Board of Directors

Board to be held at 10:00 on Thursday 7 May 2020
via video-conference in line with social distancing requirements

Agenda

Item No.	Title	Purpose	Type and Page No.	Lead
1. Introduction and Administration				
1.1	Apologies	Receive	Verbal	Chair
1.2	Declarations of Interest i) Any new interests to declare ii) Any interests to declare in relation to open items on the agenda	Receive	Verbal	Chair
1.3	Minutes of the public meeting held on 6 March 2020	Approve	Pg. 3	Chair
1.4	Matters Arising/ Action Log	Approve	No open actions	Chair
2. Chairman and Chief Executive Reports				
2.1	Chair's Report	Discuss	Verbal	Chair
2.2	Chief Executive's Report	Discuss	Verbal	Chief Executive
3. Quality				
3.1	Patient experience update	Discuss	Presentation to follow	Director of Patient Care & Chief Nurse
3.2	Summary reports Finance & Investment Committee – 2 March 2020	Note	Pg. 9	Committee Chairs
3.3	Nursing staffing update	Discuss	Pg 11	Director of Patient Care and Chief Nurse
3.4	Obstetrics and Gynaecology Training Concerns: work to develop the culture and learning environment	Discuss	Pg 18	Medical Director
3.5	Mortality Report	Discuss	Pg 22	Medical Director
3.6	Seven day services report	Discuss	Pg	Medical Director
4. Strategy				
4.1	Use of Ward 12	Note	Verbal	Director of Clinical Services
4.2	Objectives	Note	Verbal	CEO
4.3	Health Infrastructure Programme update	Discuss	Verbal	Deputy CEO
5. Performance				
5.1 5.2	Covid-19 Update Performance Report Month 12	Receive and Discuss	Pg. 47 Pg. 49	Director of Operations

Item No.	Title	Purpose	Type and Page No.	Lead
5.3 5.4	Finance Month 12 Workforce Report Month 12		Pg 62. Pg 70	Deputy CEO/ Director of Operations Director of Finance Director of Workforce
6. Assurance and Statutory Items				
6.1	Board Assurance Framework and risk	Discuss/ Approve	Pg 76	Director of Corporate Affairs
7. Governance				
7.1	Use of Trust seal	Note	Pg86	Director of Corporate Affairs
7. Closing Administration				
7.1	Any Other Business	Discuss/ Note/ Approve	Verbal	Chair
7.2	Questions from Members of the Public While under normal circumstances the public can attend part of provider board meetings, current Government social isolation requirements constitute 'special reasons' precluding face to face gatherings as permitted by legislation	Note	Verbal	Chair
7.3	Motion to Close the Meeting	Receive	Verbal	Chair
7.4	Resolution to Exclude the Press and Public The Chair to request the Board pass the following resolution to exclude the press and public and move into private session to consider private business: "That representatives of the press and members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted	Approve		Chair

BOARD OF DIRECTORS MEETING

Draft Minutes of the Board of Directors meeting held in PUBLIC on 06 March, 2020 in Room 6, Education Centre, Milton Keynes University Hospital

Present:

Simon Lloyd	Chairman
Joe Harrison	Chief Executive (slightly delayed due to major incident related to coronavirus)
Ian Reckless	Medical Director (slightly delayed as above)
John Blakesley	Deputy Chief Executive
Danielle Petch	Director of Workforce
Mike Keech	Director of Finance
Ian Reckless	Medical Director
Heidi Travis	Non-Executive Director (Chair of the Finance & Investment Committee
Tony Nolan	Non-Executive Director (Chair of the Workforce and Development Assurance Committee)
Helen Smart	Non-Executive Director (Chair of the Quality and Clinical Risk Committee)
Andrew Blakeman	Non-Executive Director (Chair of the Audit Committee)
John Clapham	Non-Executive Director (and representative of University of Buckingham)
Nicky McLeod	Non-Executive Director (Chair of the Workforce & Development Committee)
Haider Husain	Non-Executive Director
John Lisle	Non-Executive Director

In attendance:

Gemma Berrill	Lead Advanced Nurse Practitioner for Rheumatology (for item 3.1)
Alison Marlow	Trust Secretary
Julia Price	Assistant Trust Secretary

1	**Welcome**
	The Chairman welcomed all present to the meeting, new Non-Executive Directors, John Lisle and Haider Husain prior to their formal start date of April 1, 2020
	Apologies
1.1	Due to an ongoing major incident, apologies were received from Kate Jarman, Nicky Burns-Muir and Emma Livesley. Apologies were also received from Ian Wilson.
	Declarations of interest
1.2	No new interests had been declared and no interests were declared in relation to the open items on the agenda.
	Minutes of the meeting held on January 9, 2020

1.3	The minutes of the public Board meeting held on January 9,2020 were accepted as an accurate record.
	Matters Arising/ Action Log
1.4	There were no matters arising.
2	**Chairman and Chief Executive's Reports**
2.1	**Chairman's Report** • The Chairman asked the Board to note the dates of this year's Staff Engagement Event in the Tent, 11-15 May. He said the last three events had improved year on year and encouraged Non-Executive Directors to attend some of the sessions. • ICS. The Chairman said that the ICS were looking to appoint an independent Non-Executive Chair. They are holding a stakeholder meeting on March 17 and SL will attend. • He welcomed Lucy Bubb from Deloitte who were observing the Board as part of the internal Well-Led Review. • The Chairman said the Cancer Centre had now opened, with the new ward operational, with the rest of the building fully operational from March 9, with the exception of the Aseptic Suite. He invited any NEDs to have a look round after the meeting. • Annual Members' Meeting. This will take place in the Academic Centre at 4pm on September 22, 2020. • There had been some good publicity concerning the surgery robot on ITV's Dr Ranj Show earlier n the week, and some positive coverage on Radio 4. IR said the Trust was currently designing a roll out programme concerning plans for usage in different specialties of surgery. • The Chairman said that Governor elections would shortly be under way both for constituency and staff governors. **Resolved**: The Board **noted** the Chairman's' Report
2.2	**Chief Executive's Report** John Blakesley presented the report due to Joe Harrison being delayed. • Cancer Centre. The inpatient ward had successfully moved over on February 29 and it went smoothly. Good feedback had been received so far from Patient Groups who expressed positive feedback over the very straightforward name of the building. On March 9, the ground floor area would become operational. Steelwork had been constructed in preparation for the building of new offices as technical compensation. These weren't part of the original build and completion on these was expected end of April. The Aseptic Suite, which was part of a separate contract and to be operated by Pharmacy would be set up over the next 6-8 weeks. The link corridor was now in use, with final windows and doors to be fitted shortly. AB congratulated those involved with getting the Cancer Centre operational. • Kents Hill. The use of this as a quarantine site was now concluded. JB said that the experience had been very useful for senior managers in terms of training and expertise, and the fact that no guests were infected was also a positive outcome. HS asked if the extra work had impacted on the operational running of the hospital. JB said that the impact had been minimal and that although it had been time-consuming for senior managers, and that other staff had

	volunteered to work on the site. IR said the main disruption had been to managerial teams and HCAs (healthcare assistants). IR also said it had been a really positive experience, particularly in terms of relationships with East of England colleagues, the Urgent Care Centre and suppliers. JB said a number of people had been coming forward for testing and that two small portakabins had been erected outside ED, with drive through testing in operation. IR said that it was clearly a rapidly changing situation but that the Trust was making preparations. AB asked where tests were sent to – these now go to Oxford (having originally been sent to Colindale). HH asked about the possibility of using tele medicine. IR said technology could be used as and when patients were in isolation – for example Facetime and other options for relatives to keep in touch. Resolved: The Board **noted** the Chief Executive's Report
3 3.1	**Quality** **Patient Story** Gemma Berrill gave a presentation on patient experience in rheumatology. Increasing numbers of patient require regular infusions to manage their conditions, which can mean lengthy treatments – upto six hours in many cases. She said that it had been identified that the area used for outpatient treatments wasn't suitable for many reasons – that part of ward 24 was used and it was an area with no toilet facilities and no windows or suitable surfaces. Following an audit, a new area was created and the resulting feedback was 100% positive. To illustrate the patient story, Gemma cited 'Ian' and 'Sarah' two patients who had lived with their conditions for a large part of their lives. She gave examples of how they valued their treatment and also of how much their personal experience had improved as a result of changes to the treatment location. **Resolved:** the Board thanked Gemma for her passionate and informative presentation and for the positive outcome as a result of her and her team's determination to both recognise that change was required and work hard to effect that change.
3.3	**Summary Reports** Summary Reports -Finance and Investment Committee. **Resolved:** the Board received and **noted** the report.
4 4.1 4.2	**Strategy** **Cancer Centre Update.** This was given in the CEO's Update. **Operational Plan Update** Now the Cancer Centre has opened, the Trust is already using Ward 22 as an isolation facility and there are various other plans in place such they be needed. JH said that the trust had spare capacity and that there were active plans to segregate pathways at the front door, with symptomatic patients being directed through a different route.
4.3	**MKUH Quality Priorities** IR explained that the Trust is required by statute to identify three quality priorities for improvement each year which were part of the Trust's

	objectives. These had been approved by the Council of Governors at its February meeting and over the next few weeks they would be developed in terms of devising measurable outcomes.
5	**Performance**
5.1	**Performance Report M10** JB presented the report. He noted that A&E performance was not as good as they would like (almost 86%) but that it compared favourably to other Trusts. He said in the last 10 days that performance had improved considerably and on occasion 95%. He said it compared favourably with East of England trusts, where some were struggling to reach 50-60%. RTT performance. JB said that Emma Livesley recognised that there was more work to do, particularly with regard to ensuring that waiting lists were clean and without duplications IR said there had been one 52 week wait in Month 10, however 18 months ago there had been 20 such patients. He said he suspected these would increase if a pandemic was declared. HS asked about delayed transfers of care. IR said that every Tuesday staff see every super-stranded patient (LoS 21 days or more) to assess the best options for discharge. He said there were currently 4-6 homeless patients fit for discharge but there were discussions over where to find appropriate places for them. JH stressed that Trust has ring-fenced W12 to continue orthopaedic elective operations. He said this showed that the organisation is working efficiently even when under pressure. AB asked if there was any data from previous events similar to Covid-19, but JH said there wasn't. IR said the public's behaviour had been shown to change and that during the Kents Hill and Arrowe Park quarantine periods, the respective A&E attendances saw reductions. JH said a significant piece of work had been done around theatres, following the Trust being flagged as a surgical site for infections following orthopaedic revisions. W12 had been ringfenced as a clean work and significant work had been done in theatres regarding airflow and cleanliness. This situation would be reviewed in November but indications were that the new processes put in place were a positive step. IR confirmed that the Trust had revisited the whole pathway and used a best practice bundle of interventions. **Resolved**: The board **noted** the Month 10 Performance Report.
5.2	**Finance M10** MK gave a full overview of the paper and said that the Trust was £243k off plan YTD but that operational pressures translated to additional spend. He said that while 2019/20 had been challenging, 2020/21 was likely to be more challenging with general NHS pressures on staffing and containing costs. He said one of the issues was the requirement to have a maximum bed occupancy of 92%, whereas in January it had been 97%. In Trust terms 5% represented an entire ward.

	NM asked about the additional costs of running Kents Hill and MK said that while costs had been incurred there was assurance that the costs would be recovered. **Resolved**: The board **noted** the Month 10 Finance Report. **Workforce M10** Danielle Petch said that workforce numbers were up, with turnover 9% and vacancies 9%. She said sickness remained under 4% even during the winter months. Statutory Mandatory Training compliance stood at 95% and appraisal rates were up at 97%. HT commented on the excellent rates and asked if it was done to people teams or live ownership. DP said that paperwork had been changed so that staff felt that it was much more relevant. She said the uptake was the result of a collective effort across the Trust. HS said the results were tremendous especially when benchmarked nationally and when underpinned by the staff survey responses. She congratulated DP, her team and the executive team for such positive assurance JH said that the team had done a great job through DP stewardship but that they were guarding against complacency on softer metrics. NM said the figures were fantastic and asked if the new staff benefits had made a difference. DP said that it wasn't the benefits themselves that were a key driver, more the fact that it made staff feel valued. She said they were very much the foundation of a wider piece around culture. **Resolved**: The board **noted** the Month 10 Workforce Report.
6	**Assurance and Statutory Items**
6.1	**Board Assurance Framework and Risk** • JH said the challenge for the Board was if the risks were too high or low. IR said Covid 19 would come on as a consequence of recent events. • AB expressed surprise that there were not many gaps in controls. Where there were gaps it was recommended that the word 'nil' was inserted to avoid confusion. • Action: JH recommended that the Board focussed on the column regarding gaps in control to ensure this reflected actions in place. •
7	**Closing Administration**
7.1	**Any Other Business** JH announced that Caroline Hutton had accepted a secondment on to the NHSE/I national team regarding outpatients AB asked about progress re quality priorities – and JH said this would be on the next agenda regarding what had been achieved so far. SL said that this was Tony Nolan's last Public Board and he offered his thanks from the Board and hospital for his hard work over the past six years, citing his role as both NED and Chair of the Workforce Committeee. TN said it had been a privilege to be involved and that there had been considerable positive change since he joined the Board. SL also wanted to thank Associate NED Ian Wilson in his absence for his work with the Trust over the previous 12 months

7.2	**Questions from Members of the Public** There were no questions. The meeting closed at 11.30am.

Agenda item 3.2
Public Board 07/05/20

Meeting of the Finance and Investment Committee held on 2 March 2020

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

The Committee was in support of continuing with SBS for its finance and accounting service contract

Matters referred to the Board for final approval:

No matters were referred to the Board for final approval.

Matters considered at the meeting:

1. Performance dashboard M10

The Committee was informed that performance reflects the national picture with the hospital still under some pressures. With Ward 22 having moved to the Cancer Centre, the vacated space is being used as the new escalation area.

The Trust's performance continues to remain in the top two in the region, and nationally within the top 25% in terms of ED performance.

Items under consideration with regard to coronavirus were plans to develop further high dependency areas; and consideration over the hospital's ability to continue elective activity.

2. Financial Forecast

An overview of the Trust's processes to forecast the full year income and expenditure position for 2019/20 was provided and included an outline of the financial recovery plans and the requirement for 2020/21.

It was reported that month 7 was challenging, but the Trust has plans in place to ensure delivery of the 2019/20 control total. The high level of understanding of the drivers and good processes in place were acknowledged by the Committee.

3. Board Assurance Framework

Several items on the BAF were reviewed and updated.

4. Finance Report M10

The Trust reported an adverse variance in month and year to date of £250k but there was confidence that the control total was deliverable.

5. Agency update

Spend in January increased to £750k due to the holiday season and opening of escalation areas but was favourable to budget by £130k in month and year to date by £1.9m.

6. MK CCG contract terms 2020/21
   It was reported that the current form will continue for two years with an option to extend. This will cover the CCG merger period.

7. Finance and accounting service contract options
   The committee looked at three options as the current contract expires on March 31,2020. The committee was in support of continuing with SBS.

8. Draft Operational Plan for 2020/21
   The draft plan was tabled at the meeting. The committee was in support of the plan but remained concerned regarding the challenge of the £11m Cost Improvement Plan (CIP)

Meeting title	Board of Directors	**Date:** 8th May 2020	
Report title:	Nursing Staffing Report	**Agenda item: 3.3**	
Lead director **Report author Sponsor(s)**	**Name:** Nicky Burns-Muir **Name:** Matthew Sandham	**Title:** Director of Patient Care and Chief Nurse **Title:** Associate Chief Nurse	
FoI status:			
Report summary			
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [x] **Decision** [ ]
Recommendation	That the Board receive the Nursing Staffing Report.		

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

Report history	To every Public Board
Next steps	
Appendices	Appendices 1

Board of Directors Report on Nursing and Midwifery staffing levels
Amalgamated report for February and March 2020

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.

Are we safe?

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

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

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

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

CHPPD	Total Patient Numbers	Registered Midwives/Nurses	Care Staff	Overall
February	14020	4.2	2.9	7.1

Month	RN/RM Day % Fill Rate	HCA/MCA Day % Fill Rate	RN/RM Night % Fill Rate	HCA/MCA Night % Fill Rate
February	78.9%	100.0%	98.9%	130.9%

- *February 2020 data is included in Appendix 1.*

The CHPPD hours in March were not recorded due to the reconfiguration of clinical areas and wards in response to the COVIS-19 situation. Nursing staff were redeployed, and clinical ward areas closed with a different model of nursing implemented to support the increasing number of patients requiring isolation and increased acuity. Therefore we are unable to provide an accurate report due to staff sickness (including self-isolating and shielding) and redeployment of staff and changes in bed occupancy. This will be reviewed monthly during the pandemic.

Are we efficient?

Student Nurses

During the pandemic third year student nurses were offered the opportunity to complete their final clinical placement in practice and become part of the workforce on a Band 4 which is supported by HEE (Health Education England) and financed centrally through the Department of Health.

We have welcomed a cohort of 14 students to MKUH and undertaken an extensive induction and orientation programme. Alongside our students from Northampton University there are several students who have been studying across England and have returned home to the Milton Keynes area and have requested to be allocated to MKUH. There is a comprehensive training programme with educational and pastoral support for all the students ensuring protected learning time each week.

The student nurses will be supervised using a coaching model, where each group of students (under direction and supervision of a registered nurse) provides total care for a group of patients. Students are not currently counted within the establishment nursing numbers.

We are expecting a further two cohorts of nursing students and midwifery students in May 2020.

Therapies

MSK and Hand Therapy practitioners are delivering a service in outpatients to manage fracture clinics and minor injuries to support the ED pathways for COVID-19 by collaborating with Orthopaedic consultants. In collaboration with nursing teams, therapists are offering a ‘One stop Shop’ with Consultant and therapy review.

Respiratory physiotherapists have supported the COVID-19 isolation wards by monitoring and providing enhanced education for ward teams to enable them to support patients on oxygen therapy.

Thirty therapy staff received training to assist with proning patients and physiotherapists are working in a flexible role within intensive care (ICU) unit to help with any tasks required.

Therapists updated the patient information leaflet in preparation for post COVID rehabilitation i.e. energy conservation and fatigue management, providing guidance on breathing exercises and optimising positioning.

Virtual outpatient clinics were commenced, and patients were reviewed by telephone and video conferencing which has been a great success and plans are underway to continue post the pandemic period.

‘Hold My Hand’ initiative for End of Life was created by Lynn Boddy an Occupational Therapist as she identified there was an increased need to support palliative and End of life patients. This has now been taken forward in conjunction with the Palliative Care team who will provide oversight and ensure that those participating are supported.

Dietitians have increased their knowledge in critical care nutrition (including community and paediatric dietitians) in preparation for increasing patient numbers. This has resulted in a comprehensive seven day a week dietetic service to ICU. Community dietitians are working in acute areas to support nutritional needs of inpatients with COVID. Website information is also being updated and all patients on discharge have been contacted to sign post them to appropriate community nutrition advice.

Therapy Assistants have undertaken training in phlebotomy and cannulation to support the HCA workforce on the wards.

The Administration team supported the transformation of outpatient services and lead on the development of video conferencing.

Are we effective?

Senior Leadership presence on clinical areas

During the pandemic period effective and visible nurse leadership is pivotal to improving patient outcomes by driving the quality and safety culture of our organisation and striving to enhance patient experience. We expect and require that our ward leaders supervise clinical care, provide oversight for quality and safety in their areas and effectively lead their teams. The Chief Nurse requested the following actions to support the clinical areas:

- Phase 1

Matron presence on a 7-day rota with the Matrons based in Medicine recently extending their day until 20.30 to support flow and staffing pressures. During the COVID pandemic the day rota has continued with a Matron working until 20.30 on a Monday – Friday basis and at the weekends 2 Matrons have been on site covering the wards each day. In addition, the two ED Matrons have joined with one of the Medical Matrons to form a front door 7-day model.

- Phase 2

On Wednesday 8th April, a Senior Nurse rota was developed which included 2 senior nurses working the night shift (20.00 – 08.30). The Senior Nurses included in this rota are all Matrons and Senior Sister/Charge Nurses of the adult ward areas and there has also been contribution from Corporate nursing. The purpose of this rota is to continue the senior support given within the day to areas throughout the night time providing reassurance to both staff and patients, resolving any clinical concerns, enhancing patient experience and supporting the existing night team. As this rota continues there will be a focus on the enhancement of the quality and effectiveness of the care that is being delivered at night.

- Deployment of the work force

Due to the COVID pandemic and the expected pressure that this would place on our existing Intensive Care Unit (ICU), there was a clear decision made to enhance the ICU staffing model by releasing all nursing staff who had previous experience of working within the ICU environment.
This involved staff in many different positions including Advanced Nurse Practitioners, Matrons and the Head of Nursing for Surgery. The practice education team in

collaboration with an ICU Senior Sister developed a practical course to refresh skills and knowledge about this area of care.

The Head of Nursing for Medicine assumed responsibility for all inpatient adult wards and provided leadership to all senior sisters and matrons.

- Respiratory Assessment Unit (RAU)

As part of the planning for the ED response to COVID it became clear that the number of Covid patients that they would be able to safely treat in a contained environment would be limited. An alternative clinical area was identified and collaborative working with medical and nursing staff from ED, Ambulatory Emergency Care Unit, Cardiology and Ward 14, the RAU model of care was designed and set up within one week.

It was opened on the 1st April 2020 as a 24-hour assessment area for patients symptomatic of COVID and initially managed ambulance referrals only and later evolved to taking ambulatory patients. This has been an incredible journey particularly for the Ward 14 nursing staff who have embraced the challenge of increasing their knowledge and skill set to support patients in the assessment phase of a hospital attendance. These patients were potentially acutely unwell which is very different to the rehabilitative model of care that they are used to providing. The supportive nature of the team was quickly evident and is a clear example of excellent comradeship and a willingness to work differently.

- Care Commissioning Group (CCG)

We have welcomed 5 CCG partners into the Trust from 14th April 2020 to work within the Corporate Nursing team. Colleagues have clinical and non-clinical backgrounds across adult, paediatrics and learning disability domains of care and safeguarding.

They are supporting the Corporate Nursing “Professional Rounding” rota which focuses on patient safety and experience and are completing the “What Matters to Me” document to record patient information that will inform their care i.e. beliefs, hobbies etc. With the reduction in visitors this has been invaluable in enabling the clinical teams to provide individualised care for our patients.

They have feedback, they have felt supported coming into the organisation at this challenging time and hope to contribute to the care of patients as well as upskilling themselves.

We celebrate

Staff Contribution

During this challenging time caring for COVID patients in an evolving critical situation all nursing, midwifery and therapy staff have risen to the challenge and changed the way they worked to deliver care in a new model. Staff have moved from their roles to support the wider effort across the organisation and some truly exceptional care delivery has been undertaken. Rapid change has been undertaken and a flexible ‘can do’ attitude from all staff has enabled the organisation to be agile and adapt to the emerging situation. Going into the next phase we plan to take stock of the positive changes and consider the ‘new ways of working’ before transitioning to business as usual.

We thank all staff for their individual and collective contribution to the care delivery for our patients especially the pastoral care given for our patients in the absence of carer's and families.

Appendix 1

Fill rates for Nursing, Midwifery and Care Staff February 2020

Ward Name	Day		Night		Care Hours Per Patient Day (CHPPD)			
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
AMU	78.1%	88.9%	103.8%	117.5%	674	5.2	2.2	7.5
MAU 2	79.2%	113.7%	111.2%	163.0%	734	3.9	3.4	7.3
Phoenix Unit	82.3%	90.2%	101.1%	132.8%	677	3.3	3.3	6.6
Ward 15	81.9%	108.9%	100.5%	150.0%	805	3.5	2.9	6.4
Ward 16	80.7%	98.6%	99.1%	115.0%	809	3.5	2.5	6.0
Ward 17	76.4%	89.5%	99.2%	119.0%	725	4.3	2.1	6.4
Ward 18	75.4%	100.2%	100.8%	142.5%	783	3.0	4.0	7.0
Ward 19	73.6%	97.8%	100.0%	136.8%	810	2.9	3.7	6.6
Ward 20	80.6%	110.0%	101.2%	135.6%	742	3.8	3.0	6.8
Ward 21	84.5%	103.6%	97.7%	148.3%	651	3.9	2.8	6.7
Ward 22	81.5%	104.2%	101.6%	130.8%	566	4.1	3.0	7.1
Ward 23	83.0%	119.5%	101.8%	126.8%	1019	3.6	4.5	8.1
Ward 24	88.4%	123.8%	105.7%	-	490	4.7	1.7	6.4
Ward 3	80.0%	89.2%	100.0%	120.6%	766	3.2	3.5	6.7
Ward 5	76.4%	113.2%	105.2%	93.4%	523	6.6	1.5	8.1
Ward 7	79.7%	104.7%	102.3%	149.3%	676	3.5	4.8	8.3
Ward 8	70.2%	85.7%	103.4%	122.4%	703	3.3	2.7	6.0
DOCC	71.3%	84.3%	85.7%	-	173	25.0	1.4	26.4
Labour Ward								
Ward 9	77.1%	90.3%	90.3%	85.1%	995	2.5	2.0	4.5
Ward 10	87.8%	-	81.5%	-	237	5.3	0.0	5.4
NNU	80.9%	61.1%	94.7%	93.1%	462	8.9	1.2	10.2

Meeting title	Trust Board	Date: 07 May 2020
Report title:	Obstetrics and Gynaecology Training Concerns: work to develop the culture and learning environment	Agenda item: 3.4
Lead directors	Name: Ian Reckless	Title: Medical Director
FoI status:	Public Document	

Report summary				
Purpose *(tick one box only)*	Information ☐	Approval ☐	To note ☒	Decision ☐
Recommendation	This report and its appendices update Trust Board on work going on within the Department of Obstetrics and Gynaecology following concerns raised about the learning environment via annual general Medical Council (GMC) trainee surveys and Health Education England (HEE) Thames Valley quality assurance visits. Trust Board is asked to note the report and the work of its Quality and Clinical Risk (QCRC) sub-committee in this matter.			
History	These training concerns have been discussed at Trust Board intermittently over the last 12 months, and feature on the Board Assurance Framework. QCRC reviewed the training concerns, and the Trust's response to those concerns, in detail at its meeting of 23 March 2020, where non-executive members stated that they were *fully assured by the report and the account given of the challenges and the Trust's response* (draft minutes).			

Appendices	Appendix 1: Executive Summary from the report of the formative review undertaken by Dr Tony Berendt (formerly, Medical Director at Oxford University Hospitals NHS Foundation Trust) of Berendt Consulting. Appendix 2: Action Plan being progressed within the Department

Work to develop the culture and learning environment within the Department of Obstetrics and Gynaecology

Background

Each year, the General Medical Council undertakes surveys of trainers and trainees. Results of the survey are reported at a relatively granular level and offer a benchmark of trainer and trainee experience in particular specialties / training programmes (based within HEE localities or Deaneries) and at particular Local Education Providers (LEPs) or Trusts.

In addition, the Training Programme Director and / or Head of School gathers feedback from trainees across the year and in particular in the run up to the trainees' Annual Review of Competency Progression (ARCP) or appraisal process in the Spring.

Trainee feedback for the Department of Obstetrics and Gynaecology for the 2018/19 academic year became available in the summer of 2019. Trainee experience was poor across a number of domains (reported variably as bottom quartile / negative outlier). This negative experience was reinforced / confirmed by the feedback gathered by the Head of School.

Looking back at prior years, feedback from trainees in Obstetrics and Gynaecology has generally been poor, occasionally (and perhaps by random variation) improving to average.

There are some features of the Department of Obstetrics and Gynaecology in Milton Keynes which put the Trust at an immediate disadvantage in relation to surveyed trainee experience: many trainees live a long way from Milton Keynes and therefore may resent being posted to the Trust; and, the number of births in Milton Keynes means that there is just one 'middle grade' trainee on-call at any one time. In all other hospitals in the region, the number of births is such that there are two middle grade trainees on-call at any one time. This peer support is very much valued by trainees. In many other Deaneries, including East of England, a single tier rota is the norm, whilst in Thames Valley, Milton Keynes is a sole outlier. As the clinical experience of trainees and their expectations have changed over time, this relative independence in practice is perhaps feared rather than valued.

It is important to note that whilst the Executive Team is aware of the challenges and issues in the department, it does not consider the department to be dysfunctional or unsafe. Indeed, the department has grown and developed significantly over the last 6 or 7 years. The Executive Team's emphasis is on ensuring that this development continues.

Programme of Improvement Work

Following the 2019 GMC trainee survey and a triggered visit by the HEE Thames Valley Quality Team, the Medical Director put in place a programme of work to drive improvement in the training environment (and by extension, the wider department). An HEE Thames Valley Quality Team review meeting in October 2019 noted some of the work in progress but, given further negative feedback from the new trainees who had joined Milton Keynes in August 2019, elected to place the training programme in Milton Keynes in 'special measures' (known by HEE as 'ISF Category 3').

Progress to date

A lot of activity has taken place over the last year. Key elements are as follows:

1. Work led by the Divisional Director and Medical Director with the consultant body around the feedback, its importance, and the contribution which they can make as individuals and collectively.

2. Dr Tony Berendt was commissioned to undertake a formative review of the department, focusing upon working relationships with and within the consultant body, using the training environment as a particular prism through which to view departmental working. The review included 1-2-1 interviews with all consultants. The Executive Summary (received 31 January 2020) is appended as Appendix 1. The report has been discussed in some detail at QCRC on 23 March 2020.

3. There has been a significant change in leadership within the department in the last 18 months or so, including a new Divisional Director, a new Associate Director of Operations for Women's and Children's, a new Consultant Midwife and more recently, a new CSU Lead (Clinical Director) for the Department. Several members of the Consultant body are new to the organisation. A combination of 'fresh eyes' and the skills and experience of the new incumbents bodes well for the development of the department.

4. Very active engagement of trainees within the Department by all parties – from Medical Director through to College Tutor.

5. Active engagement and collaboration with the HEE Head of School for Obstetrics and Gynaecology.

6. Co-design (with managers, consultants, trainees and the Deanery) of a unified action plan drawing together recommendations from the Deanery QA visit, the Berendt review and other departmental priorities. A recent version of this action plan (as at 18 March 2020) is appended as Appendix 2 and was discussed in some detail at QCRC on 23 March 2020.

7. Active investment in the department – development opportunities for consultants (for example, leadership training and personal coaching) and investing in time for the team away from the workplace. For example, the team had an off-site away day on 13 March 2020 – just before such an event would have been rendered impossible by COVID-19 – facilitated by Professor Suzette Woodward, a leading international patient safety expert (www.suzettewoodward.com) which encouraged them to think differently about safety and culture, and allowed consultants, managers, senior midwives and a trainee representative to interact socially and positively, away from the work environment.

8. A formal follow-up visit by the HEE TV Quality Team, accompanied by the GMC, had been scheduled for 30 March 2020. In view of COVID-19, this visit was adjusted. A virtual visit took place, taking the form of a teleconference between the Trust, HEE Thames Valley and the Head of School. This was followed by non-face-to-face interviews with the trainees in the department (undertaken by HEE Thames Valley), and discussion at HEE Thames Valley Quality Committee on 21 April 2020. Subsequent feedback recognises: the Trust's significant and positive response to the feedback received in November 2019; improvements achieved (receiving positive feedback from trainees) in respect of a number of requirements; and, some areas where further development work is required. The team is currently reflecting on this feedback, and pushing forward with the improvement plan in so far as is possible given the context of COVID-19 and necessary adjustments in rotas and work practices.

Next Steps

The training programme remains in ISF Category 3 but there is a palpable degree of confidence on the part of the Head of School, the HEE Thames Valley Team and QCRC that the actions identified are the appropriate ones, and that real progress has been – and continues to be – made. A further HEE Thames Valley visit is anticipated in November 2020.

Ian Reckless

Medical Director

30 April 2020

Appendix 1: Executive Summary of the formative review undertaken by Dr Tony Berendt (formerly, Medical Director at Oxford University Hospitals NHS Foundation Trust) of Berendt Consulting

Appendix 2: Action Plan being progressed within the Department

Report of an Independent Review of the Department of Obstetrics and Gynaecology, Milton Keynes University Hospital NHS Foundation Trust

Undertaken for Dr Ian Reckless, Medical Director, MKUH

By Dr Anthony Berendt, BM, BCh, FRCP, SFFMLM, MA

Executive summary

Document history
First draft issued to Dr Reckless 10th December 2019
Re-issued with amendments 23rd December 2019
Final report issued 31st January 2020

Disclaimer.
This report is prepared in confidence and is based on information obtained during interviews, carried out in October 2019, with key staff members in and relating to the Department of Obstetrics and Gynaecology, together with a review of relevant documents, all as set out in the Terms of Reference. Opinions from the author are based on this information.
The report is prepared for Dr Ian Reckless, Medical Director, to be distributed at his discretion for the purpose of facilitating improvements in quality of patient care and staff experience in the department reviewed. All other uses of the report, or its citation out of context in whole or part, should be considered invalid.

1. Executive summary

1.1. Milton Keynes University Hospital (MKUH) commissioned an independent review into aspects of the department of obstetrics and gynaecology, after the 2019 General Medical Council (GMC) survey had highlighted concerns amongst trainees about their experience of the department and the learning environment.

1.2. In the GMC survey, MKUH scored poorly in 13 of the 18 areas where trainees assess their own experience of working in a department.

1.3. After the survey was published, the review was commissioned by MKUH Medical Director, Dr Ian Reckless. It was undertaken by Dr Anthony Berendt (of Anthony Berendt Consulting Ltd), formerly Medical Director at Oxford University Hospitals NHS Foundation Trust. The final report was received by the Trust in January 2020.

1.4. The review involved interviews with consultants (including a consultant midwife), specialist nurses, matrons, midwives, trainee doctors, pathway coordinators and managers, together with a review of selected documents, in order to consider whether the trainee experience reported in 2019 reflected wider issues within the department. Of note, the respondents to the 2019 GMC survey had rotated to other hospitals by the time of the review.

1.5. The review found that there are many areas of good practice in a department that provides safe care. The department is rated as 'good' in all quality domains by the Care Quality Commission since an inspection in 2014, recently maintaining its rating (2019). Staff reported generally good relationships with colleagues and had confidence that they all had a focus on patient care. There is confidence in midwifery leadership and generally good interactions between midwives and medical staff.

1.6. This review identifies **issues and risks**, including the following:

- The department has yet to move fully beyond some of its historical problems with some consultant behaviours impacting upon the perception of the department from outside, and some of the relationships and staff experiences within it.
- These behaviours pose an immediate risk to the department in that poor trainee experience could lead to the loss of training recognition. If unchallenged, these behaviours could also pose a longer-term risk to interdisciplinary working, morale, and quality of care.
- Postgraduate medical trainee experience continues to be difficult, with heavy workload and a sense of a lack of support from some consultants, especially when on-call. This is despite consultants stating that they are committed to training and in the context of there being good potential training opportunities.
- The management of rotas, administrative pathways and participation in meetings are also causes for some concern and need further attention to resolve adequately.

1.7. This review **recommends** that change is needed in each of the following areas:

- At the personal level, in a changed commitment to:

good communication; healthier management of disagreement and conflict; improved team working; and, adopting more standardised clinical pathways and work practices.

- At the individual level, through personal development to improve knowledge and skills in leadership and communication.

- At the team / service level, with improved, agreed and adopted organisational processes and procedures.

- At the team / service level, with improved group dynamics and group behaviours, enabled by more assertive communication, leading over time to a resetting of group expectations, norms of behaviour and performance.

1.8. An **integrated programme of work** is likely to be needed to address these areas, with a strong focus on:

- Establishing a process for improving dialogue and communication within the team – and then making the improvements over time.

- Establishing better processes for planning, coordinating and carrying out the work of the team.

- Establishing a better process for reflection on how the team is doing – its activity, outcomes, problems, team dynamics – so that it can make further improvements in line with the Trust's vision for continuous quality improvement.

1.9. Findings and recommendations should be considered in the context of a department that appears overall to be maintaining quality at acceptable levels and has done so for several years (from the CQC perspective), with the important current exception of the quality of trainee experience.

Action number	Overarching Action	Start date	Proposed Completion da	Completion Date and RAG	Evidence required/update
Theme	**Emergency Gynaecology**				
1.1	Ensure reliable day-to-day consultant-led morning provision with an emphasis on supervision and teaching of trainees.	Dec-19	Jan-20	Feb-20	Consultant Job Plans and Rotas
1.2	Senior cover and support in Emergency Gynaecology - Decision on further changes to consultant rotas aligning an afternoon of SPA following a morning of emergency gynae (including 1-2 hours of flexible DCC) - a more developed 'hot week' model with improved continuity.	Jan-20	Jan-20		On going review of consultant job plans, clinical activity and experience of trainees to determine need for business case for additional consultant PAs. Additional middle grades allocated to emergency gynaecology on the afternoons - staffing establishment allowing. Agreement that Emergency Gynae morning consultant to provide telephone support in afternoon if in Trust. Wednesdays full daytime consultant cover for Emergency Gynaecology. Emergency gyanaecology consultant cover in the afternoons provided by Labour Ward consultant. 10/03/20 - Business case submitted to Exec Directors for options of 2 or 3 additional O&G middle grades to 1. Improve Gyneacology cover and support in the afternoons and evenings 2. Increase Gynaecology cover at weekends. Investment approved (two middle grades) - recruitment awaited.
Theme	**Behaviours and Standardisation**				
2.1	Pilot mandating the wearing of scrubs by consultants when on Labour Ward duty.	Jan-20	Jan-20	Jan-20	Compulsory wearing of scrubs by Labour Ward consultant of the week - Agreed at consultant meeting with IR and NG - 29/01/2020
2.2	Individual consultant behaviours - DD/MD to meet all consultants and offer individual meetings to reflect on Berendt Consulting report (once shared) and other feedback - personal accountability and contribution to culture and behaviours.	Dec-19	Jan-20	Jan-20	Letters offering personal discussions to consultants following meeting - copied to MD - NG (CSU lead)/IR/JB and met all O&G consultants on 29/01/20. IR had 1-2-1 meetings with 4 consultants (at his request) by 12/02/2020.
2.3	DD/MD to attend 08:00 labour ward handover sporadically (with a view to time keeping, behaviours, teaching opportunities and standardisation of content).	Dec-19	Jul-20	Ongoing	IR attended 05, 09 and 25 December 2019, 16/01/20 . JB attended 10 and 31 Jan 2020. Handover audit to be undertaken.

2.4	Attendance lists at key meetings to be maintained and audited. Serial absence to be challenged.	Dec-19	Ongoing	Ongoing	New Trust audit afternoons commenced January 2020 - consultant attendance monitored and well attended to date (18/03/2020). New consultant job plans commenced 17/02/20 whcih have allocated increased SPA time for consulatnst to undertake key governance meetings and activities (e.g. risk, DATIX, complaints lead, ATTAIN, Colposcopy lead). Departmental goverance and engagement to be reviewed in CSU meetings and individually at consultant appraisal.
2.5	Consider the development of a documented evening teleconference handover meeting between consultant, day and night middle grades and senior midwife on-call.			Jan-20	EK circulated a teleconference proforma to commence from 29/01/20.
2.6	Identification of up to 3 sets of local guidelines (ideally selected by trainees) for rapid multi-professional review in order to assist in further standardisation of practice across the unit. Potential for use of QI methodology and trainee involvement. Handover and reduced fetal movements potential candidates.	Dec-19	Mar-20	Jan-20	NS update at consultants meeting 08/01/2020 - 4 guidelines identified by trainees (EPAU pathway, Pathway for reduced foetal movements, Pre-term prelabour rupture of membranes and Obstetric cholestasis). All guidelines have been reviewed and amended by consultants and circulated to trainees for comment. Approval at O&G CIG meeting 29th January 2020.
Theme	**Trainee Support**				
3.1	Director of Medical Education (RB) to meet with all specialty trainees.	Dec-19	Jan-20	Dec-19	RB has met with trainees and further scheduled meetings with trainee representative
3.2	Divisional Director (JB) to meet with FY and GPVTS trainees.	Dec-19	Jan-20	Jan-20	Completed for 13/01/2020 - awaiting list of conditions/scenarios requiring consultant presence
3.3	Medical Director to attend a O&G Junior Doctors' Forum.	Dec-19	Feb-20	Dec-19	IR attended 05 December 2019, and 06 February 2020.
3.4	Medical Director to write to all trainees to highlight issues identified around exception reporting, FTS Guardian (Phillip Ball) and approach to incident reporting and management.	Dec-19	Dec-19	Dec-19	Evidenced by letters to trainees (13/12/2019). Trainee forum attended by FTSUG, GSWH and clinical risk lead midwife in January and February 2020.
Theme	**Rota Management**				
4.1	Rota issues – KP to outline costs and benefits relating to proposed joint Divisional rota co-ordinator for W&C (such that an investment decision can be fast-tracked).	Dec-19	Dec-19	Jan-20	KP to present proposals to Exec Board members 14/01/20 - Budget reallocation completed to move existing admin budget as a trial while a team member undertakes a secondment opportunity.

4.2	Review of potential for a two tier middle grade on-call rota, set against extant guidance, staff availability and cost.	Dec-19	May-20		17/01/20 Discussions with JB/IR and Head of School - exploring ideas of additional NTNs/CESR/rotational non trainee posts and GP assistants in Gynaecology. Business case presented 10/03/20 for two additional middle grades (to provide additional daytime cover 7 days per week). Aprroved - recruitment awaited.
4.3	Doctors in training to be engaged in monthly rota planning cycle (using Allocate software) in order to make an informed decision on best model for ongoing involvement. Specific focus on how to share high level rota outputs amongst trainees to ensure transparency and equity.	Jan-20	Jan-20	Feb-20	Junior doctors engaged in monthly rota planning with CS - however ongoing experience remains suboptimal - aim to increase visibility of rota issues and service objectives with trainees with a weekly meeting between a trainee and consultant rota coordinator. Plan for weekly emails requesting for feedback regarding trainee supervision commenced on 01/02/2020. Pilot proposed for trainees to design rota for subsequent entry into Allocate HealthRoster. Following further feedback in mid February trainees take a much more significant role in rota planning supported by Rota consultant (OM) and operational staff. Trainees currently fill out rota template and put into Health Roster by Managerial support staff- supported by weekly roat meetig with consultant rota coordinator.
Theme	**Clinic Management**				
5.1	Formal audit of start time of clinics and time that all doctors leave clinic, to compare aganist booking of clinics and job plans / work schedules. Full disclosure of data to all doctors and ask for reasons for differing start/finish times to be communicated with CS/KP.	Dec-19	Feb-20	20/03/2020	Agreement in meeting with consultants and IR and NG to undertake audit. Audit commenced 03/02/20 demonstrated improved clinic efficiency for all grades of doctors. Results circulated to consulatnt body JB 20/03/20.
5.2	Review of clinic templates in terms of a baseline for the current templates, and to demonstrate any changes.	Dec-19	Jan-20	20/02/2020	Clarity and plan from Head of School on appropriate RCOG clinic templates and additional trainee admin time per clinic. Clinic templates changed on 17/02/20 and Trainees admin time reflected on rota meeting Deanery requirements.

5.3	Trainees were concerned about adequate support in clinics due to trainees frequently undertaking clinics without direct Consultant supervision and also reported lack of support out of hours	Dec-19	Feb-20	10/02/2020	Tracking trainee experience and acting upon examples of poor support with individual consultants. Formalised audit of trainee experience via weekly email requests for examples commenced 10th February sent out by College Tutor .
Theme	**Exception reporting**				
6	Exception reporting – MDO to ensure that each trainee has been given a login and understand the process of exception reporting. AK (Guardian of Safe Working**)** to attend O&G Junior Doctors' Forum in early 2020.	Dec-19	Feb-20	Feb-20	Covered in IR's letter to trainees dated 13/12. AK accepted invitation to attend 06/02/20. AK attendance at Junior Doctor's Forum - encouragement to fill in exception reports for too long shifts and lack of rest during shifts. Safety concerns can also to be raised via Datix. Evidenced in minutes.
6.1	Exception reporting to be reviewed in monthly CSU meetings.	Dec-19	Ongoing	Ongoing	CSU meeting minutes - 1 case discussed in January CSU meeting. Multiple exception reports discussed at CSU meeting 18/03/20. 14 exception reports in February and 6 in March (to date). All exception reports actioned - some awaiting trainee agreement. Evidence of individual trainee issues escalated to Educational Supervisors as necessary.
Theme	**Incident Reporting, Raising Concerns and Risk Management**				
7.1	Incident reporting – Medical Director to meet with Divisional and Trust risk leads to review feedback on incident reporting systems and how best to optimise communication and learning within the CSU.	Dec-19	Dec-19	Dec-19	Covered in IR's letter to trainees dated 13/12. Meeting took place 24/12 (outputs outlined in letter to JB, dated 24/12).
7.2	Risk Midwife to meet trainees in Junior Doctors Forum to reiterrate feedback process and discuss with trainees possible improvements	Jan-20	Feb-20	Feb-20	Plan agreed at Womens' CSU meeting 15/01/20 to attend February JDF - CH attended on 06/02/2020
7.3	Medical Director to remind trainees of the purpose and identity of the Freedom to Speak Guardian. Guardian (PB) to meet with trainees at O&G Junior Doctors' Forum on 09 January 2020.	Dec-19	Jan-20	09/01/2020	Covered in IR's letter to trainees dated 13/12. PB attended Junior Doctor's Forum 09/01/2020.
7.4	DME and FTS Guardian to meet and discuss current issues in O&G training.	Dec-19	Dec-19	Dec-19	Meeting taken place
7.5	RB to offer further point of contact for raising concerns about consultant behaviour	Dec-19	Dec-19	31/12/2019	Evidence of communication to trainees
Theme	**Junior Doctor Engagement**				
8.1	Junior Doctors Forum – needs an action log which can be shared with trainees to chart progress on actions	Dec-19	Feb-20	Jan-20	Minutes of JDF - action log sent out post each meeting and discussed as agenda item

8.2	New curriculum and e-portfolio – NS and RB to arrange a date for MK consultants early 2020. 13 March 2020 being explored (combination of training and first away day - see 10.2).	Dec-19	Mar-20	13/03/2020	Attendance of consultants at session. Session planned with Head of School (AM) and Suzette Woodward (PM) 13/03/20 - all consultants and senior midwives to attend. Clinical actvity reduced and consultants and midwives aware of mandatory attendance - 04/02/20. Meeting took place on 13/03/20 - Deanery Curriculum/portfolio (am) MK Academic Centre and patient safety (pm) sessions - offsite venue 13/03/20.
Theme	**Clinical Leadership and Management Resource**				
9.1	Receipt and sharing of Berendt Consulting report, following review of draft with Dr Berendt in mid-December 2019.	Dec-19	Jan-20	17/01/2020	Meeting with DH 17/01/20
9.2	Confirmation of new CSU Lead following agreed resignation of previous postholder in December 2019. Expressions of interest invited 13/12/2019.	Dec-19	Jan-20	10/01/2020	NG agreed to undertake from 20th January. Email sent to consultant body confirming appointment 15/01/20.
9.3	Options appraisal and decision on overall Clinical Management resource level for CSU in terms of: (1) number of programmed activities available to CSU Lead; (2) desirability (or otherwise) of a deputy role; and, (3) appropriate coverage of other leadership tasks in the service (for example, emergency gynaecology leadership). These options to cover short (2020) and longer term.	Dec-19	Jan-20	12/02/2020	KP presented proposals to Exec Board members 14/01/20 with subsequent agreement of additional SPAs.
9.4	Consider role of mentor for incoming CSU lead	Dec-19	Apr-20	12/02/2020	Informal discussions taken place 13/12/19. 17/01/20 Head of School identifed a possible mentor from OUH. Following discussion with NG, keen to have regular touchpoints and support from IR/JB initially (rather than formal mentorship). IR content with this decision.
Theme	**Departmental Development / Other**				
10.1	Development of departmental vision, strategy and objectives (both at service and individual level).	Jan-20	Apr-20		Presentation to Management Board.
10.2	Away Day to be put in place for Consultant and other selected staff - twice in 2020 and then at least annually.	Jan-20	Mar-20	Mar-20	Friday 13 March 2020

10.2	Urgent attention to potential estates improvements to Labour Ward in order to facilitate: (1) an area for consultants to attend to computer / admin work during quiet periods; (2) improved seminar facilities; and, (3) a common social / rest area to encourage closer interaction between all staff groups on Labour Ward. Goal is to appraise oprtions to permit investment decisions.	Dec-19	Jan-20	Partially complete	Walk arounds undertaken by Estates and Triumvirate members - proposals to be presented to Exec team in paper by KP on 14/01/20. Decoration of seminar room and TV for presentations on wall undertaken. Awaiting IT support for ClickShare. Business case for completion for reclining chairs, lockers, workstations and estates work to room in O&G hub awaiting final quotes - agreed in principle by Exec Directors in January. Additional computers purchased and awaiting delivery.
10.3	Interim and longer term plan for gynae-oncology service in association with Northampton General Hospital.	Nov-19	Mar-20		Succesful consultant interview on 06/01/20 - proposed start date April 2020.
10.4	Early involvement and engagement of the department with QI training and methodologies.	Jan-20	May-20		Triumvirate met with transformation / QI team on 14/01/20 to look at Divisional engagement with Trust QI process - projects identified
10.5	Scope options for leadership development / coaching for senior staff in CSU, prioritising consultants in specific leadership roles.	Jan-20	May-20		IR has had detailed discussion with a number of consultants about personal coaching (formative / developmental). Some are already engaged in group coaching / action learning.
10.6	Scope options for the provision of inter-professional communication workshops (over and above PROMPT training) to include 'courageous / difficult conversations'.	Jan-20	May-20		Consultants open to this. IR to source provider - likley for delivery autumn 2020.
10.7	Review of Berendt report to chart progress	Jan-20	Oct-20		
10.8	Review of arrangements in place for colposcopy and hysteroscopy triage (potentially in association with 'hot gynaecology' duties).	Jan-20	Mar-20		Arrangements discussed with relevant consultants Feb 2020.

Meeting title	**Trust Board**	**Date: 07 May 2020**
Report title:	**Mortality Report**	**Agenda item: 3.5**
Lead director **Report author** **Sponsor(s)**	**Dr Ian Reckless** **Dr Bina Parmar**	**Medical Director** **Associate Medical Director**
FoI status:	**Publically disclosable**	

Report summary				
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** x	**Decision** ☐
Recommendation	Implementation and monitoring of the action plan			

Strategic objectives links	Improve patient safety
Board Assurance Framework links	Risk register ID reference 616
CQC outcome/ regulation links	Trust objective – patient safety **This report relates to CQC:** **Regulation 12 – Safe care & treatment** **Regulation 17 – Good governance**
Identified risks and risk management actions	Mortality data outside the expected range would be of public & regulatory body concern
Resource implications	None
Legal implications including equality and diversity assessment	This paper has been assessed to ensure it meets the general equality duty as laid down by the Equality Act 2010

Report history	Regular update
Next steps	Implementation and monitoring of the action plan
Appendices	N/A

Executive Summary

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

The Trust's current HSMR and SHMI are both statistically 'as expected'. There has been a downward trend in HSMR over recent months. An upward trend has been observed within SHMI data but this lags some months behind HSMR. HSMR data is being adjusted / 'rebased' and will incorporate COVID-19 deaths in future reports.

The Regional Medical Examiner and Regional Medical Examining Officer visited MKUH on 29 January. The Trust received good feedback.

The Medical Examiner System underwent a review of pathways to accommodate the COVID-19 crisis. This involved compliance with the changes in Law as laid out in the Coronavirus Act. It was difficult to ascertain if a Medical Examiner System would run during the initial phase due to a significant number of the ME team being redeployed. There has been much engagement from various team members to become Medical Examiners. Two doctors who completed online training were recruited to the team at the beginning of April. A virtual ME pathway process was also developed.

The teams worked over weekends and bank holidays to ensure there has been a quick turnover of paperwork. Mortuary numbers have been kept below an alert level and this ensured alternative resources (specifically, the ice rink) have not been required during peak periods to date. During this time and presently we have reviewed all deaths through Medical Examiner scrutiny.

Mortality and Morbidity Meetings have reduced in frequency due to COVID-19 and associated pressures, this has caused a backlog of cases for discussion. We have asked that SJR requests prompted by Medical Examiners, the Serious Incident Review Group and the complaints function will be prioritised for Medicine. Surgery and Women's Health will continue to review all of their deaths.

HM Coroner is only holding inquests (virtually) that had a previously agreed date, where the next of kin had no concerns and is happy to proceed as 'read only'. All other inquests will have new dates set in due course. This will then have a significant impact on the Trust due to the high volumes. At one point it was suggested that all COVID-19 related deaths may be subject to Inquest with jury: clearly, in the current context this seems neither approprioate nor achievable.

All new coroner referrals are being processed as per usual, with the recognition that the timeframe for receiving clinicians' statements may take longer than as agreed in the standard operating procedure (SOP).

Central Medical Examiner funding has been approved for 2019/20.

Mortality Platform – The Clinical Outcome Review System (CORS) has been approved and is currently in the initial phase of template design. This system will assist in recording the process and outcome of Medical Examiner reviews and, crucially, assist in organisational learning.

Definitions

Out of hours – Nights/weekends and bank holidays

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

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

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

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

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

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

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

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

Dr Foster

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

HSMR Data from April Report
Data period: Feb 2019 – Jan 2020

Key Highlights:

- HSMR relative risk for 12 month period = 94.8 ‘as expected’ range.
- The Trust has was in the ‘as expected’ banding in the last report.
- Crude mortality rate within HSMR basket = 2.9% (MK peer group rate 3.5%).
- 0 outlier diagnoses were identified within the HSMR basket for this period.
- Palliative Care 5.84% (Peer Rate 5.15%) for 2019/20.

Divisional HSMR performance for rolling year
Data period Feb 2019 – Jan 2020

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

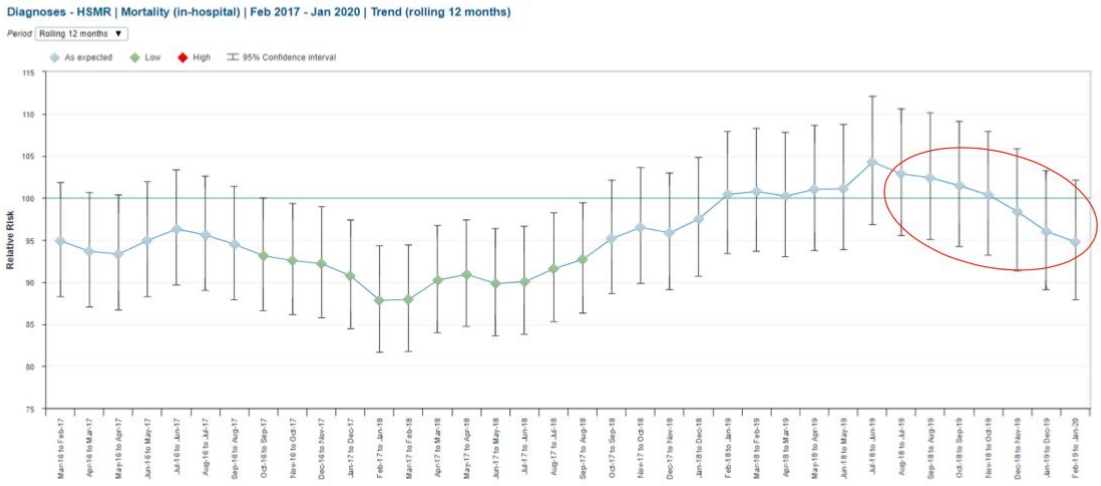
Medical Division RR = 97.9 ‘as expected’. There were 0 negative outliers (by diagnosis group) (i.e. significantly higher than expected deaths).

Surgical Division RR = 79.8 ‘as expected’. There were 0 negative outliers.

Women’s and Children’s Division RR = 39.4 ‘below expected’. There were 0 negative outliers.

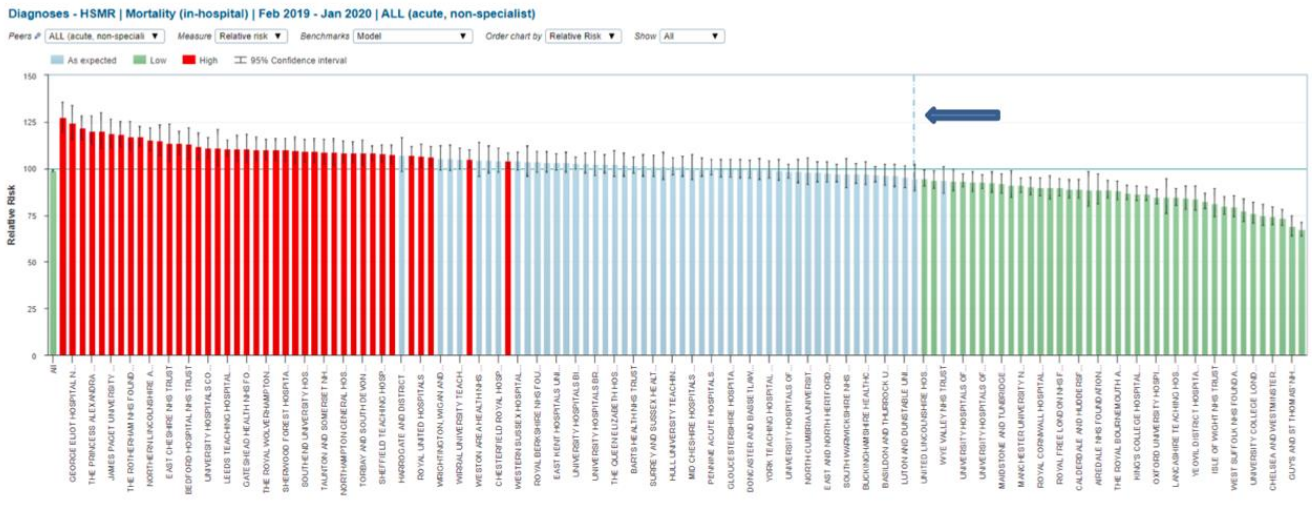
HSMR Rolling Trend
Data period Feb 2017 - Jan 2020

Figure 1.1: HSMR – Trend (Rolling 12 months) last 36 months



HSMR vs National Peers
Data period Feb 2017 - Jan 2020

Figure 2.2 – HSMR vs national peers

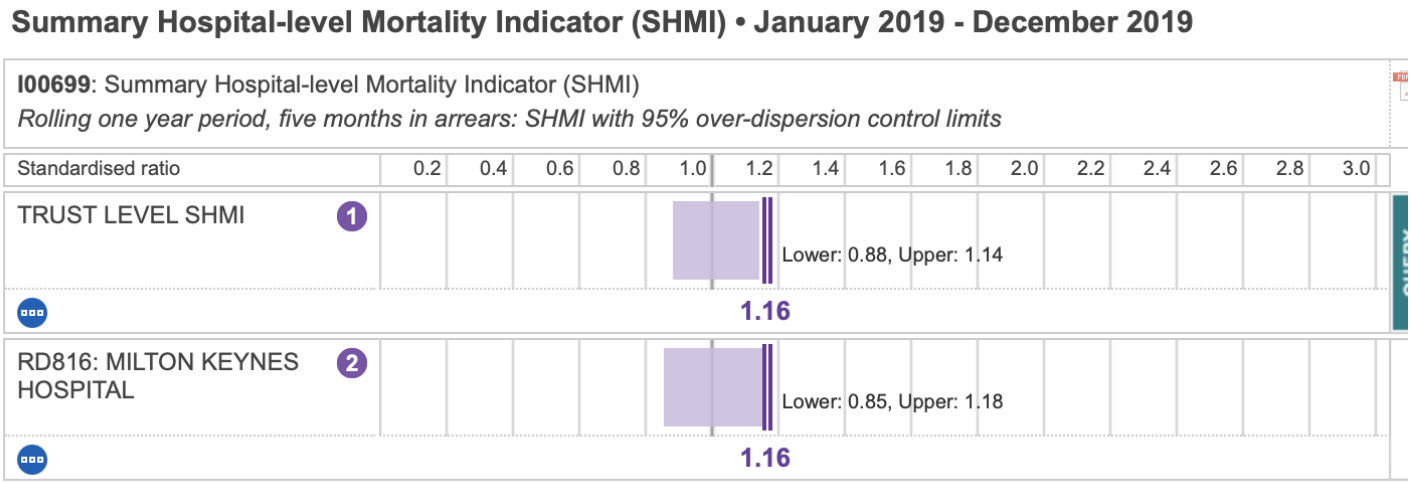


SHMI

Data period: Jan 2019 – Dec 2019 (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.

SHMI = 1.16



Investigations of Deaths

The data for Q2, Q3, Q4 and provisional Q1 are illustrated in the table below.

All deaths undergo review by the Medical Examiner System. The system will offer a point of contact for bereaved families or clinical teams to raise concerns about care prior to the death. Concerns can also be raised by the Medical Examiner following Medical Record review. Deaths with concerns will undergo a formal Structured Judgement Review.

Structured Judgement Reviews are carried out by trained reviewers who look at the medical records in a critical manner and comment on all specific phases of care. The Stuctured Judgement Review is presented at the Mortality and Morbidity Meetings. If a death is deemed avoidable a 2nd Structured Judgement Review is carried out at which point this will be graded to judge avoidability of death score (Score of 3 or less). This form will conclude with key learning messages from the case and actions to be followed.

Score 1 Definitely avoidable
Score 2 Strong evidence of avoidability
Score 3 Probably avoidable (more than 50:50)
Score 4 Possibly avoidable but not very likely (less than 50:50)
Score 5 Slight evidence of avoidability
Score 6 Definitely not avoidable

Investigations of Deaths

	Q2 Apr-Jun 2019/20	**Q3 Jul-Sep**	**Q4 Oct-Dec**	**Q1 Jan-Mar**
No. of deaths	298	261	247	302
No. of deaths reviewed by Medical Examiner†	199 (67%)	100%	100%	100%
No. of investigations (% of total)	152 (51%)	58 (22%)	31 (13%)	16 (5%)*
No of Coroner Referrals (%of total)	32.5%	38.3%	25.9%	18.5%
No. of deaths with Care Quality concerns (%)	2	1	0	0*
No. of potentially avoidable deaths (%)	1	0	0	0*

† All deaths reviewed by Medical Examiner Scrutiny process

* Q1 data are provisional and are still subject to further modification (as formal review processes occur within the Trust's clinical divisions.

Meeting title	Trust Board (Public Session)	**Date:** 07 May 2020
Report title:	7 Day Services Report	**Agenda item: 3.6**
Lead director **Report author** **Sponsor(s)**	**Name:** Dr Ian Reckless **Name:** Elisa Scaletta	**Title:** Medical Director **Title:** Business Manager
FoI status:	Publicly disclosable	

Report summary							
Purpose *(tick one box only)*	**Information**	x	**Approval**		**To note**	x	**Decision**	
Recommendation	This report provides Trust Board on progress made against priority standards from data collected in April 2020.						

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

Report history	Fourth report to Board. Previously discussed at Clinical Quality Board, Management Board and Quality and Clinical risk Committee.
Next steps	Trust Board is asked to note progress made following previous submissions, and to approve the attached data for subsequent national submission if / when requested (in the context of COVID-19).

1. Purpose of the Report

Board are asked to note performance and specifically the work in progress against priority standards 2, 6 and 8.

2. Context

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

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

The 10 standards for seven-day services are:

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

**Priority Standard*

National progress towards delivery of seven-day hospital services was previously measured by bi-annual self-assessment surveys. In February 2019, as part of a trial run, progress was measured using a board assurance process, which involved completing a self-assessment template and publishing this as part of public Trust board papers. A subsequent submission was made in June 2019. Requirement for a further submission was anticipated in early 2020, although in the event this has been 'stood down' nationally on account of the demands placed

upon services by COVID-19. The Trust has made an active decision to continue with ongoing audit against priority standards 2 and 8 as stability or improvement in these measures at a time of major service change (COVID-19) will provide assurance around quality at a time in which some routine quality metrics are not as readily available. Given the data are being collected internally, a public Board Assurance statement is appropriate (although not mandatory).

3. February 2019 Audit Results / Submission

The trial board assurance self-assessment was submitted to NHS England on 27 February 2019, with subsequent discussion at public Board on 01 March 2019. The data was from 120 randomly selected patients with emergency admissions followed by discharge / death in the weeks commencing 04 and 11 February (60 per week).

Priority standard 2 - The Trust achieved 73%

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

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

Priority standard 8 – The Trust did not achieve the 90% target; however, work is still ongoing and plans are in place to build pre-populated (auto text) templates into eCare to provide clearer documentation as to whether patient review is delegated to another member of staff.

4. June 2019 Audit Results / Submission

The summer board assurance self-assessment was submitted to NHS England on 25 June 2019, with subsequent discussion at Public Board on 03 May 2019. The data was from randomly selected patients with emergency admissions followed by discharge / death in the weeks commencing 18 March – 14 April 2019 (60 per week).

Priority standard 2 - The Trust achieved 83%

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

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

Priority standard 8 – The Trust did not achieve the 90% target; however, work is still ongoing and plans are in place to build pre-populated (auto text) templates into eCare to provide clearer documentation as to whether patient review is delegated to another member of staff.

5. November 2019 Audit Results / Submission

The Autumn board assurance self-assessment was submitted to NHS England on 19th November 2019, following discussion at Public Board on 7th November 2019. The data was from randomly selected patients with emergency admissions followed by discharge / death in the weeks commencing 9th – 22nd September 2019 (60 per week).

6. **Priority standard 2 -** The Trust achieved 84%
7. **Priority standard 5 –** The Trust achieved the 90% target with ongoing work to support inpatient echo capacity 7 days a week.
8. **Priority standard 6 –** The Trust did not meet the 90% target due to interventional radiology only being available on or offsite via an informal agreement. However, formalisation of interventional radiology is currently being reviewed and negotiated with Oxford as our tertiary centre.
9. **Priority standard 8 –** The Trust achieved 67% and therefore te Trust did not achieve the 90% target; however, work is still ongoing and plans are in place to build pre-populated (auto text) templates into eCare to provide clearer documentation as to whether patient review is delegated to another member of staff.

Therefore, the only standard that was met was standard 5.

6. April 2020 Audit Results

The data was from 120 randomly selected patients with emergency admissions followed by discharge / death from (13th April 2020 – 26th April 2020)

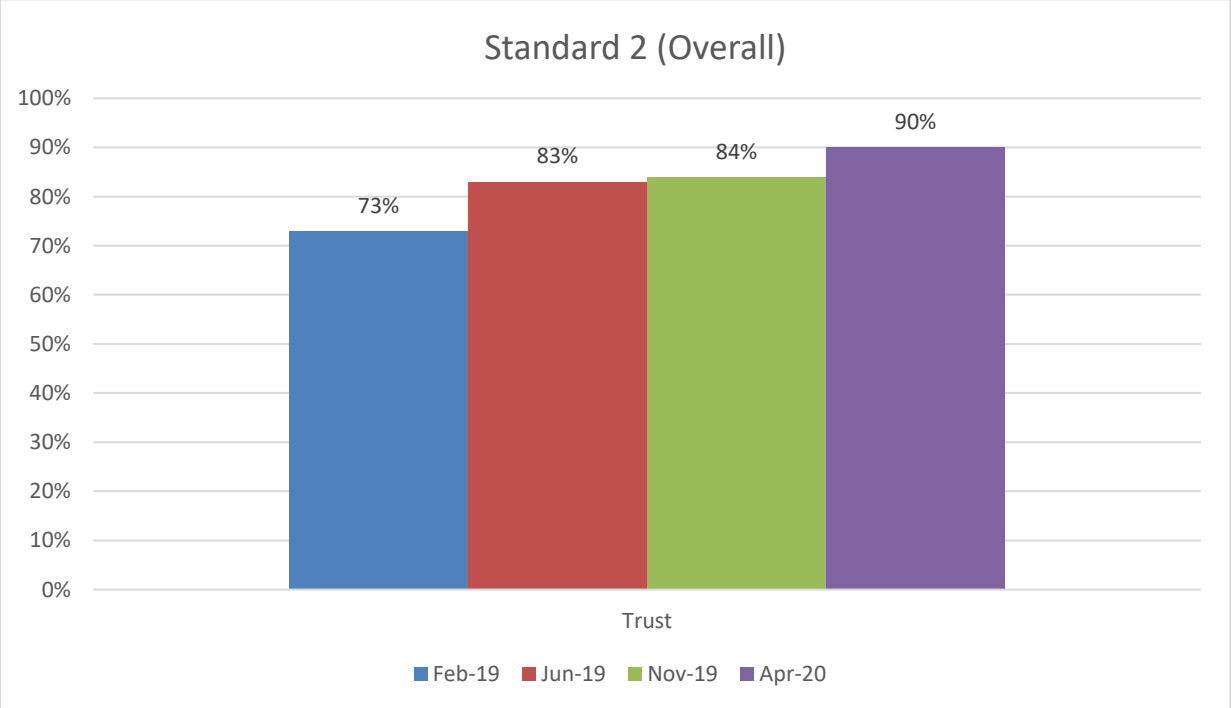
Trust	**S2 – 14 Hours**	**S8 – Daily Review**
Weekday	**91%**	88%
Weekend	86%	76%
Overall	**90%**	84%

Medicine	**S2 – 14 Hours**	**S8 – Daily Review**
Weekday	**92%**	**92%**
Weekend	**92%**	75%
Overall	**92%**	87%

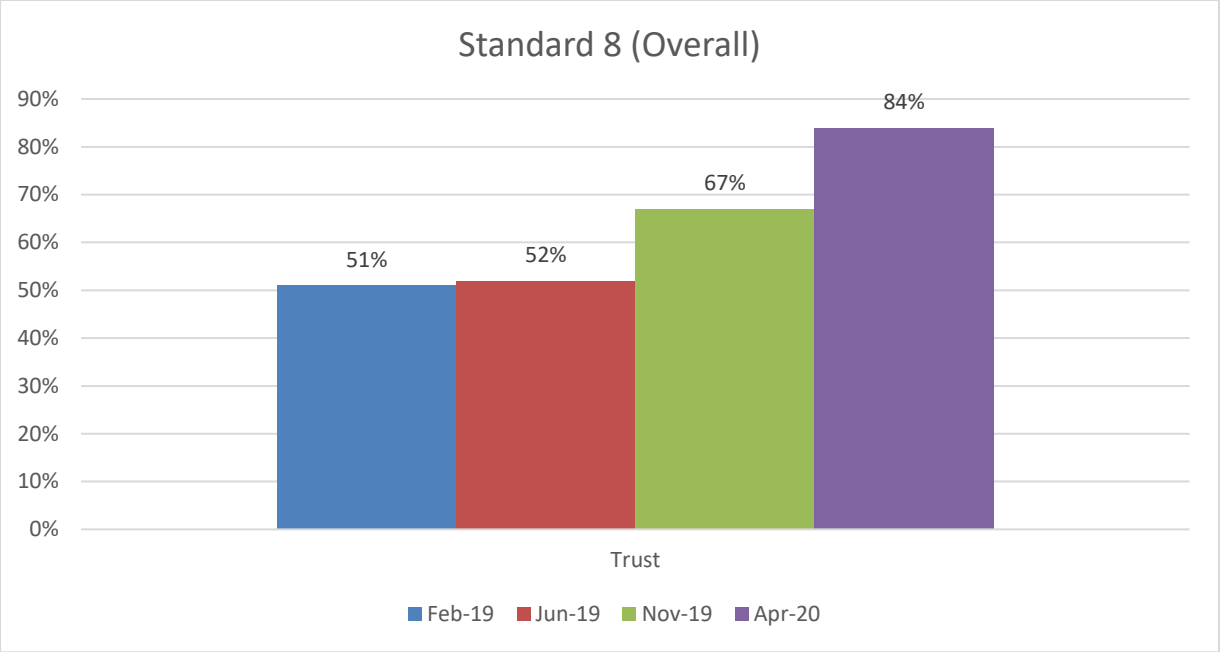
Surgery	S2 – 14 Hours	S8 – Daily Review
Weekday	79%	88%
Weekend	67%	64%
Overall	75%	82%

W&C	S2 – 14 Hours	S8 – Daily Review
Weekday	0%	75%
Weekend	50%	100%
Overall	33%	80%

Standard 2 (Overall) progress:



Standard 8 (Overall) progress:



The Trust has arguably met standard 2 requirements by achieving 90% overall. It should be noted however that the NHS England spreadsheet requires achievement in both weekday and weekend performance in order to achieve the standard (rather than mean / overall). and although standard 8 was not met, the Trust improved by 17% on daily review and is only 6% away (overall) from target.

Progress has also been made in relation to priority Standard 6 with agreement in principle with Executive Officers of Oxford University Hospitals NHS Foundation Trust around formal cross-cover for interventional radiology when we are unable to provide on-site out of hours.

7. Recommendation

Board are asked to note performance and the work in progress against priority standards 2, 6 and 8.

Elisa Scaletta

Business Manager, MDO

Ian Reckless

Medical Director

Appendix

NHS England Board Self Assurance Template completed for Spring / Summer 2020

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	120 randomly selected patients with emergency admission followed by discharge / death from 13th April - 26th April 2020. Weekday: 91% Weekend: 86% Overall: 90% The standard was met for weekdays and overall (a 6% improvement in overall since November 2019), however the national algorithm requires that the weekend standard is met in order for the overall standard to be met.	Yes, the standard is met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

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

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Interventional Endoscopy	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Emergency Surgery	Yes available on site	Yes available on site	
	NOTE: No solution feasible via STP / ICS. Formalisation of interventional radiology arrangements with OUH as our tertiary centre has been under discussion. The OUH COO and CMO agreed at a meeting on 05 March 2020 the 'heads of terms' for a service level agreement for 2020/21. The SLA has not yet been formally signed off on account of COVID-19 priorities.	Emergency Renal Replacement Therapy	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Urgent Radiotherapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Cardiac Pacing	Yes mix of on site and off site by formal arrangement	Yes available off site via formal arrangement	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	There has been some improvement since the previous reporting period. We are building pre-populated (auto text) templates into eCare to provide clearer documentation as to whether patient review is delegated to another member of staff. Of note the impact of eCARE (which will make a positive contribution in the medium term) is in a phase of maturation. By way of illustration , it can be more difficult to ascertain whether or not a consultant was physically present at a ward round in the eCARE system than it was in paper notes. Measures are being put in place to improve this. Once Daily: Weekday 88% (18% increase compared to November data) Once Daily: Weekend 76% (19% increase compated to November data) Overall: 84% (17% increase compared to November data) There was huge improvement against standard 8 and although this standard wasnt met, the work put in place to improve documentation has given a 17% (overall) increase in compliance.	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

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

7DS and Urgent Network Clinical Services

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

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
Intra-arterial clot retrieval is currently available at OUH 08:00 to 18:00 (last referral) Monday to Saturday . This is an improved service (opening hours) since March 2020. It is not yet a 24/7 service. It is hoped that this will occur during 2020/21 and MKUH is well placed to offer all patients access to this key service via the integrated MKUH / OUH acute stroke service. MKUH has adopted Brainomix (AI for time critical interpretation of acute stroke imaging).

Template completion notes

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

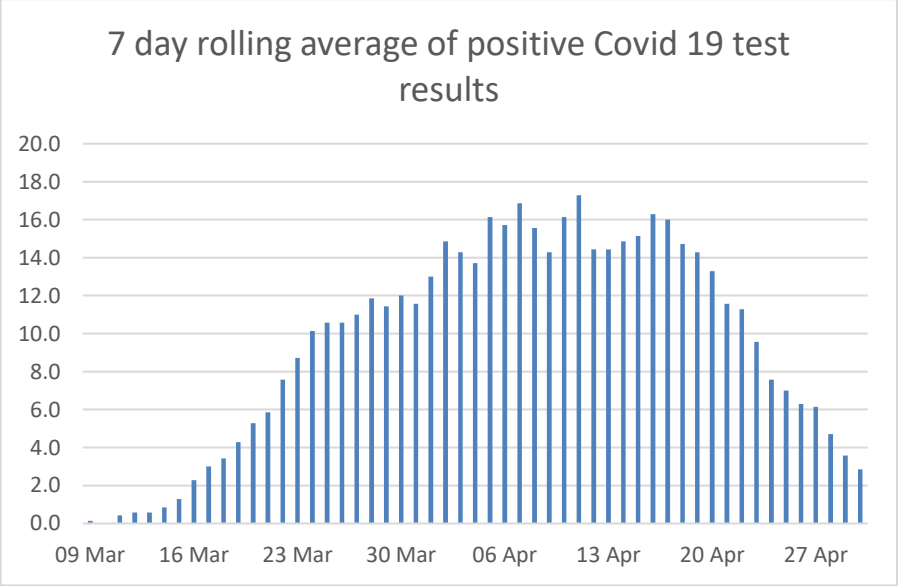
Trust Board Covid 19 report (May 2020)

1.0 Summary

Coronavirus disease 2019 **(**COVID-19**) is** an infectious disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). The disease was first identified in December 2019 in Wuhan, the capital of China's Hubei province, and has since spread globally, resulting in the ongoing 2019–20 coronavirus pandemic. As of 1 May 2020, more than 3.27 million cases have been reported across 187 countries and territories, resulting in more than 233,000 deaths. More than 1.02 million people have recovered.

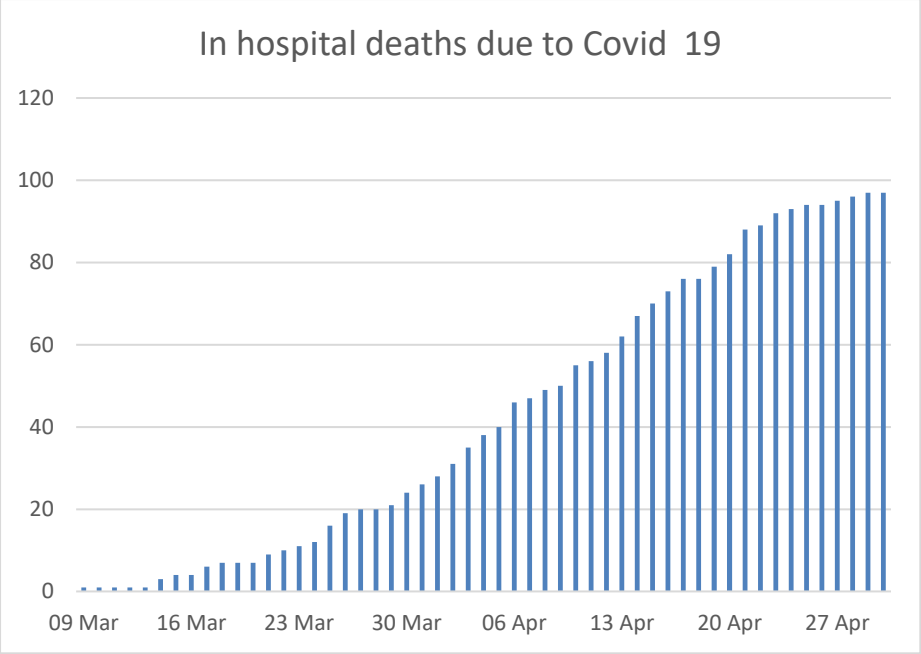
2.0 Patient testing

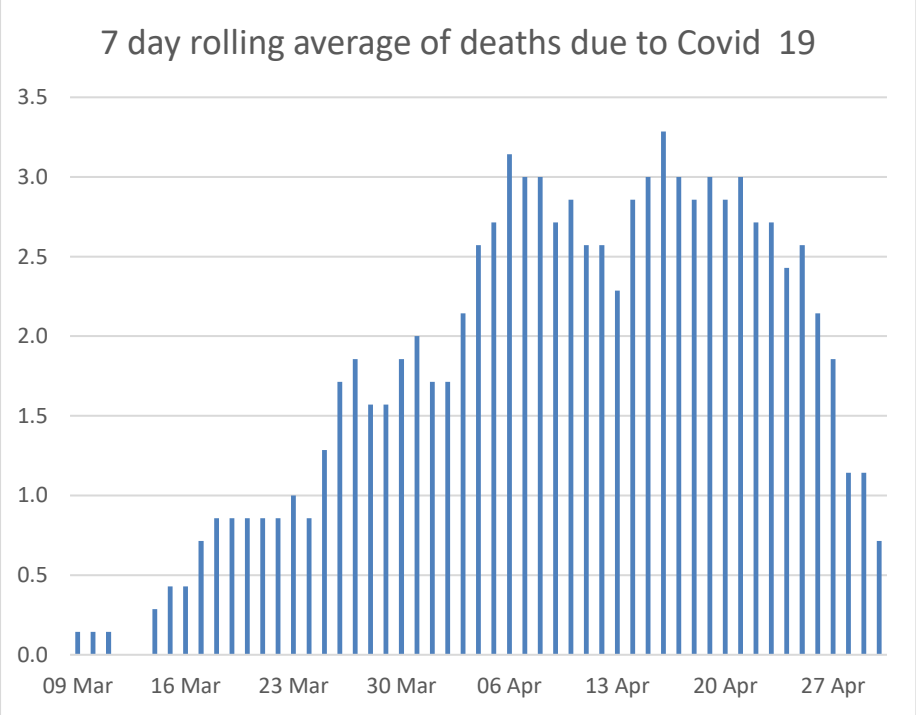
From the 1st March 2020 the trust has tested 1,367 patients presenting at the hospital with possible Covid symptoms an average of 23 per day. So far there have been 415 positive results. The graph below of the 7-day rolling average shows that locally the first wave of infections presenting to the hospital reached a peak in the second week of April and now appears to be waning.



So far 353 staff have been tested as a result of presenting with symptoms of which 129 have had a positive result. Over this time there have been 10 members of staff have been admitted to this hospital, of which 3 have required intensive care. One member of staff remains as an inpatient, with the remainder being discharged home. No members of staff have died.

The number of patients that have died in hospital as a result of their (proven) infection has reached 97. Again the 7 day rolling average shows a sharp decline in the number of patients dying over time.





3.0 Staff testing

Over the period 29/30th April all staff at work and therefore presumed to be symptom free were given the opportunity to be tested for C19 Viral load (rather than antibody) when the Trust were given access to short term testing facilities at Bart and the London Trust and Kings College Hospital. Over 1,000 look up the offer of a nasal and throat swab. With half of the results back, 17 members of staff have a positive result, a rate of c3%. These members of staff have been asked to self-isolate for 7 days before they return to work. This percentage positive rate appears to be broadly in line with similar studies at other Trusts.

Emma Livesley, Director of Operations

OBJECTIVE 1 - PATIENT SAFETY										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
1.1	Mortality - (HSMR)		100	100		97.2	✓	▲		
1.2	Mortality - (SHMI)		100	100		112.8	✗	▼		
1.3	Never Events		0	0	0	0	✓	▬	✓	
1.4	Clostridium Difficile		22	<22	14	0	✓	▬	✓	
1.5	MRSA bacteraemia (avoidable)		0	0	0	0	✓	▬	✓	
1.6	Falls with harm (per 1,000 bed days)		0.12	0.12	0.13	0.00	✓	▲	✗	
1.7	Midwife : Birth Ratio		28	28	28	26	✓	▼	✓	
1.8	Incident Rate (per 1,000 bed days)		40	40	51.38	52.64	✓	▲	✓	
1.9	Duty of Candour Breaches (Quarterly)		0	0	0	0	✓	▬	✓	
1.10	E-Coli		20	<20	25	1	✓	▲		
1.11	MSSA				5	0		▬		
1.12	VTE Assessment		95%	95%	98.1%	98.8%	✓	▲	✓	

OBJECTIVE 2 - PATIENT EXPERIENCE										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.1	FFT Recommend Rate (Patients)		94%	94%	95%	97%	✓	▲	✓	
2.2	RED Complaints Received				2	0		▬		
2.3	Complaints response in agreed time		90%	90%	89.5%	88.8%	✗	▲	✗	
2.4	Cancelled Ops - On Day		1.0%	1.0%	0.6%	0.3%	✓	▼	✓	
2.5	Over 75s Ward Moves at Night		2,112	2,112	2,043	49	✓	▲	✓	
2.6	Mixed Sex Breaches		0	0	0	0	✓	▬	✓	

OBJECTIVE 3 - CLINICAL EFFECTIVENESS										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
3.1	Overnight bed occupancy rate		93%	93%	89.1%	69.0%	✓	▲	✓	
3.2	Ward Discharges by Midday		30%	30%	24.7%	20.0%	✗	▼	✗	
3.3	Weekend Discharges		70%	70%	64.6%	57.8%	✗	▼	✗	
3.4	30 day readmissions				7.9%	7.5%		▼		
3.5	Follow Up Ratio		1.50	1.50	1.58	1.60	✗	▼	✗	
3.6.1	Number of Stranded Patients (LOS>=7 Days)		218	218		92	✓	▲		
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)		53	53		41	✓	▲		
3.7	Delayed Transfers of Care		25	25		20	✓	▲		
3.8	Discharges from PDU (%)		15%	15%	9.4%	10.8%	✗	▲	✗	
3.9	Ambulance Handovers >30 mins (%)		5%	5%	8.6%	7.0%	✗	▲	✗	

OBJECTIVE 4 - KEY TARGETS										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1	ED 4 hour target (includes UCS)		93.0%	93.0%	88.7%	87.1%	✗	▼	✗	
4.2a	RTT mean waiting time - incomplete waiting list (weeks)		9.2	9.2		13.7	✗	▼		
4.4	RTT Total Open Pathways		13,991	13,991		22,275	✗	▼		
4.5	RTT Patients waiting over 52 weeks			0		0	✓	▲		
4.6	Diagnostic Waits <6 weeks		99%	99%		95.6%	✗	▼		
4.7	All 2 week wait all cancers (Quarterly)		93.0%	93.0%		91.6%	✗	▼		
4.8	31 days Diagnosis to Treatment (Quarterly)		96.0%	96.0%		97.3%	✓	▼		
4.9	62 day standard (Quarterly)		85.0%	85.0%		87.1%	✓	▲		

OBJECTIVE 5 - SUSTAINABILITY										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
5.1	GP Referrals Received		64,193	64,193	79,728	4,274	✓	▲	✗	
5.2	A&E Attendances		89,369	89,369	90,152	5,590	✓	▲	✗	
5.3	Elective Spells (PBR)		25,641	25,641	25,061	1,747	✓	▲	✓	
5.4	Non-Elective Spells (PBR)		31,976	31,976	28,997	2,170	✓	▲	✓	
5.5	OP Attendances / Procs (Total)		381,108	381,108	383,764	25,754	✓	▲	✗	
5.6	Outpatient DNA Rate		5%	5%	7.9%	8.9%	✗	▼	✗	

OBJECTIVE 7 - FINANCIAL PERFORMANCE										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
7.1	Income £'000		268,966	268,966	280,842	34,987	✓	▲	✓	
7.2	Pay £'000		(171,021)	(171,021)	(185,105)	(24,029)	✗	▼	✗	
7.3	Non-pay £'000		(77,803)	(77,803)	(82,958)	(8,040)	✗	▼	✗	
7.4	Non-operating costs £'000		(13,359)	(13,359)	(18,936)	(7,669)	✗	▼	✗	
7.5	I&E Total £'000		6,783	6,783	(6,157)	(4,751)	✗	▼	✗	
7.6	Cash Balance £'000		2,500	2,500		16,286	✓	▲		
7.7	Savings Delivered £'000		8,419	8,419	6,187	938	✗	▲	✗	
7.8	Capital Expenditure £'000		27,926	27,926	24,787	4,251	✗	▼	✓	

OBJECTIVE 8 - WORKFORCE PERFORMANCE										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
8.1	Staff Vacancies % of establishment		11%	11%		8.3%	✓	▲		
8.2	Agency Expenditure %		8%	8%	4.7%	4.1%	✓	▼	✓	
8.3	Staff sickness - % of days lost		4%	4%		3.9%	✓	▬		
8.4	Appraisals		90%	90%		94.0%	✓	▼		
8.5	Statutory Mandatory training		90%	90%		94.0%	✓	▬		
8.6	Substantive Staff Turnover		11%	11%		9.4%	✓	▼		

OBJECTIVES - OTHER										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
O.1	Total Number of NICE Breaches		8	8		23	✗	▼		
O.2	Rebooked cancelled OPs - 28 day rule		95%	95%	86.5%	NA	✓	▲	✗	
O.4	Overdue Datix Incidents >1 month		0	0		92	✗	▼		
O.5	Serious Incidents		45	<45	66	3	✓	▲	✗	
O.8	Completed Job Plans (Consultants)		90%	90%		88%	✗	▬		

Key: Monthly/Quarterly Change

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

YTD Position

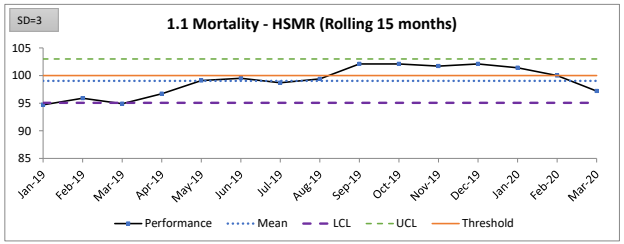
✓	Achieving YTD Target
	Within Agreed Tolerance*
✗	Not achieving YTD Target
	Annual Target breached

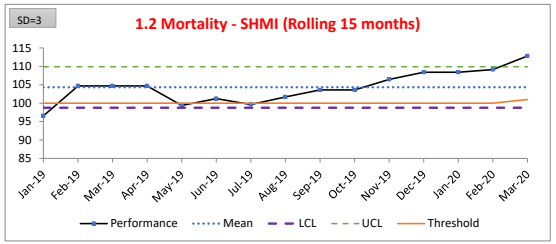
Data Quality Assurance Definitions

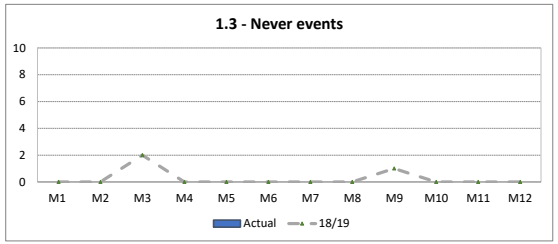
Rating	Data Quality Assurance
Green	Satisfactory and independently audited (indicator represents an accurate reflection of performance)
Amber	Acceptable levels of assurance but minor areas for improvement identified and potentially independently audited * /No Independent Assurance
Red	Unsatisfactory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

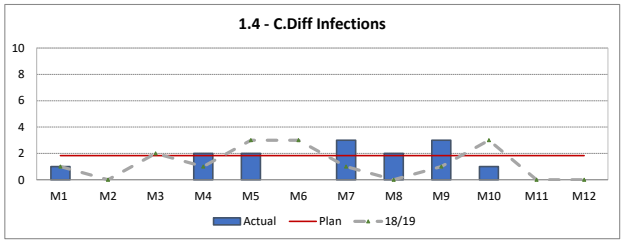
* Independently Audited – refers to an independent audit undertaken by either the Internal Auditor, External Auditors or the Data Quality Audit team.

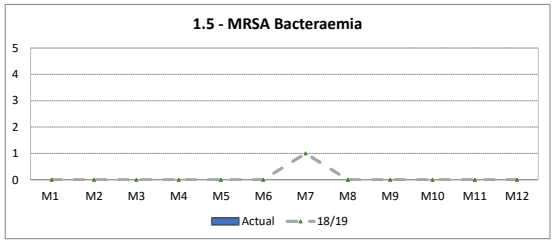
Date Produced: 23/04/2020

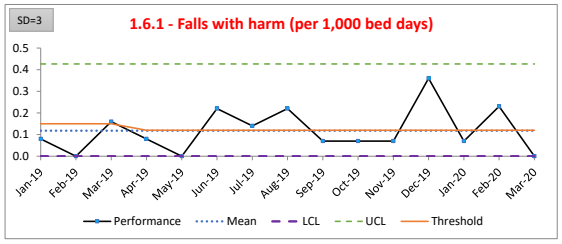


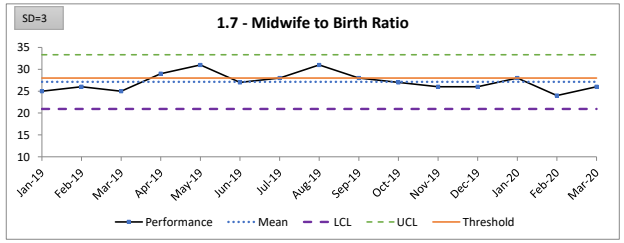


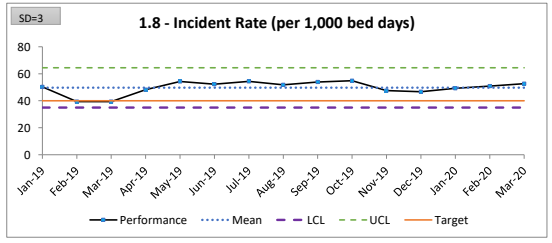


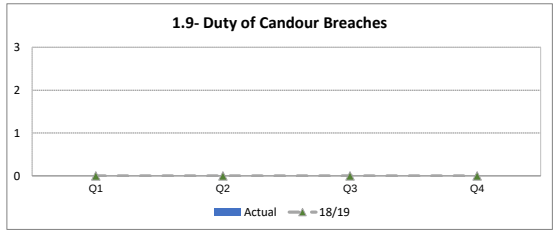


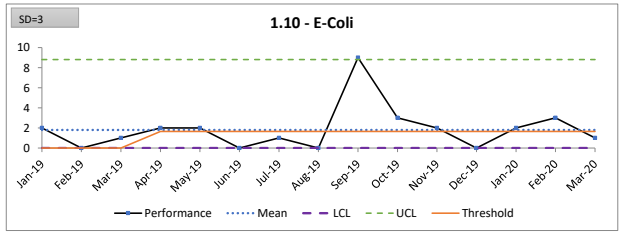


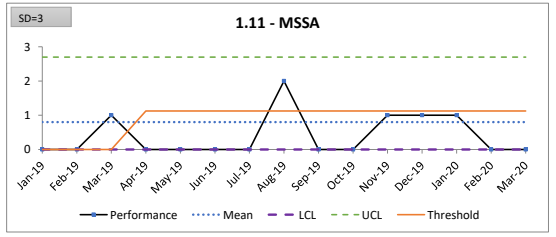


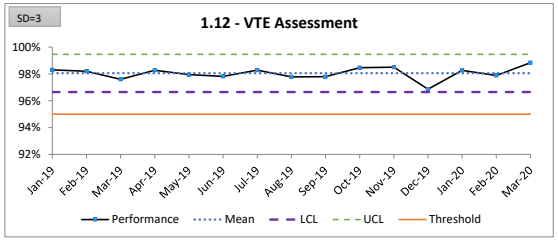












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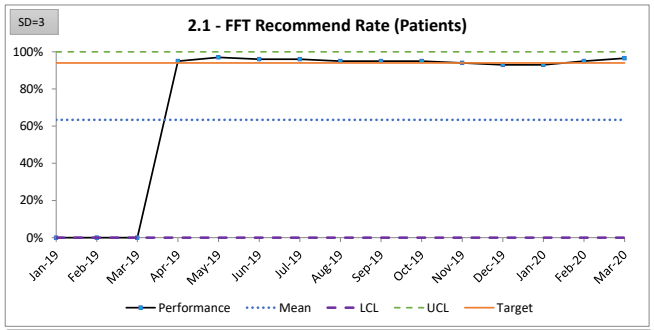

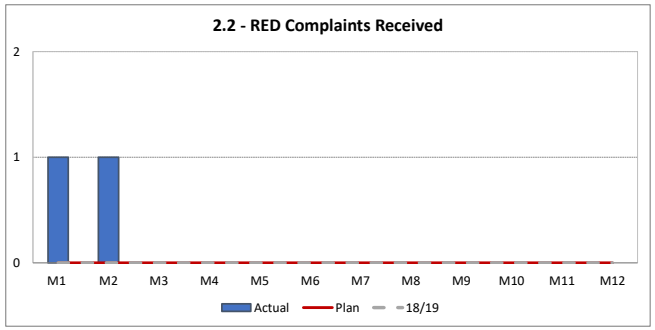

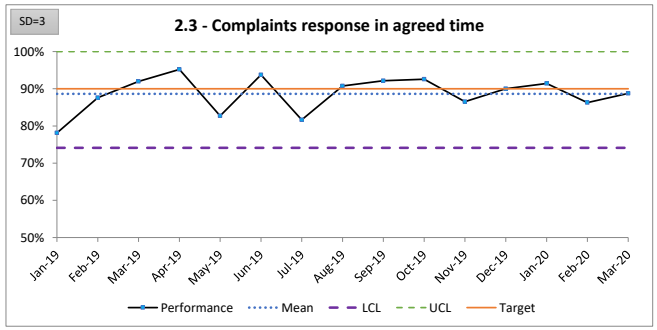

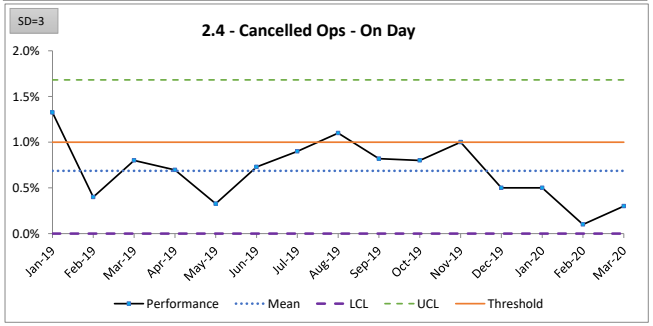

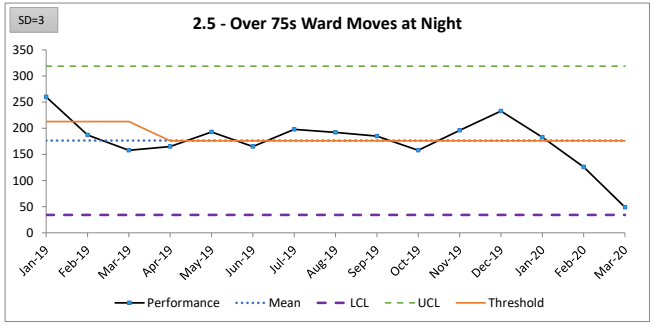

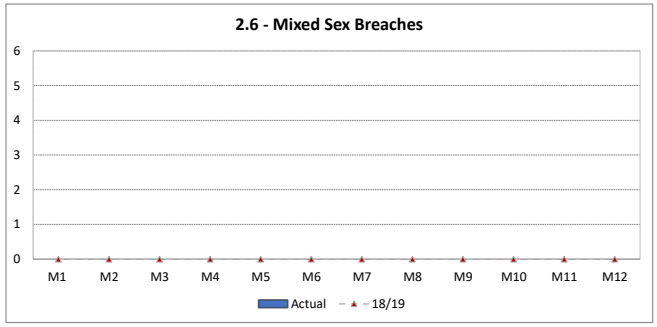

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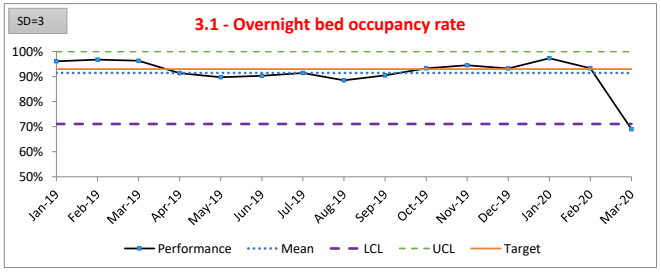

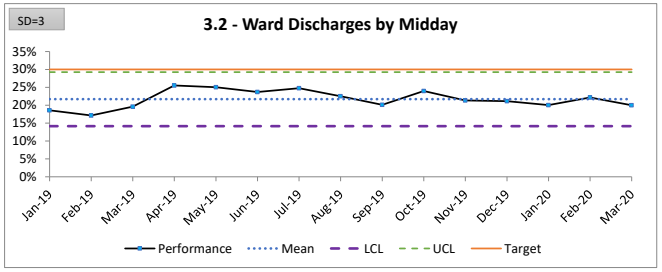

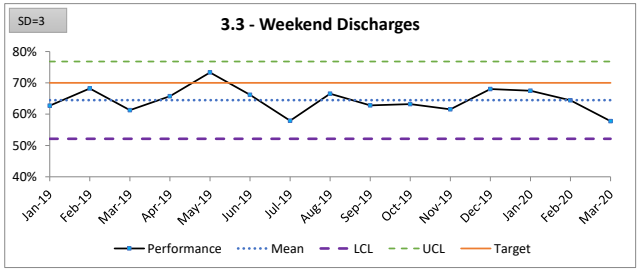

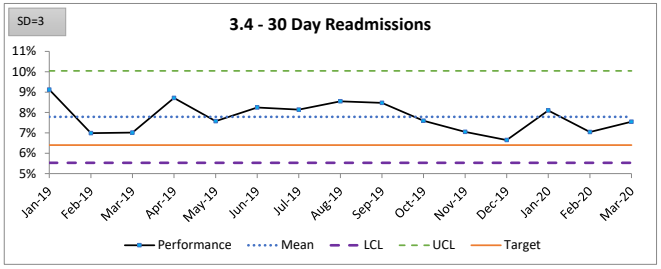

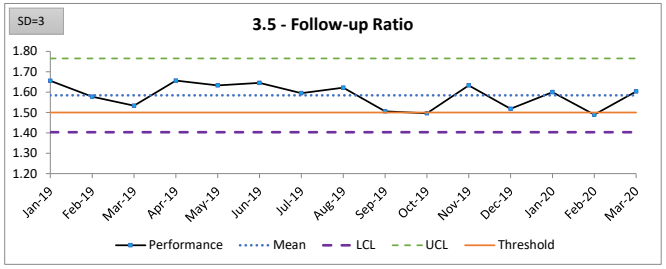

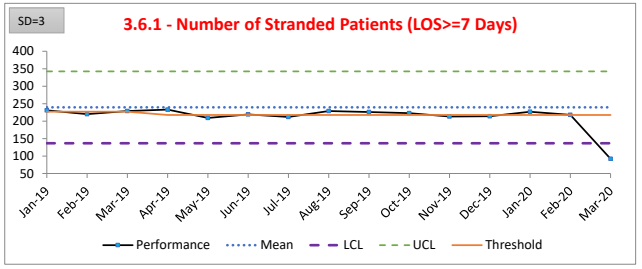

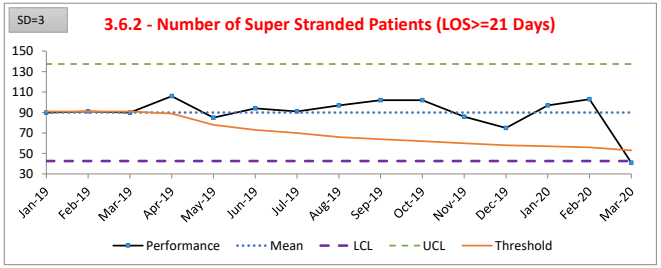

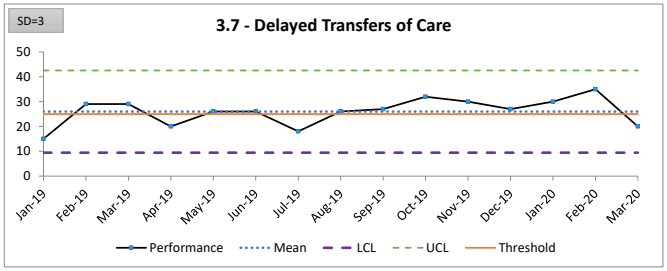

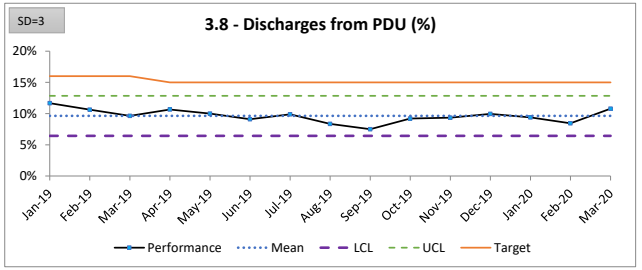

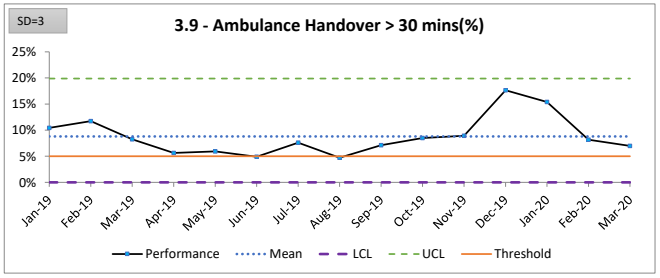

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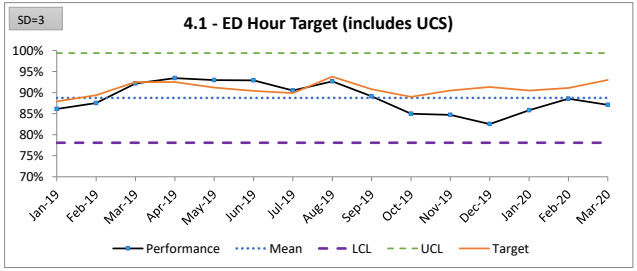
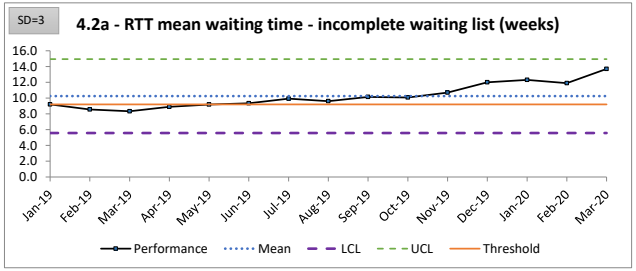
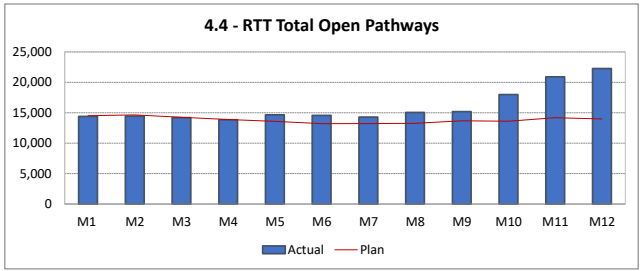
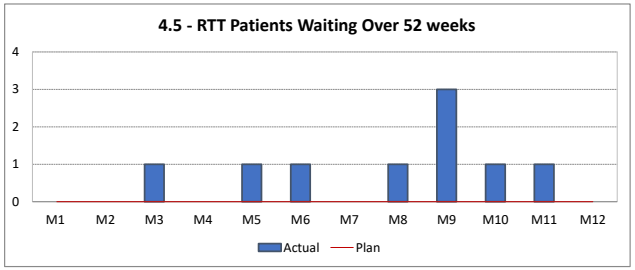
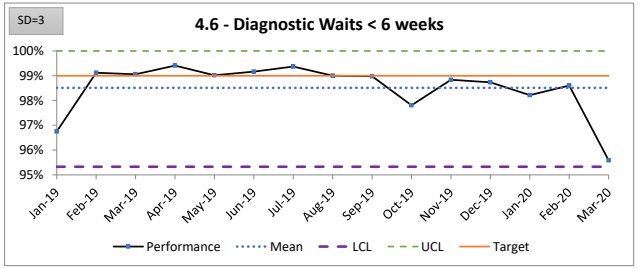
Milton Keynes University Hospital NHS Foundation Trust

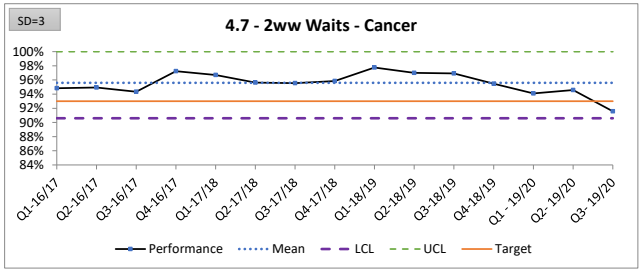


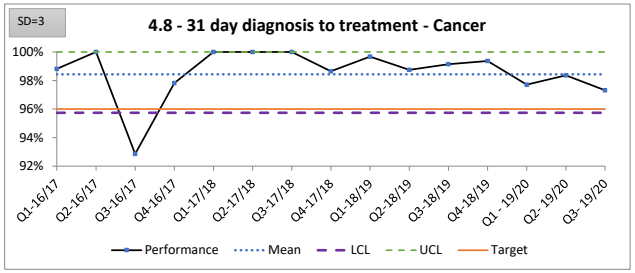


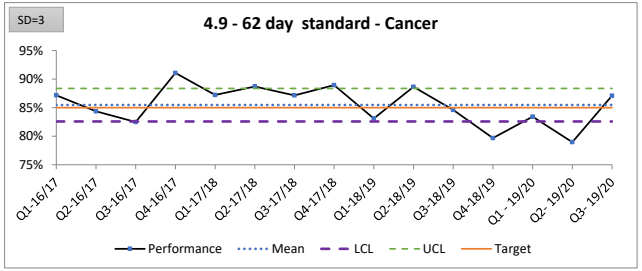












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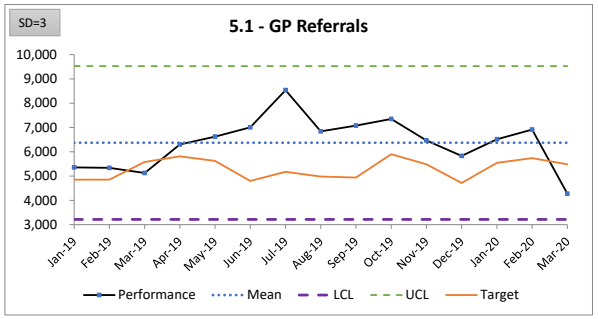

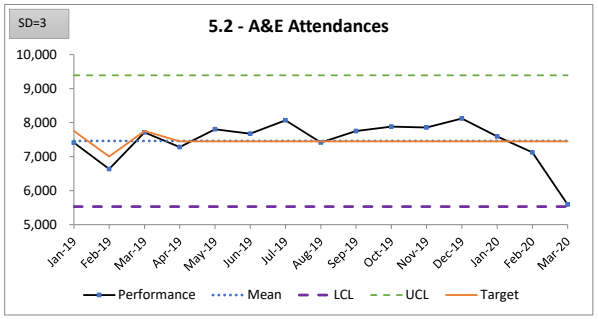

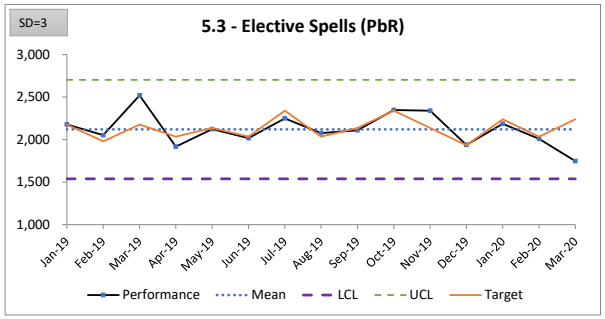

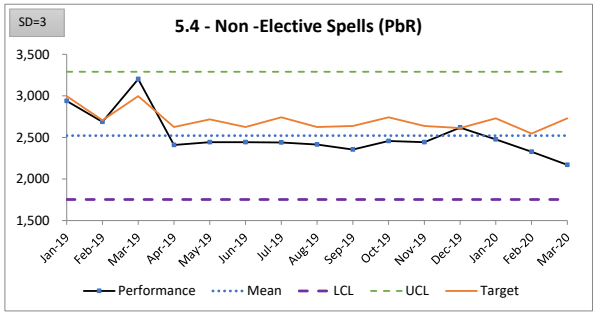

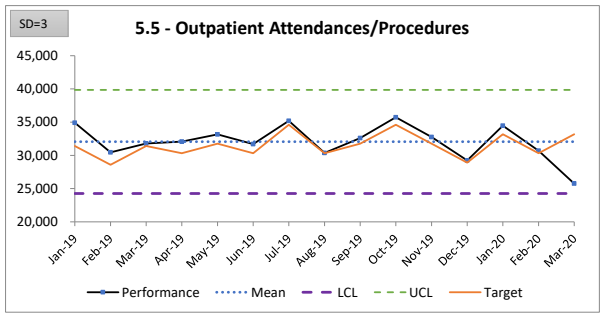

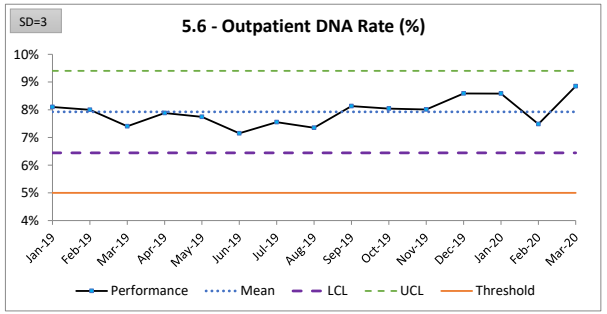

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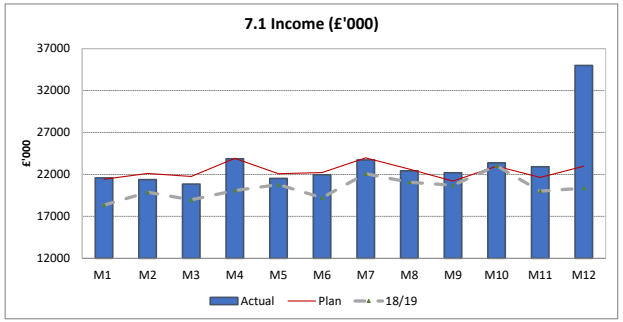
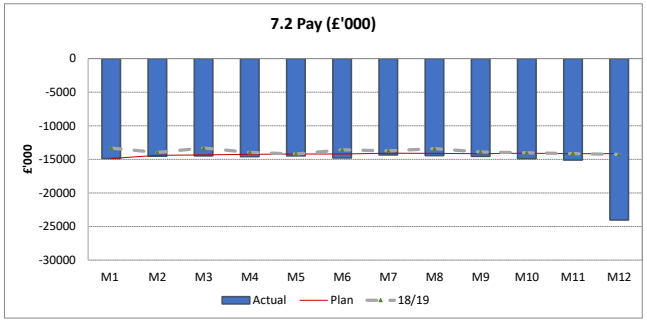
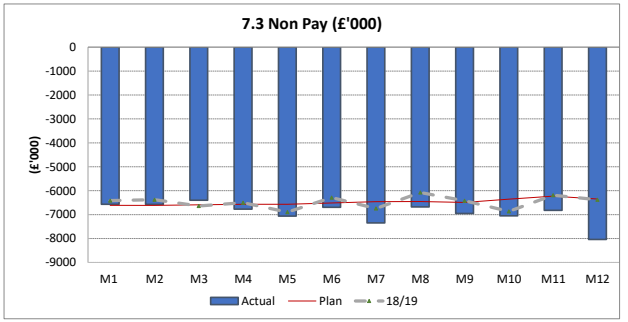
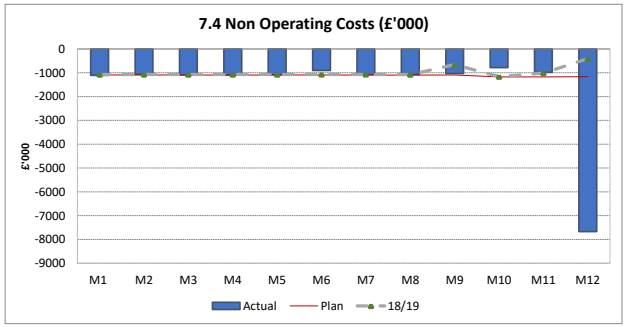
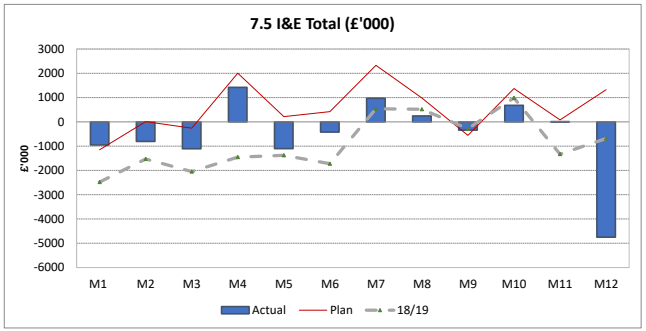
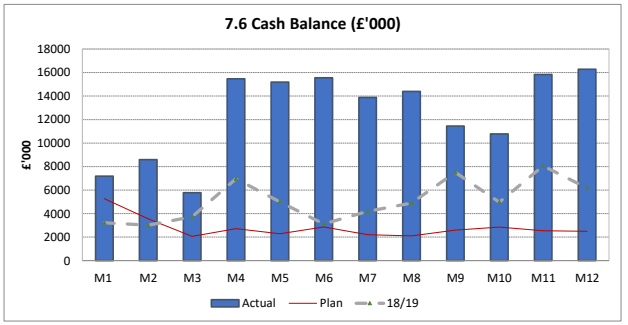

7.1 Income (£'000)
£'000
37000
32000
27000
22000
17000
12000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19

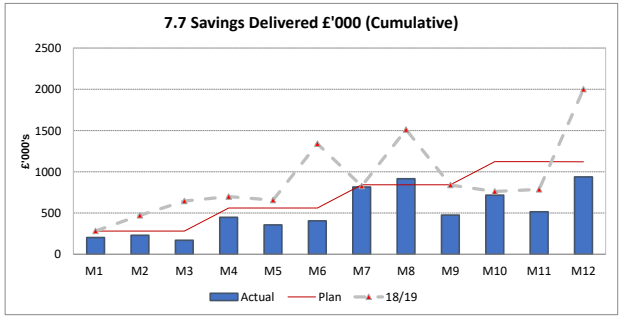

7.2 Pay (£'000)
£'000
0
-5000
-10000
-15000
-20000
-25000
-30000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19

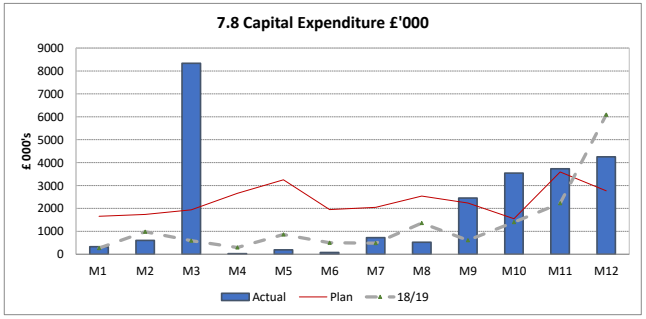

7.3 Non Pay (£'000)
(£'000)
0
-1000
-2000
-3000
-4000
-5000
-6000
-7000
-8000
-9000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19

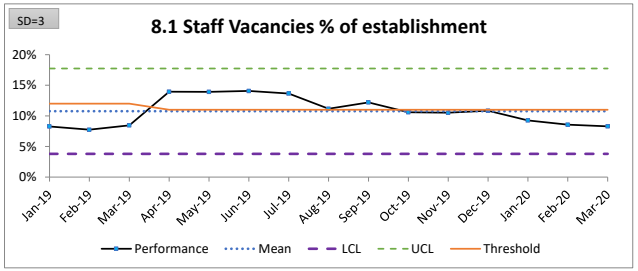

7.4 Non Operating Costs (£'000)
£'000
0
-1000
-2000
-3000
-4000
-5000
-6000
-7000
-8000
-9000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19

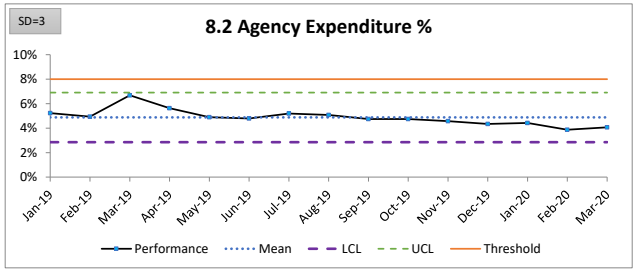

7.5 I&E Total (£'000)
£'000
3000
2000
1000
0
-1000
-2000
-3000
-4000
-5000
-6000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19

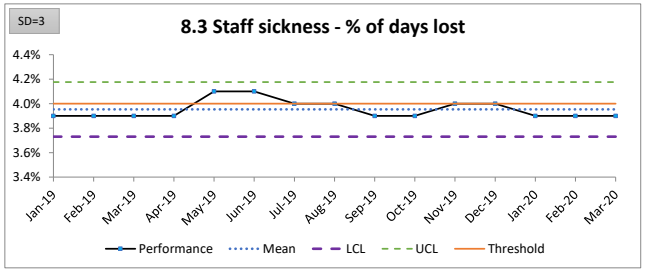

7.6 Cash Balance (£'000)
£'000
18000
16000
14000
12000
10000
8000
6000
4000
2000
0
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19

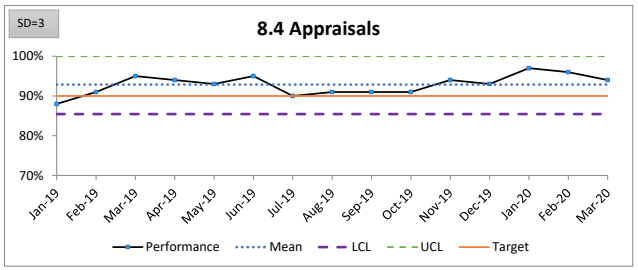

7.7 Savings Delivered £'000 (Cumulative)
£'000's
2500
2000
1500
1000
500
0
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19

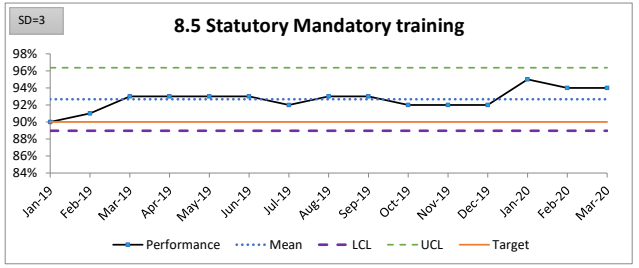

7.8 Capital Expenditure £'000
£'000's
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19

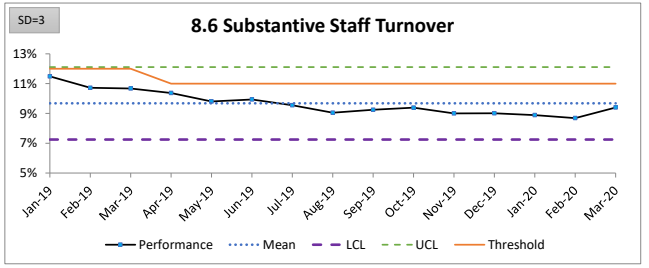






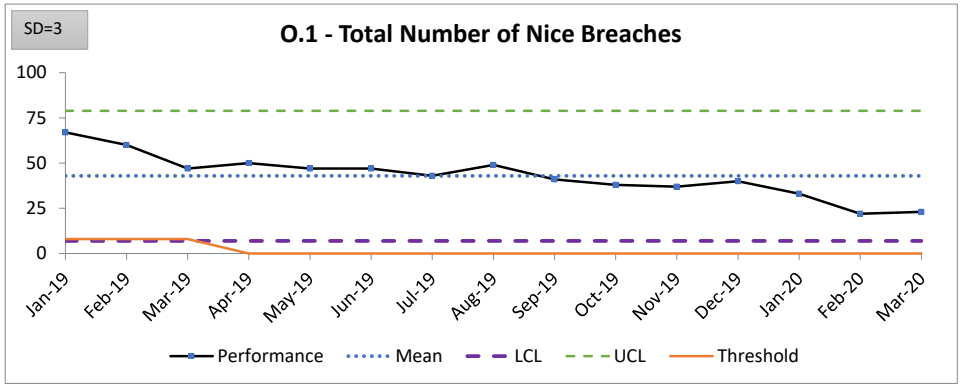


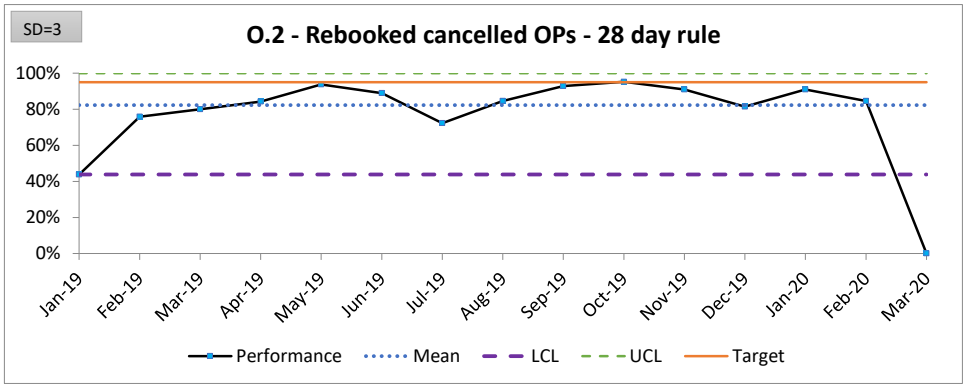


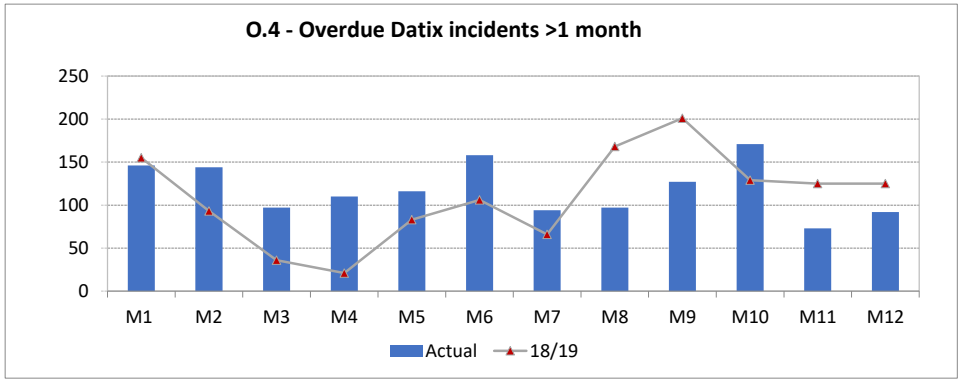


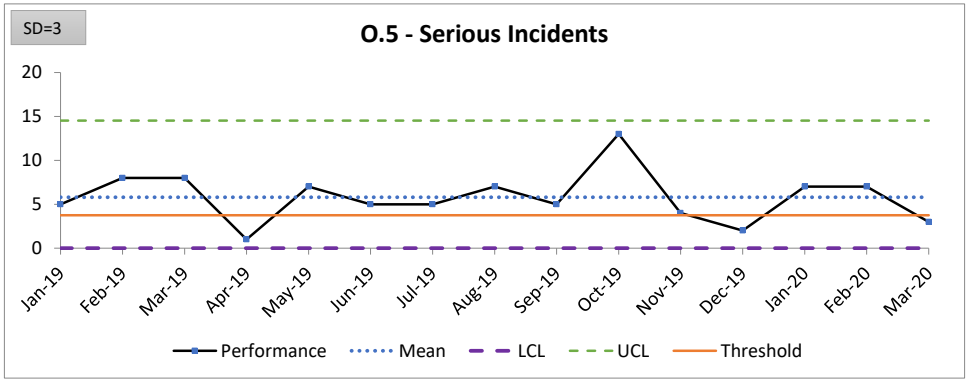
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

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



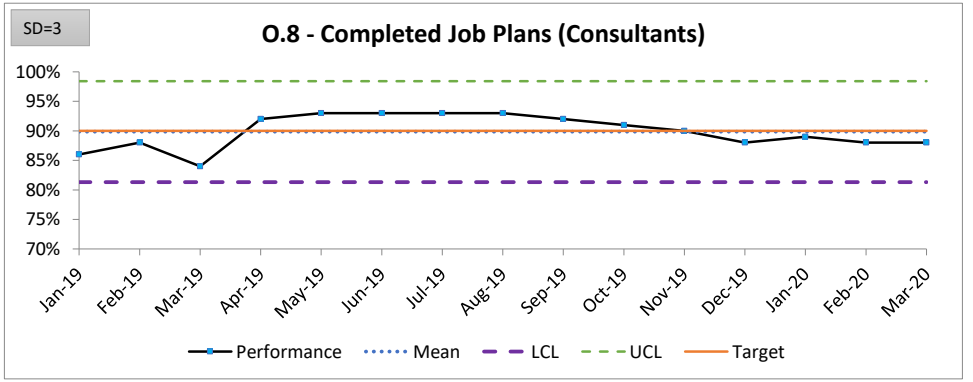






If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

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



Trust Performance Summary: M12 (March 2020)

1.0 Summary

This report summarises performance at the end of March 2020 for key performance indicators. It must be noted that service delivery and performance has been highly impacted by the changing requirements of the COVID-19 Pandemic and dealing with both COVID and Non COVID presentations and pathways.

2.0 Sustainability and Transformation Fund (STF)

Performance Improvement Trajectories

March 2020 performance against the Service Development and Improvement Plans (SDIP):

ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1	ED 4 hour target (includes UCS)		93.0%	93.0%	88.7%	87.1%	✗	▼	✗	
4.2a	RTT mean waiting time - incomplete waiting list (weeks)		9.2	9.2		13.7	✗	▼		
4.9	62 day standard (Quarterly)		85.0%	85.0%		87.1%	✓	▲		

In March 2020, ED performance of 87.1% was below the 95% national standard and the 93.0% NHS Improvement trajectory. When comparing the Trust's ED performance in March 2020, MKUH was better than the national overall performance of 84.2%. (see Appendix for details). MKUH compared favourably across the Peer Group comparator.

The Trust's average RTT waiting time for incomplete elective pathways at the end of March 2020 was 13.7 weeks.

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

For Q3 2019/20, the Trust's provisional 62-day standard performance (from receipt of an urgent GP referral for suspected cancer to first treatment) was 87.1% against a national target of 85%.

The provisional performance of the percentage of patients who started treatment within 31 days of a decision to treat was 97.3% against a national target of 96% and the percentage of patients who attended an outpatient appointment within two weeks of an urgent referral by their GP for suspected cancer was 91.6% against a national target of 93%.

3.0 Urgent and Emergency Care

Performance in urgent and emergency care continued to operate under increased pressure and the challenge of the COVID pandemic during March 2020. Two out of six measured indicators showing an improvement in their performance:

ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.4	Cancelled Ops - On Day		1.0%	1.0%	0.6%	0.3%	✓	▼	✓	
3.2	Ward Discharges by Midday		30%	30%	24.7%	20.0%	✗	▼	✗	
3.4	30 day readmissions				7.9%	7.5%		▼		
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)		53	53		41	✓	▲		
3.9	Ambulance Handovers >30 mins (%)		5%	5%	8.6%	7.0%	✗	▲	✗	
4.1	ED 4 hour target (includes UCS)		93.0%	93.0%	88.7%	87.1%	✗	▼	✗	

Cancelled Operations on the Day

In March 2020 the number of operations cancelled on the day for non-clinical reasons was 0.3% of all planned elective operations in the calendar month. Although this was higher than the February 2020 performance of 0.1%, it was the lowest reported performance (except for February) since May 2019 and an improvement on the March 2019 performance of 0.8%.

Readmissions

The Trust 30-day emergency readmission rate of 7.5% in March 2020 was in line with the performance of this key performance indicator for the financial year 2019/2020.

Delayed Transfers of Care (DTOC)

The number of DTOC patients reported at midnight on the last Thursday of March 2020 was 20. This was the lowest volume reported since May 2019 and is an improvement on the March 2019 volume of 29. Of these, 15 (75%) were in Medicine and five (25%) in Surgery.

Length of Stay (Stranded and Super Stranded Patients)

The number of super stranded patients (length of stay of 21 days or more) at the end of the month was 41. This was a notable reduction compared to previous months and a reflection of strong partnership working across the system in light of the COVID-19 pandemic.

In March 2020, the percentage of ambulance handovers to the Emergency Department taking more than 30 minutes was 7.0%. This was the best performance reported for this indicator since August 2019.

4.0 Elective Pathways

ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
3.1	Overnight bed occupancy rate		93%	93%	89.1%	69.0%	✓	▲	✓	
3.5	Follow Up Ratio		1.50	1.50	1.58	1.60	✗	▼	✗	
4.2a	RTT mean waiting time - incomplete waiting list (weeks)		9.2	9.2		13.7	✗	▼		
5.6	Outpatient DNA Rate		5%	5%	7.9%	8.9%	✗	▼	✗	

Overnight Bed Occupancy

Overnight bed occupancy was 69.0% in March 2020. This was a notable reduction compared to previous months and directly influenced by the challenges in the hospital as a result of Covid-19.

Follow up Ratio

The Trust follow up ratio in March 2020 was 1.60. Although this exceeded the target of 1.50, it was in line with the values reported for the entire financial year.

RTT Incomplete Pathways

The average waiting time baseline of 9.2 weeks was exceeded, with an average waiting time of 13.7 reported at the end of March 2020. This was a notable increase on the 11.9 weeks average waiting time which was reported at the end of February 2020 as the impact of COVID-19 has increased.

Diagnostic Waits <6 weeks

The Trust again did not meet the national standard of fewer than 1% of patients waiting six weeks or more for their diagnostic test at the end of March 2020, with a performance of 95.6%.

Outpatient DNA Rate

The DNA rate remained above the threshold of 5% with the March 2020 rate of 8.9% being higher than any other month during 2019/20. Whilst DNAs result in lost capacity and represent a challenge under the current circumstances of COVID-19 it is clear that patients are choosing not to attend the hospital and non urgent activity is being impacted.

5.0 Patient Safety

Infection Control

In March 2020 there was one case of E. coli reported in Medicine (Ward 8) and no reported cases of MRSA, Clostridium difficile (C. diff) or MSSA.

ENDS

Appendix 1: ED Performance - Peer Group Comparison

The following Trusts have been historically viewed as peers of MKUH for the purpose of Dr Foster:

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

Burton Hospitals NHS Foundation Trust was part of the peer group, but since its merger with Derby Hospitals NHS Foundation Trust, Burton Hospitals NHS Foundation Trust has ceased to exist.

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

January to March 2020 ED Performance Ranking

MKUH Peer Group Comparison - ED Performance	Jan-20	Feb-20	Mar-20
Homerton University Hospital NHS Foundation Trust	93.60%	94.70%	91.98%
Barnsley Hospital NHS Foundation Trust	86.90%	91.20%	91.03%
Milton Keynes University Hospital NHS Foundation Trust	**85.70%**	**88.40%**	**86.91%**
Southport And Ormskirk Hospital NHS Trust	84.50%	83.20%	86.55%
Mid Cheshire Hospitals NHS Foundation Trust	69.50%	79.20%	86.03%
Bedford Hospital NHS Trust	84.00%	88.80%	85.54%
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	76.80%	73.50%	83.56%
Buckinghamshire Healthcare NHS Trust	81.90%	82.60%	83.43%
The Hillingdon Hospitals NHS Foundation Trust	79.60%	82.00%	81.45%
Northampton General Hospital NHS Trust	72.90%	73.50%	80.88%
Oxford University Hospitals NHS Foundation Trust	81.30%	80.10%	80.19%
The Princess Alexandra Hospital NHS Trust	71.20%	77.70%	79.68%
North Middlesex University Hospital NHS Trust	80.40%	80.10%	75.64%
Luton And Dunstable University Hospital NHS Foundation Trust	n/a	n/a	n/a
Kettering General Hospital NHS Foundation Trust	n/a	n/a	n/a

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

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Public Board	Date: 7 May 2020
Report title:	**Finance Paper Month 12 2019-20**	**Agenda item: 5.3**
Lead director **Report authors**	Mike Keech Daphne Thomas Chris Panes	Director of Finance Deputy Director of Finance Head of Management Accounts
FoI status:	Private document	

Report summary	**An update on the financial position of the Trust at Month 12 (March 2020)**			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** X	**Decision** ☐
Recommendation	The Trust Board to note the contents of the paper.			

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

Report history	None
Next steps	None
Appendices	1 to 3

FINANCE REPORT FOR THE MONTH TO 31st MARCH 2020

PUBLIC BOARD MEETING

PURPOSE

1. The purpose of the paper is to:

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

EXECUTIVE SUMMARY

1. *Income and expenditure* –The Trust's deficit for March 2020 was £3.6m which is £5m adverse to budget in the month and £11.8m adverse YTD. The adverse full year positon is mainly due to timing differences on donations and an impairment following a revaluation of the Trust's estate. At control total level (which excludes PSF/FRF/MRET impairments & donations) the position is £0.7m adverse to control total; however, the variance relates specifically to the adverse impact of COVID-19 on the 2019/20 financial position and has been accepted by NHSI as an agreed variance to the control total (meaning the full value of FRF, PSF and MRET has been achieved).

2. Cash and capital position – the cash balance as at the end of March 2020 was £16.8m, which was £14.3m above plan due to the timing of capital expenditure and an increase in liabilities at year end. The Trust has spent £24.5m on capital up to month 12, of which £22.0m counts toward the national CDEL, £2.3m above plan

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

4. *Cost savings* – overall savings of £0.9m were delivered in month against an identified plan of £1m and the target of £1m. For the year £6.1m has been delivered against a target of £8.4m.

INCOME AND EXPENDITURE

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

All Figures in £'000	Month 12 Plan	Month 12 Actual	Month 12 Var	Month 12 Full Year Plan	Month 12 Full Year Actual	Month 12 Full Year Var
Clinical Revenue	18,827	20,108	1,281	218,726	224,052	5,326
Other Revenue	1,559	10,992	9,433	19,085	30,678	11,593
Total Income	20,386	31,100	10,715	237,811	254,731	16,919
Pay	(14,136)	(24,029)	(9,893)	(171,023)	(185,105)	(14,082)
Non Pay	(6,411)	(8,206)	(1,796)	(77,808)	(83,124)	(5,316)
Total Operational Expend	(20,547)	(32,236)	(11,688)	(248,831)	(268,230)	(19,399)
EBITDA	(162)	(1,135)	(974)	(11,020)	(13,499)	(2,480)
Financing & Non-Op. Costs	(1,026)	(532)	493	(12,575)	(10,816)	1,759
Control Total Deficit (excl. PSF)	**(1,187)**	**(1,668)**	**(481)**	**(23,595)**	**(24,315)**	**(720)**
Adjustments excl. from control total:						
PSF	489	1,691	1,202	4,197	5,871	1,674
PSF- ICS	109	923	814	923	923	0
FRF	1,729	1,729	0	14,807	14,807	0
MRET	270	270	0	3,237	3,237	0
Control Total Deficit (incl. PSF)	**1,410**	**2,945**	**1,535**	**(431)**	**523**	**954**
Donated income	0	476	476	8,000	2,476	(5,524)
Donated asset depreciation	(66)	(56)	9	(786)	(674)	112
Impairments & Rounding	(22)	(7,081)	(7,059)	5	(7,447)	(7,452)
Reported deficit/surplus	**1,322**	**(3,716)**	**(5,038)**	**6,788**	**(5,121)**	**(11,910)**

Monthly and year to date review

6. The **deficit excluding central funding (PSF, FRF and MRET) and donated income** in month 12 is £1,668k which is **£481k adverse to plan in month and £720k adverse YTD**. For M12 the Trust recognised the full allocation of provider sustainability funding (PSF) in addition to £1.2m of incentive PSF.

7. The Trust reported a deficit in month 12 of £3.6m which is £4.9m adverse to the budget surplus of £1.3m, the variance is predominately driven by a £7m impairment offset by additional PSF funding. The Trust response to COVID-19 has driven significant costs within the month over prior run rates, the majority of which has been offset with central funding. A £0.7m increase in

expenditure related to untaken annual leave due to COVID-19 has not been funded centrally, but has been accepted as an agreed variance from the Trust's control total.

8. **Income (excluding PSF/FRF/MRET and donations effect)** is £10,715k favourable to plan in March and £16,919k favourable for the year and is analysed in further detail in Appendix 1.

9. **Operational costs** in March are adverse to plan by £11,599k in month and adverse by £19,310k for the year. Further detail is included below.

10. **Pay costs** are £9,893k adverse to budget in Month 12. The variance in month is driven by a one off adjustment relating to pension contributions (requiring the Trust to include the cost of the increase in employer pension contributions from 14.38% to 20.68% which is funded centrally and offset in income (£7.0m)) as well as costs attributed as a direct impact of COVID-19 and offset in income.

11. **Non-pay** costs were £1,707k adverse to plan in month and £5,227k adverse for the year. Negative variances can be seen across most non-pay categories with significant expenditure directly related to COVID-19 including equipment and personal protective equipment (PPE).

12. Non-operational costs are adverse in month, the variance is driven by an impairment.

    Further analysis of the costs can be found in appendix 1.

COST SAVINGS

13. In Month 12, £938k was delivered against an identified plan of £1,032k and a target of £982k. For the year £6,140k has been delivered against the target of £8,421k. The CIP programme has been impacted by the response to COVID-19 with resources reprioritised.

CASH AND CAPITAL

14. The cash balance at the end of March 2020 was £16.8m, which was £14.3m above plan due to the timing of capital expenditure and an increase in liabilities at year end.

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

    - Non-Current Assets are below plan by £48.2m; this is mainly driven by the revaluation of the Trust estate in 2018/19 and 2019/20.

    - Current assets are above plan by £24.3m, this is due to cash £14.3m, inventories £0.2m and receivables £9.8m above plan.

    - Current liabilities are above plan by £65.7m. This is being driven by borrowings £51.2m (driven by various DHSC borrowings becoming due and transferred from non-current assets. These are due to be converted to PDC in 2020/21), deferred income £0.7m, provisions £0.1m and Trade and Other Creditors £13.2m above plan.

    - Non-Current Liabilities are below plan by £48.3m. This is being driven by borrowings £48.8 (driven by various DHSC borrowings becoming due and transferred from non-current assets) offset by provisions £0.5m above plan.

The Trust has spent £24.5m on capital up to month 12, of which £22.0m counts toward the national CDEL, £2.3m above plan

The key performance indicators have been met with the exception of, capital spend due to timing of projects, debtor and creditor days due to timing of invoices.

RISK REGISTER

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

a) Constraints on the NHS Capital Departmental Expenditure Limit (CDEL) may lead to delays in the Trust receiving its required capital funding or other restrictions being placed on the Trust's capital programme.

The Trust has received confirmation that the total capital spend included in its annual plan is affordable within the CDEL. Schemes are progressing and funding sources have been identified.

b) There is a risk that the Trust does not receive timely confirmation that its revenue loans due for repayment in 2019/20 have been refinanced.

On 2 April, DHSC confirmed that provided loans would be converted to PDC (effective from 1 April 2020); as a result, the Trust will not be required to make loan repayments as original scheduled in 2020/21. The total value of loans converted to PDC is circa £130m for the Trust.

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

The Trust had a transformation programme target of £8.4m in 2019/20 which was not delivered in full with £6.1m delivered in the year due to the impact of the COVID-19 pandemic which severely affected the Trust's ability to progress schemes in March 2020. However, despite this, the Trust achieved its adjusted control total for 2019/20.

RECOMMENDATIONS TO TRUST BOARD

17. Trust Board is asked to note the financial position of the Trust as at 31st March 2020 and the proposed actions and risks therein.

Appendix 1

Milton Keynes Hospital NHS Foundation Trust
Statement of Comprehensive Income
For the period ending 31st March 2020

	March 2020			Full Year			Full year
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME							
Outpatients	3,949	3,243	(706)	45,338	46,048	710	45,338
Elective admissions	2,534	1,639	(895)	29,013	26,549	(2,465)	29,013
Emergency admissions	6,299	4,829	(1,469)	73,898	69,765	(4,133)	73,898
Emergency adm's marginal rate (MRET)	(276)	(265)	11	(3,238)	(3,110)	128	(3,238)
Readmissions Penalty	(279)	(279)	0	(3,353)	(3,353)	0	(3,353)
A&E	1,202	910	(292)	14,418	14,771	353	14,418
Maternity	1,687	1,740	53	19,980	21,669	1,689	19,980
Critical Care & Neonatal	555	598	43	6,362	6,107	(255)	6,362
Excess bed days	0	0	0	0	0	0	0
Imaging	447	382	(65)	5,120	5,403	283	5,120
Direct access Pathology	413	287	(126)	4,726	4,682	(44)	4,726
Non Tariff Drugs (high cost/individual drugs)	1,625	1,700	76	19,738	18,930	(808)	19,738
Other	672	5,325	4,652	6,723	16,590	9,867	6,723
Clinical Income	**18,827**	**20,108**	**1,281**	**218,726**	**224,052**	**5,326**	**218,726**
Non-Patient Income	**4,156**	**16,081**	**11,925**	**50,249**	**57,992**	**7,743**	**50,249**
TOTAL INCOME	**22,983**	**36,189**	**13,207**	**268,975**	**282,045**	**13,069**	**268,975**
EXPENDITURE							
Total Pay	**(14,136)**	**(24,029)**	**(9,893)**	**(171,023)**	**(185,105)**	**(14,082)**	**(171,023)**
Non Pay	(4,786)	(6,506)	(1,720)	(58,070)	(64,195)	(6,126)	(58,070)
Non Tariff Drugs (high cost/individual drugs)	(1,625)	(1,700)	(76)	(19,738)	(18,930)	808	(19,738)
Non Pay	**(6,411)**	**(8,206)**	**(1,796)**	**(77,808)**	**(83,125)**	**(5,317)**	**(77,808)**
TOTAL EXPENDITURE	**(20,547)**	**(32,236)**	**(11,688)**	**(248,831)**	**(268,231)**	**(19,400)**	**(248,831)**
EBITDA*	**2,435**	**3,954**	**1,518**	**20,144**	**13,814**	**(6,331)**	**20,144**
Depreciation and non-operating costs	(983)	(7,993)	(7,010)	(11,796)	(18,814)	(7,018)	(11,796)
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**1,452**	**(4,040)**	**(5,492)**	**8,348**	**(5,001)**	**(13,349)**	**8,349**
Public Dividends Payable	(130)	324	454	(1,560)	(122)	1,438	(1,560)
OPERATING DEFICIT AFTER DIVIDENDS	**1,322**	**(3,716)**	**(5,038)**	**6,788**	**(5,122)**	**(11,910)**	**6,788**
Adjustments to reach control total							
Donated Income	0	(476)	(476)	(8,000)	(2,476)	5,524	(8,000)
Donated Assets Depreciation	66	56	(9)	786	674	(112)	786
Control Total Rounding	20	0	(20)	(5)	0	5	(5)
Impairments	0	7,079	7,079	0	7,448	7,448	
PSF/FRF/MRET	(2,595)	(4,612)	(2,017)	(23,164)	(24,839)	(1,675)	(23,164)
CONTROL TOTAL DEFICIT	**(1,187)**	**(1,668)**	**(482)**	**(23,595)**	**(24,316)**	**(720)**	**(23,595)**

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

Appendix 2

Milton Keynes Hospital NHS Foundation Trust
Group Statement of Cash Flow
As at 31st March 2020

	Group Unaudited Mth12 2019-20 £000	Mth 11 £000	In Month Movement £000
Cash flows from operating activities			
Operating (deficit) from continuing operations	(2,888)	1,037	(3,925)
Operating surplus/(deficit) of discontinued operations			
Operating (deficit)	**(2,888)**	**1,037**	**(3,925)**
Non-cash income and expense:			
Depreciation and amortisation	9,255	8,457	798
Impairments	7,448	369	7,079
(Increase)/Decrease in Trade and Other Receivables	1,156	7,615	(6,459)
(Increase)/Decrease in Inventories	183	5	178
Increase/(Decrease) in Trade and Other Payables	10,204	5,281	4,923
Increase/(Decrease) in Other Liabilities	566	2,731	(2,165)
Increase/(Decrease) in Provisions	635	(56)	691
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows	(2,476)	(2,000)	(476)
Other movements in operating cash flows	(1)	0	(1)
NET CASH GENERATED FROM OPERATIONS	**24,083**	**23,439**	**644**
Cash flows from investing activities			
Interest received	111	102	9
Purchase of financial assets	(175)	(175)	-
Purchase of intangible assets	(3,746)	(2,154)	(1,592)
Purchase of Property, Plant and Equipment, Intangibles	(17,347)	(13,756)	(3,591)
Sales of Property, Plant and Equipment	0	0	-
Net cash generated (used in) investing activities	**(21,157)**	**(15,983)**	**(5,174)**
Cash flows from financing activities			
Public dividend capital received	3,902	1,071	2,831
Loans received from Department of Health	5,300	2,915	2,385
Loans repaid to Department of Health	(1,413)	(1,316)	(97)
Capital element of finance lease rental payments	74	(158)	232
Interest paid	(1,918)	(1,440)	(478)
Interest element of finance lease	(297)	(268)	(29)
PDC Dividend paid	(405)	(606)	201
Receipt of cash donations to purchase capital assets	2,476	2,000	476
Net cash generated from/(used in) financing activities	**7,719**	**2,198**	**5,521**
Increase/(decrease) in cash and cash equivalents	**10,645**	**9,654**	991
Opening Cash and Cash equivalents	**6,175**	**6,175**	0
Closing Cash and Cash equivalents	**16,820**	**15,829**	**991**

Appendix 3

Milton Keynes Hospital NHS Foundation Trust
Group Statement of Financial Position as at 31st March 2020

	Audited Mar-19	Mar-20 YTD Plan	Mar-20 YTD Actual - Group Unaudited	In Mth Mvmt	YTD Mvmt	% Variance
Assets Non-Current						
Tangible Assets	147.3	195.2	143.2	(52.0)	(4.1)	(2.8%)
Intangible Assets	14.2	12.9	16.1	3.2	1.9	13.4%
Other Assets	0.5	0.3	0.9	0.6	0.4	96.5%
Total Non Current Assets	**162.0**	**208.4**	**160.2**	**(48.2)**	**(1.8)**	**(1.1%)**
Assets Current						
Inventory	3.6	3.2	3.4	0.2	(0.2)	(5.6%)
NHS Receivables	23.5	15.5	21.4	5.9	(2.1)	(8.9%)
Other Receivables	6.0	3.0	6.9	3.9	0.9	15.0%
Cash	6.2	2.5	16.8	14.3	10.6	171.0%
Total Current Assets	**39.3**	**24.2**	**48.5**	**24.3**	**9.2**	**23.4%**
Liabilities Current						
Interest -bearing borrowings	(80.2)	(80.7)	(131.3)	(50.6)	(51.2)	63.8%
Deferred Income	(1.7)	(1.6)	(2.3)	(0.7)	(0.6)	34.8%
Provisions	(1.6)	(1.4)	(1.5)	(0.1)	0.1	-4.3%
Trade & other Creditors (incl NHS)	(28.9)	(27.8)	(42.1)	(14.3)	(13.2)	45.7%
Total Current Liabilities	**(112.3)**	**(111.5)**	**(177.2)**	**(65.7)**	**(64.9)**	57.8%
Net current assets	**(73.0)**	**(87.3)**	**(128.7)**	**(41.4)**	**(55.7)**	**76.3%**
Liabilities Non-Current						
Long-term Interest bearing borrowings	(53.0)	(54.6)	(5.8)	48.8	47.2	(89.1%)
Provisions for liabilities and charges	(0.8)	(1.1)	(1.6)	(0.5)	(0.8)	93.5%
Total non-current liabilities	**(53.9)**	**(55.7)**	**(7.4)**	**48.3**	**46.5**	(86.3%)
Total Assets Employed	**35.1**	**65.4**	**24.1**	**(41.0)**	**(11.0)**	**(31.3%)**
Taxpayers Equity						
Public Dividend Capital (PDC)	101.4	104.7	105.3	0.6	3.9	3.9%
Revaluation Reserve	58.3	78.7	48.4	(30.3)	(9.9)	-17.0%
I&E Reserve	(124.5)	(118.0)	(129.6)	(11.6)	(5.1)	4.1%
Total Taxpayers Equity	**35.1**	**65.4**	**24.1**	**(41.3)**	**(11.0)**	**(31.4%)**

Meeting title	Trust Board	Date: 7 May 2020
Report title:	Workforce report	Agenda item: 5.4
Lead director Report author	Name: Danielle Petch Name: Paul Sukhu	Title: Director of Workforce Title: Deputy Director of Workforce
FoI status:	Public	

Report summary	This report provides a summary of workforce Key Performance Indicators for the full year ending 31 March 2020 (Month 12).			
Purpose *(tick one box only)*	Information [x]	Approval [ ]	To note [x]	Decision [ ]
Recommendation	Trust Board is asked to note the Workforce report.			

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

Report history	
Next steps	
Appendices	

Workforce report – Month 12, 2019/20

1. Purpose of the report

1.1. This report provides a summary of workforce Key Performance Indicators for the full year ending 31 March 2020 (Month 12).

2. Staff in post

2.1. The Trust's staff in post by whole time equivalent (WTE) was 3177.3 as at 31 March 2020; an increase of 85.2 WTE since March 2019.

2.2. The Trust's headcount is 3666, an increase of 93 since March 2019.

3. Vacancy rate

3.1. The Trust's overall vacancy rate is 8.1%; this has reduced from 12.9% in April 2019 (M1).

4. Turnover

4.1. The Trust's leaver turnover rate was lower throughout 2019/20 than it was in 2018/19 and this trend has continued into Q4 of 2019/20. However, the M12 position has increased from M11 from 8.7% to 9.4%.

5. Temporary Staffing

5.1. The temporary staff usage (bank + agency) for the year was 6054.1 WTE, which was 14.2% of total WTE staff employed.

5.2. Agency staff usage was 3.0% of the total WTE staff employed for the year but was 5.1% of the total annual staff expenditure.

5.3. The Trust target for Agency Staff Expenditure for 2019/20 is 8.0% (2018/19 is 8.0%)

6. Sickness absence

6.1. The sickness absence rate (N.B. 12 months to M11, 29 February 2020) is 3.9% against the Trust target of 4.0% (1.7 % short term and 2.2% long term).

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

7. Statutory and mandatory training

7.1. Statutory and mandatory training compliance as at 31 March 2020 was at 94% against the Trust target of 90%.

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

8. Appraisal compliance

8.1. Trust-wide appraisal compliance as at 31 March 2020 is 94%, against the Trust target of 90%.

8.2. Routine reminders and a series of letters to responsible managers from the Director of Workforce are now sent in order to support a culture of sustainability of the level of appraisals undertaken.

Appraisal Compliance by Division	
Core Clinical	98%
Corporate Services	94%
Medicine	90%
Surgery	91%
Women's and Children's	94%
Total	**94%**

9. Covid Response

9.1. The welfare of our workforce has been at the forefront of our minds during this time. A number of initiatives have been put in place in order to ensure our staff are looked after and cared for while they are looking after and caring for our patients. These are detailed below:

a) <u>Close monitoring of any staff sickness and welfare calls to those who are unwell</u>

As of 30th April 2020, 230 colleagues were at home either off sick or working from home as a result of self-isolating due to suspected COVID. This is decreased from its peak at the end of March when over 450 were absent due to COVID related illness/self-isolation. To date 906 have returned to work following self-isolation.

All staff who are absent with COVID/suspected COVID or isolating due to a family member being suspected of having COVID are contacted each day by one of the team via telephone. These calls are to check on the welfare of our staff, making sure they are in good spirits and that they have basic necessities, such as food

and medication. Where a need is identified volunteers are made aware of the issue and the necessary supplies are collected and delivered. These daily calls are especially vital for staff who live alone as this may be the only person they speak with that day.

The average number of welfare calls each day is 200 but it has been as high as 400 each day at its peak. To date, the teams have made over 5500 welfare calls since w/c 16 March 2020

b) Creation of the staff hub

Sarah Crane, Trust Chaplain, has created a staff hub in the recently vacated Macmillan Unit. This is a safe space staff can attend to take a few moments to relax and recharge with colleagues. This is especially important given the distressing progress of this illness. It is vital staff have a space place to process their feelings or simply to have a quiet place to reflect.

c) Extensive Health and Wellbeing Services

Alongside our regular telephone counselling service, Employee Assistance Programme (EAP) we have also introduced a secondary telephone EAP and face to face counselling service. Whilst not in regular use at the moment it is anticipated these will be vital after the COVID crisis has passed as staff take time to process the impact it has had on them. Alongside these local offerings there are also national services being put in place in conjunction with groups such as the Samaritans. These services are being well publicised to our staff and are readily available to both the Welfare Call handlers and the Staff COVID call line handlers.

d) Staff COVID call line

We have introduced a 7-day call line, over extended hours, which staff can ring to report their symptoms, book in for swabbing and ask any COVID related questions. The questions include topics such as PPE, self-isolation, COVID symptoms, child care issues and many more. The call line receives on average between 100 and 150 calls a day.

e) Staff food parcels to wards

Sarah Crane, Trust Chaplain and Kate Jarman, Director of Corporate Affairs, arranged and delivered baskets of essentials and small treats to each ward and department to keep staff refreshed and hydrated during this time. These have been very well received by staff and are much appreciated. The contents of the baskets are largely a result of the many donations of items we have received from the population and companies of Milton Keynes.

f) Staff swabbing

The Staff Health and Wellbeing team have swabbed all staff off with COVID related symptoms, in line with national criteria for swabbing. 400 staff with symptoms have been swabbed to date.

On 29th and 30th April the Trust participated in an NHS England initiative to swab asymptomatic staff. The majority of the first 500 booking slots were filled within the first hour of the call centre opening.

The Trust increased its swabbing capacity to support this at scale and pace; at the time of this report, over 1200 staff swabs had been taken across the Trust's Wards, the Ward 12 hub and a standalone Pod outside the Paediatric Accident and Emergency Department.

g) Risk assessment and reasonable adjustments to "at risk" staff

Staff who have certain medical conditions in line with national definitions have been asked to complete a risk assessment form. This is reviewed by the Divisional Triumvirate and then forwarded to the Trust Risk Assessment Panel, which consists of an Executive Director, Occupational Health and HR. This panel reviews the Divisional recommendation and then makes the final recommendation as to whether the staff member may continue with no adjustments, be moved to a lower risk area, either in the department, Division or elsewhere in the Trust, or work from home. To date 700 risk assessment forms requesting to be able to work from home or from a lower risk are have been received and processed. An appeal process has also been developed to review cases further, as required, with the support of Staff Health and Wellbeing and colleagues from the Corporate Nursing team

h) Fast track of 300 volunteers

300 volunteers have approached the Trust to offer their services during this time. These are in the process of being cleared and once ready to work are passed to the volunteer team for deployment.

i) Fast track of 100+ new bank workers

Over 100 people have registered to work via our Bank during this time. These are in the process of being cleared and once ready to work are passed to the clinical teams for deployment to service areas.

j) Substantive offer to bank staff

Bank staff were offered the option to migrate to a substantive contract (vacancies allowing) as this allows them to be rostered in advance and to benefit from full NHS terms and conditions. A reliable and regular supply of experienced staff is

essential during this time and we are pleased a number of bank workers have chosen this option.

k) Redeployment Pool

Where it has not been possible for a colleagues to continue in their current role, either as a result of there being no “lower risk area” for them following panel review, or because their regular work is not taking place, a process has been put in place to allow the Trust to assess their skills and move them to another role on a temporary basis. This includes roles such as switchboard and the welfare call lines. In addition, this group have also surveyed 500+ administrative staff asking them to identify which areas of front line work they would be able to undertake, should the need arise. This includes tasks such as cleaning, unpacking and delivering stores etc.

l) BAME Workforce

It has emerged over recent days that the BAME workforce appear to be more severely impacted by COVID than the non-BAME workforce. There is a national response soon to be published in relation to this but in the interim the Trust have arranged BAME Q&A sessions and have engaged with the local British Association of Physicians of Indian Origin (BAPIO) Lead and the Medical Advisory Committee (MAC) to discuss the issues.

10. Recommendations

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

Meeting title	**Board of Directors**	**Date: 5/2020**
Report title:	**Board Assurance Framework**	**Agenda item: 6.1**
Lead director **Report author** **Sponsor(s)**	**Kate Jarman**	**Director of Corporate Affairs**
FoI status:	**Disclosable**	

Report summary				
Purpose *(tick one box only)*	☐ **Information**	☒ ☐ **Approval**	**Discussion**	☐ **Decision**
Recommendation	The Board is asked to discuss the risks contained on the Board Assurance Framework, with Committee Chairs and Executive Risk Owners required to escalate any matter for the Board's attention following detailed discussion of risks in relevant Board Sub-Committees.			

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

Report history	Regular reporting to Board Sub-Committees and to the Board
Next steps	Board reporting
Appendices	Papers follow

Board Assurance Framework

The Sub-Committees of the Trust Board (Quality and Clinical Risk, Finance and Investment, Workforce Assurance, Audit) are required under their terms of reference to discuss, in detail, the risks on the Board Assurance Framework pursuant to their areas of business, and escalate any matters of concern for Board attention.

The Audit Committee also reviews the Trust's risk registers; and the Quality and Clinical Risk Committee reviews the Trust's clinical risk registers. The Board also has oversight of the Significant Risk Register on a quarterly basis – this month, the risks presented are those

with a residual (current) risk rating of 16 or above according to the 5x5 risk matrix (detailed in the Trust's risk management strategy).

The BAF has been updated in the month by Executive Risk Owners.

The Board is asked to discuss the risks contained on the Board Assurance Framework, with Committee Chairs and Executive Risk Owners required to escalate any matter for the Board's attention following detailed discussion of risks in relevant Board Sub-Committees. The Board is asked to review the Significant Risk Register (for the Board this is risks with a current risk score above 16 on the Trust's corporate and divisional risk registers).

Recommendation to the Board

This BAF carries forward the risks from the 2019/20 reporting year to the 2020/21 reporting year. This paper proposes the Board reviews the BAF at its June seminar, alongside the revised corporate objectives, following their update due to the Coronavirus pandemic. It is recommended that the objectives and strategic risks for the organisation undergo a comprehensive review and rescoping at that dedicated seminar.

Objective	Risk Ref	Oversight Committee	Executive Lead	Risk Description	Cause	Inherent Risk Rating	Controls	Gaps in Controls	Current Risk Rating	Target Risk Rating	Risk Appetite	SRR Link
Safety	1-1	Quality & Clinical Risk	COO	Strategic failure to manage demand for emergency care	Lack of demand management by the local health economy Inadequate primary care provision/ capacity Inadequate community care provision/ capacity Inadequate social care provision/ capacity	4x4=16	Working with partners to manage peak demand periods (e.g expediting discharge; using full community/ social care capacity)		4x3=12	4x2=8	Avoid	1917/2500
Safety	1-2	Quality & Clinical Risk	COO	Tactical failure to manage demand for emergency care	Annual emergency and elective capacity planning inadequate or inaccurate Daily flow/ site managmement plans inadequate or ineffectual Poor clinical/ operational relationships impacting on patient flow through the organisation Poor operational/ managerial relationships impacting on escalation Ineffective engagement with stakeholders to support patient flow day-to-day	4x4=16	Introduction of ED streaming Working with UCC to manage demand Implementation of national flow improvement programmes - Red2Green; 100% Challenge; EndPJParalysis; SAFER Strong clinical and operational leadership and ownership; good team working Clear escalation and well-known and understood flow management and escalation plans Positive relationships with stakeholders through daily working and medium-term planning		4x3=12	4x2=8	Avoid	1917/2500
Safety	1-3	Quality & Clinical Risk	COO	Ability to maintain patient safety during periods of overwhelming demand	Significantly higher than usual numbers of patients through the ED Significantly higher acuity of patients through the ED Major incident/ pandemic	5x4=20	Clinically and operationally agreed escalation plan Adherence to national OPEL escalation management system Clinically risk assessed escalation areas available		4x3=12	4x2=8	Avoid	1917/2500
Safety	1-4	Quality & Clinical Risk	Medical Director	Failure to appropriately embed learning and preventative measures following Serious Incidents, complaints, claims and inquests [Reviewed March 2020]	1. Failure to appropriately report, invesitgate and learn from incidents and complaints 2. Lack of system to share learning effectively from incidents - both in departments/ CSUs and across the Trust 3. Lack of evidence of learning from incidents	4x4=16	Improvement in incident reporting rate and maintenance of reports/harm ratio All SIs and action plans processed through the Serious Incident Review Group (with its wide membership) Actions including handling of learning tracked Core component of all Clinical Improvement Group (CIG) Meetings Lessons communicated via Trust-wide channels including audit afternoons and Event in the Tent Debriefing embedded in specialties and corporately Training and skills programme annually Cultural work (including Greatix, FTSU programme and maturing QI methodology) GIRFT programme has raised the profile of litigation data within teams.	Evidence of learning locally at team level could be more robust A more granular view of incident reporting behaviours could help inform QI activity and focus.	4x3=12	4x2=8	Avoid	1472
Safety	1-5	Quality & Clinical Risk	Medical Director	Failure to recognise and respond to the deteriorating patient [Reviewed March 2020]	Non compliance with the NEWS protocols; failure to appropriately escalate NEWS scores or failure to clinically assess patients outside protocols (i.e. 'hands on, eyes on' patients who are ill but not triggering on NEWS)	4x4=16	National NEWS protocol in place Level 1 pathway fully established Successful transition to an electronic platform (eCare) Successful implementation of NEWS 2 Sepsis screening and training / awareness programme Reduction in the number of incidents / serious incidents reported where failure to recognise deterioration is a significant element	Review of rapid response / night nurse practitioner / ICU outreach functions underway with a view to unified standards and team identity. Formal audit evidence in relation to NEWS2 implementation and performance.	4x2=8	4x2=8	Avoid	2495/2497
Safety	1-6	Quality & Clinical Risk	Deputy CEO	Failure to manage clinical risk during significant digital change programmes	1. Inadequate assessment of clinical risk/ impact on clinical processes and safety/ experience of digital change prgrammes 2. Inadequate resourcing of digital change programmes (including operational support) 3. Inadequate training for clinicians and support staff on new digital systems prior to and post roll out	4x4=16	1. Robust governance structures in place with programme management at all levels 2. Thorough planning and risk assessments during scoping, testing, launch and roll out 3. Resourcing reviewed regularly at programme boards 4. Training needs established in scoping and testing phases 5. Regular reviews of progress post go-live for all digital change programmes		4x3=12	4x2=8	Avoid	

Safety	1-7	Quality & Clinical Risk	COO	Failure to provide sufficient capacity to match demand for elective care (as evidenced by average waiting times, appointment slot issues (ASI) and non-RTT backlog).	Increased referrals in to secondary care. Over-emphasis on provision of emergency care. Failure to optimise OPD capacity via referral management and appropriate discharge criteria. Absence of financial drivers to increase outpatient activity (in absence of PbR tariff).	5x4=20	Improved granular understanding of demand and capacity (NHSI tool). Balanced scorecard approach to performance at Trust, Divisional, CSU and service level. Integrated approach to referral management. Agreement of local standards in relation to discharge criteria from clinic and follow up to first ratios. Agreement of internal tolerance of ASI and non-RTT. Provision of additional outpatient capacity and development of new outpatient care models.		4x4=16	4x2=8	Avoid	
Safety	1-8	Board of Directors	COO	Ability to cope with the demand for ITU and inpatient care due to the Covid-19 pandemic	Demand for ITU and inpatient beds exceeds capacity, including escalation capacity within the hospital.	5x4=20	Increased capacity across the hospital, including ITU beds. Clear escalation plans in place based on latest modelling and national guidance.	Oxygen capability is a rate limiting factor in the provision of increased ITU beds	5x3=15	5x2=10	Avoid	
Safety	1-9	Board of Directors	COO	Harm to patients due to the suspension of elective acitivity during the Covid-19 pandemic	All routine elective activity suspended to free-up capacity for inpatient care during the Covid-19 pandemic; and to reduce footfall and exposure throughout the hospital (particularly in high volume areas like Outpaitents). Cancer pathways also clinically triaged and so waiting times longer for patients requiring 2ww diagnostics.	4x4=16	Clinical triaging of patients to ensure those who need to come in for urgent treatment/ assessment are identified and seen. Clear guidance and protocols in place. Following national guidance.		4x3=12	4x2=8	Avoid	
Safety	1-10	Quality & Clinical Risk	Deputy CEO	If demand for O2 exceeds 1,600 L/Min then there is a risk that pressure will fall leading to the possibility of system failure	The Trust is supplied with liquid O2 stored in a VIE. This is converted to gaseous 02 with a theoretical maximum usage of 1,800 L/Min. if demand increases then there is a risk of inadequate supply to meet the clinical demand or system failure as the evaporators freeze	5x4=20	Daily monitoring of demand and detailed planning of capacity. Small quantities of O2 from portable cylinders are available but would not support patient care demand.	More robust business continuity plans for main ICU area. □ Daily collection of ward and departmental usage supported by clinical policies to setting of O2 ceilings □	5x4=20	4x4=16	Avoid	
Experience	2-1	Quality & Clinical Risk	Chief Nurse	Failure to achieve improvements in the patient survey	Lack of appropriate intervention to improve patient experience (measured through the national surveys)	4x4=16	Prevent Controls Coporate Patient Experince Team function, resources and governance arrangements in place at Trust, division and department levels, including but not limited to: • Patent Experince Strategy • Learning Disabilities Strategy • Dementia Strategy • Nutrition steering group • Catering steering group • Domestic planning group • Discharge steering group • Induction training Detect Controls Quarterly Patient Experience Board , monthly meetings and supporting substructure of steering groups .		4x3=12	4x2=8	Minimal	2598
Experience	2-2	Quality & Clinical Risk	COO	Failure to embed learning from poor patient experience and complaints	Learning not captured and shared in a meaningful and impactful way among individuals and team (and across the organisation) Failure to embed an appropriate system for sharing learning consistently, in a way that can be measured/ audited and evidenced	4x4=16	Prevent Controls Corporate PALS/Complaints Team function, resouces and governance in place at the Trust, division and department levels, including but not limited to : • Complaints policy and process • PALS policy and process • Ombusman policy and process • Complaints handling traininf for managers • Clinical oversight complaints/PALS process Detect Controls Quarterly Patient Experience Board, monthly meetings and integration with Patient Experience sub structure of steering groups.		4x3=12	4x2=8	Avoid	
Experience	2-3	Trust Board	CEO	Deterioration in patient experience of clinical oncology (radiotherapy) pathways, deterioration in access to treatment and reputational damage.	Break down in the established relationship (sub contract) between Oxford University Hospitals and the private Genesis Care facility (Linford Wood, Milton Keynes) which has provided local radiotherapy to MK residents for the last six years. This breakdown results in less choice and longer travel distances for patients requiring radiotherpay. Patients tend not to differentiate between the different NHS provider organisations. This risk materialised 16.12.2019 when the contract expired and no extension was agreed.	5x4=20	Contingency for the provision of treatment to patient in Oxford. Promotion of ongoing discussion between OUH and Genesis about the ongoing provision of palliative and prostate radiotherapy at Linford Wood (a limited contract extension). Promotion of agreement between OUH and Northampton General Hospital to facilitate access to facilities at Northampton for those who prefer treatment in this location. Promotion of rapid options appraisal and decision making at OUH and MKUH in relation to a medium to long term solution for radiotherapy provision on site at Milton Keynes University Hospital (build, operation, governance etc...) and route to capital funding. Proactive communications strategy in relation to current service delivery issues.		4x4=16	4x2=8	Minimal	

Effectiveness	3-1	Quality & Clinical Risk	Director Corp Aff	Failure to evidence compliance with the annual clinical audit programme	1. Lack of understanding/ awareness of audit requirements by clinical audit leads 2. Resources not adequate to support data collection/ interpretation/ input 3. Audit programme poorly communicated 4. Lack of engagement in audit programme 5. Compliance expectations not understood/ overly complex	4x4=16	1. Designated audit leads in CSUs/ divisions 2. Clinical governance and administrative support - allocated by division 3. Recruited additional clinical governance post to medicine to support audit function (highest volume of audits) 3. Audit programme being simplified, with increased collaboration and work through the QI programme 4. Audit compliance criteria being segmented to enable focus on compliance with data returns; opportunity for learning/ changing practice and communication/ engagement		4x3=12	4x2=8	Minimal	
Effectiveness	3-2	Quality & Clinical Risk	Director Corp Aff	Failure to embed learning and evidence action plans following clinical audit	1. Learning from audits not captured effectively 2. Learning from audit not shared effectively 3. No central record of learning from audit or ability to compare audit/ re-audit progress	4x4=16	1. Designated audit leads in CSUs/ divisions 2. Clinical governance and administrative support - allocated by division 3. Recruited additional clinical governance post to medicine to support audit function (highest volume of audits) 3. Audit programme being simplified, with increased collaboration and work through the QI programme 4. Audit compliance criteria being segmented to enable focus on compliance with data returns; opportunity for learning/ changing practice and communication/ engagement		4x3=12	4x2=8	Minimal	
Effectiveness	3-3	Quality & Clinical Risk	Director Corp Aff	Lack of assessment against and compliance with NICE guidance	The Trust has a number of NICE guidelines awaiting compliance declarations	3x4=12	Monthly assessments of compliance against published NICE baseline assessments Process in place to manage baseline assessments with relevant clinical lead - supported by clinical governance leads Independent review by compliance and audit lead Requires clinical engagement and ownership	Small number of breached documents	3x4=12	3x2=6	Minimal	767
Key Targets	4-1	Executive Management	COO	Failure to meet the 4 hour emergency access standard	The Trust is unable to meet the target to see 95% of patients attending A&E within 4 hours	4x4=16	Operational plans in place to cope with prolonged surges in demand Cancelling of non urgent elective operations New elective surgical ward open to reduce liklihood of above control Opening of escalation beds Working with partners for social, community and primary care Clinical reviews and prioritisation undertaken to prevent patient harm	Target currently being breached	4x4=16	4x2=8	Minimal	1917/2500
Key Targets	4-2	Executive Management	COO	Failure to meet the key elective access standards - RTT 18 weeks, non-RTT and cancer 62 days	The Trust is unable to meet the 18 week RTT and 62 day cancewr targets, and unable to reduce its non-RTT backlog as required	4x4=16	Regular PTL meetings to ensure clinical oversight of patient waiting times and executive ownership Work on improving administrative pathways Work with tertiary providers on breach allocations RTT and non-RTT action plans	Target currently being breached	4x4=16	4x2=8	Minimal	2679/2589
Effectiveness	5-1	Audit	Deputy CEO	Failure to ensure adequate data quality leading to patient harm, reputational risk and regulatory failure	Data quality governance and processes are not robust	4x4=16	Robust governance around data quality processes including executive ownership Audit work by data quality team		4x3=12	4x2=8	Minimal	2705/2572
Sustainability	6-1	Audit	Deputy CEO	Failure to adequately safeguard against major IT system failure (deliberate attack)	Weaknesses in cyber security leave the trust vulnerable to cyber attack	5x2=10	Investment in better quality systems GDE investment NHS Digital audits and penetration tests		4x2=8	4x2=8	Minimal	
Sustainability	6-2	Finance & Investment	Deputy CEO	Failure to adequately safeguard against major IT system failure (inability to invest in appropriate support systems/infrastructure)	Lack of suitable and timely investment leaves the Trust vulnerable to cyber attack	5x2=10	2 dedicated cyber security posts funded through GDE All Trust PCs less than 4 years old Robust public wifi network EPR investment		4x2=8	4x2=8	Minimal	

Sustainability	6-3	Executive Management	Deputy CEO	Failure to maximise the benefits of EPR	That the Trust does not derive all of the benefits in terms of efficiency and productivity from the EPR system as had been anticipated in the business cases	4x4=16	eCare operational delivery board being put into place in order to cover the spectrum of optimisation opportunities both financial and non-financial as a result of the implementation (and upcoming upgrades and changes). An initial schedule of opportunities that forecasts a lvel of savings in line with those in the original business case is being monitored against although there is likely to be some slippage against this when taking into account time for the new system to bed-in across the organisation.		4x3=12	4x2=8	Minimal	2177/1185
Finance	7-1	Finance & Investment	DOF	There is a risk that the constraints on the NHS capital expenditure limit (CDEL) lead to delays in the Trust receiving its approved capital funding or other restrictions being placed on the Trust's capital programme	The national NHS Capital Financing regime is under significant pressure, which is restricting the Trust's ability to spend on capital in line with it's requirements	5x4=20	1. Capital prioritisation process in place (through the Trust's Capital Control Group (CCG) and Clinical Board Investment Group (CBIG) to ernsure the Trust prioritises its capital schemes within scarce resources effectively. 2. Alternative funding sources identified to support continued investment in the Trust's estate and physcial infrastructure in line with requirements. 3. Capital bids submitted where additional NHS funding streams become available.	The Trust has only limited influence on the national policy regarding the capital funding regime and the constraints on the national CDEL.	4x2=8	4x2=8	Cautious	
Finance	7-2	Finance & Investment	DOF	There is a risk that the Trust does not receive timely confirmation that its historical revenue loans due for repayment wihtin 12 months have been refinanced or written off leading to a potential breach of the DHSC loan agreements and/or a going concern/cashflow risk to the Trust.	The Trust's historical deficits have been financed through revenue support loans which, under current terms, require repayment. Guidance for the 2020/21 suggests that provider revenue support loans will be written off; however this has not yet been confirmed with the Trust.	5x3=15	1. The Trust has made representations to NHSI and DHSC to make clear that it will be unable NHSI and DHSC that it would be unable to make its loan repayments as they currently fall due. 2. The Trust is one of a number of NHS provider organisations with revenue support loans due for repayment within 12 months meaning a national resolution of the issue is more likely.	The Trust has only limited influence on the national policy for the financing regime.	4x3=12	4x2=8	Cautious	
Finance	7-3	Finance & Investment	DOF	There is a risk that the Trust is unable to achieve the required efficiency improvements through the transformation programme leading to an overspend against plan and the potential loss of the £5.1m of Provider Sustainability Funding in the event the Trust's control total is not met.	Unless the Trust is proactive in identifying efficiency opportunities then the transformation target would not be achieved leading to a significant financial risk to the organisation.	5x5=25	1. Tracker in place to identify and track savings and ensure they are delivering against plan 2. Savings measured against Trust finance ledger to ensure they are robust and consistent with overall financial reporting 3. All savings RAG rated to ensure objectivity 4. Oversight of the transformation programme through the Transformation Programme Board and Management Board.	The Trust requires support from external partners to support the delivery of the Transformation programme which is outside of the Trust's direct control.	3x3=9	3x2=6	Cautious	
Finance	7-4	Finance & Investment	DOF	There is a risk that the Trust's guaranteed income contract does not deliver the benefits expected and/or leads to an opportunity cost to the Trust in respect of unfunded activity.	An increase in activity against planned levels could lead to unfunded cost pressures at the Trust.	5x4=20	1. Clearly defined monitoring of the monthly activity performance with lead commissioner 2. Escalation of issues to senior managers within the Trust. 3.Joint executive contract group to assess activity and performance and monitor the delivery of joint initiatives. 4. Risk-share arrangement included within the contract.	The 2019/20 contract is delivering the expected benefits. Priorities for 2021/22 and the associated governance arrangements need to be agreed.	3x3=9	3x2=6	Cautious	
Finance	7-5	Finance & Investment	DOF	There is a risk that as a result of the covid-19 pandemic the Trust incurs additional costs or has a reduction in income that leads to its financial position being unsustainable.	Increases in staff costs and non-pay costs in order to manage covid-19 Claims from suppliers under Procurement Policy Note 02/20 Reduction in clinical income as a result of changes in clinical models and fewer hospital admissions Reductions in commercial income streams as a direct result of covid-19.	4 x 4 = 16	1. PbR contracts replaced with block contracts (set nationally) for clinical income; 2. Top-up payments available where covid-19 leads to additional costs over and above block sum amounts; 3. Financial controls remain in place for approval of additional spend above budgetted levels;	Lack of clarity regarding financial regime beyond July 2020.	3 x 3 = 9	3x2=6	Cautious	

Workforce	8-1	Workforce	Director Workforce	Inability to retain staff emmployed in critical posts	Poor working culture within certain isolated teams Perceived more attractive benefits elsewhere Proximity to tertiary centres with perceived better career development opportunities	4x4=16	Variety of organisational change/staff engagement activities, e.g. Event in the Tent Schwartz Rounds and coaching collaboratives Recruitment and retention premia We Care programme Onboarding and exit strategies/reporting Staff survey Learning and development programmes Health and wellbeing initiatives, including P2P and Care First Staff friends and family results/action plans Links to the University of Buckingham Staff recognition - staff awards, long service awards, GEM Leadership development and talent management Succession planning Enhancement and increased visibility of benefits package Recruitment and retention focussed workforce strategy and plan to fill vacancies, develop new roles and deliver improvement to working experience/environment Enhanced Benefits Package		4x3=12	4x2=8	Cautious	2499/2589
Workforce	8-2	Workforce	COO	Inability to recruit to vacancies in short term (0-18 months)	National shortages of appropriately qualified staff in some clinical roles, particularly at consultant level for dermatology and acute medicine, and at middle grade level for urology and trauma and orthopaedics Competition from surrounding hospitals Buoyant locum market National drive to increase nursing establishments leaving market shortfall (demand outstrips supply)	4x3=12	Active monitoring of workforce key performance indicators Targeted overseas recruitment activity Apprenticeships and work experience opportunities Exploration and use of new roles to help bridge particular gaps Use of recruitment and retention premia as necessary Use of the Trac recruitment tool to reduce time to hire and candidate experience Rolling programme to recruit pre-qualification students Use of enhanced adverts, social media and recruitment days Rollout of a dedicated workforce website Review of benefits offering and assessment against peers Creation of recruitment "advertising" films Recruitment and retention focussed workforce strategy and plan to fill vacancies, develop new roles and deliver improvement to working experience/environment Targetted recruitment to reduce hard to fill vacancies		4x2=8	4x2=8	Cautious	2499/2589
Workforce	8-3	Workforce	Director Workforce	Inability to recruit to vacancies in medium to long term (19+ months)	National shortages of appropriately qualified staff in some clinical roles, particularly at consultant level Brexit may reduce overseas supply Competition from surrounding hospitals Buoyant locum market National drive to increase nursing establishments leaving market shortfall (demand outstrips suply) Large percentage of workforce predicted to retire over the next decade Large growth prediction for MK - outstripping supply Buoyant private sector market creating competition for entry level roles New roles upskilling existing senior qualified staffcreating a likely gap in key roles in future (e.g. band 6 nurses) Reducing potential internaltional supply New longer training models	4x4=16	Monitoring of uptake of placements & training programmes Targeted overseas recruitment activity Apprenticeships and work experience opportunities Expansion and embedding of new roles across all areas Rolling programme to recruit pre-qualification students Use of enhanced adverts, social media and recruitment days Review of benefits offering and assessment against peers Development of MKUH training programmes Workforce Planning Recruitment and retention focussed workforce strategy and plan to fill vacancies, develop new roles and deliver improvement to working experience/environment International workplace plan Assisted EU staff to register for settled status and discussed plans to stay/leave with each to provide assurance that there will be no large scale loss of EU staff post-brexit		4x3=12	4x3=12	Cautious	2499/2589

Workforce	8-4	Quality & Clinical Risk	Medical Director	Removal of up to 11 trainees from the department of obstetrics and gynaecology as a result of various concerns about the training environment. [Reviewed March 2020]	Poor training environment: lack of standardisation of process; variable levels of support; and, persistent concerns around behaviours by consultants perceived as belittling / inappropriate / bullying. Risk raised in November 2019 following HEE TV quality meeting. For discussion - would this risk be better managed via Quality and Clinical Risk Sub-Committee?	4x5=20	Heavy involvement from clinical leaders outwith the department (DD, DME, MD). Change in clinical leadership model within the service. Formative external review (Berendt consulting). Substantive recruitment to consultant posts within the service. Close liaison with HEE TV Head of School. Completion of relevant HR processes. Developmental work underway with consultant body and other senior clinicians in relation to vision and agreement of an ambitious forward-looking programme of work. Agreement around further investments within the department to improve the working lives of trainees and the quality of the training environment.	Whilst there is progress against the action plan (shared with HEETV), improvements will take some time to put in place and a further period unitl trainee feedback reflects those improvements.	4x4=16	4x2=8	Cautious	
Workforce	8-5	Workforce	Board of Directors	Ability to maintain a safe working environment during the Covid-19 pandemic	Ability to maintain a safe working environment for staff during the Covid-19 pandemic due to a lack of equipment, including PPE, or inadequate staffing numbers	4x4=16	Twice daily gold incident management oversight on equipment and staffing levels. Immediate escalation of issues; national and regional guidance on equipment (PPE) followed.	Stock nationally controlled and managed and supply potentially uinpredictable.	4x3=12	4x2=8	Cautious	
Estate	9-1	Finance & Investment	COO	Insufficient capacity in the Neonatal Unit to accommodate babies requiring special care	The current size of the Neonatal Unit does not meet the demands of the service. This risks high numbers of transfers of unwell babies and potential delayed repatriation of babies back to the hospital. There is a risk that if the Trust continues to have insufficient space in its NNU, the unit's current Level 2 status could be removed on the basis that the Trust is unable to fulfill its Network responsibilities and deliver care in line with national requirements.	4x3=12	Reconfiguration of cots to create more space Additional cots to increase capacity Parents asked to leave NNU during interventional procedures, ward rounds, etc to increase available space		4x3=12	4x2=8	Cautious	2570
Sustainability	9-2	Charitable Funds	Director Corp Aff	Failure to achieve the required level of investment (including appeal funds) to fund the Cancer Centre	Lack of suitable and timely engagement with key players within the city and wider area during the private phase of the appeal, and an inability to enthuse and gain the support of potential donors more broadly, means that the Charity is unable to achieve the required level of charitable contribution to the project	4x2=8	Fundraising strategy and plan in place Financial forecasts under very regular scrutiny Experienced consultancy engaged to support existing senior and experienced fundraising staff Tactical plan for private and public appeal phase developed and implemented		4x2=8	4x2=8	Cautious	
Strategy	10-1	Board of Directors	CEO	Inability to progress the Milton Keynes Accountable Care System and wider ACS/STP programme	Lack of effective collaboration among all the key local partners means that the goal of a comprehensive and integrated place based health and social care solution within MK is not realised	4x3=12	Chief Executive and Executive team engagement both at ICS and MK Place levels. MK Place leaders chairing 3 of the 5 ICS priority workstreams		4x2=8	4x2=8	Cautious	
Strategy	10-2	Board of Directors	COO	Insufficient preparedness for disruption to workforce or supplies (including medications) following withdrawal from the European Union	Inability to recruit or retain staff; inability to prescribe or supply pharmaceuticals; inability to keep hospital stock levels (clinical and non-clinical) at required levels	5x2=10	UK Government putting contingency plans in place Planning through Trust EPRR forums Trust working with NHSI/E to ensure any national directives are complied with		5x2=10	5x2=10	Avoid	2731

Workforce	8-3	Minimal	Workforce	Director Workforce	Inability to recruit to vacancies in medium to long term (19+ months)	National shortages of appropriately qualified staff in some clinical roles, particularly at consultant level Brexit may reduce overseas supply Competition from surrounding hospitals Buoyant locum market National drive to increase nursing establishments leaving market shortfall (demand outstrips suply) Large percentage of workforce predicted to retire over the next decade Large growth prediction for MK - outstripping supply Buoyant private sector market creating competition for entry level roles New roles upskilling existing senior qualified staffcreating a likely gap in key roles in future (e.g. band 6 nurses) Reducing potential internaltional supply New longer training models	4x4=16	Monitoring of uptake of placements & training programmes Targeted overseas recruitment activity Apprenticeships and work experience opportunities Expansion and embedding of new roles across all areas Rolling programme to recruit pre-qualification students Use of enhanced adverts, social media and recruitment days Review of benefits offering and assessment against peers Development of MKUH training programmes Workforce Planning Recruitment and retention focussed workforce strategy and plan to fill vacancies, develop new roles and deliver improvement to working experience/environment International workplace plan Assisted EU staff to register for settled status and discussed plans to stay/leave with each to provide assurance that there will be no large scale loss of EU staff post-brexit		4x3=12		2499/2589
Workforce	8-4	Avoid	Quality & Clinical Risk	Medical Director	Removal of up to 11 trainees from the department of obstetrics and gynaecology as a result of various concerns about the training environment. [Reviewed March 2020]	Poor training environment: lack of standardisation of process; variable levels of support; and, persistent concerns around behaviours by consultants perceived as belittling / inappropriate / bullying. Risk raised in November 2019 following HEE TV quality meeting. For discussion - would this risk be better managed via Quality and Clinical Risk Sub-Committee?	4x5=20	Heavy involvement from clinical leaders outwith the department (DD, DME, MD). Change in clinical leadership model within the service. Formative external review (Berendt consulting). Substantive recruitment to consultant posts within the service. Close liaison with HEE TV Head of School. Completion of relevant HR processes. Developmental work underway with consultant body and other senior clinicians in relation to vision and agreement of an ambitious forward-looking programme of work. Agreement around further investments within the department to improve the working lives of trainees and the quality of the training environment.	Whilst there is progress against the action plan (shared with HEETV), improvements will take some time to put in place and a further period unitl trainee feedback reflects those improvements.	4x4=16		
Estate	9-1	Cautious	Finance & Investment	COO	Insufficient capacity in the Neonatal Unit to accommodate babies requiring special care	The current size of the Neonatal Unit does not meet the demands of the service. This risks high numbers of transfers of unwell babies and potential delayed repatriation of babies back to the hospital. There is a risk that if the Trust continues to have insufficient space in its NNU, the unit's current Level 2 status could be removed on the basis that the Trust is unable to fulfill its Network responsibilities and deliver care in line with national requirements.	4x3=12	Reconfiguration of cots to create more space Additional cots to increase capacity Parents asked to leave NNU during interventional procedures, ward rounds, etc to increase available space		4x3=12		2570

Sustainability	9-2	**Minimal**	Charitable Funds	Director Corp Aff	Failure to achieve the required level of investment (including appeal funds) to fund the Cancer Centre	Lack of suitable and timely engagement with key players within the city and wider area during the private phase of the appeal, and an inability to enthuse and gain the support of potential donors more broadly, means that the Charity is unable to achieve the required level of charitable contribution to the project	4x2=8	Fundraising strategy and plan in place Financial forecasts under very regular scrutiny Experienced consultancy engaged to support existing senior and experienced fundraising staff Tactical plan for private and public appeal phase developed and implemented		4x2=8		
Strategy	10-1	**Avoid**	Board of Directors	CEO	Inability to progress the Milton Keynes Accountable Care System and wider ACS/STP programme	Lack of effective collaboration among all the key local partners means that the goal of a comprehensive and integrated place based health and social care solution within MK is not realised	4x3=12	Chief Executive and Executive team engagement both at ICS and MK Place levels. MK Place leaders chairing 3 of the 5 ICS priority workstreams		4x2=8		
Strategy	10-2	**Avoid**	Board of Directors	COO	Insufficient preparedness for disruption to workforce or supplies (including medications) following withdrawal from the European Union	Inability to recruit or retain staff; inability to prescribe or supply pharmaceuticals; inability to keep hospital stock levels (clinical and non-clinical) at required levels	5x2=10	UK Government putting contingency plans in place Planning through Trust EPRR forums Trust working with NHSI/E to ensure any national directives are complied with		5x2=10		2731

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Board of Directors**	**Date: 7 May 2020**
Report title:	**Use of Trust Seal**	**Agenda item: 7.1**
Lead director **Report author** **Sponsor(s)**	**Name: Kate Jarman** **Name: Alison Marlow**	**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 notes the use of the Trust seal March 2020						

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 three entries in the Trust seal register which have occurred since the last meeting of the Board.

2. Context

The Trust Seal was executed on:

- 18 March 2020 for the lease relating to the ground floor of Witan Gate
- 19 March 2020 for MKUH North Site Infrastructure stage and contract
- 23 March 2020 for the Deed of Variation to the grant agreement between Milton Keynes Council and MKUH

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