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NHS
Milton Keynes University Hospital
NHS Foundation Trust

Board of Directors
Public Meeting Agenda

Meeting to be held at 10.00 am on Thursday 08 July 2021
remotely via Teams in line with social distancing

Item No.	Timing	Title	Purpose	Page No.	Lead
Introduction and Administration					
1	10.00	Apologies	Receive	Verbal	Chair
2		Declarations of Interest • Any new interests to declare • Any interests to declare in relation to open items on the agenda	Noting	Verbal	Chair
3		Minutes of the meeting held in Public on 06 May 2021	Approve	Pg. 4	Chair
4		Matters Arising	Receive	Verbal	Chair
Chair and Chief Executive Strategic Updates					
5	10.05	Chair's Report	Receive and Discuss	Verbal	Chair
6	10.10	Chief Executive's Report • Lateral Flow Test Reporting Requirements • 2021/22 Objectives	Receive and Discuss	Verbal Verbal Presentation	Chief Executive
Quality					
7	10.30	Patient Story	Receive and Discuss	Presentation	Director of Patient Care and Chief Nurse
8	10.50	Incident, Improvement and Learning Report	Receive and Discuss	Pg. 13	Medical Director/ Director of Corporate Affairs
9	10.55	Maternity Update - Ockenden Requirements	Receive and Discuss	Pg. 19	Director of Patient Care and Chief Nurse
10	11.05	Clinical Negligence Scheme for Trusts	Approval	To Follow	Director of Patient Care and Chief Nurse

Item No.	Timing	Title	Purpose	Page No.	Lead
11	11.10	Nursing Staff Update	Receive and Discuss	Pg. 22	Director of Patient Care and Chief Nurse
Workforce					
12	11.15	Workforce Report Month 02	Receive and Discuss	Pg. 31	Director of Workforce
Performance and Finance					
13	11.20	Performance Report Month 02	Receive and Discuss	Pg. 36	Director of Operations
14	11.30	Finance Report Month 02	Receive and Discuss	Pg. 44	Director of Finance
Assurance and Statutory Items					
15	11.35	Guardian of Safe Working Hours Annual Report (2020-2021)	Receive and Discuss	Pg. 66	Medical Director
16	11.40	Significant Risk Register	For Information	Pg. 78	Director of Corporate Affairs
17	11.45	Board Assurance Framework	Receive and Discuss	Pg. 96	Director of Corporate Affairs
18	11.50	(Summary Reports) Audit Committee – a. 19 May 2021 b. 07 June 2021	For Information	Pg. 151 Pg. 152	Chair of Committee
19		(Summary Reports) Finance and Investment Committee – a. 04 May 2021 b. 01 June 2021	For Information	Pg. 153 Pg. 154	Chair of Committee
Administration and Closing					
20	11.55	Questions from Members of the Public	Receive and Respond	Verbal	Chair
21		Motion to Close the Meeting	Receive	Verbal	Chair

Item No.	Timing	Title	Purpose	Page No.	Lead
22		Resolution to Exclude the Press and Public	Approve	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.	
12.00		Close			
Next Meeting: Thursday 09 September 2021					

BOARD OF DIRECTORS MEETING

Minutes of the Public Trust Board of Directors Meeting held on Thursday, 06 May 2021 at 10.00 hours via Teams

Present:		
Alison Davis	Chair	(AD)
Professor Joe Harrison	Chief Executive	(JH)
Andrew Blakeman	Senior Independent Director / Non-Executive Director	(AB)
Heidi Travis	Non-Executive Director	(HT)
Helen Smart	Non-Executive Director	(HS)
Nicky McLeod	Non-Executive Director	(NMc)
Haider Husain	Non-Executive Director	(HH)
Professor James Tooley	Non-Executive Director	(JT)
John Blakesley	Deputy Chief Executive	(JB)
Dr Ian Reckless	Medical Director & Deputy Chief Executive	(IR)
Terry Whittle	Director of Finance	(TW)
Danielle Petch	Director of Workforce	(DP)
Nicky Burns-Muir	Director of Patient Care and Chief Nurse	(NBM)
Emma Livesley	Director of Operations	(EL)
Jackie Collier	Director of Transformation & Partnerships	(JC)

In attendance:		
Dr Luke James	Associate Non-Executive Director	(LJ)
Kate Jarman	Director of Corporate Affairs (From 11.00am)	(KJ)
Louise Worrall	Advanced Respiratory Physiotherapist (For Item 3.1)	(LW)
Sam Holden	Assistant Director of Communications and Engagement	(SH)
Kwame Mensa-Bonsu	Trust Secretary (Minutes)	(KMB)

1 Welcome

1.1 AD welcomed all present to the meeting. AD also welcomed JT and JC to their first Public Trust Board meeting and stated that John Lisle had retired from the Board at the end of March 2021. AD thanked John Lisle for his contributions to the Trust during his tenure as a Non-Executive Director.

1.2 Apologies

1.2.1 There were no apologies.

1.3 Declarations of interest

1.3.1 No new interests had been declared and no interests were declared in relation to the items on the agenda.

1.4 Minutes of the meeting held on 11 March 2021

1.4.1 The minutes of the Public Board meeting held on 11 March 2021 were reviewed and **approved** by the Board.

2.1 Chair's Update

2.1.1 AD informed the Board that she had since March 2021 continued with her induction, which included attending meetings of the Clinical Quality Board and the BAME Network, and with the Freedom to Speak Up Guardian and the Head of Equality, Diversity and Inclusion. AD advised that she had attended the Membership Engagement Committee meeting, where the discussions had been focused on

implementing improvement steps to develop the role of Governors and increasing the number of Trust members.

2.1.2 AD advised that, in line with the Trust's ambition to be rated as outstanding, she had also engaged with external stakeholders including Crishni Waring, Chair of Northamptonshire Healthcare NHS Foundation Trust (NHFT). Another meeting is scheduled for next week with Mary Elford, Chair of Cambridgeshire Community Services NHS Trust.

2.1.3 AD informed the Board that she had chaired another consultant interview panel and noted that the panel had successfully appointed a very good applicant. AD, in conclusion, stated she had begun visits to areas of the hospital, beginning with the Maternity Unit to mark the International Day of the Midwife on 05 May 2021 and was scheduled to visit other wards from the middle of May 2021.

The Board **noted** the update.

2.2 Chief Executive's Update

2.2.1 JH informed the Board that the 'International Day of the Midwife' events in the Trust, on 05 May 2021, had been very well-attended and supported. JH stated that preparations were underway in the Trust to mark the 'International Nurses Day' on 12 May 2021.

2.2.2 JH stated that the Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care System (ICS) had been selected as an accelerator system, under the auspices of the NHS England's National Accelerator Programme. To implement the Programme's remit, chosen 'Accelerator Sites' which included the Trust, would be required to deliver 120% of elective activity to quickly reduce the number of patients on waiting lists. JH informed the Board that the funding for the construction of the Trust's proposed Women's and Children's Hospital remained outstanding, while the construction project for the Pathway Unit remained on plan and on track to be completed as scheduled.

2.2.3 JH advised that only one COVID-19 patient remained on admission and noted that the hospital was managing the risk of infection associated with people who attended the hospital while quarantining after a visit abroad.

The Board **noted** the update.

3 Quality

3.1 Patient Story

3.1.1 LW presented the story, which highlighted the work being conducted by the Trust's Respiratory Physiotherapy Outpatient Service to treat patients recovering from COVID-19 and those living with Long Covid. LW noted that the Service helped manage long Covid symptoms such as breathlessness, secretion retention, fatigue and reduced exercise tolerance, and had a comprehensive and well-established post-ICU rehabilitation programme for patients who had recovered from COVID-19.

3.1.2 LW highlighted the impact of long Covid on the NHS and noted that:

- Nationally and locally, there was a 'wave' of patients requiring rehabilitation post-COVID-19. These were patients requiring rehabilitation post Intensive care/ High dependency care and those with Long Covid referred from the Community;
- Between January to March 2021, the Service received 62 acute referrals, compared to 4 acute referrals in the same period in 2020;
- Referrals to the Post ICU rehabilitation Service after the first wave of COVID-19 infections were nearly 4 times higher than the regular number of referrals;
- Office for National Statistics (ONS) estimates suggested that 1.7% (1.1m) of the population in England was experiencing long term symptoms after recovering from COVID-19.

3.1.3 LW stated that the lessons learnt so far indicated:

- That there was an ongoing emergence of evidence, guidelines and data to inform the treatment provided by the Service;
- The patients were often complex and required very careful management, as traditional approaches such as physical exercises were not appropriate for these cohort patients;
- Patients needed support with pacing and fatigue management;
- That the cohort of patients with breathing pattern disorders had increased significantly;
- Patients needed lots of support and guidance with managing daily life and support with return to work;
- In the future the demand for rehabilitation would continue to grow, and that was likely to continue be the case for years.

3.1.4 In response to HS's query around the support for long Covid patients in the community, LW stated that the Trust's Community teams did follow up on the COVID patients when they were discharged. LW added that there was additional support provided by the long Covid team from Bedford, and from the Trust's Dieticians and ICU support teams. LW stated that however, if a discharged patient required specialist physiotherapy care, then they were referred to the Respiratory Physiotherapy Outpatient Service for treatment.

The Board **noted** the patient story.

3.2 Maternity Staffing Update

3.2.1 NBM presented the maternity staffing report and noted that the Trust planned to utilise the Birthrate Plus tool to conduct a maternity safe staffing exercise which had been deferred from April 2020 because of the COVID-19 pandemic. The results of this exercise, which would provide the necessary assurance that the maternity workforce establishment was safe, would be funded by BLMK Local Maternity and Neonatal System (LMNS). The Trust was scheduled to submit the results of the safe staffing exercise to the BLMK LMNS and NHS England/Improvement (NHSE/I) in May 2021.

3.2.2 NBM advised that, while the Birthrate Plus safe staffing exercise was on hold, the Trust had conducted a local safe staffing exercise in response to the impact on the Trust's staffing model by the implementation of both the 'continuity of carer model' and the recommendations of Ockendon Review. The results of the local exercise had indicated that the Trust needed 11 extra midwives to be able to safely implement the Review's recommendations and, to become compliant for the 'continuity of carer' model's target of 51% of all pregnant women being booked onto the 'continuity of carer' pathway from March 2021. AD advised that during her visit to the Maternity Unit, she had noted that the staff had been very positive about the local staffing review which had just been completed and the related improvement actions which were being implemented.

3.2.3 In response to HS's query around the significantly increased complexity of the women who attended the Maternity Unit since 2018, NBM stated that the causes included patients who had diabetes, high BMI and high-risk geriatric pregnancies. In response to another query from HS around contingencies for progressing with the 'continuity of carer model', AD emphasised that the model would not be progressed until an implementation plan which laid out the risks and benefits thereof had been signed off by the Trust Board. NBM stated that the Trust also needed to understand what level of support for an enhanced staffing model that NHSE/I would provide before progressing with the implementation of the 'continuity of carer' model. NBM noted that while 35% of pregnant women were on the 'continuity of carer' pathway in the Trust, other NHS providers had not even began implementing the model due to the significant impact on local staffing models.

3.2.4 In response to NMc's query around funding for the extra posts required to enhance the staffing model, NBM stated the plan for the 11 extra midwives had been submitted to NHSE/I. TW stated that an £80m fund had been set aside nationally to pay for the extra posts required to implement the Ockendon Review's recommendations and advised that the Trust would be applying to NHSE/I to draw from this fund.

The Board **noted** the Maternity Staffing Update.

3.3 Serious Incident (SI) Report

3.3.1 IR presented a report which provided an overview of the 5 SIs reported in March 2021, the trends and a brief summary of linked programmes of work in response to the incidents. IR highlighted an increase in incidents of major obstetric haemorrhage (MOH)/post-partum haemorrhage (PPH) and noted that a deep dive thematic review has been requested to help identify any thematic contributing factors or issues.

3.3.2 IR reported that the Trust had received a Preventing Future Deaths Report (PFD) on March 28 following a Coronial Inquest into the death of Mr Nicholas Rousseau. The PFD related to adherence to NICE guidelines and blood lactate levels, and the Trust had drafted a detailed response for the Coroner, which would be shared with Mr Rousseau's family.

3.3.3 IR stated that the Trust continued to conduct investigations into the deaths of patients who may have succumbed to nosocomial (Healthcare Associated) COVID-19 infections. IR stated that the Trust wanted to provide the bereaved families with clear and adequate investigative reports and was also eager to learn and improve its service provision. In response to JT's query, IR advised that about only 5% of COVID-19 patients had persistently negative COVID swabs but had provided a clinical picture and X-ray (CT) changes which were highly suggestive of COVID infections. This cohort of patients were treated as being COVID-19 positive and managed accordingly.

3.3.4 In response to HH's query around the steps being taken to reduce the breaches in respect of Duty of Candour, IR noted that the breaches were mainly due to administrative delay which had improved and would continue to improve as the hospital returned to normal activity from the COVID-19 pandemic. In response to AB's query around the implementation of Appreciative Inquiry principles, IR stated that the aim was for the development of a culture which would lead to enhanced relationship-centred practices throughout the Trust. IR noted that the Maternity and Theatres teams had taken part in Appreciative Inquiry workshops and were implementing the principles in their work practices. Other clinical teams were scheduled to take part in Appreciative Inquiry workshops soon.

3.3.5 In response to AD's query, IR agreed that the section of the report titled "Summary Information on Nosocomial Infection to Families" should be made available for relevant families in whatever language was required.

The Board **noted** the SI report.

3.4 Nursing Staffing Report

3.4.1 NBM presented the report and highlighted the following:

- The Trust had successfully progressed with the recruitment of 62 staff under the Accelerated Healthcare Support Worker Recruitment Scheme and was taking steps to retain this cohort of staff who historically have had a higher rate of turnover than registered nursing and midwifery staff;
- 38 out of 40 student nurses, who completed their final placements in the hospital, had accepted offers of employment from the Trust;
- That after the arrival of 2 international nurses in April 2021, there were no further plans for international recruitments. This position would be kept under review;
- The Trust had completed a recruitment exercise to appoint 28 Band 6 Junior Sisters/ Charge Nurses. This exercise was part steps being taken to invest in senior clinical leadership with the aim of ensuring that each inpatient ward had a Band 6 Junior Nursing Sister on every shift. The aims were to, among others, enhance patient experience, safety outcomes and to provide an in-house career development opportunity for Staff Nurses;
- The appointment of a Patient and Family Experience Matron, Sharon Robertson who would provide clinical expertise to the Complaints and PALS Team and engage clinical staff in projects to deliver the Patient Experience Strategy.

3.4.2 In response to AD's query around the Trust's relationship with the Princes Trust, NBM stated that the collaboration between the two organisations under the auspices of the NHS People Plan 'Local Recruitment' Actions as well as the Talent for Care 'Widening Participation, It Matters!' Strategic Framework would continue. The Princes Trust, under its Healthcare Programme which worked to support young people aged 18-30 into roles in the healthcare sector, was interested in expanding the working relationship with the Trust into other areas.

3.4.3 In response to HH's query around the appointment of a Mental Health Practice Educator, NBM stated that the part of the new role's remit was to educate and support staff in managing patients with challenging mental health-related behaviours and issues. The other part of the remit was also to scope for the capacity and resources which would be required to provide adequate support for the mental health patients who attended the hospital before they were transferred to the appropriate mental health facilities. NBM emphasised however, that the Trust had no plans to create a mental health service to provide therapeutic mental health care in the hospital in the future.

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

4 Workforce

4.1 Workforce Report Month 12

4.1.1 DP presented the Workforce Month 12 report and highlighted the following:

- The vacancy rate had reduced to 10% in month 12, from 12.2% in month 10;
- In terms of staff sickness, COVID related absence was at 0.5% in month 12, in line with national trends. The overall sickness absence was at 4.8%, against a target rate of 4%, and this was expected to continue to improve;
- The statutory and mandatory training compliance rate was at 97% in month 12, from 95% in month 10, while appraisals compliance rate was at 95% in month 12, from 92% in month 10;
- Clinically Extremely Vulnerable colleagues, whose shielding came to an end on 31 March 2021, were being supported to gradually re-enter the workplace;
- The vast majority of frontline Trust staff had received their COVID vaccine doses;
- The Trust's 'Living our Values' Programme has commenced.

The Board **noted** the Month 12 Workforce report.

4.2 2020 Staff Survey Report

4.2.1 DP gave a presentation which provided a statistical update on the 2020 Staff Survey report and highlighted the main points as:

a. 67% of the respondents were frontline clinical staff, while 33% of the respondents were from Corporate and General Management areas;
b. The scores for two survey questions – 'Recommend the Trust as a place to work' and 'Recommend the Trust for care' – improved to scores of 74% and 76% respectively, from 66% and 70% in 2019. The scores for the Trust's comparator group were at 67% and 75% respectively;
c. The score for the survey question which related to staff experiencing violence from patients and their family members was at 17.5% in 2020, from 17.6, 15.4 and 18.3% in 2019, 2018 and 2017, respectively. The scores for the comparator group were at 14.8%, 14.1%, 14.4% and 14.2% for the period between 2017 to 2020. JH stated this would be an area of focus for the improvement steps which would be implemented;
d. The score for the question related to staff working (unpaid) beyond their normal hours was at 45.6% in 2020, from 51.3% in 2019. The benchmark scores were at 36.5% and 35% in 2019 and 2020, respectively. JH noted that though evidence indicated there had been an improvement in the area of staff being remunerated for overtime work, a significant number was still not being paid when they worked beyond their normal hours;

e. 41% of the respondents believed there was enough staff to do their job properly, from 32% who did in 2019. The comparator score was at 38%;
f. 60% of the respondents were not looking to leave the Trust within 12 months, from 55% in 2019. The comparator score was at 57%.

4.2.2 DP advised that the next steps included utilising the "Staff Survey Goes Large" approach for various departments and teams to review the data local to them, the establishment of a working group to explore issues around staff levels and workloads, and actions to identify the location of spikes in violent incidents from patients and the public so an improvement action plan could be developed and implemented. In response to LJ's query around a flexible working model for the Trust, DP stated that the Trust would continue with the hybrid working model and would take steps to embed it permanently. In response to HH's query around the low number of respondents from BAME backgrounds, DP advised that the BAME Forum and other staff networks had been revitalised in the last year, and steps would be taken to work with the BAME Forum to improve their participation.

The Board **noted** the presentation on the 2020 Staff Survey results.

4.3 Clinical Excellence Awards (CEA) 2020 Awards Process

4.3.1 IR presented the report to update the Board on the process surrounding the execution of the local clinical excellence awards in respect of consultant performance in 2019/20. CEAs were made available to eligible consultants on a competitive basis each year by application. The process was currently in the middle of a three year 'transitionary period' from the old-style CEAs to a revised version. The revised version of the scheme had not yet been agreed and articulated through national negotiation.

The Board **noted** the update.

5 Performance and Finance

5.1 Performance Report Month 12

5.1.1 EL presented the reported and noted that the Emergency Department's (ED) performance against the 4-hour waiting target was at 90.3% in month 12, from 86.7% in month 11. EL stated that this performance would continue to improve as the activity in the ED continued to recover from the response to the COVID-19 pandemic.

The Board **noted** the Month 12 Performance Report.

5.2 Elective Performance Update

5.2.1 EL provided a presentation on the Trust's recovery from the impact of the COVID-19 pandemic and stated that:

- For the 52-week wait Cancer metric, according to Model Hospital the Trust was the second top performing NHS provider in the East of England with 1000 patients on the waiting list in March 2021. The Accelerator Programme would help the Trust maintain the high activity pace needed to ensure patients on the waiting list were treated as quickly as possible;
- Per all referrals, outpatients and elective activity in the hospital were back to pre-Covid levels in March 2021;
- Less than 2000 patients were still waiting for appointments in March, from more than 7000 in February 2021. The patients who had received the appointment slots had been transferred onto waiting lists;
- To support the implementation of the Accelerator Programme, discussions were underway with Independent Sector providers to outsource more activity from the Trust;
- Under 'Waiting List' initiatives, weekend clinics were being provided in many services;
- Virtual clinic uptake continued to increase, improving productivity.

5.2.2 EL reiterated that activity had returned to pre-Covid levels, and the clinical teams were working through the waiting lists. EL highlighted the following:

- 256 Urology electives undertaken in March 2021 – the highest in month level since July 2018;
- 241 General Surgery electives undertaken in March 2021 – the highest in month performance ever;
- ENT hospital cancellations reduced from 39.5% in March 2020 to 23.4% in March 2021;
- Pain service close to providing 100% virtual activity for outpatients;
- Orthopaedic elective lists doubling productivity from 04 May 2021;
- Outstanding lung function tests reduced from 800 in December 2020 to circa 180 in March 2021.

5.2.3 EL stated that the Trust had been chosen as an Accelerator Programme site with a task to restore elective activity to 120% of the 2019/20 baseline by July 2021. EL advised that there would be funding provided for the waiting list initiatives which would be used to develop and support the implementation of the Programme. EL noted that other goals were to also develop an understanding of what it took to accelerate elective recovery faster and to cascade the learning across all systems, which should contribute to an improved patient experience in the NHS.

5.2.4 EL noted that the menu of support offered to the chosen Accelerator sites included national initiatives such as GIRFT, Model Hospital and Theatre Productivity, and BLMK ICS had been provided with a £10m fund to progress with the Accelerator Programme. In response to NMC's query around Cancer performance, EL stated that patients who had waited 104 and 62 days had declined significantly as the Trust recovered from the COVID-19 pandemic. EL noted that the 2-week wait Breast Cancer clinic was however, under pressure due to an increasing number of referrals.

The Board **noted** the presentation.

5.3 Finance Paper Month 12

5.3.1 TW presented the Month 12 Finance Report and noted that it provided the draft 2020/21 Annual Accounts position for the Trust. TW thanked the Finance Team for delivering the draft annual accounts while working remotely for the second year running. TW also highlighted the following, that:

- On a control total basis after the block payment and top up income, the Trust reported a £7.9m surplus position for the month and a £21k surplus position for the year, against a planned deficit position of £3.6m for the year;
- Capital spend for 2020/21 was £44.1m, against a budget of £44.7 – Considering the disruption to supply chains caused by pandemic, this was a significant achievement by the Estates and Finance Teams.

The Board **noted** the Month 12 Finance report.

6 Strategy and Investment

6.1 BLMK ICS Strategic Priorities

6.1.1 JH presented the BLMK ICS Strategic Priorities report for review by Board members. AD highlighted the set of principles agreed at the Partnership Board on 7 April 2021.

The Board formally **noted** the contents of report and **adopted** the set of principles agreed at the BLMK ICS Partnership Board.

7 Assurance and Statutory Items

7.1 Significant Risk Register

7.1.1 KJ presented the Significant Risk Register and noted that the Risk Team had progressed with its review and had submitted the creation of a Corporate Risk Register to the May 2021 Trust Executive Group meeting for approval.

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

7.2 Board Assurance Framework (BAF)

7.2.1 KJ presented the BAF for review. KMB stated that the steps to re-articulate the risk entries on the BAF had progressed and would be completed at the end of May 2021. KMB noted that the plan was to re-articulate all the risk entries on the risk register in the same style, as that ensured that there was clarity around the risks being described. AB observed that the improvement actions being implemented were beginning to be reflected in the document.

The Board **noted** the BAF.

7.3 Summary Report for the Audit Committee Meeting – 23 March 2021

7.3.1 The Board **noted** the report.

7.4 Summary Report for the Finance and Investment Committee Meeting – 29 March 2021

7.4.1 The Board **noted** the report.

7.5 Summary Report for the Charitable Funds Committee Meeting – 22 April 2021

7.5.1 The Board **noted** the report.

7.6 Summary Report for the Quality and Clinical Risk Committee Meeting – 23 March 2021

7.6.1 The Board **noted** the report.

7.7 Summary Report for the Workforce and Development Assurance Committee Meeting – 21 April 2021

7.7.1 The Board **noted** the report.

7.8 Use of Trust Seal

7.8.1 The Board **noted** the report.

8 Administration and Closing

8.1 Questions from Members of the Public

8.1.1 Ms Janet Croston, a bereaved member of the public, asked 2 questions:

a. Could the Board explain or comment on the MKUH policies and procedures designed to protect COVID-negative patients when there is an outbreak of COVID-19 on a covid-free ward?;

b. Were there any specific measures taken to protect patients who were already ‘clinically vulnerable’?

JH provided a verbal response below:

JH, on behalf of the Trust, apologised to the families whose relatives had been infected with COVID-19 while in hospital. JH also apologised to the patients who had been infected with COVID-19 while on admission but had since been discharged. JH noted that these infections had occurred despite the hospital fully complying with the national guidance around treatment regimes, infection control protocols, testing regimes and the PPE equipment required by staff, and emphasised how sorry the Trust was about the infections.

JH stated that the Trust recognised that it owed the patients and the bereaved families a Duty of Candour and added that the individual cases of infection were being investigated while the relevant complaints processes were being managed. Nationally, and locally at the Trust, the NHS had continued to learn from best practice, and this learning was reflected in the changes which had been made to the clinical treatment and the implementation of a speedier testing and results regime.

JH advised that, due to the nature of the COVID-19 virus, the Trust did not and could not have guaranteed a COVID-free ward during the pandemic. JH stated that there were 2 wards which catered for patients scheduled to undergo planned surgical procedures, and these patients had to have isolated themselves after returning a negative COVID-19 test before being accepted onto the wards.

JH stated that the Trust had 2 pathways, red and amber, for patients who attended the hospital through the ED pathway. The red pathway was for COVID-positive patients or for patients who presented with clinical symptoms for COVID but had not tested positive. The amber pathway was for patients who had returned a negative test for COVID or had low clinical suspicion for being COVID infected.

JH advised that patients on admission were regularly tested for COVID-19 infection, and if any patient was found to be positive, the relevant ward was closed to further admissions. JH stated that the other patients were not transferred to other wards, as that could potentially spread infection even if the patients were asymptomatic. JH added that based on the number of patients who tested positive, the Infection Control Team would decide whether to declare the ward as a COVID-19 ward or not. In terms of PPE requirements, that was only changed if a COVID-positive patient required an aerosol-generating procedure.

In terms of the second question, JH stated that the hospital deemed the majority of inpatients to be ‘clinically vulnerable’, and so all patients were provided with the same infection prevention protocols earlier described, with the aim of keeping them safe.

9 Any Other Business

9.1 The meeting closed at 12.00 noon.

Meeting title	Trust Board (public)	8 July 2021
Report title:	**Incidents, Learning and Improvement Report**	Agenda item: 8
Lead director **Report author** **Sponsor(s)**	Kate Jarman Dr Ian Reckless Tina Worth	Director of Corporate Affairs Medical Director Head of Risk & Clinical Governance
FoI status:	Public document	

Report summary	This report provides an overview of serious incidents, learning and improvement at MKUH.			
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [ ]	**Decision** [ ]
Recommendation	The Group is asked to note the contents of the report			

Strategic objectives links	Refer to main objective and link to others 1. Improve Patient Safety 3. Improve Clinical Effectiveness 4. Deliver Key Targets 7. Become Well-Governed and Financially Viable
Board Assurance Framework links	Lack of learning from incidents is a key risk identified on the BAF
CQC outcome/ regulation links	This report relates to: This report relates to CQC: Regulation 12 – Safe care & treatment Regulation 17 – Good governance Regulation 20 – Duty of Candour
Identified risks and risk management actions	Lack of learning from incidents is a key risk identified on the BAF
Resource implications	Breaches in respect of SI submission can incur a £1000 penalty fine Breaches in respect of the Duty of Candour have potential for penalty fine of £2,500 if taken forward from a legislative.
Legal implications including equality and diversity assessment	Contractual and regulatory reporting requirements.

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

Introduction and Purpose of the Report

This report is designed to give a summary of Serious Incidents (SIs) to the Board every two months (to each public Board). This report is in addition to a detailed Serious Incident report received at the Quality and Clinical Risk Committee at each of its meetings.

The purpose of this report is to be transparent around the Serious Incidents reported and investigated by the Trust, whilst maintaining the confidentiality of patients and families involved; and to provide assurance to the Board that the Trust has an effective and appropriate framework for the reporting and investigating of incidents, and ensuring actions are undertaken to reduce the likelihood of their recurrence.

The report also summarises programmes to support the continual improvement of the quality of the investigation process and outcomes in relation to learning and clinical care or service improvement.

Serious Incident Report June 2021

There were eight new SIs reported on STEIS in June 2021 (table below).

STEIS number	Category	Details
2021/12709	Maternity Service - Unexpected admission to the Neonatal Unit (NNU)	Unexpected term admission to NNU.
2021/12192	Other	Patient operation delayed as pregnancy status was not verified before scheduled theatre slot (repeat anaesthesia).
2021/13333	Pressure ulcer	Deep tissue injury to toe related to anti embolic stockings (AES)
2021/13329	Communication	Failure to follow preterm birth antenatal pathway (individualised) protocols
2021/13330	Maternity Service	Fourth degree tear
2021/13331	Delayed Diagnosis	Delayed diagnosis of rib fractures.
2021/13332	Sub-optimal care of the deteriorating patient	Delay in referral of patient to dietitians
2021/11744	Safeguarding vulnerable adult	A Deprivation of Liberty (DOLS) was not put in place when required

Trends Informing Improvement Work

- The importance of the Silver Trauma pathway for elderly patients presenting following falls as part of diagnostics for fractures.
- The impact of deviations from usual patient pathways in relation to care delivery, where staff are less knowledgeable about certain conditions.
- The continued occurrences of attempted self-harm incidents, reflecting the increase in mental health issues.

- Recurring themes from incidents – need to revisit previous actions and see how best to embed learning across all areas.

- The value of the patient's voice. Planned work scheduled to look at how restorative care and appreciative inquiry can be brought into serious incident investigations and communications with patients/families.

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

Appreciative Inquiry Programme Update

In May, the Appreciative Inquiry programme team worked closely with 13 members of the Emergency Department (ED) team with workshops and in-practice work.

Some highlights from work in the Emergency Department include:

- **Exploring and noticing what works well and trying to understand why so this can be replicated**. The Nurse in Charge has autonomy to oversee the whole picture of what is happening in ED. Sending help to the 'front door' earlier than usual (moving to action after a 15-minute wait is recorded rather than after one hour) one day meant that waiting times were reduced and number of 'breaches' were halved (note the previous day there had been fewer patients and more breaches). This same nurse when in the role of Streaming Nurse also helped out in Triage during quieter times which helped with waiting times. Staff have discussed this and plan to implement these practices going forward.
- Rethinking handovers so that they are **meaningful and enhance considering other perspectives and discussion** within a time limited period.
- Notching up the **noticing of positive everyday practices** so that these can be **amplified** and shared - Staff asking colleagues to 'notice' a positive practice, give feedback in the moment and then write it on the poster so that this can be deliberately shared with others. Staff looking at the poster intentionally together, to try out practices that had been valued.
- Visually presenting creative tools in cubicles where patients are cared for to enable people to ask patients **in the moment** how they feel about their care, how they would like to feel and what matters to them.
- Exploring the **concept of patient transfer from ED** to the wards. Using AI to focus on what matters to people, how it feels and what works well. Patient transfers to wards can be tricky especially if they have not managed to have a telephone handover prior to the transfer taking place, Staff find this stressful as they are met with hostility and resistance at times. What helps the transfer to go well is to involve the patient when they arrive. 'Hello this is my friend J who has been in ED for a couple of hours. I've been telling him all about you and how it will be for him in the ward on the way over, and he is really glad to be here.'
  If the ward staff are not ready for the patient, the ED nurses will help prepare the bed space with the ward team which also helps.
- **Recognising strengths in others**: A student nurse felt confident enough (without being asked to) on a busy shift to go into the waiting area and started to take observations of the patients. She was able to chat to people about waiting times and she could apologise for the delay as well and it saved time when the patients eventually saw her trained colleagues. She used to work for COSTA coffee and this

was a regular strategy they used there when they were busy – it was called **working the line.**

- **Talking about what people value**: How appreciative a junior doctor in Paediatric ED was when he received feedback from a Dad and his daughter, in the moment, about how he had made their day by telling them what he was doing and explaining everything so well and involving them. They came in very scared and left feeling very reassured and smiling. They completed the Friends and Family test (following the conversation which made the account of the friends and family test much more specific) and shared it with the doctor who asked if he could take a picture of it to show his Mum.

Examples of Positive practices that can be amplified:

- ED Reception staff provide a contact telephone number for relatives of patients as they are not permitted to join them. One of the receptionists adds her name on the back of this slip of paper which the other reception staff do not do, but friends and families love the fact they have a point of contact and phone regularly, and ask to speak to her, to find out what is happening for their loved one. Others are going to do this now.
- ED receptionist came out from behind the desk and the screen to speak with a patient who did not want to reveal all their details in front of others; there is little privacy and with masks and screens the patients do have to raise their voices and others can hear.
- One of the receptionists regularly hands out the friends and family test to patients, but she is the only one who does at the moment and when she has free time, she goes out into the waiting area to help patients complete them. Others are going to do this now as well.
- In ED reception, we completed a couple of GREATixes online and also offered feedback in the moment to the person we were nominating as well. Reception staff had never completed a GREATix form before this before and will do it more regularly now. They also had not really provided verbal feedback before but realised the impact of doing this specifically for the person receiving the feedback but also for the person providing this.
- One of the Band 7s in ED has a specific role supporting students and handling complaints in the department. She will use images and emotional words in her work to find out what matters to students and how to work collaboratively to support students in the ED department and copied 100 of story recording templates to help her evidence the work she is doing.

The team also worked with 21 GREATix (learning from excellence) champions in workshops.

Participants valued:

- A fresh way of looking at things
- Building connections with different staff
- Moving away from well-intentioned assumptions to the practice of checking things out with others
- Trying out new inquiry tools that make a difference instantly
- Feeling supported to try out new ways of working that make a difference tomorrow
- Valuing the ‘small’, ‘everyday’, ‘usual’ moments, practices, experiences and teasing out their true significance and worth
- Excited and intrigued to experience how a short story from practice, that felt real and relevant for them, could stimulate such varied conversations, learning and ideas for action.

Appreciative Inquiry work in-practice continues in Maternity and ED, and will focus on leadership teams (including the Board), patient experience teams and Theatres additionally in the coming months.

Nosocomial COVID – numbers and outcomes

As previously reported at Trust Board in May, over the course of the pandemic we have recorded 92 cases of positive COVID swabs in patients who had been under the care of the Trust for over 14 days at the time of the first positive swab. As such, these cases are described as *hospital onset - definite healthcare associated.* There have been a further 143 cases of positive COVID swabs in patients who had been under the care of the Trust for between 8 and 14 days at the time of the first positive swab. These cases are described as *hospital onset - probable healthcare associated.* These cases have arisen either as isolated cases or as part of an outbreak (two or more such cases linked in time and place). Where there have been outbreaks of nosocomial COVID infection, these have been reported to and investigated with NHSE/I and Public Health England. November 2020 and January 2021 were months in which the number of cases of nosocomial infection was higher. There have been no further cases of nosocomial COVID acquisition since the date of the May Trust Board.

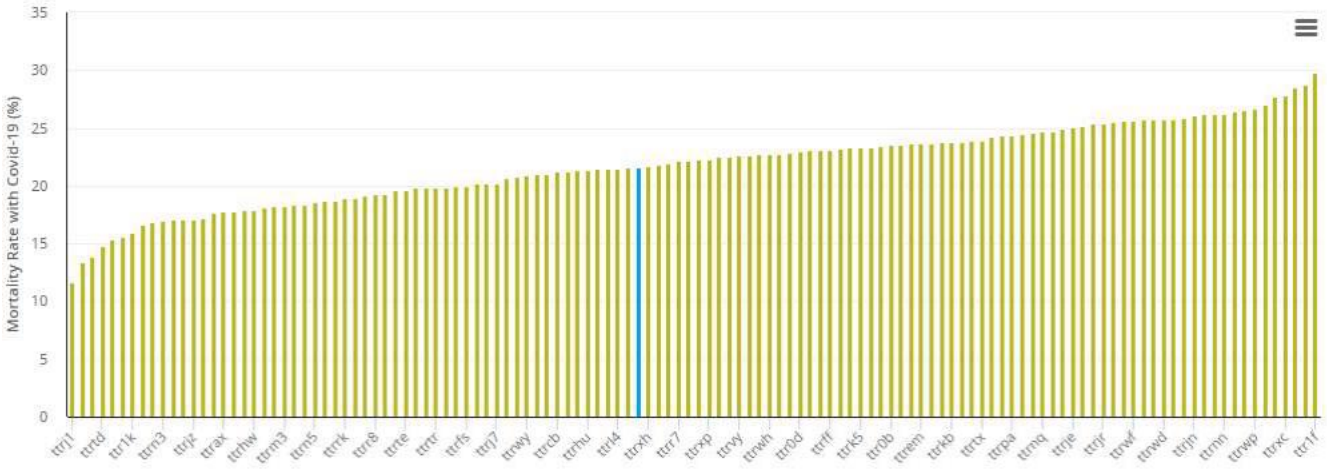
Of the 92 patients with *definite healthcare associated* COVID, 31 subsequently died. 20 of these patients died 'of COVID' (COVID was listed in part 1 of the medical certificate of cause of death), and 11 died 'with COVID' (COVID was either listed in part 2 of the medical certificate of cause of death or it was not mentioned as it was not felt to be relevant).

Of the 143 patients with *probable healthcare associated* COVID, 46 subsequently died. 35 of these patients died 'of COVID' (COVID was listed in part 1 of the medical certificate of cause of death), and 11 died 'with COVID' (COVID was either listed in part 2 of the medical certificate of cause of death or it was not mentioned as it was not felt to be relevant).

Whilst outbreaks and the acquisition of COVID by patients in hospital have been seen across the NHS (nationally, 17% of cases of COVID diagnosed via hospital laboratories – 'pillar 1 testing' – are believed to have been nosocomial and this figure is identical in Milton Keynes), it is a matter of profound regret that patients under the care of the NHS have come to harm. We have been in touch with the families of those patients who have died following COVID acquired in hospital and we are sharing summaries of care and areas of learning.

Outcomes for patients treated in hospital with COVID

Across 2020/21, the prevalence or volume of COVID varied over time and geographically. Looking across the whole of 2020/21 (incorporating the majority of 'wave 1' and all of 'wave 2'), 1913 patients were admitted to MKUH with COVID 19 as a primary diagnosis at the point of discharge or death. 414 of these patients died, giving a mortality rate of 21.6%. Nationally, the mortality rate was 21.7%.



[Source, CHKS from routinely available Hospital Episode Statistic, HES data]

We know from internal data that the availability and use of evidence-based treatments for COVID-19 (for example, dexamethasone and remdesivir) was very high at MKUH – both in the research phase and also following the publication of recommendations from that research. Taken together, these data suggest that the threshold for hospitalisation for COVID and the quality of subsequent patient management at MKUH did not deviate from the national picture.

Milton Keynes Hospital NHS
NHS Foundation Trust

Meeting title	Trust Board (public)	8 July 2021
Report title:	Maternity: Ockenden Update	Agenda item: 9
Lead director **Report author** **Sponsor(s)**	Nicky Burns- Muir	Director of Patient Care and Chief Nurse
FoI status:	Public document	

Report summary	This report provides an update on the progress made against the Ockendon Reports' recommendations			
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [ ]	**Decision** [ ]
Recommendation	The Board is asked to note the contents of the report			

Strategic objectives links	Refer to main objective and link to others 1. Improve Patient Safety 3. Improve Clinical Effectiveness 4. Deliver Key Targets 7. Become Well-Governed and Financially Viable
Board Assurance Framework links	Patient Safety
CQC outcome/ regulation links	This report relates to CQC: Regulation 12 – Safe care & treatment Regulation 17 – Good governance Regulation 20 – Duty of Candour
Identified risks and risk management actions	
Resource implications	
Legal implications including equality and diversity assessment	

Report history	
Next steps	
Appendices	Report

Maternity : Ockenden Update

An independent review by Donna Ockenden, into the maternity service at Shrewsbury and Telford was commissioned following multiple concerns being raised regarding the care of women and babies.

The Ockenden report contained seven immediate and essential actions for maternity services, including;

- Enhanced Safety
- Listening to women and families
- Staff training and working together
- Managing complex pregnancy
- Risk assessment throughout pregnancy
- Monitoring fetal wellbeing
- Informed consent

Ockenden Funding - BLMK Bid

National funding was made available to enable the implementation of three specific elements aligned with the Ockenden report, including;

- Funded establishment of midwives to Birth Rate Plus
- Funding Consultant PA's to enable compliance with twice daily seven day ward rounds
- Funding to support MDT training for those in roles other than midwives and consultants

The bid was organised across BLMK LMNS and MKUK submitted a bid for funding to support the following;

- Funded establishment of midwives to Birth Rate Plus

  Funding for a Fetal Monitoring Specialist Midwife

  Funding for midwives over and above the Birth Rate Plus establishment to enable the roll out to 51% Continuity of Carer model

  Funding for midwives to support the 5% uplift in headroom for all midwives to support compliance with mandatory training

- Funding for further Consultant PA's to support twice daily seven day ward rounds

Funding for consultant PA's to support the fetal monitoring lead Consultant role

- Funding to support members of the MDT required to attend PROMPT training to be backfilled

We are awaiting the outcome of the success of the bid. This has been delayed due to date.

Ockenden – Minimum Evidence Requirements

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Across the minimum evidence and workforce requirements the GAP document is currently demonstrating:

- 3 completed actions
- 23 actions on track
- 15 actions experiencing delay
- 1 action which will be no compliant

The areas of concern in relation to enabling the submission of evidence include:

- MSDS (Maternity Services Data Set) - challenges related to extraction of data from eCare which significantly increases the amount of time it takes to complete the required audits. Work is underway to progress against this action with diagnostics completed and identified issues being related to both user and the build of maternity eCare. The trust is seeking external expertise to resolve the build issues and user issues are being addressed through an education and training plan.
- A number of SOPs and guidelines required updating to demonstrate the processes and pathways in place for the management of nationally required pathways. All required to be progressed through the governance processes for approval which was challenging given the timeframe. An extraordinary guidelines meeting was held and for a small number of outstanding documents clarification has been provided on the current stage in the governance process and projected dates for expected approval.
- Due to the delay in feedback from the national team related to the funding bid we submitted we have not been able to meet the requirement for twice daily, seven-day ward rounds on labour ward. This is the position for the majority of trusts across the East of England and given the recruitment time once funding is agreed this will be delayed action.

  An action plan will need to be submitted for planned implementation both in the event of the Ockenden bid being successful and consideration of the trust response should funding not be agreed.

All evidence has now been submitted successfully and we await feedback from the national team with quality assurance visits planned for all East of England trusts from July 2021. We are expecting a planned '60 supportive steps to safety' on Monday 5th July from the regional maternity team.

Meeting title	Board of Directors	**Date:** July 8th 2021
Report title:	Nursing Staffing Report	**Agenda item: 11**
Lead director **Report author** **Sponsor(s)**	**Name:** Nicky Burns-Muir **Name:** Matthew Sandham Emma Thorne	**Title:** Director of Patient Care/Chief Nurse **Title:** Associate Chief Nurse Workforce Matron
FoI status:		

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

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

Report history	To every Public Board
Next steps	
Appendices	Appendices 1

Board of Directors Report on Nursing and Midwifery staffing levels
Amalgamated report for April and May 2021

1. Purpose

To provide Board with: -

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

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

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

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

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
April	11710	5.0	3.3	8.4
May	12429	4.9	3.3	8.1

Month	**RN/RM Day % Fill Rate**	**HCA/MCA Day % Fill Rate**	**RN/RM Night % Fill Rate**	**HCA/MCA Night % Fill Rate**
April	77.7%	88.1%	96.5%	111.0%
May	78.4%	88.3%	97.1%	113.8%

- *April and May 2021 data are included in Appendix 1.*

Areas with notable fill rates

During the months of April and May the Trust saw a rise in attendance which has affected the CHPPD hours in the month of May. Intensive Care Unit has seen significant increase of activity in the month of May. The number of COVD patient has dramatically reduced in the months of April and May which in turn has affected the fill rates on Ward 22 the COVID ward.

Are we safe ?

3. Recruitment Overview

The Trust has remained proactive with Nursing & Midwifery recruitment throughout the pandemic. The Senior Nursing Workforce team continue to collaborate with Human Resources/recruitment on initiatives to optimise recruitment across the organisation.

Medicine

Band	WTE Vacancy	Percentage	Turn over percentage
Band 2	10.51WTE	8 %	6.9%
Band 5&6	23.6 WTE	6%	6%

Surgery

Band	WTE Vacancy	Percentage	Turn Over percentage
Band 2	5. 13WTE	3.6 %	6%
Band 5&6	11.6 WTE	6%	5%

Women's and Children

Band	WTE Vacancy	Percentage	Turn Over percentage
Band 2	1.17WTE	4%	6 %
Band 5&6	15 WTE (all in Midwifery)	7 %	2%

To Note : Paediatrics have appointed 11WTE student nurses who qualify in September 2021

4. Health Care Support Workers Recruitment (HCSW)

As reported in previous reports Ruth May Chief Nursing Officer (CNO) for England announced a zero tolerance to HCSW vacancies in NHS Trusts. Milton Keynes University Hospital was set the objective to recruit into all 61WTE HCSW vacancies by the end of March/April 2021.

The Trust worked with NHSI on a 'Accelerated Healthcare Support Worker Recruitment Scheme'. The aim of the programme was to reduce vacancies swiftly, enhance the onboarding process, deliver training to optimise safety and enable staff to be competent and safe in practice.

Collaboratively, the Recruitment Team, Practice Education, Apprenticeship Manager and Workforce Matron delivered on this project securing the Trust £194k to assist with the onboarding and development of our new starters. This is a fantastic achievement that not only supports the reduction of vacancies and means that our workforce is well educated and well equipped to undertake their roles. This will in turn improve patient experience,

patient safety and assist in ensuring that our patients receive the right care at the right time. Feedback from new recruits has been fantastic many stating how well supported they have been and empowered with knowledge and support to deliver their roles.

5. Registered Nurses Band 5

Further to previous reports MKUH has now developed a process to offer final year nursing students the opportunity to automatically secure employment here in our organisation.

A total of 45 student nurses undertaking their final sign off placements at MKUH have therefore been offered employment (subject to satisfactory pre-employment checks), during a recruitment workshop held by the Workforce Matron.

30 students have accept this opportunity reporting that their decision was based on the support they received and their positive learning experience during the pandemic and a further eight had already applied for roles and secured positions at MKUH. Four have chosen to pursue work closer to home with the remaining three having chosen not to take up this opportunity for reasons unknown.

This initiative demonstrates that as an organisation we value our students for their commitment and contribution. For the Trust this initiative provides a supply of nurses three times a year, with the additional benefit that these newly qualified nurses have been trained by us and have been signed off by the organisation as ready for the professional register and are familiar with our values and standards.

Students that are wishing to accept this opportunity have been invited to meet with the Workforce Matron and Divisional Chief Nurses on the 17th of June 2021 to have a career conversation and discuss their preferred area of work.

7. Recruitment Campaigns

Medical/Surgical recruitment campaigns continue to attract candidates from across the country. Interviews were held on the 9th of June 2021 and a further 18 candidates have been offered Staff Nurse positions.

As vacancies reduce, both the Medical and Surgical Divisions would like to return to Divisional recruitment to tailor their recruitment campaigns going forward. The Workforce Matron will be working with the Divisional Chief Nurses on delivering this.

6. International Nurses

During the pandemic MKUH worked with Health Education England ‘Global Learners Programme’ to optimise staffing in critical care areas.
Two nurses from India were recruited (1 for Neonates and 1 for ICU). As an organisation both nurses were supported to prepare for their OSCE preparation and in June 2021 both nurses successfully passed this exam on their first attempt and are in the process of obtaining their professional NMC registration.

Are we effective?

7. Establishment Reviews

In May 2021 the Chief Nurse commenced establishment reviews for all inpatient wards and departments. To date 13 areas have undertaken their reviews with a further 5 areas scheduled for the coming weeks.

These reviews have given the opportunity to hold professional judgement conversations, consider new ways of working and review and triangulate data (including the departments funded establishment, staff in post figures, vacancy information, staff turnover rates, ward skill mix, Healthroster fill rates, Datix's linked to workforce & SafeCare) to inform the establishment reviews. The aim is to conclude the reviews by September 2021.

8. Healthroster Check and Challenge

To embed best rostering practice and optimise workforce efficiency, formal 'Check, Challenge and Support Meetings' have now recommenced.

To clarify the purpose of the check and challenge meetings is to introduce principles of best rostering practice, benchmark current practice using the e-roster dashboard and develop a supportive action plan with managers to improve roster compliance going forward.

Senior Sisters/Charge Nurses and Matrons continue to be very engaged with this process and going forward there are plans to amend the format and introduce the attendance of the Senior Matrons to optimise challenge around workforce efficiency.

Ward Sisters/Charge nurses have been asked at the next meeting to provide a verbal report on their actions and progress.

The SafeCare system is also discussed during these meetings, to ensure that data is reviewed and challenged where necessary, relating to this system.

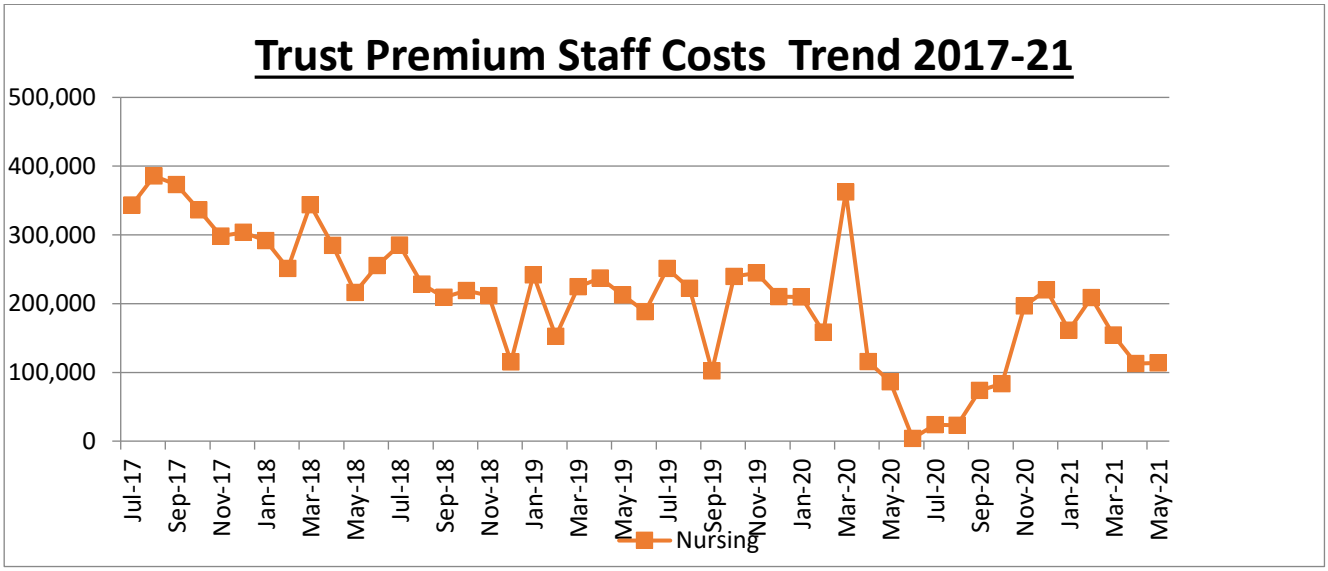
9. SafeCare Tool Update

As an organisation we remain in the 'validation and professional judgement phase' of SafeCare'.

Trust wide compliance sits at a consistent 90% for data census entry.
SafeCare continues to be used during the Daily Safety Huddle to provide transparency across the organisation and Matrons continue to use SafeCare to validate ward information and when reviewing staffing & assessing safety across the organisation.

The data from SafeCare has been referenced and considered during establishment reviews as the system allows us to review the dependency and acuity of patients in a ward area in correlation to the required care hours per patient day (CHPPD) versus actual care hours available.

10. Agency graph



To Note: During the period of April and May we saw the agency cost drop. This has been driven by staff returning to work and a reduction in staff isolating. The Agency utilisation was also restricted in the months of April and May.

We celebrate.

The Trust announced the staff awards winners for 2020 and it is with great pleasure that the nursing and midwifery team can celebrate the following winners:

Endoscopy Unit
Ward 25
Annie Sarmiento - AECU
Orthopaedic Rapid Recovery MDT
Ward 21
Susan Johns - ICU
Acute Paediatric and Neonatal Community Team
Laurie Gatehouse - NNU
End of Life Discharge Team

And in the Highly Commended category:

MSK Outpatient Physiotherapy
Silbury Case Loading Team

Nursing, Midwifery and Care Staff April 2021(Appendix 1)

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	81.8%	79.2%	100.2%	96.7%	518	7.0	2.6	9.6
ICU	80.2%	67.3%	91.5%	-	158	30.2	1.4	31.6
Ward 2	81.5%	133.0%	100.0%	114.8%	705	4.6	3.6	8.2
NNU	74.0%	87.5%	84.0%	100.0%	309	12.2	2.4	14.6
Ward 14	-	-	-	-		-	-	-
Ward 10						-	-	-
Ward 15	78.9%	88.5%	98.8%	121.7%	550	5.0	3.6	8.7
Ward 16	81.1%	91.0%	100.0%	118.3%	643	4.6	3.1	7.7
Ward 17	78.4%	99.8%	100.0%	145.0%	685	4.7	2.7	7.4
Ward 18	84.0%	98.9%	100.1%	147.1%	718	3.6	4.5	8.2
Ward 19	83.3%	96.5%	103.3%	136.7%	728	3.6	4.3	7.9
Ward 20	73.3%	80.0%	101.5%	107.2%	715	3.8	2.7	6.5
Ward 21	71.5%	76.4%	93.3%	90.0%	434	5.9	2.9	8.9
Ward 22	61.1%	52.1%	83.2%	58.2%	159	13.8	9.5	23.3
Ward 23	81.1%	101.3%	100.5%	127.3%	998	3.8	4.4	8.2
Ward 24	75.2%	74.5%	89.1%	84.5%	325	5.8	4.0	9.8
Ward 3	80.8%	79.3%	100.0%	99.4%	721	3.5	3.3	6.9
Ward 5	74.3%	75.7%	117.5%	86.7%	421	8.8	1.5	10.3
Ward 7	82.2%	81.1%	100.0%	108.9%	543	4.8	4.7	9.4
Ward 8	79.3%	85.6%	102.2%	113.3%	651	3.8	2.9	6.7
Ward 9	75.6%	95.9%	76.0%	97.9%	1191	2.0	1.9	3.8
Ward 25	76.6%	87.4%	100.0%	125.0%	538	4.9	3.7	8.6

Nursing, Midwifery and Care Staff May 2021(Appendix 1)

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	87.5%	104.7%	107.8%	128.9%	523	7.3	3.5	10.8
ICU	82.3%	99.5%	95.0%	-	200	25.3	1.6	27.0
Ward 2	77.2%	106.9%	99.3%	120.0%	685	4.7	2.9	7.5
NNU	74.3%	96.6%	83.5%	122.6%	391	10.1	2.3	12.4
Ward 14	-	-	-	-				
Ward 10								
Ward 15	82.3%	114.4%	100.1%	175.8%	725	4.1	3.9	7.9
Ward 16	82.2%	85.1%	99.1%	117.4%	743	4.1	2.7	6.8
Ward 17	76.4%	89.3%	100.8%	119.4%	725	4.5	2.3	6.8
Ward 18	84.4%	94.7%	100.0%	130.1%	779	3.3	4.0	7.2
Ward 19	80.9%	106.4%	97.8%	149.5%	753	3.5	4.7	8.1
Ward 20	85.5%	80.6%	104.3%	108.6%	699	4.2	3.2	7.4
Ward 21	80.1%	86.6%	93.5%	104.1%	447	6.1	3.4	9.5
Ward 22	47.6%	53.1%	73.1%	66.7%	179	9.3	9.3	18.7
Ward 23	82.9%	90.6%	102.4%	111.0%	1020	3.8	3.9	7.7
Ward 24	77.2%	77.7%	92.5%	98.5%	398	5.1	3.5	8.6
Ward 3	75.8%	82.7%	100.0%	106.5%	787	3.1	3.3	6.5
Ward 5	69.1%	65.3%	104.1%	83.9%	365	9.4	1.7	11.0
Ward 7	81.4%	82.8%	100.0%	116.1%	605	4.3	4.5	8.8

Ward 8	85.3%	82.5%	100.0%	106.5%	675	4.1	2.8	6.9
Ward 9	78.1%	89.6%	93.1%	90.4%	1200	2.2	1.8	4.0
Ward 25	75.8%	85.9%	101.1%	112.9%	530	5.1	3.7	8.8

Meeting title	**Trust Board**	**Date: 8 July 2021**
Report title:	**Workforce Report**	**Agenda item: 12**
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 May 2021 (Month 2) and relevant Workforce and Organisational Development updates to Trust Board			
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [x]	**Decision** [ ]
Recommendation	Trust Board is asked to note and receive the Workforce Report for Month 2.			

Strategic objectives links	Objective 8: Investing in our people
Board Assurance Framework links	BAF risks 19-24
CQC outcome/ regulation links	Well Led Outcome 13: Staffing
Identified risks and risk management actions	
Resource implications	
Legal implications including equality and diversity assessment	
Report history	
Next steps	
Appendices	

1. Purpose of the report

1.1. This report provides a summary of workforce Key Performance Indicators as at 31 May 2021 (Month 2), covering the preceding 13 months.

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

Indicator	Measure	Target	05/2020	06/2020	07/2020	08/2020	09/2020	10/2020	11/2020	12/2020	01/2021	02/2021	03/2021	04/2021	05/2021
Staff in post (as at report date)	WTE		3238.8	3266.8	3276.7	3227.3	3243.8	3245.1	3256.5	3251.3	3250.0	3284.0	3311.6	3337.3	**3304.1**
	Headcount		3723	3761	3766	3707	3727	3728	3738	3729	3730	3765	3795	3826	**3793**
Establishment (as at report date - as per finance data)	WTE		3640.2	3648.9	3658.1	3685.4	3607.7	3633.1	3630.6	3634.2	3635.5	3635.4	3635.4	3662.8	**3677.7**
	%, Vacancy Rate *(for Cost Centres, excludes Reserves)*	10%	10.9%	10.3%	10.2%	12.6%	10.0%	10.6%	10.2%	10.5%	10.6%	9.5%	8.7%	8.9%	**10.2%**
Staff Costs (12 months)	%, Temp Staff Cost		13.3%	12.9%	12.5%	12.2%	12.1%	11.9%	11.7%	11.7%	11.6%	11.6%	11.6%	11.3%	**11.3%**
	%, Temp Staff Usage		13.6%	13.2%	12.8%	12.5%	12.2%	12.0%	11.9%	11.8%	11.8%	11.8%	11.8%	11.7%	**11.8%**
Absence (12 months)	%, 12 month Absence Rate	4%	4.5%	4.5%	4.4%	4.5%	4.5%	4.6%	4.7%	4.8%	5.0%	5.1%	4.8%	4.5%	**4.4%**
	- %, 12 month Absence Rate - Long Term		*2.4%*	*2.4%*	*2.3%*	*2.4%*	*2.4%*	*2.6%*	*2.6%*	*2.7%*	*2.7%*	*2.8%*	*2.7%*	*2.7%*	***2.7%***
	- %, 12 month Absence Rate - Short Term		*2.1%*	*2.1%*	*2.1%*	*2.1%*	*2.1%*	*2.1%*	*2.1%*	*2.2%*	*2.4%*	*2.3%*	*2.1%*	*1.8%*	***1.8%***
	%,In month Absence Rate - Total		4.7%	3.4%	3.3%	3.6%	4.0%	4.1%	5.0%	6.1%	6.7%	4.7%	3.6%	3.3%	**4.2%**
	- %, In month Absence Rate - Long Term		*3.0%*	*2.1%*	*2.2%*	*2.5%*	*2.5%*	*2.7%*	*2.6%*	*3.6%*	*2.9%*	*2.9%*	*2.4%*	*2.3%*	***2.9%***
	- %, In month Absence Rate - Short Term		*1.7%*	*1.4%*	*1.1%*	*1.1%*	*1.5%*	*1.4%*	*2.4%*	*2.5%*	*3.8%*	*1.8%*	*1.2%*	*1.0%*	***1.3%***
	- %, In month Absence Rate - COVID-19 Sickness Absence		1.3%	0.5%	0.2%	0.2%	0.2%	0.2%	1.1%	2.1%	3.3%	1.3%	0.5%	0.4%	**0.4%**
Starters, Leavers and T/O rate (12 months)	WTE, Starters		363.3	355.1	355.9	362.0	360.5	336.0	329.9	329.2	313.0	318.0	311.6	322.2	**321.3**
	Headcount, Starters		415	406	408	414	413	386	376	373	358	363	356	367	**367**
	WTE, Leavers		259.9	249.5	251.7	251.5	249.0	241.2	244.7	240.1	233.7	229.3	203.4	204.5	**215.6**
	Headcount, Leavers		306	295	298	298	295	286	291	286	278	273	241	244	**255**
	%, Leaver Turnover Rate	10%	9.2%	8.8%	8.8%	8.9%	8.8%	8.5%	8.5%	8.4%	8.2%	8.0%	7.1%	7.1%	**7.4%**
	%, Stability Index		85.6%	86.3%	86.4%	86.3%	86.8%	87.0%	86.9%	87.2%	87.1%	87.0%	87.8%	87.6%	**87.5%**
Statutory/Mandatory Training	%, Compliance	90%	93%	94%	94%	95%	95%	94%	95%	95%	95%	96%	97%	95%	**95%**
Appraisals	%, Compliance	90%	90%	92%	93%	92%	92%	93%	91%	90%	92%	93%	95%	95%	**93%**
Medical and Dental Appraisals	%, Compliance	90%	95%	92%	92%	93%	86%	88%	87%	90%	86%	79%	83%	97%	**96%**
Time to Hire (days)	General Recruitment	35	58	60	49	51	48	47	41	56	49	39	43	48	**44**
	Medical Recruitment (excl Deanery)	35	59	54	40	81	97	71	32	49	34	53	52	49	**68**
Employee relations	Number of open disciplinary cases			26	26	26	27	28	25	22	19	23	14	11	**14**

2.1. The Trust's **vacancy rate** has increased slightly to 10.2% compared to the preceding quarter (average of 9.0%) following a complete reconciliation of Electronic Staff Record data with that of the Finance Ledger. A sustained programme of recruitment is ongoing in partnership with the Divisions and HR Business Partners to reduce this measure to agreed tolerance.

2.2. Overall **staff absence** has reduced to below the same period in 2021 at 4.4% which is the 12-month rolling position. Covid related absence has reduced further to 0.4% and is expected to fall further in line with national patterns. The pre-Covid absence tolerance is 4%; once Covid absence is removed from the aggregate position, the Trust's absence figure returns to agreed tolerance.

2.3. **The stability index figure** (defined as *proportion of staff in post at end of period who were in post at beginning of period).* The stability index figure has decreased slightly in-month to 87.5%. Stability within the organisation is crucial during turbulent times and is helpful to understand the longer-term impact of our various influencing interventions and staff support programmes. The 13-month trend shows an average increase of almost 2%. Similarly, **staff turnover** has improved by almost 2% in this time – at 7.4% this level is slightly above that of the previous period but, overall, reflects the Trust's ongoing and concerted efforts to support wellbeing through engagement, culture and reward initiatives.

2.4. The **time to hire** trend is improving following the impact of targeted interventions to reduce this to acceptable levels in recent months. Medical staffing time to hire has continued to experience delays in issuing visas. UK Border Agency (Visas and Immigration) centres are open but quarantine restrictions remain in place for incoming new entrants in line with national guidance from the Foreign and Commonwealth Office, contributing to the adverse impact on the reported level. The Trust continues to keep abreast of developments in Covid related immigration guidance as the UK moves towards a tentative lifting of restrictions in mid-July.

2.5. **Employee Relations cases** have remained fairly static when compared to previous reporting months. Case volumes remain stable and the number of cases resolved at informal level in line with the Trust's Fair and Just Culture principles remains high. A detailed Employee Relations case report is produced on a quarterly basis for Workforce Board and JCNC.

2.6. **Statutory and mandatory training** compliance is at 95% and **appraisals** compliance is at 93%, a slight decrease of 2% since Month 1. The Learning and Development Team continues its reminders and support processes to support our drive to 100%, further supported by the Trust's Pay Progression policy.

3. Continuous Improvement, Transformation and Innovation

3.1. Following the success of the Trust's Workforce Strategy 2018-21, the development of the 2021-24 strategy is ongoing and is due to be finalised in the coming quarter alongside the redeveloped Trust strategy and objectives.

3.2. The Trust is on course to complete Phase 1 of the **Wellbeing Guardian** implementation plan, including completion of a Wellbeing Diagnostic Tool released by NHS England and Improvement in May 2021. The Trust's nominated Wellbeing Guardian is Nicky McLeod.

3.3. The #TeamMKUH **We Care Wellbeing Group**, chaired by the Director of Workforce, the group meets each month supported by a formal agenda, minutes and action log. The papers are received by the Trust's Wellbeing Guardian with actions being reported through the Workforce Board and Workforce and Development Assurance Committee for oversight and accountability.

3.4. Phase four of the Trust's **benefits and rewards** is underway, including procurement processes to increase the Trust's lease car offering, discounted gym membership options, and ethical financial benefits (savings and financial education excluding loans) being considered. The successful installation of a staff use Amazon locker, located on the ground floor of the multistorey car park was completed recently, and a rental bikes station will be installed within the next quarter.

4. Culture and Staff Engagement

4.1. The **National NHS Staff Survey** programme has made good progress since the last report.

4.2. Planning for the 2021/22 Protect and Reflect event has commenced (October to December 2021) and the Divisional HRBPs have worked in partnership with the Divisions and CSUs to produce detailed local action plans for the improvement in their areas, supplemented by listening events.

4.3. Defined working groups have been established to decrease violence and to review areas of increased additional paid hours working, along against causation and contributory factors. The interim findings of these groups will be presented to the Workforce and Development Assurance Committee on 21 July 2021.

4.4. The Trust's **Living our Values** work has enabled meaningful and engaging *Leading with Values* and *Values into Actions* workshops to take place in June, July and August. Close to 450 colleagues have attended the Leading with Values sessions and a further 150 are booked into Values into Action workshops – all of which have evaluated to great feedback. Due to their success, further sessions have been added for July and August to support the skills development of the Trust's supervisors, team leaders, managers and senior leaders.

4.5. The underpinning staff culture survey has been published (via the weekly email/newsletter) and has had 434 respondents provide real feedback to the Values into Action workshops. The patient culture survey remains under review, awaiting approval to proceed by Corporate Nursing colleagues.

4.6. The Leading Inclusively with **Cultural Intelligence** Executive Leadership Masterclass by Above Difference was attended on 17 July by the Head of HR Business Partnering,

Head or Organisational Development and Deputy Director of Workforce. Arrangements are being made for a whole-day masterclass (10:00 to 16:00) to be held with Trust Board at its December Board Seminar, if not before, which will be supplemented with one-to-one coaching by Above Difference.

4.7. The Board seminar masterclass will be followed by the same for the Trust Executive Group, in early 2022, supplemented by group coaching and a Train the Trainer facilitation course for the Senior Workforce Team to enable support via its internal capacity for sustainability.

5. Current Affairs & Hot Topics

5.1. Further to previous reports at Board and as per the recent request from the national Chief People Officer, the Trust has reviewed the **Disciplinary Policy** in partnership with Staff Side colleagues and it has now been published on the public facing website: https://www.mkuh.nhs.uk/about-us/public-documents/trust-policies

5.2. The Assistant Director of HR Services and the Head of Equality, Diversity and Inclusion (EDI) posts are now vacant and the Senior Workforce Team is currently undergoing recruitment and selection exercises to replace these roles. The EDI remit is being strengthened to support the focus and drive of the of the Workforce Strategy on culture, organisational development and the equalities agenda. It is believed that the Trust will now be better positioned to sustain the work required into 2022/23 and beyond.

6. Recommendations

6.1. Trust Board is asked to note and receive the Workforce Report for Month 2.

Board Performance Report 2021/22
May 2021 (M02)

NHS
Milton Keynes University Hospital
NHS Foundation Trust

OBJECTIVE 1 - PATIENT SAFETY										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
1.1	Mortality - (HSMR)		100	100		97.2	✓	▼		
1.2	Mortality - (SHMI)		100	100		112.59	✗	▲		
1.3	Never Events		0	0	0	0	✓	▭	✓	
1.4	Clostridium Difficile		10	<2	0	0	✓	▭	✓	
1.5	MRSA bacteraemia (avoidable)		0	0	0	0	✓	▭	✓	
1.6	Falls with harm (per 1,000 bed days)		0.12	0.12	0.04	0.00	✓	▲	✓	
1.7	Midwife : Birth Ratio		28	28	Not Available					
1.8	Incident Rate (per 1,000 bed days)		60	60	60.18	60.41	✓	▲	✓	
1.9	Duty of Candour Breaches (Quarterly)		0	0	0	0	✓	▲	✓	
1.10	E-Coli		18	3	5	3	✓	▼	✓	
1.11	MSSA		5	<1	1	1	✗	▼	✗	
1.12	VTE Assessment		95%	95%	97.8%	97.6%	✓	▼	✓	

OBJECTIVE 2 - PATIENT EXPERIENCE										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.2	RED Complaints Received				0	0		▭		
2.3	Complaints response in agreed time		90%	90%	92.3%	92.9%	✓	▲	✓	
2.4	Cancelled Ops - On Day		1%	1%	0.81%	1.30%	✗	▼	✓	
2.5	Over 75s Ward Moves at Night		1,800	300	175	74	✓	▲	✓	
2.6	Mixed Sex Breaches		0	0	0	0	✓	▭	✓	

OBJECTIVE 3 - CLINICAL EFFECTIVENESS										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
3.1	Overnight bed occupancy rate		93%	93%	87.6%	88.5%	✓	▼	✓	
3.2	Ward Discharges by Midday		25%	25%	17.1%	17.0%	✗	▼	✗	
3.3	Weekend Discharges		70%	70%	59.1%	58.9%	✗	▲	✗	
3.4	30 day readmissions		7%	7%	6.9%	7.1%	✗	▼	✓	
3.5	Follow Up Ratio		1.5		1.34	1.27	✓	▲	✓	
3.6.1	Number of Stranded Patients (LOS>=7 Days)		184			198	✗	▼		
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)		53			69	✗	▼		
3.7	Delayed Transfers of Care		20			15	✓	▲		
3.8	Discharges from PDU (%)		15%	15%	7.1%	6.9%	✗	▼	✗	
3.9	Ambulance Handovers >30 mins (%)		5%	5%	9.0%	11.0%	✗	▼	✗	

OBJECTIVE 4 - KEY TARGETS										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1	ED 4 hour target (includes UCS)		Not Available		90.4%	89.4%	Not Available	▼	Not Available	
4.2	RTT Incomplete Pathways <18 weeks					64.5%		▲		
4.4	RTT Total Open Pathways					22,803		▼		
4.5	RTT Patients waiting over 52 weeks					518		▲		
4.6	Diagnostic Waits <6 weeks					78.7%		▲		
4.7	All 2 week wait all cancers (Quarterly)		93%	93%		86.5%	✗	▲		
4.8	31 days Diagnosis to Treatment (Quarterly)		96%	96%		93.3%	✗	▼		
4.9	62 day standard (Quarterly)		85%	85%		78.5%	✗	▲		

OBJECTIVE 5 - SUSTAINABILITY										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
5.1	GP Referrals Received		Not Available		13,864	7,046	Not Available	▲	Not Available	
5.2	A&E Attendances				16,431	8,650		▼		
5.3	Elective Spells (PBR)				4,286	2,097		▼		
5.4	Non-Elective Spells (PBR)				4,771	2,477		▼		
5.5	OP Attendances / Procs (Total)				64,928	32,619		▲		
5.6	Outpatient DNA Rate		6%	6%	5.6%	5.7%	✓	▼	✓	

OBJECTIVE 7 - FINANCIAL PERFORMANCE										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
7.1	Income £'000		Not Available		50,012	25,246	Not Available	▲	Not Available	
7.2	Pay £'000				(32,005)	(16,365)		▼		
7.3	Non-pay £'000				(15,009)	(7,388)		▲		
7.4	Non-operating costs £'000				(3,149)	(1,590)		▼		
7.5	I&E Total £'000				(150)	(96)		▼		
7.6	Cash Balance £'000					48,516		▲		
7.7	Savings Delivered £'000				Not Available					
7.8	Capital Expenditure £'000				925	750	Not Available	▼	Not Available	

OBJECTIVE 8 - WORKFORCE PERFORMANCE										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
8.1	Staff Vacancies % of establishment		10%	10%		11.7%	✗	▼		
8.2	Agency Expenditure %		5%	5%	3.0%	3.2%	✓	▼	✓	
8.3	Staff Sickness % - Days Lost (Rolling 12 months)		4%	4%		4.5%	✗	▲		
8.4	Appraisals		90%	90%		93.0%	✓	▼		
8.5	Statutory Mandatory training		90%	90%		95.0%	✓	▭		
8.6	Substantive Staff Turnover		9%	9%		7.4%	✓	▼		

OBJECTIVES - OTHER										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
O.1	Total Number of NICE Breaches		10	10		45	✗	▲		
O.2	Rebooked cancelled OPs - 28 day rule		95%	95%	82.1%	29%	✗	▲	✗	
O.4	Overdue Datix Incidents >1 month		0	0		170	✗	▼		
O.5	Serious Incidents		20	<4	18	6	✗	▲	✗	
O.8	Completed Job Plans (Consultants)		90%	90%		87%	✗	▭		

Key: Monthly/Quarterly Change

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

YTD Position

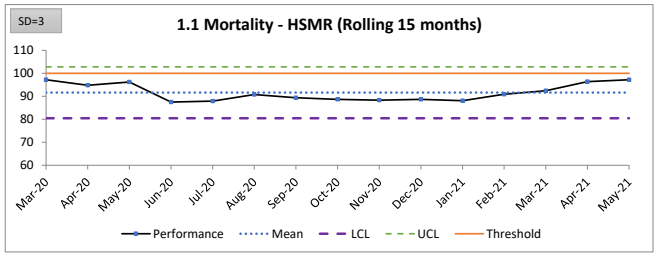
✓	Achieving YTD Target
	Within Agreed Tolerance*
✗	Not achieving YTD Target
✗	Annual Target breached

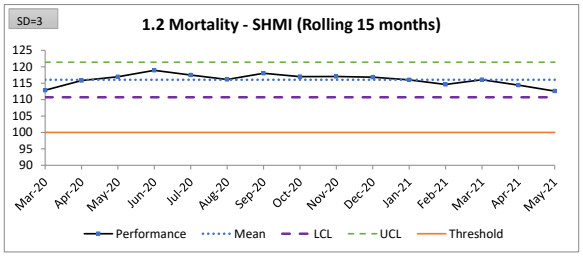
Data Quality Assurance Definitions

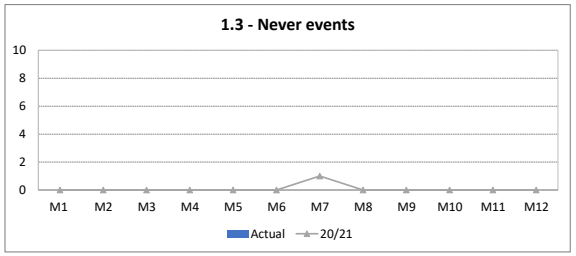
Rating	Data Quality Assurance
Green	Satisfactory and independently audited (indicator represents an accurate reflection of performance)
Amber	Acceptable levels of assurance but minor areas for improvement identified and potentially independently audited * /No Independent Assurance
Red	Unsatisfactory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

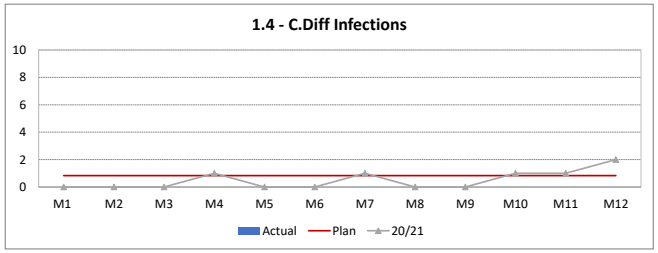
* Independently Audited – refers to an independent audit undertaken by either the Internal Auditor, External Auditors or the Data Quality Audit team.

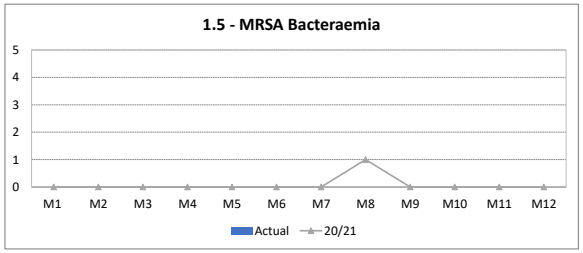
Date Produced: 14/06/2021

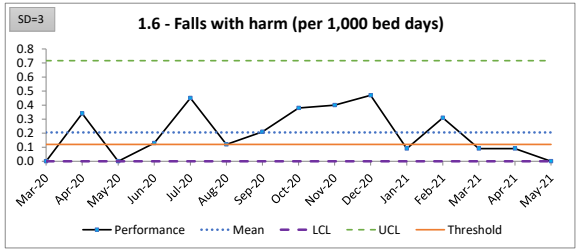


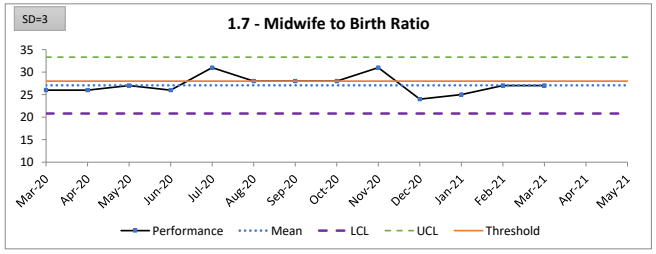


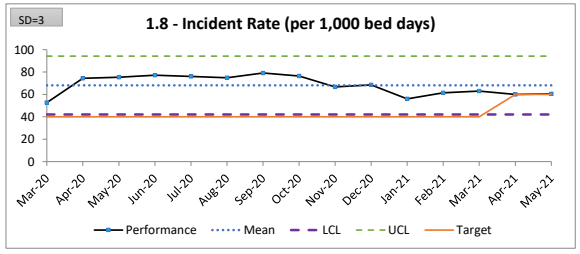


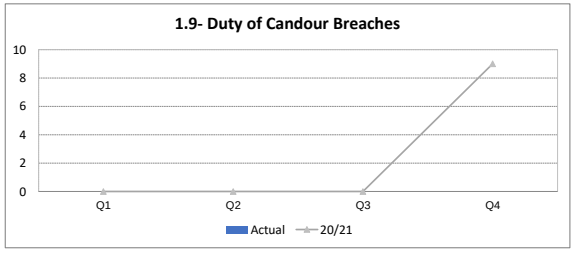


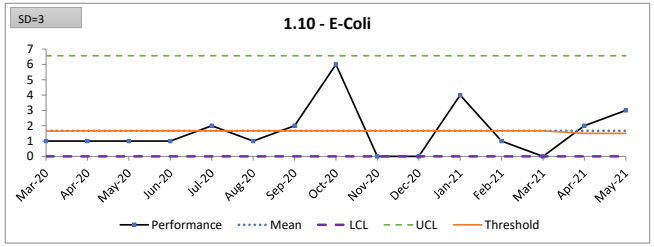


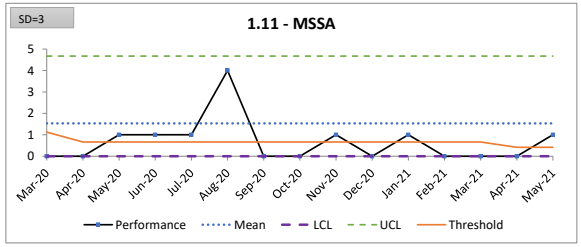


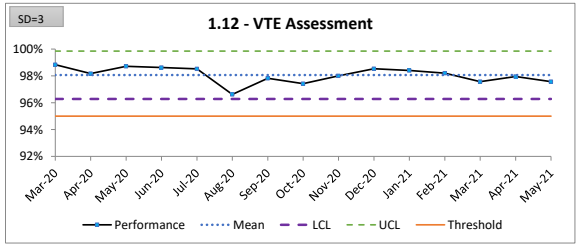








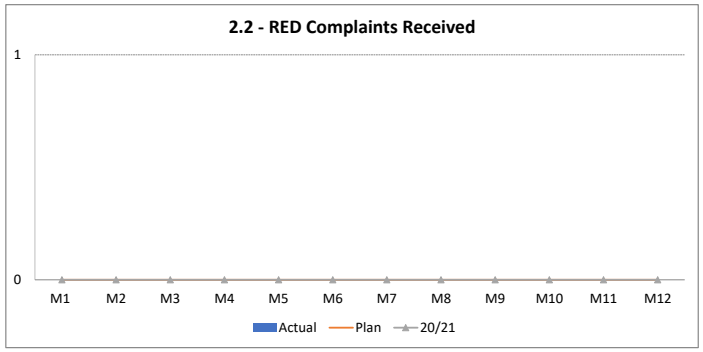


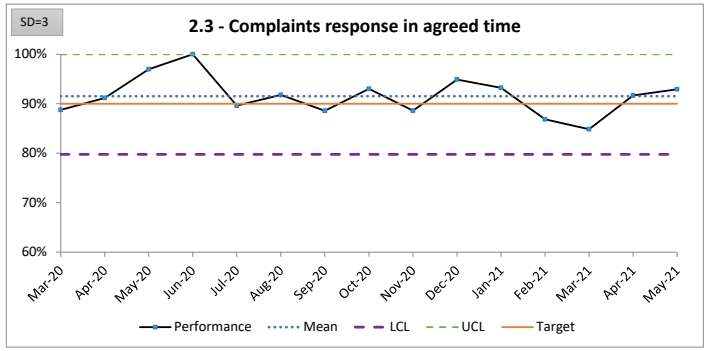


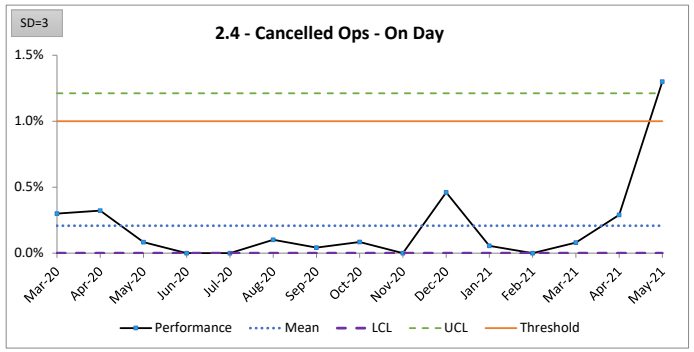
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

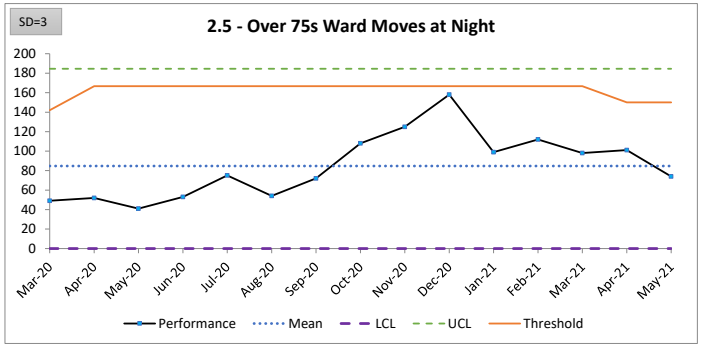
- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

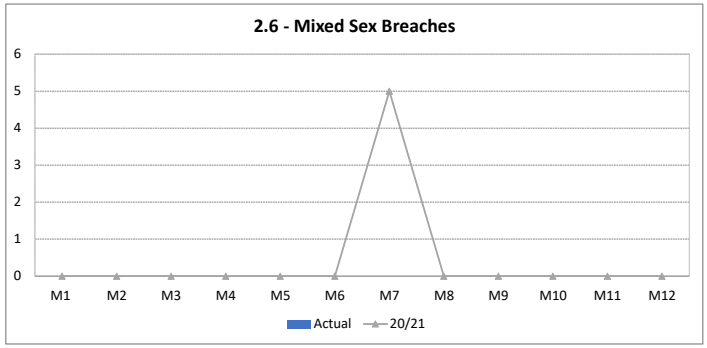
OBJECTIVE 2 - PATIENT EXPERIENCE











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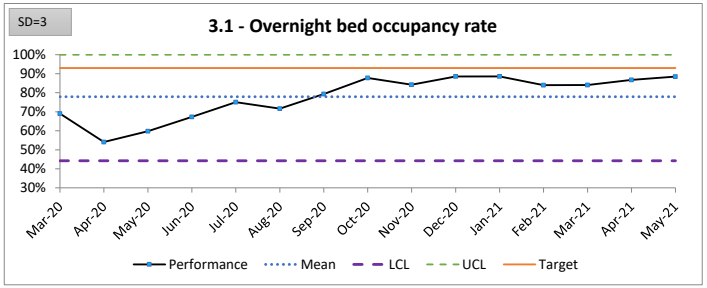
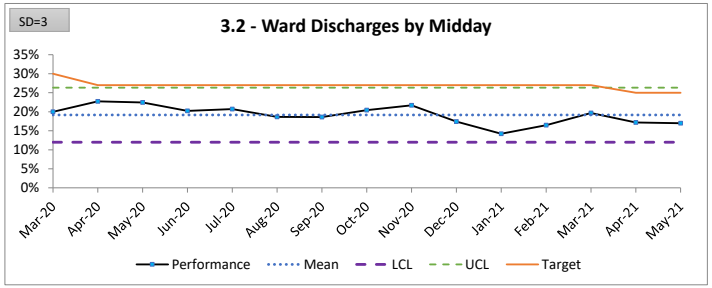
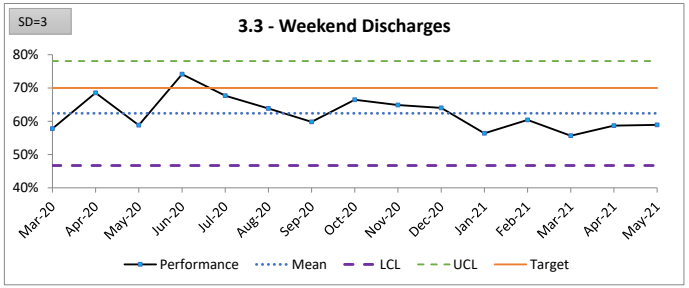
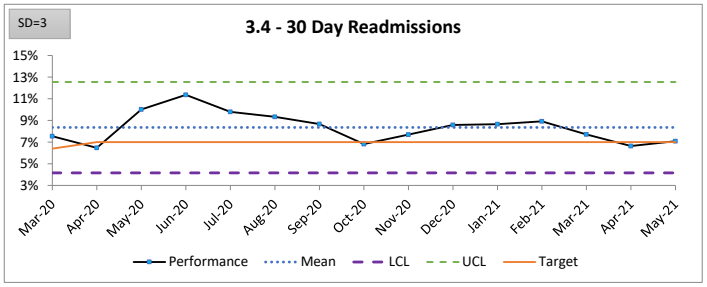
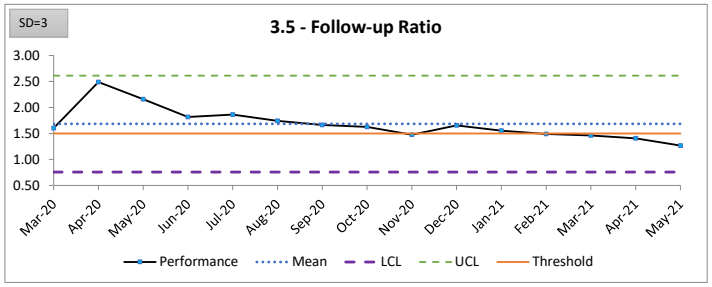
OBJECTIVE 3 - CLINICAL EFFECTIVENESS

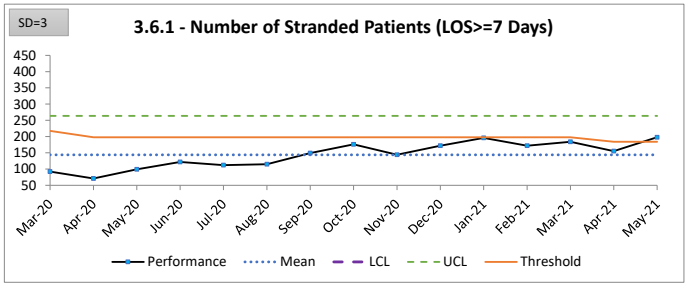


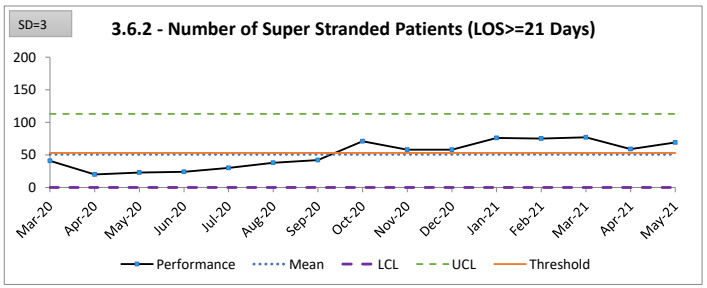


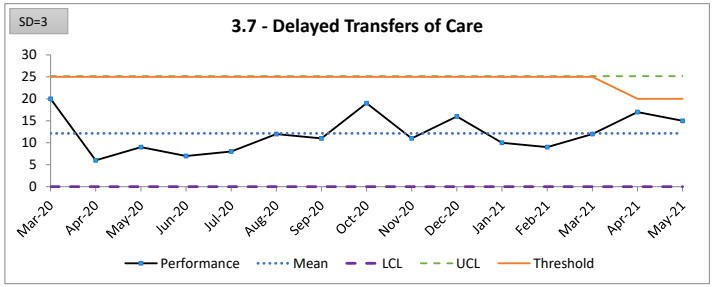


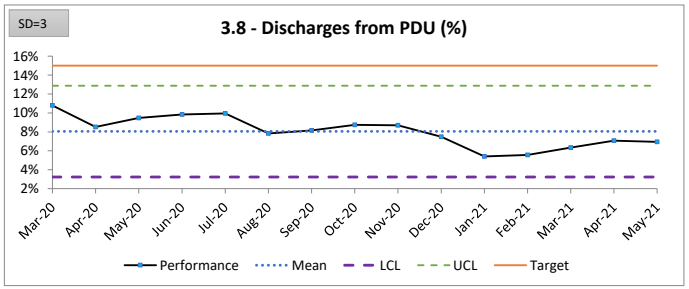


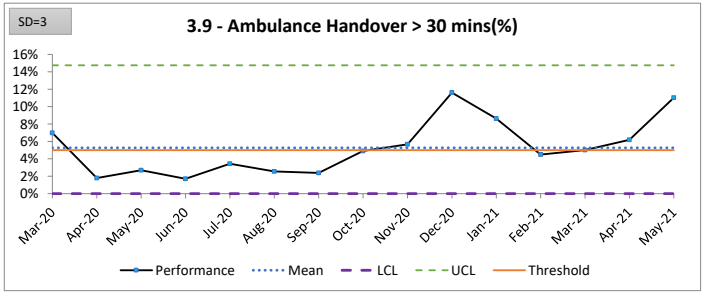












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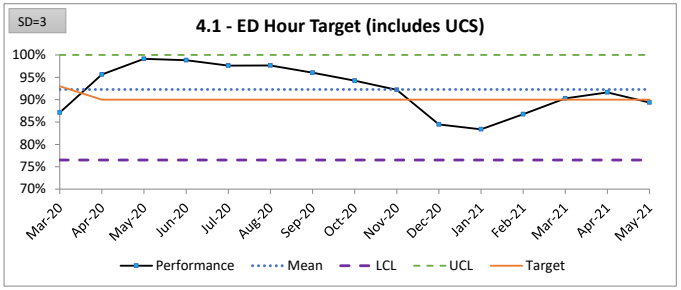
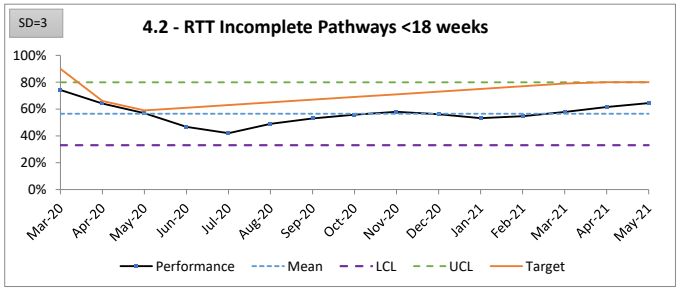
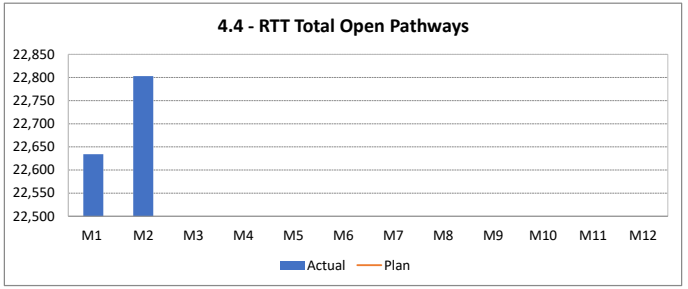
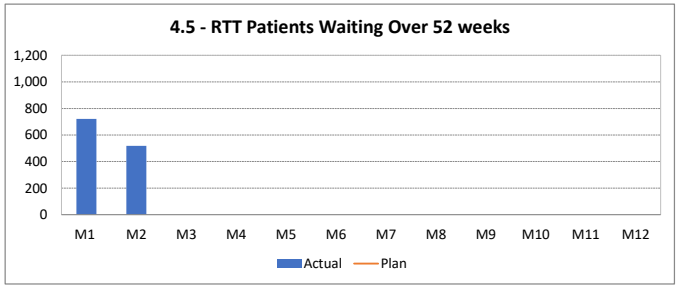
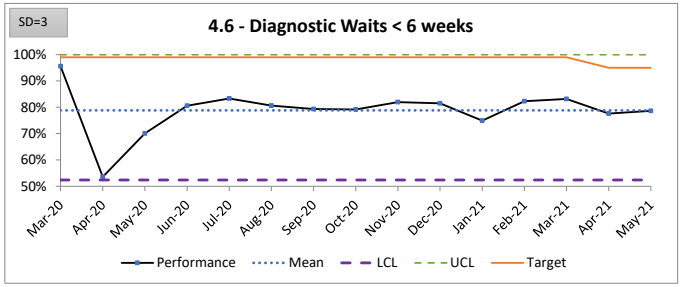
OBJECTIVE 4 - KEY TARGETS

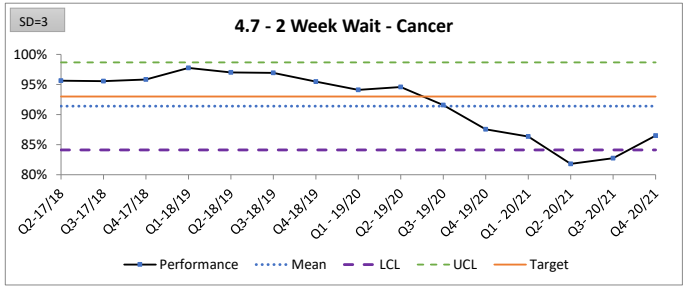


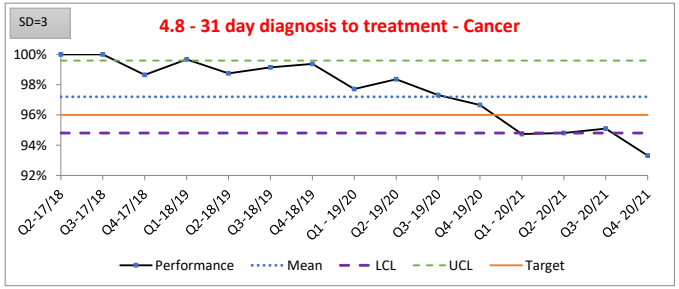


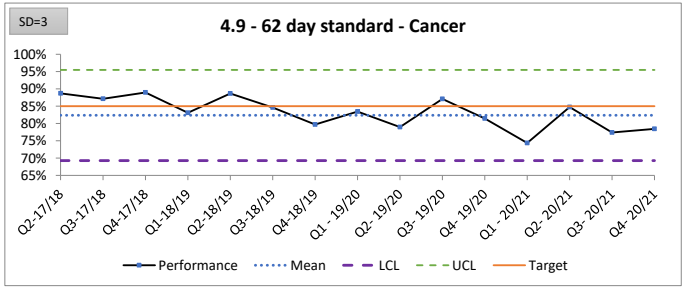












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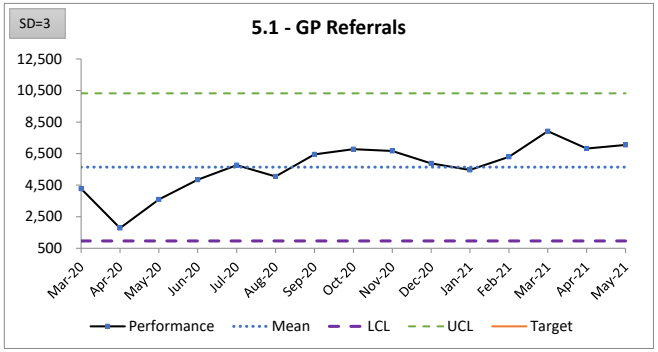

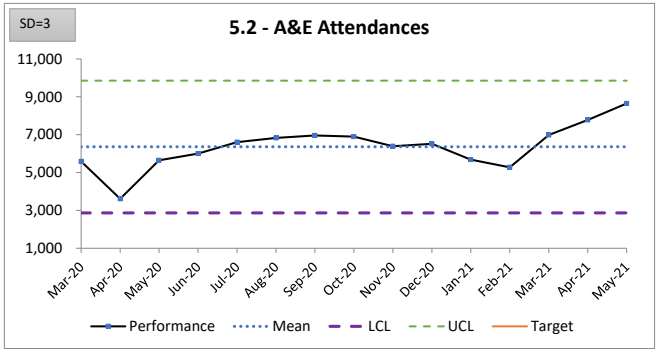

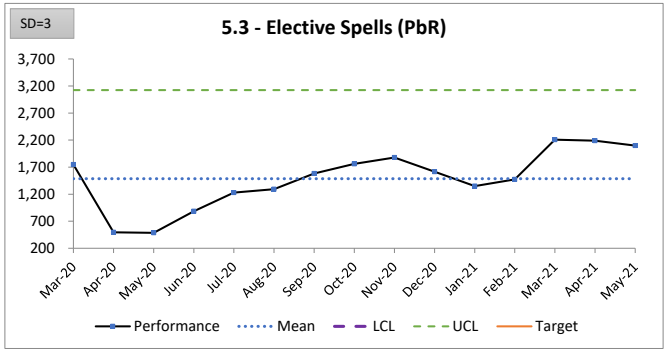

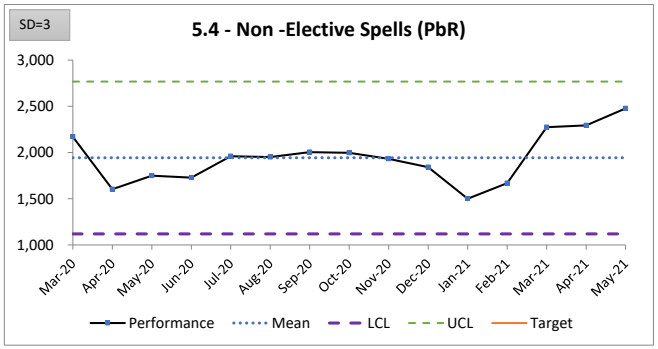

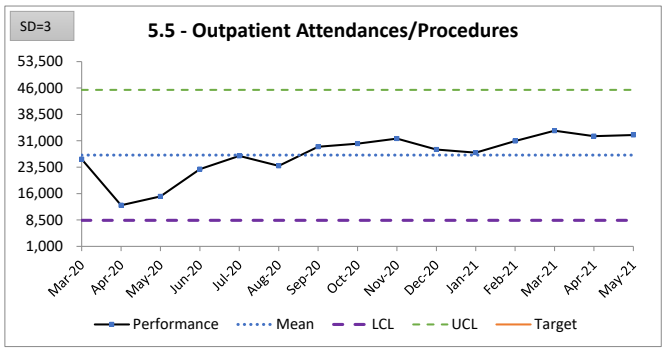

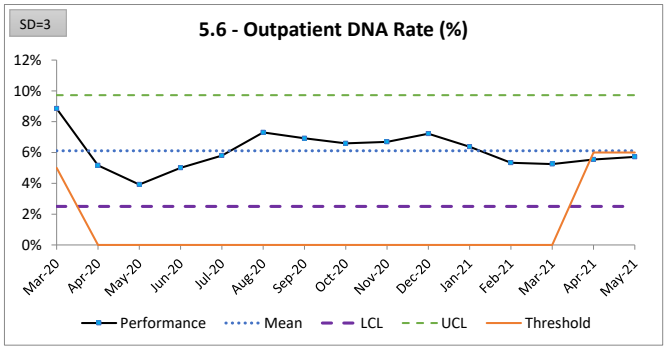

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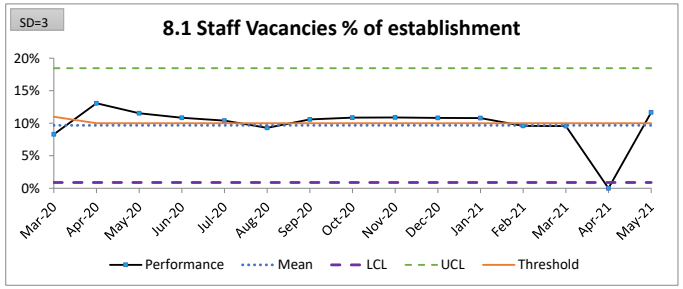
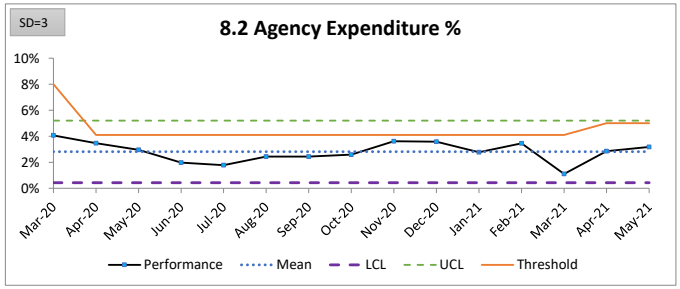
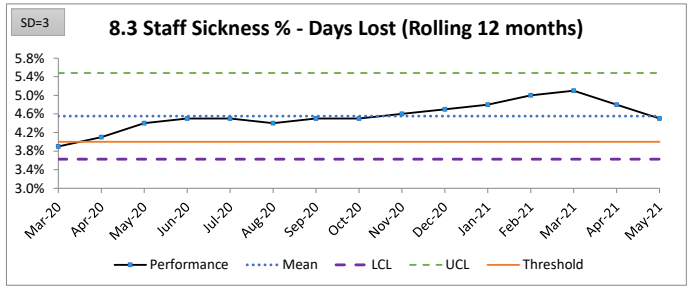
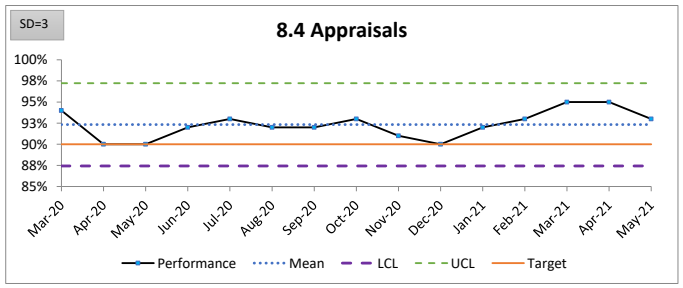
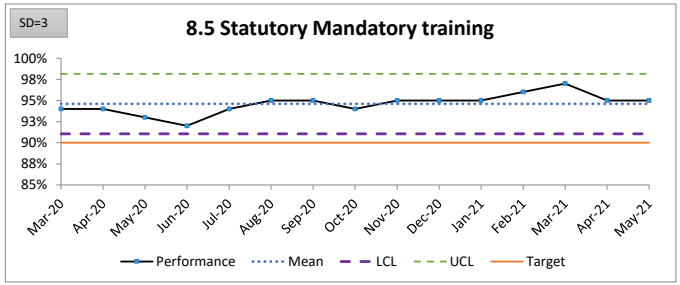
OBJECTIVE 8 - WORKFORCE PERFORMANCE

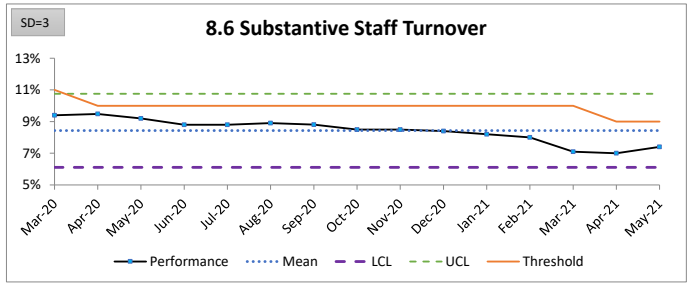












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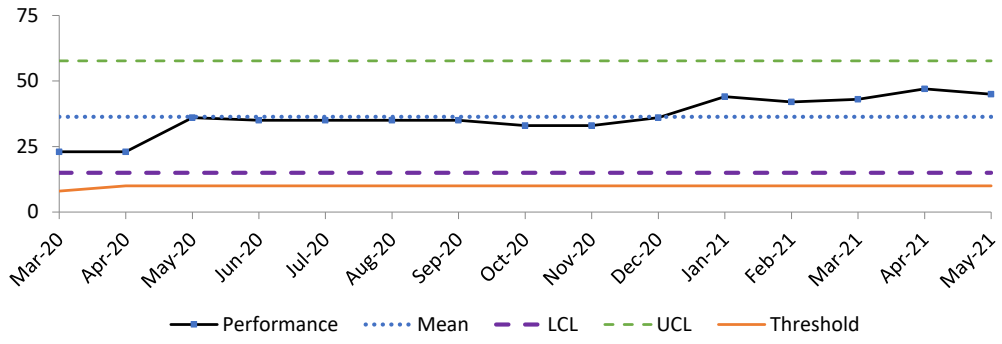
Milton Keynes University Hospital NHS Foundation Trust

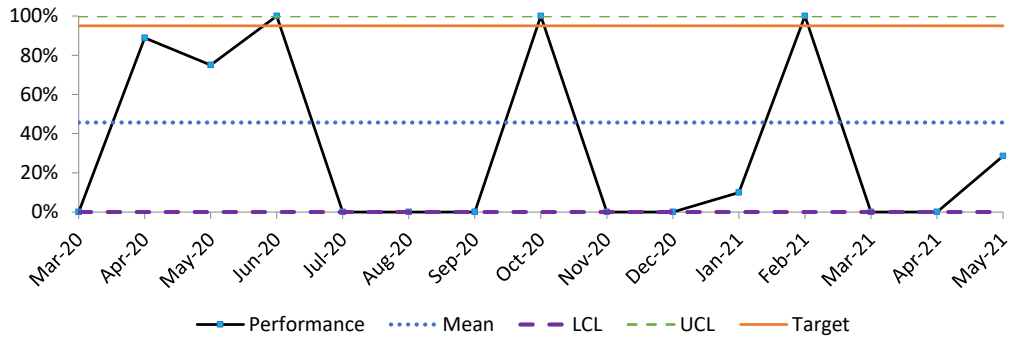
SD=3

O.1 - Total Number of Nice Breaches

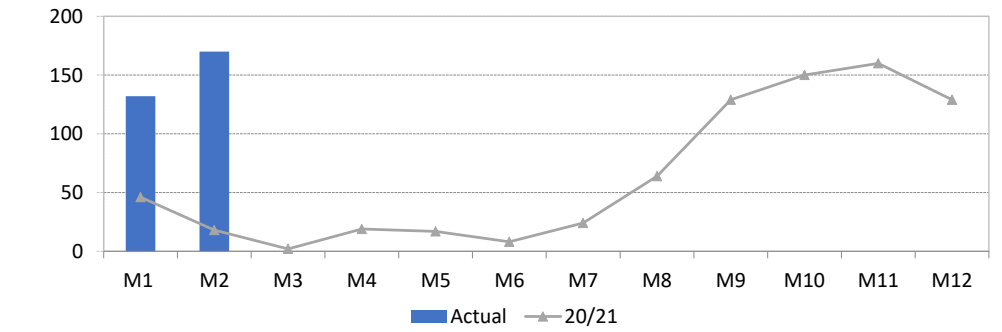


SD=3

O.2 - Rebooked cancelled OPs - 28 day rule

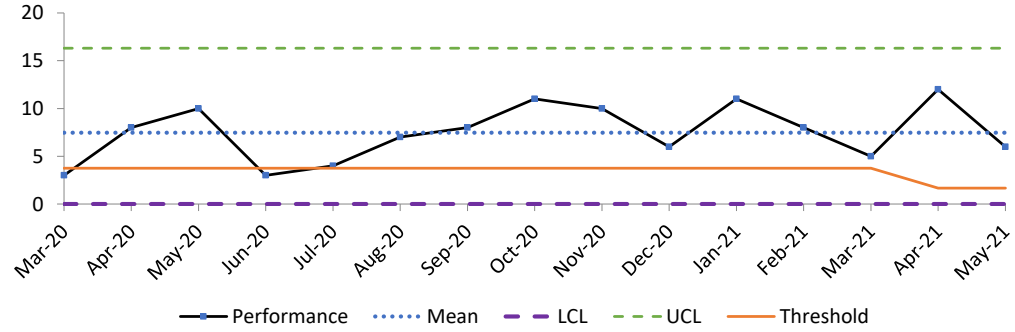


O.4 - Overdue Datix incidents >1 month



SD=3

O.5 - Serious Incidents



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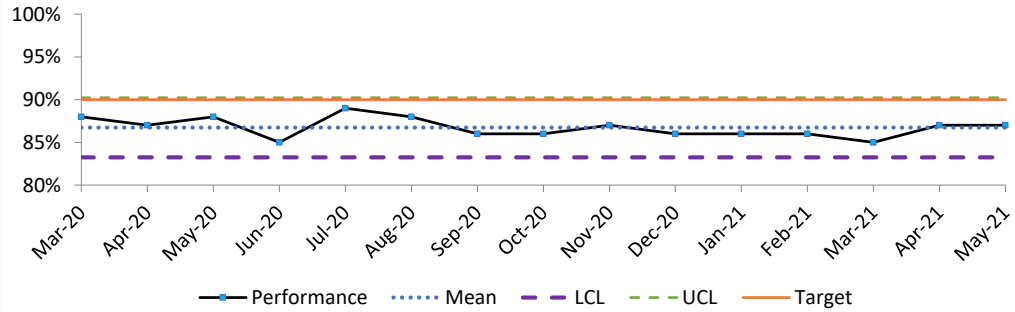
O.8 - Completed Job Plans (Consultants)



Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Trust Board	Date: July 2021
Report title:	**Finance Paper Month 2 2021-22**	**Agenda item: 13**
Lead director **Report authors**	Terry Whittle Chris Panes	Director of Finance Head of Management Accounts
FoI status:	Public Document	

Report summary	**An update on the financial position of the Trust at Month 2(May 2021)**			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** X	**Decision** ☐
Recommendation	Finance & Investment Committee 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 Appendix 16
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	June 2021 Finance and Investment Committee
Next steps	Trust Board
Appendices	1 to 13

FINANCE REPORT FOR THE MONTH TO 31st MAY 2021

FINANCE & INVESTMENT COMMITTEE

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;
    - Provide assurance to the Finance & Investment Committee that actions are in place to address any areas of concern with the Trust's financial performance; and
    - Provide assurance that the Trust is adequately responding to change in funding regime and additional financial impacts of the COVID-19 pandemic and associated service recovery.

EXECUTIVE SUMMARY

2. The Trust has concluded the budget setting process following the belated release of planning guidance from NHSE/I for the first half of the year (H1, April to September, M1-6); H2 (M1-7) guidance is expected to be issued in the next few months when the Covid situation is better known. The funding is based on a system envelope which includes the CCG allocation, system top up and covid top up based on 2020/21 H2 envelopes.

3. For H1, the block payment remains in place, but it includes an inflation and efficiency requirement which equates to a 0.5% uplift. The Trusts H1 plan is currently a £1.1m deficit. The following items will be paid outside of the block:
    - Elective Recovery Fund (ERF) for the backlog clearance for Elective, Day case and Outpatients. This will be paid at 100% and 120% if the Trust over performs the target of 85% of 19/20 activity;
    - NHSE High-Cost Drugs and Devices;
    - Specific covid costs;
    - Non-clinical services directly contracted by NHSE/I; and
    - National Service Development Fund Allocations.

4. *Income and expenditure* – For M2 the Trust has reported a positive variance of 70k (£291k YTD) against a planned deficit of £176k (£382k YTD) on a control total basis (adjusted for donations. This includes income and expenditure of £2.7M YTD associated with the ERF.

5. Cash and capital position – the cash balance as at the end of May 2021 was £48.5m. Spend on capital as at the end of May 21 was £0.7m, relating to patient safety related schemes.

INCOME AND EXPENDITURE

6. The table below summarises the MKUH H1 high level plan:

	6m to Sept 21
	£m
Operating income from patient care	152.4
Other operating income	9.2
Total income	**161.6**
Staff costs	-104.7
Non-pay costs	-55.4
Total operating expenditure	**-160.1**
Financing costs	-2.6
Total Expenditure	**-162.7**
Surplus/Deficit	**-1.1**

Included in this plan are £7.5m (FYE) of cost pressures which includes on-going COVID related costs, £2.5m (FYE) of business case expenditure but also a requirement to delivery efficiencies of £4.1m.

7. The ICS funding envelope for BLMK for H1 is £834m, with £376k assigned to BLMK acute providers, £119m for MKUH and £257m for Bedfordshire Hospitals.

BLMK Funding		£m	%
NHS	ICS Acute NHS Providers	376	45%
	Non ICS NHS providers	165	20%
Non NHS	Primary Care	160	19%
	Mental Health Services	26	3%
	Community Health Services	15	2%
	Continuing Care services	34	4%
	Acute Independent Sector contracts	20	2%
	Other commissioning & running costs	38	5%
Total Funding		**834**	**100%**

Inclusive of :	System top up	37
	COVID funding	27
	Transitional funding	14

8. Financial performance up to M2 is detailed below:

All Figures in £'000	Month 2 Plan	Month 2 Actual	Month 2 Var	Month 2 YTD Plan	Month 2 YTD Actual	Month 2 YTD Var	M1-6 Plan Plan	M1-6 Plan Forecast	M1-6 Plan Var
Clinical Revenue	19,039	21,563	2,523	38,079	38,961	882	152,915	152,915	0
Other Revenue	1,490	1,525	35	2,980	2,912	(68)	(17,099)	(17,099)	0
Total Income	20,530	23,088	2,559	41,059	41,873	814	135,816	135,816	0
Pay	(16,193)	(18,007)	(1,815)	(32,364)	(33,647)	(1,283)	(104,531)	(104,531)	0
Non Pay	(7,396)	(8,482)	(1,087)	(14,828)	(16,103)	(1,275)	(49,662)	(49,662)	0
Total Operational Expend	(23,588)	(26,490)	(2,901)	(47,192)	(49,750)	(2,558)	(154,193)	(154,193)	0
EBITDA	(3,059)	(3,401)	(343)	(6,133)	(7,877)	(1,744)	(18,377)	(18,377)	0
Financing & Non-Op. Costs	(1,481)	(1,521)	(39)	(2,975)	(3,010)	(36)	(8,934)	(8,934)	0
Control Total Deficit (excl. PSF)	**(4,540)**	**(4,922)**	**(382)**	**(9,108)**	**(10,887)**	**(1,780)**	**(27,311)**	**(27,311)**	**0**
Adjustments excl. from control total:									
National/Other Block	0	453	453	0	2,071	2,071	0	0	0
National Top up	3,430	3,430	0	6,860	6,860	0	20,580	20,580	0
COVID Top up	933	933	0	1,866	1,866	0	5,598	5,598	0
Control Total Deficit (incl. PSF)	**(177)**	**(106)**	**71**	**(382)**	**(90)**	**291**	**(1,133)**	**(1,133)**	**0**
Donated income	0	79	79	0	79	79	0	79	79
Donated asset depreciation	(69)	(69)	0	(138)	(138)	0	(414)	(414)	0
Impairments & Rounding	(12)	0	12	(12)	0	12	(26)	(26)	0
Reported deficit/surplus	**(258)**	**(96)**	**162**	**(532)**	**(149)**	**382**	**(1,573)**	**(1,494)**	**79**

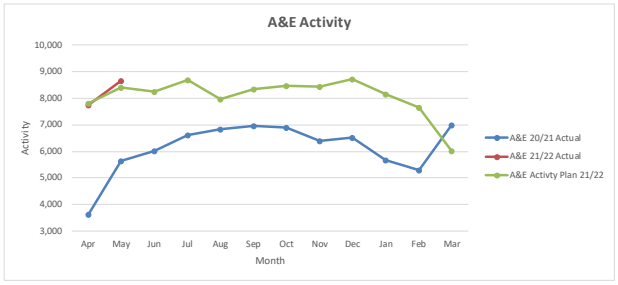
Monthly review

9. The **deficit position** in M2 is £96k and £149k YTD. On a control total basis the trust has reported a deficit of £106k in month 2 and £90k YTD, which is £71k favourable to the plan in-month and £291k YTD.

   The YTD position includes £673k of incremental COVID costs consisting of £123k non-pay, £471k pay and £80k in lost car park income. The M2 position includes income and expenditure of £2.7M YTD associated with the ERF.

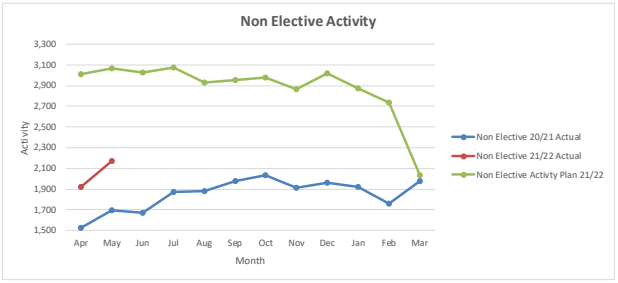
Activity Analysis

10. Key areas of Trust clinical activity vs plan are highlighted below along with comparative performance for the prior year.



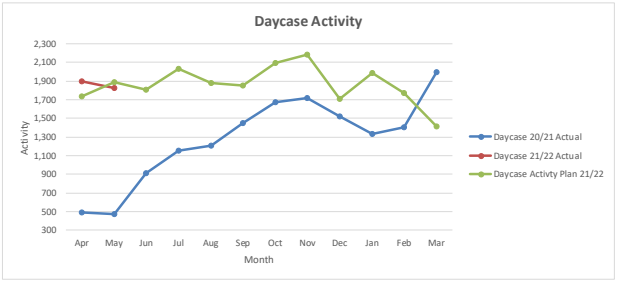
						Prior Year In Month			Prior Year YTD		
In Month Plan	In Month Actual	Variance	YTD Plan	YTD Actual	YTD Variance	Prior Year In Month	PY in month Diff	% Diff	PY YTD	Diff	% Diff
8,399	8,650	251	16,219	16,405	186	5,645	3,005	53%	9,260	7,145	77%

A&E activity is further continuing on an upward trend in May with asignificant jump in attendances in March, April and May.



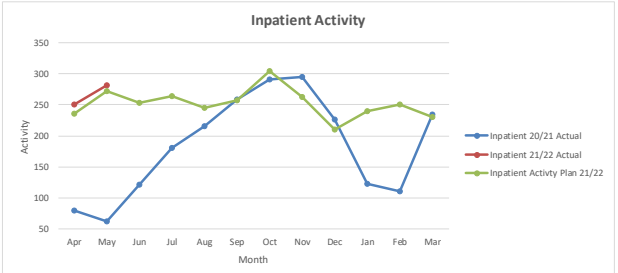
						Prior Year In Month			Prior Year YTD		
In Month Plan	In Month Actual	Variance	YTD Plan	YTD Actual	YTD Variance	Prior Year In Month	PY in month Diff	% Diff	PY YTD	Diff	% Diff
3,066	2,168	-898	6,079	4,086	-1,993	1,693	475	28%	3,218	868	27%

Non elective activity has increased slightly from April to May. This level of activty is expected to remain high folowing the relaxing of COVID restrictions.



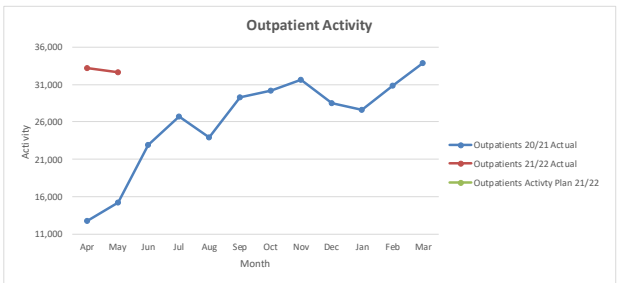
						Prior Year In Month			Prior Year YTD		
In Month Plan	In Month Actual	Variance	YTD Plan	YTD Actual	YTD Variance	Prior Year In Month	PY in month Diff	% Diff	PY YTD	Diff	% Diff
1,883	1,828	-55	3,619	3,723	104	472	1,356	287%	962	2,761	287%

Decreased daycase activity in May compare to April, however still progressing to pre covid levels.



						Prior Year In Month			Prior Year YTD		
In Month Plan	In Month Actual	Variance	YTD Plan	YTD Actual	YTD Variance	Prior Year In Month	PY in month Diff	% Diff	PY YTD	Diff	% Diff
272	282	10	508	533	25	63	219	348%	143	390	273%

Inpatient activity has continued its upward trend as the hospital continues to open eletive capacity following COVID.



						Prior Year In Month			Prior Year YTD		
In Month Plan	In Month Actual	Variance	YTD Plan	YTD Actual	YTD Variance	Prior Year In Month	PY in month Diff	% Diff	PY YTD	Diff	% Diff
33,182	32,619	-563	65,166	65,868	702	15,174	17,445	115%	27,860	38,008	136%

Outpatient activity has slightly dropped from April to May, however is back in line with pre COVID levels.

ERF and Accelerator

11. The reported position includes income associated with the Elective Recovery Fund (ERF).

12. The elective recovery fund offers additional funding at an ICS level for achievement of activity over a set baseline set at 70% of 19/20 activity in M1 and 75% of 19/20 activity in M2. However, the funding is dependent on the activity levels being met as well as specific gateway criteria achievement at an ICS level.

13. Subject to final validation of ICS gateway criteria clearance, MKUH activity performance is expected to deliver additional ERF funding of approximately £1.3m in month 2 and £2.7m YTD. The forecast ERF income for H1 is £9.5M, this is subject to sustaining additional capacity and case-mix outlined in additional capacity schemes.

14. The Accelerator funding offers an additional £3m funding for MKUH to meet a target of 120% of 19/20 activity by July 2021. Plans are currently being finalised and income will be recognised in line with the additional expenditure in the upcoming months.

COST SAVINGS

15. Work is underway with Divisions to identify efficiency savings (set at £3.5m for the H1 plan). Margin delivered via ERF income will contribute to the efficiency plan.

CASH AND CAPITAL

16. The cash balance at M2 was £48.5m,

17. Appendix 7 shows the forecast cash flow for 21/22 position with Appendix 8 showing the 13-week cash flow which is also shared with NHSI on a fortnightly basis to support the current funding arrangement.

18. The **statement of financial position** is set out in Appendix 9. The main movements from month 12 are summarised as follows:

    - Non-Current Assets have increased from March 21 by £3.0m; this is driven by the recognition of a £4.5m bond for the Pathway unit, offset by YTD depreciation.

    - Current assets have reduced by £6.5m, this is mainly due to the reduction in receivables £6.8m and cash £0.3m

    - Current liabilities have reduced in month by £3.4m, this is mainly due to the reduction in Trade Payables £4.0m, offset by an increase in deferred income £0.3m and provisions £0.3m.

    - There has been no change in Non-Current Liabilities in-month.

19. Spend on capital as at the end of May 21 was £0.7m relating to patient safety related schemes.

The Trust's CDEL allocation is £14.0m which is funded by depreciation of £13.6m and internal funds of £0.4m. In addition to the Trust has externally funded capital schemes for the Pathway Unit (£8.3m) and the New Hospitals Programme[1] (£28.0m) which is awaiting approval from NHSI/E and the DHSC.

Scheme Subcategory	**Internally funded**	**Externally Funded Awaiting Approval**	
		HIP2	4th Wave STP
	£m	£m	£m
Depreciation	13.6		
Self Funded	0.4		
PDC		28.0	8.3
Total CDEL	**14.0**	**28.0**	**8.3**
	50.3		

[1] New Hospitals Programme, formerly Health Infrastructure Programme 2 (HIP2)

20. The latest capital plan is outlined in the table below.

Capital Item	£m
CBIG Allocation	**5.00**
Pre commitments	
Finance Leases	0.30
Capitalised Staffing - IT and Estates	0.27
IT equipment	1.50
Cerner Phase C	0.45
LIMS (Pathology IT System)	0.02
HR IT system	0.10
Mammography Installation for 2 machines	0.39
Breast Unit Building Works	0.50
Sub Total Pre Commitments	***3.53***
Donated Assets	
Baby Leo 3 incubators	0.08
Pathlake	0.53
Sub Total Donated Assets	***0.61***
Strategic Schemes	
Staff Room Refurbishment	0.20
Anaesthetic rooms refurbishments	0.12
CT Scanner (prior year COVID funding)	0.53
Endoscopy (prior year COVID funding)	0.23
Xray Interventional	1.20
Angio Interventional	1.40
Still to be determined	1.20
Sub Total Strategic Schemes	***4.88***
Total CDEL	**14.01**

Awaiting Approval	
HIP2	28.00
Pathway Unit	8.28
Total awaiting approval	**36.28**

Total Forecast Capital Plan	**50.29**

RISK REGISTER

21. The Finance Risk Register is shown at Appendix 13. Risks are reviewed on a monthly basis and escalated to the BAF as appropriate.

RECOMMENDATIONS TO BOARD

22. The Board is asked to note the financial position of the Trust as of 31st May and the proposed actions and risks therein.

Milton Keynes Hospital NHS Foundation Trust
Statement of Comprehensive Income
For the period ending 31st May 2021

	FY22	M2 CUMULATIVE			M2			PRIOR MONTH	
	Annual Budget	Budget	Actual	Variance	Budget	Actual	Variance	M1 Actual	Change
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME									
Outpatients	42,867	7,167	7,315	148	3,583	3,860	276	3,455	404
Elective admissions	26,151	4,387	4,400	13	2,194	2,178	(16)	2,222	(45)
Emergency admissions	77,511	13,315	10,738	(2,577)	6,658	5,290	(1,368)	5,449	(159)
Emergency adm's marginal rate (MRET)	0	0	13	13	0	6	6	6	0
Readmissions Penalty	0	0	0	0	0	0	0	0	0
A&E	16,398	2,743	2,797	54	1,371	1,461	89	1,336	125
Other Admissions	2,670	509	358	(151)	255	9,042	8,787	(8,684)	17,726
Maternity	20,818	3,599	3,570	(28)	1,799	(6,561)	(8,360)	10,131	(16,692)
Critical Care & Neonatal	6,741	1,028	1,013	(15)	514	518	4	494	24
Imaging	5,610	979	892	(87)	489	456	(33)	436	20
Direct access Pathology	4,650	794	730	(64)	397	327	(70)	403	(76)
Non Tariff Drugs and Devices (high cost/individual drugs)	18,970	3,131	3,407	276	1,565	1,595	30	1,812	(217)
Other (inc. home visits and best practice tariffs)	8,339	1,388	3,727	2,340	694	3,392	2,698	335	3,057
CQUINS	0	0	0	0	0	0	0	0	0
Contract Risk Provision - General challenge & CIP offset	0	0	0	0	0	0	0	0	0
National Block/Top up	50,104	7,765	10,797	3,032	3,883	4,815	932	5,982	(1,167)
MKCCG Block adj	0	0	0	0	0	0	0	0	0
Clinical Income	**280,829**	**46,805**	**49,758**	**2,953**	**23,402**	**26,379**	**2,976**	**23,379**	**3,000**
Non-Patient Income	18,028	2,980	2,912	(68)	1,490	1,525	35	1,387	138
PSF Income	0	0	(0)	(0)	0	0	0	(0)	0
Donations	0	0	79	79	0	79	79	0	79
Non-Patient Income	**18,028**	**2,980**	**2,991**	**11**	**1,490**	**1,604**	**114**	**1,387**	**217**
TOTAL INCOME	**298,857**	**49,785**	**52,749**	**2,964**	**24,893**	**27,983**	**3,091**	**24,766**	**3,218**
EXPENDITURE									
Pay - Substantive	(175,472)	(29,146)	(28,699)	447	(14,582)	(15,039)	(457)	(13,660)	(1,379)
Pay - Bank	(10,711)	(1,802)	(2,646)	(843)	(901)	(1,449)	(548)	(1,197)	(253)
Pay - Locum	(1,819)	(298)	(805)	(507)	(149)	(523)	(373)	(282)	(240)
Pay - Agency	(5,908)	(1,022)	(1,374)	(353)	(512)	(929)	(417)	(445)	(484)
Pay - Other	(663)	(111)	(123)	(13)	(55)	(67)	(12)	(56)	(11)
Pay CIP	41	7	0	(7)	3	0	(3)	0	0
Vacancy Factor	56	7	0	(7)	4	0	(4)	0	0
Pay Reserves (SD/CP £0.4m o/d, Maternity £0.4m, FR2 £1.1m)		0		0	0	0	0	0	0
Pay	**(194,476)**	**(32,364)**	**(33,647)**	**(1,283)**	**(16,193)**	**(18,007)**	**(1,815)**	**(15,640)**	**(2,368)**
Non Pay	(70,362)	(11,697)	(12,696)	(999)	(5,830)	(6,887)	(1,057)	(5,809)	(1,079)
Non Tariff Drugs (high cost/individual drugs)	(18,970)	(3,131)	(3,407)	(276)	(1,565)	(1,595)	(30)	(1,812)	217
Non Pay	**(89,332)**	**(14,828)**	**(16,103)**	**(1,275)**	**(7,395)**	**(8,482)**	**(1,087)**	**(7,621)**	**(861)**
TOTAL EXPENDITURE	**(283,807)**	**(47,192)**	**(49,750)**	**(2,558)**	**(23,588)**	**(26,490)**	**(2,901)**	**(23,261)**	**(3,229)**
EARNINGS BEFORE INTEREST, TAXATION, DEPRECIATION AND AMORTISATION (EBITDA)	**15,050**	**2,593**	**2,999**	**405**	**1,304**	**1,494**	**189**	**1,505**	**(12)**
Interest Receivable	12	2	0	(2)	1	0	(1)	0	0
Interest Payable	(264)	(44)	(44)	(0)	(22)	(22)	(0)	(22)	0
Depreciation, Impairments & Profit/Loss on Asset Disposal	(12,742)	(2,124)	(2,123)	1	(1,062)	(1,077)	(15)	(1,046)	(31)
Donated Asset Depreciation	(816)	(136)	(138)	(2)	(68)	(69)	(1)	(69)	0
Profit/Loss on Asset Disposal & Impairments	0	0	0	0	0	0	0	0	0
Unwinding of discounts	0	0	0	0	0	0	0	0	0
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**1,240**	**292**	**694**	**402**	**154**	**325**	**172**	**368**	**(43)**
Dividends Payable	(4,938)	(823)	(843)	(20)	(412)	(422)	(10)	(422)	0
OPERATING SURPLUS/(DEFICIT) AFTER DIVIDENDS	**(3,698)**	**(531)**	**(149)**	**382**	**(258)**	**(96)**	**162**	**(53)**	**(43)**

Appendix 2

Milton Keynes Hospital NHS Foundation Trust
Headline financial position vs prior year
For the period ending 31st May 2021

All Figures in £'000	Month 2			Month 2 YTD			M1-6 Plan		
	Plan	Actual	Prior year	Plan	Actual	Prior Year	Plan	Forecast	Prior Year
Clinical Revenue (Excl. HCD)	17,444	20,138	13,818	34,672	22,131	33,643	143,315	143,315	100,348
Other Revenue	1,490	1,525	7,922	2,980	2,912	10,069	(17,099)	(17,099)	31,448
High Cost Drugs	1,595	1,425	1,336	3,407	16,830	2,766	9,600	9,600	8,868
Total Income	20,530	23,088	23,077	41,059	41,873	46,478	135,816	135,816	140,664
Pay	(16,193)	(18,007)	(15,949)	(32,364)	(33,647)	(32,019)	(104,531)	(104,531)	(93,728)
Non Pay (excl. HCD)	(5,801)	(7,058)	(4,624)	(11,421)	727	(9,298)	(40,062)	(40,062)	(30,236)
High Cost Drugs	(1,595)	(1,425)	(1,336)	(3,407)	(16,830)	(2,766)	(9,600)	(9,600)	(8,868)
Total Operational Expenditure	(23,588)	(26,490)	(21,910)	(47,192)	(49,750)	(44,083)	(154,193)	(154,193)	(132,831)
EBITDA	(3,059)	(3,401)	1,167	(6,133)	(7,877)	2,395	(18,377)	(18,377)	7,832
Financing & Non-Op. Costs	(1,481)	(1,521)	(1,161)	(2,975)	(3,010)	(2,321)	(8,934)	(8,934)	(7,758)
Control Total Deficit (excl. STF)	**(4,540)**	**(4,922)**	**7**	**(9,108)**	**(10,887)**	**74**	**(27,311)**	**(27,311)**	**74**
Adjustments excl. from control total:									
National Block & Top up	3,430	3,883	0	6,860	8,931	0	20,580	20,580	0
COVID Top up	933	933	0	1,866	1,866	0	5,598	5,598	0
Control Total Deficit (incl. STF)	**(177)**	**(106)**	**7**	**(382)**	**(90)**	**74**	**(1,133)**	**(1,133)**	**74**
Donated income	0	79	0	0	79	0	0	79	14
Donated asset depreciation	(69)	(69)	(68)	(138)	(138)	(136)	(414)	(414)	(407)
Reported deficit	**(258)**	**(96)**	**(61)**	**(532)**	**(149)**	**(62)**	**(1,547)**	**(1,468)**	**(318)**

Appendix 3

Milton Keynes Hospital NHS Foundation Trust
Clinical Activity Summary
For the period ending 31st May 2021

								Prior Year In Month			Prior Year YTD				
		In Month Plan	In Month Actual	Variance	YTD Plan	YTD Actual	YTD Variance	Prior Year In Month	PY in month Diff	% Diff	PY YTD	Diff	% Diff	18/19-20/21 Trend	% of PY in Month
Accident and Emergency	Accident and Emergency	8,399	8,650	251	16,219	16,405	186	5,645	3,005	35%	9260	7,145	44%		153%
Accident and Emergency Total		**8,399**	**8,650**	**251**	**16,219**	**16,405**	**186**	**5,645**	**3,005**	**53%**	**9,260**	**7,145**	**77%**		**153%**
Best Practice Tariff	Best Practice Tariff	165	206	41	332	412	80	167	39	23%	334	78	23%		123%
Best Practice Tariff Total		**165**	**206**	**41**	**332**	**412**	**80**	**167**	**39**	**23%**	**334**	**78**	**23%**		**123%**
Chemotherapy Delivery	Chemotherapy Inpatient	402	436	34	733	852	119	331	105	32%	658	194	29%		132%
	Chemotherapy Outpatient	203	0	-203	379	174	-205	142	-142	-100%	309	-135	-44%		0%
Chemotherapy Delivery Total		**605**	**436**	**-169**	**1,112**	**1,026**	**-86**	**473**	**-37**	**-8%**	**967**	**59**	**6%**		**92%**
Community	Community Services - Dietetics	184	48	-136	315	108	-207	25	23	92%	46	62	135%		192%
	Community Services - Physiotherapy	92	41	-51	208	78	-130	1	40	4000%	1	77	7700%		4100%
	Community Services - Specialist nursing	70	10	-60	122	21	-101	4	6	150%	6	15	250%		250%
Community Total		**346**	**99**	**-247**	**645**	**207**	**-438**	**30**	**69**	**230%**	**53**	**154**	**291%**		**330%**
Critical Care	Adult Critical Care	218	211	-7	398	392	-6	261	-50	-19%	503	-111	-22%		81%
	Neonatal Critical Care	462	441	-21	704	783	79	407	34	8%	750	33	4%		108%
Critical Care Total		**680**	**652**	**-28**	**1,102**	**1,175**	**73**	**668**	**-16**	**-2%**	**1,253**	**-78**	**-6%**		**98%**
Drugs and Devices	Devices excluded from National Tariff	201	137	-64	401	262	-139	27	110	407%	73	189	259%		507%
	Drugs excluded from National Tariff	0	0	0	0	0	0	0	0		0	0			
	Pharmacy Support Specialised	1,414	11	-1,403	1,414	1,110	-304	908	-897	-99%	1,855	-745	-40%		1%
Drugs and Devices Total		**1,615**	**148**	**-1,467**	**1,816**	**1,372**	**-444**	**935**	**-787**	**-84%**	**1,928**	**-556**	**-29%**		**16%**
Electives	Day Cases	1,883	1,828	-55	3,619	3,723	104	472	1,356	287%	962	2,761	287%		387%
	Elective	272	282	10	508	533	25	63	219	348%	143	390	273%		448%
	Excess bed days EL	67	19	-48	99	38	-61	0	19		102	-64	-63%		
Electives Total		**2,223**	**2,129**	**-94**	**4,226**	**4,294**	**68**	**535**	**1,594**	**298%**	**1,207**	**3,087**	**256%**		**398%**
Emergencies	Emergency Short Stay	917	3	-914	1,826	200	-1,626	239	-236	-99%	497	-297	-60%		1%
	Excess bed days Emergency	1,011	671	-340	1,684	1,336	-348	202	469	232%	783	553	71%		332%
	Non-Elective	2,149	2,165	16	4,253	3,886	-367	1,454	711	49%	2,721	1,165	43%		149%
Emergencies Total		**4,077**	**2,839**	**-1,238**	**7,763**	**5,422**	**-2,341**	**1,895**	**944**	**50%**	**4,001**	**1,421**	**36%**		**150%**
Financial Adjustments Total		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**0**	**0**			
Imaging	Diagnostic Imaging whilst Out-Patient	3,229	3,078	-151	6,479	6,109	-370	1,419	1,659	117%	2,615	3,494	134%		217%
	Direct Access	4,401	4,798	397	8,511	9,777	1,266	772	4,026	522%	1,349	8,428	625%		622%
Imaging Total		**7,630**	**7,876**	**246**	**14,990**	**15,886**	**896**	**2,191**	**5,685**	**259%**	**3,964**	**11,922**	**301%**		**359%**
Maternity Pathway	Home Births	9	13	4	12	27	15	7	6	86%	20	7	35%		186%
	Maternity Pathway - Ante-natal	366	339	-27	670	704	34	302	37	12%	673	31	5%		112%
	Maternity Pathway - Post-natal	338	351	13	643	680	37	300	51	17%	585	95	16%		117%
Maternity Pathway Total		**713**	**703**	**-10**	**1,325**	**1,411**	**86**	**609**	**94**	**15%**	**1,278**	**133**	**10%**		**115%**
Non-recurrent Total		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**0**	**0**			
Non-Tariff Total		**233**	**43**	**-190**	**467**	**86**	**-381**	**46**	**-3**	**-7%**	**74**	**12**	**16%**		**93%**
Other Non-Electives	Excess bed days Non-Elective	0	110	110	29	220	191	70	40	57%	85	135	159%		157%
	Non-Elective Non Emergency	522	316	-206	940	741	-199	377	-61	-16%	725	16	2%		84%
Other Non-Electives Total		**522**	**426**	**-96**	**969**	**961**	**-8**	**447**	**-21**	**-5%**	**810**	**151**	**19%**		**95%**
Outpatients	Bowel Scope	0	0	0	0	0	0	0	0		0	0			0%
	Non-Face to Face First Attendance	550	487	-63	1,149	1,023	-126	285	202	71%	414	609	147%		171%
	Non-Face to Face Follow Up	3,598	4,342	744	7,207	9,279	2,072	3,186	1,156	36%	6,246	3,033	49%		136%
	Outpatient FA Multi Professional Consultant Led	450	419	-31	881	829	-52	139	280	201%	139	690	496%		0%
	Outpatient FA Single Professional Consultant Led	5,556	6,732	1,176	10,726	12,575	1,849	3,035	3,697	122%	5,119	7,456	146%		222%
	Outpatient FA Single Professional Non-Consultant Led	2,699	4,890	2,191	5,156	8,951	3,795	933	3,957	424%	1,861	7,090	381%		524%
	Outpatient FUP Multi Professional Consultant Led	369	0	-369	569	42	-527	29	-29	-100%	62	-20	-32%		
	Outpatient FUP Single Professional Consultant Led	8,144	8,101	-43	16,018	15,357	-661	4,592	3,509	76%	8,184	7,173	88%		176%
	Outpatient FUP Single Professional Non-Consultant Led	7,987	6,559	-1,428	15,789	12,684	-3,105	1,775	4,784	270%	3,830	8,854	231%		370%
	Outpatient Multi-Disciplinary Clinic	4	4	0	8	9	1	4	0	0%	9	0	0%		100%
	Outpatient Procedures	3,825	1,027	-2,798	7,661	5,002	-2,659	1,137	-110	-10%	1,878	3,124	166%		90%
	Year of Care	0	58	58	0	117	117	59	-1	-2%	118	-1	-1%		98%
Outpatients Total		**33,182**	**32,619**	**-563**	**65,166**	**65,868**	**702**	**15,174**	**17,445**	**115%**	**27,860**	**38,008**	**136%**		**215%**
Pathology	Pathology	39,582	35,834	-3,748	77,280	71,668	-5,612	18,329	17,505	96%	30,624	41,044	134%		196%
	Tests	17	18	1	35	36	1	16	2	13%	30	6	20%		113%
Pathology Total		**39,599**	**35,852**	**-3,747**	**77,315**	**71,704**	**-5,611**	**18,345**	**17,507**	**95%**	**30,654**	**41,050**	**134%**		**195%**
Grand Total		**99,989**	**92,678**	**-7,311**	**193,446**	**186,229**	**-7,217**	**47,160**	**45,518**	**97%**	**83,643**	**102,586**	**123%**		**197%**

Milton Keynes Hospital NHS Foundation Trust
Pay Run Rate & Variance Analysis
For the period ending 31st May 2021

TRUST		Oct-20	Oct-20 WTE Worked	Nov-20	Nov-20 WTE Worked	Dec-20	Dec-20 WTE Worked	Jan-21	Jan-21 WTE Worked	Feb-21	Feb-21 WTE Worked	Mar-21	Mar-21 WTE Worked	Apr-21	Apr-21 WTE Worked	May-21	May-21 WTE Worked
Substantive	1 Consultant	(2,497)	183	(2,576)	182	(5,278)	183	(3,186)	184	(2,814)	183	(2,150)	183	(2,498)	185	(3,161)	183
	2 Junior Medical	(1,858)	288	(2,172)	295	(1,995)	294	(2,066)	296	(2,666)	293	(4,055)	296	(1,916)	293	(2,089)	294
	3 Nurses and Midwives	(3,547)	893	(3,736)	904	(5,384)	908	(3,670)	910	(3,694)	914	(3,641)	915	(3,620)	916	(3,775)	927
	4 Sci Tech & Ther	(1,772)	496	(1,857)	496	(2,503)	501	(1,920)	497	(1,781)	491	(1,727)	500	(1,829)	520	(1,813)	510
	5 Healthcare assistants, etc	(1,420)	604	(1,432)	585	(2,220)	585	(1,450)	577	(1,438)	601	(1,120)	618	(1,431)	623	(1,520)	618
	6 Admin & Clerical	(2,195)	705	(2,246)	701	(2,339)	703	(2,271)	706	(2,249)	711	(3,228)	706	(2,205)	710	(2,270)	719
	7 Executive	(116)	5	(147)	8	(154)	8	(137)	8	(138)	8	(185)	8	(149)	9	(398)	9
	8 Chair & NEDs	(12)	0	(12)	8	(12)	8	(12)	8	(12)	7	(11)	8	(11)	8	(12)	8
Total Substantive		**(13,417)**	**3,174**	**(14,179)**	**3,179**	**(19,886)**	**3,192**	**(14,712)**	**3,185**	**(14,792)**	**3,208**	**(16,117)**	**3,234**	**(13,660)**	**3,264**	**(15,039)**	**3,268**
Bank Staff	3 Nurses and Midwives BANK	(600)	144	(669)	157	(661)	148	(863)	160	(726)	169	(743)	173	(513)	139	(756)	133
	4 Sci Tech & Ther BANK	(52)	13	(56)	13	(68)	20	(100)	22	(111)	22	(139)	31	(77)	21	(74)	20
	5 Healthcare assistants, etc BANK	(428)	153	(488)	165	(527)	170	(648)	177	(578)	191	(626)	196	(425)	155	(444)	159
	6 Admin & Clerical BANK	(104)	49	(153)	60	(210)	68	(319)	90	(295)	95	(411)	114	(182)	71	(176)	63
Total Bank		**(1,184)**	**358**	**(1,366)**	**395**	**(1,466)**	**406**	**(1,931)**	**449**	**(1,711)**	**478**	**(1,920)**	**513**	**(1,197)**	**387**	**(1,449)**	**375**
Locums	Locum Clinical Asst	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Locum Consultant	(126)	10	(149)	12	(131)	11	(143)	10	(138)	10	(278)	10	(123)	7	(405)	7
	Locum S.H.O. (including FY2)	(52)	7	(35)	3	(47)	2	(48)	2	(48)	2	(72)	2	(83)	3	(54)	2
	Locum H.O. (including FY1)	(2)	0	0	0	0	0	(0)	0	(1)	0	(4)	0	(4)	0	0	0
	Locum SPR	(82)	3	(90)	4	(91)	3	(108)	3	(93)	3	(75)	1	(69)	2	(62)	3
	Locum Speciality Doctors	0	0	0	0	0	0	0	0	0	0	0	0	(2)	0	(2)	0
Total Locum		**(262)**	**20**	**(274)**	**19**	**(270)**	**17**	**(299)**	**16**	**(280)**	**15**	**(429)**	**13**	**(282)**	**12**	**(523)**	**13**
Agency	Agency Medical Consultant	7	1	(34)	2	(52)	3	(47)	2	(57)	4	(18)	4	(51)	2	(394)	3
	Agency Med SPR	(70)	6	(70)	6	(95)	6	(100)	6	(99)	8	(86)	6	(78)	6	(59)	3
	Agency Med SHO & HO	(79)	2	(37)	3	(33)	2	(8)	1	(63)	2	26	3	(46)	2	(83)	1
	Agency Junior Doctor ST1	(0)	0	(0)	0	0	0	(7)	0	(16)	0	(2)	0	(0)	0	(12)	0
	Agency Junior Doctor FY1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Agency Med Otr Career Gd	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Agency Other Medical	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Agency Med Staff Total	**(141)**	**9**	**(142)**	**11**	**(180)**	**11**	**(162)**	**10**	**(234)**	**14**	**(79)**	**12**	**(175)**	**11**	**(548)**	**8**
	Agency PAMs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Agency Prof & Tech	(86)	5	(174)	19	(84)	10	(50)	8	(33)	5	58	5	(48)	5	(25)	4
	Agency Admin & Clerical	(2)	0	1	0	(3)	0	(1)	0	0	0	0	0	0	0	0	0
	Agency Healthcare Asst	0	0	1	0	(2)	1	(16)	5	(17)	20	19	1	(1)	0	(9)	0
	Agency Maint & Works	0	0	0	0	0	0	(4)	1	(4)	2	(5)	1	(0)	0	(21)	0
	Ancillary Agency Staff	(30)	15	(27)	12	(30)	14	(31)	12	(37)	17	(46)	14	(30)	11	(33)	12
	Agency Senior Manager	(9)	1	(8)	1	(15)	1	(8)	1	(9)	1	(9)	1	(9)	1	(15)	1
	Agency Nursing Qualified	(77)	17	(187)	40	(213)	27	(156)	24	(200)	10	(152)	28	(110)	14	(171)	7
	Agency Nursing Midwifery	(7)	0	(10)	2	(7)	1	(5)	1	(8)	0	(2)	0	(3)	0	0	0
	Agency Radiographer	(7)	1	(7)	1	1	1	(7)	1	(7)	1	(8)	1	(19)	2	(10)	2
	Other Agency Staff	(37)	6	(41)	7	(48)	7	(43)	6	(52)	8	(65)	9	(49)	7	(97)	13
Total Agency		**(254)**	**44**	**(452)**	**81**	**(401)**	**62**	**(321)**	**59**	**(367)**	**63**	**(209)**	**61**	**(270)**	**41**	**(382)**	**40**
Apprenticeship Levy		(61)	0	(60)	0	(66)	0	(59)	0	(66)	0	(7,485)	0	(56)	0	(67)	0
Pay - Other		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pay - savings		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Vacancy Factor		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL PAY COSTS		**(15,318)**	**3,606**	**(16,474)**	**3,684**	**(22,269)**	**3,686**	**(17,484)**	**3,718**	**(17,451)**	**3,778**	**(26,239)**	**3,833**	**(15,640)**	**3,715**	**(18,007)**	**3,704**

TRUST		Month Budget	Month Actual	WTE Worked	Variance	YTD Budget	YTD Actual	YTD Variance
		£'000	£'000		£'000	£'000	£'000	£'000
Substantive	1 Consultant	(2,622)	(3,161)	183	(538)	(5,241)	(5,659)	(418)
	2 Junior Medical	(2,014)	(2,089)	294	(75)	(4,028)	(4,005)	23
	3 Nurses and Midwives	(4,025)	(3,775)	927	250	(8,047)	(7,396)	651
	4 Sci Tech & Ther	(1,918)	(1,813)	510	105	(3,835)	(3,641)	193
	5 Healthcare assistants, etc	(1,428)	(1,520)	618	(93)	(2,855)	(2,952)	(97)
	6 Admin & Clerical	(2,320)	(2,270)	719	49	(4,631)	(4,476)	155
	7 Executive	(242)	(398)	9	(156)	(485)	(547)	(63)
	8 Chair & NEDs	(13)	(12)	8	1	(26)	(23)	3
Total Substantive		**(14,582)**	**(15,039)**	**3,268**	**(457)**	**(29,146)**	**(28,699)**	**447**
Bank Staff	3 Nurses and Midwives BANK	(491)	(756)	133	(265)	(982)	(1,269)	(287)
	4 Sci Tech & Ther BANK	(42)	(74)	20	(32)	(84)	(150)	(66)
	5 Healthcare assistants, etc BANK	(285)	(444)	159	(158)	(570)	(869)	(299)
	6 Admin & Clerical BANK	(83)	(176)	63	(93)	(166)	(358)	(192)
Total Bank		**(901)**	**(1,449)**	**375**	**(548)**	**(1,802)**	**(2,646)**	**(843)**
Locums	Locum Clinical Asst	0	0	0	0	0	0	0
	Locum Consultant	(89)	(405)	7	(316)	(177)	(528)	(351)
	Locum S.H.O. (including FY2)	(13)	(54)	2	(41)	(26)	(137)	(111)
		0	0	0	0	0	(4)	(4)
	Locum SPR	(47)	(62)	3	(15)	(94)	(131)	(36)
	Locum Speciality Doctors	0	(2)	0	(2)	0	(4)	(4)
Total Locum		**(149)**	**(523)**	**13**	**(373)**	**(298)**	**(805)**	**(507)**
Agency	Agency Medical Consultant	(78)	(394)	3	(316)	(156)	(445)	(289)
	Agency Med SPR	(78)	(59)	3	19	(156)	(137)	19
	Agency Med SHO & HO	(104)	(83)	1	21	(209)	(129)	80
	Agency Junior Doctor ST1	(10)	(12)	0	(2)	(21)	(12)	9
	Agency Junior Doctor FY1	0	0	0	0	0	0	0
	Agency Med Otr Career Gd	0	0	0	0	0	0	0
	Agency Other Medical	0	0	0	0	0	0	0
	Agency Med Staff Total	**(270)**	**(548)**	**8**	**(277)**	**(541)**	**(723)**	**(182)**
	Agency PAMs	0	0	0	0	0	0	0
	Agency Prof & Tech	(64)	(25)	4	39	(127)	(73)	54
	Agency Admin & Clerical	0	0	0	0	0	0	0
	Agency Healthcare Asst	(12)	(9)	0	2	(23)	(14)	10
	Agency Maint & Works	0	(21)	0	(21)	0	(21)	(21)
	Ancillary Agency Staff	(16)	(33)	12	(17)	(33)	(63)	(30)
	Agency Senior Manager	(10)	(15)	1	(5)	(20)	(24)	(4)
	Agency Nursing Qualified	(94)	(171)	7	(77)	(185)	(243)	(58)
	Agency Nursing Midwifery	0	0	0	0	0	(0)	(0)
	Agency Radiographer	(14)	(10)	2	4	(28)	(30)	(2)
	Other Agency Staff	(32)	(97)	13	(65)	(65)	(184)	(119)
Total Agency		**(242)**	**(382)**	**40**	**(140)**	**(481)**	**(651)**	**(170)**
		(55)	(67)	0	(12)	(111)	(123)	(13)
Pay - Other		0	0	0	0	0	0	0
Pay - savings		3	0	0	(3)	7	0	(7)
Vacancy Factor		4	0	0	(4)	7	0	(7)
TOTAL PAY COSTS		**(16,193)**	**(18,007)**	**3,704**	**(1,815)**	**(32,364)**	**(33,647)**	**(1,283)**

Milton Keynes Hospital NHS Foundation Trust
Non-Pay Run Rate & Variance Analysis
For the period ending 31st May 2021

Trust		Sep 20 £'000	Oct 20 £'000	Nov 20 £'000	Dec 20 £'000	Jan-21 £'000	Feb-21 £'000	Mar-21 £'000	Apr-21 £'000	May-21 £'000	Month Budget £'000	Month Actual £'000	Month Variance £'000	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000
Non Pay	Drug expense (excl. HCD)	(383)	(288)	(355)	(363)	(441)	(265)	(295)	(161)	76	(68)	76	144	15,545	14,721	(825)
	High Cost Drugs	(1,425)	(1,625)	(1,560)	(1,572)	(1,572)	(1,572)	(2,024)	(2,024)	(2,024)	(1,850)	(2,024)	(174)	(19,348)	(18,854)	494
	Clinical supplies and services	(1,414)	(1,493)	(1,601)	(1,392)	(1,344)	(950)	(5,137)	(1,600)	(2,307)	(1,583)	(2,307)	(724)	(3,206)	(3,907)	(700)
	General supplies and services	(321)	(370)	(330)	(357)	(616)	(312)	(288)	(344)	(468)	(375)	(468)	(93)	(751)	(813)	(62)
	Establishment Expenses	(1,107)	(963)	(1,090)	(1,032)	(945)	(1,038)	(1,356)	(1,092)	(1,064)	(1,139)	(1,064)	75	(2,278)	(2,156)	122
	Premises and fixed plant	(1,391)	(2,282)	(1,630)	(1,841)	(1,449)	(1,457)	(2,807)	(1,412)	(1,328)	(1,297)	(1,328)	(31)	(2,624)	(2,740)	(116)
	Outsource to Commercial sector	(294)	(277)	(312)	(385)	(321)	(355)	679	(459)	(900)	(591)	(900)	(309)	(1,181)	(1,359)	(178)
	Education and Training Expenses	(88)	(87)	(135)	(135)	(92)	(173)	(422)	(110)	(120)	(111)	(120)	(9)	(222)	(230)	(7)
	Consultancy expenses	30	(1)	(0)	(1)	(1)	(3)	15	(1)	(8)	(1)	(8)	(7)	(2)	(9)	(7)
	Miscellaneous Operating Expenses	(266)	(595)	(406)	(1,354)	(337)	(302)	1,196	(418)	(340)	(381)	(340)	42	(762)	(757)	5
	Non Pay Savings Target			0	0	0	0	0	0	0	0	0	0	0	0	0
Total Non Pay		(6,659)	(7,982)	(7,421)	(8,432)	(7,117)	(6,427)	(10,439)	(7,621)	(8,482)	(7,396)	(8,482)	(1,087)	(14,828)	(16,103)	(1,275)
Non-operating costs	Depreciation and Amortisation	(1,000)	(989)	(1,033)	(1,059)	(469)	(225)	(221)	(1,115)	(1,146)	(1,130)	(1,146)	(16)	(2,260)	(16,156)	(13,897)
	Impairment - owned and donated							(11)	0	0	0	0	0	0	0	0
	Profit/Loss on Asset Disposal															
	Interest Payable	(46)	(2)	(23)	(23)	(23)	(23)	(23)	(22)	(22)	(22)	(22)	(0)	(44)	(44)	(0)
	Interest Receivable	1	0	0	0	0	0	0	0	0	1	0	(1)	2	0	(2)
	PDC Dividend Payable	(79)	(344)	(230)	(256)	(256)	(256)	(198)	(422)	(422)	(412)	(422)	(10)	(823)	(843)	(20)
Total Non Operating costs		(1,124)	(1,334)	(1,286)	(1,338)	(749)	(504)	(453)	(1,559)	(1,590)	(1,562)	(1,590)	(27)	(3,125)	(17,044)	(13,919)
TOTAL NON-PAY & NON OPERATING COSTS		**(7,782)**	**(9,316)**	**(8,706)**	**(9,771)**	**(7,866)**	**(6,931)**	**(10,892)**	**(9,179)**	**(10,072)**	**(8,958)**	**(10,072)**	**(1,114)**	**(17,953)**	**(33,147)**	**(15,194)**

Milton Keynes Hospital NHS Foundation Trust
Statement of Cash Flow
As of 31st May 2021

	Audited Mth12 2020-21 £000	Mth 2 £000	In Month Movement £000
Cash flows from operating activities			
Operating (deficit) from continuing operations	4,271	738	(3,533)
Operating surplus/(deficit) of discontinued operations			
Operating (deficit)	**4,271**	**738**	**(3,533)**
Non-cash income and expense:			
Depreciation and amortisation	9,947	2260	(7,687)
Impairments	11	0	(11)
Non-cash donations/grants credited to income	(727)	0	727
(Increase)/Decrease in Trade and Other Receivables	10,164	6,231	(3,933)
(Increase)/Decrease in Inventories	(286)	(5)	281
Increase/(Decrease) in Trade and Other Payables	9,819	2,108	(7,711)
Increase/(Decrease) in Other Liabilities	12,670	317	(12,353)
Increase/(Decrease) in Provisions	1,549	385	(1,164)
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows	(113)	(79)	34
Other movements in operating cash flows	0	(3)	(3)
NET CASH GENERATED FROM OPERATIONS	**47,305**	**11,952**	**(35,353)**
Cash flows from investing activities			
Interest received	4	0	(4)
Purchase of intangible assets	(7,753)	(810)	6,943
Purchase of Property, Plant and Equipment, Intangibles	(27,144)	(11,391)	15,753
De-recognition of PPE	358		
Net cash generated (used in) investing activities	**(34,535)**	**(12,201)**	**22,692**
Cash flows from financing activities			
Public dividend capital received	154,600	0	(154,600)
Loans repaid to Department of Health	(130,852)	0	130,852
Capital element of finance lease rental payments	(221)	(35)	186
Interest paid	(273)	0	273
Interest element of finance lease	(280)	(44)	236
PDC Dividend paid	(3,378)	0	3,378
Receipt of cash donations to purchase capital assets	113	79	(34)
Net cash generated from/(used in) financing activities	**19,709**	**-**	**(19,709)**
Increase/(decrease) in cash and cash equivalents	**32,479**	**(249)**	(32,728)
Opening Cash and Cash equivalents	**16,286**	**48,765**	32,479
Closing Cash and Cash equivalents	**48,765**	**48,516**	**(249)**

Milton Keynes Hospital NHS Foundation Trust
Cash Flow Forecast Table for 12 months to May 2021.

Month	May-21 £'000 Forecast	Jun-21 £'000 Forecast	Jul-21 £'000 Forecast	Aug-21 £'000 Forecast	Sep-21 £'000 Forecast	Oct-21 £'000 Forecast	Nov-21 £'000 Forecast	Dec-21 £'000 Forecast	Jan-22 £'000 Forecast	Feb-22 £'000 Forecast	Mar-22 £'000 Forecast	Apr-22 £'000 Forecast	May-22 £'000 Forecast
BANK balance b/f	**46,558**	**48,516**	**45,235**	**44,790**	**41,447**	**39,060**	**39,496**	**36,516**	**32,359**	**31,376**	**29,888**	**25,668**	**26,099**
Activity SLA's, inc Over performance	22,504	22,504	22,504	22,504	22,504	22,504	22,504	22,504	22,504	22,504	22,504	22,504	22,504
Prior year	2,000	-	-	-	-	-	-	-	-	-	-	-	-
Non activity SLAs	-	204	110	110	110	110	110	110	110	110	110	-	136
Other non patient related income	2,653	2,576	4,070	1,200	1,030	2,230	1,200	1,030	2,400	1,030	1,030	2,572	2,572
Grant for capital assets	0	0	0	0	430	0	0	0	0	0	0	0	0
Donations for Capital Assets	-	-	79	-	-	-	-	-	-	-	-	-	-
PDC STP Wave 4 (Pathway)	-	-	-	930	681	1,499	1,499	1,498	990	1,043	140	-	-
PDC HIP 2 Capital Funding	-	-	-	-	2,240	2,800	2,800	2,800	5,600	5,880	5,880	-	-
Interest receivable	0	3	3	3	3	3	3	3	3	3	3	0	0
TOTAL RECEIPTS	**27,157**	**25,287**	**26,766**	**24,747**	**26,998**	**29,146**	**28,116**	**27,945**	**31,607**	**30,570**	**29,667**	**25,076**	**25,213**
Pay (Substantive + Bank)	(15,456)	(14,734)	(14,844)	(16,610)	(14,844)	(14,844)	(15,194)	(14,844)	(15,194)	(14,844)	(15,305)	(15,244)	(15,244)
Payroll Transformation Support													
Direct debits & standing orders	(402)	(406)	(408)	(410)	(409)	(408)	(409)	(410)	(408)	(269)	(512)	(380)	(380)
NHS creditors	(1,803)	(3,916)	(1,935)	(1,685)	(1,685)	(1,685)	(1,685)	(1,685)	(1,685)	(1,685)	(1,685)	(2,301)	(2,301)
Non NHS creditors	(5,229)	(6,221)	(6,508)	(7,101)	(6,375)	(6,625)	(7,875)	(8,200)	(6,805)	(6,482)	(7,466)	(6,519)	(6,519)
Capital BAU	(841)	(147)	(573)	(709)	(729)	(1,393)	(1,211)	(2,226)	(2,758)	(2,758)	(431)	(201)	(121)
Capital Cancer Centre /helipad	-	(79)	-	-	(430)	-	-	-	-	-	-	-	-
Capital Strategic Schemes (NHSI) to be approved	(868)	(396)	-	(645)	(692)	(2,439)	(2,800)	(2,800)	(5,600)	(5,880)	(5,880)	-	-
Capital Other	(601)	(2,670)	(2,943)	-	-	-	-	-	-	-	-	-	-
Capital Pathway Unit (PDC)	-	-	-	(930)	(1,753)	(1,316)	(1,923)	(1,938)	(140)	(140)	(140)	-	-
PDC	-	-	-	-	(2,469)	-	-	-	-	-	(2,469)	-	-
TOTAL PAYMENTS	**(25,200)**	**(28,568)**	**(27,211)**	**(28,090)**	**(29,386)**	**(28,710)**	**(31,096)**	**(32,103)**	**(32,590)**	**(32,058)**	**(33,888)**	**(24,645)**	**(24,564)**
NET PAYMENTS / RECEIPTS	**1,958**	**(3,281)**	**(445)**	**(3,343)**	**(2,387)**	**436**	**(2,980)**	**(4,157)**	**(983)**	**(1,488)**	**(4,220)**	**431**	**649**
Bank balance b/f													
Bank balance c/f	**48,516**	**45,235**	**44,790**	**41,447**	**39,060**	**39,496**	**36,516**	**32,359**	**31,376**	**29,888**	**25,668**	**26,099**	**26,748**

Appendix 8

Milton Keynes Hospital NHS Foundation Trust
13-week Cash Flow Forecast up to the 27th August 2021

Week number for Cash Flow Forecast	1	2	3	4	5	6	7	8	9	10	11	12	13
Week ending: (Friday)	04-Jun-21	11-Jun-21	18-Jun-21	25-Jun-21	02-Jul-21	09-Jul-21	16-Jul-21	23-Jul-21	30-Jul-21	06-Aug-21	13-Aug-21	20-Aug-21	27-Aug-21
	£'009	£'010	£'011	£'012	£'013	£'014	£'015	£'016	£'017	£'018	£'019	£'020	£'021
	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
Bank balance b/f	**48,516**	**46,195**	**44,884**	**62,757**	**53,076**	**46,467**	**46,563**	**61,450**	**53,914**	**44,788**	**42,918**	**40,970**	**58,204**
Activity SLA's, inc Over performance & Cquin	-	-	22,504	-	-	-	22,504	-	-	-	-	22,504	-
Non activity SLAs	-	-	204	-	-	-	110	-	-	-	-	110	-
Other non patient related income	197	452	1,597	170	1,822	1,498	570	170	170	170	170	520	170
Other Income RBS	0	108	8	10	4	-	10	10	10	10	10	10	10
Other Income Citi	158	98	78	100	200	-	100	100	100	100	100	100	100
Cash Sheet Income	5	3	-	40	80	-	40	40	40	40	40	40	40
Credit Card Income	35	97	13	20	40	-	20	20	20	20	20	20	20
PDC Primary Care Streaming	-	-	-	-	-	-	-	-	-	930	-	-	-
Donations for Capital Assets	-	-	-	-	-	79	-	-	-	-	-	-	-
PDC HIP 2 Capital Funding	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Capital Funding	-	-	-	-	-	-	-	-	-	-	-	-	-
Interest receivable	-	-	-	-	3	-	3	-	-	-	-	3	-
TOTAL RECEIPTS	**197**	**452**	**24,305**	**170**	**1,825**	**1,577**	**23,187**	**170**	**170**	**1,100**	**170**	**23,137**	**170**
Payroll costs	(260)	(330)	(350)	(6,350)	(7,794)	-	(350)	(6,350)	(7,794)	(350)	(350)	(350)	(15,210)
Direct debits & standing orders	(74)	(129)	(44)	(7)	(231)	(129)	(45)	(5)	(150)	(79)	(133)	(45)	(150)
NHS creditors	(972)	-	(2,817)	-	(127)	-	(1,935)	-	-	-	-	(1,685)	-
Non NHS creditors	(835)	(1,117)	(2,811)	(1,208)	(250)	(1,208)	(2,883)	(1,208)	(1,208)	(1,434)	(1,458)	(3,000)	(1,208)
Capital PDC Covid	-	-	-	-	-	-	-	-	-	-	-	-	-
Capital Strategic schemes - NHSI funded	-	-	-	-	-	-	-	-	-	-	-	-	-
Capital Strategic schemes - Trust Funded	-	-	-	-	-	-	-	-	-	-	-	-	-
Capital Clinical Urgent and Essential Mainten	(2)	(93)	(19)	-	(32)	(143)	(143)	(143)	(143)	(177)	(177)	(177)	(177)
Capital Donation Funded	-	-	(79)	-	-	-	-	-	-	-	-	-	-
Capital External Loan Funded	(361)	-	(35)	-	-	-	-	-	-	-	-	(645)	-
Capital Other	(14)	(93)	(277)	(2,285)	-	-	(2,943)	-	-	-	-	-	-
Capital PDC Primary Care Streaming	-	-	-	-	-	-	-	-	-	(930)	-	-	-
Capital PDC GDE	-	-	-	-	-	-	-	-	-	-	-	-	-
Capital PDC IT	-	-	-	-	-	-	-	-	-	-	-	-	-
Capital PDC Urgent & Emergency Care	-	-	-	-	-	-	-	-	-	-	-	-	-
PDC	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL PAYMENTS	**(2,518)**	**(1,762)**	**(6,432)**	**(9,851)**	**(8,435)**	**(1,481)**	**(8,300)**	**(7,707)**	**(9,295)**	**(2,970)**	**(2,119)**	**(5,902)**	**(16,746)**
NET PAYMENTS / RECEIPTS	**(2,321)**	**(1,311)**	**17,873**	**(9,681)**	**(6,610)**	**96**	**14,887**	**(7,537)**	**(9,125)**	**(1,870)**	**(1,949)**	**17,235**	**(16,576)**
Bank balance c/f	**46,195**	**44,884**	**62,757**	**53,076**	**46,467**	**46,563**	**61,450**	**53,914**	**44,788**	**42,918**	**40,970**	**58,204**	**41,628**

Milton Keynes Hospital NHS Foundation Trust
Statement of Financial Position as of 31st May 2021

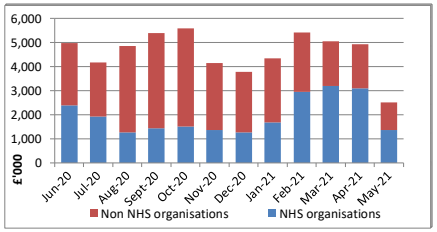
	Audited Mar-21	May-21 YTD Actual	YTD Mvmt	% Variance
Assets Non-Current				
Tangible Assets	169.5	172.3	2.8	1.7%
Intangible Assets	22.0	22.2	0.2	0.9%
Other Assets	1.0	1.0	0.0	0.0%
Total Non Current Assets	**192.5**	**195.5**	**3.0**	**1.6%**
Assets Current				
Inventory	3.7	3.7	0.0	0.0%
NHS Receivables	7.3	7.9	0.6	8.2%
Other Receivables	12.5	5.7	(6.8)	(54.4%)
Cash	48.8	48.5	(0.3)	-0.6%
Total Current Assets	**72.3**	**65.8**	**(6.5)**	**-9.0%**
Liabilities Current				
Interest -bearing borrowings	(0.2)	(0.2)	0.0	0.0%
Deferred Income	(14.9)	(15.2)	(0.3)	2.0%
Provisions	(2.9)	(3.2)	(0.3)	10.3%
Trade & other Creditors (incl NHS)	(58.5)	(54.5)	4.0	(6.8%)
Total Current Liabilities	**(76.5)**	**(73.1)**	**3.4**	**(4.4%)**
Net current assets	**(4.2)**	**(7.3)**	**(3.1)**	**73.8%**
Liabilities Non-Current				
Long-term Interest bearing borrowings	(5.6)	(5.6)	0.0	0.0%
Provisions for liabilities and charges	(1.7)	(1.7)	0.0	0.0%
Total non-current liabilities	**(7.3)**	**(7.3)**	**0.0**	0.0%
Total Assets Employed	**181.0**	**180.9**	**(0.1)**	**(0.1%)**
Taxpayers Equity				
Public Dividend Capital (PDC)	259.9	259.9	0.0	0.0%
Revaluation Reserve	50.1	50.1	0.0	0.0%
Financial assets at FV through OCI reserve	0.2	0.2	0.0	0.0%
I&E Reserve	(129.2)	(129.3)	(0.1)	0.1%
Total Taxpayers Equity	**181.0**	**180.9**	**(0.1)**	**(0.1%)**

Milton Keynes Hospital NHS Foundation Trust
Debtor Analysis as of 31st May 2021

Top ten debtors £'000	Total	0 - 30	31 - 60	61 - 90	91 - 120	121+
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	273	265	0	0	0	8
BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	242	0	22	0	147	73
NHS ENGLAND	214	107	0	0	0	107
CENTRAL AND NW LONDON NHS FOUNDATION TRUST	200	181	12	0	2	5
NHS BEDFORDSHIRE, LUTON & MILTON KEYNES CCG	198	14	0	183	0	1
BEDFORD BOROUGH COUNCIL	135	0	0	0	39	96
OXFORD HEALTH NHS FOUNDATION TRUST	129	9	0	0	38	82
NORTHAMPTONSHIRE COUNTY COUNCIL	94	0	0	0	0	94
NHS PROPERTY SERVICES LTD	93	51	0	0	2	40
UNIVERSITY OF BUCKINGHAM	83	3	0	0	0	80
OTHER	858	269	84	49	20	436
Total	**2,519**	**899**	**118**	**232**	**248**	**1,022**

Debtors by category £'000	Total	0 - 30	31 - 60	61 - 90	91 - 120	121+
NHS CLINICAL COM GROUPS	200	14	0	183	0	3
NHS COM BOARD COM SUPPORT UNIT	259	116	0	7	7	129
NHS DH SPECIAL HEALTH AUTH	-12	0	0	10	0	-22
NHS ENGLISH TRUSTS	301	270	0	2	2	27
NHS FOUNDATION TRUSTS	609	209	34	17	187	162
NON NHS COMPANY	151	86	14	0	0	51
NON NHS DH PUB CORP TRADE FNDS	94	52	0	0	2	40
NON NHS HEALTH BODIES	100	87	1	1	5	6
NON NHS INDIVIDUAL	130	7	5	6	0	112
NON NHS INSURANCE COMPANIES	9	4	0	0	1	4
NON NHS LOCAL AUTHORITIES	16	0	0	0	0	16
NON NHS OVERSEAS VISITORS	208	44	1	6	4	153
NON NHS PRIVATE PATIENT	2	1	0	0	0	1
NON NHS PUBLIC BODIES	446	9	63	0	40	334
NON NHS WELSH SCOTS+NI BODIES	3	0	0	0	0	3
STAFF	3	0	0	0	0	3
Total	**2,519**	**899**	**118**	**232**	**248**	**1,022**

Debtors by type £'000	Total	0 - 30	31 - 60	61 - 90	91 - 120	121+
NHS organisations	1,357	609	34	219	196	299
Non NHS organisations	1,162	290	84	13	52	723
Total	**2,519**	**899**	**118**	**232**	**248**	**1,022**



Debtors' comments

The debtor's position as of 31st May'21 stands at £2.5m, which is a decrease of £2.4m from the April'21 position.

- Oxford University hospitals NHS has 6 pending invoices including (£197k) relating to Q1 CLRN recharge of which is under 30 days of ageing. This mainly being as a result of £2m payment from NHS Bedfordshire Luton & Milton Keynes CCG re additional funding 20/21.
- Bedfordshire Hospitals NHS Foundation Trust has 10 pending invoices relating to salary recharges and cancer alliance funding. All being actively chased.
- NHS England has 4 overdue invoices including 19/20 final reconciliation recharge (£107k). All debt is being actively reviewed and chased for Jun'21 payment. Receipts of £80k have been received in Jun'21 to date.
- CNWL has 12 overdue invoices of which relate to Apr'21 & May'21 Non-Patient SLA. All debt is being actively chased for Jun'21 payment. Receipts of £28k have been received in Jun'21 to date.
- NHS Bedfordshire Luton & Milton Keynes CCG has 3 overdue invoices relating to Dafne training (£14k) and Maternity recharges (£184k). All invoices are being actively chased.
- Bedfordshire Borough Council has 21 overdue invoices all relating to Sexual Health cross recharges which are currently under dispute and monitored by the Divisional Business partner.
- Oxford Health NHS Foundation Trust has 5 pending invoices mainly relating to rates recharges of which are under review and actively being chased for June'21 payment. Receipts of £49k have been received in Jun'21 to date.
- Northamptonshire County Council has 11 overdue invoices all relating to Sexual Health cross recharges which are currently under dispute and monitored by the Divisional Business partner.
- NHS Property Services has 13 pending utility recharge invoices. All being chased for Jun'21 payment and actively monitored.
- University of Buckingham has 4 overdue invoices including Q4 services recharge salary recharges (£80k). All debt is being actively chased.
- Within "Other category" £0.2m of the 121+ days relate to overseas and private patients. All are being actively chased.

* A schedule of large invoices over £5k and over 60 days old is shown in **Appendix 13.**

Appendix 11

Milton Keynes Hospital NHS Foundation Trust
Debtor Invoices >60 days old and >£5,000 in value as of 31st May 2021

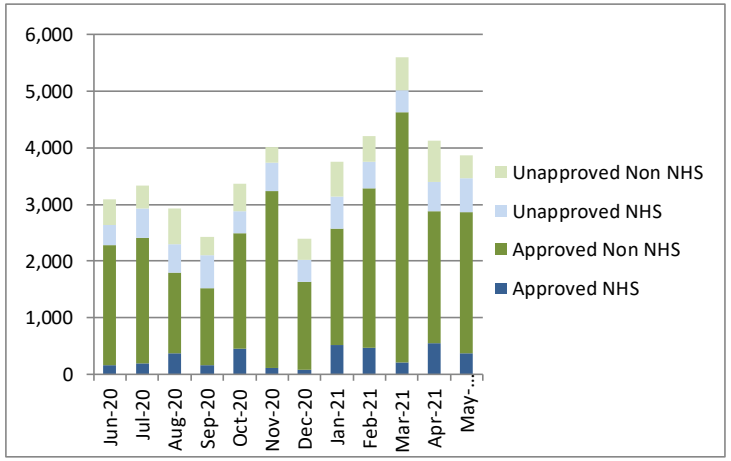
	Debtor	Total Amt over 60 days+	No. of Invoices	Date of Invoices	Total Amt over 90 days+	Status
1	BEDFORD HOSPITAL NHS FT	£208K	4	Jan'19 -Jan'21	£208K	Salary recharge invoice - currently being actively chased for Jun'21 payment.
2	NHS BEDFORDSHIRE, LUTON & MILTON KEYNES CCG	£183K	1	Feb'21		Salary (Midwifery) recharge invoice - currently being actively chased for Jun'21 payment.
3	OXFORD HEALTH NHS FT	£120K	4	Apr'19 - Mar'21	£120K	Non Domestic rates recharges. Invoice being actively chased for Jun'21 payment.
4	BEDFORD BOROUGH COUNCIL	£111K	9	Sept'18 - Feb'21	£111K	Sexual Health recharge currently under query and being actively reviewed by Senior Business Partner - Medicine.
5	NHS ENGLAND	£107K	1	Oct'20	£107K	19-20 final reconciliation recharge currently under review for Jun'21 payment.
6	NORTHAMPTONSHIRE COUNTY COUNCIL	£97K	10	Jan'18 -May'20	£97K	Sexual Health recharge currently under query and being actively reviewed by Senior Business Partner - Medicine.
7	UNIVERSITY OF BUCKINGHAM	£80K	1	Nov'20	£80K	Medical placement recharge. Actively chased for Jun'21 payment.
8	BUCKINGHAMSHIRE COUNTY COUNCIL	£54K	7	Jul'16 - Nov'19	£54K	Sexual Health recharge currently under query and being actively reviewed by Senior Business Partner - Medicine.
9	NHS ARDEN AND GEM CSU	£37K	5	Nov'20 - Mar'21	£29K	IT SLA recharge. Actively being chased for Jun'21 payment.
10	NHS PROPERTY SERVICES	£29K	1	Oct'20	£29K	Recahrge of utilities recharges. Invoice under review to achieve full payment in Jun'21.
11	SALARY OVERPAYMENTS (COVERING 2 INVOICES)	£23K	2	Oct'17 - Nov'17	£23K	Invoices under review/investigation and actively chased.
12	PP OVERSEAS PATIENT (COVERING 6 INVOICES)	£16K	3	Dec'18 - Apr'20	£16K	Invoice currently under dispute with Patients. All details have been logged with the Home Office/UK Borders.
13	FRIMLEY HEALTH NHS FOUNDATION TRUST	£15K	1	Feb'21		Salary recharge invoice - currently being actively chased for Jun'21 payment.
14	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	£11K	1	Dec'19	£11K	ENT consultant recharge - actively being chased for Jun'21 payment.
15	NHS TRUST DEVELOPMENT AUTHORITY	£9K	1	Feb'21		Talent Management Grant recharge - Actively chased for Jun'21 payment.
16	SAXON CLINICE BMI	£8K	1	Nov'20	£8K	Recahrge of utilities recharges. Invoice under review to achieve full payment in Jun'21.
17	MEDICAL PROPERTY MANAGEMENT LTD	£8K	1	Oct'20	£8K	Academic Centre property management recharge - under review for Jun'21 payment.
Total		**£1,116M**	**53**		**£901K**	
	Invoices cleared from Apr'21					
1	UNIVERSITY OF BUCKINGHAM	£677K	1	Jan'21		Paid in full May'21
2	CENTRAL BEDFORDSHIRE COUNCIL	£8K	1	Jul'17	£8K	Part CMR created May'21
3	BUCKINGHAMSHIRE COUNTY COUNCIL	£6K	1	Dec'18	£6K	Paid in full May'21
4	NHS PROPERTY SERVICES LTD	£5k	1	Dec'20	£5k	Paid in full May'21
Total		**£669K**	**4**		**£19K**	
	All other debt over 60 days less than £5K	**£509K**	**469**		**£492K**	**All debt actively reviewed and chased.**

Milton Keynes Hospital NHS Foundation Trust
Creditors Analysis
as of 31st May 2021

Approved (£'000)	Total	0 - 30	31 - 60	61 - 90	90+
NHS Organisations	372	397	0	(23)	(2)
Non NHS Orgs	2,490	1,876	451	84	79
Total	**2,862**	**2,273**	**451**	**61**	**77**

Unapproved (£'000)	Total	0 - 30	31 - 60	61 - 90	90+
NHS Organisations	608	433	55	60	60
Non NHS Orgs	393	221	87	20	65
Total	**1,001**	**654**	**142**	**80**	**125**

Total Creditors (£'000)	Total	0 - 30	31 - 60	61 - 90	90+
Total	**3,863**	**2,927**	**593**	**141**	**202**



Approved NHS (£'000)	Total	0 - 30	31 - 60	61 - 90	90+
CARE QUALITY COMMISSION	180	180	0	0	0
ST HELENS & KNOWSLEY HOSPITALS NHS TRUST	105	105	0	0	0
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	60	59	0	0	1
NHS BLOOD & TRANSPLANT	20	20	0	0	0
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	9	9	0	0	0
OXFORD HEALTH NHS FOUNDATION TRUST	7	7	0	0	0
FRIMLEY PARK HOSPITAL NHS FOUNDATION TRUST	5	5	0	0	0
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	3	4	0	0	(1)
UNIVERSITY HOSPITALS OF DERBY & BURTON NHS FOUNDATION TRUST	3	0	0	0	3
PORTSMOUTH HOSPITALS UNIVERSITY NHS TRUST	3	3	0	0	0
Others	(23)	5	0	(23)	(5)
Total	**372**	**397**	**0**	**(23)**	**(2)**

Approved Non NHS (£'000)	Total	0 - 30	31 - 60	61 - 90	90+
SUPPLY CHAIN COORDINATION LIMITED	660	403	257	0	0
WORKMAN LLP	181	181	0	0	0
OPTOS PLC	174	174	0	0	0
MEDICA REPORTING LTD	113	113	0	0	0
CERNER LTD	96	2	0	0	94
ZESTY LTD	96	0	0	0	96
HILL-ROM LTD	95	0	95	0	0
FRONTLINE PROTECTION SGD LTD	63	37	0	26	0
PORTAKABIN LTD	53	53	0	0	0
ELECTRA FIT LTD	48	0	48	0	0
Others	911	913	51	58	(111)
Total	**2,490**	**1,876**	**451**	**84**	**79**

- Approved creditors are awaiting payment, whereas unapproved creditors have not been validated or approved by the organisation.

Milton Keynes Hospital NHS Foundation Trust
Finance Risk Register
For the period ending 31st May 2021

ID	What is the risk?	What could Cause the Risk to occur?	What Impact could the risk have on the Trust	Inherent Risk Rating	Inherent Risk Level	Controls in Place	Current Risk Rating	Current Risk Level	Gaps in Controls	Target Risk Rating	Target Risk Level	Treatment Type	Action Plan	Date Risk Last Reviewed	Trend	Review Due?
940	If the future NHS funding regime is not sufficient to cover the costs of the Trust, then the Trust will be unable to meet its financial performance obligations or achieve financial sustainability.	Unknown funding regime beyond September 2021 due to disruption caused by COVID-19	1.Increase in operational expenditure in order to manage COVID-19. 2.Reductions in non-NHS income streams as a direct result of COVID-19. 3.Impaired operating productivity leading to costs for extended working days and/or outsourcing. 4.Potential for material increase in efficiency requirement from NHS funding regime to support DHSC budget affordability.	20	High / Significant Risk	1. Cost and volume contracts replaced with block contracts (set nationally) for clinical income; 2. Top-up payments available where COVID-19 leads to additional costs over and above block sum amounts (until September 2021); 3. Budgets to be reset for FY22 based on financial regime; financial controls and oversight to be reintroduced to manage financial performance 4. Cost efficiency programme to be reset to target focus on areas of greatest opportunity to deliver	16	High / Significant Risk	Financial regime for FY22 only valid for first half of the year. Trust has minimal ability to influence.	8	Moderate / Unacceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	Close monitoring of activity by F&I Committee	14/06/2021	⇔	12/07/2021
1519	There is a risk that the Trust is unable to achieve the required efficiency improvements through the transformation programme leading to an overspend	Transformation delivery is not adequately resourced and prioritised and/or schemes are unrealistic and not well planned	The Trust may not deliver its financial targets leading to TO potential cash shortfall and non-delivery of its key targets	16	High / Significant Risk	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 Trust Executive Group.	16	High / Significant Risk	Saving schemes to be identified to deliver maximum savings in 2020/21	6	Low / Acceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	Performance is reviewed at monthly Executive led Performance Review meetings with relevant actions agreed	14/06/2021	⇔	12/07/2021
3051	There is a risk that if the Trust is unable to successfully tender for external audit services in 2021 then financial audits and other required annual assurance exercises will not take place LEADING TO the Trust failing in its statutory obligations.	A number of factors are coming together leading to Firms not bidding for audits currently, including **pricing** , frameworks tendered a number of years ago before the changes in regulatory frameworks, capacity - audit work for local government is co-insuring with health audits and framework tender documents have not kept in line with changing external audit requirements and are onerous to complete thus putting off smaller firms from bidding for work	No Extremal Auditors resulting in failure to submit statutory audited account which is a breach of statutory requirements	20	High / Significant Risk	1.Discussions have been held with the current external audit firm and agreement has been reached. The contract has been approved by the Governors in May and is waiting for the contract to be finally agreed and signed of. The existingg contract expires the end of August 21.	10	Moderate / Unacceptable Risk	The Trust has only limited control over which audit firms will take up offers to tender even though they are a framework	10	Moderate / Unacceptable Risk	TOLERATE - at lowest practicable/cost-effective level	To get a contract for external audit in place as soon as possible and update the next Audit Committee with the situation and undertake a timely retender exercise for services beyond FY22 and will identify potential suppliers early in this process	14/06/2021	⇔	12/07/2021
3043	There is a risk that the Trust has insufficient cash to meet its financial obligations	Lack of control over the expenditure position due to COVID and uncertainty about the future financial funding regime	Low / negative cash balances and interruptions to supplier payments.	20	High / Significant Risk	It should be noted that the Trust currently has sufficient cash balances to manage its obligations. Monthly cash flow forecasting is undertaken to establish at which point the Trust balances become close to £1m (historically the value advised by NHSEI to be held).	12	Moderate / Unacceptable Risk	The Trust has only limited control over the external funding regime	9	Moderate / Unacceptable Risk	TREAT - above tolerable level - appropriate cost-effective control required	Close monitoring of cashflow and if issues are identified inform NHSE/I as a matter of urgency	14/06/2021	⇔	12/07/2021

Milton Keynes Hospital NHS Foundation Trust
Finance Risk Register
For the period ending 31st May 2021

ID	What is the risk?	What could Cause the Risk to occur?	What Impact could the risk have on the Trust?	Inherent Risk Rating	Inherent Risk Level	Controls in Place	Current Risk Rating	Current Risk Level	Gaps in Controls	Target Risk Rating	Target Risk Level	Treatment Type	Action Plan	Date Risk Last Reviewed	Trend	Review Due
1184	Inability to keep to affordable levels of agency and locum staffing	Transformation delivery is not adequately resourced and prioritised and/or schemes are unrealistic and not well planned.	The Trust may not deliver its financial targets leading to potential cash shortfall and non-delivery of its key targets	16	High / Significant Risk	1. Weekly vacancy control panel review agency requests. 2. Control of staffing costs identified as a key transformation work stream 3. Capacity planning 4. Robust rostering and leave planning 5. Escalation policy in place to sign-off breach of agency rates 6. Fort-nightly executive led agency reduction group meeting with aim of delivering reduction in both quantity and cost of agency used. 7. Agency cap breaches are reported to Divisions and the FIC .	9	Moderate / Unacceptable Risk	No signifiacnt gaps in control	9	Moderate / Unacceptable Risk	TOLERATE - at lowest practicable/cost-effective level	Divisional understanding of how to reduce spend on temporary staffing to be developed Exit plan to be reported and monitored monthly	14/06/2021	⇔	12/07/2021
3068	There is a risk that a data breach may occur with reference to GDPR and Data Protection Act as the procurement department deals with large volumes of data.	On the procurement ordering system there is a free text box for non catalogue items that could have patient details entered . Data is sent to external agencies such as NHS Digital, Advise Inc and tenders	A data breach may result in a significant fine	16	High / Significant Risk	1.All staff attend an annual mandatory training course on Information Governance. 2. Staff are encouraged to use catalogues which reduces the requirements for free text. 3. Data sent out to external agencies is checked for any patient details before submitting	6	Low / Acceptable Risk	Further review of data	6	Low / Acceptable Risk	TOLERATE - at lowest practicable/cost-effective level	The situation is kept under constant review within Procurement	14/06/2021	⇔	12/07/2021
3069	There is a risk that the supply of key clinical products may be disrupted	New legislation following Brexit and impact of COVID as well as supplier bankruptcy	Some deliveries and services may be delayed, disrupted or reduce resulting in impact on patient care	16	High / Significant Risk	1.Trust's top suppliers have been reviewed and issues with supply under constant review. 2.Procurement business partners use the NHS Spend Comparison Site and local knowledge supported by the clinical procurement nurse to source alternative products	6	Low / Acceptable Risk	When the Trust changes supplier it needs to ensure robust reviews are undertaken before accepting supply from them	6	Low / Acceptable Risk	TOLERATE - at lowest practicable/cost-effective level	The situation is kept under constant review within Procurement	14/06/2021	⇔	12/07/2021
2666	Fraud, Bribery and Corruption - False representation/abuse of position/ failure to disclose information for personal gain	Personal gain	Financial loss, reputational damage	12	Moderate / Unacceptable Risk	Anti-Fraud and Anti-Bribery Policy, Standards of Business Conduct Policy including Q&A section, Standing Orders, SFIs, Local Counter Fraud Specialist in place and delivery of an annual plan. Proactive reviews also undertaken by Internal Audit. Register of Gifts and Hospitality, Register of Declarations	6	Low / Acceptable Risk	Historical declaration of interests	6	Low / Acceptable Risk	TOLERATE - at lowest practicable/cost-effective level	All staff are requested to declare interests	14/06/2021	⇔	12/07/2021
3070	There is a risk that key Finance and Procurement systems are unavailable	Major IT failure internally or from external providers	1. No Purchase to pay functions available ie no electronic requisitions, ordering, receipting or payment of invoices creating delays for delivery of goods. 2. No electronic tenders being issued. 3. No electronic raising of orders or receipting of	12	Moderate / Unacceptable Risk	1. If its an external issue, SBS the service provider of the purchase to pay and order and invoicing has a business continuity plan in place 2.If its an internal issue. The Trust has arrangements with the CCG who also use SBS to use their SBS platform.	6	Low / Acceptable Risk	No current gaps in control	6	Low / Acceptable Risk	TOLERATE - at lowest practicable/cost-effective level	The situation is kept under constant review	14/06/2021	⇔	12/07/2021
3071	There is risk that there may be issues with data quality within the procurement systems	Incorrect processing through human error or system errors	Incorrect ordering resulting in a lack of stock and impacting on patient safety	12	Moderate / Unacceptable Risk	1. Monthly reviews on data quality and corrections. 2. Mechanisms are in place to learn and change processes. 3. Data validation activities occur on monthly basis. 4. A desire to put qualifying suppliers in catalogue.	6	Low / Acceptable Risk	No current gaps in control	6	Low / Acceptable Risk	TOLERATE - at lowest practicable/cost-effective level	The situation is kept under constant review within Procurement	14/06/2021	⇔	12/07/2021
3018	As a result of COVID-19 there is a risk that funding from Charities will significantly reduce	Covid-19 pandemic	Reduction in pump primed specialist clinical roles previously funded by charities such as Macmillan	12	Moderate / Unacceptable Risk	Regular monitoring of the situation and escalate any areas of concern to Executive Directors	6	Low / Acceptable Risk	The Trust has limited control over which posts may be supported by Charities	6	Low / Acceptable Risk	TOLERATE - at lowest practicable/cost-effective level	Raise awareness with relevant divisions who currently have specialist pump primed roles	14/06/2021	⇔	12/07/2021

Meeting title	**Trust Board**	**Date: 08 July 2021**
Report title:	**Guardian of Safe Working Hours Annual Report (2020-2021)**	**Agenda item: 15**
Lead director **Report author** **Sponsor(s)**	**Name:** Dr Ian Reckless **Name:** Dr Janet Costa **Name:**	**Title:** Medical Director **Title:** GOSWH **Title:**
FOI status:	**Public**	

Report summary				
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [ ]	**Decision** [ ]
Recommendation	This report is supplied to Trust Board to demonstrate compliance with current national terms and conditions for medical staff in training (imposed, subsequently accepted, in August 2016) [the '2016 T&C']. This report covers April 2020 – March 2021 and describes the system of exception reporting and the role of the Guardian.			

Strategic objectives links	• Deliver key performance targets • Become well-governed and financially viable • Improve workforce effectiveness
Board Assurance Framework links	
CQC regulations	• Regulation 17: Good Governance • Regulation 18: Staffing
Identified risks and risk management actions	As described in the paper, concerns have been raised over the year with respect to rotas, staff vacancies and excessive workload out of hours in various departments. Of note, the articulation of such concerns is the prime purpose of the GOSWH system as contained within the 2016 T&C. The departments specifically impacted include gastroenterology, O&G, acute medicine, and urology.
Resource implications	1. Excessive hours worked and reported may lead to unplanned cost through overtime payment / backfill required to facilitate time off in-lieu (TOIL). 2. Failure to achieve compliance with the employment conditions set out in the *Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016* can permit the Guardian to levy fines against the Trust in favour of doctors in training.
Legal implications including equality and diversity assessment	**N/A**

Report history	
Next steps	Report to be submitted to TEG and the Junior Doctor Forum following discussion at Trust Board.
Appendices	

1. Executive summary

This report is the annual report of Guardian of Safe Working Hours (GOSWH): Dr Janet Costa (Consultant Physician – Stroke and Care of the Elderly). The report covers 01 April 2020 to 31 March 2021. Dr Costa assumed to post in August 2020.

2020/21 has been an extremely challenging year given the context of the COVID-19 pandemic. The flexibility of doctors in training over this period, and the proactive approach of the Trust (in relation to co-design and prospective additional payment for 'surge' rotas) is to be commended.

Overall, levels of exception reporting by doctors in training have been modest. This could be considered positive, as a sign of general satisfaction on the part of doctors in training with hours and educational opportunities. However, the GOSWH is keen to ensure that exception reporting is encouraged and supported by systems, clinical opinion leaders and departmental managers across the organisation.

Key areas of improvement identified through exception reporting during the year are as follows:

Obstetrics and Gynaecology had the highest number of exception reports in Q1 (April – June 2020). These were escalated to clinical and managerial leads within the department. Initial mitigations included changes to the rotas and increased daytime consultant cover. Feedback from these changes was positive. Subsequently Trust Executive Group supported additional resources to permit a second resident middle grade doctor 24/7 to be in place from August 2021.

Gastroenterology had the highest number of exception reports in Q3 due to a rota gap in SPRs. One of the 25 reports was declared an Immediate Safety Concern (ISC). The issues were discussed in department meetings, escalated to the CSU Lead and Operational Manager. Mitigations included employing a new SPR and introducing a regular SPR rota for acute cover; the rate of exception reports from the department has since reduced.

Acute Medicine saw a peak in exception reporting and trainee concerns during the second wave of COVID-19 (December 2020 / January 2021). This reflected the combined pressures of increased acute admissions, especially to Respiratory Medicine and staff shortages due to COVID-19 related illnesses or isolation. The trainees (and the wider workforce) felt under significant pressure. This was recognised and the medical rota was reviewed on a regular basis throughout the period. Required adjustments to the SPR rota were made to increase cover and provide additional SHO cover on night shifts.

Urology exception reports peaked in Q4 (January – March 2021), one of which was classified by the reporter as an ISC. Reports highlighted concerns with excessive ward workload, busy weekend on-calls and staff not being released to attend teaching opportunities. This was escalated to the CSU Lead and Rota Co-ordinator, and multiple discussions were held with juniors. As a result, a new rota was introduced, and a two-week diary exercise has been carried out to improve the rota and allow trainees to attend teaching opportunities.

No further areas of risk were identified, and the Trust continues to provide the contractual requirements of the 2016 Terms and Conditions for doctors in training. However, more work is needed to ensure: trainees continue to be aware of the exception reporting system and its benefits; Educational Supervisors are aware of their responsibilities and are responsive to concerns; and, that junior doctor rota design remain compliant with contractual requirements.

To improve awareness, encourage and support exception reporting, regular departmental discussion sessions for both junior and senior doctors have been arranged by the GOSWH. Guidance documents will also be circulated to the junior and senior doctors, during induction and with the induction welcome pack.

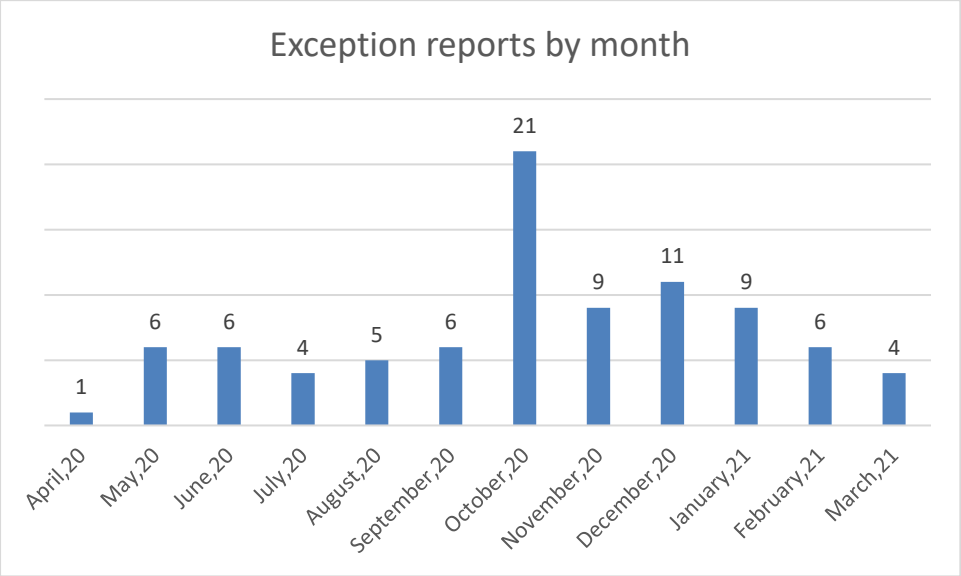
2. Exception Reporting

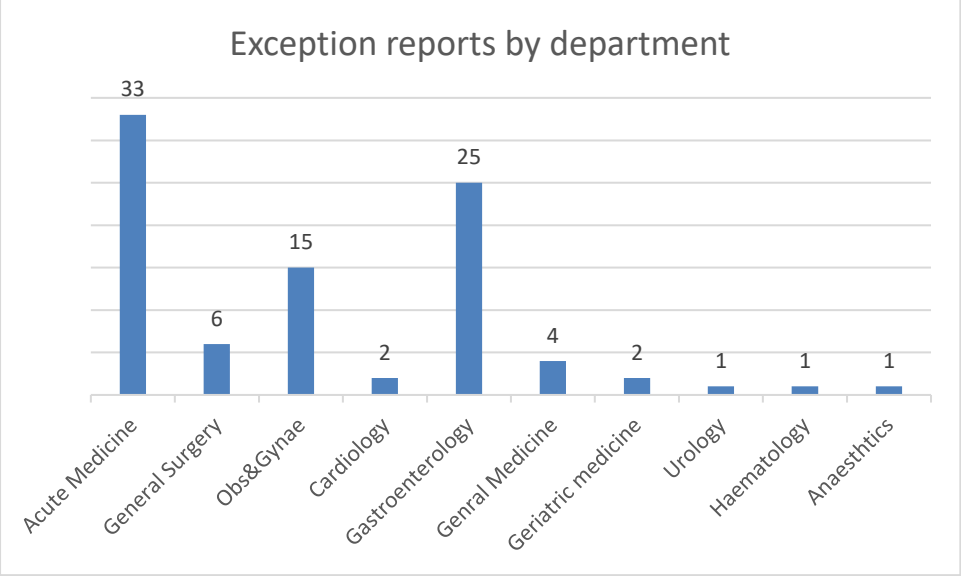
Milton Keynes University Hospital (MKUH) provides the following in support of the trainee doctors and the exception reporting process:

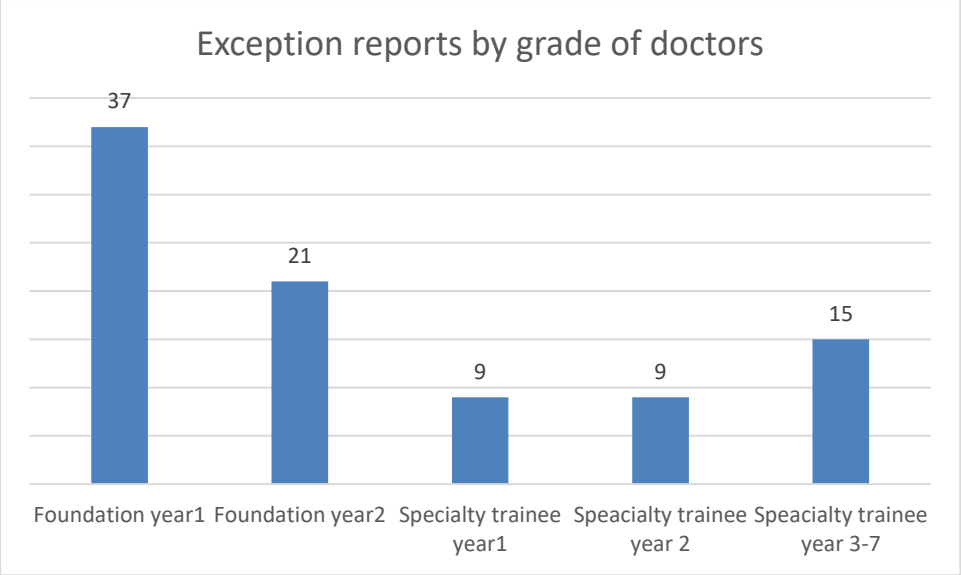
- An online exception reporting tool.
- A Guardian of Safe Working Hours (consultant responsible for overseeing compliance on safe working hours).
- A Director of Medical Education (consultant responsible for overseeing the quality of educational experience).
- A Junior Doctor Forum to discuss exception reports, fines and other arising issues affecting trainee doctors at the Trust.

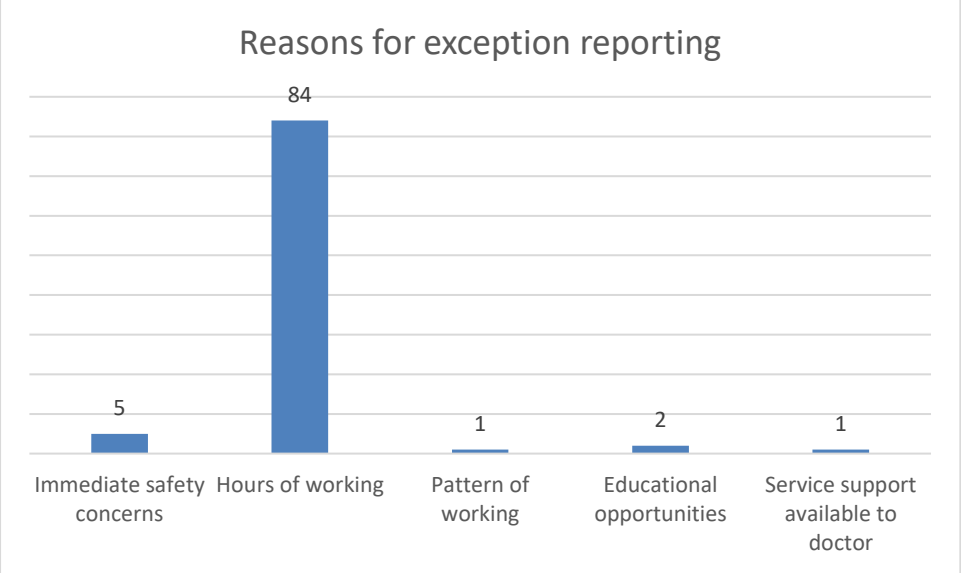
Number of doctors/dentists in training (total)	145
Number of doctors/dentists in training on 2016 T&C (total)	145
Amount of time available in job plan for guardian to do the role	1PA (4 hours per week)
Admin support provided to the guardian (if any)	0.2 WTE (via Medical Director's Office)
Amount of job-planned time for educational supervisors	0.25 PAs per trainee (1 hour per week)

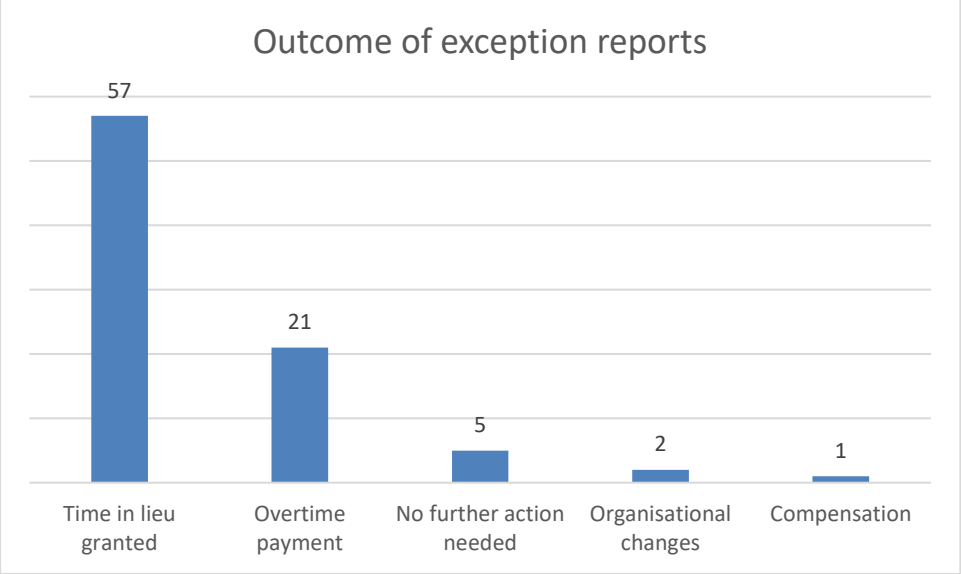
108 exception reports were raised from April 2020 – March 2021. A breakdown of the trends across the reporting period are as follows:






Exception reports by grade of doctors
37
21
9
9
15
Foundation year1
Foundation year2
Specialty trainee year1
Speacialty trainee year 2
Speacialty trainee year 3-7


Reasons for exception reporting
84
5
1
2
1
Immediate safety concerns
Hours of working
Pattern of working
Educational opportunities
Service support available to doctor


Outcome of exception reports
57
21
5
2
1
Time in lieu granted
Overtime payment
No further action needed
Organisational changes
Compensation

In summary, reports peak from October to December with 49% (53) of the entire year's exceptions being raised in these three months alone. Most exception reports were raised by FY1 trainee doctors in Acute Medicine and FY2 in Gastroenterology areas. As explained above, that peak from Gastroenterology department was due to staff shortage at registrar level, which was identified, and changes had been made. The acute medicine peak was mainly due to staff shortages during second wave of covid-19 for multiple issues e.g., covid sickness, isolation and increased number of acutely unwell patients across medical wards.

96% (104) of reports relate to hours exceptions and 1.85% (2) to educational issues, 0.93% (1) to service support and 0.93% (1) due to work patterns.

3. Reports with Immediate Safety Concerns:

Of the 88 exception reports raised in the reporting period, five were described (by the reporter) as ICSs.

	Grade			
Division/Specialty	**CT1**	**CT2**	**FY1**	**Grand Total**
Medicine	**3**	**1**		**4**
Acute Medicine	3	1		4
Surgery			**1**	**1**
General surgery			1	1
Grand Total	**3**	**1**	**1**	**5**

- **Gastroenterology:** One ISC regarding lack of junior and senior support on gastro ward on the December change-over week. This was urgently reviewed and changes were made in relation to middle grade support. There were no associated clinical incidents.

- **Acute Medicine:** Two safety reports, one due to lack of ward SHO cover for medicine nights due to sickness and a concern around a persistent need to work extra hours (to ensure safety) on the COVID respiratory ward. These reports are still being looked into and have been escalated to the medicine rota co-ordinator and relevant educators.

  Action: Medical SHO rota has been changed and cover has been increased from three to four SHOs at night.

  One other acute medicine ISC was due to staying late to deal with an acute emergency which impacted on physical and mental wellbeing of the doctor.

  Action: Detailed discussion with the doctor from his supervisor about the situation. Reassurance and support was provided.

- **General Surgery/Urology**: One ISC relating to a busy Urology weekend on calls due to high volume of acute patients, busy operating list which resulted in the FY1 Doctor working in a 12 hour shift without breaks and finishing late.

  Action: After discussion with the trainee, a diary exercise among surgery/urology juniors has been suggested to review the work schedule to look how to make changes on the Rota. An overtime payment was offered to the FY1.

4. **Departmental work schedule reviews:**

Obstetrics and Gynecology: From April 2020 – June 2020: There were 13 exception reports all from Obstetric and Gynecology junior doctors. Trends identified were in trainees having to stay late to finish admission notes and a lack of adequate structured evening handover.
Action: This was reviewed by CSU lead and departmental consultants and changes to the rota was made along with a separate consultant to cover Gynaecology during daytime and consultants to allow trainee adequate time for hand over in the evening to finish shift on time. These changes which did improve the issues and reduced future exception reporting.

Acute medicine: Due to the exception report with safety concerns for on call night cover for medicine regarding not enough junior doctors at night, night medicine SHO Rota has been reviewed and night junior doctor cover has been raised from three to four.

Gastroenterology: During September- December,2020 period there were increased number of exception reports (25) from Gastroenterology department. Most of the reports were due to staying late because of acute patients and lack of adequate middle grade doctor support. This was escalated and extensively discussed with junior doctors and consultants. There was a SPR rota gap associated with the delayed start date of one SPR.
Action: SPR rota gap had been filled and changes were made to ensure constant middle grade cover on the ward, SPR baton bleep and accessible middle grade rota to the junior. These arrangements had made significant differences and reduced exception reports from Gastroenterology department.

Urology: Review also been focused on Urology department because junior doctors raised concerns and 4 exception reports in March,2021 with 1 with safety concerns. Junior doctors' concerns were heavy workload on the ward, unable to attend theater and teaching opportunities because of heavy workload.
Action: Detailed discussion and review was undertaken by the consultants, CSU and clinical leads, and the operational manager. One-to-one discussions with junior doctors. As new Rota was introduced to ensure defined workload, to reduce excessive ward workload and allow junior doctors to attend theater and teaching opportunities. A work diary exercise also being carried to look for further scope for improvement.

5. Vacancies

The tables below summarise trainee vacancies by specialty and Quarter.

Specialty	Grade	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Medicine							
Gastro	FY1-ST2	0	0	0	1	0	0
Gastro	ST3+	1	1	1	1	1	1
MAU	FY2-ST2	1	1	1	1	0	0
MAU	FY1	0	1	1	1	0	0
Surgery							
General Surgery	FY2	1	1	1	1	0	0
General Surgery	ST3+	1	1	1	1	1	1
T&O	ST3+	0	0	0	0	1	1
Anaesthetics	ST3+	1	1	1	1	0	0
ENT	FY2	1	1	1	1	0	0
Women & Children							
Obs & Gynae	FY2-ST2	0	0	0	0	2	2
Core Clinical							
Histopathology	ST3+	2	1	1	1	1	1
Other							
OH	ST3+	1	1	1	1	1	1
GP	FY2	1	1	1	1	0	0
Psychiatry	FY2	1	1	1	1	0	0
Total		11	11	11	12	7	7

Vacancies: Oct 2020 - Dec 2020				
Specialty	Grade	Oct-20	Nov-20	Dec-20
Medicine:				
Gastro	FY2 - ST2	0	0	0
Gastro	ST3+	0	0	0
MAU	FY2 - ST2	0	0	0
MAU	FY1	0	0	1
ED	ST3+	1	1	1
Surgery:				
General Surgery	FY2	0	0	0
General Surgery	ST3+	1	1	1
T&O	ST3+	1	1	1
Anaesthetics	ST3+	0	0	0
ENT	FY2	0	0	0
Women & Children:				
Obs & Gynae	FY2 - ST2	2	2	0
Paeds	FY2 - ST3			
Core Clinical:				
Histopathology	ST3+	1	1	0
Other:				
OH	ST3+	1	1	1
GP	FY2	0	0	0
Psychiatry	FY2	0	0	0
Total		**7**	**7**	**5**

6. Fines

Fines are levied by the Guardian of Safe Working hours on departments for the following reasons:

- a breach of the 48-hour average working week (across the reference period agreed for that placement in the work schedule).
- a breach of the maximum 72-hour limit in any seven days.
- that the minimum 11 hours' rest requirement between shifts has been reduced to fewer than eight
- Where a concern is raised that break have been missed on at least 25% of occasions across a four-week reference period, and the concern is validated and shown to be correct.

Distribution of 'fine monies' is then agreed at the junior doctor forum and individual doctors awarded penalty rate payments for the hours (above normal bank rate) that take them over these contractual limits. NHS employers make it quite clear that fines should be the exception and should not happen if the system of exception reporting is responsive and working well (Guardian fines factsheet, NHS Employers).

Within the period of this report there have been no fines levied, although it is apparent that trainees on Rota patterns up to a 48-hour average week are coming close to the 48-hour average breach. The contract does not exclude 48-hour patterns, but this becomes a problem when excess hours are reported, and compensation is being award without consideration of giving time off in-lieu. The time off in-lieu would bring the average hours back down and provide the trainee with compensatory rest.

A fine has been averted as our Rota designs include an element of prospective cover (assuming a percentage of additional hours to cover colleagues leave) and as the order / repetition of Rota cycle over a training post will vary. Educational Supervisors and Rota Coordinators are being advised to explore time off in lieu, as the preferred option.

There have been no fines in last year.

7. Educational Issues

There have been two reports raised by trainees regarding educational opportunities in this year, compared to 24 reports in the previous year.

The two reports (one anesthetic, one IMT medicine) related to being unable to attend protected teaching sessions due to acute duty commitments. These have been looked in to within relevant departments and arrangements been made to enable trainees to attend teaching.

8. Junior Doctor Forum

The August 2016 Terms and conditions require that the Guardian and Director of Medical Education run a Forum for trainee doctors. This forum is both to provide advice, update, and encourage open discussion of issues with trainee doctors and to agree distribution of fines levied by the Guardian.

MKUH has run regular junior doctor forums since August 2017. This years' meetings have been chaired by Dr Carrie Anderson, CT2, Medicine and Dr James Allsopp, FY2. Standing agenda items include:

- Updates from Chairman, Guardian, DME, Local Negotiating Committee and Medical Staffing
- Round table discussion from specialties on issues arising since last meeting.
- Improvement ideas or up and coming changes.

Minutes are taken and shared with all junior doctors, Rota Coordinators, Operational and General Managers, the Director of Clinical services, and Medical Director (the Medical Director has attended 2/4 meetings this year).

9. Ongoing action plans:

For trainees: To continue to encourage trainees to raise their concerns about working hours and rotas through exception reporting,

- GOSWH will continue to share a monthly email bulletin (reports made and actions taken).
- Develop a flowchart for the trainees how to complete and the process of exception reporting.
- To include the exception report flowchart in the induction documents to be sent to all new starters from August 2021.
- GOSWH will continue to attend Foundation teaching sessions, departmental teaching sessions on a quarterly basis to discuss departmental issues.

For trainers: For better understanding of exception process and to provide adequate support to the trainees:

- GOSWH will continue the monthly information bulletin.
- GOSWH (and the Medical Director) will continue to discuss (and advocate) the exception reporting process in departmental meetings and in Medical Advisory Committee (MAC) meetings.
- GOSWH is developing a flowchart on the details of exception reporting and timelines, which to be sent to all the consultants and the new starter consultants with their induction packs.

10. Decisions required from Trust Board

This report is for information and assurance only.

To clarify reporting arrangements for the GOSWH going forward, it is proposed that monthly bulletins continue. Every quarter, three of these bulletins will be presented at Workforce Board (with a brief covering paper on trends and items for escalation). The annual report will continue to be presented at a meeting of Trust Board in public.

Appendix

References:

NHS Employers (2017), Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016, Version 2, 30th March 2017, Available online at:

http://www.nhsemployers.org/-/media/Employers/Documents/Need-to-know/Terms-and-Conditions-of-Service-for-NHS-Doctors-and-Dentists-in-Training-England-2016-Version-2--30-March-2017.pdf

NHS Employers (2017), Guardian fines factsheet, Updated 4th January 2017, Available online at:

https://www.nhsemployers.org/-/media/Employers/Documents/Need-to-know/Guardian-fines-factsheet.pdf?la=en&hash=6E91D80F0899FEBAD76A55EA5DB5242EDDB2DEBD

Definitions:

Work schedules – Each trainee doctor is given a document (work schedule) that describes the expected working hours, shift patterns and pay.

Exception reports – Trainee doctors are provided with a mechanism to report (electronically) when:

"When their day to day work varies significantly and/or regularly from the agreed work schedule"

(NHS Employers 2016, terms and conditions of service for NHS Doctors and Dentists in Training, p 31)

Exceptions are reported by the trainee and reviewed by the Educational Supervisor (typically a consultant) and an outcome agreed.

Work Schedule Reviews – A review of the rota design and staffing numbers due to exception reports.

TOIL – Time off in lieu, for extra work done at a previous time.

Fines – Fines levied by the Guardian when a service has breached the conditions set out in the August 2016 Terms and Conditions.

ISC – Immediate Safety Concern is indicated when a doctor feels there is an immediate substantive risk to safety of patients when raising an exception report.

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Public Board	July 2021
Report title:	Significant Risk Summary Report	**Agenda item: 16**
Lead director **Report author** **Sponsor(s)**	**Paul Ewers** **Kate Jarman**	**Risk & Systems Manager** **Director of Corporate Affairs**
FoI status:	**Disclosable**	

Report summary	The report includes all significant risks across all Risk Registers, where the Current Risk Rating is graded as 15 or above, as at 30th June 2021			
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [ ]	**Decision** [ ]
Recommendation	The Public Board is asked to note and discuss the contents within the report, in to ensure risks are being robustly and actively managed across the Trust.			

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

Report history	The significant 15+ risks are an ongoing agenda item
Next steps	Public Board to note and discuss the contents within the report
Appendices	Significant 15+ Risks

Executive Summary:

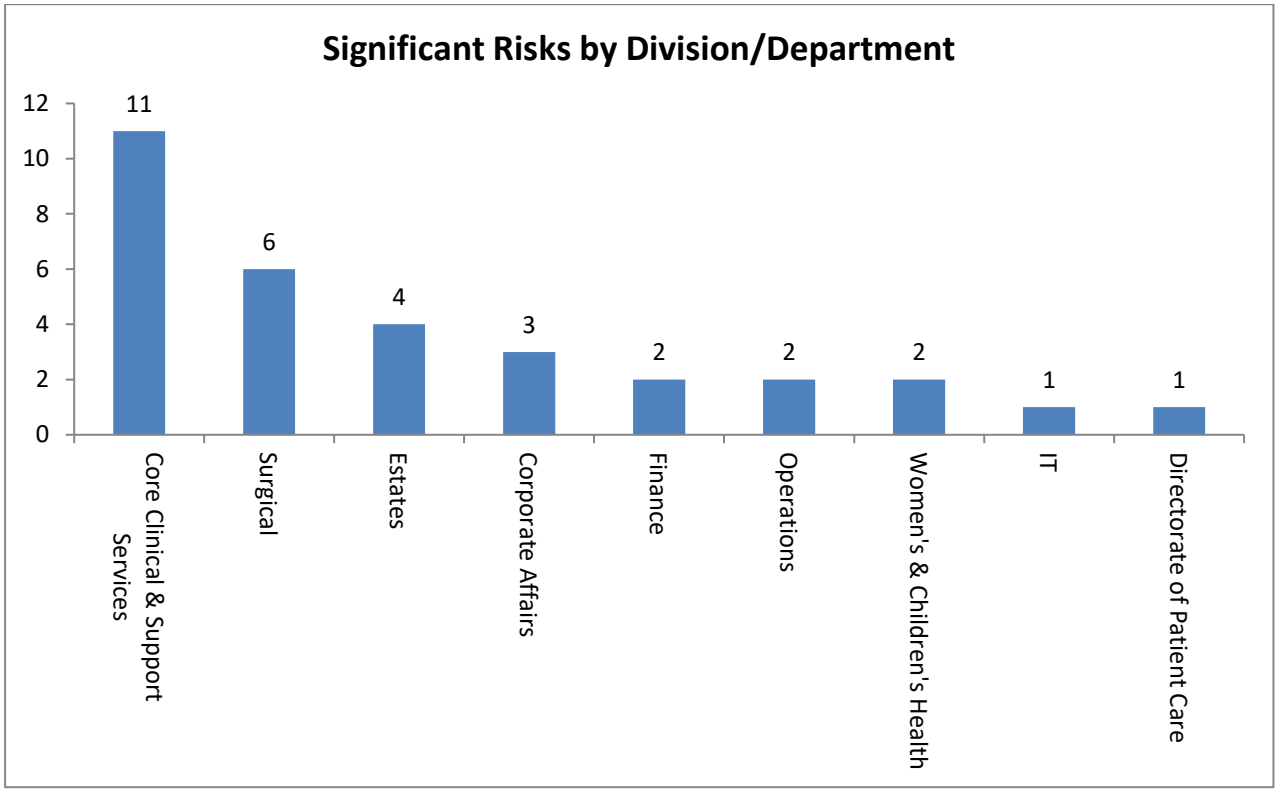
This report shows the profile of significant risks across the Trust by type and area.

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

The Board is asked to note the content of this report

Risk Profile

- There is a total of 32 significant risks identified on Risk Registers across the Trust:



- Of these risks 7 are overdue their review date and have been escalated for corporate review.

- There were three new significant risks added during May/June 2021:

  ID3087 - *Psychological wellbeing of staff on the Intensive Care Unit is at risk due to managing complex patients and families specifically following extraordinary circumstances such as the Pandemic, sudden death, and distressing situations with relatives.*
  ID3091 - *Lack of access to the current Medical Equipment Asset Management Database.*
  ID3033 - *The Pathology Laboratory Information Management System (LIMS) system is at risk of failure, virus infiltration and being unsupported by the supplier.*

- There were three significant risks closed within the last month:

  ID3040 - *There is a risk that the CO2 laser machine in Ear, Nose & Throat (ENT) Theatre could fail then the company / manufacturer may not be able to support the maintenance / repair.*
  ID3066 - *The Neurology Department runs a Botox injection clinic for patient staffed by a single consultant; this consultant is now on long term sick leave. There are 50 patients awaiting review and treatment in clinic.*
  ID2438 – *Research & Development Department has yearly running staff contracts, not permanent contracts and we are not able to provide longer term contracts for the team*

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

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

- One of the risks are categorised as being tolerated even though their Current Risk Rating is higher than the target (i.e. the level of risk identified as tolerable). This risk is being reviewed by Corporate Nursing with a view to updating the risk.

- There are no Actions identified for 11 of the risks (down one from the previous report). It should be noted that, for many of these risks, actions have been and are being undertaken, however the risks have not been updated on Datix. A process has commenced for all risks to have an additional formal annual review (see below). One of the aims of this new process is to ensure that all actions are added to the risk register for completeness and to support the ongoing management of the risk.

Corporate Risk Register

Trust Executive Group (TEG) approved the introduction of a Corporate Risk Register. This to enhance the ability to manage risks that impact more than one area of the Trust. It will also enable the Divisions to escalate significant risks that they do not have the capacity/ability to manage. Risks will not automatically move between Divisional to Corporate Risk Registers purely based on Current Risk Rating (which is currently the case), but by discussion and agreement by the Risk Board and/or TEG. This risk register will be used to ensure robust operational management of risk.

It is recognised that TEG need to have oversight of all significant risks. Therefore the Significant Risk Register will be used as a mechanism for reporting all significant risks to TEG on a regular basis.

Divisions and Departments have been asked to escalate risks that meet the criteria for the Corporate Risk Register to the Risk & Systems Manager. These will go to the next Risk & Compliance Board and then to TEG for approval

Significant Risk Register Summary

Division	Description	Controls in place	Current Risk Level
Operations	The risk of capabilities in responding to a Novel Coronavirus (COVID-19) impacting on patient care within clinical and non-clinical services, with the inability to maintain safety for staff and patients due to national pressures on supplies and infrastructure.	COVID-19 operational and contingency plans in place reviewed through Silver and Gold command structure, with meeting recorded through action logs PPE logged daily covering delivery and current stock	HIGH
Women's & Children's Health - Children's Health	Overcrowding and insufficient space in the Neonatal Unit, exacerbated by need for social distancing due to COVID-19	1. Reconfiguration of cots to create more space and extra cots and capacity, though this still does not meet PHE or national standards 2. Parents asked to leave NNU during interventional procedures, ward rounds etc. Restricted visiting during COVID 3. Added to capital plan 4. Feasibility study completed	HIGH
Women's & Children's Health - Women's Health	Inability of Trust to provide maternity care locally for some women (during times of peak demand on service, delays in clinical care) and potential increased readmission rate due to reduced length of stay	Daily huddle & bed state reviews Escalation process Review of obstetric clinical pathways Three times a day Maternity specific safety huddle (March 2021) Regular reviews with Exec Team	HIGH
Finance	If the future NHS funding regime is not sufficient to cover the costs of the Trust, then the Trust will be unable to meet its financial performance obligations or achieve financial sustainability.	1. Cost and volume contracts replaced with block contracts (set nationally) for clinical income;2. Top-up payments available where COVID-19 leads to additional costs over and above block sum amounts (until September 2021); 3. Budgets to be reset for FY22 based on financial regime; financial controls and oversight to be reintroduced to manage financial performance.4. Cost efficiency programme to be reset to target focus on areas of greatest opportunity to deliver	HIGH
Core Clinical & Support Services - Pharmacy	The risk is there will be insufficient staff in pharmacy to meet demands of the organisation and ensure patient safety in the use of medicines.	Actively recruiting, listening events with staff, identifying quick wins from staff to reduce turnover, implementing 1-1 system to support staff, reviewing work activities of 8a's and above	HIGH

Division	Description	Controls in place	Current Risk Level
Corporate Affairs	There is a risk that not all known incidents, accidents and near misses are reported onto Trust Incident Reporting System (Datix) and that they will not be robustly investigated within the required timescales	1. Incident Reporting Policy 2. Incident Reporting Mandatory/Induction Training 3. Incident Reporting Training Guide and adhoc training as required 4. Datix Incident Investigation Training sessions 5. Daily review of incidents by Risk Management Team to identify potential Serious Incidents and appropriate escalation 6. Serious Incident Review Group (SIRG) ensure quality of Serious Incident Investigations 7. SIRG ensure appropriate reporting of Serious Incidents to Commissioners 8. Staff able to have automatic feedback following investigation approval 9. Incident Reporting Awareness Campaign - September 2017 10. Standard Operating Procedure re Risk & Governance Team supporting the closure of incident investigations during unprecedented demand on service (e.g. Covid-19 Pandemic) approved - February 2021 11. Patient Safety Framework introduced	HIGH
Operations	Risk that patient discharges will significantly be delayed, especially those requiring complex coordination of the discharge process	Covering a small number of shifts with former Discharge Coordinator carrying out bank shifts, when available. Offered bank shift to train an Agency Nurse who has shown an interest in the role. Recruited in to one vacancy and interviewing in to Bucks Coordinator role on 2/8/19. Reviewed role and delegated minor responsibilities to Rotational Operations Liaison Officers. Support requested from key nursing areas who have the skills to support a number of aspects relating to the role & discharge process- awaiting confirmation	HIGH

Division	Description	Controls in place	Current Risk Level
Finance	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	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 Trust Executive Group.	HIGH
Core Clinical & Support Services - Clinical Support Services	The risk is that the trust is failing in its statutory legal duty under the Health & Safety at Work etc. Act 1974, Management of Health & Safety at Work Regulations 1999, Workplace (Health, Safety & Welfare) Regulations 1992 and Display Screen Equipment Regulations 1992 to provide a safe and well-maintained place of work including welfare facilities for Dietetic staff	Due to the number of staff within the area, some staff have to work from home (rota basis) Mobile air conditioning units distributed. Plumbed in water cooler in situ. .	HIGH
IT	IF the internal Trust telephone systems are not upgraded, THEN they will fall into a state where they cannot be supported by the Trust's IT Department or any third-party suppliers, LEADING TO potential loss of telephone systems either in small areas or across the Trust. This would have a significant impact upon operational procedures, especially during critical or busy periods.	Support in place, upgrade ETA Pending Capital funding	HIGH
Core Clinical & Support Services - Diagnostic & Screening	The 10yr old mammography machine in BS2 could fail due to its age. The increased amount of unplanned downtime this year is consistent with aging equipment. With the introduction of new technologies the availability of replacement parts is a worry. A replacement part needed to be shipped from Chicago.	Comprehensive service contract All faults reported immediately to external contractor / physicist for support. Robust QA systemin process to monitor system performance. This is reviewed weekly by medical physics.	HIGH

Division	Description	Controls in place	Current Risk Level
Surgical - Musculoskeletal	There is a risk to head injury patients not being appropriately cared for as they are not being treated in accordance with NICE guidance (CG176: Head injury: assessment and early management, updated September 2019)	1, 2 & 3. Preventive controls - On going discussions with Senior Medical Team - CSU Lead to escalate via trauma network - Alert process is in place for escalation within T&O & externally. - Resources available at tertiary site for advice/support 1, 2 c& 3. mitigating controls - Policy for management of head injuries has been developed - Awaiting appointment of head injury liaison Nurse	HIGH
Corporate Affairs	Clinical Governance and Imaging staff are unable to meet statutory and mandatory Good Governance requirements and accreditations if IT systems do not support their remit.	System in place but requires updating and Q pulse which manages Trust documentation is no longer able to archive since the shared drive was moved. Updates made to Q-Pulse and SharePoint	HIGH
Estates	IF the estates infrastructure contingency plans are not adequately tested THEN in the event of a infrastructure failure plans may not succeed LEADING TO contingency plans not being effective and to potential loss of services, poor patient experience, financial loss and loss of reputation	1. Partially tested Contingency Plans. 2. Review of Business Continuity Plan review process completed in conjunction with Gordon Austin assisting with reviewing process and plans. 3. Continuity plans reviewed and shared with team. 4. Noted that plans partially tested during the recent flooding incident. 5. Emergency Planning Officer has been sent the plan for review and comment. 6. Met EPO and reived document, awaiting publication.	HIGH
Estates	The current bleep system (main system A and back-up system B) is obsolete, and no maintenance support contract is available from the company. The risk is that the equipment may not be able to be repaired if failed.	-DISCUSSED WITH LINE MANAGER AND ESCALATED -TEMPORARY RADIO COMMUNICATION SYSTEM 3. User group formed with IT & EBME to identify options	HIGH
Core Clinical & Support Services - Diagnostic & Screening	Delayed detection of breast screening cancers due to COVID 19	Restart proposal approved by the Trust, SQAS and PHE. Guidance issued as to the management of the women to ensure that no-one is missed has been issued by Hitachi/PHE and has been implemented by the programme.	HIGH
Core Clinical & Support Services - Diagnostic & Screening	Lack of space for appropriate management of CT and MRI with additional issues of lack of scanners to manage the increasing demand.	Extended working hours and days, some scans sent off site to manage demand. Reduced appointment times to optimise service. 1.12.20 no change to risk rating services remain challenged due to lack of basic capacity made worse by Covid social distancing and cleaning issues. IS provider approached to provide more MRI capacity	HIGH

Division	Description	Controls in place	Current Risk Level
Core Clinical & Support Services - Clinical Support Services	Unable to meet the demand for existing patients leading to increased waiting times Unable to develop existing outpatient services Unable to optimise student placements	1. Extended working hours 2. Introduction of shift pattern 3. Introduction of telephone triage clinics 4. Group treatment sessions	HIGH
Core Clinical & Support Services - Clinical Support Services	There is a risk that the Women & Men's Health Physiotherapy Service is unable to meet its referral demand	Non clinical time including training, development and audit are being minimised to increase the number of available patient appointments Job plans are being completed by all staff to show impact on workload Patients are being booked into group where possible instead of individual appointment slots Recruited to all vacant posts To explore options for supporting dictation of letters to free up clinical capacity.	HIGH
Directorate of Patient Care	The MUST conformance criteria were set out in the NHS accessible information specification for compliance by the 31st July 2016	Some of the meeting individual needs resources identified i.e.BSL sign language interpreters, braille, easy read Ongoing EPR agile preparation events E Care launch plan in progress	HIGH
Core Clinical & Support Services - Diagnostic & Screening	There is a risk that the available space within Cellular Pathology will not be enough to meet the demands of the service as workload continues to expand	Storage of specimens minimised. No unnecessary specimens stored Storage period reduced from 6 weeks to 4 weeks with the approval of Pathologists and Clinical Lead	HIGH
Core Clinical & Support Services - Clinical Support Services	Increasing numbers of patients being added to the physiotherapy outpatient waiting list, in addition to those on hold due to the COVID-19 pandemic, resulting in waiting times of well over 18 weeks for any type of intervention. A further increase in referrals may result from patients with post-COVID symptoms	- Virtual management of patients - Video and telephone clinics - Additional IT sourced to support virtual management - Reconfiguration of department to support virtual working and enable social distancing along with staff working from home - recovery plans are being written/in place to enable essential patients to be seen in the department of a face to face basis - Educational material including exercise programmes and access to YouTube clips are made available to patients	HIGH

Division	Description	Controls in place	Current Risk Level
Corporate Affairs	There is a risk that changes required to practice are not implemented and we are not meeting best practice criteria	Audit report templates available to identify audit action plans. However these are not always being utilised and actions are not Always evidenced and monitored Monitoring via Clinical Audit & Effectiveness Committee (CAEB) TOR CAEB revised to include quality improvement, GIRFT etc Escalation/exception reporting to Management Board Refresh of Sharepoint data base to assist with data capture, with Level 1 audit a priority Transformation Team audit	HIGH
Core Clinical & Support Services - Clinical Support Services	The risk is that the paediatric team cannot provide a full dietetic service to children and young people in the Milton Keynes area	Existing staff are working some additional hours but this remains insufficient to meet the needs of the service.	HIGH
Estates	The current risk is that there is not enough space in the Medical Equipment Library(MEL) to carry out the required cleaning process to comply with the appropriate guidelines set by CQC and MHRA.	Staff members are taking processed equipment straight to the shelving areas as soon as it is cleaned to avoid cross contamination. This ensure equipment is kept separate, but this is not a productive method of working.	HIGH
Core Clinical & Support Services – Diagnostic & Screening	The Pathology LIMS system is at risk of failure, virus infiltration and being unsupported by the supplier.	Systems manager regularly liaises with Clinysis to rectify IT failures. Meetings with S4 to establish joint procurement take place periodically. Project Manager role identified to lead project for MKUH.	HIGH
Estates	Lack of access to the current Medical Equipment Asset Management Database.	IT provided access to remote desktop to connect to the server directly (Medical Equipment Library only), CE is to follow.	HIGH

Division	Description	Controls in place	Current Risk Level
Surgical - Anaesthetics & Theatres	Psychological wellbeing of staff on the Intensive Care Unit is at risk due to managing complex patients and families specifically following extraordinary circumstances such as the Pandemic, sudden death, and distressing situations with relatives.	Clear leadership and team support. Staff health and well-being initiatives. Access to external psychological support. Individual stress risk assessments for staff.	HIGH
Surgical - Head & Neck	Insufficient qualified dental nurses to facilitate in assisting Clinicians with the running of OMFS Outpatient clinics.	15/05/2021 business case is going to pain in May/June. Team are looking into using a specialised agency for Dental Nurses and are liaising with Matron/ HoN to establish feasibility of this. HCA`s can be utilised in a few Outpatient OMFS clinics that can be access via Trust Bank, these would need to be regular individuals due to the nature of the work required. However this will not mitigate the shortage of qualified dental nurses required to assist in the running of the Orthodontic and OMFS service.	HIGH
Surgical - Head & Neck	Insufficient qualified dental nurses to facilitate in assisting Clinicians with the running of Orthodontic Outpatient clinics.	HCA`s can be utilised in a few Outpatient OMFS clinics that can be access via Trust Bank, these would need to be regular individuals due to the nature of the work required. However this will not mitigate the shortage of qualified dental nurses required to assist in the running of the Orthodontic and OMFS service.	HIGH
Surgical - Head & Neck	Clinical data stored on visual field machine hard drives for Ophthalmology Department patients will not be transferred between two machines (visual field analysers & Windows XP computer). There is a risk of irretrievable loss of patient data when manually transferring data using USB sticks.	Data is currently stored on visual machine hard drives and Windows XP computer. It has been recommended that Data is exchanged using unencrypted USB drives.	HIGH
Surgical – Musculoskeletal	With the implementation of green pathways for elective care patients, the Trauma and Orthopaedic department has lost capacity to escalate on to elective lists for trauma patients. As such with just one trauma list per day, there may be insufficient capacity to meet trauma needs.	Divisional Director for Operations to work with T&O and Theatre teams to implement all day weekend emergency theatre lists. Utilisation of theatre pm 1 for procedures that do not include metal work twice a week if staffing is available. Cancellation of elective activity if required.	HIGH

Recommendations:

The Board are asked to review and discuss this paper.

Definitions:

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

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

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

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

Significant Risk Register

ID	Ref	Triumvirate Annual Review Date	Executive Responsible	Risk Owner	Division	Specialty	Description	Cause	Impact	C	L	Inherent Risk Rating	Inherent Risk Level	Controls in place	Assurance on Controls	C	L	Current Risk Rating	Current Risk Level	Gaps in Controls	C	L	Target Risk Rating	Target Risk Level	Treatment Category	Action Plan Summary	Date Risk Last Reviewed	Trend	Trend Rationale	Review Due?
824			Deputy CEO	Eagles, Phil	Estates	Estates	IF the estates infrastructure contingency plans are not adequately tested THEN in the event of a infrastructure failure plans may not succeed LEADING TO contingency plans not being effective and to potential loss of services, poor patient experience, financial loss and loss of reputation	untested contingency plans, in the event of a infrastructure failure plans may not succeed	an increased safety and service disruption risk to patients and staff.	5	4	20	HIGH	1. Partially tested Contingency Plans. 2. Review of Business Continuity Plan review process completed in conjunction with Gordon Austin assisting with reviewing process and plans. 3. Continuity plans reviewed and shared with team. 4. Noted that plans partially tested during the recent flooding incident. 5. Emergency Planning Officer has been sent the plan for review and comment. 6. Met EPO and reived document, awaiting publication.		5	3	15	HIGH	Waiting publication of agreed document.	5	1	5	LOW	TREAT - above tolerable level - appropriate cost-effective control required	Testing regimes to be further developed with Gordon Austin	26/05/2021	No Change	see comments	30/09/2021
1740		24/03/2021	Director of Corporate Affairs	Worth, Mrs Tina	Corporate Affairs	Clinical Governance	There is a risk that changes required to practice are not implemented and we are not meeting best practice criteria	If recommendations and actions from audit are not evidenced, monitored and completed in the Trust	Potential impact on the top 3 Trust objectives (patient Safety, Clinical Effectiveness, Patient Experience) Potential poor quality of service and associated impact on resources CQC concerns re audit activitu & learning from national audits	3	5	15	HIGH	Audit report templates available to identify audit action plans. However these are not always being utilised and actions are not Always evidenced and monitored Monitoring via Clinical Audit & Effectivess Committee (CAEB) TOR CAEB revised to include quality improvement, GIRFT etc Escalation/exception reporting to Management Board Refresh of Sharepoint data base to assist with data capture, with Level 1 audit a priority Transformation Team audit	Limited assurances from RSM audit review Sharepoint has ability for audit action plans to be attached with evidence of completion but audit cycle not completed to this level Jan - Feb 2020 repeat RSMUK reveiw due Limited assurances from RCB?CAEB - pals to move to integrated governance & divisional meetings approach	3	5	15	HIGH	Capturing audit evidence at specialty CIG meetings including actions to improve practice or examples of good practice. Divisional audit reports at CAEB detailing compliance on Level a audits Sharepoint evidence to support action plan from audits - review & overhaul of system scheduled for November at Risk Management Team Divisional accountability at Performance Management Board Implementation of new integrated governance agenda National audits on hold & local audits & audit meetings limited due to Covid pandemic	1	3	3	VLOW	TREAT - above tolerable level - appropriate cost-effective control required	Implementation of KPMG action plan, to be monitored by Audit Committee Meeting with CGLs to review Sharepoint format for capturing audit completion/complinace to best ensure this helps give accurate data & evidence Risk Systems Business Case with potential for Document Management system	23/04/2021	Increased	KPMG Audit / CQC	30/06/2021
1874			Director of Patient Care / Chief Nurse	Goodman, Mrs Julie	Directorate of Patient Care	PPI	The MUST conformance criteria were set out in the NHS accessible information specification for compliance by the 31st July 2016	The Trust currently cannot meet all of requirements set out in this specification which is driven by the NHS England, the Equality Act 2010 and Care Act 2014 to ensure patients with a disability are not discriminated against.	1. The CCG as part of the Quality Schedule 2. The CQC recognise the role of this standard as an indicator of high quality care for people with particular information and communication support needs and will be included as part of their inspections of a service. 3. A workstream to the patient led assessment of the care environment (PLACE). Identiication of non compliance could lead to an enforcement action from any of the above performance monitoring stakeholders.	3	5	15	HIGH	Some of the meeting individual needs resources identified i.e.BSL sign language interpreters, braille, easy read Ongoing EPR agile preparation events E Care launch plan in progress	Patient Experience team are working with external providers and will be picked up as part of the Quality Account	3	5	15	HIGH	Go live date agreement for EPR - Cerner have confirmed that the system will allow the required alert flags etc. Equality and Diversity Trust legal requirements to be identified, documented in policy and staff advised. This impacts on all policies and guidelines. Interpreting and translation policy - contract now agreed Gap analysis of patient information (sits with Patient Experience) - what is available?	3	2	6	LOW	TOLERATE - at lowest practicable/cost-effective level	Steering Group to monitor progress Review of proces for patient information publication & availability	28/02/2019	No Change	First review	28/08/2019
1970			Director of Clinical Services	Hyem-Smith, Ms Celia	Core Clinical & Support Services - Clinical Support Services	Physiotherapy	Unable to meet the demand for existing patients leading to increased waiting times Unable to develop exisitng outpatient services Unable to optimse student placements	The cause is the lack of clinical space available for patient treatment	The impact is failure to meet contracts, lost revenue, poor patient experience and poor staff morale	3	5	15	HIGH	1. Extended working hours 2. Introduction of shift pattern 3. Introduction of telephone triage clinics 4. Group treatment sessions		3	5	15	HIGH	Amalgamation and integration of department space and teams to utilise current space more efficiently. Potential to increase clinical space but this would require significant investment.	3	5	15	HIGH	TREAT - above tolerable level - appropriate cost-effective control required	Review of space in Therapies	17/02/2021	No Change	No change	31/05/2021
2297		07/05/2021	Director of Clinical Services	Thwaites, Elizabeth	Core Clinical & Support Services - Diagnostic & Screening	Pathology	There is a risk that the available space within Cellular Patholgy will not be enough to meet the demands of the service as workload continues to expand	Increasing workload requiring additional specimen storage, workspace additional equipment and additional staff	The department will be unable provide the storage space required to accommodate the increasing workload leading to 1. An inability to retain specimens for the period of time required to meet RCPath guidance 2. An increased risk of formalin spillage / increased levels of formalin vapour 3. Increasing risk to staff and to specimens because of cramped workspace e.g. Specimen reception area encroaches on cut-up area 4. Inability to safely operate and / or validate equipment 5. Insufficient space for record storage	3	5	15	HIGH	Storage of specimens minimised. Review of work flow and processes to improve space efficiency. Business Case has been accepted - plans to be confirmed regarding building work and expansion. Business case required for Laboratory furnishings and layout.	Controls are currently not effective due to increased workload and pressure of social distancing.	3	5	15	HIGH	Social distancing pressures in addition to digital expansion requiring further space.	3	2	6	LOW	TREAT - above tolerable level - appropriate cost-effective control required	Identify additional storage space Review space and workflow and identify activities that can be relocated Supervise build of new expansion Develop BC for internal build - Lab layout and furnishings Develop business case for space expansion into courtyard area	11/05/2021	No Change	Build Plans Approved	12/07/2021

Significant Risk Register

ID	Ref	Triumvirate Annual Review Date	Executive Responsible	Risk Owner	Division	Specialty	Description	Cause	Impact	C	L	Inherent Risk Rating	Inherent Risk Level	Controls in place	Assurance on Controls	C	L	Current Risk Rating	Current Risk Level	Gaps in Controls	C	L	Target Risk Rating	Target Risk Level	Treatment Category	Action Plan Summary	Date Risk Last Reviewed	Trend	Trend Rationale	Review Due?
2341			Director of Clinical Services	Stamp, Mr Jamie	Core Clinical & Support Services - Clinical Support Services	Dietetics	The risk is that the paediatric team can not provide a full dietetic service to children and young people in the Milton Keynes area	Insuffient capacity and on-going unsustainable demand for dietetic input for Paediatric patients (both inpatient and outpatient) Home Enterally Fed Paediatrics patients should be seen as part of community contract, currently this group of patients is being seen through our outpatient structure which is not adequate to meet their demands and needs. As a results of this staff are be stretched to cover a service that has not been resourced correctly which in turn impacts on the wider outpatient and inpatient work load. The current dietetic workforce is not able to meet the Increasing referral for children with diabetes, this means that these high risk groups of Children and	1. Patient care and patient safety will be at risk 2. Vulnerable children becoming nutritionally compromised. 3. Unable to assess and advise new patients and review existing patients in a timely manner. 4. Impacting on patients nutritional status and longer term dietary management on what is a very vulnerable group of patients. The majority of our caseload is infants or tube fed infants and children where there nutrition and growth is a priority.	3	5	15	HIGH	Existing staff are working some additional hours but this remains insufficient to meet the needs of the service.	Number of children / babies on HEF is monitored - 91 Dec 2020 Waiting list / request queue for paediatric dietetic OP's monitored	3	5	15	HIGH	There is insufficient to paediatric dietetics to manage the demand for outpatients, inpatients specifically the paediatric dietetic service is unable to deliver the national standards for Home Enterally Fed and Diabetic patients on the caseload.	1	3	3	VLOW	TREAT - above tolerable level - appropriate cost-effective control required	The need for a paediatric community dietetic service for patients on HEF being raised with CCG Current staffing provision is not sustainable and is not adequate for delivery the Home Entral feeding serivce which is not commissioned	04/05/2021	No Change	No change	01/07/2021
2640		24/03/2021	Director of Corporate Affairs	Worth, Mrs Tina	Corporate Affairs	Clinical Governance	Clinical Governance and Imaging staff are unable to meet statutory and mandatory Good Governance requirements and accreditations if IT systems do not support their remit.	Existing governance systems do not support meeting Trust /legal/stakeholder requirements and are unsupported by the Trust IT department or an external IT provider	Unable to meet statutory and mandatory Good Governance requirements and accreditations if IT systems do not support their remit.	5	5	25	HIGH	System in place but requires updating and Q pulse which manages Trust documentation is no longer able to archive since the shared drive was moved. Updates made to Q-Pulse and SharePoint	The controls are ineffective to manage documentation on such a scale to support accreditation. No response from Datix regarding system capabilities. IT support staff no longer able to support - new member of staff commences July 2018 for project to be handed over. Scoping exercise with other IT systems to Datix that may include a document management service. QPulse move to Microsoft Teams pending - further review of how manage documents	5	3	15	HIGH	Systems require updating Purchase of additional modules on Datix (business case fo Datix cloud/other system progressing)	2	1	2	VLOW	TREAT - above tolerable level - appropriate cost-effective control required	Risk Systems Business Case with potential for Document Management system	23/04/2021	No Change	New risk	30/06/2021
2740			Deputy CEO	Eagles, Phil	Estates		The current bleep system (main system A and back-up system B) is obsolete and no maintenance support contract is available from the company. The risk is that the equipment may not be able to be repaired if failed.	the equipment failure	failure of the current bleep system will have impact on patient care due to clinicians not being contacted via the bleep system	5	4	20	HIGH	-DISCUSSED WITH LINE MANAGER AND ESCALATED -TEMPORARY RADIO COMMUNICATION SYSTEM 3. User group formed with IT & EBME to identify options		5	3	15	HIGH	Identify costs of possible solutions and draft business case. Estates to own crash bleep solution; IT will own the clinical messaging and task-orientated communication functions. Digital Information Manager for Strategic estates will be driving the project to replace the emergency/urgent bleep replacement.	5	1	5	LOW	TREAT - above tolerable level - appropriate cost-effective control required		07/05/2021	No Change	no change	31/08/2021
2958			Deputy CEO	Ahmed, Ayca	Estates	Capital Planning	The current risk is that there is not enough space in the Medical Equipment Library(MEL) to carry out the required cleaning process to comply with the appropriate guidelines set by CQC and MHRA.	Space pressure increasing due to growth of the MEL and additional tasks	Lack of cleaning and processing space due to the growth of the MEL over the years means not keeping unprocessed and processed equipment separately, not complying with CQC Regulation 15: Premises and equipment and MHRA Documentation: Managing Medical Devices April 2015	3	5	15	HIGH	Staff members are taking processed equipment straight to the shelving areas as soon as it is cleaned to avoid cross contamination. This ensure equipment is kept separate, but this is not a productive method of working. Issue being raised at next Space Committee (June 2021)		3	5	15	HIGH	Nil	3	1	3	VLOW	TREAT - above tolerable level - appropriate cost-effective control		27/05/2021	No Change	New Risk	30/09/2021
2968			Director of Corporate Affairs	Noble, Deborah	Core Clinical & Support Services - Diagnostic & Screening	Imaging	Delayed detection of breast screening cancers due to COVID 19	The cessation of the programme has meant that women have been delayed an invite for screening. The programme has restarted but with reduced capacity to enable social distancing in both the mobile and static sites.	Women of screening age may receive a positive diagnosis that has been delayed due to the cessation of the programme. Treatment regimes will be delayed as a result.	5	4	20	HIGH	Restart proposal approved by the Trust, SQAS and PHE. Guidance issued as to the management of the women to ensure that no-one is missed has been issued by Hitachi/PHE and has been implemented by the programme.	KPI's monitored buy NHSBSP Regular communication with QA team and commissioners.	5	3	15	HIGH	No Gaps	2	2	4	LOW	TREAT - above tolerable level - appropriate cost-effective control required		24/04/2020	Decreased	No change	25/06/2021

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2973		30/03/2021	Director of Clinical Services	Burns, Ms Samantha	Surgical - Musculoskeletal	Trauma & Orthopaedics	With the implementation of green pathways for elective care patients, the Trauma and Orthopaedic department has lost capacity to escalate on to elective lists for trauma patients. As such with just one trauma list per day, there may be insufficient capacity to meet trauma needs.	Increasing trauma activity beyond existing capacity (5 cases per day on trauma list)	Without sufficient trauma capacity in place, the department may not be able to operate on all trauma patients within the required timelines leading to poor outcomes. The Trust may be required to close to trauma or cancel all elective lists for the day in theatres 11 and theatres 12 in order to facilitate trauma patients who are not covid swabbed, isolated for 72 hours or given social distancing advice. This will lead to longer elective wait times and possible 52 week breaches. Alternatively, the Trust may be required to close to trauma due to insufficient capacity	3	4	12	MOD	Divisional Director for Operations to work with T&O and Theatre teams to implement all day weekend emergency theatre lists. Utilisation of theatre pm 1 for procedures that do not include metal work twice a week if staffing is available. Cancellation of elective activity if required.	24/06/2021 - team report that main theatre used by T&O is closed whilst laminar flow is being repaired. This is likely to be for 6 weeks therefore this will impact on the red/ green pathways - number of elective operations will reduce, and there may be delays for emergency operations. Options to address are being considered at present. 27/04/2021 - team believe risk may be increasing therefore to continue monitoring progress. 30/03/2021 - Divisional Director for Operations to liaise with Operational Manager and teams to consider implementing all day weekend theatre lists. 19/01/21 Currently elective surgery is suspended.	3	5	15	HIGH	There are occasional surges in trauma cases especially at the weekend which impacts on trauma/ elective lists on Mondays.	3	2	6	LOW	TREAT - above tolerable level - appropriate cost-effective control required		24/06/2021	Increased	Ongoing risk	30/07/2021
2983			Director of Clinical Services	Hyem-Smith, Ms Celia	Core Clinical & Support Services - Clinical Support Services	Physiotherapy	There is a risk that the Women & Men's Health Physiotherapy Service is unable to meet its referral demand	Insufficient staffingleading to increased waiting times Referral number into service via multiple routes	Potential for poor clinical outcome, poor patient experience, complaints and staff stress Potential delay to patient treatment Potential for patients with new diagnosis of cancer and pregnant women are not seen in a timely fashion further	3	5	15	HIGH	Non clinical time including training,development and audit are being minimised to increase the number of available patient appointments Job plans are being completed by all staff to show impact on workload Patients are ebing booked into group where possible instead of individual appointment slots Recruited to all vacant posts To explore options for supporting dictationn of letters to free up clinical capacity.	Patients requiring an individual slot are often not being treated in a timely manner to meet the needds of their clinical repsentation. Team is fully established and Band 4 assistant is being used to support	3	5	15	HIGH	Staff capacity to meet current referral demand	2	4	8	MOD	TREAT - above tolerable level - appropriate cost-effective control required	Establish increasing referral rate trends, map against capacity and establish increase income vs uplift in staff to meet demand Budget reallocation and VCP for Band 6 post Therapy Strategy is being finalised to support investment for business case, to present strategy at management once shared with senior members of the Trust To discuss interim plans to manage staffing and impact on Women's division	19/06/2020	Increased	No changes to staffing	31/05/2021
2936			Director of Clinical Services	Hyem-Smith, Ms Celia	Core Clinical & Support Services - Clinical Support Services	Physiotherapy	Increasing numbers of patients being added to the physiotherapy outpatient waiting list, in addition to those on hold due to the COVID-19 pandemic, resulting in waiting times of well over 18 weeks for any type of intervention. A further increase in referrals may result from patients with post-COVID symptoms	The COVID-19 pandemic has led to outpatients only reviewing urgent patients virtually by telephone or video call, pre-COVID waiting lists could be managed effectively by groups, this is no longer possible due to social distancing and patients shielding.	Litigation and/or complaints due to lack of timely treatment intervention, potentially resulting in permanent and unecessary disability.	3	5	15	HIGH	- Virtual management of patients - Video and telephone clinics - Additional IT sourced to support virtual management - Reconfiguration of department to support virtual working and enable social distancing along with staff working from home - recovery plans are being written/in place to enable essential patients to be seen in the department of a face to face basis - Educational material including exercise programmes and access to youtube clips are made available to patients		3	5	15	HIGH	To identify process for validate routine patient lists to ensure that clinical priorities are seen the correct order	2	3	6	LOW	TREAT - above tolerable level - appropriate cost-effective control required	To develop strategy for validating routine patient waiting list	17/02/2021	No Change	new risk	31/05/2021
3056		30/03/2021	Director of Patient Care / Chief Nurse	Watson, Catherine	Surgical - Head & Neck	Oral Surgery	Insufficient qualified dental nurses to facilitate in assisting Clinicians with the running of OMFS Outpatient clinics.	The creation of an additional clinical room as the result of the recent refurbishment and the expansion of the Orthodontic service and subsequent employment of additional clinical staff has resulted in insufficient qualified Dental Nurses to be employed to support the Service	Shortage of dental nurse that assist the four handed approach that is employed in Dentistry will result in delayed treatment for patients, which are already lengthy for Orthodontic patients. Which would pose an additional risk for these patients. Outpatient clinics being cancelled on a regular basis. Increased waiting times.	3	5	15	HIGH	15/05/2021 business case is going to pain in May/June. Team are looking into using a specialised agency for Dental Nurses and are liaising with Matron/ HoN to establish feasibility of this. HCA`s can be utilised in a few Outpatient OMFS clinics that can be access via Trust Bank, these would need to be regular individuals due to the nature of the work required. However this will not mitigate the shortage of qualified dental nurses required to assist in the running of the Orthodontic and OMFS service.	Monitoring of staffing and rotas. 13/05/2021 - discussed in meeting that clinics have been cancelled when they are aware there will be nursing gaps, before booking patients to lists and this is not showing the true picture of the impact on lack of experienced Dental Nurses on the service. A plan is in place to manage clinics as per Trust standard. Although the team appreciates this may mean late cancellations on the day.	3	5	15	HIGH	Insufficient qualified dental nurses to run OMFS services.	3	2	6	LOW	TREAT - above tolerable level - appropriate cost-effective control required	Business case to increase nursing staff numbers	11/06/2021	Increased	increased risk	30/07/2021

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3082		30/03/2021	Director of Patient Care / Chief Nurse	Watson, Catherine	Surgical - Head & Neck	Orthodontics	Insufficient qualified dental nurses to facilitate in assisting Clinicians with the running of Orthodontic Outpatient clinics.	The creation of an additional clinical room as the result of the recent refurbishment and the expansion of the Orthodontic service and subsequent employment of additional clinical staff has resulted in insufficient qualified Dental Nurses to be employed to support the Service	Shortage of dental nurse that assist the four handed approach that is employed in Dentistry will result in delayed treatment for patients, which are already lengthy for Orthodontic patients. Which would pose an additional risk for these patients. Outpatient clinics being cancelled on a regular basis. Increased waiting times.	3	5	15	HIGH	HCA`s can be utilised in a few Outpatient OMFS clinics that can be access via Trust Bank, these would need to be regular individuals due to the nature of the work required. However this will not mitigate the shortage of qualified dental nurses required to assist in the running of the Orthodontic and OMFS service.	Monitoring of staffing and rotas.	3	5	15	HIGH	Insufficient qualified dental nurses to run OMFS services. Orthodontic clinics may be cancelled if experienced Dental Nurses are not available.	3	2	6	LOW	TREAT - above tolerable level - appropriate cost-effective control required	Business case to increase nursing staff numbers	13/05/2021	Increased	Increased risk	22/07/2021
3087			Director of Workforce	Adderley, Jane	Surgical - Anaesthetics & Theatres	Anaesthetics	Psychological wellbeing of staff on the Intensive Care Unit is at risk due to managing complex patients and families specifically following extraordinary circumstances such as the Pandemic, sudden death, and distressing situations with relatives.	Managing complex clinical and communication needs with patients and families. Responsibility to manage a higher ratio of patients as required and dealing with challenging situations and death that is difficult to rationalise.	All staff may have an inability to function at their designated role in a high stress situation. Increased risk of ill health, fatigue, anxiety and post traumatic stress disorder (PTSD symptoms)leading to potential increase in sickness. Impact on staff retention and staff morale.	4	5	20	HIGH	Clear leadership and team support. Staff health and well-being initiatives. Access to external psychological support. Individual stress risk assessments for staff.	Embedded psychological support from practitioners who are knowledgeable and skilled in Intensive care. Provision of Mental health First aid. Increase in staff morale, improved sickness/absence rates and retention of staff.	4	4	16	HIGH	Currently there is no embedded psychological support from practitioners who are knowledgeable and skilled in Intensive care. Staff may have a longer wait to access skilled psychological support.	4	2	8	MOD	TREAT - above tolerable level - appropriate cost-effective control required	Evidence to support business case	16/06/2021	No Change	Ongoing risk	21/07/2021
3091			Deputy CEO	Ahmed, Ayca	Estates	Estates	Lack of access to the current Medical Equipment Asset Management Database.	Clinical Engineering and Medical Equipment Library team will not be able to perform their procedures and be compliant.	Clinical Engineering (CE) and Medical Equipment Library. Lack of access to the current MEAM Database to record PPMs, repairs, loans, report on assets for training logs and associated tasks and provide KPI reports in compliance with MHRA standards and as per the CQC guidelines – Regulation 15 Premises and Equipment. As a result of not being able to run a report from the database the CE team are unable to follow up on the outstanding PPMs which may cause clinical safety impact.	4	4	16	HIGH	IT provided access to remote desktop to connect to the server directly (Medical Equipment Library only), CE is to follow.		4	4	16	HIGH	TBA	4	1	4	LOW	TREAT - above tolerable level - appropriate cost-effective control required		24/06/2021	No Change	new risk	30/07/2021
767	3-2	30/03/2021	Medical Director	James, Mr Andrew	Surgical - Musculoskeletal	Trauma & Orthopaedics	There is a risk to head injury patients not being appropriately cared for as they are not being treated in accordance with NICE guidance (CG176: Head injury: assessment and early management, updated September 2019)	1. NICE guidance sets out very specific recommendations for where and how patients should be managed and treated 2. Clinicians may have to wait for an opinion from the Tertiary Centre at Oxford 3. Head injuries frequently fall under the remit of the T&O Team or be nursed on a surgical ward(patients should be under neurological team).	- Potential reduction in patient safety - T&O surgeons and nursing teams may be unaware of how to care for patients with moderate to severe head injuries especially patient who are anticoagulated. - Clinicians may have to wait for an opinion from the Tertiary Centre. - Staff training, competency and experience - Serious incidents. - Reduced patient experience	4	3	12	MOD	1, 2 & 3. Preventive controls - On going discussions with Senior Medical Team - CSU Lead to escalate via trauma network - Alert process is in place for escalation within T&O & externally. - Resources available at tertiary site for advice/support 1, 2 c& 3. mitigating controls - Policy for management of head injuries has been developed - Awaiting appointment of head injury liaison Nurse - Long term plan for observation block to be built.	25/03/2021 Team continue to express concerns around the allocation of head injury patients to T&O. - Monitoring of Datix reported incidents by CGL for Surgery and CSU Lead - Team discussion of incidents/mortalities at CIG and M&M meetings.	4	4	16	HIGH	- 29/03/2021 T&O continues to received referral for complex head injury patients. - 23/09/2020 T&O continues to receive referrals for complex head injury patients under their speciality. - 28/01/2020 despite agreed pathway for admitting head injury patients under T&O team - non complex/ significant co-morbidities/ or anticoagulated the team are still having to care for these patient. - Trust is not in line with other trauma units - Regional trauma centre advises head injury should not be managed by trauma and orthopaedics and after 24 hours the patient should be referred to neurosurgery. - Potential delay in opinion from Tertiary Centre	4	2	8	MOD	TREAT - above tolerable level - appropriate cost-effective control required	Monitoring of incidents where tertiary advice/support was not available Monitor incidents where delay in tertiary opinion has occurred	24/06/2021	No Change	Ongoing risk	30/07/2021
3033		07/05/2021	Deputy CEO	Beech, Jill	Core Clinical & Support Services - Diagnostic & Screening	Pathology	The Pathology LIMS system is at risk of failure, virus infiltration and being unsupported by the supplier.	The IT system is outdated and contract has limited time left.	Pathology service would be halted and contingency plans would have to be implemented. Sensitive information could lost or security of the information could be breached.	4	4	16	HIGH	Systems manager regularly liaises with Clinysis to rectify IT failures. Meetings with S4 to establish joint procurement take place periodically. Project Manager role identified to lead project for MKUH.	Controls are ineffective. Increasing incidences of of downtime and LIMS issues.	4	4	16	HIGH	Current system continues to malfunction and collapses.	4	1	4	LOW	TREAT - above tolerable level - appropriate cost-effective control required	To establish a project Plan and Timeline To breakdown potential risks within the project for MKUH Develop BC for additional staffing resource to support project	08/06/2021	No Change	Implementation of new LIMS	12/07/2021

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2791			Director of Clinical Services	Orr, Mrs Julie	Operations	Patient Discharge	Risk that patient discharges will significantly be delayed, especially those requiring complex coordination of the discharge process	The Discharge Coordinators (Registered Nurses B6 level) are currently severely short staffed due to vacancies and sudden long term sickness, with an additional Discharge Coordinator due to have major surgery leading to additional long term sickness. The Discharge Team currently consists of 5 wte B6 Registered Nurses. At present there are 3wte in post however 2wte are on long term sick leave.	Increased length of stay (LOS) for complex discharges, leading to a potential for an increase in hospital acquired infections, de-conditioning Potential to affect the stranded and super stranded patient numbers and a failure achieve National target set for 2019-20, with associated impact on ED performance Increased delayed transfers of care (DToC) Poor patient experience due to the delays in discharge/discharge planning and referrals Other services capacity not being fully utilised due to delays in internal assessments Need for the Head of Clinical Services & Trust Lead for Discharge to take on some of the functions impacting on their daily roles significantly Increased workload & stress level for the remaining Discharge Coordinators in post Reduction in mandatory training compliance due to inability to release staff	4	5	20	HIGH	Covering a small number of shifts with former Discharge Coordinator carrying out bank shifts, when available. Offered bank shift to train an Agency Nurse who has shown an interest in the role. Recruited in to one vacancy and interviewing in to Bucks Coordinator role on 2/8/19. Reviewed role and delegated minor responsibilities to Rotational Operations Liaison Officers. Support requested from key nursing areas who have the skills to support a number of aspects relating to the role & discharge process- awaiting confirmation	Review of Datix incidents figures Superstranded patirnt data	4	4	16	HIGH	Additional funding to over recruit 1 WTE to for a 6 month period to cover the long term sickness	3	3	9	MOD	TREAT - above tolerable level - appropriate cost-effective control required		28/08/2019	No Change	New Risk	30/11/2019
2892			CEO	Noble, Deborah	Core Clinical & Support Services - Diagnostic & Screening	Imaging	The 10yr old mammography machine in BS2 could fail due to its age. The increased amount of unplanned downtime this year is consistent with aging equipment. With the introduction of new technologies the availability of replacement parts is a worry. A replacement part needed to be shipped from Chicago.	Failure of the machine and unavailability of parts.	Failure of the machine would lead to a loss of service capacity for the 2ww clinics and NHSBSP programme which give have a detrimental effect on Trust metrics.	4	4	16	HIGH	Comprehensive service contract All faults reported immediately to external contractor / physicist for support. Robust QA systemin process to monitor system performance. This is reviewed weekly by medical physics.	QA monitored weekly by physicists.	4	4	16	HIGH	Availability of replacement parts.	3	1	3	VLOW	TREAT - above tolerable level - appropriate cost-effective control required		13/05/2021	Increased	Aging equipment	02/08/2021
2735			Deputy CEO	York, Craig	IT	Information Technology	IF the internal Trust telephone systems are not upgraded, THEN they will fall into a state where they cannot be supported by the Trust's IT Department or any third-party suppliers, LEADING TO potential loss of telephone systems either in small areas or across the Trust. This would have a significant impact upon operational procedures, especially during critical or busy periods.	Failure of the telephone system, communications being lost across critical areas.	As system versions get older, the likelihood of there being reliability issues increases, the cyber security threat increases, and the risk that telephone system suppliers stop supporting the system increases.	4	4	16	HIGH	Support in place, upgrade planned this year		4	4	16	HIGH	Upgrade planned this year	4	1	4	LOW	TREAT - above tolerable level - appropriate cost-effective control required		07/05/2021	No Change	No change - upgrade planned	31/08/2021
2055			Director of Corporate Affairs	Stamp, Mr Jamie	Core Clinical & Support Services - Clinical Support Services	Dietetics	The risk is that the trust is not providing suitable accommodation for the dietetic team, there are too many members of staff based in an inadequate space and also the portacabin is old and therefore is no longer suitable as an office environment. The trust is therefore failing in its statutory legal duty under the Health & Safety at Work etc. Act 1974, Management of Health & Safety at Work Regulations 1999, Workplace (Health, Safety & Welfare) Regulations 1992 and Display Screen Equipment Regulations 1992 to provide a safe and well maintained place of work including welfare facilities for staff	Health and Safety lead for the Trust has confirmed that the maximum number of staff by law would be 11 staff, this is exceeeded on a regular basis as staff are unable to write their notes on the wards due to a lack of WOWs.	1. Physical and mental wellbeing concerns in relation to staff welfare with potential for sickness absence and potential litigation claims 2. Multiple breaches of statutory and regulatory duties leading to interest from the Health & Safety Executive 3.Enforcement action including formal notices; potential criminal prosecution resulting in fines and/or imprisonment dependent upon the action pursued; loss of Trust reputation; adverse publicity	4	4	16	HIGH	Due to the number of staff within the area, increased number of staff are having to work from home (rota basis), however as all the team see inpatients this is limited. Mobile air conditioning units distributed during summer months. Plumbed in water cooler in situ. .	Number of staff in the portacabin at one time is limited to 12 (this is challenging and affects effectiveness of team) During hot weather the temperature in portacabin in monitored	4	4	16	HIGH	The portacabins continues to provide insufficient space for the staff using this base, this has been further compromised by the social distancing requirements for COVID-19.	2	3	6	LOW	TREAT - above tolerable level - appropriate cost-effective control required	Risk to be reviewed by the Trust when office staff move to into MK Centre resolve short term issues - drinking water / flooring / window latches / changing facilities / secure path Upkeep of the portacabin including drinking water facilities, flooring and windown seals	04/05/2021	No Change	No change	01/07/2021

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940	16	21/09/2021	Director of Finance	Aldridge, Sophia	Finance	Financial Management	If the future NHS funding regime is not sufficient to cover the costs of the Trust, then the Trust will be unable to meet its financial performance obligations or achieve financial sustainability.	Unknown funding regime beyond September 2021 due to disruption caused by COVID-19	1.Increase in operational expenditure in order to manage COVID-19. 2.Reductions in non-NHS income streams as a direct result of COVID-19.3.Impaired operating productivity leading to costs for extended working days and/or outsourcing. 4.Potential for material increase in efficiency requirement from NHS funding regime to support DHSC budget affordability.	4	5	20	HIGH	1. Cost and volume contracts replaced with block contracts (set nationally) for clinical income;2. Top-up payments available where COVID-19 leads to additional costs over and above block sum amounts (until September 2021); 3. Budgets to be reset for FY22 based on financial regime; financial controls and oversight to be reintroduced to manage financial performance.4. Cost efficiency programme to be reset to target focus on areas of greatest opportunity to deliver	Monthly financial performance monitoring information by the F&I Committee and the Trust Board Cost efficiency reporting BLMK ICS finance performance reporting	4	4	16	HIGH	Financial regime for FY22 only valid for first half of the year. Trust has minimal ability to influence	4	2	8	MOD	TREAT - above tolerable level - appropriate cost-effective control required	Maintain dialogue with CCG re Contract Raise risk of dispute over interpretation of Contract with Monitor	14/06/2021	Increased	Reduced	12/07/2021
1472	2	24/03/2021	Director of Corporate Affairs	Ewers, Mr Paul	Corporate Affairs	Risk Management	There is a risk that not all known incidents, accidents and near misses are reported onto Trust Incident Reporting System (Datix) and that they will not be robustly investigated within the required timescales	Failure to comply with the Incident Reporting Policy; Poor incident reporting culture; Lack of understanding of the necessity and importance of reporting incidents; Lack of incentives to report incidents due to lack of feedback or poor quality investigation outcomes; Lack of consequences for failing to report; Lack of consequences for poor quality investigations; Lack of computer access to report incidents; Conflicting priorities and lack of time to report; Perceived difficulty in completing the online incident reporting form	The Trust will not have a complete list of incidents occurring in the Trust; Inability to learn from incidents, accidents and near-misses; Inability to stop potentially preventable incidents occurring; Potential failure to comply with Duty of Candour legislation requiring the Trust to report all known incidents where the severity was moderate or higher; Potential under reporting to the National Reporting & Learning System (NRLS); Potential failure to meet Trust Key Performance	4	5	20	HIGH	1. Incident Reporting Policy 2. Incident Reporting Mandatory/Induction Training 3. Incident Reporting Training Guide and adhoc training as required 4. Datix Incident Investigation Training sessions 5. Daily review of incidents by Risk Management Team to identify potential Serious Incidents and appropriate escalation 6. Serious Incident Review Group (SIRG) ensure quality of Serious Incident Investigations 7. SIRG ensure appropriate reporting of Serious Incidents to Commissioners 8. Staff able to have automatic feedback following investigation approval 9. Incident Reporting Awareness Campaign - September 2017 10. Standard Operating Procedure re Risk & Governance Team supporting the closure of incident investigations during unprecedented demand on service (e.g. Covid-19 Pandemic) approved - February 2021 11. Patient Safety Framework introduced	1. Risk Management Dashboard monitoring trends 2. Weekly overdue incident reporting 3. Routine and exception reports to Risk & Compliance Board 4. Weekly Compliance Report to Executive Team 5. Incident reporting rate and overdue incidents monitored through Trust KPIs 6. Regular reporting to Divisions through Clinical Governance reports 7. Divisional Dashboards to monitor trends 8. Bi-monthly National Reporting & Learning System reports 9. Serious Incident Review Group upward reports 10. Monitoring of Serious Incident Investigations by MKCCG 11. Escalation to Patient Safety Board for scrutiny	4	4	16	HIGH	1. Lack of a high incident reporting culture 2. Lack of robust investigations for non-Serious Incidents 3. Lack of feedback to reporters/staff following incident investigations 4. Staff lack access to a computer to report incidents 5. Staff lack time during shift to report incidents 6. More intuitive incident reporting system - procurement scoping exercise on going for Datix Cloud/new system	4	3	12	MOD	TREAT - above tolerable level - appropriate cost-effective control required	Comms Initiative being developed to coincide with launch of simpler incident reporting form and enhanced Incident reporting training at Induction/Mandatory Training - Complete Quality Improvement Project to be undertaken - Ongoing through Learning From Incidents Focus Group Recruitment of two new band 7 facilitators - complete Launch the 'SHARE' Incident Reporting Campaign with Comms Team - Complete Letter re-iterating the importance of incident reporting to be sent from CEO via wage slips - Decision made not to undertake - Complete Incident Reporting Handbook for staff to coincide with 'SHARE' launch to be developed - Decision made not to undertake - Complete Consider the increase of accessibility to computers in order to report incidents at Risk & Compliance Board - Complete Datix Manager to speak to higher reporting Trusts to see how they have developed an effective	23/04/2021	No Change	No change since last review	30/06/2021
1519	7-2	25/02/2022	Director of Finance	Aldridge, Sophia	Finance	Financial Management	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	Transformation delivery is not adequately resourced and prioritised and/or schemes are unrealistic and not well planned.	The Trust may not deliver its financial targets leading to TO potential cash shortfall and non-delivery of its key targets	4	4	20	HIGH	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 Trust Executive Group.	1. Divisional CIP review meetings in place attended by the DoF, divisional managers and finance business partners. 2. Cross-cutting transformation schemes being worked up. 3. Savings plan for 21/22 financial year not yet fully identified."	4	4	16	HIGH	Saving schemes to be identified to deliver maximum savings in 2021/22	3	3	9	MOD	TREAT - above tolerable level - appropriate cost-effective control required		14/06/2021	Increased	Schemes still need to be worked up	12/07/2021
2570	18	30/03/2021	Director of Clinical Services	Gawlowski, Dr Zuzanna	Women's & Children's Health - Children's Health	Neonatal	Overcrowding and insufficient space in the Neonatal Unit, exacerbated by need for social distancing due to COVID-19. The milk kitchen was condemned due to this.	Cot spacing does not comply with BAPM guidance or the latest PHE guidance for COVID-19. The Unit is seeking to increase both total cot spacing and cot numbers by 4 HDU/ITU cots in line with Network 5 year projections of acuity and demand, and spacing in line with National Recommendations.	Without the increase in cot numbers and corresponding cot spacing we will be unable to meet patient needs or network requirements. We will now also be unable to meet PHE recommendations for social distancing This may result in a removal of Level 2 status if we continue to have insufficient space to adequately fulfil our Network responsibilities and deliver care in line with national requirements. This may also impact on our ability to protect babies and their families during COVID	5	5	25	HIGH	1. Reconfiguration of cots to create more space and extra cots and capacity, though this still does not meet PHE or national standards 2. Parents asked to leave NNU during interventional procedures, ward rounds etc. Restricted visiting during COVID 3. Added to capital plan 4. Feasibility study completed	1. NNU Feasibility study in progress awaiting decision of the Board as to whether to proceed with major reconfiguaration and increased cots to meet TVN demand. 2.Planning for a specific W&C build is being discussed	5	4	20	HIGH	1. Outline business case for NNU rebuild has been developed by Trust and estates department and submitted to CCG/STP partners for consideration. Awaiting final decisions	3	3	9	MOD	TREAT - above tolerable level - appropriate cost-effective control required	Approval of business case - Complete Business Case for Refurnishing Milk Kitchen and Sluice	25/05/2021	No Change	No change	27/07/2021

Significant Risk Register

ID	Ref	Triumvirate Annual Review Date	Executive Responsible	Risk Owner	Division	Specialty	Description	Cause	Impact	C	L	Inherent Risk Rating	Inherent Risk Level	Controls in place	Assurance on Controls	C	L	Current Risk Rating	Current Risk Level	Gaps in Controls	C	L	Target Risk Rating	Target Risk Level	Treatment Category	Action Plan Summary	Date Risk Last Reviewed	Trend	Trend Rationale	Review Due?
2920		05/05/2021	Director of Clinical Services	Biggs, Adam	Operations	Emergency Planning	The risk of capabilities in responding to a Novel Coronavirus (COVID-19) impacting on patient care within clinical and non-clinical services, with the inability to maintain safety for staff and patients due to national pressures on supplies and infrastructure.	Surge of COVID-19 patients impacting on Trust ability to maintain patient care and clinical services. Loss of staff to support clinical and non-clinical services due to high levels of absence. Loss of national stockpile in PPE or medical devices (ventilators) resulting in the Trust not receiving deliveries to preserve the safety of patients and staff.	Loss of clinical and non-clinical services Financial impacts Risk to patient care Risk to staff wellbeing	5	5	25	HIGH	COVID-19 operational and contingency plans in place reviewed through Silver and Gold command structure, with meeting recorded through action logs PPE logged daily covering delivery and current stock		5	4	20	HIGH	Trust has no control over national stockpile of PPE and medical devices required for response. This is monitored and reported daily.	5	3	15	HIGH	TREAT - above tolerable level - appropriate cost-effective control required		21/10/2020	No Change	National oversight	09/11/2020
2928			Director of Corporate Affairs	Evans, Ms Joanne (Inactive User)	Core Clinical & Support Services - Diagnostic & Screening	Imaging	Lack of capacity for appropriate management of CT and MRI within KPI and DM01 timescales	The issue is increasing demand at upto 14% annually with a requirement to reduce turnaround times. Covid has added to the burden with covid recovery posing a significant risk to the service. Workload is increasing significantly but both CT and MRI are working at caqpacity and have no flexibility to increase capacity without additional staff and equipment.	Financial due to missed targets Reputation due to long waiting times Reputation and financial due to increased infection rates Staff leaving due to poor working conditions. This is delaying patient management and causing issues with meeting the diagnostic waiting times. Inability to manage patients privacy and dignity also increased risk of infection due to overcrowding of faciliities.	4	5	20	HIGH	Extended working hours and days, some scans sent off site to manage demand. Reduced appointment times to optimise service. 1.12.20 no change to risk rating services remain challenged due to lack of basic capacity made worse by Covid social distancing and cleaning issues. 1.6.21 Ongoing capacity issues, situation deteriorating as post covid activity builds up. Case approved for mobile MRI capacity which should be implemented in June Case for additional CT declined by Trust to be revisited in July 2021. IS provider approached to provide more MRI capacity	Future plans will increase MRI capacity and support through to Dec 21 at which point the modular units should be operational. CT capacity plan still unresolved.	4	5	20	HIGH	Currently still capacity gaps with increasing numbers of patients waiting over 42 days for routine scanning, breaching DM01 requirements	2	2	4	LOW	TREAT - above tolerable level - appropriate cost-effective control required		01/12/2020	Increased	INcreased risk	30/06/2021
2796			Director of Clinical Services	Chadwick, Ms Helen	Core Clinical & Support Services - Pharmacy	Pharmacy	The risk is there will be insuffient staff in pharmacy to meet demands of the organisation and ensure patient safety in the use of medicines.	High turnover of staff due to: work pressure, not having the opportunity to work at the top of their licence, lack of capacity for development, lack of capacity for supervision / support. Also difficulty in recruiting particularly to 8a posts. Loss of staff to primary care which offers more attractive working hours.	1. increased length of stay due to TTO delay 2. increase in prescribing errors not corrected 3. increase in dispensing errors 4. increase in missed doses 5. failure to meet legal requirements for safe and secure use of medicines All resulting in adverse patient outcomes. Lack of financial control on medicines expenditure Breach of CQC regulations	4	5	20	HIGH	Actively recruiting, listening events with staff, implementing 1-1 system to support staff, reviewing work activities of 8a's and above to identify what could stop for a period of time. Recruitment of additional Pharmacy technicians requested Aug19. Approved end of 2020. 3 appointed and in training.	Staff feedback HR metrics eg turnover Medicines reconciliation rate Datix rate	4	5	20	HIGH	Use of senior staff to support not viable long term - 28/5/21 This action has resulted in further deterioration in morale and ability to make change, increased losses Maternity leave returners leaving for more flexible / family friendly working hours	2	3	6	LOW	TREAT - above tolerable level - appropriate cost-effective control required	Bc to execes Internal review of Clinical service Undertake workforce analysis Develop a business case for the clinical pharmacy servcie Implement changes recommended in review	28/05/2021	No Change	No change - capacity	31/07/2021
3062			Director of Clinical Services	Barton-Young, Mr Phillip	Surgical - Head & Neck	Ophthalmology	Clinical data stored on visual field machine hard drives for Ophthalmology Department patients will not be transferred between two machines (visual field analysers & Windows XP computer). There is a risk of irretrievable loss of patient data when manually transferring data using USB sticks.	Both of the two Humphrey HFA 2i machines within Ophthalmology Department are outdated and there is no backup. The visual field machines are not connected to the server and currently rely on a Windows XP computer to transfer data between the two machines. The Windows XP system is no longer supported by the IT department at MKUH or by Zeiss, the manufacturer of the machines	Machines accurately calculate decline in vision therefore assessment, diagnosis and monitoring could be significantly compromised. Consultant Ophthalmologists and other clinical staff would not be able to accurately compare between tests meaning that patient treatment could be negatively impacted as there is a risk of missing progressive disease.	4	4	16	HIGH	Data is currently stored on visual machine hard drives and Windows XP computer. It has been recommended that Data is exchanged using unencrypted USB drives.	Monitoring of incidents in relation to patient data and functionality of both machines. 17/05/2021 full business case needs to be submitted as previous business case not approved.	4	5	20	HIGH	N/A	4	1	4	LOW	TREAT - above tolerable level - appropriate cost-effective control required	Business case to purchase replacement visual field analysers	17/05/2021	No Change	New risk	19/07/2021
2955	N/A	30/03/2021	Director of Patient Care / Chief Nurse	Styles, Janice	Women's & Children's Health - Women's Health	Obstetrics & Maternity	Inability of Trust to provide maternity care locally for some women (during times of peak demand on service, delays in clinical care) and potential increased readmission rate due to reduced length of stay	Location of Gynaecology patients on Ward 10 resulting in the loss of 13 obstetric beds	Delays in clinical care (inductions, pain relief etc) at times of heavy demand while beds sourced & potential need to divert to neighbouring maternity units when unable to accommodate women. Poor patient experience.	5	5	25	HIGH	Daily huddle & bed state reviews Escalation process Review of obstetric clinical pathways Three times a day Maternity specific safety huddle (March 2021) Regular reviews with Exec Team	LOS data Incident reporting rate on readmissions - deep dive analysis currently ongoing	5	4	20	HIGH	Requirement for EPAU to be away from ante and postnatal ward areas. Bed space needs to be increased	3	3	9	MOD	TREAT - above tolerable level - appropriate cost-effective control required	Review of potential plan to move EPAU away from ante and postnatal ward areas and increase bed space	25/05/2021	No Change	ongoing risk	27/07/2021

Meeting Title	Trust Board		**Date:** July 2021		
Report Title:	Board Assurance Framework		**Agenda item: 17**		
Lead Director	**Name:** Kate Jarman		**Title:** Director of Corporate Affairs		
Author	**Name:** Kwame Mensa-Bonsu		**Title:** Trust Secretary		
FoI Status:	**Public**				
Report Summary	Board Assurance Framework containing the principal risks against the Trust's objectives. 1. A new risk entry (**13**) has been approved for inclusion on the BAF by the Finance and Investment Committee. The new entry can be found on **page 33.**				
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [ ]	**Decision** [ ]	
Recommendation	The Trust Board is asked to review the content of the Board Assurance Framework				
Strategic objectives links	All				
Board Assurance Framework links	All				

CQC outcome/ regulation links	Governance/ Well Led (Regulation 17)
Identified risks and risk management actions	
Resource implications	
Legal implications including equality and diversity assessment	
Report history	Board Committees
Next steps	Trust Board
Appendices	

The Board Assurance Framework – Summary of Activity June 2021

COVID-19 Risks

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

The Board Assurance Framework

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

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

Strategic Objectives

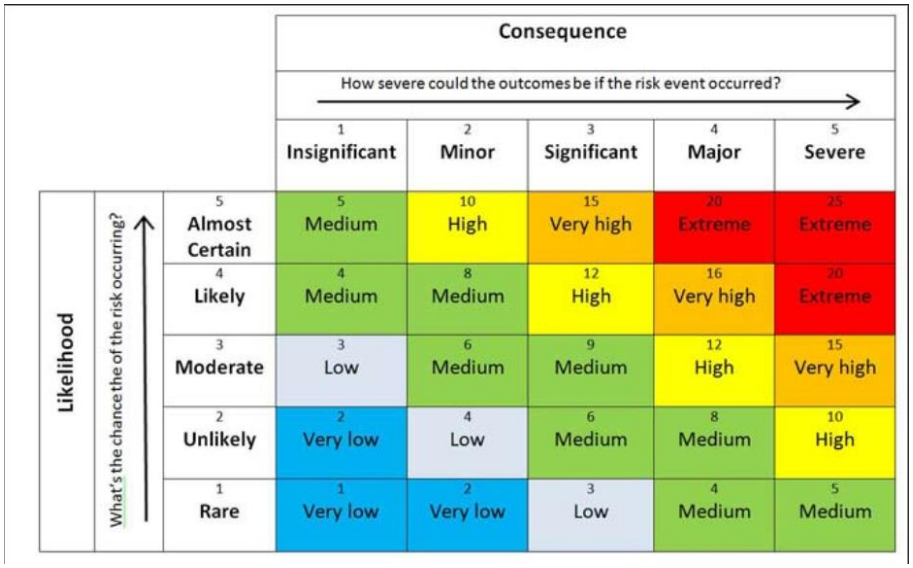
1. Improving patient safety
2. Improving patient experience
3. Improving clinical effectiveness
4. Delivering key performance targets
5. Developing MK at place
6. Developing teaching and research
7. Being well governed and financially viable
8. Investing in our people
9. Developing our estate
10. Being innovative and sustainable

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

Assurance ratings:

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

5X5 Risk Matrix:

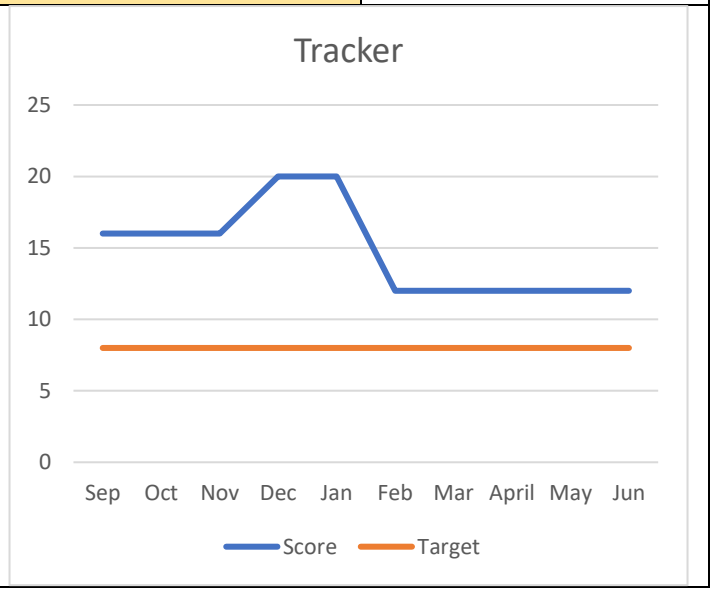


Likelihood: What's the chance the of the risk occurring?	Consequence: How severe could the outcomes be if the risk event occurred?	1 Insignificant	2 Minor	3 Significant	4 Major	5 Severe
	5 Almost Certain	5 Medium	10 High	15 Very high	20 Extreme	25 Extreme
	4 Likely	4 Medium	8 Medium	12 High	16 Very high	20 Extreme
	3 Moderate	3 Low	6 Medium	9 Medium	12 High	15 Very high
	2 Unlikely	2 Very low	4 Low	6 Medium	8 Medium	10 High
	1 Rare	1 Very low	2 Very low	3 Low	4 Medium	5 Medium

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

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If the Trust's ED does not have adequate staffing and estate capacity, and effective escalation plans, it will not be able to maintain patient safety during periods of overwhelming demand.				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Director of Operations	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	09/06/2021	**Risk Rating**	12	8		

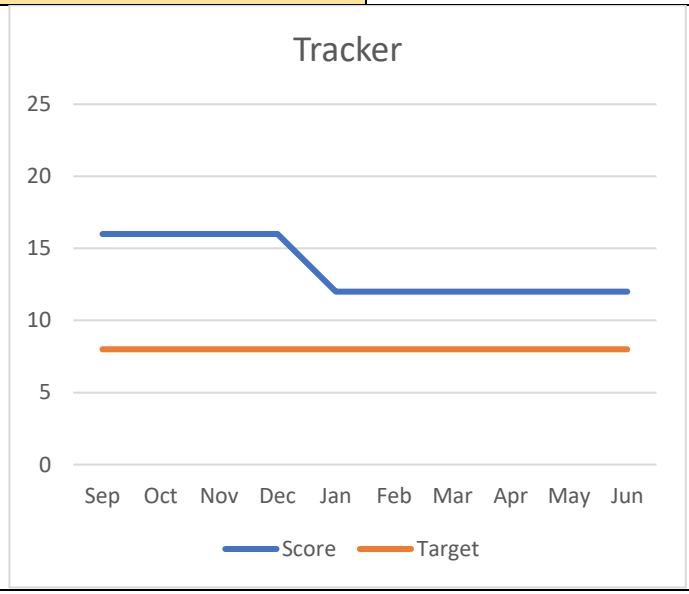


Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Significantly higher than usual numbers of patients through the ED	Clinically and operationally agreed escalation plan	Vacancies in nurse staffing Higher than normal staff	Ongoing recruitment drive	Daily huddle / silver command meetings	Short term sickness or unexpected staffing levels / surges	Escalation By CSM and Silver OCM on shift	

Significantly higher acuity of patients through the ED Major incident/ pandemic – constraints on space and adherence to IPC measures	Adherence to national OPEL escalation management system Clinically risk assessed escalation areas available. Surge plans, COVID-specific SOPs and protocols have been developed	absences and sickness	Redeployment of staff from other areas at times of need. Clinical staff continue to support rotas to manage staff deployment & patient safety through the pandemic and heightened levels of activity. Services and escalation plans are under continuous review in response to shrinking pandemic numbers and related pressures.	System-wide (MK/BLMK/ICS) Partnership Board, Alliance & Weekly Health Cell Regional and National - NHSI reporting requirements - Daily COVID sitrep			

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

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If an effective reporting, investigation and learning loop is not established and maintained, the Trust will fail to embed learning and preventative measures following serious incidents/ Never Events.						**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm		
Executive Lead	Medical Director	**Consequence**	4	4	**Risk Appetite**	Avoid		
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat		
Date of Review	21/06/2021	**Risk Rating**	12	8				

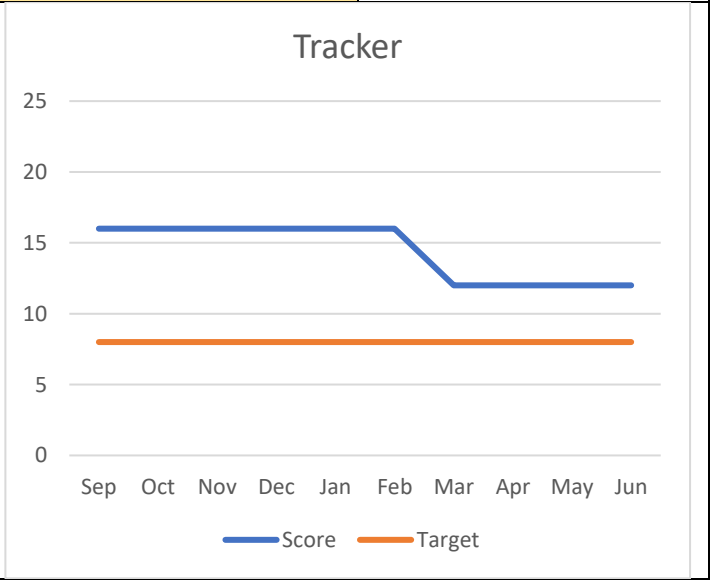
Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
Not appropriately reporting, investigating or learning from incidents.	Improvement in incident reporting rates SIRG reviews all evidence and action	Establishing Learning and Improvement Board	October 2020 - ongoing	NRLS data SIRG CCG Quality Team	Intuitive Reporting Rates	Appraisals	

A lack of systematic sharing of learning from incidents. A lack of evidence that learning has been shared	plans associated with Sis Actions are tracked Trust-wide communications in place Debriefing systems in place Training available Appreciative Inquiry training programme started (December 2020) Commencement of patient safety specialist role (April 2021)	Establishing Divisional Quality Governance Boards QI/ AI strategies and processes well embedded	October 2020 - ongoing October 2020 – ongoing				

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

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If the Trust is unable to accurately predict demand (for example, relating to the COVID-19 pandemic) and re-purpose its resources (physical, human and financial) with agility, the Trust will fail to manage clinical risk during periods of sustained or rapid change in the level or type of demand.				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Medical Director	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	21/06/2021	**Risk Rating**	12	8		



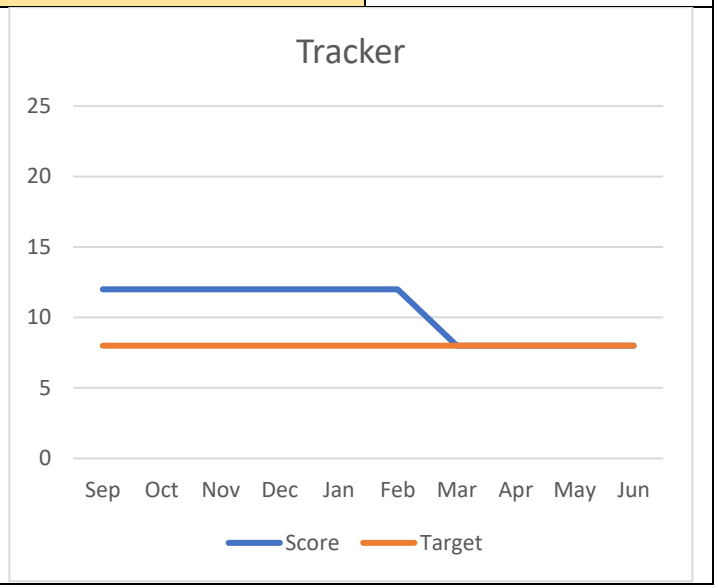
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Rapid or sustained period of upheaval and	Board approved major incident plan and procedures	Inability to accurately predict or	None Currently	MK place-based and ICS-based planning	Incomplete oversight of OP delays	Enhanced visibility of OPD PTL	

change caused by the Covid-19 pandemic and need to respond and maintain clinical safety and quality Risks have increased in view of the increased volume of non-COVID emergency demand, and also the increased volume of elective work. Number of vacant beds fewer / inpatient density higher.	Rigorous monitoring of capacity, performance and quality indicators Established command and control governance mechanisms Gold (Daily) Level 3/4 Incident management	forecast levels of activity and risk		and resilience fora Regional and national data and forecasting COVID MARC Meeting (Data, Intelligence, Collaboration with partners)		and non RTT pathways	

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

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If the Trust does not carefully manage its significant digital change programme, then the delivery of clinical services may be impaired				**Strategic Objective**	Improving Patient Safety	
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm	
Executive Lead	Deputy CEO	**Consequence**	4	4	**Risk Appetite**	Avoid	
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat	
Date of Review	17/06/2021	**Risk Rating**	8	8			



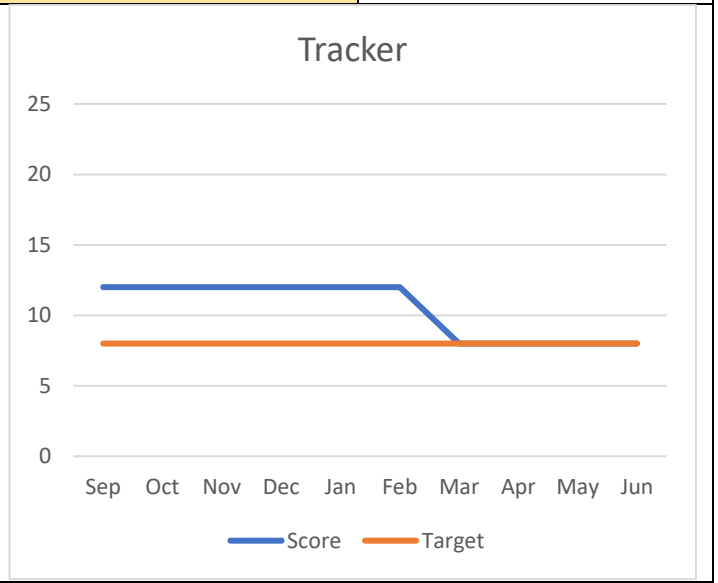
Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
Inadequate assessment of clinical risk/ impact on clinical services or practices	Robust governance structures in place with programme management at all levels Clinical oversight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

Inadequate resourcing Inadequate training	Thorough planning and risk assessment Regular review of resourcing Regular review of progress Risks and issues reported Track record of successful delivery of IT projects						

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

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If the Trust is unable to provide capacity to match demand for elective care, (such as for cancer and screening programmes), there is a risk that this could lead to patient harm.				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Director of Operations	**Consequence**	5	5	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	09/06/2021	**Risk Rating**	20	10		



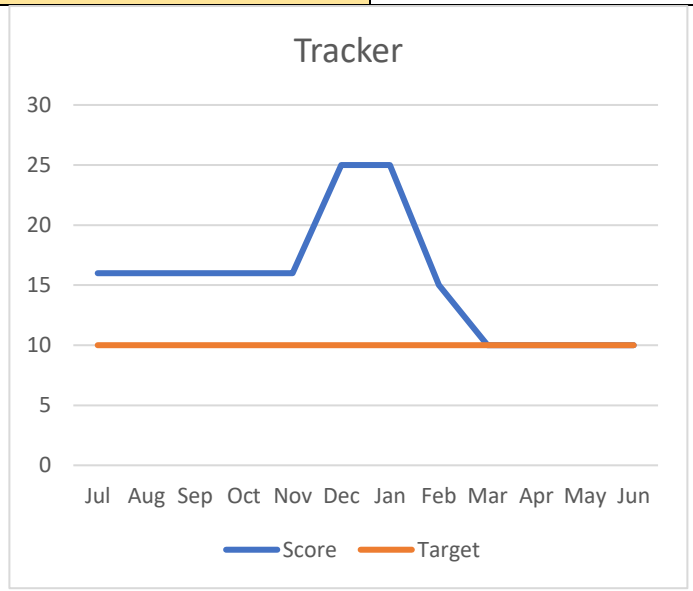
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Cessation of all routine elective care, including cancer screening and other	Compliance with national guidance Granular understanding of	None Currently	Continue to maintain programme governance and keep	Established governance and external/ independent	None Currently	None Currently	

pathways, during the peaks of the Covid-19 pandemic Inability to match capacity with demand	demand and capacity requirements with use of national tools. Robust oversight at Board, and sub committees. Divisional and CSU management of WL. Agreement of local standards and criteria for alternative pathway management – clinical prioritisation and validation Long-wait harm reviews Use of Independent Sector. Extension of working hours and additional WLI to compensate capacity deficits through distancing and IPC requirements.	Historic issue with ASI & capacity Limitations to what ISP can take. Resilience and well being of staff and need for A/L and rest.	resourcing under review Dedicated project resource commissioned Trust-wide and local Recovery Plans in place	escalation and review process Regional and national monitoring. Project reports & training programme Mutual aid options. BLMK System working.			

	Additional capacity being sourced and services reconfigured.	Set up time for services off site.	Reconfiguration of MKUH capacity services to best use ISP				

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

Strategic Objective 1: Improving Patient Safety

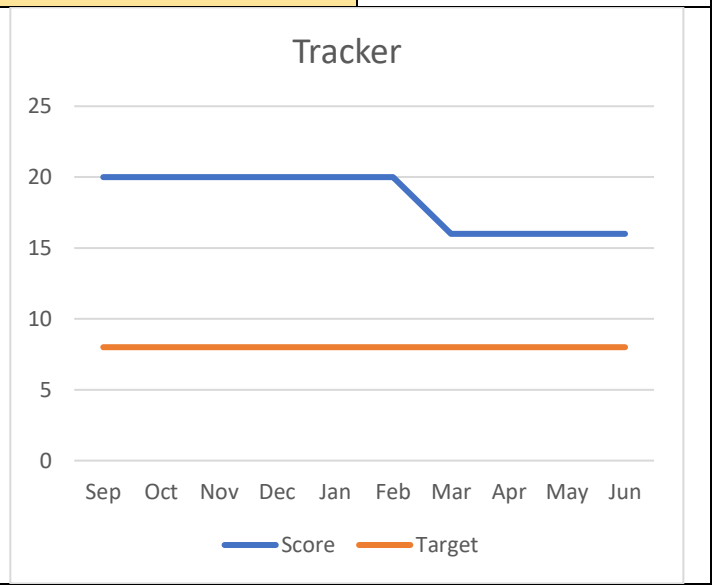
Strategic Risk	If the Trust does not establish and maintain effective capacity management processes it will be unable to cope with high demand for ITU and inpatient care during a public health crisis (or due to the Covid-19 pandemic)						**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm		
Executive Lead	Medical Director	**Consequence**	5	5	**Risk Appetite**	Avoid		
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat		
Date of Review	21/06/2021	**Risk Rating**	10	10				

Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
Demand for ITU and inpatient beds exceeds capacity,	Increased capacity across the hospital	Inability to accurately forecast demand	None currently	Tested escalation plans	None currently	None currently	

including escalation capacity within the hospital and regionally	Increased capacity for ITU Clear escalation plans Real time visibility of regional demand/ capacity			Active part of regional networks Clear view of CPAP support for COVID-19 patients Medical Director and Chief Nurse liaising with teams			

RISK 7: If the radiotherapy pathway provided until 2019/20 in Milton Keynes by Genesis Care (under contract with OUH) is not replaced, the access and experience of patients on clinical oncology (radiotherapy) pathways will continue to be negatively impacted.

Strategic Objective 2: Improving Patient Experience

Strategic Risk	If the radiotherapy pathway provided until 2019/20 in Milton Keynes by Genesis Care (under contract with OUH) is not replaced, the access and experience of patients on clinical oncology (radiotherapy) pathways will continue to be negatively impacted.				**Strategic Objective**	Improving Patient Experience	
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm	
Executive Lead	Medical Director	**Consequence**	4	4	**Risk Appetite**	Avoid	
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat	
Date of Review	21/06/2021	**Risk Rating**	16	8			

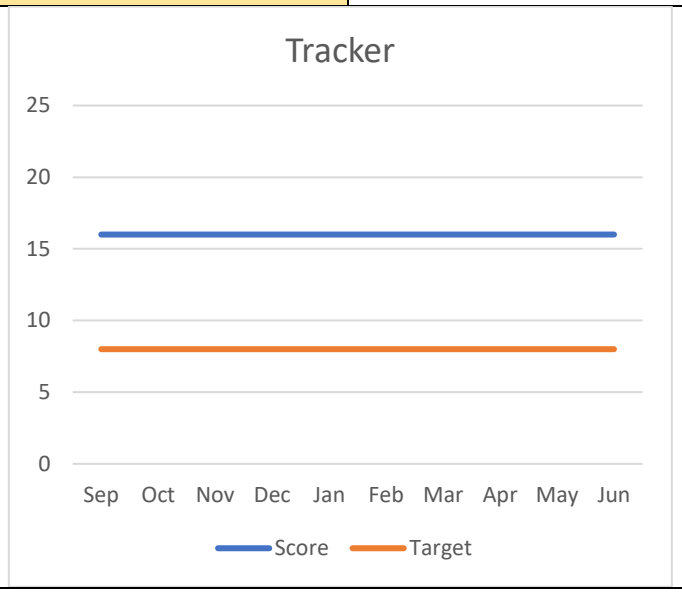
Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
Break down in the established relationship (subcontract) between Oxford University	Contingency for the provision of treatment to patients in Oxford and the ongoing provision of palliative and prostate	Contracting and commissioning process outside the Trust's direct control or management	Continued lobbying for resolution	Minutes of established radiotherapy executive group	Lines of assurance outside the Trust's direct control	Continued work with partners	

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 radiotherapy. Patients tend not to differentiate between the different NHS provider organisations. This risk materialised 16.12.2019 when the contract expired and no extension was agreed.	radiotherapy at Linford Wood or in Northampton Promotion of agreement between OUH and Northampton General Hospital to facilitate access to facilities at Northampton for those who prefer treatment in this location. Proactive communications strategy in relation to current service delivery issues.	Specific issues with the ICS CDEL limits			Impact of ICS capital control limits		

RISK 8: If the Trust does not effectively work with patients and families in delivering care and positive patient experience the national patient surveys may not demonstrate improvement.

Strategic Objective 2: Improving Patient Experience

Strategic Risk	If the Trust does not effectively work with patients and families in delivering care and positive patient experience the national patient surveys may not demonstrate improvement.				**Strategic Objective**	Improving Patient Experience
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Chief Nurse	**Consequence**	4	4	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	16/06/2021	**Risk Rating**	16	8		



Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Lack of appropriate intervention to improve patient experience (measured through the	Corporate Patient and Family Experience Team function, resources and governance arrangements in	Engagement with patients for Co-production of service developments.	To develop bank of patients to engage with for involvement in wider	**Annual:** PLACE surveys National Patient Experience Improvement Framework NHSI	Comprehensive analysis of patient ethnic groups to ensure meeting all requirements.	Liaise with information dept for info on patient demographics.	

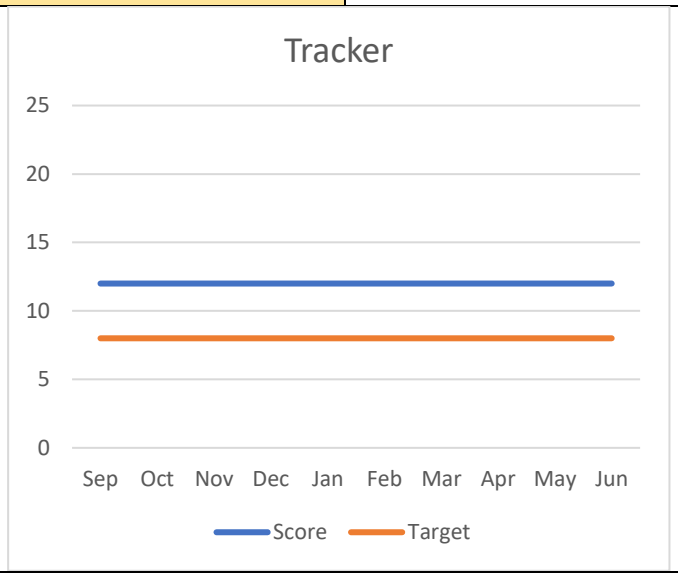
national surveys). Children and Young People Survey Adult Inpatient Survey Urgent and Emergency Care Survey Maternity Survey Cancer Patient Experience Survey	place at Trust, division and department levels, including but not limited to: • Patent Experience Strategy • Learning Disabilities Strategy • Dementia Strategy • Nutrition steering group • Catering steering group • Domestic planning group • Discharge steering group • Induction training '15 Step 'Challenge Quarterly Patient Experience Board, monthly Patient experience operational meetings and supporting		organisational changes. **Lead:** Head of Patient and Family Experience. **Timescale:** October 2021 – subject to national restrictions re COVID-19.	Assessment and action plan **Quarterly:** Quarterly reports with themes and areas of for improvement. Patient experience strategy action plan progress. Perfect Ward Patient Experience Audit. **Monthly:** FFT results – thematic review. Monthly operational meeting to review and triangulate data for top themes and inform focused areas of work for next month's activities. Department surveys **External Reviews :** Healthwatch			

	substructure of steering groups.			Maternity Voices partnership (MVP) Cancer Patient Partnership **Website:** 'You said we did'			

RISK 9: If the Trust does not effectively work to use feedback from complaints and PALS contacts to inform learning and embed related changes patient experience will not be improved.

Strategic Objective 2: Improving Patient Experience

Strategic Risk	If the Trust does not effectively work to use feedback from complaints and PALS contacts to inform learning and embed related changes patient experience will not be improved.				**Strategic Objective**	Improving Patient Experience
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Chief Nurse	**Consequence**	4	4	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	16/06/2021	**Risk Rating**	12	8		



Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Lack of appropriate intervention to improve patient experience following receipt	Corporate Patient Experience Team function, resources and governance arrangements in place at Trust, division and	Quality surveillance system to triangulate feedback from complaints with incidents and	Current review underway for systems to link and	**Annual:** Complaints and PALS Report **Quarterly:** Quarterly reports with themes and	**Patients specific** needs supporting them to feedback: Cognitively impaired	Develop mechanisms for feedback for all groups.	

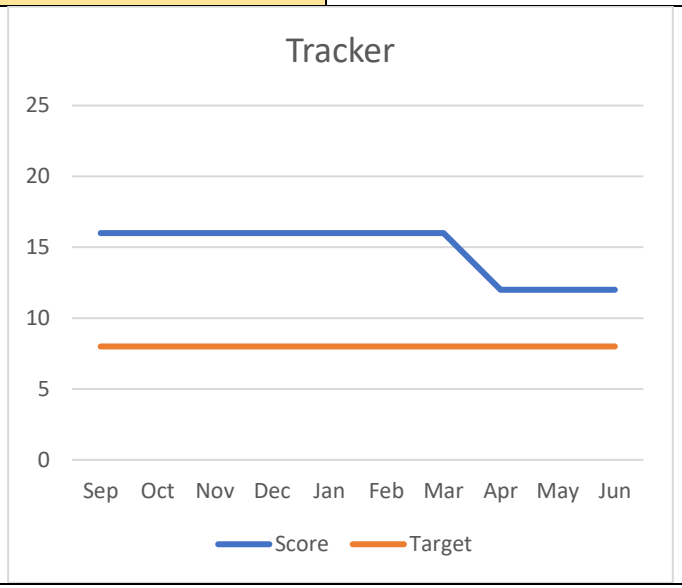
of complaints and PALS contacts.	department levels, including but not limited to: • Patent Experience Strategy • Learning Disabilities Strategy • Dementia Strategy • Nutrition steering group • Catering steering group • Domestic planning group • Discharge steering group • Induction training Customer service training – NHS Elect program Leadership training includes how to receive feedback from patients. Appreciative inquire approach to support complaints handling and response letters.	other quality measures across the organisation. Audit of identified learning in divisions to ensure learning embedded.	triangulate data. Divisions to audit learning from feedback and report to Patient Experience Board.	areas of for improvement. Patient experience strategy action plan progress. Perfect Ward Patient Experience Audit. **Monthly:** Monthly operational meeting to review and triangulate data for top complaints themes and inform focused areas of work for next month's activities. Divisional review of learning from complaints in CIG. Complaints questionnaire for complaints re process and experience. PALS KPIs responding to feedback in a	Learning Disabilities Sensory Deficit : vision, hearing , speech Language difficulties Children and young people.	Use demographic to demonstrate complaints sources.	

	Monthly divisional meetings with Head of Patient and Family Experience to review themes, complaints, associated changes, and learning.			timely manner to initiate change and learning. **Website:** 'You said we did			

RISK 10: If clinical audit requirements are not completed the Trust will fail to meet the requirements of clinical compliance regimes including NICE

Strategic Objective 3: Improving Clinical Effectiveness

Strategic Risk	If clinical audit requirements are not completed the Trust will fail to meet the requirements of clinical compliance regimes including NICE				**Strategic Objective**	Improving Clinical Effectiveness
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Director of Corporate Affairs	**Consequence**	4	4	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	15/06/2021	**Risk Rating**	12	8		

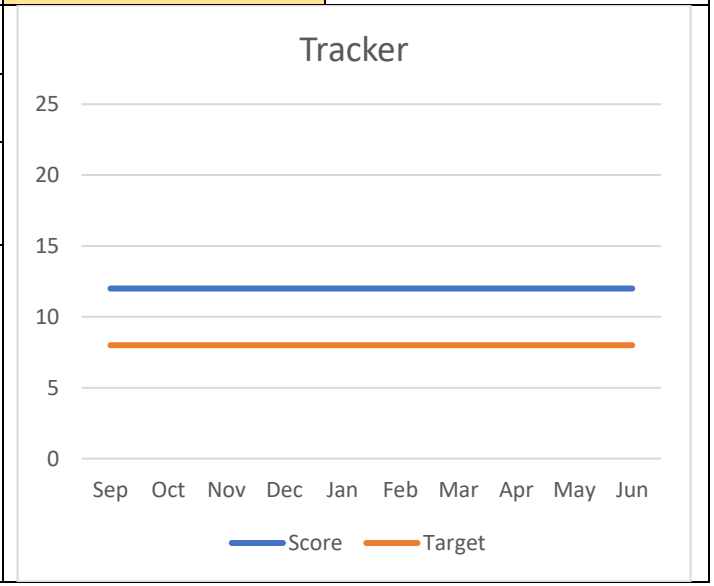


Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
1. Lack of understanding/ awareness of audit requirements by clinical audit leads	1. Designated audit leads in CSUs/ divisions 2. Clinical governance and administrative	1. Resource to complete audits 2. Audit policy out of date	1.Resource review currently underway 2. Audit policy	Clinical Audit and Effectiveness Board External benchmarking	1.External benchmarking 2. Independent audit	Add to internal audit plan for 20121/22	

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	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 5. Monthly review of all compliance requirements, including NICE and policies		being reviewed and re-written (advanced first draft commented on for further review April 21)				

RISK 11: If the Trust is unable to establish robust governance around data quality processes, there is the risk that this could lead to patient harm, reputational damage and regulatory failure.

Strategic Objective 3: Improving Clinical Effectiveness

Strategic Risk	If the Trust is unable to establish robust governance around data quality processes, there is the risk that this could lead to patient harm, reputational damage and regulatory failure.				**Strategic Objective**	Improving Clinical Effectiveness	
Lead Committee	Audit	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm	
Executive Lead	Director of Operations	**Consequence**	4	4	**Risk Appetite**	Minimal	
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat	
Date of Review	09/06/2021	**Risk Rating**	12	8			

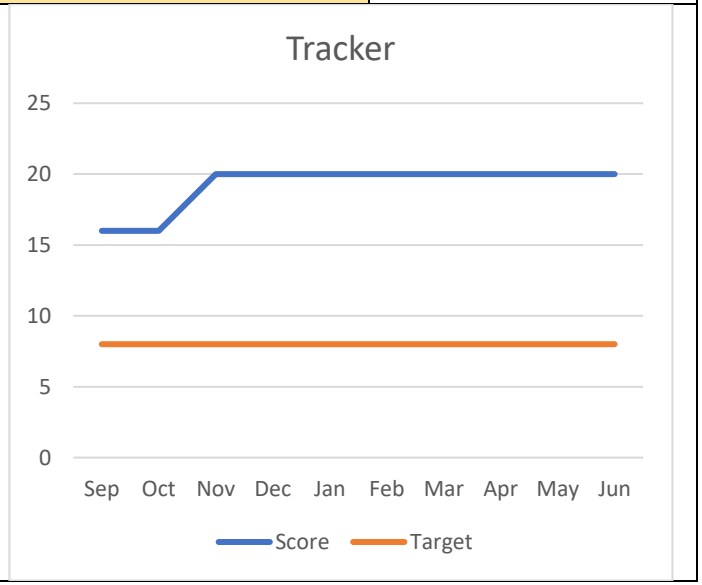
Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
Failure to ensure adequate data quality leading to patient harm, reputational risk and regulatory	Robust governance around data quality processes including executive ownership	RPAS will reduce the numbers of manual input errors	RPAS scheduled in for implementation in 2022	Data Quality Board External benchmarking	None Currently	None Currently	

failure because data quality processes are not robust	Audit work by data quality team More robust data input rules leading to fewer errors	Better training of the administration teams leading to more consistent recording of data	Director of Transformation working with OP areas to improve training				

RISK 12: If the Trust does not establish and maintain effective capacity management processes it will be unable to achieve waiting time targets due to seasonal emergency pressure (or further Covid-19 surges).

Strategic Objective 4: Meeting Key Targets

Strategic Risk	If the Trust does not establish and maintain effective capacity management processes it will be unable to achieve waiting time targets due to seasonal emergency pressure (or further Covid-19 surges).				**Strategic Objective**	Meeting Key Targets
Lead Committee	TEG	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Director of Operations	**Consequence**	5	5	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	09/06/2021	**Risk Rating**	20	10		



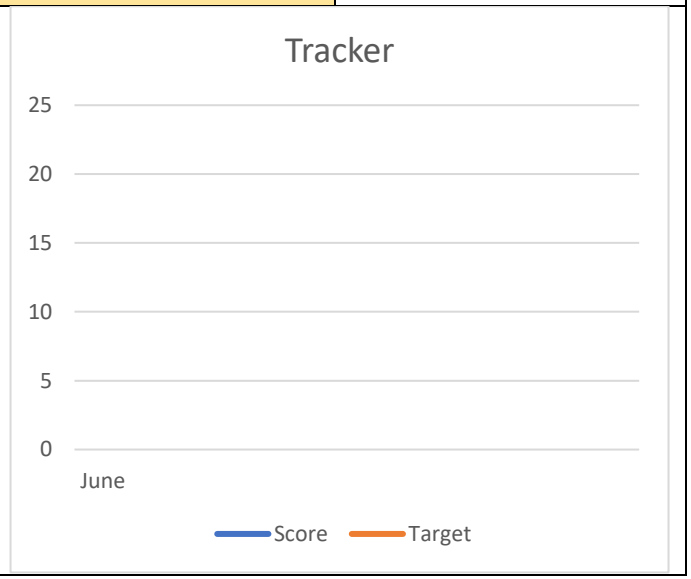
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Elective activity is suspended (locally or by national directive) to enable the Trust to cope with	Winter escalation plans to flex demand and capacity Plans to maintain urgent elective work	Unpredictable nature of both emergency demand and the surge nature of Covid-19	Continued planning and daily reviews (depending on Opel	Emergency Care Board (external partners) Regional and national tiers of	None Currently	None Currently	

emergency demand or further Covid-19 surges, resulting in increasing waits for patients needing elective treatment – including cancer care	and cancer services through periods of peak demand Agreed plans with local system National lead if level 4 incident, with established and tested plans Significant national focus on planning to maintain elective care	Workforce and space (in pandemic) rate limiting factors	and incident levels)	reporting and planning			

RISK 13: If the Trust does not have a sufficient capital expenditure limit (CDEL) then the Trust will not be able to complete the level of planned capital investment

Strategic Objective 7: Being Well Governed and Financially Viable

Strategic Risk	If the Trust does not have a sufficient capital expenditure limit (CDEL) then the Trust will not be able to complete the level of planned capital investment				**Strategic Objective**	Being Well Governed and Financially Viable
Lead Committee	Finance and Investment	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial
Executive Lead	DoF	**Consequence**	4	5	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	28/06/21	**Risk Rating**	16	10		



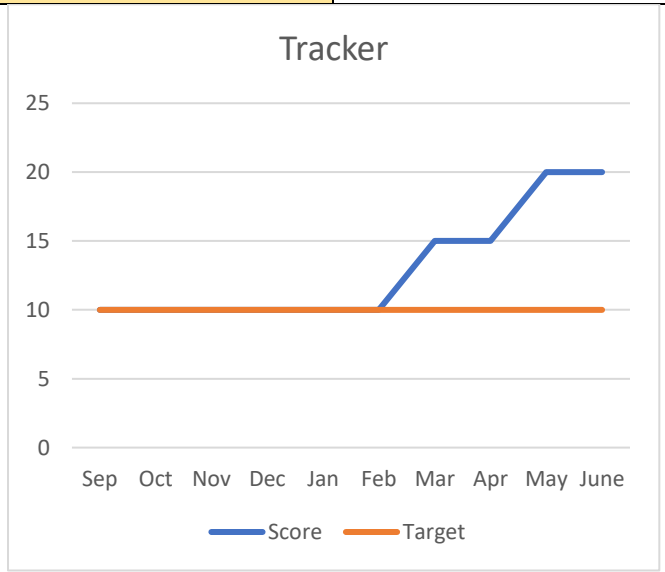
Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
Following the FY21 year end audit the Trust had to adjust misstated capital expenditure of £4.5m relating to a capital bond.	The Trust is introducing enhanced in-year capital spend monitoring to proactively manage in-year underspends across other capital	The Trust has limited control over the availability and reassignment of CDEL across the	The Trust will report the capital expenditure position (MKUH and ICS) and	Monthly capital report and BAF	CDEL reporting oversight at regional level	The Trust will engage with the NHSE/I Head of Finance	

As a consequence, the Trust has brought forward capital spending commitments of £4.5m into FY22 but does not have a sufficient capital expenditure limit to accommodate this investment.	schemes. Where agreed by management (e.g., subject to risks and strategic need) underspends across other capital schemes could free-up capital expenditure limit for utilisation against bond schemes. The Trust is engaging with NHSE/I regional colleagues and Integrated Care System partners to monitor planned capital expenditure limits (CDEL) across both ICS and regional organisations to proactively reassign available CDEL.	ICS and regional partners.	associated risks to F&IC and regularly update the Audit Committee through the BAF			for regular updates on the regional CDEL position	

RISK 14: If the Trust does not maintain investment in its IT infrastructure and systems, then all operational systems will be severely affected by IT failures such infiltration by cyber criminals.

Strategic Objective 7: Being Well Governed and Financially Viable

Strategic Risk	If the Trust does not maintain investment in its IT infrastructure and systems, then all operational systems will be severely affected by IT failures such infiltration by cyber criminals.				**Strategic Objective**	Being Well Governed and Financially Viable
Lead Committee	Finance and Investment	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial
Executive Lead	Deputy CEO	**Consequence**	5	5	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	17/06/2021	**Risk Rating**	20	10		



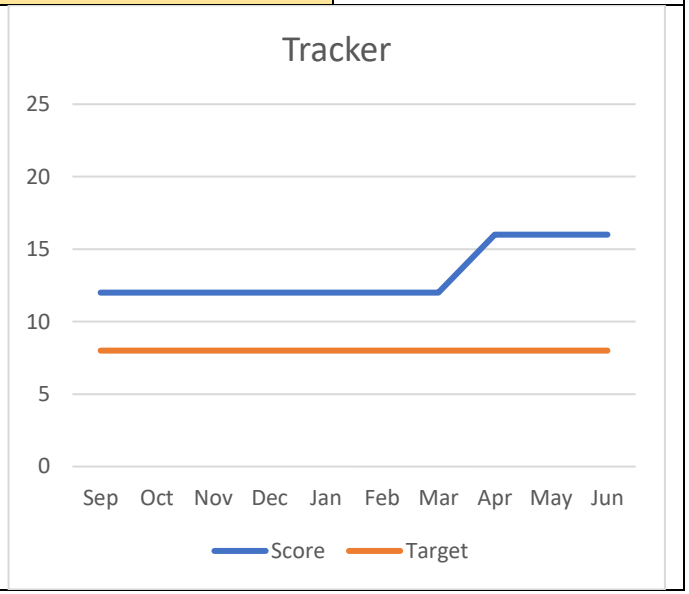
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Hardware failure due aged equipment Increasing Cyber-attacks across the	2 dedicated cyber security posts Good network protection from cyber security breaches	None identified	Continued review	External review and reporting Purchases new equipment to install in 9 months	None currently	None currently	

world and in particular in Ireland	such as Advanced Threat Protection (ATP) – A part of the national programmes to protect the cyber security of the hospital All Trust PCs less than 4 years old Purchase new hardware – not implemented yet EPR investment						

RISK 16: If the future NHS funding regime is not sufficient to cover the costs of the Trust, then the Trust will be unable to meet its financial performance obligations or achieve financial sustainability.

Strategic Objective 7: Being Well Governed and Financially Viable

Strategic Risk	If the future NHS funding regime is not sufficient to cover the costs of the Trust, then the Trust will be unable to meet its financial performance obligations or achieve financial sustainability.				**Strategic Objective**	Being Well Governed and Financially Viable
Lead Committee	Finance and Investment	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial
Executive Lead	DoF	**Consequence**	4	4	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	25/06/2021	**Risk Rating**	16	8		

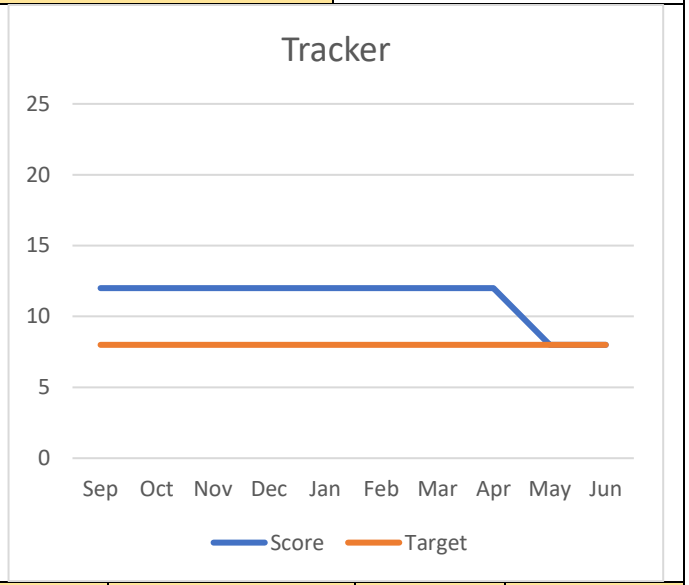


Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Increase in operational expenditure in order to manage COVID-19	1. Cost and volume contracts replaced with block contracts (set nationally) for clinical income;	Financial regime for FY22 only valid for first half of the year. Trust has minimal	Continued review of national funding intentions to maximise	Monthly financial performance reports. Cost efficiency reporting.	None Currently.	None Currently.	

Reductions in non-NHS income streams as a direct result of COVID-19. Impaired operating productivity leading to additional costs for extended working days and/or outsourcing. Potential for material increase in efficiency requirement from NHS funding regime to support DHSC budget affordability. Unknown funding regime beyond September 2021 due to disruption caused by COVID-19	2. Top-up payments available where COVID-19 leads to additional costs over and above block sum amounts (until September 2021); 3. Budgets to be reset for FY22 based on prevailing finance regime; financial controls and oversight to be reintroduced to manage financial performance. 4. Cost efficiency programme to be relaunched to target focus on areas of greatest opportunity.	ability to influence.	time to plan organisation response.	BLMK ICS finance performance reports.			

RISK 18: Insufficient capacity in the Neonatal Unit to accommodate babies requiring special care (finance and quality risk)

Strategic Objective 7: Being Well Governed and Financially Viable

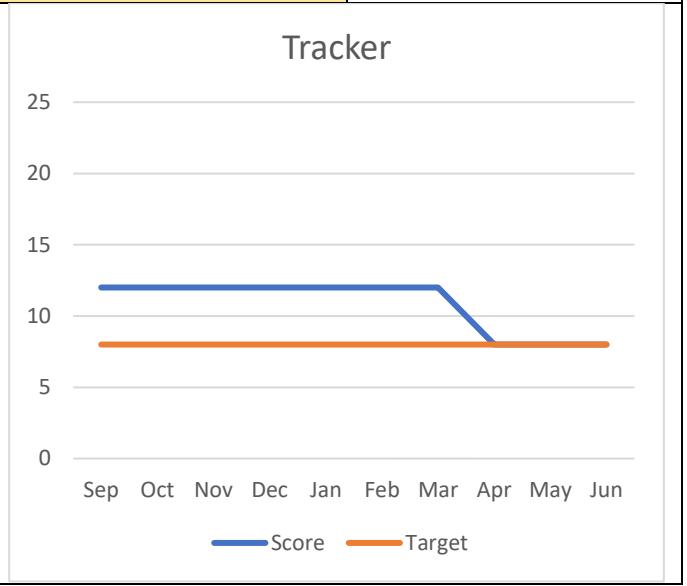
Strategic Risk	Insufficient capacity in the Neonatal Unit to accommodate babies requiring special care						**Strategic Objective**	Being Well Governed and Financially Viable/ Patient Safety
Lead Committee	Finance and Investment and Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial		
Executive Lead	Deputy Chief Executive	**Consequence**	4	4	**Risk Appetite**	Cautious		
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat		
Date of Review	17/06/2021	**Risk Rating**	8	8				

Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
The current size of the Neonatal Unit does not meet the demands of the service. This risks high numbers of transfers of unwell	Reconfiguration of cots to create more space Additional cots to increase capacity	External timeframe and approval process for HIP2 funding	Continued review	External review and reporting. Whilst a technical risk the likelihood has been downgraded on			

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 fulfil its Network responsibilities and deliver care in line with national requirements.	Parents asked to leave NNU during interventional procedures, ward rounds, etc to increase available space. HIP2 funding for new Women and Children's Hospital announced.			the basis of actual reporting			

RISK 19: If the Trust does not retain staff then posts will be vacant resulting in workforce shortages across the hospital and/or increased temporary staffing expenditure.

Strategic Objective 8: Investing in Our People

Strategic Risk	If the Trust does not retain staff then posts will be vacant resulting in workforce shortages across the hospital or increased temporary staffing expenditure.				**Strategic Objective**	Investing in Our People	
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff	
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Cautious	
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat	
Date of Review	15/06/2021	**Risk Rating**	8	8			

Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
Proximity to tertiary centres Lack of structured career development or	Variety of organisational change/staff engagement activities, e.g. Event in the Tent	None Currently	Continued review	External review and reporting Vacancy and Retention Rates	None Currently	None Currently	

opportunities for progression Benefits packages elsewhere Culture within isolated departments	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						

RISK 20: If the Trust does not recruit to vacancies in the short term (0-18 months) then there will be workforce shortages across the hospital and/or increased temporary staffing expenditure.

Strategic Objective 8: Investing in Our People

Strategic Risk	If the Trust does not recruit to vacancies in the short term (0-18 months) then there will be workforce shortages across the hospital and/or increased temporary staffing expenditure.						**Strategic Objective**	Investing in Our People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff	At target level – no tracker	
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Cautious		
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Tolerate		
Date of Review	15/06/2021	**Risk Rating**	8	8				

Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
National shortages of appropriately qualified staff in some clinical roles, particularly at consultant level for dermatology and acute medicine, and at middle grade level for urology and trauma and orthopaedics	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	None Currently	Continued review	External review and reporting Vacancy Rates	None Currently	None Currently	

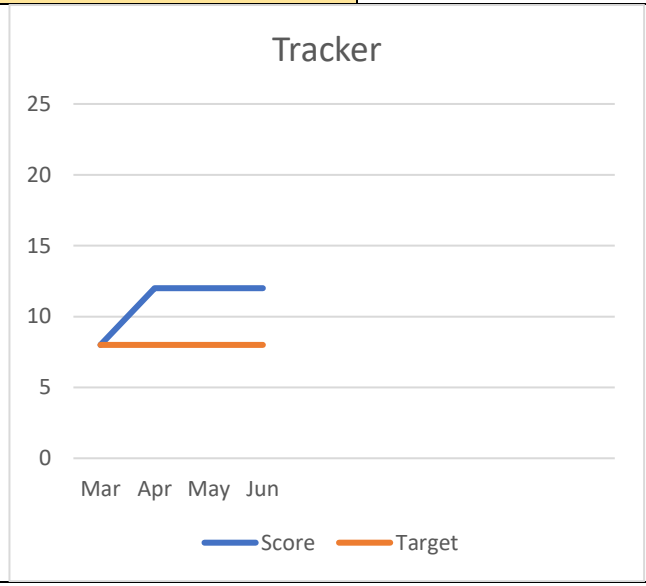
Competition from surrounding hospitals Buoyant locum market National drive to increase nursing establishments leaving market shortfall (demand outstrips supply)	Use of recruitment and retention premia as necessary Use of the Trac recruitment tool to reduce time to hire and candidate experience Rolling programme to recruit pre-qualification students Use of enhanced adverts, social media and recruitment days Rollout of a dedicated workforce website Review of benefits offering and assessment against peers. Creation of recruitment "advertising" films Recruitment and retention focussed workforce strategy and plan to fill vacancies, develop new roles and deliver improvement to working experience/ environment						

	Targeted recruitment to reduce hard to fill vacancies						

RISK 21: If the Trust does not recruit to vacancies in the long term (19+ months) then there will be workforce shortages across the hospital and/or increased temporary staffing expenditure.

Strategic Objective 8: Investing in Our People

Strategic Risk	If the Trust does not recruit to vacancies in the long term (19+ months) then there will be workforce shortages across the hospital and/or increased temporary staffing expenditure.				**Strategic Objective**	Investing in Our People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Tolerate
Date of Review	15/06/2021	**Risk Rating**	12	8		



Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
National shortages of appropriately qualified staff in some clinical	Monitoring of uptake of placements & training programmes	None Currently	Continued review	External review and reporting Vacancy Rates	None Currently	None Currently	

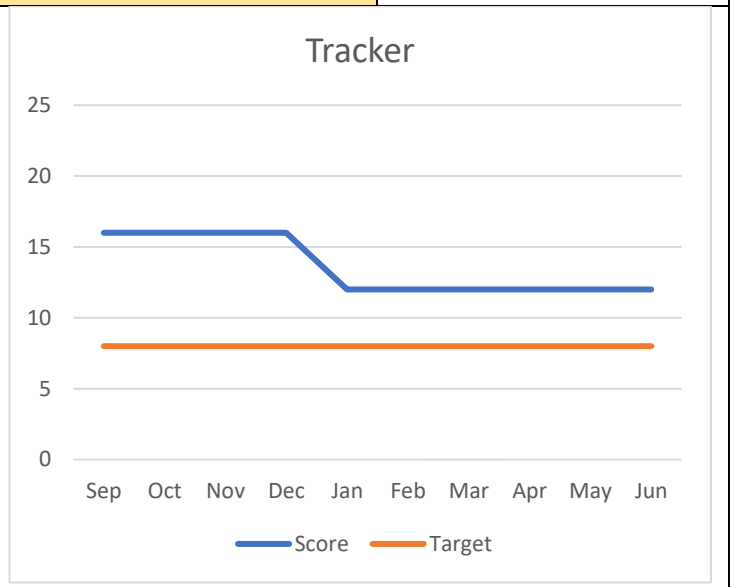
roles, particularly at consultant level Brexit may reduce overseas supply Competition from surrounding hospitals Buoyant locum market National drive to increase nursing establishments leaving market shortfall (demand outstrips supply) Large percentage of workforce predicted to retire over the next decade Large growth prediction for MK - outstripping supply Buoyant private sector market creating	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						

competition for entry level roles New roles upskilling existing senior qualified staff creating a likely gap in key roles in future (e.g. band 6 nurses) Reducing potential international supply New longer training models	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						

RISK 22: If the Trust is unable to maintain a compliant training environment, 11 postgraduate training posts remain under threat of removal by HEE.

Strategic Objective 8: Investing in Our People

Strategic Risk	If the Trust is unable to maintain a compliant training environment, 11 postgraduate training posts remain under threat of removal by HEE.				**Strategic Objective**	Investing in Our People/ Patient Safety	
Lead Committee	Workforce/ Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff	
Executive Lead	Medical Director	**Consequence**	4	4	**Risk Appetite**	Avoid	
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat	
Date of Review	21/06/2021	**Risk Rating**	12	8			



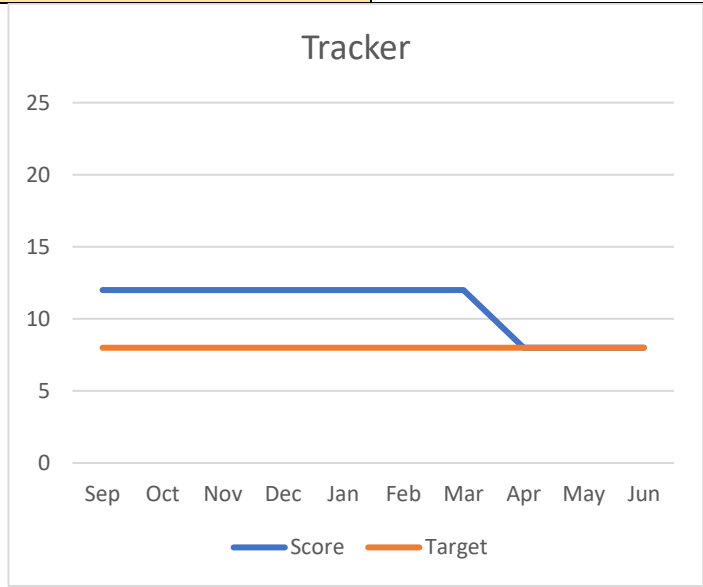
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Poor training environment: lack of standardisation of process; variable levels of	Heavy involvement from clinical leaders outside the department (DD, DME, MD).	To date, we have not recruited to the additional posts approved in order to move	Positive initial work with Professor Belinda	HEETV undertook a virtual visit on 04/12/2020 and the risk score	None Currently	None Currently	

support; and, persistent concerns around behaviours by consultants perceived as belittling / inappropriate / bullying. Risk raised in November 2019 following HEE TV quality meeting.	Change in clinical leadership model within the service. Formative external review (Berendt consulting). Close liaison with HEE TV Head of School. Developmental work 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.	away from a single tier middle grade rota 24/7. This currently sits in part with the Head of School as a rotation is envisaged. The COVID-19 situation has resulted in additional complexity (development work etc.)	Dewar (Wee Culture) across the maternity department, using appreciative inquiry. Recruitment in progress of additional middle grade doctors with anticipated start date August 2021.	(HEE intensive support framework) was reduced from 'category 3 – major concerns' to 'category 2 – significant concerns.			

RISK 23: If the Trust does not maintain stocks of Personal Protective Equipment (PPE) and continue implementing the enhanced infection control measures it will be unable to maintain a safe working environment during the COVID-19 pandemic

Strategic Objective 8: Investing in Our People

Strategic Risk	If the Trust does not maintain stocks of Personal Protective Equipment (PPE) and continue implementing the enhanced infection control measures it will be unable to maintain a safe working environment during the COVID-19 pandemic				**Strategic Objective**	Investing in Our People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat
Date of Review	15/06/2021	**Risk Rating**	8	8		



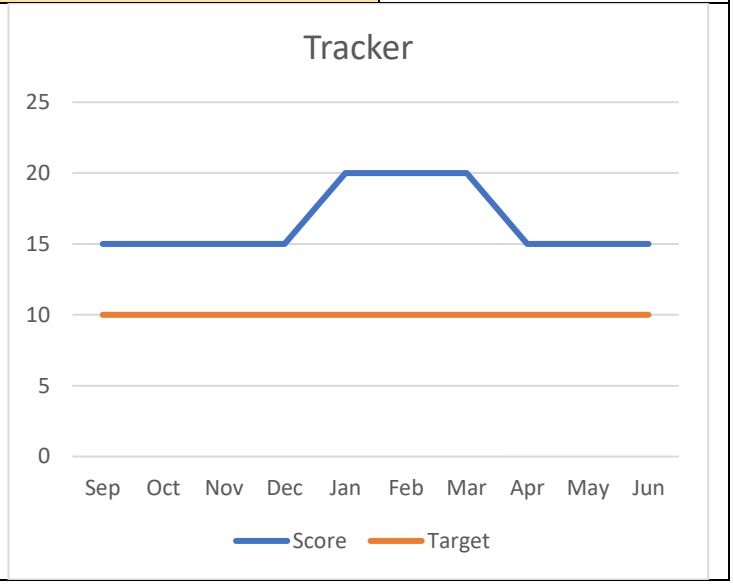
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Ability to maintain a safe working environment during the Covid-	Incident command structure in place	None currently – noted that this risk may escalate very quickly	None Currently	Completed Risk Assessments	None Currently	None Currently	

19 pandemic due to a lack of equipment, including PPE, or inadequate staffing numbers	Oversight on all critical stock, including PPE Immediate escalation of issues with immediate response through Gold/ Silver National and regional response teams in place Workforce and Workplace Risk Assessments completed and any necessary equipment or working adjustments implemented. Staff COVID-19 Self-Test and vaccine offer to all MKUH workers			PPE Stock Level Reports Staff Test Stock Levels Staff Vaccine Uptake Report			

RISK 24: If the Trust does not implement and progress staff health and wellbeing initiatives, there is the risk of staff burning out during or due to the COVID-19 pandemic

Strategic Objective 8: Investing in Our People

Strategic Risk	If the Trust does not implement and progress staff health and wellbeing initiatives, there is the risk of staff burning out during or due to the COVID-19 pandemic				**Strategic Objective**	Investing in Our People	
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff	
Executive Lead	Director of Workforce	**Consequence**	5	5	**Risk Appetite**	Avoid	
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat	
Date of Review	15/06/2021	**Risk Rating**	15	10			



Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
Staff burnout due to high-stress working environment, conditions of lock-down, recession	Significant staff welfare programme in place, with mental health, physical health and support and advice available	Significant uncertainty about next wave of the pandemic and how it will affect staff	Continued monitoring, continued communication and engagement	Regular virtual all staff events Surveys	None Currently	Package of measures to support	

and other social factors	Staff Hub in use Remote working wellness centre in place 12 weeks of wellbeing focus January to March		with staff about support systems			remote workers	

Agenda Item 18.1
Public Board 08/07/2021

Meeting of the Audit Committee held on 19 May 2021

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:
The Committee approved the Evaluation Report.

Summary of matters considered at the meeting:

Draft Annual Report 2020-21
The Committee reviewed the draft 2020/21 Annual Report.

Internal Audit
The Committee discussed the Head of Internal Audit Opinion.

Agenda Item 18.2
Public Board 08/07/2021

Meeting of the Audit Committee held on 07 June 2021

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

a. The Committee approved the Analytical Review – Annual Accounts 2020/21.
b. The Committee approved the Initial Management Response to Independent Auditor's Report

Summary of matters considered at the meeting:

Draft Annual Accounts
The Committee reviewed the draft 2020-21 Annual Accounts and recommended that the Trust Board approve it for submission to NHSI.
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Going Concern Statement
The Committee reviewed the Going Concern Statement.

Independent Auditor's Report
The Committee reviewed the Independent Auditor's Report

Draft Annual Report
The Committee reviewed the draft 2020-21 Annual Report and recommended that the Trust Board approve it for submission to NHSI.

Agenda item
Public Board 08.07.21

Meeting of the Finance and Investment Committee held on 04 May 2021

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:
The Committee approved the Evaluation Report.

Summary of matters considered at the meeting:

- Regarding the M12 Performance Dashboard, the Committee noted that Emergency Department activity had returned to pre-pandemic levels, but performance remained good. The Committee also noted that activity was lower than desired in the Theatres due to capacity constraints in theatres and the effects of the social distancing rules.

- Regarding COVID-19 related costs, the Committee noted that the spend of £16m had been offset by underspends on normal activities. The Committee also noted the anticipated significant risks posed by non-recurrent costs which will arise as the Trust returns to normal practices and behaviours.

- Regarding the Capital Programme, Committee noted that the COVID-19 hit financial year ended with a capital spend of £44.1m against an allocation of £44.7.

- The Committee discussed the draft Cancer Centre Post Project Review, and suggested amendments.

- The Committee was briefed on the developments around the revised 2022 Business Planning process.

Agenda item
Public Board 08.07.21

Meeting of the Finance and Investment Committee held on 01 June 2021

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:
N/A

Summary of matters considered at the meeting:

- Regarding the M01 Performance Dashboard, the Committee comprehensively reviewed the trajectories of all key performance indicators.

- Regarding the M01 Finance Report, the Committee was briefed on the further developments around the revised and delayed 2022 Business Planning process.

- The Committee noted the provision of an 'Elective Recovery Fund' to support the Accelerator Programme.

- The Committee reviewed the changes to public procurement regulations after Brexit and the proposed changes following publication of the Green Paper on Transforming Public Procurement.

- The Committee reviewed the 2021/22 Capital Programme.