Bundle Trust Board Meeting in Public 9 January 2025

1.1 10:00 - Agenda
0 Agenda Board Meeting in Public - 09.01.25 final
1.2 10:00 - Apologies
Chair
Item 1 Placeholder Apologies
2 10:01 - Declarations of Interest
Chair
Item 2 Placeholder Declarations of Interest
3 10:02 - Patient Story
Chief Nursing Officer
Item 3 Placeholder Patient Story
4 10:22 - Minutes of the Last Meeting
Chair
Item 4 DRAFT Minutes Trust Board Meeting in Public 14.11.2024
5 10:24 - Matters Arising and Action Log
Chair
Item 5 Board Action Log
6 10:26 - Chair's report
Chair
Item 6 Chair's Report 9 January 2025 - Final
7 10:31 - Chief Executive's Report
Chief Executive
Item 7 Chief Executive's Report 9 January 2025
Item 7.1 MKUH 9 January 2025
8 10:36 - Patient Safety Update
Chief Medical Officer/Chief Corporate Services Officer
Item 8 PSIRF Update Trust Board Jan 24_FINAL
9 10:46 - CNST Maternity Incentive Scheme and Board Assurance Framework Sign Off
Chief Nursing Officer
Item 9 CNST board paper 2025
Item 9.2 MIS Trust Board Presentation 03012025
10 10:51 - Integrated Quality Governance Report
Chief Nursing Officer
Item 10 Integrated Quality Governance Report V2 January 2025

11 10:56 - Maternity Assurance Group Update
Chief Nursing Officer
Item 11 Maternity Assurance Group Headlines Front Cover
Item 11.1 MAG assurance for Board V2_final

12 11:01 - Progress Update – 2024/25 Quality Priorities
Chief Corporate Services Officer
Item 12 Placeholder Progress Update – 2024 25 Quality Priorities

13 11:06 - Performance Report
Chief Operating Officer – Planned Care
Item 13 2024-25 Performance Report Executive Summary M8 Coversheet
Item 13.1 2024-25 Executive Summary M8
Item 13.2 2024-25 Board Scorecard M08

14 11:16 - Finance Report
Chief Finance Officer
Item 14 Finance Report Month 8 Public Board

15 11:26 - Workforce Report
Chief People Officer
Item 15 Workforce Report M8 Jan Board 2024

16 11:36 - Freedom to Speak Up Guardian Report
Chief People Officer
Item 16 Freedom to Speak Up 6 month Report Q1 and Q2 202425

17 11:41 - Safeguarding Annual Report
Chief Nursing Officer
Item 17 Safeguarding Annual Report April 2023 to March 2024

18 11:46 - Emergency Preparedness Resilience and Response (EPRR) Annual Assurance Review 2024
Chief Operating Officer - Unplanned Care
Item 18 Emergency Preparedness, Resillience & Response Annual Report

19 11:51 - MKUH Objectives update
Chief Executive/ Chief Corporate Services Officer
Item 19 Placeholder MKUH Objectives update

20 11:56 - Risk Register Report
Chief Corporate Services Officer
Item 20 Risk Management Report - January 2025

21 12:01 - Board Assurance Framework

Chief Corporate Services Officer
Item 21 Board Assurance Framework Report - January 2025

22 12:06 - Board Committees Assurance Reports
Chief Corporate Services Officer
Item 22.1 Committee Assurance Report - Audit Committee 09.01.25
Item 22.2 Committee Assurance Report - Charitable Funds Committee 09.01.25
Item 22.3 Committee Assurance Report to Board - Finance Investment Committee - v3
Item 22.4 Committee Assurance Report - Workforce and Development Assurance Committee 09.01.25
Item 22.5 Committee Assurance Report to Board - Quality & Clinical Risk Committee 9.01.25

23 12:11 - Use of Corporate Seal
Chief Corporate Services Officer
Item 23 Cover Page - Use of Corporate Seal
Item 23.1 Use of Corporate Seal 09.01.2025

24 12:16 - Forward Agenda Planner
Chair
Item 24 Trust Board in Public Forward Plan 2024-25

25 12:21 - Questions from Members of the Public
Chair
Item 25 Placeholder Questions from Members of the Public

26 12:24 - Motion to Close the Meeting
Chair
Item 26 Placeholder Motion to Close the Meeting

27 12:27 - 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."

28 12:29 - Next Meeting in Public: Thursday, 06 March 2025

TRUST BOARD MEETING IN PUBLIC

Thursday 09 January 2025, 10:00 -12:30 hours
Conference Room at the Academic Centre

AGENDA

Item No.	Timing	Title	Purpose	Lead	Paper
Introduction and Administration					
1	10:00	Apologies	Note	Chair	Verbal
2		Declarations of Interest • Any new interests to declare • Any interests to declare in relation to open items on the agenda • 2024/25 Register of Interests – Board of Directors - Register of Interests - Milton Keynes University Hospital (mkuh.nhs.uk)	Note	Chair	Verbal
3		Patient Story	Discuss	Chief Nursing Officer	Presentation
4		Minutes of the Trust Board meeting held in public on 14 November 2024	Approve	Chair	Attached
5		Matters Arising and Action Log	Note	Chair	Attached
Chair and Chief Executive Updates					
6	10:20	Chair's Report	Note	Chair	Attached
7	10:25	Chief Executive's Report • BLMK ICB Update December 2024	Discuss Note	Chief Executive	Attached Attached
Patient Safety					
8	10:30	Patient Safety Update	Discuss	Chief Medical Officer/Chief Corporate Services Officer	Attached
9	10:35	CNST Maternity Incentive Scheme and Board Assurance Framework Sign Off	Discuss	Chief Nursing Officer	Attached

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
Acting Chair: Heidi Travis

Item No.	Timing	Title	Purpose	Lead	Paper
10	10:40	Integrated Quality Governance Report	Discuss	Chief Corporate Services Officer	Attached
Break (10 mins)					
Patient Experience					
11	11:00	Maternity Assurance Group Update	Discuss	Chief Nursing Officer	Attached
12	11:05	Progress Update – 2024/25 Quality Priorities	Discuss	Chief Corporate Services Officer	Verbal
Performance					
13	11:10	Performance Report	Discuss	Chief Operating Officer – Planned Care	Attached
Finance					
14	11:20	Finance Report	Discuss	Chief Finance Officer	Attached
Workforce					
15	11:30	Workforce Report	Discuss	Chief People Officer	Attached
16	11:35	Freedom to Speak Up Guardian Report	Discuss	Chief People Officer	Attached
Assurance and Statutory Items					
17	11:40	Safeguarding Annual Report	Note	Chief Nursing Officer	Attached
18	11:45	Emergency Preparedness Resilience and Response (EPRR) Annual Assurance Review 2024	Note	Chief Operating Officer - Unplanned Care	Attached
19	11:55	MKUH Objectives update	Discuss	Chief Executive/ Chief Corporate Services Officer	Verbal
20	12:00	Risk Register Report	Discuss	Chief Corporate Services Officer	Attached
21	12:05	Board Assurance Framework	Discuss	Chief Corporate Services Officer	Attached
22	12:10	Board Committees Assurance Reports • Audit & Risk Committee • Charitable Funds Committee • Finance & Investment Committee	Note	Chairs of Board Committees	Attached

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Chief Executive: Joe Harrison
Acting Chair: Heidi Travis

Item No.	Timing	Title	Purpose	Lead	Paper
		• Workforce & Development Assurance Committee			
23	12:15	Use of Corporate Seal	Note	Chief Corporate Services Officer	Attached
Administration and Closing					
24	12:20	Forward Agenda Planner	Note	Chair	Attached
25		Questions from Members of the Public	Discuss	Chair	Verbal
26		Motion to Close the Meeting	Approve	Chair	Verbal
27		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	
12:30		Close			
Next Meeting in Public: Thursday, 06 March 2025					

Quoracy: This meeting shall be deemed quorate with not less than 3 voting Executive Directors (one of whom must be the Chief Executive or acting Chief Executive) and 3 voting Non-Executive Directors (one of whom must be the Chair or Deputy Chair).

	Members	
1	Heidi Travis	Non-Executive Director - Acting Chair
2	Joe Harrison	Executive Director- Chief Executive Officer
3	Gary Marven	Non-Executive Director
4	Haider Husain	Non-Executive Director
5	Mark Versallion	Non-Executive Director
6	Sarah Whiteman	Non-Executive Director
7	Precious Zumbika	Non-Executive Director
8	Ganesh Baliah	Non-Executive Director
9	Piers Ricketts	Non-Executive Director
10	John Blakesley	Executive Director - Deputy Chief Executive Officer
11	Ian Reckless	Executive Director - Deputy Chief Executive Officer

12	Fay Gordon	Executive Director
13	Catherine Wills	Executive Director
14	Kate Jarman	Executive Director
15	Helen Beck	Executive Director
16	Jonathan Dunk	Executive Director
17	Fiona Hoskins	Executive Director

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Chief Executive: Joe Harrison
Acting Chair: Heidi Travis

TRUST BOARD IN PUBLIC

Academic Centre/Teams

Thursday, 9 January 2025

Apologies

Heidi Travis
Chair

Verbal/ Note

TRUST BOARD IN PUBLIC

Academic Centre/Teams

Thursday, 9 January 2025

Declarations of Interest

- Any new interests to declare.
- Any interests to declare in relation to open items on the agenda.

Heidi Travis
Chair

Verbal/Note

TRUST BOARD IN PUBLIC

Academic Centre/Teams

Thursday, 9 January 2025

Patient Story

Fiona Hoskins
Chief Nursing Officer

Presentation/Discuss

BOARD OF DIRECTORS MEETING

Minutes of the Trust Board of Directors Meeting in Public
held on Thursday, 14 November 2024 at 10.00 hours in the Academic Centre, Milton Keynes University Hospital Campus and via Teams

Present:

Heidi Travis (Chair)	Acting Trust Chair	(HT)
Joe Harrison	Chief Executive Officer	(JH)
Dr Dev Ahuja	Non-Executive Director	(DA)
Cllr Mark Versallion	Non-Executive Director	(MV)
Haider Husain	Non-Executive Director	(HH)
Gary Marven	Non-Executive Director	(GM)
Catherine Wills	Chief People Officer	(CW)
Fay Gordon	Chief Operating Officer – Unplanned Care	(FG)
John Blakesley	Deputy Chief Executive	(JB)
Fiona Hoskins	Chief Nursing Officer	(FH)
Helen Beck	Chief Operating Officer – Planned Care	(HB)
Jonathan Dunk	Chief Finance Officer	(JD)

In Attendance:

Hamid Manji (For Ian Reckless)	Medical Director - Planned Care	(HM)
Tom Daffurn	Public Governor	(TD)
David Cattigan	Staff Governor	(DC)
Kate Jarman	Chief Corporate Services Officer	(KJ)
Brayden Williams	Operational Manager	(BW)
Alexandra Stock (Item 3)	Matron, Surgery	(AS)
Camron Dodson (Item 3)	Healthcare Support Worker, Ward 22	(CD)
Makaya Kiazandu (Item 3)	Healthcare Support Worker, Ward 23	(MK)
Sarah Howe (Item 3)	Healthcare Support Worker, Ward 23	(SH)
Winnie Wan Ni Wu (Item 3)	Healthcare Support Worker, Ward 17	(WW)
Virgina Bell (until 11:45)	Member of the Public	(VB)
Oluwakemi Olayiwola	Trust Secretary	(OO)
Timi Achom	Assistant Trust Secretary	(TA)

1 Welcome and Apologies

1.1 The Chair welcomed all Board members in attendance and recognised those attending virtually. The Chair also recognised the Governors who were in attendance over Teams.

1.2 There were apologies from Dr Ian Reckless, Chief Medical Officer; Sarah Whiteman, Non-Executive Director and Precious Zumbika, Non-Executive Director, Prof Ganesh Baliah, Non-Executive Director

2 Declarations of interest

2.1 There were no declarations of interest in relation to the agenda items.

3 Staff Story

3.1 AS introduced the Healthcare Support Workers (HCSWs) in attendance highlighting the importance of hearing from the HCSWs in light of the upcoming National Nursing and Maternity Support Workers' Day. HT emphasised the significance of this often-overlooked workforce and acknowledged their critical role in patient care.

3.2 Four HCSWs (CD, MK, SH and WW) shared their experiences and challenges, focusing on their day-to-day responsibilities, the impact they have on patients, and the personal satisfaction derived from their roles. Key themes included:

- **Patient Connection:** HCSWs emphasised the deep relationships they build with patients and families, often becoming trusted confidants. This connection enables them to gather valuable information that patients may not share with nurses or doctors. MK noted, "*We spend more time with patients and become trusted confidants."* This personal touch was highlighted by a story where an HCSW received a heartfelt letter from a patient's family, reflecting the profound impact they have on patient care and emotional support.
- **Challenges:**
  Frequent reassignment to unfamiliar wards emerged as a significant issue. HCSWs discussed the stress of quickly adapting to new environments, learning ward layouts, and understanding patient needs. This can be overwhelming, impacting both the quality of care and staff well-being. Additional concerns included managing violent or detoxifying patients, often without adequate support, which stretches their responsibilities beyond their core roles. A call for better on-the-ground assessment of staffing needs was made to ensure that resources match the demands of each ward.
- **Training and Career Progression:**
  HCSWs expressed a strong desire for structured career development opportunities, such as Nursing Associate programs, to support their professional growth without financial strain. Concerns were raised about inconsistent program availability, emphasising the need for a stable development framework. Additionally, there was a discussion about enhancing training to prepare HCSWs for dealing with challenging patients, particularly those with acute mental health or behavioural issues.
- **Staff Well-being and Support:**
  The emotional toll of the role was discussed, particularly when caring for confused or agitated patients. HCSWs suggested improving communication strategies to help patients understand their treatment journey, reducing confrontations. FH acknowledged these challenges and shared plans for creating a dedicated forum to address HCSW well-being and staffing issues. A new tool to assess enhanced care needs was also being piloted, aiming to provide consistent and supportive staffing solutions.

3.3 FH acknowledged the concerns and outlined plans to reinvigorate development programs, including partnerships with universities and apprenticeship opportunities. JH stressed the importance of balancing professional development with job satisfaction, committing to review and finalise career pathways for HCSWs.

3.3 The Board reaffirmed its appreciation for HCSWs, acknowledging their essential role and the personal sacrifices involved with a commitment to revisit and enhance training programs, particularly the Nursing Associate pathway, ensuring clearer progression opportunities. An action was noted for FH to present a detailed plan on career progression pathways at an upcoming meeting.

3.4 Addressing the staffing pressures and reassignment challenges was noted as a priority for improving HCSW experiences and patient care quality.

3.5 On behalf of the Board HT expressed gratitude for the dedication and passion of the HCSWs recognising the critical role HCSWs play in patient care and the broader healthcare system.

4 Minutes of the Trust Board Meeting in Public held on 04 July 2024

4.1 The minutes of meeting held on 5 September 2024 were **reviewed** and **approved** by the Board.

5 Matters Arising and action log

5.1 There were no matters arising and there were no open actions due for review.

6 Chair's Report

6.1 HT provided a verbal update on the broad range of engagement activities happening both within the Trust and across the wider community. She highlighted a recent visit with Governor Andy Forbes to a community initiative, where they were impressed by the innovative outreach programs, including a food bank and the distribution of hygiene kits to 1,500 registered individuals. These programs are providing essential support, and HT stressed the importance of leveraging such community settings to promote the Trust's work and its impact.

6.2 Feedback was shared from HT's participation in a regional East of England meeting, where discussions centred on the 10-year health plan. Key topics included digital rights, prevention, and socio-economic health equity. HT commended a session which focused on population health, equitable service delivery, and prevention initiatives, such as dementia care and early interventions. She noted the ongoing efforts to incorporate these priorities into the Trust's future strategy.

6.3 HT noted the meaningful remembrance service organised by the Pharmacy team, which was well-received by attendees. She reiterated the Trust's commitment to continuously engaging with both staff and the community in meaningful ways. HT emphasised the need to refine and adapt engagement processes to ensure they are aligned with the Trust's evolving strategic objectives.

6.2 The Board **noted** the Chair's Report.

7 Chief Executive's Report – Overview of Activity and Developments

7.1 JH reported on several key activities since the last Public Board meeting, including the long service awards and the Black History Month celebrations. The Trust also hosted a visit from the National Pay Review Body, which was pleased with the staff discussions, particularly around national issues affecting the NHS. Additionally, Faith Week events were held, with special thanks to Sarah Crane and the Chaplaincy team for their efforts.

7.2 Regarding performance, JH highlighted the improvement in the Trust's Emergency Department (ED), which had been rated as "green" across all CQC domains, reflecting a significant achievement. The Trust had also improved its emergency care performance, ranking in the top half of the country for the four-hour target, showing progress since the summer. However, JH acknowledged the ongoing challenge of elective waiting times. While the Trust had previously been highlighted for poor performance in meeting the 18-week target, recent data showed improvement, with half of the patients seen in September 2024 being treated within nine weeks. The Trust was focusing on reducing waiting lists, despite pressures from increased urgent and cancer referrals.

7.3 JH also provided an update on the ongoing staff survey, noting that the Trust had been performing well in employee engagement, ranking number one in the country for staff wanting to come to work. The results were expected to reflect the positive impact of the health and well-being initiatives put in place. Finally, JH addressed financial matters, noting that the Trust had submitted a break-even plan for the year, despite the pressures from additional work and premium costs. While the Trust faced challenges, particularly around waiting times, he stressed that performance was complex, and the Trust was working hard to manage its resources effectively and meet its goals.

7.4 JH concluded by discussing the financial impact of changes in national activity reporting and the need for ongoing discussions with regional and national teams to ensure the trust is not disproportionately affected.

7.5 Bedfordshire, Luton and Milton Keynes Integrated Care Board (BLMK ICB) update

7.5.1 The Board noted the BLMK ICB report which provided a summary of the items discussed at the ICB Board meeting on 27 September 2024. Key discussions included Annual Report and Accounts, System Strategies, BLMK Health Services Strategy, BLMK Infrastructure Strategy, Increasing NHS App Usage and Stay Well and Winter Plan.

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

8 Patient Safety Update

8.1 HM provided a comprehensive overview of patient safety activities highlighting the introduction of a new Patient Safety Incident Response Framework (PSIRF). This framework had been in use for the past six months, involving a daily multidisciplinary review of incidents, and a weekly local patient safety review in clinical specialties. The process aims to identify emerging trends and address critical issues, such as patient codes, tissue damage, and medicines management problems.

8.2 A key focus of the framework was ensuring continuous learning and improvement through a system-focused approach. Efforts to encourage open conversations about incidents and create a psychologically safe environment for staff are central to the framework's success. An important aspect of the process was the integration of reporting systems, such as RADAR, which had been linked with the Patient Safety Dashboard to improve visibility and allow quicker identification of incidents.

8.3 The Trust had seen an increase in incident reporting, signalling a positive shift towards better transparency. The Trust was also focusing on disseminating lessons learned through monthly patient safety newsletters, case studies, and multidisciplinary learning events, with 200 learning events held in the past six months.

8.4 In relation to the question raised about the impact of transitioning data systems on incident tracking and whether important information could be missed. HM assured the Board that the RADAR system, which continues to operate effectively, was not being transitioned, and the increase in reported incidents provided more assurance. While improvements to the dashboard were planned, the process was already yielding valuable insights.

8.5 HM highlighted the growing Patient Safety team and the introduction of internal guidelines for investigation timelines. He stated that the Trust was monitoring new investigations closely and adjusting resources accordingly and acknowledged that the system may require further refinement after six months.

8.6 A clarification was sought on how incidents were triaged and whether the focus was on identifying themes rather than isolated incidents. HM clarified that the new triage process was designed to pull together similar incidents into a unified action plan, avoiding multiple plans for the same issue.

8.7 Regarding the issue of staff facing physical or verbal abuse, HM stated that an improvement program was in place to address this. Work was ongoing to find the best interventions for complex patient groups, particularly those with dementia or detoxing. National guidelines were being reviewed, and learning from other areas was being incorporated.

8.8 The Board **noted** the Patient Safety Update

9 Mortality Update

9.1 HM provided an update on mortality rates, confirming that the Trust's risk-adjusted mortality was "as expected", and there were no major concerns about outlier data. There had been some volatility in the figures, mainly due to changes in coding, but a national emergency care dataset was expected to standardise the reporting. The Trust continues to use the Medical Examiner system for Structured Judgment Reviews (SJRs), now covering deaths in hospitals, community settings, and hospices.

9.2 In response to the question raised about whether there was any divergence between the outcomes of the SJRs and the coronial verdicts. HT confirmed that there had been no indication of discrepancies between the two. The reviews had highlighted areas for further investigation, but there was no evidence suggesting that harm issues were overlooked.

9.3 The Board **noted** the Mortality Update

10 Maternity Assurance Group (MAG) Update

10.1 FH provided a verbal update on the Maternity Assurance Group (MAG), highlighting the progress made in various areas, including the maternity workforce plan, perinatal mortality reviews, and the preterm optimisation quality project.

10.1.1 She stated that MAG recently welcomed Roxanne Clark, Co-Chair of the Maternity and Neonatal Voices Partnership (MNVP) and confirmed the work plan's alignment with local maternity systems and ICB directives. Improvement projects arising from this alignment would be managed through Clinical Service Units (CSUs) and overseen by MAG. A review of the maternity workforce plan highlighted a positive reduction in maternity risk and midwifery staffing levels from 15 to 10. This reduction was attributed to successful recruitment efforts and improved staffing robustness.

10.1.2 Perinatal Mortality Review:

- Four recent cases were reviewed; two remained under investigation. No evidence of care failures was found in the closed cases.
- The group continues to monitor the Maternity Incentive Scheme delivery action plan.
- Concerns were raised regarding compliance with mandatory training due to medical staff changes, but a recovery plan was in place to address this.

10.1.3 A quality improvement project focused on preterm care for babies born at specific gestational weeks was discussed. The project aimed to ensure appropriate care and placement, particularly for complex cases requiring specialist intervention.

10.1.4 It was noted that no current issues in maternity services flagged a need for separate Board-level reports beyond regular updates.

10.2 Midwifery Workforce update 6 monthly report

10.2.1 FH highlighted the following from the report:

1. **Safe Staffing and Standards Compliance:**
    - The team maintained a focus on safe staffing levels, ensuring adherence to regulatory standards.
    - A repeat of the Birthrate plus (BR+) assessment would be conducted to align staffing levels with the number of births accurately.
2. **Addressing Data Discrepancies:**
    - A data discrepancy regarding the Provider Workforce Return (PWR) had been resolved. The Board was assured that the updated figures now accurately reflect staffing targets.
3. **Current Staffing Levels:**
    - Maternity vacancy rates had decreased to below 4%, with newly qualified midwives soon joining the workforce.
    - Short-term sickness had caused minor fluctuations, but overall midwifery coverage remained robust, meeting Birthrate plus requirements.
4. **Improved Rostering Impact:**
    - Recent changes in rostering practices have enhanced midwife allocation per birth, although the initial data showed a slight decrease due to transitional adjustments.
    - The standard of ensuring every birth had a midwife present was consistently maintained.
5. **Data Reporting Improvements:**
    - Efforts were underway to align local and central data reporting timelines to ensure consistency and accuracy, particularly concerning workforce figures.

10.5 The Board **noted** the Maternity Assurance Group Update

11 Annual Patient Experience Report

11.1 Deferred to January 2025 following a review by the Quality and Clinical Risk Committee

12 Performance Report Month 6

12.1 FG provided an overview of the Month 6 Performance Report, highlighting key operational challenges faced by the Trust. She noted the challenges faced due to high attendance rates and the efforts made to maintain patient flow through the Trust and highlighted the reduction in patients with no criteria to reside and the focus on length of stay. Performance metrics indicated a 73% compliance rate, which was close to the national average of 74.2%. She stated that the team was managing well despite higher patient volumes.

12.2 There was concern about the impact of prioritisation on diagnostic performance. Teams were working closely to manage cases effectively, but resource limitations, particularly regarding CT scanners, have posed challenges. Efforts were ongoing to optimise diagnostic capacity to support overall performance.

12.3 An action plan had been established to address performance gaps, with representation from key stakeholders. JH acknowledged the difficulty in managing costs but emphasised that additional funding was available to support services until March. Specific funds for cancer diagnostics were highlighted as beneficial.

12.4 The Board **noted** the Performance Report for Month 6

13 Finance Report Month 6

13.1 JD presented the presented the finance report, highlighting a year-to-date deficit of £4.6 million and forecasting a break-even by the end of the year. He noted efficiency improvements and significant risks associated with delivery.

13.2 He discussed ongoing efficiency initiatives, indicating potential savings of around £20 million. While significant improvements were noted, risks to delivery remain and the importance of continuing efforts to improve efficiency and reduce costs was emphasised.

13.3 Concerns were raised regarding funding continuity, particularly around escalation capacity and capital projects. Assurance was provided that funding for specific programs, such as those related to cancer services, is secured. However, uncertainties remain regarding whether all initiatives would be fully supported. JD stated that the team was reviewing the costs and income generated by various educational and capacity-building initiatives to ensure financial viability.

13.4 Discussion also touched on the need to maintain service quality while managing costs. It was noted that ongoing challenges, including maintaining an 18-week treatment standard and managing long-wait patients, require careful balancing of resources.

13.5 The Board **noted** the Finance Report for Month

14 Workforce Report

14.1 CW presented the Workforce Report. Key areas of focus included current staffing levels, recruitment challenges, and strategies to address workforce pressures.

Staffing and Recruitment Challenges:

- The vacancy rate had increased (7.1%) with Additional Professional and Technical staying at its highest point in 12 months (23.8%).

- Hot spots for staffing shortages were identified, and there was an ongoing effort to reassign existing staff into substantive roles to alleviate pressure.
- Questions were raised about the persistently high vacancy rates, with concerns that some roles were essential yet difficult to fill.

Agency and Retention Issues:

- It was noted that some professional roles had high turnover, with staff moving to agency positions offering higher salaries. This had led to an increased reliance on agency staff, especially in critical, specialised roles.
- Efforts to reduce agency dependency by reviewing job descriptions and adjusting pay grades to retain staff was discussed.
- National recruitment policies were mentioned as impacting the acute care workforce, as many professionals were being drawn into primary and community care roles.

Current Strategies and Successes:

- Efforts to improve workforce stability included targeted recruitment, training programs, and retention initiatives.
- Some success had been noted in attracting staff through enhanced educational opportunities and career development pathways.
- Creative approaches, such as modifying roles and investing in professional development, were being explored to make positions more appealing.

14.2 The Board **noted** the Workforce Report

15 Antimicrobial Stewardship – Annual Report

15.1 The Antimicrobial Stewardship Annual Report was presented by HM. He highlighted key activities and outcomes for the year. The stewardship team had been actively working to improve the appropriate use of antibiotics, focusing on reducing broad-spectrum usage and ensuring compliance with best practices. HM also noted that the team conducted daily ward rounds, particularly in high-risk areas such as ICU, to monitor antibiotic use and promote conversion from IV to oral antibiotics. This year, they successfully met their target for IV-to-oral conversions.

15.2 Although the hospital's overall antibiotic consumption remained below the national average, the use of WHO "Watch" antibiotics had increased in the past two quarters, partly due to case complexity and changes in reporting metrics. Additionally, there had been a rise in multi-drug-resistant organisms, posing ongoing challenges. Enhanced monitoring and targeted interventions are being implemented to address these issues.

15.3 A notable achievement was the partnership with the University of Nigeria, funded by a successful grant from the Commonwealth Antimicrobial Stewardship Scheme. This initiative focused on enhancing antimicrobial awareness and practices in Nigeria, supporting WHO objectives.

15.4 The stewardship team faced staffing challenges during the year but managed to stabilise their operations. Former team members returned temporarily to provide support, ensuring continued functionality.

15.5 The Board **noted** the Antimicrobial Stewardship – Annual Report

16 Infection Prevention and Control Annual Report

16.1 HM provided an update on infection control, noting that there were no MRSA cases reported during the year. However, a few cases emerged after April and were under review. Additionally, there had been a slight increase in C. difficile cases, aligning with national trends. Comprehensive reviews had not identified any significant lapses in infection prevention protocols.

16.2 The Board **noted** the Infection Prevention and Control Annual Report

17 Risk Management Report

17.1 KJ discussed the Corporate Risk Register and the Board Assurance Framework, highlighting the ongoing work on system-wide risk profiling and the need to update the framework to reflect recent discussions.

17.2 The Board **noted** the Risk Management Report

18 Board Assurance Framework (BAF)

18.1 Discussed on item 17

18.2 The Board **noted** the Board Assurance Framework.

19 Annual Review of Trust Board and Committees' Terms of Reference

19.1 The Board was asked to **note** the amendments to the Terms of Reference for the Trust Board, Board Committees, and Council of Governors, and to **approve** these Terms of Reference following recommendations from the respective committees.

19.1.2 The Board **reviewed** and **approved** the revised Terms of Reference for the following Committees:

- Board of Directors
- Finance and Investment Committee
- Renumeration Committee
- Council of Governors
- Charitable Funds Committee
- Workforce and Development Assurance Committee

19.1.3 **Audit and Risk Committee**: The Board **approved** the revision of the Audit Committee's title to "Audit and Risk Committee" to reflect its broader responsibilities. Discussions included assurance processes, with a proposal to involve the committee in reviewing future amendments. However, it was agreed that the current review provided adequate oversight.

19.1.4 **Quality and Clinical Risk Committee:** The Quality and Clinical Governance Committee's updated Terms of Reference was pending further discussions and would be re-presented for approval in February 2025.

20 Use of Corporate Seal

20.1 The Board reviewed the Corporate Seal report which outlined its scheduled use for 2024/25. Agreements included the Deed of Surrender for land at Milton Keynes University Hospital (MKUH) with MPML, a Revised Pathway Unit Grant Agreement with Milton Keynes City Council for constructing a new two-storey building, and Wayleave Agreements with City Fibre Metro Networks and BT Plc for data cable access to Lloyds Court. Also noted was a Car Park Leave Agreement with Milton Keynes City Council for land south of Avebury Boulevard. The signatories for these agreements are Joe Harrison, Jonathan Dunk, and John Blakesley.

21 Forward Agenda Planner

21.1 The Board reviewed the Forward Plan and noted that there were no items captured for discussion at the January Board.

22 Questions from Members of the Public

22.1 The below questions were received from governors and members of the public:

1. "What is the Hospital Board doing to educate patients, relatives and staff about healthy and sustainable foods and to increase the range of healthy and sustainable foods, while at the same time decreasing the amount of unhealthy and unsustainable foods, available in the Hospital's food outlets - the Hospital's shops, automatic machines, café, restaurant, patients' meals and voluntary offerings?"

Response from Steven Hall, Head of Hotel Services and Francesco Fiore, Catering Manager:
We offer our patients a well-balanced menu, patient can choose:
25 hot main dishes
14 sandwich and homemade salads choices
15 hot and cold desserts
We will be introducing fresh homemade soups.

We work closely with the Hospital's Dietitian's to ensure the menus provide good nutrition. In April we introduced a new menu formal, with larger print and photographs to make it easier for patients to use.

Our new meal service system Steamplicity has reduce system food waste from an average of 16% to 2%, the hospital has invested the savings into improving patients' menu.

The Trust has signed up to the Healthy Weight Declaration with Milton Keynes council and after an audit by the council the in-house facilities are meeting nearly all of the criteria to demonstrate healthy eating and promote a better healthy weight too our staff and visitors. We are working towards the Soil Association 'Food for Life' Bronze award.

Francesco (Frank) Fiore is Co-Chairman of the Love British Food Healthcare Group that works with British Farms and Hospitals to encourage Hospital to use more British Food.

We have move to a local dairy and fruit and vegetable company who source many of their products within our region, we are about to change to a local butcher.

We have a selection of healthy meals in the Staff Restaurant, and these are sold at an increased subsidy, meaning that hospital staff can have a nutritious meal for between £2-£3 these are very popular.

2. Can you confirm the news on the Women's and Children's Hospital and how it is to be funded? Also, how efficiencies are to be made in orthopaedic surgery? i.e. what is the plan?

Response from the Deputy Chief Executive (JB):
The Trust has obtained approval for its Strategic Outline Case and has been authorised to start the next phase of an Outline Business Case. This has received funding for the first few months of work and should be completed towards the end of the next calendar year. The Trust is waiting for the results of the Government review into the timing of projects within the New Hospital Programme, this should clarify when it is likely that we will be able to start building the new Hospital. In the meantime, we have started building two enabling projects including a new Imaging Centre and a new multistorey Carpark for staff.

23 Any Other Business

HT noted that it was DA's last Board meeting and expressed gratitude for his exceptional service as a Non-Executive Director in MKUH, highlighting his dedication, hard work, and effective leadership, particularly as Chair of the Quality and Clinical Risk Committee. DA acknowledged the recognition and shared his appreciation for the support received.

The meeting closed at 12:25PM

Updated:14.11.24

Milton Keynes University Hospital NHS Foundation Trust

Trust Board Action Log

Action No.	Date added to log	Agenda Item No.	Subject	Action	Owner	Completion Date	Update	Status Open/ Closed
36	05-May-24	15	October Board Seminar: Risk Development Programme	Revisit and refresh the risk management strategies and commitment to continued education and adjustment to enhance risk management across the organisation.	Paul Ewers/KJ	06-Feb-25	Moved to February 2025 Seminar due to Yvonne Coghill Session in October	**Open**
39	04-Jul-24	12	Finance Report Month	Provide a Provider Selection Regime and the potential implications of this for the Trust/ICS Report at the Trust Board Seminar in October	JD	06-Feb-25	Moved to February 2025	**Open**
40	14-Nov-24	3	Staff Story	FH to present a detailed plan on career progression pathways at an upcoming meeting.	FH	06-Mar-25		**Open**

Meeting Title	**TRUST BOARD**	**Date: 9 January 2025**
Report Title	**Chair's Update**	**Agenda Item Number: 6**
Lead Director	**Heidi Travis**, Acting Chair	
Report Author	**Heidi Travis**, Acting Chair **Oluwakemi Olayiwola**, Trust Secretary	

Introduction	This report is a standing agenda item		
Key Messages to Note	This report informs the Board of key points arising from the Council of Governors and members' discussions and the Chair's and Non-Executive Directors most significant activities since the last Trust Board held in public. The Board is invited to NOTE the report		
Recommendation *(Tick the relevant box(es))*	**For Information** ☒	**For Approval** ☐	**For Assurance** ☐

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	1. *Keeping you safe in our hospital* 2. *Improving your experience of care* 3. *Ensuring you get the most effective treatment* 4. *Giving you access to timely care* 5. *Working with partners in MK to improve everyone's health and care* 6. *Increasing access to clinical research and trials* 7. *Spending money well on the care you receive* 8. *Employ the best people to care for you* 9. *Expanding and improving your environment* 10. *Innovating and investing in the future of your hospital*

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

1. Introduction

1.1 This report aims at updating the Board on the Acting Chair's main activities, Non-Executive Directors (NEDs) ward visits, Governors' visits and discussions as well as systems and place collaborations as part of the MKUH Board's commitment to transparency and accountability. The report further informs the Board of key points arising from the Council of Governors' discussions and the Chair's and Non-Executive Directors most significant activities since the last Trust Board held in public.

1.2 The Board is invited to NOTE the report.

2. Chair's Update

Board Effectiveness

2.1 At the Board Seminar on 5 December, Board members spent some time to reflect on the outcome of the EDI works that were undertaken by Roger Kline and Yvonne Coghill in the course of the year. Action plans were proposed with input from Board members on how to model a culture of equity, while making MKUH a safe space for every staff to feel welcome and comfortable to work. Both NEDs and Execs considered what each group most needed to support in modelling the culture of equality, while fostering constructive support and challenge, maintaining curiosity alongside clear direction, and investing in our people.

2.2 We said goodbye to Dev Ahuja at the end of November. Dev was a committed and very passionate Non-Executive Director who Chaired the Quality and Clinical Risk Committee of the Board. He will surely be missed.

2.3 We welcomed Piers Ricketts as a Non-Executive Director to the Board. Piers brings a wealth of experience in healthcare leadership, finance and audit. His appointment was effective 1 December 2024. Piers has joined the Audit & Risk Committee, Quality & Risk Committee and the Charitable Funds Committee.

I know you will all join me to welcome him to his first Trust Board in public.

System Leadership

2.4 At the NHS East of England meeting held on 8th Nov, the NHS 10-year plan was discussed particularly in terms of its collaborative approach. However, concerns were raised about the lengthy timeline, with implementation potentially delayed until 2026-2027, which may test public and governmental patience. There was consensus on the need to focus on local initiatives that could be driven with greater urgency.

2.5 The meeting also included a presentation by Chris Whitty, whose data-driven insights were well-received. The key themes of the 10-year plan were discussed, including health prevention (e.g., moving from reactive to preventative care), transitioning from analogue to digital systems, and shifting care from acute settings to the community. Opportunities for public involvement in focus groups were also mentioned, with links to be shared when available.

2.6 I was also pleased to attend the ICB sustainable Health care system seminar on 15th November. There is much great work already underway across the ICS and MKUH has some excellent projects that show commitment to our environmental plan.

NED Visits

2.7 In collaboration with the Secretariat Team, we have re-instituted the process around formal ward visits by Board members. NEDs have been scheduled to visit the hospital wards in company of the Executives on rotational basis on Board meeting days. This will provide an opportunity for our NEDs to interact with staff and patients, understand their experiences, and gather firsthand information about the challenges and successes in patient care. This will also help us as a Board in making informed decisions and ensuring that the quality of care is maintained and improved in MKUH. Following December Board we visited ED and Ward 25. With Ward 1 visited the following week.

2.8 I was delighted to have joined Helen Smith - Lead Pharmacist and Divisional director core medical. We visited all 3 sites of pharmacy at MKUH spending time with the team. There were also visits to Ward 2a, the post department, and the catering team.

Council of Governors Update

2.9 New Members Welcome

The Council was pleased to welcome three new members to their first open forum:

- Paul Newman – new public governor to represent the Extended Area
- Ian Oswald – new public governor to represent Outer Catchment Area Constituencies of Milton-Keynes University Hospital NHS Foundation Trust (MKUH).
- David Cattigan (Non-Clinical Group Constituency) - new Staff Governor

Our new members bring valuable experience in health and social care, and development which can only serve to enrich the work of the Council of Governors.

William Butler was also re-elected as Public Governor to represent Emerson Valley, Furzton, Loughton Park constituency. This marks the commencement of his third term as public governor on the council.

2.10 Governors Open Forum

The Council held their Open Forum on 4 December 2024. The meeting was well attended by governors, NEDs and new members of the council. The Chief Nursing Officer provided an update on the outcome of the Maternity Survey and the implication for the Trust. The governors were further advised on the ongoing quality improvement initiatives, including enhancing postnatal discharge processes, improving maternity documentation, expanding translation services, and refining labor induction methods. These measures aim to address identified challenges and improve maternity care experiences.

The Governors were also updated on the progress made with '*falls reduction*' as one of the Trust's Priorities for 2024/25 financial year. The governors were updated on ongoing efforts driven by the Patient Safety Incident Response Framework (PSIRF), focusing on learning and responsiveness to incidents.

2.11 Joint NEDs and Governors Christmas Ward Visits

As part of the end of the year festive activities at the Trust, the NEDs and Governors jointly visited the hospital wards to see our patients and staff who sadly spent their Christmas in the hospital. A total of 10 wards were visited with a variety of gifts shared to put a smile on their faces.

Thank you to those who made time to join us on the visits and for an enjoyable dinner together.

2.12 Other Engagements/Visits

- On 20th November along with Joe Harrison, Kate Jarman and 3 members of MKUH with 40 years' service, I attended the celebration tea of 40 years of MKUH with the Mayor of Milton Keynes, Ms Marie Bradburn.
- We were hosted at the Holiday Inn MK 25th November, for a '*thank you'* event for supporters of the Charity.
- On 17th December we met with volunteers in the Academic centre for mince pies thanking them for their incredible contribution to MKUH.
- On 28 November, I attended the Engagement Board, it was great to see some of our Governors and engagement team who made some time out of their busy schedules to attend.

Throughout the last 2 months I have met non-executives for one-to-one meetings. Chaired interview panels for consultant roles alongside medical colleagues and thank non-executive director Sarah Whiteman for Chairing one of these panels.

2 Recommendation

The Board is invited to NOTE the report.

Meeting Title	Trust Board in Public	Date: 9 January 2025
Report Title	**Chief Executive's Update**	**Agenda Item Number: 7**
Lead Director	Joe Harrison, Chief Executive	
Report Author	Joe Harrison, Chief Executive	

Introduction	This report is a standing agenda item		
Key Messages to Note	This report informs the Board of key points arising from the Chief Executive's most significant activities since the last Trust Board held in public. The Board is invited to NOTE the report		
Recommendation *(Tick the relevant box(es))*	**For Information** x	**For Approval** ☐	**For Assurance** ☐

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	1. *Keeping you safe in our hospital* 2. *Improving your experience of care* 3. *Ensuring you get the most effective treatment* 4. *Giving you access to timely care* 5. *Working with partners in MK to improve everyone's health and care* 6. *Increasing access to clinical research and trials* 7. *Spending money well on the care you receive* 8. *Employ the best people to care for you* 9. *Expanding and improving your environment* 10. *Innovating and investing in the future of your hospital*

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

1. Introduction

1.1 This report aims to update the Board on the Chief Executive's activities as part of the MKUH Board's commitment to transparency and accountability.

1.2 The Board is invited to NOTE the report.

2. Chief Executive's Update

Our People & Culture

2.1 Recruiting and retaining the best people is vital to our success. We want the MKUH team to reflect the diversity of the city, to deliver high standards of patient care, and to uphold our values. In support of this, we recently launched Values Based Recruitment. All managers will benefit from training to help them select new recruits whose personal values align with those of the Trust. While skills can be developed, values are essential to fostering a positive work environment and providing excellent standards.

2.2 Our staff-led diversity networks are thriving. We recently launched a new Men's network, and an Internationally-Educated Staff network is in the pipeline.

2.3 In November, we shone a light on our Nursing and Midwifery Support Workers with an event for this vital group of staff.

2.4 We have had our best completion rate for the staff survey for a number of years. We will analyse these responses when they become available and use them to shape our work going forward.

Operational Performance

2.5 Our position on waiting times has significantly improved, particularly for patients with the longest waits. Seasonal viruses are certainly having an impact on emergency bed pressures in the hospital, which is very busy, but we are maintaining high standards of patient care thanks to a combination of staff expertise and well-rehearsed protocols. We have managed to maintain planned (elective) activity despite significant emergency pressures. Additionally, over recent months, our cancer performance has significantly improved.

Radiotherapy Centre

2.6 On Christmas Day, there was significant flooding in the new radiotherapy centre, believed to have been caused by an issue with a mains water pipe. Thankfully, no staff or patients were affected as the building is not yet open for use. The response of our team has been truly impressive. We do not yet know how this incident will impact on the opening date of the Centre, and I will keep the Board informed of this.

NHS 10 Year Plan

2.7 In my role as NHS App National Director, I have been closely involved in the development of NHSE's new 10 Year Plan and expect that the NHS App, and digital developments, will feature heavily in it.

Planning For 2025-26

2.8 In December, our senior leaders gathered to reflect on priorities for the final quarter of this year and to start planning for 25-26. Everyone has been tasked with sharing innovative ways of working that will help us maintain high standards whilst being efficient with our resources.

2.9 My shadowing activities continue to be a great source of inspiration and learning for me. Since last Board Meeting, I have spent time in Outpatients where I gathered many valuable insights.

MK Council

2.10 I had the honour of being invited to meet the Mayor of Milton Keynes, Councillor Marie Bradburn, and then address the assembled Council. This was an opportunity to talk about our services, how we are evolving, and the hospital's incredible progress since its opening 40 years ago.

Development

2.11 The foundations for Oak Wards have now begun to be laid. Once completed, this facility will feature two 24-bed wards across two floors, significantly increasing our capacity for medical patients.

3. Recommendation

The Board is invited to NOTE the report.

Date 9 January 2025

ICB Executive Lead: Maria Wogan, Chief of Strategy and Assurance, and MK Link Director, Bedfordshire, Luton and Milton Keynes (BLMK) ICB

ICB Partner Member: Joe Harrison Chief Executive, Milton Keynes University Hospital NHS Foundation Trust

BLMK Health and Care Partnership Member: Heidi Travis, Acting Chair, Milton Keynes University Hospital NHS Foundation Trust

Report Author: Maria Wogan

Report to the: Board of Directors, Milton Keynes University Hospital NHS Foundation Trust

Bedfordshire, Luton and Milton Keynes Integrated Care Board (ICB) and Health and Care Partnership update

1.0 Executive Summary

1.1 This report summarises key items of business from the BLMK Integrated Care Board (ICB) and BLMK Health and Care Partnership arising from recent meetings.

2.0 Recommendations

2.1 The Health and Wellbeing Board is asked to **note** this report.

3.0 Key Implications

Resourcing	✓
Equality / Health Inequalities	✓
Engagement	✓
Green Plan Commitments	✓

4.0 Report

4.1 Bedfordshire, Luton and Milton Keynes Integrated Care Board

On 13 December 2024, the Board met at Priory House, Central Bedfordshire Council.

Questions from the public -There was one question from a resident, in relation to hospice funding. The question and answer can be viewed here.

Resident stories - Sexual Health Service iCaSH shared an example of their work with a resident experiencing complex health issues, homelessness and financial challenges. They explained how multi-agency support helped the resident to address immediate health concerns and access advice on employment and support for her family.

Chair and Chief Executive updates - The meeting was the last for the ICB Chair Dr Rima Makarem, who stands down at the end of December. She reflected on her four and a half year tenure with pride, noting the significant progress made across the ICS. The Deputy Chief Executive thanked Dr Makarem for her vision and leadership, and for her important work to reduce inequalities and establish a research ICS focused on innovation.

The Deputy Chief Executive announced changes to the Executive team with the appointment of Dr Andrew Rochford, who will be joining the ICB in March 2025, and thanked Dr Ian Reckless for his service as Interim Chief Medical Director. The Chief Primary Care Officer Nicky Poulain will retire in April 2025. She also set out the process for recruiting a new Chair and confirmed that Manjeet Gill, Deputy Chair of the ICB, will provide cover as Acting Chair from the new year.

The Board received an update on the development of the business case for a new Community Diagnostic Centre in Luton and agreed to delegate authority to the Chief Executive of the ICB to approve the business case. The Board also authorised the Chief Executive to sign the revised delegation and collaboration agreements for Specialised Commissioning for BLMK ICB.

Strategic priorities, dying well in BLMK – In a wide-ranging report, co-presented by Sarah Stanley, Chief Nurse and Elaine Tolliday, Clinical Director of Keech Hospice, the Board heard that in 2023 67,000 hospital bed days were used for palliative care patients in BLMK, and that there were 6,000 emergency admissions for end-of-life patients. The Board discussed how partners could develop a system approach to ensure more residents have a 'good death' in a setting of their choice. The Board agreed the formation of a diverse and expert Palliative and End of Life Programme Board to take forward the recommendations of the co-produced End of Life Review and endorsed the importance of resident voices in conversations about dying.

Primary Care Transformation Plan to deliver the National Primary Care Strategy – The Board noted the BLMK Primary Care Transformation Plan and commended work to improve primary care access through the appointment of additional clinical roles, Pharmacy First, Total Triage and Primary Medical Services. The Board asked for closer alignment with the ICB's developing estates strategy and for greater clarity on the impact the challenges in primary care have on activity in hospitals.

Improving Health Equity and Delivering on the Denny Review – The Board welcomed the system work to respond to the Denny Review and the launch of the Health Equity Programme since last year. The Board approved the proposed focus of the Health Equity Programme in Year 2 and sought a focus on measuring and demonstrating quantifiable impact. Recognition was given to the ICB's new Learning Action Network, launched in partnership with the Institute for Healthcare Improvement in November 2024. Board Members shared their own organisation's actions to respond to Denny, including Healthwatch's efforts to improve translation and interpretation services, Luton Council's appointment of more representative leaders in the Council and success in reducing child poverty, the use of Artificial Intelligence (AI) to help prioritise surgical waiting lists at Bedfordshire Hospitals Foundation Trust and CNWL's sensitivity training programme for staff.

Operational planning process for 2025/26 – The Board discussed the operational planning process and the difficult decisions that the system may need to take in 2025 to achieve a balanced plan. It was agreed that a seminar in January would help to shape the approach to planning, with a focus on the three changes outlined in the Darzi Review. The Board agreed that due regard should be had to the PA

Consulting report to drive efficiencies across the system including improving discharge pathways.

Month 7 ICS Finance Report – The Chief Finance Officer reported an improving position at month 7 following significant interventions to address a deficit across the system. It was recognised that payroll increases had impacted the deficit, and that elective recovery was attracting premium costs. Members heard that a recovery plan is in place and will be extended over the winter period to manage workforce costs and deliver efficiency programmes. It was reported that the capital programme remains in balance. The Board was informed that further improvements are expected at Month 8 and the ICB continues to forecast breakeven by year end.

Committee reports:

Audit and Risk Assurance Committee – The Board noted the report from the Audit and Risk Committee on 11 October 2024 and the update to risks in the Board Assurance Framework (BAF), including two new risks that had been added for BHFT maternity services and the risk to the sustainability of the VCSE sector on delivery of the ICS's strategic priorities.

Quality and Performance Committee – The Board noted the performance report, including the work to address major challenges in meeting elective care ambitions.

Finance and Investment Committee – The Board approved the Section 75 agreements as recommended by the Committee in the detailed report.

The Primary Care Commissioning and Assurance Committee – The Board noted the report from the Committee on 18 October 2024.

Mental Health and Learning Disabilities and Autism Collaborative Committee – The Board noted the update from the Committee.

Assertive and Intensive Community Outreach Review and Action Plan – The Board noted the NHSE requirement to review the action plan in the public Board meeting and reviewed and noted the plan, which is a dynamic document that will continue to be developed.

Corporate Governance Report – The Chief of Strategy and Assurance clarified the conflict of interest guidance regarding 'perceived' interest, and the Board agreed to delegate any further amendments to the Conflict of Interest Guardian.

The full set of Board papers can be found on our website here.

The next meeting of the Integrated Care Board will be at 9 a.m. on 21 March 2025, venue to be confirmed. Further details will be published on the website. Members of the public and partner organisations are welcome to join in person or on-line. We ask that questions to the Board from members of the public are submitted three days in advance by 17 March 2025. Questions can be emailed to blmkicb.corporatesec@nhs.net.

Board papers and a link to join the meeting is available here a week before the meeting.

If you have any queries regarding this summary, then please contact blmkicb.corporatesec@nhs.net

4.2 Bedfordshire, Luton and Milton Keynes Health and Care Partnership

The BLMK Health and Care Partnership met on 19 September 2024.
Health Services Strategy - The Health Services Strategy was a topic of much interest to members and the subject of considerable discussion. Our population will grow considerably over the next fifteen years, with a disproportionate increase in the population aged over 79. This will create huge pressures on our health system at all levels, and reminds us all that standing still is not an option. If our health system is to cope with these future demands we will need to transform the way we deliver services, embracing new technology, promoting healthier lifestyles and continuing to break down the health inequalities amongst our population that are all too evident.

Cancer Services in BLMK – We heard from the Head of the Cancer Network on developments in cancer diagnosis and treatment for the residents of BLMK. One in two of us will get cancer in our lifetimes, with smoking, obesity, diet and alcohol being major and preventable risk factors in that. We currently have no tertiary treatment centres located in BLMK, a factor which adds to the difficulties experienced by our residents with examples of patients electing palliative care due to the difficulties in travelling for treatment. This only increases the health inequalities experienced by some communities, with performance for one year survival rates in some parts of BLMK worse than in England as a whole for breast, lung and colorectal cancers.

The BLMK Cancer ten year transformation plan seeks to improve this situation. A planned increase in the workforce over the next five years will see improved access to clinical nurse specialists and other support staff, and enhanced services to the GP contract will support early cancer diagnosis. Radiotherapy is an effective treatment for many types of cancer and this will become more locally available. Milton Keynes University Hospital will shortly be opening a radiotherapy unit on the existing site in a project with the Oxford Cancer Centre. Radiotherapy currently delivered from Mount Vernon Hospital in London will be relocated to a satellite centre nearer us, either at Lister Hospital in Stevenage or at the Luton and Dunstable Hospital. An NHS England led consultation on this move will shortly commence, and partners will be encouraging our residents to take part in that.

Joint ICB/ICP Seminar on Health Equity in BLMK - The BLMK Health Equity event held in May saw contributions from partners and residents, and helped attendees to understand the difficulties faced by some of our more marginalised groups. The event concluded a week-long series of high-profile events, webinars and meetings to showcase our commitment to creating fair and inclusive health and care services. This focused event on health equity is to be scheduled annually to share and showcase best practice examples from across the system and to report progress against the Denny Review recommendations and the wider Improving Health Equity programme ambitions.

Joint ICB/ICP Seminar – Leading for Sustainability Summit – Partners came together with sustainability leaders from across BLMK and beyond on 15 November, to consider the impacts of climate change on health and to discuss how we will meet those challenges, with an opening speech delivered by Alistair Strathern MP. The ICB's Green Plan is under review and partners were asked for their ideas and recommendations to help drive this and to ensure that we all play our part in building a sustainable health service for the future. As befits a forward looking plan we were joined by Youth Councillors from across the Places with the event culminating in a youth panel discussion, leaving delegates with one key ask, **"do not leave the room and forget about these conversations, your time to act**

is now". Further discussions will take place around the Green Plan and we look forward to engaging with you as this progresses.

A full report is included at Appendix One.

The next meeting of the Health and Care Partnership will be held on 14 February 2025.

5. Next Steps

5.1 None.

List of appendices

Appendix One – Leading for Sustainability in BLMK Summit Report

Background reading

None

Meeting Title	Trust Board	Date: 09 January 2025
Report Title	**Patient Safety Update**	**Agenda Item Number: 8**
Lead Director	Dr Ian Reckless, Chief Medical Officer	
Report Author	Anna O'Neill, Patient Safety Specialist, Head of Patient Safety and Learning Specialist Dr Anna Costello, Patient Safety Specialist and Patient Safety Doctor	

Introduction	This paper provides Trust Board with an overview of patient safety activity between **01 November 2024 and 31 December 2024**. The paper seeks to familiarise Board members with the new systems and processes in place whilst also providing oversight on the number and nature of the safety incidents reports, and the responses to them.		
Key Messages to Note	1. PSIRF was launched Trustwide on 01 May 2024: a variety of new systems and processes are now in place and embedding. 2. We remain in transition from the previous system – with root cause analysis of serious incidents, and the actions resulting, having a 'long tail' in terms of timescale for formal closure. 3. The incident reporting rate is increasing (an increase being a positive finding). 4. In PSIRF, the role of Trustwide triage (daily) and local patient safety huddles (typically at directorate level, weekly) is pivotal. 5. New significant emerging patient safety themes are described within this paper. 6. An annual / bi-annual report will be produced by the patient safety team detailing patient safety themes, trends and successes from the previous year. It will also identify areas requiring additional focus (future patient safety priorities) and improvement.		
Recommendation	[x] For Information	[ ] For Approval	[ ] For Review

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	1. Keeping you safe in our hospital 2. Improving your experience of care 3. Ensuring you get the most effective treatment 4. Giving you access to timely care
Report History	Last report shared at Public Board on 14 November 2024 (covering time period to 31 October) and discussed at December's QCRC.
Next Steps	

Executive Summary

The Patient Safety Incident Response Framework (PSIRF) was launched across Milton Keynes University Hospital (MKUH) on 01 May 2024, following a period of limited piloting. This paper aims to give a brief overview of the purpose of PSIRF, how this is being implemented at MKUH and recent data: data within the paper covers the period **01 November 2024 to 31 December 2024**. Much of this information has been shared in other forums within the Trust and is shared today for information and feedback from the Board.

Key points:

1. Radar dashboards were launched on 04 November. This offers the long-awaited ability to review incidents and responses to them, drilling into the data by division and department. Initial responses have been very positive.
2. Approximately 400 incidents (since PSIRF launch) have 'overdue workflows' associated with them. This is a 24% reduction since the last Trust board in November 2024. Whilst recognising that timelines for these workflows are internally set, the nature and distribution of these delays is described in this paper. The Radar dashboards described above will enhance visibility of delays and drive completion.
3. Four incidents reported in the time frame have led to a Level 1 Patient Safety Incident Investigation (either a locally led PSII or external investigation). Three of these are maternity related incidents and have been referred for a Maternity and Newborn Safety Investigation (MNSI).
4. A stocktake of 'PSIRF at six months' was completed on 21 November 2024 such that processes can improve iteratively as a result of our experience and learning.

Main Report

Background

PSIRF represents a significant shift in the way the NHS responds to patient safety incidents. It supports Trusts to focus their resource and time into reviewing patient safety incidents where there is an opportunity to learn and to avoid repetition. This requires a considered and proportionate approach to the triage and response to patient safety incidents.

The introduction of PSIRF is a major step to improving patient safety management and will greatly support MKUH to embed the key principles of a patient safety culture which include:

- Using a system-focused approach to learning (The SEIPS model[1], ***Appendix 1***)
- Focusing on continuous learning and improvement
- Promoting supportive, psychologically safe teamwork
- Enabling and empowering speaking up by all

Patient safety incidents reported at MKUH (through our RADAR software system) are reviewed in a **2-stage process**; a daily Trust wide triage panel and weekly locally led patient safety huddles. The two stages allow for both Trust wide and local oversight and learning.

Trust wide triage includes a broad membership with representation from all key clinical areas (including patient safety, corporate nursing, medical, pharmacy, maternity, paediatrics, radiology, pathology, safeguarding). Trust wide triage occurs every working morning such that all incidents should be considered by triage within 72 hours of being reported – usually within 24 hours. Of note, relevant leaders are informed of the incident at the time of reporting through an email cascade appropriate to the geographical area / category of incident. The **local patient safety huddles** (sometimes described as 'local triage') are smaller groups and include representation from patient safety, operations, medical and nursing at either divisional or clinical directorate / clinical service unit (CSU) level. Both panels are responsible for appropriately grading all patient safety incidents using the 4 MKUH response levels *(**Appendix 2**)*. A key role of a local patient safety huddle is to review any level 4 incidents (which require further information over and above that included in the original incident report) and determine an appropriate learning response. In such cases, a rapid review form is completed by the ward/department - this ideally occurs within 7 days of the incident being discussed at daily Trust wide triage. The questions in the form are based on the following national criteria:

i. potential for learning in terms of:
   - enhanced knowledge and understanding
   - improved efficiency and effectiveness
   - opportunity for influence on wider systems improvement
ii. actual and potential impact of outcome of the incident (harm to people, service quality, public confidence, products, funds, etc.)
iii. likelihood of recurrence (including scale, scope and spread)

Based on the rapid review findings, the members of the local patient safety huddle agree to either close the incident on Radar or assign a level 1 or 2 response. For level 1 and 2 responses a learning event will be suggested. The details of the different types of learning

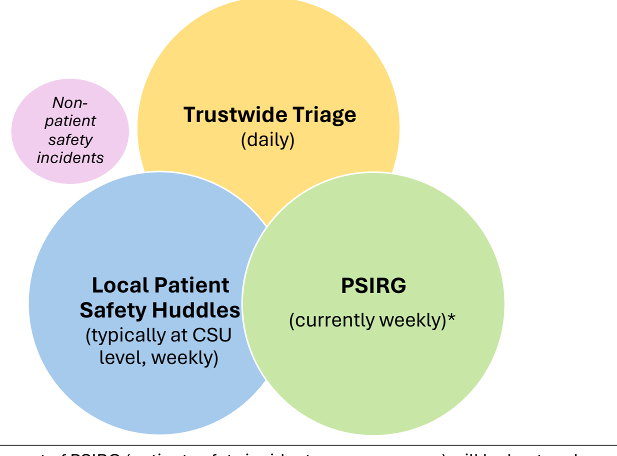
[1] B1465-SEIPS-quick-reference-and-work-system-explorer-v1-FINAL.pdf (england.nhs.uk)

events are described in ***Appendix 3***. Broadly these events have replaced local investigations, 72-hour reports and root cause analysis (RCA).

The Trust wide triage panel formally reports to the Patient Safety Incident Review Group (PSIRG), weekly, and the Patient Safety Board monthly, for oversight. In addition, a daily update is sent to members of the executive group for their information.

Other processes exist for the review of non-patient safety incidents or for patient safety incidents where robust improvement strategies are already in place. Any complaints which may have a significant patient safety component are discussed at Trust wide triage.

Key groups driving triage, understanding and management of reported patient safety incidents



* The frequency and format of PSIRG (patient safety incident response group) will be kept under review as the transition away from historic processes completes and as we optimise our focus on learning.

Outcomes (learning and actions) from learning events are shared in several different forums including local safety huddles, team newsletters, in 'Spotlight on Safety' in the CEO newsletter as well as at the Trust wide learning forums such as PSIRG. Additional forums for sharing learning such as podcasts, drop-in sessions, Schwartz Round [2] style meetings, *lunch and learn* sessions and simulation are being developed and trialed.

Reporting Period (01 November 2024 – 31 December 2024)

Radar Dashboards

Launched on 04 November 2024, the newly developed Radar dashboards offer teams and individuals the opportunity to review and interact with patient safety data. There are 2 dashboards available:

1. *Divisional Dashboards* - provide an overview of all incidents and the ability to filter and interrogate the data by drilling down into PSIRF incidents by division, CSU and department as well as adjusting date periods (see ***Appendix 5*** for snapshots of the Trustwide view of the divisional dashboard). These dashboards will be widely used at Trustwide and CSU meetings.

[2] Schwartz Rounds provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare. For further information Schwartz Rounds - Point of Care Foundation

2. *PSIRF Dashboard* – provides a more detailed overview of the PSIRF incidents, individual workflows, learning outcomes and actions (see ***Appendix 6*** for snapshots of the PSIRF dashboard). This will be predominantly used by the patient safety team.

These interactive dashboards enable teams to discuss their current patient safety data and make any changes or updates live on the system during meetings, whilst also saving time on report writing. Please note the dashboard data is not 'live' but updates every 24 hours.

Key Data

The total number of incidents reported[3] between 01 November 2024 and 31 December 2024 increased to 2226, predominantly due to a rise in reported incidents relating to violence and aggression towards staff. This increase in reporting was also reflected in the number of patient safety incidents (see graph below) which remains significantly above pre-PSIRF levels, suggestive of a positive reporting culture.

The number of incidents with overdue workflows is currently 435, a 24% reduction (from 574) since the last Trust board in November. As anticipated, this reduction is partly due to the addition of more realistic KPIs for timelines relating to the various workflows which were approved at Patient Safety Board in October and added to Radar in November. **It is important to note that there are no national KPIs for PSIRF other than guidance that PSIIs should be completed within 3-6 months.** The KPIs agreed are to provide assurance that progress is being made and learning and action occurs within a timely manner. The patient safety team are continuing to support divisions to clear their backlogs. Women's Health currently has the largest number of overdue incidents but are working as an MDT to overcome this. The planned appointment of a dedicated patient safety and learning lead in women's health will support the PSIRF processes as evidenced in the other three divisions.

The two Radar workflows contributing to the largest number of overdue incidents are the rapid reviews and the local safety huddles (described here as 'local triage').

1. Rapid reviews are required for incidents allocated as 'Level 4 – more information needed'. The process for level 4 more information includes:

[3] Incidents reported through the RADAR system include both patient safety (typically two thirds) and non-patient safety (typically a third) events.

i. Identified at initial Trustwide triage that further information is required in order for an informed decision to be made regarding learning response level.
ii. Local teams (division or CSU) are asked to clarify details and gather further information about the event (as supported by the rapid review form). The expectation is that this is completed ahead of the next weekly local safety huddle.
iii. If more work or time is required to gather the necessary information, it remains on their local task list and therefore will appear as overdue when it exceeds the agreed KPI of 15 working days (currently 176 are overdue and awaiting completion).
iv. Once more information is gathered and the rapid review form complete, the local team will either close the incident, convert it to a level 2 or 3, or ask for consideration of a Level 1 investigation (PSII). All potential PSIIs are discussed at PSIRG on a weekly basis.

2. As described above, the rapid review form needs to be completed ahead of the local safety huddle and therefore is having a knock effect on the number of overdue local safety huddles (currently described as local triage). All CSUs now have established weekly MDT meetings to review their incidents and rapid reviews. This will reduce the current local triage backlog of 167.

Level 1 Patient Safety Incident Investigations (including local PSIIs)

Since 01 November 2024, there have been two level 4 investigations identified (one locally led PSII and three MNSI investigations). One PSII has been completed, quality assured and approved at PSIRG. One is on hold and two are currently overdue. See table below for details.

INC No.	Date declared at PSIRG	Level 1 investigation type	Safety Priority (National & Local)	Description	Progress update
26824	22-Aug-24	PSII	None	Aspiration Pneumonia - Coronial case.	Completed
24659	18-Jun-24	PSII	None	30+5 neonatal death. Intrauterine rupture.	On hold - due to complexities around ongoing coronial process.
25330/ 25342	05-Aug-24	PSII	Local Priority: Deteriorating Surgical Patient	Delay in escalation of deteriorating patient on Ward 20.	Overdue[4] – report in draft. Awaiting actions meetings with wider multidisciplinary team in January.
26540	05-Aug-24	PSII	Local Priority: Delayed Diagnosis	Management of a gynaecological malignancy was neither timely nor appropriate. Typographical error relating to	Overdue[4] – Initial conversations held with both Gynaecology and Radiology teams and system analysis worked through. Now requires action setting meeting with Gynaecology.

[4] Overdue in respect of our local KPI of 3 months (still within the national KPI of 6 months)

				diagnostics contributory.	
30615/ 30590	5-Dec-2024	PSII	Never Event	Replacement of a feeding nasogastric tube (NGT). Position check on chest x-ray interpreted incorrectly and NGT used resulting in patient aspirating.	Uploaded to StEIS. Immediate safety actions taken. PSII underway.
31293	19-Dec-2024	MNSI	National Priority	Term baby required transfer to tertiary centre for cooling and ongoing care.	Awaiting acceptance from MNSI.
31554	Created 26-Dec-2024	MNSI	National Priority	Term intrauterine death	Awaiting consent from family to proceed.
31670	Created 28-Dec-2024	MNSI	National Priority	Term intrauterine death	Awaiting consent from family to proceed.

Themes from reported incidents

Potential themes identified from reported patient safety incidents are actively tracked by the team. An identified theme may lead to specific actions (for example, co-ordination of an MDT meeting to discuss and improve understanding) which may not have been warranted based on a single incident. Identified themes may also assist in the identification of training needs and patient safety priorities for future years (as identified in the annual Quality Account). The table overleaf describes themes which are continuing or newly emerging since 01 November 2024.

Category	Source	Plan / next steps
Discharge summaries – quality of / not being sent / not received by GPs	Incidents	Previous QIP in 2023 – reaudit planned and review to assess sustainability of previous actions. To be linked to discharge medication QIP.
Discharge medications	Incidents	QIP registered and initial data analysis underway. To be linked to discharge summary QIP.
Management of dysphagia – assessment, referral and following care plans	Incidents, Inquest, Safeguarding	QIP now registered and commenced following extensive learning events and reviews.
Violence and aggression towards staff	Incidents	Being managed under Health & Safety.
Delays in the documentation of a speciality review impacting patient flow through the emergency department (ED).	Incidents	Level 2 learning event planned to include ED, staff, general surgeons, trauma & orthopaedics, acute medicine and other sub-specialist teams.

Collaborative working with the clinical skills and simulation team

The patient safety team and the clinical skills and simulation team have started working together on a new approach to learning through simulation. This is a two-pronged approach working both reactively and pro-actively in response to patient safety events and optimising how learning is shared:

- A new clinical simulation learning outcome form has been introduced to capture the rationale for the simulation session, the learning generated and any quality improvement ideas. There are a variety of prompts for clinical simulation including team training requests, post clinical events and awareness days. Up until now, the learning and ideas generated during these sessions the sharing is often limited to the attendees. The hope with the new form is that learning can be shared beyond the session and become part of the patient safety learning platforms.
- Recreation of patient safety incidents using simulation in either the area that the incident occurred or recreated in the simulation wards/suite. The teams held their first planned event in December based on an incident involving a patient with a new hip replacement who sustained a hip dislocation after a controlled slide to the floor and subsequent hoisting off the floor. The scenario was recreated using the specific equipment and key members of the MDT. Key discussions were held around the correct procedure for obtaining appropriate chairs and lifting equipment, where it is stored and who has access during the day/night. Candidates also explored the need for additional staff support during patient falls, having a simple and easily accessible standardised operating procedure and having communication tools, such as graded assertiveness, to support one another to speak up when they have concerns and ideas.

Learning from Patient Safety Incidents

Learning is identified at all stages of the PSIRF process:

1. Daily triage meeting when all patient safety incidents are discussed by experts representing each hospital department.
2. Locally at weekly safety huddles (local triage).
3. Weekly PSIRG meeting where learning is identified and shared.
4. Level 1 & 2 learning events.

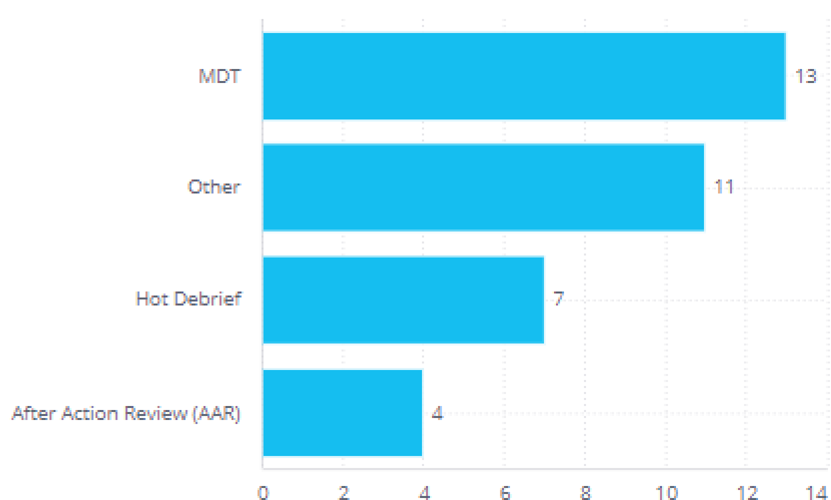
Key learning is recorded on Radar and together with case studies, are shared via the 'Spotlight On Safety' (SOS) message each week and published on the patient safety intranet page. In the past 2 months, we have been considering how best to share learning with teams across the Trust and are appraising various options including WhatsApp and MS Teams (with appropriate safeguards in terms of information governance and security).

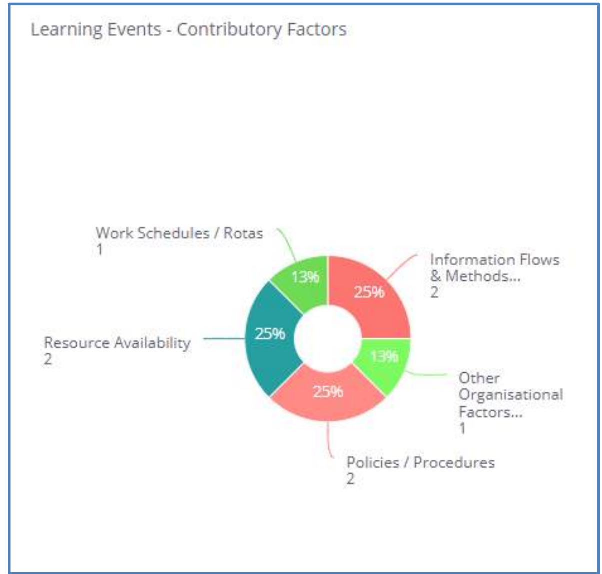
In January monthly patient safety forums commence - a drop-in session for staff to come and hear about patient safety themes, share their experiences and learn from topic experts. The first 4 forums will focus on each of the Trust's patient safety priorities, starting with diabetes management in January.

The patient safety team continues to capture learning using the Mortality and Morbidity (M&M) meeting outcome form. This is a simple Microsoft form that encourages the M&M group to identify examples of care excellence, key learning and potential quality improvement and audit opportunities. An outcome summary is developed monthly and shared across all CSUs and learning platforms for Trust wide learning.

Level 2 Learning Events

Since 01 November 2024, 35 level 2 learning events have been completed. The dashboard screenshots below illustrate the type of learning events being held and the key system factors contributing to our incidents and errors since the PSIRF launch in May 2024.





As can be seen from the charts, we need to improve the recording of ‘contributory factors’ following completion of learning events (these were only provided following a minority of the 35).

A further 99 learning events are planned over the coming 2 months. 92 are currently overdue in accordance with the local KPI of ‘within 60 days’. It is important to recognise that learning events must be facilitated at a time and place that suits the people involved both logistically and emotionally. This requires detailed planning and scheduling to ensure that the right people are able to attend. PSIRF training is continuing to up-skill the ward / department teams to facilitate timely learning events such as hot debriefs and after-action reviews. This should reduce the number of delayed learning events and hence the overdue incidents. MDTs are excellent for high quality thematic learning. Reviewing multiple incidents at one MDT learning event is beneficial in terms of time and expertise but can be more challenging to arrange which can impact the overdue incidents list.

A feedback form has been developed with a variety of feedback methods including satisfaction scales and open questions. Visual inquiry images (**Appendix 7**) are also provided as a well-established appreciative inquiry tool used at MKUH to help explore people’s feelings and thoughts about a specific experience. So far staff completing the form have rated learning events as either ‘good’ or ‘excellent’ and images chosen to describe how the learning events felt for them include:

Below are some quotes from staff explaining why these images were chosen:

It felt like a very supportive environment where we could share our ideas and collaborate with each other.

"I felt supported and listened to."

"I felt I had been brought to light about so many things."

"Thank you for leading this and supporting us to learn from the incident objectively by positive questioning and how we will disseminate this learning."

"As this was the first PSIRF learning event I attended it was nice that it was explained to all staff that attended what it was about and why we do this. Everyone was asked opinions and ideas and it was open and honest. Good outcomes of learning identified with questions generated by discussion and questions asked by PSIRF team."

A 3-month post learning event feedback form has been developed to evaluate the impact of learning events. Questions have been designed to explore how people are feeling about the incident now, whether any positive change has occurred, both personally and in terms of safety culture within their area and whether any safety actions have been completed. Feedback from this form will be shared at the next board meeting.

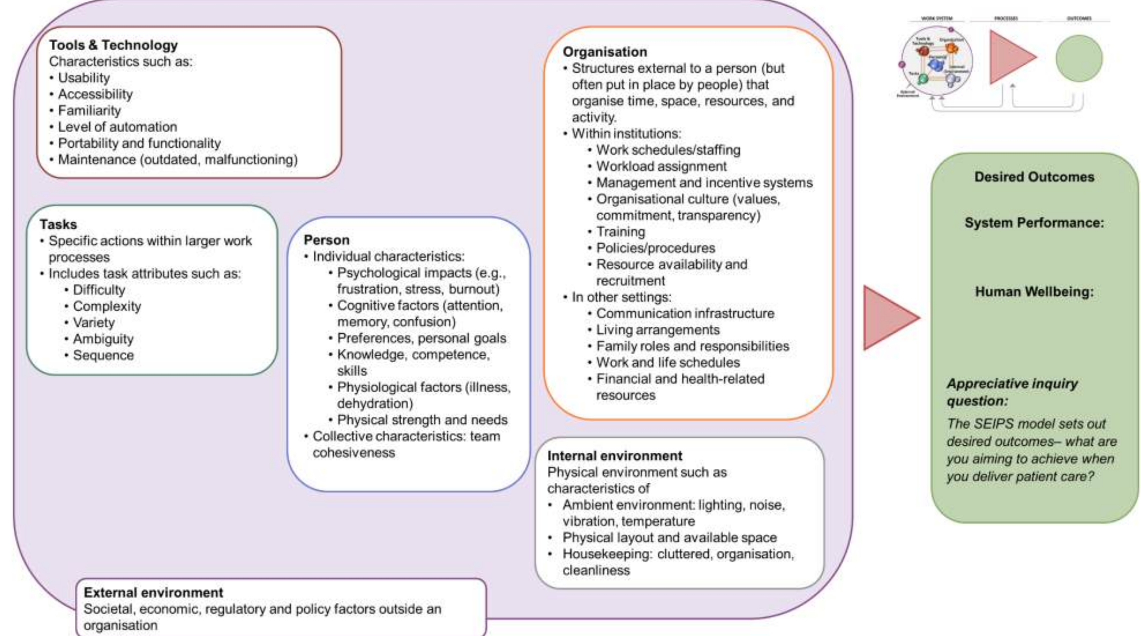
PSIRF 6-month Review

PSIRF reached its six-month milestone on 1st November 2024, and whilst the plan and policy don't require a formal review until at least May 2025, it was felt that a stocktake of our collective early experience of PSIRF would be beneficial. On 21st November, the PSIRG meeting was used to facilitate a learning event where members of the Trustwide triage group and other key stakeholders were invited to share their perspective of what is working well, any challenges and work together to identify any change ideas and improvements in the current processes and workflows. A summary of this review meeting is included in **Appendix 8.**

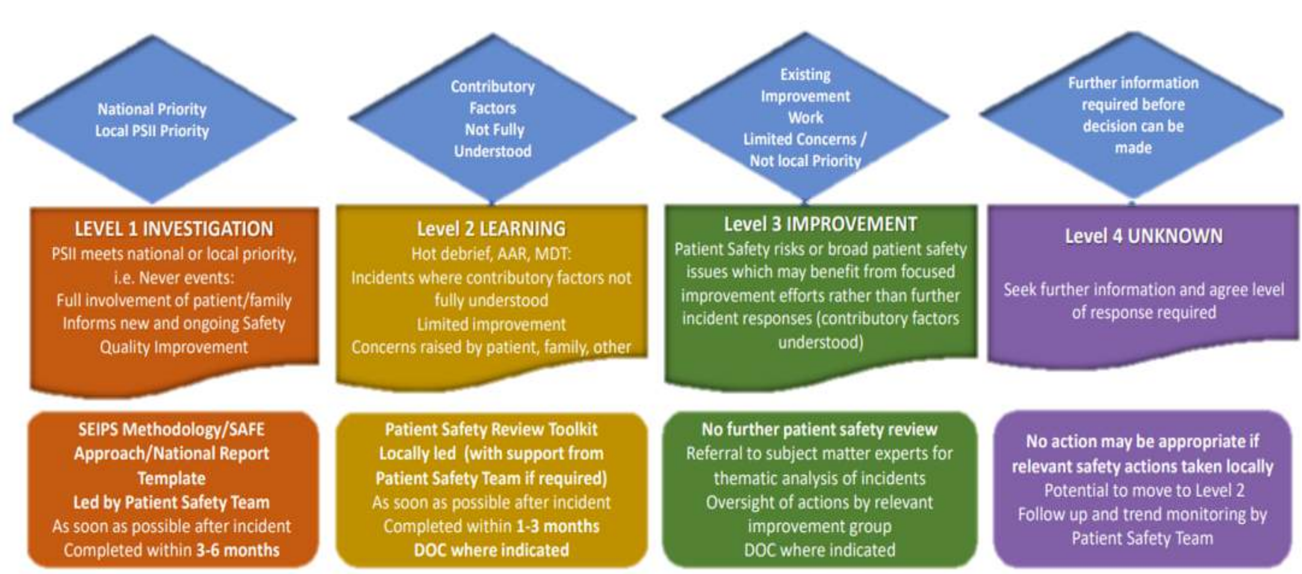
Appendices

Appendix 1 – The SEIPS model

B1465-SEIPS-quick-reference-and-work-system-explorer-v1-FINAL.pdf (england.nhs.uk)



Appendix 2 – Four response levels



Appendix 3: Types of Investigation and Learning Response Types

Response Type	Level	Description
Patient Safety Incident Investigation (PSII)	1	A PSII offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how. These are led by the central patient safety team to ensure standardisation of high-quality system focused reports in collaboration with experts in the relevant fields.
Hot Debrief	2	A psychologically safe meeting with those involved to summarise a critical event, hear from those affected and identify immediate learning. These are locally led events by skilled facilitators.
After Action Review (AAR)	2	AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the those involved and can be used to discuss both positive outcomes as well as incidents.
Multidisciplinary Team review (MDT)	2	An MDT review supports care teams to learn from patient safety incidents that have occurred. the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion, systems analysis and other techniques to understand 'work as done', to agree the key contributory factors and system gaps that impact on safe patient care. These can be useful to learn from clusters of similar events.
Learning and Innovation From Events (LIFE) session	2	LIFE sessions aim to take stories/accounts from everyday events and incidents and promote discussions that help people to use these stories/accounts as a prompt to collaboratively talk about what stood out for them, what there is to celebrate, what we are curious about and what are the ideals and practical ideas that can be taken forward to benefit those who live, work in or visit the care setting. LIFE sessions adopt a relational approach to learning and improvement, as they create space for multiple perspectives to be heard. LIFE sessions can be used to discuss stories/accounts from patients, family members or staff.
Rapid Review	4	A simple locally led review based upon national criteria. This determines whether the incident requires a level 1 or 2 learning response or can be closed. These are reviewed weekly at the local triage meetings.

Other level 2 response types can be considered such as audit, tabletop exercises, observational studies, and local learning forums.

Appendix 4 – MKUH Patient Safety Priorities

Sepsis in the Emergency Department	Delay, or failure, to recognise and manage any adult patient presenting to the Emergency Department with signs of sepsis.
Surgical Inpatients	Delay, or failure, to recognise the deteriorating surgical patient resulting in: • Change of lead speciality team • Unexpected further surgery • Unplanned admission to ICU • Death Adult patients under surgical specialities or inpatients on wards 20, 21, 23 or 24.
Diagnostics Delays	Incidents relating to diagnosis, specifically delay or failure to follow up on abnormal scan/test results resulting in: • Unexpected progression or worsening of disease • Delay in surgical intervention • Need for additional tests or procedure
Inpatient Diabetes	Incidents relating to the prescribing and administration of insulin resulting in a patient's blood glucose of >20 mmol/l (on two consecutive readings) or < 4 mmol/l. Adult patient under acute medical care (ED, Ward 1 and ward 2)

Appendix 5 – Examples of Trustwide Overview of Divisional Dashboard (data from 01 May 2024 – 31 October 2024)

Total Incidents
5,934

Non-Patient Safety Incidents - Click for Dashboard
959

Pressure Ulcers - Click for Dashboard
800

Moisture Lesions - Click for Dashboard
776

% of incidents categorised as moderate harm following discussion at initial triage. The harm level is reviewed by the triage panel and adjusted accordingly. The level can be further adjusted once further information is gathered as part of the rapid review

'Open' incidents refer to incidents that have workflows complete or pending but not yet overdue

'Click for dashboard' takes the user to an additional dashboard with more detailed data on the metric

REPORTING TREND | CATEGORY (T20) | SEVERITY | SEVERITY GROWTH | SEVERITY % | NO HARM TREND

Can swap between these graphs

Total Incidents Reported Per Month by Severity

PSIRF Incidents by Level - Following Initial Triage Meeting

PSIRF Incidents by Level - Following Local Triage Meeting

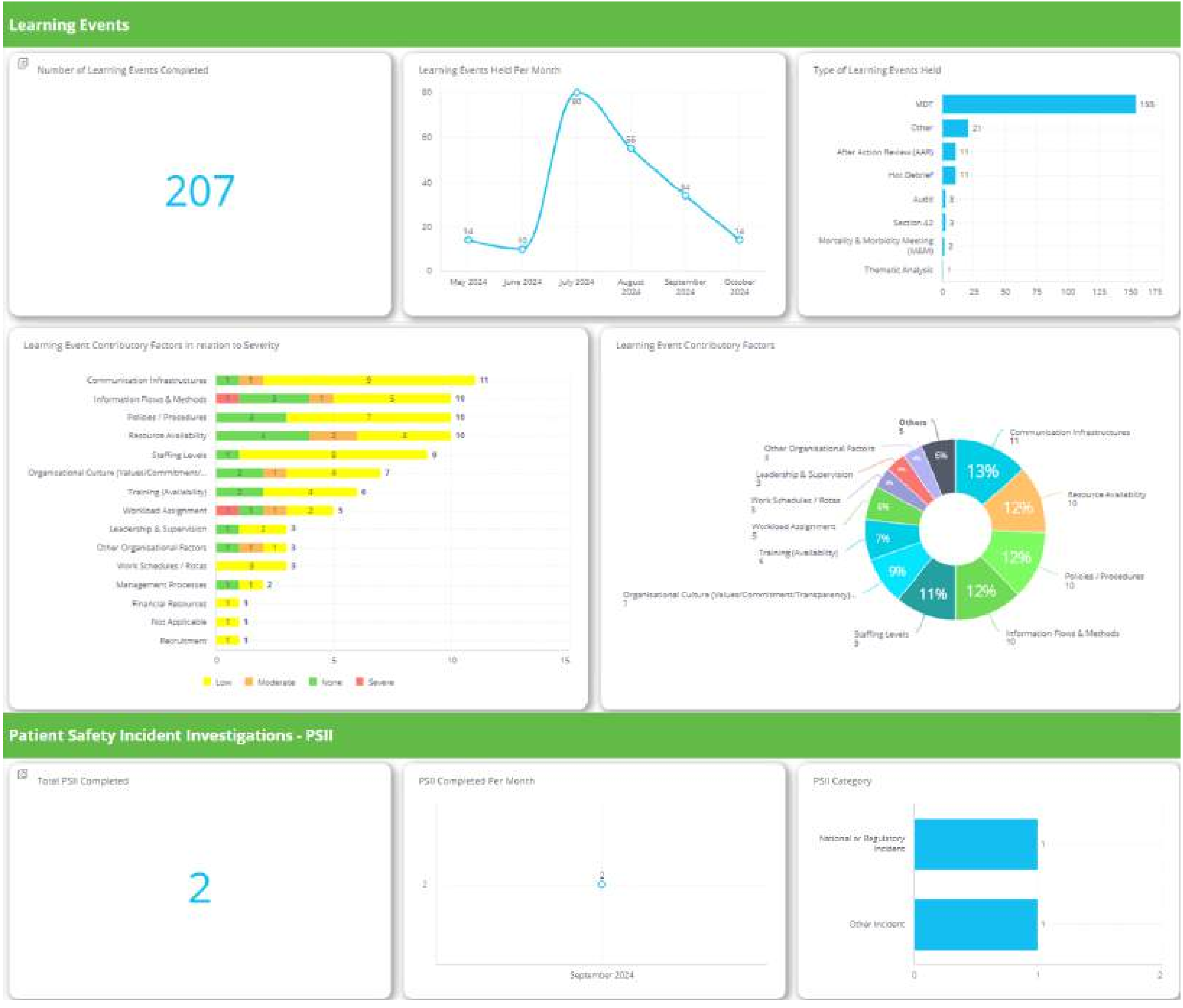
Incidents Reported By CSU/Corporate Department

Incidents Reported By Area

Incidents Reported by Category

Incidents Reported By Sub Category

Milton Keynes University Hospital
NHS Foundation Trust



Appendix 6 – Examples of PSIRF Dashboard (data from 01 May 2024 – 31 October 2024)

PSIRF Incidents by Level at Initial Triage

PSIRF Incidents by Level at Local Triage

Response Types Allocated

PSIRF Incidents by Category

PSIRF Incidents by Sub Category

% Learning Events Completed

58.08%

Learning Events Scheduled Per Month

Learning Events - Contributory Factors

Learning Event Contributory Factors

Communication Infrastructures

Information Flows & Methods

Policies / Procedures

Staffing Levels

Resource Availability

Appendix 7 – Visual Inquiry Images

6. Choose an image that best portrays how being part of the learning event/workshop/training made YOU feel? *

- ◯ Option 2
- ◯ Option 3
- ◯ Option 4
- ◯ Option 1
- ◯ Option 5
- ◯ Option 6
- ◯ Option 7
- ◯ Option 8

Appendix 8 – PSIRF 6-month review summary

PSIRF @ 6 MONTHS

WHAT'S WORKING WELL?

- Trust wide triage
- System improvements
- Staff feedback
- Engagement in learning

1

CHALLENGES

2

- RADAR
- Learning events
- Triage processes
- Medical engagement
- Inconsistent reporting

WHAT CAN WE DO MORE OF?

- Sharing Learning

3

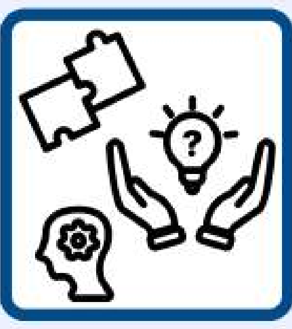
WHAT SHALL WE DO LESS OF?

- Duplication
- Level 4:more info

RECOMMENDATIONS

- Training
- Learning event outcomes
- Sharing & measure impact
- Triangulation
- Culture shift

5



WHAT NEXT?

- New learning forums
- Supportive sessions with RADAR
- Alignment in focussed departments
- Closing incidents with actions

Meeting Title	Trust Board in Public	Date: 9th January 2024
Report Title	Maternity and Neonatal Incentive Scheme for Trusts (MIS) sign off	Agenda item Number: 9
Lead Director	Fiona Hoskins- Chief Nursing Officer	
Report Author	Elaine Gilbert- Divisional Chief Midwife / Jasmine Cajee- Compliance, Assurance Lead Midwife	

Introduction	The MIS presentation and declaration form have been submitted to Trust Board as part of the sign-off process for MIS Year 6. The presentation details the expected compliance for each safety action, this is supported by evidence files (MS Teams folder access shared). The purpose of this paper is for board agreement and sign off, based on the evidence and detailed compliance. The CEO is required to discuss compliance with the ICB AO. The CEO and AO both are required to sign the Board Declaration form. The evidence has been submitted to the LMNS at regular intervals for oversight, discussion and compliance. LMNS final submission of Q3 evidence is 13/01/2025 and review and sign off meeting planned for 07/02/205		
Key Messages to Note	MIS compliance is currently as detailed below: Safety Action 1 – Compliant Safety Action 2 – Compliant Safety Action 3 – Compliant Safety Action 4 – Compliant *with action plan in place for BAPM National Standards of Nursing Workforce. Safety Action 5 –Complaint Safety Action 6 – Compliant *awaiting confirmation from LMNS Safety Action 7 – Compliant Safety Action 8 – Compliant *SBL E-learning for new medical staff- action plan under development for staff to complete prior to timeframe of 6 months for 'new starters' Safety Action 9 – Compliant Safety Action 10 – Compliant		
Recommendation (*Tick relevant box(es)*)	For Information	For approval x	For review
Strategic Objectives Links (Please delete the objectives that are not relevant to the report	1. Keeping you safe in our hospital 2. Improving your experience of care 3. Ensuring you get the most effective treatment 4. Giving you access to timely care 5. Working with partners in MK to improve everyone's health and care 6. Spending money well on the care you receive		
Report History			
Next Steps	– Trust Board sign off MIS – Trust Board Declaration Form – LMNS sign-off - Submission of completed Board declaration form to NHS Resolution by 12 noon on 3rd March 2025		
Appendices / Attachments	– MIS Year 6 Trust Board Presentation – Trust Board Declaration Form		

Maternity Incentive Scheme (MIS) Year 6

Overall compliance to 10 safety actions CNST Year 6

Anticipated compliance to 10 Safety Actions CNST Year 6		
1	Perinatal review tool	
2	MSDS	
3	ATAIN	
4	Medical Workforce	*BAPM National standards of Nursing staff (gaps in compliance)- action plan in place and shared in appropriate forum as per MIS requirement
5	Midwifery Workforce	
6	SBLCB V3	*Awaiting confirmation from LMNS
7	Patient Feedback	
8	Multi-professional training	* SBL e-learning for New medical staff action plan under development and plan to complete prior to timeframe of 6 months.
9	Safety Champions	
10	Early notification scheme (HSIB)	

TheMKWay

Safety action 1:
Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?

Safety action Lead(s):
Lila Ravel/ Tracy Rea

Link to SA1 Guidance

Reporting period: 8 December 2023 until 30 November 2024

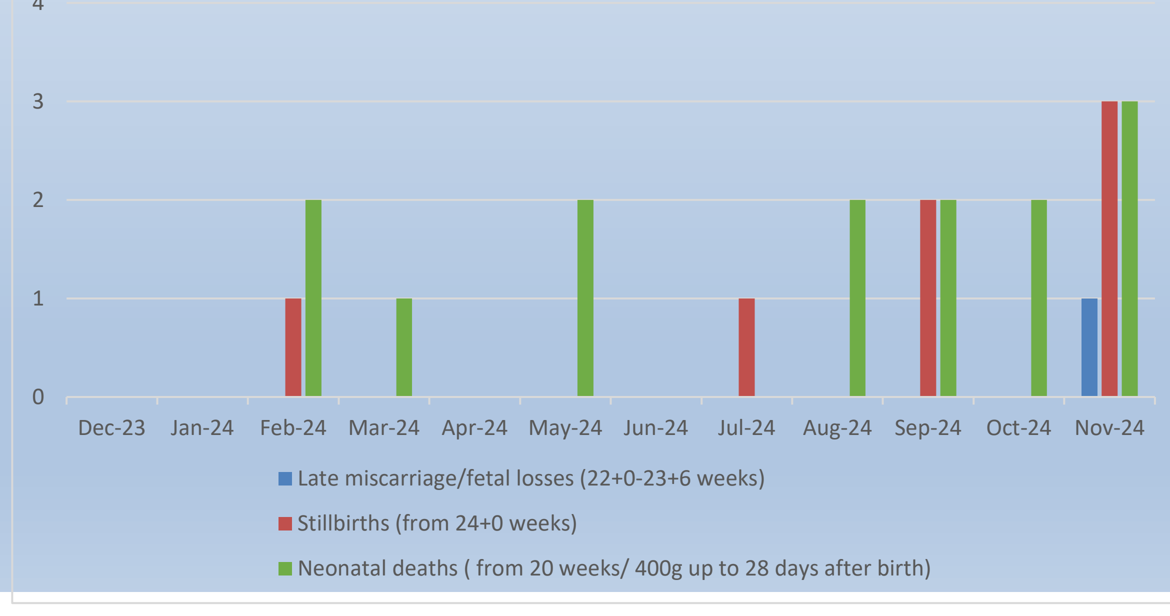
	Requirement	Lead	Actions/progress	Next update due	Compliance status
1.1	Have all eligible perinatal deaths from 8 December 2023 onwards been notified to MBRRACE-UK within seven working days?	LR/TR	23 notifications -5 from other providers therefore 18. All 18 notified within 7 working days so 100% compliance		
1.2	For at least 95% of all deaths of babies who died in your Trust from 8 December 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?	LR/TR	100% parents perspective sought		
1.3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 8 December 2023 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	LR/TR	**from 02/04/2024** 12 Cases meeting criteria for PMRT from 2/4/24. 3 shared PMRT with other Trusts. All PMRT review opened within 2 months. 100%. Confirmation- No cases between April and May 2024		
1.4	Were 60% of the reports published within 6 months of death?	LR/TR	**From 2/4/24 :** 12 Cases meeting critera. 100% compliance to date. 1 case expected to breach 6 months on 21/11 due to Inquest.		
1.5	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 8 December 2023 including reviews and consequent action plans.	LR/TR			
1.6	Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?	LR/TR			

SAFETY ACTION 1- COMPLIANT

Safety Action 1- PMRT

Safety action - 1

Have all eligible perinatal deaths from 8 December 2023 onwards been notified to MBRRACE-UK within seven working days?	For at least 95% of all deaths of babies who died in your Trust from 8 December 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?	"Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 2nd of April 24 been started within two months of each death? This includes deaths after home births where care was provided by your Trust. "	Were 60% of the reports published within 6 months of death from the 2nd of April 24?
21 from 8/12/2023 – 100% compliance	100%	100% - 17 Cases ,meeting PMRT criteria. 100% compliance to date. 3 Shared PMRT with other Trusts. All PMRT reviews opened within 2 months	50 %- 2 cases > 6 months with one breaching due to ongoing inquest



Themes within PMRT

- Preterm births
- Recognition of infection/chorioamnionitis

Deaths reported to MBRRACE-UK since 1 January 2013 are:

Late fetal losses – the baby is born at 22 or 23 completed weeks' gestation showing no signs of life, irrespective of when the death occurred.
Stillbirths – the baby is born from 24 completed weeks' gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred.
Neonatal deaths – the death of a live born baby born from 20 completed weeks' gestation (or from 400g where an accurate estimate of gestation is not available) occurring before 28 completed days after birth.
Terminations of pregnancy resulting in a registered stillbirth (from 24 completed weeks' gestation) or neonatal death (from 20 completed weeks' gestation) are also notified in order to exclude these cases from MBRRACE-UK reported statistics on perinatal mortality.

Safety action 2:
Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

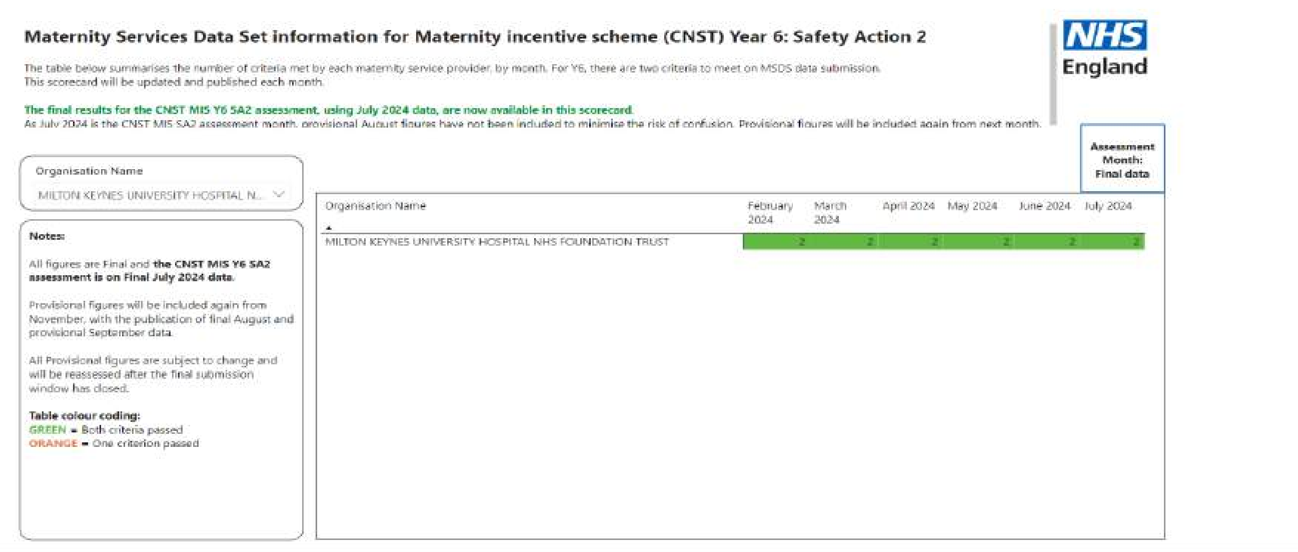
Safety action Lead(s):
Laura Crump/ Lisa Calvert

Link to SA2 Guidance

Reporting period: 2 April 2024 until 30 November 2024

	Requirement	Lead	Actions/progress	Update due	Compliance status
2.1	Was your Trust compliant with at least 10 out of 11 MSDS-only Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024? Final data for July 2024 will be published during October 2024.				
2.2	Did July's 2024 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)				

SAFETY ACTION 2- COMPLIANT



Maternity Services Data Set information for Maternity incentive scheme (CNST) Year 6: Safety Action 2

NHS England

The table below summarises the number of criteria met by each maternity service provider, by month. For Y6, there are two criteria to meet on MSDS data submission.
This scorecard will be updated and published each month.

The final results for the CNST MIS Y6 SA2 assessment, using July 2024 data, are now available in this scorecard.
As July 2024 is the CNST MIS SA2 assessment month, provisional August figures have not been included to minimise the risk of confusion. Provisional figures will be included again from next month.

Organisation Name: MILTON KEYNES UNIVERSITY HOSPITAL N...

Notes:

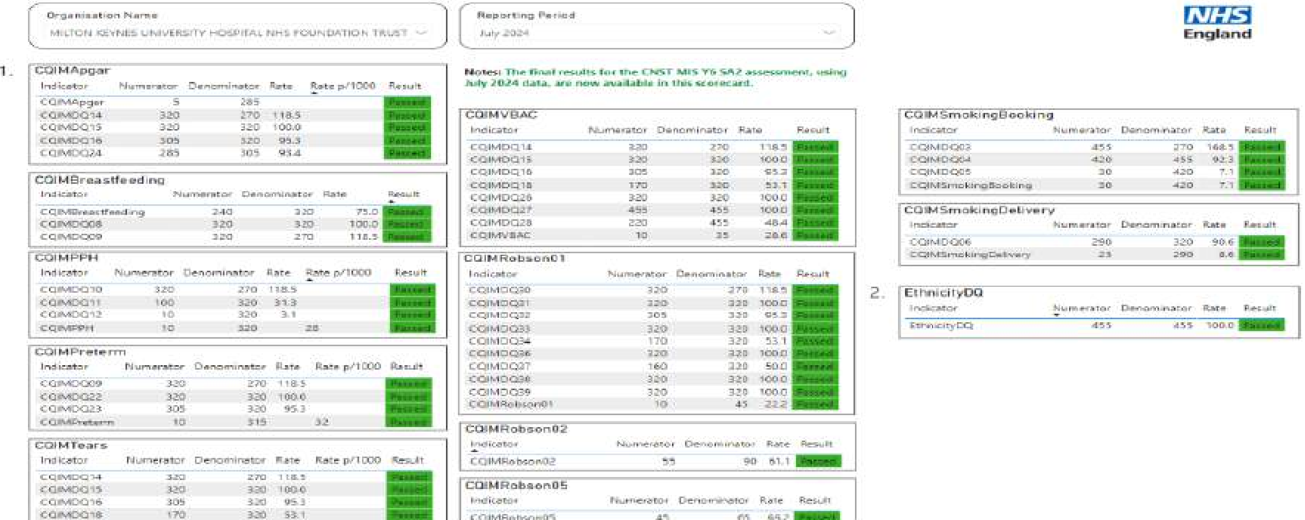
All figures are Final and **the CNST MIS Y6 SA2 assessment is on Final July 2024 data.**

Provisional figures will be included again from November, with the publication of final August and provisional September data.

All Provisional figures are subject to change and will be reassessed after the final submission window has closed.

Table colour coding:
GREEN = Both criteria passed
ORANGE = One criterion passed

Organisation Name	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024 (Assessment Month: Final data)
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	2	2	2	2	2	2



Organisation Name: MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST

Reporting Period: July 2024

NHS England

Notes: The final results for the CNST MIS Y6 SA2 assessment, using July 2024 data, are now available in this scorecard.

1.

CQIMApgar

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMApgar	5	285			Passed
CQIMDQ14	320	270	118.5		Passed
CQIMDQ15	320	320	100.0		Passed
CQIMDQ16	305	320	95.3		Passed
CQIMDQ24	285	305	93.4		Passed

CQIMBreastfeeding

Indicator	Numerator	Denominator	Rate	Result
CQIMBreastfeeding	240	320	75.0	Passed
CQIMDQ08	320	320	100.0	Passed
CQIMDQ09	320	270	118.5	Passed

CQIMPPH

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ10	320	270	118.5		Passed
CQIMDQ11	100	320	31.3		Passed
CQIMDQ12	10	320	3.1		Passed
CQIMPPH	10	320		28	Passed

CQIMPreterm

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ09	320	270	118.5		Passed
CQIMDQ22	320	320	100.0		Passed
CQIMDQ23	305	320	95.3		Passed
CQIMPreterm	10	315		32	Passed

CQIMTears

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	320	270	118.5		Passed
CQIMDQ15	320	320	100.0		Passed
CQIMDQ16	305	320	95.3		Passed
CQIMDQ18	170	320	53.1		Passed
CQIMDQ20	5	165	3.0		Passed
CQIMTears	5	165			Passed

CQIMVBAC

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ14	320	270	118.5	Passed
CQIMDQ15	320	320	100.0	Passed
CQIMDQ16	305	320	95.3	Passed
CQIMDQ18	170	320	53.1	Passed
CQIMDQ26	320	320	100.0	Passed
CQIMDQ27	455	455	100.0	Passed
CQIMDQ28	220	455	48.4	Passed
CQIMVBAC	10	35	28.6	Passed

CQIMRobson01

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ30	320	270	118.5	Passed
CQIMDQ31	320	320	100.0	Passed
CQIMDQ32	305	320	95.3	Passed
CQIMDQ33	320	320	100.0	Passed
CQIMDQ34	170	320	53.1	Passed
CQIMDQ36	320	320	100.0	Passed
CQIMDQ37	160	320	50.0	Passed
CQIMDQ38	320	320	100.0	Passed
CQIMDQ39	320	320	100.0	Passed
CQIMRobson01	10	45	22.2	Passed

CQIMRobson02

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson02	55	90	61.1	Passed

CQIMRobson05

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson05	45	65	69.2	Passed

CQIMSmokingBooking

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ03	455	270	168.5	Passed
CQIMDQ04	420	455	92.3	Passed
CQIMDQ05	30	420	7.1	Passed
CQIMSmokingBooking	30	420	7.1	Passed

CQIMSmokingDelivery

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ06	290	320	90.6	Passed
CQIMSmokingDelivery	25	290	8.6	Passed

2.

EthnicityDQ

Indicator	Numerator	Denominator	Rate	Result
EthnicityDQ	455	455	100.0	Passed

Safety action 3:
Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?

Safety action Lead(s):

Claire Danobrega/ Sophie Coetzee

Reporting period: 2 April 2024 until 30 November 2024

	Requirement	Lead	Actions/progress	Update due	Compliance status
3.1	Was the pathway(s) of care into transitional care which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies? **Evidence should include:** - Neonatal involvement in care planning - Admission criteria meets a minimum of at least one element of HRG XA04 - There is an explicit staffing model - The policy is signed by maternity/neonatal clinical leads and should have auditable standards. - The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.	N/A	N/A	N/A	
3.2	**Or** Is there an action plan signed off by Trust and LMNS Board for a move towards the TC pathway (as above) based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 5.	CN, CD, DG	QI Project in place		
Drawing on insights from themes identified from any term admissions to the NNU, undertake at least one quality improvement initiative to					
3.3	By 6 months into MIS year 6, register the QI project with local Trust quality/service improvement team.		TC registered as a QI project with local trust QI services, under Neonatal Unit with Maternity input		
3.4	By the end of the reporting period, present an update to the LMNS and safety champions regarding development and any progress.				

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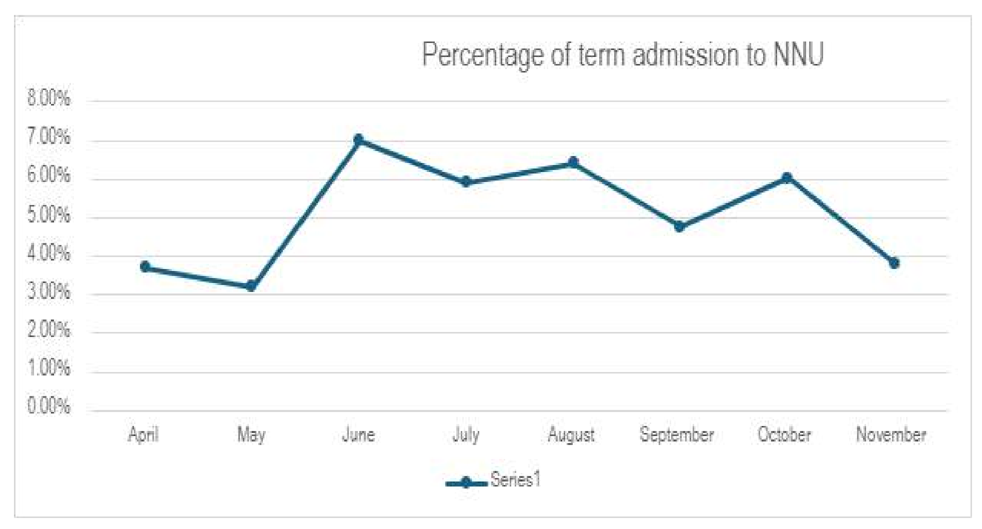
SAFETY ACTION 3- COMPLIANT

Safety Action 3- Transitional Care



November 2024:

Number of admissions for the month – 12
Number of babies born - 311
Number of babies meeting criteria for inclusion – 308

Percentage of babies admitted to NNU – 3.8% (Previous Month 6.02%)
Number of Avoidable admissions – 7 (2.2%)
Number of Unavoidable admissions – 5 (1.6%)

Of the admissions 58% of them were avoidable and 41.6% were unavoidable

4 cases (57% of the total avoidable cases) were avoidable because they could have been cared for in a Transitional Care

- TC pathway audited monthly & reported through CSU
- All term admissions to NNU recorded on Badgernet
- Monthly audits collect TC activity
- Weekly ATAIN review meetings
- Live ATAIN action plan & TC action plan in place
- Progress with ATAIN action pan shared through MAG & the maternity improvement workplan

	Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Safety action Lead(s):

Nandini Gupta/ Katy Philpott

Reporting period: 2 April 2024 until 30 November 2024

	Requirement	Lead	Actions/progress	Update due	Compliance status
Obstetric Workforce					
Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gyna					
4.1	Locum currently works in their unit on the tier 2 or 3 rota?				
4.2	OR They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual review of Competency Progrssion (ARCP)?				
4.3	OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?				
Has the Trust ensured that the following criteria are met for employing long-term locum doctors in Obstetrics and Gynaecology.					
4.4	Implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance?	NS			
RCOG compensatory rest (not reportable in MIS year 6)					
4.5	Has the Trust implemented RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day, and can the service provide assurance that they have evidence of compliance?	NS	SAS Doctors on full-shift pattern		
4.6	OR Has an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings?	N/A	N/A	N/A	
Consultant Attendance					
4.7	Has the Trust monitored their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service when a consultant is required to attend in person?		Audit		
4.8	Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance?				
4.9	Do you have evidence that the Trust position with the above has been shared with Trust Board?				
4.10	Do you have evidence that the Trust position with the above has been shared with Board level Safety Champions?				
4.11	Do you have evidence that the Trust position with the above has been shared with the LMNS?				

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SAFETY ACTION 4- COMPLIANT

NHS
Milton Keynes University Hospital
NHS Foundation Trust

Anaesthetic Workforce					
4.12	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) - Representative month rota acceptable.				
Neonatal Medical Workforce					
4.13	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing?	LA	Tier 1, 2 3 Evidence		
4.14	Is this formally recorded in Trust Board minutes?	LA	Yes- 24/10/24 meeting		
4.15	If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies.	N/A	N/A	N/A	
4.16	Was the above action plan shared with the LMNS?	LA			
4.17	Was the above action plan shared with the ODN?	LA			
Neonatal Nursing Workforce					
4.18	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing?	CN	There are gaps in compliance with BAPM within the neonatal nursing workforce. There is an action plan which has been developed and presented at MAG.		
4.19	Is this formally recorded in Trust Board minutes?	CN	Action plan presented at MAG.		
4.20	If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies.	CN	CN update action plan and share with LMNS		
4.21	Was the above action plan shared with the LMNS?	CN	Summary paper of action plan to be shared with LMNS		
4.22	Was the above action plan shared with the ODN?	CN	CD chase re: evidence email trail for ODN meeting		

SAFETY ACTION 4- COMPLIANT

Safety Action 4- Can you demonstrate an effective system of clinical workforce planning to the required standard ?

- Obstetric Medical Workforce staffing update to MAG- addressing and meeting all the requirements of MIS Year 6.
- Anaesthetic workforce- evidence of 24-hour availability for Obstetric Unit cover. SOP under review as per local process (review due Oct 2024). Being brought to January 2025 Guidelines meeting for sign-off. Present process covers requirements of MIS and evidence shared in form of duty rotas.
- Neonatal Medical workforce update to MAG in October 2024- addressing and meeting all requirements of MIS Year 6.
- Neonatal Nursing workforce- BAPM National standards of Nursing staff (gaps in compliance)- action plan in place clearly sharing gaps in compliance and planned actions with timeframes. This has been shared in appropriate forums as per MIS requirement.

Safety action 5:
Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Safety action Lead(s):
Elaine/ Roxy

Reporting period: 2 April 2024 until 30 November 2024

	Requirement	Lead	Actions/progress	Update due	Compliance status
5.1	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period. It should also include an update on all of the points below.				
5.2	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? Evidence should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.				
5.3	Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated? Evidence should include: • Midwifery staffing recommendations from Ockenden and of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. • Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. • Where deficits in staffing levels have been identified must be shared with the local commissioners. • Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall. • The midwife to birth ratio • The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.				
5.4	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty at the start of every shift.				
5.5	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with the provision of one-to-one care in active labour				
5.6	A plan is in place for mitigation/escalation to cover any shortfalls in the two points above.				

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SAFETY ACTION 5- COMPLIANT

Safety Action 5- Can you demonstrate an effective system of midwifery workforce planning to the required standard.

Midwifery Safe Staffing

NHS Resolutions compliance – Safety action 5	
Calculation of Midwifery Staffing Requirements	Birth Rate Plus
Labour Ward Co-ordinator Supernumerary Status	October 2024: 100% (MIS compliant – Rostered Supernumerary for each shift, supernumerary status at the start of the shift)
1:1 Care in Labour	October 2024: 100% data reviewed : RF10 Exception: Data entry error on 16th Oct 2024. LWC confirms was not providing 1:1 care
Midwife to Birth Ratio Planned / Actual	October 2024: 1:24 / 1:32
Consultant Attendance for Listed RCOG Clinical Situations	October 2024: 100%
Staffing Paper	Submitted Apr 24 – BR+ Commenced Oct 2024
Planned Vs Actual Midwifery Staffing (Fill Rate)	79.90% Across service – roster rebuild impacting fill rate due to increased number of shift . Increased staffing across service in line with roster rebuild.
Specialist Midwife %	10%
Mitigations for Staffing Shortfalls	Maternity escalation procedure, midwifery staffing business contingency plan

- Six monthly staffing paper submitted to MAG and Trust Board April and October 2024 to provide oversight on staffing/safety issues.
- Birthrate plus report from 2022.
- Refreshed Birthrate commissioned (as per MIS recommendations)- commenced October 2024.
- Roster rebuild and establishment review has improved staffing across service.
- Budget alignment has been sent for review.
- Regular Midwifery Workforce update via MAG outlining Midwifery Safe Staffing (as opposite).
- Compliance with Supernumerary Labour ward coordinator at commencement of shift and 1:1 care in labour- reported monthly though governance report and monitored daily via Maternity Safety Huddles.

Safety action 6:
Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

Safety action Lead(s):

Jasmine, Deanna & Maternity Matrons

Reporting period: 2 April 2024 until 30 November 2024

	Requirement	Lead	Actions/progress	Update due	Compliance status
6.1	Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3 is fully in place or will be in place, and can you evidence that the Trust Board have oversight of this assessment? (where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory.)				
6.2	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 5, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 6 to track compliance with the care bundle? **These meetings must include agreement of a local improvement trajectory against these metrics for 24/25, and subsequently reviews of progress against the trajectory.**				
6.3	Have these quarterly meetings included details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.				
6.4	Is there a regular review of local themes and trends with regard to potential harms in each of the six elements.				
6.5	**Following these meetings, has the LMNS determined that sufficient progress have been made towards implementing SBLCBv3, in line with a locally agreed improvement trajectory?**				
6.6	Is there evidence of sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate?				

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SAFETY ACTION 6- COMPLIANT

Safety Action 6- Compliance with all elements of Saving Babies Lives Care Bundle Version 3 (SBLCB v3)

- Working towards local and nationally set targets for all elements of SBLCB V3.
- Where compliance has not met set targets- action plans devised with anticipated timelines for achieving improvements/actions that have been identified.
- Two meetings with LMNS during 24/25.
- Fifty audits across all six elements.
- Regular review of local themes and trends across the six elements with regards to potential harm, through rolling audits, RADAR and scheduling MDT meetings where required to address any specific concerns/trends/ areas for improvement.
- Quarter 3 review planned for 17/01/2025 with evidence upload to NHS Futures platform by 10/01/2024.

Safety action 7:
Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

Safety action Lead(s):

MNVP- Elaine

Reporting period: 2 April 2024 until 30 November 2024

	Requirement	Lead	Actions/progress	Update due	Compliance status
7.1	Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.				
7.2	Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a member (Trusts should work towards the MNVP Lead being a quorate member), such as: • Safety champion meetings • Maternity business and governance • Neonatal business and governance • PMRT review meeting • Patient safety meeting • Guideline committee		Guidelines meetings/documents- MNVP have access to the MS Teams channel, they are invited to the meetings and they have engaged with some of these meetings. Also any documents that are circulated within Maternity for review or input are also shared with our MNVP colleagues for their input.		
7.3	Evidence of MNVP infrastructure being in place from your LMNS/ICB, such as: • Job description for MNVP Lead • Contracts for service or grant agreements • Budget with allocated funds for IT, comms, engagement, training and administrative support • Local service user volunteer expenses policy including out of pocket expenses and childcare cost	LMNS to provide	LMNS to provide	LMNS to provide	
7.4	**If evidence of funding support at expected level (as above) is not obtainable, there should be evidence that this has been formally raised via the Perinatal Quality Surveillance Model (PQSM) at Trust and LMNS level, and discussed at ICB Quality Committee as a safety concern due to the importance of hearing the voices of women and families, including the plan for how it will be addressed in response to that escalation is required.**	N/A	N/A	N/A	
7.5	Evidence of a joint review of annual CQC Maternity Survey data, such as documentation of actions arising from CQC survey and free text analysis **(if available)**, such as a coproduced action plan.				
7.6	Has progress on the coproduced action above been shared with Safety Champions?				
7.7	Has progress on the coproduced action above been shared with the LMNS?				

SAFETY ACTION 7- COMPLIANT

Safety Action 7- Listen to women, parents and families using maternity and neonatal services and co-produce services with users.

- Established Maternity and Neonatal Voices Partnership (MNVP)- quarterly meetings.
- Terms of Reference for Trust safety and governance meetings evidencing MNVP Lead as a member of these meetings.
- The annual work plan for the MKUH MNVP 2024/2025 has been agreed at ICB / LMNS level. The workplan identifies the LMNS /Trust/regional and neonatal commitments, focusing on 5 themes within the action plan which are:
  - 1. Postnatal Care
  - 2.Voices Heard
  - 3. Infant Feeding
  - 4. Accessing help
  - 5. Neonatal Focus
- The Workplan is focused on areas identified within CQC survey, themes, and areas identified with clinical incidents, complaints, and service user feedback. As well as national / local work around EDI (Equality, Diversity, and Inclusivity).
- Engagement with Senior Maternity Team to review annual CQC Maternity Survey data and to co-produce any identified actions going forward.
- Engagement from MNVP with Maternity Service User Experience Review Group (bi-monthly meetings).

Safety action 8:
Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

Safety action Lead(s):
Lila R, Jodie Bonsell, R Hobbs/ R Juffs/ N Fairgrieve/ K Evans

Link to SA8 Guidance

Reporting period: 1 December 2023 until 30 November 2024

	Requirement	Lead	Actions/progress	Update due	Compliance status
Can you demonstrate the following attendance at the end of the 12 month period 1 December 2023 to 30th November 2024:					
Fetal monitoring and surveillance (in the antenatal and intrapartum period) training					
8.1	90% of obstetric consultants		yes, 92% 24.10.24 further update - 85% 20/11/2024 further update- 100% compliance 18/12/2024		
8.2	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2024) contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)		100% of all other doctors (prior to July 2024) 24.10.24 Remains the same 20/11/2024 Further update- 100% compliance 18/12/2024		
8.3	For rotational medical staff that commenced work on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?		currently 31% plan in place for attendance within 6 months of their start date 24.10.24 20/11/2024 88% compliance. Further update- 94% compliance 18/12/2024		
8.4	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and maternity theatre midwives who also work outside of theatres		Yes, 97% 24.10.24 93% 20/11/2024 92% 18/12/2024		

Maternity emergencies and multiprofessional training					
8.5	90% of obstetric consultants				
8.6	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2024) including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows,foundation year doctors and GP trainees contributing to the obstetric rota		89% of all other doctors (prior to July 2024) 24.10.24 Remains the same 20/11/2024 Further update- 100% compliance 18/12/2024		
8.7	For rotational obstetric staff that commenced work on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?		currently 58% plan in place for attendance within 6 months from their start date 24.10.24 20/11/2024 80% compliance 18/12/2024 90% compliance		
8.8	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives		Yes, 97% 24.10.24 96% 20/11/2024 94% 18/12/2024		
8.9	90% of maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum).		Yes, 91% 24.10.24 97% 20/11/2024		
8.10	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors		74% 24.10.24 90% 20/11/2024		
8.11	90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2024) including anaesthetists in training, SAS and LED doctors **who contribute to the obstetric anaesthetic on-call rota**. This updated requirement is supported by the RCoA and OAA.		89% of all other Anaesthetic doctors (prior to July 2024) 24.10.24 100% 20/11/2024		
8.12	For rotational anaesthetic staff that commenced work on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?		currently 59% plan in place for attendance within 6 months from their start date 24.10.24 100% 20/11/2024		
8.13	Standard removed				
8.14	Can you demonstrate that at least one multidisciplinary emergency scenario is conducted in a clinical area or at point of care during the whole MIS reporting period?				

Neonatal basic life support					
8.15	90% of neonatal Consultants or Paediatric consultants covering neonatal units		Yes, 92% 24.10.24 100% 21/11/2024 Uploaded to Teams Folder		
8.16	90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2024) who attend any births		64% 24.10.24 83.3% if including 1 staff member who has been off sick for 18/12. If can exclude them 91% - 22/11/2024 Update: 100% compliance for Neonatal Basic Life Support for those not on LTS. Uploaded to Teams Folder		
8.17	For rotational medical staff that commenced work on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?		100% for all rotational medical staff currently working in the Neonatal Unit who commenced work on or after 1 July 2024. Uploaded to Teams Folder		
8.18	90% of neonatal nurses (Band 5 and above who attend any births)		10/18/2024: Current compliance at 85% for all band 5 nurses and above. Projected 100% by December 2024. Staff attending Mat Neo days 97.5% 20/11/2024 Uploaded to Teams Folder		
8.19	90% of maternity support workers, health care assistants and nursery nurses *dependant on their roles within the service - for local policy to determine.		N/A	N/A	
8.20	90% of advanced Neonatal Nurse Practitioner (ANNP)		80% 24.10.24 100% 20/11/2024 Updated on Teams Folder		
8.21	90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)		Yes, 93.7% 24.10.24 91% 20/11/2024		
8.22	In addition to the above **Neonatal basic life support (NBLS)** training, is a formal plan in place demonstrating how you will ensure a minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised have a valid **Resuscitation Council (RCUK) Neonatal Life Support (NLS)** certification or local assessment equivalent in line with BAPM basic capability guidance by year 7 of MIS and ongoing?		Current: NLS certification compliance = 94% 22.11.24 Breakdown: Consultants 14/14 Reg 11/11 Resident 8/10 Total: 33/35 (only medical staff currently on neonatal unit)		

SAFETY ACTION 8- COMPLIANT

Safety Action 8- Training Compliance

12 Month Period - December 2024

Actual figures

PROMPT

	Midwives	MSW/MCA	Obstetrician	Anaesthetists	Totals
N° of staff	187	33	42	38	300
Trained staff	175	31	40	36	282
Compliance	94%	94%	95%	95%	94%

PROMPT broken down by Obstetric group

	Consultants	Reg/SHO	Totals
N° of staff	13	29	42
Trained staff	13	27	40
Compliance	100%	93%	95%

PROMPT broken down by Anaesthetic group

	Consultant	Other	Totals
N° of staff	20	18	38
Trained staff	18	18	36
Compliance	90%	100%	95%

Actual figures

Fetal Monitoring

	Midwives	Obstetricians	Totals
N° of staff	187	38	225
Trained staff	172	37	209
Compliance	92%	97%	93%

Fetal monitoring broken down by Obstetric group

	Consultants	Reg/SHO	Totals
N° of staff	13	25	38
Trained staff	13	24	37
Compliance	100%	96%	97%

Actual figures

SBLv3

	Midwives	Doctors	Doctors New starters	Totals
N° of staff	179	26	13	205
Trained staff	172	24	2	196
Compliance	96%	92%	15%	96%

8 x due end Jan 25
3 x due end May 25

Actual figures

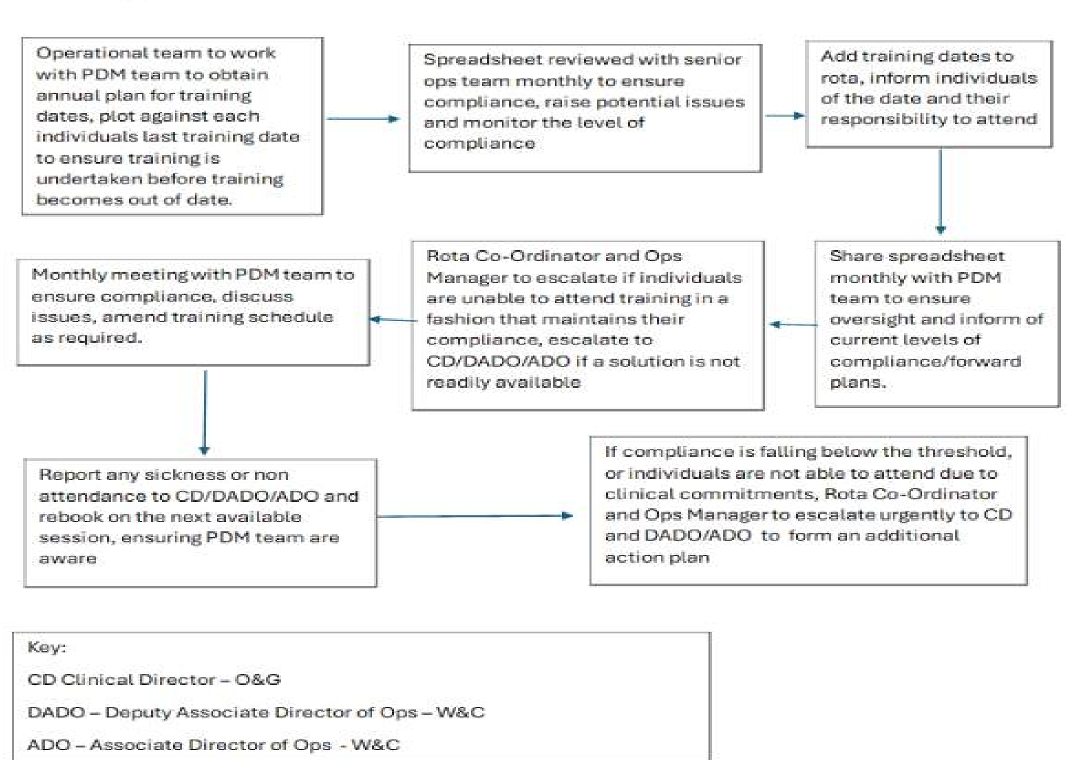
Newborn Basic Life Support (In-house)

	Midwives	Paed Con	Paed other	ANNP	NNU	Total
N° of staff	187	14	21	6	46	274
Trained staff	176	13	21	6	45	261
Compliance	94%	93%	100%	100%	98%	95%

TheMKWay

Red compliance (SBL e-learning)- New starters, x1 Reg and x1 Cons. Escalated to NS

Safety Action 8- MDT Training action plans to monitor medical staff training compliance



- Simulated training scenarios shared as evidence.
- Training compliance monitored via Maternity Practice Development team.
- Action plan submitted by ADO to achieve compliance.
- Flow chart for ongoing monitoring and compliance of training developed.
- SBL e-learning for New medical staff action plan under development and plan to complete prior to timeframe of 6 months.

Safety action 9:
Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

Safety action Lead(s):
Elaine/Lila

Reporting period: 2 April 2024 until 30 November 2024

	Requirement	Lead	Actions/progress	Update due	Compliance status
9.1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded (including the following)?				
9.2	Has a non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC)?		Yes		
9.3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) at every meeting using a minimum data set, and presented by a member of the perinatal leadership team to provide supporting context.				
9.4	Does the regular review include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.				
9.5	Do you have evidence of collaboration with the local maternity and neonatal system (LMNS)/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.				
9.6	Ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2024.				
9.7	Is the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period)?				
9.8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.				
9.9	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.				

TheMKWay

SAFETY ACTION 9- COMPLIANT

Safety Action 9- Board Assurance of Maternity & Neonatal Safety & Quality

- PQSM metrics reviewed at CSU, MAG, Trust Board.
- Non- Executive Director (Sarah Whiteman) appointed and visibly working with MKUH Board Safety Champions (Ian Reckless & Fiona Hoskins).
- Trust board level safety champion walk arounds and present in maternity, joint meetings with MNVP and trust board level safety champions.
- Review of Maternity and Neonatal Quality & Safety undertaken at Maternity Assurance Group and also shared via Patient Safety Board- Divisional Upward Report and Monthly Governance Report.
- Thematic learning- ITU thematic review, Triage review. Themes and trends monitored via PSIRF and RADAR. QI projects registered on RADAR- monitoring and oversight. Patient experience story shared by a family who mainly felt supported in their pregnancy and after the birth of their son who had anencephaly.
- Bi- monthly Maternity Patient Experience Review Group meeting.
- Monthly staff forum with board level maternity safety champions.
- Maternity Incident Learning- LMNS Sharing Meeting- monthly report compiled and presented in this forum. Safety concerns dashboard in place reported monthly & visible in clinical areas via Governance report.
- Staff engagement sessions- Maternity Team Open Forums- Culture and Safety Listening Events conducted in June 2024. Themes and detailed feedback translated into an action plan. Also, Unit meeting conducted monthly by Divisional Chief Midwife with staff having the opportunity to raise concerns, share good practice, ask questions both during the forum and anonymously.
- Trust Claims Scorecard- Claims on Governance Report- updated and presented monthly at CSU, Divisional Board, Maternity Assurance Group.
- Safety champions support maternity team attendance at Maternity & Neonatal network meetings.
- Maternity & Neonatal team actively engaged in the MatNeo Safety Improvement Programme, including attendance at optimisation forums; patient safety network meetings.
- Board Safety Champions meet with Perinatal Leadership Team on a monthly basis via Maternity Assurance Group meeting.
- Quadrumvirate have engaged in the Korn Ferry 'NHS Perinatal Quad Culture and Leadership Programme'- findings from survey presented at Maternity Assurance Group and have an action plan to support the key findings of this work and also any other culture surveys that are conducted.

Safety action 10:
Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?

Safety action Lead(s):
Lila

Reporting period: 8 December 2023 until 30 November 2024

	Requirement	Lead	Actions/progress	Update due	Compliance status
10.1	Have you reported of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024.		100% reported		
10.2	Have you reported of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 until 30 November 2024.				
10.3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme		100% - Part of DOC		
10.4	Has there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.		100% - All MNSI receive DOC		
10.5	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.				
10.6	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme?				
10.7	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?				
10.8	Have you completed the field on the Claims reporting wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.				

SAFETY ACTION 10- COMPLIANT

Women's External open investigations

Maternity

Safety action 10

Milton Keynes University Hospital NHS Foundation Trust

Incident date	Incident	Report type	Current status	Improvement plan update	Information about MNSI/EN provided to the family	Written DoC and MNSI consent
05/08/23	Therapeutic cooling	MNSI	Final report received – No safety recommendations	Improvement plan ongoing	Yes	Yes
21/09/23	IUD 40+1 early labour	MNSI	Final report received -5 Safety recommendations	Improvement plan ongoing	Yes	Yes
26/09/23	Therapeutic cooling	MNSI	Final report received -2 Safety recommendations	Improvement plan ongoing	Yes	Yes
05/11/23	Therapeutic cooling	MNSI	Final report received -4 Safety recommendations	Improvement plan ongoing	Yes	Yes
27/11/23	Maternal Death	MNSI	Final report received – 7 recommendations, 0 for maternity	Action plan draft for the Trust	Yes	Yes
17/12/23	Breech Therapeutic cooling	MNSI	Declined by MNSI	Declined by MNSI	Yes	Yes
23/03/24	Therapeutic cooling	MNSI	Final Report received – 4 Safety recommendations	Improvement plan ongoing	Yes	Yes
07/07/24	Therapeutic cooling and ECMO	MNSI	Ongoing Investigation	Ongoing Investigation	Yes	Yes
16/09/24	Maternal Death	MNSI	Ongoing investigation	Ongoing Investigation	Yes	Yes

Number of cases which met the criteria for referral to MNSI 07/12/23-06/12/24	Number of cases referred to MNSI 07/12/23-06/12/24	Number of cases accepted by MNSI 07/12/23-06/12/24	Number of cases declined by MNSI or Family 07/12/23-06/12/24
4	4	3	1

Safety Action 10- 100% of qualifying cases reported to Maternity and Newborn Safety Investigations Special Health Authority (MNSI) and NHSR Early Notification (EN) scheme

- 100% of qualifying cases reported to MNSI- monitored and evidenced via monthly Governance report, presented at CSU, Maternity Assurance Group as oversight.
- No qualifying EN cases for NHSR EN scheme- confirmed by email from NHSR therefore no fields needed to be completed on the Claims reporting wizard (CMS).
- Template letter for MNSI DOC (Duty of Candour).

Conclusion

Overview of progress on safety action requirements

Safety Action Requirements:

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	0	0	6	0	6
2	0	0	2	0	2
3	0	0	4	0	4
4	0	1	19	0	20
5	0	0	6	0	6
6	0	1	5	0	6
7	0	0	7	0	7
8	0	0	21	0	21
9	0	0	9	0	9
10	0	0	8	0	8
Total	0	2	87	0	89

Key:

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

Questions ?

Meeting Title	**Trust Board in Public**	**Date:** 9 January 2025
Report Title	**Integrated Quality Governance Exception Report**	**Agenda Item Number:** 10
Lead Director	Kate Jarman, Chief Corporate Services Officer	
Report Author	Corporate and Quality Governance Leads	

Introduction	Monthly IQG exception report		
Key Messages to Note	• Good progress in QI and audit. • Number of complex inquests (with important learning from investigations) • Continuing risks around violence and aggression (health and safety update)		
Recommendation *(Tick the relevant box(es))*	**For Information** ☒	**For Approval** ☐	**For Review** ☐

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	Safety, experience, effectiveness (and well led).

Report History	Trust Executive Committee 08/01/2025
Next Steps	Regular report
Appendices/Attachments	Paper follows

Quality Improvement and Audit

1.1 Quality Improvement Summary

The Quality Improvement (QI) team is fully established and collaborating closely with the Patient Safety (PS) team and Nursing Quality team.

The first Quality Improvement Project (QIP) addressing **scan time breaches in antenatal ultrasound scans** was successfully transitioned from the PS team, following the PSIRF mode. Project leads have been identified in US and Maternity teams and workstreams have commenced with capacity and demand data capture and reducing DNAs. The scope of the project is limited as the main driver is staffing and without increased capacity, they will not avoid breaches all together, but the collaborative team have agreed to work with what is within their control. There are plans for a patient focus group and process mapping session in the near future. However, this QIP is lacking a project sponsor (QI team request leads are identified prior to handing over for QI team support).

For large scale QIP proposals a **project charter** (appendix 1 template) is completed to outline the purpose, scope and benefits of QIP proposed. At the end of December, a QI project charter was completed with the Therapies lead, Head of Nursing Medicine and for improving Dysphagia management.

A QI project charter has been completed for **violence and abuse** driven by the latest NHS national Violence Prevention and Reduction Standards updated December 2024. A re-set meeting is organised for January 2025.

To streamline project approvals and ensure the right level of QI is adopted for safety actions post PS learning event or PSII, the QI and PS teams have developed **a proposal form** (awaiting final approval to go live on RADAR) to ensure comprehensive information is provided before QIPs are approved. The form includes essential details on the learning event, the SEIPS framework, and the designated QIP sponsors and leads. Key information can then be incorporated into a project charter.

An **audit** completed in Medicine division for **alcohol withdrawal** identified **cost savings. There is strong evidence that this pathway is expensive and not effective.** As cost savings have been identified this will be supported by the Transformation team who will include quality aspects such as NICE guidance and Quality Standards. A new policy has been drafted for further development. The team will also explore bed usage and the volume of patients that have high bed usage for limited clinical value.

A process for developing and monitoring **safety actions** post learning event may be helpful to help identify if continuous learning is required using QI tools to further

understand causal system factors and problems and to identify those safety actions which will provide **quality assurance** through associated measures.

The second **QI Trust forum** was well attended with an update on PSIRF themes and trends shared by the Head of Patient Safety and the Head of Patient Experience highlighting themes from complaints and inpatient survey. Consultants in attendance are keen to develop a more focused, proactive approach to annual QI planning which will support development of our Trust **Quality Management System**.

The QI team has also introduced well-received **on-line 'drop in' QI clinics** to assist staff with audit and quality improvement queries and is developing additional clinics focused on patient safety and health and safety to foster collaboration.

Training in Quality Improvement is being rolled out across the Trust, covering both foundational and advanced courses. However, future funding for NHS QI Coaching Training remains uncertain, potentially limiting further growth in this area. The QI team are identifying staff in key roles where QI training may be beneficial i.e. staff in champion roles. A bespoke QI session is organised in January for Tissue Viability.

Despite significant progress in several local projects, challenges such as staffing shortages and limited financial resources have slowed some initiatives. Small purchase items such as USB sticks for patient waiting area TVs, and medicine cupboard locks to enable access for responsible persons only are now having to go through purchasing approval process (charitable funds to be explored). The patient booking service is undergoing a contract renewal, meaning the addition of new screen information will be delayed until March 2025.

Data Challenges for QI

Data is a key QI component to ensure change is focused on risk and improvements are sustained. There are two issues with data impacting on QI activity

1. **Accessing e-Care information** hindering the completion of audits, baseline data and data for monitoring quality assurance which in turn affects data collection for performance evaluation and decision-making.

2. **Radar** incident data analysis is required prior to hand over of QI for QI team support from PS. SEIPS analysis further informs contributory factors and areas where QI focus is required.

In **Sepsis management**, a lack of data insight, oversight and clear metrics has been identified, with PS incidents often only being detected retrospectively via audits. This impacts our ability to assess risk and ensure treatment compliance.

The **Dementia Care QI** work is more of a continuous effort rather than meeting the original end date, much work is in development and there are some system changes to allow data gathering for intelligence rather than manual data collection. On average there can be between 60 – 70 inpatients per day with some form of cognitive impairment and the lead responds according to priority, which can unfortunately result in little time for QI, however the referral method is working well. The Dementia lead is also working alongside workstreams like violence and abuse /falls/ delirium, aiming to promote dementia friendly environment/ communication methods. Training sessions are limited in 2025 due to the availability of the dementia lead.

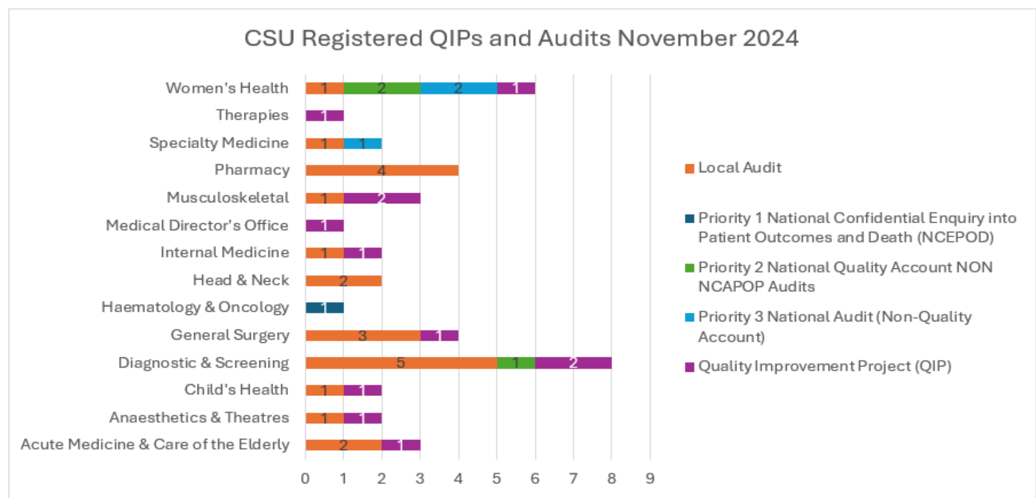
In **falls management**, there is a gap noticed in Trust guidelines and pathways for delirium management - this may delay the addition of a care plan to e-Care, pending a backlog of requests and policy updates. QI work has been registered this month for delirium, and delirium post-op for fracture neck of femur patients. QI is underway on ward 23. The areas undertaking focused Plan, Do, Study, Act work are: 20, 14, 1, 18,19,23,15, ED, 2B, 25. Hot debriefs post fall for these areas will be piloted when template is built. Trust wide 100% of all patients' high risk of falls to have a wrist band. All patients following a fall to have a completed post falls risk assessment.

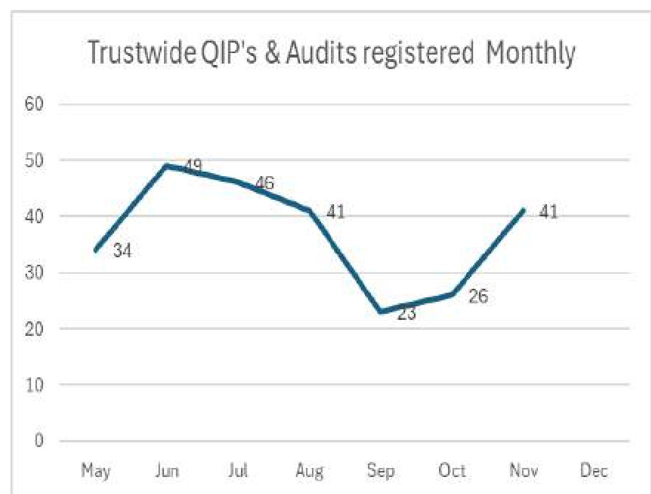
The **Pressure Ulcer** QIP which commenced January 2023 has demonstrated improvement with a day of celebration organised by the Head of Nursing held on 21st November. Various wards for recognition were handed out with Ward 1 celebrating 41 days pressure ulcer free from last pressure ulcer. The ward 7 won the most improved ward. The QIP is resetting using the SEIPS 'system thinking' model and a focused QI approach.

1.2 Actions for Registered Quality improvement projects November 2024

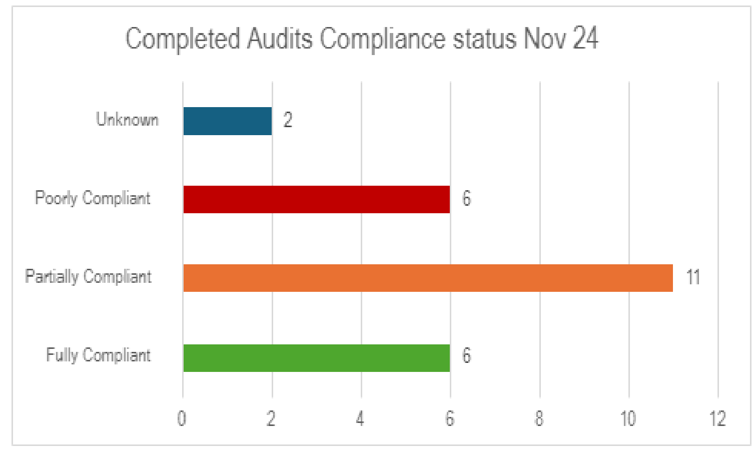
	Completed	Overdue	Pending	Planned	Grand Total
High	54	30		26	110
Low	20	6		11	37
Medium	118	79	2	93	292
Grand Total	**192**	**115**	**2**	**130**	**439**

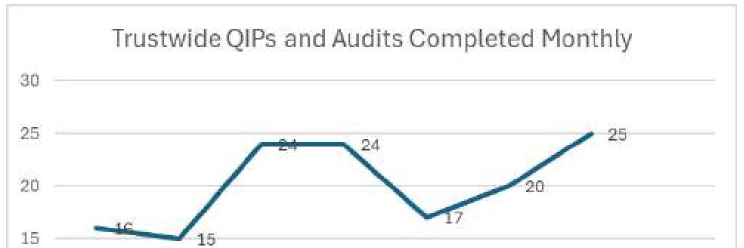
2.0 Audit/QI projects registered on Radar in November 2024 – 41 audits





2.1 QIPs & Audit Compliance with Standards Status - 25 outcome forms received in November 2024





2.2 National Quality Account and NCEPOD Audits and performance data presented 2024/2025

KEY:
Improvement plan pending
Presented and improvement plan completed

Apr-24	May-24	Jun-24	July-24	Sep-24	Oct-24	Nov-24
Acute Medicine / Diabetes	**Respiratory/ Cardiology)**	**Respiratory**	**Urology/ Paediatrics**	**Diabetes / Cardiology**	**Emergency / Acute Medicine**	**Paediatrics/ Acute Medicine**
Sentinel Stroke National Audit Programme (SSNAP) – presented in April	National Lung Cancer Audit (NLCA) – presented in May	NCEPOD - Community Acquired Pneumonia – presented in June	NCEPOD: Testicular Torsion (Twist and Shout) - presented July	National Diabetes Foot Care – presented Sep	RCEM - Care of Older People interim report published in Aug-24 – presented at CIG Oct-24	National Respiratory Audit Programme (NRAP) – Paediatric Asthma Secondary Care – presented Nov
National Adult Diabetes Audit (NDA) - National Diabetes Inpatient Safety Audit (NDISA) - presented in April	National Cardiac Audit Programme (NCAP) - National Heart Failure Audit – presented in May		National Paediatric Diabetes Audit (NPDA) - presented July	National Cardiac Audit Programme (NCAP) - National Audit of Cardiac Rhythm Management (CRM) - presented in Sep-24	National Audit of Dementia (published Spotlight Audit on Memory Assessment Services in Aug 24) - presented in Oct-24. Linked to QIP	Winter SAMBA (published last financial year) - presented Nov-24

2.3 National Confidential Enquiry into Patient Outcome and Death (NCEPOD Studies)
Clinical Questionnaires

Two clinical questionnaires and two organisational questionnaires remain outstanding.

Clinical Questionnaire	Case Notes (Returned / Requested)	Incomplete	Submitted	Total	Due by
Emergency (non-elective) procedures in children and young people: Transfer questionnaire	1/1	0	1	1	03/01/25
Emergency (non-elective) procedures in children and young people: Anaesthetic questionnaire	0/0	0	7	7	31/12/24
Emergency (non-elective) procedures in children and young people: Surgical questionnaire	5/7	**4**	3	7	**31/12/24**
Hyponatraemia-Clinician Questionnaire	4/4	0	4	4	**13/12/224**
Hypernatremia- Clinician Questionnaire	2/2	**2**	0	2	**13/12/24**

Organisational Questionnaire	Status	Due by
Emergency (non-elective) procedures in children and young people: Organisational Questionnaire	**0% completed**	**10/01/25**
Blood Sodium – Organisational Questionnaire	**28% completed**	**24/01/25**

3.0 NICE

Benchmarking the Trust service against NICE best practice identifies risks in pathways and opportunities for improvement.

3.1 NICE breaches

Total Number of NICE breaches

The total number of trust-wide breaches remains at 4.

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Whole Trust	15	14	11	9	6	7	4	4
Surgery Division	5	4	1	1	1	4	2	1
Medicine Division	8	8	7	6	4	2	1	2
Women								0
Children	1	1	2	1	0	0	0	1
Core Clinical	1	1	1	1	1	1	1	0

Highlights

Baseline assessments completed/compliance confirmed in November 2024:

- NG101 Early and locally advanced breast cancer: diagnosis and management – baseline completed fully compliant.

Lowlights

Baseline assessments pending completion:

- NG236 Stroke rehabilitation in adults – now completed – 74% compliance action plan required.
- NG155 Tinnitus: assessment and management – published March 2020 requires input from ENT (completed by Audiology - fully compliant)- No movement this month.
- NG191: COVID-19 rapid guideline: managing COVID-19. Published March 2021, updated May 2024. Awaiting respiratory medicine input.
- QS76 Acute kidney injury - Published: 22 December 2014 Last updated: 23 March 2023. Fully Compliant for adults but still needs input from Paediatrics.
- NG242 Diabetic retinopathy: management and monitoring. Published: 13 August 2024. Needs completing.

NB. *NICE guidance for women's will be added to RADAR from December 2024*

4.0 Trust Documentation

There are **19** polices overdue (from 2020 – 2023) and **29** guidelines overdue (2021 to 2023).

A meeting was held with stakeholders for the Trust Baby Child and Young Person Abduction policy to agree author and ownership for the exercise if an event should occur. A further meeting to be organised with representation from Maternity and Security services.

Governance Team support for Trust documentation to be revisited now QI team have moved all policies, guidelines, SOPs, PILs onto Radar and a process is in place for document management.

Trust policies require alignment with Corporate Governance oversight groups to ensure quality assurance is monitored, risks and gaps identified and continuous improvement action taken e.g. Trust consent and LocSSIP policies.

Appendix 1: QI Project Charter template

Title:		Reference:	TBC
Project Trigger			
Definitions			
National directives for QIP			

Problem Statement	
Examples of good practice	
What is our data telling us?	
Cost/Benefit n.b. Cost saving projects are supported by Transformation team	
Organisation Benefits	
Staff benefits	
Patient Benefits	

Project Goals	Metric	Current	Goal

Scope	Process Start	
	Process End	
	Locations Impacted	
	Departments Impacted	
	Includes	
	Other linked QIPs	

Existing safety improvement plans or links with other work which may exist or in planning phase	
Preliminary Plan - Milestones & Dates (see project goals above)	**Define & understand problems** **Measure-** **Improve.** Data driven continuous improvement methodology.
Risks and Constraints	

QI Project Lead/s		• **Project Sponsor** a senior member of staff who holds influence in the department/service and who can	

		provide expert advice on the improvement work	
QI Coach		**Oversight and Assurance Group**	

Litigation Update

Board Note: A new government document, a memorandum of understanding (MOU) between regulatory, investigatory and prosecutorial bodies - *Investigating healthcare incidents where suspected criminal activity may have contributed to death or serious life-changing harm* has been published.

This sets out how healthcare organisations, regulatory bodies, investigatory bodies and prosecutorial bodies in England will work together in cases where there is suspected criminal activity on the part of an individual in relation to the provision of clinical care or care decision making and to help deliver early, co-ordinated and effective action following incidents where there is reasonable suspicion that a patient/service user's death or serious life-changing harm occurred as a result of an incident where there is suspected criminal activity in the course of healthcare.

For more information:
Investigating healthcare incidents where suspected criminal activity may have contributed to death or serious life-changing harm (accessible version) - GOV.UK

The Trust has an internal SOP for managing internal investigations running concurrently with police investigations – this will be updated as required, to reflect this MOU.

Inquests of Note

MK 2985 (15 January 2025)

Stroke and thrombectomy. Had a fall sustaining a left neck of femur fracture, for which he underwent surgery. The following day there was a concern that he had aspirated on his Ensure drink. Patient deteriorated and died.

The provisional medical cause of death has been given as:
1a Chest infection, Ischaemic stroke, Pyeloduodenal cancer
2 Left Fracture Neck of Femur (Operated), Atrial Fibrillation, Coronary Artery Disease, Type 2 Diabetes Mellitus

Trust PSII Level 1 investigation awaiting approval.
There is a quality improvement project which is considering Radar incidents relating to Speech and Language Therapy (SLT) assessments, PSIRF learning events and an independently commissioned expert report on a cluster of choking incidents.

MK 2967 (4-5 February 2025)

Collision with a bollard and was thrown from the scooter onto the pavement, sustaining injuries to his head, leg and arm. Found to have facial and skull fractures and remained in hospital for neurological observations. Developed seizures and underwent further CT scans which showed a deterioration, and he was admitted to the Intensive Care Unit (ICU). Provisional medical cause of death given as:

a) Cerebral Oedema
b) 1b) Cerebral abscess 1c) Traumatic brain injury with facial fractures

Of note patient had an in-hospital fall associated with a seizure when out of the ward. Family's recollections of events vary significantly to those recorded on eCARE and in staff statements which is being explored. Trust PSII Level 1 investigation awaiting approval identifies a number of issues to be explored.

MK 2806: (12 – 13 February 2025)

A concern was raised by family that the patient had been found with food in his mouth. He developed aspiration pneumonia and was treated with antibiotics, fluids, oxygen and pain relief. However, despite best efforts, sadly passed away. Cause of death was reported as follows:

1a) Aspiration pneumonia
1b) Chronic dysphagia
II) Learning disability (LD), Type 2 Diabetes

There has been collaborative working with CNWL to draft an Eating and Drinking at Risk policy and supporting information, and the implementation of the Oliver McGowan training for all staff (levels 1 and 2).

Awaiting disclosure of an independent expert report commissioned by the family specifically focusing on the LD aspects of care.

Of note the Chief Medical Officer has commissioned an independent report into five choking cases in the Trust in the past year (including two previous and the above coronial case) which noted five key recommended actions for the Trust

1. The recognition of eating, drinking and swallowing issues is part of many clinical professional's responsibilities. The Trust should clarify by whom and how this should be documented in a timely manner in (i) clinical notes and (ii) ward area / patient bed space. Each clinical area must have an agreed location to provide this information, so it is visible and available to staff, families, carers, and patients.
2. The Trust should ensure appropriate feeding plans are documented for patients with an identified risk, and that there is a robust mechanism to share these and with patient, family, and any relevant care providers when a client is admitted to or discharged between different settings, either within or between care providers.
3. The Trust should monitor SLT referrals, numbers and quality and response times to establish if there is a need for more staff training and /or more SLT staffing.
4. The Trust should continue ongoing reporting and monitoring of aspiration and asphyxiation incidents and consider whether this could be a future Trust Quality Priority.

5. The Trust should ensure that MCA and DOLS assessments are consistently undertaken and documented when there is concern about an inpatient's ability to understand or consent to care.

MK 2954 (4 - 5 March 2025)

Neonatal death for a birth at 30 weeks + 4 days. Ruptured uterus given as provisional cause of death.

Perinatal mortality review tool (PMRT) review identified care issues for further exploration.

Coronial and family focus on antenatal care, especially once the mother was in labour. This is an ongoing PSII investigation

MK 2405: (scheduled for 6 weeks in March 2024)

Death in custody. The IOPC investigation has now concluded, and the Trust has conducted its own internal investigation which identified key recommendations:

- The Trust's referral pathways to the MHLT should be reviewed to ensure that they are consistent with relevant national guidance such as *Side by side - A UK-wide consensus statement on working together to help patients with mental health needs in acute hospital*
- Adherence to Toxbase guidance or rationale for non-compliance documented and signed off by a senior clinician
- Embed the use of the Royal College of Emergency Medicine (RCEM) Guideline *Emergency Department Patients in Police Custody* to improve communication on discharge for patients leaving the Emergency Department (ED) in police custody
- Partnership working and review of care pathways with CNWL (mental health)

There is ongoing focus on the management of violence and abuse and the use of restraint, and the scheduling of training for staff, which is aligned to the Health and Safety Executive (HSE) action plan.

INC- 26809 (pending coronial decision)

Death of a twin following elective C-section and transfer to tertiary centre.
Linked to ongoing work regarding quality assurance processes for imaging quality in obstetric ultrasound scan (US) department.

Milton Keynes University Hospital
NHS Foundation Trust

Learning from Inquests

MK 2921

Neonatal death at 29 weeks and 1 day. Prolonged rupture of membranes leading to an emergency C- section. Suspected chorioamnionitis.

There are two key points of learning:

- The importance of listening to a patient's views. The mother raised concerns and felt that something was wrong (given previous losses), however she did not feel listened to.
- Better communication between Ward 9 and Labour ward especially around the CTG readings

Litigation Update December 2024

Six new claims were opened in December.

Clinical negligence claims of note

MK 3038 - Failure to provide appropriate care and treatment following hospital admission in June 2022 which consequently resulted in claimant developing severe pressure ulcer injury to left buttock and resulted in surgery. Preliminary review stage only.

Safety Alerts

There are 22 open safety alerts. The three main national safety national safety alerts are:

SAF 385 - reducing risks for transfusion-associated circulatory overload. Due **4/10/24**. Action plan completed by the Blood Transfusion Team with remaining one action in breach relating to training and the Education Board agreeing to make this mandatory for doctors

SAF 364 - Transition to NRFit™ connectors for intrathecal and epidural procedures, and delivery of regional blocks. Due **31/1/25**. Fully transitioned in theatres but requires checks within other areas that carry out lumbar punctures and manometry of CSF pressure and orthopaedics where they carry out joint injections.

Corporate nursing team collating information on remaining clinical areas that use these and will be compliant by due date.

SAF 464 - Risk of oxytocin overdose during labour and childbirth. The alert seeks to balance the benefit of ensuring an oxytocin infusion can be started immediately after a woman (at high-risk of post-partum haemorrhage/PPH) has given birth and mitigate the risk of preparing the oxytocin infusion in advance. Maternity action plan in place. **Due**

31/5/25

Of Note:

- **SAF 446** - Phillips Respironics Trilogy EVO, Trilogy Evo O2, Trilogy EV300 NIV machines. Going forward will need regular filters changes. Note referenced at previous TEC. Awaiting SOP finalisation on filter changes and options paper to be presented.

Health and Safety Update

Wards/departments have been tasked with undertaking a risk survey and risk assessment in relation to violence and abuse – deadline end of February 2025.

Workplace health and safety inspection self-audits are underway by wards/department managers – deadline for returns end of January 2025.

Marion Fowler DipNEBOSH, Health and Safety Advisor has picked up the work around violence and abuse and will be focusing on the actions identified by the HSE in their improvement notice. Recruitment is ongoing for an additional health and safety advisor (with previous rounds of recruitment unsuccessful), with temporary support being sought.

Work on compliance with risk assessments relating to health and safety subjects forms part of the 2025/26 health and safety workplan to be presented at the next Health and Safety Committee in February 2025.

The Health and Safety Committee last sat on 10th December 2024 highlights below :

- (272) Total number of incidents reported from Q3 Oct/November, (348) Q1 April to June (282) Q2 July to October.
- (188) Total number of incidents of violence and unacceptable behaviour – ongoing work re risk identification and management/welfare support for staff
- Highest reported incident locations for violence and unacceptable behaviour – ward 3, 19, 18, 8, ED
- (1**)** staff member fall on new car park facility based on the location of the old helipad – risk assessments and mitigations in place
- During Q3 to date there were (2) incidents reported to the Health & Safety Executive under RIDDOR
- ASCOM call bell system remains an ongoing issue
- Racial abuse is increasing with staff reporting more incidents and the impact of it on them with one staff member saying they would not be able to work in this country if they did not tolerate this abuse
- All staff are encouraged to report incidents of violence & abuse to the police
- A short staff survey will be conducted early in 2025 to gauge staff safety and their expectations in relation to the management of violence & abuse, this will then form part of the workplan for violence & abuse

Trust-wide Incidents

RADAR incident category	24/25 Q1	24/25 Q2	24/25 Q3
Violence & Abuse	219	151	188
Accident - Other Injury	21	15	7
Slips / Trips / Falls	21	21	12
Exposure to Hazardous Substances	8	7	3
Estates, buildings, and unsafe environment	22	40	27
Sharps Injury	24	21	11
Manual Handling Incidents	9	6	2
Fire Safety	24	21	22
Total	**348**	**282**	**272**

Fire Update

Fire incidents of note – patients smoking on wards.

Estates, buildings, and unsafe environment – no significant concerns/themes or trends noted

A Trust site-wide fire enforcement notice was issued 13th December 2023, this enforcement was issued with the maximum timeline for resolution and extension requests were expected and discussed at the outset with the Fire Service due to the significant works required to address the matters to a level of absolute assurance. The Fire Service last visited on 15th November 2024 and are returning early in the New Year.

The original visit by the fire brigade found examples of the following non-compliance, items highlighted green were closed by the Fire Brigade in November 2024, items in amber are complete but not yet closed and items in yellow are nearing completion. There is positive, dedicated progress in fire compliance, with a commitment to working with the Fire Service to ensure ongoing compliance, improvement and development across a complex site.

Item Number	Item	Concern Raised	Explanatory Notes	Anticipated Closure Date (by Fire Service)
1	Fire Risk Assessments	Suitable and sufficient fire risk assessments have not been carried out throughout the premises to identify the fire risks	Maintain repeat Fire Risk Assessments as per policy	13th May 2025
2	No Safety Assistance	Not enough competent people have been appointed to help you.	Fire Safety Officer currently post	13th May 2025
3	Maintenance - fire alarm system. (cause and effect)	The fire alarm system was not properly tested and maintained.	This relates to a few issues with the 'Cause and Effect' (eg. what Fire Doors close and what alarms sound when an activation occurs in a certain area)	13th May 2025
4	Unsuitable door fastenings. (manual overrides)	Exit doors must be openable from inside without the use of a key or code and without having to manipulate more than one mechanism.	Some doors mechanisms on Fire Escape routes were noted to be non-compliant	13th May 2025
5	Fire resisting corridors. (hold-open devices)	Escape routes can become compromised quickly if fire doors are wedged open.	Some fire doors were observed held open with wedges	13th May 2025

6	Unsuitable door fastenings on final exit doors	Exit doors must be openable from inside without the use of a key or code and without having to manipulate more than one mechanism.	Two final exit doors were difficult to open and need review. Some signage on final exit doors needs updating	13th May 2025
7	Carry out drills	People do not understand what to do in case of fire and may behave inappropriately if fire breaks out.	Up to date Fire Drills for all areas, both full evacuations and desktop exercises	13th May 2025
8	Add alarm device	The existing system is not suitable because it does not appear to be to a L1 standard.	The L1 standard requires detectors in every room, the Trust was built to L2 standards where detectors are only in risk spaces	13th May 2025
9	Obstructed escape routes	The escape route to some fire exits were obstructed by storage of sterile equipment within the clean area corridors.	Stock review in theatres - the clean area corridors in both Phase 1 & 2 Theatres have been considerably narrowed by storage of sterile equipment	13th May 2025
10	Item 10 – Fire resisting corridors (wedging devices)	Fire doors throughout Theatres Phases 1 & 2 were wedged open.	Ensure doors remain closed - Phases 1 & 2 Operating Theatre doors are held open with a manual wedging device attached to the doors	13th May 2025

11	Inadequate fire safety signage	Numerous emergency exits had incorrect door operation instructions such as “push bar to open” when the door wasn’t fitted with a push bar.	For a sign to comply with the signs and signals regulations it must be in pictogram form. The pictogram can be supplemented by text if this is considered necessary	13th May 2025

- The Trust has requested that regular engagement meetings are reinstated with the CQC to ensure regular communication and information flow (no response received as yet)

- Maternity inspection report awaited from inspection in August 2024

- Number of requests around fire safety compliance in maternity with the following information provided
  - *Fire risk assessments for maternity services which have been updated (18/12/24) with any actions closed since they were last provided.*
  - *PAT testing is conducted in-line with the attached Safe Working with Electricity Policy, which is in-date and live on the intranet. PAT testing was completed in these areas in July and August 2023, copies of certification attached.*
  - *PAT testing is as follows:*
    - *ADAU all items passed 2023 PAT testing. Evidence attached.*
    - *Labour Ward PAT testing faults checked on job 173746. All fault items listed in the 2023 PAT testing report had been removed from the ward. Evidence attached.*
    - *Ward 9 PAT testing faults checked on job 173750. All fault items listed in the 2023 PAT testing report had been removed from the ward. Evidence attached.*
    - *Ward 10 all items passed 2023 PAT testing. Evidence attached.*

Meeting Title	Trust Board (Public)	**Date:** 9th January 2024
Report Title	Maternity Assurance Group	**Agenda item Number 11**
Lead Director	Ian Reckless Chief Medical Officer	
Report Author	Fiona Hoskins Chief Nursing Officer	

Introduction	The Maternity Assurance Group is chaired by Non-Executive Director Sarah Whiteman and attended by the Maternity Safety Champions and the senior maternity and neonatal team. The purpose of the group is to add scrutiny to the maternity and neonatal governance process and provide assurance to Board around maternity and neonatal care. The group adheres to an annual workplan with on-going review of key metrics. The November meeting was held on the 28th of the month with good attendance.		
Key Messages to Note	All agenda items were presented as planned and reviewed. Items to be brought to the attention of the Board are presented on the Maternity Assurance Group Headlines Slide.		
Recommendation (*Tick relevant box(es)*)	For Information X	For approval	For review
Strategic Objectives Links (Please delete the objectives that are not relevant to the report	1. Keeping you safe in our hospital 2. Improving your experience of care 3. Ensuring you get the most effective treatment 4. Giving you access to timely care 5. Working with partners in MK to improve everyone's health and care 6. Spending money well on the care you receive		
Report History	All items discussed at November Maternity Assurance Group		
Next Steps			
Appendices / Attachments	Maternity Assurance Group November 2024 agenda *(See Supplementary Shelf)*		

Maternity Assurance Group - November 2024 Headlines

FASP Action Plan:
Assure: Action plan confirmed as completed. Confirmation of Action Plan closure from SQAS received December 2024.

PREM 7 (Preterm Optimisation):
Advise: No births in MKUH as opposed to a tertiary centre (L3 NNU) since October 2024.

Complaints:
Advise: 12 complaints received in October relating to care delivery across the year – 3 overdue.
Top Three Themes: Communication, clinical care & compassion and empathy. Quality Improvement programmes in place.

Saving Babies Lives:
Advise: Within the bundle the following elements require improvement; reduction of smoking in pregnant women; compliance with USS completion within 72 hours for reduced fetal movement and compliance guidance for mid and high-risk pregnancies identified at booking. Quality Improvement programmes in place.

Risk Register
There are 14 maternity risks and 1 gynae registered within the division.
Alert: New risk (591) relating to ultrasound capacity in relation to the requirements of Saving Babies Lives Care Bundle discussed.
Assure: Interventional radiology provided assurance that the department is using the NHS England toolkit to establish demand and capacity work. Findings to come to January 2025 MAG.
Advise: Risk 101 – availability of separate obstetric theatre downgraded from 15 to 9.

Midwifery staffing:
Advise: Increased the number of rostered on shift midwives from 7 to 8 on the labour ward. Fill rate remains at around 80% however data is evidencing increased midwifery time on both the labour and postnatal wards.

With new starters coming into the numbers the Trust anticipates achieving the 1:24 ratio by the end of December 2024.

CQC Picker Survey 2024:
Advise: Trust identified as an outlier with 22 areas significantly worse than the national average scores and 11 areas worse than historical comparisons.
Alert: Key areas for improvement included care on labour ward and postnatal care.
Assure: Survey covered timeframe of February 2024 with data collation in May 2024. Internal and system patient engagement earlier in the year picked up the themes of this survey and improvement plans already in train.

TRUST BOARD IN PUBLIC

Academic Centre/Teams

Thursday, 9 January 2025

Progress update – 2024/25 Quality Priorities

Kate Jarman
Chief Corporate Services Officer

Discuss

Meeting Title	**Trust Board in Public**	**Date: 9 January 2025**
Report Title	2024-25 Executive Summary M8	**Agenda Item Number: 13**
Lead Director	John Blakesley, Deputy CEO	
Report Author	Information Team	

Introduction	Purpose of the report: Standing Agenda Item
Key Messages to Note	**Emergency Department:** - There were 8,912 ED attendances in November 2024, a decrease of 295 attendances compared to October 2024. - The percentage of attendances admitted, transferred, or discharged within 4 hours was 72.8%, a decrease in performance compared to 73.8% in October 2024. - 77.9% of ambulance handovers took less than 30 minutes in November 2024 and 96.0% took less than 60 minutes. **Outpatient Transformation:** - There were 41,569 outpatient attendances in November 2024. - 11.5% of these appointments were attended virtually and 5.7% of patients did not attend. **Elective Recovery:** - There were 2,782 elective spells in November 2024. - At the end of November 2024, 28,086 patients were on an open RTT pathway: o 316 patients were waiting more than 65 weeks. o 47 patients were waiting over 78 weeks. - At the end of November 2024,13,500 patients were waiting for a diagnostic test. Of these, 58.1% were waiting less than 6 weeks. **Inpatients:** - Overnight bed occupancy in adult G&A beds was 89.2% in November 2024. - A considerable proportion of beds were unavailable due to: o 80 patients not meeting the criteria to reside. o 78 super stranded patients (length of stay 21 days or more). **Human Resources:** - In November 2024: o Substantive staff turnover was 13.1%. o Agency expenditure remained well below the threshold of 5%, at 2.3%. o Appraisals achieved 94% and mandatory training 95%. **Patient Safety:** - In November 2024, the following infections were reported: o Klebsiella Spp bacteraemia: 5 o MSSA: 1 o E Coli:1 o P.aeruginosa bacteraemia: 1 o C.Diff: 0 o MRSA bacteraemia: 0

Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Assurance** ☐

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	*1. Keeping you safe in our hospital* *2. Improving your experience of care* *3. Ensuring you get the most effective treatment* *4. Giving you access to timely care* *5. Working with partners in MK to improve everyone's health and care* *6. Increasing access to clinical research and trials* *7. Spending money well on the care you receive* *8. Employ the best people to care for you* *9. Expanding and improving your environment* *10. Innovating and investing in the future of your hospital*

Report History	Standing Agenda Item
Next Steps	Standing Agenda Item
Appendices/Attachments	ED Performance – Peer Group Comparison

Trust Performance Summary: M08 (November 2024)

1.0 Summary

This report summarises performance against key performance indicators and provides an update on actions to sustain or improve upon Trust and system-wide performance.

This commentary is intended only to highlight areas of performance that have changed or are in some way noteworthy. It is important to highlight that some local transitional or phased targets have been agreed to measure progress in recovering performance. It should however also be noted that NHS Constitutional Targets remain, as highlighted in the table below:

Indicator Description	Transitional Target	Constitutional Target
ED 4 hour target (includes UCS)	73.9%	95%
RTT Incomplete Pathways <18 weeks	92%	92%
RTT Patients waiting over 65 weeks	320	0
Diagnostic Waits <6 weeks	95%	99%

To ensure that the continued impact of COVID-19 is reflected, monthly trajectories are in place to ensure that they are reasonable and reflect a realistic level of recovery for the Trust to achieve.

2.0 Operational Performance Targets

November 2024 performance against transitional targets and recovery trajectories:

Indicator	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
ED 4 hour target (includes UCS)	78.2%	73.9%	73.8%	72.8%	✗	▼	✗	
RTT Incomplete Pathways <18 weeks	92.0%	92.0%		43.8%	✗	▲		
RTT Patients waiting over 65 weeks (Total)	0	320		316	✓	▲		
Diagnostic Waits <6 weeks	95.0%	95.0%		58.1%	✗	▲		
62 day standard (Quarterly)	70.3%	66.2%		52.8%	✗	▼		

The percentage of ED attendances that were admitted, transferred, or discharged within four hours was 72.8%. This was above the national performance of 72.1% and above all but two of the MKUH peer group (see Appendix 1).

The volume of open RTT pathways was 29,086, a decrease of 1,970 compared to October 2024. Of this total, 316 patients had waited more than 65 weeks for treatment. The Trust has robust recovery plans in place to support an improvement in RTT performance and to reduce patient waiting times. The cancellation of non-urgent elective activity and treatment for patients on an incomplete RTT pathway is also being proactively managed.

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

In Q2 2024/25, the 62-day standard performance (from receipt of an urgent GP referral for suspected cancer to first treatment) was 52.8% against a national target of 85%, declining from 54.5% in the previous quarter. The percentage of patients to begin cancer treatment within 31 days of a decision to treat increased from 94.5% to 95.2%, below the national target of 96%. The 28 Day Faster Diagnosis performance was 71.6%, up from 68.8% in the previous quarter.

3.0 Urgent and Emergency Care

During November 2024, one of these indicators saw a month-on-month improvement:

Indicator	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Cancelled Ops - On Day	1%	1%	0.50%	0.72%	✓	▼	✓	
Ward Discharges by Midday	25%	25%	17.5%	17.7%	✗	▼	✗	
Patients not meeting Criteria to Reside	50			80	✗	▼		
Number of Super Stranded Patients (LOS>=21 Days)	50			78	✗	▲		
Ambulance Handovers <60 mins (%)	100%	100%	96.4%	96.0%	✗	▼	✗	

Cancelled Operations on the Day

In November 2024, 21 operations were cancelled on the day for non-clinical reasons. The majority were due to insufficient time and theatre staff unavailable.

Patients not Meeting Criteria to Reside

The number of inpatients not meeting the criteria to reside at the end of November 2024 was 80 against a threshold of 50. This was a slight deterioration compared to 75 reported last month.

Length of Stay (Stranded and Super Stranded Patients)

The number of super stranded patients (e.g. length of stay of 21 days or more) at the end of the month was 78, a significant improvement when compared to October 2024 which was 114. This was also the lowest volume since this metric was first reported in April 2022.

Ambulance Handovers

In November 2024, the percentage of ambulance handovers to the Emergency Department taking less than 30 minutes was 77.9%. This was an improvement in performance compared to 76.6% in the previous month.

The percentage of ambulance handovers to the Emergency Department taking less than 60 minutes was 96.0%. This was a slight deterioration in performance compared to 96.8% in the previous month.

4.0 Elective Pathways

Indicator	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Overnight Bed Occupancy - Adult G&A	95.4%	97.4%	92.1%	89.2%	✓	▲	✓	
RTT Incomplete Pathways <18 weeks	92.0%	92.0%		43.8%	✗	▲		
RTT Total Open Pathways (inluding ASIs)	32,549	33,301		34,182	✗	▲		
Diagnostic Waits <6 weeks	95.0%	95.0%		58.1%	✗	▲		

Overnight Bed Occupancy

Overnight bed occupancy was 89.2 % in November 2024, below the threshold of 97.4%.

RTT Incomplete Pathways

The Trust's RTT 18 week performance at the end of November 2024 was 43.8% and the number of patients waiting over 65 weeks was 316. Total RTT open pathways was 29,086.

Diagnostic Waits <6 weeks

At the end of November 2024, performance was 58.1%, an improvement from 55.0% from last month.

5.0 Patient Safety

Infection Control

In November 2024, the following infections were reported:

Infection	Number of Infections
Klebsiella Spp bacteraemia	2
MSSA	1
E-Coli	1
P. aeruginosa bacteraemia	1
C.Diff	0
MRSA bacteraemia	0

ENDS

Appendix 1: ED Performance - Peer Group Comparison

Several other NHS Acute Trusts have historically been considered as peers of MKUH. Their ED performance compared to MKUH over the past three-months can be found below:

September 2024 to November 2024 ED Performance Ranking

MKUH Peer Group Comparison - ED Performance	Sep-24	Oct-24	Nov-24
Homerton Healthcare NHS Foundation Trust	83.0%	81.2%	77.3%
Mersey and West Lancashire Teaching Hospital (Formerly Southport and Ormskirk)	73.0%	72.6%	73.3%
Milton Keynes University Hospital NHS Foundation Trust	73.0%	73.8%	72.8%
The Hillingdon Hospitals NHS Foundation Trust	69.0%	70.4%	70.1%
Oxford University Hospitals NHS Foundation Trust	73.1%	69.0%	68.8%
Buckinghamshire Healthcare NHS Trust	70.7%	70.6%	68.1%
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	65.2%	66.5%	63.7%
North Middlesex University Hospital NHS Trust	70.1%	66.2%	63.6%
Northampton General Hospital NHS Trust	71.6%	69.7%	62.7%
Barnsley Hospital NHS Foundation Trust	64.1%	62.8%	61.0%
Mid Cheshire Hospitals NHS Foundation Trust	60.4%	57.0%	56.6%
The Princess Alexandra Hospital NHS Trust	62.6%	58.1%	54.9%

Board Performance Report 2024/25
November 2024 (M08)

OBJECTIVE 1 - PATIENT SAFETY									
Indicator	**DQ Assurance**	**Threshold 2024-25**	**Month/YTD Threshold**	**Actual YTD**	**Actual Month**	**Month Perf.**	**Month Change**	**YTD Position**	**Rolling 15 months data**
Mortality - (HSMR) ★	Green	90.0	90.0		92.1	✗	▼		
Mortality - (SHMI)	Green	100.0	100.0		110.7	✗	▲		
Never Events	Amber	0	0	Not Available					
Clostridium Difficile	Amber	47	<32	21	0	✓	▲	✓	
MRSA bacteraemia (avoidable)	Amber	0	0	3	0	✓	▲	✗ (black)	
Falls with harm (per 1,000 bed days)	Amber	0.12	0.12	0.17	0.35	✗	▼	✓	
Incident Rate (per 1,000 bed days)	Amber	60	60	54.63	63.05	✓	▲	✗	
Duty of Candour Breaches (Quarterly)	Amber	0	0	1	1	✗	▼	✗ (black)	
E-Coli	Green	57	38	11	1	✓	▬	✓	
MSSA	Green	17	<12	7	1	✓	▬	✓	
VTE Assessment	Green	95%	95%	97.5%	97.8%	✓	▲	✓	
Klebsiella Spp bacteraemia	Green	17	<12	14	2	✗	▬	✗	
P.aeruginosa bacteraemia	Green	10	<7	2	1	✗	▼	✓	

OBJECTIVE 2 - PATIENT EXPERIENCE									
Indicator	**DQ Assurance**	**Threshold 2024-25**	**Month/YTD Threshold**	**Actual YTD**	**Actual Month**	**Month Perf.**	**Month Change**	**YTD Position**	**Rolling 15 months data**
RED Complaints Received	Amber	0	0	0	0	✓	▬	✓	
Formal Complaints responded in agreed time	Amber	90%	90%	60.7%	70.4%	✗	▲	✗	
Cancelled Ops - On Day	Green	1%	1%	0.50%	0.72%	✓	▼	✓	
Over 75s Ward Moves at Night	Green	1,500	1,000	1,087	136	✗	▲	✗	

OBJECTIVE 3 - CLINICAL EFFECTIVENESS									
Indicator	**DQ Assurance**	**Threshold 2024-25**	**Month/YTD Threshold**	**Actual YTD**	**Actual Month**	**Month Perf.**	**Month Change**	**YTD Position**	**Rolling 15 months data**
Overnight Bed Occupancy - Adult G&A	Green	95.4%	97.4%	92.1%	89.2%	✓	▲	✓	
Ward Discharges by Midday	Green	25%	25%	17.5%	17.7%	✗	▼	✗	
Weekend Discharges	Green	63%	63%	60.7%	62.4%	✗	▲	✗	
Patients not meeting Criteria to Reside	Amber	50			80	✗	▼		
Number of Stranded Patients (LOS>=7 Days)	Green	184			235	✗	▲		
Number of Super Stranded Patients (LOS>=21 Days)	Green	50			78	✗	▲		
Discharges from PDU (%)	Green	12.5%	12.5%	10.5%	9.3%	✗	▼	✗	
Ambulance Handovers <30 mins (%)	Red	95%	95%	78.4%	77.9%	✗	▲	✗	
Ambulance Handovers <60 mins (%)	Red	100%	100%	96.4%	96.0%	✗	▼	✗	

OBJECTIVE 4 - KEY TARGETS									
Indicator	**DQ Assurance**	**Threshold 2024-25**	**Month/YTD Threshold**	**Actual YTD**	**Actual Month**	**Month Perf.**	**Month Change**	**YTD Position**	**Rolling 15 months data**
ED 4 hour target (includes UCS)	Amber	78.2%	73.9%	73.8%	72.8%	✗	▼	✗	
Total time in ED no more than 12 hours	Amber	95%	95%	94.7%	94.2%	✗	▲	✗	
Triage within 15 Minutes	Amber	90%	90%	68.1%	64.1%	✗	▼	✗	
RTT Incomplete Pathways <18 weeks	Amber	92.0%	92.0%		43.8%	✗	▼		
RTT Total Open Pathways (inluding ASIs)	Amber	32,549	33,301		34,182	✗	▲		
Open AFBs					3,395		▼		
Referrals Waiting for Triage					1,895		▲		
RTT Patients waiting over 65 weeks (Total)	Green	0	320		316	✓	▲		
RTT Patients waiting over 65 weeks - Non-Admitted	Green				207		▲		
RTT Patients waiting over 65 weeks - Admitted	Green				109		▲		
RTT Patients waiting over 78 weeks (Total)	Green	0	0		47	✗	▲		
Diagnostic Waits <6 weeks	Amber	95.0%	95.0%		58.1%	✗	▲		
31 days Diagnosis to Treatment (Quarterly) ✎	Amber	96.0%	96.0%		95.2%	✗	▲		
62 day standard (Quarterly) ✎	Amber	70.3%	66.2%		52.8%	✗	▼		
28 Day Faster Diagnosis (Quarterly) ✎	Amber	78.0%	76.5%		71.6%	✗	▲		

OBJECTIVE 5 - SUSTAINABILITY									
Indicator	**DQ Assurance**	**Threshold 2024-25**	**Month/YTD Threshold**	**Actual YTD**	**Actual Month**	**Month Perf.**	**Month Change**	**YTD Position**	**Rolling 15 months data**
Total Referrals Received	Green	Not Available		141,295	14,553	Not Available	▼	Not Available	
Total ASIs	Green	0	0		372	✗	▲		
Total RTT Non-Admitted Open Pathways	Green				29,086		▲		
Total RTT Admitted Open Pathways	Green				5,096		▼		
A&E Attendances	Green	101,918	67,711	70,463	8,912	✗	▲	✗	
Elective Spells	Amber	26,032	16,882	20,485	2,782	✓	▲	✓	
Non-Elective Spells	Amber	28,831	18,800	20,495	2,749	✗	▼	✗	
OP Attendances / Procs (Total)	Amber	443,414	293,271	325,959	41,569	✓	▼	✓	
Outpatient DNA Rate	Amber	5%	5%	7.0%	5.7%	✗	▼	✗	
Virtual Outpatient Activity	Amber	25%	25%	13.7%	11.5%	✗	▼	✗	

OBJECTIVE 7 - FINANCIAL PERFORMANCE									
Indicator	**DQ Assurance**	**Threshold 2024-25**	**Month/YTD Threshold**	**Actual YTD**	**Actual Month**	**Month Perf.**	**Month Change**	**YTD Position**	**Rolling 15 months data**
Income £'000	Green	393,248	258,813	274,707	35,152	✓	▼	✓	
Pay £'000	Green	(246,892)	(164,857)	(175,323)	(21,428)	✗	▲	✗	
Non-pay £'000	Green	(115,359)	(78,485)	(87,530)	(11,316)	✗	▲	✗	
Non-operating costs £'000	Green	(30,997)	(17,543)	(15,795)	(2,005)	✓	▼	✓	
I&E Total £'000	Green	0	(2,072)	(3,940)	403	✗	▲	✗	
Cash Balance £'000	Green		14,813		11,426	✗	▼		
Savings Delivered £'000	Green	23,822	15,880	14,559	2,021	✓	▼	✗	
Capital Expenditure £'000	Green	(28,670)	(16,374)	(19,464)	(3,228)	✗	▲	✗	
Elective Spells (% of 2019/20 performance)	Amber	130%	130%	117.7%	115.7%	✗	▲	✗	
OP Attendances (% of 2019/20 performance)	Amber	130%	130%	118.0%	119.9%	✗	▲	✗	

OBJECTIVE 8 - WORKFORCE PERFORMANCE									
Indicator	**DQ Assurance**	**Threshold 2024-25**	**Month/YTD Threshold**	**Actual YTD**	**Actual Month**	**Month Perf.**	**Month Change**	**YTD Position**	**Rolling 15 months data**
Staff Vacancies % of establishment	Green	7.5%	7.5%		6.8%	✓	▲		
Agency Expenditure %	Green	5.0%	5.0%	3.5%	2.3%	✓	▲	✓	
Staff Sickness % - Days Lost (Rolling 12 months) ✎	Green	5.0%	5.0%		4.9%	✓	▬		
Appraisals (excluding doctors)	Green	90%	90%		94.0%	✓	▲		
Statutory Mandatory training	Green	90%	90%		95.0%	✓	▬		
Substantive Staff Turnover	Green	12.5%	12.5%		13.1%	✗	▲		

OBJECTIVES - OTHER									
Indicator	**DQ Assurance**	**Threshold 2024-25**	**Month/YTD Threshold**	**Actual YTD**	**Actual Month**	**Month Perf.**	**Month Change**	**YTD Position**	**Rolling 15 months data**
Total Number of NICE Breaches	Amber	8	8		4	✓	▬		
Rebooked cancelled OPs - 28 day rule	Green	90%	90%	86.8%	92.9%	✓	▲	✗	
Patient Safety Incidents (Reported)	Amber	9876	6584	6416	900	✓	▲	✗	
Patient Safety Incidents which resulted in moderate harm or above	Amber	1716	1144	1186	195	✗	▼	✗	

Key: Monthly/Quarterly Change

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

YTD Position

Symbol	Meaning
✓ (green)	Achieving YTD Target
(amber)	Within Agreed Tolerance*
✗ (red)	Not achieving YTD Target
✗ (black)	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: 12/12/2024

Meeting Title	**Public Trust Board Meeting**	**Date: 9 January 2025**
Report Title	**Finance Paper Month 8 2024-25**	**Agenda Item Number: 14**
Lead Director	**Jonathan Dunk**	**Chief Finance Officer**
Report Authors	**Sue Fox** **Cheryl Williams**	**Head of Financial Management** **Head of Financial Control and Capital**

Introduction	This report provides an update on the financial position of the Trust at Month 8 (Nov 2024).		
Key Messages to Note	➢ The Trust is reporting a deficit position of £3.9m (on a Control Total basis) to the end of November, adverse to plan by £1.9m. The in-month position is a surplus of £0.4m (adverse to plan by £0.6m). ➢ Elective Recovery Fund (ERF) performance is 139% above pre-Covid levels, which is above the 106% national target and our internal budget target of 124%. As a result, ERF income is £14.3m above the national target as at M08 giving rise to a favourable variance to plan of £5.6m year to date. ➢ The Trust financial plan includes a savings target of 6% (£23.8m). £14.6m has been achieved to date against a year-to-date plan of £15.9m. The key issues are as follows: • The adverse to plan position is driven primarily by £0.8m of pay award pressure (costs outstripping income uplifts) and unfunded support for RTT premium costs • The year to date reported position has benefitted from non-recurrent elements (most notably prior year ERF income settlement) • Further extended RTT recovery premium costs represents an increasing pressure on the financial position • Unfunded escalation capacity costs incurred because of discharge challenges/emerging winter pressure • Further risks remain regards any impact of the counting and coding changes for SDEC on ERF and full delivery of recovery plan actions		
Recommendation	**For Information** ☐	**For Approval** ☐	**For Assurance** ☒

Tick the relevant box(es)			

Strategic Objectives Links	7. *Spending money well on the care you receive* 10. *Innovating and investing in the future of your hospital*

Report history	None
Next steps	To note the contents of this report.
Appendices	Pages 8-10

FINANCE REPORT FOR THE MONTH TO 30th NOVEMBER 2024

FINANCE & INVESTMENT COMMITTEE

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EXECUTIVE SUMMARY

Measures

Ref	All Figures in £'000	In Month			YTD			Full Year			RAG
		Plan	Actual	Var	Plan	Actual	Var	Plan	Forecast	Var	
1	Clinical Revenue	30,725	33,169	2,445	244,563	256,977	12,413	367,434	384,168	16,734	
2	Other Revenue	2,401	2,010	(391)	18,278	22,751	4,473	31,856	37,609	5,753	
3	Pay	(20,670)	(21,428)	(758)	(168,428)	(175,324)	(6,896)	(251,560)	(261,283)	(9,723)	
4	Non Pay	(9,171)	(11,316)	(2,145)	(79,261)	(87,530)	(8,269)	(117,213)	(130,644)	(13,431)	
5	Financing & Non-Ops	(2,090)	(2,056)	34	(16,523)	(16,202)	321	(24,931)	(24,264)	667	
6	Surplus/(Deficit)	1,194	379	(816)	(1,371)	672	2,043	5,586	5,586	-	
7	Control Total Surplus/(Deficit)	993	403	(591)	(2,071)	(3,942)	(1,871)	-	-	-	
	Memos										
8	IA Cost	-	-	-	-	(153)	(153)	-	(153)	(153)	
9	High Cost Drugs	(2,077)	(2,378)	(301)	(16,745)	(19,455)	(2,710)	(25,096)	(25,096)	-	
10	Financial Efficiency	1,985	2,021	36	15,881	14,559	(1,322)	23,822	23,822	-	
11	Cash	14,813	11,426	(3,387)	14,813	11,426	(3,387)	12,356	12,356	-	
12	Capital Plan - CDEL (excluding donated)	(3,886)	(3,228)	658	(20,035)	(19,464)	571	(35,287)	(43,800)	(8,513)	

Key messages

The Trust is reporting a deficit position of £3.9m (on a Control Total basis) to the end of November 2024. This is adverse to plan by £1.9m.

At month 8 the Trust is behind its savings plan by £1.3m which is reflected in the pressure on the expenditure budgets.

ERF performance is currently above the 106% target, with estimated income showing £14.3m above the national target as at M08 which is £5.6m above plan. There is a risk relating to SDEC coding which could impact the ERF position in the second half of the financial year.

The capital expenditure programme is £0.6m below plan, no risk has been identified to scheme expenditure at year-end.

(1 & 2.) Revenue – Clinical revenue for Integrated Care Board (ICB), NHS England (NHSE) contracts, and variable (non-ICB income) is above plan, due to Elective Recovery Fund (ERF), high-cost drugs (HCD) over performance and unbudgeted income from CDC and SDF (offset by delivery costs). Other revenue is above plan due principally to donated income received.

(3. & 4.) Operating expenses – Pay costs are higher than plan due to the wage award funding gap (£0.8m), cost of temporary staff in escalation wards and additional hours carried out to reduce elective backlogs. Bank and Agency expenditure has reduced in November. Non-pay is overspent with an overspend on drugs (partly offset by income for high-cost drugs), outsourcing and clinical supplies and services.

(7.) Control Total Deficit - The Trust is reporting a deficit position to the end of November.

(8.) Industrial Action costs – Industrial action took place in June and July and costs were reflected in the month 3 position.

(10.) Financial Efficiency – £14.6m delivered against an annual target of £23.8m. This increases the year to date position by £2m in month with a significant number of schemes having been approved from a quality perspective.

(11.) Cash – Cash balance is £11.4m, equivalent to 10 days cash to cover operating expenses.

(12.) Capital – Capital expenditure is below YTD plan due to the timing of capital schemes however the Trust is now forecasting above its original plan due to the approval of additional funding for the NHP enabling scheme for Imaging which was received during August and additional digital Diagnostic Funding for Imaging in October. The forecast includes the NHP HV scheme £2.9m which the Trust is in discussions with the National NHP Team with regards to deferral to 25/26.

FORECAST

2. Forecast

The annual plan for 2024/25 is for a breakeven position. The phasing of the final submitted plan delivers a deficit in the first 5 months of the year and a surplus in the remaining months to arrive at breakeven by March 2025.

The Trust continues to forecast a breakeven position in line with plan. However, there are very clear risks to delivery of this, including the need to recover the adverse year to date position, need to ensure payment of additional ERF income, costs of approved RTT recovery investments, additional cost pressures from utility costs and, more generically, the risk of full delivery of planned efficiency savings. As would be expected, the Trust is ensuring all possible options to mitigate against these risks, and ensure plan delivery, are explored.

3. Risks to Plan Achievement

Industrial action cost and lost income, ongoing cost of escalation capacity, cost pressures from RTT recovery, winter pressures, financial efficiency slippage, ERF baseline adjustments, the impact of Emergency Data Set reporting on ERF achievement.

4. Opportunities to improve the Position

ERF income for additional elective work, funding for RTT plans, baseline adjustment for SDEC, recovery from community providers for delayed discharges and non-recurrent plan mitigation.

Key message

We have developed a mitigation plan to reach breakeven and this continues to evolve. Achievement of the plan will depend heavily on the required savings being realised and the run rate steadily improving in the remaining months of the financial year, as well as achieving additional ERF income to offset investment in RTT recovery.

CASH

5. Summary of Cash Flow
The cash balance at the end of November was £11.4m, £0.7m behind the planned figure of £12.1m. This reflects receipt of capital PDC (not yet spent), offset by the delay in receipt of ERF income which was planned to have been received earlier in the year. It is a £2.1m decrease on last month's figure of £13.5m (see opposite). The decrease in the month was caused by a £2.1m deficit in operating working capital.

6. Cash arrangements 2024/25
The Trust will continue to receive block funding for FY25 which includes an uplift for growth plus any additional incentive funding linked to activity delivery and funding for high-cost drugs on a pass-through basis.

7. Better Payment Practice
The Trust has fallen below the national target of 95% of all bills paid within the target timeframe in terms of value and volume. This is due the ongoing issues with agency invoicing, NHS approvals and the current creditor stretching to meet the cash envelope available. This metric will continue to be monitored in accordance with national guidance and best practice.

Better payment practice code	Actual M8 YTD Number	Actual M8 YTD £'000	Actual M7 YTD Number	Actual M7 YTD £'000
Non NHS				
Total bills paid in the year	39,874	144,546	36,267	130,797
Total bills paid within target	34,024	130,286	32,576	119,677
Percentage of bills paid within target	**85.3%**	**90.1%**	**89.8%**	**91.5%**
NHS				
Total bills paid in the year	1,502	7,969	1,336	6,887
Total bills paid within target	1,374	6,007	1,215	4,986
Percentage of bills paid within target	**91.5%**	**75.4%**	**90.9%**	**72.4%**
Total				
Total bills paid in the year	**41,376**	**152,515**	**37,603**	**137,684**
Total bills paid within target	**35,398**	**136,292**	**33,791**	**124,663**
Percentage of bills paid within target	**85.6%**	**89.4%**	**89.9%**	**90.5%**

Key message
Cash at the end of November was £0.7m behind plan, mostly due to the receipt of capital PDC offset by delayed receipt of ERF income. There was a month on month decrease of £2.1m from October, due to an in-month working capital deficit.

BPPC performance has reduced in month due to internal measures to maintain cash balances.

BALANCE SHEET

8. Statement of Financial Position

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

- Non-Current Assets have increased from March 24 by £7.8m; this is driven by a £10.5m increase in tangible assets, offset by a £1.3m decrease in the Right of Use assets, a £1.5m decrease in Intangible assets.
- Current assets have increased by £3.9m; this includes increases in other receivables of £11.4m (£13.7m increase in prepayments, offset by a £2.3 decrease in non-NHS debtors) and in NHS receivables of £8.3m, offset by a decrease in cash of £15.8m.
- Current liabilities have increased by £2.6m; this is due to the £3.1m increase in payables and £1.0m increase in deferred income, offset by the £0.8m decrease in Right of Use assets liability.
- Non-Current Liabilities have increased from March 24 by £0.5m; this is due to the Right of Use assets, related to IFRS 16.

9. Aged debt

- The debtors position as of November 24 is £3.9m, which is a decrease of £1.4m from the prior month. Of this total £1.1m is over 121 days old.

10. Creditors

- The creditors position as of November 24 is £114.6m, which is an increase of £4.6m from the prior month. £2.8m is over 30 days of ageing with £0.6m approved for payment.

Key message
Main movements in year on the statement of financial position are the reduction in cash of £15.8m and increase in supplier payables £5.5m; offset by increases in receivables of £19.7m and reduction in provisions of £3.1m.

RECOMMENDATIONS TO BOARD OF DIRECTORS

11. The Board is asked to note the financial position of the Trust as of 30th November 2024 and the proposed actions and risks therein.

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

APPENDICIES

Appendix 1

Statement of Comprehensive Income
For the period ending 30th November 2024

	FY25	M8 CUMULATIVE			M8			PRIOR MONTH	
	Annual Budget £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	M7 Actual £'000	Change £'000
INCOME									
Outpatient First	34,746	22,877	24,268	1,391	3,125	3,572	447	4,075	(503)
Outpatient Procedures	5,250	3,169	4,009	840	495	663	168	609	54
Chemotherapy delivery	2,512	1,704	1,542	(162)	209	220	11	189	31
Day Case Admissions	21,868	14,201	17,259	3,059	1,956	2,649	694	2,284	365
Elecitve Admissions	17,174	11,050	10,903	(146)	1,764	1,651	(112)	1,290	361
High Cost Drugs & Devices	26,195	17,416	17,612	196	2,272	2,308	36	2,881	(574)
Total Variable Income	***107,746***	***70,416***	***75,594***	***5,178***	***9,820***	***11,064***	***1,244***	***11,328***	***(265)***
Outpatient Follow up	25,166	16,832	16,833	1	2,295	2,295	0	2,548	(252)
Emergency Admissions	95,445	62,495	62,505	11	7,935	7,937	3	9,036	(1,099)
A&E	21,137	14,043	14,042	(0)	1,761	1,760	(0)	2,137	(377)
Other Admissions	17,492	11,620	1,664	(9,956)	1,417	211	(1,206)	201	10
Maternity Other (including Deliveries_	0	0	9,964	9,964	0	1,207	1,207	1,274	(67)
Maternity pahtway (ante/post natal)	9,318	6,339	6,343	4	800	800	(0)	885	(85)
Critical Care (adult)	4,289	2,788	2,785	(4)	609	609	(1)	245	364
Neonatal	3,840	2,551	2,551	(0)	355	355	(0)	403	(48)
Imaging	7,587	4,895	4,895	0	752	752	0	809	(56)
Direct Access Pathology	6,307	4,218	4,218	(0)	558	558	(0)	619	(61)
Best Practice Tariffs	646	423	423	(0)	54	55	1	63	(8)
Other block income	8,806	5,887	5,887	(0)	733	733	(0)	864	(131)
Total Block / Fixed income	***200,033***	***132,092***	***132,112***	***20***	***17,270***	***17,274***	***4***	***19,084***	***(1,811)***
Non-recurent & additional income	0	(2,424)	4,790	7,214	(1,926)	(728)	1,198	1,058	(1,786)
National Block	59,655	44,479	44,479	0	5,560	5,560	0	6,532	(972)
Clinical Income	**367,434**	**244,563**	**256,977**	**12,413**	**30,725**	**33,169**	**2,445**	**38,005**	**(4,836)**
Non-Patient Income	25,563	17,114	17,731	617	2,142	1,983	(159)	2,660	(677)
Donations	6,293	1,164	5,020	3,856	259	27	(232)	(15)	42
Non-Patient Income	**31,856**	**18,278**	**22,751**	**4,473**	**2,401**	**2,010**	**(391)**	**2,645**	**(635)**
TOTAL INCOME	**399,290**	**262,841**	**279,727**	**16,886**	**33,125**	**35,179**	**2,054**	**40,650**	**(5,471)**
EXPENDITURE									
Pay - Substantive	(234,049)	(156,592)	(151,930)	4,662	(19,243)	(19,237)	6	(23,589)	4,352
Pay - Bank	(10,573)	(7,039)	(13,457)	(6,418)	(892)	(1,603)	(711)	(1,952)	349
Pay - Locum	(2,235)	(1,490)	(4,716)	(3,226)	(186)	(610)	(423)	(593)	(16)
Pay - Agency	(5,123)	(3,586)	(6,084)	(2,498)	(384)	(499)	(115)	(824)	324
Pay - Other	(942)	(628)	(699)	(71)	(78)	(109)	(31)	(83)	(26)
Pay CIP	1,312	874	1,563	689	109	630	521	405	225
Vacancy Factor	50	33	0	(33)	4	0	(4)	0	0
Pay	**(251,560)**	**(168,428)**	**(175,324)**	**(6,896)**	**(20,670)**	**(21,428)**	**(758)**	**(26,636)**	**5,207**
Non Pay	(92,117)	(62,516)	(68,074)	(5,559)	(7,094)	(8,938)	(1,844)	(8,937)	(1)
Non Tariff Drugs (high cost/individual drugs)	(25,096)	(16,745)	(19,455)	(2,710)	(2,077)	(2,378)	(301)	(2,810)	432
Non Pay	**(117,213)**	**(79,261)**	**(87,530)**	**(8,269)**	**(9,171)**	**(11,316)**	**(2,145)**	**(11,747)**	**431**
TOTAL EXPENDITURE	**(368,773)**	**(247,689)**	**(262,853)**	**(15,165)**	**(29,841)**	**(32,745)**	**(2,903)**	**(38,383)**	**5,638**
EARNINGS BEFORE INTEREST, TAXATION, DEPRECIATION AND AMORTISATION (EBITDA)	**30,517**	**15,152**	**16,874**	**1,722**	**3,284**	**2,435**	**(849)**	**2,267**	**167**
Interest Receivable	480	320	764	444	40	90	50	104	(14)
Interest Payable	(1,268)	(845)	(387)	458	(106)	(48)	57	(48)	(0)
Depreciation, Impairments & Profit/Loss on Asset Disposal	(16,979)	(11,229)	(11,288)	(60)	(1,428)	(1,436)	(8)	(1,436)	(1)
Donated Asset Depreciation	(707)	(464)	(406)	59	(58)	(51)	7	(51)	0
Profit/Loss on Asset Disposal & Impairments	0	0	0	0	0	0	0	0	0
DEL Impairments	0	0	(464)	(464)	0	(58)	(58)	(58)	(0)
AME Impairments	0	0	0	0	0	0	0	0	0
Unwinding of Discounts	0	0	0	0	0	0	0	0	0
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**12,044**	**2,934**	**5,092**	**2,158**	**1,733**	**931**	**(801)**	**779**	**152**
Dividends Payable	(6,457)	(4,305)	(4,420)	(115)	(538)	(552)	(14)	(552)	0
OPERATING SURPLUS/(DEFICIT) AFTER DIVIDENDS	**5,586**	**(1,371)**	**672**	**2,043**	**1,194**	**379**	**(816)**	**226**	**152**

Appendix 2

Statement of Cash Flow
As of 30th November 2024

	Mth12 2023-24 £000	Mth 8 £000	Mth 7 £000	In Month Movement £000
Cash flows from operating activities				
Operating (deficit)/surplus from continuing operations	13,970	5,180	4,231	949
Operating surplus/(deficit) of discontinued operations				
Operating (deficit)/surplus from continuing operations	**13,970**	**5,180**	**4,231**	**949**
Non-cash income and expense:				
Depreciation and amortisation	17,229	11,694	10,208	1,486
(Increase)/Decrease in Trade and Other Receivables	(3,720)	(19,705)	(18,382)	(1,323)
(Increase)/Decrease in Inventories	(127)	(33)	(13)	(20)
Increase/(Decrease) in Trade and Other Payables	544	(3,509)	(3,213)	(296)
Increase/(Decrease) in Other Liabilities	(6,967)	1,066	1,062	4
Increase/(Decrease) in Provisions	8,698	(3,161)	(1,449)	(1,712)
Income in respect of capital donations	(8,415)	(5,020)	(5,022)	2
Other movements in operating cash flows	891	0	0	0
NET CASH (USED IN) GENERATED FROM OPERATIONS	**22,103**	**(13,488)**	**(12,578)**	**(910)**
Cash flows from investing activities				
Interest received	1,399	764	674	90
Purchase of intangible assets	(425)	(83)	(66)	(17)
Purchase of Property, Plant and Equipment	(34,087)	(12,357)	(10,733)	(1,624)
Process from sale of Property, Plant and Equipment	252	0	0	0
Net cash (used in) investing activities	**(32,861)**	**(11,676)**	**(10,125)**	**(1,551)**
Cash flows from financing activities				
Public dividend capital received	11,039	7,918	7,918	0
Capital element of finance lease rental payments	(5,078)	693	156	537
Unwinding of discount	0	(464)	(406)	(58)
Interest element of finance lease	(680)	(387)	(339)	(48)
PDC Dividend paid	(5,725)	(3,398)	(3,398)	0
Receipt of cash donations to purchase capital assets	8,415	5,020	5,022	(2)
Cash flows from (used in) other financing activities	0	0	0	0
Net cash generated from/(used in) financing activities	**7,971**	**9,382**	**8,953**	**429**
(Decrease)/increase in cash and cash equivalents	**(2,787)**	**(15,782)**	**(13,750)**	**(2,032)**
Opening Cash and Cash equivalents	**27,208**	**27,208**	**27,208**	
Closing Cash and Cash equivalents	**27,208**	**11,426**	**13,458**	**(2,032)**

Appendix 3

Statement of Financial Position as of 30th November 2024

	Mar-24 Audited	Nov-24 YTD Actual	YTD Mvmt	% Variance
Assets Non-Current				
Tangible Assets	241.4	251.9	10.5	4.3%
Intangible Assets	16.6	15.1	(1.5)	(9.0%)
ROU Assets	18.6	17.3	(1.3)	(7.0%)
Other Assets	3.2	3.3	0.1	3.1%
Total Non Current Assets	**279.8**	**287.6**	**7.8**	**2.8%**
Assets Current				
Inventory	5.3	5.3	0.0	0.0%
NHS Receivables	12.0	20.3	8.3	69.2%
Other Receivables	7.5	18.9	11.4	152.0%
Cash	27.2	11.4	(15.8)	(58.1%)
Total Current Assets	**52.0**	**55.9**	**3.9**	**7.5%**
Liabilities Current				
Interest -bearing borrowings	(1.5)	(0.7)	0.8	(53.3%)
Deferred Income	(11.6)	(12.6)	(1.0)	8.6%
Provisions	(11.7)	(8.6)	3.1	(26.5%)
Trade & other Creditors (incl NHS)	(60.8)	(66.3)	(5.5)	9.0%
Total Current Liabilities	**(85.6)**	**(88.2)**	**(2.6)**	**3.0%**
Net current assets	**(33.6)**	**(32.3)**	**1.3**	**(3.9%)**
Liabilities Non-Current				
Long-term Interest bearing borrowings	(18.2)	(18.7)	(0.5)	2.7%
Deferred Income	(0.5)	(0.5)	0.0	0.0%
Provisions for liabilities and charges	(1.6)	(1.6)	0.0	0.0%
Total non-current liabilities	**(20.3)**	**(20.8)**	**(0.5)**	**2.5%**
Total Assets Employed	**225.9**	**234.5**	**8.6**	**3.8%**
Taxpayers Equity				
Public Dividend Capital (PDC)	294.2	302.1	7.9	2.7%
Revaluation Reserve	64.6	64.6	0.0	0.0%
Financial assets at FV through OCI reserve	(2.6)	(2.6)	0.0	0.0%
I&E Reserve	(130.3)	(129.6)	0.7	(0.5%)
Total Taxpayers Equity	**225.9**	**234.5**	**8.6**	**3.8%**

GLOSSARY OF TERMS

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

Meeting Title	**Trust Board in Public**	**Date: 9 January 2025**
Report Title	Executive Director Update (Workforce)	**Agenda Item Number: 15**
Lead Director	*Catherine Wills, Chief People Officer*	
Report Author	*Louise Clayton, Deputy Chief People Officer*	

Introduction	*Standing Agenda Item* *This report provides a summary of workforce Key Performance Indicators for the previous 12 months up to 30 November 2024 (M8) and relevant Workforce and Organisational Development updates*		
Key Messages to Note	*Points to note in the report for the members of the Board:* • *Temporary Staffing spend and usage has reduced over these last 12 months from 13.4% of the pay bill to 11.5%. However this remains an area of focus as we continue to seek to reduce temporary solutions and work towards a more sustainable and stable workforce, balanced against operational need in response to escalation and reducing waiting lists.* • *Absence has increased to 4.9% for November and is currently at above 5% - linked to higher levels of Flu, Cough and Cold in the population in general and within the workforce. Proactive campaigns for vaccination continue in an attempt to alleviate the impact of this.* • *Time to Hire has reduced in the last 2 months down to 43 days – this has been in part driven by the divisional alignment of recruitment to improve the manageable aspects of the process.* • *The Healthcare Support Worker B2-3 MoU has now completed full sign off through our JCNC and the first phase for the re-banding is almost complete, with many now in receipt of payment.* • *In line with our cultural programme of work, sessions were held throughout December with the Board, TEC and the leadership forum to provide feedback on the outcomes of the Yvonne Coghill and Roger Kline Reports and actions underway now include Values Based Recruitment training which commenced in December. Further engagement is due throughout January with the wider organisation to further develop and refine the plans.*		
Recommendation *(Tick the relevant box(es))*	**For Information** √	**For Approval** ☐	**For Assurance** ☐

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	8. *Employ and retain the best people to care for you*

Report History	*This is the first version of this report*
Next Steps	*This report shall be considered by JCNC*
Appendices/Attachments	None

1. Purpose of the report

1.1. This report provides a summary of workforce Key Performance Indicators as at 30 November 2024 (Month 8), covering the preceding 13 months.

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

Indicator	Measure	Target	11/2023	12/2023	01/2024	02/2024	03/2024	04/2024	05/2024	06/2024	07/2024	08/2024	09/2024	10/2024	11/2024
Staff in post *(as at report date)*	Actual WTE		3820.9	3826.0	3834.9	3850.3	3869.1	3861.1	3880.6	3879.2	3913.0	3873.3	3875.2	3885.2	**3909.6**
	Headcount		4351	4352	4368	4381	4402	4392	4415	4412	4449	4408	4406	4414	**4439**
Establishment *(as per ESR)*	WTE		4005.3	4001.9	4012.1	4008.1	4018.1	4109.9	4144.0	4156.7	4162.7	4159.1	4170.8	4187.0	**4196.1**
	%, Vacancy Rate - Trust Total	**10.0%**	4.6%	4.4%	4.4%	3.9%	3.7%	6.1%	6.4%	6.7%	6.0%	6.9%	7.1%	7.2%	**6.8%**
	%, Vacancy Rate - Add Prof Scientific and Technical		15.7%	19.5%	18.6%	17.7%	16.1%	19.9%	21.4%	22.2%	23.0%	23.8%	23.8%	23.9%	**23.5%**
	%, Vacancy Rate - Additional Clinical Services *(Includes **HCA** s)*		9.5%	11.1%	16.0%	15.3%	15.3%	16.3%	15.5%	14.7%	14.4%	16.7%	19.1%	18.8%	**18.4%**
	%, Vacancy Rate - Administrative and Clerical		3.1%	2.1%	1.5%	1.6%	1.4%	2.9%	2.9%	3.1%	2.8%	4.5%	3.9%	3.3%	**3.6%**
	%, Vacancy Rate - Allied Health Professionals		16.0%	16.0%	15.3%	13.1%	12.1%	11.6%	17.0%	18.6%	18.0%	16.0%	14.9%	16.5%	**15.0%**
	%, Vacancy Rate - Estates and Ancillary		4.6%	4.9%	3.6%	3.8%	4.3%	9.2%	8.7%	8.2%	7.7%	6.6%	7.0%	7.9%	**8.2%**
	%, Vacancy Rate - Healthcare Scientists		0.0%	-1.7%	-0.5%	0.2%	-0.9%	4.1%	5.2%	5.0%	2.6%	1.9%	1.6%	0.0%	**1.1%**
	%, Vacancy Rate - Medical and Dental		0.0%	-2.3%	-1.8%	-1.0%	-1.3%	1.4%	2.1%	3.0%	-0.5%	1.2%	1.6%	0.9%	**0.3%**
	%, Vacancy Rate - Nursing and Midwifery Registered		2.5%	1.3%	-0.8%	-2.0%	-2.2%	0.9%	0.8%	1.5%	1.5%	2.0%	1.7%	2.4%	**1.6%**
Staff Costs (12 months) *(as per finance data)*	%, Temp Staff Cost (%, £)		13.4%	12.7%	12.4%	12.2%	12.2%	11.9%	11.7%	11.7%	11.7%	11.8%	11.8%	11.6%	**11.5%**
	%, Temp Staff Usage (%, WTE)		13.1%	12.8%	12.6%	12.4%	12.2%	12.2%	12.0%	11.9%	11.9%	11.8%	11.8%	11.7%	**11.6%**
Absence (12 months)	%, 12 month Absence Rate	**5.0%**	4.6%	4.6%	4.7%	4.7%	4.7%	4.8%	4.8%	4.8%	4.8%	4.9%	4.9%	**4.9%**	*4.9%*
	- %, 12 month Absence Rate - Long Term		*2.5%*	*2.5%*	*2.6%*	*2.5%*	*2.6%*	*2.6%*	*2.6%*	*2.6%*	*2.6%*	*2.6%*	*2.7%*	***2.6%***	*2.6%*
	- %, 12 month Absence Rate - Short Term		*2.1%*	*2.1%*	*2.2%*	*2.2%*	*2.1%*	*2.2%*	*2.2%*	*2.2%*	*2.3%*	*2.3%*	*2.2%*	***2.3%***	*2.3%*
	%,In month Absence Rate - Total		5.0%	5.6%	5.6%	5.0%	4.5%	4.8%	4.4%	4.3%	4.9%	4.9%	4.8%	**5.1%**	*5.2%*
	- %, In month Absence Rate - Long Term		*3.0%*	*3.1%*	*3.0%*	*2.8%*	*2.7%*	*2.4%*	*2.4%*	*2.4%*	*2.7%*	*2.8%*	*2.7%*	***2.5%***	*2.9%*
	- %, In month Absence Rate - Short Term		*2.0%*	*2.5%*	*2.6%*	*2.2%*	*1.8%*	*2.4%*	*2.0%*	*2.0%*	*2.2%*	*2.1%*	*2.1%*	***2.6%***	*2.3%*
Starters, Leavers and T/O rate (12 months)	WTE, Starters (In-month)		56.9	24.8	48.0	37.0	40.4	31.8	43.8	43.0	36.1	25.4	26.5	32.8	**46.3**
	Headcount, Starters (In-month)		66	28	53	41	47	36	51	49	45	28	29	38	**50**
	WTE, Leavers (In-month)		32.9	32.9	41.0	29.8	31.1	43.2	34.5	39.3	36.0	55.1	39.5	29.9	**26.5**
	Headcount, Leavers (In-month)		37	42	47	36	39	52	39	49	41	64	51	35	**30**
	%, Leaver Turnover Rate (12 months)	**12.5%**	13.0%	12.9%	12.8%	13.0%	12.6%	13.2%	13.1%	13.1%	12.5%	13.3%	13.1%	13.3%	**13.1%**
Statutory/Mandatory Training	%, Compliance	**90.0%**	96%	96%	95%	94%	94%	95%	96%	95%	94%	95%	95%	95%	**95%**
	Moving and Handling - Level 1 - 3 Years							94.0%	94.0%	94.0%	93.0%	93.0%	93.0%	93.0%	**93.0%**
	Moving and Handling - Level 2 - 3 Years							94.0%	94.0%	94.0%	94.0%	94.0%	93.0%	92.0%	**92.0%**
Appraisals	%, Compliance	**90%**	89%	90%	90%	91%	92%	92%	92%	91%	91%	90%	93%	93%	**94%**
Time to Hire (days)	General Recruitment	**35**	46	50	48	44	43	49	54	48	44	51	51	42	**43**
	Medical Recruitment (excl Deanery)	**35**	93	45	62	69	52	79	76	51	54	68	86	65	**40**
Employee relations	Number of open disciplinary cases		21	21	22	21	19	16	20	12	18	12	17	18	**18**
Number of payroll payments to all staff *(inc. Doctors in Training)* **for all payrolls processed**	*Number of Overpayments in monthly period*									10	19	27	30	11	**41**
	Number of Underpayments in monthly period									177	181	70	81	23	37
	Percentage of Payroll errors									4.2%	4.4%	2.1%	2.4%	0.7%	1.7%

2.1. **Temporary staffing usage** and cost has **reduced** slightly and is now the lowest it has been for 13 months. Areas with high bank usage remain under review. Changes to rostering practices to include unpaid breaks for all shifts over 6 hours, reversion to TOIL for extra time worked up to an hour per day for admin staff, and greater oversight and scrutiny of approving shifts to send to bank, have all had a positive impact on this.

2.2. The Trust's **headcount has increased in month** and there are now 4439 employees in post. The **vacancy rate** has decreased to 6.8% with Additional Professional Scientific and Technical and Additional Clinical Services staff groups remaining high. 'New year' recruitment campaigns launch in January to increase the profile through this key recruitment period.

2.3. **Staff absence remains at 4.9%** for the 12-month period and has increased to 5.2% in month, which is higher than previous trends for Q3. Flu is having a significant impact on staff absence and the trust continues with the flu vaccination campaign. Increased training is being rolled out to ensure managers are complying with 'return to work' processes to better support their staff.

2.4. **Staff turnover has reduced to 13.1%.** Retention projects in areas of high turnover continue and the HRBPs are carrying out bespoke pieces of work where turnover is high. Healthcare Assistants remain an area of focus for improved retention and as the re-banding process approaches completion, it is anticipated that attrition rates will improve for this staff group.

2.5. **Time to hire is at 43 days** which is a significant improvement from M1. The manageable delays in processes are being reviewed to close the timeline where possible. The recruitment team have been aligned to Divisions to provide a more consistent support to Divisions.

2.6. The number of **open disciplinary cases** remains at 18. A detailed Employee Relations case report is produced monthly to JCNC.

2.7. **Statutory and mandatory training** compliance is at 95% and **appraisal** compliance is at 94%.

3. Continuous Improvement, Transformation and Innovation

3.1. The HR Services Team have been working with Deloitte's (appointed by NHS England) to review **payroll processes** and look at possible automation solutions to improve pay-impacting changes. The team are working with our IT team and Digital Programme Lead at BLMK to review interoperability between an e-form solution and ESR.

3.2. As part of the **People Digital Programme**, the team have submitted four key priority areas for improving people processes to BLMK. These are being reviewed at People Digital Board and will help inform the community of practice within the system to review commonalities and develop a shared programme of work. The Trust has been awarded funding to deliver on automation solutions for HR Services and the team are working with IT to shape what the delivery for this might be.

4. Culture and Staff Engagement

4.1. The **Protect and Reflect Event** came to an end on 29th November. The final report from Quality Health showed an achievement of a 51% return rate following final validation. The national results will be released in March, however HRBPs will work with Divisions to share their data locally in February and action plans for engaging staff in the outcomes will follow.

4.2. The **Staff Health and Wellbeing Team** are launching their new Occupational Health System in January including a new way of making management referrals. Managers will be able to view their referrals in real time and retrieve outcome reports from the system. The new referral process launches on 8th January.

5. Current Affairs & Hot Topics

5.1. **Values Based Recruitment** training commenced in M9 and was well-received by managers. The training will be delivered four times per month from January. Managers that frequently recruit will be contacted directly to book on by their Recruitment Specialists. Once completed, they will be given a 'Licence to Hire with Values' and be able to use the values approach to recruitment, including applying some key inclusive techniques for writing adverts, shortlisting, and interviewing.

5.2. The first phase of the **re-banding of Healthcare Support Workers** is almost complete with final appeals being heard in M9. The next phase is to review those that were promoted from a Band 2 Healthcare Support Worker to a Band 3 Senior Healthcare Support Worker prior to the Trust's re-banding process to ensure there is no displacement of salary point for these staff.

5.3. As part of our **Culture Programme** of work, the outputs from the Yvonne Coghill and Roger Kline reports have now been presented and discussed widely at Board, TEC and the leadership forum. Immediate actions have been identified that can happen straight away such as Values Based Recruitment. Engagement on this programme will continue throughout January with wider sessions across the organisation planned to gain involvement in the development of the plan.

6. Recommendations

6.1. Members are asked to note the report.

Meeting Title	Trust Board in Public	Date: 9 January 2025
Report Title	**Freedom to Speak Up Bi-Annual Report – Q1 and Q2 - 2024/25**	**Agenda Item Number: 16**
Lead Director	Catherine Wills, Chief People Officer	
Report Author	Janice Scott, Lead Freedom to Speak Up Guardian	

Introduction	This report provides an update on FTSU activity for the period 1 April – 30 September 2024		
Key Messages to Note	The infrastructure for the service has been reviewed and refreshed including the policy and development of a 3-year strategy. The highest number of concerns relate to perceived fairness and equity in the application of processes and support from managers which is being reported as poor staff emotional and mental wellbeing. Referrals to FTSU continue and capacity will be increased by the recruitment of additional Guardians and Champions.		
Recommendation *(Tick the relevant box(es))*	**For Information** ☒	**For Approval** ☐	**For Review** ☐

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	To employ and retain the best people to care for you

Report History	This report has been submitted to Execs and Trust Executive Committee
Next Steps	Review at Workforce and Development Assurance Committee
Appendices/Attachments	Appendix 1: FTSU Strategy (*Supplementary Shelf)*

Freedom to Speak Up Bi-Annual Report 1 April - 30 September 2024

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1. Executive Summary

This report provides information on speaking up activity undertaken during Q1 and 2 from 1st April to 30th September 2024. A review of the FTSU function was completed by the Lead Guardian alongside feedback from stakeholders. The output of this has been the development of a FTSU Strategy, an improved and compliant case management process, additional collection of data, and a revised reporting process. There has also been some reduction in Guardian and Champion capacity, with recruitment planned for Q3 and Q4.

1.1 Additional thematic categories have been added to the reporting system to ensure National Guardian Office compliance. Additional commentary for collection has been added to aid understanding of the data.

1.2 The FTSU policy has been reviewed and updated and is progressing through the governance process.

1.3 A 3-year FTSU Strategy and action plan has been completed which focusses on 5 key objectives to support the ongoing development of a more open, transparent and honest reporting culture, focussing on building staff trust and empowering, enabling and supporting managers to appropriately follow up on issues raised.

1.4 There were 64 concerns raised via FTSU during the period which is 4% less than the same period the previous year.

1.5 The 6 additional themes of concerns now being collected provide an improved breadth of choice when reporting, enabling stronger alignment as well as capacity to determine the concerns being raised and support the resolution of the concerns.

1.6 The highest number of concerns reported for the period was ‘the application of systems and processes’ which is a new category to MKUH. This is when a staff member perceives a process of policy has not been correctly followed, or that they have been treated differently or made to work in a different way to their colleagues. The second highest was also a new category; ‘senior and middle managers’ which is staff reporting a lack of support from their managers, particularly if they are speaking up or sharing a concern.

1.7 FTSU is often approached at a late stage, meaning cases have multiple themes. When this data is collated, we see the application of systems and processes and a lack of support from managers having an impact on staff emotional and mental wellbeing.

1.8 The reduction of cases from Surgery and the change to numbers in each division can be aligned with a change of Guardians. The breakdown of cases by division and themes is in its infancy and will be monitored monthly to identify specific themes in a timely manner.

1.9 Data reporting on FTSU case resolution will commence from Q3.

1.10 FTSU month evidenced that generic and service-based engagement provides staff with the reassurance of confidentiality as opposed to individualised action.

1.11 KPI’s will be developed to assist monitoring the effectiveness of the FTSU offer.

2. FTSU service changes

2.1 Support and staffing

The previous Lead Guardian retired at the end of March with the new Lead Guardian starting early June. The gap was covered by the FTSU Guardian team who worked together to provide ongoing support to staff and the Trust. The Lead Guardian's priority has been to better understand the current offer in order to develop a 3-year strategy.

It is important to note that as part of early engagement with staff across all staffing levels, there was some discontent with elements of the FTSU support given to individuals, which resulted in the Lead Guardian reviewing and progressing a number of previously raised concerns. These concerns revolved around the effective and confidential management of concerns.

As a function that serves to support staff who may be feeling vulnerable, lacking in trust, and needing a confidential space to discuss their concerns, it is imperative to implement a trusted and accountable process-related service.

Work has been carried out to review the current structure, resource and case management process. This has resulted in an updated case management process that ensures compliance with the National Guardian Office (NGO) requirements, adhering to data protection processes and a clear escalation process.

There has been a renewed energy on ensuring that the Guardians and Champions have the knowledge, skills, and time to be able to carry out their roles. Standard Guardian processes have been introduced to provide clarity on capacity, availability, recording and dedication to the roles. There were also specific requests from the Guardians and engaged Champions for more support, guidance and direction. As both roles attract protected time, there was a need for oversight and assurance on support being provided and work being undertaken by these staff members, and their capacity to continue to do so. This has resulted in some reduction in Guardians and Champions. The current FTSU resource is:

- 1 wte Lead FTSU Guardian
- 2 FTSU Guardians with protected time
- 10 FTSU Champions with protected time

The Guardians meet as a group monthly for case management guidance and updates on changes to the system, this will progress to include case reviews. The Champions have been offered two meetings to revisit training, identify signposting routes and to provide support on their role.

Recruitment is currently underway for additional Guardians and Champions across all wards, divisions and levels of role.

The reviewed and revised FTSU offer has enabled the FTSU policy to be refreshed and this is currently going through the governance process. The above work has resulted in a 3-year FTSU Strategy and action plan (Appendix 1) which focusses on the actions under 5 key objectives which will support the development of an open and honest reporting culture, where all staff have a role in breaking down the barriers to speaking up.

The Trust compliance for Speak up, Listen up and Follow Up training remains above target at 97%.

2.2 Reporting

This report contains an increased amount of data in an anonymised format, as per NGO guidance, to respond to the request for a better understanding of the concerns raised through FTSU and how these concerns are resolved.

It is noted that each person speaking up is counted as a separate case even where several individuals may be speaking up about the same matter together or separately. The theme of concern is determined by what the reporter states and this is often worked through via discussion with the Guardian.

Whilst the data is accurate, it should be noted that two concerns have been consumed within other datasets to ensure anonymity due to them potentially being identifiable.

The additional categories under the theme of concerns come from the NGO guidance on reporting. System Process, Cultural, Leadership, Senior/Middle Management issues and Infrastructure/environment were not previously utilised.

There is a further breakdown of themes of concerns linked to divisions, of concerns related to protected characteristics, and staff reporting that they fear or believe they are suffering detriment as a result of speaking up.

3. Numbers and themes of FTSU concerns raised

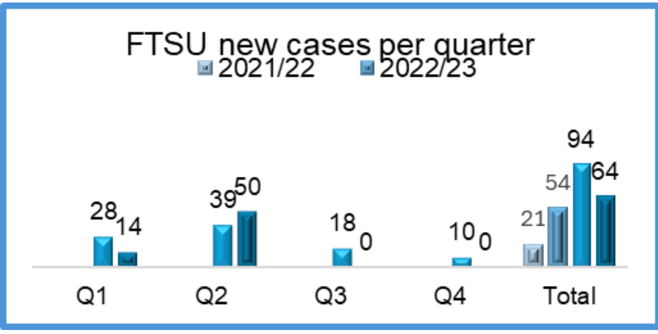
3.1 Quarterly breakdown of concerns raised to FTSU Guardians

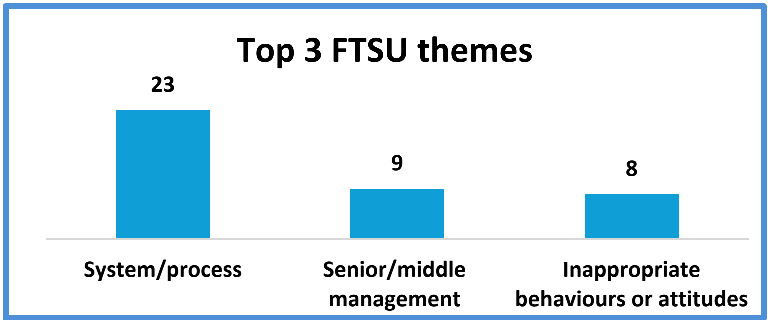
Staff can speak up or be signposted to a Guardian via a variety of means:

- Telephone – via call, text or WhatsApp;
- Computer - Teams, FTSU email, personal email, QR code where an anonymous form can be completed; and
- Signposting from a Champion, Staff Network, colleague or manager

As anticipated, due to the small break in between Lead Guardians, there was a 66% decrease in the number of new concerns for Q1 in comparison with the previous period. This number has more than doubled between quarters and shows an overall 4% decrease in comparison with the same period last year.

	Q1	Q2	Q3	Q4	Year Total
2021/22					**21**
2022/23					**54**
2023/24	**28**	**39**	**18**	**10**	**94**
2024/25	**14**	**50**	**-**	**-**	**64**





Primary theme of concerns*

	2023/24	2024/25				
		Q1	Q2	Q3	Q4	Total 2024/25
Patient safety / quality	12	3	4			**7**
Bullying / harassment	22		5			**5**
Behavioural/ relationship	-	-	-			**0**
System/process	-	1	22			**23**
Staff safety	26	3	1			**4**
Cultural	-	-	2			**2**
Leadership	-	-	-			**0**
Senior/Middle management issue	-	-	9			**9**
Infrastructure/environment	-	-	4			**4**
Inappropriate attitude or behaviours	25	5	3			**8**
Other/ anonymous	9 (detriment)	2	-			**2**
Total	**94**	**14**	**50**			**64**

Categories are suggested by the National Guardian's Office; discussion with staff and judgement of the Guardian determines which category a concern is recorded against.

The additional use of themes as per NGO guidance means there has been a change in the breakdown of themes reported. Staff and Guardians now have the breadth of choice and the ability to better align the primary theme of the concern and a further breakdown where multiple issues/themes occur.

The highest reported concern thus far is Systems /process. For this period this ranged from recruitment processes, performance management, grievance outcomes, reasonable work adjustments, access to information, access to training and progression. The actions and processes following submitting Radars was a common concern.

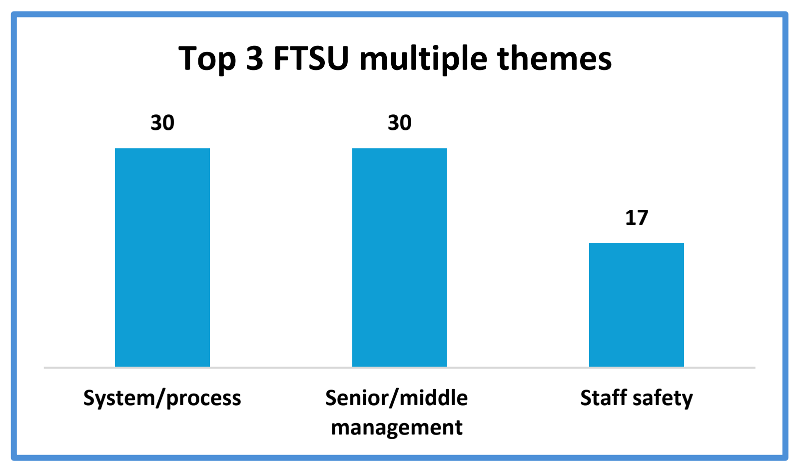
The second highest reported concern was staff not feeling supported by either a middle or senior manager. This ranged from not being supportive with regards a disability, a lack of support provided to staff following speaking up about a work task or issue and a lack of consistent support to students.

Inappropriate behaviours and attitudes came a close third, with inappropriate comments not being addressed, staff reporting being belittled by managers and microaggression perceptions related to race, disability and gender.

3.3 FTSU cases with multiple themes*

	Q1	Q2	Q3	Q4	Total 2024/25
Patient safety / quality	3	8			**11**
Bullying / harassment	4	12			**16**
Behavioural / relationship	-	6			**6**
System/process	2	28			**30**
Staff safety	4	13			**17**
Cultural	-	11			**11**
Leadership	-	-			**0**
Senior/Middle management issue	2	28			**30**
Infrastructure/environment	-	5			**5**
Inappropriate attitude or behaviours	7	6			**13**
Other/ anonymous	2	-			**2**
Total	**24**	**117**			**141**

**** Categories are suggested by the National Guardian's Office; discussion with staff and judgement of the Guardian determines which category a concern is recorded against.***



Staff will often present to FTSU at a later stage of experiencing negative behaviours or when a situation has escalated over time. By this time, multiple concerns are being raised which the NGO require reporting on. Combining the multiple themes changes the picture slightly.

Senior and middle management along with the application of systems and processes have the highest number of concerns with staff safety having the second highest combined number.

Staff safety concerns range from negative behaviours and processes which have had an impact predominantly on staff's mental, emotional or physical wellbeing. So, we can surmise that the effects of perceived processes not being consistently followed, lack of support from managers and the negative behaviours of colleagues has an impact on staff wellbeing.

3.4 Concerns by division

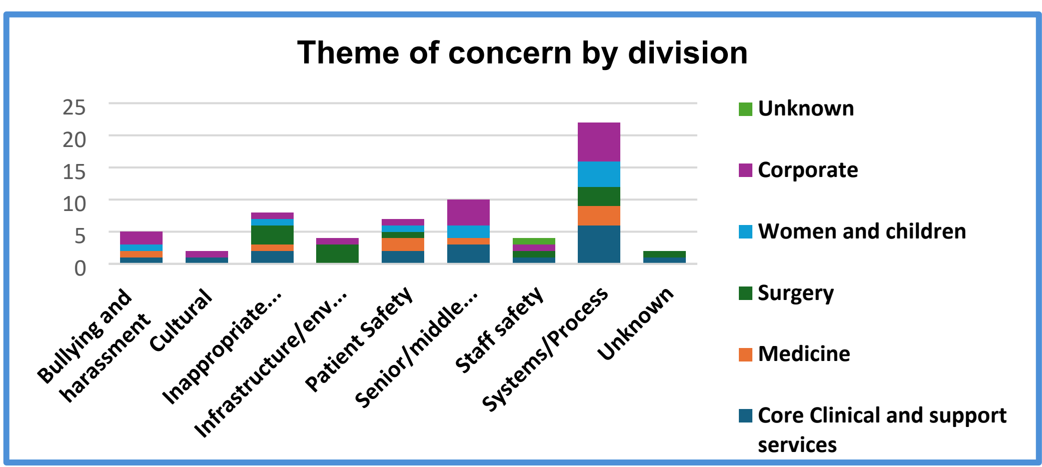
		Q1	Q2	Q3	Q4	Total 2024/25
Core Clinical and Support Services	26	1	16			**17**
Corporate	12	2	15			**17**
Medicine	11	3	5			**8**
Surgery	36	6	6			**12**
Women and Children's	9	1	8			**9**
Not disclosed	-	1	-			**1**
Total	**94**	**14**	**50**			**64**

The difference in concerns from each division could be aligned with the change in division of the Guardians. This will be reviewed quarterly alongside Staff Survey results to identify if targeted engagement or a dedicated Champion or Guardian role for a specific area would be supportive and beneficial.

3.5 Theme of concern by division 2024/25

	Core Clinical and Support Services	Medicine	Surgery	Women and children	Corporate	Unknown
Bullying and harassment	1	1	0	1	2	0
Cultural	1	0	0	0	1	0
Inappropriate behaviours or attitudes	2	1	3	1	1	0
Infrastructure/ environment	0	0	3	0	1	0
Patient Safety	2	2	1	1	1	0
Senior/middle management	3	1	0	2	4	0
Staff safety	1	0	1	0	1	1
Systems/Process	6	3	3	4	6	0

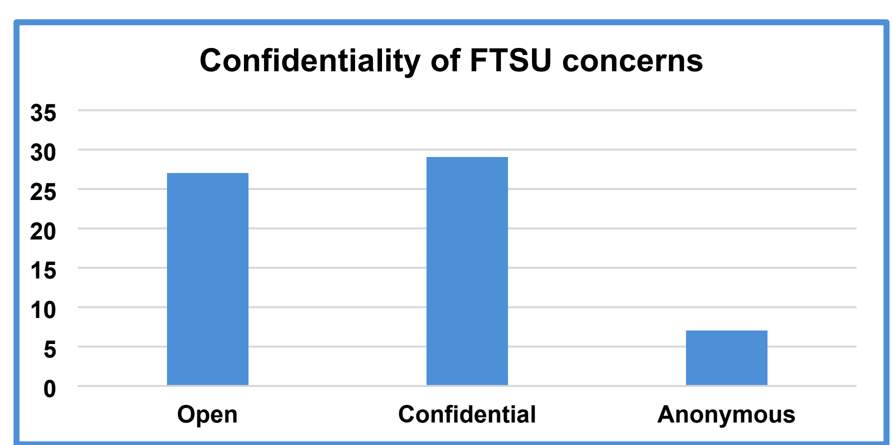
Unknown	1	0	1	0	0	0
Total	**17**	**8**	**12**	**9**	**17**	**1**



This data is in its infancy and so will be monitored monthly to identify if specific themes are arising in each division, department or ward.

3.6 Confidentiality of FTSU concerns

	Q1	Q2	Q3	Q4	Total 2024/54
Open	6	21			**27**
Confidential	3	26			**29**
Anonymous	5	2			**7**
Total	14	50			**64**
Staff in fear of or already suffering detriment	3	27			**30**



A total of 42% of concerns raised through FTSU were raised openly. This is encouraging in one sense as it shows staff have trust and confidence in utilising the process. However, it is noted that many of the open cases are already known and staff have either exhausted all avenues of support and come to FTSU as a last resort, or they are beyond caring if a manager is aware as they have given up hope.

Of concerns raised, 11% were completely anonymous for the full period, this has reduced to 4% in Q2. This is a positive reduction and the revised way of working and building confidence in in the speaking up process should further support this.

4. People profile

	2023/24	Q1	Q2	Q3	Q4	Total 2024/25
Additional clinical services	12	1	1			**2**
Additional professional scientific and technical	7	-	2			**3**
Administrative and clerical	10	3	15			**18**
Allied Health Professionals	16	6	10			**16**
Estates and ancillary	4	-	3			**3**
Healthcare Scientists	9		1			**1**
Medical and dental	3	1				**1**
Nursing and midwifery registered	25	-	14			**14**
Students	2	-	1			**1**
Other	3	1	1			**2**
Not known	3	2	2			**4**
Total	**94**	**14**	**50**			**64**

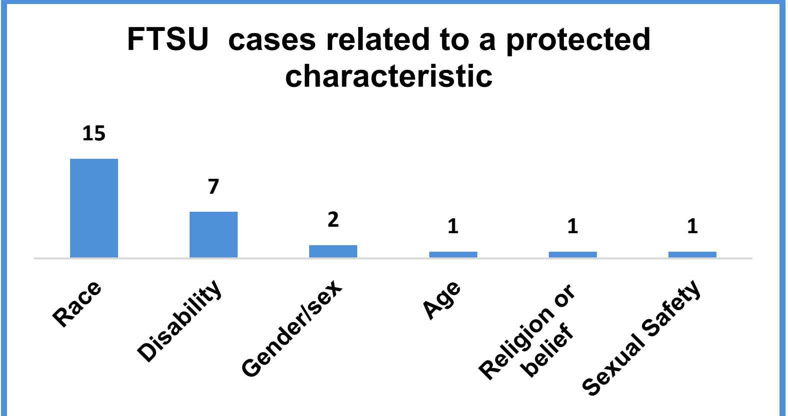
Professional level

	Q1	Q2	Q3	Q4	Total 2024/25
Manager	-	16			**16**
Worker	10	31			**41**
Worker – Bank	1	1			**2**
Not disclosed	3	2			**5**
Total	**14**	**50**			**64**

There is a notable and positive change between Q1 and Q2 with concerns raised from managers. It is also acknowledged that managers within this category range through the banding levels.

4.2 Concerns related to a protected characteristic

	Q1	Q2	Q3	Q4	Total 2024/25
Age	-	1			**1**
Disability	1	6			**7**
Gender/sex	1	1			**2**
Gender Reassignment	-	-			**0**
Marriage/civil partnership	-	-			**0**
Pregnancy & Maternity	-	-			**0**
Race	1	14			**15**
Religion or belief	-	1			**1**
Sexual Orientation	-	-			**0**
Sexual Safety	-	1			1



As data on diversity is now collected during case development and from feedback forms and not in the initial conversation, more data is available when there is a specific concern that individuals believe is related to or because of a protected characteristic. FTSU input is being provided to the Sexual Safety at Work Steering Group on reporting and supporting staff if they raise a concern within this area.

4.2 FTSU case resolution

Staff that approach FTSU will be supported to have their concerns resolved through the most informal approach possible although they will not be dissuaded from taking a more formal approach. Each case will have its differences and so a bespoke individualised approach is always taken dependent on the information provided and level of risk identified.
There are six main routes for resolution:

1. Listen, encourage and take no action – themes of concerns are fed back through generic engagement and reporting.
2. Signpost/introduction to an appropriate internal service or function.
3. Empower the individual/group to have a conversation with the colleague, colleagues or manager themselves.
4. FTSU facilitate conversations with a manager/s regarding the concern.
5. FTSU support the person/group to raise a formal complaint.
6. FTSU escalate the concern dependent on level of risk and consent. A process for escalation sits under this.

The data on FTSU cases resolved through informal resolution will be reported on from Q3 onwards.

4.3 FTSU cases linked to a HR process

	Q1	Q2	Q3	Q4	Total 2023/24
Not linked	12	37			**49**
Grievance	2	4			**6**
Disciplinary	-	3			**3**
Mediation	-	1			**1**
Other – consultation etc	-	5			**5**
FTSU cases supported to raise a formal concern	-	-			

The inclusion of this data is for monitoring. This data will identify links between how long staff may wait until approaching FTSU, if FTSU supports a more formal resolution and, in time, the cases which are resolved informally through facilitation.

5. FTSU month activity

FTSU month opened with a Town Hall led by the Trust Chair and Non-Executive Lead, the Chief Corporate Services Officer and FTSU Lead Guardian. The focus for the session was acknowledging the past, understanding the fears around speaking up, and encouraging trust in order to make changes.

In line with this, the FTSU intranet pages were updated to reflect recent changes and to share more clearly how staff can speak up, and the process which underlines this. The Thursday FTSU drop-in was launched along with a zone-based engagement exercise across the month.

5.1 Preliminary FTSU engagement feedback

- Staff were extremely welcoming of the in-person engagement and reflections included that this had dropped off. Coming to them made it feel like their views were important.
- There were service areas that felt they were never engaged with and felt like they were not seen as being important to or a part of the Trust.
- There was an overwhelming feeling of apathy – staff will not speak up because nothing happens, particularly if they had done so previously without result.
- The real fear from staff of suffering retribution or detriment from speaking up was significant.
- There were frequent references to nepotism and cliques which prevented staff from speaking up or even taking seemingly serious concerns formal.
- With little encouragement, staff are able to speak about negative experiences, processes and behaviours and acknowledge they will not speak up due to the reasons above.
- Whilst staff shared numerous concerns, they openly shared they would not raise them.
- Particular groups of staff who felt powerless to speak up included students and other groups which will be shared with the appropriate managers.

Whilst FTSU is well utilised, the generic engagement provides a softer opportunity for staff to share their concerns confidentially where they can be addressed via feedback reports to the relevant management team. This engagement forms part of the Strategy

action plan and a diary for the year will be implemented based on zones and off-site locations.

6. FTSU priorities Q3 and Q4

- Recruitment and training of additional Guardians and Champions.
- Development of Champion and Guardian peer support network.
- Distribution, collation and review of FTSU case feedback form.
- Review and refresh of FTSU communication to include social media.
- Continued FTSU support to specific work programmes which have a link to speaking up and inappropriate behaviours.
- Development of KPI's to assist monitoring the effectiveness of the FTSU offer.

7. National/Regional Update

All Guardians continue to support and contribute to the NGO regional and national meetings and initiatives.

The Lead Guardian presented at the East of England regional network on cultural intelligence as a FTSU Guardian, following completion of the Above Difference Cultural Intelligence 4-day training course.

8. Recommendations

Members are asked to note the contents of this report.

Meeting Title	Trust Board in Public	Date: 9 January 2025
Report Title	Safeguarding Annual Report 2023-2024	Agenda Item Number: 17
Lead Director	Fiona Hoskins Chief Nursing Officer	
Report Author	Sarah Sandham Head of Safeguarding	
Introduction	This Annual Report on Safeguarding Adults and Children activity at MKUH for April 2023 to March 2024	
Key Messages to Note	The Milton Keynes University Hospital Foundation Trust (MKUH) has a statutory obligation to establish safe and efficient systems to safeguard adults, children, and young people who may be at risk of any form of abuse, neglect, or exploitation. This annual report summarises the Trust's Safeguarding activities from April 2023 to March 2024. The report highlights the increased activity and complexity of adult and child safeguarding cases. The report has several objectives, including assuring the Board that the Trust is fulfilling its safeguarding obligations. The report also provides an overview of the support offered by the Safeguarding Team to operational and clinical services. Additionally, it emphasises the Trust's priority to safeguard children, young people, and adults and provides an overview of local and national developments in safeguarding over the past 12 months. The report highlights how these developments have impacted the Trust's service and how we work collaboratively as a partnership board to protect patients and their families accessing Milton Keynes services. In the past year the leadership of the team has transitioned following the appointment of the Head of Safeguarding. This has strengthened the leadership and oversight of safeguarding activities. There have been several additional appointments and the involvement of temporary staff to support the increasing demand and workload of the safeguarding team as safeguarding activity increases. The way the team deliver safeguarding activity has changed and is progressing to a model that better meets the needs of the trust, our patients and staff. The Board is asked to note and approve the content of this report.	
Recommendation	[X] For Information [ ] For Approval [ ] For Review	
Strategic Objectives Links	1. *Keeping you safe in our hospital* 2. *Improving your experience of care* 3. *Ensuring you get the most effective treatment* 4. *Giving you access to timely care* 5. *Working with partners in MK to improve everyone's health and care* 7. *Spending money well on the care you receive* 8. *Employing the best people to care for you*	

Report History	Trust Executive Committee November 2024 Quality and Clinical Risk Committee
Next Steps	N/A
Appendices/Attachments	N/A

Safeguarding Annual Report 2023 – 2024

Sarah Sandham – Head of Safeguarding

Foreword

Safeguarding services have experienced a challenging yet responsive year at Milton Keynes University Hospital NHS Foundation Trust (MKUH) with many changes and a complete reform of the team in September 2023. As the service moves into 2024, we wish to celebrate the success achieved thus far and set our agenda for the year ahead.

Our ambitions for 2022/23 have been successfully met and we are now looking to further develop and surpass these to develop the Safeguarding service to meet the needs of our Trust, our local partners and most importantly our service users.

There is evidence that there has been an exponential increase in the vulnerability of our children and young people, child cruelty and neglect offences have doubled in the last 5 years (NSPCC 2023). The incidence of domestic abuse surged following the pandemic and has remained at an increased level (ONS 2023) with 1 in 5 residents in Milton Keynes experiencing this type of violence (MKC 2020)

Safeguarding children, young people and adults is not a role undertaken by just the safeguarding team, we need the collaboration of all our partner agencies and all the trust staff to ensure we protect all those who are at risk of harm abuse or neglect.
Our most important belief is that safeguarding is everyone's responsibility and every contact with a patient and their family is an opportunity to safeguard. We want now as a Trust to move to a 'Think Family' strategy. Every contact or member of a person or child's family and/or caring community count to them and must be included in planning for the future safety and security of the individual.

Safeguarding is complex and is challenging for all of our staff so it is the team's ambition to inform, enable and empower all our clinical and non-clinical staff to assess where a safeguard is needed and how to meet this need with the safeguarding team's guidance and support where required.

Our aim is to provide exceptional safeguarding support, supervision and training to detect and prevent harm, safeguard our patients, their family and our local community, and for MKUH to be a safe organisation where the staff feel empowered and enabled to put safeguarding central to the well-being of our patients and themselves alike.

Milton Keynes University Hospital NHS Foundation Trust (MKUHNHSFT) for the duration of this report will be referenced as Milton Keynes University Hospital (MKUH).

Contents

1. Introduction
2. Governance
3. Team achievements 2023
4. Safeguarding Training
5. Safeguarding Children activity
6. Safeguarding Adult activity
7. Looking forward to 2024/25
8. Conclusion

1. Introduction

This comprehensive report highlights the safeguarding efforts carried out at Milton Keynes University Hospital (MKUH) to safeguard and promote the welfare and well-being of children, young people and adults at risk between April 2023 and March 2024.
The report will also outline the achievements, challenges and priorities met during the reporting period.
It is essential to recognise that all safeguarding work is firmly rooted in **The MK Way** which encompasses the trust vision, values, strategy and objectives.

The MK Way

Our vision – where we want to get to

Our **vision** for Milton Keynes University Hospital NHS Foundation Trust is to be an **outstanding** acute hospital and part of a health and care system working well together.

Our values – what we stand for

We care: We deliver safe, effective and high-quality care for every patient. We treat everyone who uses our services, and their families, friends and carers, with dignity, respect and compassion; and we treat each other as we would wish to be treated ourselves.

We communicate: We say #hellomynameis; we keep patients informed about and involved and engaged in their treatment and care; and each other informed about what's happening in our hospital. We know we can speak up to make sure our hospital is safe and our patients are well cared for.

We collaborate: We are **#TeamMKUH**. We work together and with GPs, primary care, community care, social care and mental health providers and other hospitals to

deliver great care and services for people in Milton Keynes, Buckinghamshire and beyond.

We contribute: We develop goals and objectives in support of the hospital's vision and strategy. We are willing to join in and play our part to make our hospital the best it can be. We acknowledge and share good practice so that others can learn what works well and why, and we learn from others so that we keep improving the care and services we provide.

MK way Safeguarding

Everyone has the right to be safe and free from abuse and protected from harm, regardless of who they are, or their circumstances. The term 'safeguarding' encompasses all activities to assist children, young people and adults at risk to live a life that is free from abuse or neglect and to enable independence, wellbeing, dignity and choice.

Safeguarding includes the early identification and prevention of harm, exploitation and abuse by using national guidelines, local multi-agency procedures and by disseminating 'lessons learnt' promoting best practice from patient safety incident reviews or enquiry to improve future service development for patients and staff.

The Trust as a registered provider with the Care quality Commission (CQC) must be aware and adhere to the regulations as established by the Health and Social care Act (2008) specifically in relation to Regulation 13 and 17 regarding protection of service users from abuse and good governance; and the Children's Act (2004) section 11.

2.0 Governance

2.1Statutory Framework and National Policy Drivers

Whilst safeguarding shares the same agendas and principals for adults and children, there are significant differences in the laws and policies that shape how we safeguard these groups. The legal framework to protect children is contained in Working Together to Safeguard Children (2018 updated 2024) and the Care Act (2014) for adults. However, the overarching objective for both is to enable children and adults to live a life free from harm, abuse or neglect.

The Children Act (1989) and Section 11 of the Children Act (2004) places a statutory duty on all NHS Trusts to have plans to ensure that it has regard for the need to safeguard and promote the welfare of children when exercising its functions.

The statutory guidance 'Working Together to Safeguard Children (2018 updated 2024) supports the multi-agency safeguarding arrangements set out in the Children and Social Work Act (2017).

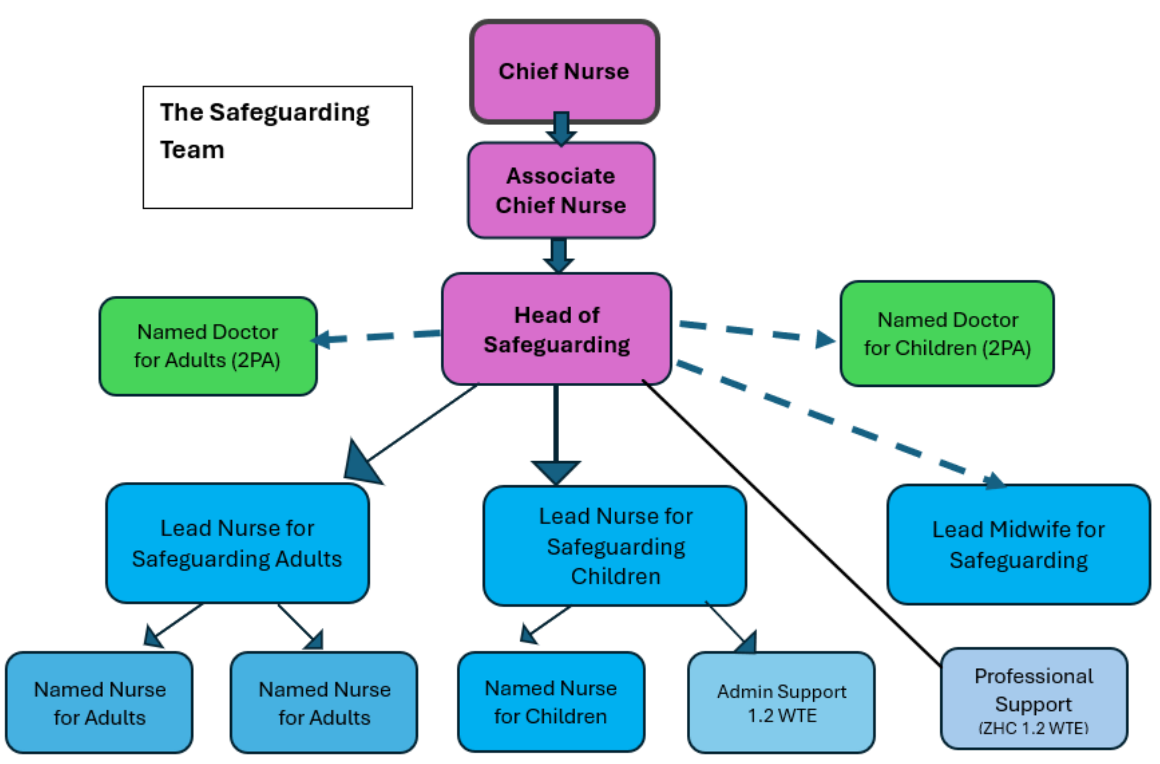
The Care Act (2014) set out a clear legal framework for how local authorities and other agencies should protect adults at risk of abuse or neglect. The focus is on personalised

and outcome-based care with an emphasis on making adult safeguarding 'personal', Adults should therefore be seen as experts in their own lives and safeguarding means working 'with the adult' and not a process that is done to or for an adult.

2.2 Local Governance

The Chief Nurse is the Executive Director for Safeguarding and has strategic responsibility for all safeguarding activity functions in the Trust. The Associate Chief Nurse for Safeguarding has delegated responsibility for oversight while the leadership and coordination of all safeguarding activity is then delegated to the Head of Safeguarding.

Current Safeguarding Team Structure



Please note the Learning Disability and Dementia Nurse Specialist are not included in the above structure even though a part of the team.

MKUH has a clear governance structure whereby all safeguarding concerns are addressed promptly and actions, as required, formulated to improve practice and shared learning. Safeguarding incidents are monitored by the Trust's Safeguarding Committee who meet bimonthly and report to Patient Safety Board and to the Quality and Clinical risk Committee.
Safeguarding team members attend internal and external forums to ensure Safeguarding is considered at appropriate internal meetings and contributes actively to the MK Together affiliate boards. The table below provides a summary of required attendance.

Internal Meeting Representation	External Meeting Representation
• Nursing Midwifery Therapy Advisory Group • Care Assurance • Trust Senior Sister/ Matron meeting • PSIRF • Safeguarding Committee/Board • Section 42 panel • Patient Safety Board • Clinical Board/Clinical Quality Board • Daily Safety Huddle • Violence and aggression group • Care Review and Learning Panel	• MK Together Review Board • MK Together Assurance Board • MK Together Partnership Board • MARAC • MATAC • DAPP • Escalation/ Review Meetings/CAMHs • Interface Meeting • Prevent Board • Navigator Meeting • LeDeR panel • LeDeR Assurance Board • MASH Interface Meeting • Unborn Planning Meeting • MEP • BLMK Child Death • East of England Safeguarding Forum • Domestic Abuse Strategic Partnership Board • Domestic Abuse Operational Group

3.0 Team Achievements

There have been significant achievements made by the Safeguarding team.

3.1 Recruitment

Following changes in the team structure an active recruitment campaign has resulted in the establishment of a full team. All posts are now recruited to with an ongoing requirement for additional temporary support. The current team with the additional support can meet the demand at this time, it is likely the demand will outstrip capacity as the number of vulnerable adults and children increases due to the impact of recent socioeconomic factors and changes nationally and locally.
Additionally, the Lead Nurse for Dementia, the Learning Disability Nurse Specialist and the Armed Forces Covenant Support Officer have been relocated to Safeguarding.

The Safeguarding team became fully established in September 2023 and the initial skill set in the team was challenged as new appointees had limited safeguarding experience. However, this is now improving significantly as the team develops wide ranging safeguarding exposure and experience, the skill set of the team is robust and professional. A business case is being developed to substantiate the posts that are currently temporary positions supporting the demand on the team. In addition, the business case proposes a

weekend cover model for safeguarding, as the current service is office hours only. There is an emergent need for weekend cover.

3.2 Policy

A number of policies have been updated and improved in line with National guidance and are progressing through the Trust approval pathway.

- The Safeguarding Adults Policy
- The Children's Safeguarding Policy
- Ligature Risk Policy

3.3 Process

A number of safeguarding processes have been reviewed and improved by the team. Improvements relate primarily to streamlining and refining process to reduce workload for our colleagues in wards and departments whilst continuing to meet statutory duty and timeline.

This currently includes

- Section 42
- Deprivation of Liberty Safeguarding (DoLs).

3.4 Data

The team have reviewed the data streams for safeguarding and found some activity is not captured appropriately. New methods of recording and capturing activity have been implemented making it easier for the whole team to access activity data. This has resulted in some gaps in the 2023 data which will be remedied for 2024/2025 reporting cycle. All current data collection has been designed and input by the team and it would be a valuable strategy to move to a dashboard for activity which would require funded Informatics support.

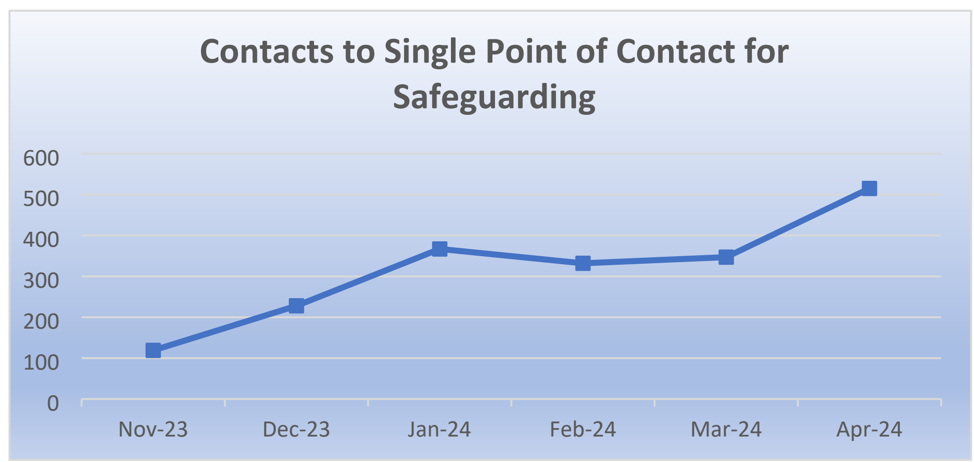
3.5 Single Point of Contact (SPOC)

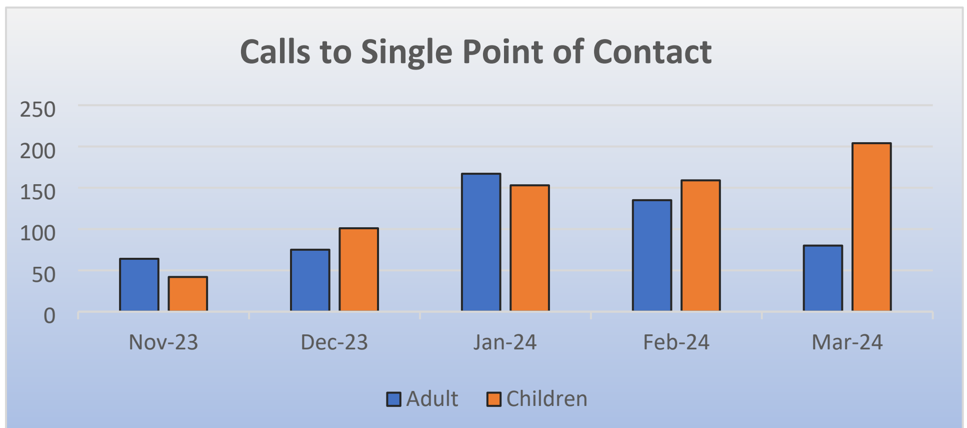
Established in November 2023, this invaluable model offers our busy trust staff immediate access to advice and guidance from the Safeguarding team. Whilst policy, protocol and guidance are always available staff find a helpline accessible and informative. The immediacy of the response affords rapid decision making and enables staff to move patient care forwards without delay. This is a commodity that is vital in today's healthcare environment where patient safety and patient flow are trust priorities and safeguarding advice can guide the right decision by clinical staff.

The whole team are allocated to this duty and this has supported the development of a multiskilled workforce with adult and children's staff responding to general and specific safeguarding enquiry.

The uptake has been excellent from Trust staff as shown in the chart below which illustrates the rising number of contacts per month since inception.

The current service operates from 08.00 until 17.00 Monday to Thursday and 08:00 until 16:30 on Fridays. We currently see increased contacts on a Monday and Friday. This would suggest the weekend may present some vulnerability and as such would recommend some weekend cover may support our staff at a time of increased need.





The total numbers in the contacts list includes general enquiry, support for external agencies and for the unborn so the numbers in the adult/children chart are not the overall total calls to the SPOC.

3.6 Trust information sharing – safeguarding

Information Sharing is a component of children's safeguarding developed in response to an advisory document from HM Government (2018) Whist this was not a statutory requirement MKUH has established an enhanced information sharing process for children, young people and children behind an adult. The information Sharing Form (ISF) is sent to the local Multi Agency Safeguarding Hub (MASH) for the child to inform them of an attendance and to enable them to track and trigger when a child may be demonstrating signs of increased risk.
The process adopted by MKUH is thorough and is superior to some trusts who rely on staff recognition of risk and frequency of attendance balanced against parental explanation. Social care can offer an objective view of received ISF and will review the information in light of their knowledge of the child and or the family.

The team have been committed to improving all elements of safeguarding practice and process to ensure trust staff can complete their statutory duties in a robust and timely manner.

3.7 Team Development

The Safeguarding team committed to developing the skills of the team and ensuring a wide range of skill is available to the Trust.
This includes:

- Domestic Abuse Stalking and Honour Based Violence Assessment (DASH)
- Level 4 Safeguarding
- Supervision training

The ambition is to have a multiskilled enable empowered safeguarding team.

4 Safeguarding Training for the Trust.

4.1 Mandatory training

The mandatory training of staff is guided by the Intercollegiate Documents (2019 and 2024) It is of fundamental importance that staff are aware of their safeguarding duties for all their contacts through the course of a working day. The current model for training for trust staff uses a mixed approach with E-Learning and face to face classes.
The Trust has a key performance indicator (KPI) expectation of 90% which is achieved for the majority of training; however, level 3 Safeguarding Children training requires improvement.
There are a number of staff who require mandatory level 3 training for children's safeguarding who have not accessed this and on occasions the uptake of training is poor. There is a requirement for trust managers and their staff to show a commitment to achieving this KPI and ensure those who require level 3 children training attend. Oliver McGowan training on Learning Disability and Autism part 1 is just achieving 90%.

Current Safeguarding Training Compliance

Training	Trust Compliance
Safeguarding Adults Level 1 – 3 years	98%
Safeguarding Adults Level 2 – 3 years	96%
Safeguarding Adults Level 3 – 3 years	94%
Basic Prevent Awareness - 3 years	97%
Prevent Awareness – 3 years	94%
Safeguarding Children Level 1 – 3 years	96%
Safeguarding Children Level 2 – 3 years	96%
Safeguarding Children Level 3 – 3 years	89%

Oliver McGowan Training Part 1	90%

4.2 Think Family

The Safeguarding Team are changing the training package with an updated approach that ensure the trust staff receive education in safeguarding that is

- Aligned to the intercollegiate requirements
- Approaches safeguarding from a 'Think Family' perspective
- Is more relatable for staff
- Demonstrates the need for routine enquiry
- Is in line with our current socioeconomic challenges

5 Safeguarding Children activity

The Safeguarding Team are committed to safeguarding and promoting the health and well-being of all children and young people attending the Emergency Department (ED), as outpatients or, those admitted to the paediatric wards, the paediatric assessment unit, or any adult wards where 16-year-olds require support. The Trust also has a duty toward 'unseen' children whose parents have been admitted or have attended ED where safeguarding concerns may exist. Alerts regarding children's and young people's attendance can be completed as an Information Sharing Form or a Multi-Agency Referral.

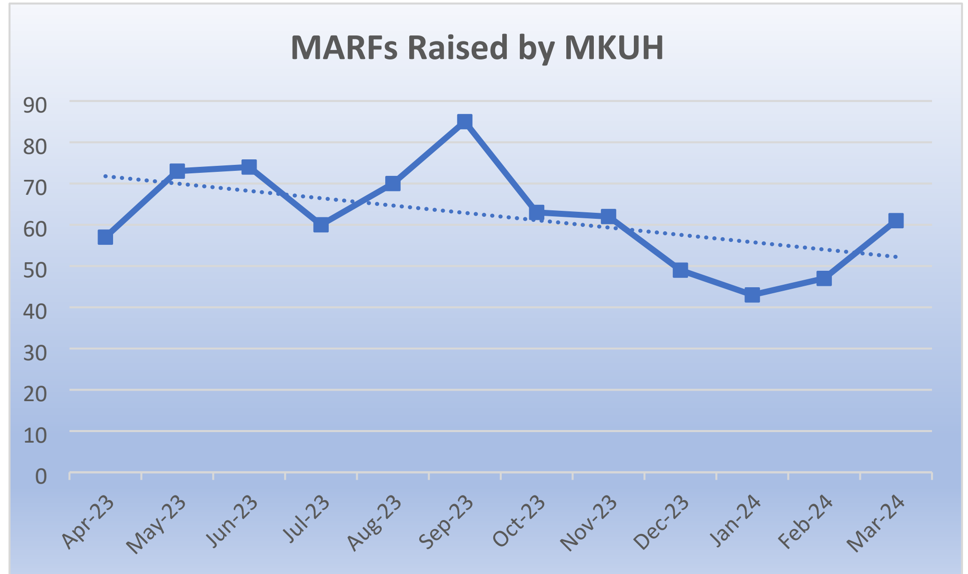
5.1 Information Sharing Forms (ISF)

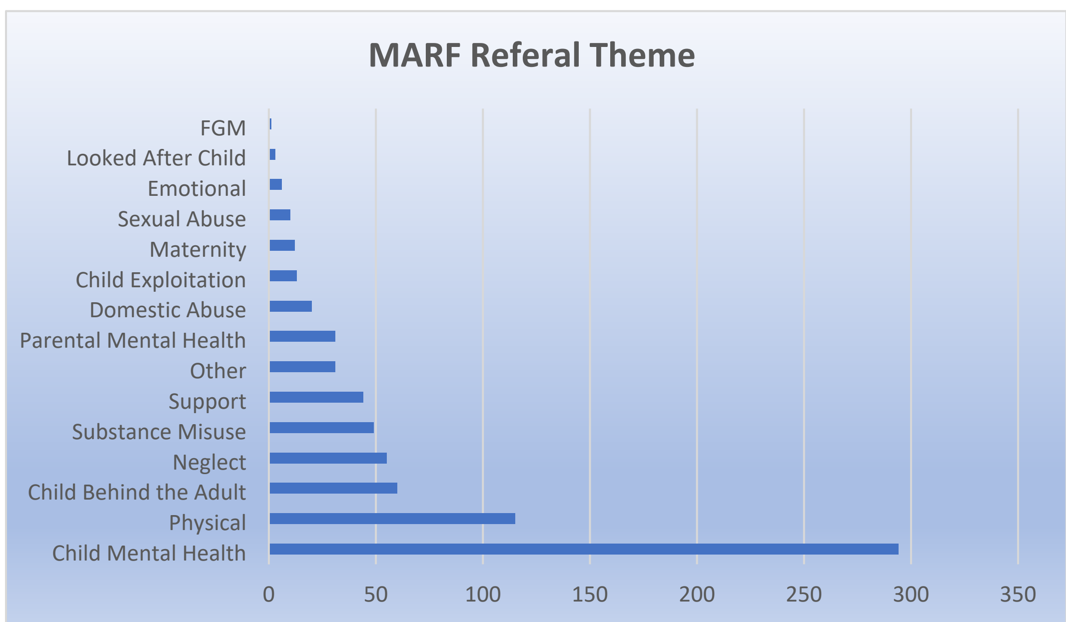
The Emergency Department (ED) complete an online ISF for children who attend the department where a safeguarding concern is noted, if the child is known to children's social care or when a parent attends adult ED and discloses there are children in their care and the staff feel the children may be directly or indirectly at risk.
The forms are then triaged by the safeguarding team within 24 hours (except at weekends) who then determine if further action is required.

- 2022 – 2023 = 1217 forms generated
- 2023 – 2024 = 2051 forms generated

5.2 Multi- Agency Referrals (MARF)

There have been 744 MARF generated in 2023 – 2024, this is a decrease of 6% compared to the previous year and is showing an overall downwards trend over the course of the year. A MARF are predominately completed by ED, Paediatric wards, Maternity areas and the Safeguarding team.





Child Mental Health continues to present the greatest challenge to our children services with self-harm and eating disorders the most notable issue for our young population. There continue to be significant delays in sourcing placements for the ongoing care and management which gives rise to delayed discharges and bed pressures in our children wards. Alongside this is the unknown, unmeasured impact this delay has on the well-being and recovery from such illnesses.

5.3 Child Protection Medicals (CPM)

Child protection medicals have decreased in this reporting year by 6%

- 2021 – 2022 = 44
- 2022 – 2023 = 66
- 2023 – 2024 = 57

There is ongoing work with MK partners – MKUH, Milton Keynes City Council, Central Northwest London Trust (CNWL), and the BLMK Integrated Care Board developing a system – wide approach to child protection medicals including how child neglect medicals are managed outside of MKUH.
Internally there is now a process for managing CPM requests involving the Consultant on call who triages the request and books the medical if required.

5.4 Child Exploitation

In England, the government has proposed a mandatory duty for those working or volunteering with children to report known or suspected child sexual abuse.
This duty applies when they are told about abuse by a child or the person who carried it out, or if they witness the abuse happening.
While there won't be criminal penalties for failing to report, individuals who conceal abuse or obstruct reporters could face imprisonment.
The law aims to prioritize child safety over reputation and will be part of the Criminal Justice Bill. Once the bill receives Royal Assent guidance will provide details on how staff have to comply. This will be added to training but will also require immediate sharing across the Trust.

5.5 Safeguarding Supervision

MKUH has up until recent times offered very limited Safeguarding supervision with one member of the team qualified to offer this vital support to staff who hold a caseload. There are now 3 team members who can support supervision. The key objectives for supervision are supporting learning through reflection, competency development, accountability and it also provides a restorative function which is of paramount importance for staff who manage difficult or complex safeguarding scenarios. This service will be available to more of the trust staff and the ambition is to ensure the whole Safeguarding team can provide supervision.

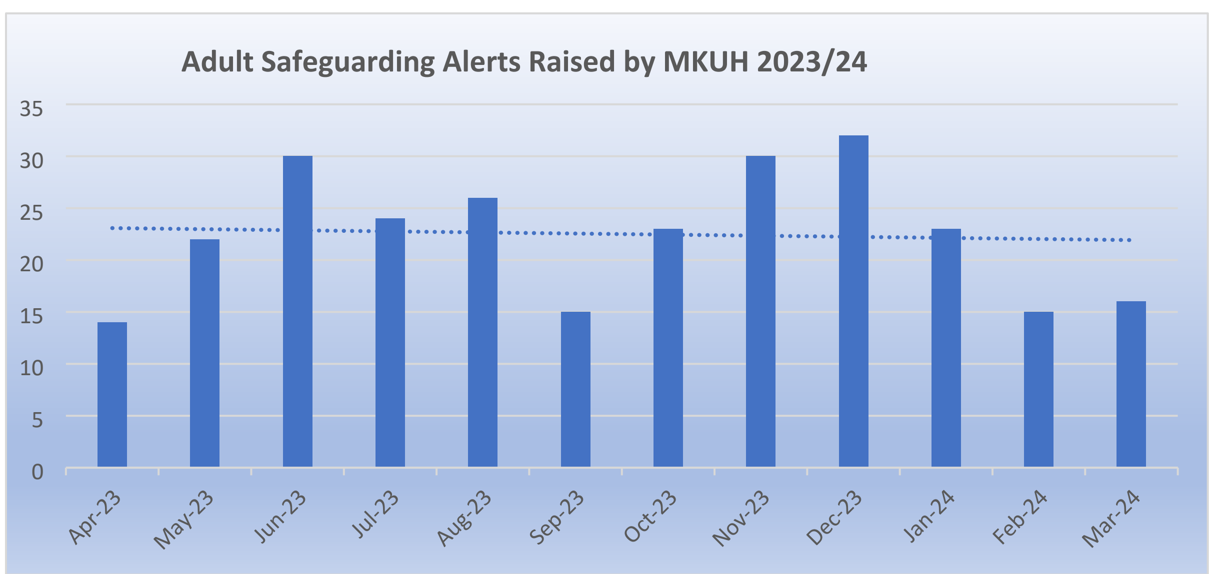
6 Safeguarding Adult Activity

The Safeguarding Adult Team continue to provide advice and support for a wide range of safeguarding issues relating to adults who may be at risk of deliberate abuse or abuse as the result of omission. The team have become more visible by attending the daily huddle to hear the wards report on their vulnerable patients so they are aware of any 'hot spots'. They also attend wards and outpatients to support staff with individual patient issues and will also attend wards to support staff completing safeguarding paperwork if they are finding it challenging.
The clinical teams are often challenged with busy high-pressured environment and this is when they will require enhanced support from the team when safeguarding might be most needed

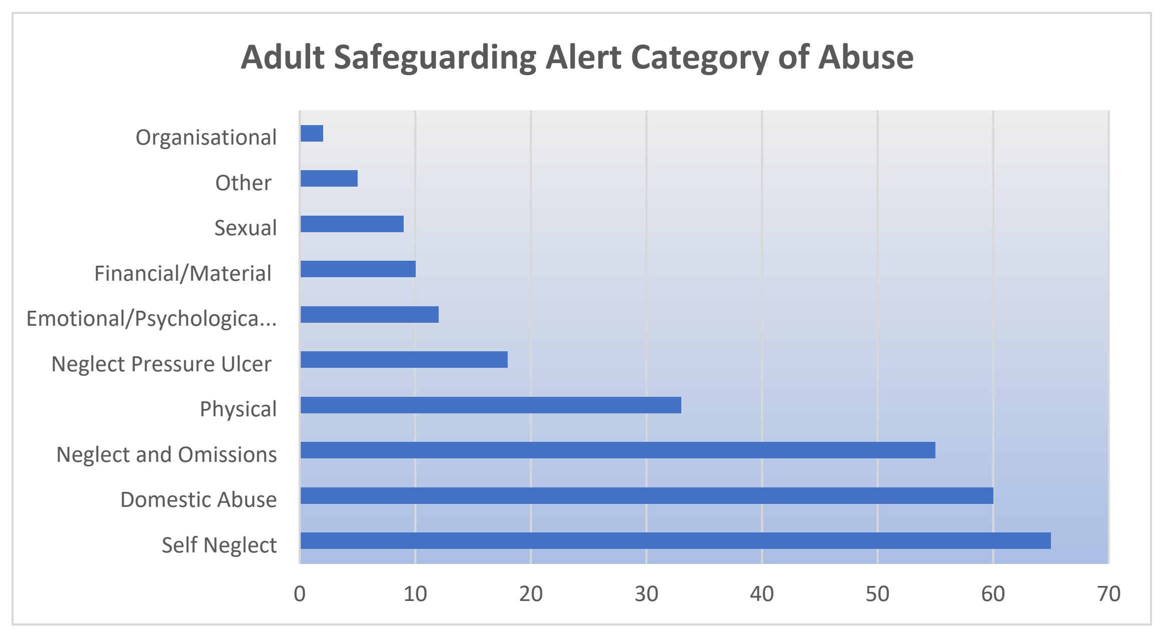
6.1 Safeguarding Adult Alerts

There were 270 safeguarding adult alerts raised by MKUH staff during this reporting cycle demonstrating an increase of 32% in comparison to last year.

- 2021 – 2022 = 228
- 2022 – 2023 = 205
- 2023 – 2024 = 270



The monthly totals of safeguarding alerts vary but show an overall constant trend.



The highest category of abuse causing our staff concern enough to raise an alert is self-neglect. Domestic abuse is the second highest category and is possibly a reflection of

what is being seen nationally, in Milton Keynes and as previously stated reflects our socioeconomic post pandemic landscape.

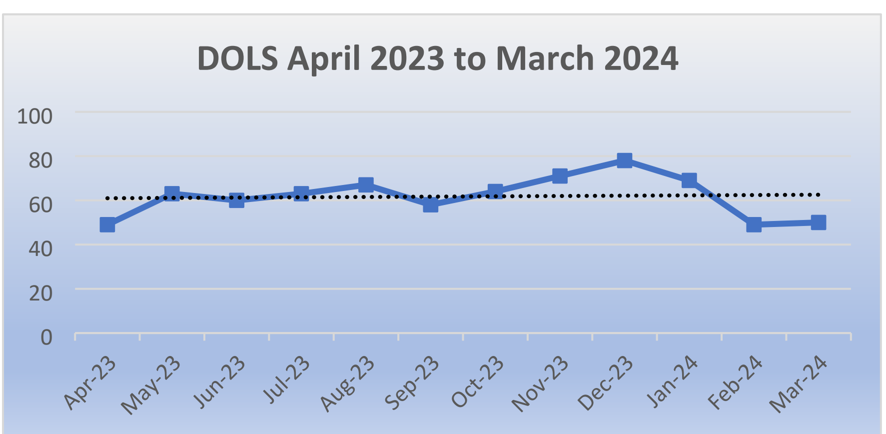
6.2 Deprivation of Liberty Safeguarding (DoLS)

Patients who lack the mental capacity to make decisions for themselves in relation to health and welfare will require protection of their rights. It is appropriate to ensure that the liberty of all people is protected and restricted as little as possible. The Safeguarding Team are responsible for managing the DoLS process for the Trust and do not allow an urgent DoLS application to be submitted until it is complete, meets the council standard and is verified. The year ending March 2023 shows a 200% increase in urgent DoLS submissions.
Applications for DoLS

- 2021 – 2022 = 177
- 2022 – 2023 = 247
- 2023 – 2024 = 741

This is a significant rise for this reporting period and is multifactorial; it includes

- A reflection of the work undertaken by the Safeguarding team to increase awareness and application of the 'acid test'
- The Safeguarding team attendance at daily huddle to monitor reports of wards with issues of safety in relation to numbers of patient reported to be requiring additional supervision
- The direct support the Safeguarding team provide with ward visits and involvement with the vulnerable patient
- An increasing elderly population with multiple comorbidities in the current socioeconomic landscape.



The majority of applications for DoLS is to ensure a vulnerable person without capacity will receive care and treatment.

6.3 Section 42

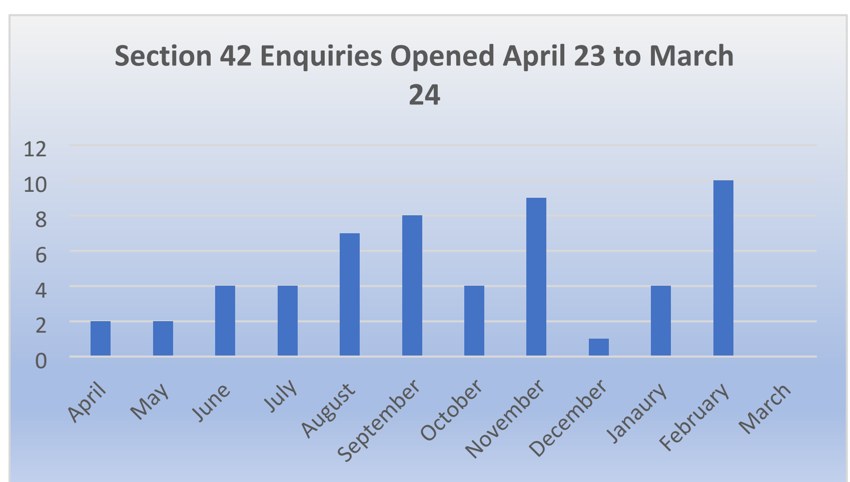
A section 42 is raised when a local authority determines an adult safeguarding alert requires a formal enquiry and follows a 28-day timeline. The Safeguarding team support and advise ward teams on the enquiry, review the report, support the ward with action planning if required, hear the investigative outcomes, and ensure the timeline is adhered to.
Following a bespoke training programme delivered by the Safeguarding team the band 7 team (Senior Sister/Charge Nurses/ Departmental Managers) from across the trust now complete the investigation and bring the completed report to a section 42 meeting to receive senior oversight, review and support.

For this reporting period we have received 55 Section 42 enquiries related to care in our Trust in comparison to previous reporting periods.

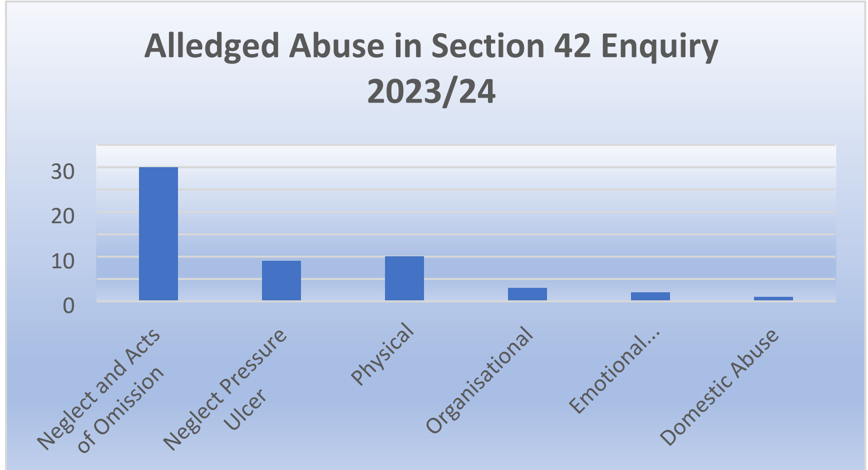
- 2021 – 2022 = 32
- 2022 – 2023 = 65
- 2023 – 2024 = 55

Of the enquiries 42 were raised by external bodies and 8 we raised against ourselves.

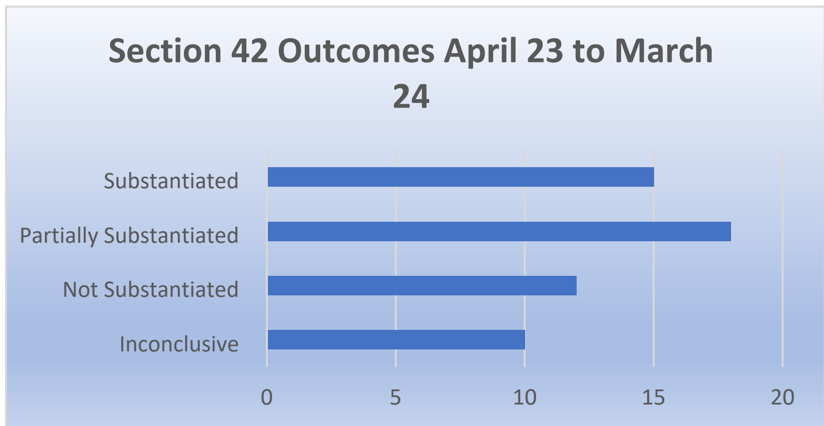
The chart overleaf shows the spread of section 42 enquiries received over the course of the year.



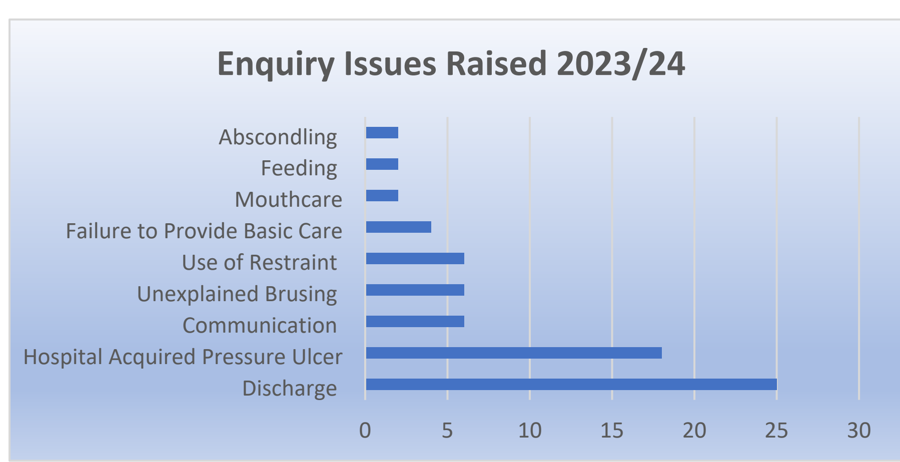
The alleged type of abuse within the enquiry is shown in the chart below.



Of the Section 42 Enquiries the following are the outcomes determined by MKUH investigators.



The greatest issue raised in the section 42 enquiries was primarily relating to discharge from hospital, followed by hospital acquired pressure ulcers. Some enquiries included more than one investigatory point so the number below are greater than the number of enquiries received.



These enquires are opportunity to learn from patient experiences and perceptions of care which is why it is vital the investigator is part of the team that provided care for the patient and who has the leadership to promote change and improvements to avoid repeated occurrence.

6.4 Health Independent Domestic Violence Advisor (HIDVA)

Domestic Abuse has seen an increase nationally and locally with Milton Keynes council estimating 12,000 adults in Milton Keynes experience and survive Domestic Abuse annually (Domestic Abuse Needs Assessment 2020) This equates to 1 in 5 residents. Our Emergency Department sees an average of 240 patients daily and we do not know what percentage of injuries are or could be related to some form of Domestic Abuse.

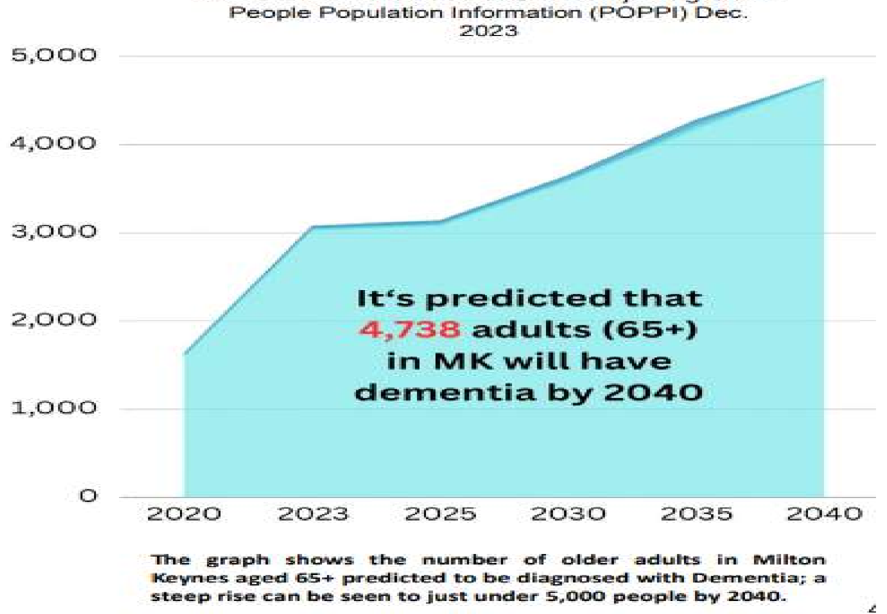
The current HIDVA is employed by the council and spends time onsite but does not have a dedicated space to see or speak to victims and survivors of Domestic Abuse. A permanent location is being explored. The post holder is required to see patients and staff who may need emotional or practical support, safety planning, sign posting and risk assessments.

The profile of Domestic Abuse needs to rise in the Trust as there have been reported incidences where there has been a failure of Trust staff to recognise injury that is related to Domestic Abuse or occasions when staff have failed to act on information shared. Part of the new approach to training will raise this issue however this will not be adequate and there needs to be the presence of a routine enquiry question added to all trust admission/assessment/triage/discharge paperwork. We must start asking all people if they '*feel safe at home'* as a matter of routine not just when we suspect there may be abuse in the home.

Recruitment is planned to appoint a second HIDVA.

6.5 Dementia Care

The demographic population of Milton Keynes is rapidly changing with the older age groups demonstrating the most rapid growth. There are, according to the Institute of Primary Care, 2,827 people aged 65+ living with a dementia diagnosis on Milton Keynes. This is predicted to rise to 4,738 by the year 2040.



Dementia can be difficult to recognise and takes time to diagnose, as such is it purported that only 65% of the public with dementia has a formal diagnosis and the further 35% have dementia without a formal diagnosis.
On any day there are circa 65 people with a dementia diagnosis as an inpatient in MKUH and with the percentage of those undiagnosed it is possible this number could reach 100 patients per day. This is approximately one fifth or 20% of our bed capacity. Given that a person with dementia can have complex needs, extended length of stay, difficult challenging discharges and is vulnerable to harm acquired in hospital this represents a significant proportion of our daily activity. People with dementia need to be supported to live well and for their inpatient stay to be as short as required to enable them to be discharged safely.

The continuing trajectory for MKUH is to be a recognised dementia friendly organisation delivering patient centred care supporting the person with dementia, their relatives and carers. The aim is for a skilled and effective workforce who champion compassionate respectful care and who work in partnership with everyone who is important to the person who has dementia.
The Dementia Lead nurse post was vacant for some time and was appointed into in 2023. Since commencing the lead nurse has made a significant contribution and is visible and supportive to MKUH wards where dementia patients are present. The achievement and challenges for this post are as follows.

Achievements for 2023

- Dementia Quality Improvement Steering Group
- Dementia Awareness week
- Radar adapted to capture violence and aggression incident associated with dementia
- Lead Nurse involvement in Violence and Aggression working group

- Bitesize training on managing cognitive impairment
- Memory wall
- ‘**What matters to me’** launch

Key Challenges
- Uptake and completion of ‘**what matters to me’**
- Tier 2 training for staff involved with dementia patients
- Complaints – most often is the issue that other patients are disturbed or distressed by someone with a dementia diagnosis
- Meaningful activities co-ordinator post finished in March 2024 and has not been replaced – Business case to be developed.
- Discharge – especially placement for complex patients and those who need mental health care and support

This role contributes positively to the management of dementia patients, their families and carers.

6.6 Learning Disability Care

There is a requirement to better understand the numbers of Learning Disability (LD) people who attend the trust and to improve understanding of their care needs and where improvements are required. There is currently no clear data on how many LD people there are in Milton Keynes who may access our services; however, it is well known that they often have complex care needs, have longer lengths of stay, can be subject to inequalities in health and care quality and may die young. For people with such specialised needs and a requirement for us to make reasonable adjustments there is no clarity on the size of the issue or what might be required to address it.

MKUH took part in the Learning Disability Improvement Standards National Benchmarking in 2021/2022 and formulated an improvement action plan which was implemented and completed. This action plan must now be reviewed, evaluated and assessed for the improvement changes that have been sustained and those which may require further action.
MKUH is also represented at the local Learning from Lives and Deaths of people with a learning disability and autistic people (LeDeR) to ensure there is learning associated with appropriate management and care of LD people to sustain life where appropriate and to promote health and an ongoing quality of life.

The LD nurse post was vacant for a period of time and was appointed to late in 2023. There have been some improvement made in the care of the person with an LD or autism and the LD nurse is visible and supportive in the clinical environment. The changes made include
- Piloting of a cognitive impairment pain assessment tool
- Flagging on eCare of a person with LD or autism
- Launch of the ‘**What Matters to Me’**
- Collaboration with Practice Education to start developing a champion model

- Learning Disabilities awareness week

On reviewing formal complaints made by or on behalf of a person with an LD or autism there were 19 complaints in total for 2023. Subject matter included

- Communication and documentation
- Appointments
- Clinical treatment
- Admission and discharge process
- Staff values and behaviours

Work is underway to complete the Learning Disability Strategy for the Trust which should help define the forward trajectory for care of this small group of people who attend the trust but who have complex needs and require specialist support.
The plan going forwards is to

- Improve the data collected
- Review and evaluate the Benchmarking action plan
- Develop an audit tool for assessment of the care of LD and people with autism
- Complaint issues
- Communication and Documentation of reasonable adjustments
- Continue to Improve relationships with local partners

It is hoped to make some real improvements for people with LD and those with autism.

7 Looking forward to 2024/25

The aspirations of the team are to continue to grow and improve as a service and provide the best safeguarding support for all our patients and staff.

- Team structure
  There is a business case being developed to consider the requirements to strengthen the current team structure and to consider recruitment requirements to move the safeguarding service forward. This has yet to be costed but will require investment if the trust wishes to address a gap in team structure and/or develop the service further to weekend safeguarding support.

- Domestic Abuse
  The gap in knowledge and awareness needs to be addressed for our staff, we cannot afford to miss opportunity to protect people from domestic abuse. Recruitment of second HIDVA.

- Learning Disability and Dementia
  We need to ensure the current practitioners are fully merged into the safeguarding team structure and that collaborative working occurs. There is a need to fully understand the issues that the Learning Disabled and Dementia patient experience

whilst in our hospital and any gaps in service provision and develop an action plan to address any reasonable adjustments. The team have recently launched the '**What matters to me'** document to support the individual with their usual routines or practices and to describe in their own words/communication style how they wish their care to be provided.
We need to develop stronger links with community care providers to develop and ambition for seamless communication and care provision.

- Training
  'Think Family' training is to be launched in September 2024, the package encourages staff to be more questioning and professionally enquiring, to consider the whole family not just the patient, has more relatable scenarios and it is updated to align to current policy changes. Our team aim is to offers Increased commitment to training compliance for Children's level 3 and Oliver McGowan.

- Process review
  The team are committed to continue to review all safeguarding process and practice to ensure that they are as easy as possible for Trust staff to complete and that statutory timelines are met. In addition, ensuring alignment with the Patient Safety Incident Response Framework.

8 Conclusion and Recommendations

The annual report demonstrates how the Safeguarding Team is committed to ensuring the Trust meets it statutory requirements whilst continuing to develop safeguarding to meet the needs of the people who access our hospital. Making sure the vulnerable are protected is our ambition and commitment.
The Trust Executive Committee, Quality and Risk Committee and Trust Board are asked to note the content of the report for discussion and assurance of the Trust compliance with Safeguarding Policies and Procedures.

References

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ONS 2023 Domestic abuse in England and Wales overview - Office for National Statistics (ons.gov.uk) last accessed 20 June 2024

MKC 2020 8. Item 7_ Delegated Decisions Report - Domestic Abuse Strategy 20 October Annex B.pdf (moderngov.co.uk) last accessed 20 June 2024

HM Government 2018 https://www.childsafeguardingtoolkit.org.uk/static/principles-files/Information_sharing_advice_practitioners_safeguarding_services.pdf. Last accessed 20 June 2024

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Royal College of Nursing, 2023. Adult safeguarding: Roles and competencies for health care staff. Royal College of Nursing. Available at: https://remedy.bnssg.icb.nhs.uk/media/igekotxo/intercollegiate-documents-for-adults-_2024_.pdf last accessed on 03/09/2024

Primary Care Dementia Data, February 2024 - NHS England Digital

Emergency Preparedness Resilience and Response (EPRR)
Annual Report 2024/25

1.0 Background

This report covers Emergency Preparedness, Resilience and Response (EPRR) annual review for 2024/25 and summary of Core Standards Self-Assessment for MKUH.

2.0 NHS England Core Standards 2024 Compliance

2.1 Background

First published in January 2013, the NHS England Core Standards are the minimum EPRR standards which NHS organisations and providers of NHS funded care must meet. Core standards are assured by completion of self-assessments which enable NHS England to assess the preparedness of NHS organisations across a range of assurance indicators. The full list of compliance questions and answers can be found in the embedded document held in Appendix B.

2.2 2024/25 Requirements

For 2024/25 the self-assessment process for NHSE East of England is illustrated in table below with regional letter inserted for reference (Appendix C).

Ref	Task	Responsible	Timings
1	ICB EPRR Leads and NHSE EoE EPRR MS Teams meeting to discuss and review the assurance process and ICB approach.	NHSE EoE EPRR Team	24th July 2024
2	NHS Trusts and providers of NHS Funded Care are to ensure that their core standards audit and associated documentation is completed, signed off and returned (email) to their ICB EPRR Lead.	Trusts and Providers of NHS Funded Care	30th August 2024
3	Confirm and challenge ICB and NHS Trusts*	ICB EPRR Lead	2nd – 14th September 2024
4	LHRP Support Group Peer Review	ICB EPRR Lead	18th – 26th September 2024
5	Confirm and challenge sessions with EoE Regional Team	NHSE EoE EPRR Team	4th – 14th November 2024
6	NHS England to facilitate confirm and challenge sessions with ICBs (to review the ICB and wider system provider assurance). AEOs from NHSE EoE and the ICB are required to be present at these meetings.	NHSE EoE EPRR Team	4th November 2024 – 14th November 2024

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.

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7	ICBs to submit a System assurance summary to the NHSE EoE EPRR Team via NHS Futures.	ICB AEO/EPRR Leads	By 2nd December 2024
8	Regional EPRR team to submit an assurance report for the NHSE EoE Regional Executive Team.	NHSE EoE EPRR Team	19th December 2024
9	Regional assurance ratings to be submitted to the National NHSE EPRR Team.	NHSE EoE EPRR Team	27th December 2024

BLMK ICB to arrange point 5 date with MKUH.

2.3 Deep Dive Requirements

Each year the Core Standards review specific areas of EPRR through a 'Deep Dive' process where evidence is required and presented as part of the Core Standard return. This process **does not** contribute to the overall score, with 2024 'Deep Dive' theme covering cyber security and IT related incidents.

2.4 Evidence Requested

This year NHS EoE and BLMK ICB has requested additional evidence and assurances as part of evidence submitted to the ICB. The Trust will be providing further evidence through both a presentation as part of the 'Confirm and Challenge' meeting with BLMK ICB and additional evidence to answer the following questions.

- Whether the organisation's AEO is a board level director, is familiar with their responsibilities and has the appropriate authority, resources and budget to direct the EPRR portfolio – *A copy of the organisational chart would be supportive.*
  MKUH Answer: Emma Livesley is AEO at board level with Emergency Planning outlining within Trust organisational structure.

- Whether there is sufficient and appropriate EPRR resource proportionate to the size of the organisation, to ensure it can fully discharge its duties and responsibilities including the ability to plan for, respond to and facilitate the immediate recovery from incidents or events of up to 96-hour duration, 24/7/365' - *A method statement would be supportive incorporating:*
  - *What is the EPRR resource for the organisation (inc WTE and banding)?*
    MKUH Answer: 1WTE Emergency Planning Officer at Band 8a

  - *How does the organisation resource EPRR functions and EPRR response (this may include additional EPRR responsibilities, on call etc)*
    MKUH Answer: EPRR has a designated annual budget in place with EPO supporting additional roles such as Climate Change Adaptation (within Green Plan) and Silver On Call (development purposes).

  - *How would the organisation facilitate the immediate recovery from incidents or events of up to 96-hour duration, 24/7/365*
    MKUH Answer: The Trust Incident Response Plan outlines the recovery team process and how rotas would be developed to support 24/7 duration that has been tested through COVID Pandemic and recent Critical Incident declared January 2024. All involved recovery up to extended periods of time.

    Method Statement (EPRR resources for 96 hours)

    EPRR Resource= 1.0 wte

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.

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Day 1
EPO would be supported by Operational Teams in providing additional EPRR resource during an incident through AEO agreement.

EPO member 1 x 8hrs 06:00 to 14:00
Ops member 2 x 8hrs 14:00 to 22:00
Ops member 3 x 8 hrs 22:00 to 06:00
Ops member 4 x normal days providing BAU

Above rostering would take place over each 24hours rotating to cover 96hour period

- Whether organisations have suitable business continuity plans in place and whether Business Continuity Management Systems are appropriate for each organisation - *A copy of the Trust business continuity policy, outline of the internal governance process for signing off the business continuity policy, plans and BIA's. Details of the last sign off date, and last exercise date(s).*
  MKUH Answer: MKUH Business Continuity Management Policy recently revised forwarded to ICB with last exercise date 09/05/2024

3.0 MKUH Assurance Rating

NHE England national letter outlines assurance rating for Core Standards as follows:

Compliance Level	Evaluation and Testing Conclusion
Full	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

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MKUH has RAG rated its 2024/25 EPRR Core Standards Self-Assessment and this is shown in table below:

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	10	1	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	7	0	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	9	1	0
Hazmat/CBRN	12	12	0	0
Total	62	60	2	0
Deep Dive	**Total standards applicable**	**Fully compliant**	**Partially compliant**	**Non compliant**
Cyber Security	11	8	3	0
Total	11	8	3	0

The Self-Assessment shows 97% compliance (excluding Deep Dive) within core standard questions resulting in the Trust being at **Substantial Compliance Level**.

To ensure MKUH moves from 'Substantial' to 'Fully Compliant' prior to 2025/26 Core Standards submission an action plan has been developed, outlining the outstanding areas in Appendix A, including 'Deep Dive' actions.

4.0 EPRR Work Plan 2024

The following outlines this year's work developed under EPRR programme to ensure statutory obligations set under Civil Contingencies Act 2004, EPRR Framework and other national guidance are met.

4.1 Revised EPRR Plans for 2024

Following documents to be signed off at September TEC:

- **MKUH Business Continuity Management System Policy**
- **MKUH CBRN/HAZMAT SOP**
- **eCare Business Continuity Plan**

Following documents to be revised and signed off by December 2024:

- **Major Incident Action Cards**
- **Crisis Communication Plan**
- **Pandemic Plan**
- **Annual Business Continuity Plan review of all service level plans (supported by Audit committee following RSM report)**

Monitoring of all work will be conducted through the Emergency Planning Steering Committee chaired by AEO.

All new plans will form part of the EPRR training and exercise programme to ensure staff roles outlined within are tested and embedded. All plans are accessible to all staff on the EPRR Intranet page and Trust Documentation Site with communication cascade to notify all staff of revised plans when required. Hard copies are held within all Incident Coordination Centres (ICC).

4.2 EPRR Incidents of Note

Incident	Dates	Level of Response
BMA Industrial Action	11th-15th September 2023	Business Continuity
BMA Industrial Action	24th-25th September 2023	Business Continuity
BMA Industrial Action	19th-22nd September 2023	Business Continuity
BMA Industrial Action	2nd-4th October 2023	Business Continuity
Operation Paladin (AI Government Conference)	1st – 2nd November 2023	Multi Agency Planning in support of Government held conference at Bletchley Park
BMA Industrial Action	20th – 23rd December 2023	Business Continuity
BMA Industrial Action	3rd – 9th January 2024	Business Continuity
Critical Incident*	25th – 26th January 2024	Incident Response Plan activated with command structures put into place

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BMA Industrial Action	24th – 28th February 2024	Business Continuity
BMA Industrial Action	27th June – 2nd July 2024	Business Continuity
NHSBT Amber Alert	25th July 2024	Emergency Blood Management

*Structured debriefs were held with a post incident report to be developed and agreed with executive team outlining number of recommendations

4.3 Training and Exercising

Below outlines the training and exercises delivered since last annual report. All records are held with EPO in accordance with national guidance on record management for EPRR except for exercise organised by external partners.

Name of Course / Exercise	Organiser	Date	Comment / Type of Exercise
Exercise Jigsaw	EPO	18/08/2023	Comms Exercise
ED Major Incident Training	EPO	18/08/2023	Training
ED Major Incident Training	EPO	15/09/2023	Training
Major Incident Legal Awareness Training	EPO	25/09/2023	Training
Major Incident On Call Training	EPO	26/09/2023	Training
Major Incident On Call Training	EPO	18/10/2023	Training
Major Incident On Call Training	EPO	20/10/2023	Training
ED Major Incident Training	EPO	15/11/2023	Training
Major Incident On Call Training	EPO	13/12/2023	Training
Major Incident On Call Training	EPO	02/01/2024	Training
Major Incident On Call Training	EPO	12/01/2024	Training
Major Incident On Call Training	EPO	08/02/2024	Training
Exercise Jackpot	BLRF	25/04/2024	Table-Top
Clinical Site Manager Major Incident Training day	EPO	26/04/2024	Table-Top
Major Incident On Call Training	EPO	29/04/2024	Training
EoE TTX: Measles	NHSE	29/04/2024	Table-Top
Exercise Silver Birch	ICB	09/05/2024	Table-Top
Thames Valley Trauma Network Exercise	OUH	24/05/2024	Live
ED Major Incident Training (Doctors)	ED Consultant	12/06/2024	Training
Exercise Enterprise Part 2	NHS EoE	17/06/2024	Table-Top
Major Incident Loggist Training	EPO	18/06/2024	Training

Major Incident On Call Training	EPO	18/06/2024	Training
ED Band 6 Nurses Major Incident Training (Includes Exercise Decon)	EPO	19/06/2024	Training
ED Band 6 Nurses Major Incident Training (Includes Exercise Decon)	EPO	26/06/2024	Training
Exercise Move	EPO	10/07/2024	Table-Top
Volunteers Major Incident Awareness Training	EPO	15/07/2024	Training
Clinical Site Manager Major Incident Training day	EPO	17/07/2024	Table-Top
Exercise Move	EPO	26/07/2024	Table-Top
Clinical Site Manager Major Incident Training day	EPO	05/08/2024	Table-Top
Cyber Exercise	EPO	27/09/2024	Table-Top

5.0 Next Steps

- For executive team to receive the report and to confirm they are assured of the Trusts compliance against statutory and national Core Standards for Emergency Preparedness, Resilience and Response.
- For this report to be placed on Public Board agenda for final approval.

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
Acting Chair: Heidi Travis

Appendix A: MKUH Core Standards and Deep Dive Action Plan

Core Standards Ref	Question	Evidence Required	MKUH Answer	Self-Assessment	Action	Date for Completion
13	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	New guidance published on 15th July with MKUH Pandemic Plan to be revised in line with new information		MKUH Pandemic plan to be revised	October 2024
47	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Not all services have revised BCPs for 2024 cycle review with recommendation taken following external audit by RSM		For RSM action to be concluded by December 2024	

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Chief Executive: Joe Harrison
Acting Chair: Heidi Travis

Deep Dive	**Question**	**Evidence Required**	**MKUH Answer**	**Self-Assessment**	**Action**	**Date for Completion**
DD2	The organisation has developed threat specific cyber security and IT related incident response arrangements with regard to relevant risk assessments and that dovetail with generic organisational response plans.	Arrangements should: -consider the operational impact of such incidents -be current and include a routine review schedule -be tested regularly -be approved and signed off by the appropriate governance mechanisms -include clearly identified response roles and responsibilities -be shared appropriately with those required to use them -outline any equipment requirements -outline any staff training needs -include use of unambiguous language -demonstrate a common understanding of terminology used during incidents in line with the EPRR	IT Disaster Recovering plan being revised within current Trust template to be signed off at IT governance meeting in due course. Further review to take place on third part suppliers and cloud-based solution that are not controlled by IT. Current IT alert levels in place concerning cyber against responding actions for IT department tied into Trust Incident Response arrangements.		IT Department to revise Disaster Recovery Plan	31 December 2024

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		framework and cybersecurity requirements.'				
DD5	The exercising and/ or testing of cyber security and IT related incident arrangements are included in the organisations EPRR exercise and testing programme.	- Evidence of exercises held in last 12 months including post exercise reports - EPRR exercise and testing programme	MKUH attended BLRF cyber exercise in April 2024, with plan to run tabletop exercise on 27th September 2024		Cyber incident tabletop exercise to be held on 27th September 2024 in testing current BCPs and capabilities	27 September 2024
DD9	The Cyber Security and IT teams are aware of the organisation's critical functions and the dependencies on IT core systems and infrastructure for the safe and effective delivery of these services	-robust Business Impact Analysis including core systems -list of the organisations critical services and functions -list of the organisations core IT/Digital systems and prioritisation of system recovery	To be outlined within IT Disaster Recovery Plan under review with BIA Templates supporting critical functions of each service		IT Department to revise Disaster Recovery Plan with EPO to support list of critical functions	31 December 2024

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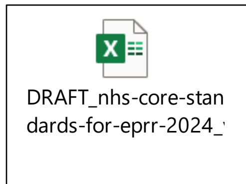
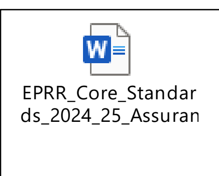
Chief Executive: Joe Harrison
Acting Chair: Heidi Travis

Appendix B: Core Standards MKUH Self-Assessment



Appendix C: NHS East of England Core Standards Letter



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Chief Executive: Joe Harrison
Acting Chair: Heidi Travis

TRUST BOARD IN PUBLIC

Academic Centre/Teams

Thursday, 9 January 2025

MKUH Objectives Update

Kate Jarman/Joe Harrison
Chief Executive/Chief Corporate Services Officer

Discuss

Meeting Title	Trust Board in Public	Date: 9th January 2025
Report Title	**Risk Register Report**	**Agenda Item Number: 20**
Lead Director	***Kate Jarman, Director of Corporate Affairs***	
Report Author	***Paul Ewers, Senior Risk Manager***	

Introduction	The report provides an analysis of all risks on the Risk Register, as of 2nd January 2025.		
Key Messages to Note	Please take note of the trends and information provided in the report. **Risk Appetite:** This is defined as the amount of risk the Trust is willing to take in pursuit of its objectives. The risk appetite will depend on the category (type) of risk.		
	Category	Appetite	Definition
	Financial	Open	Willing to consider potential delivery options and choose while also providing and acceptable level of reward and value for money
	Compliance/ Regulatory	Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
	Strategic	Seek	Eager to be innovative and to choose options offering potentially higher business rewards despite greater inherent risk
	Operational	Minimal/ As low as reasonably practicable	Preference for ultrasafe delivery options that have a low degree of inherent risk and only for limited reward potential
	Reputational	Open	Willing to consider potential delivery options and choose while also providing and acceptable level of reward and value for money
	Hazard	Avoid	Preference to avoid delivery options that represent a risk to the safety of patients, staff, and member of the public
	Note: The Risk Appetite statements are currently under review.		
Recommendation ***(Tick the relevant box(es))***	**For Information** ☐	**For Approval** ☐	**For Review** √

Strategic Objectives Links ***(Please delete the objectives that are not relevant to the report)***	*Objective 1: Keeping you safe in our hospital* *Objective 2: Improving your experience of care* *Objective 3: Ensuring you get the most effective treatment* *Objective 4: Giving you access to timely care* *Objective 7: Spending money well on the care you receive* *Objective 8: Employ the best people to care for you* *Objective 10: Innovating and investing in the future of your hospital*

Report History	The Risk Report is an ongoing agenda item
Next Steps	
Appendices/Attachments	Appendix 1: Corporate Risk Register Appendix 2: Significant Risk Register *(See Supplementary Shelf)*

Risk Management Dashboard (Radar):

Number of Open Risks

Total Risks
265

Significant Risks by Current Risk Score

Significant Risks
62

Risks Raised within Last 30 Days

New Risks
9

Compared to 30 days ago ▲9

Risks Closed within the Last 30 Days

Closed risks
2

Compared to 30 days ago ▲0

Current Risk Score Heat Map

Consequence

Likelihood	1	2	3	4	5
5	0	3	10	12	0
4	0	12	30	22	8
3	2	18	45	27	10
2	0	7	26	15	3
1	1	1	0	9	4

Risks with Overdue Reviews

Overdue Risks
56

Risks Overdue by Next Review Date

Month	Jun 2024	Jul 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025
Risks	1	1	1	4	42	7

Outstanding Risk Controls

Outstanding Controls
332

Overdue Risk Controls

Overdue Controls
126

Exception Reporting:

The above dashboard provides a summary of the key metrics to provide assurance that the risk management process is working as intended.

The key highlights are as follows:

1. There has been a slight increase in the total number of risks (n=265).

2. Just under a quarter of the risk identified (62) are currently graded as significant. The heat map shows that around half of the risks are graded as moderate harm. Around three quarters of the risks identified are either moderate or significant risks to the Trust objectives – therefore highlighting the importance of these being effectively managed.

3. There are currently 55 risks (21%) that are overdue their review date. This is **an increase of 6** from the previous report. This is in part due to a high number of risks being given review dates of 31st December or 1st January and not reviewed during the Christmas period.

4. 9 of the 55 overdue risks are more than 1 month overdue, of which **2 risks are more than 3 months overdue**:

Reference	Risk Owner	CSU	Days Overdue
RSK-475	Julian Robins	Head & Neck	189
RSK-131	Paula Robinson	Diagnostic & Screening	155

5. There are 332 controls that have been identified and are in progress. This shows that when risks are identified, controls are being identified to mitigate the risk. However, of these 126 are past their expected implementation date. This is **an increase of 36**.

6. Following Internal Audit recommendations, a proposal has been made to the Education Board that Risk Management training is made mandatory for all staff bands 7 and above, with a 3 yearly renewal. This should support staff understanding of the importance of the process and their role in ensuring risks are regularly identified, assessed, controlled and reviewed.

   Update (2nd January 2025)**:** The November Education Board was not quorate; therefore, no decision was made re the Risk Management Training being essential to role for bands 7 and above. Item to be discussed outside of the meeting and decision to be made.

Risks Escalated by Division/Corporate Department:

No risks have been identified as requiring escalation onto the Corporate Risk Register this month.

Recommendations:

1. Considering the increasing number of risks overdue their review date it is recommended that the Divisions/Corporate Departments put plans in place to ensure that all overdue risks to be updated by 31st January 2025.

2. Divisions/Corporate Departments to ensure that controls are reviewed and updated as part of reviewing each risk. It is recommended that all controls are updated and either closed or their due dates extended by 31st January 2025.

Meeting Title	**Trust Board in Public**	**Date: 9th January 2025**
Report Title	**Board Assurance Framework**	**Agenda Item Number: 21**
Lead Director	*Kate Jarman, Chief Corporate Services Officer*	
Report Author	*Paul Ewers, Senior Risk Manager*	

Introduction	This report is to provide assurance that the Board Assurance Framework (BAF) is being effectively managed.		
Key Messages to Note	The format of this report has been changed in order to make reporting on the BAF more succinct and make it easier to highlight key messages and concerns.		
Recommendation	**For Information** ☐	**For Approval** ☐	**For Assurance** x

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

Report History	Regular Committee cycle
Next Steps	*N/A*
Appendices/Attachments	*The following report can be found under item 21 in the Supplementary Shelf:* • *Board Assurance Framework*

BAF Dashboard:

	Strategic Risk	Executive Lead	Inherent Risk (level of risk without controls)	Current Risk												Target Risk (level of risk deemed tolerable)	Risk Appetite	Treatment Strategy	Assurance Rating
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec				
1	Continued industrial action resulting in significant disruption to care/ service provision	Chief People Officer	12				9	9	9	9	9	9	9	9	9	3	Avoid	Tolerate	Positive Assurance
2	Insufficient capital funding to meet the needs of population we serve	Chief Financial Officer	25	20	20	20	20	20	20	20	20	20	20	20	20	10	Avoid	Treat	Negative Assurance
3	If the future NHS funding regime is not sufficient to cover the costs of the Trust, then the Trust will be unable to meet its financial performance obligations or achieve financial sustainability.	Chief Financial Officer	20	20	20	20	20	20	20	20	20	20	20	20	20	8	Cautious	Treat	Negative Assurance
4	Patients experience poor care or avoidable harm due to delays in planned care	Chief Operating Officer – Planned Care	25				20	20	20	20	20	20	20	20	20	10	Avoid	Treat	Inconclusive Assurance
5	Patients experience poor care or avoidable harm due to inability to manage emergency demand.	Chief Operating Officer – Unplanned Care	25				20	20	20	20	20	20	20	20	20	10	Avoid	Treat	Positive Assurance
6	System inability to provide adequate social care and mental health capacity.	Chief Operating Officer – Unplanned Care	20				20	20	20	20	20	20	20	20	20	8	Avoid	Treat	Inconclusive Assurance
7	Political instability and change	Chief Executive Officer	15				6	6	6	6	6	6	6	6		6	Cautious	Tolerate	Positive Assurance
8	If the pathway for patients requiring head and neck cancer services is not improved, then users of MKUH services will continue to face disjointed care, leading to unacceptably long delays for treatment and the risk of poor clinical outcomes	Chief Medical Officer	25	15	15	15	15	15	15	15	15	15	15	15	15	10	Avoid	Treat	Inconclusive Assurance
9	Insufficient staffing levels to maintain safety	Chief People Officer	15	10	10	10	10	10	10	10	10	10	10	10	10	5	Avoid	Treat	Positive Assurance

Longer-term Risks: Nine longer-term risks have been identified.

- Conflicting priorities between the ICS and providers
- Lack of availability of skilled staff
- Increasing turnover
- Lack of time to plan and implement long-term transformational change
- Long-term financial arrangements for the NHS
- Growing/ageing population
- A pandemic
- Continued industrial action resulting in significant disruption to service/ care provision
- Political instability and change

Exception Reporting:

At the Board Risk Seminar in October 2024, the strategic risks around industrial action and political instability/change were moved to the list of Longer-Term risks (see below). The board identified 6 potential new strategic risks.

Finance & Investment Committee.

The following risks were discussed and it was decided that these did not require adding to the BAF:

- Capital funding for deteriorating quality of estate
- Recording and reporting of SDEC dataset
- Pathology LIMS system contract. System is no longer sufficient for the needs of the department

Audit & Risk Committee.

The following risks were discussed and it was decided that these will be added to the BAF in January:

- Cyber Security
- Deteriorating quality of data

Clinical Risk Committee.

The following risk was discussed and it was recognised that the risk would need to be appropriate worded so that it reflects what MKUH can influence/control. The Committee decided that this needs further discussion at Board**:**

- Widening health inequalities

Recommendations:

1. The Trust Executive Committee are asked to review and discuss the Board Assurance Framework and have an awareness of the potential new risks being added to the BAF and those still under discussion.

Meeting Title	**TRUST BOARD (PUBLIC)**	**Date: 9 January 2025**
Report Title	Audit & Risk Committee Assurance Report	**Agenda Item Number: 22**
Committee Chair	**Mark Versallion**, Non- Executive Director & Chair of the Committee	
Report Author	**Oluwakemi Olayiwola**, Trust Secretary	

Introduction	The purpose of the report is to provide an update to the Trust Board on the activities of the Audit & Risk Committee since the Trust Board held in public on 5 September 2024. The committee had met on two occasions since the last update to the Board: 16 September 2024 and 9 December 2024		
Key Messages to Note	The Trust Board is invited to NOTE the report.		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Assurance** x

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	1. *Keeping you safe in our hospital* 2. *Improving your experience of care* 3. *Ensuring you get the most effective treatment* 4. *Giving you access to timely care* 5. *Working with partners in MK to improve everyone's health and care* 6. *Increasing access to clinical research and trials* 7. *Spending money well on the care you receive* 8. *Employ the best people to care for you* 9. *Expanding and improving your environment* 10. *Innovating and investing in the future of your hospital*

1. Committee Discussion and Decision

Key points to note:

- The committee had met on two occasions since the last update to the Board: 16 September 2024 and 9 December 2024.
- The meeting title was changed by a decision of the Board on 14 November to '*Audit and Risk Committee'*

The following decisions were made at the Audit Committee held on **16 September 2024**

The meeting was quorate and chaired by Mark Versallion - NED

Agenda Item	**Decision Made**	**Comments**

External Audit Findings Improvement Action Plan	The Committee **noted** the External Audit Findings Improvement Action Plan	The committee received the audit improvement findings in relation to the 2023/24 audit and outstanding items from the 2022/23 audit, the project plans in place to address said findings, and project progress to date. A few points from the previous year's plan remain incomplete due to resource shortages, committee noted that plans were in place to address these issues this year, with prioritisation given to the most critical tasks.
Internal Audit Progress Report	The committee noted the report.	Key highlights were the completion of the previous year's (2023/24) final audit on appraisals, which received positive feedback. Another audit from the 2024-25 plan on the Estates program also received positive feedback, with minor recommendations around governance. An audit related to the Data Security and Protection Toolkit (DSPT) will be replaced with a cyber review or medical equipment audit.
Counter Fraud Progress Report	The committee **noted** the report	It was reported that two proactive reports were under development: • The first report focuses on the various routes available for reporting fraud within the Trust, including fraud incident reporting, HR, and the Freedom to Speak Up initiative. The report was nearing completion and would be presented at the next Audit & Risk Committee meeting. • The second report addresses secondary employment and the associated conflicts of interest. Terms of reference had been issued, and data collection was ongoing to assess whether employees with secondary jobs were properly declaring them.
Financial Controller's Report	The committee approved reported write offs and noted report	The committee noted that salary overpayments had been a recurring issue. Divisional reporting had been reinstated to make these issues more visible to operational managers. Overpayments often resulted from incomplete paperwork or processes not being followed, and bringing this information to divisions had helped address the issue
Waiver Report	The committee **noted** the report	The committee noted the Q2 waiver trends and progress on the reduction plan There were no further comments.

Health & Safety Report	The committee **noted** the report	Key highlights were the challenges around enforcing a zero-tolerance policy on violence and abuse, particularly in cases involving patients with cognitive impairments such as dementia.
Terms of Reference	The committee noted the amendments to the Terms of Reference and recommended to the Board for approval.	There were no other comments.
Board Assurance Framework (BAF)	The committee **noted** the report	Two emerging risks: the deteriorating quality of the estate and data/cybersecurity were considered. Escalated for further discussions at the upcoming session in October 2024 (Board Seminar) to review risks and assess the effectiveness of the BAF process.
Risk Management Report	The committee **noted** the report	The report highlighted ongoing efforts to manage risks, particularly addressing overdue controls and reviewing high-risk items more frequently. Monthly meetings between the risk manager and divisional leads help maintain oversight
The following decisions were made at the Audit Committee held on 9 December 2025		
External Audit Update	The committee **noted** the External Audit Update	There were no significant new developments to report since the last update. The planning process for the 2024/25 External Audit cycle was reported underway
External Audit Findings Improvement Action Plan	The committee discussed and noted the report	The committee received the update on the progress of the Finance and Value for Money action plans. Key completed actions include improvements in contract management, board agenda options, and BAF reporting
Internal Audit Progress Report	The committee **noted** the Internal Audit Progress Report	The committee were that the Head of Internal Audit opinion would be delivered by the March 2025 meeting, a month ahead of schedule, with no significant issues to report at this stage. The committee further noted the challenges in recruiting cybersecurity specialists due to salary disparities and the increased complexity of the toolkit.

		Minor updates to global internal audit standards, which aligned with public sector standards were highlighted. The report was reflective of strong engagement from the Trust and supports a positive outlook for the Head of Internal Audit opinion
Counter Fraud Progress Report	The committee **noted** the Counter Fraud Progress Report	Key highlights include: • **Proactive Reviews:** Reviews were undertaken during the year, focusing on reporting culture, secondary employment, and a procurement-related piece for the NHS Counter Fraud Authority • **Fraud Awareness Month** was marked with on-site visit, where the team engaged staff in the restaurant, distributed materials, and handed out promotional items • **Referrals:** A total of 7 fraud referrals had been received this year, with 1 carried forward to the CPS due to its complexity • **AI and Recruitment:** a technical update on the role of AI in recruitment, a topic previously discussed and noted that information on this would be circulated.
Financial Controller's Report	The committee **noted** the Financial Controller's Report and **approved** the write offs.	The committee received and reviewed a summary of the values and volumes associated with write-offs and salary overpayments made for the period September to November, relating to overseas patients and salary overpayments
Government Banking Updates	The committee **noted** the Government Banking Update	It was noted that evaluation and moderation phases were nearing completion, and the new contracts were expected to be announced in early 2025. Key risks identified include potential disruption to financial operations and dependencies on third-party providers. Mitigation measures, such as parallel operation of old and new accounts and redirection facilities, aim to minimise disruptions during the transition. The Trust had taken proactive actions, including reviewing banking limits, validating mandates, and flagging risks with stakeholders such as shared business services (SBS) and ELFS (payroll provider).

Standing Financial Instructions and Standing Orders	The committee **noted** and **approved** the proposed changes to the current Standing Financial Instructions subject to above (item 11.3)	It was noted that the policy had been refreshed to better align with the Trust's current governance structure, job titles, and roles, ensuring compliance with EU thresholds, NHS regulations and industry best practices
ADMK Annual Accounts 2023/24	The committee **noted** the ADMK report and agreed to revisit strategic and operational considerations after the January 3rd meeting.	The committee received the accounts and noted that the accounts had been successfully submitted to Companies House.
Health and Safety Report	The committee **noted** the Health and Safety Report	The report highlighted ongoing work around violence and aggression prevention, the challenges in recruiting for the Health and Safety team, and the need for better partnership working to address patient-related issues.
Board Assurance Framework/Corporate and Significant Risk Register Report	The committee **reviewed** and **noted** the reports	The committee agreed the need to clarify risk appetite, prioritise impactful risks, and distinguish between issue management and risk assessment. A detailed discussion on risk appetite particularly in balancing performance and finance risks and risk prioritisation was scheduled for the February 2025 Board seminar

2. Assurance

(In the comments)

3. Areas for escalation to the Board for further discussion or decision from the agenda items

The following were escalated from the committee to the Trust Board:

- Terms of Reference
- Deteriorating quality of data for further discussion at Trust Board.

Recommendation

- The Board are invited to NOTE the report.

TheMKWay

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

Meeting Title	**TRUST BOARD (PUBLIC)**	**Date: 9 January 2025**
Report Title	Charitable Funds Committee Report	**Agenda Item Number: 22**
Committee Chair	**Haider Husain**, Non- Executive Director & Chair of the Committee	
Report Author	**Oluwakemi Olayiwola**, Trust Secretary	

Introduction	The purpose of the report is to provide an update to the Trust Board on the activities of the Charitable Funds Committee since the Trust Board held in public on 5 September 2024. The committee had met on one occasion since the last update to the Board: 7 November 2024		
Key Messages to Note	The Trust Board is invited to NOTE the report.		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Assurance** x

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	1. *Keeping you safe in our hospital* 2. *Improving your experience of care* 3. *Ensuring you get the most effective treatment* 4. *Giving you access to timely care* 5. *Working with partners in MK to improve everyone's health and care* 6. *Increasing access to clinical research and trials* 7. *Spending money well on the care you receive* 8. *Employ the best people to care for you* 9. *Expanding and improving your environment* 10. *Innovating and investing in the future of your hospital*

1. Committee Discussion and Decision

The committee had met on one occasion since the last update to the Board: 7 November 2024

The following decisions were made at the Charitable Funds Committee held on **7 November 2024**

The meeting was quorate and chaired by Haider Husain - NED

Agenda Item	Decision Made	Comments
Charitable Funds Report	The committee **noted** the Charitable Funds Report.	Discussions included the virtual tour of maternity, delays in order completion due to financial review, and the use of funds for laptops in the Cancer unit.

Finance Report	The committee **noted** the Finance Report.	Discussions included the charity's cash balance, the need for clarity on restricted and unrestricted funds, and the review of the charity's Reserve Policy.
Charity Annual Report and Accounts	The committee **approved** the Charity Annual Report and Accounts.	The need to present the information appealingly to potential donors was highlighted.
Charity Investment Policy	The Charitable Funds Committee **noted** the Charity Investment Policy and agreed the review of the policy wording when due for a review.	The current objective was to ensure the charity's liquidity.
Terms of Reference	The committee **approved** the Terms of Reference and **recommended** for Trust Board approval.	The addition of requirement to complete a business case for requests was welcomed by the committee and agreement was made to circulate for clarity, details of the process including the conception of an agreement in principle paper.
Risks Highlighted During the Meeting for Consideration to CRR/BAF	Discussed	Financial risk related to the charity's liquidity was highlighted. There were no further comments.

2. Assurance

The Chair and Non-Executive Directors were assured that:

- As noted in comments

3. Areas for escalation to the Board for further discussion or decision from the agenda item

The following were escalated from the committee to the Trust Board:

- The Charitable Funds Terms of Reference
- Financial Risk
- Arts for Health

Recommendation

- The Board are invited to NOTE the report.

Meeting Title	TRUST BOARD (PUBLIC)	Date: 9 January 2025
Report Title	Finance & Investment Committee Assurance Report	Agenda Item Number: 22
Committee Chair	**Gary Marven,** Non- Executive Director & Chair of the Committee	
Report Author	**Oluwakemi Olayiwola,** Trust Secretary	

Introduction	The purpose of the report is to provide an update to the Trust Board on the activities of the Finance & Investment Committee since 5 September Board held in public. The committee had met on two occasions: on **28 October 2024 and 16 December 2026**		
Key Messages to Note	The Trust Board is invited to NOTE the report		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Assurance** X

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	1. *Spending money well on the care you receive* 2. *Employ the best people to care for you* 3. *Expanding and improving your environment* 4. *Innovating and investing in the future of your hospital*

1. Board Assurance Framework

Strategic Risk 2	Insufficient capital funding to meet the needs of population we serve						
Lead Committee	Finance & Investment Committee	Risk Rating	Inherent	Current	Target	Risk Type	Financial
Executive Lead	Chief Financial Officer	Consequence	5	5	5	Risk Appetite	Avoid
Date of Assessment		Likelihood	5	4	2	Risk Treatment Strategy	Treat
Date of Review	May 2024	Risk Rating	25	20	10	Assurance Rating	Negative Assurance
Linked Trust Objectives	1. Keeping you safe in our hospital 2. Improving your experience of care 3. Ensuring you get the most effective treatment 7. Spending money well on the care you receive 9. Expanding and improving your environment 10. Innovating and investing in the future of your hospital						
Linked Corporate Risks	RSK-305 RSK-526						
Trend	Tracker chart (see below)						

Strategic Risk 3	If the future NHS funding regime is not sufficient to cover the costs of the Trust, then the Trust will be unable to meet its financial performance obligations or achieve financial sustainability.						
Lead Committee	Finance & Investment Committee	Risk Rating	Inherent	Current	Target	Risk Type	Financial
Executive Lead	Chief Financial Officer	Consequence	4	4	4	Risk Appetite	Cautious
Date of Assessment	March 2023	Likelihood	5	5	2	Risk Treatment Strategy	Treat
Date of Review	May 2024	Risk Rating	20	20	8	Assurance Rating	Negative Assurance
Linked Trust Objectives	1. Keeping you safe in our hospital 2. Improving your experience of care 3. Ensuring you get the most effective treatment 7. Spending money well on the care you receive 9. Expanding and improving your environment 10. Innovating and investing in the future of your hospital						
Linked Corporate Risks							
Trend	Tracker (chart)						

2. Committee Discussions and Decisions

The Committee had met on two occasions since the last update to the Board on 5 September 2024: 28 October 2024 and 16 December 2024

The following decisions were made at the meeting held on **28 October 2024**

Agenda Item	Decision Made	Comments
Financial Performance Report	The committee **noted the** Report and the financial position of the Trust as of 30 September 2024	Highlights included: • The Trusts deficit position of £4.6m (on a Control Total basis) to the end of the September, this being adverse to plan by £0.6m • The positive in-month position was also reported, with a surplus of £0.4m (adverse to plan by £0.3m). • The Elective Recovery Fund (ERF) performance was 136% above pre-Covid levels (above the 106% national target and the internal budget target of 124%). ERF income showed £8.8m above the national target as at M06, which had resulted in a favourable income variance to plan of £3.3m

		The Trust had achieved £9.8m efficiency delivery against the year-to-date plan of £11.9m. • Improvements in the run rates and pay due to the closure of escalation wards were noted.
New Hospital Programme	The committee **approved** the extension to contracts subject to them holding the appropriate stop clauses	The committee noted the current predicted cost is £10.9m underbudget but there are early warnings of additional costs offsetting this. The committee received assurances that any potential overspends will be mitigated through the design process progresses and value engineering. The committee approved extending contracts and noted the financial exposure in the current year if the programme is not approved From discussions the committee received assurances that this was low risk. A decision is expected in January.
Capital Updates	The committee noted the Capital Update	Capital year to date position as of 30 September 2024 of £50.1m, which included £6.3m of grants was confirmed. The committee noted the backend loading of expenditure.
Medium Term Financial Planning	The committee noted the report	The plan had been completed as part of the Bedford, Luton & Milton Keynes (BLMK) Integrated Care System (ICS) planning process and NHS England - wide exercise. The report had been submitted to the East of England region on 30 September 2024. The MTFP had been brought up to date to include the FY2024/25 forecast outturn and was noted to include a further 4 additional years up to and including FY2028/29 that would incorporate the first year of the New Hospital Programme. Planning assumptions had been agreed locally based on FY 2024/25 assumptions
Integrated Performance Report	The committee noted the report	The report highlighted the inpatient occupancy for September 2024. There were no further comments.
Estates ERIC Report	The committee noted the report	The key metrics contained in the report for the past 10 years were highlighted. Backlog maintenance was noted to be rising due to a number of factors including changes in guidance and best practise from Health Technical Memorandum. Utility costs were reported to have risen over the past year
BAF & High-Level Risks (15+)	The committee **noted** the BAF & High-Level	It was agreed that the scores for the following risks were to remain at the same level with a review of the scoring for the

Relating to Committee Areas	Risks (15+) Relating to Committee Areas.	Capital Funding outside of the meeting. Mitigations on the BAF risks were confirmed to be reviewed as an executive team.
Contract Approvals for Clinical Engineering Services – Draeger MVS	The committee **recommended** the 1-year extension of the Draeger MVS contract for Board approval.	The committee received the estates department request to utilise the optional 1-year contract extension from 01/10/2024 to 30/09/2025 for a value of £2,674,254 for the Multi-Vendor Service (Clinical Engineering) with Dreager and to combine the Olympus & Karl Storz contracts into the contract to achieve economy of scale. The arrangement was in preparation of a full tender to take place in 2025.
Terms of Reference	The committee approved the Terms of Reference and Recommended for approval of the Trust board	The changes to the ToR were noted to include: • a change in wording in respect of the attendance of the Deputy Chief Executive Officer to an attendee deputising for the Chief Executive Officer
The following decisions were made at the committee held on **16 December 2024**		
Financial Performance	The committee **noted** the Financial Performance Report and the financial position of the Trust as of 30 November 2024	It was noted that financial planning for 2025/26 was underway whilst national guidance was expected by 24 December 2024 with key headline messages. The full version of the draft plan was expected to be completed by the end of January 2025.
Cash Flow Report	The committee **noted** the month 8 closing cash position and the forecast cash position for FY 2024/25.	The report highlighted the Trust's closing cash position for month 8 of £11.4m, and the year- end closing cash position of £9.2m.
Efficiency Report	The committee **noted** the report	Highlights included a reported forecast outturn of £16.0m for month 8, with an additional £2.45m of schemes in planning, risk-adjusted by 50%. There was a gap of £5.3m to identify for the 2024/25 programme, which had increased due to the re-application of a 50% risk adjustment to schemes in the planning phase.
NHP Financial Overview	**noted** the NHP Financial Overview and **recommended** the continuation of the programme to the Trust Board, pending	It was noted that the continuation at cost had been approved by the Trust Board to the end of December 2024 at a risk cost of £1.169m whilst formal approval for the funding is received from the NHP team. To continue to the end of the financial year it was noted there is a potential total risk of £3.069m.

	any decision from the Secretary of State	
Capital Updates	The committee **noted** the Trust's request for additional capital to support the replacement of the theatre's air handling unit, the risks around future funding for the ongoing design work of the main NHP scheme beyond October, the risks to delivery of the NHP enabling scheme for high voltage by the end of March 2025, and the uncertainty on the capital funding allocation for 2025/26.	The capital year to date position as of 30 September 2024 of £50.1m, which included £6.3m of grants. Formal approval for funding of the New Hospital Programme design work beyond October 2024 was reported to be outstanding. The Trust's current Capital Departmental Expenditure Limit (CDEL) allocation remained at £43.8m, unchanged since the end of July 2024
Integrated Performance Report	The committee **noted** the Integrated Performance report and the improvements to the super-stranded patients	It was highlighted that in October 2024, there were 9,207 attendances, an increase of 519 from September 2024. The percentage of attendances admitted, transferred, or discharged within 4 hours was 73.8%, showing an improvement from 73.0% in September 2024. There were 41,791 outpatient attendances in October 2024, with 12.4% attended virtually and a 6.2% non-attendance rate. There were 2,701 elective procedures recorded in October 2024. By the end of October 2024, 36,150 patients were on an open RTT pathway, with 467 waiting over 65 weeks and 70 waiting more than 78 weeks.
Progress Against Environmental Sustainability Strategy/Green Plan	The committee **noted** the report.	It was highlighted that early stages of engagement meetings had commenced in November 2024 to create a system-wide focus on reducing carbon emissions. MKUH continued to plan for the 2030 net zero target for those in scope 1 and 2, with good progress made to date. Updated National NHSE guidance for sustainability planning and targets was expected to be released in January 2025
BAF and High-Level Risks (15+)	The committee **noted** the BAF and High-Level Risks (15+)	There were no additions or changes to the risks scored 15 or above, as listed below since the last meeting:

Relating to Committee	Relating to Committee Areas.	• Strategic Risk 2: Insufficient capital funding to meet the needs of population we serve • Strategic Risk 3: If the future NHS funding regime is not sufficient to cover the costs of the Trust, then the Trust will be unable to meet its financial performance obligations or achieve financial sustainability

3. Assurance

The Chair and Non-Executive Directors were assured that:

- As noted in comments

4. Areas for escalation to the Board for further discussion or decision from the agenda item

The following items have been recommended to be escalated to the Trust Board for further discussions and approvals:

- Outstanding £1.5m payment from Buckingham, Oxford and Berkshire ICS
- Capabilities of the Trust in a worst-case scenario that the NHP is not approved to be discussed at Board
- The continuation of the New Hospital Programme at the risk pending any decision from the Secretary of State.

5. Recommendation

The Board are invited to note the Finance Committee Assurance report.

Meeting Title	TRUST BOARD (PUBLIC)	Date: 9 January 2025
Report Title	Workforce & Development Assurance Committee Report	Agenda Item Number: 22
Committee Chair	**Haider Husain**, Non- Executive Director & Chair of the Committee	
Report Author	**Oluwakemi Olayiwola**, Trust Secretary	

Introduction	The purpose of the report is to provide an update to the Trust Board on the activities of the Workforce and Development Committee since the Trust Board held in public on 5 September 2024. The committee had met on one occasion on 21 November 2024		
Key Messages to Note	The Trust Board is invited to NOTE the report.		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Assurance** ☒

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	*1. Keeping you safe in our hospital* *2. Improving your experience of care* *3. Ensuring you get the most effective treatment* *4. Giving you access to timely care* *5. Working with partners in MK to improve everyone's health and care* *6. Increasing access to clinical research and trials* *7. Spending money well on the care you receive* *8. Employ the best people to care for you* *9. Expanding and improving your environment* *10. Innovating and investing in the future of your hospital*

1. Committee Discussion and Decision

The committee had met on 21 November 2024.

The following decisions were made at the Workforce and Development Committee held on **21 November 2024**

The meeting was quorate and chaired by Haider Husain - NED

Agenda Item	Decision Made	Comments
Board Assurance Framework	The committee **noted** the update on the Board Assurance Framework and **approved** the splitting of the overarching risk.	The committee noted the decision to transfer the BAF risk related to potential industrial action to the list of longer-term risks due to mitigations in place and reduced likelihood of industrial action. They also approved splitting the overarching recruitment and

		retention risk into two separate risks: hard-to-recruit posts and retention of staff.
Workforce Risk Register	The committee **noted** the Workforce Risk Register.	The top workforce risks were reviewed and updated. The risk related to the Manual Handling and Ergonomics Advisor vacancy was closed due to successful recruitment. Discussions included the need for better visibility of risks and ensuring correct decisions in the first place.
Freedom to Speak Up Report	The committee **noted** the Freedom to Speak Up Report.	The report highlighted concerns about fairness and equality, apathy about speaking up, and fear of raising concerns. The committee discussed the importance of understanding where issues are and the need for better data capture and engagement plans.
Workforce Strategy	The committee **noted** the Workforce Strategy.	Achievements included a temporary staffing review, streamlined onboarding, and the launch of benefits. The committee discussed the need for more engaging metrics and the importance of leadership training.
Objectives Update	The committee **noted** the Objectives Update.	The committee reviewed historical reporting metrics and discussed initiatives to improve EDI and Disability and BAME representation. They emphasised the need for a clear plan for EDI before recruitment and the importance of having the right structure to support improvements.
GMC National Training Survey (NTS) Survey	The committee **noted** the GMC National Training Survey (NTS) Survey.	The survey results showed positive improvements in several areas, with a focus on improving relationships with rota coordinators and ensuring allocation of study time. The committee discussed the importance of addressing personal elements and connecting with the deanery for signposting.
Education Annual Review	The committee **noted** the Education Annual Review.	The review covered various achievements, including compliance with statutory and mandatory training, the launch of new modules, and an increase in apprenticeship levy spend. The committee discussed the need for better visibility of practice education and the importance of supporting newly qualified staff.

2. Assurance

The Chair and Non-Executive Directors were assured that:

- As noted in comments

Recommendation

- The Board are invited to NOTE the report.

Meeting Title	TRUST BOARD (PUBLIC)	Date: 9 January 2024
Report Title	Quality & Clinical Risk Committee Assurance Report	Agenda Item Number: 22
Committee Chair	**Dev Ahuja**, Non- Executive Director & Chair of the Committee (till 30 November 2024) **Sarah Whiteman,** Non-Executive Director & Chair of Committee (WEF December 2024)	
Report Author	**Oluwakemi Olayiwola**, Trust Secretary	

Introduction	The purpose of the report is to provide an update on the activities of the Quality & Clinical Risk Committee since the last Trust Board held in public. The committee met on two occasions since the last report to the Trust Board: on 16 September and 9 December 2024		
Key Messages to Note	The Trust Board is invited to NOTE the report.		
Recommendation	For Information ☐	For Approval ☐	For Assurance x

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	1. *Keeping you safe in our hospital* 2. *Improving your experience of care* 3. *Ensuring you get the most effective treatment* 4. *Giving you access to timely care* 5. *Working with partners in MK to improve everyone's health and care* 6. *Increasing access to clinical research and trials* 7. *Spending money well on the care you receive* 8. *Employ the best people to care for you*

1. Committee Decision Log

Key points to note:

- The committee met on two occasions since the last report to the Board: on 16 September and 9 December 2024
- The committee chair changed from Dev Ahuja (NED) to Sarah Whiteman (NED) on 30 November 2024

The following decisions were made at the committee meeting held on 16 September 2024. The meeting was quorate and chaired by Dev Ahuja (NED)

Agenda Item	Decision Made	Comments
Patient Safety	The committee **noted** the Patient Safety and PSIRF update	Discussions were reported as ongoing to implement a bi-monthly patient safety report for presentation at the internal meetings of Patient Safety Board and Trust Executive Committee before presentation at Trust Board.

		The PSIRF update highlighted the systems and processes that had been imbedded within the Trust since the launch of PSIRF on 1 May 2024
Annual Infection Prevention & Control Report, Incorporating IPC BAF	The committee **noted** the report	The report highlighted the increase of case numbers for CDIF and ECOLI. The committee were assured that after review, the infections did not have links to the hospital.
Clinical Quality Risks on the Board Assurance Framework	The committee **noted** the BAF risks	It was noted that the risks held were static and required review at Trust Board via presentation by each Executive outlining timelines with end dates to enable the tracking of improvement. Structured deep dives were to be scheduled at future QCRC meetings for upward reporting to the Audit Committee, starting with strategic risk 4: Patients Experience Poor Care or Avoidable Harm Due to Delays in Planned Care at the December 2024 meeting.
Quarterly Mortality Update	The committee **noted** the report.	It was highlighted that the numbers remained volatile due to the changes in the denominator. It was noted that the crude mortality rate had not changed, and no major concerns had been raised by the medical examiner system.
Integrated Quality Governance Report	The committee noted the update.	The report highlighted the changes to the data protection safety toolkit and the required training, high risk inquests which the change to audit afternoons to facilitate improvements linked to quality improvement projects. The committee noted that the report had previously been presented to the Trust Board. The committee additionally received the in-patient survey results and were assured of the planned improvements that were to be monitored through the Patient Experience Board via a thematic review across the hospital.
Quality Dashboard	The committee **noted** the dashboard.	There were no other comments.
Annual Complaints Report	The committee **noted** the report	The report highlighted that there was a planned change to the complaints process. Complaint themes received were in line with areas of improvement highlighted in the patient survey. It was further noted that recent improvements that had been led through the

		complaints team included the implementation of Sign Live and the clothing project
Safeguarding Update	The committee **noted** the Safeguarding Update.	The update highlighted the continued training of staff in areas of domestic abuse, harm from care and learning disability care. The focus on domestic abuse was supported by MKACT. The emergency and maternity departments were identified as key areas to train. Development of a level 3 training package was in process. Section 42 reviews were being undertaken as part of the PSIRF process, to enable improvements in reporting and investigation. It was noted that a review had been commissioned in respect of the incorrect diet/Speech and Language Therapy (SALT) incidents and awaited the outcome. Capacity issues within the Central and Northwest London Foundation Trust (CNWL) who gave provision of SALT was highlighted as a contributory factor.
Antimicrobial Stewardship – Annual Report	The committee **noted** the report	The report highlighted the exciting partnership teaching exchange work with the University of Nigeria and the new pathway for nebulized gentamicin which enabled early discharge.
Research & Development Annual Report	The committee **noted** the report	Assurances were received of the work undertaken by the Research and Development team to forge relationships with peers in the new region. Funding in the area had remained static and participation was noted to have declined over the timescale of the report but this was due to the type of trials open to recruitment (and not MKUH action/engagement).
Medical Revalidation Report	The committee **noted** the report	The report confirmed the good progress of revalidation
Guardian of Safe Working Hours Annual Report	The committee **noted** the report	The report highlighted the annual presentation of the report at the Workforce & Development Assurance Committee, where issues with rosters were reviewed. Issues had been identified via conversations with the GOSWH for Senior House Officer (SHO) level doctors at weekends, resulting in changes. Since the publication of the annual report, agreement had been made to implement (with financial investment), an additional doctor on weekends in general surgery.

Clinical Governance Structure Change Update	The committee **noted** the report	It was noted that the structural changes were in review and under consultation. An update was agreed to be presented at the December 2024 meeting.
Emergency Preparedness, Resilience & Response Annual Report	The committee **noted** the report	The self-assessment had shown 97% compliance within core standard questions resulting in the Trust being at '*substantial compliance level*'. An action plan was confirmed to be in place to meet the gaps identified
Terms of Reference	The committee noted and recommended for Board approval	For further conversations to take place relating to timing, content and frequency outside of the meeting ahead of the presentation to Trust Board.
The following decisions were made at the committee meeting held on 9 December 2024. The meeting was quorate and chaired by Prof Ganesh Balia (NED)		
Patient Safety	The committee **noted** the report	The committee noted the variety of imbedded new systems and processes implemented since the inception of the Patient Safety Incident Reporting Framework (PSIRF).
Clinical Quality Risks on the Board Assurance/ Board Assurance Framework Deep Dive: Patients Experience Poor Care or Avoidable Harm Due to Delays in Planned Care	The committee discussed and noted the committee risks on the BAF	The committee discussed risks related to widening health inequalities, and noted that further discussion was required in terms of the implementation threshold for the Trust as a provider/partner within a wider system
Quarterly Mortality Update	The committee **noted** the update	The committee noted that the mortality statistics remained within the expected statistical range. The crude mortality rate stood at 1.25%, the Hospital Standardised Mortality Ratios (HSMR) matched the national peer values at 90.7 and the SHMI remained as expected at 111.2. The internal review of all individual deaths had continued, and it was noted that no major care or quality issues had been identified over the previous 3-months
Quarterly Highlight Report from the Chief Medical Officer and Chief Nursing Officer	The committee **noted** the update	Key highlights include: • longstanding issues with out of hours ophthalmology service for MK residents were highlighted. The plan to develop a Bedford, Luton & Milton Keynes (BLMK) service for April 2025 were in progression. Challenges to ensure patients

		access the care required had been highlighted to the Integrated Care Board (ICB). • the transfer of the head and neck cancer pathway from Northampton to Oxford on account of operational and quality concerns continued at a slow pace, involvement of the specialist commissioners continued, with further challenges noted due to inter-ICB and inter-regional boundaries
Safeguarding Annual Report	The committee **noted** the update	It was noted that the safeguarding team were undergoing transformation to increase the team capacity and enable the implementation of robust processes, including working partnerships to improve section 42 reporting and Deprivation of Liberties (DoLs) applications. Safeguarding training was reported to be well embedded with two areas of improvement seen – Oliver McGowan training Part 1 and Safeguarding Children Level 3. Increasing numbers of information shared forms for children reflected the complexity and vulnerability of children seen nationally. Focussed work for 2024/25 included domestic abuse, learning disability and dementia and the further embedding of training
Integrated Quality Governance Report	The committee **noted** the update	Thee report highlighted the quality improvement work undertaken in collaboration with the Patient Safety and Nursing Quality teams. The area of focus was on audits and National Institute for Clinical Excellence (NICE) breaches to ensure improvements in care. Compliance work for policies and guidelines were confirmed to be under scrutiny at the monthly Trust Executive Committee meetings. The Trust had met compliance against the two improvements notice action plans to ensure competent persons for manual handling and violence and aggression were employed. Work continued to ensure compliance, with a competent manual handling officer in post.
Quality Dashboard	The committee **noted** the update	The introduction of EO45 for a 45-minute ambulance handover was noted not to hold any current concerns due to the good level of performance in the Emergency Department (ED).
Safeguarding Update	The committee **noted** the update	highlighted the continual work to support the domestic abuse agenda. Dedicated space had been made

		available for the team and two support workers were working towards their white ribbon accreditation
Minutes of the Patient Safety Board/ Summary Highlight Report of the Patient & Family Experience Board	The committee **noted** the minutes of the November 2024 Safety Board and noted the highlights the update	It was noted that the SignLive initiative required further review to ensure a long-term resolution, including signing in foreign languages in collaboration with the Integrated Care Board (ICB).
Summary Highlight Report of Complaints & PALS	The committee **noted** the Summary Highlight Report of Complaints & PALS.	The committee noted that an analysis of the complaint numbers found no evidence indicating an increase in the cases received. It was noted that PALS cases resolved within 24 hours had not been reflected in reporting figures. Work continued to ensure clear oversight of the team's activities for future improvements using AI.

3. Assurance

- (as stated in the comments)

4. Areas for escalation to the Board for further discussion or decision from the agenda item

- Quality & Clinical Risk Committee Terms of Reference
- Presentation of each BAF risk held by Executive Officer, to outline timelines and end dates
- Emergency Preparedness, Resilience & Response Annual Report
- The widening health inequalities risk for consideration to the BAF referred back to the Trust Board for wider discussion concerning the Trust's implementation threshold as provider/partner within a wider system
- Upcoming Inquests attracting national press coverage
- Ophthalmology out of hours service provision
- ENT/Head and neck pathway transfer of provision

5. Recommendation

- The Board are invited to note the report.

Meeting Title	TRUST BOARD (PUBLIC)	Date: 9 January 2025
Report Title	Use of Corporate Seal	Agenda Item Number: 23
Lead Director	Kate Jarman, Director of Corporate Services	
Report Author	Oluwakemi Olayiwola, Trust Secretary	

Introduction	To update the Trust Board on the use of the Corporate Seal in accordance with the Trust's Constitution		
Key Messages to Note	Trust Board to NOTE.		
Recommendation *(Tick the relevant box(es))*	**For Information** x	**For Approval** ☐	**For Review** ☐

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	1. *Spending money well on the care you receive* 2. *Expanding and improving your environment* 3. *Innovating and investing in the future of your hospital*

Report History	*Standing Agenda Item*
Next Steps	*N/A*
Appendices/Attachments	Schedule of Use of Corporate Seal

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
Acting Chair: Heidi Travis

SCHEDULE OF USE OF CORPORATE SEAL 2024/25

	Description	Parties	Purpose	Value	Date	Signatories
1	Construction Professional Services	Milton Keynes University Hospital NHS Foundation Trust and Arcadis	Call of Agreement Arcadis Consultants for the New Hospital Programme (NHP) at MKUH	N/A	8/11/24	John Blakesley – Deputy Chief Exec Kate Jarman – Chief Corporate Services Officer
2	Warranty	Milton Keynes University Hospital NHS Foundation Trust, ADMK and Morgan Sindall	Contractor Warranty for Radiotherapy	N/A	8/11/24	Fiona Hoskins – Chief Nursing Officer Catherine Wills – Chief People Officer
3	Payment Guarantee	Milton Keynes University Hospital NHS Foundation Trust, ADMK and Morgan Sindall	Payment Guarantee	N/A	8/11/24	Joe Harrison – Chief Exec
4	Warranty	Milton Keynes University Hospital NHS Foundation Trust, ADMK and Morgan Sindall	Contractor Warranty for the Imaging Centre	N/A	12/11/24	Fay Gordon – Chief Operating Officer Fiona Hoskins – Chief Nursing Officer
5	Warranty	Milton Keynes University Hospital NHS Foundation Trust, ADMK and Morgan Sindall	Contractor Warranty for Oak Wards	N/A	14/11/24	Fay Gordon – Chief Operating Officer Catherine Wills – Chief People Officer
6	Deed of Easement	Milton Keynes University Hospital NHS Foundation Trust and North Southern Gas PLC	Deed of Easement for Gas Infrastructure	N/A	09/12/24	John Blakesley – Deputy Chief Exec Ian Reckless– Chief Medical Officer

TRUST BOARD MEETING IN PUBLIC

Forward Plan 2024-25

	Agenda Item	Lead	Purpose	Frequency Paper(P)/Verbal (V)	Seminar 04-Apr-24	Formal 02-May-24	Seminar 06-Jun-24	Formal 04-Jul-24	Formal 05-Sep-24	Seminar 03-Oct-24	Formal 14-Nov-24	Seminar 05-Dec-24	Formal 09-Jan-25	Seminar 06-Feb-25	Formal 06-Mar-25
1	Apologies	Chair	Receive	Standing Item (V)											
2	Meeting Quorate	Chair	Note	Standing Item (V)											
3	Declaration of Interests	Chair	Note	Standing Item (V)											
4	Minutes of the previous meeting	Chair	Approve	Standing Item (P)											
5	Action Tracker	Chair	Note	Standing Item (P)											
6	Chair's Report	Chair	Information	Standing Item (V)											
7	Chief Executive's Report	Chief Executive	Receive and Discuss	Standing Item (V)											
8	Patient Story/Staff Story (Rotational)	Chief Nursing Officer	Receive and Discuss	Standing Item (P)											
9	Nursing Workforce Update	Chief Nursing Officer	Receive and Discuss	Standing Item (P)											
10	Performance Report	Chief Operating Officer	Receive and Discuss	Standing Item (P)											
11	Finance Report	Chief Finance Officer	Receive and Discuss	Standing Item (P)											
12	Workforce Report	Chief People Officer	Receive and Discuss	Standing Item (P)											
13	Patient Safety Update	Chief Medical Officer/Chief Corporate	Receive and Discuss	Standing Item (P)											
14	Objectives Update	Chief Executive	Assurance Receive and Discuss	(P)											
15	Equality, Diversity & inclusion (ED&I) Update	Chief People Officer	Assurance Receive and Discuss	(P)											
16	CNST Maternity Incentive Scheme and Board Assurance Framework	Chief Nursing Officer	Assurance Receive and Discuss	(P)											
17	Progress update – 2024/25 Quality Priorities	Chief Corporate Services Officer	Assurance Receive and Discuss	(P)											
18	Declaration of Interests Report	Chief Corporate Services Officer	Assurance Receive and Discuss	Annually (P)											
19	Maternity Patient Survey 2024 interim report	Chief Nursing Officer	Assurance Receive and Discuss	(P)											
20	Annual Claims Report	Chief Medical Officer	Assurance Receive and Discuss	Annually (P)											
21	Falls Annual Report	Chief Nursing Officer	Assurance Receive and Discuss	Annually (P)											
22	Freedom to Speak Up Guardian Report	Chief People Officer	Assurance Receive and Discuss	(P)											

23	Pressure Ulcers Annual Report	Chief Nursing Officer	Assurance Receive and Discuss	Annually (P)
24	Green Plan Update	Chief Finance Officer	Assurance Receive and Discuss	(P)
25	Green Plan Update (C/F from July 2024)	Chief Finance Officer	Assurance Receive and Discuss	(P)
27	Mortality Update	Chief Medical Officer	Assurance Receive and Discuss	(P)
28	Safeguarding Annual Report	Chief Nursing Officer	Assurance Receive and Discuss	Annually (P)
	Research & Development Annual Report	Chief Medical Officer	Assurance Receive and Discuss	(P)
30	Emergency Preparedness, Resilience and Response Annual Report	Chief Operating Officer	Assurance Receive and Discuss	(P)
31	Annual Complaints Report	Chief Corporate Services Officer	Assurance Receive and Discuss	Annually (P)
32	Annual Patient Experience Report	Chief Corporate Services Officer	Assurance Receive and Discuss	Annually (P)
34	Antimicrobial Stewardship - Annual Report	Chief Medical Officer	Assurance Receive and Discuss	Annually (P)
35	Infection Prevention and Control Annual Report	Chief Nursing Officer	Assurance Receive and Discuss	(P)
36	Patient Safety Update	Chief Medical Officer/Chief Corporate Services Officer	Patient Safety	Standing Item (P)
37	Maternity Assurance Group Update	Chief Nursing Officer	Assurance Receive and Discuss	Standing Item (P)
	Update to the Terms of Reference of the Board and its Committees	Chief Corporate Services Officer	Assurance Discuss and Approve	Annually (P)
38	Summary Reports from Board Committees	Chairs of Board Committees	Assurance and Information	Standing Item (P)
39	Significant Risk Register Report	Chief Corporate Services Officer	Assurance Receive and Discuss	Standing Item (P)
40	Board Assurance Framework	Chief Corporate Services Officer	Assurance Receive and Discuss	Standing Item (P)
41	Trust Seal	Chief Corporate Services Officer	As required	(P)
42	Forward Agenda Planner	Chair	Administration and Closing Information	Standing Item (P)
43	Questions from Members of the Public	Chair	Administration and Closing Receive and Respond	Standing Item (V)
44	Motion To Close The Meeting	Chair	Administration and Closing Receive	Standing Item (V)
45	Resolution to Exclude the Press and Public	Chair	Administration and Closing Approve	Standing Item (V)
SEMINAR SCHEDULE				
	Annual Risk Seminar	Chief Corporate Services (	Risk Management	
	Board Assurance Framework (BAF) Review	Chief Corporate Services (	Assurance	
	Collaborative partnership/s—with whom and for what services. Future plans	Chief Executive	Assurance	
	The Trust role around, and contribution to, population health management/Place	Chief Executive	Assurance	
	Annual Objectives Review	Chief Executive	Assurance	
	Annual Strategy Review	Chief Executive	Assurance	
	Strategic links with community groups/organisations/ businesses	Chief Executive	Assurance	

	The Trust's representations on the BLMK ICB and ICP, and the implications thereof	Chief Executive	Assurance													

TRUST BOARD IN PUBLIC

Academic Centre/Teams

Thursday, 9 January 2025

Questions from Members of the Public

Heidi Travis
Chair

Verbal/Discuss

TRUST BOARD IN PUBLIC

Academic Centre/Teams

Thursday, 9 January 2025

Motion to Close the Meeting

Heidi Travis
Chair

Verbal/ Approve