though the Trust's cyber security arrangements were still regarded as being exceedingly good by NHSX standards, it would be appropriate to review the risk score further in view of the continuing hostile activity being experienced by various NHS providers.

The Board **noted** the BAF.

16 Trust Board of Directors – Terms of Reference

16.1 The Board **reviewed** and **approved** the revised Terms of Reference.

17 Summary Report for the Audit Committee Meeting – 19 July 2021

17.1 The Board **noted** the report.

18.1 Summary Report for the Finance and Investment Committee Meeting – 28 June 2021

18.1.1 The Board **noted** the report.

18.2 Summary Report for the Finance and Investment Committee Meeting – 03 August 2021

18.2.1 The Board **noted** the report.

19 Summary Report for the Charitable Funds Committee Meeting – 15 July 2021

19.1 The Board **noted** the report.

20 Summary Report Workforce and Development Assurance Committee – 21 July 2021

20.1 The Board **noted** the report.

21 **Questions from Members of the Public**

21.1 There was none.

22 Any Other Business

22.1 JB informed the Board that Macmillan Cancer Support had awarded the Cancer Centre with the Macmillan Quality Environment Mark (MQEM). JB noted that the Centre had been awarded the maximum score of 5 or 'excellent' in each of the four assessment standards:

a. Design and use of space
b. The user's journey
c. Service experience
d. The user's voice

MQEM was a detailed quality framework used for assessing whether cancer care environments met the standards required by people living with cancer. JB stated that this was a tremendous achievement because the previous Cancer Centre had been stripped of the MQEM mark as the environment had slipped for patients. AD, in agreement, stated that it was a great achievement which would significantly enhance the reputation of the Trust's Cancer Services. AD added she had been to the Centre for a brief visit and planned to visit for a more extensive tour of the facility.

22.2 The meeting closed at 12 noon.

Meeting Title	**Trust Board**	**Date: 04.11.2021**
Report Title	**Chair's Report**	**Agenda Item: 5**
Lead Director	**Name: Alison Davis**	**Title: Chair**
Report Author	**Name: Alison Davis**	**Title: Chair**

Key Highlights/ Summary	An update for the Board on activity and points of interest			
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Noting** x	**For Review** ☐

Strategic Objectives Links	*N/A*
Board Assurance Framework (BAF)/ Risk Register Links	*N/A*

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

Chair's Report

To provide details of activities and matters to note, to the Trust Board:

1. The Inclusion Leadership Council (ILC) will be launching on the 3rd November 2021. A key part of MKUH's equality, diversity and inclusion (EDI) agenda, this Council will provide a forum for direct access from the staff networks to the Trust Board. Initially the Council will provide feedback and comments for consideration, based on the papers to be presented at Trust Board meetings. The intention, however, is that its role will evolve to support the aim of ensuring all staff have an opportunity to reach their full potential and ambition. Our new EDI leads, Idris Mohammed and Tim Brown have made a great start in supporting the work in this area as well as the broader remit they cover.

2. Black History Month was celebrated in October 2021 with a number of online and face to face activities. I took part in a question-and-answer session with Joe Harrison and Nicky Burns-Muir which raised suggestions and reflections on a number of different issues including the opportunities for staff progression into more senior roles. It emphasised the importance of the ILC and other actions taking place to deliver on our EDI ambitions.

3. The Freedom to Speak Up (FTSU) Month was also observed in October 2021. As a key element of patient and staff safety, ensuring everyone feels confident to raise issues of concern is vital. Work around this agenda will also evolve and grow momentum.

4. Work with partners in the Bedfordshire, Luton and Milton Keynes Integrated Care System (BLMK ICS) has progressed, as we prepare for statutory changes to come into force from April next year, creating an Integrated Care Board (ICB) and an Integrated Partnership Board (ICP). For further information about the ICS the link is What is the ICS: BLMK (blmkpartnership.co.uk)

5. As part of my link with the ICS, I visited the Lakes Estate in September 2021 with Michael Bracey, CEO of Milton Keynes Council and Rima Makarem, Chair of BLMK ICS to see and hear about the proposed redevelopment of the area. The proposed redevelopment provides an opportunity for the involvement of many partners including healthcare and voluntary/third sector.

6. The Board held an Awayday in September 2021, providing an opportunity to develop as a team, with several of us being new members and to meet face to face after so long in a virtual environment.

7. I have continued my visits to various areas including:
    - The Research and Development Department
    - HR, IT and Procurement departments at Witan Gate

- Further ward visits
- Urgent Care Centre
- Chaplaincy

My Non-Executive colleagues have also started to visit areas, where appropriate and subject to the pressures on services, which continue as we move into the winter months.

8. Working with Governors the review of the Trust's Constitution is under way and will be presented to the Board in due course.

9. Lastly, I would like to note our thanks to Alan Hastings, who will shortly be completing his term of office as a Governor with the Trust and stepping down as Lead Governor. His support over many years has been unstinting and he has provided valuable perspectives to the organisation as a 'critical friend'. We know he will continue his support in other ways, but we are grateful for his long service. Steps are under way to identify the new Lead Governor.

TheMKWay
CARE. COMMUNICATE.
COLLABORATE. CONTRIBUTE.

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

MKUH Stroke Services

Nina Roberts
Stroke ANP

&

Alexandra Stock
Ward Manager

2021

As a teaching hospital, we conduct education and research to improve
patients. During your visit students may be involved in your care, or you
participate in a clinical trial. Please speak to your doctor or nurse if you have

Stroke Multi Disciplinary Team

Milton Keynes University Hospital NHS Foundation Trust

19 Registered Nurses
7 Senior Stroke Nurses
19 Health Care Assistants

64

3 Occupational Therapists
4 Physiotherapists
2 Therapy Assistants
1 Speech and Language Assistant
1 Dietician

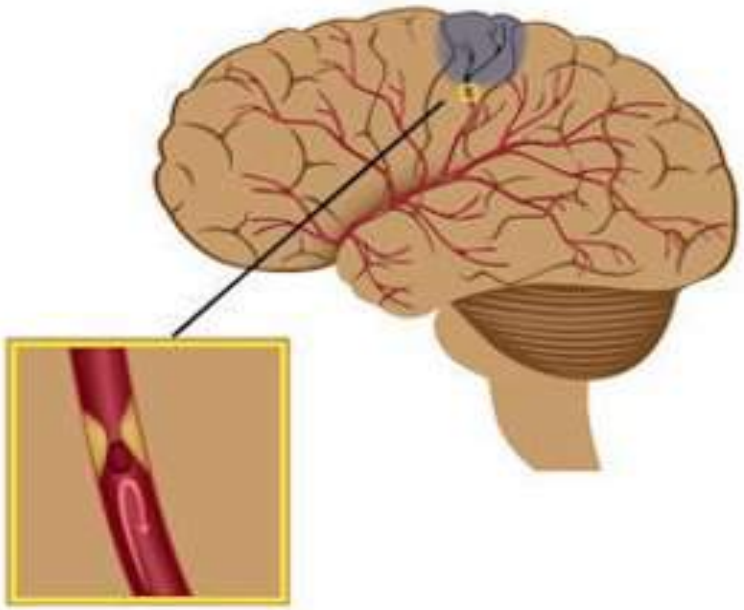
3 Stroke Consultants
1 Registrar
4 Junior Doctors

Why have a Stroke service?

Milton Keynes University Hospital NHS Foundation Trust

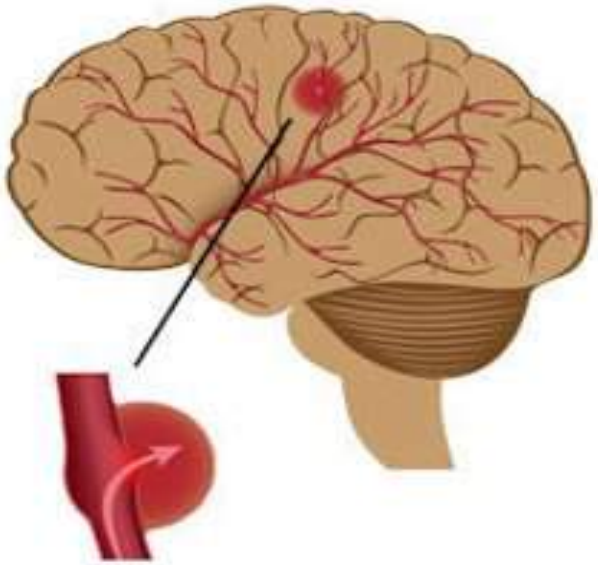
- Stroke is a medical emergency
- Stroke is the **4th** biggest killer in the UK.
- Stroke causes more disabilities than any other condition
- Not just the elderly

Types of Stroke



Blockage of blood vessels,
lack of blood flow to affected area

Ischemic Stroke



Rupture of blood vessels,
leakage of blood in affected area

Hemorrhagic Stroke

FAST

Lack of awareness of stroke is a significant problem. People do not know what a stroke is, what the symptoms are, or that it is a treatable disease that warrants the same response as a heart attack.

National stroke Strategy (2007)

Treatments

Milton Keynes University Hospital NHS Foundation Trust

An estimated **1.9** million neurons are lost every **1** minute a stroke is untreated.

Thrombolysis	Thrombectomy - OUH
< 4.5 hours	< 6 hours

Haemorrhagic Stroke	Carotid endarterectomy
Neurosurgery OUH	Bedford

Contraindications

No ID

08:15 – Collapse

Unable to talk
Right arm and leg weakness

08:55 - 2222 stroke call
09:05 – Patient arrived in ED
09:19 - CT head scan
09:29 – CTA
09:35 – Discussion with OUH
09:50 – Transfer to OUH

DJ Mr Z

- 47year old gentleman
- Hemorrhagic stroke
- Could not talk
- Swallowing difficulties
- Right sided weakness

Why a Stroke unit?

Milton Keynes University Hospital NHS Foundation Trust

Decreased length of stay	Early insertion of Feeding tube for nutrient
Earlier recognition of deterioration	Appropriate medications
Early mobilisation	All staff understanding and more competent to communicate with patients with new difficulties
Earlier investigations	Understanding of visual loss

How do we measure up?

Audit for stroke is "SSNAP"
Sentinel Stroke National audit programme.

SSNAP Score A

Interprofessional working		
SCAS Ambulance service	Emergency department	Bed Managers
CT department	MRI department	Vascular US

Milton Keynes University Hospital NHS Foundation Trust

What is next?

Training

- Clinicians - Regular Grand round presentations & inductions
- Register nurses – Validated University module Northampton
- HCA's – Inhouse 3-day course

New Kitchenette

Problem solving

Safety Awareness

Initiation/Planning

Manipulation of objects

Memory

Sequencing

Attention

Aspirations

- 24 hour thrombolysis service
- More space in-between beds.
- Equipment storage space.
- Speech and language therapist.
- Psychologist.

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

Any questions?

Milton Keynes Hospital NHS
NHS Foundation Trust

Meeting title	Trust Board (public)	4 November 2021
Report title:	Incident/serious incident (SI) report	Agenda item: 8
Lead director **Report author** **Sponsor(s)**	Tina Worth	Head of Risk & Clinical Governance
FoI status:	Public document	

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

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

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

Serious Incident Report November 2021

There were 12 new SIs reported on STEIS in October 2021 (table below).

STEIS number	Category	Details
2021/20638	Hospital Acquired Pressure Ulcer - ESCHAR	Deep tissue injury (TDI) to heel Ward 2
2021/21607	Drug Incident (general)	Patient discharged from Ward 8 with missing take home medications & subsequently readmitted
2021/21606	Drug Incident (general)	Discrepancy on prescribing on admission
2021/20185	Pressure Ulcer	Plaster case related pressure ulcer from application in the Emergency Department (ED)
2021/21604	C.Diff & Health Care Acquired Infections	MSSA Bacteraemia from a cannula site on Ward 22
2021/21609	Sub-optimal care of the deteriorating patient	Maternal admission to the Intensive Care Unit (ICU) post miscarriage with sepsis
2021/21603	Ward closure	Ward 19 outbreak closure due to Covid
2021/20184	Ward closure	Ward 15 outbreak closure due to Covid
2021/21608	Drug Incident (general)	Incorrect prescription for a month of Thyroxine
2021/21605	Wrong Site Surgery	Never event. Incorrect cyst removed from patient's labia
2021/20638	Hospital Acquired Pressure Ulcer - ESCHAR	DTI to heel Ward 8
2021/22049	Hospital acquired thromboembolism	T&O
2021/22054	Hospital acquired thromboembolism	Medicine

Trends/concerns

- Number of medication incidents. Working group established initially focusing on Parkinson's medications
- Matrons and Senior Nurses looking at scoring system & documentation by nursing staff in relation to cannula case & linked infections
- All outbreaks for Covid reported with investigation reports submitted to Public Health England. Ongoing scrutiny of local infection prevention & control procedures to maintain patient/staff safety
- We are piloting the SAFE team approach to review certain events/incidents. This approach focuses on staff and patient support and uses caring conversations to understand how they are feeling and exploratory discussions to understand from their perspective, what happened and why.
- VTE due to incorrect/inaccurate prescribing against patients' weights. Guide available on eCARE although no alert flag if incorrect dose prescribed

-

The Trust is moving from Datix to a new incident reporting system from November called Radar which is more user intuitive from a reporting perspective, has inbuilt analytics to help triangulate learning across the various modules of claims, incidents and complaints and enable programmed workflows to improve efficiency of processes.

Inquests October 2021

MK 2431

Conclusion - Baby died as a result of a spinal cord injury (Cervical level 1 & 2) caused by the inappropriate use of Kielland's forceps during delivery for which her mother had not given informed consent.

The Trust also received a Regulation 28 report noting two points of concern:

- That the mother did not have a birth plan & the midwives did not attempt to complete one. There was therefore no indication as to her preferences for treatment and care throughout her labour.
- The baby was delivered by the use of Kielland's forceps that resulted in a catastrophic spinal cord injury. NM Coroner believed the Hospital should carry out an urgent review of the use of Kielland's forceps & decide that they should no longer be used.

Meeting Title	**Trust Board**	**Date: 4/11/21**
Report Title	**Research & Development Annual Report 2020/21**	**Agenda Item: 9**
Lead Directors	**Name: Dr Ian Reckless**	**Title: Medical Director**
Report Author	**Name: Antoanela Colda**	**Title: Lead Nurse / Manager, R&D**

Key Highlights/ Summary	Receipt of Regulation report from HM Coroner & noted trends/concerns			
Recommendation *(Tick the relevant box(es))*	**For Information** [x]	**For Approval** [ ]	**For Noting** [ ]	**For Review** [ ]

Strategic Objectives Links	Improving clinical effectiveness Developing teaching and research
Board Assurance Framework (BAF)/ Risk Register Links	N/A

Report History	June 2021 Quality Committee and Clinical Risk Committee Meeting
Next Steps	N/A
Appendices/Attachments	a. 2020/21 Annual Report for R&D b. R&D strategy – 2021 to 2026

Executive Summary

The R&D team at MKUH produces an Annual Report.

It was determined in 2018/19 that a summary document would be more accessible to key audiences and would constitute a better format that a traditional report.

The report for 2020/21 is appemnded.

There are several key points to highlight:

- R&D activity at MKUH continues to perform well.
- It is notable that the R&D team made a major contribution to the COVID response (initially through FIT testing of masks and clinical redeployment, subsequently through crucial patient and public health trials). They are to be commended.
- Even in this strangest of years, the R&D team has maintained a number of KPIs.

The R&D team is also in the process of refreshing it's strategy. This incorporates the refreshed Trust objectives – recast through the lens of patient experience.

As discussed at Trust Board in June, three specific priorities are to:

1. Enable patients in all specialties to participate in NIHR portfolio research – there are currently gaps in some specialties
2. Provide bespoke support to clinicians who have the skills, drive and inclincation to develop their own grant-funded research programmes
3. Make an active decision in relation to the innovation agenda, and becoming (or not) a test-bed for commercial innovation.

We shall ensure that these aspects are woven into the draft strategy prior to formal adoption.

Welcome

We are delighted to present the 2020-2021 Annual Report on behalf of the Research and Development (R&D) Department at Milton Keynes University Hospital NHS Foundation Trust (MKUH).

As we welcome you to read this annual report, the Sars-Cov-2 (COVID-19) pandemic has continued to be the major focus of research at MKUH. The development of effective vaccines in record-breaking time has been an astonishing achievement and the UK has been at the forefront of this work through the Oxford-AstraZeneca vaccine collaboration.

Although the rare complication of blood clots has complicated its use in younger adults it remains a key and cost-effective part of the worldwide fight against the COVID-19 virus. MKUH has contributed to therapeutic and mechanistic studies in COVID-19 research in the past year such as the RECOVERY trial, ISARIC, GENOMICC, PRIEST, Remap-CAP, UKOSS and PAN-COVID. We have been amongst the highest recruiting hospitals of our size to the RECOVERY trial that identified Dexamethasone and Tocilizumab as having significant benefit in saving the lives of COVID-19 patients.

As we wrote last year, there has been a tremendous atmosphere of collaboration and enthusiasm from acute physicians, intensive care consultants and other colleagues across the Trust who have led these studies at MKUH. The R&D managers, research nurses and other research staff also delivered much of the mask FIT testing at MKUH and have worked tirelessly to support the key COVID-19 studies and to maintain critical non-COVID-19 studies throughout the pandemic. It is worth restating our view that the pandemic demonstrated in the clearest way possible the importance of resilient health and social care systems, the importance of staff, technology and materials and the critical importance of data and of clinical and basic science research in tackling the challenges of the pandemic. We hope that this will lead to greater investment in research and development in the future to tackle other challenges such as developing life-saving therapies for cancer, heart disease and inflammation.

As we write this, the UK Government is aiming to end restrictions over the next month or so and the hope is that the level of vaccination in the UK will avoid further lockdowns and life will start returning to normal. This in turn will allow the increasing resumption of our broader research portfolio.

Overall, MKUH continued to maintain a high level of recruitment of participants to COVID19 and other research studies with a total recruitment of 5,533 participants which is at the upper end of recruitment in the NIHR Research Activity League Table for Small Acute Trusts. Other notable activities this year include the regular meetings (by MS Teams) of the regional university networking group to develop collaborative research and training under the direction of Professor Oliver Pearce who has also been collaborating on research into the use of drones for medicines delivery. Antoanela Colda, R&D Manager has continued to lead, develop and motivate the R&D Team following the retirement of her co-manager, Sara Greig, who we thank for her many years of hard work and wish her the best for the future. The new Cancer Centre is now fully operational and is a great opportunity for us to expand our cancer research activities.

We were delighted to congratulate our R&D staff receiving awards at the Thames Valley and South Midlands NIHR Clinical Research Network (CRN) Awards Event in 2020 for their outstanding contributions to research delivery. This was hosted by Professor Joe Harrison and Professor Belinda Lennox at MKUH as a 'blended' on site and remote activity. We also congratulate Professor Attila Kardos and colleagues for the receipt of a grant to explore the use of artificial intelligence in cardiac imaging analysis.

We remain very grateful for the support that we receive from the Thames Valley and South Midlands NIHR Clinical Research Network who fund a significant part of our research team. We further thank the Trust and other hospital departments who have been very supportive of R&D activities. The R&D team has once more worked tirelessly to support clinicians and ensure that studies were done to the highest standards of good clinical practice.

As we have done previously we are presenting our activities as an infographic and hope you find it easy to read and that it again highlights our key COVID-19 and other research activities. If you need more information on any of our studies or about research at MKUH, please don't hesitate to get in touch.

Professor Simon Bowman
R&D Director

Dr Ian Reckless
Medical Director

Research and Development Strategic Aims April 2021-March 2026

Research and Development is one of the three key aims that make up Milton Keynes University Hospital Strategy.

In order to achieve our ambitious plans over these five years, R&D Team have six strategic themes. Our strategic aims for R&D are to:

1. Increasing research output and R&D income

2. Developing staff capacity and expertise in doing research

3. Enhancing our relationships with local, regional and national networks

4. Creating a robust R&D organisational structure and governance system

5. Developing research facilities

6. Raising the profile of R&D at MKUH internally and externally

Studies

MKUH are hosting, participating and supporting trials in a range of specialities. These include commercial, non-commercial and sponsored studies helping to increase research activity, increasing and improving opportunities for participation.

Speciality areas include:

- **Anaesthesia**
- **Cancer**
- **Cardiovascular**
- **Children**
- **Critical Care**
- **Dementias**
- **Dermatology**
- **Diabetes**
- **Gastroenterology**
- **Haematology**
- **Health Services**
- **Hepatology**
- **Infection**
- **Musculoskeletal**
- **Public Health**
- **Reproductive Health**
- **Stroke**
- **Surgery**
- **Trauma and Emergency**

Awards and Achievements

In 2020-2021 MKUH Research and Development Team received the following awards from the NIHR Thames Valley and South Midlands Local Clinical Research Network ; Highly Commended All-round High Performing Team; Highly Commended Research Nurse of the Year (Louise Mew) ; Recognition of contribution to research through the Research Fellowship Scheme 2020 (Annie Rose); Outstanding Research Champion (Edel Clare) and the Rising Star 2020 (Amy Oakley).

The R&D team was the highest recruiter nationally for several Trauma and Orthopaedic studies and advised other sites regarding our efficient and effective recruitment strategy for a Covid-19 study and MKUH was the first site in the U.K to recruit a participant into a complex cancer drug trial.

Patient satisfaction

Over the past year the importance of Research has been spotlighted. During this time patients have welcomed the approaches from the research team and have been willing to trial the medications which were thought to have potential to improve outcomes in the fight against COVID-19.

Being supernumerary allowed us to spend some time with isolated patients during the research process, provide some reassurance and meet some of the patients' comfort needs. This, along with keeping the clinical teams informed of the progresses in research was felt to be beneficial for all.

Many patients reported that they felt we were offering them a lifeline in the possibility of an additional treatment. Although we ensured all participants understood there may be no benefit, we felt they had more hope and optimism.

TheMKWay
CARE. COMMUNICATE. COLLABORATE. CONTRIBUTE.

NHS
Milton Keynes University Hospital
NHS Foundation Trust

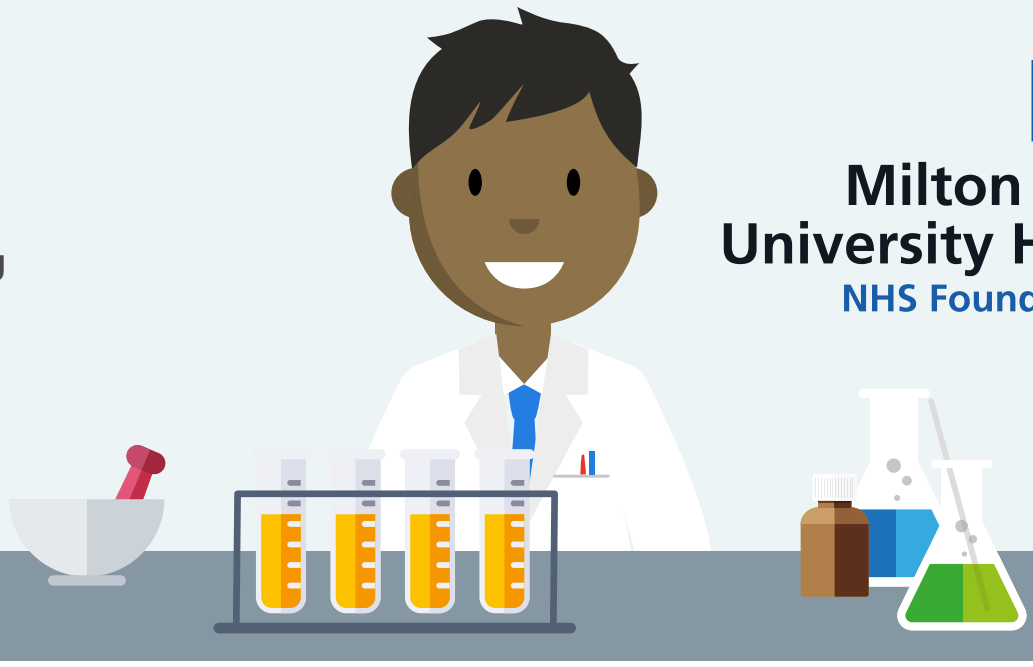
Get involved!

Want to learn more about research at MKUH?
Are you interested in getting involved? Contact the team today:
Jeannette Smith 01908-996685 or Veronica Edgell 01908-995137

Research & Development
Annual Highlights 2020/21

Highlights 2020/21

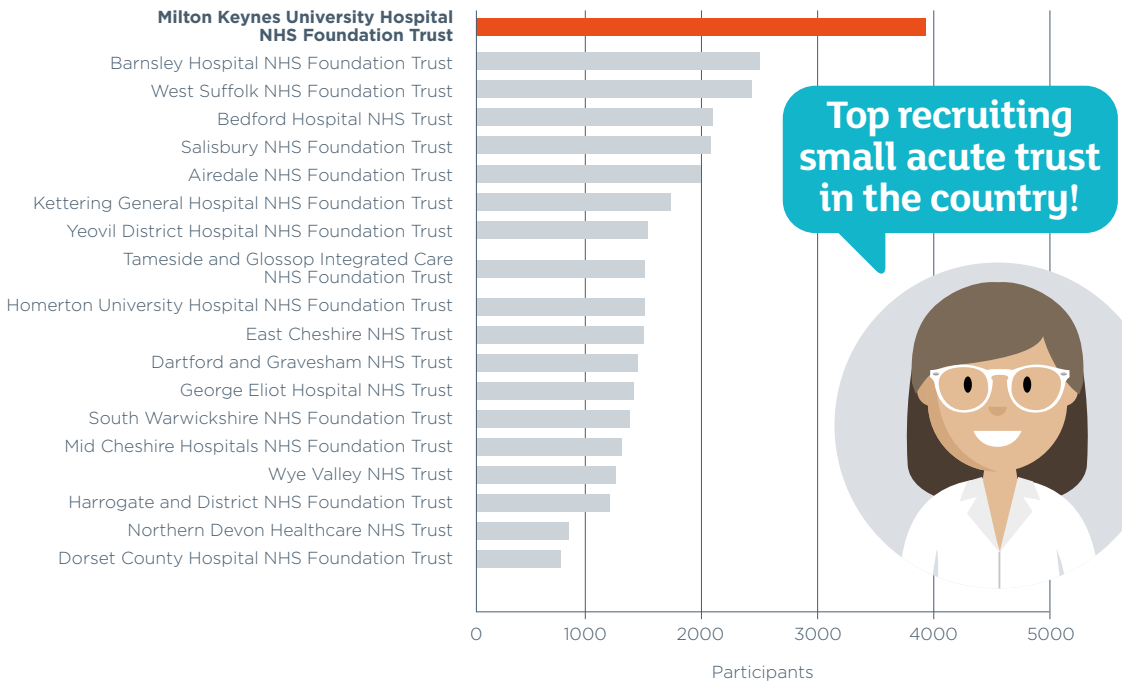
At Milton Keynes University Hospital (MKUH) we are committed to deliver high quality care giving patients in Milton Keynes and Buckinghamshire parity of access to clinical trials, providing them with the latest medical treatments/devices or offering our patients an alternative/additional choice of treatment through research.



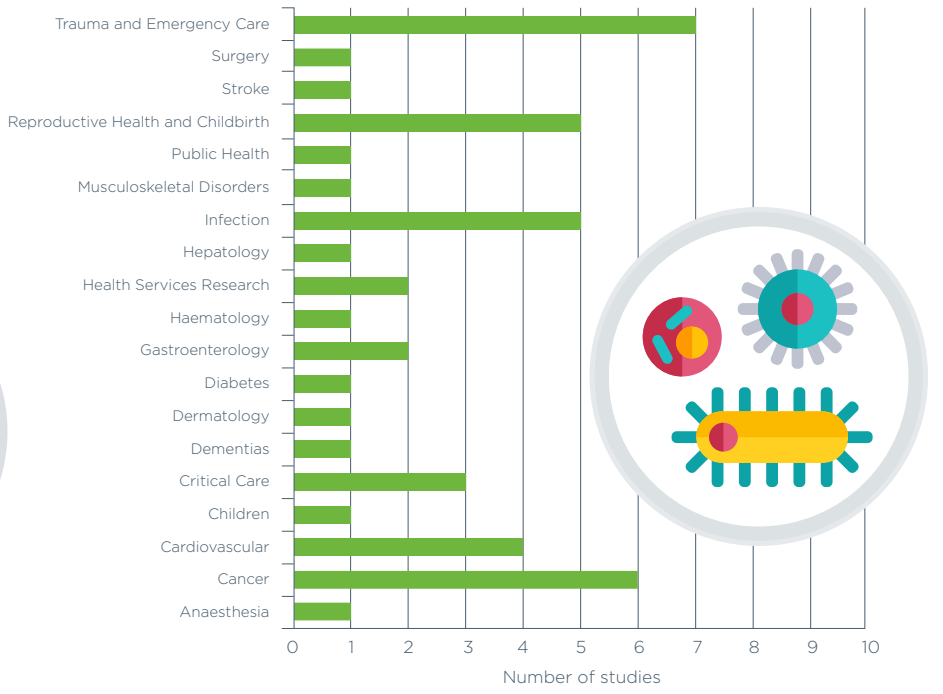
NHS
Milton Keynes University Hospital
NHS Foundation Trust

Performance:

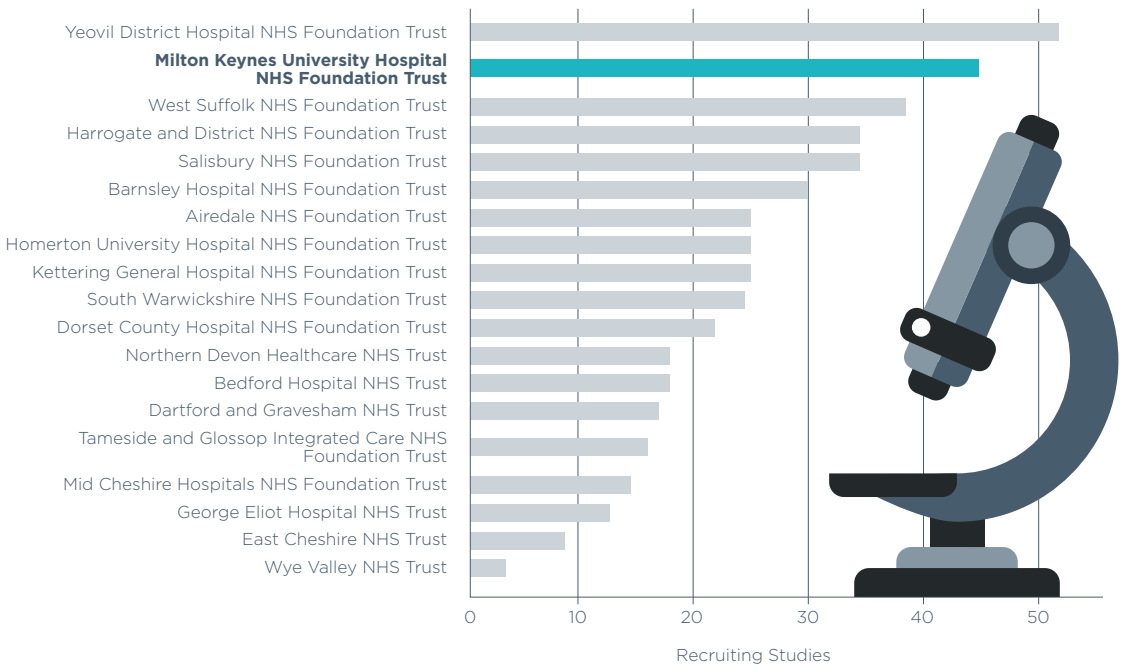
Participant recruitment at small acute trusts



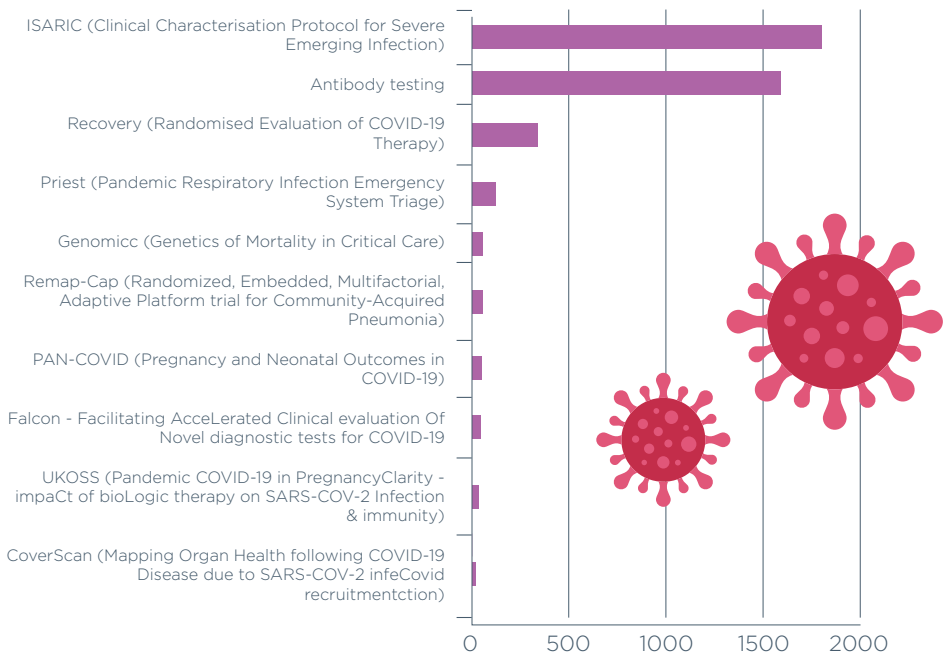
Clinical speciality recruitment areas



Number of recruiting studies at small acute trusts



COVID-19 study recruitment



Stats

4000+ participants
recruited to **21** Clinical research studies and **1,580** staff members recruited to COVID-19 Antibody testing.

MKUH R&D Dept has received
£754,000
in 2020/21 to deliver NIHR portfolio research.

7 studies have been sponsored by MKUH R&D Dept

Team quotes

Without the Research team, participating in the race for information and treatments through research would have been almost impossible at MKUH. Equally, without the support of the clinical teams across the hospital we would not have been able to contribute the numbers that we did. A huge collaborative effort, thank you all!

The positive attitude from managers and willingness to get involved during the pandemic and embrace change has filtered down to everyone in the department. Makes me proud to be part of this team.

We had to learn as we went along and pick up new skills like Mask Fit testing. Thanks to all for sharing your knowledge.

Raising the profile of R&D at MKUH

The team have continued to work hard to raise the profile of research in the Trust and wider community, supporting and engaging with:

- **Local media:** local and social media: highlighting patients and staff stories, patients and public engagement sessions, radio interviews
- **Events:** virtual school careers events, International clinical trials day, Event In The Tent
- **External collaborations** with local, national and international Universities and Partners
- **Trust level:** COVID-19 Antibody testing (1580 staff members recruited), supporting COVID-19 Vaccination Hub, FIT testing (over 2,500 staff members tested).

If you are interested in knowing more about research ask a member of staff about how to get involved or email **research@mkuh.nhs.uk**

** LATE DRAFT – for discussion at QCRC **
5 Year Research & Development (R&D) Strategy

April 2021-March 2026

Executive Summary & Strategic Aims

There is robust evidence that taking part in research is good for patients and good for hospitals. Milton Keynes University Hospital has had a successful three years as one of the top recruiting small hospitals in England of participants to National Institute for Health Research (NIHR) portfolio studies. Furthermore, we have risen to the challenge of the COVID-19 pandemic, recruiting patients to key national studies such as ISARIC, RECOVERY and REMAP-CAP among others. This strategy document allows us to build on our 2018-2021 strategy and to formally set out the current activities of the R&D Department and our ambitions for the next 5 years. Our strategy is to maintain our current position, allowing for some changes in emphasis/priorities and to continue to deepen and broaden our research activities over the next three years for patient benefit.

Our strategic aims for R&D are to:

- Increase our research output and R&D income
- Develop staff capacity and expertise in doing research
- Enhance our relationships with local, regional and national networks
- Establish robust R&D and governance structures delivering NIHR metrics
- Develop a dedicated research facility
- Raise the profile of R&D at MKUH and enhance clinician, patient and public engagement

At its heart this strategy is about ensuring that we have the 'basics' right to maximize our involvement in NIHR portfolio studies to the highest standards whilst also creating an environment in which we can take advantage of opportunities for innovation and 'own account' research and development as and when they arise.

The MK Way

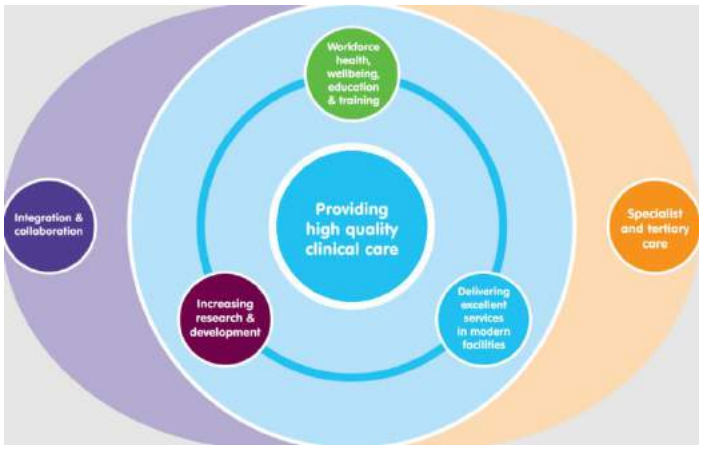
The MK Way is our refreshed vision, values, strategy and objectives for Milton Keynes University Hospital and have been developed in collaboration with our staff. These are all important as they provide the framework in which we operate, and our values particularly outline what we all believe is important in how we work.

All members of #TeamMKUH have a huge part to play in contributing to our goal of providing exceptional patient care and experience and through creating our new strategy, values and objectives, each and every staff member will understand how they can support the organization in delivering our vision.

Our Purpose, Vision, Values, Strategy and Objectives
Our Purpose*:* High quality care for everyone we serve.
Our Vision: for Milton Keynes University Hospital NHS Foundation Trust is to be an outstanding acute hospital and part of a health and care system working well together.
Our Values: We CARE, We COMMUNICATE, We COLLABORATE, We CONTRIBUTE
Our Strategy: has five key priorities which will help us to be an outstanding acute hospital and part of a health and care system working well together.
Our Objectives include: Keeping you safe in our hospital; Improving your experience of care; Ensuring you get the most effective treatment; and, Increasing access to clinical research and trials.

R&D Vision:

To deliver high quality patient care through robust and innovative research and development



Introduction

Milton Keynes University Hospital (MKUH) is committed to delivering high quality clinical care. Patients who are cared for in a research-active hospital have better overall healthcare outcomes (1), lower overall risk-adjusted mortality rates following acute admission (2) and better cancer survival rates (3,4). Furthermore, health economic data shows that interventional cancer trials are associated with reduced treatment costs benefitting the NHS financially (5). These benefits may result from a culture of quality and innovation associated with research active institutions. There is a reasonable further assumption that departments and clinicians within the Hospital, who are research active, provide better care. In turn, this suggests that it is desirable to encourage as many clinicians and departments to become research active as is practicable.

COVID-19

COVID-19 led to a near-complete interruption of research in the UK during 2020 and a rapid replacement by studies directed at tackling COVID-19. MKUH participated in a number of national studies delivered through Urgent Public Health including RECOVERY, REMAP-CAP, Genomicc, PRIEST, FALCON and ISARIC. In addition, we facilitated Department of Health studies into antibody testing. The timeframe for partial or full resumption of non-COVID research is uncertain and depends on how the pandemic and the response to this unfolds but we expect to fully restart non-COVID research and to continue to actively deliver research according to NIHR priorities over the next 5 years.

With regard to the major challenge of COVID-19 Dr Louise Wood, Director of Science, Research and Evidence at DHSC and co-lead for NIHR said:

"I appreciate the fantastic job thousands of research staff have been doing over several months in very difficult circumstances (both at work and in their personal lives) and recognise that, despite huge commitment and resilience from the research delivery workforce, R&D office staff and the NIHR, the capacity in the system is finite. We are reaffirming the priorities set out in the Restart Framework and specifying COVID-19 UPH vaccine and prophylactic studies and platform therapeutics trials as the top priority for research infrastructure support. I encourage you to use the prioritisation framework to support and enable local decision making about the allocation of resources. The NIHR CRN High Level Objective associated with Restart is an ambition and not a target. "

National Priorities and the National Institute for Health Research (NIHR)

The NHS is committed to research through its Constitution and through its operational plans, policy frameworks and planning guidance. The main organization delivering research in the NHS is the National Institute for Health Research (NIHR). The NIHR's budget in 2020-2021 is £285,852,633, made up of £226,023,878 of fixed funding, £56,505,968 of variable funding, £2,070,141 of top-sliced funding and £1,252,646 of excess treatment costs.

Fifteen Local Clinical Research Networks (LCRNs) support the delivery of NIHR adopted portfolio research, to ensure patient access to research across England. MKUH is a member of the Thames Valley and South Midlands (TVSM) LCRN, hosted by Oxford University Hospitals NHS Foundation Trust. The 2020-2021 funding allocation for TVSM LCRN is £16,017,123. MKUH will receive £755,00 of this in 2020-2021. Our assumption is that overall NIHR funding and the proportion allocated to MKUH is likely to be broadly similar over the next 5 years. (https://www.nihr.ac.uk/documents/nihr-local-clinical-research-network-funding-allocations-202021/11735

NIHR high level objectives:
The NIHR CRN measures its effectiveness against a set of High Level Objectives which we will embed into the MKUH R&D strategic and operational plans wherever practicable. These objectives include:

- Increasing the proportion of CRN Portfolio studies that deliver in line with the study's planned delivery time and participant recruitment targets
- Increasing the number of research participants
- Reducing the time it takes for a study to set up and start at each research site
- Increasing the number of life-sciences studies supported by the CRN
- Increasing the number of health and care organisations active in research
- Increasing the number of participants involved in research into dementias
- Demonstrating to research participants that their contribution is valued

https://www.nihr.ac.uk/about-us/our-contribution-to-research/research-performance/clinical-research-network-performance.htm

National Institute for Health Research http://www.nihr.ac.uk/
Heath Research Authority (HRA) http://www.hra.nhs.uk/

MKUH Research Output and Research Income

NIHR LCRN funding provides most of MKUH R&D income. This supports the salaries of R&D staff in exchange for MKUH clinicians recruiting participants to NIHR portfolio studies, thereby providing benefit to patients, clinicians and to MKUH. In the last three years Milton Keynes University Hospital NHS Foundation Trust has delivered significant achievements in R&D, increasing research activity and engaging clinicians across most speciality areas.

In the financial year 2015/2016, 2018/19 and 2019/2020 we were the top recruiting small acute hospital for NIHR LCRN Portfolio studies in England. We plan to deliver a sustainable R&D budget that manages risks associated with income and expenditure variation from year to year whilst living within our means. In 2020-2021 total R&D income was £933k very close to our target of £1M which we expect to reach within the next 5 years.

Increase recruitment to NIHR LCRN Portfolio Studies:
To maintain our position as a high recruiting small acute hospital over the next 5 years, to increase the number of participants recruited into NIHR LCRN Portfolio studies according to NIHR and MKUH strategic priorities whilst delivering a sustainable budget.

Increase our commercial research studies:
Commercial studies offer patients access to new treatments, diagnostic tools and/or devices which may otherwise be unobtainable. For some patients, eg those under cancer care, commercial research may present a last option when all avenues of standard care are exhausted. Commercial Research also brings in additional revenue for the Trust, for us to reinvest further into research. Our focus is on phase II-IV. We have no phase I programme (first in man). We aim to increase the number of commercial NIHR LCRN research studies performed at MKUH over the next 5 years.

Develop investigator led 'own account' research and external grant income:
'Own account' investigator-led research provides an opportunity for clinicians to develop their own ideas, individually or in partnership with external partners, to bring in grant income and to offer new approaches to clinical assessment or therapy for patient benefit and thereby enhancing the reputation of the Trust. In order to support this, we provide general advice/signposting and R&D expertise (e.g. in protocol and grant writing, completing Research Ethics Committee applications, trial design, data management and analysis, quality assurance and pharmacovigilance), to research-active clinicians who wish to develop their 'own account' investigator led research. We will offer this support directly wherever possible or through networking/signposting to external support where we do not have this expertise in house. Wherever possible we will encourage 'own account' research to be delivered through external grant funding and study registration on the NIHR research portfolio. Examples of 'own account research at MKUH include **VECTRA-ECG** (Validation study to assess the utility of a cardiac electrical biomarker (CEB) in patients with chest pain and **CHESS** (ChroniSense National Early Warning Score Study of a wearable wrist device to measure vital signs in hospitalized patients). Over the next 5 years we aim to develop increased R&D support and advisory services for clinicians at MKUH to develop their own account research and applications for external grant funding

Developing Staff Capacity and Expertise in Doing Research

Research active clinicians are more likely to deliver high quality patient care. The R&D Department will therefore continue to encourage staff to engage in research and to ensure that staff have the necessary knowledge, skills and confidence to carry out high-quality research. We will facilitate the completion of Good Clinical Practice training by staff members involved in, or wanting to become involved in research, as well as completion of other core research training offered by the NIHR for research active staff, for example, Principal Investigator oversight training, research awareness, fundamentals of clinical research. We are committed, therefore, to support and develop a sustainable workforce with the skills to deliver high quality research at MKUH.

We will encourage and support the recognition of research activity in appraisals, revalidation and job plans for existing research active staff. We aim to work with divisional research leads to promote and increase the understanding by all MKUH staff of the importance of research and innovation in high quality clinical care.

We will encourage the Trust to include research roles and responsibilities into job descriptions for new appointments where appropriate. We will explore the potential for this to include trainee medical and non-medical staff undertaking research projects and education as well as service (eg as Clinical Fellows), together with their Clinical/Educational Supervisors. Where appropriate we will engage external partners in developing these roles.

We will explore the potential for clinical nurses to gain a better understanding of the research nurse role. We will also explore potential secondment opportunities for nursing and other health care professionals within the R&D team and encourage participation of staff in developing small research and practice development projects.

Networks & Innovation

A major strength of Milton Keynes University Hospital NHS Foundation Trust is that we are based in an enviable location in the golden triangle between Oxford, Cambridge and London with existing or developing relationships with several Universities.

1. The University of Buckingham
2. The Open University
3. The University of Bedford
4. Cranfield University
5. University of Oxford
6. University of Warwick
7. Other interested academic centres (overseas)

Milton Keynes has the 2nd fastest growing economy in the UK. It will have an estimated population of 310,000 by 2026. MKUH already has a strong partnership with the University of Buckingham through the new medical school. There is also a longstanding agreement to teach University of Oxford medical students. As clinical research at MKUH develops we are committed to strengthening existing

partnerships and building new ones to develop innovative research and we will respond to new opportunities as they arise. We also have strong relationships with the Oxford Academic Health Sciences Network and through this with the Milton Keynes Chamber of Commerce. We aim to expand our existing relationships with Universities and health sector commercial organizations and to develop innovative approaches to healthcare through clinical studies.

Establishing Robust R&D & Governance Structures and Reporting Metrics

The R&D Department and R&D Steering Committee is responsible through the Quality Committee to the Medical Director and Trust Board and meets regularly to review R&D activities and advise the Medical Director. The Steering Committee includes clinical staff as well as public/patient representation.

Most research studies are LCRN adopted with nationally determined approvals and monitoring processes that MKUH R&D facilitates locally. For studies where MKUH is acting as sponsor the same level of assessment and quality assurance is in place through Trust based Standard Operating Procedures underpinned by sound financial processes. The R&D Steering Committee is responsible for maintaining and monitoring the R&D risk register.

R&D Nursing Capacity & Pharmacy Support

Capacity is an issue throughout NHS R&D in relation to pharmacy and nurse specialist/administrative support for research studies. We will work with Oxford and Thames Valley LCRN to look to minimize the number of studies that we are unable to perform at MKUH due to these capacity limitations.

Reporting Metrics

1. Recruitment of first participant to a clinical trial within 70 days of receipt of a valid research application and meeting associated national standards
2. Recruitment to time and target for commercial trials
3. Submission of annual and completion reports by principal investigators for 'own account' research studies
4. Publications arising from research at MKUH
5. Record of studies rejected due to capacity issues

Developing Research Facilities

In order to physically see and assess research participants it is an increasing priority for the research team to secure a dedicated facility including consulting rooms, a waiting area and an area for storage of clinical trials equipment, centrifuges, consumables, a freezer and appropriate safety level hoods for processing of samples. We aim to develop a business plan for this as the opportunity arises for further hospital site development.

Raising the Profile of R&D at MKUH

Over the past 3 years R&D at MKUH has increased the profile of research within the Trust, TV&SM LCRN and nationally through various activities. These have ranged from meetings with research participants and research champions to training and teaching sessions and task group sessions. We have continuously expanded our interactions and contributions. Members of the R&D team regularly participate in radio interviews, publish quarterly patient's stories with support from the LCRN communications team and we are planning to continue, develop and grow these activities over the next 5 years.

R&D at MKUH actively participates in several the Trust's Boards such as the Clinical Quality Board, the Patient and Family Experience Board, Nursing, Midwifery and Therapies Board and in external Boards such as that of the AHSN.
We will continue to raise the profile of R&D at MKUH internally and externally and develop an improved web presence on the MKUH internet and intranet pages to inform and engage patients and the public as well as staff and other clinicians about research taking place at MKUH

Monitoring and Reporting

This strategy will be reviewed annually by the R&D Steering Committee reporting to the Clinical Quality Board along with an annual report underpinned by detailed financial management.

References

1. Boaz A, Hanney S, Jones T, et al. Does the engagement of clinicians and organisations in research improve healthcare performance: a three-stage review, BMJ Open. 2015; 5(12):e009415

2. Ozdemir BA, Karthikesalingam A, Sinha S, Poloniecki JD, Hinchliffe RJ, Thompson MM, et al. Research Activity and the Association with Mortality. PLoS ONE 2015: 10(2).

3. Rich AL1, Tata LJ, Free CM, Stanley RA, Peake MD, Baldwin DR, Hubbard RB. (2011) How do patient and hospital features influence outcomes in small-cell lung cancer in England? Br J Cancer. 2011 Sep 6;105(6):746-52.

4. Downing A, Morris EJA, Corrigan N,et al. High hospital research participation and improved colorectal cancer survival outcomes: a population-based study. Gut. 2017 Jan;66(1):89-96.

5. Liniker E, Harrison M, Weaver JM, Agrawal N, Chhabra A, Kingshott V, Bailey S, Eisen TG, Corrie PG. Treatment costs associated with interventional cancer clinical trials conducted at a single UK institution over 2 years (2009-2010). Br J Cancer. 2013 Oct 15;109(8):2051-7.

TheMKWay
CARE. COMMUNICATE.
COLLABORATE. CONTRIBUTE.

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

Maternity Services Update

Trust Board November 2021

Nicky Burns-Muir

Director of Patient Care and Chief Nurse

Executive Maternity Lead and Maternity Safety Champion

BACKGROUND

Maternity services have been under significant scrutiny for a number of years with ‘Better Births’ the report of the National Maternity Review in 2016, which set out a vision for maternity services in England which are safe and personalised.

At the heart of this vision was the drive that women should have continuity of the person looking after them during their maternity journey; before, during and after the birth. NHS England launched the transformational change of maternity services with the implementation of Continuity of Carer (CoC), to ensure safe care based on a relationship of mutual trust and respect, in line with the women's decisions.

The Ockenden review, published on the 10th of December 2020, set out initial findings from the independent review of the maternity services at Shrewsbury and Telford Hospital NHS Trust. Recommendations included the requirement to undertake a workforce gap analysis and set out plans to meet Birthrate Plus standards for maternity workforce transformation. The Ockenden review funded MKUH for a further 10WTE Midwives to support the uplift of Midwives required to deliver the CoC model and meet the Birthrate Plus standards, and for a specialist Fetal Surveillance Midwife.

CONTINUITY OF CARER MODEL

The Continuity of Carer model provides a mechanism whereby Midwives can gain a holistic understanding of women's needs and triage women to the new forms of best practice care, such as the elements of Saving Babies' Lives care bundle.

Research informs us that mortality rates remain high for black and asian babies and those born to mothers living in the most deprived areas.

Continuity of Carer models help reduce baby loss, preterm birth hospital admissions, the need for intervention during labour and improve the women's experience of care .

MKUH position 43% Continuity of Carer, which equates to approximately 1500 women being cared for within this model. 65% of the caseload are from deprived areas and 45% are BAME women.

STAFF DEVELOPMENTS

Midwifery Staffing

- Awaiting a comprehensive implementation plan before roll out of more CoC teams
- Implement availability of Midwives for elective section lists - **Actioned**
- CoC Midwives allocated for postnatal discharges and NIPE - **Actioned**
- Registered Nurses pilot on Ward 9 - **Actioned** (Evaluation underway)
- International recruitment - MKUH are part of an East of England initiative
- Virtual open days for recruitment

Medical Staffing

- Implementation of a 'two middle grade on-call system' from August 2021 – over and above RCOG/HEE requirements *(internally funded - + 3 middle grades, -1 SHO)*
- Following Ockenden review – agreement and funding to increase consultant establishment by 1.3 WTE *(additional internal funding and job planning agreed to recruit 2 WTE, interviews held and offers made)*

ACTIVITY DATA

- Significant increase in births in 2021/22
- Relatively stable elective/emergency C-Sections
- Increase in admissions to NNU Q1 (Ward 10 closed)
- Bed days increased, 500 more bed days in Q1 2021/22
- Neonatal bed days increased by 226 in Q1 2021/22

Year	Q	Births	IOL	Elect C-Sect	Emerg C-Sect	Admit NNU
19/20	1	838	36%	15.3%	18.5%	12.4%
20/21	4	815	43.7%	18.3%	19.9%	10.8%
21/22	1	975	31.3%	17.89%	19%	12%
21/22	2	987	27%	16.3%	18.7%	11%

MATERNITY SAFETY INITIATIVES

- Maternity Safety Champions – Medical Director, Chief Nurse and Non-Executive Director. This initiative also addresses issues raised in the Ockenden review, recommendations regarding the disconnect between 'ward and board' and facilitates the escalation of concerns to senior leaders

- Chief Nurse and Medical Director meet bi-monthly with all of the Senior Maternity and Neonatal Teams providing an opportunity to discuss issues and raise concerns

- A major element of safe maternity care is the focus to support **multidisciplinary teams training together** and further develop skills and experience in leadership, multi-professional team communication, human factors and situation awareness, cardiotocography (CTG) as well as major free and obstetric emergencies skills and drills

- Maternity Voice Partnership (MVP) meet monthly with Chief Nurse for feedback and discussion on areas for improvement and positive feedback received via their communication channels

Meeting title	Board of Directors	**Date:** November 4th 2021
Report title:	Nursing Staffing Report	**Agenda item:**
Lead director **Report author** **Sponsor(s)**	**Name:** Nicky Burns-Muir **Name:** Matthew Sandham Emma Thorne	**Title:** Director of Patient Care/Chief Nurse **Title:** Associate Chief Nurse Workforce Matron
FoI status:		

Report summary							
Purpose *(tick one box only)*	**Information**	x	**Approval**		**To note**	**Decision** x	
Recommendation	That the Board receive the Nursing Staffing Report.						

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

Report history	To every Public Board
Next steps	
Appendices	Appendices 1

Board of Directors Report on Nursing and Midwifery staffing levels Amalgamated report for August and September 2021

1. Purpose

To provide Board with: -

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

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

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

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

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

CHPPD	Total Patient Numbers	Registered Midwives/Nurses	Care Staff	Overall
August	13419	4.2	2.8	7.1
September	13552	4.1	2.8	6.9

Month	**RN/RM Day % Fill Rate**	**HCA/MCA Day % Fill Rate**	**RN/RM Night % Fill Rate**	**HCA/MCA Night % Fill Rate**
August	69.8%	78.2%	93.7%	107.1%
September	66.3%	75.0%	91.9%	106.5%

- *August and September 2021 data are included in Appendix 1.*

Areas with notable fill rates

During the months of August and September the Trust saw a continued rise in attendance which has affected the CHPPD hours in the month of September. The Day % fill rate has dropped in both August and September.

Are we safe ?

3. Recruitment Overview

The Tables below are the residual numbers of vacancies.

Medicine

Band	WTE Vacancy	Percentage	Turn over percentage
Band 2	23.56WTE	12%	6.9%
Band 5&6	50 WTE	15%	6%

Medicine's Band 5's has increased due to a small number of staff going on Maternity leave, areas of note are wards 17 and 22.

Surgery

Band	WTE Vacancy	Percentage	Turn Over percentage
Band 2	13.11WTE	5 %	6%
Band 5&6	23.16 WTE	8 %	5%

Surgery has reduced the number of Band 2 vacancies by 3 WTE. Band 5 vacancies have slightly increased 3.5 WTE in theatres.

Children

Band	WTE Vacancy	Percentage	Turn Over percentage
Band 2	1.89 WTE	4%	6 %
Band 5&6	5.6 WTE	9 %	2%

Paediatrics have successfully recruited 7 WTE Band 5 nurses leaving the 5.6 WTE residual vacancies.

Maternity

Band	WTE Vacancy	Percentage	Turn Over percentage
Band 2	0.54 WTE	N/A	3%
Band 5&6	9 WTE	9%	6%

Maternity have offered 5 WTE midwives that qualify in March 2022.

4. Recruitment

Student Nurse to Bank Initiative

Student Nurses have been fast tracked onto the hospital Bank as HCSW. This opportunity allows students to undertake paid work to complement their nurse training. Therefore, allowing our students to earn on a flexible basis and around their university studies.

The Tables below track the number of students on placement over the next three years.

2022	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
BSc Adult Nursing		3		10					1	20		
BSc Children & Young People Nursing									4	7		
Bsc Midwifery				8					17			
Trainee Nurse Associates					2					7		
Nurse Associate to RN												
Total	0	3	0	18	2	0	0	0	22	34	0	0

2023	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
BSc Adult Nursing	2			5					4	24		
BSc Children & Young People Nursing				3					4	3		
Bsc Midwifery									12			
Trainee Nurse Associates				5								
Nurse Associate to RN					2	3						
Total	2	0	0	13	2	3	0	0	20	27	0	0

2024	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
BSc Adult Nursing	7	2		8						TBC		
BSc Children & Young People Nursing				2								
Bsc Midwifery	4			5					TBC 16			
Trainee Nurse Associates												
Nurse Associate to RN												
Total	11	2		15								

Band 5

Recruitment campaigns continue to be successful. More recently Divisions have been supported to undertake bespoke adverts, focusing on harder to recruit areas or areas with higher vacancies.

The table below shows the current recruitment activity for the week of 11th October 2021.

Department	Role	Closing Date
Bank	Staff Nurse	18th October
Ward 3	Sister/Charge Nurse	20th October
Fracture Clinic	Staff Nurse	15th October
Paediatrics	Community Sister	15th October
Ward 19	Staff Nurse	15th October
Ward 19	HCA	15th October
Ward 15/16	Staff Nurse	21st October
Ward 20	Sister/Charge Nurse	21st October
Emergency Surgical Clinic	Staff Nurse (Internal)	22nd October
Ward 19	Sister/Charge Nurse	22nd October
Medicine	Staff Nurse	27th October
Surgery	Staff Nurse	27th October
Bank	Student Nurse	27th October
NNU	Advanced Nurse Practitioner	13th October

International Nurse Recruitment

The Trust has announced the commitment to recruit 125 International registered Nurses and Midwives to support vacanciesand to ultimately ensure patients at MKUH receive safe, effective care.

The Trust Board will be updated with progress at the January 2022 Trust Board meeting.

Are we effective?

5. Establishment Reviews

The Chief Nurse has now undertaken establishment reviews across all inpatient areas. The focus of the establishment reviews has been to:

- Review the funded establishment
- Review staff in post
- Review vacancies and plans for recruitment
- Review the current needs of the patient group, the service and national agendas.
- Review of turnover rates
- Review Safety
- Review of SafeCare and Healthroster compliance
- Professional judgement conversations.

Table below details the establishment reviews undertaken and the actions associated with them to date.

Ward	Establishment Review Actions
2	Business case required to ensure establishment reflects assessment staffing requirements.
7	Establishment of Acute Stroke unit supernumerary bleep holder to be business cased.
8	To review the activity of elective admissions. Budget to be reviewed to support an additional registered nurse shift for acuity and elective admission day – unaccounted for activity . To add ward attenders to safeCare Tasks. Nurse Led Discharge for elective patients to be explored
15	Review skill mix template/staffing model Review skills and training needs analysis (TNA) and look at the educational support required. To work up plan of a potential future High Dependency Unit (HDU)model/respiratory model (including Ward 16).
16	Review skill mix template/staffing model - considering additional Band 6 support for NIV patients . Review skills and look at the educational support required to develop current staff. To meet with Healthroster & Workforce Matron to amend Band 2 template.
17	Review skills and training needs analysis (TNA) and look at the educational support required.
18	Review skills mix and staffing template To consider additional Nurse Associates roles into staffing model.

19	Staffing establishment to be reviewed against acuity business case required once staffing establishment reviewed. To ensure that Staff Datix staffing associated issues.
20	Review skill mix against safecare tool. HDU model for surgical patients to be considered.
21	Establishment and business case presented to Executive Directors
22	To advertise for Staff Nurses adopting the 5-step recruitment tool. Consider skill mix and staffing model. Consider the education programmes on offer. Consider ACP roles and how this would sit on Ward 22/14
24	Establishment and business case presented to Executive Directors
25	To support and develop the new Band 6 Sisters/Charge Nurses. To explore and consider how the ward could utilise and enhance care by using Nurse Associates.
ED	Establishment sheet to be reviewed. Matron to map establishment against Royal Colleague of Nursing standards and complete gap analysis.
Maternity	Establishment paper presented to Trust Board as part of the Ockenden Report.

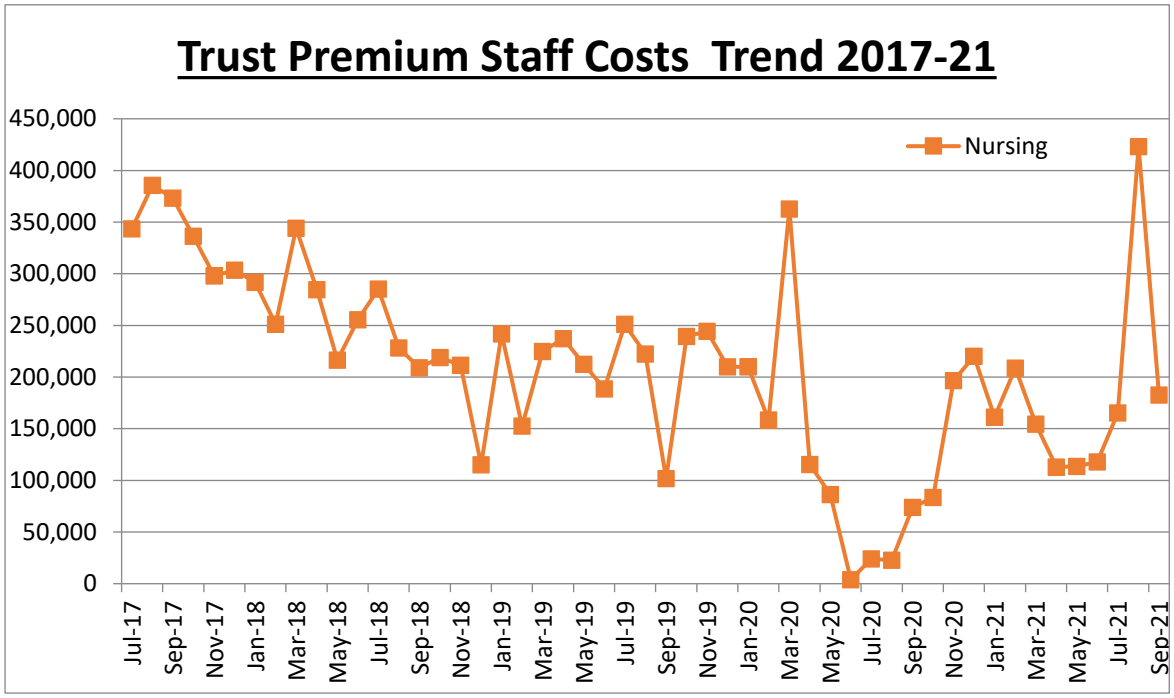
6. SafeCare Tool Update

SafeCare is now 'live' in all in patient wards across the organisation. Trust wide compliance currently sits at 75% compliance rate (a noted decline from previous months).

SafeCare has been used to assist the Chief Nurse with establishment reviews over the last three months. The data has helped in triangulating information. In particular, providing information on the Care Hours Per Patient Day (CHPPD) vs the actual CHPPD available.

SafeCare continues to be used during the Trusts 'Daily Safety Huddle' and Matrons refer to this SafeCare when reviewing staffing and assessing safety across the organisation. To review the Trusts SafeCare practice we have invited a Senior Workforce Transformation Manager to undertake an external review. This visit is scheduled for Tuesday 16th November 2021.

7. Agency graph



During the period of August, we saw the agency cost rise. This has been driven by increased capacity and staff sickness. September dropped back to within normal range.

We celebrate.

We are pleased to announce that Emma Codrington Divisional Chief Nurse has been successful in gaining a place on the Elizabeth Garret NHS Leadership Programme MSc and Lisa Viola Matron for Neonatal has also been successful gaining a place on the Florence Nightingale Foundation Aspiring Director course.

Following a successful recruitment we have offered the following staff the opportunity to undertake a Chief Nurse BAME Fellowship Programme commencing December 2021.

Adelaide Atu – Senior Sister Ward 2
Mariama Bah Sister Ward 1
Helen Omoloyin Staff Nurse Ward 17
Dinusha Fernado Sister Theatres
Alice Holland Staff Nurse Theatres

Each will have a bespoke leadership programme including shadowing opportunities , reverse mentoring and undertake corporate projects to learn QI methodology and influence change .

Appendix 1

Nursing, Midwifery and Care Staff August 2021

Ward Name	Day		Night		Care Hours Per Patient Day (CHPPD)			
	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
AMU	75.40%	70.40%	95.00%	108.00%	732	4.6	1.9	6.5
ICU	65.00%	82.80%	76.90%	-	208	24.6	1.3	25.9
Ward 2	75.20%	87.70%	131.70%	133.90%	689	4.5	3.1	7.5
NNU	73.60%	64.80%	91.90%	96.80%	438	9.3	1.5	10.7
Ward 14	-	-	-	-				
Ward 10	20.20%	2.30%	9.00%	0.00%	87	1	0.1	1.1
Ward 15	77.10%	77.70%	100.30%	108.10%	750	3.8	2.4	6.3
Ward 16	73.70%	85.10%	92.70%	119.40%	768	3.5	2.6	6.1
Ward 17	69.00%	99.90%	97.00%	133.50%	776	3.8	2.4	6.2
Ward 18	73.70%	90.60%	101.80%	136.60%	844	2.9	3.6	6.5
Ward 19	74.80%	82.70%	106.20%	124.70%	882	2.9	3.2	6.1
Ward 20	77.40%	70.10%	99.10%	103.30%	714	3.9	2.8	6.8
Ward 21	64.00%	73.20%	81.50%	88.70%	399	5.9	3.2	9.1
Ward 22	69.70%	76.70%	118.20%	103.30%	441	5.7	5.6	11.3
Ward 23	74.60%	88.80%	98.40%	109.10%	1091	3.2	3.6	6.8
Ward 24	66.90%	67.80%	82.60%	87.10%	273	6.6	4.5	11.1
Ward 3	60.00%	60.90%	78.30%	78.30%	720	3.3	3.3	6.7
Ward 5	67.50%	82.60%	113.00%	141.20%	485	7.2	1.8	9
Ward 7	70.70%	79.60%	100.00%	117.20%	679	3.5	3.9	7.4
Ward 8	65.80%	72.80%	97.80%	103.20%	732	3.1	2.3	5.4
Ward 9	60.10%	80.40%	67.00%	84.70%	1104	1.6	1.2	2.8
Ward 25	68.10%	82.10%	98.00%	104.80%	607	4.1	3	7.2

Nursing, Midwifery and Care Staff September2021

Ward Name	Day		Night		Care Hours Per Patient Day (CHPPD)			
	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
AMU	72.60%	71.70%	95.00%	93.20%	619	5.4	2	7.5
ICU	65.30%	69.00%	77.80%	-	200	25.1	1.6	26.6
Ward 2	67.50%	66.50%	122.90%	105.00%	737	3.7	2.2	5.9
NNU	71.80%	62.00%	92.50%	90.00%	371	10.5	1.6	12.1
Ward 14	-	-	-	-				
Ward 10	-	-	-	-		-	-	-
Ward 15	64.80%	86.30%	82.60%	133.30%	692	3.4	2.9	6.3
Ward 16	70.00%	81.80%	94.20%	113.30%	843	3	2.2	5.2
Ward 17	68.30%	85.50%	99.20%	128.30%	765	3.7	2.1	5.8
Ward 18	65.40%	71.90%	100.00%	134.40%	670	3.2	3.9	7.2
Ward 19	71.30%	75.90%	99.40%	126.90%	857	2.6	3	5.7
Ward 20	65.00%	70.20%	101.00%	101.10%	722	3.4	2.7	6.1
Ward 21	65.30%	77.40%	89.20%	85.00%	461	5.4	2.7	8.1
Ward 22	64.70%	80.00%	111.80%	95.80%	541	4.2	4.4	8.6
Ward 23	74.30%	83.50%	98.60%	113.90%	1022	3.4	3.7	7.1
Ward 24	57.60%	70.30%	81.10%	93.80%	341	4.6	3.7	8.3
Ward 3	56.20%	69.80%	86.70%	95.00%	1206	3.2	3.4	6.5
Ward 5	66.40%	83.50%	98.00%	86.70%	488	6.5	1.7	8.2
Ward 7	68.00%	73.60%	100.00%	107.40%	669	3.4	3.6	7
Ward 8	64.50%	71.80%	99.00%	115.00%	731	2.9	2.4	5.3
Ward 9	55.70%	63.20%	58.40%	65.60%	1061	2	1.4	3.4
Ward 25	72.20%	79.30%	96.80%	121.60%	556	4.7	3.4	8.1

TheMKWay
CARE. COMMUNICATE.
COLLABORATE. CONTRIBUTE.

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

Nursing and Midwifery Strategy 2022-25

Proud Ambitious Courageous









Welcome to Ward 20











Message from Nicky Burns-Muir

Chief Nurse and Director of Patient Care

I am delighted to present our Nursing and Midwifery Strategy 2022-2025 which sets out our strategic ambitions for the coming years. This is an exciting time to be part of the MKUH team. This strategy has been co-produced across the organisation with midwifery and nursing teams. We are inspiring and developing the workforce and profession for the future.

It is vital that the nursing and midwifery workforce offers enough flexibility and innovation to meet future changes in models of care delivery. We will do this through leadership, education and professionalism and develop competent, confident, critical thinking and innovative nurses and midwives.

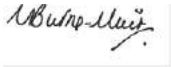
Whatever your role within the MKUH nursing and midwifery family this strategy is for you and we must hold ourselves to account for the implementation of the strategy.

We have much to be proud of here at MKUH in the care nursing and midwifery teams deliver.

We must take this opportunity to make this strategy a reality that is embedded in everything we do.

I am immensely proud to be your Chief Nurse and I will be your greatest advocate

and ensure the voice of nursing and midwifery is heard at all levels of the organisation.



Introduction

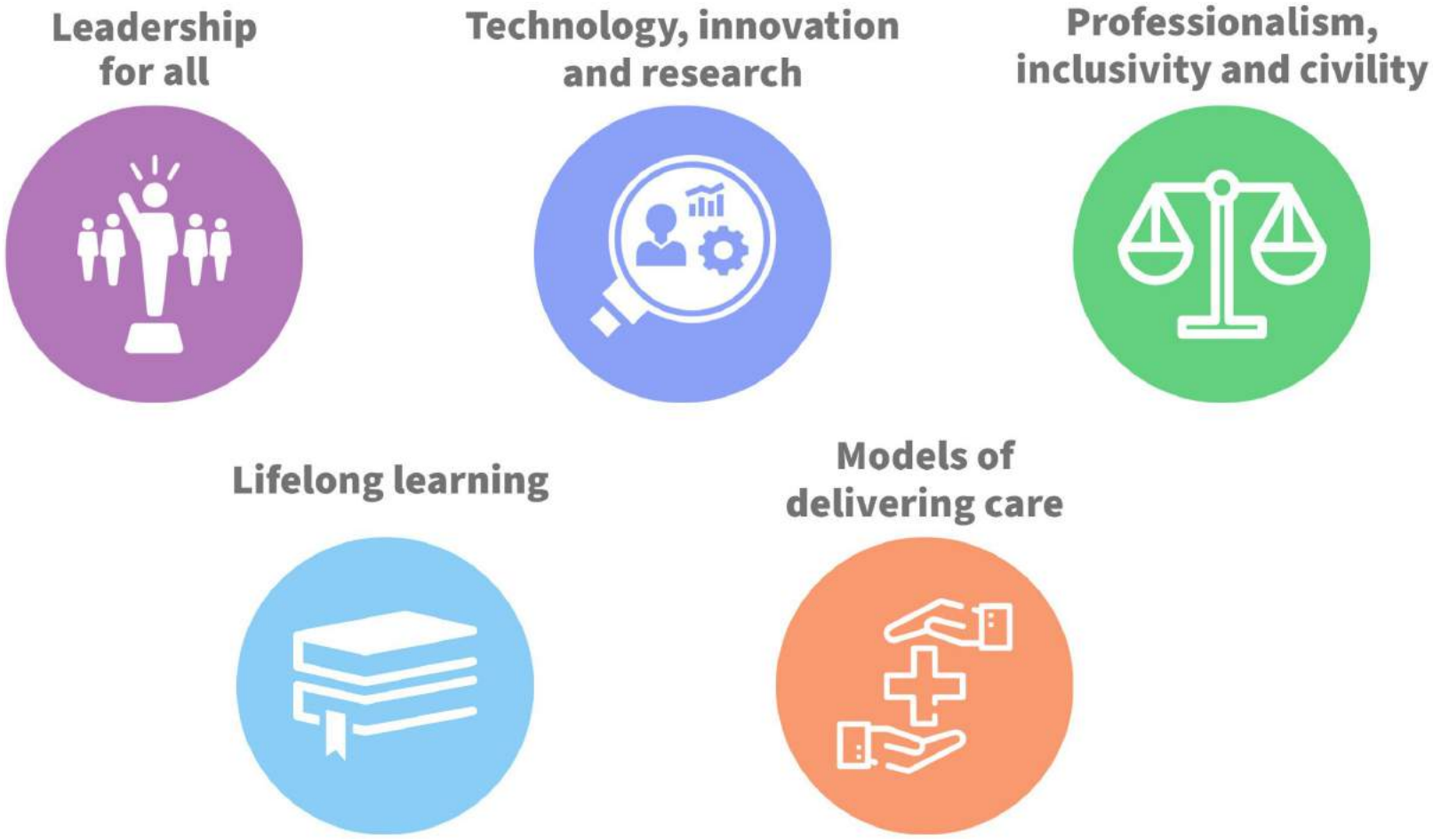
We believe that a pre-requisite to the provision of excellent care is having a nursing and midwifery workforce that feels invested in, listened to and valued.

Our nurses, midwives, nursing associates, health and maternity support workers are **proud, ambitious and courageous**. They have come together and co-created this strategy in order to describe and communicate their vision for the direction of nursing and midwifery workforce overthe next 3 years.

The strategy is framed by a series of five ambitions. Each ambition is jointly led by a senior nurse and senior midwife. The commitments attached to each ambition have been developed, defined and prioritised by our nursing and midwifery teams.

This strategy will support our teams to be the best they can be.

Our strategic ambitions for Nursing and Midwifery 2021 - 2023



Ambition 1
Leadership for all

Every member of our nursing and midwifery teams will be supported to recognise the art of their possible and to reach their full potential.

Our leaders will be visible role models who nurture future talent.

Our teams said:

- We would like to have yearly career development conversation beyond appraisal
- We would like to shadow senior members of the nursing andmidwifery teams as ‘insight days’
- We would like a reverse mentorship programme with senior leaders
- We will look for daily events that we can reflect upon and learn fm

Our Commitment to the Teams

Accessibility and visibility of leaders

Our nursing and midwifery leaders will share their own career stories

We will offer reverse mentorship for senior leadership teams

We will facilitate shadowing of our most senior leaders and encourage shadowing as ‘insights’ into the roles of leaders.

Belonging to a supportive team

We will encourage creative thinking and new ideas

We will create environments where peer review is encouraged.

Nurturing future talent

We will support all staff to feel valued and fulfilled in their roles.

We will encourage horizontal career movement and movement between teams through secondments and shadowing.

We will structure career development conversations outside of appraisals to review staff members progress with their goals.

We will develop an ‘expanding horizons programme’ that will enable staff to apply for secondment opportunities in other areas and departments.

We will develop a retire and return programme for experienced nurses and midwives who wish to change their work life balance.

Ambition 2
Professionalism, Inclusivity and Civility

Every member of our nursing and midwifery teams will be inclusive and see the worth in all. We will treat our colleagues, our patients and families with professionalism and civility. We are proud of ourselves and each other.

Our teams said:

We shall be respectful and accountable to each other as professionals and establish professional forums offering a safe environment for professional challenge

We recognise that we represent our teams, our hospital as well as our professions when communicating with others.

Our team meetings / debriefs will be inclusive, respectful environments allowing everyone to contribute
We will always treat our patients with kindness and civility, introduce ourselves and take time to understand their individuality

Our Commitment to the Teams

Inclusivity in our teams

We will ensure that everyone has a voice and can contribute to decisions and discussions about nursing and midwifery. All voices matter

Our team members come from around the world – we will celebrate this and appreciate and embrace our cultural differences.

We will provide opportunities for fellowships that promote inclusivity

We strive to ask for and listen to feedback from patients and families and support teams to learn from their lived experiences.

Civility

We will treat everyone with dignity and respect, encouraging a ‘confidence to speak up’ culture and cultivating environments that welcome kindness. We do not tolerate incivility.

We will challenge practice or behaviours that we feel are not aligned with the Trust values or our professional codes of conduct.

We encourage and share positive feedback so others can learn from and recognise the contributions of the teams

Professionalism

All teams will demonstrate their understanding and adherence to their professional code

We will develop/adopt a code of conduct with and for our health care and maternity support workers.

Ambition 3
Models of delivering care

Our nurses, midwives and nursing associates will harness their professional voice, understand their contribution and optimise their influence. Together, with our Healthcare Support Workers, we will deliver expert care, embracing new roles and ways of working.

Holistic, person-centred care is our always event.

Our teams said:

We want to build upon the positive impact of working differently and learning new skills across during the pandemic

We will meet with other teams across the hospital to share best practice and learn from each other.

We want to be involved in the development of new services and pathways within the trust and within the Integrated care system.

Our Commitment to the Teams

Delivering care together

We will support teams to understandand new nursing and midwifery roles and plan together how we can embrace new models of delivering expert care. We are interdependent not separate.

We will continue to support staff who were redeployed during Covid to maintain and develop their new clinical skills and relationships

We will encourage teams to explore new models of delivering care locally and nationally

Finding our professional voice

We will provide staff with the necessary influencing skills to harness their professional voice and influence change

We will foster free thinking and empower all staff to ask questions and constructively challenge.

We will support the introduction of the professional advocacy in nursing programme and expansion of the professional midwifery advocacy programme

Growing New Roles

We will develop the role of the maternity support worker aligned to the new national competency framework.

We will support our nursing associates as they are embedded within our clinical teams to fully explore the capabilities of their roles.

We will formalise our advancing practice programme to support the development of new roles within and across services.

Ambition 4
Lifelong Learning

Our hospital will provide a transformative learning environment, encouraging a professionally curious nursing and midwifery workforce who seek new opportunities to learn and support others to develop.

Our teams said:

We will encourage all team members to expand their knowledge and Experience

We want to have a learning profile for each ward and department

We create foster learning environments that encourage professional curiosity and questioning

Our Commitment to the Teams

A transformative learning environment

We will develop a learning profile for each ward and department and provide training and education relevant to the learning environment.

Every ward and department will have an annual training needs analysis and implementation plan.

Ways of learning

We will develop scenario-based learning for pan-professional teams.

We will provide speciality based training and learning opportunities that suit varied learning styles – peer to peer learning, bite size learning, professional learning sets.

We will provide opportunities to spend time with specialist teams, other departments and senior leaders from across and beyond the Trust to increase collaboration,enhance knowledge.

We will share journal articles and new evidence through journal clubs,team meetings and Nursing and midwifery led grand rounds.

Career pathways and planning progression

All staff will be supported to develop a personal learning and career plan.

We will expand the breadth of opportunities available to health care and maternity support workers.

We will support nurses, midwives and nursing associates to apply for Florence Nightingale Fellowships

Ambition 5
Technology, innovation and research

We will deliver expert care that is evidence-based, embracing new technology and digital solutions. Our nursing and midwifery teams will actively engage in research and share their knowledge within and beyond the organisation.

Our teams said:

We will continue to use virtual platforms to connect patients with their families

We will embrace new systems and include digital systems to enhance patient and family care and experience

We will ensure changes to our practice are evidence-based.

Our Commitment to the Teams

New technology

We will use technology to share knowledge and expertise about our individual patients.

We will use Apps to develop understanding of new evidence base for conditions.

We will explore digital platforms to improve efficiency.

Evidence based practice

We will talk about the importance of evidence-based care and the importance of keeping up to date.

We will offer support and encourage staff to write for publication.

We will create a nursing and midwifery led symposium to share best practice.

Research and clinical audit

We will encourage all to undertake research and share the output of research through Trust forums and through publicaitons

We will increase knowledge of the research available and support teams feel thatresearch is accessible to all.

How will we know we have achieved our ambitions?

We have committed to our nursing and midwifery workforce that the ambitions described and defined in this strategy will guide our workstreams over the next 3 years.

We will be driving this forward through the working groups attached to each ambition and their progress will be shared, discussed and reviewed at our Nursing, Midwifery and Therapies Advisory Group.

The ambitions interlay with other Trust strategies and will feed into and from these workstreams:

- The Equality, Diversity and Inclusion strategy
- The Education and Workforce strategies
- The Research and Development strategy
- Quality, Learning and Improvement strategy

The development of this strategy

This strategy was co-produced through a series of engagement activities with our nursing and midwifery workforce.

32 Wards and departments shared their ambition posters

150 Ambition posters created a live feedback wall over 6 weeks in the staff restaurant

15 e-feedback packs were received from individuals

3 Were from teams

12 focus groups involving **80** nurses, midwives, nursing associates, health and maternity support workers and students were held to gain further feedback on the thematic analysis and create our commitment statements

additional workshops with our Trust executive group, Trust chair and non-executive directors and our nursing and midwifery students gained important feedback


Standards
Innovation
Evidence
Care
Talent
Culture
Professionalism
Compassion
Learning
Pride
Creativity
Leadership
Nursing Associates
Courage
Progression
Opportunity
Midwives
Nurses
MCAs
Kindness
HCAs


Volunteering
with

Milton Keynes Hospital NHS
NHS Foundation Trust

Meeting Title	**Trust Board**	**Date: 4/11/21**
Report Title	**Infection Prevention and Control 2020/21 Annual Report**	**Agenda Item: 13**
Lead Directors	**Name: Nicky Burns-Muir**	**Title: Director of Patient Care and Chief Nurse**
Report Author	**Name: Angela Legate** **Name: Martin Parker**	**Title: Assistant Director, Infection Prevention and Control** **Title: Health Care Associated Infection (HCAI) Data Analyst**

Key Highlights/ Summary				
Recommendation *(Tick the relevant box(es))*	**For Information** [x]	**For Approval** [ ]	**For Noting** [ ]	**For Review** [ ]

Strategic Objectives Links	Improving patient safety Improving patient experience
Board Assurance Framework (BAF)/ Risk Register Links	

Report History	September 2021 Quality and Clinical Risk Committee Meeting
Next Steps	N/A
Appendices/Attachments	Annual Report

The Infection Prevention & Control Annual Report

For the period April 2020 – March 2021

Produced by Angela Legate, Assistant Director, Infection Prevention & Control

And Martin Parker, Health Care Associated Infection (HCAI) Data Analyst

The purpose of this annual report from the Infection Prevention and Control Team is to provide the Board with information on both trust performance and the provision of assurance that suitable processes are being employed to prevent and control infections.

The data in this account is for the period 1st April 2020 to 31st March 2021.

The board is provided with an update on the following:

1 Key points/Executive summary/Assurance statement

2 COVID-19 to end of March 2021.

3 Performance against alert organisms and infections

4 Viral, including seasonal viral infections.

5 Surgical Site Infection Surveillance (SSISS)

6 Water Safety and Ventilation

7 TB Nursing Service

8 Education and training (includes mandatory)

9. Our new life – MKUH Vaccination Hub

10 Conclusion and Ambition

1. Key Points/Executive Summary

This report demonstrates how the Trust has systems in place for compliance with the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance.

The Trust set out to continue the commitment to improve performance in infection prevention practice, as outlined in the Health and Social Care Act 2008, to deliver:

- continuous improvements of care
- it meets the need of the patient

The reporting year was dominated by the COVID-19 pandemic and a summary of the contribution of Infection Prevention and Control to the Trust response is included in this report.

The Infection Prevention and Control holds a critical role in the maintenance and subsequent return to 'normal business' across the entire Trust whilst maintaining preparedness for any increase in COVID-19 cases and ensuring traditional infection control standards are delivered to the highest level.

As we moved through the pandemic, we took the opportunity to reflect and refocus our efforts on the preventative measures that mitigate the risk of infection for patients and staff.

The year has seen some success and some challenges, and these are highlighted below and described in more detail throughout the report.

- Response to the COVID-19 Pandemic. This has involved a major local response, with the Trust supporting the national approach during the initial specialist 'containment' phase up until early March 2020.

- Seven (7) cases against a threshold of thirteen for cases of Closteroides (Clostridium) difficile. The Trust continues to have a low rate of C diff.
- Successful inclusion of caesarean section delivery (CSD) to the Surgical Site Infection Surveillance programme to recruit all women consented for CSD
- An improvement of 75% seen in hip replacement surgery
- Zero infection in knee replacement surgery
- The launch of the infection prevention and control e-learning mandatory training module has been associated with improvement in compliance.

The position regarding bacteraemia both Gram positive (S. aureus) and Gram negative remains challenging and will need to remain in focus for the work plan for the remainder of 2021/22, in combination with the ongoing response to COVID-19.

Further analysis is underway for MSSA bacteraemia as our threshold of five was almost doubled by an outrun of nine cases.

A zero tolerance remains for MRSA – MKUH registered 1 case in the reporting year

Infection Prevention and Control Board Assurance Framework (IPC BAF)

In May 2020 NHSE/I issued an Infection Prevention and Control Board Assurance Framework for all acute Trusts to use to assess practice and use as a tool to monitor actions required to ensure continuous improvement.

The Trust completed its self-assessment, and this now forms part of ongoing assurance to the board. The responsibility for review and update, sits with the Infection Prevention and Control Committee.

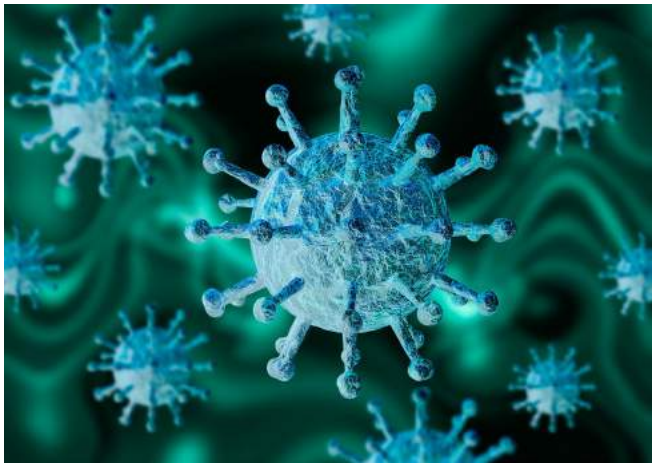
The IPC BAF is not included in this report as is considered a “live” document. The current version is accessible on the hospital intranet.

2. COVID-19. Severe Acute Respiratory Syndrome Coronavirus-2 (SARS-CoV-2

From March 2020 the Trust concentrated on the worldwide coronavirus pandemic. Coronaviruses are a large family of viruses with some causing less serious disease, such as the common cold, and others causing more severe illness such as Middle East respiratory syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS) coronaviruses.

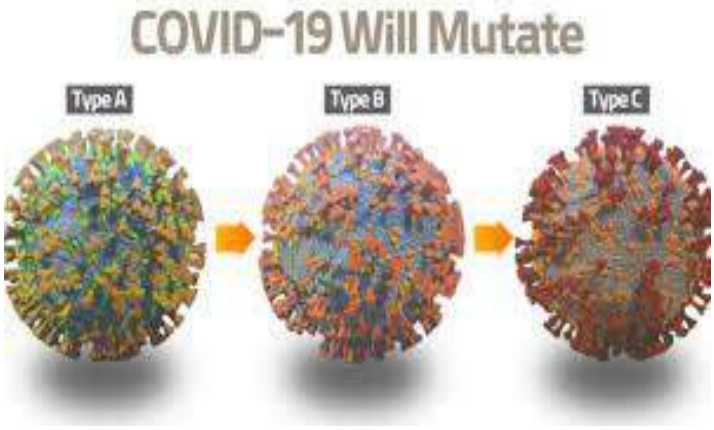
On 31st December 2019, the World Health Organisation (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan City, Hubei Province, China. By mid-January 2020, it was announced that a novel coronavirus had been identified in samples obtained from cases and that initial analysis of virus genetic sequences suggested that this was the cause of the outbreak.

This virus is referred to as SARS-CoV-2, and the associated disease as COVID-19.



Early image of Covid-19 virus 2020

By mid -summer 2020, mutation was being reported



The Trust response to the Pandemic has gone through several iterations, from the initial exposure when we received and managed relatively few individuals, to the peaks experienced as spread of the virus accelerated throughout our communities impacting our staff and patients.

Critical incident command and control informed our responses in making rapid change to process as we experienced exponential rise in cases being admitted.

Major review and change to how safest to use our facilities included the re-deployment of human and other resources often launched at speed to allow for stability of services. This became crucial in managing staff, patient, and public anxiety.

At the peak of the epidemic, we were looking after more than 270 patients with known or suspected COVID-19 with several requiring critical care level management.

Throughout the pandemic, the Infection Prevention and Control Team has supported the organisation with expert advice and interpretation of the guidance from national bodies, including Public Health England (on behalf of the UK's public health bodies) and NHS England/Improvement (NHSE/I).

The Trust has contributed to regional guidance and national high-level planning, in particular the grading of disposable Personal Protective Equipment (PPE) for use in healthcare, as stock levels across the nation became threatened by poor quality supplies coming in from other countries and use of PPE rose to an all level high.

Supporting Staff and Patients. The Trust intra-net was rapidly expanded with frequently asked questions documents, videos, posters, and other materials, to ensure the correct guidance was always available to all staff for all aspects of patient care and management relative to COVID-19.

Even before the Covid-19 pandemic reached the UK in 2020, the drive for the NHS to make better use of digital technology had already started to take shape. The introduction of lockdown, requirements for social distancing and guidance for people to work remotely where practicable all contributed to the need to change the way we delivered care.

The pandemic accelerated our use of digital platforms as we moved to new virtual ways of working, the microbiology laboratories introduced analysers and face to face education sessions (staff and patients) switched to teams or the use of zoom.

The infection prevention and control nurse team joined others across the hospital in supporting out of hours and weekend cover across a twelve-month span.

The IPC team attended daily meetings on transmission avoidance / control on COVID-19, including placement of patients, advice on ventilation, Personal Protective Equipment (PPE) for different procedures, management of clusters of patients, outbreaks, and additional methods of reducing transmission e.g., improving social distancing of patients by removing beds from bays, and education of staff, particularly when guidance changed at a pace.

Of enormous benefit throughout the pandemic has been our on-site laboratories. The biomedical scientists worked long hours and overcame many obstacles to rapidly introduce and accelerate testing for COVID-19.

Due to the perceived threat of using microscopy, alternative processing methods were used for patient samples. This enabled appropriate use of antimicrobial therapies to continue and real time management to continue.

Nationally, the test for COVID-19 was developed which allowed for analysis at reference laboratories from February 2020.

Whilst we relied totally on Oxford Hospital Reference Laboratory in the beginning, our drive to get our own analysers on site remained a daily priority. A range of new testing machines were procured nationally for laboratories to increase testing capability to cope with the volume of analysing required.
At the time of writing, we offer a 24/7 Covid-19 in-house testing service, with protected analysers for use in our emergency department.

Microbiology Laboratory services (local and regional)
The Infection Prevention and Control Team work closely with the clinical microbiology department and PHE microbiology laboratory which provides comprehensive bacteriology, virology, parasitology, and mycology services.

The microbiology department at MKUH is UKAS accredited and participates fully in external quality assurance schemes for the full repertoire of tests.
Out of hours, the on-call duty Consultant microbiologists provide Infection Prevention and Control advice for the Trust.

3.Performance against alert organisms and infections.

Closteroides (Clostridium difficile)

The external objective for reportable cases of C. difficile (C. diff) for 2020/2021 was to achieve no more than thirteen cases.
Reportable cases are those that have C. diff ‘toxin’ detected in stool (Enzyme-linked Immunoassay or ‘EIA’ positive) beyond two (changed from three) days of admission to our hospital (attributed).

In addition, the Trust must determine and escalate to the Milton Keynes Clinical Commissioning Group (MKCCG) reportable cases deemed to involve any ‘lapse in care’.

All hospital onset cases were reviewed through a post infection review process, involving the multidisciplinary team responsible for the patient, the IPCT and the MK CCG IPC and Quality. The Trust has seen zero lapses in care.

Please see graph showing wards/cases of C. diff in the reporting year.

Clostridioides difficile cases attributed to MKUH and lapse in care		
Division	**Speciality**	**Lapses in care**
	Medicine	
Ward 3 (x2)	Female, frail elderly care	0
Ward 17 (x2)	Mixed gender, cardiology	0
Ward 19	Mixed gender, patients presenting with acute/chronic endocrine issues, diabetes in the main.	0
Ward 23	Mixed gender, predominantly Surgery, elective & emergency. Main specialities, ENT. Trauma and Orthopaedics	0
Ward 25	Mixed gender, Haematology and Oncology	0

Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemia. (Bloodstream infection) NHS England has a 'zero-tolerance' approach to MRSA bacteraemia meaning the Trust objective is for zero avoidable cases assigned to the hospital.

A formal Post Infection Review (PIR) is conducted for each case. Following the national change in 2018, cases are assigned to the Trust purely based on the admission date: all cases identified at admission date plus two or more days are automatically assigned to the Trust.

A single case occurred in November 2020 when an emergency patient presented with life threatening cardiac problems requiring difficult and urgent treatment which likely saved the patient's life. The patient was subsequently found to have MRSA in blood cultures taken during a period of sepsis.

The Consultants in Medicine, with the cardiology team responsible for the investigation found it has not been possible to establish with absolute certainty that MRSA was introduced into the patient's bloodstream during the insertion of a cardiac pacing wire to stabilise the heart, nor can the possibility of introduction to the blood stream on placement of intravenous cannula be excluded during emergency treatment.

Ordinarily, emergency admissions are consented for MRSA screening close to the decision to admit being made, the exceptions to this are those requiring resuscitation and or life saving intervention. MRSA screening for patients in this category are expected to be undertaken within 24 – 48 hours of admission.

Meticillen Sensitive Bacteraemia (MSSA)

All MSSA bacteraemia are reportable to the PHE but there is no formal objective for the Trust. There has seen a significant rise of attributable MSSA bacteraemia in the reporting timeframe, almost double that of the previous year.

Staphylococcus aureus bacteraemia (SAB) are an important cause of sepsis and contribute to significant morbidity and mortality. There has been a consistent rise of SAB cases nationally and locally in MKUH which triggered the review that commenced in 2018.

To date, the management of ninety-eight cases (both community and hospital acquired) have been reviewed, retrospectively from 2016-2018, against the current national standard. The study was completed in Nov 2019 and highlighted the need for additional infection specialist input into management of cases in our hospital.

In Feb 2020, weekly SAB bacteraemia ward rounds were introduced and subsequently (July 2020) the addition of an electronic follow up pathway for every case of SAB in the trust was implemented.

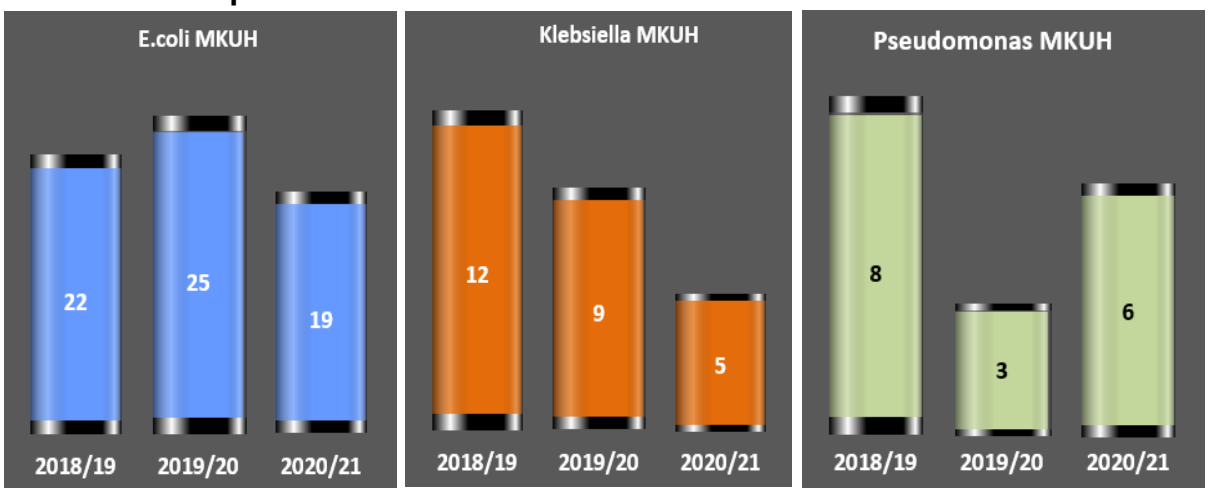
Modernisation of our microbiology laboratory during this period with MALDI TOF (same day pathogen identification system) also supported augmentation of the refreshed clinical service. Despite the demand on clinical microbiology service increasing due to the pandemic from March 2020, the weekly review of SAB has continued.

Gram negative bacteraemia

The national ‘ambition’ for England to reduce healthcare-associated Gram-negative blood stream infection (GNBSI) by 25% by 2020/21 and by 50% by 2023/24 remains in place.

For this ‘ambition’, GNBSI are defined as three organisms: E coli, Klebsiella (all species) and Pseudomonas aeruginosa as these constitute a majority of reported GNBSI. Of these the E coli are by far the most numerous, many of which are community onset.
Public Health England changed the way in which cases are assigned from 1st April 2018 to bring them in line with the approach taken for MRSA and MSSA, i.e., pre and post 2 days admission.

Graph below details cases allocated to MKUH from 2018.



4.Viral, including seasonal viral infections.

Influenza

The season started and peaked much earlier than usual but the peak was much shorter than previous years. Covid-19 did not impact testing and admissions were unaffected. There were no clusters or outbreaks associated with influenza during the reporting year.

There were no outbreaks of respiratory syncytial virus (affects paediatrics in the main) or norovirus/other gastrointestinal pathogens during the reporting timeframe.

Covid-19 incident (cluster) and outbreak

Outbreak occurred despite a comprehensive patient and staff safety program being implemented. Included in this, were the dedicated Covid-19 wards with isolation rooms, or cohort bays where indicated, personal protective equipment in accordance with national recommendations, personal protective equipment donning and doffing stations and monitoring of compliance, universal masking, restriction of visitors, and rapid testing of symptomatic and asymptomatic patients.

The recommendation on the cohort of suspected or confirmed Covid-19 patients, when all single room provision is exhausted, does not adequately isolate them from susceptible non-covid-19 patients. The long incubation period and the high proportion of asymptomatic infections, creates the perfect environment for silent transmission in the healthcare setting.

The Milton Keynes Hospital sits on one site and admits both Covid-19 and non-Covid-19 patients which can result in a high colonisation pressure of the virus, exposing both susceptible patients and Health Care Workers (HCW`s) to the risk of healthcare-associated infection.

The Milton Keynes Hospital experienced both outbreak of Covid-19 and cluster, (patients admitted to non- covid-19 wards with negative screening in the first few days and symptom free (asymptomatic incubation) who then tested positive.

Where this occurred, all effort was made to isolate the positive patient(s) in single rooms. As the number of cases rose in the community, this was reflected in the number of positive admissions, direct from the community and, in those inpatients, that during routine retesting, had a positive Covid-19 test result.

The hospital has a proven track record of outbreak avoidance and containment with viral agents such as gastroenteritis or influenza. Like all other healthcare providers, it will not have experienced the speed and reach of Covid-19. The sense of responsibility for making decisions that could affect the outcome for our patients felt at times relentless which affected staff, patients, and families deeply.

From March 2020, all national guidance has been followed regarding communications, behavioural insight, and Covid-19 campaigns to engage with staff and patients to maintain safety.

Governance. Absolute clarity in the ongoing management and recognition of emerging Covid-19 outbreak incidents has been evidenced by the escalation through the standard organisational governance process to Board level.

In addition, these incidents are shared and supported by the regional IPC team, reporting in turn to NHSE/I via the agreed Emergency Preparedness Resilience and Response (EPRR) command and control arrangements. Internally, outbreaks are reviewed daily, with all progression towards return to normal service scrutinised.

As we moved through the first and second wave of the pandemic with a paradigm shift in management practices of viral respiratory outbreaks, we acknowledge the vast improvements made by in-house testing becoming available, initially with one analyser, quickly increasing in number, which added value to the suite of patient safety programmes.
These expanded testing criteria appear to be crucial in identifying and controlling outbreaks but are yet to be evidenced as playing a significant role in avoidance.

5.Surgical Site Infection Surveillance (SSIS)

As described in our previous year report, a collaboration between the IPCT and the women's and children division has enabled expansion of our SSISS portfolio to include caesarean section delivery (CSD).

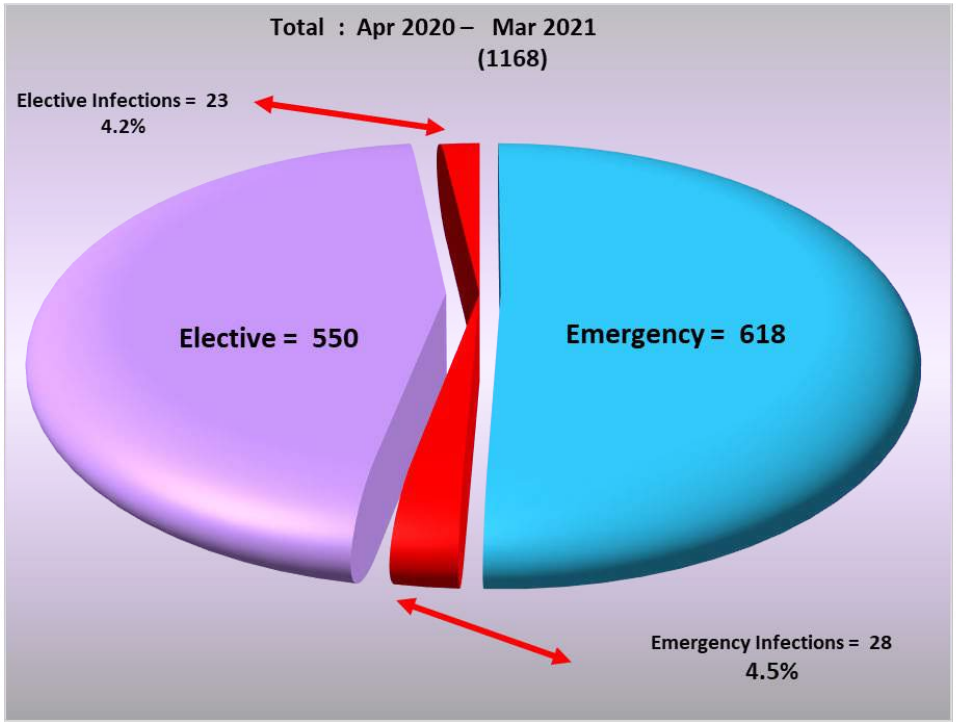
SSIS is established in three surgical specialties and is monitored across a twelve-month period.

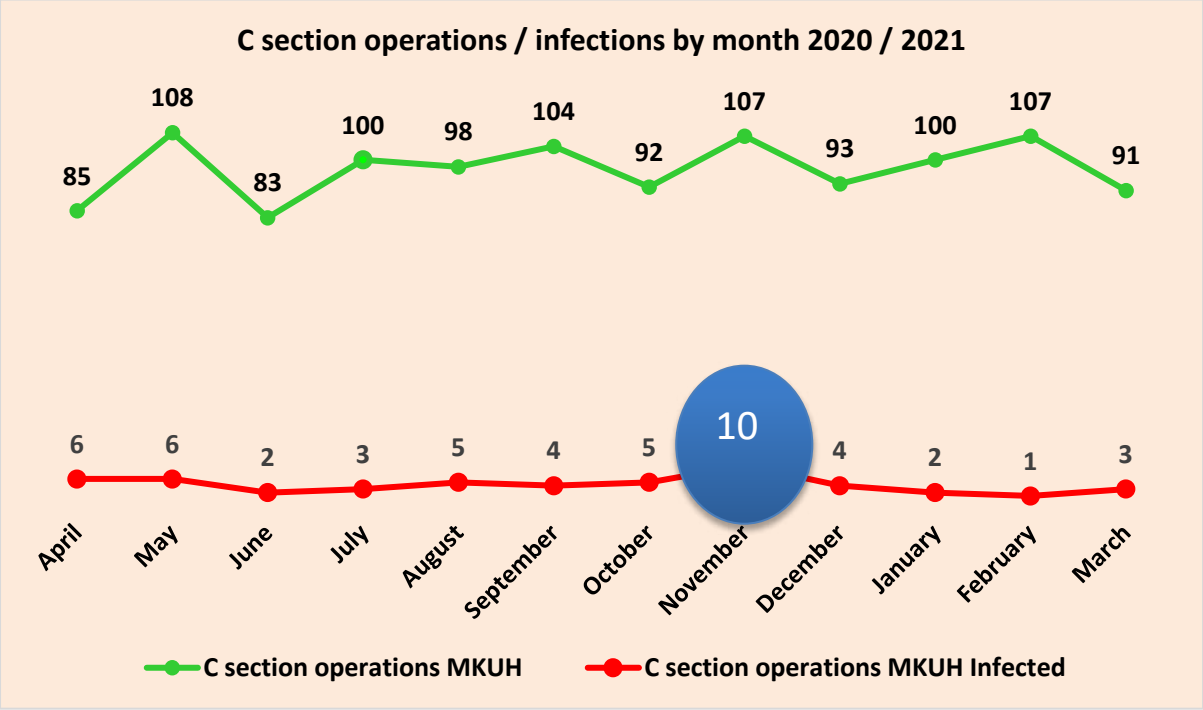
Caesarean Section Delivery.

Our aim in re-introducing this criterion for surveillance was to estimate the burden of surgical site infection following caesarean section delivery and to identify potential improvement achievable through implementation of a surveillance programme.

One thousand, one hundred and sixty-eight women were recruited to the audit. The graph below shows the number of emergency sections being greater than elective and the associated infections in both groups.

Please see year end update following the re- implementation of the Public Health England (PHE) Surgical Site Infection Surveillance Service (SSISS) for HCAI in Caesarean Section @ MKUH April 2020 – March 2021





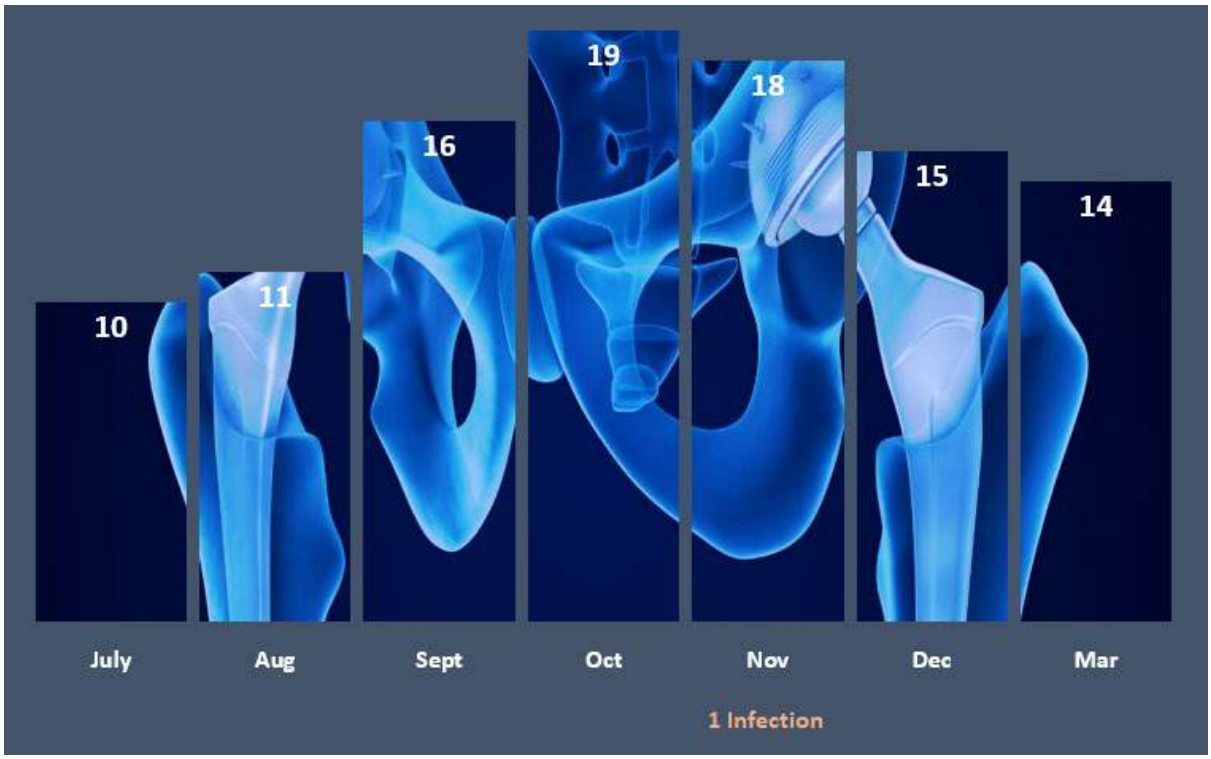
Graph showing month by month cases, with a peak in November 2020.

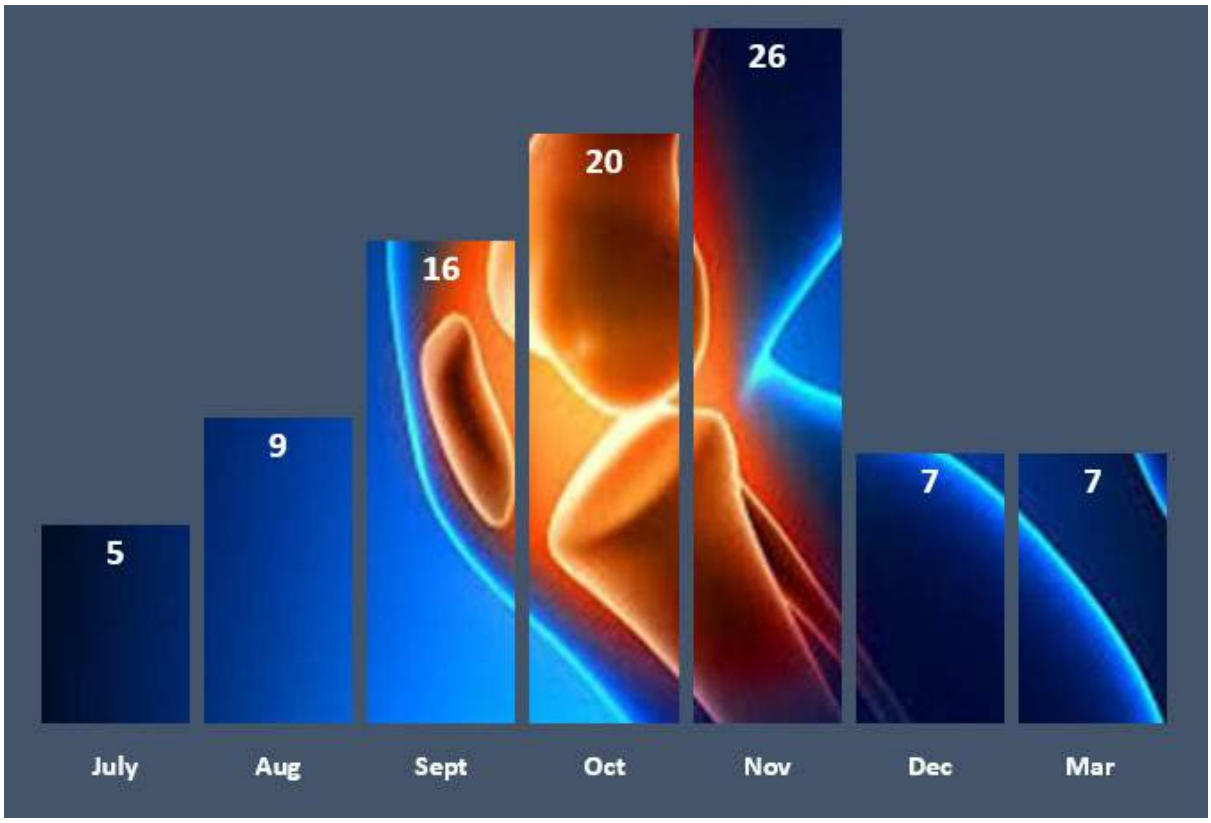
A shared approach has informed our collective action and through working with the Obstetric Consultant and midwifery teams, the following progress has been made:

- Combining and rewrite of patient information leaflet regarding skin preparation and wound care for elective CSD
- Obtain shaver for Ward 9 for CSD women
- Refresher training re skin preparation with Chloraprep for all
- Refresher training re scrubbing for all
- Octenisan wash or wipes for skin prep and postnatal care
- Standard Operating Procedure for vaginal wash (stops bacteria migrating up into the uterus during caesarean delivery)

An ongoing challenge has been the difficulties reported by theatre staff in capturing real time data required for the SSISS programme and on reflection, given that not all data impacts on patient experience being improved, the decision has been taken not to continue with the national programme but to audit CSD in-house, using electronic patient data and local data sources which on testing has proved more reliable.

SSISS for Hips and Knees. Please note the absence of April, May June months due to elective work being suspended as per national guidance on COVID-19





6.Water Safety and Ventilation

Water and ventilation issues are monitored by the Water Safety Group and the separate Ventilation Group. Both report into the Infection Prevention and Control Committee (IPCC)

The purpose of the **water safety group** is to provide assurance on the following:

1. The environmental (water) controls required in all healthcare facilities to prevent healthcare associated infection from water sources are met.
2. Scheduled Risk assessment is in place in augmented care units to prevent infection from water sources
3. A quality managed water system is maintained to prevent infection from water sources including bottled water
4. Advice is current on routine sampling and testing of water systems in healthcare facilities
5. Surveillance and actions required in healthcare facilities if healthcare-associated infection from water sources is suspected

Hospital water is a recognised potential source of Pseudomonas aeruginosa (hereafter 'P. aeruginosa'), which is a microorganism that can act as an opportunistic pathogen and colonise and infect vulnerable patients. Several outbreaks of P. aeruginosa have been attributed to contaminated water systems in other hospitals.

As part of the 2016 revision of HTM 04-01, (2013) those sections of the addendum that introduced healthcare organisations to the concept of Water Safety Groups and Water Safety Plans are now a fundamental part of HTM 04-01 Parts A and B.

For the purposes of this document, the patient groups in augmented care settings include those patients who are severely immunosuppressed because of disease or treatment: this will include transplant patients and similarly heavily immunosuppressed patients during high-risk periods in their therapy; those cared for in units where organ support is necessary, for example critical care (adult paediatric and neonatal). At a local level, we have added the cancer centre to the monitoring schedule.

Positive results for Legionella species or Pseudomonas aeruginosa are subject to remedial actions, re-tested until clear and reported to the IPCC.

Ventilation: The reduction in theatre activity that resulted from the cancellation of elective surgery during the COVID-19 pandemic provided an opportunity to conduct a detailed review of the specialist ventilation systems in the Trust.

All specialist ventilation systems in theatres and other interventional departments have had a comprehensive engineering review by specialist contractors and a programme of maintenance, improvement and refurbishment has been drawn up and begun.
As the pandemic progressed, so did our understanding of the need to employ a layered approach to reduce exposures to the virus that causes COVID-19. This includes using multiple mitigation strategies, especially those requirements to improve ventilation across the hospital in tandem with social distancing, wearing face masks, hand hygiene, correct levels of PPE and vaccination.

7.TB Nursing Service

The effects of COVID-19 go far beyond the death and disease caused by the virus itself. The suspension of elective intervention is testament to that, as is the impact on some outpatient activity.

The disruption to essential services for people with TB is one other example of the ways the pandemic disproportionately affected some of the world's poorest people, already at higher risk for TB.

As staff with respiratory nursing skills were redeployed to support wards seeing increasing numbers of Covid-19 patients, the seeds for a joint venture between the medical division and the IPCT were sown. In June 2020, and with support from the executive team, an expression of interest was invited from nurses and midwives to support the service.

Following an intensive education and training programme delivered by the respiratory/infectious diseases consultants and imaging lead, the two registered nurses responding to the opportunity to run the TB nursing service, took on the challenge.
The service has thrived during the pandemic, accepting referrals from the Multidisciplinary Team (MDT); such as Gastroenterology, Bowel screening, Ear Nose Throat (ENT), Rheumatology, Urology, Dermatology, Blood Borne Virus (BBV) Clinic and Paediatrics. Some of these patients require TB chemoprophylaxis if Latent TB is identified prior to commencing immunological treatment.

Fast forward nine months and we have a flourishing, refreshed service and have recruited Imelda Ogatis, as TB nurse lead and Amran Ali, TB specialist nurse. The latter post is funded by Clinical Commissioning Group (CCG) Milton Keynes (MK). Agnes Whiting, Infection Control Nurse will continue to support the service as part of her extended role. The TB nursing service is managed by Angela Legate, Asst.

Director of Infection Control Prevention with Dr Mansoor Raza as the Infectious Disease lead Consultant. (Imelda and Agnes responded to the expression of interest)

Objectives towards improving the service both in acute and community settings have been achieved in the main, with some elements rolling over as the now substantive team progress with their plan to reduce the incidence of TB and drive out any stigma associated with it.

- To innovate TB nursing documentation by integrating to E-care, Chief Nursing Information Officer Lesley Johnson is supporting this transition.
- Basic Eye Screening will be included as part of TB nursing role; this would mean that there would be no delay in eye screening test for patients who are going to start with Ethambutol drug. The ophthalmology nurses are going to arrange the training this July 2021.
- Establish patient discharge community pathway to monitor patient compliance with treatment e.g., Directly Observed Therapy (DOT), Pill count for TB medication.
- Increase education opportunities in our communities

8.Education and Training (includes mandatory)

Mandatory update for infection prevention and control education is via e-learning and the compliance for the reporting year is seen here:

Infection Prevention and Control - Level 1 - 3 Years	99%
Infection Prevention and Control - Level 2 - 1 Year	96%

A phenomenal amount of education and training unfolded outside of mandatory update requirement.

For stability to be maintained, the IPCT became very flexible to think and do things differently while providing clinical learning that met the rapidly evolving pandemic picture.

The Team has a wider remit which supports the Trust's Quality Agenda and includes membership on operational groups and committees. Active involvement with the tender process for services, procurement of equipment and the review of buildings redesign and refurbishment remains core business.

The infection control nurses are members of the Infection Prevention Society (IPS) and have pulled learning from national guidelines, research, and educational events into daily practice. The lead nurse belongs to the Hospital Infection Society (HIS) and uses networking opportunities to support professional development relative to the assistant DIPC role.

The IPCT work closely with external agencies and acknowledge those strong working relationships with the local Clinical Commissioning Group, Public Health England (PHE) and NHS Improvement as being instrumental in maintaining patient and staff safety.

Members of the Infection Prevention and Control Team participate in several groups within the Trust:
• Health, Safety and Security
• Water Safety
• Medical Devices
• Decontamination
• Emergency Preparedness, Resilience and Response
• Antimicrobial Stewardship
• Product Evaluation Group

The IPCT meets formally every week to discuss a range of topics including governance, assessing progress against programmes of work, performance targets, discussion and resolution of issues, review of surveillance data and ensure necessary information, including feedback from groups, committees and meetings attended, is disseminated appropriately to the wider team.

The Infection Prevention and Control Team operate in line with national guidance on the prevention of infections in the healthcare environment. Adherence to policies and procedures is based on national guidance and the evidence base supports the Trust in continually reducing the risk from avoidable infection in patients and staff.
All policies and procedures are readily available on the Trust's intranet page.

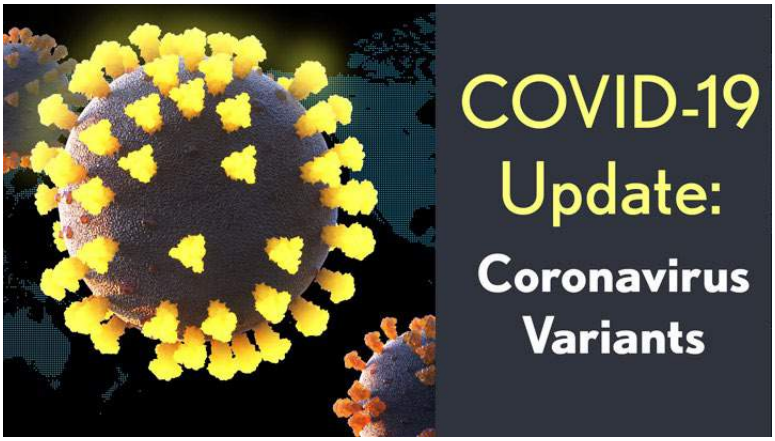
The Director of Infection Prevention and Control (DIPC) gives an overview of the most recent infection prevention performance data to members of the Board, concerning the Trust's performance against external and internal infection prevention targets and other infection related issues.

9.Our new life
The MKUH Vaccination Hub.

The success of the vaccination rollout, alongside falling covid-19 infections and associated hospital admissions has paved the way for the safe and gradual lifting of restrictions.
Vaccines mean that fewer people will get COVID-19 and that those who do are far less likely to come to hospital or to die. There are a number of adults who chose not to be vaccinated and, even when vaccinated, there is still a chance people can contract the virus and pass it on.
No vaccine is 100% effective, and, like all viruses, COVID-19 can mutate. As a result, as lockdown is lifted, there will sadly be more cases, hospitalisations and deaths. The pandemic has emphasised the importance of controlling the spread of infections while reinforcing the challenges involved in the care of patients who already have an infection.

Our collective learning ensures

- We are prepared for future COVID waves/emergencies
- Part of that readiness will be to sustain, where practicable business as usual in the event of a future COVID wave
- The need to increase capacity in advance in the event of a future COVID wave
- Recognising and acting upon key risks to preparing for/managing a future wave.
- Understanding the impact of new variants in paediatric as well as adult services



2021 image of variant strain of Covid-19.

Variants arise from random genomic changes as SARS-CoV-2 makes copies of itself in an infected person. At the top of the list of at least three variants carrying mutations that potentially make them more dangerous is the variant known as B.1.1.7, first detected in the United Kingdom in September 2020. This variant is considerably more contagious than the original virus.

10. Conclusion and Ambition

The Covid-19 pandemic confirmed the agility of the executive team and wider workforce to adapt quickly and effectively to completely transform the way we organised and delivered services.

As we worked with greater flexibility, on site and remotely, across different teams, it allowed for a sense of freedom to innovate, particularly around safe use of our hospital wards and departments and redeployment of staff to support increasing demand on our services.

As we move into the next phase of healthcare, post pandemic, it is imperative we maintain our commitment to collaborative action, along with the dexterity and pace in decision-making that has been witnessed throughout the pandemic.

A proactive approach with the emphasis on being visible and approachable, particularly ensuring that expert advice and support can be readily accessed is considered de rigueur for the Infection Prevention and Control Team.

References;

Department of Health publications
NHS Premises Assurance Model (NHS PAM).
https://www.gov.uk/government/publications/nhs-premises-assurance-model-launch
Health Building Notes
Health Building Note 00-09 − Infection control in the built environment.
https://www.gov.uk/government/publications/guidance-for-infection-control-in-the-builtenvironment

NICE Pathways last updated: November 05, 2020.
http://pathways.nice.org.uk/pathways/tuberculosis

NIH.gov, Director's Album
Infections with 'U.K. Variant' B.1.1.7 Have Greater Risk of Mortality Posted on March 30th, 2021 by Dr. Francis Collins https://directorsblog.nih.gov/2021/03/30/infections-with-u-k-variant-b-1-1-7-have-greater-risk-of-mortality/

Policy paper: The future of healthcare: our vision for digital, data and technology in health and care Published 17 October 2018

Public Health England. PHE; London: 2020. Transmission characteristics and principles of infection prevention and control.
https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/transmission-characteristics-and-principles-of-infection-prevention-and-control

Van Doremalen N., Bushmaker T., Morris D.H., Holbrook M.G., Gamble A., Williamson B.N. Aerosol and surface stability of SARS-CoV-2 as compared with SARS-CoV-1. N Engl J Med. 2020;382:1564–1567. [Europe PMC free article]

Milton Keynes Hospital NHS
NHS Foundation Trust

Meeting Title	**Trust Board**	**Date: 4/11/21**
Report Title	**Complaints 2020/21 Annual Report**	**Agenda Item: 14**
Lead Directors	**Name: Nicky Burns-Muir**	**Title: Director of Patient Care and Chief Nurse**
Report Author	**Name: Julie Goodman**	**Title: Trust Lead for Complaints and PALS**

Key Highlights/ Summary				
Recommendation *(Tick the relevant box(es))*	**For Information** [x]	**For Approval** [ ]	**For Noting** [ ]	**For Review** [ ]

Strategic Objectives Links	Improving patient safety Improving patient experience
Board Assurance Framework (BAF)/ Risk Register Links	

Report History	June 2021 Quality and Clinical Risk Committee Meeting
Next Steps	N/A
Appendices/Attachments	Annual Report

SUBJECT Complaints Annual Report

DATE April 2020 to March 2021

REPORT BY Julie Goodman, Trust Lead for Complaints and PALS

---

1. Executive Summary

This is the complaints annual report for Milton Keynes University Hospital NHS Foundation Trust (MKUH) for the period 1 April 2020 to 31 March 2021. In this year there were 73,397 attendees to the Emergency Department, 16,255 elective admissions, 22,208 emergency admissions, 313,363 outpatient attendances and 3537 babies delivered.

The National Health Service Complaints (England) Regulations 2009 state that all Trusts must prepare an annual report on the handling and consideration of complaints. This report provides detail on the required inclusions and will be made public on the Trust's website and sent to the commissioners of the Trust.

National regulations are further supported by the publication of national reports including the Francis Report 2013, Clwyd and Hart Report 2013, Designing Good Together Parliamentary and Health Service Ombudsman (PHSO) 2013, and My Expectations for Raising Concerns and Complaints (PHSO) 2015, highlighting best practice in respect of dealing with concerns and complaints. Extensive analysis of the NHS England's toolkit - 'Assurance of Good Complaints Handling for Acute and Community Care - A toolkit for commissioners', has revealed that the Trust's complaints service and process is robust and accessible to our public.

Complaints are an important feedback tool and are a strong indicator of patient experience. The vision of the Trust is that we want all people using our services to be able to say, 'I feel confident to speak up and making my complaint was simple', 'I felt listened to and understood', and 'I felt that my complaint made a difference'.

2. Summary of NHS Complaints Procedures

In April 2009 the NHS Complaints Procedure was amended and the latest NHS (Complaints) Regulations came into force. The Local Authority Social Services and NHS Complaints (England) Regulations 2009 are a Statutory Instrument that all Trusts including Foundation Trusts have a duty to implement. Whilst the procedures are not prescriptive the regulations set out various obligations for NHS bodies in relation to the handling of complaints. Since 1st April 2009 there has been a single approach across Health and Adult Social Care in dealing with complaints. The regulations set out a two-stage complaint system:

Stage 1 Local resolution – working with the complainant to understand and resolve their concerns in a timely and proportionate way.

Stage 2 Referral to the Parliamentary and Health Service Ombudsman (PHSO) – if local resolution is not successful and complainants are dissatisfied with the way their complaint has been handled, they can refer their case to the Ombudsman for review.

The national complaints legislation requires that concerns raised by the public are responded to personally and positively and that lessons are learnt by the local organisation. The local resolution stage focuses on the complainant and enabling organisations to tailor a flexible response that seeks to ensure all complainants receive a positive response to their complaint or concern. It places an emphasis on resolving complaints or concerns as fairly and as quickly as possible and ensuring that lessons are learned and shared to improve the experience of care.

The Parliamentary and Health Service Ombudsman is a free and independent service, set up by Parliament. Their role is to investigate complaints where individuals have been treated unfairly or have received poor service from the NHS in England. If local resolution is not successful, the complainant can refer their case to the Ombudsman for review. The Ombudsman makes the final decisions regarding the complaints individuals make about the NHS.

3. MKUH Complaints Process

Systems and processes are in place within the Complaints and PALS teams to provide the Trust's commissioners with assurance that:

- All complaints are well managed
- The learning from complaints is identified and used for improvement
- The complaints service is accessible, open, and transparent

Each complaint provides an opportunity for the Trust to learn and introduce improvements in areas that patients, carers and relatives tell us are important to them when using our services. We understand that handling concerns and complaints effectively matters for people who use our services. Our patients deserve an

explanation when things go wrong and they have a right to know what tangible changes have been made to prevent something similar happening to anyone else.

Every complaint is triaged by the Associate Chief Nurse and the Head of Patient and Family Experience to ensure an appropriate investigation into the issues raised is undertaken.

The remit of PALS is to provide advice, information and guidance on how to make a formal complaint. The team administrate the investigative process for any matters of concern that have/may have caused low/no harm and focus on resolving issues without the need for a formal process. If concerns are regarding current or treatment that has taken place very recently, action should be taken to resolve the issues as soon as possible to ensure the person goes on to have a good experience. Not every complaint needs to be resolved by an in-depth investigation.

Complaints that are more complex and raise issues that have/may have caused serious or moderate harm require a formal investigation. These formal complaints are administrated by the Complaints team and an investigation is undertaken by the relevant senior clinical staff/manager.

The Complaints and PALS team aim to provide a person-centred approach to all comments, compliments, concerns and complaints. The Trust actively encourage staff closest to the care and services being received to deal with concerns and problems as they arise. This is to ensure that issues are remedied quickly and the Trust can be responsive to individual need and circumstances to improve the experience of the patient. Such timely intervention can prevent an escalation of a complaint and achieve a more satisfactory outcome for all involved. The Trust encourages concerns and complaints and ensure that any lessons learnt are shared throughout the Trust and this information is used to inform service improvements for our patients and public.

When dealing with complaints, the principles, as laid down by the Parliamentary Health Service Ombudsman (PHSO), should be taken into consideration and adhered to. The principles are as follows:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

Most importantly, the Trust should put the complainant at the centre of process and ensure that the complaint is dealt with in the way the complainant wishes, wherever possible. The Trust should not decide on behalf of the complainant how the complaint will be processed; the decision should be made in conjunction with the complainant.

4. Annual Complaint Figures

MKUH is organised into four core divisions, these are Surgical Services, Medical Services, Women's and Children's Services, and Core Clinical Services, each of which are led by a triumvirate team which includes a Divisional Director, Chief Divisional Nurse, and an Assistant Director of Operations, who are collectively supported by Corporate Services.

The complaint numbers during 2020/21 have been collated for each division and the number and type of complaints received has been closely monitored and analysed to identify themes and trends to inform future improvements moving forward.

A total of **832 complaints** were received by the Trust during 2020/21, as detailed on the chart below, this a decrease from 2019/20 of 32.2% (n=1227).

	Q1 Apr - Jun 20	Q2 Jul – Sep 20	Q3 Oct – Dec 20	Q4 Jan – Mar 21	**TOTAL**
Complaint Numbers	146	230	217	239	832 (n = 1227 2019/20 **decrease 32.2%**)

Source: DATIX Risk Management System as at 05/2021

The decrease in the number of complaints during this year could be attributed to the Covid-19 pandemic. Additionally in November 2020 the PALS team made changes to their processes to ensure that concerns are dealt with more efficiently. This has resulted in 352 concerns being resolved within 24 hours of receipt. According to national regulations, any concern resolved within 24 hours does not have to be logged as a complaint. The information arising from concerns that are resolved within 24 hours are recorded on the Trust's database separately to complaints. This ensures that valuable information is retained and used to determine performance and learning across the divisions in relation to all feedback. There has been an increase in the number of concerns resolved within 24 hours when compared to 2019/2020 (n=108) of 225% (n= 352).

The chart below details the number of complaints received compared to the total attendances to MKUH.

Year	Total Complaints	Total Footfall (Inpatient and Outpatient including A&E attendances and births)	% of complaints to footfall
2018/19	1415	535063	0.26%
2019/20	1227	531545	0.23%
2020/21	832	428760	0.19%

5. Responding to complaints

The following definitions are used to provide clarity about whether an issue of concern is handled in line with the NHS complaints procedure and to ensure that the Trust provides the most appropriate response:

Formal Complaint – A formal complaint can be defined as an expression of dissatisfaction with the service provided (or not provided) or the circumstances associated with its provision which requires an investigation and a formal response to promote resolution between the parties concerned.

Informal Complaint – An informal complaint can be defined as a matter of interest, importance or anxiety which can be resolved to the individual's satisfaction within a short period of time without the need for formal investigation and formal correspondence. Informal complaints are received by staff throughout the organisation. Where it has not been possible to resolve the complaint quickly (i.e., by the end of the next working day) and to the satisfaction of the person/s raising it, they will be asked if they would like their concern investigated as a formal complaint under the NHS Complaints Regulations (2009). All complaints whether resolved by the next working day or not, are recorded, reported on, reviewed, collated, and analysed on a local basis.

It is important that complaints are handled in accordance with the needs of the individual case and investigated fairly and proportionately.

The Trust follows the Department of Health guidance and legislation (the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009) which outlines the requirement to acknowledge all complaints within three working days. Under the current legislation Trusts have six months in which to resolve a complaint to the satisfaction of the complainant providing a more flexible agreement with each complainant. MKUH aims to provide a response in as timely a manner as possible and work to an internal benchmark of 30 working days or 60 working days for complaints graded as Red (severe harm).

During 2020/21 from April to July NHS England advised that a national pause should be placed on the complaints system in recognition that all clinical staff needed to be fully engaged in clinical duties. Whilst the pause was in place the PALS team continued to deal with concerns that were either low or no harm and were in relation to administrative issues. The formal complaints process recommence the process in June 2020.

To ensure that people feel safe and supported to make a complaint everyone is directed to additional information, advice, and advocacy support. Complainants are also signposted to the Parliamentary and Health Service Ombudsman (PHSO) (stage 2 of the NHS complaints process) where they remain dissatisfied with the results of the Trust's investigation and complaint handling.

All complaints are dealt with in line with the Trust's complaints policy which includes an initial triage process to ensure complaints are investigated at the appropriate level and in a timeframe considering the severity of harm. Each complainant has the

opportunity to speak directly to the Complaints or PALS team to discuss their complaint in further detail to ensure expectations can be met. This process ensures absolute clarity on the issues to be addressed and confirms what the complainant wants to achieve as an outcome from the process, along with how they would like to receive their response, in writing or a meeting with responsible medical staff, or both.

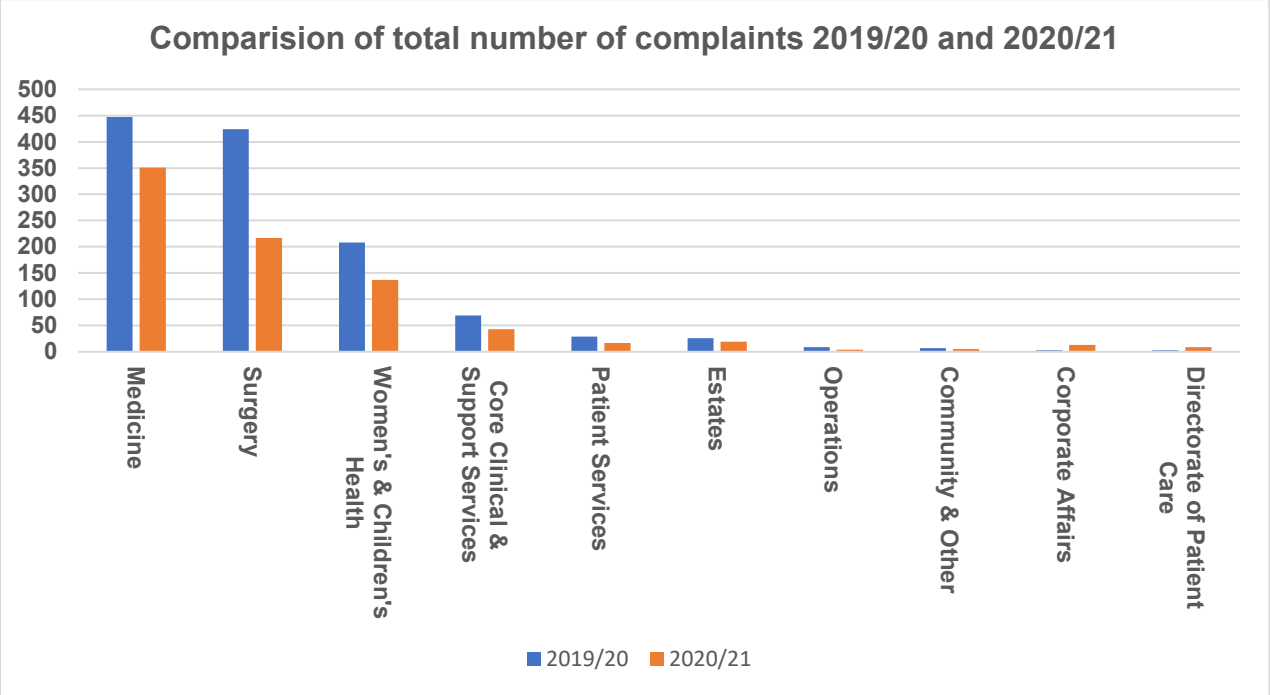
6. Complaint statistics

The 832 complaints received in 2020/21 were represented across the divisions as outlined in the table below, this also shows a comparison to the number of complaints received in 2019/20.

Complaints by division

The chart below compares the number of complaints received by division for 2019/20 and 2020/21.

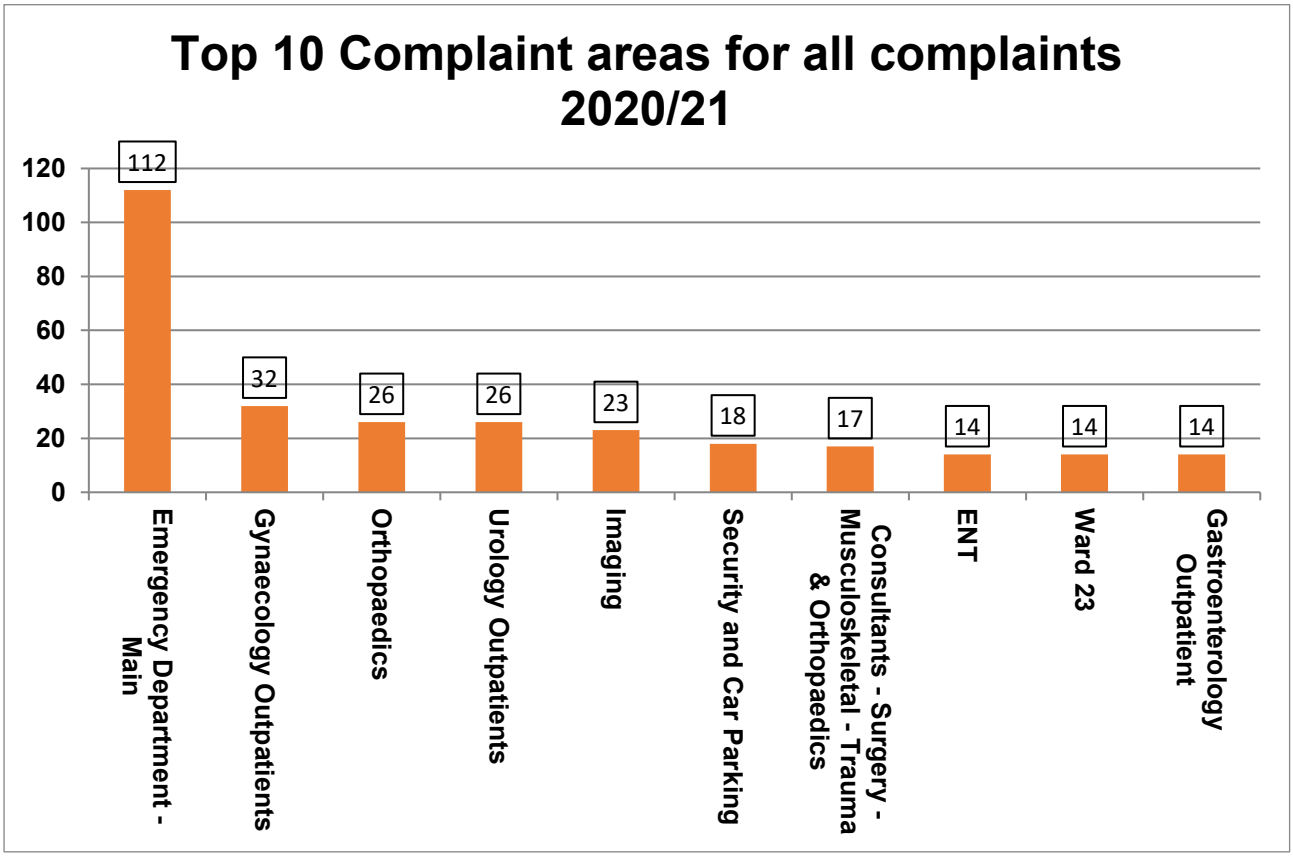
Chart 1 – Comparison of total number of complaints per division 2019/20 and 2020/21



7. Complaints by area

The chart below details the top 10 areas receiving complaints in 2020/21.

Chart 2 -Top 10 Complaint areas for all complaints 2020/21



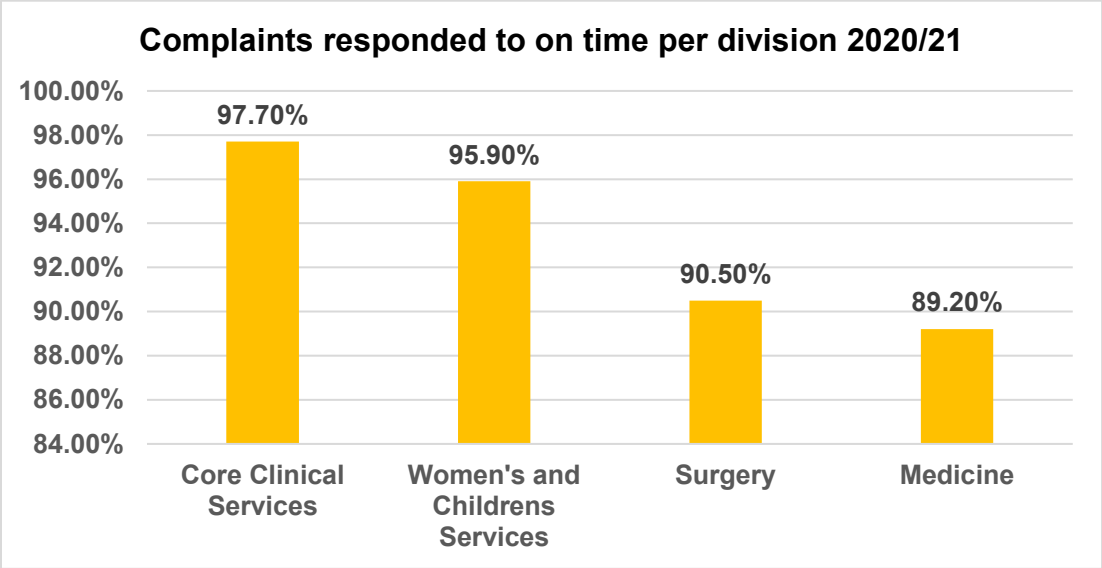
8. Responding

Each triaged category has associated timescales in which a response to the complainant should be made, as follows:

Green and Yellow (No and Low Harm):	15 Working Days
Amber (Moderate Harm):	30 Working Days
Red (Severe Harm):	60 Working Days

The chart below details the number of complaints responded to on time per division in percentage terms for 2020/21.

Chart 4 – Complaints responded to on time per division in percentage terms for 2020/21

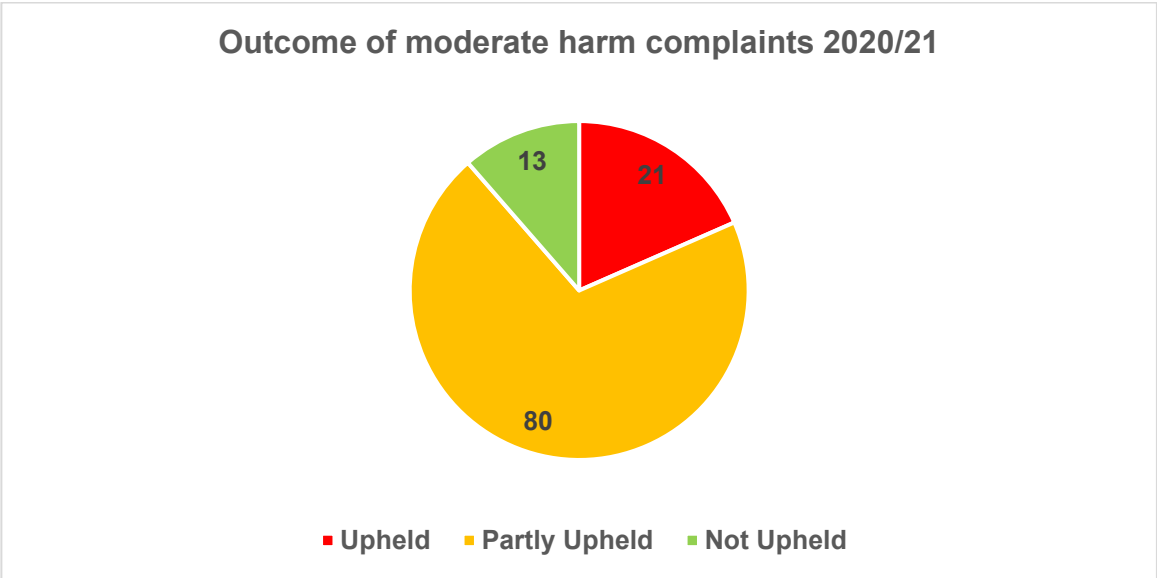


Trust wide 91% of complaints were responded to on time which is an increase in performance from 2019/20 of 1.8%.

9. Complaints by outcome

The chart below shows the number of moderate harm (Amber) complaints upheld, partially upheld, or not upheld (taken from those that were resolved as at 01/04/2021). There were 157 moderate harm complaints received in 2020/21.

Chart 5 - Moderate and Severe Harm Complaints Outcome 2020/21



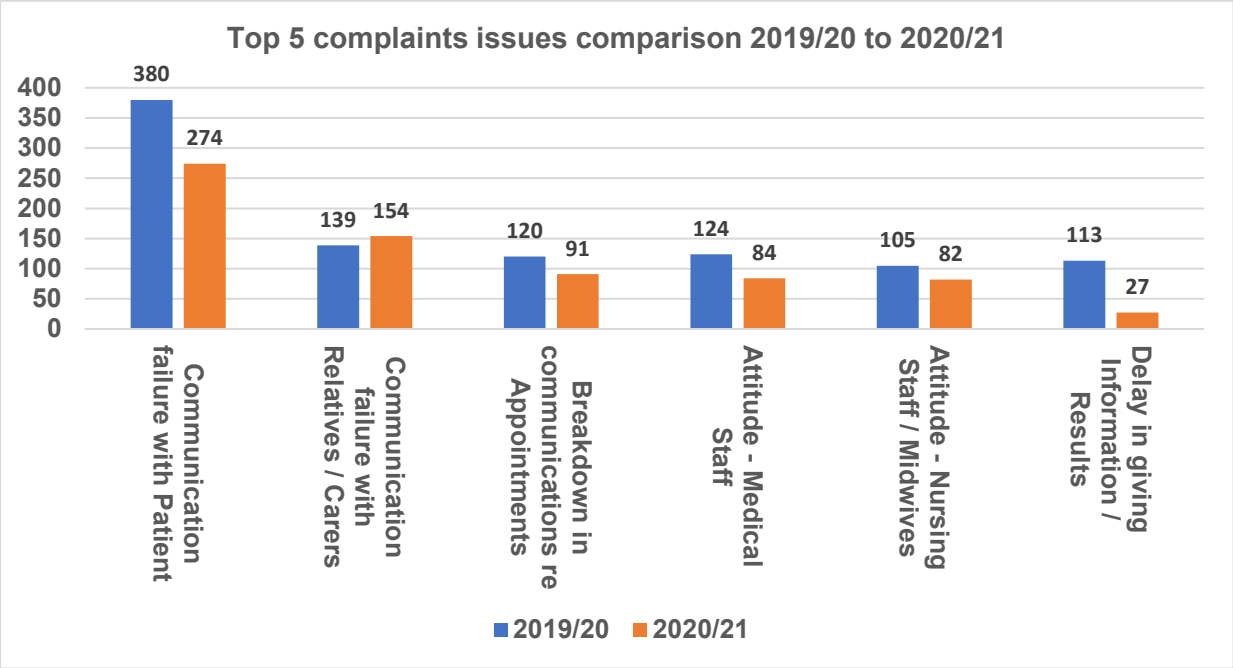
10. Category of Complaints

Complaints are recorded and categorised to help the organisation identify themes and trends and identify improvement actions in response to the findings.

Each issue reported in a complaint is logged onto the complaints database (DATIX) using the category it pertains to. Some complaints have more than 1 issue and to ensure a true reflection of issues encountered all issues are recorded.

The chart below gives a comparison of the top 5 issues raised in complaints for 2019/20 and 2020/21.

Chart 6 – Comparison of top 5 categories for 2019/20 and 2020/21



Communication and staff behaviour and attitude account for most of the Trust's complaints for 2020/21 with this position not having changed when compared to 2019/20.

In respect of complaints raised regarding staff behaviour and attitude the staff involved are asked to ensure that they undertake a reflective piece of work following receipt of a complaint. This reflection should be shared with their manager to confirm that there has been learning as a result and they understand the effect that their behaviour has had on the person's experience. If during the complaint investigation issues of a serious nature come to light the Chief Nurse or Medical Director are made aware and their advice sought.

11. Internal monitoring

The numbers and subjects of complaints are shared with the Board in the quarterly Complaints and PALS report.

Governance Groups are provided with a summary of complaints for each CSU by their Clinical Governance Lead. The summary encompasses details of complaints received by individual service..

13. Reopens

If a complainant remains unhappy with the response to their complaint they are encouraged to return to the Trust with their outstanding issues. These files are reopened and further investigation if required takes place with the final resolution taking the form of a meeting with the complainant or a further written response. The re-opening of a file takes place to enable the Trust to understand why a complainant is unhappy with their initial complaint response and to ensure that any outstanding issues are dealt with in a timely manner and this performance can be measured.

The number of complaints that have been reopened for further investigation in this year amounted to 38 (4.57%). This is an improvement in performance when comparing the reopens from 2019/20 (82= 6.68%). There is no national guidance regarding the re-opening of complaints and therefore no benchmarking either locally or nationally is available.

14. Complaints and the Parliamentary and Health Services Ombudsman (PHSO)

If a complainant is dissatisfied with the way their complaint has been dealt with by the Trust and local resolution of their complaint has not been satisfactory the complaint can be brought to the attention of the Parliamentary and Health Service Ombudsman (PHSO), for independent review. The PHSO will request a copy of the complaint file and medical records and any other relevant documentation to enable them to fully consider how the complaint has been dealt with and if there is anything further the Trust should do to address the complaint.

During this year 2 (0.24%) complaints have been sent to the Parliamentary Health Service Ombudsman (PHSO) for review. A decision by the PHSO, on both complaints, is still awaited (May 2021). This is an improvement on performance compared with 2019/20 (0.41%).

15. PALS activity

The PALS team deal with calls from patients and the public requesting information, advice or the need of signposting to a different organisation or department.

The number of contacts in this respect, for the year 2020/21 with a comparison for previous years, is shown below.

	2018/19	2019/20	2020/21
Feedback	112	62	66
Information	1262	1134	735
Signposting	710	814	557
Total	2084	2010	1358

16. Lessons learned, and actions taken from complaints

The Trust values the opportunity that each complaint brings to learn and improve and recognises the importance of sharing the learning from complaints across the organisation for the benefit of our patients and their families, and staff. We continue to strive to demonstrate the changes that have been made as a result of the learning from complaints and to sustain the changes for long term improvement.

The Trust acts on feedback to make improvements to its services wherever possible. Details of lessons learned and actions taken are inputted on Datix. Every action mentioned in the response to the complainant, is allocated for completion to the responsible member of staff through the DATIX system.

There have been many actions for complaints this year across the CSU's including:

- Dissemination of lessons learned/shared learning - by discussion at staff meetings, one to one supervision for reflection and reiteration of correct practice to individuals or groups of staff and audit
- Processes/Procedures/Guidelines/Policy - amended/review or new
- Staff training, individual/group ongoing and training
- Patient information leaflets reviewed or new

17. Achievements

We care

In April 2021 the Complaints and PALS team launched a dedicated email address where relatives could send letters and photographs to their loved ones. The letter and photographs were laminated by the team and delivered to the ward areas. If the patient was unable to read their letters, ward and support staff would read the letters to them. Letters were also read to a patient at the end of life whilst a member of staff was sat with the patient. This service will continue to be available to patients and their families.

In response to the Covid-19 pandemic and the resultant restrictions for visitors to the hospital a relative's line was set up to enable families to call for a general update on their loved one. This service was put in place due to the pressure on the ward areas

and staff needing to concentrate wholly on the care of patients. The line was administrated by the PALS team with calls returned by registered nurses.]

Compliments

All compliments received into the Trust are now logged on to the Trust's database, Datix, and shared with the staff named in the compliment and their managers. The CEO writes to all staff mentioned in any compliment to thank them for their contribution to improving the experience for our patients.

We collaborate

The Complaints and PALS team in collaboration with the Chaplaincy Services and the Volunteering team undertook a virtual national presentation for Fab Change day (the Fab Academy) in October 2020 celebrating the services that were put in place for patients and their families during the pandemic. This was very well received by the academy.

Both the complaints and the PALS team launched surveys to gather feedback on their services. The surveys run continuously and encourage complainants/users of the service to feedback on their specific experience regarding the team(s). The feedback from surveys is used to highlight good practice and for this to be shared and to recognise where improvements should be made. The results and information regarding the action taken is reported in the Complaints and PALS quarterly reports.

PALS receive many calls from people who need to contact colleagues at other Trusts and organisations i.e., they wish to make a complaint about a GP, or they need to know how to obtain a copy of their health records. These callers are provided with the information they need on how this can be achieved. An analysis of calls is undertaken at the end of each quarter. Should there be a number of calls regarding a particular service, the team ensures the Trust's internet pages are updated with details of how services can be accessed within the hospital and contact details are provided for other organisations. Moving forward collaborative work will be undertaken with other organisations to improve the patient's experience in respect of contact.

The Complaints and PALS team moved the recording of staff sickness and absence to E-Rostering. This has resulted in a more uniformed approach in line with other teams across the Trust.

We communicate

The patient experience internet pages on the Trusts website, 'Tell Us About Your Care' were re-written during the summer. The new pages make it easier for our patients and their families to find information on how they can feedback on their care/the care of a loved one and details the actions that have been taken as a result of feedback in a 'You Said, We Did' page.

Training sessions in respect of communication issues have been held with the medical teams in the Emergency Department. The training focuses on considering that each person is an individual and has individual needs and that communication styles must

be adapted to meet the needs of the recipient, taking into account the impact their illness/condition is having on their life.

We contribute

The team offer a shadowing programme to staff who, as part of their development, have expressed an interest in finding out more about the team. The person shadowing spends time with both teams and the Head of Patient and Family Experience to obtain a full picture regarding how feedback is collected and how it is acted upon. An activity booklet is provided to the member of staff which enables them to reflect on what they have learned so they can take this back to their workplace for sharing.

In the summer of 2020, in conjunction with NHS Elect and staff across the Trust, a training package was made available to complaints and PALS staff. The training focused on written skills and how to produce professional communications. The training also explored how Trust staff feel about receiving a complaint and the impact it has. This work was intended to support the complaints and PALS team to understand the perspective of clinical staff regarding complaints and to encourage empathy and civility amongst the teams. This training has been followed up monthly with the team receiving monthly training on subjects that will improve the service for our patients and staff.

During March 2021, virtual training sessions were held with Milton Keynes College, Health and Social Care Students. The training session focused on what good patient experience looks like and was delivered by the Head of Patient and Family Experience and the Complaints Office Manager. The sessions were well received by the students and the college have requested this is repeated when they receive a new cohort of students.

18. Conclusion

It is the responsibility of all staff to deal with any complaint or concern that is brought to their attention. If the member of staff is not able to deal with the issue, then they must escalate this to their manager. Patients and their families should never be discouraged from making a complaint and information on how to make a complaint is available on the Trust's internet site and in the complaints and PALS leaflets and through PALS and available on all ward areas/departments.

The complaints process used at MKUH is aligned to local policy and national regulations and guidance and, as such, all complaints are encouraged and dealt with in a timely manner with an appropriate response being given. The themes and trends from complaints were considered when setting the priorities for the Trust's Patient Experience Strategy 2020/23.

Meeting Title	**Trust Board**	**Date: 4 November 2021**
Report Title	**Workforce Report**	**Agenda Item: 15**
Lead Director	**Name: Danielle Petch**	**Title: Director of Workforce**
Report Author	**Name: Paul Sukhu**	**Title: Deputy Director of Workforce**

Key Highlights/ Summary	This report provides a summary of workforce Key Performance Indicators for the full year ending 30 September 2021 (Month 6) and relevant Workforce and Organisational Development updates to Trust Board			
Recommendation *(Tick the relevant box(es))*	**For Information** ✓	**For Approval** ☐	**For Noting** ☐	**For Review** ☐

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

Report History	
Next Steps	TEG, 10 November 2021 JCNC, 11 September 2021
Appendices/Attachments	

1. Purpose of the report

1.1. This report provides a summary of workforce Key Performance Indicators as at 30 September 2021 (Month 6), covering the preceding 13 months.

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

Indicator	Measure	Target	09/2020	10/2020	11/2020	12/2020	01/2021	02/2021	03/2021	04/2021	05/2021	06/2021	07/2021	08/2021	09/2021
Staff in post (as at report date)	WTE		3243.8	3245.1	3256.5	3251.3	3250.0	3284.0	3311.6	3337.3	3304.1	3310.7	3328.5	3321.9	**3328.6**
	Headcount		3727	3728	3738	3729	3730	3765	3795	3826	3793	3797	3810	3799	**3807**
Establishment *(as per ESR)*	WTE		3607.7	3633.1	3630.6	3634.2	3635.5	3635.4	3635.4	3662.8	3677.7	3681.7	3675.1	3714.0	**3724.7**
	%, Vacancy Rate	10%	10.0%	10.6%	10.2%	10.5%	10.6%	9.5%	8.7%	8.9%	10.2%	10.1%	9.4%	10.6%	**10.6%**
Staff Costs (12 months) *(as per finance data)*	%, Temp Staff Cost		12.1%	11.9%	11.7%	11.7%	11.6%	11.6%	11.6%	11.3%	11.3%	11.4%	11.6%	11.7%	**11.9%**
	%, Temp Staff Usage		12.2%	12.0%	11.9%	11.8%	11.8%	11.8%	11.8%	11.7%	11.8%	12.0%	12.2%	12.4%	**12.6%**
Absence (12 months)	%, 12 month Absence Rate	4%	4.5%	4.6%	4.7%	4.8%	5.0%	5.1%	4.8%	4.5%	4.4%	4.5%	4.6%	4.7%	***4.8%***
	- %, 12 month Absence Rate - Long Term		*2.4%*	*2.6%*	*2.6%*	*2.7%*	*2.7%*	*2.8%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.8%*	*2.8%*	***2.9%***
	- %, 12 month Absence Rate - Short Term		*2.1%*	*2.1%*	*2.1%*	*2.2%*	*2.4%*	*2.3%*	*2.1%*	*1.8%*	*1.8%*	*1.8%*	*1.8%*	*1.9%*	***1.9%***
	%,In month Absence Rate - Total		4.0%	4.1%	5.0%	6.1%	6.7%	4.7%	3.6%	3.3%	4.2%	4.4%	4.6%	5.0%	***5.1%***
	- %, In month Absence Rate - Long Term		*2.5%*	*2.7%*	*2.6%*	*3.6%*	*2.9%*	*2.9%*	*2.4%*	*2.3%*	*2.9%*	*2.8%*	*3.3%*	*3.2%*	***3.5%***
	- %, In month Absence Rate - Short Term		*1.5%*	*1.4%*	*2.4%*	*2.5%*	*3.8%*	*1.8%*	*1.2%*	*1.0%*	*1.3%*	*1.6%*	*1.3%*	*1.9%*	***1.5%***
	- %, In month Absence Rate - COVID-19 Sickness Absence		0.2%	0.2%	1.1%	2.1%	3.3%	1.3%	0.5%	0.4%	0.4%	0.3%	0.5%	0.6%	***0.6%***
Starters, Leavers and T/O rate (12 months)	WTE, Starters		360.5	336.0	329.9	329.2	313.0	318.0	311.6	322.2	321.3	330.7	331.7	327.9	**333.0**
	Headcount, Starters		413	386	376	373	358	363	356	367	367	376	377	374	**376**
	WTE, Leavers		249.0	241.2	244.7	240.1	233.7	229.3	203.4	204.5	215.6	219.7	223.0	216.8	**227.7**
	Headcount, Leavers		295	286	291	286	278	273	241	244	255	259	264	258	**271**
	%, Leaver Turnover Rate	10%	8.8%	8.5%	8.5%	8.4%	8.2%	8.0%	7.1%	7.1%	7.4%	7.5%	7.7%	7.5%	**7.8%**
	%, Stability Index		86.8%	87.0%	86.9%	87.2%	87.1%	87.0%	87.8%	87.6%	87.5%	87.1%	86.6%	86.5%	**86.2%**
Statutory/Mandatory Training	%, Compliance	90%	95%	94%	95%	95%	95%	96%	97%	95%	95%	96%	96%	95%	**96%**
Appraisals	%, Compliance	90%	92%	93%	91%	90%	92%	93%	95%	95%	93%	92%	89%	90%	**91%**
Medical and Dental Appraisals	%, Compliance	90%	86%	88%	87%	90%	86%	79%	83%	97%	96%	91%	93%	94%	**94%**
Time to Hire (days)	General Recruitment	35	48	47	41	56	49	39	43	48	44	47	48	46	**59**
	Medical Recruitment (excl Deanery)	35	97	71	32	49	34	53	52	49	68	62	68	52	**53**
Employee relations	Number of open disciplinary cases		27	28	25	22	19	23	14	11	14	9	6	6	**7**

2.1. The Trust's **vacancy rate** is unchanged from M5 (10.6%). Nationally there continues to be an increase in vacancy rates although the impact is felt slightly less at MKUH due to improvements in retention and stability over recent years. Headcount and establishment have significantly increased over the past 12 months. The HRBPs continue to work with Clinical Divisions and Recruitment to ensure that vacancies are pursued in line with workforce plans, as well as supporting bespoke recruitment advertising campaigns in Q3.

2.2. Overall **staff absence** has increased slightly while Covid related absence remains the same as previous months from 2021/22. Management of absence remains a key priority for the Trust and is carefully balanced with not putting colleagues under undue pressure to attend work when they are too unwell to do so.

2.3. The **stability index figure** (defined as *proportion of staff in post at end of period who were in post at beginning of period)* has deteriorated slightly in-month to 86.2%. Similarly, **staff turnover** has increased slightly, however, remains well below target; in part attributable to increased support through Staff Health and Wellbeing, engagement through Teams sessions and debriefs to support staff and managers affected by Covid and the ever-improving staff rewards and benefits package.

2.4. **Time to hire** overall remains lower than the same period last year, with General Recruitment being above the KPI. The team have instigated increased support to managers whilst they experience significant clinical pressures, particularly where shortlisting, interviews, and outcomes are creating delays in recruitment due to clinical shortages and reduction in off-ward admin time. Targeted interventions for improvements will start to come into effect by the end of Quarter 3. Factual references have been introduced and face-to-face ID checks have been reinstated and should improve this measure.

2.5. The number of **Open Disciplinary Cases** continues to decrease as the team supports remedial and informal actions, placing emphasis on the learning from events and incidents, promoting support and development. A detailed Employee Relations case report is produced on a quarterly basis for Workforce Board and JCNC.

2.6. **Statutory and mandatory training** compliance is at 96% and **appraisals** compliance has increased to its agreed tolerance of 91% as the Trust's reporting period enters the winter period. The Trust's Pay Progression policy, supported by the HR Services and Learning and Development teams, continues to positively impact on the workforce's motivation to remain compliant and HRBPs continue to raise underperformance against the targets with their Divisions.

3. Continuous Improvement, Transformation and Innovation

3.1. Clinical service delivery is being supported by ongoing efforts to secure long-line agency bookings in areas of ongoing absence and significant clinical pressure. The team are increasing the bank pool across the Trust through a wider advertising

campaign for unqualified technical roles across support services. This is in addition to the rolling bank recruitment campaigns that have commenced.

3.2. The Trust's prevention of violence and unacceptable behaviour steering group has also made good progress, with a poster campaign due to launch in Q3 and steering groups set up to create streamlined processes for staff debriefing and support and a 6-month communication strategy.

4. Culture and Staff Engagement

4.1. The National NHS Staff Survey 2021 was launched with the arrival of surveys on 5 October. The survey fieldwork stage runs until 26 November and as in previous years, the **Protect and Reflect** event provides colleagues who have booked their Covid-19 booster and/or Flu vaccination with the protected time and reflection space to complete their survey. Colleagues, departments and Divisions are encouraged to attend – Protect & Reflect Event 2021 - MKUH - Intranet (or book via the MS Bookings application: MKUH COVID-19 Booster and Flu Vaccinations - Health and Care Staff (office365.com). At the end of the second week of Staff Survey collection, the Trust's response rate is 21.1%

4.2. The Trust's **Inclusion Leadership Council** (ILC) agreed its first formal agenda with council members on 20 October 2021 at a pre-meeting chaired by the Trust Chair. The first ILC is scheduled for 3 November 2021 with a formal update to Trust Board due on its public agenda on 4 November 2021.

5. Current Affairs & Hot Topics

5.1. The Trust's **Vaccination Centre** remains open to run its Covid-19 booster and Flu vaccination programmes for the Trust and various site frequenting/based external partners such as SCAS, CNWL, Willen House, amongst others as part of the Trust's Protect and Reflect event.

5.2. In addition to electronic booking via the MS Bookings application, the Trust has enabled simple email responses to be produced to inform the Staff Health and Wellbeing Team that colleagues have had their vaccinations elsewhere, wish to decline the offer, or cannot have their vaccinations due to medical reasons. Over 100 responses have been received using this means in the first few days. The Trust is also writing directly to colleagues to encourage them to have their vaccinations and complete their Staff Survey.

6. Recommendations

6.1. Trust Board is asked to note and receive the Workforce Report for Month 6.

Meeting Title	Trust Board	Date: 4 November 2021
Report Title	2020 Staff Survey Update	Agenda Item: 16
Lead Director	Name: Danielle Petch	Title: Director of Workforce
Report Author	Name: Danielle Petch	Title: Director of Workforce

Key Highlights/ Summary	This report provides a summary of the ongoing activities in response to the 2020 Staff Survey Report			
Recommendation *(Tick the relevant box(es))*	For Information ✓	For Approval ☐	For Noting ☐	For Review ☐

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

Report History	
Next Steps	
Appendices/Attachments	

1. Introduction

The 2020 Staff Survey report for MKUH was very positive, with the Trust scoring well and/or showing improvement in almost all areas. Only two areas required significant improvement:

1. Staff working beyond their normal hours (Q10b)
2. Staff experiencing violence from patients or their families (Q12a)

In previous years the Staff Survey Goes Large engagement approach has proven to work well and so it was agreed this would be utilised again. Alongside this team-focused approach two Trustwide reviews would take place to address concerns regarding points 1 and 2 above. This paper provides an update on this work.

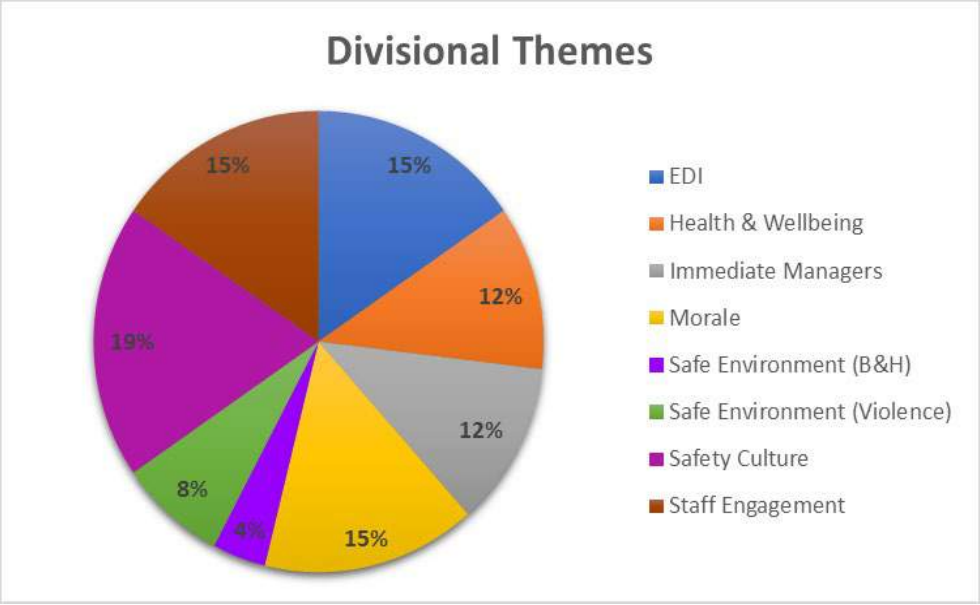
2. Staff Survey Goes Large – Divisional Overview

The HRBPs have been working with their divisions and triumvirate leads to continue to engage with staff to address the theme areas requiring improvement and also to learn from best practice in other divisions where theme areas have exceeded Trust or sector response rates.

This engagement has been in the form of large and small group listening events, allowing staff the chance to share their thoughts and feedback. These events are ongoing and are a mechanism for open two-way feedback between managers and their teams.

The Trust's Staff Survey Heatmap report was used for this work with analysis broken down by division, CSU, and department to identify departments that required this focus. Where less than 11 responses were received by a department (and therefore potentially identifiable), these were analysed as a CSU.

Theme analysis was conducted and identified similar themes occurring across the divisions. This is shown in the chart below.



3. Staff Survey Goes Large - Actions Overview

All managers will continue to review their action plans at departmental meetings and monitor their progress against them. Below is a small subset of the actions from the listening events so far:

- Logging hours worked above and beyond normal working hours closely and ensuring TOIL is taken where appropriate. Reviewing staffing levels to ensure there are enough staff to undertake the work needed in departments.
- Introducing more regular meetings where staff can share feedback with managers, introducing feedback forms to share feedback with managers.
- Manager reaffirming to employees the need to not come to work when unwell – work on culture within teams to address these concerns.
- Introduction of social events within teams, recognition, and celebration of staff locally in these areas which are often overlooked in awards.
- Development meetings with managers, use of appraisals to understand where employees wish to develop their career and how managers can support them.
- Review and gain feedback about how staff want concerns to be raised and to routinely discuss errors that everyone can learn from. To look at the most common issues and improve the process.
- Recruitment with support from the BAME Network, BAME representatives in interviews.
- More focus on Equality, Diversity and Inclusion (ED&I) during recruitment ensuring engagement from a more diverse group of applicants.
- Publicise the positive progress of departments against operational targets, e.g. accelerator programme targets.
- Undertake Cultural Intelligence / Awareness learning with staff.
- Provide mental health support to all staff and run Wellbeing sessions on Teams, including counselling for traumatic events.
- Provide mental health support to both junior and senior doctors and extend this action to the rest of the Trust in collaboration with Staff Health & Well Being (SHWB).
- Proactive promotion of SHWB initiatives and support to all staff - ensure staff are aware of support before they need to ask for it and how to access services, where information is.
- Link in with SHWB to ensure that initiatives are accessible to medics and to understand if anything else could be offered
- Ensure managers review any suggested reasonable adjustments proposed by either the employee or SHWB with HR before deciding on a way forward.
- Promote the use of the Employee Passport for employees to document health conditions, disabilities, or caring responsibilities to ensure support is given and that any line manager is aware of the support needed without the employee having to re-discuss their needs.

4. Staff Working Beyond Their Normal Hours

The Workforce Teams continue to monitor the number of hours staff are working over and above their contracted hours, both paid and unpaid.

In recent months there has been unprecedented demand on services, both during the pandemic and the recovery. The Trust is an accelerator site and so additional activity has been taking place. Staff are working additional shifts through the bank to ensure they are compensated fairly for their additional efforts. Hours worked overall are monitored through the e-Rostering system to ensure no-one is working excessive hours.

In addition to the paid hours it is recognised that some staff are doing additional unpaid hours. NHS contracts for 8a and above do not allow for additional paid hours, stating the hours worked are as reasonably required to complete the tasks of the role. In recent times it has been noted that there is unprecedented demand so people have gone above and beyond their usual role. As a result, in a small number of cases, staff at band 8a and above have been permitted to also undertake bank work so as to ensure they are paid for their additional hours.

In all cases the Workforce teams monitor the hours being worked and people are actively discouraged from working excessive hours.

Finally, all staff have been reminded periodically throughout the year to ensure they are taking their leave and the opportunity to rest and recharge.

5. Violence and Aggression Reduction Group

A Violence and Aggression Reduction Group was formed to review the reports of violence and aggression and to suggest ways to target it. The Group is jointly chaired by the Director of Corporate Affairs and the Director of Workforce and is being driven operationally by the ADO HR and the Health and Safety Lead.

To date the Group has:

- Reviewed the incidents reported to try to establish common themes
- Reviewed the Trust's policy and procedures in this area
- Completed a "self assessment" to determine areas for improvement
- Compared and contrasted MKUH processes with NHS best practice processes to determine further areas for improvement
- Designed and about to launch a poster campaign aimed at reducing violence in patient areas and increasing reporting of incidents
- Formed task and finish groups to take forwards focussed pieces of work:
    - Debriefing and Staff Support – reviewing and redesigning the procedure/process for debriefing and supporting staff following an incident
    - Comms & Listening – planning and implementing a series of listening and engagement events to hear from staff who have experienced violence and aggression

- Behaviour Marking on eCARE - design a way of recording on eCARE if a patient is likely to be violent or aggressive towards staff and/or patients

6. 2021 Staff Survey

The 2021 Staff Survey campaign began in early October 2021 as part of the Trust's 2nd annual Reflect and Protect event, incorporating the staff survey and flu/covid vaccination campaigns. The campaign will continue until the end of November, when the national staff survey closes, after which time the vaccine centre will remain open into December.

So far, uptake has been positive with over 25% of the Trust having completed and returned their staff survey by the end of the second week of the campaign. Last year 45.5% of the Trust returned their survey and so the Trust is on target for an improved return rate this year if attendance continues at the current rate.

Alongside the staff survey, colleagues are also being given the chance to complete the Trust's travel survey and benefits survey, both of which will be used to influence strategic agendas in the coming months.

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	Trust Board of Directors	Date: 04/11/2021
Report Title	2021-22 Executive Summary M06	**Agenda Item:** 17
Lead Director	**Name:** John Blakesley	**Title:** Deputy CEO
Report Author	**Name:** Performance and Information Team	**Title:**

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

Strategic Objectives Links	Improving patient safety Improving patient experience Improving the effectiveness of the care provided Improving access to timely care
Board Assurance Framework (BAF)/ Risk Register Links	The need to improve patient safety, experience, effectiveness of clinical care and access to case are key risks identified on BAF.

Report History	The Trust Executive Group and the Finance and Investment Committee meetings in October 2021
Next Steps	N/A
Appendices/Attachments	a. Performance Report b. Balanced Scorecard c. ED Performance – Peer Group Comparison

Trust Performance Summary: M06 (September 2021)

1.0 Summary

This report summarises performance in September 2021 for key performance indicators and provides an update on actions to sustain or improve upon Trust and system-wide performance. This commentary is intended only to highlight areas of performance that have changed or are in some way noteworthy. It is important to highlight that the NHS Constitution Targets remain in situ and are highlighted in the table below.

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

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

2.0 Sustainability and Transformation Fund (STF)

Performance Improvement Trajectories

September 2021 performance against the Service Development and Improvement Plans (SDIP):

ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1	ED 4 hour target (includes UCS)		Not Available		86.4%	82.1%	Not Available	▼	Not Available	
4.2	RTT Incomplete Pathways <18 weeks					61.0%		▼		
4.9	62 day standard (Quarterly)		85%	85%		74.6%	×	▼		

In September 2021 the ED performance was 82.1%. Although this was a slight deterioration in performance when compared to 82.3% in August 2021, MKUH performance was significantly higher than both the national overall performance of 75.2% and the majority of its Peer Group (see Appendix for details).

The Trust's RTT Incomplete Pathways <18 weeks performance stood at 61.0% at the end of September 2021. This was a deterioration on the performance at the end of August 2021 of 66.4%.

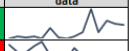
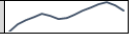
The Trust has put in place robust activity recovery plans, which will support further improvement in RTT performance and closely manage the cancellation of any non-urgent elective activity and treatment for patients on an incomplete RTT pathway.

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

For Q1 2021/22, the Trust's provisional 62-day standard performance (from receipt of an urgent GP referral for suspected cancer to first treatment) was 74.6% against a national target of 85%.

The provisional performance of the percentage of patients who started treatment within 31 days of a decision to treat was 94.0% against a national target of 96%. The percentage of patients who attended an outpatient appointment within two weeks of an urgent referral by their GP for suspected cancer was 86.0% against a national target of 93%.

3.0 Urgent and Emergency Care

ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.4	Cancelled Ops - On Day		1%	1%	0.65%	0.62%	✓	▲	✓	
3.2	Ward Discharges by Midday		25%	25%	14.9%	12.8%	×	▼	×	
3.4	30 day readmissions		7%	7%	7.1%	8.0%	×	▼	×	
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)		53			62	×	▲		
3.9	Ambulance Handovers >30 mins (%)		5%	5%	10.6%	12.1%	×	▼	×	
4.2	RTT Incomplete Pathways <18 weeks		Not Available			61.0%	Not Available	▼		

Cancelled Operations on the Day

In September 2021, there were 15 operations cancelled on the day for non-clinical reasons as detailed below:

Cancellation Reason	Number of Cancellations
Staffing Issue	5
Insufficient Time	3
Bed Availability	2
No Reason Provided	2
Patient Injury	1
Medication Issue	1
Equipment Availability	1

Readmissions

The Trust's 30-day emergency readmission rate in September 2021 was 8.0% (please note that the readmission rate in September 2021 may include patients that were readmitted with Covid-19).

This was a deterioration in performance when compared to the August 2021 rate of 7.7%.

Delayed Transfers of Care (DTOC)

The number of DTOC patients reported at midnight on the last Thursday of September 2021 was 25 patients: 21 in Medicine and four in Surgery.

This was a deterioration in performance when compared to the number of DTOC patients reported at midnight on the last Thursday of August (21).

Length of Stay (Stranded and Super Stranded Patients)

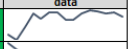
The number of super stranded patients (length of stay of 21 days or more) at the end of the month was 62. This was a decrease on the 77 super stranded patients reported at the end of August 2021.

Ambulance Handovers

In September 2021, the percentage of ambulance handovers to the Emergency Department taking more than 30 minutes was 12.1%.

This was a deterioration in performance when compared to the August 2021 value of 11.8% and is the highest value since January 2020 (15.4%).

4.0 Elective Pathways

ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
3.1	Overnight bed occupancy rate		93%	93%	87.9%	85.5%	✓	▲	✓	
3.5	Follow Up Ratio		1.5		1.40	1.40	✓	▼	✓	
4.2	RTT Incomplete Pathways <18 weeks		Not Available			61.0%	Not Available	▼		

Overnight Bed Occupancy

Overnight bed occupancy was 85.5% in September 2021. This was an improvement compared to the August 2021 occupancy of 88.4% and it remains well within the 93% threshold.

Follow up Ratio

The Trust outpatient follow up ratio in September 2021 was 1.40 which was a slight deterioration in performance when compared to the August 2021 ratio of 1.38.

RTT Incomplete Pathways

The Trust's RTT Incomplete Pathways <18 weeks at the end of September 2021 was 61.0% and the number of patients waiting more than 52 weeks without being treated was 732. These patients were in Surgery (659 patients), Medicine (45 patients), Women and Children (23 patients) and Core Clinical (5).

Diagnostic Waits <6 weeks

The Trust did not meet the national standard of fewer than 1% of patients waiting six weeks or more for their diagnostic test at the end of September 2021, with a performance of 69.6%.

This was an improvement in performance when compared to the August 2021 performance of 67.5%.

5.0 Patient Safety

Infection Control

In September 2021 there were two reported cases of C. Diff in Medicine (one case in Ward 2 and Ward 8 respectively). There was also one reported case of MRSA in Surgery (Ward 6 (DOCC)).

There were no reported cases of E. Coli or MSSA.

ENDS

Appendix 1: ED Performance - Peer Group Comparison

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

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

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

July 2021 to September 2021 ED Performance Ranking

MKUH Peer Group Comparison - ED Performance	Jul-21	Aug-21	Sep-21
Homerton University Hospital NHS Foundation Trust	87.5%	89.6%	86.2%
Milton Keynes University Hospital NHS Foundation Trust	85.4%	82.3%	82.1%
Southport And Ormskirk Hospital NHS Trust	77.2%	77.2%	78.1%
Northampton General Hospital NHS Trust	78.7%	71.5%	73.6%
North Middlesex University Hospital NHS Trust	79.0%	76.2%	72.2%
Oxford University Hospitals NHS Foundation Trust	74.5%	76.6%	72.1%
Buckinghamshire Healthcare NHS Trust	75.2%	74.3%	72.1%
Barnsley Hospital NHS Foundation Trust	66.1%	66.8%	70.2%
The Hillingdon Hospitals NHS Foundation Trust	72.5%	73.3%	69.7%
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	73.2%	68.6%	64.5%
The Princess Alexandra Hospital NHS Trust	70.0%	69.4%	62.9%
Mid Cheshire Hospitals NHS Foundation Trust	66.2%	63.9%	62.4%
Bedfordshire Hospitals NHS Foundation Trust	-	-	-
Kettering General Hospital NHS Foundation Trust	-	-	-

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

Board Performance Report 2021/22
September 2021 (M06)

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

OBJECTIVE 1 - PATIENT SAFETY										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
1.1	Mortality - (HSMR)		100	100		90	✓	▭		
1.2	Mortality - (SHMI)		100	100		111.60	✗	▲		
1.3	Never Events		0	0	0	0	✓	▭	✓	
1.4	Clostridium Difficile		10	5	5	2	✗	▼	✓	
1.5	MRSA bacteraemia (avoidable)		0	0	1	1	✗	▼	✗	
1.6	Falls with harm (per 1,000 bed days)		0.12	0.12	0.15	0.48	✗	▼	✗	
1.7	Midwife : Birth Ratio		28	28	33	33	✗	▲	✗	
1.8	Incident Rate (per 1,000 bed days)		60	60	54.49	48.08	✗	▼	✗	
1.9	Duty of Candour Breaches (Quarterly)		0	0	0	0	✓	▭	✓	
1.10	E-Coli		18	9	7	0	✓	▭	✓	
1.11	MSSA		5	<3	5	0	✓	▲	✗	
1.12	VTE Assessment		95%	95%	97.9%	97.3%	✓	▼	✓	

OBJECTIVE 2 - PATIENT EXPERIENCE										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.2	RED Complaints Received				0	0		▭		
2.3	Complaints response in agreed time		90%	90%	93.6%	89.6%	✗	▼	✓	
2.4	Cancelled Ops - On Day		1%	1%	0.65%	0.62%	✓	▲	✓	
2.5	Over 75s Ward Moves at Night		1,800	900	605	100	✓	▲	✓	
2.6	Mixed Sex Breaches		0	0	0	0	✓	▭	✓	

OBJECTIVE 3 - CLINICAL EFFECTIVENESS										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
3.1	Overnight bed occupancy rate		93%	93%	87.9%	85.5%	✓	▲	✓	
3.2	Ward Discharges by Midday		25%	25%	14.9%	12.8%	✗	▼	✗	
3.3	Weekend Discharges		70%	70%	58.8%	57.3%	✗	▼	✗	
3.4	30 day readmissions		7%	7%	7.1%	8.0%	✗	▼	✗	
3.5	Follow Up Ratio		1.5		1.40	1.40	✓	▼	✓	
3.6.1	Number of Stranded Patients (LOS>=7 Days)		184			178	✓	▲		
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)		53			62	✗	▲		
3.7	Delayed Transfers of Care		20			25	✗	▼		
3.8	Discharges from PDU (%)		15%	15%	7.4%	8.0%	✗	▲	✗	
3.9	Ambulance Handovers >30 mins (%)		5%	5%	10.6%	12.1%	✗	▼	✗	

OBJECTIVE 4 - KEY TARGETS										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1	ED 4 hour target (includes UCS)		Not Available		86.4%	82.1%	Not Available	▼	Not Available	
4.2	RTT Incomplete Pathways <18 weeks					61.0%		▼		
4.4	RTT Total Open Pathways					29,314		▼		
4.5	RTT Patients waiting over 52 weeks					732		▼		
4.6	Diagnostic Waits <6 weeks					69.6%		▲		
4.7	All 2 week wait all cancers (Quarterly) ✎		93%	93%		86.0%	✗	▼		
4.8	31 days Diagnosis to Treatment (Quarterly) ✎		96%	96%		94.0%	✗	▲		
4.9	62 day standard (Quarterly) ✎		85%	85%		74.6%	✗	▼		

OBJECTIVE 5 - SUSTAINABILITY										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
5.1	GP Referrals Received		Not Available		42,160	7,080	Not Available	▲	Not Available	
5.2	A&E Attendances				51,404	8,556		▼		
5.3	Elective Spells (PBR)				12,725	2,105		▲		
5.4	Non-Elective Spells (PBR)				15,639	2,650		▼		
5.5	OP Attendances / Procs (Total)				194,578	32,560		▲		
5.6	Outpatient DNA Rate		6%	6%	6.1%	6.7%	✗	▼	✗	

OBJECTIVE 7 - FINANCIAL PERFORMANCE										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
7.1	Income £'000		Not Available		160,747	28,290	Not Available	▲	Not Available	
7.2	Pay £'000				(103,741)	(18,716)		▼		
7.3	Non-pay £'000				(48,988)	(8,086)		▲		
7.4	Non-operating costs £'000				(9,460)	(1,590)		▼		
7.5	I&E Total £'000				(1,442)	(102)		▲		
7.6	Cash Balance £'000					54,918		▲		
7.7	Savings Delivered £'000				Not Available			Not Available		Not Available
7.8	Capital Expenditure £'000				5,999	858		▲		

OBJECTIVE 8 - WORKFORCE PERFORMANCE										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
8.1	Staff Vacancies % of establishment		10%	10%		10.5%	✗	▼		
8.2	Agency Expenditure %		5%	5%	3.7%	3.4%	✓	▲	✓	
8.3	Staff Sickness % - Days Lost (Rolling 12 months) ✎		4%	4%		4.7%	✗	▼		
8.4	Appraisals		90%	90%		91.0%	✓	▲		
8.5	Statutory Mandatory training		90%	90%		96.0%	✓	▲		
8.6	Substantive Staff Turnover		9%	9%		7.8%	✓	▼		

OBJECTIVES - OTHER										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
O.1	Total Number of NICE Breaches		10	10		4	✓	▭		
O.2	Rebooked cancelled OPs - 28 day rule		95%	95%	79.6%	50.0%	✗	▼	✗	
O.4	Overdue Incidents >1 month		0	0		158	✗	▲		
O.5	Serious Incidents		20	10	47	6	✗	▲	✗	
O.8	Completed Job Plans (Consultants)		90%	90%		90%	✓	▲		

Key: Monthly/Quarterly Change

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

YTD Position

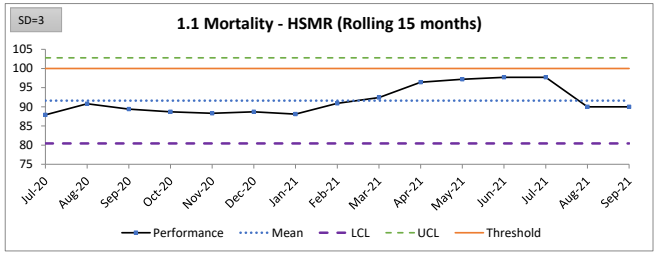
✓	Achieving YTD Target
	Within Agreed Tolerance*
✗	Not achieving YTD Target
✗	Annual Target breached

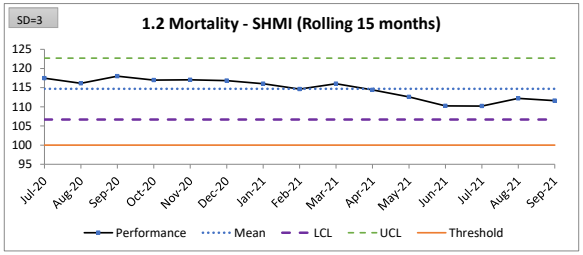
Data Quality Assurance Definitions

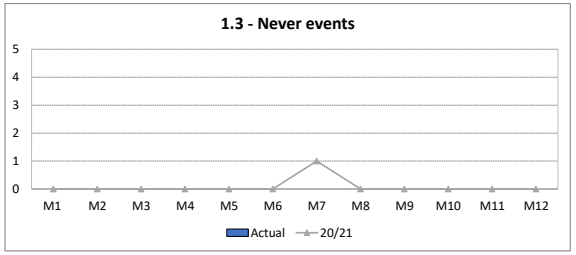
Rating	Data Quality Assurance
Green	Satisfactory and independently audited (indicator represents an accurate reflection of performance)
Amber	Acceptable levels of assurance but minor areas for improvement identified and potentially independently audited * /No Independent Assurance
Red	Unsatisfactory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

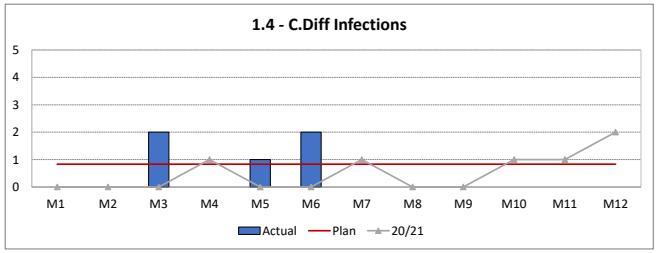
* Independently Audited – refers to an independent audit undertaken by either the Internal Auditor, External Auditors or the Data Quality Audit team.

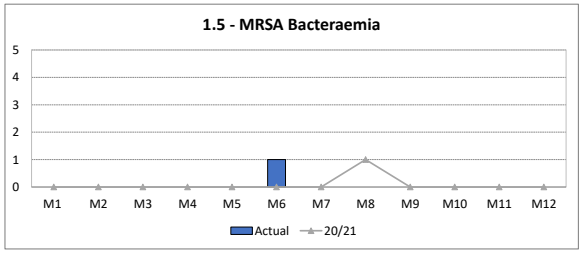
Date Produced: 14/10/2021

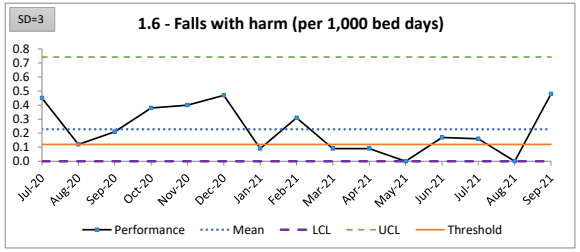


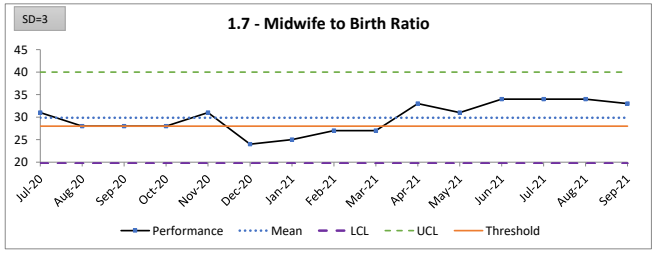


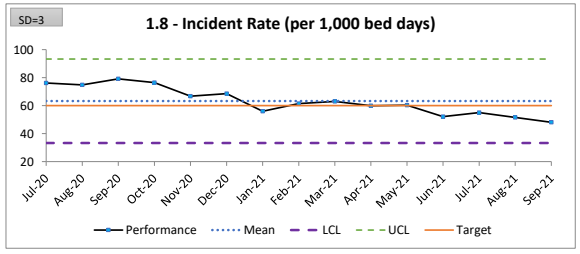


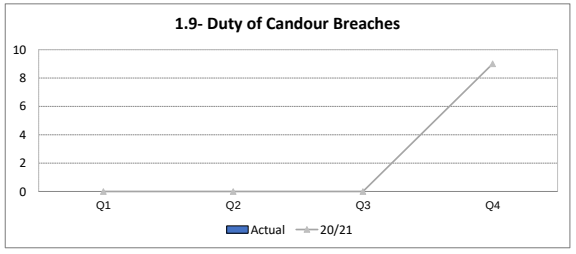


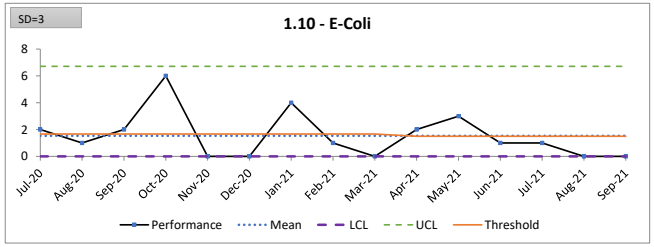


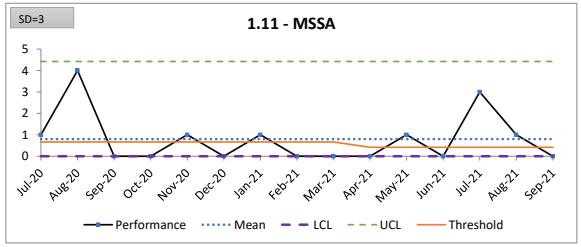


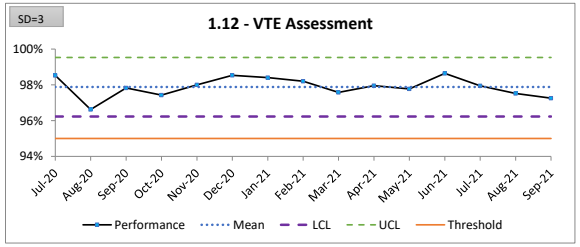








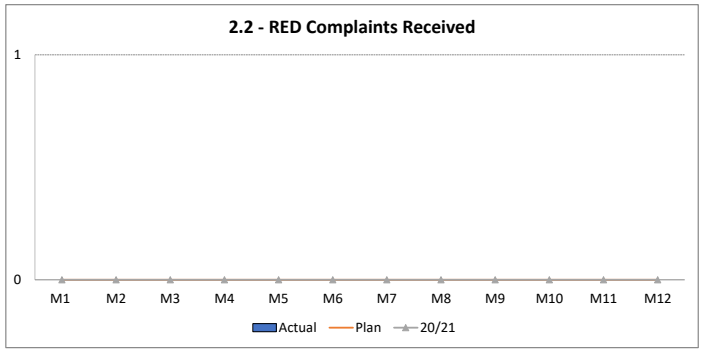


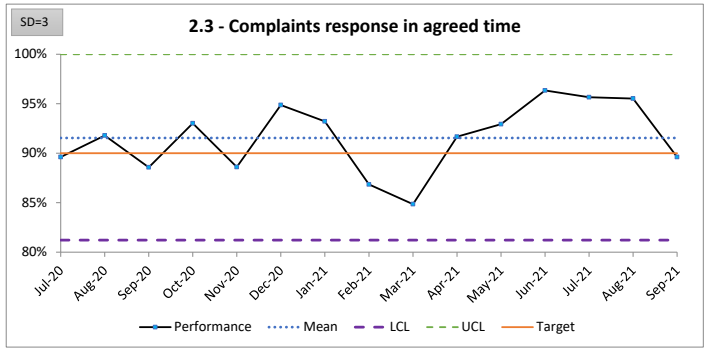


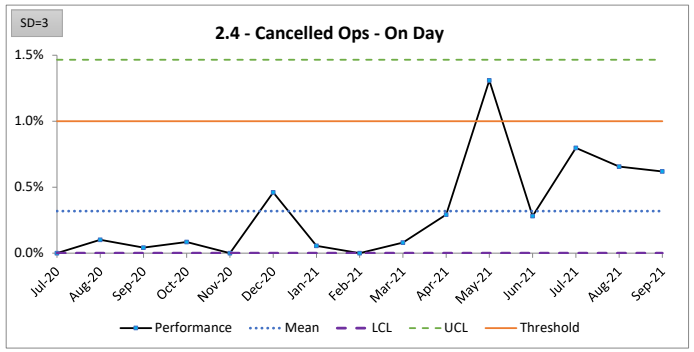
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

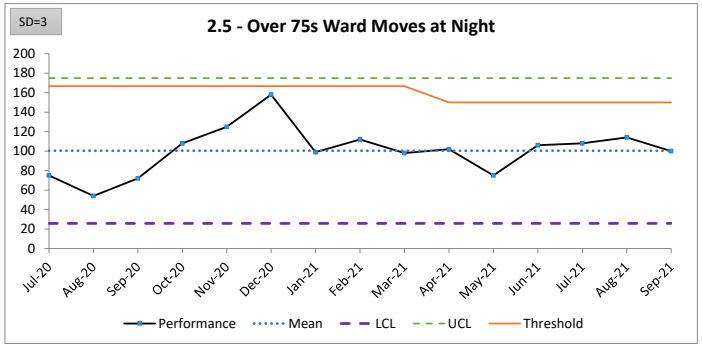
- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

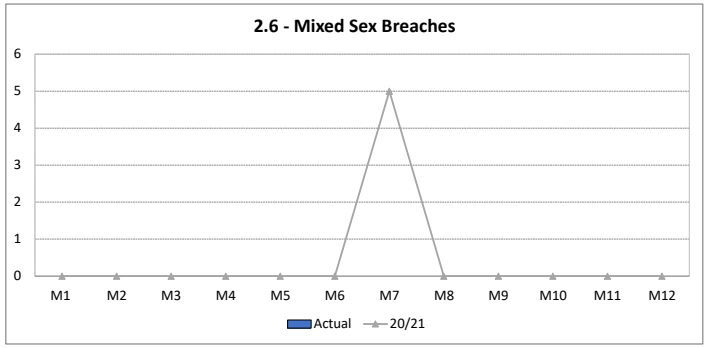
OBJECTIVE 2 - PATIENT EXPERIENCE







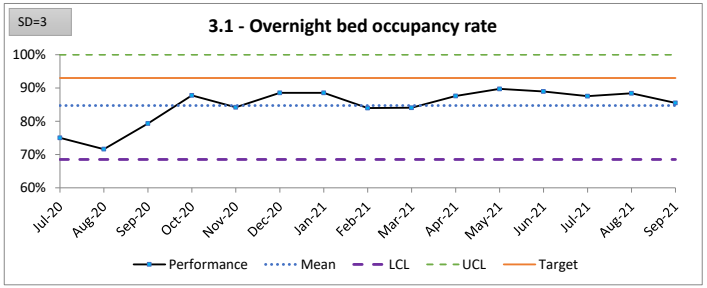


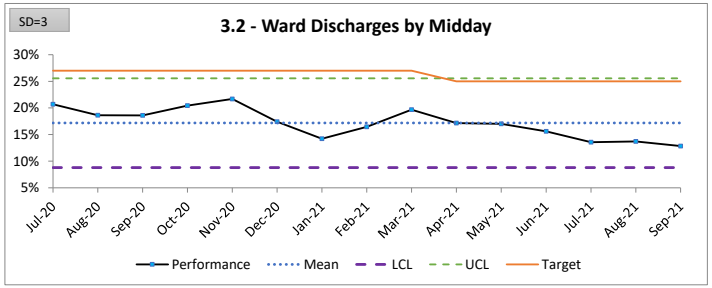


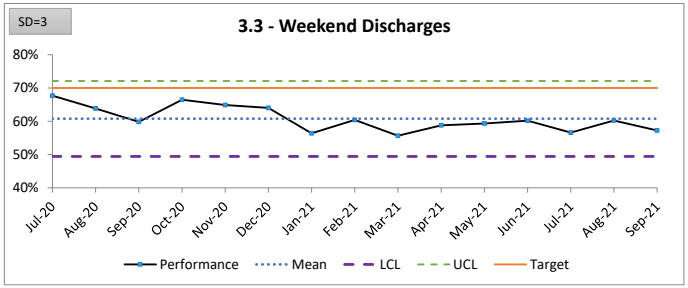
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

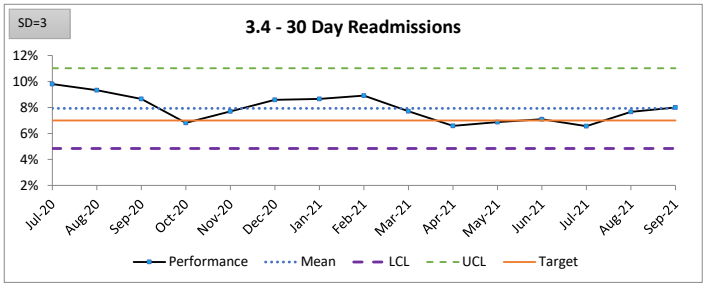
- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

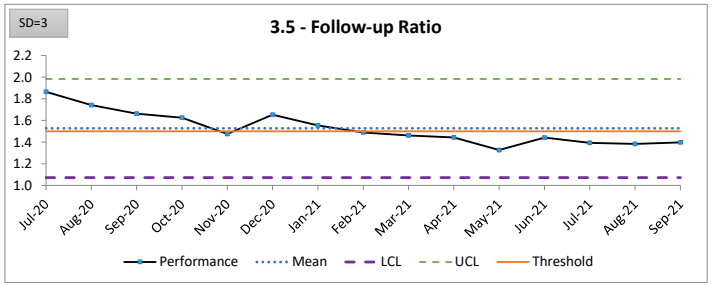
OBJECTIVE 3 - CLINICAL EFFECTIVENESS

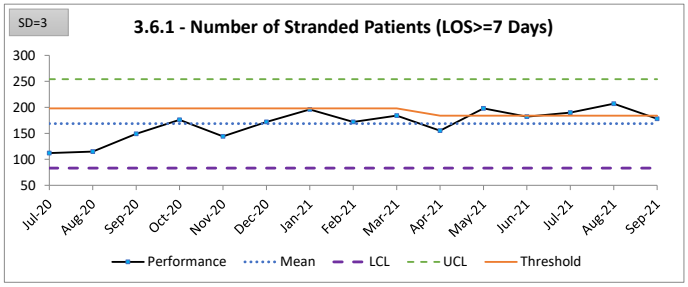


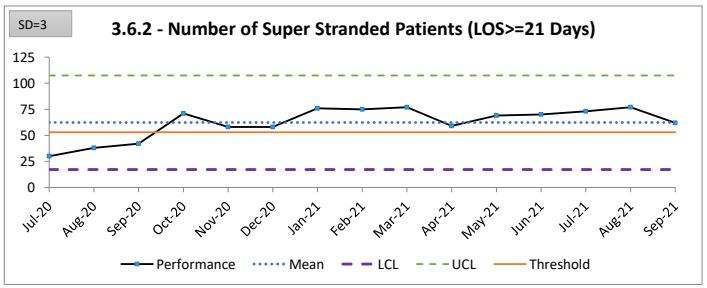


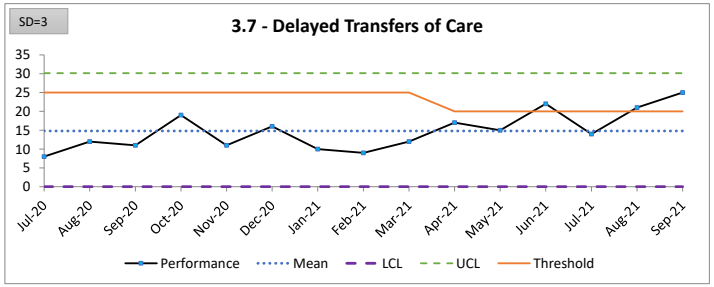


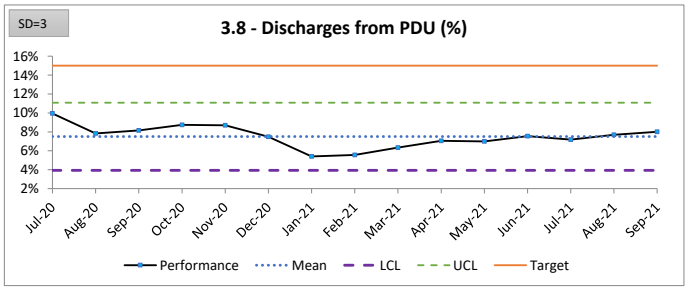


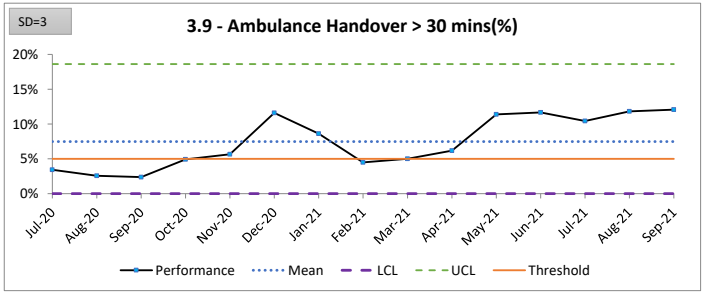








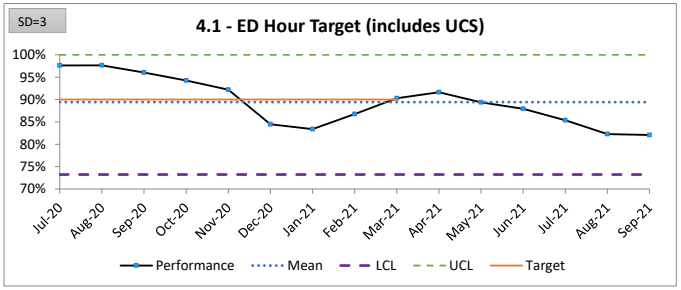


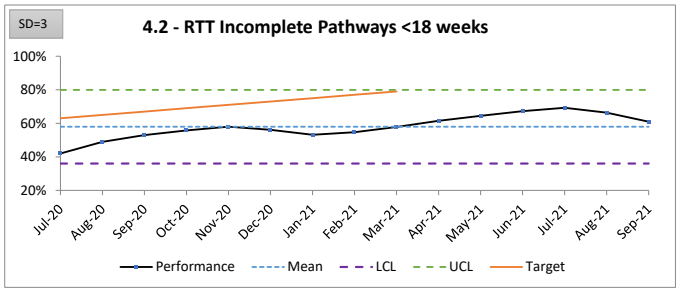


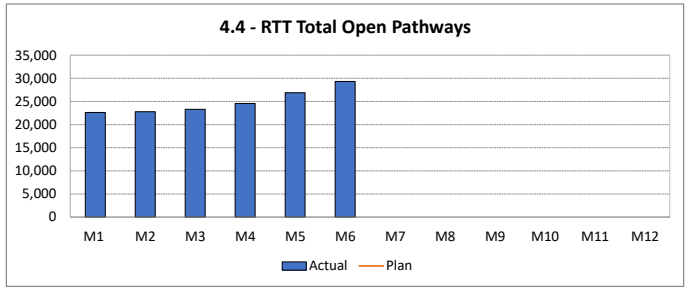
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

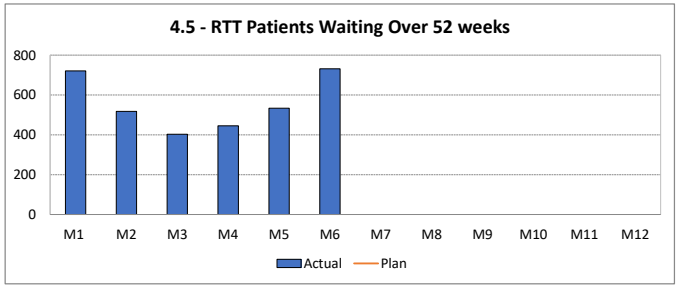
- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

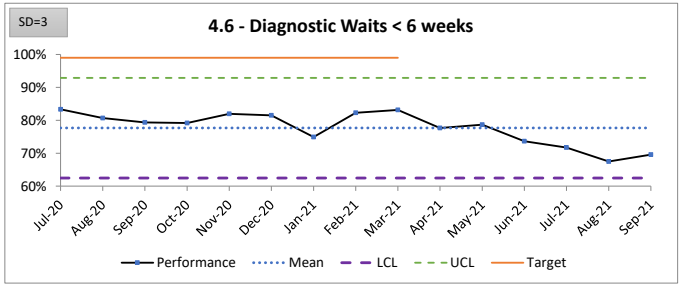
OBJECTIVE 4 - KEY TARGETS

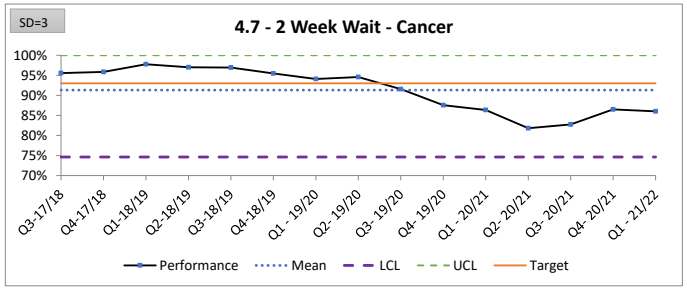


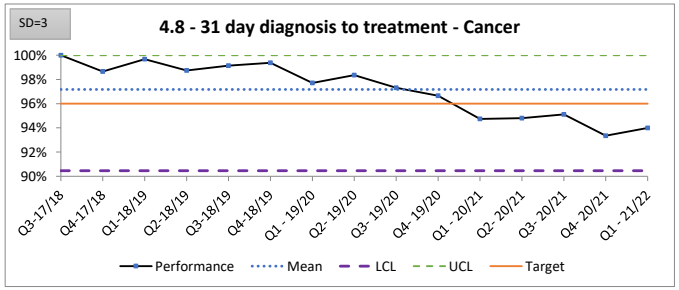


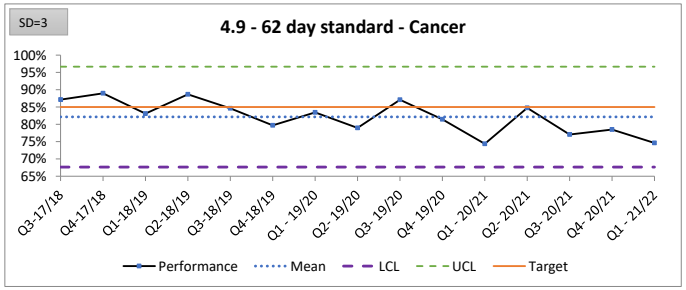






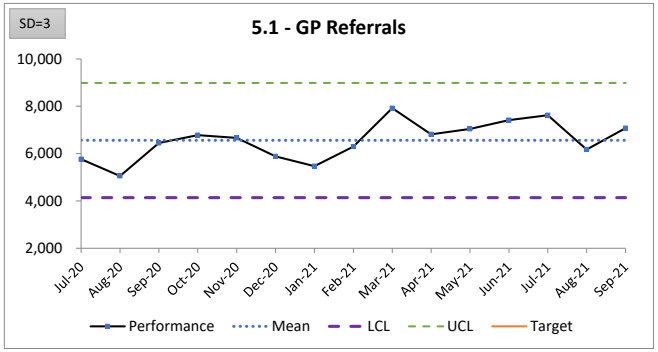


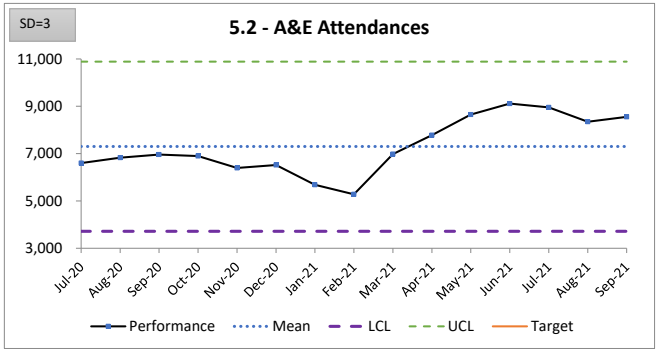


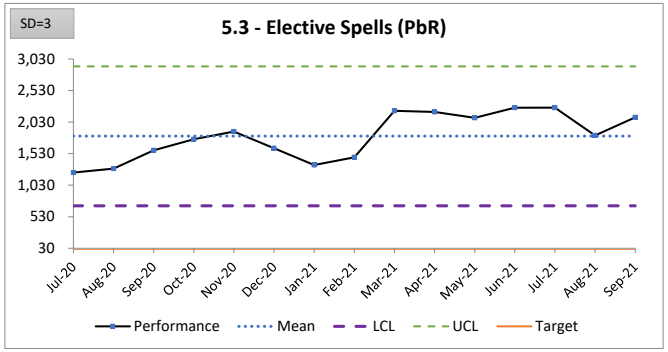


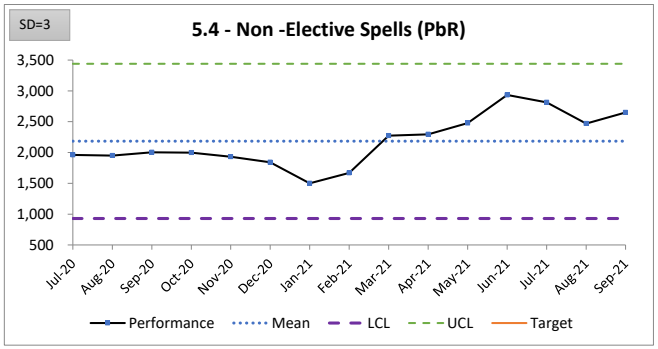
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

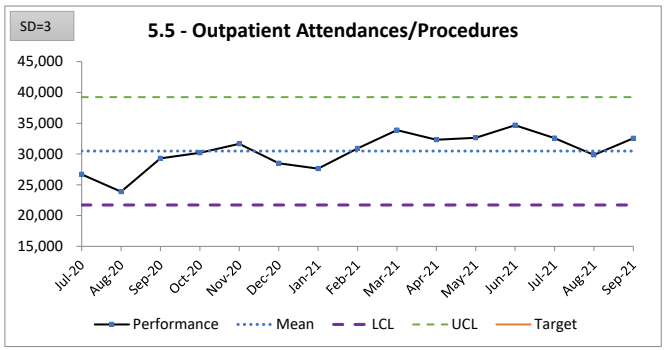
- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

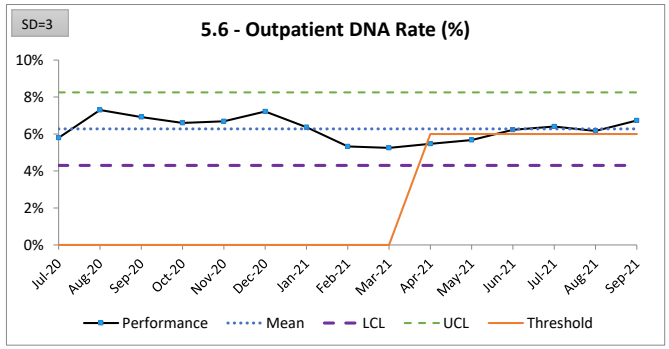








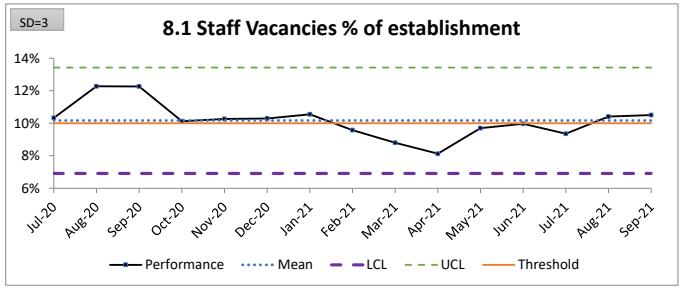


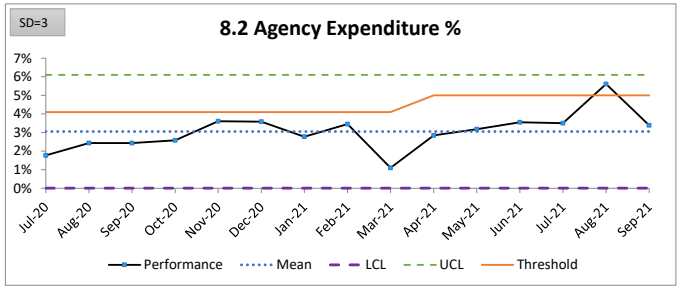


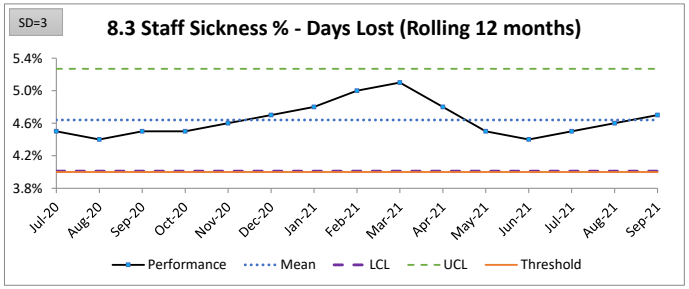
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

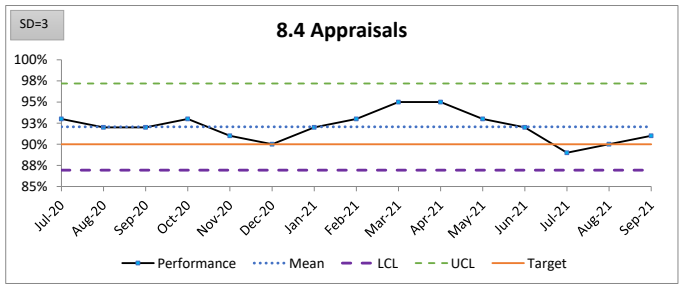
- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

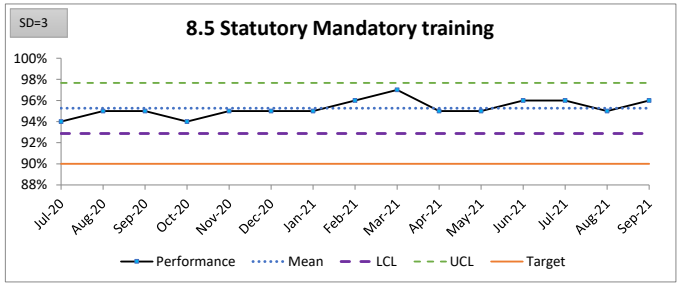
OBJECTIVE 8 - WORKFORCE PERFORMANCE

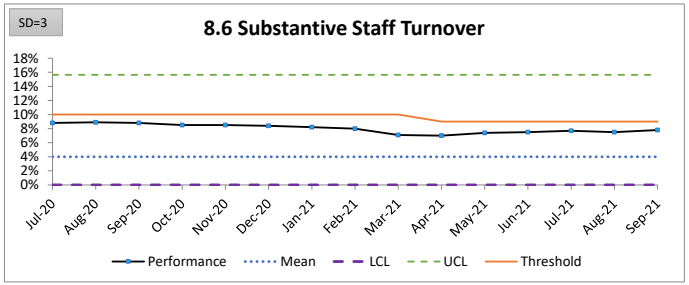










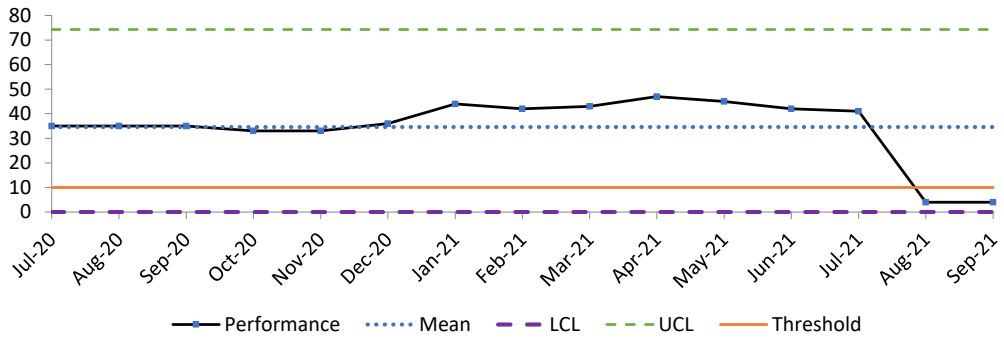


If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

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

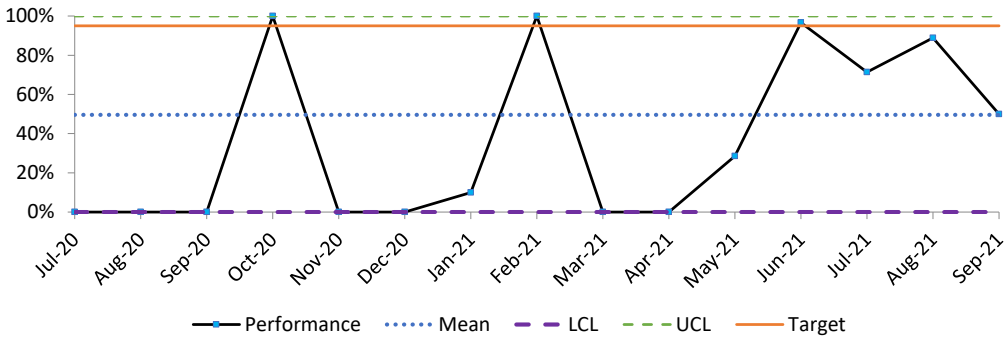
SD=3

O.1 - Total Number of Nice Breaches

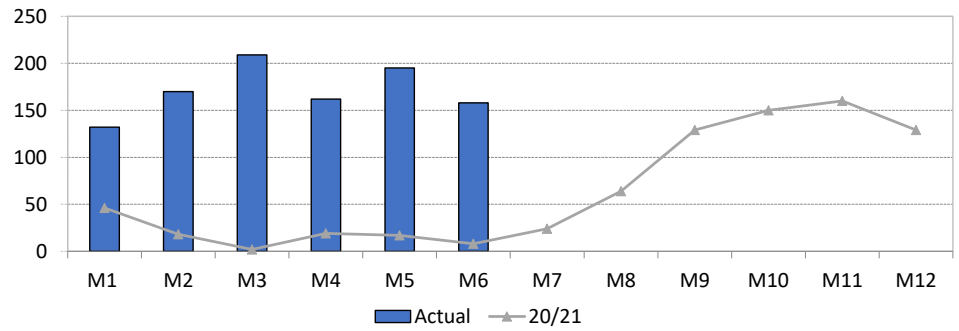


SD=3

O.2 - Rebooked cancelled OPs - 28 day rule

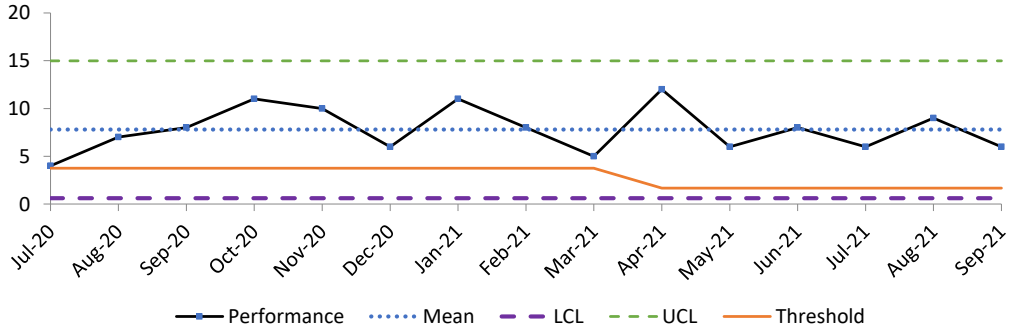


O.4 - Overdue Incidents >1 month



SD=3

O.5 - Serious Incidents

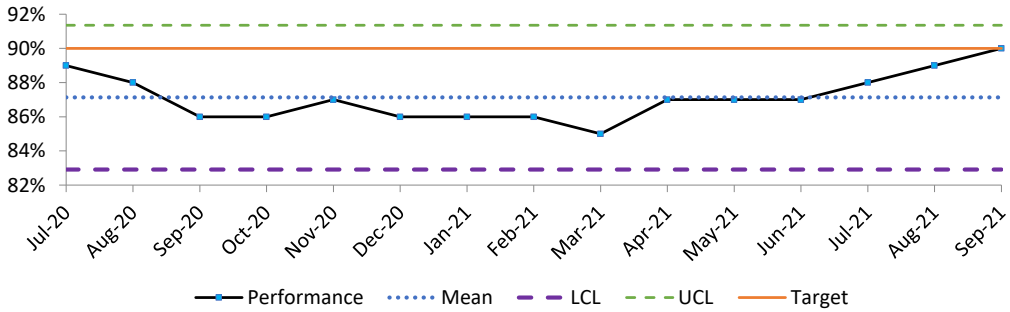


If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

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

SD=3

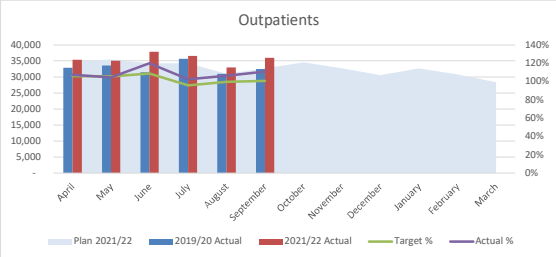
O.8 - Completed Job Plans (Consultants)

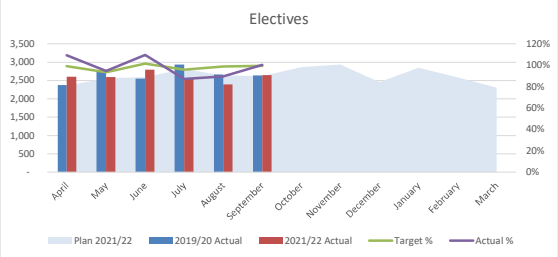


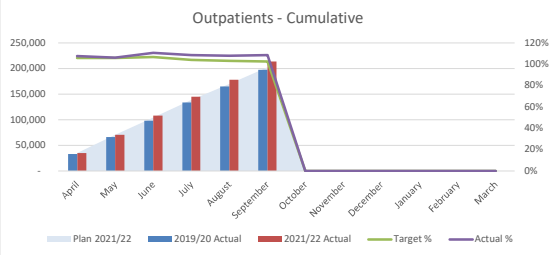
Accelerator Comparison

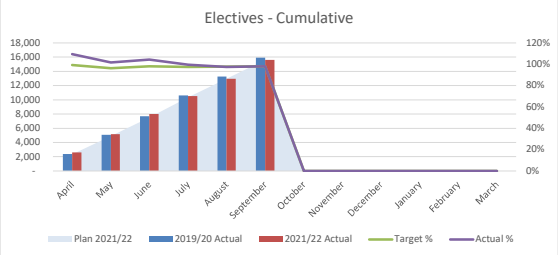
Elective and Outpatient Plan Vs Actual Accelerator Comparison

Include		Y	Y	Y	Y	Y	Y	N	N	N	N	N	N
Month		April	May	June	July	August	September	October	November	December	January	February	March
Outpatients	2019/20 Actual	32,893	33,539	31,526	35,705	31,037	32,484						
	Plan 2021/22	34,840	35,432	34,281	34,271	30,913	32,644	34,512	32,632	30,522	32,640	30,732	28,388
	Target %	106%	106%	109%	96%	100%	100%						
	2021/22 Actual	**35,342**	**35,116**	**37,853**	**36,596**	**32,952**	**36,025**						
	Actual %	107%	104.7%	120.1%	102.5%	106.2%	110.9%						
Electives	2019/20 Actual	2,378	2,732	2,551	2,935	2,667	2,638						
	Plan 2021/22	2,360	2,556	2,590	2,810	2,638	2,622	2,868	2,931	2,453	2,852	2,584	2,308
	Target %	99%	94%	102%	96%	99%	99%						
	2021/22 Actual	**2,599**	**2,590**	**2,795**	**2,557**	**2,391**	**2,651**						
	Actual %	109%	94.8%	109.6%	87.1%	89.7%	100.5%						





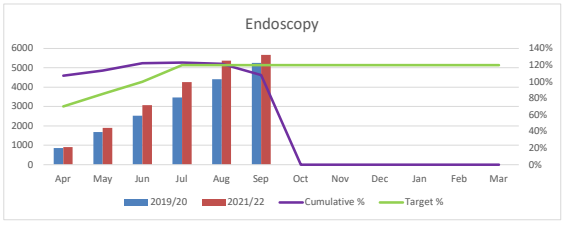


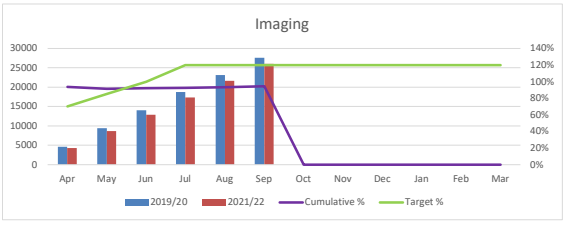


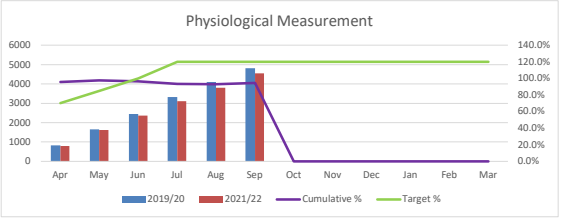
Key:
2019/20 Actual - represents the actual activity associated with FY 2019/20
Plan 2021/22 - represent the divisional planned activity that have been provided by each of the clinical divisions for FY 2021/22
Target % - represents that anticipated "Target Percentage" based on the divisional planned activity for FY 2021/22 against the actual activity during FY 2019/20
2021/22 Actual - represents the actual activity associated with FY 2021/22
Actual % - represents that "Actual Percentage" based on the divisional plan for FY 2021/22 against the FY 2021/22 Actual

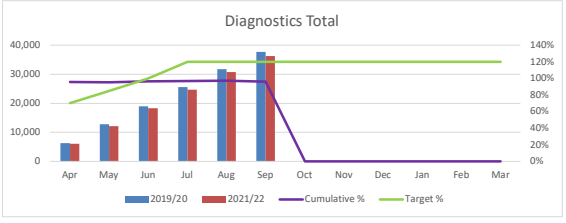
Diagnostics Accelerator Comparison

Include		Y	Y	Y	Y	Y	Y	N	N	N	N	N	N
Month		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Endoscopy	Colonoscopy	355	409	473	408	400	75						
	Cystoscopy	168	190	268	286	266	201						
	Flexi sigmoidoscopy	87	85	104	120	101	8						
	Gastroscopy	299	311	329	376	326	25						
	Total	**909**	**995**	**1,174**	**1,190**	**1,093**	**309**	-	-	-	-	-	-
	Total as % of 2019/20	**107.1%**	**119.6%**	**140.1%**	**124.9%**	**116.0%**	**36.5%**						
	Target	70%	85%	100%	120%	120%	120%	120%	120%	120%	120%	120%	120%
Imaging	Computed Tomography	850	940	796	888	967	796						
	Magnetic Resonance Imaging	460	497	592	651	643	556						
	Non-obstetric ultrasound	3,007	2,846	2,891	2,922	2,647	3,069						
	Total	**4,317**	**4,283**	**4,279**	**4,461**	**4,257**	**4,421**	-	-	-	-	-	-
	Total as % of 2019/20	**93.5%**	**89.3%**	**93.2%**	**93.6%**	**97.1%**	**99.5%**						
	Target	70%	85%	100%	120%	120%	120%	120%	120%	120%	120%	120%	120%
Physiological Measurement	Audiology - Audiology Assessments	180	166	128	106	107	123						
	Cardiology - echocardiography	303	409	355	413	336	383						
	Cardiology - electrophysiology	238	203	210	190	193	164						
	Respiratory physiology - sleep studies	56	22	44	32	64	63						
	Urodynamics - pressures & flows	17	16	13	4	-	4						
	Total	**794**	**816**	**750**	**745**	**700**	**737**	-	-	-	-	-	-
	Total as % of 2019/20	**95.8%**	**99.6%**	**94.2%**	**84.7%**	**90.3%**	**103.1%**						
	Target	70%	85%	100%	120%	120%	120%	120%	120%	120%	120%	120%	120%
Grand Total	Grand Total	6,020	6,094	6,203	6,396	6,050	5,467						
	Grand Total as % of 2019/20	95.6%	94.5%	99.7%	96.9%	99.2%	91.1%						
	Target	70%	85%	100%	120%	120%	120%	120%	120%	120%	120%	120%	120%



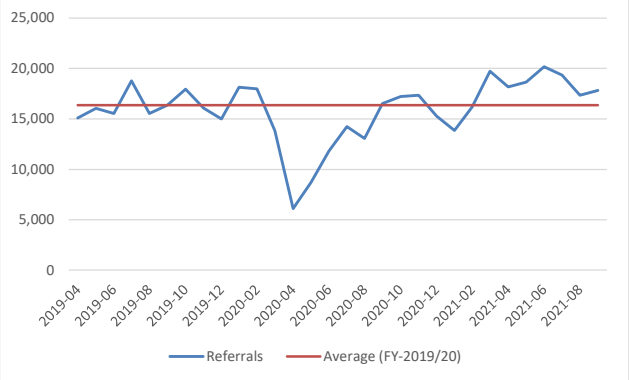




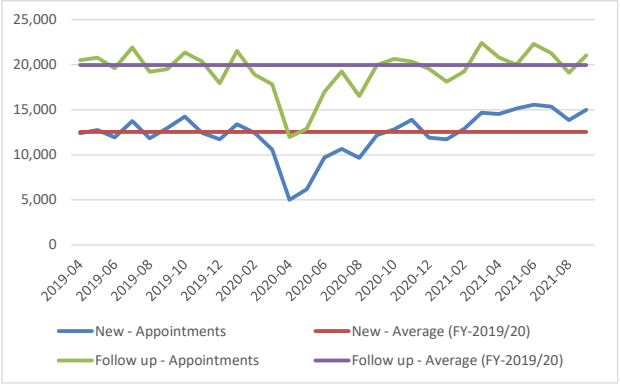


Recovery Plan Graphs

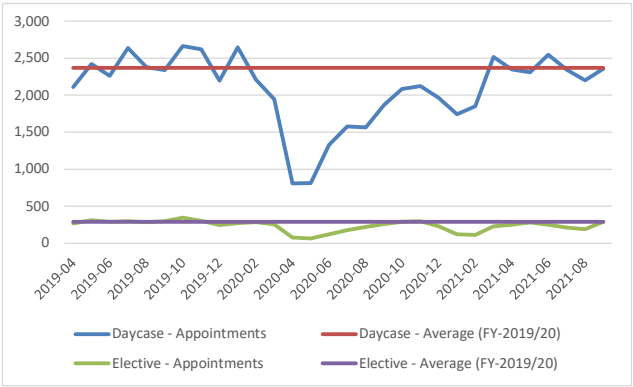
Referrals



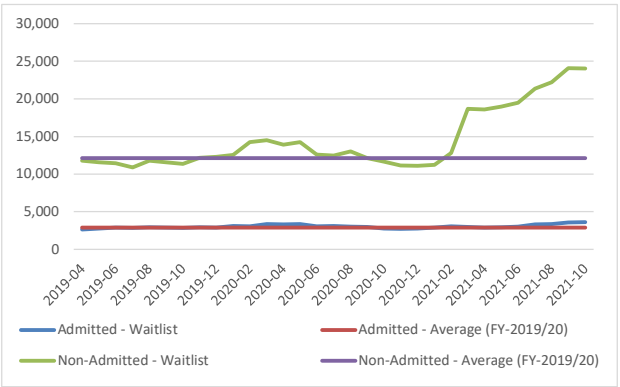
Outpatients



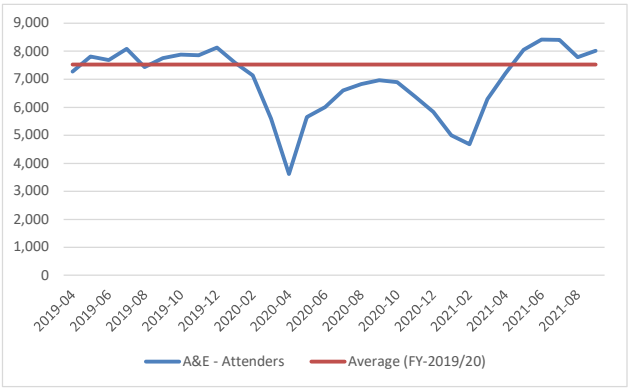
Elective



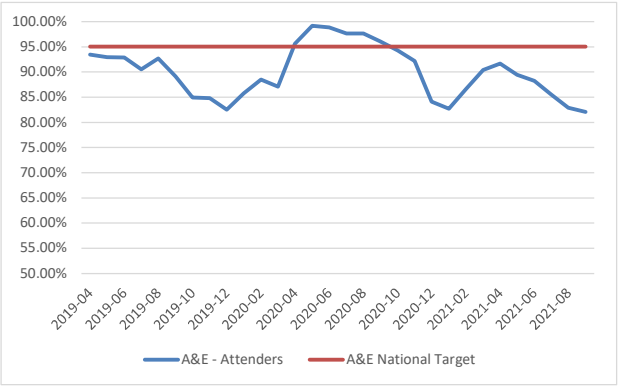
Waiting List



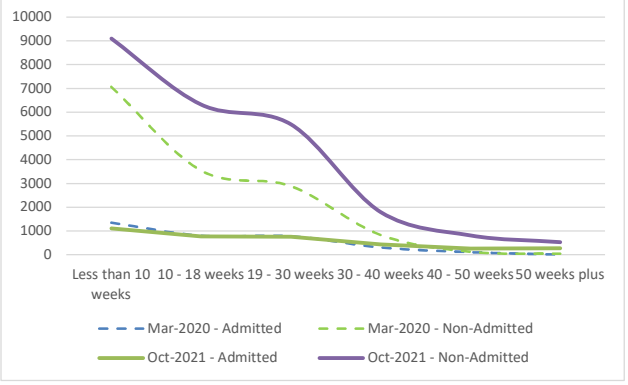
A&E Arrivals



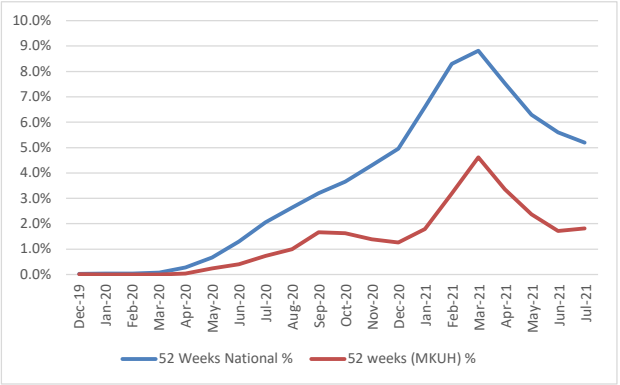
A&E Performance



Waiting List Shape



% 52+ weeks waiters



NHS
Milton Keynes
University Hospital
NHS Foundation Trust

Meeting title	**Public Board**	**Date:**
Report title:	**Finance Paper Month 6 2021-22**	**Agenda item: 18**
Lead director **Report authors**	Terry Whittle Sue Fox	Director of Finance Deputy Head of Financial Management
FoI status:	Public document	

Report summary	An update on the financial position of the Trust at Month 6 (September 2021)						
Purpose *(tick one box only)*	**Information**	☐	**Approval**	☐	**To note**	x	**Decision** ☐
Recommendation	Trust Board is asked to note the financial position of the Trust as of 30th September and the proposed actions and risks therein.						

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

Report history	None
Next steps	
Appendices	Pages 15-17

FINANCE REPORT FOR THE MONTH TO 30th SEPTEMBER 2021

FINANCE & INVESTMENT COMMITTEE

CONTENTS

1	Executive summary	Page 3
2	Financial performance - month 6 (September)	Page 4
3	Financial performance - cumulative (April-Sept)	Page 5
6	Activity & Elective Recovery Fund	Pages 6-7
7	Efficiency savings	Page 8
8	Capital	Pages 9
9	Cash	Page 10
10	Statement of Financial Position (Balance Sheet)	Page 11-12
11	BAF & financial risks	Page 13
13	Recommendations to the Board	Page 14
14	Appendices	Pages 15-17
15	Glossary of terms	Page 18

EXECUTIVE SUMMARY

(1. & 2.) Revenue – Clinical revenue is paid as part of a block contract. Additional clinical revenue (£7.6m) is received from the Elective Recovery Fund (ERF), and specialised drugs. Non-clinical revenue is higher than plan due to vaccination income which offsets costs incurred.

(3. & 4.) Operating expenses – Pay and non-pay are overspent to plan due to the cost of additional activity completed as part of elective care recovery (offset by ERF). High vacancy rates, annual leave and sickness gaps have contributed to increased temporary staffing costs.

(5.) Non-operating expenditure – The variance on non-operating expenditure is because of higher than planned PDC costs.

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

(10.) Financial Efficiency– Financial efficiency is being delivered in the first half of the year by managing operating costs within our allocated funding envelope (which included a 0.28% efficiency requirement).

(11.) Cash – The Trust cash balance is £54.9m, equivalent to 68 days cash to cover operating expenses. Balances include £22.1m for capital schemes.

(12.) Capital – The Trust is £0.7m lower than plan excluding the New Hospital Programme (NHP). The variance is driven by timing differences on the Maple Centre scheme.

(13.) Elective Recovery Fund– Lower than planned levels of ERF were recorded up to Month 6 (M6). Operational issues and increased annual leave impacted delivery against plan.

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

Ref	All Figures in £'000	Month 6 YTD Plan	Month 6 YTD Actual	Month 6 YTD Var	M1-6 Plan Plan	M1-6 Plan Forecast	M1-6 Plan Var	RAG
1	Clinical Revenue	140,415	150,976	10,561	152,915	152,915	-	
2	Other Revenue	9,087	9,772	685	9,079	9,158	79	
3	Pay	(97,117)	(103,741)	(6,624)	(104,531)	(104,531)	-	
4	Non Pay	(44,584)	(48,988)	(4,404)	(49,662)	(49,812)	(150)	
5	Financing & Non-Ops	(9,374)	(9,460)	(86)	(9,374)	(9,374)	-	
6	Surplus/(Deficit)	(1,573)	(1,441)	132	(1,573)	(1,644)	(71)	
7	Control Total Surplus/(Deficit)	(1,133)	(1,102)	31	(1,133)	(1,283)	(150)	
8	Inc. COVID expenditure	(5,598)	(2,194)	3,404	(5,598)	(5,598)	-	
9	High Cost Drugs	(9,455)	(10,910)	(1,455)	(9,486)	(9,486)	-	
10	CIP Delivery	3,480	-	(3,480)	3,480	3,480	-	
11	Cash	38,700	54,918	16,218	38,700	38,700	-	
12a	Capital Plan (excluding NHP)	6,514	5,825	(689)	6,514	5,993	(521)	
12b	Capital Plan (including NHP)	8,754	5,999	(2,755)	8,754	5,993	(2,761)	
13	ERF Delivery	9,532	7,557	(1,975)	9,532	8,196	(1,336)	
14	ICS Financial Position	-	-	-			-	

Key message

The Trust is reporting cumulative financial performance (£1.1m deficit) marginally better than plan. Operational issues (theatre downtime and staff availability) adversely impacted ERF received during quarter 2. The Trust has a robust cash position and is paying creditors promptly. The capital programme is behind plan due to timing differences (plan phasing) in the Maple Centre scheme, this is forecast to be on plan by the end of the year.

FINANCIAL PERFORMANCE- OVERVIEW MONTH 6

2. **Summary Month 6**

For the month of September 2021, financial performance (on a Control Total basis) is a deficit of £28k compared to a £162k planned deficit. Overspends on pay relating to the wage award are offset by additional clinical income.

3. Clinical Income
Clinical income shows a favourable variance of £2.8m explained by additional ERF (£0.3m) and £1.9m for reimbursement of the 3% national wage award. Further detail is included in Appendix 1.

4. Other Income
Other income shows a positive variance of 0.5m. During September, the Trust received higher vaccination funding and car park income than planned.

5. Pay
There is a negative variance to plan in August of £2.5m, £1.9m cost relates to the wage award.

6. Non-Pay
There is a negative variance in September of £0.7m. £0.3m is due to additional ERF activity and £0.2m is due to higher than planned prescribing of high-cost drugs.

7. Non-Operating Expenditure
Non-operating expenditure is over plan in-month due to donated asset depreciation costs.

All Figures in £'000	Month 6 Plan	Month 6 Actual	Month 6 Var	Month 6 YTD Plan	Month 6 YTD Actual	Month 6 YTD Var	M1-6 Plan Plan	M1-6 Plan Forecast	M1-6 Plan Var
Clinical Revenue	19,040	21,873	2,833	114,237	124,798	10,561	126,737	126,737	0
Other Revenue	1,528	2,009	481	9,087	9,648	561	9,079	9,079	0
Total Income	20,568	23,882	3,314	123,324	134,445	11,121	135,816	135,816	0
Pay	(16,185)	(18,716)	(2,530)	(97,117)	(103,741)	(6,624)	(104,531)	(104,531)	0
Non Pay	(7,417)	(8,086)	(669)	(44,584)	(48,988)	(4,404)	(49,662)	(49,812)	(150)
Total Operational Expenditure	(23,602)	(26,801)	(3,199)	(141,701)	(152,728)	(11,028)	(154,193)	(154,343)	(150)
EBITDA	(3,034)	(2,919)	115	(18,377)	(18,283)	94	(18,377)	(18,527)	(150)
Financing & Non-Op. Costs	(1,490)	(1,472)	18	(8,934)	(8,997)	(63)	(8,934)	(8,934)	0
Control Total Deficit (excl. top ups)	**(4,525)**	**(4,391)**	**133**	**(27,311)**	**(27,280)**	**31**	**(27,311)**	**(27,461)**	**(150)**
Adjustments excl. from control total:									
National Top up	3,430	3,430	0	20,580	20,580	0	20,580	20,580	0
COVID Top up	933	933	0	5,598	5,598	0	5,598	5,598	0
Control Total Deficit (incl. top ups)	**(162)**	**(28)**	**133**	**(1,133)**	**(1,102)**	**31**	**(1,133)**	**(1,283)**	**(150)**
Donated income	0	45	45	0	124	124	0	79	79
depreciation	(68)	(69)	(1)	(408)	(414)	(6)	(414)	(414)	0
Impairments & Rounding	(4)	(49)	(45)	(32)	(49)	(17)	(26)	(26)	0
Reported deficit/surplus	**(234)**	**(101)**	**132**	**(1,573)**	**(1,441)**	**132**	**(1,573)**	**(1,644)**	**(71)**

Key message
For the month of September 2021, the position on a Control Total basis is a deficit of £28k, which is £133k favourable to plan. Overspends on pay and non-pay relate to delivery of ERF and additional wage award costs. These costs are offset by additional clinical income.

FINANCIAL PERFORMANCE- OVERVIEW YTD

8. **Summary Year to Date**
Cumulative financial performance (April to September) on a Control Total basis is a deficit of £1.1m. This is consistent with the plan for the first half of the year. Overspends on pay and non-pay related to delivery of additional elective activity, and wage awards, both items are offset through the ERF and (backdated) central funding for pay.

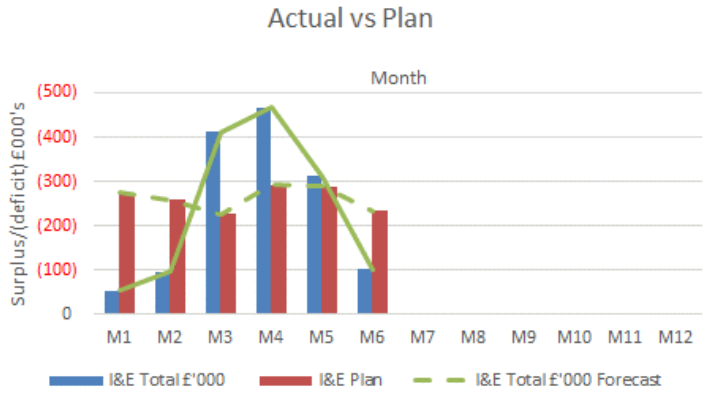
9. Clinical Income YTD
Clinical Income shows a favourable variance of £10.5m YTD, the Trust has recognised £7.6m related to ERF. Further detail is included in Appendix 1.

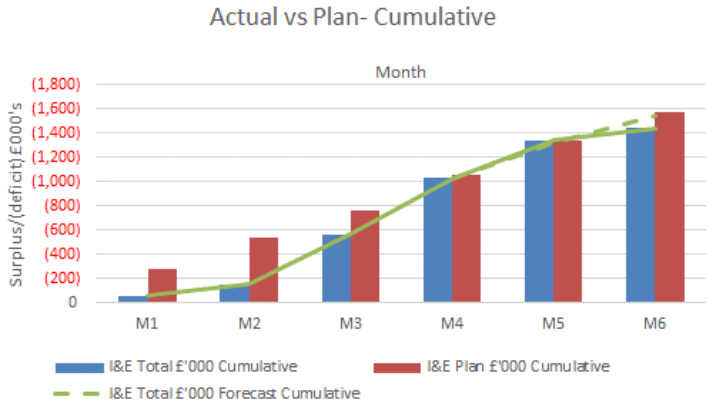
10. Other Income YTD
Other income is £0.7m above plan YTD due to receipt of additional E&T and R&D income above planned levels.

11. Pay YTD
There is a negative variance YTD of £6.6m. £4m of pay expenditure has been reported as a direct result of additional activity required to deliver elective recovery and we have provided a further £1.4m for anticipated cost of recovery. Further detail is included in Appendix 1.

12. Non-Pay YTD
There is a negative variance YTD of £4.4m. £2.9m of non-pay expenditure has been reported as a direct result of additional activity to deliver elective recovery. A further £1.5m of variance is against drugs expenditure. Further detail is included in Appendix 1.

13. Non-Operating Expenditure YTD
Non-operating expenditure is £0.8m over plan YTD due to additional PDC charges.





Key message
YTD as of September 2021, the position on a Control Total basis is a deficit of £1.1m. This is in line with the planned deficit. Overspends on pay and non-pay relate to the delivery of ERF activity and are offset by additional clinical income.

The Trust will continue to monitor expenditure to ensure the cost of additional activity is covered through ERF incentive payments.

ACTIVITY PERFORMANCE & ERF

14. Activity in the first half of 2021/22 is to be measured against 2019/20 baseline, with expectations set by NHSE/I as a percentage of 2019/20 levels (adjusted for working days) Starting with 70% target in April rising by 5% increments each month, with the upper threshold set at 95%. Under this guidance the Trust developed its own recovery plan in line with activity requirements of the Accelerator programme, by which the Trust planned to meet 120% of the 2019/20 baseline by July. The Trust has revised the forecast delivery downwards from July onwards to consider performance YTD and known factors limiting activity over July and August. In addition, NHSE/I revised the policy baselines from July onwards (to 95%) in response to a robust activity recovery from the NHS.

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

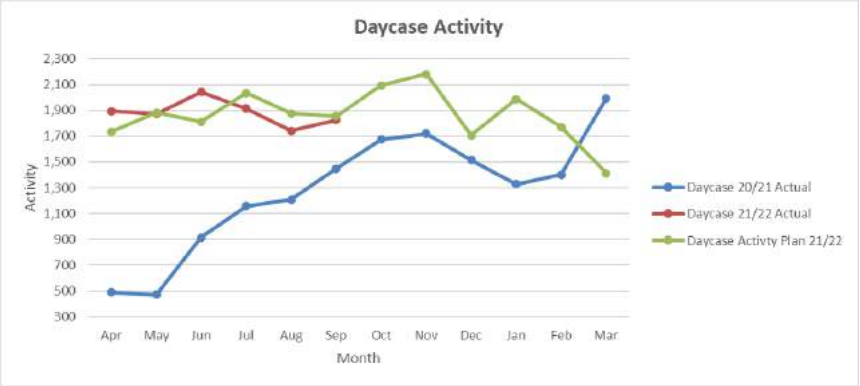
Day case activity-
Is below plan in month and above plan YTD. This is below the ambition set-out in the Accelerator business case. Operational issues and A/L have impacted performance, this is expected to continue to recover during October.

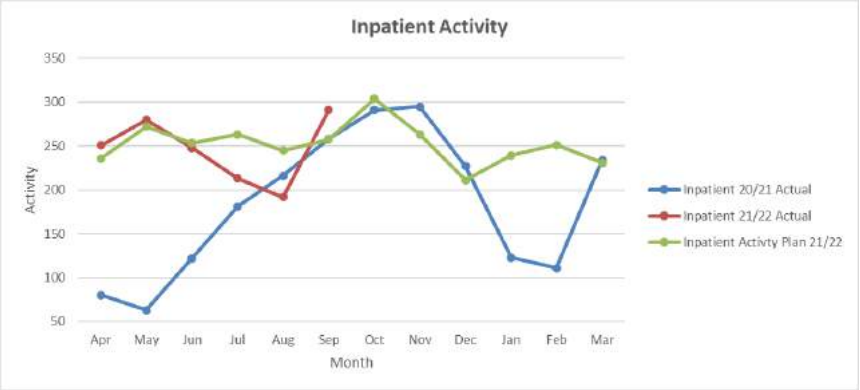
Elective Inpatient Activity-
Robust recovery in September and is now above last year's activity and the 21/22 plan.

Outpatient Activity-
Has increased slightly in September but is still behind plan. Outpatient activity is expected to improve again in October with work taking place to increase the number of virtual appointments for patients.

Non-Elective Spells-
Is below the plan in month and YTD. While still at lower levels than the 19/20 baseline, the Trust is treating greater numbers of non-elective activity month-on-month.

A&E activity-
Is higher than plan in month and YTD, the Trust continues to experience sustained high levels of A&E attendances.





Key message
Month 6 has seen recovery from lower levels of activity in July and August. This is expected to improve further in October.

16. ERF position summary

NHSE/I has introduced the Elective Recovery Fund (ERF) for the first half of 2021/22. A financial adjustment will be made if 2019/20 activity targets are exceeded. If the activity levels exceed the relevant threshold (stepped performance increases April to July) 100% of the financial value of that activity will be paid in addition to block funding. Initially if activity levels exceed 85%, activity completed above the 85% threshold will be paid at 120%. The 85% threshold was amended in Q2 to 95% therefore reducing the available ERF.

It must be noted that any ERF incentive payment is calculated on overall system performance and the clearance of associated ERF gateway criteria. There is no guarantee MKUH (or any single organisation within the system) will receive funds if it over performs (but the aggregate system position is not achieved). It is important to note that the ERF achievement is calculated as a financial value of the activity, with specific methodology used to price that activity (it is different to standard National Tariff rules). The case-mix of the activity therefore is very significant in the calculations – for example it is quite possible that activity targets could be exceeded but the financial value of that activity does not exceed 2019/20 levels and no additional funding will be received.

17. The Trust achieved £7.6m of ERF over the first six months of the year. This value is £4m lower than originally planned, £3.0m is due to the change in baselines and an additional £1m is due to unplanned theatre downtime and high uptake of staff annual leave during July and August.

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

	Actual	Actual	Actual	Actual	Actual	FC
%19/20	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**
DC	101%	102%	98%	94%	90%	105%
EL	99%	95%	80%	58%	73%	88%
OPA	110%	119%	109%	110%	113%	120%
OPROC	110%	106%	107%	97%	73%	3%

	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Total**
£ Totral ERF Value	£2,514,535	£2,494,358	£1,772,312	£203,809	£235,643	£336,431	£7,557,088

Key message
Although elective care activity increased in September compared to July and August, the estimated value of ERF received is substantially lower than the £2.5m initially planned.

EFFICIENCY SAVINGS

19. As of September, the Trust has reported a breakeven position to plan, included within this position is £3.5m of efficiency target. The Trust has met the planned efficiency target by managing the cost of delivering additional activity (e.g., to support recovery) within the funding available.

20. For the second half of the financial year (October to March 2022) the Trust is increasing the focus on financial efficiency through the Better Value Brighter Outcomes programme. The Trust has identified £1.1m from schemes submitted to date.

Key message
YTD the trust has delivered its £3.5m efficiency requirement for H1. This has been achieved through productivity savings against activity. Work is progressing through the Trust 'Better Values and Better Outcomes' programme to identify schemes in line with the efficiency target for H2.

CAPITAL- OVERVIEW YTD

21. The YTD spend on capital (excluding donated assets and de-recognised assets) is £5.8m, which is behind the Trusts capital plan (excluding the New Hospitals Programme (NHP)) by £0.7m. The CBIG allocation is above plan by £0.9m due to early approval of some schemes, offset by the timing of the costs for the Maple Centre which are expected later in the year.

22. The Trust has recently bid for additional capital from the national capital team for the elective recovery from the Targeted Investment Fund (TIF). Two bids were submitted, one for diagnostics equipment £3m, and the second for digital equipment £1.7m. The Trust is anticipating formal approval of these schemes during November.

23. The funding for the Maple Centre has been confirmed as £8.3m for 21/22. The NHP funding is now not expected to be £28m but the Trust has submitted a three-year proposal of £11.4m for continuing the development work for this scheme. The 21/22 component is £1.8m. The full breakdown of all funding and sources of application is shown in the table below.

	ICS Approved CDEL Allocation 2021/22			National CDEL Allocation 2021/22		
				Externally Funded		
Scheme Subcategory	**Internally funded**	**Externally Funded Awaiting Approval**		**Planned**	**Approved**	**Awaiting Approval**
	£m	£m		£m	£m	£m
Depreciation	13.6					
Self Funded	0.26					
PDC						
Diagnostic funding		0.15				
New Hospital Programme				28.0		1.8
Maple Unit				8.3	8.3	
TIF (ERF Diagnostics)						3.0
TIF(Digital)						1.7
Sub Total CDEL	**13.86**	**0.15**		**36.30**	**8.3**	**6.5**
CDEL Allocation	***14.01***			***36.30***	***8.3***	***6.5***
TOTAL Planned CDEL	**50.3**					

Capital Item	**YTD Plan up to end of Sept 21** £m	**Actual up to end of Sept21** £m	**Variance YTD** £m	**Status**	**Comments** Status
CBIG Allocation	**0.79**	**1.66**	**0.87**		Schemes progressing earlier than planned
Finance Leases	0.03	0.00	-0.03		Still being reviewed
Capitalised Staffing - IT and Estates	0.03	0.12	0.09		Timing due to Cerner implementation
IT equipment	0.14	0.01	-0.13		Expenditure now not expected until Q4
Cerner Phase C	0.04	0.14	0.10		Timing due to Cerner implementation
LIMS (Pathology IT System)	0.00	0.02	0.02		Fully committed
HR IT system	0.01	0.01	0.00		Expenditure now not expected until Q4
Mammography Installation for 2 machines	0.04	0.23	0.19		Equipment costs all in Q2, originally not expected until Q4
Breast Unit Building Works	0.05	0.00	-0.05		Waiting for BC to be written
Sub Total Pre-commitments	***0.34***	***0.54***	***0.20***		
Donated & Derecognised Assets (are excluded from CDEL)					
Baby Leo 3 incubators	0.08	0.08	0.00		Fully committed
Pathlake	0.43	0.00	-0.43		Expenditure not expected until Q3
COVID Donated assets		0.05	0.05		Not in the plan but no impact on capital spend
Derecognition of assets		0.36	0.36		Not in the plan but no impact on capital spend
Sub Total Donated & Recognised Assets	***0.51***	***0.48***	***-0.03***		
Strategic Schemes					
Staff Room Refurbishment	0.02	0.00	-0.02		Expenditure now not expected until Q3 & Q4
CT Scanner (prior year COVID funding)	0.05	0.00	-0.05		Currently under discussion if required
Endoscopy (prior year COVID funding)	0.02	0.01	-0.02		Not required
Xray Interventional	0.11	0.00	-0.11		Currently under discussion if required
Angio Interventional	0.13	0.00	-0.13		Orders placed, long lead time for equipment
Unallocated offsetting schemes with no CDEL allocation					
Prior year schemes not allocated CDEL					
Endoscopy Fit Out (Whitehouse)	0.00	0.00	0.00		Not in Capital plan
MRI installation	0.00	0.00	0.00		Not in Capital plan
Flat roofs	0.00	0.00	0.00		Not in Capital plan
HIP2 Infrastructure schemes	0.00	0.99	0.99		Not in Capital plan but committed to
Sub Total Strategic Schemes	***0.33***	***1.00***	***0.67***		
Total ICS CDEL (excluding donated & derecog assets)	**1.46**	**2.84**	**1.07**		Above CDEL approved value
Other National Approved funding approved					
Maple Unit	5.05	2.98	-2.07		Timing of the scheme
Total Capital (excluding NHP)	**6.51**	**5.82**	**-0.69**		Actuals below plan
Awaiting Approval					
New Hospital Programme (NHP)	2.24	0.17	-2.07		Orig plan based on £28m, not approved, revised to £1.8m
Total Capital (including NHP)	**8.75**	**5.99**	**-2.76**		Actuals below plan

Key message
Capital expenditure is behind plan by £0.7m YTD, excluding the NHP, which is due to the timing of costs for the Maple Centre. The Trust is awaiting final approval of £6.5m (£4.7m TIF and £1.8m NHP) from the national capital team

CASH

24. Summary of Cash Flow

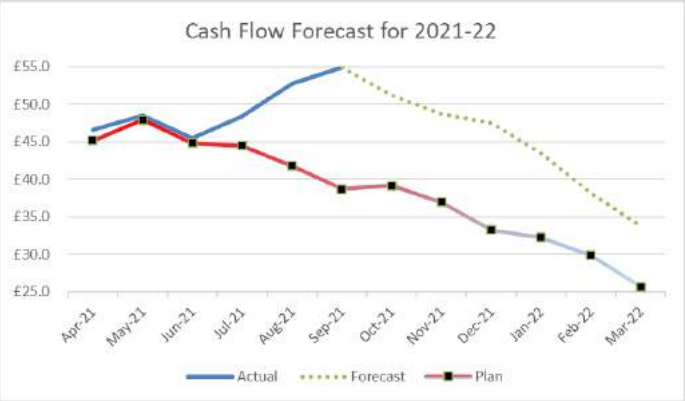
The cash balance at the end of September was £54.9m, this was £13.1m higher than the planned figure of £41.8m. This is an increase on last month's figure of £52.8m. The Trust is forecasting a year end cash balance of £33.8m (see opposite).

25. Cash arrangements 2021/22

The current cash funding arrangements for H2 are that the Trust is receiving monthly block payments as per its plan, plus any additional funding for high-cost drugs on a pass-through basis. The Trust received £2.5m ERF funding in September (for prior period performance).

26. Better Payment Practice

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



Better payment practice code	Actual M6 YTD Number	Actual M6 YTD £'000	Actual M5 YTD Number	Actual M5 YTD £'000
Non NHS				
Total bills paid in the year	28,413	80,420	24,574	70,563
Total bills paid within target	27,014	76,957	23,578	67,582
Percentage of bills paid within target	**95.1%**	**95.7%**	**95.9%**	**95.8%**
NHS				
Total bills paid in the year	1,001	3,387	815	2,799
Total bills paid within target	825	2,211	680	1,851
Percentage of bills paid within target	**82.4%**	**65.3%**	**83.4%**	**66.1%**
Total				
Total bills paid in the year	**29,414**	**83,807**	**25,389**	**73,361**
Total bills paid within target	**27,839**	**79,168**	**24,258**	**69,433**
Percentage of bills paid within target	**94.6%**	**94.5%**	**95.5%**	**94.6%**

Key message

Cash is above plan by £13.1m, and the Trust has fallen marginally below the 95% target for BPPC when looking at the number of invoices paid.

BALANCE SHEET

27. Statement of Financial Position

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

- Non-Current Assets have decreased from March 21 by £0.6m; this is driven by YTD depreciation.
- Current assets have increased by £5.3m, this is mainly due to the increase in cash £6.1m offset by a reduction in receivables (£0.8m).
- Current liabilities have increased by £3.8m, this is mainly due to the increase in Trade Payables.
- There has been no change in Non-Current Liabilities in month.

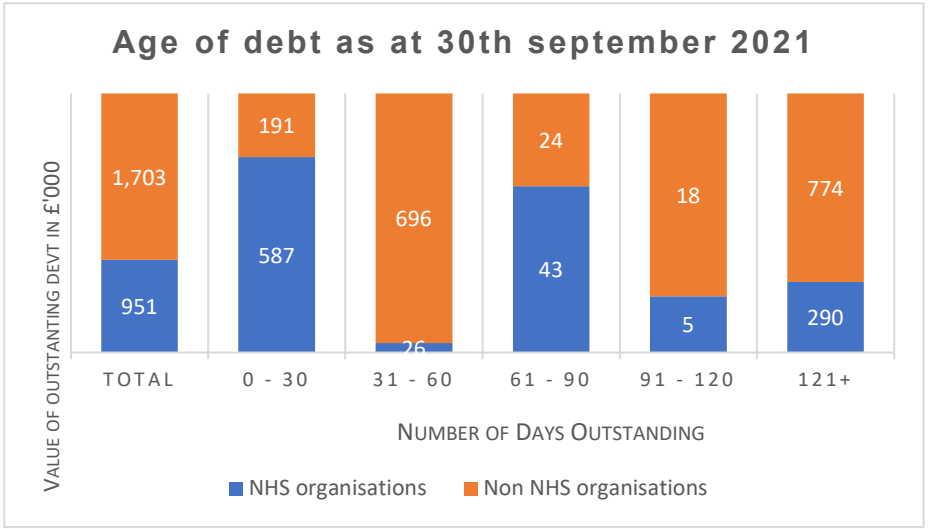
28. Aged debt

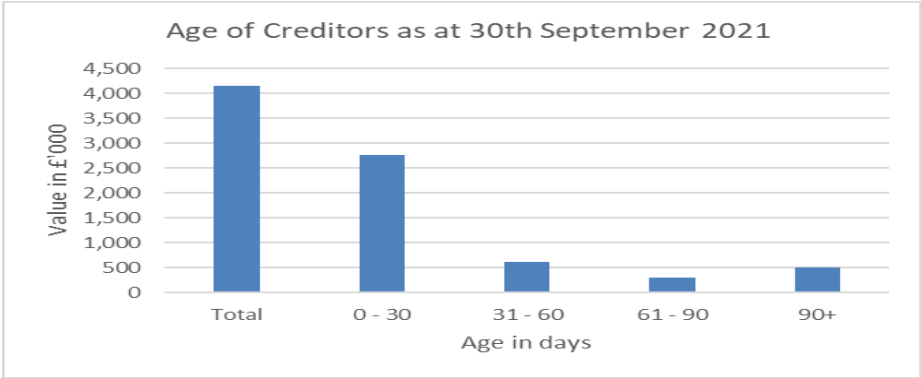
The debtors position as of 30th September is £2.7m, which is a slight decrease of £0.4m from the August position. Of this total £1.12m is over 121 days old.

The three largest NHS debtors are Bedford Hospital £0.4k for salary recharges, Central and NW London NHS Foundation Trust £0.1m for M5 non patient SLA recharge and NHS England £0.1m for 19/20 final year reconciliation. The largest non-NHS debtors include £0.2m for overseas patients, £0.3m with Bedfordshire and Northamptonshire councils for sexual health, £0.6m with Buckinghamshire University for medical services placement.

29. Creditors

The creditor's position as of 30th September 21 is £4.2m, which is a slight decrease of £0.4m from the August 21 position. Of this £1.4m is over 30 days, with £0.5m approved for payment.





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

RECOMMENDATIONS TO BOARD

30. Finance & Investment Committee is asked to note the financial position of the Trust as of 30th September and the proposed actions and risks therein.

APPENDICIES

Appendix 1

Statement of Comprehensive Income
For the period ending 30th September 2021

	FY22	M6 CUMULATIVE			M6			PRIOR MONTH	
	Annual Budget	Budget	Actual	Variance	Budget	Actual	Variance	M5 Actual	Change
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME									
Outpatients	29,214	26,847	28,752	1,905	4,522	4,894	372	4,580 ▲	314
Elective admissions	18,960	13,282	12,584	(697)	2,287	2,342	55	1,766 ▲	576
Emergency admissions	71,699	39,411	36,380	(3,031)	6,357	6,984	626	5,883 ▲	1,101
Emergency adm's marginal rate (MRET)	0	0	0	0	0	0	0	0 ▲	0
Readmissions Penalty	0	0	0	0	0	0	0	0 ▲	0
A&E	16,398	8,367	8,668	301	1,410	1,429	19	1,429 ▲	1
Other Admissions	(3,624)	1,439	1,046	(393)	240	205	(35)	166 ▲	39
Maternity	14,226	11,110	11,363	253	1,774	1,790	16	2,007 ▼	(217)
Critical Care & Neonatal	4,835	3,274	3,534	260	507	545	38	650 ▼	(105)
Imaging	7,562	2,852	2,844	(8)	461	396	(65)	520 ▼	(124)
Direct access Pathology	0	2,460	2,235	(225)	407	301	(106)	384 ▼	(83)
Non Tariff Drugs and Devices (high cost/individual drugs)	32,936	9,455	10,910	1,455	1,583	1,757	174	1,814 ▼	(57)
Other (inc. home visits and best practice tariffs)	45,882	3,213	10,556	7,343	547	1,281	734	3,046 ▼	(1,765)
CQUINS	0	0	0	0	0	0	0	0 ▲	0
Contract Risk Provision - General challenge & CIP offset	0	0	0	0	0	0	0	0 ▲	0
National Block/Top up	42,742	18,704	22,103	3,399	3,306	4,311	1,005	4,300 ▲	11
MKCCG Block adj	0	0	0	0	0	0	0	0 ▲	0
Clinical Income	**280,829**	**140,415**	**150,976**	**10,561**	**23,403**	**26,236**	**2,833**	**26,544 ▼**	**(308)**
Non-Patient Income	18,044	9,087	9,648	561	1,528	2,010	482	1,428 ▲	582
PSF Income	0	0	(0)	(0)	0	0	0	0 ▲	0
Donations	0	0	124	124	0	45	45	0 ▲	45
Non-Patient Income	**18,044**	**9,087**	**9,772**	**685**	**1,528**	**2,054**	**526**	**1,428 ▲**	**626**
TOTAL INCOME	**298,873**	**149,502**	**160,747**	**11,245**	**24,931**	**28,290**	**3,359**	**27,972 ▲**	**318**
EXPENDITURE									
Pay - Substantive	(180,503)	(90,109)	(88,321)	1,788	(17,130)	(16,026)	1,104	(15,087) ▼	(939)
Pay - Bank	(10,785)	(5,431)	(8,381)	(2,950)	(929)	(1,661)	(731)	(1,420) ▼	(240)
Pay - Locum	(1,821)	(923)	(2,444)	(1,520)	(149)	(313)	(164)	(528) ▲	215
Pay - Agency	(5,868)	(2,894)	(4,206)	(1,312)	(455)	(635)	(180)	(1,017) ▲	382
Pay - Other	4,388	2,194	(390)	(2,583)	2,470	(81)	(2,550)	(63) ▼	(18)
Pay CIP	41	20	0	(20)	3	0	(3)	0 ▲	0
Vacancy Factor	56	26	0	(26)	5	0	(5)	0 ▲	0
Pay	**(194,492)**	**(97,117)**	**(103,741)**	**(6,624)**	**(16,185)**	**(18,716)**	**(2,530)**	**(18,115) ▼**	**(601)**
Non Pay	(56,397)	(35,128)	(38,077)	(2,949)	(5,834)	(6,329)	(495)	(6,780) ▲	451
Non Tariff Drugs (high cost/individual drugs)	(32,936)	(9,455)	(10,910)	(1,455)	(1,583)	(1,757)	(174)	(1,814) ▲	57
Non Pay	**(89,334)**	**(44,584)**	**(48,988)**	**(4,404)**	**(7,417)**	**(8,086)**	**(669)**	**(8,594) ▲**	**508**
TOTAL EXPENDITURE	**(283,826)**	**(141,701)**	**(152,728)**	**(11,028)**	**(23,602)**	**(26,801)**	**(3,199)**	**(26,708) ▼**	**(93)**
EARNINGS BEFORE INTEREST, TAXATION, DEPRECIATION AND AMORTISATION (EBITDA)	**15,047**	**7,801**	**8,019**	**218**	**1,329**	**1,489**	**160**	**1,263 ▲**	**225**
Interest Receivable	12	6	0	(6)	1	0	(1)	0 ▲	0
Interest Payable	(264)	(132)	(156)	(24)	(22)	(44)	(22)	(23) ▼	(21)
Depreciation, Impairments & Profit/Loss on Asset Disposal	(12,742)	(6,371)	(6,369)	2	(1,062)	(1,065)	(3)	(1,062) ▼	(3)
Donated Asset Depreciation	(816)	(408)	(414)	(6)	(68)	(69)	(1)	(69) ▼	(0)
Profit/Loss on Asset Disposal & Impairments	0	0	(48)	(48)	0	(48)	(48)	0 ▼	(48)
Unwinding of discounts	0	0	0	0	0	0	0	0 ▲	0
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**1,237**	**896**	**1,031**	**135**	**178**	**263**	**85**	**110 ▲**	**153**
Dividends Payable	(4,938)	(2,469)	(2,472)	(3)	(412)	(365)	47	(422) ▲	57
OPERATING SURPLUS/(DEFICIT) AFTER DIVIDENDS	**(3,701)**	**(1,573)**	**(1,441)**	**132**	**(234)**	**(102)**	**132**	**(312) ▲**	**210**

Statement of Cash Flow
As of 30th September 2021

	Mth 6 £000	Mth 5 £000	In Month Movement £000
Cash flows from operating activities			
Operating (deficit) from continuing operations	1,236	879	(132)
Operating (deficit)	**1,236**	**879**	**(132)**
Non-cash income and expense:			
Depreciation and amortisation	6,783	5,650	(1,131)
(Gain)/Loss on disposal	-48	0	0
(Increase)/Decrease in Trade and Other Receivables	783	(2,485)	(625)
(Increase)/Decrease in Inventories	(11)	(11)	1
Increase/(Decrease) in Trade and Other Payables	12,352	13,188	(4,767)
Increase/(Decrease) in Other Liabilities	119	778	1,134
Increase/(Decrease) in Provisions	(32)	(28)	4
NHS Charitable Funds	(124)	(79)	0
Other movements in operating cash flows	(4)	(3)	(1)
NET CASH GENERATED FROM OPERATIONS	**21,054**	**17,889**	**(5,517)**
Cash flows from investing activities			
Purchase of intangible assets	(1,454)	(1,892)	163
Purchase of Property, Plant and Equipment, Intangibles	(13,241)	(11,876)	918
Net cash generated (used in) investing activities	**(14,695)**	**(13,768)**	**1,081**
Cash flows from financing activities			
Public dividend capital received	2,309	0	0
Capital element of finance lease rental payments	(71)	(82)	18
Interest element of finance lease	(156)	(112)	23
PDC Dividend paid	(2,412)	0	0
Receipt of cash donations to purchase capital assets	124	79	0
Net cash generated from/(used in) financing activities	**(206)**	**(115)**	**41**
Increase/(decrease) in cash and cash equivalents	**6,153**	**4,006**	(4,395)
Opening Cash and Cash equivalents	**48,765**	**48,765**	
Closing Cash and Cash equivalents	**54,918**	**52,771**	**(4,395)**

Statement of Financial Position as of 30th September 2021

	Audited Mar-21	Sep-21 YTD Actual	YTD Mvmt	% Variance
Assets Non-Current				
Tangible Assets	169.5	171.1	1.6	0.9%
Intangible Assets	22.0	19.8	(2.2)	(10.0%)
Other Assets	1.0	1.0	0.0	0.0%
Total Non Current Assets	**192.5**	**191.9**	**(0.6)**	**(0.3%)**
Assets Current				
Inventory	3.7	3.7	0.0	0.0%
NHS Receivables	7.3	9.0	1.7	23.3%
Other Receivables	12.5	10.0	(2.5)	(20.0%)
Cash	48.8	54.9	6.1	12.5%
Total Current Assets	**72.3**	**77.6**	**5.3**	**7.3%**
Liabilities Current				
Interest -bearing borrowings	(0.2)	(0.1)	0.1	(50.0%)
Deferred Income	(14.9)	(15.1)	(0.2)	1.3%
Provisions	(2.9)	(2.8)	0.1	(3.4%)
Trade & other Creditors (incl NHS)	(58.5)	(62.3)	(3.8)	6.5%
Total Current Liabilities	**(76.5)**	**(80.3)**	**(3.8)**	**5.0%**
Net current assets	**(4.2)**	**(2.7)**	**1.5**	**(35.7%)**
Liabilities Non-Current				
Long-term Interest bearing borrowings	(5.6)	(5.6)	0.0	0.0%
Provisions for liabilities and charges	(1.7)	(1.7)	0.0	0.0%
Total non-current liabilities	**(7.3)**	**(7.3)**	**0.0**	**0.0%**
Total Assets Employed	**181.0**	**181.9**	**0.9**	**0.5%**
Taxpayers Equity				
Public Dividend Capital (PDC)	259.9	262.2	2.3	0.9%
Revaluation Reserve	50.1	50.1	0.0	0.0%
Financial assets at FV through OCI reserve	0.2	0.2	0.0	0.0%
I&E Reserve	(129.2)	(130.6)	(1.4)	1.1%
Total Taxpayers Equity	**181.0**	**181.9**	**0.9**	**0.5%**

GLOSSARY OF TERMS

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

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Public Board	November 2021
Report title:	Significant Risk Summary Report	**Agenda item: 19**
Lead director **Report author** **Sponsor(s)**	**Kate Jarman** **Paul Ewers**	**Director of Corporate Affairs** **Risk Manager**
FoI status:	**Disclosable**	

Report summary	The report includes all significant risks across all Risk Registers, where the Current Risk Rating is graded as 15 or above, as at 01 October 2021			
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [ ]	**Decision** [ ]
Recommendation	The Public Board is asked to note and discuss the contents within the report, in to ensure risks are being robustly and actively managed across the Trust.			

Strategic objectives links	Objective 1 Improve Patient Safety Objective 7 Become well led and financially viable
Board Assurance Framework links	Compliance paper
CQC fundamental Standards	Good governance Safe
Identified risks and risk management actions	Compliance risk – good governance
Resource implications	None
Legal implications including equality and diversity assessment	None

Report history	October 2021 Trust Executive Group Meeting
Next steps	N/A
Appendices	Significant 15+ Risks

Executive Summary:

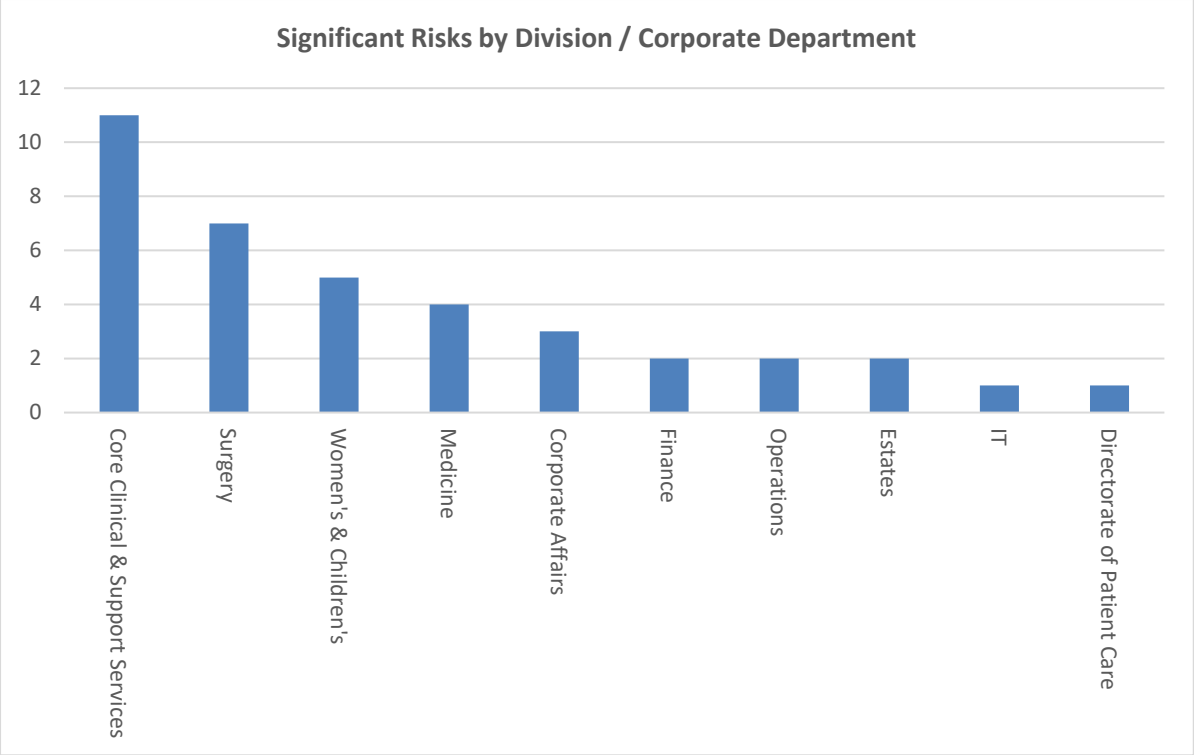
This report shows the profile of significant risks across the Trust by type and area.

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

The Board is asked to note the content of this report

Risk Profile

- There is a total 38 significant risks identified on Risk Registers across the Trust:



- Of these risks 22 are overdue their review date and have been escalated for corporate review.

- There were 2 new significant risks added during September 2021:

  ID 3123 - Avoiding Term Admissions into Neonatal Units (ATAIN) is a programme of work initiated under patient safety to identify reasons for admission to the neonatal unit at term and the proportion of admissions which are avoidable vs those which are unavoidable . ATAIN is also included within the Clinical Negligence Scheme for Trusts (CNST) compliance. It has been identified that we are currently experiencing over a 2-month delay with our ATAIN cases. To date, cases have been reviewed up until 13/06/2021 which is subsequently resulting in the Trust being significantly behind on completion of Datix incidents due to cases regarding ATAIN remaining open until they have been reviewed and any learning or actions required have been identified. In addition, any cases which may require immediate system or process learning have not been reviewed thus potentially impacting on the safety within maternity and neonatal services. (4x4=16)

ID 3129 - The maternity service at MKUK makes use of Phase 1 theatres for all cases, we do not have our own dedicated set of theatres. Elective Caesarean work is completed the Theatre 1 during a booked morning session, Theatre 3 is set for obstetric emergencies. All Phase 1 theatres in the afternoon are used for emergency lists for the whole trust. This leaves maternity vulnerable to not having a guaranteed emergency theatre available 24hrs a day. There is only 1 theatre team on site overnight for all emergency surgery in the trust, should they be dealing with an emergency outside of obstetrics, obstetrics would have to call on call theatre team in from home increasing the risk for mother and baby. (5x3=15)

- There were 0 significant risks closed within the last month

- There is one risks that are graded the same as the Target Risk rating

  ID1970 - Unable to meet the demand for existing patients leading to increased waiting times. Unable to develop existing outpatient services. Unable to optimise student placements.

- There are no Actions identified for 16 of the risks (up three from the previous report). It should be noted that, for many of these risks, actions have been and are being undertaken, however the risks have not been updated on Datix. A process has commenced for all risks to have an additional formal annual review (see below). One of the aims of this new process is to ensure that all actions are added to the risk register for completeness and to support the ongoing management of the risk.

Recommendations:

The Board are asked to review and discuss this paper.

Definitions:

Significant Risks: Any risk where the Current Risk Register (the level of risk now) is graded 15 or above

Current Risk: This is the level of risk posed at the time of the risk's last review

Target Risk: Recognising that there is always an element of risk and that (depending on the risk) the lowest level of risk is not always the optimum (e.g. cost vs benefit), this is the level of risk that the Trust is willing to accept/tolerate.

Assurance on controls: This is where the risk owner identifies how the Trust monitors whether the controls in place are effective and that the risk is being managed. For example, monitoring the increase/decrease of reported incidents etc.

Significant Risk Register

ID	Ref	Triumvirate Annual Review Date	Executive Responsible	Risk Owner	Division	Specialty	Description	Cause	Impact	C	L	Inherent Risk Rating	Inherent Risk Level	Controls in place	Assurance on Controls	C	L	Current Risk Rating	Current Risk Level	Gaps in Controls	C	L	Target Risk Rating	Target Risk Level	Treatment Category	Action Plan Summary	Date Risk Last Reviewed	Trend	Trend Rationale	Review Due?
2920		05/05/2021	Director of Clinical Services	Biggs, Adam	Operations	Emergency Planning	The risk of capabilities in responding to a Novel Coronavirus (COVID-19) impacting on patient care within clinical and non-clinical services, with the inability to maintain safety for staff and patients due to national pressures on supplies and infrastructure.	Surge of COVID-19 patients impacting on Trust ability to maintain patient care and clinical services. Loss of staff to support clinical and non-clinical services due to high levels of absence. Loss of national stockpile in PPE or medical devices (ventilators) resulting in the Trust not receiving deliveries to preserve the safety of patients and staff.	Loss of clinical and non-clinical services Financial impacts Risk to patient care Risk to staff wellbeing	5	5	25	HIGH	COVID-19 operational and contingency plans in place reviewed through Silver and Gold command structure, with meeting recorded through action logs PPE logged daily covering delivery and current stock		5	4	20	HIGH	Trust has no control over national stockpile of PPE and medical devices required for response. This is monitored and reported daily.	5	3	15	HIGH	TREAT - above tolerable level - appropriate cost-effective control required		21/10/2020	No Change	National oversight	09/11/2020
2570	18	18/01/2022	Director of Clinical Services	Gawlowski, Dr Zuzanna	Women's & Children's Health - Children's Health	Neonatal	Overcrowding and insufficient space in the Neonatal Unit, exacerbated by need for social distancing due to COVID-19. The milk kitchen was condemned due to this.	Cot spacing does not comply with BAPM guidance or the latest PHE guidance for COVID-19. The Unit is seeking to increase both total cot spacing and cot numbers by 4 HDU/ITU cots in line with Network 5 year projections of acuity and demand, and spacing in line with National Recommendations.	Without the increase in cot numbers and corresponding cot spacing we will be unable to meet patient needs or network requirements. We will now also be unable to meet PHE recommendations for social distancing This may result in a removal of Level 2 status if we continue to have insufficient space to adequately fulfil our Network responsibilities and deliver care in line with national requirements. This may also impact on our ability to protect babies and their families during COVID	5	5	25	HIGH	1. Reconfiguration of cots to create more space and extra cots and capacity, though this still does not meet PHE or national standards 2. Parents asked to leave NNU during interventional procedures, ward rounds etc. Restricted visiting during COVID 3. Added to capital plan 4. Feasibility study completed	1. NNU Feasibility study in progress awaiting decision of the Board as to whether to proceed with major reconfiguaration and increased cots to meet TVN demand. 2.Planning for a specific W&C build is being discussed	5	4	20	HIGH	1. Outline business case for NNU rebuild has been developed by Trust and estates department and submitted to CCG/STP partners for consideration. Awaiting final decisions	3	3	9	MOD	TREAT - above tolerable level - appropriate cost-effective control required	Approval of business case - Complete Business Case for Refurnishing Milk Kitchen and Sluice	22/09/2021	No Change	No change	18/01/2022
2928			Director of Corporate Affairs	Evans, Ms Joanne (Inactive User)	Core Clinical & Support Services - Diagnostic & Screening	Imaging	Lack of capacity for appropriate management of CT and MRI within KPI and DM01 timescales	The issue is increasing demand at upto 14% annually with a requirement to reduce turnaround times. Covid has added to the burden with covid recovery posing a significant risk to the service. Workload is increasing significantly but both CT and MRI are working at caqpacity and have no flexibility to increase capacity without additional staff and equipment.	Financial due to missed targets Reputation due to long waiting times Reputation and financial due to increased infection rates Staff leaving due to poor working conditions. This is delaying patient management and causing issues with meeting the diagnostic waiting times. Inability to manage patients privacy and dignity also increased risk of infection due to overcrowding of facilities.	4	5	20	HIGH	Extended working hours and days, some scans sent off site to manage demand. Reduced appointment times to optimise service. 1.12.20 no change to risk rating services remain challenged due to lack of basic capacity made worse by Covid social distancing and cleaning issues. 1.6.21 Ongoing capacity issues, situation deteriorating as post covid activity builds up. Case approved for mobile MRI capacity which should be implemented in June Case for additional CT declined by Trust to be revisited in July 2021. IS provider approached to provide more MRI capacity	Future plans will increase MRI capacity and support through to Dec 21 at which point the modular units should be operational. CT capacity plan still unresolved.	4	5	20	HIGH	Currently still capacity gaps with increasing numbers of patients waiting over 42 days for routine scanning, breaching DM01 requirements	2	2	4	LOW	TREAT - above tolerable level - appropriate cost-effective control required		01/12/2020	Increased	INcreased risk	30/06/2021
3062			Director of Clinical Services	Barton-Young, Mr Phillip	Surgical - Head & Neck	Ophthalmology	Clinical data stored on visual field machine hard drives for Ophthalmology Department patients will not be transferred between two machines (visual field analysers & Windows XP computer). There is a risk of irretrievable loss of patient data when manually transferring data using USB sticks.	Both of the two Humphrey HFA 2i machines within Ophthalmology Department are outdated and there is no backup. The visual field machines are not connected to the server and currently rely on a Windows XP computer to transfer data between the two machines. The Windows XP system is no longer supported by the IT department at MKUH or by Zeiss, the manufacturer of the machines	Machines accurately calculate decline in vision therefore assessment, diagnosis and monitoring could be significantly compromised. Consultant Ophthalmologists and other clinical staff would not be able to accurately compare between tests meaning that patient treatment could be negatively impacted as there is a risk of missing progressive disease.	4	4	16	HIGH	Data is currently stored on visual machine hard drives and Windows XP computer. It has been recommended that Data is exchanged using unencrypted USB drives.	Monitoring of incidents in relation to patient data and functionality of both machines. 19/07/2021 two new machines have been purchased awaiting items to be in situ and then risk can be closed. 17/05/2021 full business case needs to be submitted as previous business case not approved.	4	5	20	HIGH	N/A	4	1	4	LOW	TREAT - above tolerable level - appropriate cost-effective control required	Business case to purchase replacement visual field analysers	19/07/2021	No Change	New risk	20/09/2021

Significant Risk Register

ID	Ref	Triumvirate Annual Review Date	Executive Responsible	Risk Owner	Division	Specialty	Description	Cause	Impact	C	L	Inherent Risk Raing	Inherent Risk Level	Controls in place	Assurance on Controls	C	L	Current Risk Rating	Current Risk Level	Gaps in Controls	C	L	Target Risk Rating	Target Risk Level	Treatment Category	Action Plan Summary	Date Risk Last Reviewed	Trend	Trend Rationale	Review Due?
3126		18/01/2022	Director of Patient Care / Chief Nurse	Davis, Mrs Melissa	Women's & Children's Health - Women's Health	Obstetrics & Maternity	Avoiding Term Admissions into Neonatal Units (ATAIN) is a programme of work initiated under patient safety to identify reasons for admission to the neonatal unit at term and the proportion of admissions which are avoidable vs those which are unavoidable . ATAIN is also included within the Clinical Negligence Scheme for Trusts (CNST) compliance. It has been identified that we are currently experiencing over a 2-month delay with our ATAIN cases. To date, cases have been reviewed up until 13/06/2021 which is subsequently resulting in the Trust being significantly behind on completion of Datix incidents due to cases regarding ATAIN remaining open until they have been reviewed and any learning or actions required have been identified. In addition, any cases which may require immediate system or process learning have not been reviewed thus potentially impacting on the safety within	1.Inability to identify/review in a timely manner any cases where there may be immediate system or process learning. 2. Inability to complete Datix incident reporting system in a timely manner.	Maternity/ Neonatal services -Staff/ patients/Trust. Staff, patients, Trust reputation.	4	5	20	HIGH	1.ATAIN meetings still taking place when possible/ quorate. 2. Completing Datix retrospectively Action Plan in place: Weekly ATAIN meetings to review current backlog of cases and ensure all current cases are reviewed weekly to ensure that there are no further backlogs of cases which would increase the risk of not capturing immediate learning. Complete Datix once incident/ case has been identified after weekly meeting. Shadowing opportunities at other trusts to review ways in which to manage ATAIN to increase the effectiveness of the group. Allocation of appropriate MDT time within roles to attend ATAIN meetings		4	4	16	HIGH	Weekly ATAIN meetings to review current backlog of cases and ensure all current cases are reviewed weekly to ensure that there are no further backlogs of cases which would increase the risk of not capturing immediate learning. Complete Datix once incident/ case has been identified after weekly meeting. Shadowing opportunities at other trusts to review ways in which to manage ATAIN to increase the effectiveness of the group. Allocation of appropriate MDT time within roles to attend ATAIN meetings	3	3	9	MOD	TREAT - above tolerable level - appropriate cost-effective control required		29/09/2021	No Change	new risk	20/10/2021
3110		20/07/2022	Director of Finance	Hotchkin, Karan	Finance	Financial Services	If the Trust does not have a sufficient capital expenditure limit (CDEL) then the Trust will not be able to complete the level of planned capital investment	Following the FY21 year end audit the Trust had to adjust misstated capital expenditure of £4.5m relating to a capital bond. As a consequence, the Trust has brought forward capital spending commitments of £4.5m into FY22 .	Insufficient capital expenditure limit to accommodate the Trusts investment.	4	5	20	HIGH	The Trust is introducing enhanced in-year capital spend monitoring to proactively manage in-year underspends across other capital schemes. Where agreed by management (e.g., subject to risks and strategic need) underspends across other capital schemes could free-up capital expenditure limit for utilisation against bond schemes.	The Trust will report the capital expenditure position (MKUH and ICS) and associated risks to F&IC and regularly update the Audit Committee through the BAF.	4	4	16	HIGH	The Trust has limited control over the availability and reassignment of CDEL across the ICS and regional partners.	2	5	10	MOD	TREAT - above tolerable level - appropriate cost-effective control required		13/09/2021	No Change	New risk for July 21	08/10/2021
2791			Director of Clinical Services	Orr, Mrs Julie	Operations	Patient Discharge	Risk that patient discharges will significantly be delayed, especially those requiring complex coordination of the discharge process	The Discharge Coordinators (Registered Nurses B6 level) are currently severely short staffed due to vacancies and sudden long term sickness, with an additional Discharge Coordinator due to have major surgery leading to additional long term sickness. The Discharge Team currently consists of 5 wte B6 Registered Nurses. At present there are 3wte in post however 2wte are on long term sick leave.	Increased length of stay (LOS) for complex discharges, leading to a potential for an increase in hospital acquired infections, de-conditioning Potential to affect the stranded and super stranded patient numbers and a failure achieve National target set for 2019-20, with associated impact on ED performance Increased delayed transfers of care (DToC) Poor patient experience due to the delays in discharge/discharge planning and referrals Other services capacity not being fully utilised due to delays in internal assessments Need for the Head of Clinical Services & Trust Lead for Discharge to take on some of the functions impacting on their daily roles significantly Increased workload & stress level for the remaining Discharge Coordinators in post Reduction in mandatory training compliance due to inability to release staff	4	5	20	HIGH	Covering a small number of shifts with former Discharge Coordinator carrying out bank shifts, when available. Offered bank shift to train an Agency Nurse who has shown an interest in the role. Recruited in to one vacancy and interviewing in to Bucks Coordinator role on 2/8/19. Reviewed role and delegated minor responsibilities to Rotational Operations Liaison Officers. Support requested from key nursing areas who have the skills to support a number of aspects relating to the role & discharge process- awaiting confirmation	Review of Datix incidents figures Superstranded patirnt data	4	4	16	HIGH	Additional funding to over recruit 1 WTE to for a 6 month period to cover the long term sickness	3	3	9	MOD	TREAT - above tolerable level - appropriate cost-effective control required		28/08/2019	No Change	New Risk	30/11/2019
940	16	21/09/2021	Director of Finance	Hotchkin, Karan	Finance	Financial Management	If the future NHS funding regime is not sufficient to cover the costs of the Trust, then the Trust will be unable to meet its financial performance obligations or achieve financial sustainability.	Increase in operational expenditure in order to manage COVID-19	1.Uncertaintly around the funding streams post Sept 21 2.Reductions in non-NHS income streams as a direct result of COVID-19.3.Impaired operating productivity leading to costs for extended working days and/or outsourcing. 4.Potential for material increase in efficiency requirement from NHS funding regime to support DHSC budget affordability.	4	5	20	HIGH	1. Cost and volume contracts replaced with block contracts (set nationally) for clinical income;2. Top-up payments available where COVID-19 leads to additional costs over and above block sum amounts (until September 2021); 3. Budgets to be reset for FY22 based on financial regime; financial controls and oversight to be reintroduced to manage financial performance.4. Cost efficiency programme to be reset to target focus on areas of greatest opportunity to deliver	Monthly financial performance monitoring information by the F&I Committee and the Trust Board Cost efficiency reporting BLMK ICS finance performance reporting	4	4	16	HIGH	Financial regime for FY22 only valid for first half of the year. Trust has minimal ability to influence	4	2	8	MOD	TREAT - above tolerable level - appropriate cost-effective control required	Maintain dialogue with CCG re Contract Raise risk of dispute over interpretation of Contract with Monitor	13/09/2021	No Change	no change	08/10/2021

Significant Risk Register

ID	Ref	Triumvirate Annual Review Date	Executive Responsible	Risk Owner	Division	Specialty	Description	Cause	Impact	C	L	Inherent Risk Raing	Inherent Risk Level	Controls in place	Assurance on Controls	C	L	Current Risk Rating	Current Risk Level	Gaps in Controls	C	L	Target Risk Rating	Target Risk Level	Treatment Category	Action Plan Summary	Date Risk Last Reviewed	Trend	Trend Rationale	Review Due?
940	16	21/09/2021	Director of Finance	Hotchkin, Karan	Finance	Financial Management	If the future NHS funding regime is not sufficient to cover the costs of the Trust, then the Trust will be unable to meet its financial performance obligations or achieve financial sustainability.	Increase in operational expenditure in order to manage COVID-19	1.Uncertaintly around the funding streams post Sept 21 2.Reductions in non-NHS income streams as a direct result of COVID-19.3.Impaired operating productivity leading to costs for extended working days and/or outsourcing. 4.Potential for material increase in efficiency requirement from NHS funding regime to support DHSC budget affordability.	4	5	20	HIGH	1. Cost and volume contracts replaced with block contracts (set nationally) for clinical income;2. Top-up payments available where COVID-19 leads to additional costs over and above block sum amounts (until September 2021); 3. Budgets to be reset for FY22 based on financial regime; financial controls and oversight to be reintroduced to manage financial performance.4. Cost efficiency programme to be reset to target focus on areas of greatest opportunity to deliver	Monthly financial performance monitoring information by the F&I Committee and the Trust Board Cost efficiency reporting BLMK ICS finance performance reporting	4	4	16	HIGH	Financial regime for FY22 only valid for first half of the year. Trust has minimal ability to influence	4	2	8	MOD	TREAT - above tolerable level - appropriate cost-effective control required	Maintain dialogue with CCG re Contract Raise risk of dispute over interpretation of Contract with Monitor	13/09/2021	No Change	no change	08/10/2021
2735			Deputy CEO	York, Craig	IT	Information Technology	IF the internal Trust telephone systems are not upgraded, THEN they will fall into a state where they cannot be supported by the Trust's IT Department or any third-party suppliers, LEADING TO potential loss of telephone systems either in small areas or across the Trust. This would have a significant impact upon operational procedures, especially during critical or busy periods.	Failure of the telephone system, communications being lost across critical areas.	As system versions get older, the likelihood of there being reliability issues increases, the cyber security threat increases, and the risk that telephone system suppliers stop supporting the system increases.	4	4	16	HIGH	Support in place, upgrade planned this year		4	4	16	HIGH	Upgrade planned this year	4	1	4	LOW	TREAT - above tolerable level - appropriate cost-effective control required		04/08/2021	No Change	No change - upgrade planned	30/11/2021
3033		07/05/2021	Deputy CEO	Beech, Jill	Core Clinical & Support Services - Diagnostic & Screening	Pathology	The Pathology LIMS system is at risk of failure, virus infiltration and being unsupported by the supplier.	The IT system is outdated and contract has limited time left.	Pathology service would be halted and contingency plans would have to be implemented. Sensitive information could lost or security of the information could be breached.	4	4	16	HIGH	Systems manager regularly liaises with Clinysis to rectify IT failures. Meetings with S4 to establish joint procurement take place periodically. Project Manager role identified to lead project for MKUH.	Controls are ineffective. Increasing incidences of of downtime and LIMS issues.	4	4	16	HIGH	Current system continues to malfunction and collapses.	4	1	4	LOW	TREAT - above tolerable level - appropriate cost-effective control required	To establish a project Plan and Timeline To breakdown potential risks within the project for MKUH Develop BC for additional staffing resource to support project	23/08/2021	No Change	Implement ation of new LIMS	30/11/2021
2892			CEO	Noble, Deborah	Core Clinical & Support Services - Diagnostic & Screening	Imaging	The 10yr old mammography machine in BS2 could fail due to its age. The increased amount of unplanned downtime this year is consistent with aging equipment. With the introduction of new technologies the availability of replacement parts is a worry. A replacement part needed to be shipped from Chicago.	Failure of the machine and unavailability of parts.	Failure of the machine would lead to a loss of service capacity for the 2ww clinics and NHSBSP programme which give have a detrimental effect on Trust metrics.	4	4	16	HIGH	Comprehensive service contract All faults reported immediately to external contractor / physicist for support. Robust QA systemin process to monitor system performance. This is reviewed weekly by medical physics.	QA monitored weekly by physicists.	4	4	16	HIGH	Availability of replacement parts.	3	1	3	VLOW	TREAT - above tolerable level - appropriate cost-effective control required		13/05/2021	Increased	Aging equipment	02/08/2021
2055			Director of Corporate Affairs	Stamp, Mr Jamie	Core Clinical & Support Services - Clinical Support Services	Dietetics	The risk is that the trust is not providing suitable accommodation for the dietetic team, there are too many members of staff based in an inadequate space and also the portacabin is old and therefore is no longer suitable as an office environment. The trust is therefore failing in its statutory legal duty under the Health & Safety at Work etc. Act 1974, Management of Health & Safety at Work Regulations 1999, Workplace (Health, Safety & Welfare) Regulations 1992 and Display Screen Equipment Regulations 1992 to provide a safe and well maintained place of work including welfare facilities for staff	Health and Safety lead for the Trust has confirmed that the maximum number of staff by law would be 11 staff, this is exceeeded on a regular basis as staff are unable to write their notes on the wards due to a lack of WOWs.	1. Physical and mental wellbeing concerns in relation to staff welfare with potential for sickness absence and potential litigation claims 2. Multiple breaches of statutory and regulatory duties leading to interest from the Health & Safety Executive 3.Enforcement action including formal notices; potential criminal prosecution resulting in fines and/or imprisonment dependent upon the action pursued; loss of Trust reputation; adverse publicity	4	4	16	HIGH	Due to the number of staff within the area, increased number of staff are having to work from home (rota basis), however as all the team see inpatients this is limited. Mobile air conditioning units distributed during summer months. Plumbed in water cooler in situ. .	Number of staff in the portacabin at one time is limited to 12 (this is challenging and affects effectiveness of team) During hot weather the temperature in portacabin in monitored	4	4	16	HIGH	The portacabins continues to provide insufficient space for the staff using this base, this has been further compromised by the social distancing requirements for COVID-19.	2	3	6	LOW	TREAT - above tolerable level - appropriate cost-effective control required	Risk to be reviewed by the Trust when office staff move to into MK Centre resolve short term issues - drinking water / flooring / window latches / changing facilities / secure path Upkeep of the portacabin including drinking water facilities, flooring and windown seals	04/10/2021	No Change	No change	22/11/2021

Significant Risk Register

ID	Ref	Triumvirate Annual Review Date	Executive Responsible	Risk Owner	Division	Specialty	Description	Cause	Impact	C	L	Inherent Risk Raing	Inherent Risk Level	Controls in place	Assurance on Controls	C	L	Current Risk Rating	Current Risk Level	Gaps in Controls	C	L	Target Risk Rating	Target Risk Level	Treatment Category	Action Plan Summary	Date Risk Last Reviewed	Trend	Trend Rationale	Review Due?
767	3-2	30/03/2021	Medical Director	James, Mr Andrew	Surgical - Musculoskeletal	Trauma & Orthopaedics	There is a risk to head injury patients not being appropriately cared for as they are not being treated in accordance with NICE guidance (CG176: Head injury: assessment and early management, updated September 2019)	1. NICE guidance sets out very specific recommendations for where and how patients should be managed and treated 2. Clinicians may have to wait for an opinion from the Tertiary Centre at Oxford 3. Head injuries frequently fall under the remit of the T&O Team or be nursed on a surgical ward(patients should be under neurological team).	- Potential reduction in patient safety - T&O surgeons and nursing teams may be unaware of how to care for patients with moderate to severe head injuries especially patient who are anticoagulated. - Clinicians may have to wait for an opinion from the Tertiary Centre. - Staff training, competency and experience - Serious incidents. - Reduced patient experience	4	3	12	MOD	1, 2 & 3. Preventive controls - On going discussions with Senior Medical Team - CSU Lead to escalate via trauma network - Alert process is in place for escalation within T&O & externally. - Resources available at tertiary site for advice/support 1, 2 c& 3. mitigating controls - Policy for management of head injuries has been developed - Awaiting appointment of head injury liaison Nurse - Long term plan for observation block to be built.	25/03/2021 Team continue to express concerns around the allocation of head injury patients to T&O. - Monitoring of Datix reported incidents by CGL for Surgery and CSU Lead - Team discussion of incidents/mortalities at CIG and M&M meetings.	4	4	16	HIGH	- 29/03/2021 T&O continues to received referral for complex head injury patients. - 23/09/2020 T&O continues to receive referrals for complex head injury patients under their speciality. - 28/01/2020 despite agreed pathway for admitting head injury patients under T&O team - non complex/ significant co-morbidities/ or anticoagulated the team are still having to care for these patient. - Trust is not in line with other trauma units - Regional trauma centre advises head injury should not be managed by trauma and orthopaedics and after 24 hours the patient should be referred to neurosurgery. - Potential delay in opinion from Tertiary Centre	4	2	8	MOD	TREAT - above tolerable level - appropriate cost-effective control required	Monitoring of incidents where tertiary advice/support was not available Monitor incidents where delay in tertiary opinion has occurred	21/07/2021	No Change	Ongoing risk	30/09/2021
767	3-2	30/03/2021	Director of Clinical Services	James, Mr Andrew	Surgical - Musculoskeletal	Trauma & Orthopaedics	There is a risk to head injury patients not being appropriately cared for as they are not being treated in accordance with NICE guidance (CG176: Head injury: assessment and early management, updated September 2019)	1. NICE guidance sets out very specific recommendations for where and how patients should be managed and treated 2. Clinicians may have to wait for an opinion from the Tertiary Centre at Oxford 3. Head injuries frequently fall under the remit of the T&O Team or be nursed on a surgical ward(patients should be under neurological team).	- Potential reduction in patient safety - T&O surgeons and nursing teams may be unaware of how to care for patients with moderate to severe head injuries especially patient who are anticoagulated. - Clinicians may have to wait for an opinion from the Tertiary Centre. - Staff training, competency and experience - Serious incidents. - Reduced patient experience	4	3	12	MOD	1, 2 & 3. Preventive controls - On going discussions with Senior Medical Team - CSU Lead to escalate via trauma network - Alert process is in place for escalation within T&O & externally. - Resources available at tertiary site for advice/support 1, 2 c& 3. mitigating controls - Policy for management of head injuries has been developed - Awaiting appointment of head injury liaison Nurse - Long term plan for observation block to be built.	25/03/2021 Team continue to express concerns around the allocation of head injury patients to T&O. - Monitoring of Datix reported incidents by CGL for Surgery and CSU Lead - Team discussion of incidents/mortalities at CIG and M&M meetings.	4	4	16	HIGH	- 29/03/2021 T&O continues to received referral for complex head injury patients. - 23/09/2020 T&O continues to receive referrals for complex head injury patients under their speciality. - 28/01/2020 despite agreed pathway for admitting head injury patients under T&O team - non complex/ significant co-morbidities/ or anticoagulated the team are still having to care for these patient. - Trust is not in line with other trauma units - Regional trauma centre advises head injury should not be managed by trauma and orthopaedics and after 24 hours the patient should be referred to neurosurgery. - Potential delay in opinion from Tertiary Centre	4	2	8	MOD	TREAT - above tolerable level - appropriate cost-effective control required	Monitoring of incidents where tertiary advice/support was not available Monitor incidents where delay in tertiary opinion has occurred	21/07/2021	No Change	Ongoing risk	30/09/2021
2740			Deputy CEO	Eagles, Mr Phil	Estates	Estates	The current bleep system (main system A and back-up system B) is obsolete and no maintenance support contract is available from the company. The risk is that the equipment may not be able to be maintained if required.	The ability of the manufacturer to provide support if required.	Contingency arrangement would be put into place in the event of failure of the current bleep system could delay clinicians and/or support staff being contacted via the bleep system for an urgent response when required.	5	4	20	HIGH	1. Discussed with Line Manager and Escalated 2.Temporary radio communication system is available if required 3. User group formed with IT, EBME and Clinical and non-Clinical leads to identify options 4. Business case approved and order placed for the implementation of new emergency response bleep system. 5. I.T. Infrastructure agreed to support new emergency call bleep system and service contract support from manufacturer in place ready for when the new system goes live. 6. Additional handheld walkie talkie purchased and available for staff use, in a contingency situation, located within Silver Command Control Room.		5	3	15	HIGH	1. Pilot system in place and fully tested, staff training to be arranged, and roll out date planned 2. Estates to own crash bleep solution; IT will own the clinical messaging and task-orientated communication functions. Digital Information Manager for Strategic estates will be driving the project to replace the emergency/urgent bleep replacement. 3. Policy to be updated detailing maintenance procedures, final draft available for final approval. 4. Critical Bleep Group Membership has been revised and confirmed with service leads, to be reviewed in a regular basis as stated in the bleep policy.	5	1	5	LOW	TREAT - above tolerable level - appropriate cost-effective control required		09/09/2021	No Change	no change	25/10/2021

Significant Risk Register

ID	Ref	Triumvirate Annual Review Date	Executive Responsible	Risk Owner	Division	Specialty	Description	Cause	Impact	C	L	Inherent Risk Raing	Inherent Risk Level	Controls in place	Assurance on Controls	C	L	Current Risk Rating	Current Risk Level	Gaps in Controls	C	L	Target Risk Rating	Target Risk Level	Treatment Category	Action Plan Summary	Date Risk Last Reviewed	Trend	Trend Rationale	Review Due?
2968			Director of Corporate Affairs	Noble, Deborah	Core Clinical & Support Services - Diagnostic & Screening	Imaging	Delayed detection of breast screening cancers due to COVID 19	The cessation of the programme has meant that women have been delayed an invite for screening. The programme has restarted but with reduced capacity to enable social distancing in both the mobile and static sites.	Women of screening age may receive a positive diagnosis that has been delayed due to the cessation of the programme. Treatment regimes will be delayed as a result.	5	4	20	HIGH	Restart proposal approved by the Trust, SQAS and PHE. Guidance issued as to the management of the women to ensure that no-one is missed has been issued by Hitachi/PHE and has been implemented by the programme.	KPI's monitored buy NHSBSP Regular communication with QA team and commissioners.	5	3	15	HIGH	No Gaps	2	2	4	LOW	TREAT - above tolerable level - appropriate cost-effective control required		24/04/2020	Decreased	No change	25/06/2021
3106			Deputy CEO	Marsh, Tony	Estates	Estates	Obstructions stored in hospital street (main, fire-protected, circulation routes) hindering evacuation or access to fight a fire.	Items such as beds, mattresses, cages (both empty and full of combustibles), trolleys, cots for examples are stored in hospital streets due to a lack of storage facilities and/or due to operational constraints including excess stocking of essential items for ward use. This impedes on the safety of movement by individuals either walking, using mobility aids, beds, and staff delivering/manoeuvring equipment through the hospital streets.	Delays in attending fire, delayed fire evacuation could lead to smoke inhalation/burns/death	5	4	20	HIGH	Fire warning systems in place Fire doors in situ and close when fire occurs (safe to 60 Minutes) Ward/department fire risk assessments conducted and documented including personal evacuation plans for vulnerable individuals (sight, hearing, frailty/disability) Procedures for horizontal evacuation in place – evacuation or table top exercises take place. Staff training in fire safety procedures & measures completed and regular updates mandatory. Fire alarm points. Firefighting equipment in situ. Trained Fire Wardens to monitor fire safety in departments. Fire Safety Policy documented and available to all staff. All incidents to be reported onto Trust		5	3	15	HIGH	Storage unit to be created to assist with safe location of excess stores.	5	1	5	LOW	TREAT - above tolerable level - appropriate cost-effective control required		25/08/2021	No Change	new risk	25/10/2021
1874			Director of Patient Care / Chief Nurse	Goodman, Mrs Julie	Directorate of Patient Care	PPI	The MUST conformance criteria were set out in the NHS accessible information specification for compliance by the 31st July 2016	The Trust currently cannot meet all of requirements set out in this specification which is driven by the NHS England, the Equality Act 2010 and Care Act 2014 to ensure patients with a disability are not discriminated against.	1. The CCG as part of the Quality Schedule 2. The CQC recognise the role of this standard as an indicator of high quality care for people with particular information and communication support needs and will be included as part of their inspections of a service. 3. A workstream to the patient led assessment of the care environment (PLACE). Identiication of non compliance could lead to an enforcement action from any of the above performance monitoring stakeholders.	3	5	15	HIGH	Some of the meeting individual needs resources identified i.e.BSL sign language interpreters, braille, easy read Ongoing EPR agile preparation events E Care launch plan in progress	Patient Experience team are working with external providers and will be picked up as part of the Quality Account	3	5	15	HIGH	Go live date agreement for EPR - Cerner have confirmed that the system will allow the required alert flags etc. Equality and Diversity Trust legal requirements to be identified, documented in policy and staff advised. This impacts on all policies and guidelines. Interpreting and translation policy - contract now agreed Gap analysis of patient information (sits with Patient Experience) - what is available?	3	2	6	LOW	TOLERATE - at lowest practicable /cost-effective level	Steering Group to monitor progress Review of proces for patient information publication & availability	28/02/2019	No Change	First review	28/08/2019
1970			Director of Clinical Services	Hyem-Smith, Ms Celia	Core Clinical & Support Services - Clinical Support Services	Physiotherapy	Unable to meet the demand for existing patients leading to increased waiting times Unable to develop exisitng outpatient services Unable to optimse student placements	The cause is the lack of clinical space available for patient treatment	The impact is failure to meet contracts, lost revenue, poor patient experience and poor staff morale	3	5	15	HIGH	1. Extended working hours 2. Introduction of shift pattern 3. Introduction of telephone triage clinics 4. Group treatment sessions		3	5	15	HIGH	Amalgamation and integration of department space and teams to utilise current space more efficiently. Potential to increase clinical space but this would require significant investment.	3	5	15	HIGH	TREAT - above tolerable level - appropriate cost-effective control required	Review of space in Therapies	17/02/2021	No Change	No change	31/05/2021
2936			Director of Clinical Services	Hyem-Smith, Ms Celia	Core Clinical & Support Services - Clinical Support Services	Physiotherapy	Increasing numbers of patients being added to the physiotherapy outpatient waiting list, in addition to those on hold due to the COVID-19 pandemic, resulting in waiting times of well over 18 weeks for any type of intervention. A further increase in referrals may result from patients with post-COVID symptoms	The COVID-19 pandemic has led to outpatients only reviewing urgent patients virtually by telephone or video call, pre-COVID waiting lists could be managed effectively by groups, this is no longer possible due to social distancing and patients shielding.	Litigation and/or complaints due to lack of timely treatment intervention, potentially resulting in permanent and unecessary disability.	3	5	15	HIGH	- Virtual management of patients - Video and telephone clinics - Additional IT sourced to support virtual management - Reconfiguration of department to support virtual working and enable social distancing along with staff working from home - recovery plans are being written/in place to enable essential patients to be seen in the department of a face to face basis - Educational material including exercise programmes and access to youtube clips are made available to patients		3	5	15	HIGH	To identify process for validate routine patient lists to ensure that clinical priorities are seen the correct order	2	3	6	LOW	TREAT - above tolerable level - appropriate cost-effective control required	To develop strategy for validating routine patient waiting list	17/02/2021	No Change	new risk	31/05/2021

Significant Risk Register

ID	Ref	Triumvirate Annual Review Date	Executive Responsible	Risk Owner	Division	Specialty	Description	Cause	Impact	C	L	Inherent Risk Raing	Inherent Risk Level	Controls in place	Assurance on Controls	C	L	Current Risk Rating	Current Risk Level	Gaps in Controls	C	L	Target Risk Rating	Target Risk Level	Treatment Category	Action Plan Summary	Date Risk Last Reviewed	Trend	Trend Rationale	Review Due?
2983			Director of Clinical Services	Hyem-Smith, Ms Celia	Core Clinical & Support Services - Clinical Support Services	Physiotherapy	There is a risk that the Women & Men's Health Physiotherapy Service is unable to meet its referral demand	Insufficient staffingleading to increased waiting times Referral number into service via multiple routes	Potential for poor clinical outcome, poor patient experience, complaints and staff stress Potential delay to patient treatment Potential for patients with new diagnosis of cancer and pregnant women are not seen in a timely fashion further	3	5	15	HIGH	Non clinical time including training,development and audit are being minimised to increase the number of available patient appointments Job plans are being completed by all staff to show impact on workload Patients are ebing booked into group where possible instead of individual appointment slots Recruited to all vacant posts To explore options for supporting dictationn of letters to free up clinical capacity.	Patients requiring an individual slot are often not being treated in a timely manner to meet the needds of their clinical repsentation. Team is fully established and Band 4 assistant is being used to support	3	5	15	HIGH	Staff capacity to meet current referral demand	2	4	8	MOD	TREAT - above tolerable level - appropriate cost-effective control required	Establish increasing referral rate trends, map against capacity and establish increase income vs uplift in staff to meet demand Budget reallocation and VCP for Band 6 post Therapy Strategy is being finalised to support investment for business case, to present strategy at management once shared with senior members of the Trust To discuss interim plans to manage staffing and impact on Women's division	19/06/2020	Increased	No changes to staffing	31/05/2021
2297		07/05/2021	Director of Clinical Services	Thwaites, Elizabeth	Core Clinical & Support Services - Diagnostic & Screening	Pathology	There is a risk that the available space within Cellular Patholgy will not be enough to meet the demands of the service as workload continues to expand	Increasing workload requiring additional specimen storage, workspace additional equipment and additional staff	The department will be unable provide the storage space required to accommodate the increasing workload leading to 1. An inability to retain specimens for the period of time required to meet RCPath guidance 2. An increased risk of formalin spillage / increased levels of formalin vapour 3. Increasing risk to staff and to specimens because of cramped workspace e.g. Specimen reception area encroaches on cut-up area 4. Inability to safely operate and / or validate equipment 5. Insufficient space for record storage	3	5	15	HIGH	Storage of specimens minimised. Review of work flow and processes to improve space efficiency. Business Case has been accepted - plans to be confirmed regarding building work and expansion. Business case required for Laboratory furnishings and layout.	Controls are currently not effective due to increased workload and pressure of social distancing.	3	5	15	HIGH	Social distancing pressures in addition to digital expansion requiring further space.	3	2	6	LOW	TREAT - above tolerable level - appropriate cost-effective control required	Identify additional storage space Review space and workflow and identify activities that can be relocated Supervise build of new expansion Develop BC for internal build - Lab layout and furnishings Develop business case for space expansion into courtyard area	23/08/2021	No Change	Building work ongoing	30/11/2021
2341			Director of Clinical Services	Stamp, Mr Jamie	Core Clinical & Support Services - Clinical Support Services	Dietetics	The risk is that the paediatric team can not provide a full dietetic service to children and young people in the Milton Keynes area	Insuffient capacity and on-going unsustainable demand for dietetic input for Paediatric patients (both inpatient and outpatient) Home Enterally Fed Paediatrics patients should be seen as part of community contract, currently this group of patients is being seen through our outpatient structure which is not adequate to meet their demands and needs. As a results of this staff are be stretched to cover a service that has not been resourced correctly which in turn impacts on the wider outpatient and inpatient work load. The current dietetic workforce is not able to meet the Increasing referral for children with diabetes, this means that these high risk groups of Children and Young People are not accessing the necessary specialist nutritional support at the appropriate time in their development. This was highlighted as a serious concerns at a Paediatric peer review in March 2020.	1. Patient care and patient safety will be at risk 2. Vulnerable children becoming nutritionally compromised. 3. Unable to assess and advise new patients and review existing patients in a timely manner. 4. Impacting on patients nutritional status and longer term dietary management on what is a very vulnerable group of patients. The majority of our caseload is infants or tube fed infants and children where there nutrition and growth is a priority.	3	5	15	HIGH	Existing staff are working some additional hours but this remains insufficient to meet the needs of the service.	Number of children / babies on HEF is monitored - 91 Dec 2020 Waiting list / request queue for paediatric dietetic OP's monitored	3	5	15	HIGH	There is insufficient to paediatric dietetics to manage the demand for outpatients, inpatients specifically the paediatric dietetic service is unable to deliver the national standards for Home Enterally Fed and Diabetic patients on the caseload.	1	3	3	VLOW	TREAT - above tolerable level - appropriate cost-effective control required	The need for a paediatric community dietetic service for patients on HEF being raised with CCG Current staffing provision is not sustainable and is not adequate for delivery the Home Entral feeding serivce which is not commissioned	04/10/2021	No Change	No change	01/11/2021

Significant Risk Register

ID	Ref	Triumvirate Annual Review Date	Executive Responsible	Risk Owner	Division	Specialty	Description	Cause	Impact	C	L	Inherent Risk Raing	Inherent Risk Level	Controls in place	Assurance on Controls	C	L	Current Risk Rating	Current Risk Level	Gaps in Controls	C	L	Target Risk Rating	Target Risk Level	Treatment Category	Action Plan Summary	Date Risk Last Reviewed	Trend	Trend Rationale	Review Due?
3129		18/01/2022	Director of Patient Care / Chief Nurse	Davis, Mrs Melissa	Women's & Children's Health - Women's Health	Obstetrics & Maternity	The maternity service at MKUK makes use of Phase 1 theatres for all cases, we do not have our own dedicated set of theatres. Elective Caesarean work is completed the Theatre 1 during a booked morning session, Theatre 3 is set for obstetric emergencies. All Phase 1 theatres in the afternoon are used for emergency lists for the whole trust. This leaves maternity vulnerable to not having a guaranteed emergency theatre available 24hrs a day. There is only 1 theatre team on site overnight for all emergency surgery in the trust, should they be dealing with an emergency outside of obstetrics, obstetrics would have to call on call theatre team in from home increasing the risk for mother and baby.	No dedicated obstetrics theatres and theatre team	Mother and Babies - Increased risk of poor outcome if theatre delay. Staff – Psychological trauma of dealing with potentially avoidable poor outcome. Financial implication to the trust.	5	3	15	HIGH	Cannot currently mitigate		5	3	15	HIGH	SOP to be created for the following: Increased communication pathway between theatres and labour ward to have increased oversight of emergency theatre need, for overnight cases anticipate need for the on call team, Labour Ward to keep in regular contact with the theatre team in case of other emergency surgery need within the trust.	3	3	9	MOD	TOLERATE - at lowest practicable /cost-effective level		29/09/2021	No Change	new risk	20/10/2021
2973		30/03/2021	Director of Clinical Services	Burns, Ms Samantha	Surgical - Musculoskel etal	Trauma & Orthopaedics	With the implementation of green pathways for elective care patients, the Trauma and Orthopaedic department has lost capacity to escalate on to elective lists for trauma patients. As such with just one trauma list per day, there may be insufficient capacity to meet trauma needs.	Increasing trauma activity beyond existing capacity (5 cases per day on trauma list)	Without sufficient trauma capacity in place, the department may not be able to operate on all trauma patients within the required timelines leading to poor outcomes. The Trust may be required to close to trauma or cancel all elective lists for the day in theatres 11 and theatres 12 in order to facilitate trauma patients who are not covid swabbed, isolated for 72 hours or given social distancing advice. This will lead to longer elective wait times and possible 52 week breaches. Alternatively, the Trust may be required to close to trauma due to insufficient capacity	3	4	12	MOD	Divisional Director for Operations to work with T&O and Theatre teams to implement all day weekend emergency theatre lists. Utilisation of theatre pm 1 for procedures that do not include metal work twice a week if staffing is available. Cancellation of elective activity if required.	24/06/2021 - team report that main theatre used by T&O is closed whilst laminar flow is being repaired. This is likely to be for 6 weeks therefore this will impact on the red/ green pathways - number of elective operations will reduce, and there may be delays for emergency operations. Options to address are being considered at present. 27/04/2021 - team believe risk may be increasing therefore to continue monitoring progress. 30/03/2021 - Divisional Director for Operations to liaise with Operational Manager and teams to consider implementing all day weekend theatre lists. 19/01/21 Currently elective surgery is	3	5	15	HIGH	There are occasional surges in trauma cases especially at the weekend which impacts on trauma/ elective lists on Mondays.	3	2	6	LOW	TREAT - above tolerable level - appropriat e cost-effective control required		20/07/2021	Increased	Ongoing risk	30/09/2021
3111			Director of Clinical Services	Barton-Young, Mr Phillip	Surgical - Head & Neck	ENT	Endoscopic Stack system in ENT outpatients is not linked to EPR (Cerner Millennium)	Lack of visibility of patient records in a secure system	Patients – Clinicians unable to see images from previous visits and compare current and previous to look for changes	3	3	9	MOD	no controls	- reported incidents when patient care compromised. 27/08/2021 team are concerned that the risk is still ongoing. Without resolution there is a risk to service development and will impact on collaborative working. ENT needs to be in line with corporate digital expansion. Business in progress.	3	5	15	HIGH	Need to establish Link between systems	3	2	6	LOW	TREAT - above tolerable level - appropriat e cost-effective control required	Business case and work with IT to enable the link between stack and eCare	27/08/2021	No Change	New risk	30/11/2021

Significant Risk Register

ID	Ref	Triumvirate Annual Review Date	Executive Responsible	Risk Owner	Division	Specialty	Description	Cause	Impact	C	L	Inherent Risk Raing	Inherent Risk Level	Controls in place	Assurance on Controls	C	L	Current Risk Rating	Current Risk Level	Gaps in Controls	C	L	Target Risk Rating	Target Risk Level	Treatment Category	Action Plan Summary	Date Risk Last Reviewed	Trend	Trend Rationale	Review Due?
1740		24/03/2021	Director of Corporate Affairs	Worth, Mrs Tina	Corporate Affairs	Clinical Governance	There is a risk that changes required to practice are not implemented and we are not meeting best practice criteria	If recommendations and actions from audit are not evidenced, monitored and completed in the Trust	Potential impact on the top 3 Trust objectives (patient Safety, Clinical Effectiveness, Patient Experience) Potential poor quality of service and associated impact on resources CQC concerns re audit activitu & learning from national audits	3	5	15	HIGH	Audit report templates available to identify audit action plans. However these are not always being utilised and actions are not Always evidenced and monitored Monitoring via Clinical Audit & Effectivess Committee (CAEB) TOR CAEB revised to include quality improvement, GIRFT etc Escalation/exception reporting to Management Board Refresh of Sharepoint data base to assist with data capture, with Level 1 audit a priority Transformation Team audit Structure review - staff realignment to support audit agenda Scheduled implementation of Radar audit module Autumn 2021 onwards Pilot of new governance approach to reports/CIG meetings (ED pilot area)	Limited assurances from RSM audit review Sharepoint has ability for audit action plans to be attached with evidence of completion but audit cycle not completed to this level Jan - Feb 2020 repeat RSMUK reveiw due Limited assurances from RCB?CAEB - pals to move to integrated governance & divisional meetings approach	3	5	15	HIGH	Capturing audit evidence at specialty CIG meetings including actions to improve practice or examples of good practice. Divisional audit reports at CAEB detailing compliance on Level a audits Sharepoint evidence to support action plan from audits - review & overhaul of system scheduled for November at Risk Management Team Divisional accountability at Performance Management Board Effectiveness of CAEB - corporate level meetings to be reviewed Roll out of new governance approach Radar build Realigned staff moved across with new Implementation of new integrated governance agenda National audits on hold & local audits & audit meetings	1	3	3	VLOW	TREAT - above tolerable level - appropriat e cost-effective control required	Implementation of KPMG action plan, to be monitored by Audit Committee Meeting with CGLs to review Sharepoint format for capturing audit completion/complinace to best ensure this helps give accurate data & evidence Risk Systems Business Case with potential for Document Management system	06/07/2021	Increased	KPMG Audit / CQC	31/08/2021
2640		24/03/2021	Director of Corporate Affairs	Worth, Mrs Tina	Corporate Affairs	Clinical Governance	Clinical Governance and Imaging staff are unable to meet statutory and mandatory Good Governance requirements and accreditations if IT systems do not support their remit.	Existing governance systems do not support meeting Trust /legal/stakeholder requirements and are unsupported by the Trust IT department or an external IT provider	Unable to meet statutory and mandatory Good Governance requirements and accreditations if IT systems do not support their remit.	5	5	25	HIGH	System in place but requires updating and Q pulse which manages Trust documentation is no longer able to archive since the shared drive was moved. Updates made to Q-Pulse and SharePoint Scheduled implementation of new system Radar (documents module)Autumn 2020 onwards	The controls are ineffective to manage documentation on such a scale to support accreditation. No response from Datix regarding system capabilities. IT support staff no longer able to support - new member of staff commences July 2018 for project to be handed over. Scoping exercise with other IT systems to Datix that may include a document management service. QPulse move to Microsoft Teams pending - further review of how manage documents	5	3	15	HIGH	Systems require updating Purchase of additional modules on Datix (business case for Datix cloud/other system progressing). Since approved move to Radar	2	1	2	VLOW	TREAT - above tolerable level - appropriat e cost-effective control required	Risk Systems Business Case with potential for Document Management system	06/07/2021	No Change	New risk	31/08/2021
3104			Director of Clinical Services	Martucci, Mr Mark	Surgical - Anaesthetic s & Theatres	Main Theatres	Staffing shortages within the theatre department. The staffing demands within theatres has significantly increased, these changes have arisen from changes and developments in our service. For the theatre team to safely cover the theatre sessions additional staff are required. Examples of the increased staffing demand below: Robotic lists x 5 days a week, COVID-19 secure pathway, increased elective activity & trauma activity & staffing the theatre procedure room.	Inability to cover the increased demand of both elective and emergency/trauma theatre sessions. Some staff currently in post are junior and are learning within their specialities. The lack of experienced staff creates issues around staff skill mix.	Patients being cancelled due to a lack of staff, we also experience issues due to the amount of junior staff within the department – creating difficulties with skill mix. This creates increased stress level with the clinical teams.	3	4	12	MOD	This risk is currently being mitigated by the use bank, approx. 80 /100 shifts of varying lengths per week. Agency staff approx. 300 hours per week. Even with the additional support from bank and agency staff we still struggle to provide staff for all sessions, this has recently led to cancelling lists. These risks are exacerbated when staff are off sick or absent for training / annual leave.	Monitoring of staffing levels and when theatre lists are taken down.	3	5	15	HIGH	There are significant gaps in the theatre rota - 26 WTE posts are required to meet latest review of theatre staffing requirements.	3	2	6	LOW	TREAT - above tolerable level - appropriat e cost-effective control required		15/09/2021	No Change	ongoing risk	20/10/2021

Significant Risk Register

ID	Ref	Triumvirate Annual Review Date	Executive Responsible	Risk Owner	Division	Specialty	Description	Cause	Impact	C	L	Inherent Risk Raing	Inherent Risk Level	Controls in place	Assurance on Controls	C	L	Current Risk Rating	Current Risk Level	Gaps in Controls	C	L	Target Risk Rating	Target Risk Level	Treatment Category	Action Plan Summary	Date Risk Last Reviewed	Trend	Trend Rationale	Review Due?
3107			Director of Clinical Services	Sutton, Ms Laura	Medicine - Acute Medicine	Acute Medical	This a ligature risk assessment ward 1 in various locations: - Bay 1,2 3 and 4 (6 Beds per bay) - Siderooms 1,2 and 3 - Bathroom/Toilets - Kitchen - Attending to and/or witnessing vulnerable patients/ self harm/suicide attempts - Sluice - Store cupboards/Clinic rooms/Corridors	- Ligature points - Ligatures	- Patients admitted with acute mental health problems. Majority involve those who have attempted suicide or caused deliberate self harm. Leading to physical injury/cuts/overdose/ill health/death - Patients admitted with acute mental health problems. Majority involve those who have attempted suicide or caused deliberate self harm. These persons can vary in sex and age. - Patients admitted with acute mental health problems. Majority involve those who have attempted suicide or caused deliberate self harm. - Staff/Patients/Visitors: Psychological impact, stress, anxiety, breakdown; Absence from work; Reduced staffing through absence Ongoing mental health impact -	5	3	15	HIGH	See attached Risk Assessment.		5	3	15	HIGH	Education and training regarding Mental Health and suicide risk. Mental Health Practice Development nurse has been recruited by the Trust and will be working alongside the ward when in post. Hopsicom brackets to be removed in all other bed spaces on the ward. Estates aware, this is an ongoing piece of work across the Trust POD cupboard to be replaced (These have been ordered) as some missing and some not fit for use. Estates will install when delivered. Minor works request has been made for Bathroom door that only swings one way. Unable to remove Manual handling bars as they are an assistance device for all	5	2	10	MOD	TREAT - above tolerable level - appropriate cost-effective control required		21/09/2021	No Change	New Risk	15/11/2021
3114					Medicine - Specialty Medicine	Endoscopy	We had 2 lithotripsy handles that broke and were replaced like for like, pre 2016 Information For Use (IFU's) was not considered mandatory and therefore could be reprocessed by HSDU. The new handles (post 2016) require FUI's but the one provided by Olympus lack of alignment with UK sterilisation parameters and Olympus are unable to recommend a reprocess technique that is UK compliant with a washer disinfector, so we are unable to reprocess the lithotripsy handle.	Once current clean lithotripsy handles have been used, they will not be able to be reprocessed by HSDU as Olympus have not provided UK compliant guidelines for HSDU to follow.	Patients with large stones will not be able to have them manually crushed during ERCP procedure, this may mean patient remain compromised by stones blocking the common bile duct, a repeat / further procedure elsewhere or surgery resulting increased risk and morbidity to patient. Cost to trust.	4	4	16	HIGH	Alternative handles have been reviewed but have the same issue in regard to not having UK compliant guidelines. Single use handles have also been reviewed but do not have the ability to use guidewires which is a safety concern.		4	4	16	HIGH										
3050		20/04/2021	Director of Clinical Services	Matthews, Dr Lucy	Medicine - Specialty Medicine	Neurology	Staffing risk for epilepsy service. Consultant lead on extended leave and no epilepsy specialist nurse in post. Follow-ups, responding to queries and First Seizure- type appointments are delayed. NICE CG137 guidance for First Seizures is to see patients within 14 days. Delay in transitioning paediatric patients with Epilepsy to Adult service.	Epilepsy lead on extended sick leave, epilepsy nurse retired - currently recruiting to fill the post.	The team may be unable to meet the standard (NICE CG137) of reviewing all First Fit patients within 14 days. Epilepsy follow-up appointments will be delayed. Patients do not have the benefit of an appointment with an epilepsy specialist nurse following first seizures, the diagnosis of epilepsy, pregnancy and breast feeding counselling. Potential risk of sudden unexpected death in epilepsy patients + obstetric risk. Reduced consultant cover contributing to backlog of new patients to be seen.	4	4	16	HIGH	- Agency locum in post temporarily, and are actively recruiting for a further NHS locum. - Substantive neurology consultants are seeing patients ad hoc and through waiting list initiative work. - The substantive neurology consultants are answering queries from patients and GPs when possible. - Recruitment of an epilepsy specialist nurse is underway. -Paediatric patients are discharged back to their GPs and some remain under CNWL community paediatric nurses -Urgent patients to be flagged to consultant Neurologists covering the Epilepsy service - Transition waiting has been shared to Adult service Ops Manager and consultant Neurologists		4	4	16	HIGH	- Nurse ANP - Wait list 630+	3	2	6	LOW	TREAT - above tolerable level - appropriate cost-effective control required		21/06/2021	No Change	New Risk	20/09/2021
3087			Director of Workforce	Adderley, Jane	Surgical - Anaesthetics & Theatres	Anaesthetics	Psychological wellbeing of staff on the Intensive Care Unit is at risk due to managing complex patients and families specifically following extraordinary circumstances such as the Pandemic, sudden death, and distressing situations with relatives.	Managing complex clinical and communication needs with patients and families. Responsibility to manage a higher ratio of patients as required and dealing with challenging situations and death that is difficult to rationalise.	All staff may have an inability to function at their designated role in a high stress situation. Increased risk of ill health, fatigue, anxiety and post traumatic stress disorder (PTSD symptoms)leading to potential increase in sickness. Impact on staff retention and staff morale.	4	5	20	HIGH	Clear leadership and team support. Staff health and well-being initiatives. Access to external psychological support. Individual stress risk assessments for staff.	Embedded psychological support from practitioners who are knowledgeable and skilled in Intensive care. Provision of Mental health First aid. Increase in staff morale, improved sickness/absence rates and retention of staff.	4	4	16	HIGH	Currently there is no embedded psychological support from practitioners who are knowledgeable and skilled in Intensive care. Staff may have a longer wait to access skilled psychological support.	4	2	8	MOD	TREAT - above tolerable level - appropriate cost-effective control required	Evidence to support business case	15/09/2021	No Change	Ongoing risk	17/11/2021

Significant Risk Register

ID	Ref	Triumvirate Annual Review Date	Executive Responsible	Risk Owner	Division	Specialty	Description	Cause	Impact	C	L	Inherent Risk Rating	Inherent Risk Level	Controls in place	Assurance on Controls	C	L	Current Risk Rating	Current Risk Level	Gaps in Controls	C	L	Target Risk Rating	Target Risk Level	Treatment Category	Action Plan Summary	Date Risk Last Reviewed	Trend	Trend Rationale	Review Due?
1917	1 / 12	20/04/2021	Director of Clinical Services	Nicholson, Mr Simon	Medicine - Emergency Medicine	Emergency Department (A&E)	Lack of flow in the organisation leading to unsafe environment for patient care causing increased waits within the ED and inability to meet Emergency Access Targets	Overcrowding within the ED department and or significant number of patients with a high acuity/dependency being cared for in areas that are not suitable for safe care	Unsafe environment for patients and staff due to bed space capacity, ambulance queues, missed trust targets and overcrowding into ED/radiology corridors creating H+S hazard and continued pressure, leading to poor patient care/treatment and delays in discharge/transfer and the potential for an increase of incidents being reported regarding assessment/care/treatment. Potential for aviodable deaths ocurring Increased staff stress/burn-out Reduces training experience for students/trainees risking poor feedback to university/deanery and consequences thereof. Trust reputation	5	5	25	HIGH	"1. EPIC consultant in place to aid flow within department and speed up decision making 2. Recruitment drive for more nurses/HCA's and consultants ongoing. Active management of Nursing/Consultant and Registrar gaps in rota daily to ensure filled. 3. RAT-ing process and medical specialty referrals having a RAG system developed to prioritise sickest patients to be assessed. 4. Walking majors and resus reconfigured. Expanded Cubicle space in Majors - extra 10 spaces, increased capacity using Acorn Suite. 5. Internal escalation policy in place. CSU lead developing trust escalation criteria to alert trust leads to problems sooner - diverting patients to; Ambulatory care 6. Since Covid pandemic, phasing plan in place with red and green zones within ED. 7. Escalation plan for ED to mitigate patient pressures."	Meeting national targets consistently Nursing vacancy level at acceptable level	4	4	16	HIGH	Nurse staffing issue - added to Risk Register development of pathway unit; sameday emergency care model, improving streaming and RAT provision, ambulance teams working together to reduce attendances at ED	3	3	9	MOD	TREAT - above tolerable level - appropriat e cost-effective control required	Escalation Guideline now developed - requires ratification at CIG and assurance of being used operationally develop GP Specialty referral to ED RAG rating protocol CSU lead to develop escalation policy to Trust level for when flow/capacity of ED deteriorates Matrons to identify if need to add nurse staffing levels to Risk Register	09/09/2021	Increased	improved flow and reconfigura tion	29/10/2021
1472	2	24/03/2021	Director of Corporate Affairs	Ewers, Mr Paul	Corporate Affairs	Risk Management	There is a risk that not all known incidents, accidents and near misses are reported onto Trust Incident Reporting System (Datix) and that they will not be robustly investigated within the required timescales	Failure to comply with the Incident Reporting Policy; Poor incident reporting culture; Lack of understanding of the necessity and importance of reporting incidents; Lack of incentives to report incidents due to lack of feedback or poor quality investigation outcomes; Lack of consequences for failing to report; Lack of consequences for poor quality investigations; Lack of computer access to report incidents; Conflicting priorities and lack of time to report; Perceived difficulty in completing the online incident reporting form	The Trust will not have a complete list of incidents occurring in the Trust; Inability to learn from incidents, accidents and near-misses; Inability to stop potentially preventable incidents occurring; Potential failure to comply with Duty of Candour legislation requiring the Trust to report all known incidents where the severity was moderate or higher; Potential under reporting to the National Reporting & Learning System (NRLS); Potential failure to meet Trust Key Performance	4	5	20	HIGH	1. Incident Reporting Policy 2. Incident Reporting Mandatory/Induction Training 3. Incident Reporting Training Guide and adhoc training as required 4. Datix Incident Investigation Training sessions 5. Daily review of incidents by Risk Management Team to identify potential Serious Incidents and appropriate escalation 6. Serious Incident Review Group (SIRG) ensure quality of Serious Incident Investigations 7. SIRG ensure appropriate reporting of Serious Incidents to Commissioners 8. Staff able to have automatic feedback following investigation approval 9. Incident Reporting Awareness Campaign - September 2017 10. Standard Operating Procedure re Risk & Governance Team supporting the closure of incident investigations during unprecedented demand on service (e.g. Covid-19 Pandemic) approved - February 2021 11. Patient Safety Framework introduced 12. Ongoing move to new reporting system - Radar	1. Risk Management Dashboard monitoring trends 2. Weekly overdue incident reporting 3. Routine and exception reports to Risk & Compliance Board 4. Weekly Compliance Report to Executive Team 5. Incident reporting rate and overdue incidents monitored through Trust KPIs 6. Regular reporting to Divisions through Clinical Governance reports 7. Divisional Dashboards to monitor trends 8. Bi-monthly National Reporting & Learning System reports 9. Serious Incident Review Group upward reports 10. Monitoring of	4	4	16	HIGH	1. Lack of a high incident reporting culture 2. Lack of robust investigations for non-Serious Incidents 3. Lack of feedback to reporters/staff following incident investigations 4. Staff lack access to a computer to report incidents 5. Staff lack time during shift to report incidents 6. More intuitive incident reporting system - procurement scoping exercise on going for Datix Cloud/new system (since agreed move to Radar from October 2020). Ongoing implementation plan	4	3	12	MOD	TREAT - above tolerable level - appropriat e cost-effective control required	Comms Initiative being developed to coincide with launch of simpler incident reporting form and enhanced Incident reporting training at Induction/Mandatory Training - Complete Quality Improvement Project to be undertaken - Ongoing through Learning From Incidents Focus Group Recruitment of two new band 7 facilitators - complete Launch the 'SHARE' Incident Reporting Campaign with Comms Team - Complete Letter re-iterating the importance of incident reporting to be sent from CEO via wage slips - Decision made not to undertake - Complete Incident Reporting Handbook for staff to coincide with 'SHARE' launch to be developed - Decision made not to undertake - Complete Consider the increase of accessibility to computers in order to report incidents at	06/07/2021	No Change	No change since last review	31/08/2021
2796			Director of Clinical Services	Chadwick, Ms Helen	Core Clinical & Support Services - Pharmacy	Pharmacy	The risk is there will be insuffient staff in pharmacy to meet demands of the organisation and ensure patient safety in the use of medicines.	High turnover of staff due to: work pressure, not having the opportunity to work at the top of their licence, lack of capacity for development, lack of capacity for supervision / support. Also difficulty in recruiting particuarly to 8a posts. Loss of staff to primary care which offers more attractive working hours.	1. increased length of stay due to TTO delay 2. increase in prescribing errors not corrected 3. increase in dispensing errors 4. increase in missed doses 5. failure to meet legal requirements for safe and secure use of medicines All resulting in adverse patient outcomes. Lack of financial control on medicines expenditure Breach of CQC regulations	4	5	20	HIGH	Actively recruiting, listening events with staff, implementing 1-1 system to support staff, reviewing work activities of 8a's and above to identify what could stop for a period of time. Recruitment of additional Pharmacy technicians requested Aug19. Approved end of 2020. 3 appointed and in training.	Staff feedback HR metrics eg turnover Medicines reconciliation rate Datix rate	4	5	20	HIGH	Use of senior staff to support not viable long term - 28/5/21 This action has resulted in further deterioration in morale and ability to make change, increased losses Maternity leave returners leaving for more flexible / family friendly working hours	2	3	6	LOW	TREAT - above tolerable level - appropriat e cost-effective control required	Bc to execes Internal review of Clinical service Undertake workforce analysis Develop a business case for the clinical pharmacy servcie Implement changes recommended in review	28/05/2021	No Change	No change - capacity	31/07/2021

Meeting Title	Board of Directors	**Date:** November 2021
Report Title	Board Assurance Framework	**Agenda Item: 20**
Lead Director	**Name:** Kate Jarman	**Title:** Director of Corporate Affairs and Communication
Report Author	**Name:** Kwame Mensa-Bonsu	**Title:** Trust Secretary

Key Highlights/ Summary	Board Assurance Framework containing the principal risks against the Trust's objectives. 1. The risk score for the following risk entry has been revised upwards: a. Risk Entry 20 – From 8 to 12 (page 41)			
Recommendation *(Tick the relevant box(es))*	**For Information** [x]	**For Approval** [ ]	**For Noting** [ ]	**For Review** [ ]

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

Report History	Board Committees and Trust Executive Group
Next Steps	N/A
Appendices/Attachments	Board Assurance Framework

The Board Assurance Framework – Summary of Activity in October 2021

COVID-19 Risks

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

Strategic Maternity Risks to be Reviewed to the BAF and the Risk Register by December 2021

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

The Board Assurance Framework

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

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

Strategic Objectives

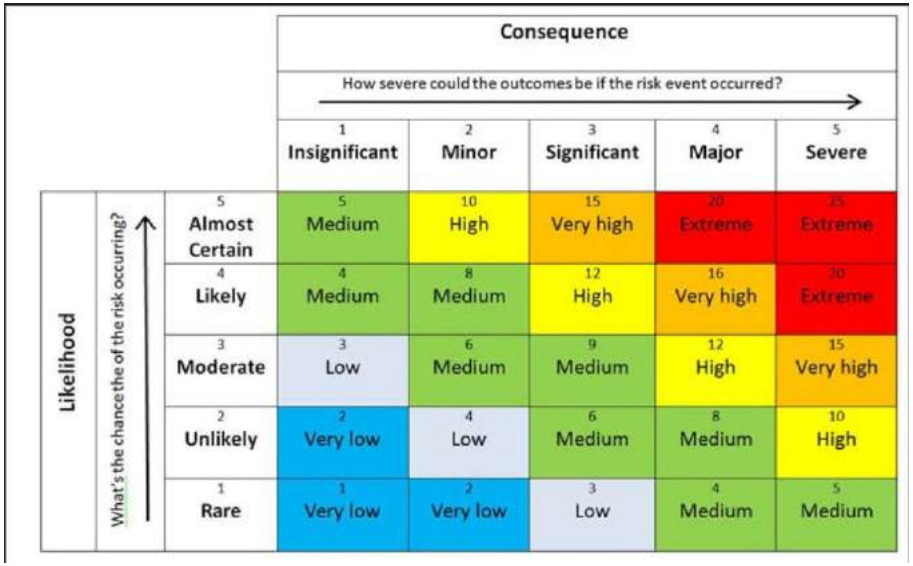
1. Keeping you safe in our hospital
2. Improving your experience of care
3. Ensuring you get the most effective treatment
4. Giving you access to timely care
5. Working with partners in MK to improve everyone's health and care
6. Increasing access to clinical research and trials
7. Spending money well on the care you receive
8. Employ the best people to care for you
9. Expanding and improving your environment
10. Innovating and investing in the future of your hospital

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

Assurance ratings:

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

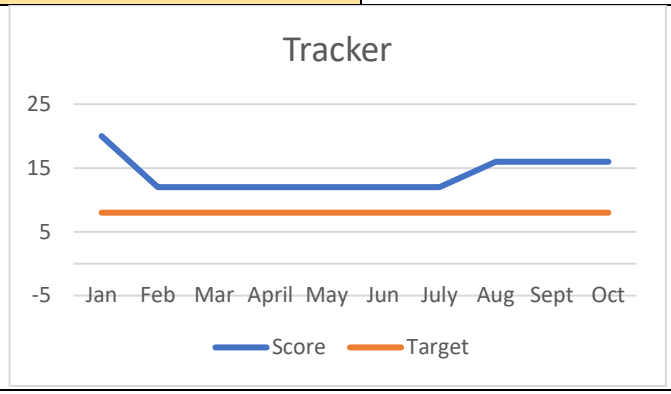
5X5 Risk Matrix:



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

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If the Trust's ED does not have adequate staffing and estate capacity, and effective escalation plans, it will not be able to maintain patient safety during periods of overwhelming demand.				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Director of Operations	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	13/10/21	**Risk Rating**	16	8		



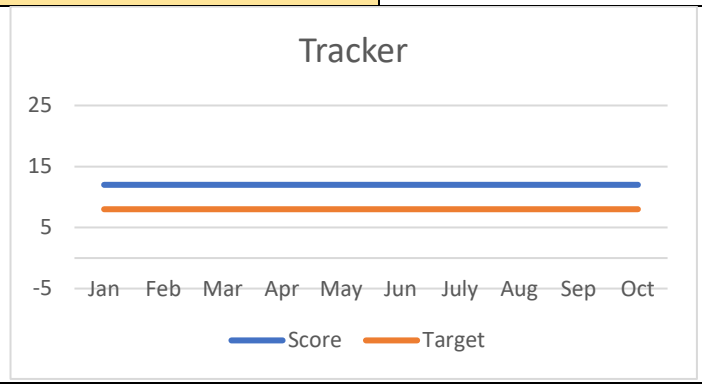
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Significant increase in activity and number of patients through the ED Significantly higher acuity of	Clinically and operationally agreed escalation plan Adherence to national OPEL escalation	ED staffing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

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

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

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If an effective reporting, investigation and learning loop is not established and maintained, the Trust will fail to embed learning and preventative measures following serious incidents/ Never Events.				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Medical Director	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	15/10/21	**Risk Rating**	12	8		



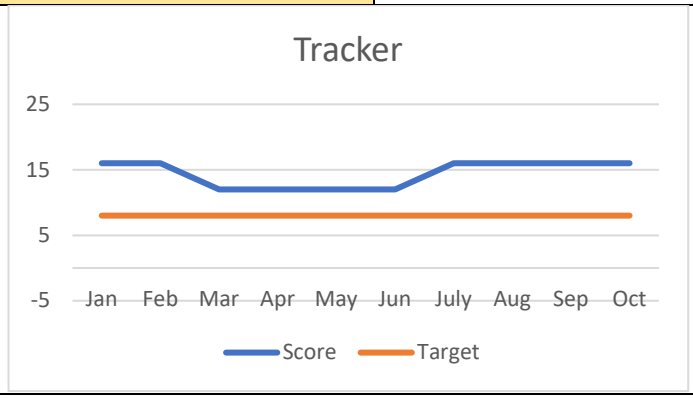
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Not appropriately reporting, investigating or learning from incidents. A lack of systematic sharing of learning from incidents.	Improvement in incident reporting rates SIRG reviews all evidence and action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

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

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

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If the Trust is unable to accurately predict demand (for example, relating to the COVID-19 pandemic) and re-purpose its resources (physical, human and financial) with agility, the Trust will fail to manage clinical risk during periods of sustained or rapid change in the level or type of demand.				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Medical Director	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	15/10/21	**Risk Rating**	16	8		



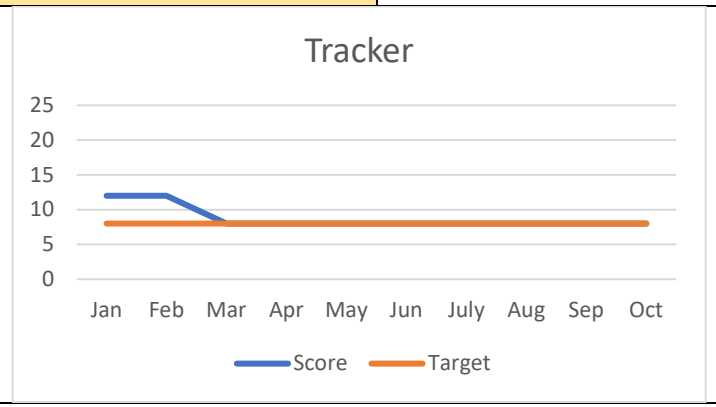
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Rapid or sustained period of upheaval and change caused by the Covid-19 pandemic and need to respond	Board approved major incident plan and procedures Rigorous monitoring of capacity,	Inability to accurately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

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

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

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If the Trust does not carefully manage its significant digital change programme, then the delivery of clinical services may be impaired				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Deputy Chief Executive	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat
Date of Review	15/10/21	**Risk Rating**	8	8		



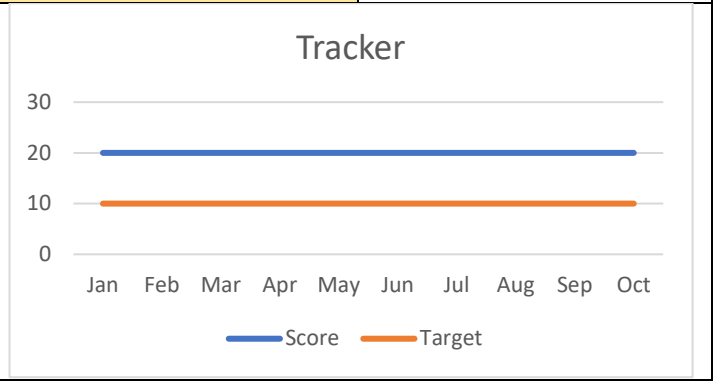
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Inadequate assessment of clinical risk/ impact on clinical services or practices Inadequate resourcing Inadequate training	Robust governance structures in place with programme management at all levels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

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

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

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If the Trust is unable to provide capacity to match demand for elective care, (such as for cancer and screening programmes), there is a risk that this could lead to patient harm.				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Director of Operations	**Consequence**	5	5	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	13/10/21	**Risk Rating**	20	10		



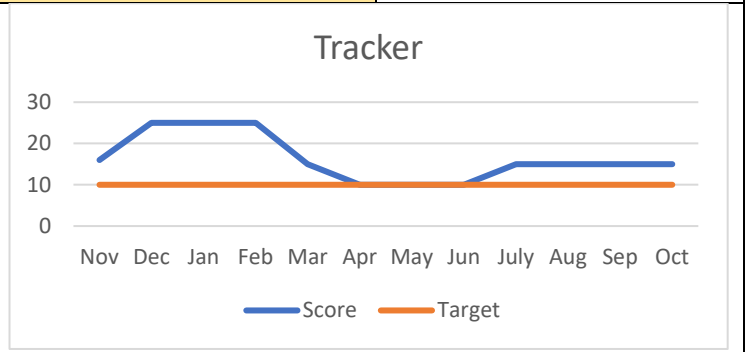
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Cessation of all routine elective care, including cancer screening and other pathways, during the peaks of the Covid-19 pandemic	Compliance with national guidance Granular understanding of demand and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

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

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

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If the Trust does not establish and maintain effective capacity management processes it will be unable to cope with high demand for ITU and inpatient care during a public health crisis (or due to the Covid-19 pandemic)				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Medical Director	**Consequence**	5	5	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	15/10/21	**Risk Rating**	15	10		



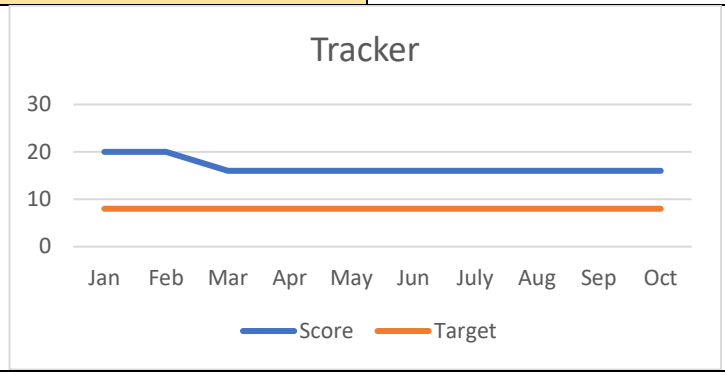
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Demand for ITU and inpatient beds exceeds capacity, including escalation capacity within the hospital and regionally.	Increased capacity across the hospital Increased capacity for ITU Clear escalation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

Risks have increased (since May 2021) in view of the combination of planned and emergency demand which exceeds pre-pandemic levels, coupled with a resurgence in COVID cases is placing the Trust under significant pressure.	Real time visibility of regional demand/ capacity			COVID-19 patients Medical Director and Chief Nurse liaising with teams			

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

Strategic Objective 2: Improving Patient Experience

Strategic Risk	If the radiotherapy pathway provided until 2019/20 in Milton Keynes by Genesis Care (under contract with OUH) is not replaced, the access and experience of patients on clinical oncology (radiotherapy) pathways will continue to be negatively impacted.				**Strategic Objective**	Improving Patient Experience
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Medical Director	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	15/10/21	**Risk Rating**	16	8		



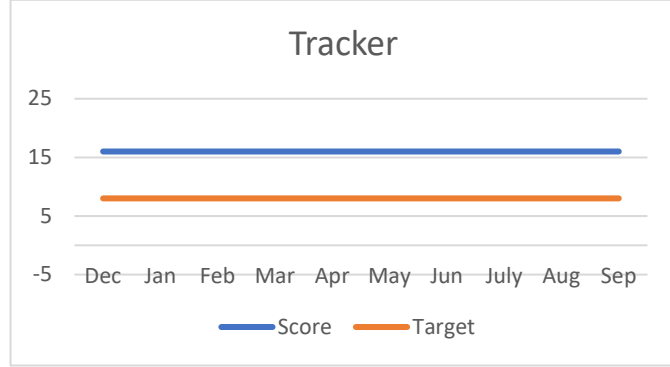
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Break down in the established relationship (subcontract) between Oxford University Hospitals and the private Genesis Care facility (Linford Wood, Milton Keynes)	Contingency for the provision of treatment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

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

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

Strategic Objective 2: Improving Patient Experience

Strategic Risk	If the Trust does not effectively work with patients and families in delivering care and positive patient experience the national patient surveys may not demonstrate improvement.				**Strategic Objective**	Improving Patient Experience
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Chief Nurse	**Consequence**	4	4	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	15/10/21	**Risk Rating**	16	8		



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

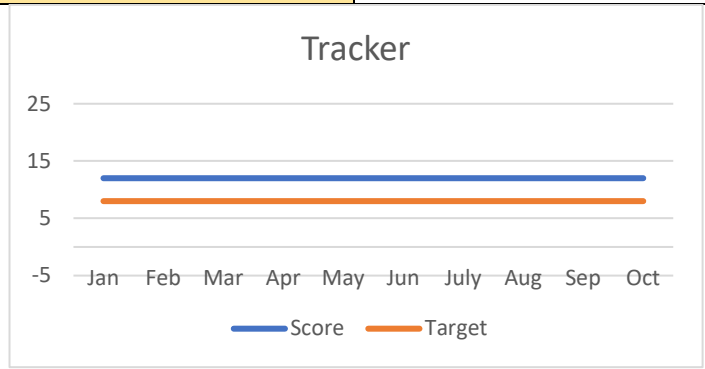
Children and Young People Survey Adult Inpatient Survey Urgent and Emergency Care Survey Maternity Survey Cancer Patient Experience Survey	• Patent Experience Strategy • Learning Disabilities Strategy • Dementia Strategy • Nutrition steering group • Catering steering group • Domestic planning group •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

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

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

Strategic Objective 2: Improving Patient Experience

Strategic Risk	If the Trust does not effectively work to use feedback from complaints and PALS contacts to inform learning and embed related changes patient experience will not be improved.				**Strategic Objective**	Improving Patient Experience
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Chief Nurse	**Consequence**	4	4	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	15/10/21	**Risk Rating**	12	8		



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

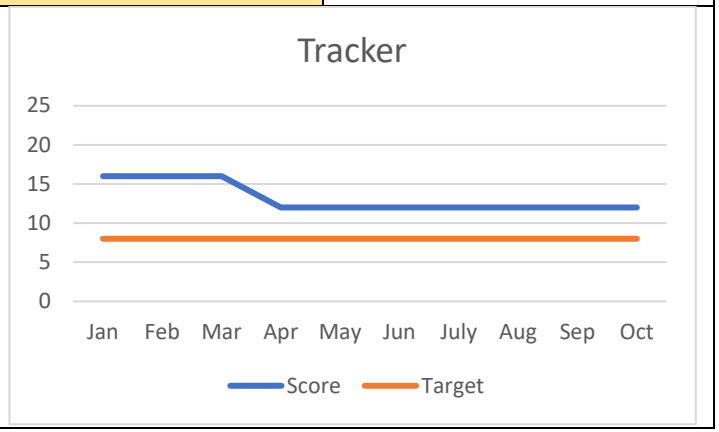
	• Patent Experience Strategy • Learning Disabilities Strategy • Dementia Strategy • Nutrition steering group • Catering steering group • Domestic planning group • Discharge steering group • Induction training Customer service training – NHS Elect program Leadership training includes how to receive feedback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

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

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

Strategic Objective 3: Improving Clinical Effectiveness

Strategic Risk	If clinical audit requirements are not completed the Trust will fail to meet the requirements of clinical compliance regimes including NICE				**Strategic Objective**	Improving Clinical Effectiveness
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Director of Corporate Affairs	**Consequence**	4	4	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	19/10/21	**Risk Rating**	12	8		

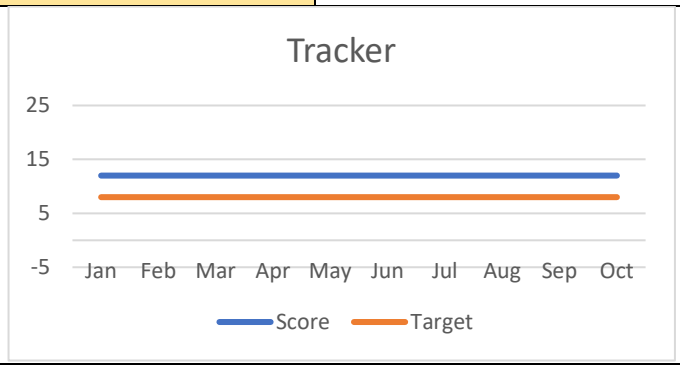


Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
1. Lack of understanding/ awareness of audit requirements by clinical audit leads 2. Resources not adequate to support data	1. Designated audit leads in CSUs/ divisions 2. Clinical governance and administrative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

collection/ interpretation/ input 3. Audit programme poorly communicated 4. Lack of engagement in audit programme 5. Compliance expectations not understood/ overly complex	governance post to medicine to support audit function (highest volume of audits) 3. Audit programme being simplified, with increased collaboration and work through the QI programme 4. Audit compliance criteria being segmented to enable focus on compliance with data returns; opportunity for learning/ changing practice and communication/ engagement 5. Monthly review of all compliance requirements, including NICE and policies		awaiting approval by the December 2021 Audit Committee				

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

Strategic Objective 3: Improving Clinical Effectiveness

Strategic Risk	If the Trust is unable to establish robust governance around data quality processes, there is the risk that this could lead to patient harm, reputational damage and regulatory failure.				**Strategic Objective**	Improving Clinical Effectiveness	
Lead Committee	Audit	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm	
Executive Lead	Director of Operations	**Consequence**	4	4	**Risk Appetite**	Minimal	
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat	
Date of Review	13/10/21	**Risk Rating**	12	8			

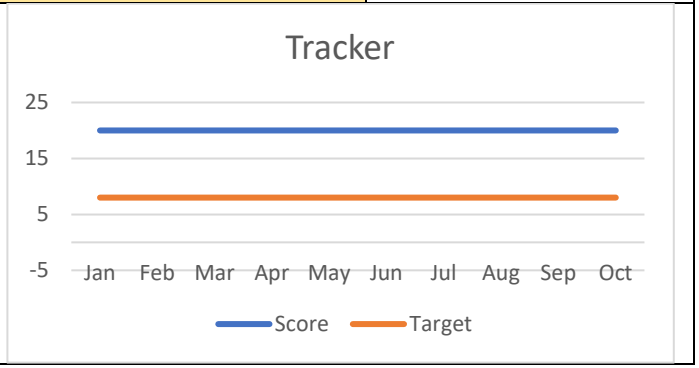
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Failure to ensure adequate data quality leading to patient harm, reputational risk and regulatory failure because data quality processes are not robust	Robust governance around data quality processes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

		more consistent recording of data	improve training				

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

Strategic Objective 4: Meeting Key Targets

Strategic Risk	If the Trust does not establish and maintain effective capacity management processes it will be unable to achieve waiting time targets due to seasonal emergency pressure (or further Covid-19 surges).				**Strategic Objective**	Meeting Key Targets
Lead Committee	TEG	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Director of Operations	**Consequence**	5	5	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	13/10/21	**Risk Rating**	20	10		



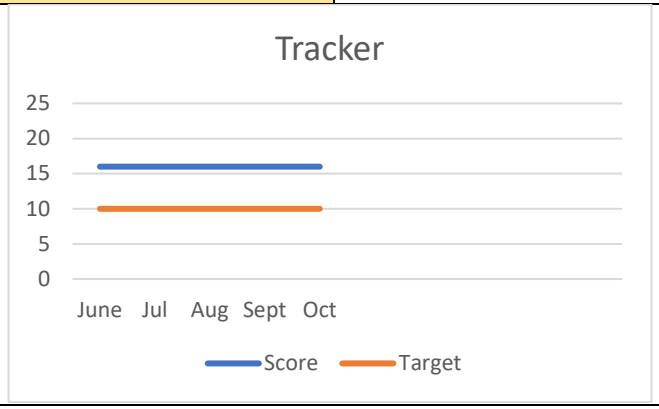
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Elective activity is suspended (locally or by national directive) to enable the Trust to cope with emergency demand or further Covid-19 surges, resulting in increasing waits	Winter escalation plans to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

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

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

Strategic Objective 7: Being Well Governed and Financially Viable

Strategic Risk	If the Trust does not have a sufficient capital expenditure limit (CDEL) then the Trust will not be able to complete the level of planned capital investment				**Strategic Objective**	Being Well Governed and Financially Viable
Lead Committee	Finance and Investment	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial
Executive Lead	Director of Finance	**Consequence**	4	5	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	20/10/21	**Risk Rating**	16	10		



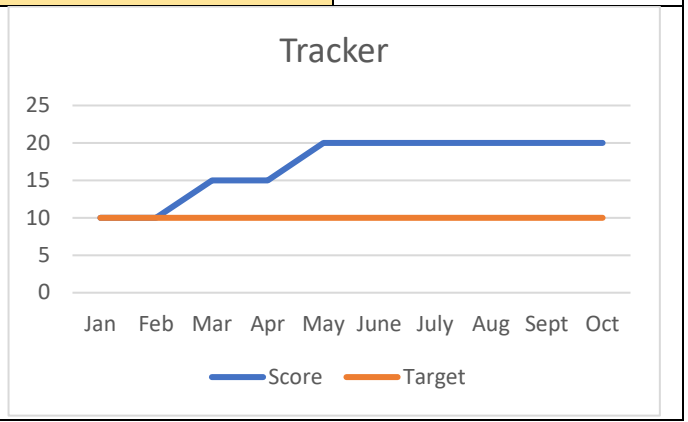
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Following the FY21 year end audit the Trust had to adjust misstated capital expenditure of £4.5m relating to a capital bond. As a consequence, the Trust has brought	The Trust is introducing enhanced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

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

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

Strategic Objective 7: Being Well Governed and Financially Viable

Strategic Risk	If the Trust does not maintain investment in its IT infrastructure and systems, then all operational systems will be severely affected by IT failures such infiltration by cyber criminals.				**Strategic Objective**	Being Well Governed and Financially Viable
Lead Committee	Finance and Investment	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial
Executive Lead	Deputy Chief Executive	**Consequence**	5	5	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	15/10/21	**Risk Rating**	20	10		



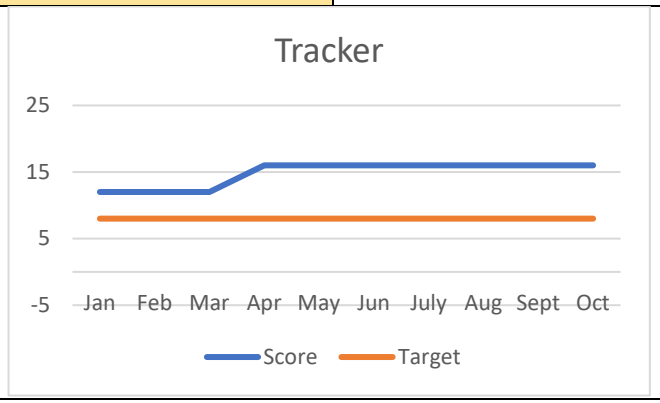
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Hardware failure due aged equipment Increasing Cyber-attacks across the world and in particular in Ireland	2 dedicated cyber security posts Good network protection from cyber security breaches such as Advanced Threat Protection (ATP) – A part of the	None identified	Continued review	External review and reporting Purchases new equipment to install in 9 months	None currently	None currently	

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

RISK 16: If the future NHS funding regime is not sufficient to cover the costs of the Trust, then the Trust will be unable to meet its financial performance obligations or achieve financial sustainability.

Strategic Objective 7: Being Well Governed and Financially Viable

Strategic Risk	If the future NHS funding regime is not sufficient to cover the costs of the Trust, then the Trust will be unable to meet its financial performance obligations or achieve financial sustainability.				**Strategic Objective**	Being Well Governed and Financially Viable
Lead Committee	Finance and Investment	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial
Executive Lead	Director of Finance	**Consequence**	4	4	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	20/10/21	**Risk Rating**	16	8		

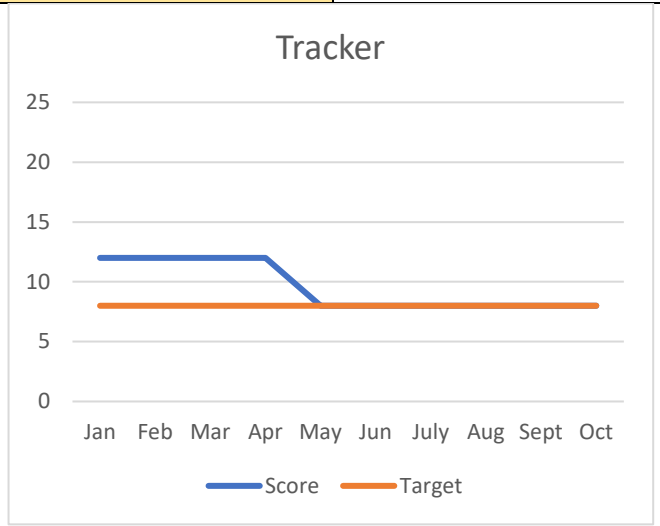


Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Increase in operational expenditure in order to manage COVID-19 Reductions in non-NHS income streams as a	1. Cost and volume contracts replaced with block contracts (set nationally) for clinical income; 2. Top-up payments available where COVID-19 leads to additional costs over	Financial regime for FY22 only valid for first half of the year. Trust has minimal ability to influence.	Continued review of national funding intentions to maximise time to plan organisation response.	Monthly financial performance reports. Cost efficiency reporting. BLMK ICS finance	None Currently.	None Currently.	

direct result of COVID-19. Impaired operating productivity leading to additional costs for extended working days and/or outsourcing. Potential for material increase in efficiency requirement from NHS funding regime to support DHSC budget affordability. Unknown funding regime beyond September 2021 due to disruption caused by COVID-19	and above block sum amounts (until September 2021); 3. Budgets to be reset for FY22 based on prevailing finance regime; financial controls and oversight to be reintroduced to manage financial performance. 4. Cost efficiency programme to be relaunched to target focus on areas of greatest opportunity.			performance reports.			

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

Strategic Objective 7: Being Well Governed and Financially Viable

Strategic Risk	Insufficient capacity in the Neonatal Unit to accommodate babies requiring special care						**Strategic Objective**	Being Well Governed and Financially Viable/ Patient Safety	
Lead Committee	Finance and Investment and Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial			
Executive Lead	Deputy Chief Executive	**Consequence**	4	4	**Risk Appetite**	Cautious			
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat			
Date of Review	15/10/21	**Risk Rating**	8	8					

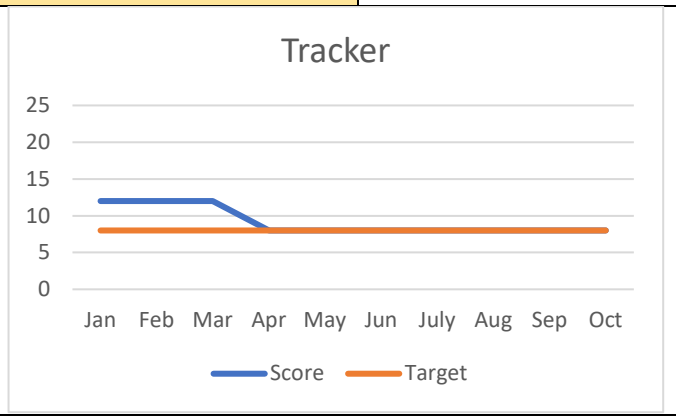
Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
The current size of the Neonatal Unit does not meet the demands of the service. This risks high numbers of transfers of unwell babies and potential delayed	Reconfiguration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

repatriation of babies back to the hospital. There is a risk that if the Trust continues to have insufficient space in its NNU, the unit's current Level 2 status could be removed on the basis that the Trust is unable to fulfil its Network responsibilities and deliver care in line with national requirements.	interventional procedures, ward rounds, etc to increase available space. HIP2 funding for new Women and Children's Hospital announced.						

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

Strategic Objective 8: Investing in Our People

Strategic Risk	If the Trust does not retain staff then posts will be vacant resulting in workforce shortages across the hospital or increased temporary staffing expenditure.				**Strategic Objective**	Investing in Our People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat
Date of Review	13/10/21	**Risk Rating**	8	8		



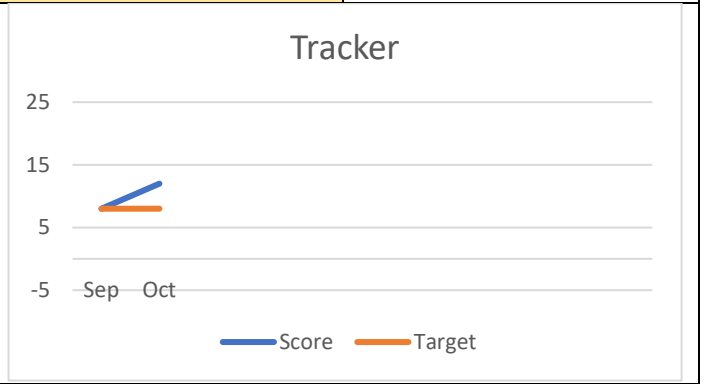
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Proximity to tertiary centres Lack of structured career development or opportunities for progression	Variety of organisational change/staff engagement activities, e.g. Event in the Tent Schwartz Rounds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

Benefits packages elsewhere Culture within isolated departments	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 management Succession planning Enhancement and increased visibility of benefits package Recruitment and retention focussed workforce strategy and plan to fill vacancies, develop new roles and deliver improvement to working experience/ environment. Enhanced Benefits Package						

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

Strategic Objective 8: Investing in Our People

Strategic Risk	If the Trust does not recruit to vacancies in the short term (0-18 months) then there will be workforce shortages across the hospital and/or increased temporary staffing expenditure.				**Strategic Objective**	Investing in Our People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	13/10/21	**Risk Rating**	12	8		



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

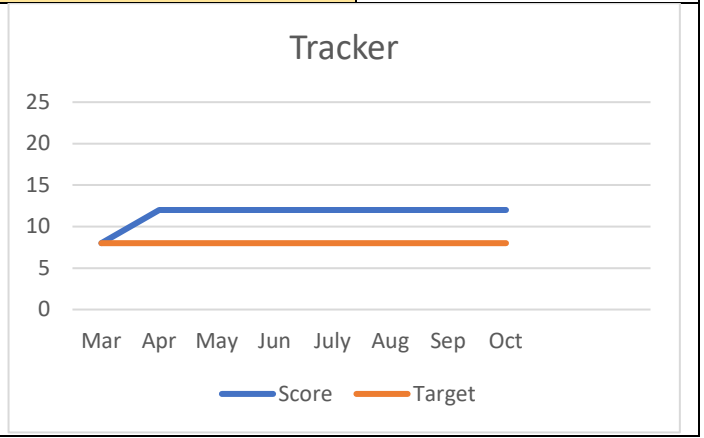
urology and trauma and orthopaedics Competition from surrounding hospitals Buoyant locum market National drive to increase nursing establishments leaving market shortfall (demand outstrips supply)	Exploration and use of new roles to help bridge particular gaps Use of recruitment and retention premia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

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

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

Strategic Objective 8: Investing in Our People

Strategic Risk	If the Trust does not recruit to vacancies in the long term (19+ months) then there will be workforce shortages across the hospital and/or increased temporary staffing expenditure.				**Strategic Objective**	Investing in Our People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	13/10/21	**Risk Rating**	12	8		



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

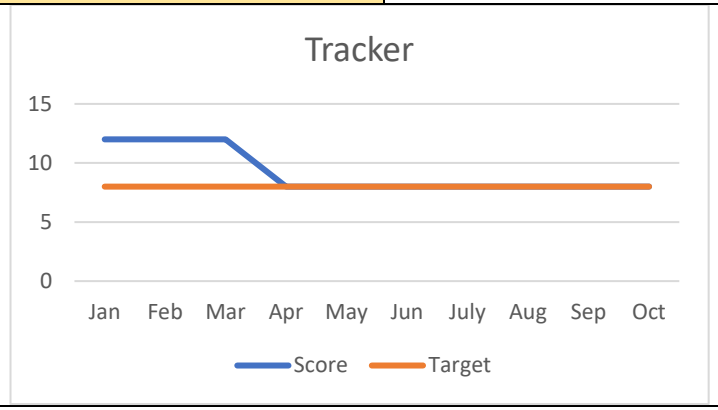
Brexit may reduce overseas supply Competition from surrounding hospitals Buoyant locum market National drive to increase nursing establishments leaving market shortfall (demand outstrips supply) Large percentage of workforce predicted to retire over the next decade Large growth prediction for MK - outstripping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

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

RISK 23: If the Trust does not maintain stocks of Personal Protective Equipment (PPE) and continue implementing the enhanced infection control measures it will be unable to maintain a safe working environment during the COVID-19 pandemic

Strategic Objective 8: Investing in Our People

Strategic Risk	If the Trust does not maintain stocks of Personal Protective Equipment (PPE) and continue implementing the enhanced infection control measures it will be unable to maintain a safe working environment during the COVID-19 pandemic				**Strategic Objective**	Investing in Our People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat
Date of Review	13/10/21	**Risk Rating**	8	8		



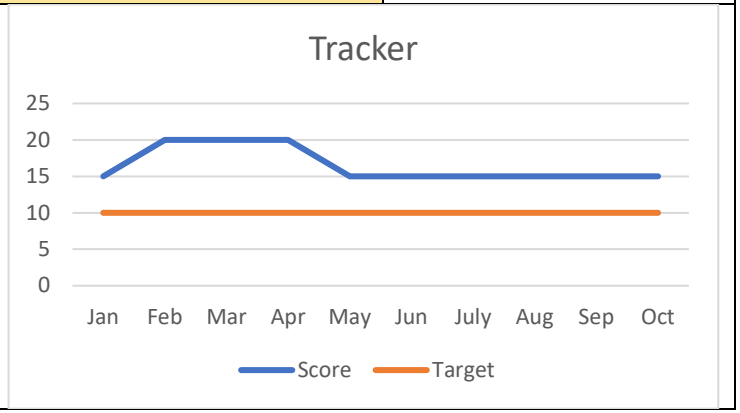
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Ability to maintain a safe working environment during the Covid-19 pandemic due to a lack of equipment, including PPE, or	Incident command structure in place Oversight on all critical stock, including PPE	None currently – noted that this risk may escalate very quickly	None Currently	Completed Risk Assessments PPE Stock Level Reports Staff Test Stock Levels	None Currently	None Currently	

inadequate staffing numbers	Immediate escalation of issues with immediate response through Gold/ Silver National and regional response teams in place Workforce and Workplace Risk Assessments completed and any necessary equipment or working adjustments implemented. Staff COVID-19 Self-Test and vaccine offer to all MKUH workers			Staff Vaccine Uptake Report			

RISK 24: If the Trust does not implement and progress staff health and wellbeing initiatives, there is the risk of staff burning out during or due to the COVID-19 pandemic

Strategic Objective 8: Investing in Our People

Strategic Risk	If the Trust does not implement and progress staff health and wellbeing initiatives, there is the risk of staff burning out during or due to the COVID-19 pandemic				**Strategic Objective**	Investing in Our People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff
Executive Lead	Director of Workforce	**Consequence**	5	5	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	13/10/21	**Risk Rating**	15	10		



Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Staff burnout due to high-stress working environment, conditions of lock-down, recession and other social factors	Significant staff welfare programme in place, with mental health, physical health and support and advice available Staff Hub in use	Significant uncertainty about next wave of the pandemic and how it will affect staff	Continued monitoring, continued communication and engagement with staff about support systems	Regular virtual all staff events Surveys	None Currently	Package of measures to support remote workers	

	Remote working wellness centre in place 12 weeks of wellbeing focus January to March						

AUDIT COMMITTEE
TERMS OF REFERENCE

1. Constitution

1.1 The Trust Board hereby resolves to establish a Committee of the Trust Board to be known as the Audit Committee (known as 'the Committee'). The Committee is a non-executive chaired committee and as such has no delegated authority other than that specified in the Terms of Reference;

1.2 The Committee has been established by the Trust Board to:

- Ensure the effectiveness of the organisation's governance, risk management and internal control systems
- Ensure the integrity of the Trust's financial statements, the Trust's Annual Report and in particular the Annual Governance Statement
- Monitor the work of internal and external audit and ensure that any actions arising from their work are completed satisfactorily.

2. Delegated Authority

The Committee has the following delegated authority:

2.1.1. The authority to require any officer to attend and provide information and/or explanation as required by the Committee;

2.1.2. The authority to take decisions on matters relevant to the Committee;

2.2 The Committee does not have the authority to commit resources. The Chair may recommend to the Board that resources be allocated to enable assurance in relation to particular risks or issues.

3. Accountability

3.1 The Committee is accountable to the Trust Board. Any changes to the Terms of Reference must be approved by the Trust Board, and notified to the Council of Governors;

3.2 The Chair of the Committee is accountable to the Board and to the Council of Governors.

4. Reporting Lines

4.1 Following each meeting, the Committee will provide a written report to the next available meeting of the Trust Board, drawing the Board's attention to any issues requiring disclosure or Board approval;

4.2 The Committee will report back to the Council of Governors through a regular written report;

4.3 The Committee will receive regular reports from the other assurance Committees and formal reports from directors to cover the breadth of its delegated responsibilities.

4.4 The Committee will report to the Board at least annually on its work in support of the annual governance statement, specifically commenting on:

- The fitness for purpose of the assurance framework
- The completeness and embeddedness of risk management in the organisation
- The integration of governance arrangements
- The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a Trust
- The robustness of the processes behind the quality accounts

4.5 The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

5. Purpose

5.1 The Audit Committee will provide assurance to the Board on:

- the effectiveness of the organisation's governance, risk management and internal control systems
- the integrity of the Trust's financial statements, the Trust's Annual Report and in particular the Annual Governance Statement
- the work of internal and external audit and any actions arising from their work

5.2 The Audit Committee will have oversight of the internal and external audit functions and make recommendations to the Board and to the Nominations Committee of the Council of Governors on the reappointment of the external auditors.

5.3 The Audit Committee will review the findings of other assurance functions such as external regulators and scrutiny bodies and other committees of the Board.

6. Duties of the Audit Committee

To promote the Trust's mission, values, strategy and strategic objectives.

6.1 Integrated Governance, Risk Management and Internal Control

6.1.1 The Audit Committee shall review the establishment and maintenance of an effective system of governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) that support the achievement of the organisation's objectives.

6.1.2. In particular, the Committee will review the adequacy of:

- the Board Assurance Framework;
- the Annual Governance Statement, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to discussion by the Board where possible;
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the disclosure statements in the above;

- the policies for ensuring compliance with NHS Improvement and other regulatory, legal and code of conduct requirements;
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority;
- the Trust's insurance arrangements.

6.1.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these. It will also seek reports and assurances from officers as appropriate, concentrating on the overarching systems of governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key Committees so that it understands processes and linkages. However, these other Committees must not usurp the Audit Committee's role.

6.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management, which meets the requirements of the Public Sector Internal Audit Standard 2017 and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal
- reviewing and approving the Internal Audit programme and operational plan, ensuring that this is consistent with the audit needs of the organisation
- reviewing the major findings of internal audit work, management's response, and ensuring co-ordination between the Internal and External Auditors to optimise audit resources
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- reviewing the responses by management to the internal audit recommendations
- annually reviewing the effectiveness of internal audit

6.3. External Audit

The Committee shall review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work. This will be achieved by:

- considering the appointment and performance of the External Auditor
- discussing and agreeing with the External Auditor, before the audit commences, on the nature and scope of the audit as set out in the annual plan.
- discussing with the External Auditors their local evaluation of audit risks and assessment of the Trust and the impact on the audit fee

- reviewing all External Audit reports, including discussion of the annual audit letter and any work carried outside the annual audit plan, together with the appropriateness of management responses
- Ensure that there is in place a clear policy for the engagement of external auditors to supply non audit services.

6.4 Whistleblowing

The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical and safety matters and ensure that any such concerns are investigated proportionately and independently. In this regard, the Committee will receive a quarterly update from the Trust's Freedom to Speak Up Guardians.

6.5 Other Assurance Functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications on the governance of the organisation.

These will include, but will not be limited to, any reviews by NHS Improvement , Department of Health, Arms' Length Bodies or others (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

In addition, the Committee will receive the minutes and review the work of other committees within the organisation, whose work could be of assistance to the Committee in gaining assurance around risk management and internal control across the organisation.

The committee will periodically review its own effectiveness and report the results of that review to the Board.

6.6 Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Counter Fraud Authority standards and shall review the outcomes of the work in these areas.

7. Membership

7.1 The Membership of the Audit Committee shall be as follows:

- A Non-Executive Director who is not the Chairman or Chair of another Board Committee will be appointed by the Chair of the Trust Board to Chair the Audit Committee.
- Two other Non-Executive Directors, neither of whom should be the Chair of the Finance and Investment Committee, or the Chair of the Trust Board.

7.2 Other Non-Executive Directors of the Trust, but not including the Board Chair, may substitute for members of the Audit Committee in their absence, in order to achieve a quorum.

7.3 The meeting is deemed quorate when at least two members are present. The attendance of other Non-Executive Directors of the Trust who are substituting for members, will count towards achieving a quorum.

7.4 At least one member of the Audit Committee must have recent and relevant financial experience. Other members of the Committee must receive suitable training and induction on taking on their role.

8. Attendance

8.1 The following posts shall be invited to attend routinely meetings of the Audit Committee in full or in part, but shall neither be a member nor have voting rights:

- The Director of Finance
- Deputy Chief Executive
- Deputy of Director of Finance
- Financial Controller
- Director of Corporate Affairs
- The Internal Auditor
- The External Auditor
- A Counter Fraud Specialist
- The Trust Secretary

8.2 The Chair of the Trust Board and Chief Executive should be invited to attend to discuss with the Committee the process for assurance that supports the Annual Governance Statement.

8.3 The Committee may ask any other officials of the organisation to attend to assist it with its discussions on any particular matter.

8.4 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

9. Responsibilities of Members, Contributors and Attendees

9.1 Members of the Committee must attend at least 75% of meetings, having read all papers beforehand (Attendees (or their substitutes as agreed with the Chair in advance of the meeting) should attend all meetings);

9.2 Officers presenting reports for consideration by the Committee should submit such papers to the Trust Secretary by the published deadline (at least 7 days before the meeting). Papers received after this deadline will normally be carried over to the following meeting except by prior approval from the Chair;

9.3 Members and Attendees must bring to the attention of the Committee any relevant matters that ought to be considered by the Committee within the scope of these Terms of Reference that have not been able to be formalised on the agenda under Matters Arising or Any Other Business. All efforts should be made to notify the Trust Secretary of such matters in advance of the meeting;

9.4 Members and Attendees must send apologies to the Trust Board Secretary and also seek the approval of the Chair to send a deputy if unable to attend in person at least 3 days before the meeting;

9.5 Members and Attendees must maintain confidentiality in relation to matters discussed by the Committee;

9.6 Members and Attendees must declare any conflicts of interest or potential conflicts of interest at the start of each meeting in accordance with Milton Keynes University NHS Foundation Trust policy (even if such a declaration has previously been made);

10 Information Requirements

10.1 For each meeting the Audit and Risk Assurance Committee will be provided (ahead of the meeting) with:

• a report summarising any significant changes to the organisation's strategic risks and a copy of the strategic/corporate Risk Register;

• a progress report from the Head of Internal Audit summarising: work performed (and a comparison with work planned);

• key issues emerging from the work of internal audit;

• management response to audit recommendations;

• any changes to the agreed internal audit plan; and

• any resourcing issues affecting the delivery of the objectives of internal audit;

• a progress report (written/verbal) from the External Audit representative summarising work done and emerging findings (this may include, where relevant to the organisation, aspects of the wider work carried out by the National Audit Office, for example, Value for Money reports and good practice findings);

• management assurance reports; and

• reports on the management of major incidents, "near misses" and lessons learned.

10.2 As appropriate the Committee will also be provided with:

• proposals for the terms of reference of internal audit / the internal audit charter;

• the internal audit strategy;

• the Head of Internal Audit's Annual Opinion and Report;

• quality assurance reports on the internal audit function;

• the draft accounts of the organisation;

• the draft Governance Statement;

• a report on any changes to accounting policies;

• external Audit's management letter;

• a report on any proposals to tender for audit functions;

• a report on the Trust's approach to cyber-security, including updates on how cyber

threats have been dealt with

- a report on co-operation between internal and external audit; and
- the organisation's Risk Management Strategy.

11 Frequency

11.1 The Committee will meet at least five times a year in March, May, June, July, September and December. The May meeting shall specifically focus on reviewing the Trust's Annual Report and Accounts and will be timed to fit in with the statutory timetable set down by Monitor. The Chair of the Audit Committee may convene additional meetings, as necessary.

11.2 The Board or the Accounting Officer may ask the Committee to convene further meetings to consider particular issues on which the Committee's advice is required.

12 Management

The Committee shall request and review reports and seek positive assurances from directors and managers on the arrangements for governance, risk management and internal control

The Committee may also request specific reports from individual functions within the organisation (e.g. clinical audit) as relevant to the arrangements.

13 Financial Reporting

The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

The Audit Committee shall review the Annual Report and Financial Statements, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- changes in, and compliance with, accounting policies and practices
- unadjusted mis-statements in the financial statements
- decisions on the interpretation of policy
- significant judgements in preparation of the financial statements
- significant adjustments resulting from internal and external audits.
- Letters of representation
- Explanations for significant variances.

The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

14 Committee Administration

14.1 The Trust Secretary shall provide secretarial support to the Committee;
14.2 Papers should be distributed to Committee members no less than five clear days before the meeting;
14.3 Draft minutes of meetings should be made available to the Chair for review within 14 days of the meeting and distributed to all members and attendees within 1 month;

15. Review

Terms of Reference will normally be reviewed annually, with recommendations for changes submitted to the Trust Board for approval.

Version Control

Version	Date	Author	Comments	Status
0.1	December 2008	James Bufford	Approved for Board by Audit Committee December 2008	Draft
1.0	January 2009	James Bufford	Approved by Board	Approved
1.1	Dec 09	Maria Wogan	Reviewed by Audit Committee – proposed amendments to the Board March 2010	For approval
1.2	March 10	Maria Wogan	Annual Review by the Board	Approved
2.0	Sept 2011	Geoff Stokes	Annual review by the Board	Approved
2.1	Jan 2012	Geoff Stokes	Add clinician to attendees list	
2.2	June 2012	Michelle Evans-Riches	Change to membership as Clinician cannot be a member	Approved
3.0	March 2013	Michelle Evans-Riches	Review by Audit Committee and Trust Board	Approved
4.0	Sep 2013	Michelle Evans-Riches	Annual Review	Approved
5.0	Sep 2014	Michelle Evans-Riches	Annual Review	Approved
6.0	Nov 2017	Adewale Kadiri	Annual Review	Approved
7.0	Oct 2018	Adewale Kadiri	Annual Review	Approved
8.0	Nov 2020	Julia Price	Annual Review by the Board	Approved
9.0	November 2021	Kwame Mensa-Bonsu	Annual Review by the Board	

Milton Keynes University Hospital NHS Foundation Trust

Quality and Clinical Risk Committee
TERMS OF REFERENCE

1. CONSTITUTION:

The Quality and Clinical Risk Committee (QCRC) is a sub-committee of the Board of Directors and has no powers other than those specifically delegated in these terms of reference.

The QCRC is constituted under Paragraph 5.8 of Annex 7 to the constitution. The Terms of Reference will be reviewed annually.

1.1 Authority

The QCRC is authorised by the Board to investigate any activity within its terms of reference. It is authorised to request the attendance of individuals from inside or external to the Trust with relevant experience and expertise if it considers this necessary. All employees are directed to co-operate with any request made by the Committee.

2. PURPOSE:

The QCRC is charged by the Board with the responsibility for providing assurance to the Board that the Trust is providing safe, effective and high quality services to patients, supported and informed by effective arrangements for monitoring and continually improving the safety and quality of care, and the patient experience. It will receive information from the CSUs and Divisions via the Trust Executive Group and will, where necessary, escalate issues to the Board.

3. MEMBERSHIP, ATTENDANCE AND QUORUM:

3.1 Membership

The Membership of the QCRC shall be as follows:

- A Non-Executive Director who is not the Chairman, Deputy Chairman or Chair of another Board committee will be appointed by the Chair of the Trust to chair the QCRC
- Two other Non-Executive Directors
- The Chair of the Trust Board (ex-officio)
- The Chief Executive (ex-officio)
- The Director of Patient Care and Chief Nurse (or Deputy)
- The Medical Director (or Deputy)

- The Director of Operations (or their representative)
- The Director of Corporate Affairs

Other Non-Executive Directors of the Trust may substitute for members of the QCRC in their absence and will count towards achieving a quorum.

Members of the QCRC are expected to attend all meetings of the Committee.

3.2 Attendance

The following posts shall be invited to attend routinely meetings of the QCRC in full or in part but shall neither be a member nor have voting rights:

- Head of Clinical Governance and Risk
- Senior members of Divisional Management will be invited to attend meetings as required.

3.3 Quorum

A quorum of the Committee shall be two NEDs and one Executive Director. Other Directors of the Trust, including Directors who are substituting for members can be counted in the quorum. Ex-officio members of the Committee also count for quorum but are not required to attend every meeting

4. ACCOUNTABILITY:

The QCRC is a committee of and accountable to the Board of Directors.

A minute of each meeting will be taken and approved by the subsequent meeting. Once the draft minutes have been approved by the Chair of the Committee, these approved minutes will be submitted to the next private meeting of the Board of Directors. They will also be submitted to the Audit Committee. An action log will be maintained by the meeting secretary.

The Chair of the Committee shall present a written report to the Public Board meeting immediately following each Committee meeting.

The Committee will also make an annual report to the Board.

5. MEETINGS AND CONDUCT OF BUSINESS:

5.1 Frequency of Meetings:

The Committee will meet at least on a quarterly basis, with the possibility that additional meetings may be scheduled as necessary at the request of the Committee Chair.

5.2 Agenda

The Agenda for meetings will be circulated to all Board members who have requested to receive particular papers.

In line with Standing Order 3.4, full papers will be sent to members of the Committee so that they are available to them **5 clear days before the meeting**.

There will be an expectation for information from the Committee to be cascaded to front line staff by managers.

6. DUTIES OF THE QUALITY AND CLINICAL RISK COMMITTEE:

- To define the Trust's approach to ensuring the quality of its services as part of its overall strategic direction and organisation objectives.
- To promote clinical leadership so that the culture of the Trust reflects a strong focus on quality, clinical effectiveness, safety and patient experience.
- To ensure appropriate structures and systems are in place to support and deliver quality governance including clinical effectiveness, patient safety and patient experience.
- To assure the Board that systems operate effectively within each Division and to report any specific problems as they emerge.
- To receive reports on serious incidents, incidents and near misses, complaints, inquests, claims and other forms of feedback from patients, ensuring learning from all clinical risk management activity, identifying trends, comparing performance with external benchmarks and making recommendations to the Board as appropriate.
- To identify serious unresolved clinical and non-clinical risks to the Audit Committee and the Board.
- To oversee the effective management of risks, as set out within the Board Assurance Framework (BAF) as appropriate to the purpose of the Committee.
- To ensure that the views and experience of patients and staff are heard and acknowledged in the work of the Committee and by the Board, and that this drives the delivery of the Trust's services.
- To monitor strategies and annual plans for quality governance, clinical audit and effectiveness, research and development, public and patient engagement and equality and diversity. To oversee the production of the Trust's annual Quality Accounts, ensuring compliance with national guidance.
- To ensure that effective consultation with stakeholders takes place, and to monitor the delivery of the quality targets.
- To agree and submit annual quality governance assurance report to the Board.
- To receive relevant reports from internal reviews and external bodies and assurance regarding the implementation of associated action plans.
- To commission, as appropriate, internal and external audits and reviews of services to assure the Board that the Trust is compliant with statutory and regulatory requirements.
- To approve and monitor the Trust's clinical audit programme ensuring it is aligned with Trust priorities, responds to trends in complaints and incidents and is led by and involves staff from all disciplines, liaising with the Audit Committee as appropriate.
- To monitor compliance with the terms of the Trust's CQC registration and NHS Resolution Risk Management Standards.

Version Control

Version	Date	Author	Comments	Status
1.0	26.05.10	Maria Wogan Trust Secretary	Final draft approved by the Board of Directors	Approved
2.0	Aug 2011	Geoff Stokes	Annual review by the Board	Approved
3.0	May 2012	Michelle Evans-Riches	Review by Quality Committee following Committee Review by Board	Approved
4.0	March 2013	Michelle Evans-Riches	Review by Quality Committee recommended to Board	Approved
5.0	April 2017	Adewale Kadiri	Review by Quality and Clinical Risk Committee recommended to Board	Approved
6.0	November 2018	Adewale Kadiri	Review by Quality and Clinical Risk Committee recommended to Board	Approved
7.0	November 2020	Julia Price	Annual Review by the Board	Approved
8.0	November 2021	Kwame Mensa-Bonsu	Annual Review by the Board	

Milton Keynes University Hospital NHS Foundation Trust

Finance and Investment Committee
TERMS OF REFERENCE

1. CONSTITUTION

The Board of Directors hereby resolves to establish a sub - committee of the Board to be known as the Finance and Investment Committee. The Finance and Investment Committee is a committee of the Board and has no executive powers other than those specifically delegated in these terms of reference.

The Finance and Investment Committee is constituted under paragraph 41 of the Constitution and under Standing Order 5 of the Annex 7 of the constitution.

2. ACCOUNTABILITY

The Finance and Investment Committee is a committee of the Board of Directors of the Trust and accountable to them.

The Chair of the Committee shall make a written report to the public meeting of the Board of Directors immediately following each Committee meeting, drawing Board's attention to any issues that require disclosure to the full Board or Board approval.

The Committee will also make an annual report to the Board.

The Committee will make a written report to the Council of Governors.

3. PURPOSE:

The Finance and Investment Committee will provide assurance to the Board on:

- the effectiveness of the organisation's financial management systems
- the integrity of the Trust's financial reporting mechanisms
- the effectiveness and robustness of financial planning
- the effectiveness and robustness of capital investment management
- the robustness of the Trust's cash investment strategy
- business case assessment and scrutiny (including ensuring that quality and safety considerations have been taken into account)
- the management of financial and business risk
- the capability and capacity of the finance function
- the administration, investments and financial systems relating to all charitable funds held by the Trust
- the effectiveness of the Trust's health informatics and information technology strategies and their implementation

- decisions for future investment in information technology
- the effective implementation and management of the Trust's estates strategy, ensuring that this is in line with the Trust's overall strategy.

The Finance and Investment Committee will review the findings of other assurance functions where there are financial and business implications.

4. MEMBERSHIP, ATTENDANCE AND QUORUM

Membership

The Membership of the Finance and Investment Committee shall be as follows:

- A Non-Executive Director who is not the Chairman, or Chair of another Board Committee will be appointed by the Chair of the Trust to Chair the Finance and Investment Committee
- Two other Non-Executive Director, who should not be the Chair of the Audit or Quality and Clinical Risk Committees. One of these Non-Executive Directors can chair a meeting in the absence of the Committee's Chair.
- The Chief Executive or the Deputy Chief Executive
- The Director of Finance or appointed Deputy
- The Chair of the Trust (ex-officio)
- Medical Director or appointed Deputy
- The Director of Operations.

Other Non-Executive Directors of the Trust may substitute for members of the Finance and Investment Committee in their absence and will count towards achieving a quorum.

Members of the Finance and Investment Committee are expected to attend all meetings of the Committee.

Attendance

The following should attend Finance and Investment Committee meetings:

- The Deputy Director of Finance
- Trust Secretary or nominated representative

Quorum

A quorum of the Committee shall be three members at least two of whom shall be a Non-Executive Director. Other Non-Executive Directors of the Trust, including associate Non-Executive Directors, who are substituting for members can be counted in the quorum.

5. MEETINGS AND CONDUCT OF BUSINESS

Frequency

The Committee will meet regularly as agreed by the Chair of the Committee and the Board.

Calling of additional meetings

An additional meeting may be called by the Chair of the Committee or any two of the other Members of the Committee.

In exceptional circumstances where an urgent capital investment decision is required which cannot wait until the next meeting of the relevant authorising group e.g. essential medical equipment which has failed, the approval of the Chairman and one other member of the Group may be sought. Where approval is sanctioned, the decision must be recorded and formally reported at the next meeting of the relevant authorising group where the decision would have been made

Committee Administration

The Committee will at least annually review these terms of reference.

Committee administration will be provided by the Trust Secretariat. The agenda for meetings will be circulated to all Board members who have requested to receive particular papers. In line with Standing Order 3.4, full papers will be sent to members of the Board so that they are available to them at their normal electronic address 5 clear days before the meeting. Draft minutes of meetings should be available to the Chair for review within fourteen days of the meeting.

Responsibilities of Members

Members of the Committee are expected to attend at least 75% of meetings. In the event that they identify any items for consideration by the Committee, these should be brought to the attention of the Chair at least 14 days before the meeting. Members must declare any conflicts of interest or potential conflicts of interest at the start of each meeting in accordance with the Trust's Conflicts of Interests Policy (even if such a declaration has previously been made).

6. DUTIES OF THE FINANCE AND INVESTMENT COMMITTEE

Financial Management

- To ensure a comprehensive budgetary control framework that accords with guidance and legislation.
- To review financial plans and strategies and ensure they are consistent with the overall Trust Strategic Planning process.
- To approve budget setting timeframes and processes and recommend budgets to the Board of Directors.
- To monitor business performance against planned levels and hold to account for corrective action planning, including finance, activity, workforce, and capacity.

- To scrutinise and assess business cases.

Financial Reporting

- To review the content and format of financial information as reported to ensure clarity, appropriateness, timeliness, accuracy and sufficient detail.

Performance Management

- To review the potential or actual financial impact of operational performance against a defined set of indicators, such indicators to be subject to on-going review.

Business and Financial Risk

- To consider business risk management processes in the Trust.
- To review arrangements for risk pooling and insurance.
- To consider the implications of any pending litigation against the trust.

Value for Money and Efficiency

- To ensure at all times the Trust receives value for money and operates as efficiently as possible.

Capital Investment

- To ensure robust capital investment plans are in place, kept updated, and progress monitored. (reporting arrangements as per Appendix 1)

Cash

- To act as the Investment Committee in line with approved Investment Policy.
- Ensure cash investments are monitored and give best returns.
- Ensure cash balances are robust, and continue to be so, on a 12-month rolling basis.

Technology

- To ensure that the Health Informatics strategy is implemented effectively and to review decisions for future investment in technology
- To oversee the implementation of the Trust's information technology strategy and ensure that this is developed in line with best practice within the sector and in accordance with the Trust's overall strategy.

Estates

- To oversee the implementation and development of the Trust's estate strategy in line with the Trust's overall strategy.

7. RELATIONSHIP WITH AUDITORS AND AUDIT COMMITTEE

The auditors interact with the Trust through the Audit Committee, neither internal nor external audit are therefore included as members of the Finance and Investment Committee. However, both parties can, if required, request an invitation to attend.

The Audit Committee is distinct and separate from the Finance and Investment Committee, and as such areas of overlap should be minimised. The Finance and Investment Committee should specifically exclude itself from:

Audit

- Review of audit plans and strategies.
- Review of reports from auditors.
- Review of the effectiveness of the internal control framework and controls assurance plans.
- Any recommendations or plans on auditor appointments.

Annual Accounts

- Consideration of the content of any report involving the Trust issued by the Public Accounts Committee or the Controller and Auditor General and the review of managements proposed response.

SFI's and SO's

- Examinations of circumstances when waivers occur.
- Review of schedules of losses and compensations.
- Monitoring of the implementation on standards of business conduct for members and staff.

Fraud

- The review of the adequacy of the policies and procedures for al***l*** work related to fraud and corruption as set out in the Secretary of State Directions and as required by the Directorate of Counter Fraud Services.

Version Control

Version	Date	Author	Comments	Status
0.1	5 January 2009	Wayne Preston	Approved for Board	Draft
1.0	January 2009	James Bufford	Approved by Board	Approved
1.1	11 Sept 2009	James Bufford	Added requirement for annual review of these terms of reference	Draft for Finance Cttee
1.2	March 2010	Maria Wogan	Additional amendments from Finance Director re: meeting frequency	Draft for approval by Board
1.3	March 10	Maria Wogan	Annual Review by the Board	Approved
2.0	Nov 2011	Geoff Stokes	Annual review by the Board	Approved
2.1	Aug 2012	Michelle Evans-Riches	Financial Reporting triggers included as appendix	Approved
3.0	Mar 2013	Michelle Evans-Riches	Review by Committee and Trust Board	Approved
4.0	Sep 2013	Michelle Evans-Riches	Annual Review	Draft for approval by Board
5.0	Oct 2013	Michelle Evans-Riches	Annual review by the Board	
6.0	March 2015			
7.0	October 2017	Ade Kadiri	Annual Review	Draft for approval by Board
8.0	October 2018	Ade Kadiri	Annual Review	Draft for approval by the Board
9.0	November 2020	Julia Price	Annual Review by the Board	Approved
10.	November 2021	Kwame Mensa-Bonsu	Annual Review by the Board	

Workforce and Development Assurance Committee
TERMS OF REFERENCE

1. Constitution

1.1 The Trust Board hereby resolves to establish a Committee of the Trust Board to be known as the Workforce and Development Assurance Committee (known as 'the Committee'). The Committee is a non-executive chaired committee and as such has no delegated authority other than that specified in the Terms of Reference.

1.2 The Committee has been established by the Trust Board to:

1.3 Ensure that the workforce has the capacity and capability to provide high quality, effective, safe patient care in line with the Trust's strategic objectives and values;

1.4 Monitor the governance of the Trust's workforce strategy, ensuring accountability for the continuous improvement of quality and performance.

1.5 The Committee is established under Standing Order 5 of Annex 7 of the Trust's Constitution.

2. Delegated Authority

2.1 The Committee has the following delegated authority:

2.1.1 The authority to require any officer to attend and provide information and/ or explanation as required by the Committee;

2.1.2 The authority to take decisions on matters relevant to the Committee;

2.2 The Committee does not have the authority to commit resources. The Chair may recommend to the Board that resources be allocated to enable assurance in relation to particular risks or issues.

3. Accountability

3.1 The Committee is accountable to the Trust Board. Any changes to the Terms of Reference must be approved by the Trust Board.

3.2 The Chair of the Committee is accountable to the Board and to the Council of Governors.

4. Reporting Lines

4.1 The Committee will report to the Trust Board through a regular written escalation and assurance report following each Committee meeting.

4.2 The Committee will report back to the Council of Governors through a regular written report.

4.3 The Committee will receive regular reports from the Workforce Board on specific initiatives, business cases and activities that support the delivery of the Trust's Workforce Strategy.

4.4 The Committee will receive formal reports from directors and other Trust staff, covering the breadth of the workforce agenda, including statutory requirements.

4.5 The Committee will receive at each meeting, either via the attendance of a member or members of staff, or a representation made on their behalf, an account of their experience of working in the Trust, taking account of relevant workforce strategies, initiatives and activities.

4.6 The Committee will receive at each meeting, or as they become available, quarterly reports from the Trust's Guardian of Safe Working Hours to confirm compliance with the relevant terms and conditions relating to trainee doctors and dentists.

5. Duties

5.1 To promote the Trust's mission, values, strategy and strategic objectives.

5.2 To keep under review the development and delivery of the Trust's workforce strategy to ensure performance management is aligned to strategy implementation and promote this across the organisation.

5.3 To hold the executives to account for the delivery of the Trust's strategic objectives to improve workforce effectiveness.

5.4 To review progress on clinical and non-clinical training, development and education for Trust employees.

5.5 To ensure that the Trust meets its statutory obligations on equality, diversity and inclusion.

5.6 To monitor the progress of the Trust's plans to improve staff engagement.

5.7 To ensure that processes are in place to understand and improve staff health and wellbeing.

5.8 Provide assurance to the Board that there are mechanisms in place to allow staff to raise concerns and that these are dealt with in line with policy and national guidance.

5.9 The Committee will provide **assurance** to the Trust Board in relation to the following:

5.9.1 Ensure all workforce indicators are measured and monitored;

5.9.2 Ensure that all key performance indicators of a well-managed workforce are regularly reviewed and remedial action is put in place as necessary

5.9.3 Ensure that legal and regulatory requirements relating to workforce are met.

5.9.4 Review and provide assurance on those elements of the strategic risk register/board assurance framework are identified, seeking where necessary further action/assurance

6. Membership

6.1 A Non-Executive Director will be appointed by the Chair of the Board of Directors to Chair the Workforce and Development Assurance Committee.

6.2 The Committee will comprise the following members:

- Two other Non-Executive Directors
- Director of Workforce

6.3 Other Non-Executive Directors of the Trust, but not including the Board Chair, may substitute for members of the Committee in their absence, to achieve a quorum.

6.4 The meeting is deemed quorate when at least two members are present. The attendance of other Non-Executive Directors of the Trust who are substituting for members, will count towards achieving a quorum.

7. Attendance

7.1 The following posts shall be invited to attend routinely meetings of the Committee in full or in part but shall neither be a member nor have voting rights:

- Trust Board Chair
- Deputy Director of Workforce
- Assistant Director of HR
- Director of Patient Services & Chief Nurse (or deputy)
- Director of Operations (or deputy)
- Medical Director (or Associate Medical Director)

Other Directors and Trust staff may be invited to attend at the discretion of the Chair.

8. Responsibilities of Members

8.1 Members of the Committee are required to

7.1.1 Attend at least 75% of meetings,

7.1.2 Identify any agenda items in addition to those included on the Committee's workplan, for consideration by the Chair at least 14 days before the meeting;

7.1.3 Submit papers to the Trust Secretary by the published deadline (at least 7 days before the meeting);

8.2 Members should bring to the attention of the Committee any relevant matters that ought to be considered by the Committee that are within the scope of these terms of reference, but have not been included on the agenda

8.3 In the event that Committee members are unable to attend a meeting they must send apologies to the Trust Board Secretary and where appropriate seek the approval of the Chair to send a deputy if unable to attend in person;

8.4 Members must maintain confidentiality in relation to matters discussed by the Committee;

8.5 Members must declare any actual or potential conflicts of interest at the start of each meeting in accordance with Milton Keynes University Hospital NHS Foundation Trust policy (even if such a declaration has previously been made);

9. Frequency of Meetings

9.1 Meetings will normally take place quarterly and at least 14 days prior to the Trust Board to allow a Committee report to be submitted. Meetings may take place more frequently at the Chair's discretion;

9.2 The business of each meeting will be transacted within a maximum of two hours.

10. Committee Administration

10.1 Committee administration will be provided by the Trust Secretariat;

10.2 Papers should be distributed to Committee members no less than five clear days before the meeting;

10.3 Draft minutes of meetings should be made available to the Chair for review within 14 days of the meeting.

11. Review

11.1 Terms of Reference will normally be reviewed annually, with recommendations for changes submitted to the Trust Board for approval.

Version Control

Version	Date	Author	Comments	Status
1.0	Nov 2019	Adewale Kadiri Trust Secretary	Final draft approved by the Board of Directors	Approved
2.0	Nov 2020	Julia Price	Annual review by the Board	Approved
3.0	November 2021	Kwame Mensa-Bonsu	Annual Review	

Milton Keynes University Hospital NHS Foundation Trust

Finance and Investment Committee
REMUNERATION COMMITTEE

1. CONSTITUTION

The Committee is a sub-committee of the Trust Board and will report to the Trust Board on an annual basis.

The Committee is authorised by the Trust Board on the matter of remuneration to obtain outside legal, remuneration or other independent professional advice to secure the attendance of individuals and authorities from outside the Trust with the relevant experience and expertise if it considers it necessary for or expediant to the exercise of its functions.

2. ACCOUNTABILITY

The Remuneration Committee is accountable to the Board of Directors of the Trust.

A minute of each meeting will be taken and approved by the subsequent meeting. Once the draft minutes have been approved by the Chair of the Committee, these unapproved minutes will be submitted to the next meeting of the Board of Directors.

The Chair of the Committee shall make a verbal report to the Board immediately following each Committee meeting, drawing Board's attention to any issues that require disclosure to the full Board or Board approval.

3. PURPOSE:

The purpose of the Committee is:

- The Committee will have delegated authority from the Trust Board to set the remuneration, allowances and other terms and conditions of office for the Executive Directors and to recommend and monitor the structure of remuneration including setting pay ranges.

4. MEMBERSHIP, ATTENDANCE AND QUORUM

Membership

The membership of the Committee shall comprise:

- All Non-Executive Directors
- The Trust Chairman
- The CEO and Director of ~~HR~~ Workforce shall normally be in attendance except when issues regarding their own remuneration is discussed

Attendance

Members of the Remuneration Committee are expected to attend all meetings of the Committee.

Quorum

The Comittee shall be quorate when the Chair and at least three Non Executive Directors are present.

5. MEETINGS AND CONDUCT OF BUSINESS

Frequency

Annually, or more freqeuently should it be necessary

Agenda

The Agenda for meetings will be circulated to all Board members who have requested to receive particular papers.

In line with Standing Order 3.4, full papers will be sent to members of the Committee so that they are available to them at their normal address 5 clear days before the meeting.

The Committee will at least annually:

- review these terms of reference

DUTIES OF THE REMUNERATION COMMITTEE:

The main duties of the Committee are to:

- To agree and keep under review the overall remuneration policy of the Trust.
- To set the individual remuneration, allowances and other terms and conditions of office (including termination arrangements) for the Trust's Executive Directors
- To recommend and monitor the structure of remuneration, including setting pay ranges.
- To monitor and evaluate the performance of the Trust's Chief Executive and Executive Directors against objectives for the previous year and note forward objectives. Performance of other senior managers will be monitored and evaluated by their line managers.
- To ratify decisions taken between meetings by the Chair of the Committee.
- In determining remuneration policy and packages, to have due regard to the policies and recommendations of the Department of Health and Social Care and the NHS, and to adhere to all relevant laws, codes and regulations.
- To keep abreast of executive level remuneration policy and practice and market developments elsewhere in the NHS and in other relevant organisations, drawing on external advice as required.
- To agree those Compromise Agreements, Settlements and Redundancy Payments which require final approval by ~~Monitor/~~HM Treasury as well as any proposed termination payment to the Chief Executive or an Executive Director.

- To receive regular reports on other Compromise Agreements, Settlements and Redundancies approved in accordance with Trust policies.
- Receive an annual report on the outcome of the employer-based (local) Clinical Excellence Awards round.
- To undertake any other duties as directed by the Trust Board.

Version Control

Version	Date	Author	Comments	Status
1.0	October 2013	Norma French	Separated the functions of the Combined Terms of reference of Remuneration and Workforce Committee	Approved
1.1	October 2021	Danielle Petch	Annual review by Committee – updated to reflect amended terminology/practice	
2	November 2021	Danielle Petch	Annual review by the Trust Board	

Milton Keynes University Hospital
NHS Foundation Trust

CHARITABLE FUNDS COMMITTEE TERMS OF REFERENCE

1. Constitution

1.1 The Trust Board hereby resolves to establish a Committee of the Trust Board to be known as the Charitable Funds Committee (known as 'the Committee'). The Committee is a non-executive chaired committee and as such has no delegated authority other than that specified.

1.2 The Committee is established under Standing Order 5 of Annex 7 of the Trust's Constitution.

2. Delegated Authority

2.1 The Committee has the following delegated authority:

2.1.1 The authority to require any officer to attend a meeting and provide information and/ or explanation as required by the Committee

2.1.2 The authority to take decisions on matters relevant to the Committee

2.1.3 The authority to establish sub-committees and the terms of reference of those sub-committees

2.2 The Committee has the authority to commit charitable fund resources. The Committee supports the fundraising activities of the Hospital Charity on behalf of the NHS Trust. The Hospital Charity is a charitable trust and the corporate trustee is the NHS Foundation Trust. All Board members act as trustees of the Charity.

3. Accountability

The Charitable Funds Committee is a committee of the Board. A minute of each meeting will be taken and approved by the subsequent meeting.

The Chair of the Committee shall make a written report to the Trust Board immediately following each Charitable Funds Committee meeting, drawing Members' attention to any issues that require disclosure to the Committee and may require Board approval.

The Committee will also make an annual report to the Board.

4. Duties of the Charitable Funds Committee

The Charitable Funds Committee is charged by the Board to:

i) support, guide and encourage the fundraising activities of the Trust;
ii) monitor charitable and fundraising income;
iii) oversee the administration, investment and financial systems relating to all charitable funds held by the hospital charity;
iv) develop policies for fundraising and for the use of funds;
v) ensure compliance with all relevant Charity Commission regulations, and other relevant items of guidance and best practice;
vi) review the work of other committees within the organisation, whose work can provide relevant assurance to the Charitable Funds Committee's own scope of work;
vii) consider any funding request above the Directorate Fund level, or outside the scope of these funds, which is made to the Charitable Funds Committee. These must have been through the relevant standard Trust approvals processes for either Capital or Revenue (See Appendix One).
viii) consider and approve any urgent requests in advance of any formal meeting, on an exceptional basis through the approval of the named executive director and the committee chair.
ix) oversee and advise on the running of major fundraising campaigns.

5. Membership, Attendance and Quorum

5.1 Membership

The Membership of the Charitable Funds Committee shall be as follows:

- A Non-Executive Director will be appointed by the Chair of the Board of Directors to Chair the Charitable Funds Committee.
- One Non-Executive Director who may be an associate Non-Executive Director
- Director of Corporate Affairs.
- A named Governor from the Council of Governors.

The Chief Executive and the Chair of the Trust Board of Director will be ex-officio members of the Committee, but their attendance will not count towards quorum.

Other Non-Executive Directors of the Trust, including associate Non-Executive Directors may substitute for members of the Charitable Funds Committee in their absence. Such directors will count towards the achievement of a quorum.

An external individual may be appointed as a member of the Committee with the consent of the Board.

The Secretary of the Committee will be the Trust Secretary.

The meeting is deemed **quorate** when at least one Non-Executive Director, one Executive Director and one other member is present. Deputies cannot be considered as contributing to the quorum.

6. Attendance

6.1 The following posts shall be invited to routinely attend meetings of the Charitable Funds Committee in full or in part but shall neither be a member nor have voting rights.

- Head of Charity
- Named representatives (2) from the Finance Directorate
- Trust Secretary
- Invited representatives from the clinical directorates

7. Responsibilities of Members and Attendees

7.1 Members or attendees of the Committee have a responsibility to:

7.1.1 Attend at least 75% of meetings
7.1.2 Identify agenda items for consideration by the Chair at least 14 days before the meeting
7.1.3 Submit papers, as required, by the published deadline (7 days before the meeting) on the approved template
7.1.4 If unable to attend, send apologies to the Trust Secretary and where appropriate seek the approval of the Chair to send a deputy
7.1.5 Maintain confidentiality, when confidential matters are discussed within the Committee.
7.1.6 Declare any conflicts of interest or potential conflicts of interest at the start of each meeting in accordance with Milton Keynes University Hospital NHS Foundation Trust policy, even if such a declaration has already been made.

8. Meetings and Conduct of Business

8.1 Frequency

The Committee will meet four times a year on a quarterly basis and at least 14 days prior to the Trust Board to allow a committee report to be submitted.

8.2 Calling Meetings

Meetings of the Charitable Funds Committee are subject to the same procedures as specified in Standing Order 3 of Annex 8 of the Constitution for the Board of Directors. A meeting may be called by the Secretary of the Committee or the Chair of the Committee or the other Non-Executive Director Member of the Committee.

8.3 Agenda

The Committee will at least annually review these terms of reference. The agenda for meetings will be circulated to all Board members who have requested to receive papers. Full papers will be sent to members of the Committee at least 5 clear days before the meeting.

Version Control

Version	Date	Author	Comments	Status
0.1	December 2008	Wayne Preston	Considered by Charitable Funds Committee and approved for Board	Draft
1.0	January 2009	James Bufford	Approved by Board	Approved
1.1	March 2010	Maria Wogan	Minor amendments recommended to Board 24.03.10	For approval
1.2	March 10	Maria Wogan	Annual Review by the Board	Approved
1.3	April 2012	Michelle Evans-Riches	Review of Committee Structure By Finance and Investment Committee	For approval
1.4	September 2012	Michelle Evans-Riches	Implement changes from Charitable Funds Committee 27 September 2012	For approval
2	August 2013	Michelle Evans-Riches	Annual Review and changes to Committee Structure	For approval
2.1	November 2013	Jonathan Dunk	Updated to reflect new charitable funds approval guidance	For approval
3	June 2014	Michelle Evans-Riches	Review following changes to Terms of Reference template	For approval
4	October 2017	Ade Kadiri	Annual Review	For approval
5	February 2019	Ade Kadiri	Annual review and changes to the procedure for bid applications	For approval
6	October 2019	Ade Kadiri	Annual review (continued) including replacement of the charitable order form	For approval
7	November 2020	Julia Price	Annual review by Trust board	Approved
8	Aug 2021	Kwame Mensa-Bonsu	Annual Review	Draft
8.1	27 Aug 2021	Haider Husain	Review & mark-up of draft	Draft
9	10 September 2021	Kwame Mensa-Bonsu	Review Completed	Draft
10	November 2021	Kwame Mensa-Bonsu	Annual Review by the Board	

Milton Keynes University Hospital NHS Foundation Trust

Agenda Item 22.1
Public Board 04/11/2021

Meeting of the Audit Committee held on 20 September 2021

REPORT TO THE BOARD OF DIRECTORS

Summary of matters considered at the meeting:

Annual Auditor's Report
The Audit Committee received the report on the external audit of the 2020/21 Financial Accounts, which noted that the External Auditors had "issued an unqualified opinion on the Trust's financial statements on 14 June 20212, and that they had not identified "any matters where, in our opinion, proper practices had not been observed in the compilation of the financial statements".

Internal Audit Report
The Committee noted that Internal Auditors had completed 4 internal audit reports with positive opinions on the following areas:

- Governance arrangements during the COVID-19 pandemic
- Risk management arrangements during the COVID-19 pandemic
- Financial planning and delivery
- Data Security and Protection Toolkit

Local Counter Fraud Specialist (LCFS) Progress Report
The Committee reviewed the report and the noted the activities of the LCFS since July 2021.

Financial Controller's Report
The report noted that as 31 August 2021, there were 75 outstanding salary overpayments worth £110k relating to previous employees. The Committee noted that these outstanding overpayments extended to 2017 and was assured that progress was being made to recoup these. The Committee was assured that the last of these overpayments was made in May 2020.

Audit Committee Terms of Reference
The Audit Committee reviewed the revised Terms of Reference and recommended it for approval by the Trust Board of Directors.

Escalation items for Board attention

- Risk and assurance processes in the organisation were in good working order.
- Processes for the Annual Audit of the Trust's 2020/21 Annual Accounts had been completed.
- The Audit Committee would receive and note the ADMK's 2020/21 Annual Accounts at the next meeting in December 2021
- There were a number of salary overpayments, for which steps were being taken to retrieve.

Milton Keynes University Hospital NHS Foundation Trust

Agenda item 22.2
Public Board 04.11.21

Meeting of the Finance and Investment Committee held on 07 September 2021

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:
N/A

Summary of matters considered at the meeting:

- Regarding the M04 Performance Dashboard, the Committee comprehensively reviewed the trajectories of all key performance indicators. It was noted that:
  a. All bed capacity was open;
  b. Patient referrals and activity was increasing;
  c. The number of patients with COVID-19 being admitted was increasing;
  d. Staff vacancies had increased, especially due to annual leave allocations.

- Regarding the M04 Finance Report, the Committee reviewed the trajectories of all the key income and expenditure indicators.

- The Committee noted that the formal confirmation of funding for the Maple Centre construction project had been received and was being drawn down. The Maple Centre is currently scheduled to be opened in Autumn 2022.

- The Committee received an update on the progress of the completed Outline Business Case for the New Hospital Programme.

- The Committee reviewed its revised Terms of Reference and recommended it for approval by the Trust Board of Directors.

Milton Keynes University Hospital NHS Foundation Trust

Agenda item 22.3
Public Board 04.11.21

Meeting of the Finance and Investment Committee held on 05 October 2021

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

a. The Committee **approved** the Trust's independent sector contracts with two local independent sector care providers to support the Elective Recovery Programme.

b. The Committee **approved** the replacement of the Trust's Cardiac Cath Lab Angiography Suite.

Summary of matters considered at the meeting:

- Regarding the M05 Performance Dashboard, the Committee reviewed the report and noted the significant operational and staffing pressures impacting on the Trust.

- Regarding the M05 Finance Report, the Committee noted that there was cumulative deficit of £1.1m from April 2021 to August 2021 which was around £100k off plan. The cumulative deficit was driven by staffing issues and the loss of income caused by the disruption to theatres throughout July 2021.

- The Committee noted that capital spend was £0.4m behind plan.

- The Committee noted that bids had been submitted to the NHSE/I Regional Finance Team through the Bedfordshire, Luton and Milton Keynes Integrated Care System (BLMK ICS) in respect of additional capital funding for schemes under the Elective Recovery Programme.

Agenda item 22.4
Public Board 04/11/2021

Meeting of the Charitable Funds Committee held on 14 October 2021

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee

The Committee **approved** the Charity Annual Report and Accounts 2020-21.

The Charitable Funds Committee **approved** its revised Terms of Reference.

Summary of matters considered at the meeting:

Fundraising Update –

a. The High Sheriff of Buckinghamshire's Golf Day on 19 October 2021 raised £40k for the Cancer Centre.
b. The John Lewis and Partners MK have chosen the Hospital Charity as their elected cause. As part of this, the John Lewis Fashion Show in November 2021 will be in support of the Hospital Charity
c. NHS Charities Together (NHS CT) confirmed in September 2021 the award of £88k to fund the provision of COVID-19 support for staff.

The Committee received an update from the Meaningful Activities Facilitator on their activities since they started in the Trust in July 2021. The Meaningful Activities Facilitator is funded by the Charity

The Committee noted that the Charity funded MK Arts for Health's part-time Collection and Exhibitions Manager.

The Committee, in line with the Hospital Charity's collaborative fund raising strategy, invited its various partners to attend the meeting. The purpose of the meeting was to engender an enhanced collaborative relationship with the partners.

Agenda item 22.5
Public Board 04/11/2021

Workforce & Development Assurance Committee Meeting held on 21 October 2021

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

a. The Committee approved its Terms of Reference.

Summary of matters considered at the meeting:

Staff Story – The Committee received a presentation from the Freedom to Speak Up Guardian (FTSUG) on their experiences during the COVID-19 pandemic. The FTSUG, who is also the Lead Nurse for End of Life and Palliative Care, provided the Committee with an account of the frightening circumstances during the pandemic. The FTSUG highlighted the speed with which patients died due the first wave of the pandemic and the opportunities for change which was created by the pandemic.

Workforce Information Quarterly Report (Q2) – The Committee noted that the sickness absence rates and use of agency staff reflected the pressures the organisation was under. It was also noted that, though staff turnover and retention rates remained relatively good, exhausted staff were reluctant to undertake bank shifts due to fatigue.

Employee Relations – The Committee noted that the task and finish group to support the reduction in violence, bullying and harassment was meeting regularly and progressing with its remit.

Equality, Diversity & Inclusion (EDI) – The new EDI Leads had been in post for six weeks and were making good progress with the statutory returns and corresponding action plans. They were also establishing contacts in the community and other external stakeholders.

Living Our Values Programme – The Committee noted that, as of October 2021, 480 members of staff had participated in Living Our Values workshops, and that the outputs were being distilled into a set of expected behaviours which would form the basis of a 'Behaviours Framework'.

Educational Annual Report – The Committee reviewed the Annual Report and noted that that compliance levels with statutory and mandatory training requirement had remained consistently high throughout 2020/21 and rose to 95% in August 2021. Over 2000 colleagues had also accessed personal development training in year across the Trust, half of whom were from nursing and midwifery or allied health professional groups and for whom funding was obtained from HEE.

Staff Health and Wellbeing Annual Report – The Committee reviewed the Staff Health and Wellbeing (SHWB) 2020/21 Annual Report and noted that the Team continued to provide the

full range of Occupational Health services to the Trust and income generation clients through a challenging period impacted by the COVID-19 pandemic.

Milton Keynes University Hospital NHS Foundation Trust

Agenda item 22.6
Public Board 04/11/2021

Meeting of the Quality & Clinical Risk Committee held on 20 September 2021

REPORT TO THE BOARD OF DIRECTORS

Matters Approved by the Committee:

The Committee approved its Terms of Reference.

Summary of matters considered at the meeting:

Clinical Quality Risks on the Board Assurance Framework (BAF) – The Committee noted the correlation between staffing risks and the impact on service quality.

Quarterly Highlight Report – The Committee reviewed and discussed four themes:

a. The Maternity Unit received a broadly positive 'Sixty Supportive Steps to Safety' assurance visit in July 2021 from the Regional Chief Midwife Leadership Team. While there were many areas of good practice, the areas for improvement included ensuring all guidelines were up to date, optimizing MEOWS (maternity early warning scores) and the proactive triage of women attending ADAU.
b. The increasing number unvaccinated patients with COVID.
c. The Trust received a regional NHSE Infection Prevention and Control visit in June 2021 and the feedback congratulated the Trust for being engaging, and the staff for being open. The visiting team also noted that all relevant staff were professional and responsive to suggestions for improvement, and they took away some best practice items to share across the region.
d. The hospital was under pressure in all areas including non-elective COVID pathways, non-elective non-COVID pathways, elective pathways, Paediatrics and Maternity. Staff were fatigued and not taking up extra bank shifts.

Complaints Quarterly Report Q4 – The Committee reviewed the quarterly report and noted that the top theme remained communication, with an increasing number of complaints being around staff attitudes. The expectations were that:

a. Outputs from the values workshops that took place over the summer would form the basis for behaviour standards for staff.
b. The Appreciative Inquiry work taking place across the Trust will also contribute to improvements regarding communication
c. A planned education and training programme for all Trust staff utilising a variety of resources including scenario-based videos depicting best practice and examples of poor communication skills with families and patient/family stories would also contribute to improvements.

Falls Prevention Quality Improvement Plan – The Committee noted the establishment of the Harm Improvement Group had resulted in a reduction to the number of inpatient falls in Quarter 1 of 2021/22

Infection Prevention and Control (IPC) 2020/21 Annual Report – The Committee reviewed the annual report and noted how challenging the COVID-19 pandemic had been for the IPC Team.

Trust Board Meeting in Public

Forward Agenda Planner

Standing Items

Standing Business Items	Standing Trust Board Meeting In Public Items
Apologies	Patient Story
Meeting Quorate	Nursing Staffing Update
Declaration of Interests	Mortality Update
Minutes of the previous meeting	Performance Report
Action Tracker	Finance Report
Risk highlighted during meeting for consideration to CRR/BAF	Workforce Report
Escalation items for Board attention	Board Assurance Framework
AOB	Trust Seal
Forward Agenda Planner	Summary Reports from Board Committees
	Significant Risk Register Report
	Serious Incident Report

Additional Agenda Items

Month	Assurance Reports/Items
January	Objectives Update
	Antimicrobial Stewardship - Annual Report
March	Quality Priorities
	Freedom to Speak Up Guardian Annual Report
May	
July	CNST Maternity Incentive Scheme – Board Assurance Statement and Sign-Off
	Guardian of Safe Working Hours Annual Report
	Medical Revalidation Annual Report
	Objectives
	Annual Complaints Report
	Annual Claims Report
	Research & Development Annual Report
	Falls Annual Report
	Pressure Ulcers Annual Report

	Safeguarding Annual Report
September	
November	Infection Prevention and Control Annual Report