Milton Keynes University Hospital NHS Foundation Trust

Board of Directors

Public Meeting Agenda

Meeting to be held at 10.00 on Friday 5 January 2017 in Room 6 at the Education Centre, Milton Keynes University Hospital NHS Foundation Trust.

Item No.	Title	Purpose	Type and Ref.	Lead
1. Introduction and Administration				
1.1	Apologies	Receive	Verbal	Chairman
1.2	Declarations of Interest • Any new interests to declare • Any interests to declare in relation to open items on the agenda	Noting	Verbal	Chairman
1.3	Minutes of the meeting held in Public on 3 November 2017	Approve	Pages 3-12	Chairman
1.4	Matters Arising/ Action Log	Receive	Pages 13-14	Chairman
2. Chair and Chief Executive Strategic Updates				
2.1	Chairman's Report	Receive and Discuss	Verbal	Chairman
2.2	Draft Minutes of the Council of Governors Meeting held on 15 November 2017	Receive	Pages 15-24	Chairman
2.3	Chief Executive's Report • Update on winter preparedness	Receive and discuss	Pages 25-28	Chief Executive
2.4	Sustainability and Transformation Plan	Note	Verbal	Chief Executive
3. Quality				
3.1	Patient Story – The "Hug in a Bag" initiative	Receive and Discuss	Verbal	Director of Patient Care & Chief Nurse
3.2	Mortality update report	Discuss and Note	Pages 29-38	Medical Director
3.3	Nursing Staffing Update	Receive and Discuss	Pages 39-46	Director of Patient Care & Chief Nurse
3.4	Approach to Safety Checklists within the Trust	Receive and Discuss	Pages 47-56	Medical Director
3.5	Update on the Electronic Patient Record Programme	Receive and Discuss	Pages 57-62	Director of Clinical Services
3.6	Healthy Food CQUIN update	Note	Pages 63-68	Director of Patient Care and Chief Nurse
4. Performance and Finance				
4.1	Performance report Month 8	Receive and Discuss	Pages 69-82	Deputy Chief Executive

Item No.	Title	Purpose	Type and Ref.	Lead
4.2	Finance update report Month 8	Receive and Discuss	Pages 83-90	Director of Finance
5. Assurance and Statutory Items				
5.1	Implementation of the General Data Protection Regulation	Note	Pages 91-96	Director of Corporate Affairs
5.2	Health and Safety Update	Discuss	Pages 97-104	Director of Corporate Affairs
5.3	(Summary Report) Audit Committee – 12 December 2017	Note	Pages 105-108	Chair of Committee
5.4	(Summary Report) Finance and Investment Committee - 6 November and 18 December 2017	Note	Pages 109-114	Chair of Committee
5.5	(Summary Report) Workforce and Development Assurance Committee – 6 November 2017	Note	Pages 115-116	Chair of Committee
5.6	Use of the Trust Seal	Note	Pages 117-118	Director of Corporate Affairs
6. Administration and closing				
6.1	Questions from Members of the Public	Receive and Respond	Verbal	Chair
6.2	Motion to Close the Meeting	Receive	Verbal	Chair
6.3	Resolution to Exclude the Press and Public	Approve	The Chair to request the Board pass the following resolution to exclude the press and public and move into private session to consider private business: *"That representatives of the press and members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted."*	Chair

Milton Keynes University Hospital NHS Foundation Trust

BOARD OF DIRECTORS MEETING

Minutes of the Board of Directors meeting held in PUBLIC on Friday 3 November 2017 in Room 6, Education Centre, Milton Keynes University Hospital

Present:

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

In Attendance:

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

2017/11/01	**Welcome**
1.1	The Acting Chairman welcomed all present to the meeting.
2017/11/02	**Apologies**
2.1	There were no apologies for this meeting.
2017/11/03	**Declarations of interest**
3.1	No new interests had been declared and no interests were declared in relation to the open items on the agenda.
2017/09/04	**Minutes of the meeting held on 8 September 2017**
4.1	The minutes of the public Board meeting held on 8 September 2017 were accepted as an accurate record. In response to a question from Bob Green about

	development of the RightStaff app, the Chief Nurse explained that good progress is being made, and that the Trust is receiving credit for its role in the process. The first major uptake by other organisations is likely to occur in December.
2017/11/05	**Matters Arising/ Action Log**
5.1	There were no matters arising in addition to those included on the agenda.
5.2	The action log was reviewed in turn: <u>347 M2 Performance Report</u> The Medical Director has commissioned a study, in conjunction with the relevant consultants, to assess whether readmissions in respect of a cohort of 353 patients could have been avoided. Indications are that 10 to 15% could have been prevented either by the hospital or other partners within the system. More formal outcomes from this work will be presented in a month or two.
2017/11/06	**Draft Minutes of the Council of Governors' Meeting held on 12 September 2017**
6.1	The draft minutes of the Council of Governors' meeting held on 12 September 2017 were received and noted.
2017/11/07	**Chairman's Report**
7.1	The Chairman reported that the non-executive directors had paid a worthwhile visit, in advance of the meeting, to wards 2 and 24.
7.2	He also gave feedback on a meeting of Trust Chairs that he had recently attended. It had been organised by NHS Improvement, and had focused on A&E performance, winter planning, finances and meeting the cancer target. It confirmed that MKUH is doing well on all the key targets, but there is concern nationally about the impact that this winter could have on finances and performance. The need for frontline staff to be protected against flu had also been stressed.
7.3	At that meeting, a presentation showing the different directions that are being taken across the country in the development of STPs and ACSs was also received. These ranged from the complex relationships being navigated through in Lincolnshire, to the vertical integration taking place in Wolverhampton, where the trust had taken over the running of a number of local GP practices. The overall message is that there is no one size fits all, and it is for local partners to agree on what is right for their areas. **Resolved**: The Board **noted** the Chairman's report.
2017/11/08	**Chief Executive's Report**
8.1	The Chief Executive drew the Board's attention to the written summary of discussions at the recent Management Board meeting. This is a new development and feedback on its usefulness was welcomed.

8.2	Planning for flu nationally is at an advanced stage. NHS England are planning for 400,000 cases, which would be significantly higher than for over a decade. In Milton Keynes, cases on such a scale would impose previously unseen pressures on the system.
8.3	A roundtable meeting on education has been held, in the course of which the University of Buckingham came out well. As a result, Phillip Dunne, the health minister is to visit the Trust to see what is on offer for students here.
8.4	NHS Providers Board meeting is to be held next week. There is a growing concern about the link that has been created between removal of the pay cap and the need to make productivity gains – there is an expectation that a 4% improvement in efficiency would need to be delivered. This Trust is already expected to deliver over £10m this year.
8.5	Andrew Harrington has been appointed Chief Executive of the Milton Keynes GP Federation. He has expressed optimism about the opportunities for positive service developments across the system.
8.6	The Chief Nurse informed the Board of the recently launched John's Campaign within the Trust. This is an initiative that provides access for carers to come into the hospital and participate in the care of their loved one (it had been mentioned in a patient's story about 6 months ago). Radiology is to be one of the first areas to take it up, and any lessons emerging from their early adoption would be taken on board as part of the more general roll out. The Chief Nurse also announced that the Trust had won the Nursing Times award for Emergency and Critical Care for the "Hug in a Bag" initiative that helps women who have suffered a miscarriage to maintain their dignity. A more detailed presentation on the initiative will be given at the next public meeting of the Board. **Action: Chief Nurse**
8.7	Parmjit Dhanda raised a question about the steps that are being taken to improve the response rate for the staff survey. The Director of Workforce indicated that the Trust publicises the survey each year, and that this year, a "you said we did" campaign had been launched at the pop-up Event in the Tent. There will also to be a prize draw linked to completion of the survey.
8.8	In response to another question from Mr Dhanda about pressures on the breast service, the Director of Clinical Services stated that services in neighbouring trusts are under similar strain. She speculated that a recent breast awareness campaign may have led to an upsurge in referrals. This Trust's service is receiving support from Bedford Hospital, and a wider review of the service is being discussed as there are challenges in getting appointments in a timely fashion – cancer related cases always take priority.
8.9	In response to a question about the impact that a 1% (or more) pay award would have on the Trust's finances, the Director of Finance stated that planning assumptions would be based on those being made nationally, and the question as to whether additional funding would be made available. The risks against achieving the Trust's financial target are to be discussed at the Finance and Investment

	Committee meeting next week.
8.10	David Moore raised the issue of informatics and digitising hospitals, noting the Health Secretary's 2020 target for the NHS to be completely paperless. The Chief Executive indicated that the Trust is investing heavily in its IT infrastructure, but the challenge is to achieve effective connectivity. The Chief Nurse fed back to the Board about her attendance at Cerner's Healthcare Conference, highlighting the exciting decision making tools under development that are currently being trialled in the US, and therefore not yet ready for adoption here in the UK. The point was made, however, that the more that Cerner products are taken up in the NHS, the greater the likelihood that these tools will be introduced here more quickly. It was also noted that the Zesty platform now gives patients the opportunity to change their appointments on their smartphones. However, e-prescribing is not yet in place at the Trust.
8.11	A letter has been received from NHS Improvement with regard to the pathology network arrangement. Conversations have been held with East and North Hertfordshire, who are linked to Addenbrooke's, as well as with Oxford, which, it would appear, would be the logical hub for this Trust. NHS Improvement are content for the Trust to explore this option, and the Board would be advised about outcomes. The Trust has significant links with Oxford and Bucks Health, and it would make sense to enter into formal partnership with a high tech provider. NHS Improvement has been open with the Trust as to its thinking in this area, but its final decision could be affected by considerations elsewhere.
8.12	In response to a question from Andrew Blakeman about EPR, the Director of Clinical Services indicated that the project is going as well as is to be expected. The design and build phase has been concluded, and testing has commenced. This is a major change management process – training plans are being developed, and operational engagement is growing, as the focus moves away from the executive team and the Board. Regular progress updates will be provided to the Board, as there is much hard work to be done over the coming months. **Resolved**: The Board **noted** the Chief Executive's Report.
2017/11/09	**Sustainability and Transformation Partnership update**
9.1	The Chief Executive reminded the Board that BLMK is one of 8 areas to be included in wave 1 of STPs that are to become ACS's. As a result of this, the partnership has been able to access some transformation funding. MKUH put forward a bid to fund work on breaking down barriers within the local health and care system that currently prevents patients from being cared for by a single entity for the entirety of their journey. This bid was successful and £500k of funding has been provided to help create a single system within MK, including the Council, CCG and Community Health. The first priority for this work would be to seek to gain a better understanding about how patients access health and social care. Success at this stage would enable appropriate clinical models to be put in place to support the relatively small number of patients that are known to be the heaviest users of local health and social care resources. This initiative is at the early stages of development to define what is achievable.

9.2	The Trust has agreed to engage an American company, Optum, that has expertise in health systems, to recommend the best way forward, based on the various needs within MK itself and across the wider STP footprint. This work will also take account of models being developed in other parts of the country, and the various governance challenges. The Trust wants to be better able to engage with the different parts of the system, in accordance with its strategy. The Board will receive regular updates on this programme.
9.3	The work leading up to the merger between Luton and Dunstable FT and Bedford Hospital is continuing. A meeting is to be held with the CCGs this week at which the plans will be outlined. It was also noted that the 4 local authorities within the patch have formed a joint Overview and Scrutiny Committee. Their first meeting is to be held this month. **Resolved**: The Board **noted** the Sustainability and Transformation Partnership update.
2017/11/10	**Patient Story**
10.1	Michaela Tait, Patient Engagement Manager, attended to deliver three brief patient stories, all of which related to the Red 2 Green initiative, as seen from the patient's perspective. In summary, mention was made of: • A 53 year old lady who attends the hospital on a 6 to 12 monthly basis for a particular procedure. Following her challenge to the clinical team as to what she needed to do to get home on the day, her discharge was in fact arranged for that day. • The second story was of a 69 year old gentleman whose bloods needed to be checked. He challenged the doctors that he wanted to go home that day, stating that he could receive the results from his GP. He was subsequently discharged on the day. • A 55 year old lady who was awaiting a liver transplant asked what she needed to do in order to be discharged on that day. She was told that she needed to be able to climb up stairs. She was able to demonstrate that she could do this, and was therefore discharged.
10.2	Andrew Blakeman confirmed that the Red 2 Green initiative had brought about impressive improvements in patient care, and that confirmation of this had been received at the recent Quality and Clinical Risk Committee meeting. However Tony Nolan queried why the doctors involved in these cases appeared to have a bias against early discharge. The Medical Director indicated that there is always a delicate balance to be struck in cases of this nature. Some wards are not yet working at the same level of efficiency as others and it can sometimes be a challenge to decide on an expected date of discharge. Also, the patient may be medically fit, but needs a social care bed which is not yet available. In response to a question whether Red 2 Green is a 7 day programme, the point was made that it is fundamentally a Monday to Friday exercise, but that some wards have the infrastructure to deliver it on a 7 day basis. **Resolved**: The Board **noted** the patient stories.

2017/11/11	**Mortality update report**
11.1	The Medical Director presented this regular report. He notified the Board that the Trust's Hospital Standardised Mortality Rate (HSMR) remains lower than expected, and that at 1.01, the Summary Hospital-level Mortality Indicator (SHMI) is also lower than it has been in previous months. There are 2 areas in which the Trust is an outlier, but the Medical Director confirmed that neither of these is important.
11.2	The Trust aims to qualitatively review a quarter of all deaths by the end of the financial year – it achieved 35% in Q1. Nationally, it is thought that between 3 and 4% of recorded deaths are avoidable, and at this Trust, it has been found so far that 2 deaths could have been avoided, amounting to less than 1% of all deaths here. It was noted that this remains a work in progress, and a more in-depth analysis will be presented at the Quality and Clinical Risk Committee. It was also noted that the feedback from relatives to this process has been positive. **Resolved**: The Board **noted** the Mortality Update report.
2017/11/12	**Nursing staffing update**
12.1	The Chief Nurse presented this routine report on nursing staffing. She announced that 52 newly qualified nurses have commenced employment at the Trust, but the Trust is carrying the highest ever level of vacancies, with Medicine, for example, having a 31% vacancy rate.
12.2	With regard to overseas recruitment, it was noted that 7 Filipino nurses have now started work at the Trust, and a business case is shortly to be presented at Management Board for a new exercise to be carried out. The recruitment process takes up to a year and cannot be sped up.
12.3	A private company has been engaged to conduct a detailed analysis of the Trust's maternity staffing, and the results will be presented at either the January or March public Board meeting. The Chief Nurse made the point that the Trust is doing all that it should on recruitment, but beds are being opened at an increased rate.
12.4	There is concern that although the September cohort of the University of Northampton nursing programme is full, only 25 out of 75 places on the March programme, which is often filled by more mature students, have been taken up. It is believed that this shortfall is as a result of the removal of the bursary for student nurses. The Trust is working with the university on possible solutions.
12.5	The nursing associate programme is progressing well, and it is likely that a business case for the recruitment of a large group to start next March will be taken to Management Board.
12.6	Parmjit Dhanda made reference to reports in the media of the dramatic fall in nurse recruitment from the EU and the fact that not enough nurses are being trained locally, and he wondered whether the Trust has made projections about its staffing needs in the medium to long term. The Chief Executive stressed that current

	staffing levels are safe, and made the point that winter planning would give the hospital the opportunity to test how far current levels can be stretched. The Trust's 3 to 5 year plan has not yet been presented to the Board – this could be done in February. It was noted that a recent King's Fund report has found that nursing numbers across the country have fallen by 1.5% on real terms.
12.7	In response to a question from Andrew Blakeman as to whether it would be possible to ascertain at which point the hospital would no longer be safe, the Chief Nurse remarked that according to the available quantitative data, the Trust is a higher than average spender on medical staffing and that the hospital is performing well, taking account of its size and scale. There is however, a need to make better use of technology in supporting qualified nurses and doctors on the wards to focus on work that makes best use of their skills and training. **Resolved**: The Board **noted** the nursing staffing update.
2017/11/13	**Update on Winter Readiness Planning**
13.1	The Director of Clinical Services delivered a presentation setting out the steps that are being taken nationally, across Milton Keynes and by the Trust in preparation for winter. Points made in the course of the presentation included that: • There is a broad consensus that the flu season this year will be more serious than in previous years. • One of the key areas of focus this year has been on ensuring system wide planning and ensuring that patients are not unnecessarily held up at any point within the system. • As part of its planning response, MK has been divided into zones for the purpose of care provision. However, to date, efforts to access additional private provision to help alleviate delays in discharging patients have not been successful. • The number of social workers who will be on site at the Trust to help facilitate discharges will be significantly increased. • The Warm Up for Winter programme, which will help to identify things that could be done differently to assist flow through the hospital will commence in the next few days. • There is a clear senior management focus on this, across the entire local system, and there will also be significant regulatory oversight throughout the period.
13.2	In response to a challenge from Parmjit Dhanda about the focus on care home beds in terms of the range of discharge solutions, the Chief Nurse made the point that although only a relatively small number of patients require care home beds, they tended to be the ones with the most complex needs and therefore tended to account for the majority of bed days among those whose discharges had been delayed. Across the hospital, there are two wards worth of patients still admitted but who no longer need an acute hospital bed. There are as yet unresolved bottlenecks in the care provided outside the hospital.
13.3	With regard to the Trust's Emergency Preparedness, Resilience and Response

	Plan, it was noted that there is a requirement for a non-executive director to oversee its delivery. It was agreed that in view of the high profile nature of the issues involved, the Acting Chairman should be put forward as the responsible NED. It was agreed that the updated Plan would be circulated to the Board after this meeting. **Resolved:** The Board **noted** the update on winter planning, and **agreed** that the Acting Chairman would be the non-executive director responsible for delivery of the Trust's Emergency Preparedness, Resilience and Response Framework.
2017/11/14	**Performance Report Month 6**
14.1	The Deputy Chief Executive introduced the month 6 Performance Report and highlighted the following points: • A Never Event had been declared (discussed at the last Board meeting) • There is still a small number of patients who have been waiting for 52 weeks for elective care. These delays in providing care are entirely due to patient choice issues • The percentage of patients who failed to attend their outpatient appointments is now up to 6.7% • The Trust will not meet the cancer 62 day target in October, but will meet it in the quarter as a whole. **Resolved**: The Board **noted** the Month 6 Performance Report.
2017/11/15	**Finance Update Report Month 6**
15.1	The Director of Finance presented the Month 6 position and highlighted the following points: • In the year to date, then Trust is on target to meet its control total, despite the fact that it appears to be off target against its planned deficit (this is as a result of planned donations that have not yet been received) • An extra £2.2m of STF funding will be accessed in the second half of the year. However, the Board noted that the trust was compelled to lodge an appeal in relation to its failure to access £200k worth of funding relating to A&E performance in Q2 as a result of a late change to the guidance. • Pay costs remain below budget, and agency costs are significantly under budget. • High cost drugs are significantly overspent. • The Trust has still not received a response from NHS Improvement to its application for capital funds • Performance of the Transformation Programme has improved with the recognition of some agency savings, but it is still £700k below target. • The Trust has been confirmed as a Fast Follower in the Global Digital Exemplar programme, with £5m of capital funding to be received over 3 years. **Resolved**: The Board **noted** the Month 6 Finance Update Report.

2017/11/16	**Board Assurance Framework**
16.1	The director of Corporate Affairs introduced the BAF, which has been updated following the latest round of Committee meetings. She informed the Board that an in-house peer review exercise is being undertaken and the Trust is working with KPMG to benchmark the framework against those of other similar trusts. Ideas around better graphical representation of movements within the framework are also being explored, and the Quality and Clinical Risk Committee is to embark on deep dives into a number of different areas. The expectation is that all of this work will lead to the evolution of a different type of reporting to the Board. **Resolved**: The Board **noted** the latest version of the Board Assurance Framework.
2017/11/17	**Update of Terms of Reference for the Board Committees**
17.1	The Director of Corporate Affairs introduced proposed updates to the Terms of Reference of the Board of Directors and its Committees. David Moore enquired about the role of the Finance and Investment Committee in terms of scrutinising IT in generally, and whether it had a role in relation to information governance. It was agreed that FIC's role was in relation to the Trust's investment in IT projects, but that issues such as cyber security and information governance would be for the Audit Committee which would report to the Board on the adequacy of the arrangements for the management of the risks.
17.2	In terms of attendance at meetings, it was agreed that the Medical Director would not be required to attend Audit Committee meetings. The Chief Executive also clarified that for most Committees, it is the non-executive directors who are members, and the others are attendees, but is agreed that those considered as core-attendees should continue to be named in the terms of reference. It was also agreed that for all Committees, except Audit, the Chairman and Chief Executive should be listed. The 2 appendices to the FIC terms of reference are also to be updated. **Resolved**: The Board **approved** the updated Board and Committee Terms of Reference, subject to final approval by the Chairs of each Committee.
2017/11/18	**Summary Reports**
18.1	The Board noted the contents of the summary reports of recent Board Committee meetings as follows: • Audit Committee meeting held on 26 September 2017 • Finance and Investment Committee meeting held on 2 October 2017 • Charitable Funds Committee meeting held on 2 October 2017 • Quality and Clinical Risk Committee meeting held on 20 October 2017
18.2	In relation to the QCRC meeting, Andrew Blakeman updated the Board on the first of the divisional deep dives with representatives of the Medicine Division attending to present at the meeting. He also asked that the Trust do more to raise the profile of volunteering across the Trust in order that more people might be interested in

	participating. The Chief Nurse confirmed that a lot of work is being done in this area, and agreed to bring an update to the next public Board meeting. **Action: Director of Patient Care and Chief Nurse**
2017/11/19	**Questions from Members of the Public**
19.1	The Acting Chairman informed the Board that a written question had been received from a member of the public in advance of today's meeting. A detailed response had been prepared and shared with the member of public, who is in attendance at the today's meeting. The Acting Chairman read out the question and a summary of the Trust's response – the question and the full response are attached as an appendix to these minutes.
19.2	In response to the question whether the member of public was satisfied with the response to her question, she thanked the Trust for the detailed response, but queried whether the Board is satisfied that there had been sufficient public engagement around the changes to the service in question. The Medical Director explained that as a "district general hospital", MKUH is constrained in the level of specialist and sub-specialist care that it can provide on its own, and often relied on forging clinical partnerships with regional tertiary and specialist providers. In relation to the particular service in question, the actions being taken are in response to retirement of a consultant who had previously provided the service. The Trust had been unable to find a consultant who had an interest in the area. Although consultation with the public in this regard would have been difficult, it was acknowledged that communication could have been better.
19.3	A member of the Council of Governors in attendance welcomed the introduction of a written report from the Chief Executive, and questioned whether a similar report on the STP could also be circulated. The Director of Corporate Affairs stated that there is information in the public domain that could be sent out. There was also a plea for patient involvement around the pathology hub and spoke discussions.
19.4	Another member of the Council of Governors raised the issue of cyber security. In response, it was confirmed that the Audit Committee would report on this issue to the Board. The Chief Executive confirmed that the Trust's systems had not been affected by the recent malware attack although the Trust had taken its own internal preventative steps.
2017/11/20	**Any other business**
20.1	There was no other business

	All					Action log – All items				
	Public/ Private	**Action item**	**Mtg date**	**Agenda item**		**Action**	**Owner**	**Due date**	**Status**	**Comments/Update**
Board of Directors	Public	347	7 Jul 2017	15.5	Perf Report M2	An update on the rate of 30 day readmissions to be provided at the November Board meeting	Caroline Hutton	5 Jan 2018	Closing	On the agenda
Board of Directors	Public	349	7 Jul 2017	19.7	Health and Safety update	Consideration to be given to the provision of a sprinkler system across the hospital, with a view to ensuring that patients, staff and visitors have enough time to escape in the event of a fire. This is to be reflected in the next health and safety update	Kate Burke	9 Mar 2018	Open	
Board of Directors	Public	350	11 Nov 2017	8.6	CEO Report	The Chief Nurse is to provide a more detailed presentation on the award winning “Hug in a Bag” initiative	Lisa Knight	5 Jan 2018	Closing	This is on the agenda as the patient story
Board of Directors	Public	351	11 Nov 2017	18.2	Committee Summary Reports	The Chief Nurse agreed to provide an update on volunteering within the Trust to the next Public Board	Lisa Knight	5 Jan 2018	Open	

Milton Keynes University Hospital NHS Foundation Trust

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

DRAFT minutes of a meeting of the Council of Governors' of the Milton Keynes University Hospital NHS Foundation Trust, held in public at 5.00pm on Tuesday the 14 November 2017, in room 6 of the Education Centre at Milton Keynes University Hospital, Milton Keynes

Present:
Simon Lloyd - Chairman

Public Constituency Members:
William Butler (WB)
Paul Griffiths (PG)
Alan Hastings (AH)
Alan Hancock (Aha)
Clare Hill (CH)
Robert Johnson-Taylor (RJ)
Amanda Jopson (AJ)
Peter Skingley (PS)
Liz Wogan (LW)

Appointed Members:
Andrew Buckley (AB) - Milton Keynes Council
Clare Walton (CW) - Community Action:MK
Maxine Taffetani (MT) - Healthwatch Milton Keynes

Staff Constituency Members:
Keith Marfleet (KM)
Lesley Sutton (LS)
Kim Weston (KW)

In Attendance:

Executive Directors
Joe Harrison (JH) - Chief Executive
John Blakesley(JB) - Deputy Chief Executive
Caroline Hutton (CH) - Director of Clinical Services
Mike Keech (MK) - Director of Finance
Ian Reckless (IR) - Medical Director

Non Executive Directors
David Moore (DM)

Also in Attendance
Jacqui Page (JP) Item 3.2- eCARE Programme Operational Lead

Sharon Webb (SW) Item 3.2- eCARE Programme

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

There were no members of the public in attendance at the meeting.

1.	**WELCOME & ANNOUNCEMENTS**
	The Acting Chairman extended a warm welcome to everyone present and introduced at their first meeting, newly elected Public Governors William Butler and Amanda Jopson
1.1	**APOLOGIES**
	Apologies for absence were received from, John Blakesley, Andrew Blakeman, Kate Burke, Douglas Campbell, Jean Button, Parmjit Dhanda, John Ekpa, Ogechi Emeadi, Bob Green, Paul Griffiths, Clare Hill, Carolyn Peirson, Tony Nolan, Matt Webb and Jill Wilkinson
1.2	**DECLARATIONS OF INTEREST**
	There were no new declarations of interest received and no interests received in relation to any other open items on the agenda.
1.3	**MINUTES**
(a)	**Minutes from the Council of Governors meeting held on the 12 September 2017.** The draft minutes of the meeting held on the 12 September 2017 were considered. **<u>Resolved:</u> That the draft minutes of the meeting held on the 12 September be agreed as a correct record of the meeting.**
(b)	**MATTERS ARISING / ACTION LOG**
	Action Log There were no outstanding action log items. **<u>Resolved:</u> That the action log as updated at the meeting was received.**
2	**CHAIRMAN AND CHIEF EXECUTIVE REPORTS**
(a)	**Chairman's Report**
	The Chairman thanked Governor Lesley Sutton, for her time as the rotational Lead Governor for the duration of the 17th May 2017 until 14th November 2017. Public Governor Liz Wogan will start her tenure as Lead Governor from the 15th November until the 11th May 2018. The Chairman also took the opportunity to remind everyone of the joint meeting with the Non Executive Directors that was taking place on the 22nd November 2017 at Herons Lodge. With the Trust's commitment to provide support for Governors to carry out their role effectively, NHS Providers GovernWell will also be able to join the meeting on the 22nd. GovernWell provide the national training programme to equip all NHS Foundation Trust Governors with the skills required to undertake this very important role and It is an excellent opportunity to have them join us here in Milton Keynes.

	The Chairman, also gave feedback on a meeting of Trust Chairs that he had recently attended. It had been organised by NHS Improvement, and had focused on A&E performance, winter planning, finances and meeting the cancer target. It confirmed that MKUH is doing well on all the key targets, but there is concern nationally about the impact that this winter could have on finances and performance. The need for frontline staff to be protected against flu had also been stressed. At that meeting, a presentation showing the different directions that are being taken across the country in the development of STPs and ACSs was also received. These ranged from the complex relationships being navigated through in Lincolnshire, to the vertical integration taking place in Wolverhampton, where the trust had taken over the running of a number of local GP practices. The overall message is that there is no one size fits all, and it is for local partners to agree on what is right for their areas. The Chairman concluded by thanking Public Governors Phil Gerrella and Sid Nandi-Purkayastha for their time as Public Governors and wished them well for the future. Both had both unfortunately recently tendered their resignations, due to work commitments. **<u>Resolved:</u> That the Chairman's report be received and accepted.**
(b)	**Chief Executives Report,**
	The Chief Executive drew the Council of Governors attention to the written summary of discussions at the recent Management Board meeting. This is a new development and feedback on its usefulness was welcomed. Planning for flu nationally is at an advanced stage. NHS England are planning for 400,000 cases, which would be significantly higher than for over a decade. In Milton Keynes, cases on such a scale would impose previously unseen pressures on the system. A roundtable meeting on education has been held, in the course of which the University of Buckingham came out well. As a result, Phillip Dunne, the health minister is to visit the Trust to see what is on offer for students here. The NHS Providers Board meeting is to be held. There is a growing concern about the link that has been created between removal of the pay cap and the need to make productivity gains – there is an expectation that a 4% improvement in efficiency would need to be delivered. This Trust is already expected to deliver over £10m this year. Andrew Harrington has been appointed Chief Executive of the Milton Keynes GP Federation. He has expressed optimism about the opportunities for positive service developments across the system. In response to a question from Public Governor Alan Hastings, The Chief Executive reported that trials were expected to take place on offering electronic options to enable appointments to be changed online. In response to a question from Public Governor Peter Skingley, The Chief Executive stated that the campaign for all forms of smoking no longer being allowed anywhere on the hospital site was working very well, but emphasised the importance of its sustainability.

	<u>Resolved</u>: That the Chief Executive's report be received and accepted.
3.	**Sustainability and Transformation Partnerships**
	The Chief Executive reminded that BLMK is one of 8 areas to be included in wave 1 of STPs that are to become ACS's. As a result of this, the partnership has been able to access some transformation funding. MKUH put forward a bid to fund work on breaking down barriers within the local health and care system that currently prevents patients from being cared for by a single entity for the entirety of their journey. This bid was successful and £500k of funding has been provided to help create a single system within MK, including the Council, CCG and Community Health. The first priority for this work would be to seek to gain a better understanding about how patients access health and social care. Success at this stage would enable appropriate clinical models to be put in place to support the relatively small number of patients that are known to be the heaviest users of local health and social care resources. This initiative is at the early stages of development to define what is achievable. The Trust has agreed to engage an American company, Optum, that has expertise in health systems, to recommend the best way forward, based on the various needs within MK itself and across the wider STP footprint. This work will also take account of models being developed in other parts of the country, and the various governance challenges. The Trust wants to be better able to engage with the different parts of the system, in accordance with its strategy. The Board will receive regular updates on this programme. The work leading up to the merger between Luton and Dunstable FT and Bedford Hospital is continuing. A meeting is to be held with the CCGs this week at which the plans will be outlined. It was also noted that the 4 local authorities within the patch have formed a joint Overview and Scrutiny Committee. Their first meeting is to be held this month. In response to a question from Appointed Governor Clare Walton, The Chief Executive reported that that the funding was well received and a positive in recognising development in MK. **<u>Resolved:</u> That the Sustainability and Transformation Partnership update be received.**
3.1	**Update on Estate Development**
	The Deputy Chief Executive provided a verbal report for the Estate Development Update and the following was highlighted:- • To support the growing demand there were now 24 new visitor car parking spaces in the car park B area (behind cardiology) adjacent to the entrance barrier. • Work has begun on the construction of the new multi-storey car park, the contractors will be working within a designated site to minimise any disruption caused. • The new multi- storey car park is scheduled to be opened in April 2018. • The Cancer Therapy Centre programme is underway with expected completion in 2019. • The construction of the Medical School Academic Centre is now very visual

	from the road when entering the Trust from Standing Way and is expected to open in February 2018. **<u>Resolved:</u> That the Update on Estate Development be received and accepted**
3.2	**Electronic Patient Record**
	An eCare Programme presentation was given to the Governors by the eCARE Operational Lead. The following was highlighted:- • The future vision for the 21st Century is for a modern, connected and paperless system that consistently provides efficient outstanding and personalised care for all. • The MKUH journey to paperless by 2020 consists of 4 phases. • **Modern** (Phase A) the efficient access to systems & Information, from Jan 2015 – December 2016. • **Connected** (Phase B), commence single record view from September 2016 – March 2018. • **Paperlite** (Phase C) enhancing a single record view from June 2018 – August 2019. • **Paperless** (Phase D) complete single record view from September 2019 • So where are we? 1. Current State Review – review current processes 2. Commence the Design and Build 3. Review Design and Build progress 4. Sign off initial design ready for testing – 22nd September 5. Integration Testing completed ready for training – 30th December 2017. 6. System taken down to complete upgrade 13 April 2018 – Night before go live. 7. Review go live – 30th April 2018 • Operational Readiness, there is a group set up to review all activities required to ensure we are ready as an organisation:- Ensuring consistent management message 1. Ensuring effective change programme for staff 1. Go live and roll out planning 2. Training – ensuring effective and meets needs of staffs 3. Representatives from all areas of the organisation 4. Monitor the benefits (financial, quality and safety). • Key eCARE benefits linked to the top three Trust Objectives:- 1. Patient Safety, reduces errors with transcribing patient history manually received from GP's, Improved visibility of patients condition and plan and screening tools to identify risks such as patients falling. 2. Improving Patient Experience, right test with the right information at the right time reduces delays, discharges more efficient as collating clinical information in advance and encourage standard ways of working which should reduce length of stay.

	3. Improving Clinical Effectiveness standardises tests for conditions, timely completion of assessments and recorded e.g.VTE and standardised drug formulary which will promote generic prescribing and compliance. **The Chief Executive left the meeting** In response to a question from Public Governor, Liz Wogan the eCARE Operational Lead confirmed, that although a national project that eCARE at MKUH was being carefully managed. **Resolved: That the Electronic Patient Record Presentation be Received**
4.1	**Integrated Performance Report Month 6**
	The Deputy Chief Executive introduced this report and highlighted the following:- • There is still a small number of patients who have been waiting for 52 weeks for elective care. These delays in providing care are entirely due to patient choice issues • This year we have used our Warm Up for Winter campaign to find ways in which we can better share information across the organisation, including with our colleagues based at Witan Gate House. With forecasting predicting another difficult winter, it is really important that we are able to have the right staff in the right place at the right time, which includes every single member of staff. • Following some feedback sessions and workshops over at Witan Gate this week, there will be a number of new projects launching over the coming weeks to better support information flow, which will ultimately improve patient flow. In response to a question from Public Governor Alan Hastings, The Director of Clinical Services reported that some hospitals send letters to DNAs stating the costs incurred by missing an appointment. In response to a question from Public Governor Alan Hastings, The Deputy Chief Executive reported that DNA's for the Urgent Care Centre were also included in the data. **Resolved: That the Integrated Performance Report Month 6 be received.**
4.2	**Finance Report Month 6**
	The Director of Finance presented this report and highlighted the following:- • In the year to date, then Trust is on target to meet its control total, despite the fact that it appears to be off target against its planned deficit (this is as a result of planned donations that have not yet been received) • An extra £2.2m of STF funding will be accessed in the second half of the year. However, it was noted that the trust was compelled to lodge an appeal in relation to its failure to access £200k worth of funding relating to A&E performance in Q2 as a result of a late change to the guidance. • Pay costs remain below budget, and agency costs are significantly under

	budget. • High cost drugs are significantly overspent. • The Trust has still not received a response from NHS Improvement to its application for capital funds • Performance of the Transformation Programme has improved with the recognition of some agency savings, but it is still £700k below target. • The Trust has been confirmed as a Fast Follower in the Global Digital Exemplar programme, with £5m of capital funding to be received over 3 years. **Resolved: That Finance Report for Month 6 be received and accepted.** **The Deputy Chief Executive left the meeting** **Governor Clare Walton left the meeting**
5.1	**(Summary Report from) Finance and Investment Committee**
	The Chairman of the Committee presented the summary report from the Finance and Investment Committee Meeting held on the 2 October 2017. The following was highlighted:- • Agency spend is at its lowest for some time at £844k, and this has coincided with higher spend on the staff bank. • The challenge would be to maintain this as winter approaches. **Resolved: That the Finance and Investment Committee Summary Report be noted.**
5.2	**(Summary Report from) the Charitable Funds Committee**
	The summary report of the Charitable Funds Committee meeting held on the 2 October 2017 was considered. **Resolved: That the summary report from the Charitable Funds Committee be noted**
5.3	**(Summary report from) the Quality and Clinical Risk Committee**
	The summary report of the Quality and Clinical Risk Committee meeting held on the 20 October 2017 was considered. **Resolved: That the the summary report of the Quality and Clinical Risk Committee meeting held on the 20 October 2017 was noted.**
5.4	**(Summary report from) the Audit Committee**
	The summary report of the Audit Committee meeting held on the 26 September 2017 was considered. **Resolved: That the the summary report of the Audit Committee meeting held on the 26 September 2017 was noted.**

6.	**Healthwatch Milton Keynes Update**
	Maxine Taffetani, appointed governor from Healthwatch Milton Keynes presented the Healthwatch Milton Keynes update by first thanking the hospital staff for their support and engagement for the first Healthwatch enter and view exercise. The following was highlighted:- • Healthwatch Milton Keynes first enter and view exercise had been undertaken at the Hospital in Wards 17 and 18. The Hospital team had promptly responded to the recommendations outlined in the report and had clearly laid out how they will be acted upon. • The report has been published and sent to Joe Harrison, CEO and other stakeholders at the hospital, in advance of the Council of Governors meeting, • Hard copies were also distributed to Governors. In response to a question from Public Governor Liz Wogan, Maxine Taffetani, appointed governor from Healthwatch Milton Keynes confirmed that the enter and view activity had been carried out by two Healthwatch trained authorised representatives. **Resolved: That the Healthwatch Milton Keynes Update Report be noted.**
6.1	**Engagement Group Update**
	Alan Hastings Public Governor as Chair of the Engagement Group, provided the update from the Engagement Group Meeting that took place on the 4th October and the following was highlighted:- • There were 90 attendees at the AMM held on the 27th September at the Venue:MK, Walton High. • The 'Beyond the C' Choir who sang in the foyer as people arrived was a great success and many compliments had been received. • 20 new members were recruited • Thank you to all of the Governors who helped make the evening a success, we have received some comments from those in attendance that it was the best AMM that they had been to, to date. Alan Hastings as Chair of the Engagement Group reported that the next Engagement Group Meeting is to take place on the 6th December at 11.00am in the Elm Room, Oak House and reminded that the role of the Engagement Group is to review and improve engagement between the hospital and its members, between governors and their members and between the hospital and the wider community. All Governors are deemed to be members of the Engagement Group, but it is not compulsory to attend every meeting, all Governors who wish to attend are most welcome. **Resolved**: **That the Engagement Group Update be received and accepted.**
7.1	**Timetable of Council of Governor and Board of Director Meetings 2018**

	The Governor and Membership Manager presented the timetable for the Council of Governor and Public Board of Director Meetings for 2018 **Resolved: That the Timetable of Council of Governor and Board of Director Meetings 2018 be noted.**
7.2	**Charitable Funds Committee Governor Representative**
	The Chairman reported that The Charitable Funds Committee terms of reference states that a named Governor be included in the membership of the Committee and its meetings. Further to this, a request has been received from the Charitable Funds Committee for a Governor to join the Committee. Discussions with Governors for a representative has now taken place, with one application since received and accepted. **Resolved: That the Charitable Funds Committee Governor Representative be Received.**
7.3	**Governor Elections**
	The Governor and Membership Officer provided an update on the recent Governor Elections results for the contested constituency areas of Linford South, Bradwell, Campbell Park and Emerson Valley, Furzton, Loughton Park. Further Governor elections will be required in the new year for current vacancies and current tenures coming to an end in the early part of 2018. **Resolved: That the Governor Elections Update be received**
7.4	**Motions and Questions from Council of Governors**
	None Received **Resolved: That the Motions and Questions from the Council of Governors be received and accepted.**
7.5	**Annual Work Plan**
	The Annual Work Plan was considered and any items pertaining to this meeting are to be added. **Resolved: That the Annual Work Plan be noted.**
7.6	**Any other business**
	There was none
7.7	**Date and Time of next meeting** The date of the next meeting of the Council of Governors is on the 23rd January at 9.30am in room 6 at the Education Centre.

7.8	**RESOLUTION TO EXCLUDE THE PRESS AND PUBLIC** **<u>Resolved:</u> that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted.**

Carol Duffy
Governor and Membership Manager
21 November 2017

Meeting title	**Board of Directors**	**Date: 5 January 2017**
Report title:	**Chief Executive's Report**	**Agenda item: 2.3**
Report author	**Name: Joe Harrison**	**Title: Chief Executive**
FoI status:	**Public document**	

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

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

Report history	
Next steps	
Appendices	None

Chief Executive's Report - key points arising from the Management Board meeting on 20 December 2017

1. **Sustainability and Transformation Partnership/ Accountable Care System Update**

- The formal merger agreement between Luton and Dunstable and Bedford Hospitals is due to be produced before Christmas.
- Funding is now in place for the development of a Milton Keynes specific care system involving the CCG, Local Authority and mental health providers.
- Confirmation has now been received that the Trust has been included in the South 4 pathology network.

2. **Proposed Strategy for Imaging**

- An outline strategy was presented, with the aim of future proofing imaging services – there is a need to ensure that services are fit for purpose for the next 5-10 years.
- It was noted that there has been a steep rise in the number of complex requests and clinical based assessments. Discussions are to be held with the existing provider and these will be reported back to Management Board.

3. **7 day services**

- The 7 day service standards were introduced in 2013, and implementation of the six standards is to be achieved by March 2018 and March 2020. Work is underway to ensure that the Trust is able to meet these standards within the respective timescales.

4. **Draft recruitment strategy**

- The draft strategy has been updated to include detail on recruitment processes. It was also suggested that the strategy highlights connections with the universities and the Trust's research and development strategy.

5. **Patient Access Programme (Outpatients Transformation)**

- The proposal to centralise the management of the administrative teams supporting outpatient activity was approved. Formal briefings to the staff affected will begin after Christmas in collaboration with staff side representatives.

6. **Performance dashboard and report M8**

- A new indicator, relating to E.coli infections, has been added to the dashboard. No target has yet been set, but this is to become a national target for local health economies.
- A report on the small number of patients who have been waiting for more than 52 weeks for treatment is to be presented at the next Management Board meeting.
- RTT performance has fallen to 90.4%

7. **Finance Report M8**

- The Trust needs to recover £800k in month 9 in order to achieve the sustainability and transformation funding (STF).
- The Trust is in discussion with the CCG on the rules around procedures of limited clinical value in order to limit future challenges.

- A further paper was presented highlighting actions that are to be taken to generate further savings, including:
    - An embargo on new non-urgent minor works
    - An embargo on agency appointments in non-clinical areas
- The freezing of corporate vacancies.

8. Transformation Programme M8 delivery

- The programme is currently £5m off-plan, although there has been a small over-delivery in month on the temporary staffing scheme. Work is underway with the divisions to bring forward additional schemes in year.

9. Capital update

- The Trust continues to await confirmation from NHS Improvement as to whether its application for capital funding for the EPR programme has been approved. In the meantime, the expenditure envelope for essential items has been increased from £5m to £6m.

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Public Board**	**Date: 05 January 2018**
Report title:	**Mortality update report**	**Agenda item: 3.2**
Lead director **Report author** **Sponsor(s)**	**Dr Ian Reckless** **Dr James Bursell**	**Medical Director** **Associate Medical Director**
FoI status:	**Publicly disclosable**	

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

Strategic objectives links	Improve patient safety
Board Assurance Framework links	
CQC outcome/ regulation links	Trust objective – patient safety This report relates to CQC: Regulation 12 – Safe care & treatment Regulation 17 – Good governance
Identified risks and risk management actions	Mortality data outside the expected range would be of public & regulatory body concern
Resource implications	None
Legal implications including equality and diversity assessment	This paper has been assessed to ensure it meets the general equality duty as laid down by the Equality Act 2010

Report history	This is a regular paper at Trust Board
Next steps	To note
Appendices	N/A

Executive Summary

This paper summarises the Trust's current position in relation to mortality based on the latest Dr Foster data available and as discussed through the Trust's mortality review group (MRG). In addition, it reports upon the qualitative review work undertaken within services to examine the care provided by the Trust to patients who have died (through the mortality and morbidity, M&M, meeting framework), including the assessment of 'avoidability'.

Definitions

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

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

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

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

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

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

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

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

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

HSMR

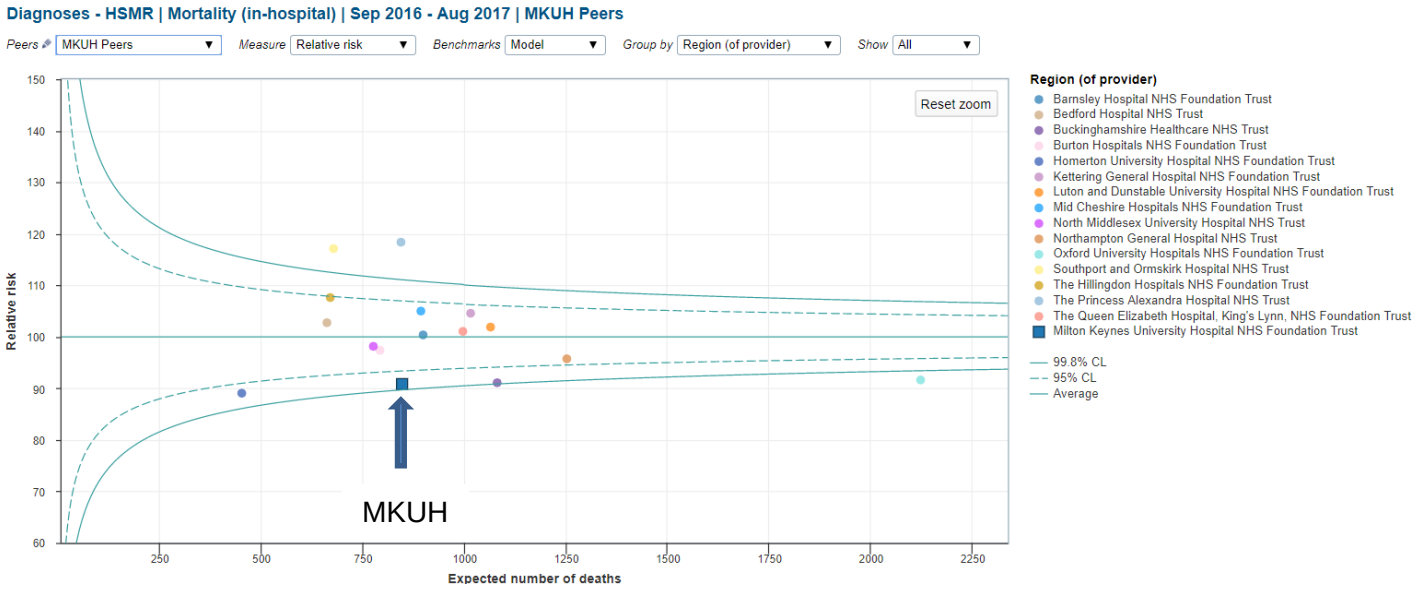
Data period: September 2016 – August 2017

Key Highlights:

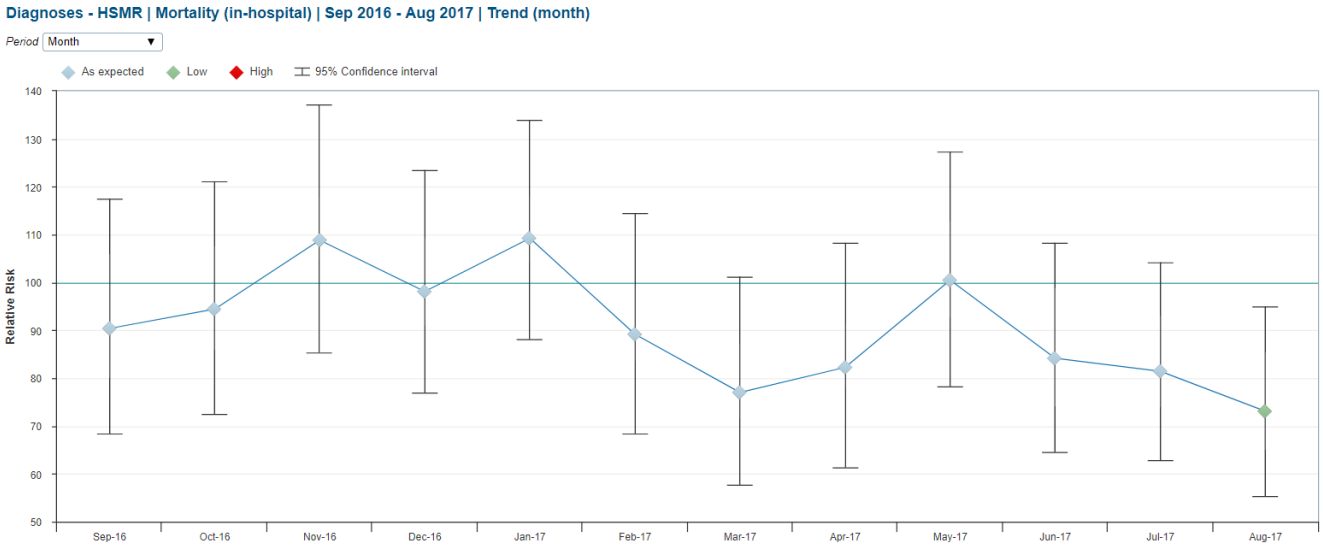
- HSMR relative risk for 12 month period = **90.8** 'lower than expected' range
- Crude mortality rate within HSMR basket = **3.3%** (MKUH local acute peer group rate = 3.5%, national crude rate 3.9%)
- **0 significant outliers** were identified within the HSMR basket for this period.

The Trust currently ranks 2nd (2nd lowest HSMR relative risk value) against its MKUH peer group and 33rd lowest (best) against national peers. The Trust is one of only 4 Trusts from 21 within the peer group with an HSMR which is statistically 'lower than expected'.

HSMR Funnel Plot – Trust vs. MKUH peer group (September 2016 – August 2017)

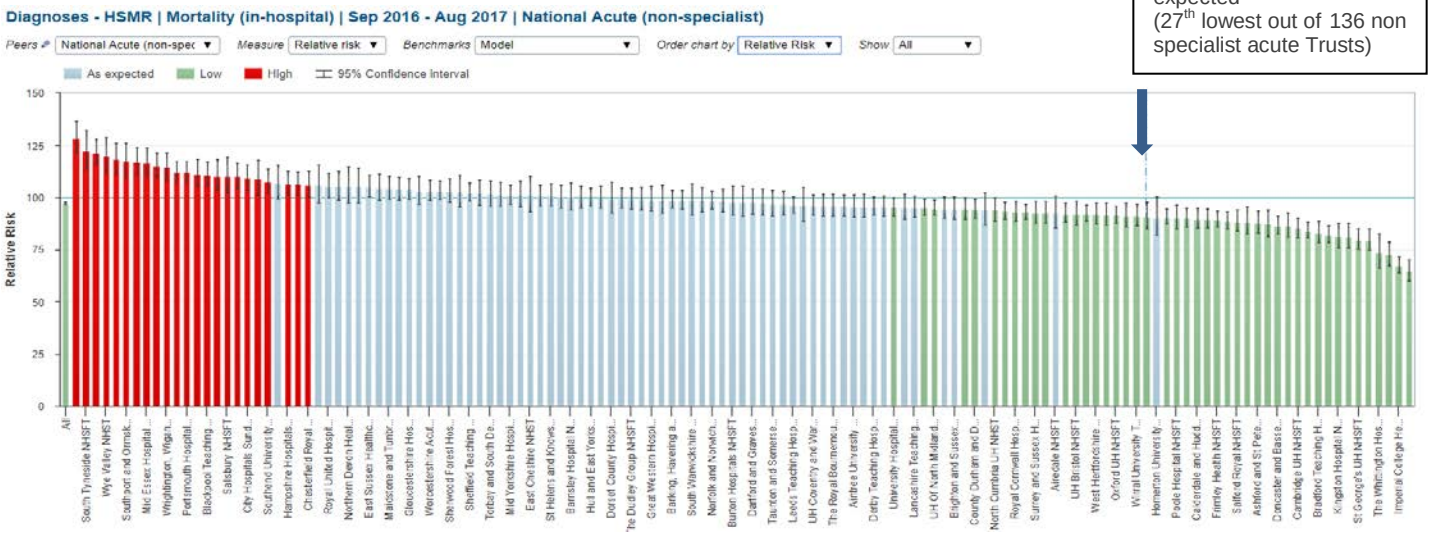


Trust level HSMR monthly performance for rolling year (September 2016 – August 2017)



HSMR position vs. national acute peers: September 2016 – August 2017

HSMR = **90.8** 'lower than expected'
(27th lowest out of 136 non specialist acute Trusts)



HSMR relative risk = 90.8 'lower than expected' (27th lowest out of 136 non-specialist acute). 1st lowest ranking indicates the trust with the lowest (best) HSMR relative risk.

HSMR by diagnosis group: September 2016 – August 2017

In the period September 2016 to August 2017, there were 0 (zero) outlying diagnosis groups that included a significantly higher than expected number of deaths. In the period August 2016 to July 2017 (12 month HSMR data also published since November Public Board meeting) there were also 0 (zero) outlying diagnosis groups.

CUSUM (Tracking Runs of Negative Outcomes)

In the period September 2016 to August 2017 there were no new CUSUM alerts. There have been no new CUSUM alerts since the last Public Board meeting in September 2017.

SHMI

Data period: April 2016 – March 2017 (most up to date data available)

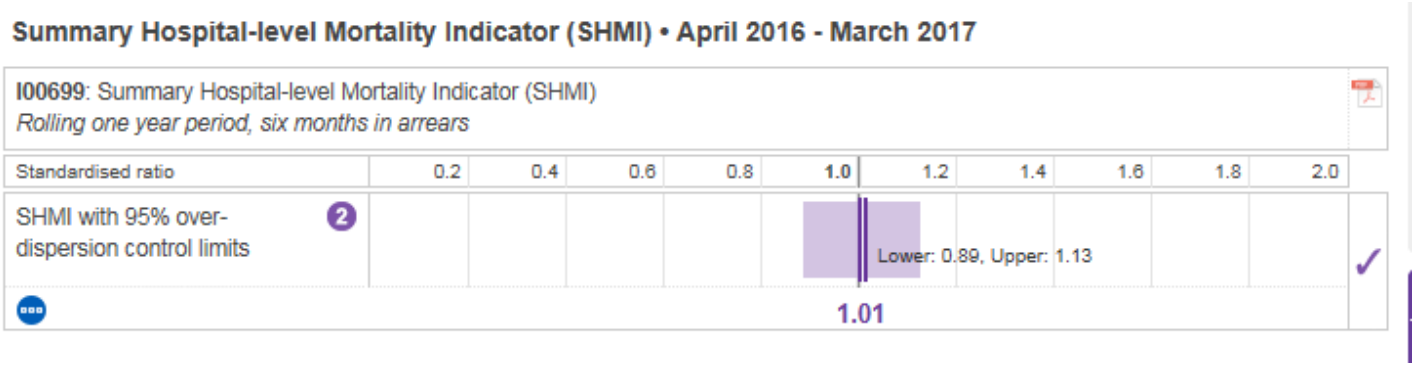
The Summary Hospital-level Mortality Indicator (SHMI), which includes out of hospital deaths occurring within 30 days of discharge, is measured by the Health and Social Care Information Centre (HSCIC). The SHMI relative risk is the ratio between the actual number of patients who die following treatment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

Key Highlights:

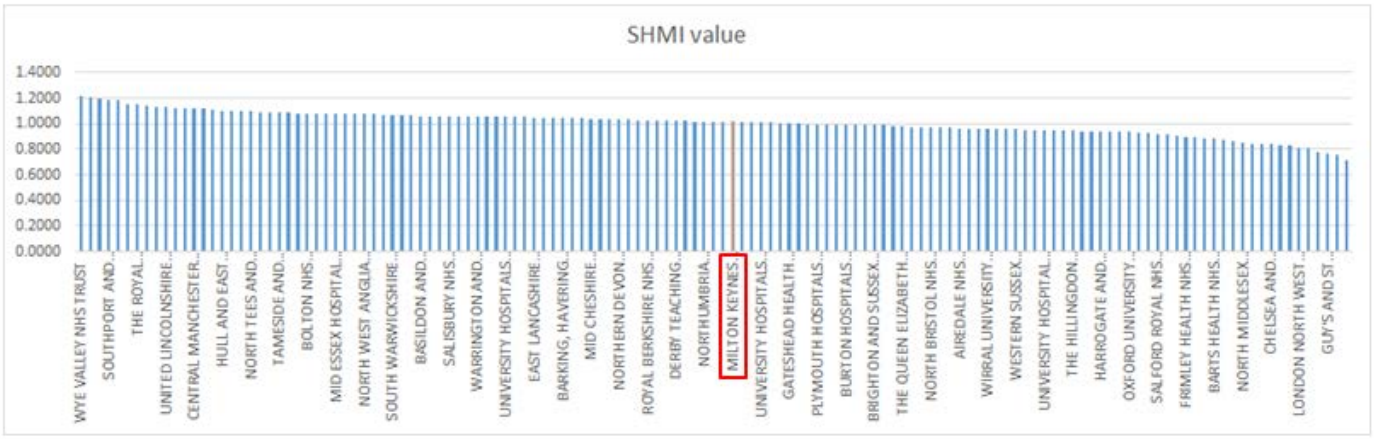
The latest SHMI published in March 2017 by HSCIC for the rolling 12 months to March 2016 = **1.01** '**as expected'** range.

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

There were 0 (zero) negative outlying SHMI diagnostic groups for the period April 2016 to March 2017.



SHMI position vs. national acute peers: April 2016 – March 2017



Investigations of Deaths

In September 2017, as directed by the NQB, the Trust updated the Mortality policy outlining how we respond to deaths and learn from the deaths of patients.

The Trust has reviewed data collection methods, including Structured Judgement Review case note methodology published by the Royal College of Physicians (RCP), proposed by the NQB to ensure that processes are in place to maximise learning from deaths. Changes to current Trust processes when reviewing deaths to incorporate a 'Scale of Avoidability' as proposed by the NQB and RCP are included in the updated Trust policy. It is recognised nationally that adoption of these new review processes require training of multidisciplinary staff members in the specific methodologies. Clinical and nursing staff attended Royal College of Physicians teaching programmes in October and November and there are plans to roll out training to a cohort of consultants in 2018.

As part of an ongoing improvement process around learning from deaths the Trust is involved in a project, led by the Academic Health Service Network (AHSN), to establish regional approaches to mortality issues. The 1st meeting of this group took place in December and facilitated sharing of challenges and solutions when developing the methodology of SJRs and in particular how cases are identified for more in depth review. The role of Medical Examiner in the independent review of hospital deaths and incorporation of this role into Trusts' Learning from Deaths policies was also discussed.

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

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

2. Undergone formal review – the Trust aims for ~ 25% of all deaths to undergo a formal review process. The data was accurate as of 20th December. It should be recognised that deaths that occur within Q3 are still undergoing the process of formal review as per the Trust Mortality policy and more complete data will be available for Q3 at the next Trust Board meeting.

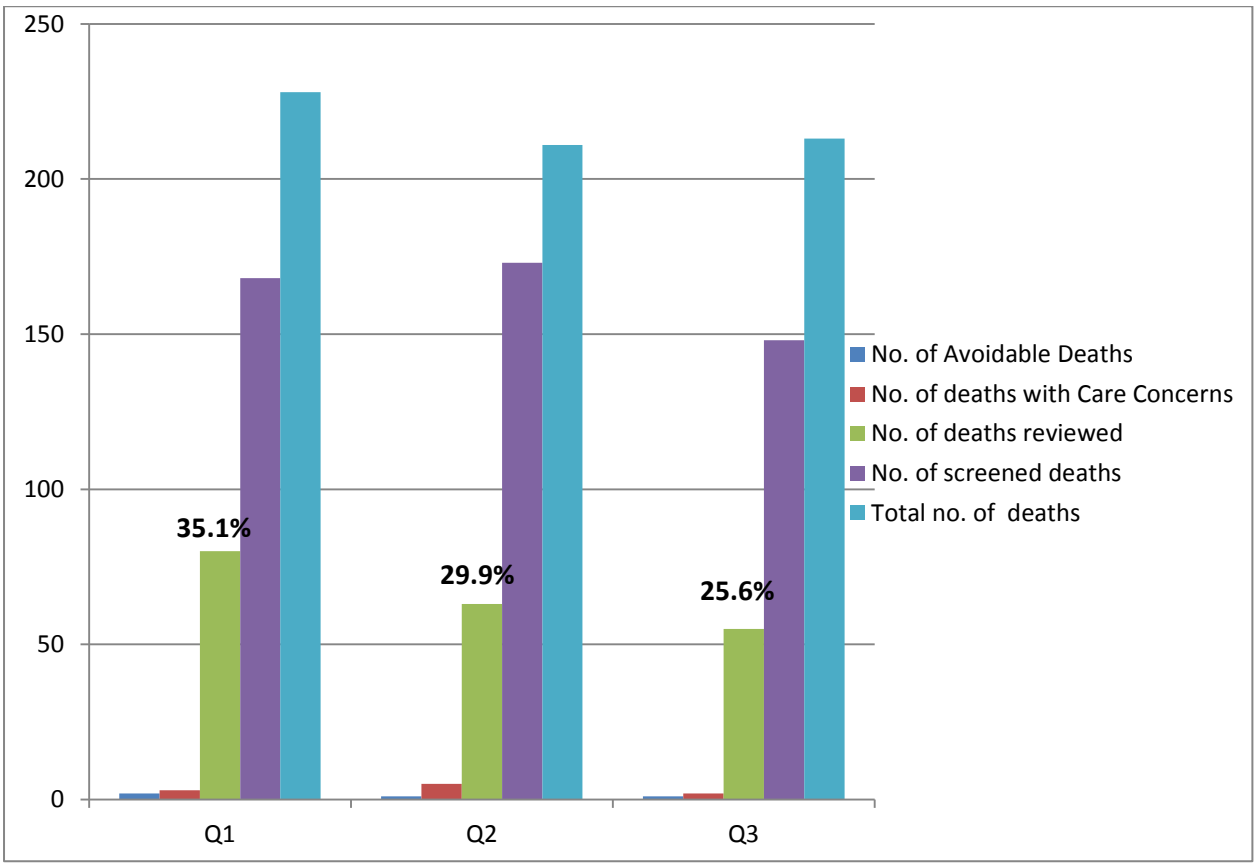
3. Judged as potentially 'avoidable' – using the current system of classification within the Trust this includes 'suboptimal care where different management MIGHT have changed outcome and 'suboptimal care where different management WOULD have changed outcome'

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

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

	Q1	***Q2***	***Q2***
No. of deaths	***228***	***211***	***213***
No. of deaths assessed by responsible consultant (% of total)	***74%***	***82%***	***69% ****
No. of reviews (% of total)	***80 (35.1%)***	***63 (29.9%)***	***55 (25.6%) ****
No. of deaths with Care Quality concerns (%)	***3 (1.3%)***	***5 (2.4%)***	***2 (0.9%) ****
No. of potentially avoidable deaths (%)	***2 (0.8%)***	***1 (0.5%)***	***1 (0.5%) ****

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



Qualitative information of deaths (whilst maintaining patient anonymity)

Q2 Avoidable deaths

A surgical patient in her 8th decade with multiple co-morbidities died in the Department of Critical Care. Initial review of the case found that the patient was not clinically reviewed by medical staff appropriately and an ultrasound scan report showing evidence of pathology was not chased up by medical staff in a timely manner.

Actions from Serious Incident Review Group;

a. Instil culture of screening for sepsis – Sepsis working group action plan.
b. Strengthen online medical handover tool.
c. Friday afternoon handover to on–call team re-instigated.
d. Update Standard Operating Procedure for duties of On-Call doctor to clarify team roles.

Note: This case was also described in the previous Board paper examining deaths which occurred during Q1 and Q2.

Q2 deaths – Care Quality concerns that would not have changed outcome

1. Inadequate assessment and documentation of patient's mental capacity and delayed documentation of resuscitation status.
2. Recognition of possible surgical complication not recognised on readmission. Not related to death.
3. Poor communication between teams as to who was leading care but no delay in treatment.
4. No CT angiography reporting overnight led to a decision to delay investigation.

5. Lack of consultant-consultant communication hampered decision making regarding appropriate clinical area for patient treatment.
6. Sup-optimal communication between hospital managers and clinical staff when considering transfer of sick patient out of ED.

Q3 Avoidable deaths

A surgical patient in his 10th decade had relatively minor emergency surgery. Intravenous fluids were prescribed at a rate too great for a frail elderly patient with chronic heart failure. This likely contributed to a degree of fluid overload and pulmonary oedema. Prior clerking of the patient including poor documentation of patient's medicines

Actions

a. Surgical Division to disseminate learning points regarding fluid prescription and the importance of medication reconciliation at clerking to junior doctors and medical students.

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

1. Delay in doctors reviewing scan results and abnormality on radiology report not highlighted to referring clinician.
2. Earlier change of antibiotics to cover for alternative source of infection.
3. No microbiology samples taken to assist in antibiotic choice.
4. No documentation of mother being given information by midwife regarding poor fetal movements.
5. Poor documentation of medical assessment of fetal growth and fetal movements.

Meeting title	Board Of Directors	**Date:** 5 January 2018
Report title:	Nursing Staffing Report	**Agenda item:** 3.3
Lead director **Report author Sponsor(s)**	**Name:** Lisa Knight **Name:** Matthew Sandham	**Title:** Director Of Patient Care/Chief Nurse **Title:** Associate Chief Nurse
FoI status:		

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

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

Report history	To every Public Board
Next steps	
Appendices	Appendix A - Fill rates for Nursing, Midwifery and Care Staff October 2017
	Appendix B – Nurse to Patient Ratio

Board of Directors Report on Nursing and Midwifery staffing levels Amalgamated report for October 2017and November 2017

1. Purpose

To provide Board with:-

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

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

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

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

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

CHPPD	Total Patient Numbers	Registered Midwives/Nurses	Care Staff	Overall
October	15030	4.3	2.6	6.9
November	14122	4.6	2.9	7.5

Hospital Monthly Average Fill Rates for October and November 2017

Month	RN/RM Day % Fill Rate	HCA/MCA Day % Fill Rate	RN/RM Night % Fill Rate	HCA/MCA Night % Fill Rate
October	84.5%	89.7%	98.8%	133.9%
November	87.2%	104.0%	100.5%	124.5%

We have seen an improvement in both fill rates as well as CHPPD following the recruitment of newly qualified staff who commenced in November.

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

3. Recruitment

Our estimated vacancies in December are:

60 WTE vacancies in Medicine, most of these are on the elderly care ward, but we have altered the skill mix on these wards to try to offset these vacancies. In addition we have appointed 14 newly qualified nurses to start in March.

25 WTE vacancies in Surgery – Surgery continues to recruit on a rolling advert. Theatres continues to be the area with the highest number of vacancies. .

10 WTE vacancies in Maternity following an appointment of 4 Midwives on the 11th November 2017.

15.4 WTE vacancies in Paediatrics- recruitment to Paediatrics continues to be challenging due to the recognised national shortfall in Paediatric Staff Nurses. The number of Paediatric nurses being trained versus the number required is growing, as we currently only train a small number of nurses.

4. Overseas Nurses

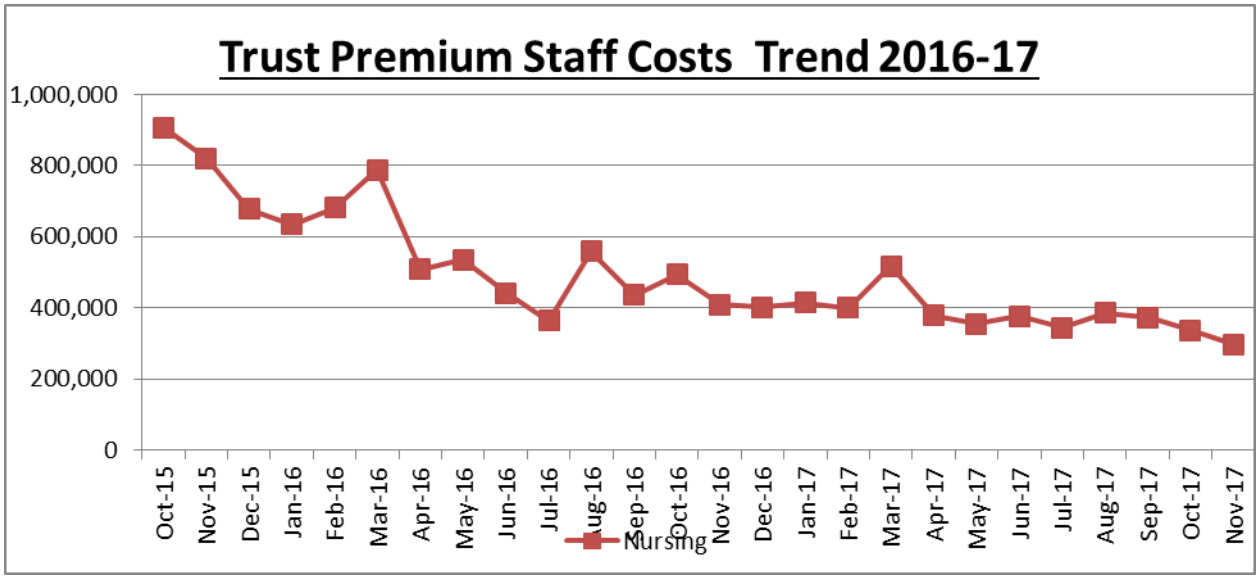
Currently the Trust has 7 nurses from the Philippines who are working within the organisation. All 7 candidates have passed their final test and are now on the Nursing and Midwifery Council register as a registered Nurse.

We have a further 7 candidates who have passed their IELTS test and 3 who have progressed to the final stages and should be with the Trust in the next month. We are awaiting results for 3 IELTS tests and have retracted offers to 12 candidates.

The Nursing and Midwifery Council (NMC) is making alternative options available for nurses and midwives, trained outside the UK, to demonstrate their English language capability.
It is currently felt that this will make no difference to the number of overseas nurses from the Philippines as the requirements do not change significantly enough.

5. Controlling Premium Cost

Agency nursing expenditure continues stabilise in October and November.



We have seen a reduction in agency usage in the past year but much of this has been offset by the rise in bank costs as we used an enhanced bank rate to incentivise bank shift take up. The decision has been made to reduce this enhancement in most areas to deliver savings, with agreed higher risk areas remaining on a better rate to ensure staff coverage.

6. Nurse to patient ratio

We use multiple tools to assess whether services are staffed with the appropriate number and mix of clinical professionals to deliver the right quality care. The Board has regular updates on CHPPD and sees our 6 monthly assessments on dependency on the wards.

Another one of these tools is the use of nurse to patient or bed ratios. There have been multiple ward reconfigurations and as a result alterations in staffing this year and so recalculations have been made. The National Quality Board guidance suggests the maximum ratio of 1 nurse to 8 beds on days and 1 nurse to 10 beds on nights. It is important to remember that these are maximum suggested numbers are many of the wards have much higher acuity and dependency meaning that there ratios of nurse to patients are much lower. The Board is asked to note the table at Appendix B.

The nurse to patient or patient to nurse ratio reflects the number of patients cared for by one Registered nurse; this ratio is calculated by each shift.
Ward sisters are in addition to these numbers, fully supernumery.

Fill rates for Nursing, Midwifery and Care Staff October 2017

Ward Name	Day		Night		Care Hours Per Patient Day (CHPPD)			
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
MAU Ward 1	84.5%	88.4%	98.7%	124.2%	862	4.2	1.9	6.1
MAU Ward 2	83.6%	93.3%	106.5%	158.2%	839	3.1	2.8	6.0
Ward 3	81.0%	79.3%	101.1%	120.4%	875	2.9	3.1	6.0
Ward 5	80.3%	86.5%	107.6%	88.8%	544	6.8	1.3	8.1
DoCC	80.9%	67.9%	82.0%	-	195	24.2	1.5	25.8
Ward 7	97.9%	77.3%	103.2%	130.1%	674	4.2	4.1	8.3
Ward 8	79.0%	86.0%	104.3%	143.2%	770	3.3	2.8	6.1
Ward 9	82.4%	85.5%	90.3%	87.1%	637	4.6	1.1	5.6
Ward 10	92.7%	88.7%	100.0%	-	299	5.1	2.4	7.5
Ward 14	76.8%	124.9%	98.9%	101.6%	739	2.8	2.9	5.7
Ward 15	85.8%	91.2%	97.6%	151.1%	898	3.2	2.6	5.8
Ward 16	84.0%	92.9%	129.1%	114.5%	895	3.2	2.3	5.5
Ward 17	69.6%	83.6%	98.4%	117.7%	738	3.1	2.1	5.3
Ward 18	82.5%	91.8%	102.2%	135.6%	878	2.9	3.5	6.4
Ward 19	77.6%	101.0%	100.3%	226.0%	925	2.6	3.2	5.8
Ward 20	77.3%	91.8%	100.0%	104.1%	810	3.5	2.4	5.8
Ward 21	83.6%	86.9%	101.1%	132.3%	747	3.4	2.3	5.7
Ward 22	81.8%	89.7%	101.1%	154.6%	675	3.2	2.8	6.0
Ward 23	77.1%	92.2%	100.0%	138.7%	1120	3.1	3.2	6.4
Ward 24	82.3%	81.3%	96.9%	-	475	4.4	0.8	5.3
Labour Ward	117.6%	90.0%	99.2%	96.7%	228	25.8	3.1	29.0
NNU	84.3%	74.0%	86.5%	86.8%	207	15.2	2.9	18.2

Fill rates for Nursing, Midwifery and Care Staff November 2017

Ward Name	Day		Night		Care Hours Per Patient Day (CHPPD)			
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
MAU Ward 1	84.8%	124.4%	98.1%	129.0%	793	4.4	2.5	6.9
MAU Ward 2	85.6%	99.7%	101.9%	141.7%	740	3.4	3.1	6.5
Ward 3	86.9%	96.9%	100.0%	115.5%	821	3.1	3.5	6.5
Ward 5	81.2%	106.5%	121.1%	93.2%	611	6.3	1.3	7.6
DoCC	86.7%	88.6%	87.6%	-	169	29.0	2.3	31.2
Ward 7	90.8%	92.8%	100.0%	121.6%	641	4.0	4.4	8.5
Ward 8	81.2%	98.6%	102.2%	118.2%	713	3.5	3.0	6.4
Ward 9	80.7%	80.0%	90.0%	80.0%	623	4.4	1.0	5.4
Ward 10	99.2%	93.3%	95.0%	-	300	5.0	2.3	7.2
Ward 14	83.5%	129.5%	100.0%	105.0%	657	3.2	3.3	6.4
Ward 15	97.0%	97.6%	101.7%	115.0%	820	3.7	2.5	6.3
Ward 16	91.0%	107.7%	131.1%	137.2%	806	3.6	2.9	6.5
Ward 17	88.6%	99.2%	101.7%	121.7%	743	4.3	2.3	6.5
Ward 18	81.8%	102.7%	100.0%	137.8%	800	3.0	4.0	7.0
Ward 19	76.5%	121.5%	97.8%	153.7%	849	2.7	4.2	6.9
Ward 20	79.6%	97.2%	102.4%	114.3%	746	3.7	2.7	6.4
Ward 21	83.4%	99.0%	100.0%	133.3%	665	3.7	2.6	6.3
Ward 22	91.7%	120.6%	101.1%	126.7%	623	4.1	3.0	7.2
Ward 23	86.6%	113.8%	101.7%	136.3%	1061	3.5	3.6	7.1
Ward 24	86.4%	82.9%	96.7%	-	443	4.8	0.9	5.7
Labour Ward	101.0%	98.3%	98.1%	0.0%	186	28.7	2.4	31.1
NNU	94.4%	72.3%	97.4%	79.6%	312	11.1	1.7	12.8

Appendix B

Nurse to Patient Ratio January 2018

Ward		Beds	Early			Late			Night		
			RN	HCA	Ratio 1	RN	HCA	Ratio 1	RN	HCA	Ratio
Medicine											
Ward 1	Assessment Unit	27	6	2	4.50	6	2	4.50	5	2	5.40
Ward 2	Short Stay Medicine	28	4	3	7.00	4	3	7.00	3	2	9.33
Ward 3	Elderly Female	28	4	4	7.00	4	4	7.00	3	3	9.33
Ward 7	Acute Stroke	24	4	4	6.00	4	4	6.00	3	3	8.00
Ward 8	Gastroenterology	25	4	3	6.25	4	3	6.25	3	2	8.30
Ward 14	Rehabilitation	24	3	3	8.00	3	3	8.00	3	2	8.00
Ward 15	Male Respiratory	28	4	3	7.00	4	3	7.00	4	2	7.00
Ward 16	Female Respiratory	29	4	3	7.25	4	3	7.25	4	2	7.25
Ward 17	Cardiology	26	5	2	5.20	5	2	5.20	4	2	6.50
Ward 18	Medicine	28	4	4	7.00	4	4	7.00	3	3	9.30
Ward 19	Medicine	28	4	4	7.00	4	4	7.00	3	2	9.30
Ward 22	Haem/Oncology	22	4	2	5.50	4	2	5.50	3	2	7.30
ED	Emergency Dept.	N/A	13	4	N/A	13	4	N/A	12	4	N/A
Surgery											
Ward 20	Acute Surgery	28	5	2	5.60	5	2	5.60	3	3	9.30
Ward 21	Elective Surgery	27	4	2	6.75	4	2	6.75	3	2	9.00
Ward 23	Trauma/Elective	40	6	4	6.70	6	4	6.70	4	4	10.00
Ward 24	Elective Surgery	20	3	1	6.70	3	1	6.70	3	0	6.60
DoCC	Intensive Care	9	7	1	N/A	7	1	N/A	7	1	N/A
Childrens											
Ward 4	Paeds Assessment	N/A	3	1	N/A	3	1	N/A	3	1	N/A
Ward 5	Acute Paediatrics	25	6	1	4.10	6	1	4.10	4	1	6.25
NNU	Neonatal unit	16	6	1	N/A	6	1	N/A	6	1	N/A
Total	**Beds**	**457**	**92**	**52**		**92**	**52**	**4.10**	**75**	**41**	

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

Meeting title	Trust Board	**Date:** 5 January 2018
Report title:	Approach to Safety Checklists within the Trust	**Agenda item: 3.4**
Lead director **Report author** **Sponsor(s)**	**Name:** Dr Ian Reckless **Name:** Dr Ian Reckless	**Title:** Medical Director **Title:** Medical Director
FoI status:		

Report summary				
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [ ]	**Decision** [ ]
Recommendation	This report updates Trust Board on the use of Safety Checklists in the theatre environment and has been developed in response to prior discussions at Board following on from the occurrence of Never Events during 2017.			

Strategic objectives links	Improve patient safety
Board Assurance Framework links	▪ Improve patient safety ▪ Improve patient experience ▪ Improve clinical effectiveness
CQC regulations	
Identified risks and risk management actions	Non-compliance with national / international standards. Occurrence of further Never Events – patient harm and reputational damage.
Resource implications	
Legal implications including equality and diversity assessment	

Report history	Report developed following prior discussion at Board in relation to serious incidents and Never Events.
Next steps	Monitoring of performance in relation to utilisation of checklists through Divisional and Trust dashboards ('business as usual'). Continued work around development and maintenance of positive safety culture across the Trust.
Appendices	Appendix 1 WHO Surgical Safety Checklist (adapted for England and Wales), NRLS/NPSA, January 2009. Appendix 2 Local example of WHO Checklist

1. Purpose of the Report

This report updates Trust Board on the use of Safety Checklists in the theatre environment and has been developed in response to prior discussions at Board following on from the occurrence of Never Events during 2017.It is intended to provide Trust Board with assurance on systems and processes in place within the organisation.

2. Context

WHO Checklist

Mistakes in healthcare can have a devastating impact upon patients and their families. Such mistakes can also have significant implications for healthcare professionals involved in care (through loss of confidence, loss of livelihood and mental ill health). An example, in the public domain, is shown in Box 1 below.

Box 1

The Case of Mr Graham Reeves

Mr John Roberts, Consultant Urologist, and his registrar Mr Mahesh Goel worked at Llanelli's Prince Philip Hospital. 70 year old Graham Reeves, a retired power station worked and Korean War veteran, was admitted for the removal of his diseased and non-functioning right kidney in January 2000. He had signed a consent form for this procedure.

The operating list stated that the left kidney was to be removed, and this was the procedure carried out. The operating list reflected the incorrect information on a hospital admittance slip.

Mr Goel, who removed the kidney, assumed that his boss had done cross-checks. A medical student who was observing the procedure recognised that the wrong kidney was being removed but her challenge was not heeded.

Mr Reeves went on to develop septicaemia. His diseased right kidney was also removed. He was transferred to another hospital for dialysis but died on 01 March 2000.

Mr Roberts and Mr Goel were ultimately cleared of manslaughter at Cardiff Crown Court in June 2002. The pathologist has not been sure that the death was the direct result of the incorrect operation.

In 2007, 129,419 incidents related to surgical specialties were reported to the National Reporting and Learning Service (NRLS) in England and Wales. These included 271 deaths.

In June 2008, the World Health Organization (WHO) launched a Global Patient Safety Challenge entitled 'Safe Surgery Saves Lives'. The Surgical Safety Checklist was part of this initiative and was designed for use in any operating theatre environment, with the aim of reducing death and complications.

NRLS adapted the checklist for use in the NHS and its adoption was encouraged throughout the NHS by the Department of Health and other organisations from January 2009 onwards. The checklist contains core content but it is suitable for local adaptation to suit the needs of

particular specialties (for example, cataract surgery, maternity and interventional radiology). The original generic WHO Surgical Safety Checklist is included as appendix 1.

The checklist identifies three specific opportunities for the team to pause and actively consider safety critical issues:

Sign in: Typically in the anaesthetic room with the patient awake and participating

Time out: Typically immediately prior to 'knife to skin'

Sign out: Prior to skin closure at the end of the procedure (before any member of the team leaves the operating room)

The checklist affords an opportunity, and creates the expectation, for these checks to be documented as having occurred for each specific patient.

In addition, the WHO checklist process advocates the use of a 'team briefing' prior to an operating session where: team members introduce themselves and their roles to one another; a common understanding of the running order of the list is confirmed; anticipated equipment needs are confirmed; and, any specific issues that have been identified about individual cases or the operating environment are brought to the attention of the whole team. The occurrence of the team briefing is not captured in the WHO checklist itself (which is patient / case specific).

Never Events

Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

The concept of never events was introduced to the NHS in February 2009 as the Never Events Framework 2009/10. The framework defined a number of occurrences which should be regarded as never events and placed an obligation on then Primary Care Trusts to monitor and report upon their occurrence. The list of never events has been modified over the years but originally included three 'surgical' events:

- Wrong site surgery
- Retained instrument post-operation
- In-hospital maternal death from post-partum haemorrhage after elective Caesarean section

Definitions and the designated list of never events were adjusted in April 2015, with the extant guidance being the Never Events List 2015/16 (https://www.england.nhs.uk/wp-content/uploads/2015/03/never-evnts-list-15-16.pdf).

Between 01 April 2016 and 31 January 2017 (10 months), 365 never events were reported in respect of NHS-commissioned care in England. Sufficient detail was available in relation to 351 to enable further analysis. The categories were as follows:

Category of Never Event	Number
Wrong Site Surgery	143
Retained foreign Object	89
Wrong implant / prosthesis	44
Other (non-surgical)	75

Total	**351**

Never Events at MKUH

Since 2012 eleven Never Events have been declared at MKUH. Three of these have occurred in the financial year 2017/18 (to date). These eleven events can be categorised as follows:

- Wrong site surgery (including interventional procedures) – 5
- Retained foreign object – 3
- Wrong implant insertion – 2
- Fall from an unrestricted window - 1

The 2017/18 Never Events have involved:

- Insertion of a chest drain on the incorrect side (interventional radiology)
- Incorrect combination of implant components for a hip procedure
- Retained swab following a gynaecological procedure

These three incidents have all been reported appropriately to commissioners and regulators. They have been investigated according to usual processes and the duty of candour has been applied with patients fully aware of the incident and involved in subsequent investigation.

In the investigation of each of these events, check lists do appear to have been completed in real time. Completion, in retrospect, may have been inaccurate in some instances. This raises a wider question as to systems in place for assuring and improving safety practices in theatre / interventional environments. The fact of completion of a series of tick boxes on a checklist may be *indicative* of robust safety processes but it is not in itself *definitive and conclusive* evidence that robust safety processes are fully embedded.

The remainder of this paper describes the process in use for auditing performance in relation to the WHO checklist, and wider work being undertaken to ensure that the WHO checklist process sits within the context of a positive, energised and open safety culture.

3. Body of the Report

Methodology for auditing WHO checklist performance

The WHO checklist in use in theatres at MKUH was modified in September / October 2017 following discussion and reflection in light of the incident involving incorrect implant components (appendix 2). The changes agreed and incorporated involve potential separation of the 'time out' element. This recognises that the time interval between the beginning of draping of the patient (when some visual cues are lost) and 'knife to skin' can be lengthy, particularly when the operating surgeon is involved in bespoke positioning of the patient. Time out can now incorporate an element before the surgeon scrubs and the moment immediately prior to skin incision. In other circumstances, these two aspects can proceed in tandem.

The WHO checklist audit methodology involves reviewing an average of 62 WHO checklists per month. Three operative cases per weekday are sampled by recovery staff – across phase 1 and phase 2 theatres – in order to achieve a spread across elective / non-elective

surgery, and the various surgical specialties. If aspects of a form are incomplete then this is recorded as a deficit. Deficits – and the absence of signatures in particular – are then brought to the attention of the theatre team involved in near real time.

Data for 2017 (until end November) are shown in the table below. Figures have been separated to note the limited redesign of the process in September / October 2017.

	9 months to September 2017	**October / November 2017**
Elements of form completed in totality	75%	92%
Sign in complete	91%	98.5%
Time out complete	91%	99.5%
Sign out complete	91%	95.5%
All signatures evident *	93%	95.5%

** Signatures evident as opposed to ticking of boxes within checklist sections*

Relevant work beyond the WHO Surgical Safety Checklist

As described in section 2 above, the presence of a checklist on paper does not necessarily provide *definitive and conclusive* evidence of an optimal theatre safety culture. A team briefing could potentially be structured, inclusive, audible and professional. Alternatively, it could be chaotic, occurring in the absence of all team members, inaudible and undertaken in a tokenistic manner. The quantitative WHO checklist audit will not capture such information.

Several other interventions are being undertaken or actively explored to gather qualitative evidence for assurance, including:

- Occasional observation of the WHO briefing process by senior staff (for example, matron)
- Efforts to increase the profile of executive team members in the theatre environment
- Potential for peer review assurance visits with colleagues in other Trusts to observe safety processes
- Heightened profile of incident reporting (see below)
- Potential for further focused human factors training sessions

There are other areas of ongoing work which, whilst not directly related to the WHO checklist approach, together act to reinforce appropriate behaviours and practices and make it easier for individual members of staff to ‘do the right thing all the time’.

A. Cleanliness – Hand Hygiene and Uniform

The Hand Hygiene Audit is carried out monthly, and includes all theatre staff, and medical colleagues. Following some unsatisfactory results earlier in 2017, the department was audited by an external moderator and steps were taken to improve hand hygiene practice. These included improved signage and installation of more hand washing devices throughout both theatre complexes. Actions undertaken include:

- Improved access to hand gel dispensers across both theatre complexes
- Teaching sessions and awareness raising on audit afternoons
- Promotion of the ‘5 moments for hand hygiene’ concept at huddles and via the intranet site
- Designation of hand hygiene “champions”

The 5 moments for hand hygiene, and performance in the November 2017 audit, are as follows:

Opportunity / Moment	Descriptor	Number of breaches observed in day surgery in November audit (30 observations)
Hand Hygiene 1	On entering clinical areas.	4
Hand Hygiene 2	Before and after review / assisting each patient.	1
Hand Hygiene 3	Before and after any clinical procedure.	0
Hand Hygiene 4	Before and after handling any clinical equipment (including patient notes / patient equipment)	2
Hand Hygiene 5	Before leaving clinical area.	1

There has been a focus on compliance with uniform policy during 2017, particularly with regard to the appropriate use of theatre attire outside the confines of theatres. Interventions have included: increased profile at the time of induction for new staff; simple interventions such as installation of mirrors to heighten self-awareness when leaving theatres; development of plans to change foot-fall within theatres (see below); and, spot-checks and interventions by senior staff.

Detailed plans for Estates work in phase 2 theatres have now been drawn up and finance for the project has been secured. The main changes will be: an additional set of doors at the entrance to theatres creating a lobby area in which visitors to Theatres will be received and be able to wait; and, new external entrances to the changing rooms so that staff members will always enter theatres via the changing rooms rather than directly into the main theatre corridor as they do currently. These changes should ensure that the main corridor is no longer a thoroughfare used by staff and visitors in outdoor clothes, but will be used only by staff in appropriate attire. Works are expected to commence in mid-January.

B. Incident Reporting and Open Culture

High levels of incident reporting are known to be associated with a high quality safety culture. Incident reporting rates at MKUH in general remain modest although the majority of the incidents that are reported are ‘no harm’ or ‘low harm’ which is held to be positive.

It has been noted in recent years that reporting examples of where care has gone particularly well (as opposed to adverse clinical incidents) can provide an opportunity for both celebration and learning. Adopting systems to report both successes and adverse events is likely to lead to a more balanced practice in terms of attitudes to reporting systems, and improve the context for team learning.

Theatres hosted the launch of the *Greatix* reporting system in MKUH. Early experience has been very positive.

The Trust’s Freedom to Speak-Up Guardian is currently identifying how best to engage with theatre staff specifically.

Morning safety huddles have been a routine part of the theatre day for several years now and continue. This affords an opportunity to disseminate any shared learning from adverse events and highlight any changes to procedures or other pressing issues among the teams on a daily basis.

C. Overarching Governance Arrangements

The theatre governance group (TIGS) has been reinvigorated, with enhanced attendance and a revised standing agenda. This has led to early benefits including agreement to pilot transfer of emergency gynaecology between phases 1 and 2 theatres, which is likely to result in improved patient experience in relation to patients suffering miscarriage.

4. Recommendations/ Actions

Trust Board is invited to receive this update on actions being taken in relation to surgical safety checklists and the theatre environment more broadly.

WHO Surgical Safety Checklist

(adapted for England and Wales)

NHS
National Patient Safety Agency
National Reporting and Learning Service

SIGN IN (To be read out loud)

Before induction of anaesthesia

Has the patient confirmed his/her identity, site, procedure and consent?
- ☐ Yes

Is the surgical site marked?
- ☐ Yes/not applicable

Is the anaesthesia machine and medication check complete?
- ☐ Yes

Does the patient have a:

Known allergy?
- ☐ No
- ☐ Yes

Difficult airway/aspiration risk?
- ☐ No
- ☐ Yes, and equipment/assistance available

Risk of >500ml blood loss (7ml/kg in children)?
- ☐ No
- ☐ Yes, and adequate IV access/fluids planned

TIME OUT (To be read out loud)

Before start of surgical intervention
for example, skin incision

Have all team members introduced themselves by name and role?
- ☐ Yes

Surgeon, Anaesthetist and Registered Practitioner verbally confirm:
- ☐ What is the patient's name?
- ☐ What procedure, site and position are planned?

Anticipated critical events

Surgeon:
- ☐ How much blood loss is anticipated?
- ☐ Are there any specific equipment requirements or special investigations?
- ☐ Are there any critical or unexpected steps you want the team to know about?

Anaesthetist:
- ☐ Are there any patient specific concerns?
- ☐ What is the patient's ASA grade?
- ☐ What monitoring equipment and other specific levels of support are required, for example blood?

Nurse/ODP:
- ☐ Has the sterility of the instrumentation been confirmed (including indicator results)?
- ☐ Are there any equipment issues or concerns?

Has the surgical site infection (SSI) bundle been undertaken?
- ☐ Yes/not applicable
  - Antibiotic prophylaxis within the last 60 minutes
  - Patient warming
  - Hair removal
  - Glycaemic control

Has VTE prophylaxis been undertaken?
- ☐ Yes/not applicable

Is essential imaging displayed?
- ☐ Yes/not applicable

SIGN OUT (To be read out loud)

Before any member of the team leaves the operating room

Registered Practitioner verbally confirms with the team:
- ☐ Has the name of the procedure been recorded?
- ☐ Has it been confirmed that instruments, swabs and sharps counts are complete (or not applicable)?
- ☐ Have the specimens been labelled (including patient name)?
- ☐ Have any equipment problems been identified that need to be addressed?

Surgeon, Anaesthetist and Registered Practitioner:
- ☐ What are the key concerns for recovery and management of this patient?

This checklist contains the core content for England and Wales

www.npsa.nhs.uk/nrls

PATIENT DETAILS

Last name:

First name:

Date of birth:

NHS Number:*

Procedure:

*If the NHS Number is not immediately available, a temporary number should be used until it is.

0861 January 2009

Sign In

Procedure.....

.....

The pre-list briefing has occurred with all team members? ☐ Yes ☐ No

The patient has confirmed his/her identity, site, procedure and consent? ☐ Yes ☐ No

Is the surgical site marked?
☐ Yes (Circle which) Left Right ☐ N/A

Does the patient have any known allergies?
☐ No ☐ Yes
Allergies.....

Antibiotics required?
☐ Yes ☐ No

Airway risk or anaesthetic risk?
☐ Yes ☐ No

Is there a valid Group & Save sample?
☐ Yes ☐ No

Significant medical/infection problems highlighted to team? ☐ Yes ☐ No

ASA Grade 1 2 3 4 5 6

VTE assessment completed?
☐ Yes ☐ No ☐ N/A (Paediatric)

Sign In has taken place
Staff Signature:

Everyone stop - Time Out

after patient positioning / **before** surgeons scrub

- Patient ID and consent match, and the Scrub has visualised the consent? ☐ Yes ☐ No
- State Allergies out loud

Surgeon

1. Please confirm that this is the correct operation (state operation) on the correct site (state side) on this patient? ☐ Yes ☐ No
2. Any changes since the pre-list briefing? ☐ Yes ☐ No
3. Have you everything you need to proceed? ☐ Yes ☐ No

Anaesthetist

1. Is the patient stable and do you have everything you need to allow the operation to start? ☐ Yes ☐ No
2. Have prescribed antibiotics been given? ☐ Yes ☐ No ☐ N/A

Scrub Nurse

1. Please confirm that your instruments are sterile and you have everything you need to proceed? ☐ Yes ☐ No

Final Pause & Check

After patient prepped & draped / **Before** Surgical Procedure begins

Procedure and **consent form** confirmed with operating surgeon? ☐ Yes ☐ No

Team Members confirm that this part of the checklist has been completed? ☐ Yes ☐ No

Time Out completed
Staff Signature:

Final Count - Sign Out

Can be read out by any member of the Team.

Surgeon to confirm...

1. Name of procedure confirmed?
☐ Yes ☐ No

2. Sharps, instruments and swab count correct? ☐ Yes ☐ No

3. Specimen is labelled?
☐ Yes ☐ No ☐ N/A

4. Any special instruction for Recovery? ☐ Yes ☐ No

5. Any Team issues to be highlighted?
☐ Yes ☐ No

Theatre.....

Date.....

Surname:
Forename:
DOB:
Hospital No.
Or affix Patient Label

WHO form completed
Medical or Registered Staff Signature:

Meeting title	Board of Directors	**Date:** 5 January 2017
Report title:	eCARE Implementation Update Report	**Agenda item: 3.5**
Lead director **Report author** **Sponsor(s)**	**Name:** Caroline Hutton **Name:** Clare Craven **Name:** Joe Harrison	**Title:** Director of Service Development **Title:** Snr eCARE Programme Manager **Title:** Chief Executive
FoI status:	**Public**	

Report summary	This report provides an update report to the Board on the progress of the eCARE Implementation programme. The report describes the position as at 22 December 2017.			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** [x]	**Decision** ☐
Recommendation	The Board is asked to note the report on the status of the implementation of eCARE and acknowledge the key risks and the escalation through Health Informatics Programme Board as necessary.			

Strategic objectives links	1. Improving patient safety 2. Improving patient experience 3. Improving clinical effectiveness 4. Deliver key performance targets 5. Develop a robust and sustainable future 6. Improve workforce effectiveness
Board Assurance Framework links	1.1 Causing avoidable harm to patients 5.3 Inadequate resilience or preparedness for a major/ critical incident
CQC outcome/ regulation links	Regulation 9: Person-centred care Regulation 12: Safe care and treatment Regulation 17: Good governance
Identified risks and risk management actions	All risks are referenced on Datix.
Resource implications	Included within business case
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	First update report
Next steps	NA
Appendices	NA

Contents:

1. Purpose of the Report

To provide an update report to the Board on the progress of the eCARE Implementation programme

2. Context

Following the expiry of the nationally funded Local Service Provider (LSP) contract in October 2015, the Trust entered into a ten year contract with Cerner further to a successful procurement process. A Business Case was agreed and the eCARE programme was created in 4 stages, (1) the movement of all Trust data into its own Data Warehouse (DC Flip), (2) the upgrade to the latest code base (Phase A) and the subsequent implementation of (2&3) Phase B and C to enhance the system with clinical documentation and ordering.

The Trust successfully transferred the data centre from BT to Cerner, and completed a successful code upgrade in February 2016.

Since the completion of phase A in February 2016, the Trust has gone through significant internal consultation and analysis of impact of change of clinical modules and the phasing was agreed for Phase B and C and is as described below.

Phase B	Phase C
• Emergency Department • Maternity • Clinical Documentation – Adults – Nursing, Doctors and AHP's • Electronic Prescribing & Medication Administration - Adults • Order Communications • PAS Enhancements • Health Information Exchange (ability to see GP data and present MK data to the GP) • 724 (downtime back up system) • Vitalslink – vitals capture and direct integration into Cerner with no transcription	• Anaesthetics • Critical Care • Clinical Documentation – Paediatrics • Electronic Prescribing & Medication Administration – Paediatrics • Theatres Enhancements

Table 1: MKUH eCare Phases

Phase B commenced September 2016 and the main body of the report contains an overview of the progress to date.

3. Phase B Programme Plan and progress

3.1 Phase B Stages

The contract with Cerner includes the delivery of the programme using their project management framework known as 'Method M'. The Trust worked with Cerner to change the methodology within the build phase to include a more 'agile' approach. This involved the build of the system using Cerner's model content and the ability to view this prototype with designated clinicians and 'tweak' the system to meet the specific needs of the Trust.

The benefit of this approach is that operational and clinical leads across the Trust gain access to the system much earlier in the process and are considered more advanced in their system knowledge at this stage of the programme than they would have been if we had followed the standard Cerner methodology. They are able to change and test the system alongside Cerner throughout the process which also enables an understanding of the training and support required at go-live as well as the benefits that may be achieved and the risks that require mitigation.

Cerner separates the programme into 3 main phases shown below as:

Align

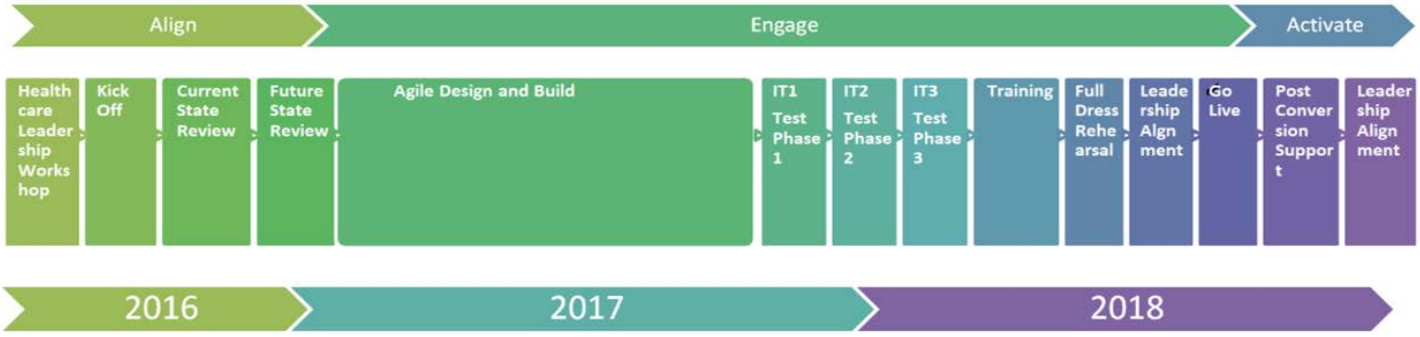
- Review of current processes and documentation against the model content as part of the programme
- Gap analysis against future state

Engage

- Completion of design of system and build
- All testing phases
- End User Training
- Dress Rehearsal

Activate

- The Go Live and support after Go Live



The Trust has completed the Align stage and is currently in the Engage phase, about to enter Integration Test Phase 3 (IT3). Key activities are focussed around testing the system, understanding the workflows and preparing for end user training.

3.2 Key Delivery Dates for the Remainder of Phase B

Task Name	Duration	Start	Finish
Integration Testing 2 - Test Window	15 days	20/11/2017	09/12/2017 Completed
Integration Testing 2 - Fix Window	10 days	04/12/2017	15/12/2017 Completed
Regression Testing (for IT3)	5 day	22/01/2018	26/01/2018
Proposed Date for IT3 Exit Checkpoint	1 day	23/01/2018	23/01/2018
Integration Testing 3 - Test Window	10 days	29/01/2018	09/02/2018
Integration Testing 3 - Fix Window	10 days	05/02/2018	16/02/2018
End User Training	40 days	19/02/2108	13/04/2018
Technical Full Dress Rehearsal	10 days	26/02/2018	09/03/2018
Operational Full Dress Rehearsal	10 days	12/03/2018	23/03/2018
Go-Live + ELS	10 days	14/04/2018	27/04/2018

Trust Go Live is scheduled for the weekend of 14th April 2018 and the programme is currently on track to meet this deadline. All identified issues and risks are being monitored daily within mitigating actions taken as required and are outlined later in this report.

3.3 Current Position in Integration Test Phase 2 (IT2)

Testing Phase 2 closed for testing on 15th December with completion of 92% of all front end workflows that were scheduled to be tested. The remaining 8% of untested workflows is due to outstanding change requests that require additional system building review / work and therefore time is allocated in January to complete these once the functionality is delivered.

Order Comms (requesting and reporting of diagnostic tests) and EPMA (electronic prescribing and medications administration) catalogue remains ongoing and the Information Team are testing that all clinical data inputted into the front end is available to be utilised in any reporting requirements in the future. This will complete in IT3 (Testing Phase 3).

3.4 Test Issues

During each testing phase any areas of the system that are found to not operate correctly are logged as a Test Issue for Cerner to fix following which these are returned to the Trust for re-testing. The current position is as follows:

Since the commencement of Phase B to date, 827 Test Issues have been raised, of these 612 are now closed and 47 have been fixed and are waiting re-testing by the Trust. The remaining numbers of open test issues are:

Priority 1 (P1) - 9
Priority 2 (P2) - 20
Priority 3 (P3) - 73
Priority 4 (P4) - 13
Priority 5 (P5) – 3

P1 and P2 issues are recognised to be significant issues that may have an impact operationally and are individually assessed by the operational and programme teams with escalation through the Clinical Advisory Group (CAG) and the Health Informatics Programme Board (HIPB) throughout the process.

P3, P4 and P5 test issues are not expected to have a detrimental operational effect on operation of the system, however, the cumulative effect of multiple P3's may result in an adverse impact which will be assessed through the Clinical Advisory Group (CAG) and Health Informatics Programme Board (HIPB).

The status and assessment of all test issues will be assessed throughout the programme and particularly prior to exit of IT3 and up until Go Live to ensure that the system is operationally safe to take live.

3.5 Training

The testing and training team are concentrating on the development of training materials and lesson plans for the commencement of the training period on 19th February. Training will run until 13 April 2018 to allow maximum time for staff to complete training prior to go live

The Training Schedule was published on 22nd December and all managers have been contacted to ratify their staff lists for training numbers and confirm training requirements.

Booking onto courses is expected to commence in early January 2018.

Super users and Floor Walkers are also currently being identified in each area following which specific training models will be developed to support these roles going forward.

3.6 Operational Readiness

The Health Informatics Programme Board (HIPB) is Chaired by the CEO who is the SRO (senior responsible officer) for the Programme. This reports into the monthly Management Board but in December the HIPB moved to fortnightly meetings to ensure closer oversight as the Programme activity increases towards go-live. Operational Steering Groups have been set up with an Executive lead as part of each working group. There are separate steering groups for training and communications which are also executively led. Each of these groups will report progress into an overarching Operational Readiness Board which is chaired by the Director of Clinical Services and has representation from the Chief Nurse and Medical Director. The Operational Readiness Board reports into the HIPB.

This governance structure is driving all activities required to ensure that the Trust is ready for Go Live, training is completed, benefits identified, the go live weekend is planned and all change management plans have been executed successfully.

The Clinical Advisory Group meets regularly under the direction of the Medical Director to review all design decisions for clinical safety and operational impact to the organisation.

A cutover manager has been appointed whose responsibility it is to plan every detail of the go live weekend and the full dress rehearsal to practice the actual cutover and move onto the upgraded system. This role will work very closely with the Trusts Emergency Preparedness, Response and Recovery Board to ensure all business continuity plans are in place and work through the Operational Readiness Board to ensure all plans are in place for Go Live to take place.

3.7 Devices

A Devices group chaired by the Deputy CEO has also been instrumental in reviewing potential options for device procurement to support implementation and operational working following go live. Procurement for devices is expected to commence in January 2018.

3.8 Risks and issues

Please see below a summary of key risks at present, all of which have mitigation plans in place and are regularly monitored. Any unacceptable risks are escalated through the Health Informatics Programme Board.

Test issue status

The agreed criteria for successfully exiting IT2 is zero P1's and zero P2's which currently has not been achieved. There is flexibility within the plan to resolve the issues without impacting the critical path or the go-live date. Cerner have committed to resolving the issues and the position is being reviewed on a daily basis and reported to the HIPB.

Resource to carry out all testing and training activities remains a risk

The programme is working in collaboration with the IT Department to ensure sufficient resource to carry out these activities against the plan. Additional staffs are being requested from the Trust to supplement the training and provide a valuable clinical perspective on the operational workflows.

Release of staff to training

This remains a risk which is being mitigated by publishing the training schedule as well as developing a blended learning approach specific to roles with e-learning material for additional support. The uptake of training will be monitored closely through the operational readiness group and the HIPB.

4. Recommendations/ Actions

The Board is asked to note the report on the status of the implementation of eCARE and acknowledge the key risks and the escalation through Health Informatics Programme Board as necessary.

Meeting title	**Board of Directors**	**Date: 5 January 2018**
Report title:	**CQUIN Update: Healthy Food (1b)**	**Agenda item: 3.6**
Lead director **Report author** **Sponsor(s)**	**Name: Lisa Knight** **Name: Marc Yerrell** **Name: Caroline Shaw**	**Title: Director of Patient Care and Chief Nurse** **Title: Acting Catering & Domestic Manager** **Title: Transformation Programme Manager**
FoI status:	**Public**	

Report summary				
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** x	**Decision** ☐
Recommendation	As part of CQUIN milestone requirements, the Board is asked to note progress to date against CQUIN indicator 1b: Healthy Food for NHS staff, visitors and patients.			

Strategic objectives links	2. Improving patient experience 4. Deliver key performance targets
Board Assurance Framework links	None
CQC outcome/ regulation links	Regulation 14: Meeting nutritional and hydration needs
Identified risks and risk management actions	None
Resource implications	None
Legal implications including equality and diversity assessment	This paper has been assessed to ensure it meets the general equality duty as laid down by the Equality Act 2010

Report history	N/A
Next steps	None required
Appendices	Appendix 1: Healthy Option Compliance audit

Contents:

1. Purpose of the Report

To provide Board with:-

- An overview of the Healthy Food Health and Wellbeing CQUIN
- An overview of planned activities to ensure continued delivery of the CQUIN

2. Context

The NHS England Commissioning for Quality and Innovation (CQUIN) framework supports improvements in the quality of services and the creation of new, improved patterns of care.

The CQUIN scheme is intended to deliver clinical quality improvements and drive transformational change. With these objectives in mind the scheme is designed to support the ambitions of the Five Year Forward View and directly link to the NHS Mandate and it focuses on two areas:

1. Clinical quality and transformational indicators - 13 indicators have been defined which aim to improve quality and outcomes for patients including reducing health inequalities, encourage collaboration across different providers and improve the working lives of NHS staff.
2. Supporting local areas:
    - Sustainability and Transformation Plans – reinforcing the critical role providers have in developing and implementing local STPs.
    - Local financial sustainability – encouraging providers and commissioners to work together to achieve financial balance and to complement the introduction of system control totals at STP level

Public Health England's (PHE) report "Sugar reduction – The evidence for action" published in October 2015 outlined the clear evidence behind focussing on improving the quality of food on offer across the country. Almost 25% of adults in England are obese, with significant numbers also being overweight. Treating obesity and its consequences alone currently costs the NHS £5.1bn every year. Sugar intakes of all population groups are above the recommendations, contributing between 12 to 15% of energy tending to be highest among the most disadvantaged who also experience a higher prevalence of tooth decay and obesity and its health consequences. Consumption of sugar and sugar sweetened drinks. It is important for the NHS to start leading the way on tackling some of these issues, starting with the food and drink that is provided & promoted in hospitals and the Healthy Food for NHS staff, visitors and patients looks to address these issues.

3. Actions taken

The 2017/18 Health food for NHS staff, visitors and patients CQUIN aims to build on work completed in 2016/17 to ensure that healthy options are available to patients at all time with MKUHFT taking an innovative approach to meeting indicator requirements. The Trust is required to ensure:

- 70% of drinks lines stocked must be sugar free (less than 5 grams of sugar per 100ml) including energy drinks, fruit juices with added sugar and milk based drinks with sugar content of over 10g per 100ml
- 60% of confectionery and sweets do not exceed 250kcal
- At least 60% of pre-packed sandwiches and other savoury pre-packed meals available contain 400kcal or less per serving

The Hotel Services department aims to always exceed the CQUIN targets whilst still keeping the customer happy through careful innovation and sourcing of new products, such as a carbonated drink containing 50% fruit juice and no added sugar which was brought in to replace a sugary drink. This particular product now far exceeds the sales of the original drink.

It is essential that the Trust continues respect consumer choice and through the League of Friends (LoF) and vending machines, a small selection of items such as crisps and chocolate will continue to be provided, however the Restaurant will be developed as a 'healthy hub' to improve the health and wellbeing of staff, visitors and patients that choose to dine with us. The emphasis is on fresh, good value, homemade and healthy food without unnecessary fat, sugar and salt.

To date, the Trust has taking a number of actions to meet the CQUIN requirements:

- Relationships formed between the League of Friends and Trust Catering Manager, with a commitment to work together on the CQUIN and promote healthier choices. Permission granted for the Acting Catering & Domestic Manager to audit LoF and offer advice on changing products where necessary
- Decision taken to remove all drinks with added sugar from the restaurant, but still offer the consumers choice from vending machines or the LoF
- Number of pre-packed sandwiches in the Eaglestone Restaurant & Eatery reduced to meet CQUIN target of 60% less than 400Kcal and 5g sat fat per 100g. Plans to remove pre-packed sandwiches were considered as well as commence a freshly made sandwich service
- The hot food menu in the Eaglestone Restaurant was overhauled to ensure that freshly made, home cooked food, and healthy options are available. Furthermore, fresh salad bowls were introduced at a discounted price to encourage healthy eating in the summer months, with increased offers of soups and vegetarian stews planned for winter
- Eaglestone Restaurant awarded 'most improved team' at the MK Hospital staff awards
- Management of Fresh Vend, the Trust cold food vending machine provider transferred to the League of Friends. LoF ensure that the machine is regularly topped up with freshly made sandwiches, healthy snacks and fruit etc.
- Vending agreement signed new suppliers which supports the CQUIN for the duration of the contract
- The Compass group, owners of Costa and Subway, report CQUIN compliance to NHS England
- High fat, high sugar, high salt (HFSS) items were removed from all meal deals and where applicable, replaced with healthy options such as water
- LoF introduced nutritional information on their sandwiches and significantly reduced the amount of pies & pasties sold
- Fresh fruit on all till points in the restaurant and LoF
- Milton Keynes Clinical Commissioning Group visit to review progress to date
- Regular audit of compliance across Trust food and drink providers are undertaken (Appendix 1)

In 2018, the Hotel Services department plans the following actions to support delivery:

- Pre-packed sandwiches to be removed from the Eaglestone Restaurant and replaced with freshly made, 100% CQUIN compliant sandwiches (i.e. all sandwiches will be under 400kcal) with staff training to commence January 2018
- Continued meetings with the LoF to further improve healthier eating options with joint strategies. The target is not just to meet CQUIN requirements, but exceed any target given

- Increased point of sale (POS) advertising and promotions with reference to healthy eating
- Regular meetings arranged with Trust dietitians to discuss new menu ideas
- Open an area available to staff 24/7, to allow staff to cook food or purchase from a hot food machine
- Host regular tasting sessions in the Eaglestone Restaurant, working with suppliers to showcase the latest CQUIN complaint items

Recommendations/ Actions

The Board is asked to note progress to date against CQUIN indicator 1b: Healthy Food for NHS staff, visitors and patients.

Appendix 1: Healthy Option Compliance audit

	Eaglestone Restaurant			League of Friends			Eatery			
	70% drinks sugar free	60% confectionary does not exceed 250kcal	60% pre-packed meals >400kcal	70% drinks sugar free	60% confectionary does not exceed 250kcal	60% pre-packed meals >400kcal	70% drinks sugar free	60% confectionary does not exceed 250kcal	60% pre-packed meals >400kcal	Actions
11.04.2017	Y	Y	Y	Y	Y	Y	Y	Y	Y	
15.05.2017	Y	Y	Y	Y	Y	Y	Y	Y	Y	
12.06.2017	Y	Y	Y	Y	Y	Y	Y	Y	Y	
19.07.2017	Y	Y	Y	Y	Y	Y	Y	Y	Y	
18.08.2017	Y	Y	Y	Y	Y	Y	Y	Y	Y	Sugar free drinks exclusively
15.09.2017	Y	Y	Y	Y	Y	Y	Y	Y	Y	
20.10.2017	Y	Y	Y	Y	Y	Y	Y	Y	Y	
16.11.2017	Y	Y	Y	Y	Y	Y	Y	Y	Y	
20.12.2017	Y	Y	Y	Y	Y	Y	Y	Y	Y	

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Trust Board	Date: 5 January 2018
Report title:	Performance Report indicators for 2017/18 (Month 8)	Agenda item: 4.1
Lead director Report author Sponsor(s)	Name: John Blakesley Name: Hitesh Patel	Title: Deputy Chief Executive Title: Associate Director of Performance and Information
FoI status:	Disclosable	

Report summary	Lists the proposed key performance metrics for the Trust for the financial year 2017/18			
Purpose *(tick one box only)*	Information [x]	Approval [ ]	To note [ ]	Decision [ ]
Recommendation				

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

Report history	None
Next steps	None
Appendices	None

Trust Performance Summary: M08 (November 2017)

1.0 Summary

This report summarises performance in November 2017.

The Trust continues to be dominated by non-elective demand with the lagging indicators showing the hospital under stress. With inpatient occupancy at over 98.8% the hospital will always perform inefficiently (as seen by ward discharges before midday, increasing readmissions and patients with a LoS >14 days) DToCs performance improved dramatically. Short term clinical quality appears unaffected with pressure ulcers and HCAI performing well.

This operational pressure directly affects the Trust's ability to meet the emergency access standard in A&E and we achieved 91.5% albeit against a national backdrop of England only achieving 88.9% placing the Trust at 61st (down from 44th) out of 137. In recent weeks the England position has been deteriorating significantly, however the Trust must attain performance in quarter 3 of over 90% to maintain access to STF funding.

Whilst on the elective side the RTT target was not achieved in month at 90.7% and may continue to deteriorate over the coming weeks. In October the England performance was 88.9% with MKUH being 54th out of 159 Trusts. Non admitted performance is holding up well but with many elective cancellations the admitted breached has increased by around 100. Of particular concern are the growing numbers of breaches over 52 weeks as this will ensure that we are seen as an outlier.

The Trust reported a deficit (on a control total basis before STF) of £1.9m, £0.2m adverse to plan. Improvements in income were offset by additional costs related to operational pressures as a result of high non-elective demand. The Trust is now £0.8m below its control total plan year to date.

2.0 Sustainability and Transformation Fund (STF)

Performance Improvement Trajectories

November 2017 performance against the Service Development and Improvement Plans (SDIP):

OBJECTIVE 4 - KEY TARGETS								
ID	Indicator	DQ Assurance	Target 17-18	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change
4.1	ED 4 hour target (includes UCS)		95%	92.0%	92.4%	91.5%	✗	▽
4.2	RTT Incomplete Pathways <18 weeks		92%	92.2%		91.7%	✗	▽
4.9	62 day standard (Quarterly)		85%	85%		88.7%	✓	△

ED performance was 91.5% for November 2017. This was below the national threshold of 95% and was also less than the Trust's NHS Improvement trajectory of 92%. On a more positive note, Trust performance compared favourably to the national A&E performance of 88.9% in November 2017.

The criteria to achieve the STF performance based funding for A&E during Q3 is yet to be confirmed at the time of writing. The Trust trajectory submitted to NHS Improvement at the beginning of the year was to achieve 91.7% during Q3. Actual performance for Q3 to date (to the end of November 2017) was 91.03%, meaning that the Trust is presently below the required level of performance.

The Trust did not achieve the referral to treatment (RTT) national operating standard of 92% during November 2017. The aggregate performance was 91.7% against an NHS Improvement trajectory of

92.2%. At the end of October 2017, NHS England reported that nationally 89.3% of patients waiting to start treatment (incomplete pathways) had been waiting for less than 18 weeks.

Cancer waiting times are reported quarterly, usually six weeks after the end of each quarter. During Q2 2017/18, the Trust exceeded the 85% national target for the 62 day referral to treatment waiting time standard, achieving 88.7%. This was better than the NHS Improvement trajectory and notably higher than the combined NHS England national performance of 82.2%.

3.0 Urgent and Emergency Care

Performance in urgent and emergency care operated under increasing winter pressure in November 2017. This presented a challenge in terms of delivering performance in the following series of KPIs:

ID	Indicator	DQ Assurance	Target 17-18	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change
2.4	Cancelled Ops - On Day		1.0%	1.0%	1.0%	1.5%	✗	▼
3.2	Ward Discharges by Midday		30%	30%	23.5%	20.7%	✗	▼
3.4	30 day readmissions		6.4%	6.4%	8.2%	8.0%	✗	▲
3.7	Delayed Transfers of Care		25	25		21	✓	▲
3.9	Ambulance Handovers >30 mins (%)		5%	5%	3.8%	8.8%	✗	▼
4.1	ED 4 hour target (includes UCS)		95%	92.0%	92.4%	91.5%	✗	▼

Cancelled Operations on the Day

The volume of operations that were cancelled on the day for non-clinical reasons during November 2017 increased markedly to 45 compared to 23 in the previous month. This was 1.5% of all planned elective operations, exceeding the 1% tolerance. Of those cancelled on the day, 27 (60%) were due to no beds available in the Trust. The availability of theatre staff was described as the second most frequent reason for cancellation, contributing to eight cancelled procedures (18% of the total).

Readmissions

The 30 day readmission rate continued above the 6.4% threshold but did reduce to 8.0%. This was the lowest rate since June 2017. The rate for Medicine was improved to 12.6%, the lowest reported rate since May 2017. The rate for Surgery reduced to 4.6% (the lowest in the year to date). The rate in Women and Children however increased to 4.6%, which was the highest rate reported within this division for more than two years. This increase was influenced by Paediatric readmissions.

Delayed Transfers of Care (DTOC)

The volume of DTOC reported internally within the Trust on the last Thursday of November 2017 was reduced to 21; the lowest since January 2014. The low volume was reported as below 30 for a seven day period from 24th to 30th November 2017 after a steady reduction during the month.

Ambulance Handovers

The number of ambulance handovers that took longer than 30 minutes breached the 5% threshold for the first time in the year to date. It was reported that 8.8% of ambulance handovers (159) took longer than 30 minutes in November 2017 (35 of which waited for longer than 60 minutes).

4.0 Elective Pathways

ID	Indicator	DQ Assurance	Target 17-18	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change
3.1	Overnight bed occupancy rate		93%	93%	96.5%	98.8%	✗	▲
3.5	Follow Up Ratio		1.50	1.50	1.53	1.48	✓	▲
4.2	RTT Incomplete Pathways <18 weeks		92%	92.2%		91.7%	✗	▼
5.6	Outpatient DNA Rate		5%	5%	5.9%	5.4%	✗	▲

Overnight Bed Occupancy

Overnight bed occupancy in the Trust continued above the 93% threshold, but did reduce a little compared to October 2017. However, at 98.8% it remained high which can increase the risk of infection and also affect the timely admission of patients presenting to ED or for booked surgery.

Follow up Ratio

The follow up ratio was below the threshold for the first time since May 2017 at an average of 1.48 follow up attendances for every new attendance seen in November 2017. This may be an indication of an increase in first outpatient attendances as opposed to a reduction in follow up activity.

RTT Incomplete Pathways

The Trust did not achieve either the national or NHS Improvement target for incomplete pathways at the end of November 2017. The number of patients on an RTT waiting list for more than 18 weeks without receiving treatment was over 1,000 for the first time since October 2016. Six patients at the end of November 2017 were reported as having waited for more than 52 weeks.

Diagnostic Waits <6 weeks

The Trust continued to meet the standard of less than 1% of patients waiting six weeks or longer for a Diagnostic test at the end of November 2017. Early diagnosis is important to patients and is also key to improving outcomes and minimising waiting times for patients on an RTT pathway. ENDS

Performance Report 2017/18
November 2017 (M08)

Milton Keynes University Hospital NHS Foundation Trust

OBJECTIVE 1 - PATIENT SAFETY										
ID	Indicator	DQ Assurance	Target 17-18	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
1.1	Mortality - (HSMR)		100	100		90.8	✓	▲		
1.2	Mortality - (SHMI) - Quarterly		1	1		1.01	✗	▲		
1.3	Never Events		0	0	3	0	✓	▬	✗	
1.4	Clostridium Difficile		20	13	7	1	✓	▬	✓	
1.5	MRSA bacteraemia		0	0	3	0	✓	▬	✗	
1.6	Pressure Ulcers Grade 2, 3 or 4 (per 1,000 bed days)		0.86	0.86	0.55	0.44	✓	▼	✓	
1.7	Falls with harm (per 1,000 bed days)		0.19	0.19	0.13	0.07	✓	▲	✓	
1.8	WHO Surgical Safety Checklist		100%	100%	100%	100%	✓	▬	✓	
1.9	Midwife : Birth Ratio		30	30	30	29	✓	▬	✓	
1.10	Incident Rate (per 1,000 bed days)		40	40	33.54	33.38	✗	▲	✗	
1.11	Duty of Candour Breaches (Quarterly)		0	0	0	0	✓	▬	✓	
1.12	E-Coli		TBC	TBC	19	1		▲		

OBJECTIVE 2 - PATIENT EXPERIENCE										
ID	Indicator	DQ Assurance	Target 17-18	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
2.1	FFT Recommend Rate (Patients)		94%	94%	94%	94%	✓	▬	✓	
2.2	RED Complaints Received		10	7	2	1	✗	▬	✓	
2.3	Complaints response in agreed time		90%	90%	85.8%	84.3%	✗	▼	✗	
2.4	Cancelled Ops - On Day		1.0%	1.0%	1.0%	1.5%	✗	▼	✓	
2.5	Over 75s Ward Moves at Night		2,000	1333	1,873	227	✗	▲	✗	
2.6	Mixed Sex Breaches		0	0	4	0	✓	▬	✗	

OBJECTIVE 3 - CLINICAL EFFECTIVENESS										
ID	Indicator	DQ Assurance	Target 17-18	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
3.1	Overnight bed occupancy rate		93%	93%	96.5%	98.8%	✗	▲	✗	
3.2	Ward Discharges by Midday		30%	30%	23.5%	20.7%	✗	▼	✗	
3.3	Weekend Discharges		70%	70%	69.4%	59.7%	✗	▼	✗	
3.4	30 day readmissions		6.4%	6.4%	8.2%	8.0%	✗	▲	✗	
3.5	Follow Up Ratio		1.50	1.50	1.53	1.48	✓	▲	✗	
3.6	Number of Patients with LOS >14 Days		120	120		136	✗	▲		
3.7	Delayed Transfers of Care		25	25		21	✓	▲		
3.8	Discharges from PDU (%)		16%	16%	13.1%	14.8%	✗	▲	✗	
3.9	Ambulance Handovers >30 mins (%)		5%	5%	3.8%	8.8%	✗	▼	✓	

OBJECTIVE 4 - KEY TARGETS										
ID	Indicator	DQ Assurance	Target 17-18	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
4.1	ED 4 hour target (includes UCS)		95%	92.0%	92.4%	91.5%	✗	▼	✓	
4.2	RTT Incomplete Pathways <18 weeks		92%	92.2%		91.7%	✗	▼		
4.3	RTT Patients Waiting Over 18 Weeks		911	890		1093	✗	▼		
4.4	RTT Total Open Pathways		11,388	11,412		13,210	✗	▼		
4.5	RTT Patients waiting over 52 weeks			0		6	✗	▼		
4.6	Diagnostic Waits <6 weeks		99%	99%		99.1%	✓	▼		
4.7	All 2 week wait all cancers (Quarterly)		93%	93%		95.6%	✓	▼		
4.8	31 days Diagnosis to Treatment (Quarterly)		96%	96%		100.0%	✓	▬		
4.9	62 day standard (Quarterly)		85%	85%		88.7%	✓	▲		

OBJECTIVE 5 - SUSTAINABILITY										
ID	Indicator	DQ Assurance	Target 17-18	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
5.1	GP Referrals Received		60,189	40,530	41,015	5,439	✓	▼	✓	
5.2	A&E Attendances		89,338	58,743	59,930	7,239	✓	▼	✓	
5.3	Elective Spells (PBR)		26,524	17,853	17,064	2,232	✗	▲	✗	
5.4	Non-Elective Spells (PBR)		32,365	21,628	22,636	3,082	✓	▲	✓	
5.5	OP Attendances / Procs (Total)		376,752	253,194	236,098	31,560	✗	▲	✗	
5.6	Outpatient DNA Rate		5%	5%	5.9%	5.4%	✗	▲	✗	

OBJECTIVE 7 - FINANCIAL PERFORMANCE										
ID	Indicator	DQ Assurance	Target 17-18	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
7.1	Income £'000		223,967	148,299	147,281	19,292	✓	▲	✗	
7.2	Pay £'000		(158,813)	(106,122)	(105,692)	(13,496)	✗	▼	✓	
7.3	Non-pay £'000		(67,625)	(44,611)	(47,260)	(6,059)	✗	▲	✗	
7.4	Non-operating costs £'000		(12,954)	(8,556)	(8,186)	(1,024)	✓	▼	✓	
7.5	I&E Total £'000		(15,426)	(10,990)	(13,857)	(1,287)	✗	▲	✗	
7.6	Cash Balance £'000		2,504	3,303		3,386	✓	▼		
7.7	Savings Delivered £'000		10,500	5,469	3,923	571	✗	▼	✗	
7.8	Capital Expenditure £'000		(28,389)	(9,925)	(6,497)	(1,097)	✓	▼	✓	

OBJECTIVE 8 - WORKFORCE PERFORMANCE										
ID	Indicator	DQ Assurance	Target 17-18	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
8.1	Staff Vacancies % of establishment		14%	14%		12.0%	✓	▲		
8.2	Agency Expenditure %		10%	10%	7.5%	6.5%	✓	▲	✓	
8.3	Staff sickness - % of days lost		4%	4%		4.2%	✗	▬		
8.4	Appraisals		90%	90%		84.0%	✗	▬		
8.5	Statutory Mandatory training		90%	90%		89.0%	✗	▼		
8.6	Substantive Staff Turnover		14%	14%		11.6%	✓	▲		
8.7	FFT Response Rate Staff (Quarterly)		18%	18%	20.4%	19.8%	✓	▼	✓	

OBJECTIVES - OTHER										
ID	Indicator	DQ Assurance	Target 17-18	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
O.1	Total Number of NICE Breaches		8	8		60	✗	▲		
O.2	Rebooked cancelled OPs - 28 day rule		95%	95%	73.4%	56.5%	✗	▼	✗	
O.3	Maternity Bookings <13 weeks		90%	90%	87.5%	88.0%	✗	▲	✗	
O.4	Overdue Datix Incidents >1 month		0	0		30	✗	▲		
O.5	Serious Incidents		58	39	33	0	✓	▲	✓	
O.6	Dementia Measures Met ✎		3	3		3	✓	▬		
O.7	Energy Consumption (GJ)		200,684	126,987	153,178	20,995	✗	▲	✗	
O.8	Completed Job Plans (Consultants)		90%	90%		91%	✓	▲		

Key: Monthly/Quarterly Change

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

YTD Position

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

Data Quality Assurance Definitions

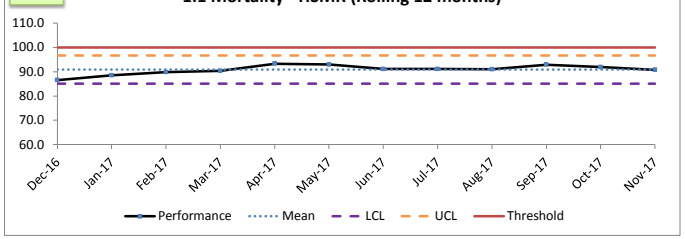
Rating	Data Quality Assurance
Green	Satisfactory and independently audited (indicator represents an accurate reflection of performance)
Amber	Acceptable levels of assurance but minor areas for improvement identified and potentially independently audited * /No Independent Assurance
Red	Unsatisfactory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

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

Milton Keynes University Hospital NHS Foundation Trust

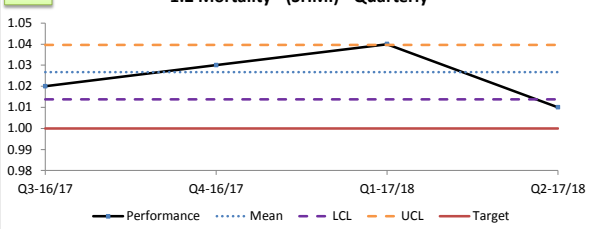
SD=3

1.1 Mortality - HSMR (Rolling 12 months)

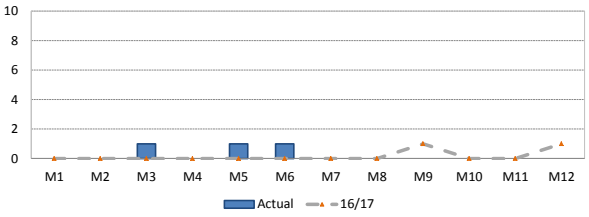


SD=3

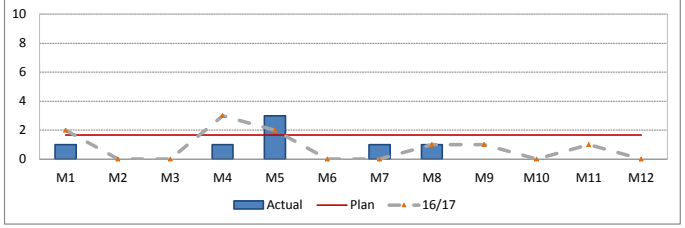
1.2 Mortality - (SHMI) - Quarterly



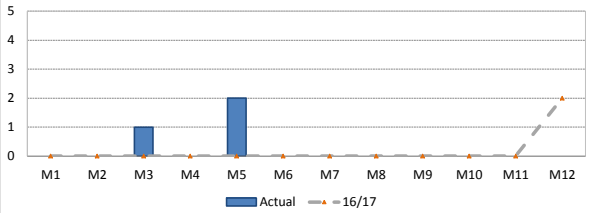
1.3 - Never events



1.4 - C.Diff Infections

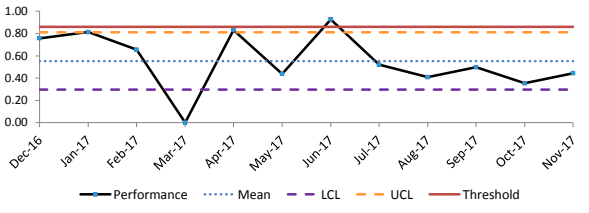


1.5 - MRSA Bacteraemia



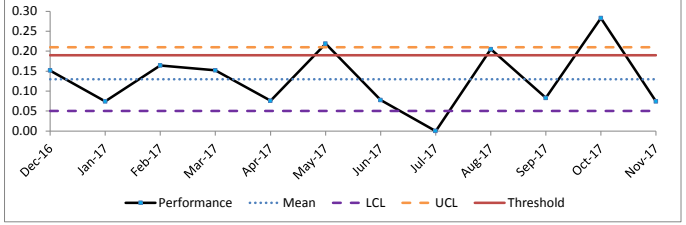
SD=1

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

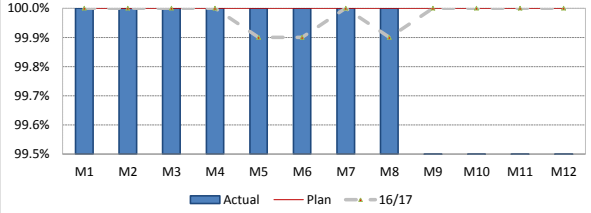


SD=1

1.7 - Inpatient falls causing harm

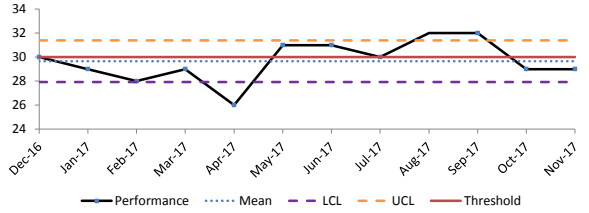


1.8 - WHO Surgical Safety Checklist



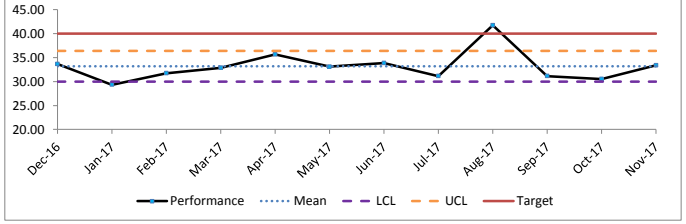
SD=1

1.9 - Midwife to Birth Ratio

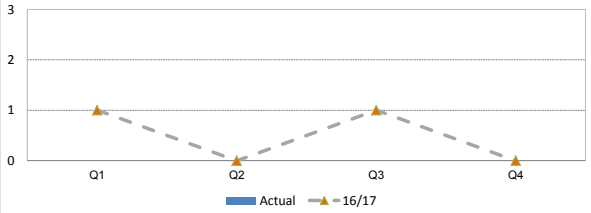


SD=1

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



1.11- Duty of Candour Breaches



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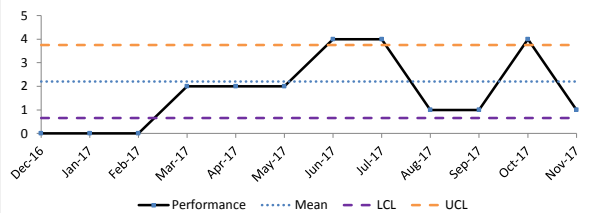
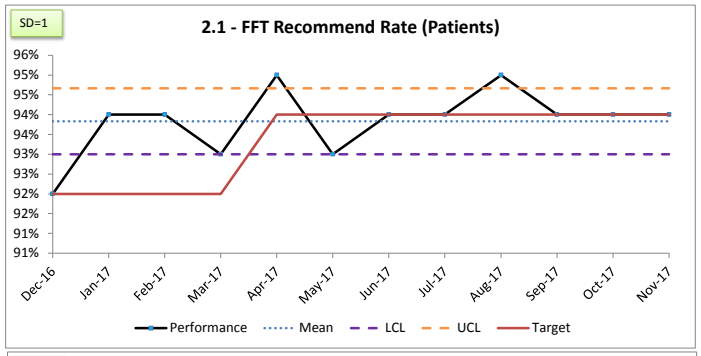
1.12 - E-Coli

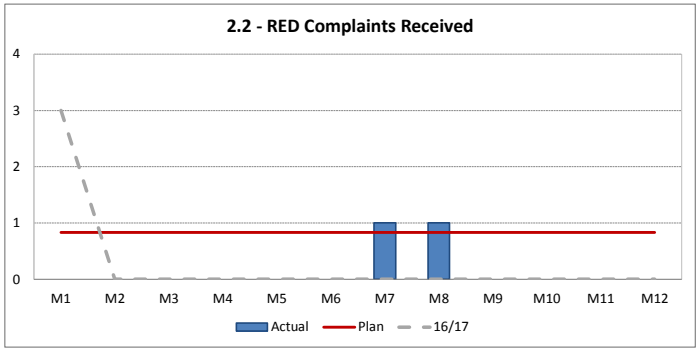


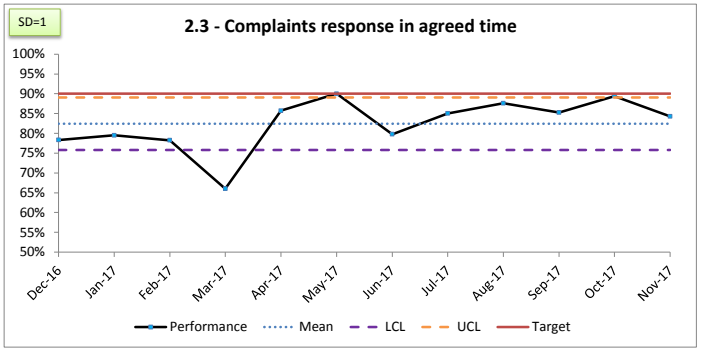
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

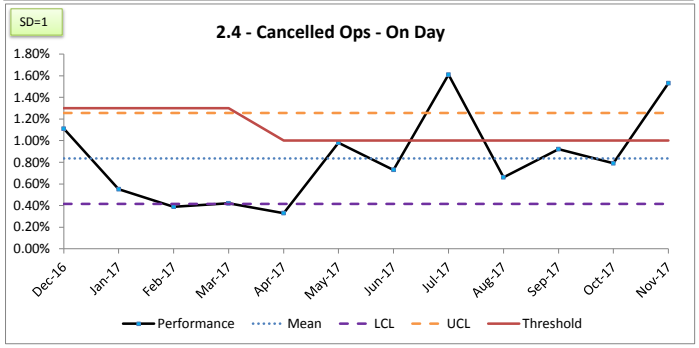
- Performance activity on a rolling 12 months/quarterly
- Average on a rolling 12 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

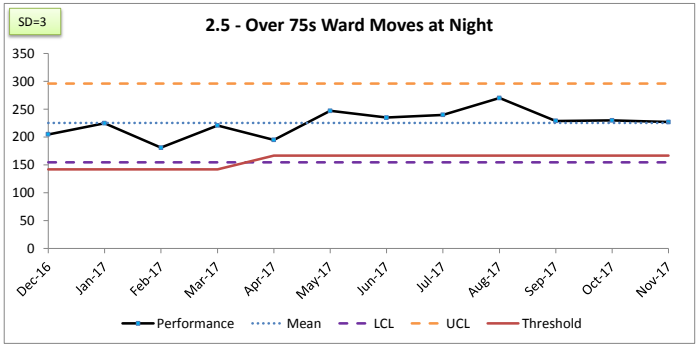
OBJECTIVE 2 - PATIENT EXPERIENCE

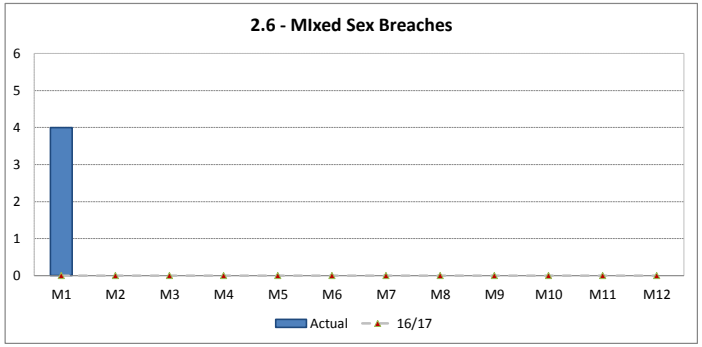












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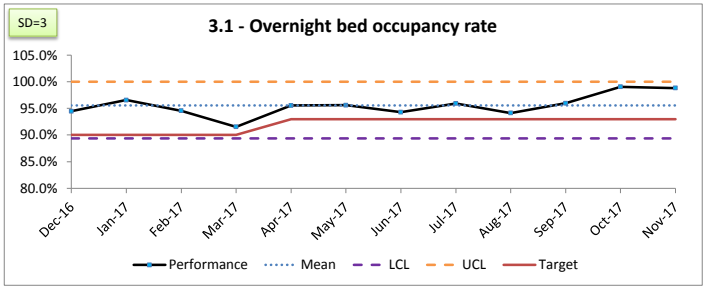
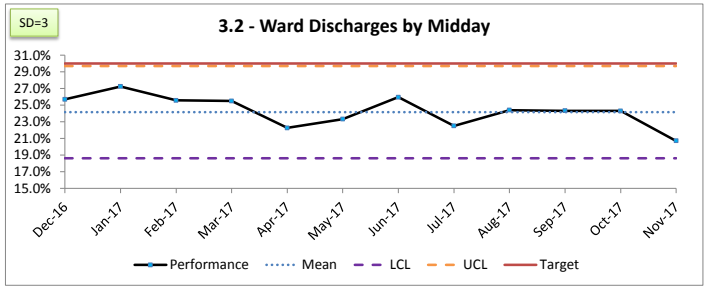
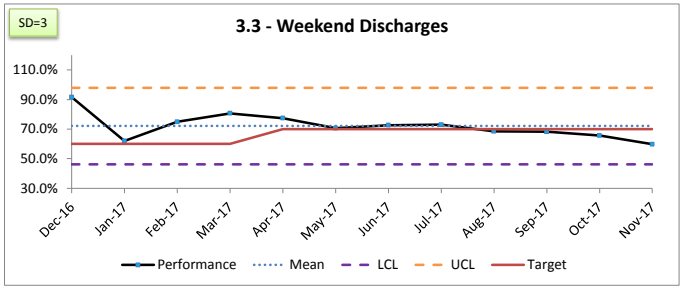
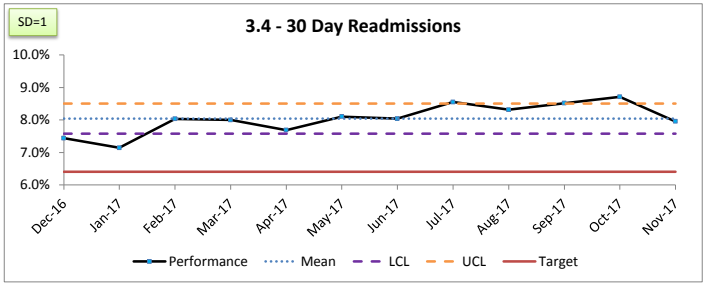
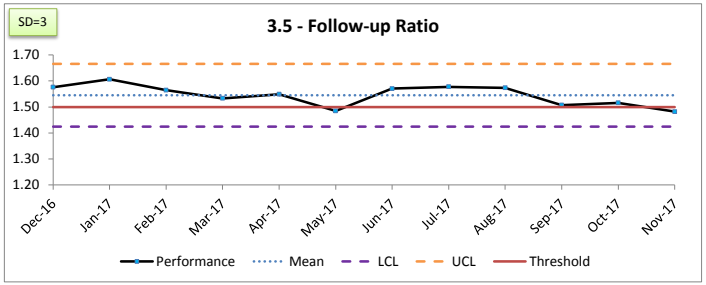
OBJECTIVE 3 - CLINICAL EFFECTIVENESS

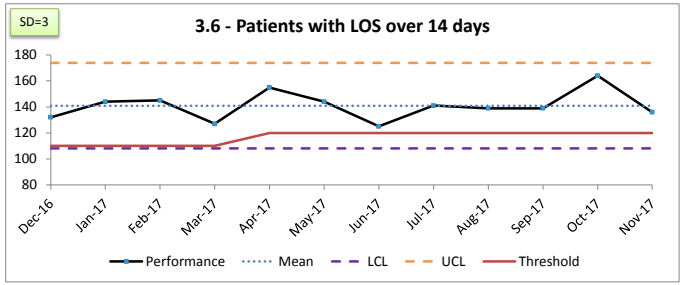


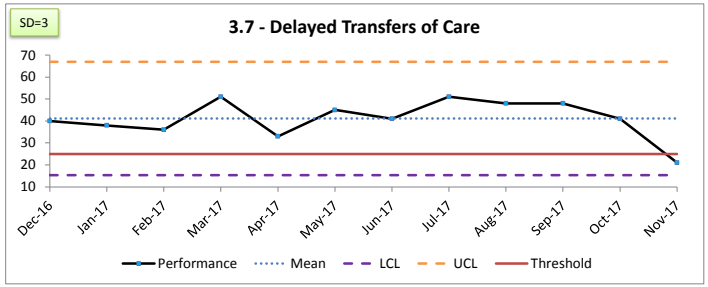


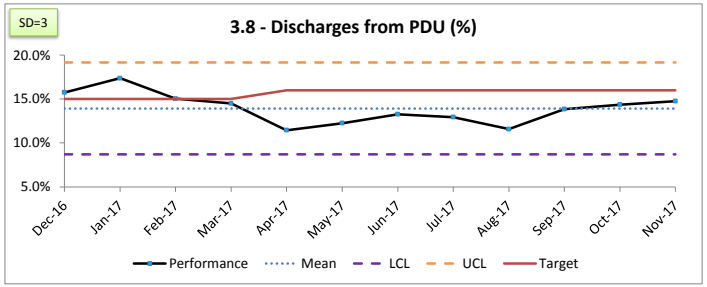


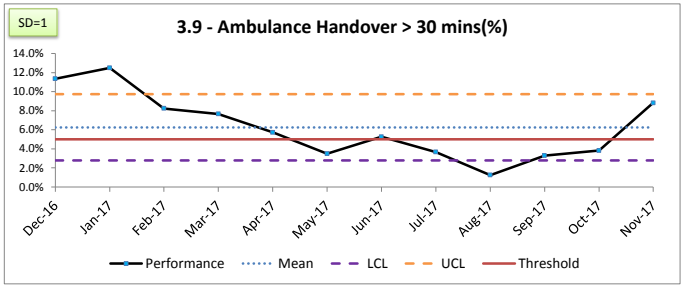












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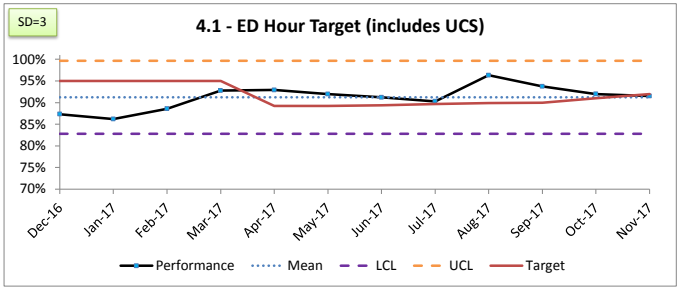
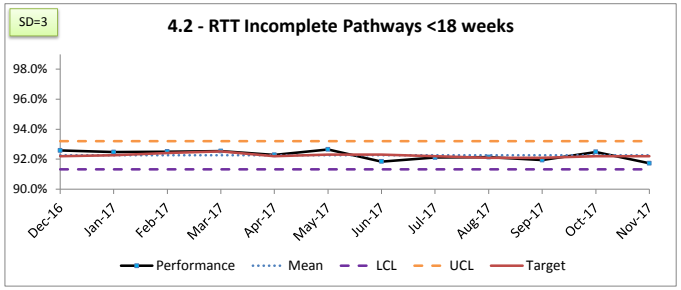
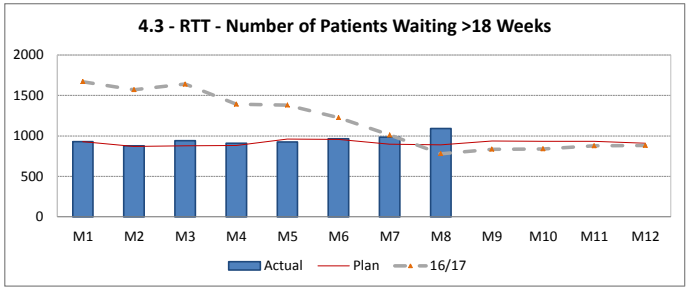
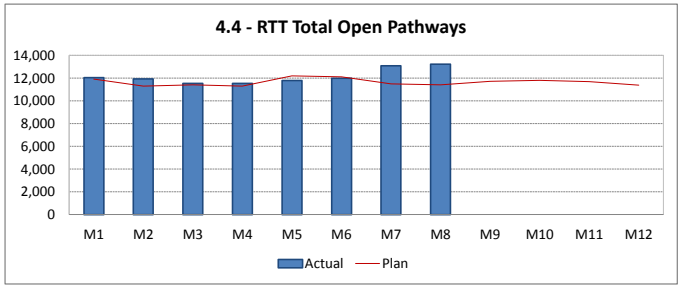
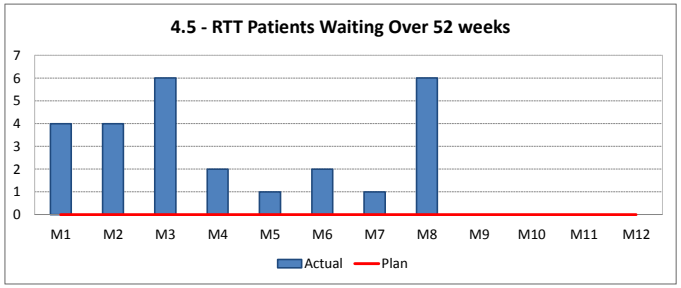
OBJECTIVE 4 - KEY TARGETS

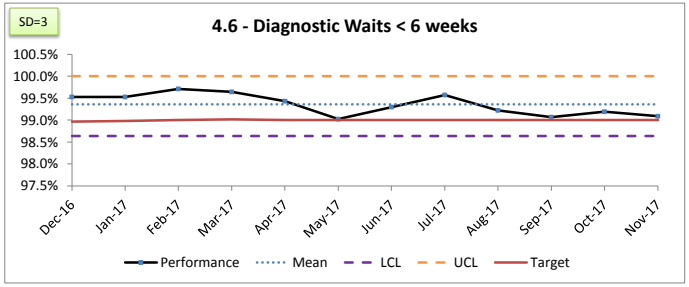


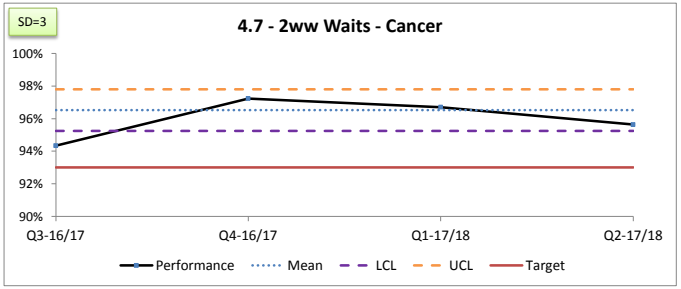


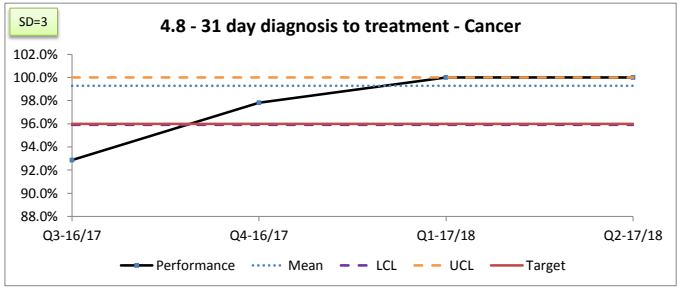


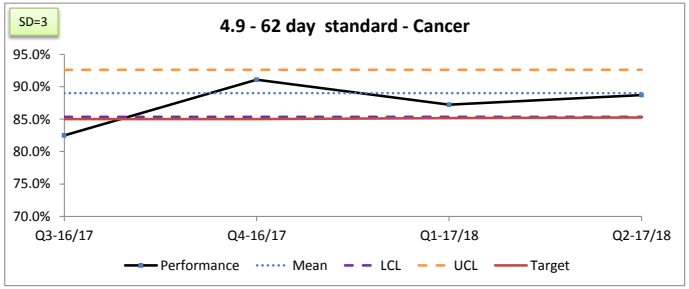












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- Performance activity on a rolling 12 months/quarterly
- Average on a rolling 12 months/quarterly
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- Upper Control Limit
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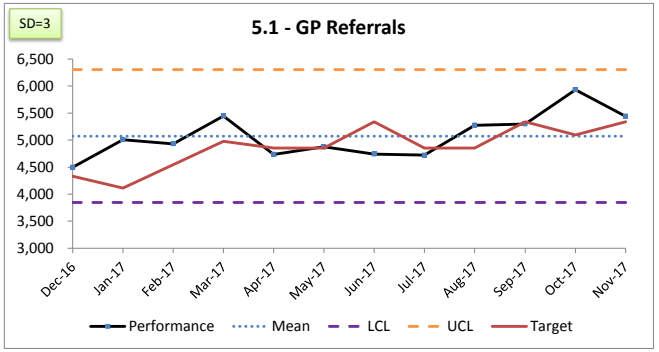

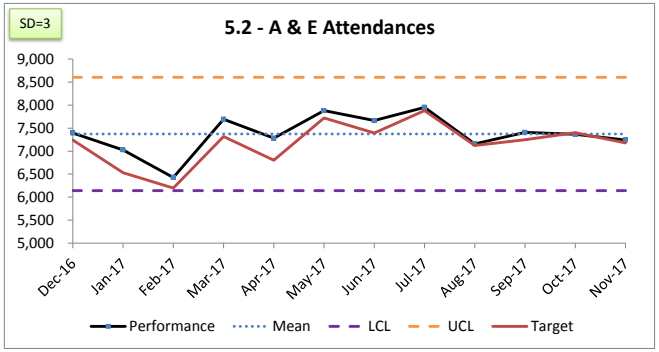

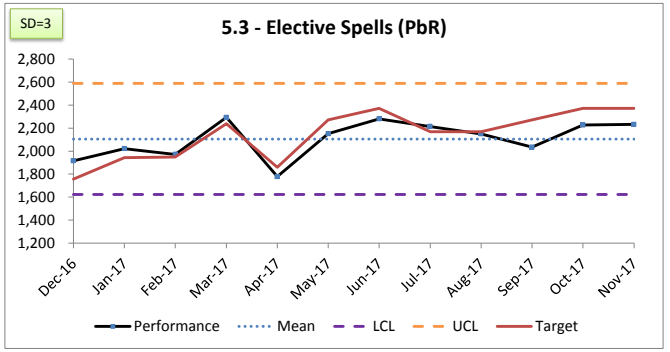

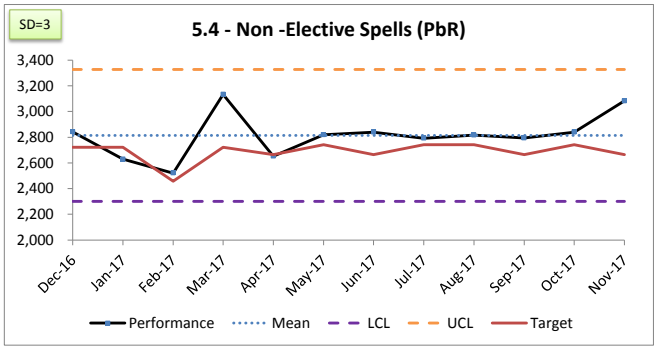

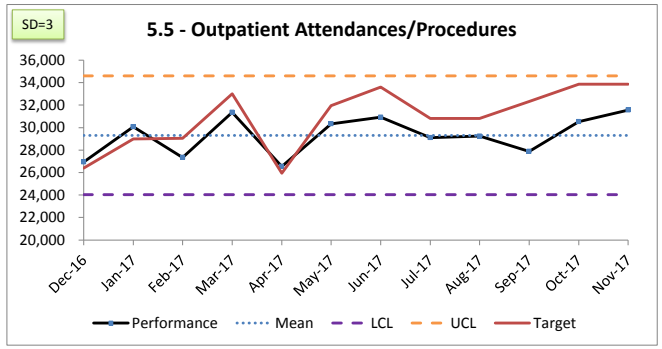

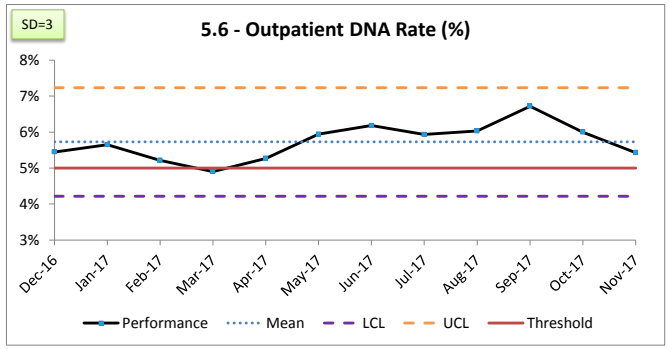

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- Average on a rolling 12 months/quarterly
- Lower Control Limit (LCL)
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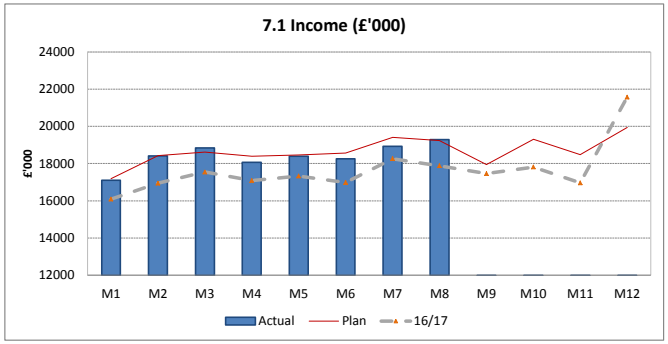
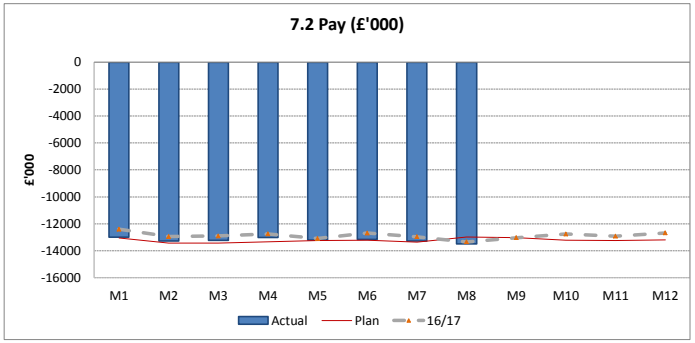
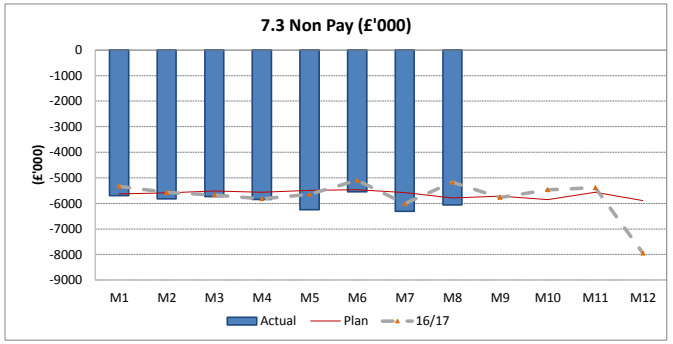
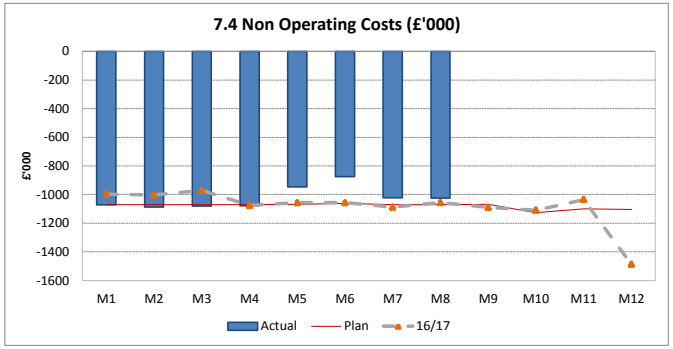
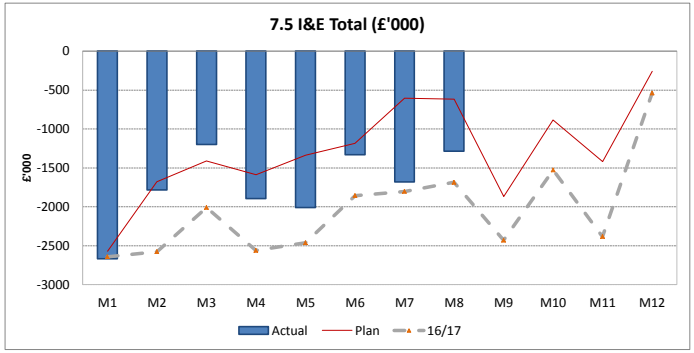
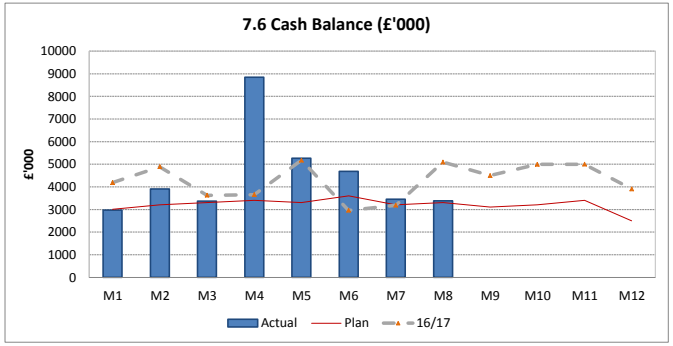

7.1 Income (£'000)
£'000
24000
22000
20000
18000
16000
14000
12000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
16/17

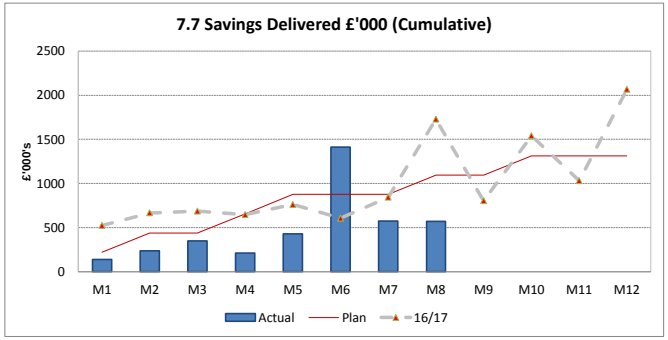

7.2 Pay (£'000)
£'000
0
-2000
-4000
-6000
-8000
-10000
-12000
-14000
-16000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
16/17

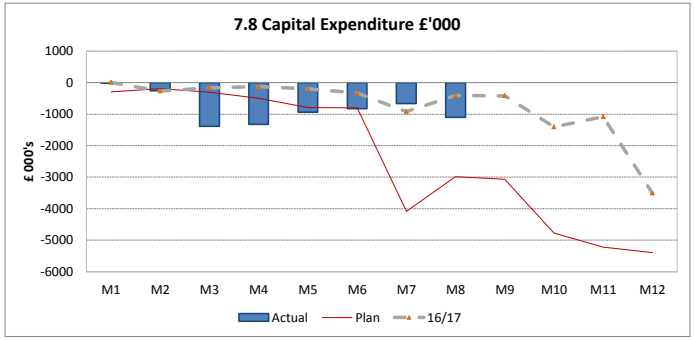

7.3 Non Pay (£'000)
(£'000)
0
-1000
-2000
-3000
-4000
-5000
-6000
-7000
-8000
-9000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
16/17


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

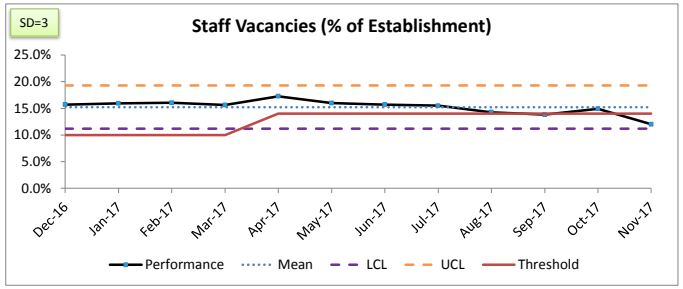

7.5 I&E Total (£'000)
£'000
0
-500
-1000
-1500
-2000
-2500
-3000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
16/17

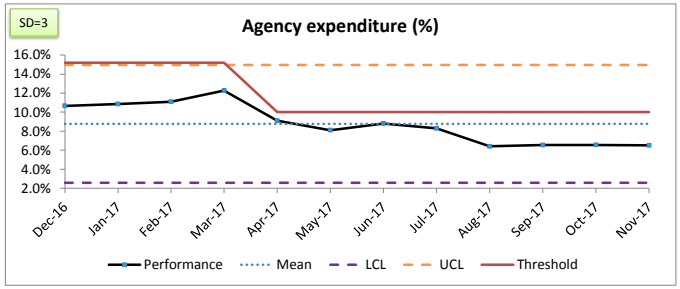

7.6 Cash Balance (£'000)
£'000
10000
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
16/17

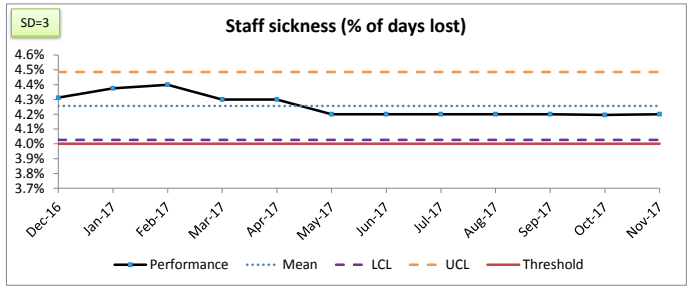

7.7 Savings Delivered £'000 (Cumulative)
£'000's
2500
2000
1500
1000
500
0
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
16/17

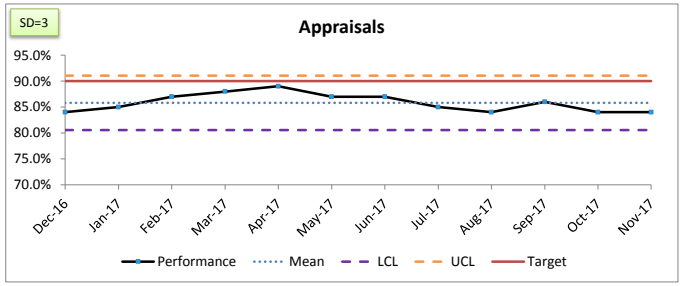

7.8 Capital Expenditure £'000
£'000's
1000
0
-1000
-2000
-3000
-4000
-5000
-6000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
16/17

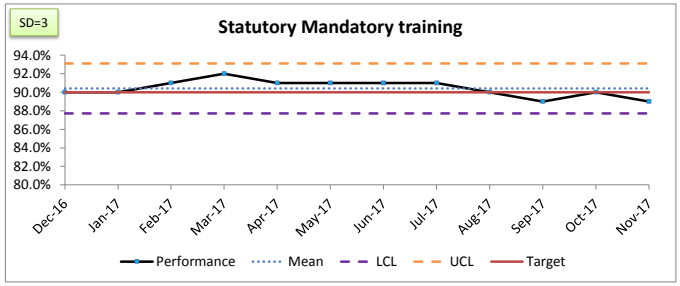
OBJECTIVE 8 - WORKFORCE PERFORMANCE

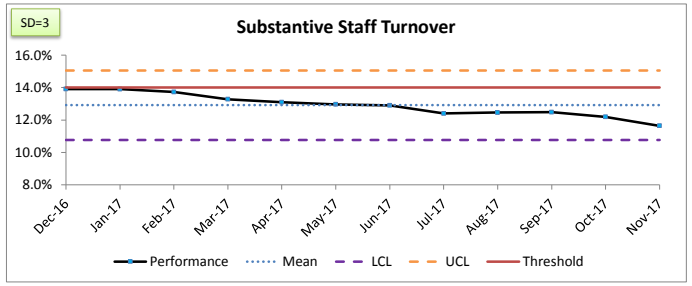


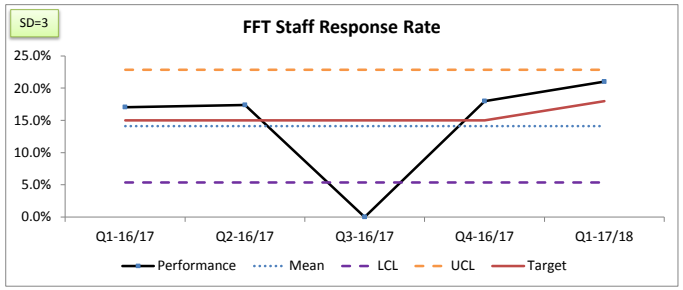












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- Performance activity on a rolling 12 months/quarterly
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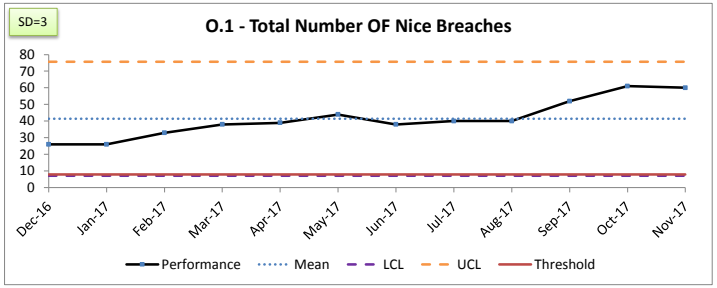
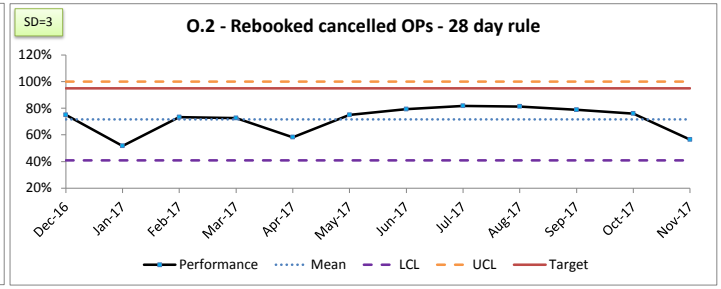
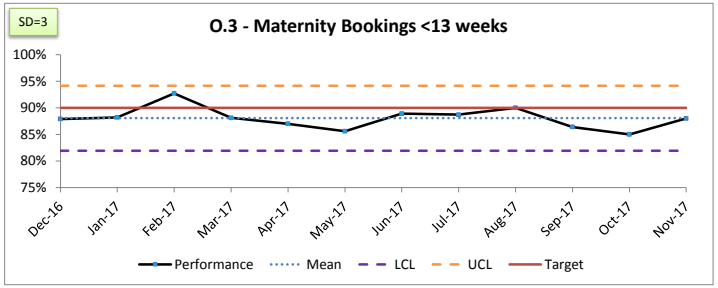
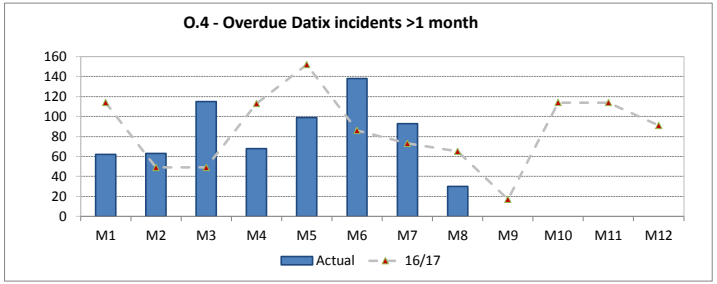
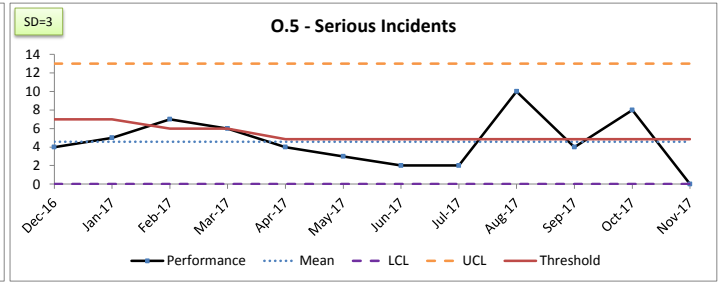
OBJECTIVES - OTHER

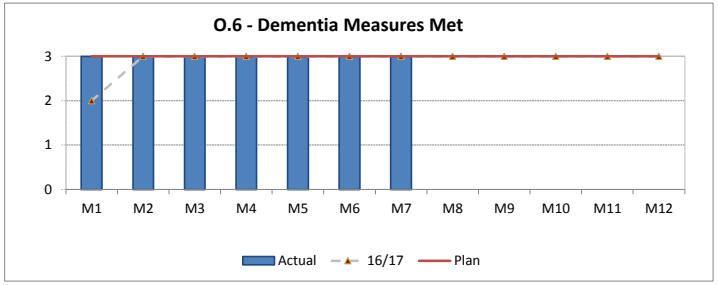


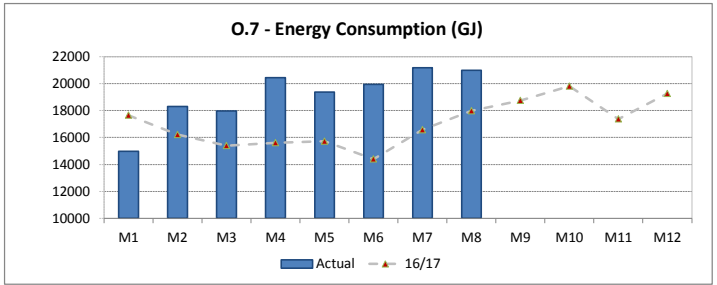


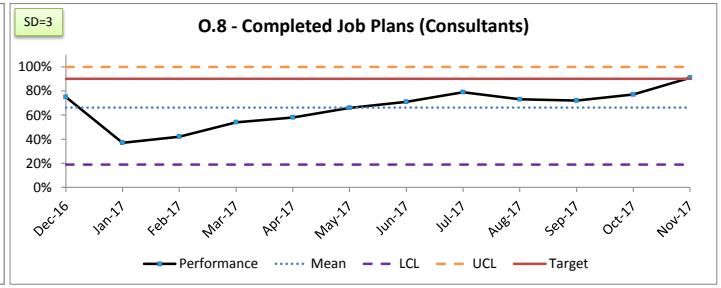












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Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Public Board	Date: 5 January 2018
Report title:	**Finance Paper Month 8 2017-18**	**Agenda item: 4.2**
Lead director **Report authors**	Mike Keech Daphne Thomas Christopher Panes	Director of Finance Deputy Director of Finance Head of Management Accounts
FoI status:	Public document	

Report summary	An update on the financial position of the Trust at Month 8 (November 2017)			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** X	**Decision** ☐
Recommendation	The Trust Board is asked to note the contents of the paper.			

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

Report history	None
Next steps	To receive future updates on the Trust's financial position.
Appendices	1 to 3

FINANCE REPORT FOR THE MONTH TO 30th NOVEMBER 2017

PUBLIC BOARD MEETING

PURPOSE

1. The purpose of the paper is to:

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

EXECUTIVE SUMMARY

2. *Income and expenditure* – On a control total basis the Trust's deficit for November 2017 was £1.3m which is £0.7m adverse to plan and £0.2m adverse to the control total in month. Year to date the Trust is £2.9m adverse to Plan and £0.8m adverse to its control total.

3. *Cash and capital position* – the cash balance as at the end of November 2017 was £3.4m, which was £0.1m above plan. The Trust has spent £6.5m on capital year to date; however it is still waiting for formal approval on the proposed 17/18 capital plan by NHS Improvement.

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

5. *Cost savings* – overall savings of £0.6m were delivered in month against an identified plan of £0.5m. Overall £5.4m of plans has been identified and validated against a £10.5m target.

INCOME AND EXPENDITURE

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

All Figures in £'000	Month Plan	Month Actual	Month Var	YTD Plan	YTD Actual	YTD Var	Full Year Plan	Full Year Forecast	Full Year Var
Clinical Revenue	16,590	16,992	402	130,672	130,811	139	194,357	196,984	2,627
Other Revenue	1,461	1,570	109	11,740	12,454	714	18,310	19,219	909
Total Income	18,051	18,562	510	142,411	143,265	853	212,667	216,203	3,536
Pay	(13,039)	(13,496)	(457)	(106,251)	(105,690)	561	(158,813)	(159,813)	(1,000)
Non Pay	(5,791)	(6,059)	(267)	(44,611)	(47,260)	(2,649)	(67,625)	(70,806)	(3,181)
Total Operational Expend	(18,830)	(19,554)	(724)	(150,862)	(152,950)	(2,089)	(226,438)	(230,619)	(4,181)
EBITDA	(779)	(993)	(214)	(8,451)	(9,686)	(1,235)	(13,772)	(14,416)	(644)
Financing & Non-Op. Costs	(1,020)	(969)	51	(8,159)	(7,748)	411	(12,354)	(11,708)	646
Operational net Surplus/(Deficit)	**(1,799)**	**(1,962)**	**(163)**	**(16,610)**	**(17,434)**	**(824)**	**(26,125)**	**(26,124)**	**1**
Adjustments to reach control total:									
Performance STF	219	219	0	1,205	1,205	0	2,190	2,190	0
Financial STF	511	511	0	2,811	2,811	0	5,110	5,110	0
Control Total Deficit (incl. STF)	**(1,069)**	**(1,232)**	**(163)**	**(12,594)**	**(13,418)**	**(824)**	**(18,825)**	**(18,824)**	**1**
Donated income	500	0	(500)	2,000	0	(2,000)	4,000	4,000	0
Donated asset depreciation	(50)	(55)	(5)	(397)	(439)	(42)	(600)	(659)	(59)
Reported deficit	**(619)**	**(1,287)**	**(668)**	**(10,991)**	**(13,857)**	**(2,867)**	**(15,425)**	**(15,483)**	**(58)**

Monthly and year to date review

7. The **deficit** in month 8 is £1.3m which is £0.7m adverse against a planned deficit of £0.6m and £2.7m adverse year to date against a planned deficit of £11.0m. However, the plan includes donations and other items that are excluded from the control total calculation – adjusting for these the Trust's performance YTD is £824k adverse to its month 8 control total of £16.6m.

8. **Income** (excluding STF and donations) was £510k above plan in month 8 by £10k and £853k above plan YTD;

   There were a number of underlying activity variances in the month - continued lower than planned activity across maternity and electives has been more than offset by non-elective income and pass-through income for high costs drugs. Performance on outpatients improved in month to be in line with plan.

   Further analysis of the income position can be found in Appendix 1.

9. **Operational costs** in November are adverse to plan by £724k and adverse £2,089k YTD. Further detail on pay and non-pay variances is include below.

10. **Pay costs** are £457k adverse to budget in Month 8 and £561k favourable YTD. Positive variance on agency and locum is offset by higher substantive and bank expenditure. Additional staff costs were incurred in month in order to manage high levels of non-elective activity. Despite the increase in staff costs, agency spend remains below planned levels.

11. Non pay costs were £267k adverse to plan in month and £2,649k YTD. The main cause of the overspend in month was high cost drug spend which is matched by income.

12. Non-operational costs are £46k positive in month and £369k YTD. The in-month and YTD variance is due to positive variances against budgeted loan interest

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

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COST SAVINGS

13. In Month 8, £571k was delivered against an identified plan of £482k and £3,923k of an identified plan of £3,399k YTD. A total of £3,923k has been delivered against a budgeted target of £5,469k leaving an adverse variance of £1,546k.

14. Only £5.4m of plans have been identified against a target of £10.5m and this is clearly a risk to delivering the full year Plan.

CASH AND CAPITAL

15. The cash balance at the end of November 2017 was £3.4m, which was £0.1m above plan.

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

    - Current assets are above plan by £3.4m. The main variance relates to receivables £2.8m, inventories £0.5m and cash £0.1m above plan.

    - Current liabilities are above plan by £37.6m. This is being driven by the re-categorisation of part of the NHSI loan from non-current to current borrowings £31.1m, provisions £0.4m, Deferred Income £0.1m and Trade and Other Creditors £5.9m above planned levels

27. The Trust has spent a total of £6.5m on capital year to date; however the Trust has still not received a decision on its capital loan application submitted to the Department of Health in July 2017. Receipt of the capital loan to support the capital programme is becoming increasingly urgent.

RISK REGISTER

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

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

    Funding to cover the planned financial deficit in 2017/18 is subject to approval by DH on a monthly basis. Capital funding has also not yet been agreed but is becoming increasingly urgent.

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

The Trust has a challenging target of £10.5m to deliver for the 2017/18 financial year. At month 8 the Trust is behind plan on delivery, but is working to accelerating scheme identification.

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

The Trust has an annual agency ceiling of £15.12m in 2017-18 which is in line with the level included in the financial plan. At month 8, the Trust's spend is favourable to planned levels and is forecast to achieve the full year target.

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

In order to receive the full amount of Sustainability and Transformation funding in 2017-18, the Trust needs to achieve its financial control total (linked to 70% of funding), and meet performance standards in respect of urgent and emergency care (linked to 30% of funding). The targets are measured on a quarterly basis. The Trust met its requirements for quarter 1 and quarter 2 but meeting the targets for the remainder of the financial year will be increasingly challenging.

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

If the Trust over performs against the contract this places financial pressure on the Trust's commissioners who are more likely to challenge other areas in the contract such as the application of penalties. This risk is mitigated by close working with the CCG and monitoring of contract performance.

RECOMMENDATIONS TO THE BOARD

29. Public Board is asked to note the financial position of the Trust as at 30th November 2017 and the proposed actions and risks therein.

Appendix 1

Milton Keynes Hospital NHS Foundation Trust
Statement of Comprehensive Income
For the period ending 30th November 2017

	November 2017			8 months to November 2017			Full year
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME							
Outpatients	3,740	3,754	14	28,209	26,635	(1,574)	42,026
Elective admissions	2,601	2,443	(158)	19,747	18,543	(1,204)	29,297
Emergency admissions	4,482	5,724	1,242	37,293	40,579	3,286	55,815
Emergency adm's marginal rate (MRET)	(108)	(359)	(251)	(878)	(1,732)	(854)	(1,314)
Readmissions Penalty	(99)	(236)	(137)	(808)	(2,042)	(1,234)	(1,208)
A&E	1,038	1,034	(4)	8,495	8,586	92	12,919
Maternity	1,885	1,682	(203)	15,238	14,436	(802)	22,825
Critical Care & Neonatal	560	416	(144)	4,554	3,885	(669)	6,814
Excess bed days	0	0	0	0	0	0	0
Imaging	375	324	(50)	2,809	2,472	(337)	4,171
Direct access Pathology	431	396	(35)	3,234	3,043	(191)	4,801
Non Tariff Drugs (high cost/individual drugs)	1,002	1,197	195	8,149	9,766	1,617	12,190
Other	682	616	(67)	4,630	6,640	2,010	6,326
Clinical Income	**16,590**	**16,992**	**401**	**130,672**	**130,811**	**139**	**194,663**
Non-Patient Income	**2,691**	**2,300**	**(391)**	**17,756**	**16,470**	**(1,286)**	**29,610**
TOTAL INCOME	**19,281**	**19,292**	**9**	**148,427**	**147,281**	**(1,147)**	**224,273**
EXPENDITURE							
Total Pay	**(13,039)**	**(13,496)**	**(457)**	**(106,251)**	**(105,690)**	**561**	**(159,120)**
Non Pay	(4,789)	(4,861)	(72)	(36,462)	(37,494)	(1,032)	(55,435)
Non Tariff Drugs (high cost/individual drugs)	(1,002)	(1,197)	(195)	(8,149)	(9,766)	(1,617)	(12,190)
Non Pay	**(5,791)**	**(6,059)**	**(267)**	**(44,611)**	**(47,260)**	**(2,649)**	**(67,625)**
TOTAL EXPENDITURE	**(18,830)**	**(19,554)**	**(724)**	**(150,862)**	**(152,950)**	**(2,089)**	**(226,745)**
EBITDA*	**451**	**(264)**	**(715)**	**(2,435)**	**(5,670)**	**(3,234)**	**(2,472)**
Depreciation and non-operating costs	(933)	(887)	46	(7,459)	(7,091)	368	(11,308)
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**(482)**	**(1,151)**	**(669)**	**(9,893)**	**(12,762)**	**(2,867)**	**(13,779)**
Public Dividends Payable	(137)	(137)	0	(1,097)	(1,096)	1	(1,646)
OPERATING DEFICIT AFTER DIVIDENDS	**(619)**	**(1,287)**	**(668)**	**(10,991)**	**(13,858)**	**(2,866)**	**(15,425)**
Adjustments to reach control total							
Deferred Income	(500)	0	500	(2,000)	0	2,000	(4,000)
Donated Assets Depreciation	50	55	5	397	439	42	600
CONTROL TOTAL DEFECIT	**(1,069)**	**(1,232)**	**(163)**	**(12,594)**	**(13,419)**	**(824)**	**(18,825)**

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

Milton Keynes Hospital NHS Foundation Trust
Statement of Cash Flow
As at 30th November 2017

	Mth 8 £000	Mth 7 £000	In Month Movement £000
Cash flows from operating activities			
Operating (deficit) from continuing operations	(11,304)	(10,300)	(1,004)
Operating surplus/(deficit) of discontinued operations			
Operating (deficit)	**(11,304)**	**(10,300)**	**(1,004)**
Non-cash income and expense:			
Depreciation and amortisation	5,915	5,175	740
(Increase)/Decrease in Trade and Other Receivables	2,494	3,372	(878)
(Increase)/Decrease in Inventories	(12)	(9)	(3)
Increase/(Decrease) in Trade and Other Payables	(517)	(1,381)	864
Increase/(Decrease) in Other Liabilities	24	299	(275)
Increase/(Decrease) in Provisions	(691)	(551)	(140)
Other movements in operating cash flows	(3)	(3)	0
NET CASH GENERATED FROM OPERATIONS	**(4,094)**	**(3,398)**	**(696)**
Cash flows from investing activities			
Interest received	7	7	0
Purchase of Property, Plant and Equipment, Intangibles	(3,879)	(3,257)	(622)
Net cash generated (used in) investing activities	**(3,872)**	**(3,250)**	**(622)**
Cash flows from financing activities			
Public dividend capital received	400	400	0
Loans received from Department of Health	9,885	8,361	1,524
Loans repaid to Department of Health	(636)	(477)	(159)
Capital element of finance lease rental payments	(107)	(142)	35
Interest paid	(962)	(843)	(119)
Interest element of finance lease	(221)	(193)	(28)
PDC Dividend paid	(913)	(913)	0
Cash flows from (used in) other financing activities		(1)	1
Net cash generated from/(used in) financing activities	**7,446**	**6,192**	**1,254**
Increase/(decrease) in cash and cash equivalents	**(520)**	**(456)**	(64)
Opening Cash and Cash equivalents	**3,906**	**3,906**	
Cash and Cash equivalents at start of period for new FTs			
Cash and Cash equivalents changes due to transfers by absorption			
Closing Cash and Cash equivalents	**3,386**	**3,450**	**(64)**

Milton Keynes Hospital NHS Foundation Trust
Statement of Financial Position as at 30th November 2017

	Audited Mar-17	Nov-17 FY17 Plan	Nov-17 FY17 Actual	In Mth Mvmt	YTD Mvmt	% Variance
Assets Non-Current						
Tangible Assets	160.4	157.0	158.6	1.7	(1.7)	(1.1%)
Intangible Assets	5.7	8.5	8.0	(0.5)	2.3	39.8%
Other Assets	0.3	0.3	0.5	0.2	0.2	68.0%
Total Non Current Assets	**166.4**	**165.8**	**167.1**	**1.4**	**0.7**	**0.4%**
Assets Current						
Inventory	3.0	2.6	3.1	0.5	0.0	0.4%
NHS Receivables	16.6	11.4	12.3	0.9	(4.3)	(25.9%)
Other Receivables	3.2	2.9	4.8	1.9	1.6	51.9%
Cash	3.9	3.3	3.4	0.1	(0.5)	-13.3%
Total Current Assets	**26.7**	**20.2**	**23.5**	**3.4**	**(3.1)**	**-11.8%**
Liabilities Current						
Interest -bearing borrowings	(32.2)	(1.1)	(32.2)	(31.1)	(0.1)	0.2%
Deferred Income	(1.6)	(1.5)	(1.6)	(0.1)	(0.0)	1.5%
Provisions	(3.1)	(2.0)	(2.4)	(0.4)	0.7	-22.4%
Trade & other Creditors (incl NHS)	(15.5)	(22.6)	(28.5)	(5.9)	(13.0)	83.6%
Total Current Liabilities	**(52.4)**	**(27.2)**	**(64.7)**	**(37.6)**	**(12.3)**	23.6%
Net current assets	**(25.7)**	**(7.0)**	**(41.2)**	**(34.2)**	**(15.5)**	**60.4%**
Liabilities Non-Current						
Long-term Interest bearing borrowings	(55.0)	(108.2)	(70.3)	37.9	(15.4)	27.9%
Provisions for liabilities and charges	(0.9)	(0.8)	(0.9)	(0.1)	0.0	0.0%
Total non-current liabilities	**(55.9)**	**(109.0)**	**(71.2)**	**37.8**	**(15.4)**	27.5%
Total Assets Employed	**84.8**	**49.7**	**54.7**	**5.0**	**(30.1)**	**(35.5%)**
Taxpayers Equity						
Public Dividend Capital (PDC)	96.1	96.1	96.6	0.5	0.5	0.5%
Revaluation Reserve	70.6	64.9	70.6	5.6	(0.1)	-0.1%
I&E Reserve	(98.8)	(111.3)	(112.4)	(1.1)	(13.6)	13.7%
Total Taxpayers Equity	**67.9**	**49.7**	**54.7**	**5.0**	**(13.2)**	**(19.4%)**

Meeting title	Trust Board	**Date:** 5 January 2018
Report title:	Implementation of the General Data Protection Regulation	**Agenda item:** 5.1
Lead director **Report author**	**Name:** Kate Burke **Name:** Dawn Budd	**Title:** Director of Corporate Affairs **Title:** Information Governance/ICT Security Manager
FoI status:	**Disclosable**	

Report summary	An update to the Board of the steps that the Trust is taking to ensure that it is ready for the implementation of the General Data Protection Regulation when it comes into force in May 2018.			
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [x]	**Decision** [ ]
Recommendation	The Board is asked to note this update.			

Strategic objectives links	2. Improve patient experience 10. Develop as a good corporate citizen
Board Assurance Framework links	None
CQC regulations	Regulation 17: Good governance
Identified risks and risk management actions	Increase in the potential financial liability on organisations from the current £500k to 4% of turnover.
Resource implications	
Legal implications including equality and diversity assessment	

Report history	
Next steps	
Appendices	

Purpose
To ensure the Trust Board is updated on the requirements of the General Data Protection Regulations and the action plan to ensure the Trust is ready for its implementation.

Information Governance Delivery Plan

The Trust has a delivery plan for the implementation of the General Data Protection Regulations. The Information Governance Department is currently working through the requirements to ensure the Trust is ready for implementation in May 2018.

The General Data Protection Regulation is a regulation by which the European Parliament, the Council of the European Union and the European Commission intend to strengthen and unify data protection for all individuals within the European Union. It also addresses the export of personal data outside the EU. The primary objectives of the GDPR are to give control back to citizens and residents over their personal data. When the GDPR takes effect, it will replace the Data Protection Act 1998. Although this is European Legislation it has been confirmed that England will still be governed under this regulation. GDPR comes into full effect in May 2018 and replaces the current Data Protection Act 1998. The UK Data Protection Bill is currently in draft format and this will become the Data Protection Act 2018 based on the regulations. It will change the way the Trust can collect, use and transfer personal data.

There are 12 significant steps that the Trust needs to take to ensure that it is ready and compliant. These are:-

1 <u>Awareness</u>

The Trust must make sure that decision makers and key people in the organisation are aware that the law is changing to the GDPR. This will have a significant impact.

This is being addressed in various forums, through Information Governance training, reports to meetings, corporate communications channels and staff briefings.

2 <u>Information the Trust Holds</u>

All personal data must be documented, included where it came from and who it is shared with. This will be carried out through data mapping exercises (highlighted below).

The scale of this task and the engagement required from senior and middle management should not be underestimated.

3 <u>Communicating Privacy Information</u>

The Trust must review its current privacy notices and ensure all necessary changes are made in line with the GDPR. Privacy Notices are a legal requirement and must be displayed across the Trust in all areas that patients, staff and visitors have access to.

The Trust currently has a privacy notice which will need updating. A child friendly privacy notice needs designing along with one for fundraising and one for staff.

4 Individual Rights

The Trust must review and amend its procedures to ensure they cover all the rights individuals have:-

- **Right of access**
- **Right to object**
- **Right to erasure (to be forgotten)**
- **Right to be informed**
- **Right to rectification**

This is not a new requirement and therefore this is business as usual.

5 Subject Access Requests

The Trust must update its procedures and plan how it handles requests within the new timescales of one calendar month. Under the GPDR, the Trust will no longer be able to levy a charge for Subject Access Requests.

This is envisaged to have a significant impact on resources and current workload within the Information Governance Department. At present the Trust receives in excess of 200 Subject Access Requests a month taking into account all categories i.e. police, patients, solicitors, Social Services, etc.

The Trust is currently able to charge between £10 and £50 for requests (depending on volume). The charge is believed to deter individuals from requesting records and so the Trust may see a rise post the abolition of fees. If the volume of requests increase significantly, the Trust will also need to review the resourcing model for this area of Information Governance.

6 Lawful basis for processing personal data

The Trust must identify the lawful basis for processing activity under GDPR; this must be documented and placed in the Privacy Notice.

7 Consent

More clarity on requirement for consent for processing data is required from the Information Commissioner's Office and v. Consent is not always necessary if there is another lawful basis, and should not be sought if the processing is mandatory (for example, some public health reporting is statutory and exempt from consent). There will be implications for research and clinical audits as GDPR requires focus on an "opt in" rather than "opt out" model. Further guidance is awaited.

The Trust must review how it seeks, records and manages consent and whether it needs to make changes. The Trust must refresh existing consent if it does not meet the GDPR standard.

8 Children

The Trust needs to look at the procedures and systems that are in place to verify individuals' ages and to obtain parental or guardian consent for any data processing activity.

Child friendly Privacy Notices and consideration of children's capacity (Gillick competency) must be addressed in relation to direct care/treatment.

9 Data Breaches

The 72-hour requirement for reporting serious data breaches will be mandatory across all sectors. Financial penalties may be up to 4% of organisations' worldwide turnover (current limit is £500,000).

The Trust must ensure that it has the right procedures in place to detect, report and investigate a personal data breach. Fines will be rising to 4% of the annual turnover.

10 Data Protection by Design and Data Protection Impact Assessments (PIA)

The Trust must familiarise itself now with the ICO's code of practice on Privacy Impact Assessments and work out how and when to implement them in the organisation.

The Trust began implementation of this standard in 2016. PIA completion is now part of the procurement and business case procedures. The Information Governance Department is working with Finance and Procurement Departments to ensure early PIA assessment and adoption.

11 Data Protection Officers

The Trust must designate someone to take responsibility for data protection compliance and assess where this role will sit within the organisation structure and governance arrangements.

The Trust has always had a Data Protection Officer and this sits under the Information Governance Manager's remit (reporting to the Director of Corporate Affairs). The Information Governance Manager will update the Board on all matters under the GDPR via reports to the Management Board presented by the SIRO (Deputy CEO) /Caldicott Guardian (Medical Director).

12 International

If the Trust operates in more than one EU Member state (i.e. carries out cross border processing) it must identify the lead supervisory authority – whether this is the ICO or equivalent authority in other countries.

Progress to Date

The Information Governance team are working hard on ensuring compliance. This is a significant task and the co-operation of all staff across the Trust is paramount to its success. This is particularly relevant in the following areas:-

- Data Mapping
- Information Asset Registers
- System Assurance
- Privacy by Design
- Third Party Agreements

Data Mapping

Data Mapping has been a long standing requirement within the Information Governance Toolkit and will be a legal requirement under GDPR. All flows of personal identifiable information both inside and outside the Trust must be identified and mapped.

Currently compliance is challenging and the Information Governance Department are currently meeting all heads of departments to ensure that they understand the requirement and are fulfilling their obligations. This is resource intensive.

Information Asset Registers

Corporate Records Management is being led by the Company Secretary and is an essential component of GPRD compliance. Departments will need to list their assets including their retention and destruction methods.

System Assurance

The Trust continues to move forward with this; is reliant our Information Asset Owners producing the documentation required. The Trust has identified 153 systems which hold

Personal Identifiable information. Out of these system 39 are complete, the rest are awaiting documentation and responses to include 3rd party agreements, identification of the asset owners and administrators'.

New systems are identified on a regular basis; this is improving since the embedding of the Privacy Impact Assessment process in procurement and finance.

Privacy Impact Assessments (PIA)

The Trust already carries out a PIA process and has done for the last 16 months. This process will be further tightened as part of the compliance plan for GDPR. All new systems and processes which use personally identifiable information should be assessed for compliance with the current Data Protection Act and pending GDPR to ensure that the Trust is compliant with the Act and that the Trust has a legal basis to process the information. Once the PIA has been written it will need to be submitted to the Information Governance Steering Group for sign off. This is a legal requirement under the GDPR.

Third Party Agreements

The Trust's Third Party Agreement has been updated by Capsticks and should be used when engaging a third party who will have access to Personally Indefinable/Business Critical information. This is process must be adhered to.

Recommendation

The Board are asked to note this update. The Audit Committee (December 2017) received a copy of the working compliance action plan.

Milton Keynes University Hospital
NHS Foundation Trust

Meeting title	Trust Board	**Date: 5 January 2018**
Report title:	Health & Safety Update	**Agenda item: 5.2**
Lead director **Report author** **Sponsor(s)**	Kate Burke Marion Fowler	Director of Corporate Affairs Health & Safety Advisor

Report summary	This report provides information in relation to health, safety and welfare activity undertaken within the Trust during the period August to December 2017. It includes a summary of incidents, concerns and positive achievements during the period in order to provide assurance in relation to health and safety management compliance.			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** x	**Decision** ☐
Recommendation	The Trust Board is asked to note the contents of the report.			

Strategic objectives links	1. Improve Patient Safety 4. Deliver Key Targets 7. Become Well-Governed and Financially Viable 8. Improve workforce effectiveness 9. Make best use of the estate
Board Assurance Framework links	N/A
CQC outcome/ regulation links	Regulation 12 – Safe Care and Treatment Regulation 15 – Premises and equipment Regulation 17 – Good governance Regulation 18 - staffing
Identified risks and risk management actions	Staff, patient, third party injury Personal injury claims Failure to meet duties under health and safety legislation Enforcement action, formal notices, prosecution Poor patient experience Media interest/adverse publicity
Resource implications	Personal injury claims
Legal implications including equality and diversity assessment	Failure to meet statutory and regulatory duties of health and safety legislation. Failure to provide safe place of work, safe working practices and equipment and failure to provide competent advice in relation to manual handling.

Report history	The information provided is extracted from the Health & Safety Committee meetings held in September and November 2017
Next steps	Ongoing monitoring at Health & Safety Committee

1. Purpose of the Report

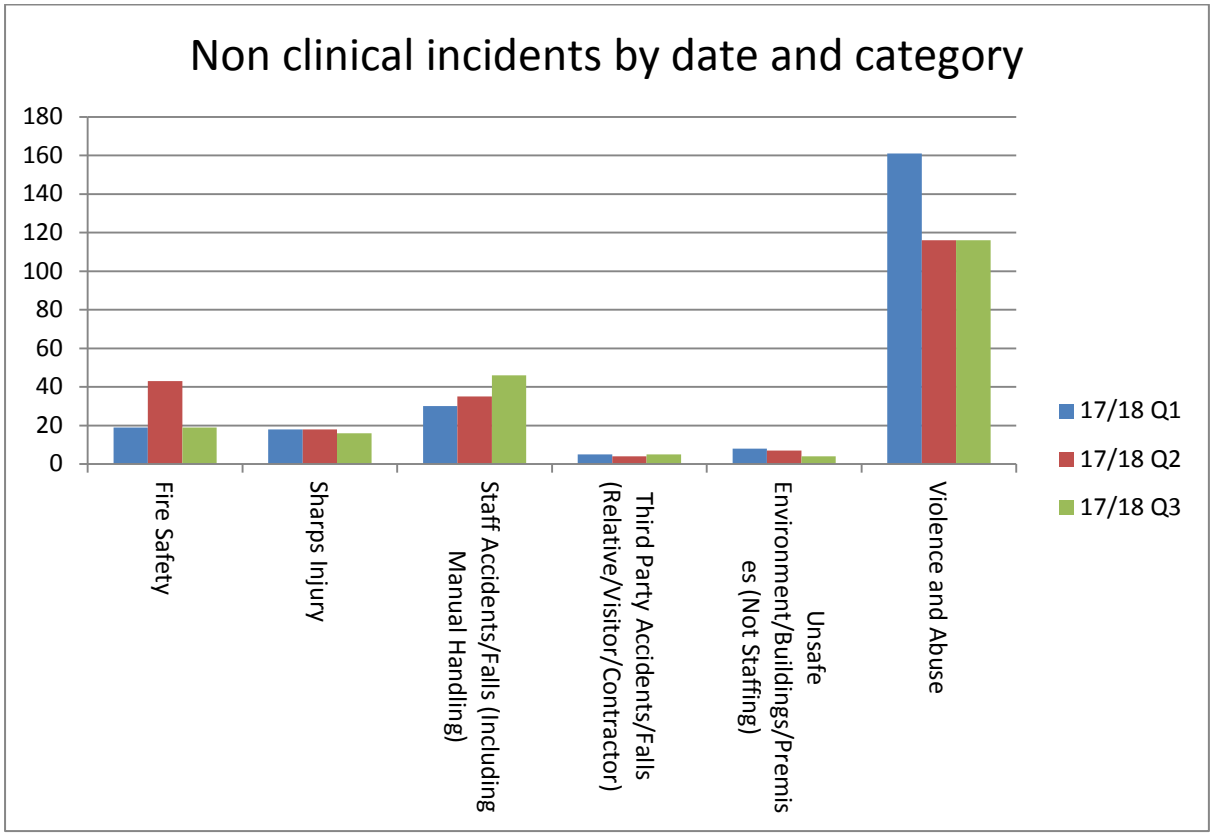
This report highlights health, safety and welfare activity across the Trust during the period of August to December 2017, and upward reports information discussed at the Trust Health & Safety Committee meetings held in September and November respectively. The report covers incidents, concerns and other relevant health and safety information. Information provided is in relation to health and safety only, the incidents reported relate mainly to staff and third party accidents that have been as a result of work or work activities.

2. Health & Safety Committee

During the period covered by this report, the Trusts Health, Safety & Security Board has been dissolved and replaced by the Health & Safety Committee, in line with legal requirements of the Health & Safety at Work etc. Act 1974 and best practice of the Health & Safety Executive. The terms of reference and attendance has been reviewed and updated to include a Divisional management representation. It is hoped that by engaging operational management a two way channel of communication, and therefore a better understanding and improvement in culture in relation to health and safety will be afforded. The first meeting of the newly formed committee was held in November 2017 with good representation from each Division.

3. Incident Reporting

The information provided relates information reported onto the DATIX system under health and safety categories which mainly relate to staff and third parties involved in accidents that have been a result of the workplace or work activities as defined in health and safety law.



DATIX Category	17/18 Q1	17/18 Q2	17/18 Q3
Fire Safety	19	43	19
Sharps Injury	18	18	16
Staff Accidents/Falls (Including Manual Handling)	30	35	46
Third Party Accidents/Falls (Relative/Visitor/Contractor)	5	4	5
Unsafe Environment/Buildings/Premises (Not Staffing)	8	7	4
Violence and Abuse	161	116	116
TOTAL	**241**	**223**	**206**

Top 3 categories reported:

- Violence and abuse
- Staff accidents
- Fire safety

Violence and abuse continues to be the most reported category although a drop has been seen since Q1 reporting figures were produced. These types of incident continue to cause concern. Although the harm levels being sustained are not recorded as significant, staff that are routinely and consistently exposed to violence and abuse can eventually be subject to work related stress and anxiety. It is important that measures are taken to ensure the risks around violence and aggression are assessed; documented and adequate controls are in place to mitigate the risks including the provision of suitable training and support for staff post incident. This is a legal requirement placed upon the Trust in the Management of Health and Safety at Work Regulations 1999, Regulation 3. Incidents are reviewed with follow up led by the Security Manager/Departmental Manager and sanctions/action taken as appropriate. In the majority of cases, underlying factors relate to patient medical condition/cognitive impairment.

A spike in incidents recorded under the category of ***fire safety*** was seen in Q2, this was discussed at the Health & Safety Committee and a request for further information and assurance around the number of incidents reported has been requested by the Chair of the Committee and is to be provided by the Fire Safety Manager/Advisor to the next meeting. It was suggested better reporting may be one rationale for the increase. The number of unwanted fire signals has reduced.

No further issues or concerns were raised.

Reporting of Injuries, Diseases and Dangerous Occurrence Regulations 2013 (RIDDOR) – reports to the Health & Safety Executive

The Trust is legally obliged to report certain workplace accidents, injuries, ill health and dangerous occurrences to the Health & Safety Executive within a legally defined timeframe dependent upon the incident. http://www.hse.gov.uk/riddor/

Below is a table of incidents reported during Q1.

There were **(7)** incidents reported in Q2/3; making a total of **(9) YTD.** **(2)** breached the legally defined reporting timeframe. There has been no interest from the HSE in relation to those breaching the timeframe.

Ref	Incident date	RIDDOR notified	DATIX Sub category	RIDDOR category	Outcome/ Harm	Type	Severity	Location of incident	Division
April to June 2017									
Web49022	10/04/2017	OUH 21/4/17 Reported 21/4/17	collision with an object	over 7 day	fracture finger	third party staff	Mod	Renal	Oxford Hospitals
Web50369	05/06/2017	15/06/2017	slip, trip, fall	over 7 day	sprain wrist	staff	Mod	OT	Medicine
Web50930	03/07/2017	05/07/2017	slip, trip, fall	Specified injury fracture	arm	staff	Major	Pathology external steps	Core Clinical
Web51185	13/07/2017	24/07/2017	accident (other)	over 7 day	concussion	staff	Mod	Imaging	Core Clinical
Web51715	06/08/2017	10/08/2017	Fall from height	Specified injury fracture	spinal fracture	patient	Mod	External roof top	Medicine Security
Web52114	24/08/2017	29/08/2017	Sharps	dangerous occurrence	Exposure to hep c BBV	staff	Mod	Ward 8	Medicine
October to December 2017									
Web54055	16/11/2017	24/11/2017	manual handling load	over 7 day	injury to back/shoulder	staff	Mod	Theatres (HSDU)	Core Clinical
Web53849	08/11/2017	24/11/2017	slip, trip, fall	over 7 day	injury to shoulder	staff	Mod	Ward 17	Internal Medicine
web53962	13/11/2017	29/11/2017	staff accident	over 7 day	back pain	staff	Mod	NNU	Women & Children's

4. Claims received

Claims register from April 2017 – this table provides information in relation to claims received into the Trust during 2017 to date.

DATIX Ref	Incident date	Synopsis	Type	Division
April to June 2017				
Web22243	14/08/2013	Injury following fall from hoist/ swing	Patient	Medicine
Unknown	unknown	Injury following falling roll cage	Contractor	Stores (Core Clinical)
July to September 2017				
Not reported	24/03/2016	Injury following fall from chair	Visitor	Medicine

5. Concerns Raised

The following issue(s) are highlighted as concerns:

- **Manual Handling Advisor**

The Manual Handling Advisor left the Trust at the beginning of December 2017 and has not been replaced. The post has gone out to advert, however there has been no success in shortlisting during this round of recruitment. This leaves a gap in compliance for the Trust in terms of the absence of competent advice in relation to manual handling.

Manual handling is managed by Staff Health & Wellbeing – the concern has been placed on the risk register entry number 2520.

- **Staff accommodation**

Following a (no harm) incident where unsafe and unauthorised alterations were made to a Trust-owned and managed residential property; the Chair of the Health & Safety Committee has asked for assurance from Accommodation management that appropriate action has been taken to address the specific issues raised..

- **Fire Authority Notification of Deficiencies**

The Trust Fire Manager advised this notice had been issued in respect of the high number of unwanted fire signals. Investigation has identified that the signals were in response to misuse of toasters, patients hitting the break glass points in either frustration or by accident and the reheating of food splatter on food trolleys. The number of unwanted fire signals has now reduced considerably and re-inspection by Buckingham Fire Service is due to take place in December. If inadequate progress is deemed to have been made a further notice to improve within three months could be served. Failure to improve thereafter could result in prosecution. Close monitoring of these signals is taking place.

6. Health & Safety Executive Contacts & Prosecutions

There have been no contacts from the Health & Safety Executive (HSE) in this quarter.

The following information is in relation to relevant prosecutions recently concluded and coming under the umbrella of the Health & Safety at Work etc. Act 1974. There are lessons to be taken from both of these prosecutions in light of Trust recent incidents and/or potential incidents. These were circulated to the Health & Safety Committee membership during this reporting period for cascade and follow up.

6.1 London Borough of Brent – staff assault

Court action has been taken against *London Borough of Brent* for failing to protect staff against the risks of violence & aggression and lone working. The authority has been ***fined £100,000*** after two of its social workers were assaulted by the mother of a vulnerable child they were visiting.

https://www.ioshmagazine.com/article/council-fined-violent-mothers-assault-social-workers

Action for MKUH

A timely reminder to ensure risks in relation to violence & aggression, lone working and security of staff and others are undertaken and adequate controls and support for staff are implemented and available including the communication of known individuals to staff and others who might be affected.

6.2 Shrewsbury and Telford Hospital NHS Trust – deaths of five elderly patients

Shrewsbury and Telford Hospital NHS Trust has been fined following a series of HSE investigations into the deaths of five elderly patients.

Stafford Crown Court heard that the patients, ranging between 72 and 92 years, sustained fatal injuries as result of falling while being cared for in hospitals run by the Trust. Four died as result of falling at the Princess Royal Hospital, Telford. The fifth succumbed to injuries at the Royal Shrewsbury Hospital. The deaths took place between June 2011 and November 2012.

The HSE investigations found that fall prevention measures, including close supervision of those in a confused mental state, were not properly applied. This was made worse by poor consideration and communication surrounding measures to protect against falls arising from each patient's particular frailties.

Shrewsbury and Telford Hospital NHS Trust of Princess Royal Hospital, Apley Castle, Telford pleaded guilty to breaching Section 3(1) of the Health and Safety at Work Act 1974. It was fined £333,333 and ordered to repay £130,000 in costs.

https://www.shponline.co.uk/nhs-trust-fined-following-fatal-falls/?cid=%3FCID%3Dema-Newsletter_SHP%20Plus%20Weekly-29th%20November%202017-In%20court-

Action for MKUH

A timely reminder that risks in relation to falls including those from windows, balconies, access/exit points should be assessed and secure in order to prevent falls from occurring.

7. Positive achievements

- Health, Safety & Welfare Training exceeded the Trust Target of 80% achieving 92% attendance.
- Roll out of Health & Safety Policy.
- Roll out of First Aid policy.
- Drafting and consultation of Health & Safety Risk Assessment process.
- Health & Safety Dashboard implemented.
- Health & Safety Quarterly Checklist return target of 60% exceeded, 62% achieved.
- Recruitment of Fire Safety Advisor.
- Review of Fire Safety Management within the Trust including warden training, evacuation procedures and processes and audible alarm testing.
- Manual Handling Training is on track at 90% with a target of 80%.
- The Safer Handling policy which includes the heavier patient pathway is out for consultation.
- Risk Assessment and Safe Systems of Work paperwork for manual handling is now available for staff to refer to.

8. Recommendations

The Board is asked to note the contents of this report and the information provided and make comment as appropriate.

Audit Committee Summary Report

1. Introduction

The Audit Committee met on 12 December 2017. A summary of the key matters discussed is provided for the Board:

2. Data Quality

The Deputy Chief Executive presented an interim summary progress report on data quality, which is a key part of the action plan for addressing the issues that have been raised by external audit over the last few years. The likelihood that the Trust will continue to have its Quality Account indicators qualified was acknowledged – A&E staff, in particular, are being retrained, but it is not expected that there will be a step change in performance until the EPR system is introduced in April 2018. The new system will not lead to instant transformation, and there are likely to be issues that would need to be addressed. The expectation is that discernible improvements will start to be noticed from September 2018 onwards.

With regard specifically to the 18 week target, it was noted that the Director of Corporate Affairs is leading a Patient Administration Programme, the aim of which is to centralise the management and working practices of the various teams, thereby improving patient experience and the efficiency of booking procedures.

3. External Audit

The External Auditor presented the audit plan for 2017/18, and introduced its key elements. He highlighted the 3 significant audit risks as revenue recognition, management override and going concern, consistent with last year. For this Trust, one of the key issues around its going concern status is the £31m loan which is due for repayment – the Trust is continuing to push for clarity around this, although the auditor highlighted NHS Improvement guidance which is that a trust remains a going concern unless it is about to close for business. However, it was agreed that consideration would be given as to whether failure to repay this loan could give rise to cross-defaults with third parties.

Areas to be looked at with regard to value for money would be financial sustainability and data quality. The guidance is likely to be similar to what it was last year. The materiality level is more or less the same.

With regard to the Quality Account indicators, while it was acknowledged that most trusts are qualified, there was concern that at MKUH around 50% of the cases tested were wrong. The governors would once again be required to select a local indicator to be tested. This year, the draft Quality Account is also to be considered by the QCRC.

4. Internal Audit

The Internal Auditor presented this update indicating that it had been a busy quarter:

- The agency staffing final report had been published with a rating of significant assurance with minor improvement opportunities, including the need to ensure

that the spend is appropriate, and that no payments are made without authorisation. All of the recommendations had been agreed by management.
- The fieldwork and draft report relating to the financial management audit has been completed, and again the assessment is that the report provides significant assurance with minor improvement opportunities. The final report is to be presented to the Committee at its meeting in March.
- The first part of the data quality work has been completed and the report issued to the Deputy Chief Executive and his team. Work has started on the capital projects governance review.
- Some changes have been made to the plan, and the divisional governance review will now be carried out in 2018/19. More work is being done to improve risk management with a view to making it more accessible and innovative. There is currently a large number of risks on the registers, and work is being done around thematic risk categorisation to make it more manageable.
- There are now no overdue high rated actions. There is one outstanding action around emergency planning which is to be completed by March 2018.

5. Counter Fraud Progress Report

During the last quarter the team has mainly been involved in business as usual activities. A presentation was delivered to the finance team and this was found to have been useful. There was also a session at the Event in the Tent, which is to be repeated in May.

Other activities included:

- Sickness absence review – time is being taken to meet with managers on the ground
- Work is being done with internal audit on procurement processes to ensure that they are in line with NHS Protect standards.
- A referral originating from data matching is being considered.

6. Financial Controller Report

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

- Write offs amounted to £15k (including £6.5k on overseas patients). There were also some salary overpayments. Further education is to be provided to managers on the impact of late forms.
- Loses and special payments amounted to £10k, £8.6k of which related to pharmacy and stock write-offs.
- There were no credit notes over £20k in this period.
- There were 4 tender waivers in the period the largest of which was £377k relating to A&E modifications.

7. Board Assurance Framework

There had been a good discussion at the last Board meeting, following which a summary of the proposed changes had been shared with Exec Directors. Work on the new BAF continues. Going forward, it is proposed that a narrative report would be sent to the Committees, highlighting movements in the risks relevant to their work. Deep

dives are also to be scheduled to test all controls, and the Committee Chairs are to carry out RAG rated assessments. A number of further improvements to the proposed new template were suggested, and these are to be incorporated into the version to be presented at the January Board meeting.

8. GDPR action plan

It was noted that the GDPR will usher in a host of new actions, including the appointment of a data protection officer who would be required to report to the Board. Consent will also be a major issue, although there are some waivers for the NHS. For this Trust, it could have an impact on fundraising and how the details of donors are stored, and there is the likelihood that some of them will be lost. The Trust is benchmarking well on its progress towards implementation and Capsticks have been asked to review the plan. A further update will be taken to the Board before the regulation comes on line.

9. Minutes from Board Committees

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

- Finance and Investment Committee meetings on 4 September and 2 October 2017 (approved)
- Quality and Clinical Risk Committee meeting on 20 October 2017 (draft)
- Charitable Funds Committee on 2 October 2017 (draft)
- Workforce and Development Assurance Committee meeting on 6 November 2017 (draft)

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

None

11. Items for Escalation to the Board

i) BAF development
ii) Internal audit action plan
iii) GDPR action plan

12. Any other business

None

13. Recommendation

The Board is asked to:

i) note the report; and
ii) consider the escalation items and any necessary actions.

Milton Keynes University Hospital NHS Foundation Trust

MEETING OF THE FINANCE AND INVESTMENT COMMITTEE HELD ON 6 November 2017

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

- There were no matters requiring the Committee's approval at this meeting.

Matters referred to the Board for final approval:

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

Other matters considered at the meeting:

1. Minutes of the last meeting and Matters Arising:

   I. EPR funding - The decision on funding is still awaited. It was noted that the Trust could potentially be acting ultra vires in committing to schemes that are required on health and safety grounds without funding. The Board would be made aware of the position before existing funding streams have been exhausted.
   II. Review of readmissions – an update had been provided at the last Board meeting on the audit on readmissions. Discussions are ongoing with the CCG on both the rebasing of the MRET tariff and the re-investment of MRET monies. These are to be raised against the joint Board meeting in January.

2. Performance Dashboard:

The Committee noted:

   I. GP referrals are recovering and impacting positively on activity, but readmissions remain high. The latter generates a financial impact of around £750 a day on the Trust, but the operational impact is more significant.
   II. An appeal has been lodged in respect of the STF payment linked to the ED 4 hour target due to the late change in guidance.
   III. Meeting the control total in Quarters 3 and 4 will get progressively more difficult.
   IV. There are 2 patients who have been waiting more than 52 weeks for elective care, believed to be for patient choice reasons. It was confirmed that where elective work has been cancelled as a result of bed pressures, priority is given to patients who have waited the longest or require urgent treatment.

3. Board Assurance Framework (BAF)

The following changes had been made to scores on the BAF:

   I. The score around agency spend risk has been reduced to 12 to reflect the progress in reducing agency spend.
   II. Ref 7.2 (timing of release of strategic capital and revenue funding for 2017/18) is increasingly important as a result of the long awaited decision on EPR funding.

III. In relation to Ref 7.4 (main commissioner is unable to pay for the volume of activity undertaken by the Trust), it was noted that the CCG are in financial turnaround.

4. Finance Report:

The Committee noted that:

I. The Trust met its control total in Q2 despite underperformance on income. Regular meetings with the divisions and speciality teams are continuing.
II. With regard to the high amount of debt relating to sexual health that has been accrued by Buckinghamshire County Council and Bedford, it was explained that this is being escalated, and a further report would be provided to the Committee.

5. 2017/18 Forecast update:

This update described the financial performance for the first 6 months of the year and the methodology for forecasting the remainder of the year. There have been some one-off items that have supported the M1-6 positon, but there is uncertainty around the impact that winter pressures and actions to mitigate these will have. It was noted that the PA Consulting team have already helped to deliver some savings, particularly around procurement. However, one of the risks in the forecast relates to the 0.5% CQUIN included as risk reserve which the CCG has thus far refused to pay in accordance with NHS England guidance.

6. Agency update

Agency spend continues to track on a slow downward trajectory, with nursing agency remaining between £350k and £400k a month. There are potential risks around winter, but this was felt to be manageable. Agency spend is now lower than bank spend for the first time.

7. Patient-level costing – Early Implementer Programme

The Trust has been invited to join the 2nd round of the costing transformation early implementer programme. Assuming that it agrees to take part in the programme, the Trust would not be required to make a reference cost submission and it will have access to benchmarking data to compare itself to other PLICS organisations.

8. Transformation Programme Board update

I. At month 7, £1.4m worth of savings were achieved against a plan of £0.5m. The programme is £750k behind plan but agency has significantly underspent.
II. If the total Transformation Programme target is delivered, the control total would be achieved. Divisional business meetings have been reinstated in the last 4 weeks to support them in meeting their targets.
III. There are plans to manage staff accommodation more commercially, but any decisions will also take account of affordability.
IV. It was acknowledged that there are data recording issues with regard to the sepsis CQUIN, but it is anticipated that this will resolve itself once EPR goes live.

9. Timeline for strategic capital projects

Legal advice has been received to the effect that there is nothing to prevent the Trust from taking out a non-secured loan to fund construction of the new multi-story car park.

10. Other business

A number of risk and governance related suggestions were made:

- The issue of cyber security should be overseen by the Audit Committee, whose name ought to be changed to the Audit and Risk Committee. This Committee should also oversee non-clinical risks.
- Clinical risks should go through the Quality and Clinical Risk Committee.
- Financial risks should continue to be managed through this Committee and the health informatics strategy should go through the Board.

The issue of the number of University of Buckingham students who ought to receive their training at MKUH as against the two other hospitals, with which the university has relationships, is to be taken up by the Chief Executive.

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

- MRET
- Transformation programme
- Medical agency
- Forecast and winter pressures

Milton Keynes University Hospital NHS Foundation Trust

MEETING OF THE FINANCE AND INVESTMENT COMMITTEE HELD ON 18 December 2017

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

- The Committee approved the Waste Management Contract Business Case.

Matters referred to the Board for final approval:

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

Other matters considered at the meeting:

1. Minutes of the last meeting and Matters Arising:

   I. EPR funding - The Director of Finance received assurance from NHS Improvement that this and the Trust's other capital funding requirements would be discussed at an upcoming capital summit.
   II. A new construction company has been engaged to consider whether they would be able to deliver the Cancer Centre within the guaranteed minimum price
   III. A challenge has been issued to the CCG on the reinvestment of MRET monies. This issue is to be discussed at the next Board meeting.

2. Performance Dashboard:

The Committee noted:

   I. GP referrals are at their highest for the year.
   II. A&E performance is good, but maintaining this in M9 would be challenging
   III. The STF appeal for Q2 was successful, but uncertainty remains around the requirement for Q3.
   IV. The hospital is one of the fullest in the country. In addition, some wards have been closed to new patients as a result of norovirus and flu cases in the hospital.
   V. Elective performance is at its highest level for the year, but this is expected to fall due to the high number of cancellations.

3. Marginal Rate Emergency Tariff and Readmissions

   I. The Trust's penalties for MRET and readmissions were significantly above planned levels at £1.5m. The Trust believes that the readmissions threshold should be raised. This is not likely to happen in 2017/18, but it is expected to form part of contract negotiations for next year.
   II. The Trust has issued a contract challenge notice to the CCG over the reinvestment of MRET monies, and this is being handled through a dispute resolution process.

4. Finance Report:

The Committee noted that:

I. At M8, the Trust's deficit was £0.7m adverse to plan, but the run rate improved significantly and is £163k below the control total.
II. Outpatient activity has improved significantly and delivered against plan; non-elective activity has over-performed in month. However, the £850k income has been eroded, in part by MRET.
III. For the first time, in many months, pay is above budget, but agency continues to track between £800k and £900k. Non-pay costs have improved compared to previous months.
IV. The report did not include the expected release of winter pressure funding of around £750k, which, if received, would help the Trust to meet its control total.
V. The Trust expects to achieve 95% against the A&E 4 hour target at the end of March 2018 as required.

5. Agency update

Agency spend remained largely the same for October and November. Medical and Nursing continue to record the highest levels of spend, and the Medicine Division is still the highest user of agency staff. The forecast of £12.2m for the year, well below the £15.12 ceiling, remains achievable.

6. Update from PA Consulting

Jackie Collier from PA Consulting attended to present on the support that that firm provided to the Transformation Team from September to November 2017. The following points were highlighted:

I. Within theatres, the team had helped to develop a scheduling tool to improve efficiency. They also helped to reduce the number of lists starting late, and assisted with the reconfiguration of the Day Surgery Unit to improve patient flows with ward 24.
II. The team's work had focussed on benefit identification rather than delivery, and they had left the divisions with plans to deliver further benefits. There are opportunities to use time and space more efficiently, including the running of 3 lists a day, although it was noted that due to the space limitations in Outpatients, procedures that could be undertaken there tend to be done in theatres.
III. Within Diagnostics there is an opportunity to rationalise the number of providers, although this not likely to generate significant savings. It was acknowledged that EPR will help to change behaviours to reduce the numbers of tests that are requested.
IV. For procurement, a one year 5% reduction in the cost of MRIs has been negotiated, and a potential £87k of savings has been identified in the sourcing of surgical consumables. 6% savings have been identified in catering by consolidating supplies through a third party.
V. There is more to be done, particularly around the standardisation of theatre kit. The Director of Clinical Services is to provide a paper on next year's plans for Transformation.

7. Sustainability and Transformation Fund Incentive Scheme

The shift in focus in relation to the accessing of incentive funding from provider to system performance in this year's guidance was noted. It is anticipated that the Trist would be deemed a shadow Accountable Care System for these purposes.

8. Waste Management Contract Business Case

This business case, for £123k was approved, having previously been presented to the Board.

9. Use of Resources Assessment

This paper showed the Trust's current performance against its peers, although it would be difficult at this stage to predict what its rating might be. A decision regarding the £31m loan is still awaited, and failure to resolve this could affect the Trust's cash flow in 2018.

The following issues were highlighted:

- The Trust spends more than other similar trusts on its medical staffing, but this is improving.
- Finance costs for 2015/16 reflect additional resources linked to the healthcare review.
- The Trust remains an outlier in terms of HR provision.

10. Other Business

The Trust's wholly owned subsidiary has now been registered as ADMK. Its business plan is being developed and will be presented to this Committee.

NHS Trusts are being challenged on VAT for IT services – this is relevant in the context of the £1m being spent on devices for EPR.

A portion of the £5m from the GDE programme is now available for drawdown.

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

None

12. Escalation items for Board attention:
    - MRET and readmissions
    - Transformation Programme
    - Activity pressures
    - GDE
    - Business case for ADFMK to be presented at the February meeting of this Committee

Milton Keynes University Hospital NHS Foundation Trust

Workforce and Development Committee Summary Report

1. Introduction

The Workforce and Development Committee met on 6 November 2017. A summary of key issues discussed is provided below.

2. Workforce

2.1 **Staff Story** – The Deputy Security Manager joined the Trust on a part time basis in 2014. He found a welcoming environment on his arrival and was quickly made aware of a number of development opportunities available to him. He attended the team leader development course and began an apprenticeship at NVQ level 5 in management. He subsequently transferred to the Security and Car Parks department, while continuing with his studies, and later became Acting Deputy Security Manger (he is now substantive in this role), and has received the Baroness Wall Hero of the Year award for his role in preventing a suicide on site. He is part of the Peer to Peer initiative through which colleagues who are in difficulty are able to talk through their problems.

He stressed the importance of staff being encouraged to enrol onto courses and apprenticeships, and that managers should be supported to challenge their staff in this area. He commended the Trust for the support that he has received, particularly while undertaking his apprenticeship.

2.2 **Workforce Quarterly Report** – This was received and noted. Highlights include the fact that the vacancy rate and agency expenditure decreased in Q2, and for the first time, bank spend exceeded agency spend. It was noted that problems with unreported absence persist, and this is being addressed. Overall, sickness absence has continued to decline. Statutory and mandatory training levels dipped slightly, but they are expected to increase as the year progresses.

There was further discussion about vacancies, and it was confirmed that nursing vacancies are significantly higher than for the rest of the Trust. In this regard, it was agreed that the Committee would give more focus to the risk on the BAF relating to the inability to recruit to critical posts.

With regard to sickness absences, it was noted that the rates of 2% and 3% reported by Luton and Dunstable and Bedford respectively relates to the fact that they use a manual system to collect their data. The Committee also noted the number of leavers within nursing and midwifery – to be considered in more detail at the next meeting.

2.3 **Agency controls and usage** – The reduction in pay costs in the last quarter was noted. Premium staff costs at below £900k for September were reported to be the lowest in many years, although it as noted that these are likely to increase over the winter. The focus has now shifted to internal bank rates, and there is concern that this could force staff from bank back to agency. The Trust's success in its use of the RightStaff app is to be reported in the Nursing Times.

2.4 **Staff health and wellbeing report** – The number of interactions with Care First has reduced slightly from 444 in 32015/16 to 379 in 2017/18. It was noted that the majority of contacts have been for counselling sessions, although there is no indication as to how long staff are having to wait from referral to contact.

With regard to staff health and wellbeing, the number of activities on offer was noted, but it was suggested that more needs to be done to highlight the opportunities, possibly through a dedicated intranet page.

2.5 **Staff engagement** – In recognition of the changes that are likely to occur in the way that services are delivered, the Trust is proposing to focus on organisational culture as a key theme of its workforce strategy for 2018 to 2020. The plan is for staff engagement to commence early in 2018. Results from the staff survey will be discussed at the next meeting.

2.6 **Equality and Diversity** – The annual report on equality and diversity was due to have been published in March. It was noted that the more senior staff are, the less diverse the cohort. This is to be looked into, bearing in mind that BME staff tend to be highly qualified. The low return on disability and workforce is the same as at most trusts, and it was noted that many staff do not declare disabilities at recruitment.

3. Education

3.1 **Education Update –** There will be a small allocation of education funding in bands 1 to 4 from HEETV, but going forward, staff in these bands would be expected to access apprenticeships. The take up of apprenticeships is currently low, but an Apprenticeship Manager has been appointed, and discussions are ongoing with providers around large scale apprenticeship degrees for managers in health.

3.2 Medical Education Update – Michael Clubbs presented the UB Medical School report. Highlights included:

- Students in the junior rotation are now more comfortable working in clinical areas
- Blocks and theme leads and deputies have been recruited, including AHPs and specialist nurses.
- Block leads are preparing 150 exam questions per block and a tight assurance process through the University of Leicester is in place.
- The feedback from students is very positive, as was the informal feedback following the GMC visit in July 2017
- There were 6 incidents reported on Datix relating to students and all are now closed.
- The Academic Centre is scheduled to open on 8 January 2018.
- There was concern that the university does not appear to be making the filling of the Trust's quota of students a priority, considering the investment that the Trust has made on the venture. This is to be raised at the Finance and Investment Committee.

4. Action required

The Board is asked to note the summary report.

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Board of Directors**	**Date: 5 January 2018**
Report title:	**Use of Trust Seal**	**Agenda item: 5.6**
Lead director **Report author** **Sponsor(s)**	**Name: Kate Burke** **Name: Adewale Kadiri**	**Title: Director of Corporate Affairs** **Title: Company Secretary**
FoI status:	**Public**	

Report summary	**To inform the Board of the use of the Trust seal.**						
Purpose *(tick one box only)*	**Information**	x	**Approval**		**To note**	x	**Decision**	
Recommendation	That the Board of Directors note the use of the trust seal for the settlement of P22 deeds of agreement for a minor and a major works scheme between MKUH FT and Galliford Try.						

Strategic objectives links	Objective 7 become well led and financially sustainable.
Board Assurance Framework links	**None**
CQC outcome/ regulation links	**None**
Identified risks and risk management actions	**None**
Resource implications	
Legal implications including equality and diversity assessment	None

Report history	None
Next steps	None
Appendices	

Use of Trust Seal

1. Purpose of the Report

In accordance with the Trust Constitution, this report informs the Board of two entries in the trust seal register which has occurred since the last meeting of the Board.

2. Context

The Trust Seal was executed on 22 December 2017 for the settlement of P22 deeds of agreement between Milton Keynes University Hospital NHS Foundation Trust and Galliford Try for a minor work scheme and a major work scheme.