Board of Directors

Board to be held at 10:00 on Thursday 9 January 2020 in
Conference Room, Academic Centre, Milton Keynes University Hospital

Agenda

Item No.	Title	Purpose	Type and Page No.	Lead
1. Introduction and Administration				
1.1	Apologies	Receive	Verbal	Chair
1.2	Declarations of Interest i) Any new interests to declare ii) Any interests to declare in relation to open items on the agenda	Receive	Verbal	Chair
1.3	Minutes of the public meeting held on 7 November 2019	Approve	Pg. 2	Chair
1.4	Matters Arising/ Action Log	Approve	No open actions	Chair
2. Chairman and Chief Executive Reports				
2.1	Chair's Report	Discuss	Verbal	Chair
2.2	Chief Executive's Report	Discuss	Verbal	Chief Executive
3. Quality				
3.1	Patient story	Discuss		
3.2	Nursing staffing update	Receive and Discuss	Pg. 12	Director of Patient Care and Chief Nurse
3.3	Summary reports • Finance & Investment Committee - 2 December 2019 • Quality & Clinical Risk Committee – 19 December 2019 • Audit Committee – cancelled (to be reconvened)	Note	Pg. 21 Pg. 23	Committee Chairs
4. Strategy				
4.1	Cancer Centre update		Verbal	
4.2	Winter plan update		Verbal	
4.3	MKUH Objectives update	Receive and Discuss	Pg. 25	

Item No.	Title	Purpose	Type and Page No.	Lead
5. Performance				
5.1	Performance Report Month 8	Discuss	Pg. 42	Deputy CEO/ Director of Operations
5.2	Finance Month 8	Discuss	Pg. 54	Director of Finance
5.3	Workforce report Month 8	Discuss	Pg. 62	Director of Workforce
6. Assurance and Statutory Items				
6.1	Board Assurance Framework and risk	Discuss/ Approve	Pg. 66	Director of Corporate Affairs
7. Closing Administration				
7.1	Any Other Business	Discuss/ Note/ Approve	Verbal	Chair
7.2	Questions from Members of the Public	Receive and Respond	Verbal	Chair
7.3	Motion to Close the Meeting	Receive	Verbal	Chair
7.4	Resolution to Exclude the Press and Public The Chair to request the Board pass the following resolution to exclude the press and public and move into private session to consider private business: “That representatives of the press and members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted	Approve		Chair

Milton Keynes University Hospital NHS Foundation Trust

BOARD OF DIRECTORS MEETING

Minutes of the Board of Directors meeting held in PUBLIC on 07 November 2019 in the Conference Room, Academic Centre, Milton Keynes University Hospital

Present:

Simon Lloyd	Chairman
Joe Harrison	Chief Executive
John Blakesley	Deputy Chief Executive
Caroline Hutton	Director of Quality Improvement
Danielle Petch	Director of Workforce
Nicky Burns-Muir	Director of Patient Services and Chief Nurse
Mike Keech	Director of Finance
Ian Reckless	Medical Director
Heidi Travis	Non-Executive Director (Chair of the Finance & Investment Committee
Tony Nolan	Non-Executive Director (Chair of the Workforce and Development Assurance Committee)
Helen Smart	Non-Executive Director (Chair of the Quality and Clinical Risk Committee)
Parmjit Dhanda	Non-Executive Director (Chair of the Charitable Funds Committee)
Andrew Blakeman	Non-Executive Director (Chair of the Audit Committee)

In attendance:

Julie Goodman	Trust Lead for Complaints and PALS (item 3.1)
Kate Jarman	Director of Corporate Affairs
Adewale Kadiri	Company Secretary
Alison Marlow	Communications Manager

2019/11/01	**Welcome**
1.1	The Chairman welcomed all present to the meeting.
2019/11/02	**Apologies**
2.1	Apologies had been received from Nicky McLeod and John Clapham.
2019/11/03	**Declarations of interest**
3.1	No new interests had been declared and no interests were declared in relation to the open items on the agenda.
2019/11/04	**Minutes of the meeting held on 5 September 2019**
4.1	The minutes of the public Board meeting held on 5 September 2019 were accepted as an accurate record.

2019/11/05	**Matters Arising/ Action Log**
5.1	<u>365 Nursing staffing report</u> The information sought around the number of healthcare assistants employed by the Trust and the amount of care that they are responsible for delivering has been included in this month's nursing staffing report. Action closed.
2019/11/06	**Chairman's Report**
6.1	The Chairman reported that he had held a positive meeting with the Chair of Central and North West London Foundation Trust with a particular focus on the development of a placed based approach to healthcare in MK.
6.2	The pre-election 'period of sensitivity' has commenced, and the guidance to avoid making any politically sensitive pronouncements or decisions has been noted.
6.3	The Chairman informed the Board that an individual organised an event, ostensibly to raise money for the Cancer Centre Appeal, but no funding has subsequently been passed on in spite of repeated requests. The individual has now informed the Head of Fundraising that the event did not generate any profits and has offered an explanation to support this position. The Charities Commission and Fundraising Regulator have been informed of the position, and they are both supportive of the action that the Trust has taken. The Chairman will continue to liaise with the Head of Fundraising about the matter and will update the Board further.
6.4	The Staff Awards event is to take place a week on Friday at the MK Dons Stadium. This year has seen the highest number of nominations so far, and it promises to be a memorable occasion to celebrate the work of all staff. **Resolved**: The Board **noted** the Chairman's' Report
2019/11/07	**Chief Executive's update**
7.1	The Chief Executive highlighted the very successful visit by the Prime Minister last Friday. He had spent more time than expected on the children's ward and colleagues had taken the opportunity to set out in detail the Trust's site development plans. He thanked all those who had been involved in the visit, stating that Mr Johnson had received a clear narrative about the Trust's priorities.
7.2	Matthew Gould, the Chief Executive of NHSX, the new organisation that had been set up to speed up the digital transformation of the NHS and social care, had also visited, following up Baroness Harding's earlier visit. This had also been a positive visit, as Mr Gould had signalled his intention to focus on those organisations that are leasing the way on this agenda.
7.3	Lisa Bayliss Pratt, the Chief Nurse at Health Education England, who will be shortly be taking up the role of Pro Vice chancellor at Coventry University, also visited the Trust. 2020 is to be the International Year of Nurses and Midwives, and Professor Bayliss Pratt will be leading the

	events around this in England. She wants the Trust to identify how it will develop 20 young people in leadership roles.
7.4	Julian Kelly, the Director of Finance for NSHI&E will be visiting soon as part of his drive to build relationships at regional and national levels.
7.5	Helen Smart enquired about the source of the briefings that were provided ahead of these VIP visits. The Chief Executive responded that the Prime Minister's team had approached the Trust directly, but that Baroness Harding's briefing had been provided by the region. He remarked that the hospital is very busy and will continue to be, but it is likely to continue to be used as a media hub.
7.6	The Chief Executive informed the Board of a number of incidents of violence and aggression towards members of staff. There had also been two occasions recently when it had been necessarily to briefly lock the hospital down. The executive are reflecting on measures that may need to be taken going forward. The Chief Executive reiterated his gratitude to all staff, some of whom have to work in difficult circumstances. He confirmed that the significant act of aggression that had been directed at a member of staff who challenged a member of the public for smoking on the site is being pursued through the criminal justice system. A message will be put out around this, and consideration is to be given to enhancing CCTV coverage across the site. Resolved: The Board **noted** the Chief Executive's Report
2019/11/08	**Patient's Story**
8.1	The Complaints and PALS Lead attended to deliver the patient's story in conjunction with the Chief Nurse. This story relates to the experience of a carer whose wife suffered with Motor Neurone Disease (MND) – a very difficult life limiting disease that affects around 5000 adults in UK, and 25 locally. Around 80% of sufferers have communications difficulties.
8.2	The PALS team became involved while visiting ward 16 as part of efforts to gain an understanding of patients' experience of care. The carer was there with his wife and told the team of the experience they had had on ward 1 previously. He knew that his wife was coming to end of her life, and she could only communicate using a computer attached to her wheelchair and with eye contact. While on ward 1 she had needed wheelchair by her bed because of the computer, but this was not permitted due to the space constraints on that ward. This resulted in her not being able to communicate for five days. For the same reasons of space, the ward had not allowed him to stay with her overnight.
8.3	The carer had been reluctant to make a complaint and had been very positive about ward 16 – the staff there had been very caring and he had been allowed to stay overnight, albeit that all they had been able to provide for him was a reclining chair.
8.4	A task and finish group has been set up in conjunction with community-based partners with the aim of improving pathways for MND, but also for other patients with complex needs. The need to educate all staff has been identified, and this story is being used to highlight the impact that decisions

	can have on patients. A staff nurse on ward 2 who has worked with patients with learning disabilities is to join that group to provide the benefit of her experience. The Chief Nurse indicated that on speaking to the staff on ward 1, she had gained the impression that they had not felt empowered to make the change necessary to give the patient and her carer the level of care required. They had instead been too focused on the lack of space.
8.5	Helen Smart highlighted the inconsistency in approach around overnight carer stays between wards 1 and 16. In response, the Director of Corporate Affairs confirmed that the Trust's policy supports John's Campaign and the organisation actively supports carers staying overnight – work is being done to ensure that this approach is applied consistently across the organisation.
8.6	Andrew Blakeman expressed shock at the story and admitted that it had shaken his confidence in the overall quality of care across the organisation. The Chief Nurse explained that the rationale behind presenting the story is to empower people to make changes in their care environment. She explained that there are other situations where there can be communication issues, such as with deaf patients or those with learning disabilities. The Chief Executive highlighted the impact that poor design in some parts of the hospital sometimes has on the quality of care. Andrew Blakeman was also concerned that even on ward 16, the patient's husband had had to sleep in a chair. Heidi Travis was concerned that staff become so busy that they may sometimes lose sight of the patient. **Resolved**: The Board **noted** the patient's story, and thanked the Chief Nurse for presenting it
2019/11/09	**Patient Experience Strategy**
9.1	The Chief Nurse presented the Patient Experience Strategy 2019 to 2022 for approval, explaining that this sets out the areas that will be focused on for the next three years. She added that once the strategy has been approved, it would be for the Patient Experience Board to consider how progress against implementation is to be measured.
9.2	Helen Smart commended the document as being clear and well-presented but asked if there is to be an accompanying action plan. In response, the Chief Executive stated that there is to be no separate action plan, as the strategy is linked to the Trust objectives in relation to which there is already a measurement plan. Tony Nolan also commended the document but acknowledged that achieving the aims set out will be tough. He particularly noted that communication is one of the hardest aspects to get right. Andrew Blakeman added that the document is really well written and clear. **Resolved**: The Board **approved** the Patient Experience Strategy
2019/11/10	**Nursing Staffing Update**
10.1	The Chief Nurse presented this routine paper. She remarked that the Care Hours Per Patient Day (CHPPD) measure remains consistent, as it has

	been in the last few months. It was noted that fill rates lower, as staff are increasingly choosing not to do late shifts.
10.2	The Board at its last meeting had asked that a breakdown be provided to show what proportion of care is delivered by healthcare assistants – this has been set out in the paper.
10.3	In relation to recruitment, it was noted that there is a concern around Band 5s within Medicine. However, plans are in place, and a recruitment day is to be held on Saturday. Some good work has been done in Theatres, taking advantage of the staff benefits package. However, there is a significant vacancy factor in the Department of Critical Care, with staff there moving on to do other things internally and externally. Maternity have run a successful campaign. The total vacant factor is 17%, but the figure for healthcare assistants has gone up.
10.4	The Board's attention was drawn to the "deep dive" that has been done into the reasons for healthcare assistants leaving, and the expectation that the development programme that is being put together will address the issues raised.
10.5	In response to the question whether the Trust is efficient, it was noted that agency costs continue to drop and the turnover rate has also fallen. The sickness absence rate among nursing staff is also below the Trust-wide target.
10.6	The success of the first cohort of staff to attend the band 6 development programme was noted. Recruitment for cohorts 2 and 3 is underway, and it is possible that 60 members of staff would have gone through the programme by the end of the year. It has been agreed that the preceptorship programme will run for two years. The Trust has also agreed to increase its student uptake. Interviews are being held today for the nursing cadet programme.
10.7	Helen Smart commended the work that has been done on retention and sickness. She asked where the highest vacancy rate was and whether there are any concerns. The Chief Nurse acknowledged that ward 14 presents and interesting working environment as it has a different model. The senior sister on ward 15 has resigned recently, and there have been concerns there. The matron is undertaking close supervision.
10.8	Andrew Blakeman enquired why a fill rate of 78.5% is not deemed to be dangerous. In response the Chief Nurse explained that the matrons are successful at moving staff around in order to balance acuity and available resources. Parmjit Dhanda indicated that the Workforce and Development Assurance Committee had considered the issue of headcount but could not agree on what an ideal pie-chart should look like. The Chief Nurse acknowledged that it would be difficult to present this for the whole organisation.
10.9	The Medical Director confirmed that the higher fill rates at night relate to the use of enhanced observation. **Resolved**: The Board **noted** the nursing staffing report.

2019/11/11	**7-day Services Update**
11.1	The Medical Director provided this update on the Trust's progress towards meeting the 4 priority standards under 7-day services. The organisation is now getting a better idea of where it needs to focus its efforts. The work in progress is being managed through Divisional Management Board. The Medical Director informed the Board that the Trust's performance is in line with the national average, but he would be able to obtain more detailed feedback.
11.2	Tony Nolan noted that standard 2 is not being met during weekdays and asked how the executive is assured that no harm is being done. In response, the Medical Director indicated that he constantly challenges clinicians around this, and is working with the different specialities to improve, although he acknowledged that the position is different in relation to gynaecology. He also agreed that scale is an issue, particularly in relation to standard 3 as in most cases there are only 4 or 5 available consultants. The Chief Nurse added that being seen by a consultants in the Emergency Department does not count because it is not after admission. It was acknowledged that in all specialities consultants should be seeing patients after admission. This needs to be put in place for urology
11.3	Andrew Blakeman questioned whether it always has to be a consultant. It was noted that efforts had been made to bring both consultants and registrars closer to the front of the hospital, but there are practical difficulties.
11.4	In response to a question from Helen Smart as to the consequences of not delivering, it was acknowledged that this is currently unknown. However, the point was made that it would cost the trust £2m to deliver standard 8, and the Trust has limited control over what happens at Oxford. **Resolved**: The Board **noted** the data presented and **approved** its submission to NHS England.
2019/11/12	**Mortality Update Report**
12.1	The Medical Director introduced this regular report on mortality. He informed the Board that in line with the National Patient Safety Strategy, death and mortality are now considered under the Patient Safety Strategy. In this regard, the Trust is required to review all community deaths.
12.2	The Trust's HSMR sits at around 100 and is "as expected". There has been a rise in the divisional HSMR, relating to 'other perinatal conditions', and this led to the production of a mortality alert. The Medical Director expressed confidence that this is an incorrect alert and is likely to have been caused by a change in coding practice or a coding error. In fact, the Trust has good assurance that deaths in this are in fact steadily falling, and more recent data indicates that this alert is no longer present.

12.3	In response to a question whether the Trust would become an outlier if its HSMR remained above 100, the Medical Director stated that this would only become the case if the rate reached around 107. **Resolved**: The Board **noted** the mortality update
2019/11/13	**Performance Report Month 6**
13.1	The Deputy Chief Executive presented this routine update on the Trust's operational performance, reiterating that the Trust is under pressure, but that it is at the same time required to improve its performance. **Resolved**: The board **noted** the Month 4 Performance Report.
2019/11/14	**BLMK Longer Term Plan**
14.1	The Director of Finance presented the BLMK draft long-term plan. He informed the Board that the Region had been set a 4-year financial trajectory, based on national modelling, which includes a 0.5% efficiency requirement with a view to creating a regional contingency reserve. For the Trust, this amounts to a £1.3m cost in 2020/21. At MK Place level, this would amount to a £3.1m risk in 2020/21, rising to £13m to 2023/24.
14.2	The Director of Finance highlighted the financial risk of accepting this trajectory, and he also made reference to the fact that under these proposals, a substantial part (75%) of future PSF would be defined by STP performance. He reminded the Board that in 2018/19 both the Trust and the CCG delivered on their plans. However, in 2019/20, as at month 6, the ICS is £6.5m behind control total, although this position is expected to improve.
14.3	The Director of Finance clarified that the risk is less about the Trust's position, but that the additional requirement constricts the funding that is available for the MK Place. There is also risk to the FRF. The Chief Executive indicated that other organisations within the ICS had not met their obligations, but he acknowledged that from the Region's point of view, BLMK is one system. Nevertheless, he thought that it would be important to highlight the potentially punitive impact of this approach on the MK Place in the most appropriate fashion. It was agreed that refusing to accept the plan would not be helpful, but an alternative approach could be to respond to ICS to highlight the Trust's concerns and seek some form of mitigation. The Board suggested that Simon Lloyd as Trust Chairman, ought to engage with Richard Carr, the ICS lead, and in parallel with Ann Radmore, the NHSE & I regional director.
14.4	It was noted that the final plan submission is due on the 15th of November.
14.5	The Board confirmed that it is content with proposed approach. **Resolved**: The Board **approved** the plan subject to agreeing the financial arrangements
2019/11/15	**Finance Report Month 6**

15.1	The Director of Finance introduced the routine finance report. **Resolved**: The Board **noted** the month 6 Finance Report.
2019/11/16	**Workforce Report Month 6**
16.1 16.2	The Director of Workforce presented the month 6 workforce report. She observed that performance is good against all the key performance indicators except the vacancy rate. The headcount is steadily rising, which is positive. The popularity of the staff benefits package, and the training and development offer were cited as key reasons behind this. The drive towards compliance in relation to staff appraisals is also thought to be having an impact. The Board recognised the improvement across most of the indicators and commended the workforce team for their efforts. **Resolved:** The Board **noted** the Month 6 Workforce Report.
2019/09/17	**Board Assurance Framework**
17.1 17.2 17.3	The Director of Corporate Affairs introduced the latest iteration of the BAF, informing the Board that work is ongoing to transition to a new format for managing board level risk. She indicated that discussions have taken place about raising the ratings of the risks around A&E performance and the management of demand. The intention is to elevate these in accordance with the ratings on the Significant Risk Register. It was also noted that eCare poses an increasing risk. Violence and aggression towards staff is increasingly an issue and is a theme in the staff survey results – the Director of Workforce confirmed this and indicated that staff side representatives have raised it as a concern. There is data to support this through incidents reported on the Datix system as well as the staff survey returns – this is in relation to violence and aggression both from members of the public and other members of staff. **Resolved:** The Board **noted** the Board Assurance Framework
2019/11/18	**Update to the Terms of Reference of the Board and its Communities**
18.1 18.2	The Director of Corporate Affairs informed the Board that the draft updated Terms of Reference of the Board Committees are presented for approval, following discussion and approval by the respective Committees. The Chairman informed the Board that although Douglas Campbell had resigned as a Governor, he was willing to continue as a member of the Charitable Funds Committee – Mr Lloyd was keen that the Committee continues to have the benefit of his deep knowledge of charitable matters. The Board noted that this is permitted under that Committee's terms of reference and approved the proposal. Mr William Butler, a Public

	Governor, has put himself forward as the Council of Governor representative on the Committee. **Resolved**: The Board approved the update to the Terms of Reference.
2019/11/19	**Board Register of Interest**
19.1 19.2	The Director of Corporate Affairs presented the latest version of the Board's Register of Interests ahead of publication on the Trust website. It was noted, in relation to other members of staff who are also required to submit declarations, that the low percentage of consultant medical staff who have done so if a matter of concern. The Trust Secretary will be working with the Medical Director and the Director of Workforce to address this. **Resolved**: The Board **noted** the updated Board Register of Interests
2019/11/20	**Finance and Investment Committee summary report 30 September 2019**
20.1	The Board **noted** the summary report of the Finance and Investment Committee meeting held on 30 September 2019
2019/11/21	**Workforce Development Assurance Committee summary report 28 October 2019**
21.1	The Board **noted** the summary report of the Workforce and Development Assurance Committee meeting held on 28 October 2019.
2019/11/22	**Audit Committee summary Report 23 September 2019**
22.1	The Board **noted** the summary report of the Audit Committee meetings held on 23 September 2019
2019/11/23	**Quality and Clinical Risk Committee Report 23 September 2019**
23.1	The Board **noted** the summary report of the Quality and Clinical Risk Committee held on 23 September 2019
2019/11/24	**Questions from members of the public**
24.1	There were no questions from members of the public.
2019/11/25	**Any other business**
25.1	A question was raised in relation to a letter that was received about six months ago, indicating that the Trust's stroke hyperacute ought to be subjected to an inspection. The Medical Director confirmed that the issue had been resolved

Meeting title	Board of Directors	**Date:** 9th January 2020	
Report title:	Nursing Staffing Report	**Agenda item:**	
Lead director **Report author Sponsor(s)**	**Name:** Nicky Burns-Muir **Name:** Matthew Sandham	**Title:** Director of Patient Care/Chief Nurse **Title:** Associate Chief Nurse	
FoI status:			
Report summary			
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [x] **Decision** [ ]
Recommendation	That the Board receive the Nursing Staffing Report.		

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

Report history	To every Public Board
Next steps	
Appendices	Appendices 1 and 2

Board of Directors Report on Nursing and Midwifery staffing levels
Amalgamated report for October 2019 and November 2019

1. Purpose

To provide Board with: -

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

Are we safe?

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

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

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

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

CHPPD	Total Patient Numbers	Registered Midwives/Nurses	Care Staff	Overall
October	14865	4.8	3.2	8.0
November	14815	4.7	3.1	7.8

Hospital Monthly Average Fill Rates for June 2019 and July 2019

Month	RN/RM Day % Fill Rate	HCA/MCA Day % Fill Rate	RN/RM Night % Fill Rate	HCA/MCA Night % Fill Rate
October	80.3%	101.9%	97.9%	131.0%
November	82.9%	101.3%	100.3%	129.6%

The ward breakdown of fill rates for October and November 2019 is included in Appendix 1.

The CHPPD hours in October was slightly higher than November due to both Wards 1 and 2 having lower number of admissions.

Areas with notable fill rates

Department of Critical Care (DoCC) continues to have a high CHPPD due to low number of patients admitted in both October and November. The Surgical Division is currently reviewing the bed occupancy of DoCC.

3. Recruitment

All divisions have rolling adverts out on the NHS job site and have agreed open days for 2020. The Matron for workforce has developed an annual recruitment calendar for Trust wide recruitment events.

- March 7th
- June 20th
- November 14th

On 23rd November 2019 a recruitment event took place. The event went extremely well with over 100 attendees.

On the day presentations were included for Health Care Assistants, the Trust preceptorship course for newly qualified nurses and the array of development opportunities that we prove at MKUH. These sessions were extremely popular and feedback from attendees was very positive.

Our staff, as always, were welcoming, professional, engaging and a true credit to our organisation.

In total we provisionally offered:

- 16 Staff Nurse posts
- 16 HCA's positions.

Pre-employment checks were also undertaken on the day with support from Human Resources and Health and Well-being teams.

Women's and Children Division

Maternity continue to have a low of vacancy factor of 3.5% (2.35 WTE). They have a planned recruitment day for Band 6 midwives in January 2020.

Registered Staff Vacancies

Division	WTE vacancies now	% vacancy now	Post recruited to	Residual WTE vacancy	Residual % vacancy
Women's & Children	21.05wte	12.5%	9wte	12.05wte	9%
Medicine	96wte	25%	21wte	75wte	18%
Surgery	35wte	17%	7.4wte	28wte	15%

Total vacancy rate for registered staff including new staff in post approx. **16%**

Health Care Assistant (HCA)Vacancies

Division	WTE vacancies now	% vacancy now	Post recruited to	Residual WTE vacancy	Residual % vacancy
Women's & Children	4.81wte	3%	0wte	4.81wte	3%
Medicine	34wte	22%	22wte	13wte	10%
Surgery	21.56wte	20%	6wte	15.56wte	13%

Total Trust vacancy rate for HCA's including new staff in post approx. **10%**

Please note that these figures are dynamic and so are changing daily – and recruited to posts will still be subject to leavers. The vacancies need to be validated against vacancies recorded on Electronic Staff Record (ESR) to ensure factual accuracy.

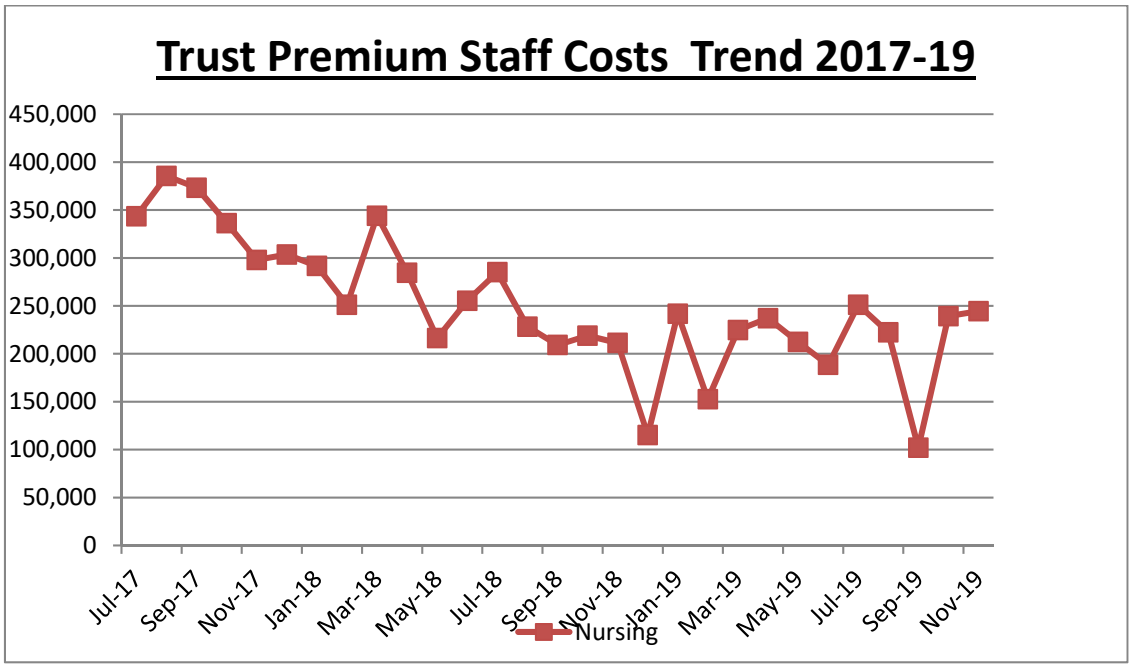
Within these figures the areas with the highest vacancy factor are – Wards 14,15,16,20 and the Emergency Department. These areas will be monitored and supported by the Heads of Nursing.

We are currently not meeting the Chief Nurse's ambition of 0% vacancies for Health Care Assistants (HCA) an action plan to achieve this is being developed with the temporary workforce Matron to ensure we have an increased supply of HCA's on the bank that will be available for permanent positions.

Are we efficient?

4. Controlling Premium Cost

Agency nursing expenditure continues to stabilise with a drop in September due the reduction of Agency Health Care Assistants being booked. We are still booking agency staff to open escalation beds on Day Surgery Unit, Wards 3a, 7 and 19.



3. Retention

Retention of staff is a key issue for the NHS and is a crucial factor in securing a skilled and sustainable workforce for the future. In addressing the challenges of workforce supply MKUH is focusing on recruitment and retention by ensuring new and existing staff are being supported and encouraged to remain at MKUH.

In Month 6 as reported in the Workforce Board report Nursing and Midwifery registered staff turnover rate has continued to drop to 5.7 % significantly below the National average which is 11%. This is again a further improvement on previous months and has been due the continued work carried out as part of a programme we have developed in line with the "Interim NHS Peoples plan" as set out by NHSi that supports the trust with interventions that are known to have the biggest impact in improving retention, including:

- We ensure all newly qualified staff are well supported through a two-year preceptorship programme.
- A flexible working shift pattern
- And career development opportunities such as the band 6 development programme.

4. Sickness

Sickness of staff is one of the key issues for the Trust which contributes to the requirement for temporary staff. The Divisions work very closely with their Human Resources Business Partners (HRBP) to ensure sickness management is robustly monitored. Month 8 Workforce Board report recorded registered Nursing and Midwifery sickness has remained stable at 3.84 % against the Trust target of 4%.

Are we effective?

5. Nurse Cadets

Nurse Cadet Pilot at MKUH

The Nurse Cadet programme is a national initiative to increase the number of young people considering a career in Nursing. MKUH is collaborating with the Thames Valley regional group to design and delivery of this new initiative and learning opportunity. MKUH is partnering with Central North West London in the delivery of the Nurse Cadet programme locally.

The programme is designed to give regular clinical placement experience to a cohort of 16 -18year old young people who are currently undertaking a Level 3 Health & Social Care qualification. At this early implementation stage MKUH is working with Milton Keynes College and will take be recruiting their students for the first cohort. In the future following evaluation of the programme a wider range of schools will be offered an opportunity to be involved.

- **Programme**

  The programme will last two years which maps the duration of the Health and Social Care qualification. In the first year the students will be allocated to a base ward to enable them to develop confidence, competence and integrate into the ward team. In the second year we plan to provide a more varied experience of clinical areas, designed where possible, around their aspirations and competence.

  The students will be placed in the hospital for a total of 200 hours in their first year and 300 hours in the second year. These days will be Monday and Thursday.

  The students will work 9-5 pm in their first year. The students cannot work unsocial hours at any point in their course but some negotiation in their second year might allow them to start earlier to experience the early-morning elements of ward routine including handover.

- **Cadets**

  We will have 17 first year Nurse Cadets and 4 second year Nurse Cadets starting with the Trust in early December 2019 for an initial induction week and taster days on the wards. A parents evening during the induction was well attended where an overview of the programme was provided, and parents were given reassurance about the pastoral care for cadets that will be provided by the Practice Education team.

  This is a new initiative with national interest and as such MKUH will be continually evaluating and reviewing the programme and cadet feedback.

- **Midwifery Continuity of Care**

  The definition of 'Midwifery Continuity of Carer' used by the Royal College of Maternity (RCM) is the continuity across the whole continuum: antenatal, intrapartum and postnatal.

  At MKUH Midwifery have implemented Maternity Continuity of Carer (MCOC) model, which ensures safe care based on a relationship of mutual trust and respect in line with the woman's decisions.

  Every woman should have a midwife, who is part of a small team of 4 to 6 midwives, based in the community who knows the women and family, and can provide continuity throughout the pregnancy, birth and postnatally.

  Each team of midwives should have an identified obstetrician who can get to know and understand their service and can advise on issues as appropriate.

  The woman's midwife should liaise closely with obstetric, neonatal and other services ensuring that she gets the care she needs and that it is joined up with the care she is receiving in the community.

  Currently we have 19% of new mums being looked after under the MCOC model and with a further team coming on line in February 2020 which will increase the MCOC care offer to 24% of our new mums. The national target is 35 % by March 2020 which will

be challenging to achieve due to the t investment requirement to meet the model specifications.

The RCM believes that the potential benefits of MCOC for women, families and midwives supports the implementation of a safe and sustainable MCOC maternity service for the future.

We celebrate

6. Announcements

1. Nursing Associates commenced the Florence Nightingale programme each undertaking a Quality Improvement project to benefit patient care, such as mouth care.

2. Antoanela Colda has applied for a prestigious Churchill Fellowship and successfully passed the first stage. The Churchill Fellowship is awarded to 150 exceptional people from across the UK who are then provided with a travel grant for the fellow to go overseas and research a project that they believe can make a major difference to their profession or community when they return. If successful Antoanela will be expected to publish her finding on her return and put the recommendations into actions. Previous fellows have influenced public policy and professional practice and ongoing support is provided to the fellow from the Winston Churchill Memorial Trust.

3. 2020 is International Year of the Nurse and Midwife and a programme of celebrations is planned throughout the year including a visit by the CNO Ruth May and other influential leaders. MKUH is participating in the Nightingale Challenge – Professor Lisa Bayliss-Pratt who visited the Trust in 2019 is the programme lead “Our ambition is to nurture and support the talent and potential that already exist in our young nurses and midwives across the world” says Professor Lisa Bayliss-Pratt. The Challenge is a way of recognising the crucial contribution they can make to securing universal health coverage and improving the quality of care for their communities.’

Appendix 1

Fill rates for Nursing, Midwifery and Care Staff October 2019

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	76.3%	109.7%	102.0%	128.7%	696	5.6	2.7	8.3
MAU 2	81.3%	121.0%	109.0%	164.7%	787	4.0	3.6	7.5
Phoenix Unit	78.7%	99.5%	98.9%	138.7%	716	3.1	3.6	6.7
Ward 15	84.5%	99.6%	100.0%	136.4%	860	3.7	2.7	6.4
Ward 16	80.3%	95.0%	99.4%	114.4%	889	3.4	2.4	5.7
Ward 17	76.8%	90.4%	100.5%	126.0%	724	4.5	2.3	6.9
Ward 18	85.8%	107.6%	100.1%	152.6%	824	3.4	4.2	7.7
Ward 19	75.8%	91.4%	98.9%	134.2%	850	3.0	3.6	6.6
Ward 20	81.4%	117.2%	102.4%	137.1%	814	3.7	3.0	6.8
Ward 21	79.4%	133.3%	102.2%	164.7%	740	3.5	3.2	6.7
Ward 22	80.4%	114.4%	100.0%	137.2%	644	3.9	3.1	7.0
Ward 23	84.0%	125.4%	100.8%	137.9%	1146	3.7	4.6	8.3
Ward 24	83.9%	96.2%	97.8%	-	527	4.5	1.1	5.6
Ward 3	83.0%	90.7%	101.1%	108.6%	864	3.2	3.2	6.4
Ward 5	87.0%	147.2%	122.8%	177.0%	636	6.9	2.1	9.0
Ward 7	65.8%	89.4%	100.0%	122.4%	705	3.5	4.1	7.6
Ward 8	77.3%	90.5%	105.6%	150.0%	756	3.6	3.0	6.6
DOCC	75.6%	81.3%	85.7%	-	190	24.7	1.6	26.4
Labour Ward								
Ward 9	73.7%	84.1%	91.8%	86.0%	1018	2.6	2.0	4.6
Ward 10	80.9%	-	66.8%	-	177	6.7	0.1	6.8
NNU	73.9%	53.5%	81.6%	86.2%	302	12.9	1.8	14.8

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Fill rates for Nursing, Midwifery and Care Staff November 2019

Ward Name	Day		Night		Care Hours Per Patient Day (CHPPD)			
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AMU	83.7%	95.2%	101.3%	128.3%	710	5.4	2.4	7.8
MAU 2	88.2%	113.1%	106.0%	176.6%	810	3.9	3.2	7.1
Phoenix Unit	81.1%	117.0%	100.5%	174.8%	710	3.1	4.2	7.3
Ward 15	85.4%	115.3%	99.8%	151.3%	852	3.7	2.9	6.6
Ward 16	83.8%	92.7%	100.0%	123.2%	851	3.5	2.4	5.9
Ward 17	77.3%	85.0%	101.7%	125.0%	742	4.4	2.1	6.5
Ward 18	83.7%	103.1%	103.0%	134.1%	793	3.4	4.0	7.4
Ward 19	80.7%	107.0%	101.1%	153.3%	842	3.0	4.1	7.1
Ward 20	86.1%	102.8%	108.9%	114.2%	752	4.1	2.7	6.9
Ward 21	85.7%	107.8%	100.8%	134.5%	695	3.8	2.7	6.5
Ward 22	81.6%	138.4%	98.9%	173.3%	637	3.9	3.7	7.6
Ward 23	87.2%	111.2%	103.4%	134.4%	1106	3.7	4.3	8.0
Ward 24	87.2%	86.8%	97.1%	-	533	4.4	0.9	5.3
Ward 3	84.0%	79.5%	100.0%	97.8%	833	3.1	2.9	6.0
Ward 5	76.3%	115.1%	122.3%	119.8%	559	6.9	1.6	8.5
Ward 7	83.4%	101.1%	100.0%	142.1%	716	3.8	4.5	8.3
Ward 8	71.2%	95.3%	125.8%	110.0%	738	3.6	2.7	6.3
DOCC	71.3%	61.1%	82.2%	-	171	25.0	1.3	26.3
Labour Ward								
Ward 9	78.6%	85.4%	90.7%	85.5%	1119	2.5	1.8	4.2
Ward 10	81.4%	-	88.6%	-	271	4.7	0.0	4.7
NNU	81.6%	62.4%	93.6%	89.6%	375	11.2	1.6	12.8

Meeting of the Finance and Investment Committee held on 2 December 2019

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

There were no matters that were approved by the Committee.

Matters referred to the Board for final approval:

No matters were referred to the Board for final approval.

Matters considered at the meetings:

1. Performance dashboard M7

The Committee was informed that performance reflects the national picture with an early onset of winter pressures.

2. Financial Forecast

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

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

3. Long Term Plan submission update

The submission of the Trust's Long Term Plan was noted. It was also reported that the Trust is seeking to agree a new contract with its main commissioner Milton Keynes CCG in the New Year, in advance of the national deadline for signing contracts.

4. Finance Report M7

The Trust reported an adverse variance of circa £400k at month 7; however this included some one-off items and plans are in place to ensure delivery of the control total for the full year.

5. Agency update

Agency expenditure in November was similar to September's figures and spend remains well below the ceiling set by regulators.

6. Transformation Programme

The Committee noted the improvement in the performance of the Transformation Programme and acknowledged that further work is needed order to deliver the full Transformation Programme target for the year.

7. Timeline for strategic capital projects

The Committee discussed the strategic capital projects and noted that the Trust remains on plan with regard to spend.

Quality and Clinical Risk Committee Summary Report

1. Introduction

The Quality and Clinical Risk Committee met on 19 December 2019.

2. Key matters

The following items were presented to the Committee:

Quarterly highlights report

- MKUH is part of a pilot on average waiting times and it was reported that the Trust's ASI rate (appointment slot issues) is increasing but there is considerable focus on this.
- Radiotherapy. For the past six years patients have mainly been receiving radiotherapy in MK through Genesis. The Genesis/OUH contract came to an end on December 15, 2019. Contingency plans for radiotherapy are now in place for the short term, with patients treated at OUH and NGH, causing significant inconvenience for some patients.
- There had been a further meeting with HEE TV and regarding trainee experience in Obs & Gynae. Feedback from current trainees was negative. Actions are in place and with two new consultants joining the department in early 2020 there is confidence that the trainee experience will improve.
- Orthopaedic elective total hip replacements. Following reports from the NJR that revision rates at MKUH over the past 10 years were high, further investigations were held. A meeting with orthopaedic surgeons highlighted anecdotal cases of infection, and as a precaution joint replacement services were suspended for two weeks. Considerable work has been undertaken and improvements put in place. There had been a deep cleaning of theatres and the piloting of a 'cold/clean' orthopaedic unit, with Ward 12 being trialled for this purpose.
- There had been a significant drop in performance in ED, although the Trust still sits in a reasonable position nationally. ED processes and flow/leadership were cited as factors and two new consultant posts commence in the New Year to strengthen leadership, focus on process and compliance,
- Length of Stay (LoS). Senior leaders were visiting wards teams to engage with this, leading to a shared sense of direction and a forthcoming post-acute bed review.
- Following the CQC inspection in which IPC compliance in ED was highlighted, a handwashing promotion 'High Five Saves Lives' had been launched in the department, with good audits. It is due to be rolled out across the Trust in 2020.
- There had been a cluster of whooping cough (pertussis) cases within community midwifery. With the support of Public Health, the situation was escalated, a number of midwives vaccinated and contact made with 300 women/babies who may have come into contact with the virus

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

It was stated that the Trust needed to identify and articulate key learning actions from reporting incidents, including improving the reporting culture, especially among trainees. It was also stressed that QI was vital once areas for learning had been identified. Greatix, a system of reporting positive incidents, was proving useful: the next stage of learning in this would be to look at why things had gone well.

Quarterly mortality update

- The Committee noted that the Trust's Hospital Standard Mortality Ratios (HSMR) score was 104.7 – higher than previously, but there was no evidence that clinical quality had changed. Two GP medical examiners had been appointed to the team.

Quarterly trust wide progress report – Serious Incidents

- 6 serious incidents have been recorded during the quarter relating to delayed diagnoses, including two regarding ECGs and three delayed recognition of fracture.

Clinical Quality update
The Committee heard that the Patient Safety Board and Patient Experience Boards were working well.

Clinical Audit
A new governance structure had been put in place to gain assurance around level one audits with good progress being made.

Pharmacy
There was an informative presentation on Pharmacy and a focused discussion on staffing, with more pharmacy technician places planned for 2020 and a career progression plan to encourage staff retention.

Infection prevention and control workplan
A presentation was given regarding a one-year programme to drive change by achieving greater compliance through optimised behaviours

3.Conclusions
The Committee was assured that the hospital was busy but remains safe.

The Board is asked to note this report.

TheMKWay
CARE. COMMUNICATE.
COLLABORATE. CONTRIBUTE.

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

MKUH Objectives update

Trust Board

January 2020

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

Chief Executive: Joe Harrison
Chairman: Simon Lloyd

TheMKWay
CARE. COMMUNICATE. COLLABORATE. CONTRIBUTE.

NHS
Milton Keynes University Hospital
NHS Foundation Trust

Summary

Review of Trust Board reported objectives – progress to date

Item	Exec	RAG	Report due		Item	Exec	RAG	Report due
1.05 7-day working development	IR	A	Q3 (Jan20)		6.02 Continued progress on R&D targets	IR	G	Q3 (Jan20)
1.06 Reducing variation through GIRFT	CH	G	Q3 (Jan20)		6.03 Further development of clinical schools	DP	G	Q3 (Jan20)
2.01 Elective access / outpatients (processes / reducing DNAs)	KJ	R	Q3 (Jan20)		7.01 Delivery of the financial position	MK	A	MTHLY
2.03 Catering improvements	JB	G	Q3 (Jan20)		7.05 Commission and delivery well-led review	KJ	G	Q3 (Jan20)
3.08 Delivery of a credible audit programme	KJ	A	Q3 (Jan20)		7.06 Deliver CQC action plan	KJ	A	Q3 (Jan20)
4.03 National targets improvement / delivery	EL	R	MTHLY		8.01 Staff benefits package delivery	DP	G	Q3 (Jan20)
5.03 Constructive relationship with ICP/ICS	JH	A	Q3 (Jan20)		8.06 Diversity and inclusion	DP	G	Q3 (Jan20)

Objectives update: 1.05 7-day working development

Report date	Exec Lead	Objective description	RAG Status
Q3 2019	Ian Reckless	National initiative to introduce 7-day consultant-led services	AMBER

Summary of progress this period:

In respect of the 4 priority standards, a further return was made by the Trust Board in November as follows with NHSE/I teleconf on 28/11/19:

- **Standard 2** - 84% from 73% in Spring (non-compliant). Generally being met in the (high volume) medicine division. With additional focus via Divisional Management Board, the 90% threshold is within reach.
- **Standard 5** - standard is met with the only area of reported non-compliance being echocardiography at weekends
- **Standard 6** - is close to agreement. Oxford University Hospitals (OUH) have engaged on this issue (approximately 18 months following request) with a service level agreement for interventional radiology having been shared in draft.
- **Standard 8 -** 67% from 52% in Spring (non-compliant)

Key milestones:

1. Compliance with S2 - consultant review within <14 h of admission (Mar20)
2. Compliance with S5 - 7day access to diagnostic services and meeting standards for reporting based on patient acuity (Mar20)
3. Compliance with S6 - formal arrangements for specific interventions (Mar20)
4. Compliance with S8 - ward leadership and recording of board rounds (2021)

Summary of expected progress next period:

1. Delivery of Standard 2 by March 2020 – in part through attention to job planning, specific clinical pathways / protocols and focus on the 7DS goal in surgery and W&C.
2. Attention to Standard 8 – ward leadership and recording of Board Rounds.
3. Agreement (and achievement) of S6 following negotiation / agreement with OUH.
4. Clarification around echocardiography competencies and plans at weekends going forward (consultant and technician).

Summary of expected benefits:

1. Agreement of formal pathways with OUH will have a positive patient safety impact.
2. Increased focus on the presence of senior nurses on weekend daytime shifts (to increase efficiency of consultant input) will have additional quality benefits.
3. Reputational benefits as performance against 7DS standards has been identified as a key metric in relation to ‘service sustainability’.

Red risks and issues:

Risk/ issue description	Considered Mitigating Actions
Progress towards Standard 8 will be made with additional focus, improved recording and efforts to ensure senior nursing presence at weekends – however, the 90% target is unlikely to be achieved.	Discussions at Executive and Board level as to the extent to which achievement of standard 2 should be prioritized given the other performance and financial challenges faced by the organisation.

Objectives update: 1.06 Reducing variation through GIRFT

Report date	Exec Lead	Objective description	RAG Status
Q3 2019	Caroline Hutton	**Reviewing and implementing the recommendations from the 21 GIRFT reviews and those forthcoming** **Implementing a sustainable process for management and monitoring of GIRFT as part of QI**	GREEN

Summary of progress this period:

1. leadership, structure and process in place to manage the GIRFT Programme and report nationally on progress
2. Divisional and specialty ownership of action plans in place with traction on delivery of prioritised actions underway being monitored by QI team
3. Alignment of GIRFT action plans with other projects/programmes and cost improvement opportunities developing well
4. QI team now ensuring all top actions have a robust delivery plan to support and evidence improvement
5. Following specialties have undergone GIRFT review this period: Respiratory / Rheumatology / Geriatric Medicine
6. Following specialties have had follow up meeting for recommendations
    - Acute and General Medicine
    - Breast Surgery
7. In Q2 Deep Dives have been carried out in the following specialties with follow up meeting for recommendations to commence in Q3:
    - Respiratory - 20/01/202
    - Gastroenterology - TBC
    - Rheumatology – TBC

Key milestones:

1. Delivery plans for prioritised GIRFT actions in place and owned by clinical leads
2. Delivery of prioritised actions reported and evidenced
3. Plans fully aligned with other projects/programmes and CIPs identified and tracked

Summary of expected progress next period:

1. Each top GIRFT action to have a robust delivery plan and date
2. Reporting on delivery status of top actions
3. Following GIRFT reviews planned for next period:
    - Anaesthetic & Perioperative - 18/12/2019
    - Vascular – 03/01/2020
    - Emergency Medicine – 16/01/2020
    - Intensive Care and Critical Care -22/01/2020
    - Cardiology -30/01/2020
    - Dermatology – 04/02/2020

Summary of expected benefits:

- Improvement of LOS
- Patient mortality rates
- Cost Savings
- Improved Pathways
- Making best use of currently available staff, skills, tools, techniques and facilities to achieve significant and sustainable benefits.

Red risks and issues:

Risk/ issue description	Considered Mitigating Actions
1. Risk that the divisional and specialty ownership and delivery is not prioritised against other operational pressures	1. QI lead on each specialty action plan with regular review meetings with clinical/operational leads to support and monitor progress

Objectives update: 2.01 Elective access / outpatients (processes / reducing DNAs)

Report date	Exec Lead	Objective description	RAG Status
Q3 2019	Kate Jarman	Delivery of administrative improvement programme	RED

Summary of progress this period:

1. The Patient Access Board continues to meet monthly and has undertaken a re-scoping exercise to focus transformation resource on areas most likely to see a financial benefit.
2. The key milestones on the right denote the core areas of focus for the PAB and work is underway in each of these areas – with progress being made.
3. There has been a significant improvement in daily operational management (and therefore the reduction of clinical risk); letter production (Big Hand letters waiting to be typed down by 95% (now less than 100), EDM letters waiting to be sent down by 52%) ; SOPs and training (supporting DQ). However this has lead to a significant increase in cost for the service.
4. New booking support tool being trialed.

Summary of expected progress next period:

1. Understanding the cause of the increase in DNA rates; and putting together targeted interventions is a key area of focus for the next three months.
2. Starting a manual clean-up of templates so that slot utilisation can be reported accurately (with most challenged services capacity-wise selected first). These pieces of work should, together, enable lost capacity to be utilised fully; improve efficiency and save administrative time and resource in re-bookings.
3. Prospective validation of RTT patients introduced to support better DQ and pathway management.

Key milestones:

1. Substantive staffing structure in place with bank use reset as a flexible, demand-led resource, with predictable forecast expenditure
2. Reduction in DNA rates to under 6% (combined and per clinical division)
3. Reduction in hospital-initiated appointment cancellations to less than 5% of total appointment figure (news and follow-ups)
4. Appointment template clean-up to enable accurate data collection and reporting
5. Improvement in slot utilization to >95%
6. Elimination of letter backlog and all routine letters dictated, typed, signed and sent within five days from appointment
7. Improvement in data quality – measured through regular internal audit and through annual external audit testing

Summary of expected benefits:

1. Reduction in wasted capacity/ more effective and efficient use of current capacity
2. Better use of clinical time
3. More efficient administrative service (reduction in additional bank spend in scheduling)
4. Improvement in RTT position (need to consider how that is reflected through average mean measure)

Red risks and issues:

Risk/ issue description	Considered Mitigating Actions
1. Containing staffing spend	1. Close monitoring of spend on substantive structure and bank spend. Traditionally high attrition rates amongst administrative staff and so opportunity for regular review
2. Obtaining information to enable insightful analysis of DNA rates	2. Working with information team to understand how business intelligence can be best used to support objective

Objectives update: 2.03 Catering improvements

Report date	Exec Lead	Objective description	RAG Status
Q3 2019	Emma Livesley / (John Blakesley)	Options assessment and procurement regarding the patient catering offering at MKUH	GREEN

Summary of progress this period:

1. Detailed report on the food options commissioned and delivered
2. Management Board agreed the preferred food delivery system
3. Finance agreed the procurement route
4. Business case in preparation

Key milestones:

1. Identify the potential food delivery options that can be supported by the current estate
2. Management Board approval for delivery method
3. Procurement based on NHS framework
4. Selection of winning tender – identify preferred supplier
5. Complete Business Case approval
6. Implementation phase leading to new food service – operational mid-May2020

Summary of expected progress next period:

1. Business case to Management Board and Trust Board
2. Agree the specification and scoring matrix
3. Procure using a mini competition within the established framework

Summary of expected benefits:

1. Improved patient experience as measured by the patient survey
2. Reduced food wastage

Red risks and issues:

Risk/ issue description	Considered Mitigating Actions
1. Existing food supply contract with Tillery Valley is ending 2. All new food delivery systems will require some capital investment	The need for capital will be an essential part of the scoring matrix

Objectives update: 3.08 Delivery of a credible audit programme

Report date	Exec Lead	Objective description	RAG Status
Q3 2019	Kate Jarman	**Delivery of all Level 1 and 2 audits with tracked action plans.** **Learning from audit captured and published.**	AMBER

Summary of progress this period:

1. Prioritised audit programme with compliance tracking – closely monitored and managed through Risk and Compliance Board and divisional governance structures
2. Additional governance resource recruited to the medicine division to provide more support to clinical audit leads
3. Assurance available regarding progress on level 1 audits

Key milestones:

1. Audit compliance tracked against agreed annual plan
2. Every audit lead meeting defined timescales for completion of audits and for the provision of evidence to provide actions/ learning delivered
3. Audit evidence available for Quality Account and for regulatory (or other) inspections and reviews

Summary of expected progress next period:

1. Revised quality governance structure with new Quality Improvement and Clinical Effectiveness Board (replacing previous CEAB to bring QI and audit together to better support both functions)
2. Revisiting audit resource and use of scheduled audit time (audit half days) to make best use of an expensive clinical resource
3. Implementation of new templates to capture action and learning evidence (to support compliance with CQC regulation 17 requirements)

Summary of expected benefits:

1. Demonstrable shift in compliance against audit programme delivery
2. Increased participation in stat/ mad audits if supported by QI

Red risks and issues:

Risk/ issue description	Considered Mitigating Actions
1. Clinical engagement remains poor	1. Using QI as a platform to increase clinical engagement across related audit activities
2. Clinical audit leads not in place in all CSUs (particularly medicine)	2. Reviewing with divisional directors

Objectives update: 4.03 National targets improvement / delivery

REPORTED MONTHLY AT TRUST BOARD / MANAGEMENT BOARD

Objectives update: 5.03 Constructive relationship with ICP/ICS

Report date	Exec Lead	Objective description	RAG Status
Q3 2019	Joe Harrison	**Participation in ICP activities; to support everyone in Milton Keynes to live to their best wellbeing by providing high-quality care, oriented around the needs of our people and their families.**	AMBER

Summary of progress this period:

1. Further CEO workshop with Carnall Farrar progressing ICP progress plans, defining high level services and budget (approx. £485m). Preferred organisational form identified with 3 lead providers and MKUH as lead provider for Physical Health in MK.
2. First MK Clinical Leaders meeting taken place with increased engagement from GPs in AHSN already begun
3. Ongoing discussions with Region regarding identifying a solution to the likely adverse FRF impact on MK

Key milestones:

1. Agreement on priorities for MK Place
2. Structural agreement for MK Place (how funding will flow)
3. Commissioning intentions received for 2020/21
4. Arrangements for GIC or equivalent for 2020/21
5. Population health segmentation
6. MK ICP Go Live April 2021 (when CCGs merge into a strategic commissioner at ICS level)

Summary of expected progress next period:

1. Development of the MK Alliance highlighting how organisations in the system will work together in practice, particularly primary care engagement
2. Regular Clinical Leaders meetings scheduled with targeted programme
3. Discussions at both regional and national level continue regarding MK FRF following BLMK ICS submission of financial plans for the broader system.

Summary of expected benefits:

1. Increased cooperative working with MKCCG
2. End to end management of pathways leading to increased efficiencies across the sector and improved patient experience and safety as patients are managed through the system and not passed between systems
3. Alignment of priorities leading to investment being directed appropriately
4. Focus on delivery of objectives rather than contractual penalties
5. Moving the system towards financial balance

Red risks and issues:

Risk/ issue description	Considered Mitigating Actions
1. Funding arrangements for 2020/21 effectively involve MK subsidizing other systems	1. Clarity regarding the funding requirement for MK ICP
2. Focus on PLACE rather than hospital	2. Core Executive participation in MK ICP whilst in infancy
3. MKUH has insufficient time to prepare for taking on the full physical health budget for MK	3. Planning / strategic requirements established in advance of a final outcome
4. MK Council focus on alternative priorities	4. Continue to build MKC / MKUH relationship

Objectives update: 6.02 Continued progress on R&D targets

Report date	Exec Lead	Objective description	RAG Status
Q3 2019	Ian Reckless	Maintain current share of NIHR funding via LCRN	GREEN

Summary of progress this period:

1. Trust performance has improved / been maintained in relation to:
- Funding;
- Patient recruitment – approx 10% up in Q1 and Q2 19/20, compared to 18/19
- Spread of studies across specialties;
- Time to first recruitment following commencement; and,
- Own / home-grown studies

2. MKUH colleagues were recognized at LCRN regional awards in September 2019 as follows:
- All-round high performing team (reproductive health and childbirth)
- Research team leader (Lynn Wren)
- Greatest Improvement in recruitment (sexual health)

Key milestones:

1. Maintain or increase MKUH share of R&D funding
2. Continue upward trajectory in recruitment volumes
3. Increased level of studies (breadth) undertaken at MKUH

.

Summary of expected progress next period:

1. Maintained recruitment targets.

2. Increased profile of local projects (recognised by NIHR) developed by cardiology.

3. Potential for Trust CEA unused funding to support specific research related activity / development.

Summary of expected benefits:

Widespread activity and participation in research and education ensures that staff perform at the top of their licences – with awareness of cutting edge thinking and an environment supportive of questioning and innovation.

Red risks and issues:

Risk/ issue description	Considered Mitigating Actions
The LCRN budget going forward – globally and the MKUH 'slice' - is subject to change (reduction) as a result of national policy rather than solely local performance.	Investigate alternative opportunities for funding, recognizing that the Trust is a much smaller participant in this arena.

Objectives update: 6.03 Further development of clinical schools

Report date	Exec Lead	Objective description	RAG Status
Q3 2019	Danielle Petch	**Explore partnerships and opportunities for developing additional specialty schools to be offered alongside the Medical School**	GREEN

Summary of progress this period:

1. Scoping work continues to understand areas where development may be possible/feasible.
2. Very early discussions have taken place around the idea of an entry level modular clinical course.
3. Development / commencement of 8 new training programmes for nursing and AHPs
4. Met with DoPC & MD to identify areas/priorities for new roles such as Physicians Associates, Advanced Nurse/Clinical Practitioners, Consultant Pharmacist/Nurse/Therapist etc.

Key milestones:

1. Identification and agreement of areas for developments
2. Identification and agreement of partners
3. Agreement of courses/programmes
4. Outline of courses/programmes
5. Plan for delivery of new courses/programmes

Trust Board support required:
Establish whether direction and scope of this objective is supported and develop further

Summary of expected progress next period:

1. Suitability of areas identified
2. Assessment of demand
3. Assessment of prospects of success
4. Assessment of availability of potential partners
5. Review of staffing in areas identified for new roles
6. Draft of strategy for advanced roles

Summary of expected benefits:

1. Increased student placements
2. Increased training opportunities
3. Budget growth
4. Increased reputational value
5. Increased capacity and reduced vacancy levels

Red risks and issues:

Risk/ issue description	Considered Mitigating Actions
No red issues or risks at this time	

Objectives update: 7.01 Delivery of financial position

REPORTED MONTHLY AT TRUST BOARD / MANAGEMENT BOARD

Objectives update: 7.05 Commission and deliver Well-led review

Report date	Exec Lead	Objective description	RAG Status
Q3 2019	Kate Jarman	**Commission an independent Well Led review to meet regulatory obligations and support Board development**	GREEN

Summary of progress this period:

1. Procurement process well underway, with a mini competition held between eligible providers; results reviewed and assessed on 7th October
2. Timeframe for programme to be agreed by EDs and by the Board
3. Tender evaluation on 11 November. Deloitte UK appointed.

Key milestones:

1. Delivery of review as per NHS Improvement guidance
2. Agreed review programme and outcomes
3. Combined action plan agreed by the Board (in the context of moving from good to outstanding under CQC grading framework)

Summary of expected progress next period:

Expected that review will be undertaken and completed in next quarter

Summary of expected benefits:

1. Aid Board development, planning and focus
2. Support the Trust in continuing to improve and develop sound governance systems and leadership capacity and capability
3. Support progress to CQC outstanding
4. Identify areas for further development

Red risks and issues:

Risk/ issue description	Considered Mitigating Actions
No red issues or risks at this time	

Objectives update: 7.06 Deliver CQC action plan

Report date	Exec Lead	Objective description	RAG Status
Q3 2019	Kate Jarman	Development and delivery of improvement/ action plan following CQC inspection reports	AMBER

Summary of progress this period:

1. Action plan to address regulatory breaches developed and shared with CQC
2. Divisional and CSU meetings taking place to develop specific actions and interventions to support corporate/ Trust-wide work
3. Plans to come to Management Board in October for review
4. Revised Management Board structure established supporting Trust-wide CQC compliance focus
5. Hand Hygiene 'No Nonsense November' approach run by Infection Control team
6. Surgical site infection review underway

Key milestones:

1. Actions RAG rated with projected timescales for delivery
2. Internal assessment of compliance against regulatory breaches to be undertaken in December 2019

Summary of expected progress next period:

1. Formal internal assessment of compliance against regulatory breaches to be undertaken in December 2019 to assess effectiveness of actions
2. Evidence review in December 2019 – move to Teams storage
3. Surgical site infection monthly review at Management Board in relation to current infection issues and cleaning requirements

Summary of expected benefits:

1. Ability to evidence ongoing compliance through available evidence
2. Better management of inspection processes

Red risks and issues:

Risk/ issue description	Considered Mitigating Actions
Staff awareness and engagement	Engagement and information events held; use of huddle and nursing forums

Objectives update: 8.01 Staff benefits package delivery

Report date	Exec Lead	Objective description	RAG Status
Q3 2019	Danielle Petch	**Create and deliver detailed, flexible and bespoke MKUH benefits package which, alongside NHS standard offering and MKUH environment, forms the MKUH Employee Value Proposition (EVP). Evaluate, review and improve EVP regularly (annually as a minimum)**	GREEN

Summary of progress this period:

1. Implementation of phase 1 benefits underway including:
- Free parking
- Free tea and coffee
- Revised flexi working policy
- Revised special leave policy (compassionate leave)
- Discounted gym membership
- Painting classes
- Enhanced Occupational Health
- Financial advice
- Flexible pensions options

2. Phase 2 benefits evaluation work begun

Key milestones:

1. Rollout of phase1 benefits
2. Rollout of phase 2 benefits
3. Rollout of phase 3 benefits
4. Assessment of impact

Summary of expected progress next period:

1. Complete phase 1 benefits rollout
2. Begin phase 2 implementation:
- Lease cars
- White goods/electrical goods
- Fairer finance
- Holiday vouchers
- Amazon locker

Summary of expected benefits:

19/20 – vacancy rate reduced by 1%
20/21 – vacancy rate reduced by a further 1%
19/20 – turnover rate reduced by 1%
20/21 – turnover rate reduced by a further 1%

Red risks and issues:

Risk/ issue description	Considered Mitigating Actions
No red issues or risks at this time	

Objectives update: 8.06 Diversity and Inclusion

Report date	Exec Lead	Objective description	RAG Status
Q3 2019	Danielle Petch	**Develop and implement ED&I strategy to improve experience for staff and patients with protected characteristics.**	GREEN

Summary of progress this period:

1. Equality, Diversity and Inclusion Manager recruited
2. Staff networks (Women, LGBT, Disability) set up and continuing to meet – programmes of work being taken forwards within these groups
3. BAME network being consulted upon

Diversity & Inclusion Glossary

BAME: Black, Asian and Minority Ethnic
EDS2: Equality Delivery System (2) – launched 2011
LGBTQ+: Lesbian, Gay, Bisexual, Transgender, Questioning
WDES: Workforce Disability Equality Standard
WRES: Workforce Race Equality Standard

Key milestones:

1. Networks created and meeting:
   - Women's
   - LGBT
   - Disability
   - BAME
2. Equality, Diversity and Inclusion Manager in post and actively taking forward strategy
3. Active programme of community engagement events
4. Completion of EDS2, WDES, WRES, Gender Pay report & regulator returns
5. Achievement of NHSI/E target - TBC

Summary of expected progress next period:

1. Equality, Diversity and Inclusion Manager to start in post
2. BAME network established
3. Networks continue to meet and develop

Summary of expected benefits:

1. 10% reduction in ED&I tribunal costs
2. Workforce breakdown to remain representative of local community
3. 1% improvement in all protected characteristic workforce statistics
4. 10% reduction in protected characteristics listed as "Do not wish to disclose" on ESR

Red risks and issues:

Risk/ issue description	Considered Mitigating Actions
No red issues or risks at this time	

Q2 RED objectives - update

The Board also asked for an update on previously reported schemes with a red RAG rating. This is provided in the table below:

Item	Exec	RAG @ Q2	RAG @ Q3	Progress update
1.01 Reducing Length of Stay	**IR**	**R**	**R**	1. Positive second meeting with ECIST team - adjustments made to our weekly review process and a member of the ECIST team to join us and advise 10.12.2019. 2. Focused work with Local Authority around homelessness issues. 3. Relaunch of bed review 13.12.2019. 4. Colleagues attending regional LOS workshops on 10.12.2019 and 11.12.2019. 5. Recruitment to the transformation team to support (Nicola Lester, start date - January 2020). 6. Roadshows planned for 9.12.2019 onwards - Exec and senior manager visiting each ward based MDT to engage them on the LOS agenda.
9.03 Cancer Centre	**JB**	**R**	**G**	1. Project on track for delivery on revised date (24/01/20)

Trust Performance Summary: M08 (November 2019)

1.0 Summary

This report summarises performance at the end of November 2019 for key performance indicators and provides an update on actions to sustain or improve upon Trust and system-wide performance.

This commentary is intended only to highlight areas of performance that have changed or are in some way noteworthy.

2.0 Sustainability and Transformation Fund (STF)

Performance Improvement Trajectories

November 2019 performance against the Service Development and Improvement Plans (SDIP):

ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1	ED 4 hour target (includes UCS)		93.0%	90.5%	90.1%	84.7%	✗	▼	✗	
4.2a	RTT mean waiting time - incomplete waiting list (weeks)		9.2	9.2		10.7	✗	▼		
4.9	62 day standard (Quarterly)		85.0%	85.0%		79.1%	✗	▼		

ED performance continued to decline, dropping from 85.0% in October 2019 to 84.7% in November 2019. This was below the 95% national standard and the NHS Improvement trajectory, which was 90.5%. Performance was however above the most recently published national A&E performance, which was confirmed as 83.6% in October 2019. That was the lowest reported national performance since the collection began. The 95% standard was most recently delivered nationally in July 2015, while only three of 118 reporting trusts achieved the 95% standard during October 2019.

At the end of November 2019, the Trust did not achieve the RTT average waiting time threshold of 9.2 weeks for incomplete elective pathways. An aggregate mean waiting time of 10.7 weeks was reported, which was an increase of 0.6 weeks when compared to October 2019 performance. There was one 52-week plus waiter reported at the end of November 2019 in General Medicine.

Cancer waiting times are reported quarterly, six weeks after the end of a calendar quarter. They are initially published as provisional data and later finalised in line with the NHSE revisions policy. The Trust's provisional 62-day standard performance (from receipt of an urgent GP referral for suspected cancer to first treatment) for Q2 2019/20 was below the national standard of 85% at 79.1%. On a more positive note, the percentage of patients who attended an outpatient appointment within two weeks of an urgent referral by their GP for suspected cancer or breast symptoms in Q2 was 94.5% against a national target of 93%. Also, regarding patients with cancer, the percentage who started treatment within 31 days of a decision to treat was 98.4% against a target of 96%.

3.0 Urgent and Emergency Care

Performance in urgent and emergency care continued to come under pressure in November 2019, as reflected by the indicators below:

ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.4	Cancelled Ops - On Day		1.0%	1.0%	0.8%	1.0%	✓	▼	✓	
3.2	Ward Discharges by Midday		30%	30%	23.4%	21.3%	✗	▼	✗	
3.4	30 day readmissions				8.0%	7.2%		▲		
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)		53	60		86	✗	▲		
3.9	Ambulance Handovers >30 mins (%)		5%	5%	6.7%	8.9%	✗	▼	✗	
4.1	ED 4 hour target (includes UCS)		93.0%	90.5%	90.1%	84.7%	✗	▼	✗	

Cancelled Operations on the Day

In November 2019, the number of operations cancelled on the day for non-clinical reasons increased to 27 from 23 in October 2019. This represented 1.0% of all planned elective operations in-month.

Of the 27 operations that were cancelled on the day during November 2019, 13 (48%) were due to insufficient time, 12 (44%) were due to bed availability and two were cancelled for other reasons.

Readmissions

The Trust 30-day emergency readmission rate was 7.2% in November 2019. The rate for Medicine remained relatively low at 10.9%, while Surgery remained consistent at just above 5%. Women and Children reduced to 3.0%, which was the lowest reported readmission rate since May 2019.

Delayed Transfers of Care (DTOC)

The number of DTOC patients as at midnight on the last Thursday of November 2019 reduced to 30 (from 32 in October 2019). This however was still higher than the agreed threshold of 25.

Length of Stay (Stranded and Super Stranded Patients)

The number of super stranded patients (with a length of stay of 21 days or more) at the end of the month was reduced to 86. This was higher than the monthly NHS Improvement trajectory of 60 but represented a noteworthy improvement on recent months. Reducing the volume of stranded and super stranded patients releases beds, improves patient experience and reduces infection risk.

Ambulance Handovers

In November 2019, the proportion of ambulance handovers to the Emergency Department that took longer than 30 minutes increased from 8.5% in October 2019 to 8.9% in November 2019. This was the highest reported percentage since winter 2018/19, when it peaked at 11.7% in February 2019.

4.0 Elective Pathways

ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
3.1	Overnight bed occupancy rate		93%	93%	90.6%	94.5%	✗	▼	✓	
3.5	Follow Up Ratio		1.50	1.50	1.58	1.59	✗	▼	✗	
4.2a	RTT mean waiting time - incomplete waiting list (weeks)		9.2	9.2		10.7	✗	▼		
5.6	Outpatient DNA Rate		5%	5%	7.7%	7.9%	✗	▲	✗	

Overnight Bed Occupancy

Bed occupancy increased up to 94.5% in November 2019 after lower levels were reported in August and September 2019. The latest overnight bed occupancy data published by NHS England reported that the average occupancy rate for general and acute beds nationally was 90.1% in Q2 2019/20.

Follow up Ratio

During November 2019, the follow up ratio increased to 1.59 follow up attendances for every new attendance in the month. Reducing follow up capacity can free up capacity for new referrals.

RTT Incomplete Pathways

At the end of November 2019, the RTT average mean waiting time threshold of 9.2 weeks was not achieved, with a reported average of 10.7 weeks. This was an increase of 0.6 weeks compared to the average waiting time at the end of October 2019. The total waiting list size in this period had increased by more than 5% (758 patients). There was one patient reported to have been waiting for 52 weeks or more at the end of November 2019. This was a General Medicine patient.

Diagnostic Waits <6 weeks

The Trust again did not meet the national standard of no more than 1% of patients waiting six weeks or longer for a diagnostic test at the end of November 2019, with a performance of 98.8%. The most recent national statistics published by NHS England (end of September 2019) confirmed that 3.8% of the total number of patients waiting for a diagnostic test had waited for more than six weeks.

Outpatient DNA Rate

The DNA rate was higher than the threshold of 5% and has been consistently in the region of 8% during the last three months. DNAs represent capacity that cannot be otherwise utilised and is an area that is currently under scrutiny to ensure that services adhere to the Trust Access Policy and are doing everything they can to reduce DNA rates to minimise their impact on outpatient capacity.

5.0 Patient Safety

Infection Control

There were two cases of C-Diff reported in November 2019, both on Medical wards with one each in Wards 8 and 19. There were also two cases of e-Coli reported, again both in Medical Wards (7 and 22). There was a single case of MSSA reported (Ward 17) but no reported MRSA cases.

ENDS

OBJECTIVE 1 - PATIENT SAFETY										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
1.1	Mortality - (HSMR)		100	100		101.7	✗	▲		
1.2	Mortality - (SHMI)		100	100		106.4	✗	▼		
1.3	Never Events		0	0	0	0	✓	▬	✓	
1.4	Clostridium Difficile		22	<15	10	2	✗	▲	✓	
1.5	MRSA bacteraemia (avoidable)		0	0	0	0	✓	▬	✓	
1.6	Falls with harm (per 1,000 bed days)		0.12	0.12	0.11	0.07	✓	▬	✓	
1.7	Midwife : Birth Ratio		28	28	28	26	✓	▲	✓	
1.8	Incident Rate (per 1,000 bed days)		40	40	51.72	45.72	✓	▼	✓	
1.9	Duty of Candour Breaches (Quarterly)		0	0	0	0	✓	▬	✓	
1.10	E-Coli		20	<14	19	2	✗	▲		
1.11	MSSA				3	1		▼		
1.12	VTE Assessment		95%	95%	98.1%	98.3%	✓	▼	✓	

OBJECTIVE 2 - PATIENT EXPERIENCE										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.1	FFT Recommend Rate (Patients)		94%	94%	95%	94%	✓	▼	✓	
2.2	RED Complaints Received				2	0		▬		
2.3	Complaints response in agreed time		90%	90%	89.7%	86.5%	✗	▼	✗	
2.4	Cancelled Ops - On Day		1.0%	1.0%	0.8%	1.0%	✓	▼	✓	
2.5	Over 75s Ward Moves at Night		2,111	1,408	1,439	184	✗	▼	✗	
2.6	Mixed Sex Breaches		0	0	0	0	✓	▬	✓	

OBJECTIVE 3 - CLINICAL EFFECTIVENESS										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
3.1	Overnight bed occupancy rate		93%	93%	90.6%	94.5%	✗	▼	✓	
3.2	Ward Discharges by Midday		30%	30%	23.4%	21.3%	✗	▼	✗	
3.3	Weekend Discharges		70%	70%	64.7%	61.6%	✗	▼	✗	
3.4	30 day readmissions				8.0%	7.2%		▲		
3.5	Follow Up Ratio		1.50	1.50	1.58	1.59	✗	▼	✗	
3.6.1	Number of Stranded Patients (LOS>=7 Days)		218	218		213	✓	▲		
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)		53	60		86	✗	▲		
3.7	Delayed Transfers of Care		25	25		30	✗	▲		
3.8	Discharges from PDU (%)		15%	15%	9.3%	9.4%	✗	▲	✗	
3.9	Ambulance Handovers >30 mins (%)		5%	5%	6.7%	8.9%	✗	▼	✗	

OBJECTIVE 4 - KEY TARGETS										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1	ED 4 hour target (includes UCS)		93.0%	90.5%	90.1%	84.7%	✗	▼	✗	
4.2a	RTT mean waiting time - incomplete waiting list (weeks)		9.2	9.2		10.7	✗	▼		
4.4	RTT Total Open Pathways		13,991	13,264		15,047	✗	▼		
4.5	RTT Patients waiting over 52 weeks			0		1	✗	▼		
4.6	Diagnostic Waits <6 weeks		99%	99%		98.8%	✗	▲		
4.7	All 2 week wait all cancers (Quarterly)		93.0%	93.0%		94.5%	✓	▲		
4.8	31 days Diagnosis to Treatment (Quarterly)		96.0%	96.0%		98.4%	✓	▲		
4.9	62 day standard (Quarterly)		85.0%	85.0%		79.1%	✗	▼		

OBJECTIVE 5 - SUSTAINABILITY										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
5.1	GP Referrals Received		64,193	42,708	45,378	4,435	✓	▲	✗	
5.2	A&E Attendances		89,369	59,580	61,729	7,856	✗	▲	✗	
5.3	Elective Spells (PBR)		25,641	17,196	17,365	2,475	✗	▼	✗	
5.4	Non-Elective Spells (PBR)		31,976	21,356	19,758	2,770	✗	▼	✓	
5.5	OP Attendances / Procs (Total)		381,108	255,498	262,267	31,543	✓	▲	✗	
5.6	Outpatient DNA Rate		5%	5%	7.7%	7.9%	✗	▲	✗	

OBJECTIVE 7 - FINANCIAL PERFORMANCE										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
7.1	Income £'000		268,966	180,147	176,872	22,431	✗	▼	✗	
7.2	Pay £'000		(171,021)	(114,457)	(116,530)	(14,440)	✗	▼	✗	
7.3	Non-pay £'000		(77,803)	(52,378)	(54,033)	(6,675)	✗	▲	✗	
7.4	Non-operating costs £'000		(13,359)	(8,752)	(8,478)	(1,073)	✓	▼	✓	
7.5	I&E Total £'000		6,783	4,560	(2,169)	243	✗	▼	✗	
7.6	Cash Balance £'000		2,500	2,108		14,392	✓	▲		
7.7	Savings Delivered £'000		8,419	4,210	3,544	916	✓	▲	✗	
7.8	Capital Expenditure £'000		27,926	17,782	10,809	526	✓	▲	✓	

OBJECTIVE 8 - WORKFORCE PERFORMANCE										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
8.1	Staff Vacancies % of establishment		11%	11%		10.5%	✓	▲		
8.2	Agency Expenditure %		8%	8%	5.0%	4.6%	✓	▲	✓	
8.3	Staff sickness - % of days lost		4%	4%		4.0%	✓	▼		
8.4	Appraisals		90%	90%		94.0%	✓	▲		
8.5	Statutory Mandatory training		90%	90%		92.0%	✓	▬		
8.6	Substantive Staff Turnover		11%	11%		9.0%	✓	▲		

OBJECTIVES - OTHER										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
O.1	Total Number of NICE Breaches		8	8		37	✗	▲		
O.2	Rebooked cancelled OPs - 28 day rule		95%	95%	87.9%	91.3%	✗	▼	✗	
O.4	Overdue Datix Incidents >1 month		0	0		97	✗	▼		
O.5	Serious Incidents		45	<30	47	4	✗	▲	✗	
O.8	Completed Job Plans (Consultants)		90%	90%		90%	✓	▼		

Key: Monthly/Quarterly Change

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

YTD Position

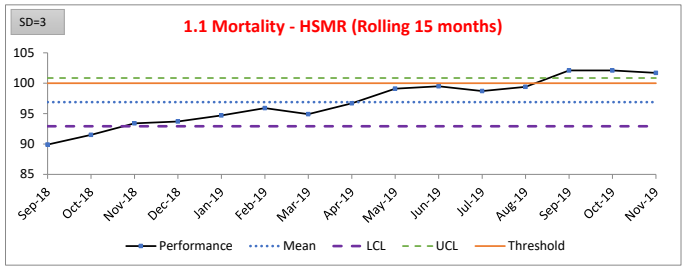
✓	Achieving YTD Target
	Within Agreed Tolerance*
✗	Not achieving YTD Target
	Annual Target breached

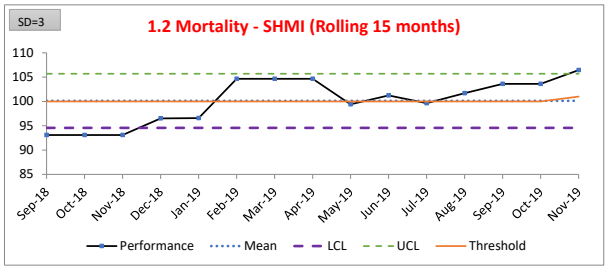
Data Quality Assurance Definitions

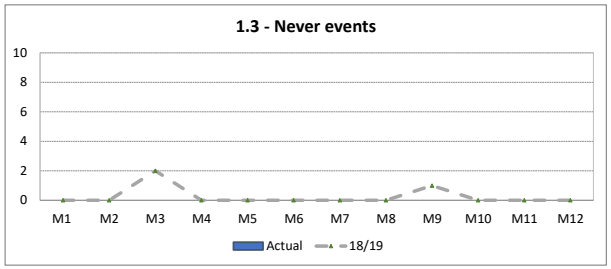
Rating	Data Quality Assurance
Green	Satisfactory and independently audited (indicator represents an accurate reflection of performance)
Amber	Acceptable levels of assurance but minor areas for improvement identified and potentially independently audited * /No Independent Assurance
Red	Unsatisfactory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

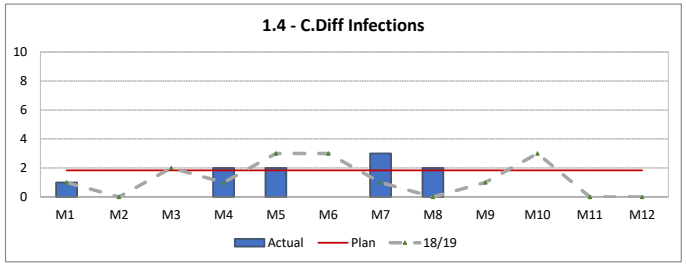
* Independently Audited – refers to an independent audit undertaken by either the Internal Auditor, External Auditors or the Data Quality Audit team.

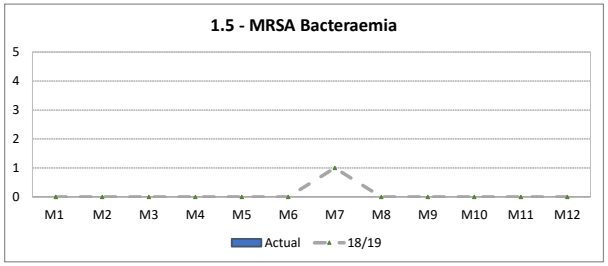
Date Produced: 12/12/2019

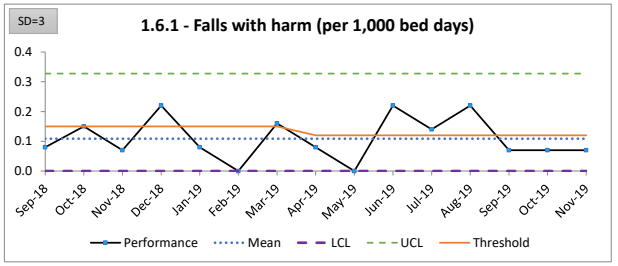


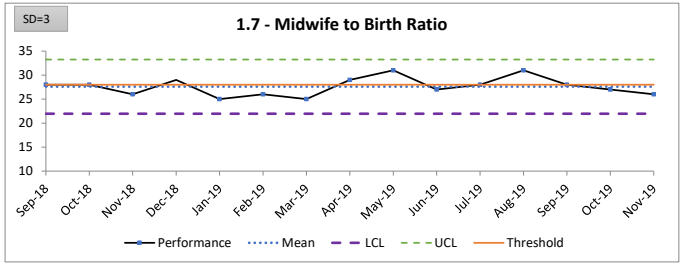


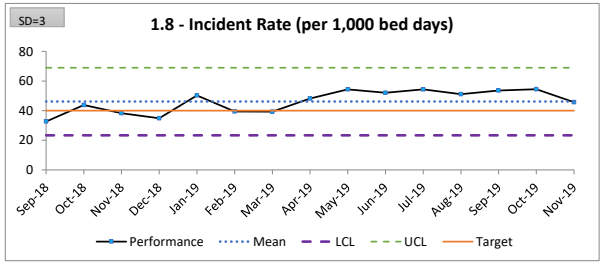


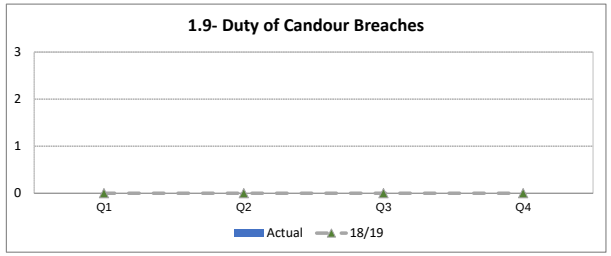


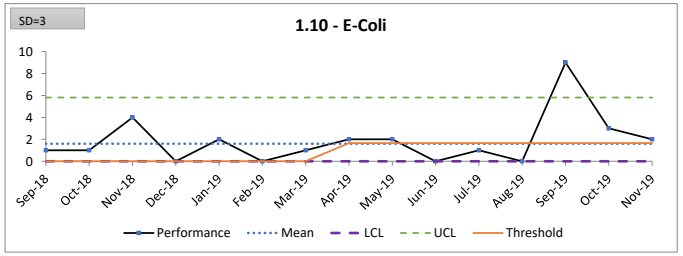


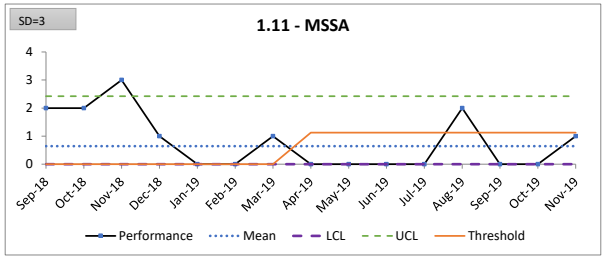


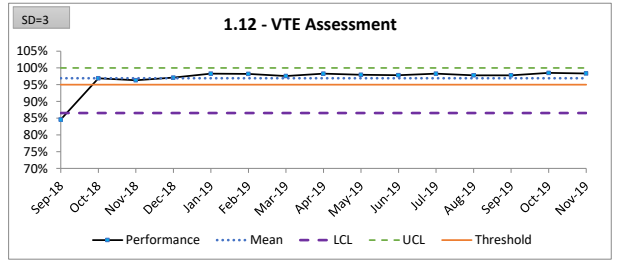










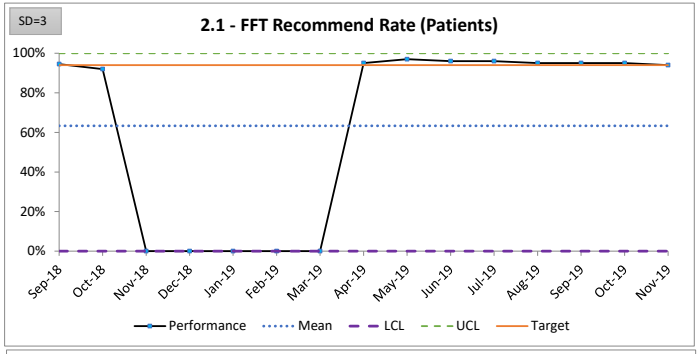


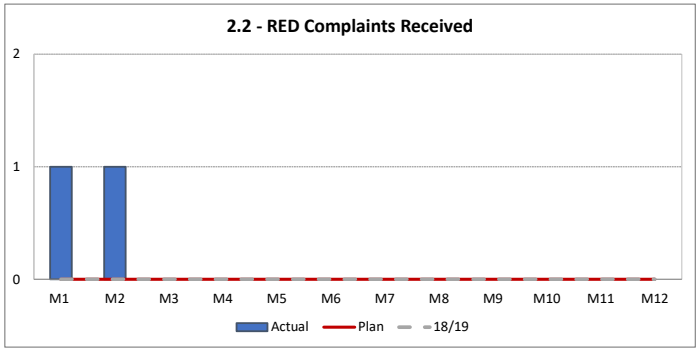
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

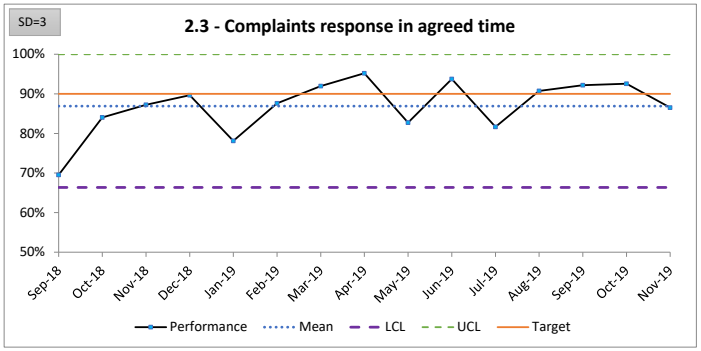
233 209 219 212
106 85 94 91

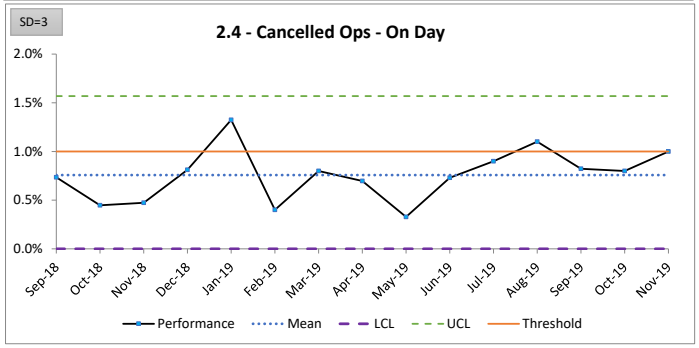
- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

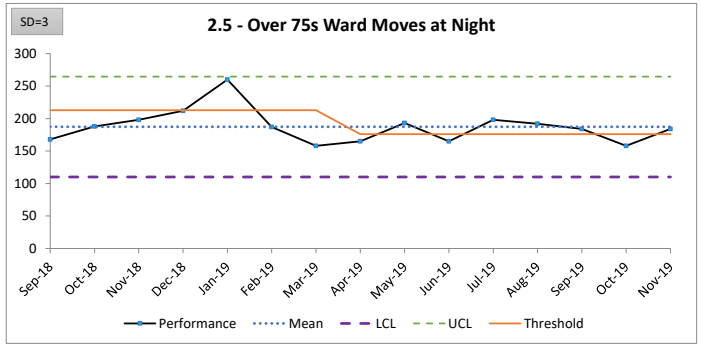
OBJECTIVE 2 - PATIENT EXPERIENCE

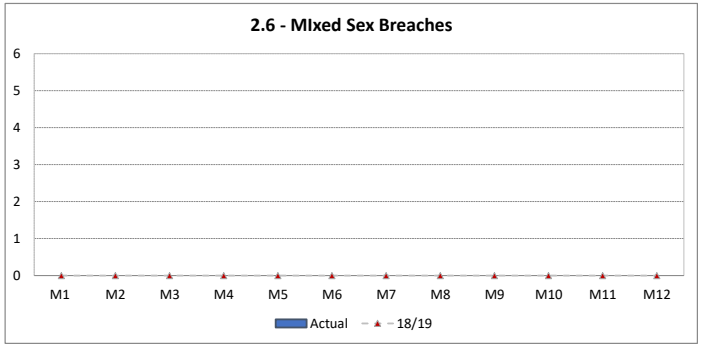












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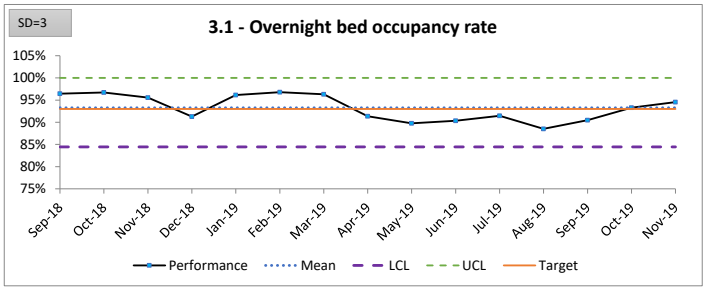
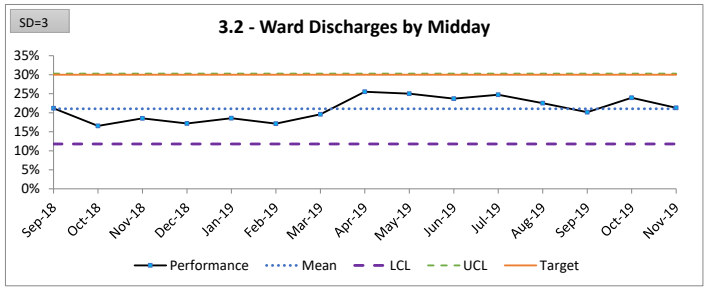
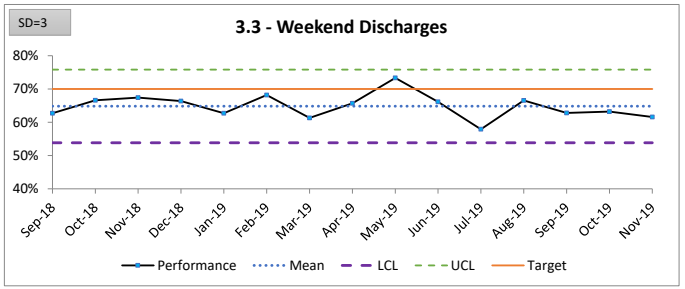
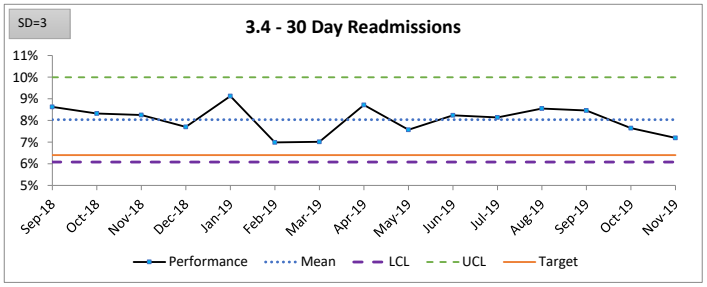
- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

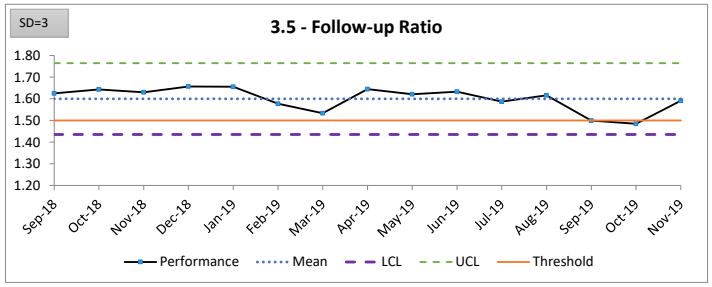
OBJECTIVE 3 - CLINICAL EFFECTIVENESS

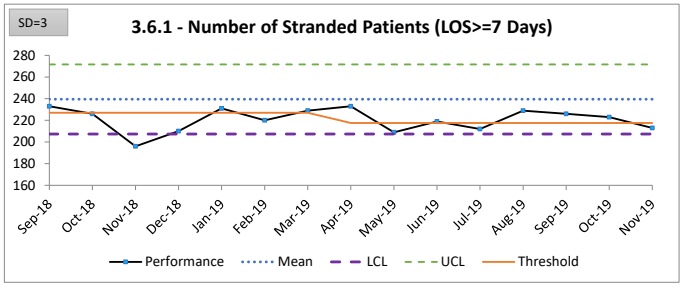


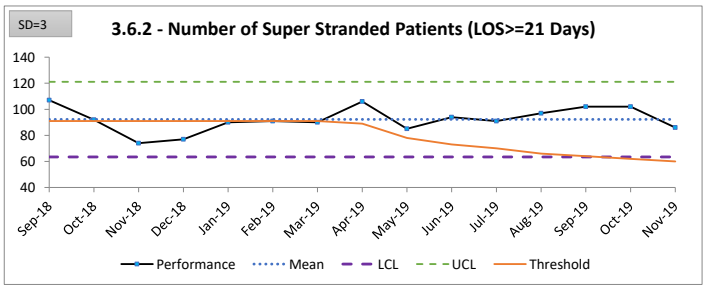


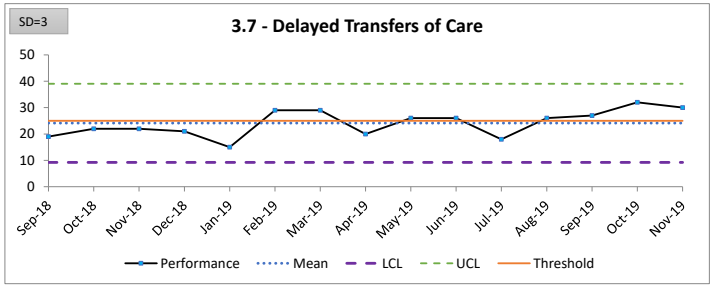


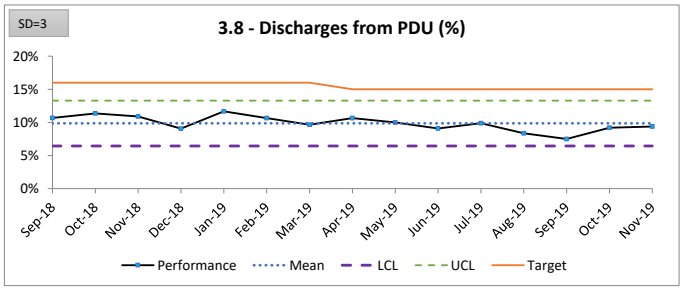


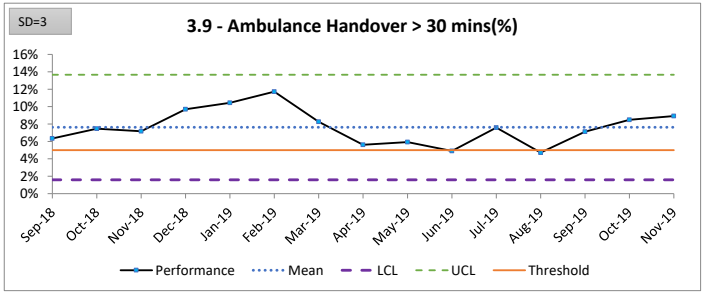












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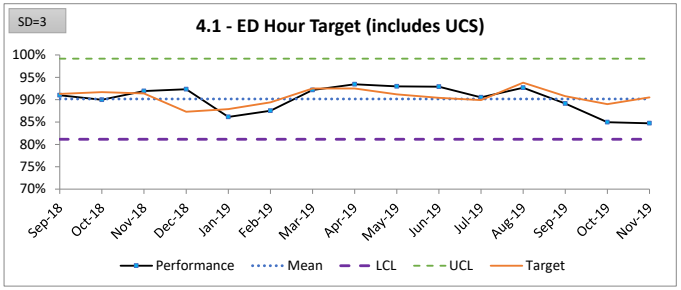
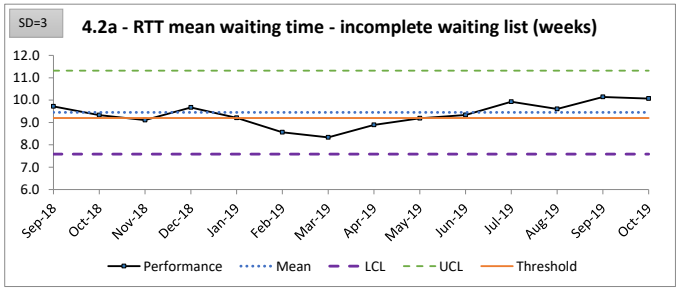
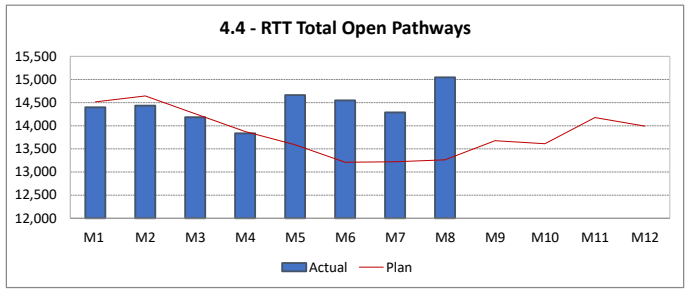
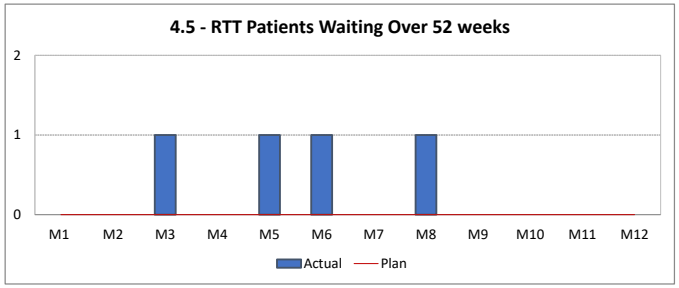
- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

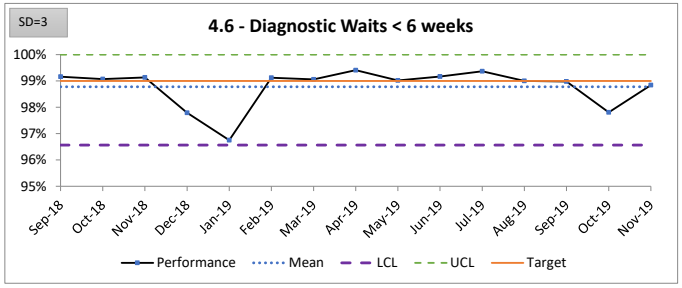
OBJECTIVE 4 - KEY TARGETS

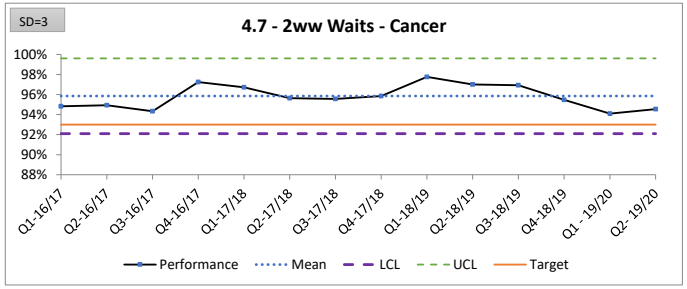


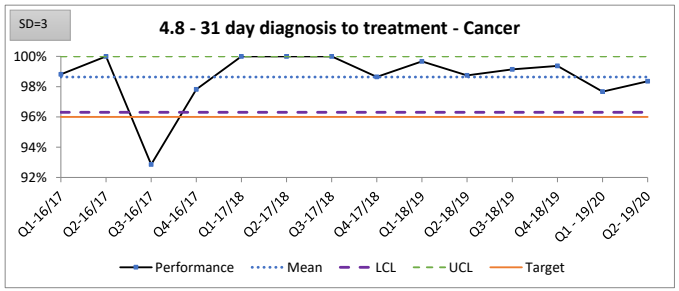


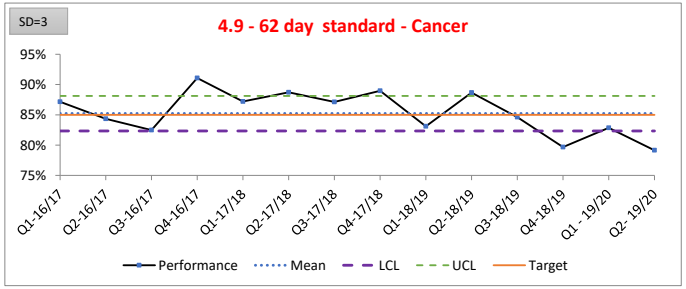












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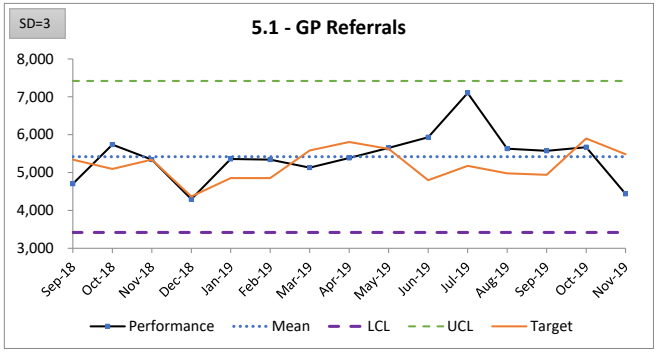
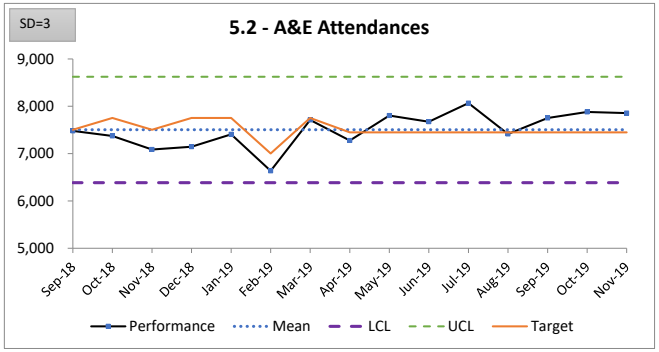
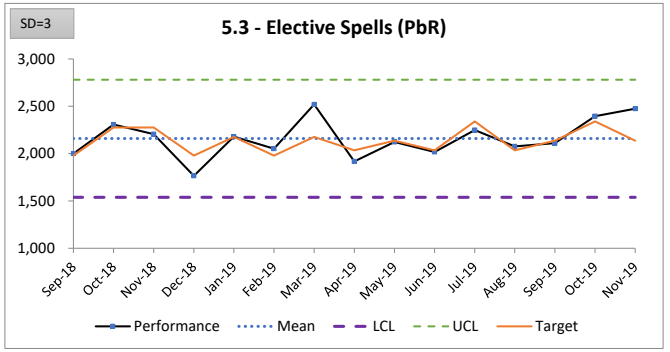
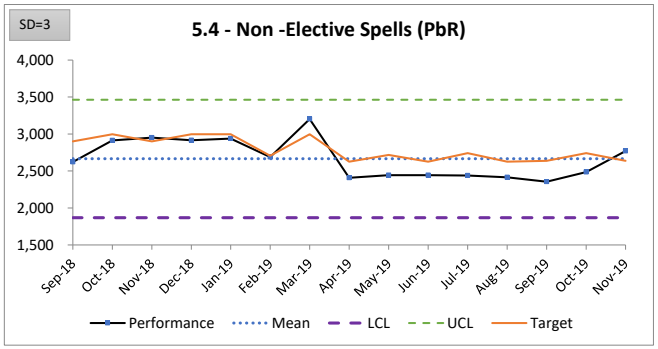
- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

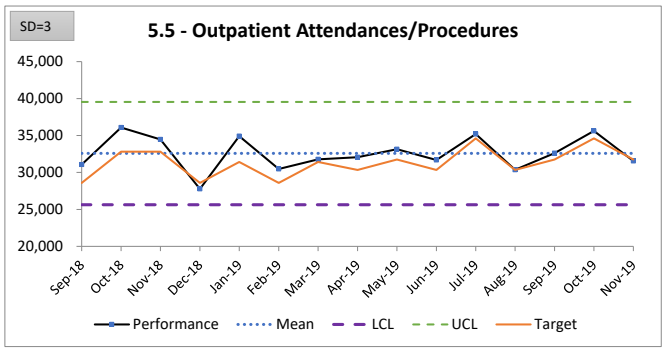
233	209	219	212	229
106	85	94	91	97

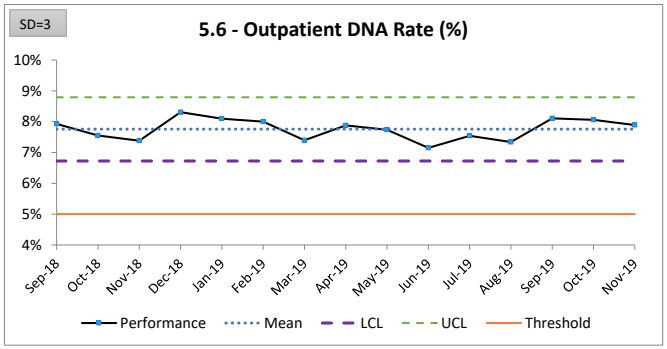












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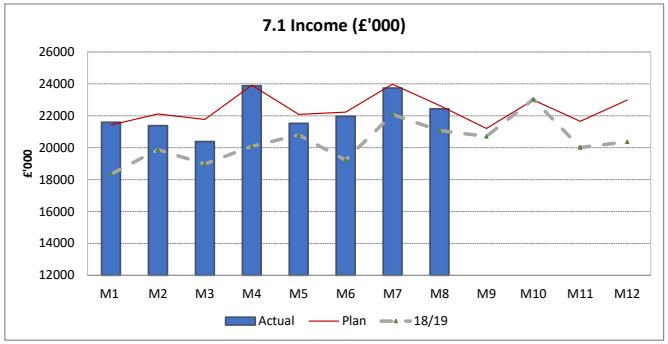
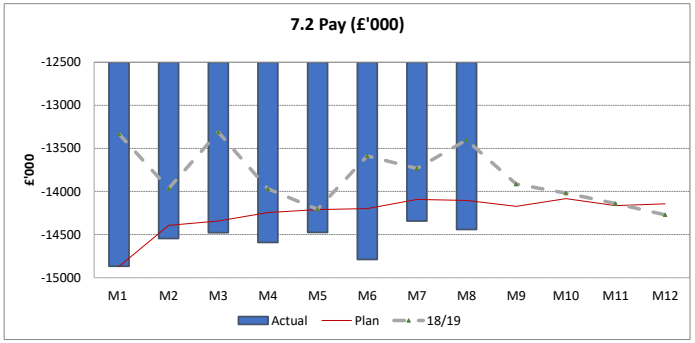
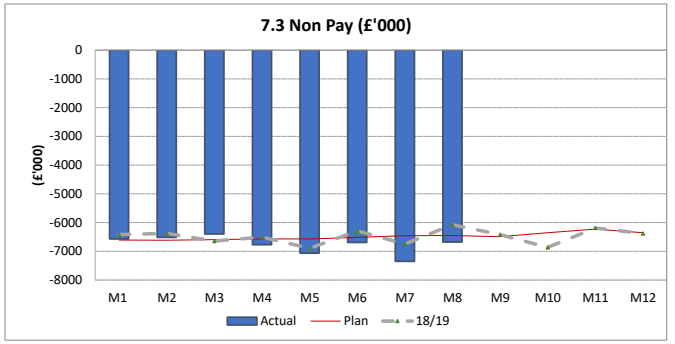
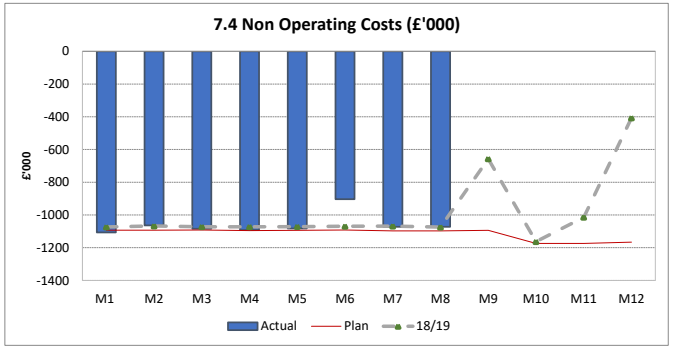
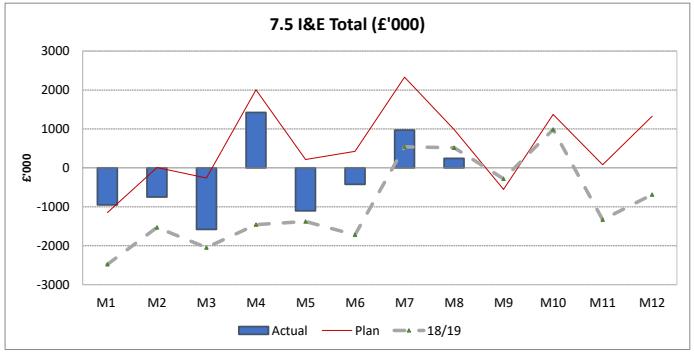
- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

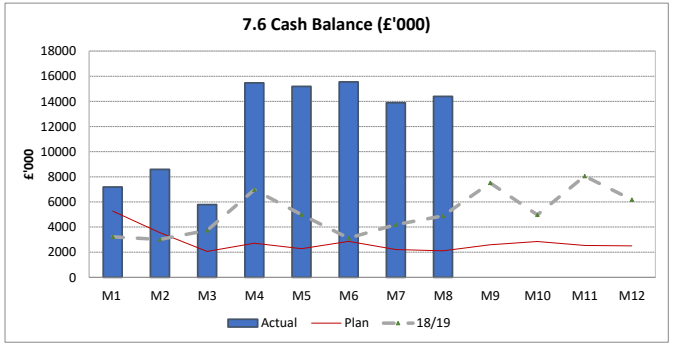

7.1 Income (£'000)
£'000
26000
24000
22000
20000
18000
16000
14000
12000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19

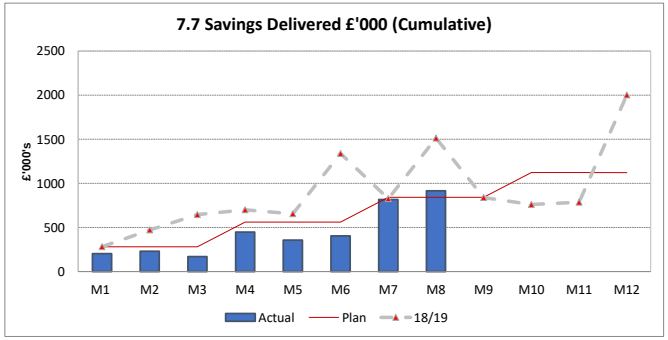

7.2 Pay (£'000)
£'000
-12500
-13000
-13500
-14000
-14500
-15000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19

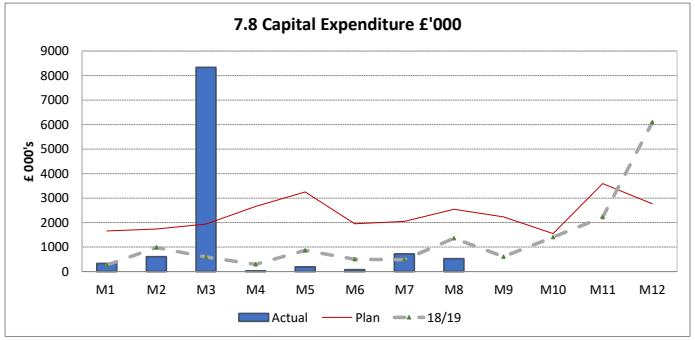

7.3 Non Pay (£'000)
(£'000)
0
-1000
-2000
-3000
-4000
-5000
-6000
-7000
-8000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19


7.4 Non Operating Costs (£'000)
£'000
0
-200
-400
-600
-800
-1000
-1200
-1400
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19


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

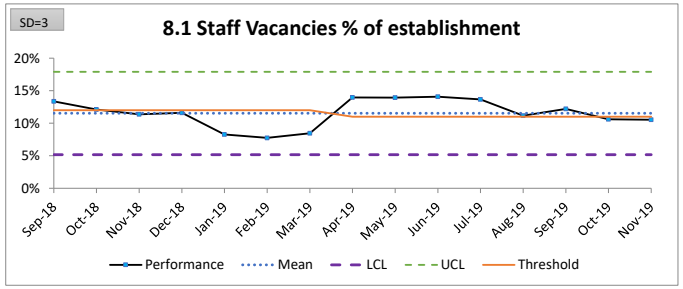

7.6 Cash Balance (£'000)
£'000
18000
16000
14000
12000
10000
8000
6000
4000
2000
0
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19

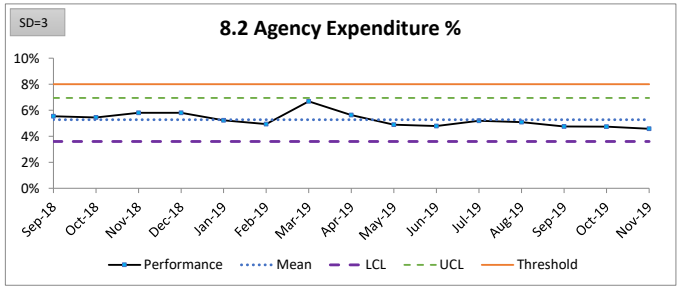

7.7 Savings Delivered £'000 (Cumulative)
£'000's
2500
2000
1500
1000
500
0
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19

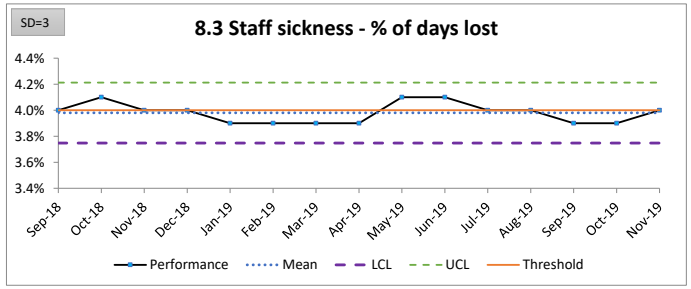

7.8 Capital Expenditure £'000
£ 000's
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19

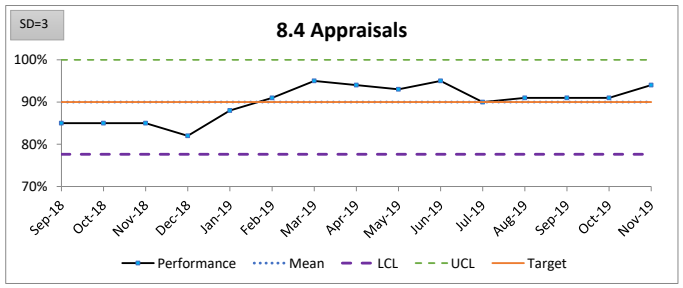
0
0.87

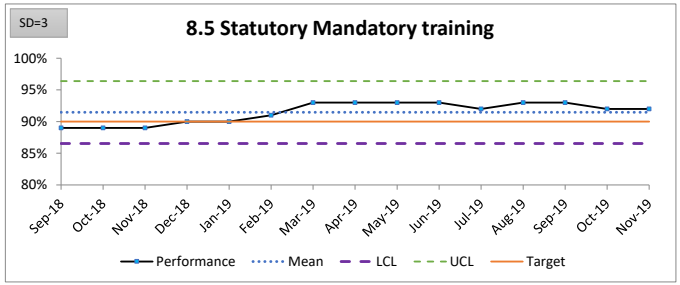
OBJECTIVE 8 - WORKFORCE PERFORMANCE

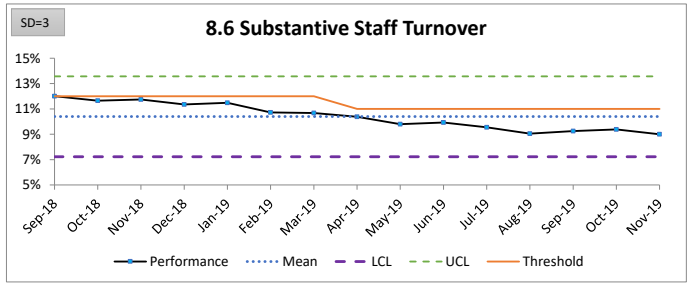












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- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
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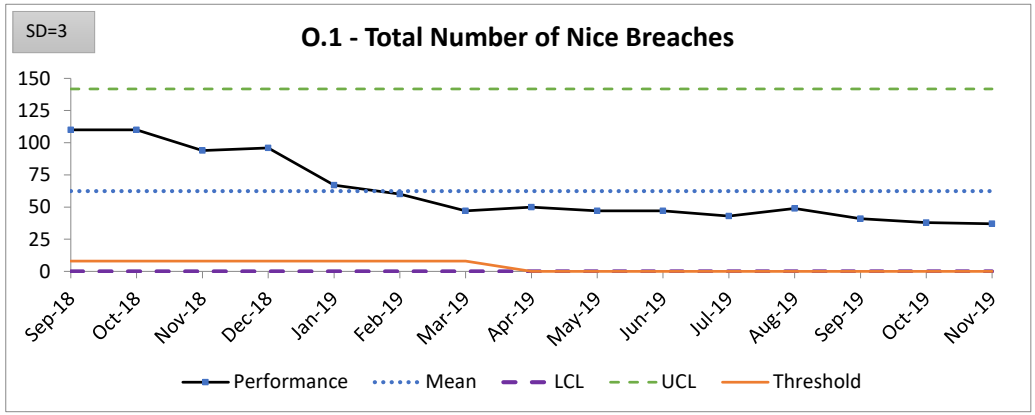
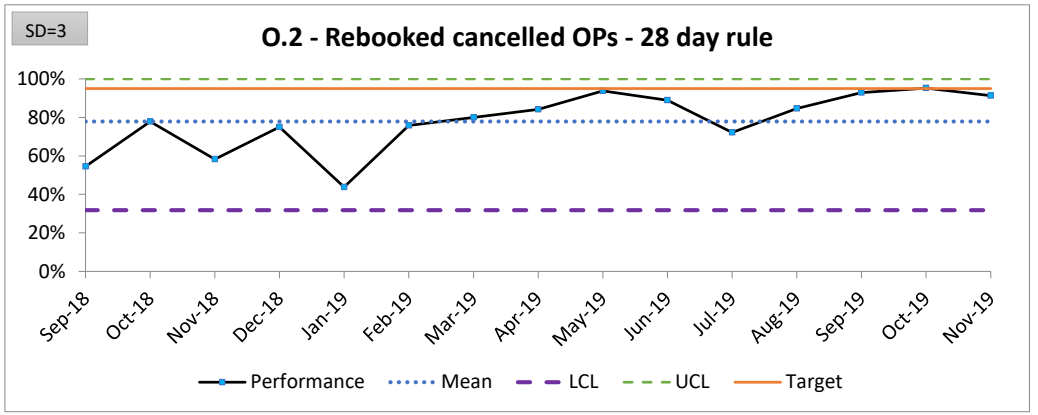
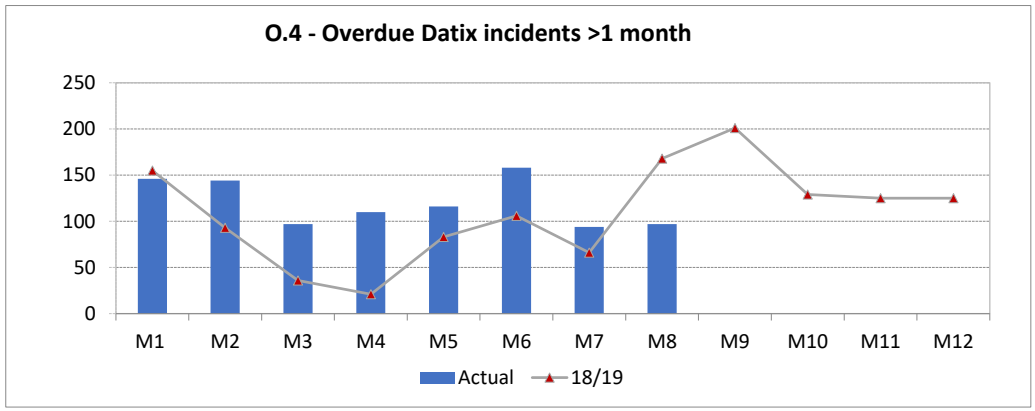
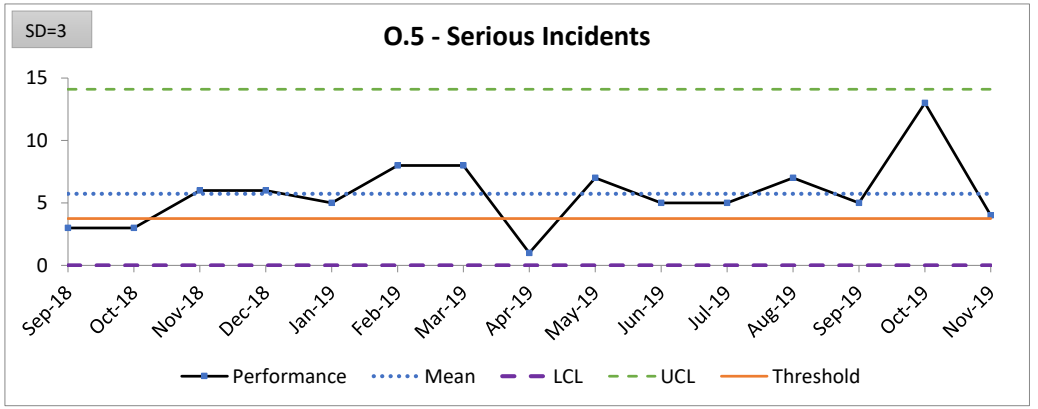


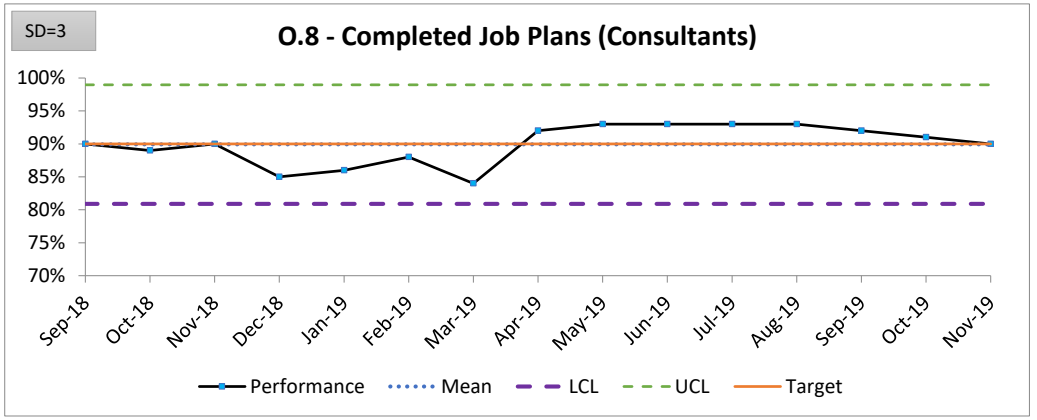






If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

- 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



Milton Keynes University Hospital NHS Foundation Trust

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Meeting title	Public Board	Date: 9 January 2020
Report title:	**Finance Paper Month 8 2019-20**	**Agenda item:**
Lead director **Report authors**	Mike Keech Daphne Thomas Chris Panes	Director of Finance Deputy Director of Finance Head of Management Accounts
FoI status:	Public document	

Report summary	**An update on the financial position of the Trust at Month 8 (November 2019)**			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** X	**Decision** ☐
Recommendation	The Trust Board to note the contents of the paper.			

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

Report history	None
Next steps	None
Appendices	1 to 3

FINANCE REPORT FOR THE MONTH TO 30th NOVEMBER 2019

PUBLIC BOARD MEETING

PURPOSE

1. The purpose of the paper is to:

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

EXECUTIVE SUMMARY

2. *Income and expenditure* –The Trust's Surplus for November 2019 was £0.2m which is £0.7m adverse to budget in the month and £6.3m adverse YTD. However, since this adverse variance is largely driven by the timing of donations (£5.9m) which is to support the capital programme, the operational deficit at control total level (excluding central PSF/FRF/MRET funding & donations) is significantly better, with an adverse variance of £0.4m reported on a YTD basis.

3. Cash and capital position – the cash balance as at the end of November 2019 was £14.4m, which was £12.3m above plan due to the timing of capital expenditure and receipts from prior year PSF funding. The Trust has spent £10.8m on capital up to month 8. The Trust continues to forecast that it will spend its full capital budget of £28.7m in the 2019/20 financial year.

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

5. *Cost savings* – overall savings of £0.9m were delivered in month against an identified plan of £0.9m and the target of £0.8m. YTD £3.5m has been delivered against a plan of £3.6m and a target of £4.6m. As at month 8, £5.8m of schemes have been validated and added to the cost savings tracker against the full year £8.4m target.

INCOME AND EXPENDITURE

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

All Figures in £'000	Month 8 Plan	Month 8 Actual	Month 8 Var	Month 8 YTD Plan	Month 8 YTD Actual	Month 8 YTD Var	Full Year Plan	Full Year Forecast	Full Year Var
Clinical Revenue	18,152	18,462	310	146,343	147,795	1,452	218,726	222,514	3,788
Other Revenue	1,589	1,798	209	12,836	14,464	1,628	19,085	21,172	2,087
Total Income	19,741	20,260	519	159,179	162,259	3,080	237,811	243,686	5,875
Pay	(14,105)	(14,440)	(335)	(114,466)	(116,530)	(2,063)	(171,023)	(174,861)	(3,838)
Non Pay	(6,441)	(6,675)	(238)	(52,293)	(54,093)	(1,800)	(77,808)	(80,759)	(2,951)
Total Operational Expend	(20,546)	(21,115)	(573)	(166,759)	(170,623)	(3,864)	(248,831)	(255,620)	(6,789)
EBITDA	(805)	(855)	(50)	(7,580)	(8,364)	(783)	(11,020)	(11,934)	(914)
Financing & Non-Op. Costs	(1,048)	(1,017)	31	(8,380)	(8,030)	350	(12,570)	(11,656)	914
Control Total Deficit (excl. PSF)	**(1,853)**	**(1,872)**	**(19)**	**(15,960)**	**(16,394)**	**(433)**	**(23,590)**	**(23,590)**	**(0)**
Adjustments excl. from control total:									
PSF	420	420	0	2,311	2,783	472	4,197	4,669	472
PSF- ICS	92	0	(92)	505	0	(505)	923	0	(923)
FRF	1,481	1,481	0	8,144	8,144	0	14,807	14,807	0
MRET	270	270	0	2,158	2,158	0	3,237	3,237	0
Control Total Deficit (incl. PSF)	**410**	**299**	**(111)**	**(2,842)**	**(3,309)**	**(466)**	**(426)**	**(877)**	**(451)**
Donated income	631	0	(631)	7,866	2,000	(5,866)	8,000	8,000	0
Donated asset depreciation	(66)	(56)	9	(524)	(449)	75	(786)	(615)	171
Rounding	4	0	(4)	69	0	(69)	0	0	0
Reported deficit/surplus	**980**	**243**	**(737)**	**4,569**	**(1,758)**	**(6,326)**	**6,788**	**6,508**	**(280)**

Monthly and year to date review

7. The **deficit excluding central funding (PSF, FRF and MRET) and donated income** in month 8 is £1,872k which is **£19k adverse to plan in month and £433k adverse YTD**. For M8 the Trust recognised a loss of income of £92k (£505k YTD) due to the financial performance of the BLMK ICS which is currently not meeting its control total. The total central funding allocation recognised in the position is £2,171k (£13,085k YTD) which includes additional funding of £472k relating to prior year financial performance.

8. The Trust reported an overall surplus in month 8 of £243k which is £737k adverse to the budget surplus of £980k largely due to the negative variance against plan on donated income relating to the Cancer Centre project.

9. **Income (excluding PSF/FRF/MRET and donations effect)** is £519k favourable to plan in November and £3,080k favourable YTD and is analysed in further detail in Appendix 1.

10. **Operational costs** in November are adverse to plan by £573k in month and adverse by £3,933k YTD. The higher cost base is to support higher levels of activity and also reflects the delays in savings from the CIP programme.

11. **Pay costs** are £335k adverse to budget in Month 8. Substantive pay has increased in month and costs remain high with the use of additional sessions to support higher than budgeted activity levels. Bank and Locum expenditure has remained relatively static from M7 and is significantly above budgeted levels. Negative variances against bank are offset by positive variances against agency which remain within the NHSI/E agency ceiling.

12. **Non-pay** costs were £238k adverse to plan in month and £1,869k adverse YTD. Negative variances can be seen across a number of non-pay categories, the notable variances are against clinical supplies, premises & fixed plant and outsourcing.

13. **Non-operational** costs are marginally favourable in month

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

COST SAVINGS

14. In Month 8, £916k was delivered against an identified plan of £930k and a target of £842k. YTD £3,544k has been delivered against a plan of £3,571k and a target of £4,633k.

CASH AND CAPITAL

15. The cash balance at the end of November 2019 was £14.4m, which was £12.3m above plan due to the timing of capital expenditure and receipts from prior year PSF funding – see Appendix 2 for the year to date cash flow position.

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

    - Non-Current Assets are below plan by £36.8m; this is mainly driven by the revaluation of the Trust estate in 2018/19 and timing of capital projects.

    - Current assets are above plan by £12.6m, this is due to cash £12.3m, inventories £0.4m above plan offset by receivables £0.1m below plan. See Appendix 12 and Appendix 13 for further debtor details.

    - Current liabilities are above plan by £5.4m. This is being driven by Trade and Other Creditors £2.8m, deferred income £2.6m and provisions £0.1m above plan offset by borrowings £0.1m below plan.

- Non-Current Liabilities are below plan by £1.1m. This is being driven by provisions £0.3m and borrowings £0.8m below plan.

RISK REGISTER

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

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

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

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

Funding to cover the ongoing funding requirements in 2019/20 is subject to approval by DHSC on a monthly basis and remains a risk in the new financial year. As in previous years the Trust will liaise with NHS Improvement in respect of revenue loans due for repayment in 2019/20.

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

The Trust has a target of £8.4m of which all will need to be delivered through cost reduction, this remains a risk to meeting the Trust's year end control total.

RECOMMENDATIONS TO BOARD

18. The Trust Board is asked to note the financial position of the Trust as at 30th November 2019 and the proposed actions and risks therein.

Appendix 1

Milton Keynes Hospital NHS Foundation Trust
Statement of Comprehensive Income
For the period ending 30th November 2019

	November 2019			8 months to November 2019			Full year
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME							
Outpatients	3,764	3,910	146	30,282	31,518	1,237	45,166
Elective admissions	2,411	2,476	65	19,402	18,683	(719)	28,930
Emergency admissions	6,060	6,273	213	49,074	46,471	(2,602)	73,498
Emergency adm's marginal rate (MRET)	(267)	(256)	11	(2,162)	(2,076)	85	(3,238)
Readmissions Penalty	(279)	(279)	0	(2,235)	(2,235)	0	(3,353)
A&E	1,202	1,269	68	9,612	10,164	551	14,418
Maternity	1,654	1,702	48	13,331	14,445	1,114	19,980
Critical Care & Neonatal	530	644	114	4,267	3,937	(330)	6,362
Excess bed days	0	0	0	0	0	0	0
Imaging	421	458	37	3,388	3,709	321	5,053
Direct access Pathology	394	392	(2)	3,169	3,225	56	4,726
Non Tariff Drugs (high cost/individual drugs)	1,633	1,659	26	13,141	12,461	(681)	19,488
Other	631	215	(415)	5,074	7,494	2,420	7,695
Clinical Income	**18,152**	**18,462**	**310**	**146,343**	**147,795**	**1,452**	**218,726**
Non-Patient Income	**4,483**	**3,969**	**(514)**	**33,820**	**29,549**	**(4,271)**	**50,249**
TOTAL INCOME	**22,635**	**22,431**	**(204)**	**180,163**	**177,344**	**(2,819)**	**268,975**
EXPENDITURE							
Total Pay	**(14,105)**	**(14,440)**	**(335)**	**(114,466)**	**(116,530)**	**(2,063)**	**(171,023)**
Non Pay	(4,804)	(5,016)	(212)	(39,083)	(41,633)	(2,550)	(58,320)
Non Tariff Drugs (high cost/individual drugs)	(1,633)	(1,659)	(26)	(13,141)	(12,461)	681	(19,488)
Non Pay	**(6,437)**	**(6,675)**	**(238)**	**(52,224)**	**(54,093)**	**(1,869)**	**(77,808)**
TOTAL EXPENDITURE	**(20,542)**	**(21,115)**	**(573)**	**(166,690)**	**(170,623)**	**(3,933)**	**(248,831)**
EBITDA*	**2,093**	**1,316**	**(777)**	**13,473**	**6,721**	**(6,751)**	**20,144**
Depreciation and non-operating costs	(983)	(942)	41	(7,864)	(7,612)	252	(11,796)
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**1,110**	**373**	**(736)**	**5,609**	**(892)**	**(6,500)**	**8,349**
Public Dividends Payable	(130)	(130)	(0)	(1,040)	(867)	174	(1,560)
OPERATING DEFICIT AFTER DIVIDENDS	**980**	**243**	**(737)**	**4,569**	**(1,758)**	**(6,325)**	**6,788**
Adjustments to reach control total							
Donated Income	(631)	0	631	(7,866)	(2,000)	5,866	(8,000)
Donated Assets Depreciation	66	56	(9)	524	449	(75)	786
Control Total Rounding	(4)	0	4	(69)	0	69	0
PSF/FRF/MRET	(2,262)	(2,171)	91	(13,118)	(13,086)	32	(23,164)
CONTROL TOTAL DEFECIT	**(1,853)**	**(1,872)**	**(19)**	**(15,960)**	**(16,394)**	**(433)**	**(23,590)**

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

Appendix 2

Milton Keynes Hospital NHS Foundation Trust
Statement of Cash Flow
As at 30th November 2019

	Mth 8 £000	Mth 7 £000	In Month Movement £000
Cash flows from operating activities			
Operating (deficit) from continuing operations	564	10	554
Operating surplus/(deficit) of discontinued operations			
Operating (deficit)	**564**	**10**	**554**
Non-cash income and expense:			
Depreciation and amortisation	6,157	5,395	762
(Increase)/Decrease in Trade and Other Receivables	7,485	4,682	2,803
(Increase)/Decrease in Inventories	5	5	0
Increase/(Decrease) in Trade and Other Payables	2,194	2,759	(565)
Increase/(Decrease) in Other Liabilities	2,454	3,035	(581)
Increase/(Decrease) in Provisions	(43)	(43)	0
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows	(2,000)	(2,000)	0
Other movements in operating cash flows	(1)	(1)	0
NET CASH GENERATED FROM OPERATIONS	**16,815**	**13,842**	**2,973**
Cash flows from investing activities			
Interest received	71	61	10
Purchase of financial assets	(175)	(175)	0
Purchase of intangible assets	(1,486)	(1,472)	(14)
Purchase of Property, Plant and Equipment, Intangibles	(8,813)	(6,658)	(2,155)
Sales of Property, Plant and Equipment			0
Net cash generated (used in) investing activities	**(10,403)**	**(8,244)**	**(2,159)**
Cash flows from financing activities			
Loans received from Department of Health	2,915	2,915	0
Loans repaid to Department of Health	(1,097)	(938)	(159)
Capital element of finance lease rental payments	(106)	(91)	(15)
Interest paid	(1,106)	(996)	(110)
Interest element of finance lease	(195)	(171)	(24)
PDC Dividend paid	(606)	(606)	0
Receipt of cash donations to purchase capital assets	2,000	2,000	0
Net cash generated from/(used in) financing activities	**1,805**	**2,113**	**(308)**
Increase/(decrease) in cash and cash equivalents	**8,217**	**7,711**	506
Opening Cash and Cash equivalents	**6,175**	**6,175**	0
Closing Cash and Cash equivalents	**14,392**	**13,886**	**506**

Appendix 3

Milton Keynes Hospital NHS Foundation Trust
Statement of Financial Position as at 30th November 2019

	Audited Mar-19	Nov-19 YTD Plan	Nov-19 YTD Actual	In Mth Mvmt	YTD Mvmt	% Variance
Assets Non-Current						
Tangible Assets	147.3	190.5	151.9	(38.6)	4.6	3.1%
Intangible Assets	14.2	12.6	14.1	1.5	(0.1)	(0.7%)
Other Assets	0.5	0.3	0.6	0.3	0.2	38.2%
Total Non Current Assets	**162.0**	**203.4**	**166.6**	**(36.8)**	**4.7**	**2.9%**
Assets Current						
Inventory	3.6	3.2	3.6	0.4	0.0	0.0%
NHS Receivables	23.5	18.7	15.2	(3.5)	(8.3)	(35.3%)
Other Receivables	6.0	3.5	6.9	3.4	0.9	15.0%
Cash	6.2	2.1	14.4	12.3	8.2	132.3%
Total Current Assets	**39.3**	**27.5**	**40.1**	**12.6**	**0.8**	**2.0%**
Liabilities Current						
Interest -bearing borrowings	(80.2)	(81.9)	(81.8)	0.1	(1.6)	2.0%
Deferred Income	(1.7)	(1.6)	(4.2)	(2.6)	(2.5)	146.2%
Provisions	(1.6)	(1.4)	(1.5)	(0.1)	0.1	-4.3%
Trade & other Creditors (incl NHS)	(28.9)	(28.8)	(31.6)	(2.8)	(2.7)	9.4%
Total Current Liabilities	**(112.3)**	**(113.7)**	**(119.1)**	**(5.4)**	**(6.8)**	6.0%
Net current assets	**(73.0)**	**(86.2)**	**(79.0)**	**7.2**	**(6.0)**	**8.2%**
Liabilities Non-Current						
Long-term Interest bearing borrowings	(53.0)	(54.3)	(53.4)	0.9	(0.4)	0.7%
Provisions for liabilities and charges	(0.8)	(1.1)	(0.8)	0.3	0.0	0.0%
Total non-current liabilities	**(53.9)**	**(55.4)**	**(54.2)**	**1.2**	**(0.4)**	0.7%
Total Assets Employed	**35.1**	**61.8**	**33.4**	**(28.0)**	**(1.7)**	**(4.7%)**
Taxpayers Equity						
Public Dividend Capital (PDC)	101.4	103.3	101.3	(2.0)	(0.1)	-0.1%
Revaluation Reserve	58.3	78.7	58.3	(20.4)	0.0	0.0%
I&E Reserve	(124.5)	(120.2)	(126.2)	(6.0)	(1.7)	1.4%
Total Taxpayers Equity	**35.1**	**61.8**	**33.4**	**(28.4)**	**(1.8)**	**(5.0%)**

Meeting title	**Trust Board**	**Date: 09 January 2020**
Report title:	**Workforce report**	**Agenda item:**
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 30 November 2019 (Month 7).			
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [x]	**Decision** [ ]
Recommendation	Trust Board is asked to note the Workforce report.			

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

Report history	Full monthly Corporate Workforce Information report - Executive Management Board, Divisional Accountability, 18 December 2019
Next steps	
Appendices	

Workforce report – Month 7, 2019/20

1. Purpose of the report

1.1. This report provides a summary of workforce Key Performance Indicators for the full year ending 30 November 2019 (Month 7).

2. Staff in post

2.1. The Trust's staff in post by whole time equivalent (WTE) was 3124.6 as at 30 November 2019; an increase of 57.0 WTE since November 2018.

2.2. The Trust's headcount is 3609, an increase of 60 since November 2018.

2.3. The largest increase of staff in post since November 2018 has been the Additional Professional Scientific and Technical staff group (9% headcount increase; 100 to 109).

3. Vacancy rate

3.1. The Trust's overall vacancy rate is 9.7%; this has reduced from 12.9% in April 2019 (M1).

3.2. The highest vacancy factors are in the Medical and Dental (14.8%), Nursing and Midwifery (13.9%) and Allied Health Professionals (12.6%) staff groups.

3.3. In line with the Trust's Workforce Strategy, the Divisional HR Business Partners continue to collaborate with Finance and Clinical Divisional colleagues to formulate plans to reduce actual vacancies in their establishments on a line-by-line basis and by use of overarching strategies.

3.4. It is anticipated that this work, will impact further upon temporary staffing expenditure, and in the coming months, time spent on recruitment activities will increase significantly for Recruiting Managers and the Trust's Recruitment team. The Trust may not see the full impact of this work until towards the end of 2019/20 and into 2020/21 as vacancies start to be filled.

4. Turnover

4.1. The Trust's leaver turnover rate was lower throughout 2018/19 than it was in 2017/18 and this trend has continued into Q3 of 2019/20. The M7 position is further reduced to 9.1%.

4.2. The Trust's turnover rate has continued to improve in the wake of ongoing engagement work in respect of Staff Benefits and the NHS Staff Survey engagement activities.

4.3. Nursing and Midwifery turnover (5.7%) is significantly lower that it was in November 2018, owing to improvements in senior Nursing and Midwifery management and leadership capability, coupled with staff engagement work highlighted above.

5. Temporary Staffing

5.1. The temporary staff usage (bank and agency) for the rolling year-to-date was 6134.1 WTE, which was 14.5% of total WTE staff employed.

5.2. Agency staff usage was 3.4% of the total WTE staff employed for the rolling year to date but was 5.5% of the total annual staff expenditure. This is predominantly driven by high cost Medical and Dental agency locums and volume of Nursing agency staff where comparative vacancy rates are above 13%.

5.3. Detailed analysis of non-standard basic pay and expenditure is being undertaken to target interventions for greater effect as the Trust seeks to reduce expenditure and standardise its pay offering in line with systems development work.

6. Sickness absence

6.1. The sickness absence rate (N.B. 12 months to M6, 31 October 2019) has increased slightly to 3.99% against the Trust target of 4.0% (1.70 % short term and 2.29% long term).

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

6.3. In July 2019, Workforce Board agreed to remove the 'Unknown' reason for absence from the manager entry screens of the HealthRoster system, to reduce the number of 'Unknown' episodes recorded. This has reduced now reduced from 31.4% of absence to 26.2% and further reduction is anticipated as the year progresses, due to the impact on the rolling 12 months of data.

6.4. More detail on sickness absence is reported and discussed at Divisional Executive Management Board (Divisional Accountability – monthly), Workforce Board and Workforce and Development Assurance Committee (both quarterly).

7. Statutory and mandatory training

7.1. Statutory and mandatory training compliance as at 30 November 2019 was at 93% against the Trust target of 92%.

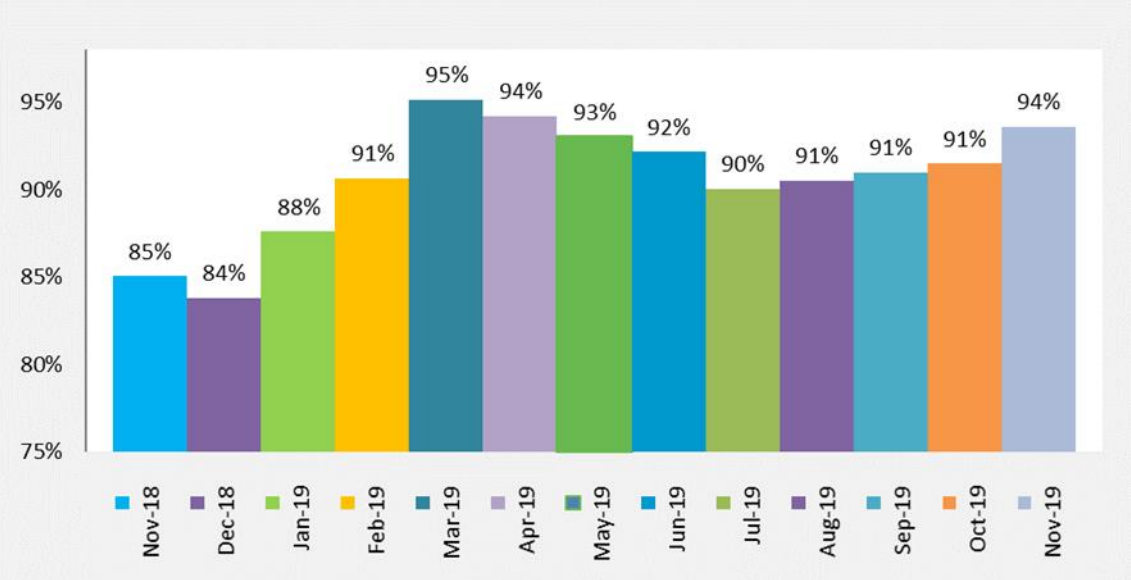
Training Compliance by Division	
Core Clinical	95%
Corporate Services	93%
Medicines Unplanned Care	91%
Surgical Planned Care	92%
Women's and Children's	92%
Trust Total Compliance	**92%**

8. Appraisal compliance

8.1. Trust-wide appraisal compliance as at 30 November 2019 is 94%, against the Trust target of 90%.

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

Appraisal Completion by Division	
Core Clinical	97%
Corporate Services	87%
Medicines Unplanned Care	94%
Surgical Planned Care	96%
Women's and Children's	92%
Total Trust	**94%**



9. Recommendations

9.1. Trust Board is asked to note the Workforce report

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Board of Directors**	**Date: 09/01/2020**
Report title:	**Board Assurance Framework**	**Agenda item: 6.1**
Lead director **Report author** **Sponsor(s)**	**Kate Jarman**	**Director of Corporate Affairs**
FoI status:	**Public**	

Report summary	**Board Assurance Framework**			
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [ ]	**Decision** [ ]
Recommendation	That the Board notes the risks on the BAF – which have been discussed in detail at Board sub-Committees – and discusses those risks that remain at a high residual rating or that are not at a tolerable level.			

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

Report history	The BAF is reported to the Board on a quarterly basis (minimum) and to every Board sub-Committee
Next steps	Board Committees
Appendices	Papers follow

Board Assurance Framework

The Board is asked to note the contents of the Board Assurance Framework, the individual risks contained therein having been discussed in-depth at Board sub-Committees.

The Board is asked is pay particular attention to risks where the residual risk rating is rated ‘red’. The Board has set its risk appetite against individual risks, but is noted that some risks are tolerated, although controls, assurances and actions are regularly reviewed and challenged.

There are three new risks on the BAF, which were discussed at the Quality and Clinical Risk Committee – one under patient safety, one under patient experience and one under workforce. These risks are significant and require board discussion.

Objective	Risk Ref	Risk Appetite	Oversight Committee	Executive Lead	Risk Description	Cause	Inherent Risk Rating	Controls	Gaps in Controls	Current Risk Rating	Trend (from previous month)	SRR Link
Safety	1-1	Avoid	Quality & Clinical Risk	COO	Strategic failure to manage demand for emergency care	Lack of demand management by the local health economy Inadequate primary care provision/ capacity Inadequate community care provision/ capacity Inadequate social care provision/ capacity	4x4=16	Working with partners to manage peak demand periods (e.g expediting discharge; using full community/ social care capacity)		4x3=12		1917/2500
Safety	1-2	Avoid	Quality & Clinical Risk	COO	Tactical failure to manage demand for emergency care	Annual emergency and elective capacity planning inadequate or inaccurate Daily flow/ site managmement plans inadequate or ineffectual Poor clinical/ operational relationships impacting on patient flow through the organisation Poor operational/ managerial relationships impacting on escalation Ineffective engagement with stakeholders to support patient flow day-to-day	4x4=16	Introduction of ED streaming Working with UCC to manage demand Implementation of national flow improvement programmes - Red2Green; 100% Challenge; EndPJParalysis; SAFER Strong clinical and operational leadership and ownership; good team working Clear escalation and well-known and understood flow management and escalation plans Positive relationships with stakeholders through daily working and medium-term planning		4x3=12		1917/2500
Safety	1-3	Avoid	Quality & Clinical Risk	COO	Ability to maintain patient safety during periods of overwhelming demand	Significantly higher than usual numbers of patients through the ED Significantly higher acuity of patients through the ED Major incident/ pandemic	5x4=20	Clinically and operationally agreed escalation plan Adherence to national OPEL escalation management system Clinically risk assessed escalation areas available		4x3=12		1917/2500
Safety	1-4	Avoid	Quality & Clinical Risk	COO	Failure to appropriately embed learning and preventative measures following Serious Incidents, complaints, claims and inquests	1. Failure to appropriately report, invesitgate and learn from incidents and complaints 2. Lack of system to share learning effectively from incidents - both in departments/ CSUs and across the Trust 3. Lack of evidence of learning from incidents	5x3=15	All SIs and action plans processed through the Serious Incident Review Group Actions including learning distribution tracked through SIRG Core component of all Clinical Improvement Group Meetings Lessons communicated via Trust-wide channels Debriefing embedded in specialties and corporately Training and skills programme annually Cultural work (inc Greatix and FTSU Guardians		4x3=12		1472
Safety	1-5	Avoid	Quality & Clinical Risk	Medical Director	Failure to recognise and respond to the deteriorating patient	Non compliance with the NEWS protocols; failure to appropriately escalate NEWS scores or failure to clinically assess patients outside protocols (i.e. 'hands on, eyes on' patients who are ill but not triggering on NEWS)	5x3=15	National NEWS protocol in place Level 1 pathway in place Successful implementation of NEWS 2 Sepsis screening and training/ awareness programme		4x3=12		2495/2497
Safety	1-6	Avoid	Quality & Clinical Risk	Deputy CEO	Failure to manage clinical risk during significant digital change programmes	1. Inadequate assessment of clinical risk/ impact on clinical processes and safety/ experience of digital change prgrammes 2. Inadequate resourcing of digital change programmes (including operational support) 3. Inadequate training for clinicians and support staff on new digital systems prior to and post roll out	4x4=16	1. Robust governance structures in place with programme management at all levels 2. Thorough planning and risk assessments during scoping, testing, launch and roll out 3. Resourcing reviewed regularly at programme boards 4. Training needs established in scoping and testing phases 5. Regular reviews of progress post go-live for all digital change programmes		4x3=12		
Safety	1-7	Avoid	Quality & Clinical Risk	COO	Failure to provide sufficient capacity to match demand for elective care (as evidenced by average waiting times, appointment slot issues (ASI) and non-RTT backlog).	Increased referrals in to secondary care. Over-emphasis on provision of emergency care. Failure to optimise OPD capacity via referral management and appropriate discharge criteria. Absence of financial drivers to increase outpatient activity (in absence of PbR tariff).	5x4=20	Improved granular understanding of demand and capacity (NHSI tool). Balanced scorecard approach to performance at Trust, Divisional, CSU and service level. Integrated approach to referral management. Agreement of local standards in relation to discharge criteria from clinic and follow up to first ratios. Agreement of internal tolerance of ASI and non-RTT. Provision of additional outpatient capacity and development of new outpatient care models.		4x4=16		
Experience	2-1	Avoid	Quality & Clinical Risk	Chief Nurse	Failure to achieve improvements in the patient survey	Lack of appropriate intervention to improve patient experience (measured through the national surveys)	4x4=16	Prevent Controls Coporate Patient Experince Team function, resources and governance arrangements in place at Trust, division and department levels, including but not limited to: • Patent Experince Strategy • Learning Disabilities Strategy • Dementia Strategy • Nutrition steering group • Catering steering group • Domestic planning group • Discharge steering group • Induction training Detect Controls Quarterly Patient Experience Board , monthly meetings and supporting substructure of steering groups .		4x3=12		2598
Experience	2-2	Avoid	Quality & Clinical Risk	COO	Failure to embed learning from poor patient experience and complaints	Learning not captured and shared in a meaningful and impactful way among individuals and team (and across the organisation) Failure to embed an appropriate system for sharing learning consistently, in a way that can be measured/ audited and evidenced	4x4=16	Prevent Controls Corporate PALS/Complaints Team function, resouces and governance in place at the Trust, division and department levels, including but not limited to : • Complaints policy and process • PALS policy and process • Ombusman policy and process • Complaints handling traininf for managers • Clinical oversight complaints/PALS process Detect Controls Quarterly Patient Experience Board, monthly meetings and integration with Patient Experience sub structure of steering groups.		4x3=12		
Experience	2-3	Avoid	Trust Board	CEO	Deterioration in patient experience of clinical oncology (radiotherapy) pathways, deterioration in access to treatment and reputational damage.	Break down in the established relationship (sub contract) between Oxford University Hospitals and the private Genesis Care facility (Linford Wood, Milton Keynes) which has provided local radiotherapy to MK residents for the last six years. This breakdown results in less choice and longer travel distances for patients requiring radiotherpay. Patients tend not to differentiate between the different NHS provider organisations. This risk materialised 16.12.2019 when the contract expired and no extension was agreed.	5x4=20	Contingency for the provision of treatment to patient in Oxford. Promotion of ongoing discussion between OUH and Genesis about the ongoing provision of palliative and prostate radiotherapy at Linford Wood (a limited contract extension). Promotion of agreement between OUH and Northampton General Hospital to facilitate access to facilities at Northampton for those who prefer treatment in this location. Promotion of rapid options appraisal and decision making at OUH and MKUH in relation to a medium to long term solution for radiotherapy provision on site at Milton Keynes University Hospital (build, operation, governance etc...) and route to capital funding. Proactive communications strategy in relation to current service delivery issues.		4x4=16		
Effectiveness	3-1	Avoid	Quality & Clinical Risk	Director Corp Aff	Failure to evidence compliance with the annual clinical audit programme	1. Lack of understanding/ awareness of audit requirements by clinical audit leads 2. Resources not adequate to support data collection/ interpretation/ input 3. Audit programme poorly communicated 4. Lack of engagement in audit programme 5. Compliance expectations not understood/ overly complex	4x4=16	1. Designated audit leads in CSUs/ divisions 2. Clinical governance and administrative support - allocated by division 3. Recruited additional clinical governance post to medicine to support audit function (highest volume of audits) 3. Audit programme being simplified, with increased collaboration and work through the QI programme 4. Audit compliance criteria being segmented to enable focus on compliance with data returns; opportunity for learning/ changing practice and communication/ engagement		4x3=12		

Effectiveness	3-2	Avoid	Quality & Clinical Risk	Director Corp Aff	Failure to embed learning and evidence action plans following clinical audit	1. Learning from audits not captured effectively 2. Learning from audit not shared effectively 3. No central record of learning from audit or ability to compare audit/ re-audit progress	4x4=16	1. Designated audit leads in CSUs/ divisions 2. Clinical governance and administrative support - allocated by division 3. Recruited additional clinical governance post to medicine to support audit function (highest volume of audits) 3. Audit programme being simplified, with increased collaboration and work through the QI programme 4. Audit compliance criteria being segmented to enable focus on compliance with data returns; opportunity for learning/ changing practice and communication/ engagement		4x3=12		
Effectiveness	3-3	Avoid	Quality & Clinical Risk	Director Corp Aff	Lack of assessment against and compliance with NICE guidance	The Trust has a significant backlog of NICE guidelines	3x4=12	Monthly assessments of compliance against published NICE baseline assessments Process in place to manage baseline assessments with relevant clinical lead - supported by clinical governance leads Independent review by compliance and audit lead Requires clinical engagement and ownership	Target currently being breached	3x4=12		767
Key Targets	4-1	Avoid	Executive Management	COO	Failure to meet the 4 hour emergency access standard	The Trust is unable to meet the target to see 95% of patients attending A&E within 4 hours	4x4=16	Operational plans in place to cope with prolonged surges in demand Cancelling of non urgent elective operations New elective surgical ward open to reduce liklihood of above control Opening of escalation beds Working with partners for social, community and primary care	Target currently being breached	4x4=16		1917/2500
Key Targets	4-2	Avoid	Executive Management	COO	Failure to meet the key elective access standards - RTT 18 weeks, non-RTT and cancer 62 days	The Trust is unable to meet the 18 week RTT and 62 day cancewr targets, and unable to reduce its non-RTT backlog as required	4x4=16	Regular PTL meetings Work on improving administrative pathways Work with tertiary providers on breach allocations RTT and non-RTT action plans	Target currently being breached	4x4=16		2679/2589
Effectiveness	5-1	Avoid	Audit	Deputy CEO	Failure to ensure adequate data quality leading to patient harm, reputational risk and regulatory failure	Data quality governance and processes are not robust	4x4=16	Robust governance around data quality processes including executive ownership Audit work by data quality team		4x3=12		2705/2572
Sustainability	6-1	Avoid	Audit	Deputy CEO	Failure to adequately safeguard against major IT system failure (deliberate attack)	Weaknesses in cyber security leave the trust vulnerable to cyber attack	5x2=10	Investment in better quality systems GDE investment NHS Digital audits and penetration tests		4x2=8		
Sustainability	6-2	Avoid	Finance & Investment	Deputy CEO	Failure to adequately safeguard against major IT system failure (inability to invest in appropriate support systems/infrastructure)	Lack of suitable and timely investment leaves the Trust vulnerable to cyber attack	5x2=10	2 dedicated cyber security posts funded through GDE All Trust PCs less than 4 years old Robust public wifi network EPR investment		4x2=8		
Sustainability	6-3	Avoid	Executive Management	Deputy CEO	Failure to maximise the benefits of EPR	That the Trust does not derive all of the benefits in terms of efficiency and productivity from the EPR system as had been anticipated in the business cases	4x4=16	eCare operational delivery board being put into place in order to cover the spectrum of optimisation opportunities both financial and non-financial as a result of the implementation (and upcoming upgrades and changes). An initial schedule of opportunities that forecasts a lvel of savings in line with those in the original business case is being monitored against although there is likely to be some slippage against this when taking into account time for the new system to bed-in across the organisation.		4x3=12		2177/1185
Finance	7-1	Cautious	Finance & Investment	DOF	There is a risk that the constraints on the NHS capital expenditure limit (CDEL) lead to delays in the Trust receiving its approved capital funding or other restrictions being placed on the Trust's capital programme	The national NHS Capital Financing regime is under significant pressure, which is restricting the Trust's ability to spend on capital above its Capital Expenditure Limit	**5x4=20**	1. Annual plan re-submitted to include only approved capital loans from DHSC. Funding sources identified for other schemes. 2. Capital prioritisation process in place (through the Trust's Capital Control Group (CCG) and Clinical Board Investment Group (CBIG) to ernsure the Trust prioritises its capital schemes within scarces resources effectively		4x3=12		
Finance	7-2	Avoid	Finance & Investment	DOF	There is a risk that the Trust does not receive timely confirmation that its revenue loans due for repayment in 2019/20 have been refinanced leading to a potential breach of the DHSC loan agreements and risk to going concern		5x5=25	1. NHSI and DHSC are aware that the Trust is unable to make its loan repayments; 2. DHSC has confirmed that refinancing decisions will be made in 2019/20 where required		5x3=15		
Finance	7-3	Cautious	Finance & Investment	DOF	There is a risk that the Trust is unable to achieve the required efficiency improvements through the transformation programme leading to an overspend against plan and the potential loss of the £5.1m of Provider Sustainability Funding in the event the Trust's control total is not met.	Transformation schemes are taking lonmger to implement and identify due to otherr competing priorities.	5x5=25	1. Tracker in place to identify and track savings and ensure they are delivering against plan 2. Savings measured against Trust finance ledger to ensure they are robust and consistent with overall financial reporting 3. All savings RAG rated to ensure objectivity 4. Oversight of the transformation programme through the Transformation Programme Board and Management Board.		4x4=16		
Finance	7-4	Cautious	Finance & Investment	DOF	There is a risk that the Trust's guaranteed income contract does not deliver the benefits expected and/or leads to an opportunity cost to the Trust in respect of unfunded activity.	Increases in unfunded activity and costs	5x4=20	1. Clearly defined monitoring of the monthly activity performance with lead commissioner 2. Escalation of issues to senior managers within the Trust. 3. Newly established joint executive contract mobilisation group to assess activity and performance and monitor the delivery of joint initiatives.		4x4=16		
Workforce	8-1	Cautious	Workforce	Director Workforce	Inability to retain staff emmployed in critical posts	Poor working culture within certain isolated teams Perceived more attractive benefits elsewhere Proximity to tertiary centres with perceived better career development opportunities	4x4=16	Variety of organisational change/staff engagement activities, e.g. Event in the Tent Schwartz Rounds and coaching collaboratives Recruitment and retention premia We Care programme Onboarding and exit strategies/reporting Staff survey Learning and development programmes Health and wellbeing initiatives, including P2P and Care First Staff friends and family results/action plans Links to the University of Buckingham Staff recognition - staff awards, long service awards, GEM Leadership development and talent management Succession planning Enhancement and increased visibility of benefits package Recruitment and retention focussed workforce strategy and plan to fill vacancies, develop new roles and deliver improvement to working experience/environment		4x3=12		2499/2589

Workforce	8-2	Minimal	Workforce	COO	Inability to recruit to vacancies in short term (0-18 months)	National shortages of appropriately qualified staff in some clinical roles, particularly at consultant level for dermatology and acute medicine, and at middle grade level for urology and trauma and orthopaedics Competition from surrounding hospitals Buoyant locum market National drive to increase nursing establishments leaving market shortfall (demand outstrips supply)	4x3=12	Active monitoring of workforce key performance indicators Targeted overseas recruitment activity Apprenticeships and work experience opportunities Exploration and use of new roles to help bridge particular gaps Use of recruitment and retention premia as necessary Use of the Trac recruitment tool to reduce time to hire and candidate experience Rolling programme to recruit pre-qualification students Use of enhanced adverts, social media and recruitment days Rollout of a dedicated workforce website Review of benefits offering and assessment against peers Creation of recruitment "advertising" films Recruitment and retention focussed workforce strategy and plan to fill vacancies, develop new roles and deliver improvement to working experience/environment Targetted recruitment to reduce hard to fill vacancies		4x2=8		2499/2589
Workforce	8-3	Minimal	Workforce	Director Workforce	Inability to recruit to vacancies in medium to long term (19+ months)	National shortages of appropriately qualified staff in some clinical roles, particularly at consultant level Brexit may reduce overseas supply Competition from surrounding hospitals Buoyant locum market National drive to increase nursing establishments leaving market shortfall (demand outstrips suply) Large percentage of workforce predicted to retire over the next decade Large growth prediction for MK - outstripping supply Buoyant private sector market creating competition for entry level roles New roles upskilling existing senior qualified staffcreating a likely gap in key roles in future (e.g. band 6 nurses) Reducing potential internaltional supply New longer training models	4x4=16	Monitoring of uptake of placements & training programmes Targeted overseas recruitment activity Apprenticeships and work experience opportunities Expansion and embedding of new roles across all areas Rolling programme to recruit pre-qualification students Use of enhanced adverts, social media and recruitment days Review of benefits offering and assessment against peers Development of MKUH training programmes Workforce Planning Recruitment and retention focussed workforce strategy and plan to fill vacancies, develop new roles and deliver improvement to working experience/environment International workplace plan Assisted EU staff to register for settled status and discussed plans to stay/leave with each to provide assurance that there will be no large scale loss of EU staff post-brexit		4x4=16		2499/2589
Workforce	8-4	Avoid	Workforce Assurance	Medical Director	Removal of up to 11 trainees from the department of obstetrics and gynaecology as a result of various concerns about the training environment.	Poor training environment: lack of standardisation of process; variable levels of support; and, persistent concerns around behaviours by consultants perceived as belittling / inappropriate / bullying. Risk raised in November 2019 following HEE TV quality meeting.	4x5=20	Heavy involvement from clinical leaders outwith the department (DD, DME, MD). Change in clinical leadership model within the service. Formative external review (Berendt consulting). Substantive recruitment to consultant posts within the service. Close liaison with HEE TV Head of School.		3x5=15		
Estate	9-1	Cautious	Finance & Investment	COO	Insufficient capacity in the Neonatal Unit to accommodate babies requiring special care	The current size of the Neonatal Unit does not meet the demands of the service. This risks high numbers of transfers of unwell babies and potential delayed repatriation of babies back to the hospital. There is a risk that if the Trust continues to have insufficient space in its NNU, the unit's current Level 2 status could be removed on the basis that the Trust is unable to fulfill its Network responsibilities and deliver care in line with national requirements.	4x3=12	Reconfiguration of cots to create more space Additional cots to increase capacity Parents asked to leave NNU during interventional procedures, ward rounds, etc to increase available space		4x3=12		2570
Sustainability	9-2	Minimal	Charitable Funds	Director Corp Aff	Failure to achieve the required level of investment (including appeal funds) to fund the Cancer Centre	Lack of suitable and timely engagement with key players within the city and wider area during the private phase of the appeal, and an inability to enthuse and gain the support of potential donors more broadly, means that the Charity is unable to achieve the required level of charitable contribution to the project	4x2=8	Fundraising strategy and plan in place Financial forecasts under very regular scrutiny Experienced consultancy engaged to support existing senior and experienced fundraising staff Tactical plan for private and public appeal phase developed and implemented		4x2=8		
Strategy	10-1	Avoid	Board of Directors	CEO	Inability to progress the Milton Keynes Accountable Care System and wider ACS/STP programme	Lack of effective collaboration among all the key local partners means that the goal of a comprehensive and integrated place based health and social care solution within MK is not realised	4x3=12	Chief Executive and Executive team engagement both at ICS and MK Place levels. MK Place leaders chairing 3 of the 5 ICS priority workstreams		4x2=8		
Strategy	10-2	Avoid	Board of Directors	COO	Insufficient preparedness for disruption to workforce or supplies (including medications) following withdrawal from the European Union	Inability to recruit or retain staff; inability to prescribe or supply pharmaceuticals; inability to keep hospital stock levels (clinical and non-clinical) at required levels	5x2=10	UK Government putting contingency plans in place Planning through Trust EPRR forums Trust working with NHSI/E to ensure any national directives are complied with		5x2=10		2731

Strategic Objective	Risk Ref	Committee	Risk Description	Proximity	Risk Score (consequence v likelihood)				Trend	Target	Risk Appetite
					Apr-19	Jun-19	Sep-19	Dec-19			
SO1: Patient Safety	1-1	Quality and Clinical Risk	Strategic failure to manage demand for emergency care	Next 3 to 6 months	(3x4)=12	(4x3) = 12	(4x3) = 12	(4x3) = 12	Static	(4x2) = 8	Avoid
SO1: Patient Safety	1-2	Quality and Clinical Risk	Tactical failure to manage demand for emergency care	Next 3 to 6 months	(3x4)=12	(4x3) = 12	(4x3) = 12	(4x3) = 12	Static	(4x2) = 8	Avoid
SO1: Patient Safety	1-3	Quality and Clinical Risk	Ability to maintain patient safety during periods of overwhelming demand	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(4x3)= 12	(4x3)= 12	Static	(4x2) = 8	Avoid
SO1: Patient Safety	1-4	Quality and Clinical Risk	Failure to appropriately embed learning and preventative measures following Serious Incidents	Next 3 to 6 months	(5x2) = 10	(4x3) = 12	(4x3) = 12	(4x3) = 12	Static	(4x1) = 4	Avoid
SO1: Patient Safety	1-5	Quality and Clinical Risk	Failure to recognise and respond to the deteriorating patient	Next 3 to 6 months	(5x2) = 10	(4x3) = 12	(4x3) = 12	Recommend Closure	Static	(4x2) = 8	Avoid
SO1: Patient Safety	1-6	Quality and Clinical Risk	Failure to manage clinical risk during significant digital change programmes	Next 3 to 6 months	Risk Closed	(4x3) = 12	(4x3) = 12	(4x3) = 12	Static	(4x2) = 8	Cautious
	1-7		Failure to provide sufficient capacity to match demand for elective care (as evidenced by average waiting times, appointment slot issues (ASI) and non-RTT backlog).	Next 3 to 6 months	Not on BAF	Not on BAF	Not on BAF	(4x4)= 16		(4x2) = 8	Avoid
SO2: Patient Experience	2-1	Quality and Clinical Risk	Failure to provide an appropriate patient experience	Next 3 to 6 months	(4x4) = 16	(4x4) = 16	(4x3)= 12	(4x3)= 12	Static	(4x2) = 8	Cautious
SO2: Patient Experience	2-2	Quality and Clinical Risk	Failure to embed learning from poor patient experience and complaints	Next 3 to 6 months	Not on BAF	(4x4)=16	(4x3)= 12	(4x3)= 12	Static	(4x2) = 8	Cautious
	2-3		Deterioration in patient experience of clinical oncology (radiotherapy) pathways, deterioration in access to treatment and reputational damage.	Next 3 to 6 months	Not on BAF	Not on BAF	Not on BAF	(4x4)= 16		(4x2) = 8	
SO3: Clinical Effectiveness	3-1	Quality and Clinical Risk	Failure to evidence compliance with the annual clinical audit programme	Next 3 to 6 months	(3x4) = 12	(4x4) = 16	(4x3) = 12	(4x3) = 12	Static	(4x2) = 8	Cautious
SO3: Clinical Effectiveness	3-2	Quality and Clinical Risk	Failure to embed learning and evidence action plans following clinical audit	Next 3 to 6 months	Not on BAF	(4x4)=16	(4x3)= 12	(4x3)= 12	Static	(4x2) = 8	Cautious
SO3: Clinical Effectiveness	3-2	Quality and Clinical Risk	Lack of assessment against and compliance with NICE guidance	Next 3 to 6 months	(3x4) = 12	(4x4) = 16	(3x4) = 12	(3x4) = 12	Static	(4x2) = 8	Cautious
SO4: Key Targets	4-1	Management Board	Failure to meet the 4 hour emergency access standard	Next 3 to 6 months	(4x4) =16	(4x3) =12	(4x3)= 12	(4x3)= 12	Static	(4x2) = 8	Cautious
SO4: Key Targets	4-2	Management Board	Failure to meet the key elective access standards - RTT 18 weeks, non-RTT and cancer 62 days	Next 3 to 6 months	(4x4) = 16	(4x5) = 20	(4x5) = 20	(4x5) = 20	Static	(4x2) = 8	Cautious
SO5: Sustainability	4-3	Audit	Failure to ensure adequate data quality leading to patient harm, reputational risk and regulatory failure	Next 3 to 6 months	(4x3) = 12	(4x4) = 16	(4x4) = 16	(4x4) = 16	Static	(4x2) = 8	Cautious
SO5: Sustainability	5-1	Audit	Failure to adequately safeguard against major IT system failure (deliberate attack)	Next 3 to 6 months	(5x2) = 10	(5x2) = 10	(5x2) = 10	(5x2) = 10	Static	(5x1) = 5	Cautious
SO5: Sustainability	5-2	Finance	Failure to adequately safeguard against major IT system failure (inability to invest in appropriate support systems/infrastructure)	Next 3 to 6 months	(4x2) = 8	(5x2) = 10	(5x2) = 10	(5x2) = 10	Static	(4x2) = 8	Cautious
SO5: Sustainability	5-4	Management Board	Failure to maximise the benefits of EPR	Next 3 to 6 months	(4x2) = 8	(4x2)=8	(4x2)= 8	(4x2)= 8	Static	3x2 = 6	Minimal
SO5: Sustainability	5-5	Management Board	Failure to maximise the benefits of the Trust's digital strategy (patient access)	Next 3 to 6 months	Not on BAF	Not on BAF	Not on BAF	Not on BAF	Static	(4x2) = 8	Seek
SO7: Finance and Governance	7-2	Finance	Constraints on CDEL leads to delays in receiving approved capital funding and other restrictions on the capital programme	Next 12 months	(4x3) = 12	(5x4) = 20	(4x3)= 12	(4x3)= 12	Static	(4x3) = 12	Open
SO7: Finance and Governance	7-3	Finance	Lack of timely confirmation that revenue loans due for repayment in 2019/20 have been refinanced leading to potenial breach of the agreements with DHSC	Next 12 months	(4x3) = 12	(5x3) = 15	(5x3) = 15	(5x3) = 15	Static	(5x2) = 10	Seek
SO7: Finance and Governance	7-4	Finance	The Trust is unable to achieve the required efficiency improvements through the Transformation Programme leading to an overspend against plan	Next 12 months	(4x3) =12	(4x4) = 16	(4x4)= 16	(4x4)= 16	Static	(3x3) = 9	Seek
SO7: Finance and Governance	7-5	Finance	The Trust's guaranteed income contract does not deliver the benefits expected	Next 3 to 6 months	Not on BAF	(4x4) = 16	(4x4) = 16	(4x4) = 16	Static	(3x3) = 9	Seek
SO7: Finance and Governance	7-6	Board	Failures in compliance leading to regulatory intervention (CQC)	Next 12 months	(4x2) = 8	Risk Closed	Risk Closed	Risk Closed	Static	(4x2) = 8	Cautious
SO8: Workforce	8-1	Workforce	Inability to retain staff employed in critical posts	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3) = 12	Static	(4x2) = 8	Seek
SO8: Workforce	8-2	Workforce	Inability to recruit to vacancies in the short term (0-18 months)	Next 3 to 6 months	Not on BAF	(4x3) = 12	(4x3) = 12	(4x3) = 12	Static	(4x1) = 4	Seek
SO8: Workforce	8-3	Workforce	Inability to recruit to vacancies in the medium term (19+ months)	Next 12 months	Not on BAF	(4x3)=12	(4x4)= 16	(4x4)= 16	Static	(3x3) = 9	Seek
	8-4		Removal of up to 11 trainees from the department of obstetrics and gynaecology as a result of various concerns about the training environment.	Next 3 to 6 months	Not on BAF	Not on BAF	Not on BAF	(3x5) = 20		(3x3) = 9	
SO9: Estate	9-1	Finance	Insufficient capacity in the Neonatal Unit to accommodate babies requiring special care	Next 3 to 6 months	(4x3)=12	(4x3)=12	(4x3)=12	(4x3)=12	Static	(4x2) = 8	Minimal
SO10: Corporate Citizen	10-1	Charitable Funds	Failure to achieve the required level of investment (including appeal funds) to fund the Cancer Centre	Next 3 to 6 months	(4x2) = 8	(4x4) = 16	(4x4) = 16	(4x4) = 16	Static	(4x3) = 12	Open
SO10: Corporate Citizen	10-2	Board	Inability to progress the Milton Keynes Accountable Care System and wider ACS/STP programme	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3) = 12	Static	(4x2) = 8	Seek
SO10: Corporate Citizen	10-3	Board	Insufficent preparedness for disruption to workforce or supplies (including medications) following withdrawal from the European Union	Next 3 to 6 months	(5x2) = 10	(4x3)=12	(5x2) = 10	(5x2) = 10	Static	(5x1) = 5	Avoid

RISK ASSURANCE MAPPING			Assurance Providers																	
			Business Management (First Line)						Corporate Oversight (Second Line)						Independent Assurance (Third Line)					
			Identifying risks and improving actions. Implementing controls. Reporting on progress. Mangement assurance.						Designing policies. Setting direction. Ensuring compliance. Compliance oversight.						Independent challenge, audit. Reporting on assurance. Audut of assurance providers. Entity level assurance.					
			Strategies & Business Plans	Performance Management	Financial Management & Reporting	Core Financial System	Core Procurement	Self-Assessment & Declarations	Governance Strucutres & Processes	Functional Compliance Reviews	Quality Control Checks	Internal Business Change	Customer Satisfaction Surveys/ Complaints	Corporate Risk Management/ Assurance	External Project/ Programme Reviews	Adjudicators/ Tribunals	External Accreditation	Strategic Partners Assurance Reporting	Internal Audit Engagements
Risk	**Risk Owner**	**Strategy/ Objective**																		
Strategic failure to manage demand for emergency care	Director of Operations	Improving Patient Safety	●	●	●			●	●	●	●	●	●	●				●		
Tactical failure to manage demand for emergency care	Director of Operations	Improving Patient Safety	●	●	●			●	●	●	●	●	●	●				●		
Ability to maintain patient safety during periods of overwhelming demand	Director of Operations	Improving Patient Safety	●	●					●	●	●							●		
Failure to appropriately embed learning and peventative measures following SIs, complaints, claims and inquests	Medical Director	Improving Patient Safety	●	●				●	●	●	●			●						●
Failure to recognise and respond to the deteriorating patient	Medical Director	Improving Patient Safety	●	●					●	●	●									
Failure to manage clincial risk during significant digital change programmes	Medical Director	Improving Patient Safety	●	●	●		●	●	●	●	●	●		●	●				●	
Failure to provide sufficient capacity to match demand for elective care (as evidenced by average waiting times, appointment slot issues (ASI) and non-RTT backlog).	Medical Director	Improving Patient Safety	●	●					●	●	●								●	
Failure to achieve improvements in the patient survey	Chief Nurse	Improving Patient Experience	●	●				●	●	●	●		●		●				●	
Failure to embed learning from poor patient experience and complaints	Chief Nurse	Improving Patient Experience	●	●				●	●	●	●		●		●				●	
Deterioration in patient experience of clinical oncology (radiotherapy) pathways, deterioration in access to treatment and reputational damage.	Chief Executive	Improving Patient Experience	●	●					●	●	●								●	
Failure to evidence compliance with the annual clincial audit programme	Director of Corporate Affairs	Improving Clinical Effectiveness	●	●				●	●	●	●		●							●
Failure to embed learning and evidence action plans following clincial audit	Director of Corporate Affairs	Improving Clinical Effectiveness	●	●				●	●	●	●		●							●
Lack of assessment against, and compliance with, NICE guidelines	Director of Corporate Affairs	Improving Clinical Effectiveness	●	●				●	●	●	●		●							●
Failure to meet the 4 hour emergency access standard	Director of Operations	Meeting Key Targets	●	●	●			●	●	●	●	●	●	●	●				●	
Failure to meet the key elective access standards	Director of Operations	Meeting Key Targets	●	●	●			●	●	●	●	●	●	●	●				●	
Failure to ensure adequate data quality leading to patient harm, reputational risk and regulatory failure	Deputy CEO	Meeting Key Targets	●	●				●	●	●				●						●
Failure to adequately safeguard against major IT system failure	Deputy CEO	Sustainability	●	●	●		●	●	●	●	●	●	●	●	●		●	●		
Failure to maximise the benefits of ECARE	Deputy CEO	Sustainability	●	●	●		●	●	●	●	●	●		●	●				●	
Constraints on NHS captial expenditure limit lead to delays or restrictions	Director of Finance	Financial Management	●	●	●	●	●	●	●	●	●	●		●	●		●	●	●	●
The Trust does not receive timely confirmation that its revenue loans sue for repayment in 19/20 have been re-financed	Director of Finance	Financial Management	●	●	●	●	●	●	●	●	●	●		●	●		●	●	●	●

The Trust is unable to achieve the required efficiency improvements leading to overspend and the loss of PSF funding	Director of Finance	Financial Management	●	●	●	●	●	●	●	●	●	●		●	●		●	●	●
The Trust's guaranteed income contract does not deliver the benefits expected or leads to underfunded activity	Director of Finance	Financial Management	●	●	●	●	●	●	●	●	●	●		●	●		●	●	●
Inability to retain staff employed in critical posts	Director of Workforce	Developing the Workforce	●	●	●			●	●	●		●	●	●				●	
Inability to retain staff employed in critical posts	Director of Workforce	Developing the Workforce	●	●	●			●	●	●		●	●	●				●	
Inability to recruit to vancancies in the short term (0-18 months)	Director of Workforce	Developing the Workforce	●	●	●			●	●	●		●	●	●				●	
Inability to recruit to vacancies in the medium to long term (19 months plus)	Director of Workforce	Developing the Workforce	●	●	●			●	●	●		●	●	●				●	
Removal of up to 11 trainees from the department of obstetrics and gynaecology as a result of various concerns about the training environment.	Medical Director	Developing the Workforce																	
Insufficient capacity in the Neonatal Unit to accommodate babies requiring special care	Director of Operations	Best use of the Estate	●	●	●				●	●	●	●	●	●	●			●	
Failure to achieve required level of investment (appeal funds) to fund the Cancer Centre	Director of Corporate Affairs	Best use of the Estate	●	●	●				●	●	●	●		●					
Inability to progress the MK Accountable Care System and wider ICS programme	Chief Executive	Innovation and Partnerships	●	●	●			●	●	●				●				●	
Insufficient preparedness to workforce or supplies following withdrawal from the European Union	Director of Workforce	Pan-Objective	●			●	●	●	●					●				●	

CORE SYSTEMS AND PROCESSES - ASSURANCE MAPPING			Assurance Providers																	
			Business Management (First Line)						Corporate Oversight (Second Line)						Independent Assurance (Third Line)					
			Identifying risks and improving actions. Implementing controls.						Designing policies. Setting direction. Ensuring compliance.						Independent challenge, audit. Reporting on					
			Strategies & Business Plans	Performance Management	Financial Management & Reporting	Core Financial System	Core Procurement	Self-Assessment & Declarations	Governance Strucutres & Processes	Functional Compliance Reviews	Quality Control Checks	Internal Business Change	Customer Satisfaction Surveys/ Complaints	Corporate Risk Management/ Assurance	External Project/ Programme Reviews	Adjudicators/ Tribunals	External Accreditation	Strategic Partners Assurance Reporting	Internal Audit Engagements
Core Systems/ Processes																				
System/ Process	**Functional Head**	**Strategic Objective/ Priority**																		
Organisational Governance																				
Strategic and Business Planning																				
Performance Mangement																				
Mangement Information																				
Funding, Grants and Awards																				
Financial Processes and Reporting																				
Procurement and Contract Managemnt																				
HR																				
Health and Safety																				
IT Systems																				
Estates and Infrastructure																				
Physical and Information Security																				
Legal and Regulatory Compliance																				
Projects, Programme and Change Management																				
Communications																				