Bundle Trust Board Meeting in Public 9 March 2023

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- 14. Maternity Staffing Overview Trust Board Report March 2023 FINAL (002).pdf

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20 Motion to Close the Meeting

20 Questions from Members of the Public

21 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."

22 Appendices

1. Appendices front sheet.docx

10.1 Appendix 1 Milton Keynes University Hospital NHS Foundation Trust.pdf

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14.2 Appendix 1 - Labour ward co-ordinator supernumerary status.xlsx

14.3 Appendix 2 - One to One Care in Labour Action Plan.xlsx

14.4 Appendix 3 Neonatal Nursing and Medical Workforce Action Plan.xlsx

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16.1 Corporate Risk Register - as at 21st February 2023.pdf

16.2 Significant Risk Register - as at 21st February 2023.pdf

Agenda for the Board of Directors' Meeting in Public

Meeting to be held at 10:00 am on Thursday 9 March 2023
in the Conference Room at the Academic Centre and via MS Teams

Item No.	Timing	Title	Purpose	Lead	Paper
Introduction and Administration					
1	10:00	Apologies	Receive	Chair	Verbal
2		Declarations of Interest • Any new interests to declare • Any interests to declare in relation to open items on the agenda 2022/23 Register of Interests – Board of Directors - Register of Interests - Milton Keynes University Hospital (mkuh.nhs.uk)	Information	Chair	Verbal
3		Patient Story	Receive and Discuss	Director of Patient Care and Chief Nurse	Presentation
4		Minutes of the Trust Board meeting held in public on 12 January 2023	Approve	Chair	Attached
5		Matters Arising and Action Log	Note	Chair	Attached
Chair and Chief Executive Updates					
6	10:20	Chair's Report	Information	Chair	Attached
7	10:25	Chief Executive's Report	Receive and Discuss	Chief Executive	Verbal
Patient Safety					
8	10:30	Serious Incident and Learning Report	Receive and Discuss	Director of Corporate Affairs/ Medical Director	Attached
9	10:40	Feedback from Maternity Assurance Group	Receive and Discuss	Divisional Chief Midwife and Chief Nurse	Verbal

Item No.	Timing	Title	Purpose	Lead	Paper
Patient Experience					
10	10:50	CQC Maternity Patient Experience Update	Receive and Discuss	Divisional Chief Midwife and Chief Nurse	Attached
Performance					
11	11:00	Performance Report	Receive and Discuss	Chief Operations Officer	Attached
Finance					
12	11:10	Finance Report	Receive and Discuss	Director of Finance	Attached
11:20 – Break (10 mins)					
Workforce					
13	11:30	Workforce Report	Receive and Discuss	Director of Workforce	Attached
14	11:40	Maternity Staffing Report	Receive and Discuss	Divisional Chief Midwife and Chief Nurse	Attached
15	11:50	Inclusion Leadership Council Feedback	Receive and Discuss	Chair	Attached
Assurance and Statutory Items					
16	12:00	Risk Register Report	Receive and Discuss	Director of Corporate Affairs	Attached
17	12:10	Board Assurance Framework	Receive and Discuss	Director of Corporate Affairs	Attached
18	12:20	(Summary Reports) Board Committees • Audit Committee 12/12/2022 • Finance Committee 06/12/2022 • Trust Executive Committee 14/12/022 and 11/01/2023 • Quality & Clinical Risk Committee 12/12/2022	Assurance and Information	Chairs of Board Committees	 Attached Attached Attached Attached

Item No.	Timing	Title	Purpose	Lead	Paper
		• Charitable Funds Committee 05/12/2022			Attached
Administration and Closing					
19	12:25	Forward Agenda Planner	Information	Chair	Attached
20		Questions from Members of the Public	Receive and Respond	Chair	Verbal
21		Motion To Close The Meeting	Receive	Chair	Verbal
22		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, 4 May 2023					

Our Values: We Care-We Communicate-We Collaborate-We Contribute

Board Behaviours: Kindness-Respect-Openness

Milton Keynes University Hospital NHS Foundation Trust

BOARD OF DIRECTORS MEETING

Minutes of the Trust Board of Directors Meeting in Public held on Thursday, 12 January 2023 at 10.00 hours via Teams

Present:

Alison Davis	Chair	(AD)
Professor Joe Harrison	Chief Executive Officer	(JH)
Haider Husain	Non-Executive Director	(HH)
Gary Marven	Non-Executive Director	(GM)
Bev Messinger	Non-Executive Director	(BM)
Dr Dev Ahuja	Non-Executive Director	(DA)
John Blakesley	Deputy Chief Executive	(JB)
Dr Ian Reckless	Medical Director & Deputy Chief Executive	(IR)
Danielle Petch	Director of Workforce	(DP)
Yvonne Christley	Director of Patient Care and Chief Nurse	(YC)
Emma Livesley	Director of Operations	(EL)
Terry Whittle	Director of Finance	(TW)

In Attendance:

Kate Jarman	Director of Corporate Affairs	(KJ)
Jason Sinclair	Associate Non-Executive Director	(JS)
Ganesh Baliah	Associate Non-Executive Director	(GB)
Precious Zumbika-Lwanga	Associate Non-Executive Director	(PZL)
Julie Goodman	Head of Patient and Family Experience (For Item 3)	(JG)
Connie Wake	Quality Improvement Lead (For Item 3)	(CW)
Melissa Davies	Head of Midwifery, Gynaecology & Paediatrics (For Item 12)	(MD)
Nandini Gupta	Consultant, Obstetrics and Gynaecology (For Item 12)	(NG)
Thomas Dunkley	Head of Employee Relations (For Item 21)	(TD)
Idrees Mohammed	Equality, Diversity and Inclusion (EDI) Business Partner (For Item 21)	(IM)
Babs Lisgarten	Public Governor/Lead Governor	(BL)
William Butler	Public Governor	(WB)
John Garner	Public Governor	(JG)
Clare Hill	Public Governor	(CH)
Baney Young	Public Governor	(BY)
Tracy Rea	Staff Governor	(TR)
Yolanda Potter	Staff Governor	(YP)
Emma Isted	Staff Governor	(EI)
Cllr Keith McLean	Representative Governor, Milton Keynes Council	(KM)
Maxine Taffetani	Representative Governor, Healthwatch, Milton Keynes	(MT)
Kwame Mensa-Bonsu	Trust Secretary	(KMB)

1 Welcome and Apologies

1.1 AD welcomed all present to the meeting. There were apologies from Heidi Travis, Non-Executive Director/Senior Independent Director; and Mark Versallion, Non-Executive Director.

1.2 AD advised that DA was appointed to a full Non-Executive Director (NED) role in January 2023. AD also informed the Board that, after the recruitment exercise in December 2022, GB and PZL were appointed as Associate Non-Executive Directors and Mark Versallion as a Non-Executive Director.

2 Declarations of interest

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

3 Patient Story

3.1 JG introduced CW, who joined the Trust three months ago as the Quality Improvement Lead. CW provided a presentation on Appreciative Inquiry (AI) Life Stories, which had the aim of:

- Using skilled caring conversations and using this as the impetus for development;
- Implementing a set of core principles that developed existing patterns of everyday conversation and ways of relating and give voice to new and diverse perspectives to expand what can be possible.

CW advised that the AI principles underpinning the examples or Life Stories being presented could be taken forward and implemented across the Trust to the benefit of both patients and staff.

3.2 CW stated that the various techniques and tools and principles of AI encompassed caring conversations, ways of collaborating and talking to one another in an open and honest way with feeling. It was noted that underpinning these AI principles was the theory that organisations could create and sustain change by focusing on what's working well and seek to build on those instead of the more traditional focus on problems and weaknesses. CW advised that for the Trust, this translated to focusing on what mattered to patients, and how services could be developed and delivered. CW stated that with this focus on implementing these AI principles, the Trust would significantly enhance patient safety and clinical effectiveness, which would result in the sustainable improvement of services and the experience of patients.

3.3 CW stated that the appreciative approach involved discovering through questions what was working well, envisioning how that could be improved, co-creating with other stakeholders any improvements, and then embedding the new improved approach in a sustainable manner. CW noted that the next step was for staff to apply relevant AI tools to share the changes and to continue to improve. The presentation shared the story which detailed a patient who had accepted a cup of coffee in the mistaken belief that their scheduled surgery had been cancelled. This communication error resulted in the surgeon actually having to cancel the surgery, which was successfully undertaken at a later date.

3.4 CW stated that post-surgical review of the patient's experiences revealed that, among other issues:

a. The call bell was not always answered in a timely way.
b. Using the bed pan was embarrassing and difficult to use, this caused extra work for staff due to bed becoming wet, nurses were already busy, and the patient did not want 'to bother' nurses.
c. The patient felt powerless, couldn't do things for themselves, they were reliant on nurses.
d. Certain staff were wonderful, clearly enjoyed their job, they were calm, concerned and always introduced themselves, there was a nice atmosphere.
e. Nurses made patient feel important and remembered their needs, resulting in the patient feeling supported and cared for as an individual – "I felt like me".

JG, in summarising, stated that though the experience of the patient had not begun very well, they had left for their home feeling well cared for as an individual.

3.5 CW advised during AI sessions in the Trust, participants were always really willing to engage with this story, focus on the good feedback and explore how the issues such as communication errors could be sustainably resolved. Participants learnt that patients were different individuals with different needs, and so it was important that staff communicated with them as such, empowering patients to input into their own care and making continuous improvements to processes.

3.6 AD commented that it was a positive presentation, which had clearly set out AI's approach to learning and embedding lessons, while recognising the many good practices being undertaken in the hospital. AD advised that the Trust would benefit significantly from implementing the AI principles. In response to HH's query around the number of staff who had undergone training, CW stated that about 30 members of staff had attended the AI training provided by the Wee Culture team who had introduced the AI concept to the Trust in 2021/22. CW noted that she had not had much traction when, in December 2022, she had followed up on those who had undertaken the training exercises with the Wee Culture team. CW stated however, that Maternity and areas in Surgery had applied AI principles to focus on improving their good practices, to make improvements to issues which had caused patient dissatisfaction and complaints and to include patients in their own care.

3.7 IR stated that while involving the individual patients in their own care could be very fulfilling, the challenge was engaging the members of staff around AI-related conversations in sustainably larger numbers than the 30 who were trained initially. IR added that it was also difficult to determine where AI conversations were being undertaken. KJ, in response, stated that the model was for a cohort of staff to be trained initially as experts, who would then go on and become part of a rollout programme to train other members of staff on the application of AI principles in their operational practices. KJ added that was about a big cultural change, about behaviours in action, about learning from the good practice, about different ways of framing questions, and about ensuring that it could be realised in practice. KJ stated that AI was a very different framework, which would be quite aligned to the new Patient Safety Incident Response Framework (PSIRF) that was being implemented and added that this was very much work in progress which would take years of work to change modes of working accordingly. JG stated that the '15 Steps Challenge' was being undertaken on the wards to sensitise the staff to the need for different modes of working to be implemented. The 15 Steps Challenge focused on seeing care through a patient or carer's eyes, exploring their first impressions and working with them to design and improve services.

3.8 YC stated that this story was chosen because we want to expand the narrations of AI stories and to get clinical staff noticing and wondering about the type of patient experience that's reflected in those stories. YC added that these had been shared at the Band 7 nursing meeting and not just with individual clinical team. Formal clinical staff meetings were being structured to begin and end with one of these stories and asking them to think and reflect about the issues raised, good practices revealed and on the patient experience. YC stated that this would ensure that patient feedback was placed on a wider platform and cautioned that this was just the beginning of a developmental journey.

3.8 AD thanked CW and JG for a very informative presentation.

4 Minutes of the Trust Board Meeting in Public held on 03 November 2022

4.1 The minutes of the Trust Board Meeting in Public held on 03 November 2022 were reviewed and **approved** by the Board.

5 Matters Arising

5.1 The due actions on the log were reviewed as follows.

Action 12 – Executive Directors to review the content of the report to provide more accessible data
The revised report would be tested at the February 2023 Board Seminar before use at the next Board meeting in public. **Closed.**

Action 17 – Violence and Aggression Programme Update
KJ to circulate the Victim's Charter. This had been circulated. **Closed.**

Action 22 – Performance Report
EL and JB to provide context in trend reporting and to include comparative data with peers against the metrics. JB advised that the Performance Report was being redesigned to make it easier to digest. The redesigned report would be reviewed at the next Trust Executive Committee before being submitted to the March 2023 Board meeting in public. **Closed.**

Action 23 – Performance Report
KMB to schedule a meeting before the end of the year for the NEDs to meet with Lee Poulastides (Head of Informatics) to participate in the codesign of the metrics. Meeting held in December 2022. **Closed.**

Action 24 – Significant Risk Register
KJ, KMB and Paul Ewers to review the front sheet of the report to include an overview of the Trust's risk position and appetite. To be progressed after the Trust's Risk Appetite Statement has been reviewed. **Open.**

There were no other matters arising.

6 Chair's Report

6.1 AD presented the Chair's Report and highlighted the following:

a. That, on 20 December 2023, she had attended her first Christmas and Carol Service in the Trust. The Service had been organised for the patients and staff by the Chaplaincy team.
b. At its meeting in January 2023, the Inclusion and Leadership Council approved a revised agenda which would refresh and refocus its meetings, The aim of the revisions was to ensure the different staff networks could provide regular formal feedback on their activities to the ILC. The Board would receive regular updates on the submissions to the ILC.
c. The ILC also discussed the steps necessary for developing a sustainable culture for staff to engage with the various networks, and other local avenues such as Freedom to Speak Up, to confidently raise any concerns they may have. The ILC would also look at how support could be provided to the networks on how to prepare business cases to secure the funds to support their activities.

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

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

7.1 JH provided the Board with an overview of activities and developments, highlighting the following:

a. The operations of South-Central Ambulance Service NHS Foundation Trust (SCAS) had not been impacted by the strike actions being taken by workers across the NHS. The SCAS was the provider of ambulance services for the Trust.
b. To date, the Trust was also not being affected at all by the strike actions being taken by NHS nurses. The ballot for strike action had not reached the 50% turnout threshold for the vote to be successful.
c. The Trust was monitoring the progress of rolling strike actions by the NHS's physiotherapist workforce, the first of which would be taken on 26 January 2023. The Trust was not on the list of NHS providers affected by the first strike action and was awaiting to find out whether it would be impacted by the planned follow up actions to be taken on 7 and 9 February 2023.

d. The Trust was awaiting the result of the strike ballot which junior doctors were currently undertaking. If the ballot was successful in the Trust, steps would be taken to try and maintain services.
e. JH stated that the Trust continued to achieve comparably higher rates of patients accessing urgent and emergency care, adding to the pressures on the Trust highlighted earlier. JH thanked the Trust's staff for continuing to provide excellent patient care in spite of all the pressures.
f. The construction work on the new Radiotherapy Centre continued to progress with the projection that it would be completed in the Spring of 2024. The new Radiotherapy Centre, which would be located adjacent to the Cancer Centre, would complete the cancer services offering available at the Trust and improve access to healthcare for Milton Keynes residents.
g. Milton Keynes City Council, in January 2023, agreed to progress a research trial to promote and incentivise physical activity amongst the 17,000 residents with Type 2 diabetes. The trial, which was funded by the NHS, would test out how wearable devices could record participant movement, and how potentially, a mobile app could offer tailored prompts and hints to be physically active. The trial, which would be conducted in conjunction with the Trust, would help health and council partners around the UK determine whether adopting their own version of the scheme would help patients and reduce long term costs.
h. The Trust officially unveiled Milton in November 2022, a delivery robot designed to help speed up processes and relieve pressure on staff. There would be operational trials through 2023 where Milton would be delivering medicines on specific routes to assist staff. As part of the trial, Milton will learn to safely navigate the environment between the Pharmacy Department and a selected in-patient ward. The Trust had worked with the Academy of Robotics, a small British artificial intelligence company, to develop Milton.
i. JH was the new Executive Sponsor for the BAME Network. JH stated that the Trust had provided £1000 to each of the staff networks to support their publicity and engagement activities.

7.2 The Board **noted** the Chief Executive's update.

8 Serious Incident Report

8.1 KJ presented the SI Report to the Board.

8.2 The report highlighted the six Sis which occurred in November and December 2022, notably:

a. Two patient falls which had resulted in injuries.
b. The death of a patient, sectioned under the Mental Health Act. The deceased patient had very complex physical healthcare needs.

KJ stated that all six Sis were being comprehensively investigated.

8.3 KJ stated that the Quality Assurance (QA) training, being provided to groups of staff in the clinical divisions, would from February 2023 be topped up with QI Practitioner training. With regards to the fluctuations in the reporting of incidents, KJ noted that this was due to the implementations of a new risk management system and a new NHSE Learning From Patient Safety Events (LFPSE) reporting template which had posed some challenges to the members of staff. The Risk Management Team was taking steps to support the staff, including the provision of enhanced training support and the redesign of forms to make them more user friendly. In response to JH's query, KJ stated that NHSE had mandated NHS providers to migrate to the use of the new LFPSE reporting form. The Trust, and other pioneering NHS providers, had engaged with NHSE so they could take the necessary steps to ensure the reporting template became as user friendly as possible.

8.4 The Board **noted** the SI Report.

9 Feedback from Maternity Assurance Group (MAG)

9.1 YC presented the report on the November 2022 MAG meeting. The MAG was a monthly meeting, implemented to enable a forum where the Board level Maternity & Neonatal Safety Champions, alongside the Non-Exec Director, could review the detail of maternity & neonatal assurance information.

9.2 YC informed the Board that the Group had reviewed 10 outstanding actions, focusing on those RAG-rated 'amber, and highlighted the following:

a. Connectivity in the Community – Community midwives, due to internet connectivity issues especially in the rural areas, were unable to always record patient notes on e-Care in a contemporaneous way. Steps were being taken in conjunction with the Information Team, so the Community midwives won't have to record these patients notes retrospectively.
b. Access to Obstetric Theatres – The MAG have asked for a standard operating procedure to provide a very clear understanding about how access to the Theatres could be managed.
c. Birmingham Symptom Specific Obstetric Triage System (BSOTS) – YC stated the BSOTS had been fully implemented in the Trust. YC noted that MAG had asked for a detailed evaluation of what the impact of this implementation had been on the Trust. BSOTS was a maternity triage system, which improved the safety of mothers, babies, and the management of the department, and it consisted of a prompt and brief triage of women when they presented with unexpected problems or concerns, and then a standardised way of determining the clinical urgency in which they needed to be seen.

AD advised that, as Chair of the MAG, she wanted to acknowledge the enormous amount of work that was being undertaken to complete the actions and improve Maternity Services.

9.3 The Board **noted** the feedback from the Maternity Assurance Group.

10 Infection Prevention and Control (IPC) April 2021 – March 2022 Annual Report

10.1 IR presented the IPC 2021 – 2022 Annual Report.

10.2 The Annual Report was focused on:

a. Performance against alert organisms - The Trust's Healthcare-associated infections (HCAIs) objectives for Clostridioides difficile infection (CDI), Methicillin Resistant Staphylococcus aureus (MRSA) and Gram-negative bloodstream infections (GNBSI) were determined nationally and usually received from NHSE prior to the start of the financial year. It was noted that due to the COVID-19 pandemic, the publication of national objectives was suspended temporarily.
b. Cluster and Outbreaks associated with Covid-19 – Each of these outbreaks was investigated appropriately with the input of the Regional Infection Prevention Control Team.
c. Surgical Site Infection Surveillance (SSIS) – It was positive and provided assurance that of the 288 hip and knee replacement operations, there was only one case of infection.

10.3 IR informed the Board that, following the retirement of Nicky Burns-Muir as Chief Nurse, he was holding the Director of Infection Prevention and Control portfolio. IR stated that he would be working with the IPC team so future IPC Annual Reports would have more focus on the Trust's processes, performance and lessons learnt. In response GB's query around whether the assuring SSIS performance was tied to a change in protocols around prophylaxis, IR stated that the key action taken by the Trust four years ago had been to set up a ring-fenced Orthopaedics Unit with two dedicated Theatres, and this had made the difference.

10.4 The Board noted the IPC Annual 2021 – 2022 Annual Report.

11 Pressure Ulcers Quarterly Update (June to November 2022)

11.1 YC presented the quarterly report which provided an update on the incidence of Hospital-Acquired Pressure Ulcers (HAPU) in the Trust between June and November 2022 and summarised the improvement activities designed to reduce the HAPUs over the next six months.

11.2 The report stated that, due to a significant increase in both community-acquired, and hospital-acquired pressure ulcers, various forms of reviews were conducted which provided clear indication of the contributory factors. YC highlighted the main factors as:

a. Delay in the reporting and validation and escalation of pressure ulcers – Improvement steps were being undertaken to improve the validation of data, as well as correctly identifying, reporting and

separating soft tissue injuries from deep tissue injuries. Currently all tissue injuries were being reported as deep tissue injuries.

b. Bed Management Competencies – The Trust would ensure all staff have training and completed competencies on the safe and effective management of the hospital bed stock.
c. Impact of escalation beds – YC stated that there would be work to determine how or whether the increased use of escalation beds was contributing to the increasing number of HAPUs. This would help in determining what improvement actions needed to be undertaken.
d. Education – Improve and implement training for all nursing staff on preventing and managing pressure ulcers and the provision of information on pressure redistributing devices.

11.2 In response to GM's query around whether the significantly increased patient activity in the hospital was contributing to the increased HAPUs, YC stated that data analysis and reporting would henceforth take patient bed days into consideration as well. YC noted that, due to the increased utilisation of escalation beds, this would provide the Trust with a fuller picture both for benchmarking purposes and for effective improvement actions to be undertaken. In terms of future trends, YC advised that the plan was to reduce HAPUs by half in the next six months.

11.3 The Board **noted** the pressure ulcers quarterly update for June to November 2022.

12 Maternity Clinical Negligence Scheme for Trusts (CNST) Sign Off

12.1 MD presented the report on the CNST sign off to the Board.

12.2 MD introduced the report and advised that the CNST and maternity incentive scheme was applicable to all NHS providers who provided maternity care. Additionally, all of those NHS providers were required to have in place 10 safety actions with associated actions for which they had to demonstrate compliance on an annual basis. NHS providers who achieved compliance, receive a rebate on the incentive premium they pay annually, and if they don't achieve compliance, improvements actions have to be undertaken. Those with improvement actions were assessed to determine if they required financial support. MD advised that the report, being presented for Board review and approval, included the evidence being provided by the Trust to demonstrate compliance with the 10 safety actions, after which JH would sign it off. The report would also be reviewed by the local maternity neonatal service system and then signed off by the CEO of BLMK ICS.

12.2 MD informed the Board that the Trust was not compliant with Safety Action 5 – Effective Midwifery Workforce Planning - because there was no evidence as per Trust Board minutes of an agreement to fund the birth rate plus establishment. It was noted that the difference between the current funded establishment and the 2021 birth rate plus establishment was 6 whole time equivalent (WTE) midwives, and the Trust Board was being asked to support an agreed plan for a staged increase of 6 WTE Band 6 midwives, once the service was fully recruited to the current funded establishment. AD stated that the Board fully supported the agreed plan, so the CNST declaration form could be revised and updated accordingly.

12.3 The Board **approved** the following:

- The agreed plan for a staged increase of 6 WTE Band 6 midwives, once the service is fully recruited to the current funded establishment.
- JH to, on behalf of the Board, to sign the updated CNST declaration from for submission.

13 Complaints and Patient Advice and Liaison Service (PALS) Quarterly Report

13.1 KJ presented the report which detailed the Trust's overall position regarding the number of complaints received, the type of complaints, and the performance in relation to responding to complaints on time during Q2 2022/23.

13.2 KJ noted that the number formal complaints was increasing to 42 (18%) in Q2 from 41(15.2%) in Q1, which was impacting on the performance of the Complaints Team. KJ stated that the aim was to deal with most complaints informally and in a timely manner and in accordance with the complainants' wishes, without the need to raise a formal complaint. KJ advised that the complexity of a complaint, sometimes

made this aim difficult to achieve. The report noted that 34.2% of all PALS cases were resolved within 24 hours and were logged as complaints, which was a favourable performance against the KPI of 30%.

13.3 KJ highlighted that patients' complaints continued to be around the themes of:

a. Communication
b. Appointments
c. Clinical treatment

KJ stated the steps were being taken to appoint, as a pilot, a dedicated Complaints Investigations Officer to deal with those patients that submit PALS cases around their appointments. The aim was to improve the Complaints Team's capacity to resolve cases before they became formal complaints. Overall, other appointments are being made, and have been made, to stabilise and improve the capacity of the Complaints team. KJ added that there was a plan to also support the team with the relevant training programmes which would help develop their individual skill sets.

13.4 JH commented that there was a very clear correlation between the number of patients phoning the hospital to complain and the length of waiting times and added that these pressures exacerbated the legacy issues relating to communications. HH queried why the Trust's Radar risk management system was unable to reopen closed complaints for further investigations, because Somerset NHS Foundation Trust's Radar system could reopen closed complaints. KJ, in response, stated that the Trust's Risk Manager was working with Radar to configure the system and align it more fully with other internal systems while also providing more training support to the other members of staff. KJ noted that this reconfiguration would ensure that all the different systems were themed to the same format, so for any issue, a good comprehensive thematic review of could be undertaken.

13.5 The Board **noted** the Complaints and PALS Quarterly Report.

14 Patient and Family Experience Quarterly Report

12.1 KJ presented the report which provided a quarterly overview of patient experience, engagement and feedback across the Trust, and of the actions taken to improve patient and family experience within Q2.

12.2 KJ stated that the Trust had agreed to renew the contract for the Patient Experience Platform (PEP) for next year. KJ noted that the wealth of information collated on the PEP dashboard had enabled the Patient and Family Experience team to conduct the comprehensive and necessary thematic work needed for sustainable improvement actions to be undertaken. KJ advised that steps were being undertaken to renew the Volunteers Strategy, so there was more focus on how volunteers were utilised in the Trust over the next couple of years. In response to DA's query around patient access to the Meaningful Activities Facilitator (MAF) and the effectiveness of the role, KJ stated that the postholder proactively visited the wards to engage with patients but could also be called to a ward when needed. KJ agreed to share data on the impact of the MAF role with the Board. JH added that, due to its very positive impact, the Trust was looking to expand the MAF model, and there was an agreement for the Trust to provide funding for it when the Hospital Charity funding stream ended in the summer of 2023. The aim of the MAF role was to enrich the experience for any adult patient who was feeling low in mood, having difficulty being in hospital, or needed some encouragement to support their wellbeing.

Action: KJ to share data on the effectiveness of the MAF role on the patients.

12.3 The Board **noted** the Patient and Family Experience Quarterly Report.

15 Item Withdrawn

16 Antimicrobial Stewardship – 2021/22 Annual Report

16.1 IR presented the Annual Report which summarised the key performance indicators and all the major activities performed by the Antimicrobial Stewardship (AMS) team between April 2021 and March 2022.

16.2 The report highlighted the activities within the year including:

a. Staffing challenges – IR suggested that ideally antimicrobial stewardship should be owned by all the staff under the guidance of the microbiologists and pharmacists. IR stated that the Trust had been able to recruit a Lead Antimicrobial Pharmacist in June 2022 which eased some of the staffing pressures,
b. COVID had an impact around antimicrobial stewardship, as most hospitalised patients were treated with antibiotics which resulted in an increase in antimicrobial-resistant infections.
c. Microguide AM app – The microguide app had replaced the Rx guidance as the AM app at the Trust. The transfer of data was completed in March 2021, and the app was made live since this time. However, some updates remained pending due to unavailability of an AM pharmacist during 2021-22. The app provided the Trust with the ability to collaboratively create, edit, and publish its own local guidance and policies. With guidance downloaded directly to devices, there was no need to worry about internet connectivity in the hospital as staff would always have access to the content needed locally.

16.2 In response to GB's query around the management of patient expectations, IR agreed that patients needed to know what antibiotics they had been prescribed and why rather than them being passive recipients. IR stated that the first step was for the Trust to move to a position where the prescription and management of antibiotics was not doctor-driven and led, but nurses were also empowered to stop or downgrade antibiotic dosages where necessary.

16.3 The Board **noted** the Antimicrobial Stewardship 2021/22 Annual Report.

17 Performance Report for Month 8

17.1 EL presented the report which summarised performance in November 2022 against key performance indicators and provided an update on actions to sustain or improve upon Trust and system-wide performance.

17.2 EL reviewed the report and highlighted the following:

a. Emergency activity continued to increase in November 2022, and consequently there was a slight deterioration in the performance to 78.9% against the national target of 95%. It was noted that this was the worst performance in the year.
b. In November 2022, the ambulance handover within 30 minutes position deteriorated to 74.9%, against the national target of 95%, which was the worst performance in the year.
c. 60 non-criteria to reside patients were in the hospital at the end of November 2022.
d. Outpatient attendances increased in November 2022. It was a challenge to keep delivering the virtual activity and clinic deliveries, while the challenges associated with delivering elective activity continued to increase due to the increasing emergency pressures.
e. Cancer referrals had increased by about 30 patients per month this year, and this created further pressure in the delivery of the 62-day, 31-day and 2-week wait targets.
f. Between 80 and 100 escalation beds have been opened since the end of December 2022.
g. Staffing pressures continued to impact on the hospital's operations, and this was being exacerbated by the winter pressures and the generally increased referral rates.

EL expressed her appreciation to the staff as they continued to provide high quality patient care under very difficult circumstances.

17.2 In response to GM's query around the most challenged areas of the hospital, EL highlighted Ophthalmology and Orthopaedics, and noted that there were detailed plans for some additional interventions to be implemented after December 2022 with the aim of significantly reducing the number of long waiting patients. EL stated that the hospital needed to also focus on supporting the elective care

pathway and diagnostics departments as well, so those areas could maintain their levels of activity. JH noted that about £10m had been invested to provide the Trust with the capacity to manage the increasing referral rates. JH stated that, because of this investment, the Trust was one of only two NHS providers in the East of England that was able to deliver above performance targets in terms of numbers of patients treated. JH advised that due to pressures on funding, the Trust may have to make a decision on whether to continue investing additional funding in increased capacity and noted that the waiting times were likely to increase if a decision had to be made to discontinue the investment.

17.3 The Board **noted** the Month 08 Performance Report.

18 MK Deal Update

18.1 The MK Deal was a partnership of local authority, health and care organisations, and other partners including Healthwatch Milton Keynes and the Integrated Care Partnership, who were coming together to influence and improve services in Milton Keynes. The MK Deal was agreed following the creation of the Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care Board (ICB) and received its final approval in November 2022. The partners of the MK Deal included:

a. Buckinghamshire Fire and Rescue
b. BLMK Integrated Care Board
c. Central North West London (CNWL) NHS Trust
d. Healthwatch MK
e. Voluntary Community and Social Enterprise
f. Milton Keynes University Hospital NHS FT
g. Milton Keynes City Council
h. Primary Care Network
i. Thames Valley Police

The aims for the MK Deal included:

a. Improving system flow
b. Tackling obesity
c. Children and young people's mental health
d. Managing people with complex needs

18.2 In response to BM's query around accountability for delivery of the objectives, JH stated that there were two levels of accountability. JH noted that the entities in Milton Keynes Place would be expected to hold themselves and each other to account for delivery, and all parties had agreed to develop a healthy challenge environment. JH added that the next level of accountability would be held by the BLMK ICB.GM advised that considering the current staffing pressures and probable financial challenges in the near future, it would be important for a Board discussion on the hospital's top 5 priorities. GM added that this discussion on priorities should be undertaken in view of the various external objectives that the hospital was a stakeholder to including those of Milton Keynes Place and the BLMK ICB. AD advised that there would be an opportunity for such a discussion on priorities and objectives at the April 2023 Board Seminar.

18.3 The Board **noted** the update on the MK Deal.

19 Finance Report – Month 08

19.1 TW presented a report which set out the financial position of the Trust at Month 08.

19.2 The month 08 report highlighted the following:

a. That on a cumulative basis the Trust was reporting a deficit of £4 million. The deficit position was broadly on plan and the Trust was forecasting the achievement of a breakeven position at the end of the year.

b. Pay spend was above plan by £7.8m YTD due to the extra costs associated with extra investment to expand capacity so the waiting list initiatives and increasing referral rates could be managed and the in-year pay award which amounted to £4m.
c. Non-pay was broadly on plan with inflationary cost pressures offset by underspends on clinical consumables relating to activity performed. The Trust was managing significant inflationary pressures as there were significant price increases whenever big contracts came up for renewal.
d. The income position was modestly above plan at £209m YTD.
e. Capital spend was at £9.7 million YTD. It was noted that Radiotherapy Centre project was the single biggest capital investment.

19.3 The Board **noted** the Finance Report – Month 08

20 Workforce Report

20.1 DP presented the Workforce report which provided a summary of Workforce KPIs for the previous 12 months up to 30 November 2022 (Month 8).

20.2 DP provided the following highlights from the report:

a. The vacancy rate declined to below 10% for the first time in 2022/23. There were 174 more staff members in the Trust compared to 2021/22.
b. The sickness absence declined slightly to 4.7% in November 2022, from 5% in October 2022. The sickness rate was expected to increase during the winter season.
c. Staff turnover remained at 16.9%, which was not an outlier in the BLMK ICS, but as it had doubled over the last 12 months the Turnover and Retention Group had been reformed to address this increase and to understand why people are leaving. The Trust's exit interview process had been relaunched and had been enhanced. Compliance with the exit interview is currently optional, but discussions were being undertaken around whether compliance should be mandatory for the compliance rate to improve. One area doing well with the exit interview process was the Maternity Unit, so the Turnover and Retention Group would look to learn from them.
d. Time to hire was declining, - so candidates were being recruited and placed into posts more quickly.
e. Statutory and mandatory training compliance was at 93% and appraisals compliance was at 92%.
f. Food provision for staff during the Winter – From December 2022 there would be free breakfast cereals, bread and spreads for toast available in the staff hub and at Witan Gate.
g. Bank Loyalty Scheme – This scheme was introduced to incentivise staff to shifts of a certain type each month between July and December 2022, then they got a payment in their Christmas pay. The staff who participated received payment in their Christmas pay, but for a small number of staff, they either didn't get the payment or got a payment that weren't entitled to it. The affected staff had been contacted and steps were being agreed for repayments to be made. It was noted that over 1000 members of staff had participated in the scheme and had benefitted from the payments.

20.3 In response to JS's query, DP agreed that future reports would include data on:

a. The cost of hiring – to ascertain whether the cost of hiring was dropping in line with the declining time to hire.
b. The number of staff who were leaving in the first year of joining – to find out why those members of staff were leaving quicker than expected.

In response to another query from JS around whether the Trust measured any disparities across the protected characteristics in certain areas and certain roles just to make sure recruitment was inclusive and fair, DP stated that such detailed data was collated for the WRES report. DP added that the recruitment team had recently met with all staff networks to assess how the Trust's recruitment process was perceived by each of the networks. In response to HH's query around the increased number of disciplinary cases, DP stated that there was no clarity on the reasons yet, but TD was monitoring the trend to make the necessary assessments and conclusions. DP stated that the Trust had worked hard to establish a fair and just culture to encourage disciplinary processes were resolved informally. DP noted that with the appropriate communication avenues a significant number of disciplinary cases were being resolved informally.

Action: To include, from the March 2023 Workforce Report, data on the cost of hiring, and data on the number of staff leaving within a year of joining and why they were leaving.

20.4 GM highlighted the 16.9% leaver rate as unsustainable and advised that the Board needed to receive data on the profile of those who were leaving. DP stated that one of the primary roles of the Turnover and Retention Group was to review that profile data and to identify what could be done to make improvements. DP advised that appropriate profile data would be produced and reviewed by the Group and Workforce and Development Assurance Committee prior to its submission to the Trust Board.

Action: To include, from the May 2023 Workforce Report, data on the profile of the leavers.

20.5 The Board **noted** the Workforce Report.

21 Update – Equality, Diversity & inclusion (ED&I)

21.1 TD provided a presentation on the progress of the EDI agenda in the Trust, with a particular focus of its impact on the Black and Minority Ethnic (BME) staff.

21.2 The presentation highlighted the following:

a. The gender pay gap had consistently declined year on year from 20% in 2020 to 16.1% in 2022. So that is reducing every year.
b. Employees with disabilities believe that the Trust provided them with equal opportunity for career progression and promotion.
c. IM had been nominated for the Employee Resource Group Award. This was an award which recognised the work of groups or individuals that had made a positive impact in the last 3 years on their organisation and on senior stakeholder engagement. IM was nominated for his work on Diversity and Inclusion.
d. 36% of the Trusts employees were BAME, compared with people of BAME backgrounds making up 26 of the population in Milton Keynes, according to the 2011 census data.
e. BAME employees are more likely to access non-mandatory training and CPD opportunities than White employees.
f. Unfortunately, inspite of the significant progress, BAME employees are more likely to face discrimination, abuse, bullying or harassment from patients and colleagues than White employees. It must be noted less BAME employees faced harassment, bullying or abuse from patients – 33% in 2021 against 27% in 2022; less BAME employees faced harassment, bullying or abuse from colleagues – 36% in 2021 against 22% in 2022; less BAME employees faced discrimination from their line manager – 16% in 2021 against 12% in 2022.
g. More BAME employees, 49% in 2022 believed that the Trust provided equal opportunities for career progression and promotion than in 2021 (42%).
h. An increased number of BAME employees had been recruited in all bands, including the senior bands from bands 6, 7 and 8.
i. The Trust had undertaken a lot of work and actions through various avenues including a violence and aggression and unacceptable behaviours group, cultural awareness training events, the Inclusion Leadership Council and Chief Nurse Fellowships awarded to disadvantaged groups. The impact of these actions was reflected in the improving statistics.
j. The ED&I Team and the BAME Network had created links with the Milton Keynes Intercultural Forum and local faith networks, allowing for shared knowledge and engagement in activities.
k. JH, as CEO, would be taking over as Executive Sponsor for the BAME Network.

21.3 TD stated that the areas requiring improvement included:

a. Improved representation of BAME employees in senior management roles
b. Improved representation of BAME colleagues across all areas and job groups
c. The eradication of bullying, abuse and harassment in the Trust
d. Increased access to career development opportunities
e. Fair and equitable recruitment practices

21.4 The presentation advised that future improvement actions included:

a. Talent Management – The creation of a talent management programme, ensuring succession planning, stretch opportunities, career ladders, formal career planning, development opportunities, coaching and mentoring for all employees.
b. Overseas Recruits Group – As the number of BAME nurses being recruited from overseas increase, the ED&I Team was working with the Associate Chief Nurses, the BAME Network and the Resourcing Team to develop an Overseas Recruits Group that provided a forum for these employees, who had unique experiences of working with the Trust.
c. The creation of Freedom To Speak Up (FTSU) Champions in each staff network – to promote the culture of openness in the Trust.

21.5 AD highlighted the steps being taken to create an Overseas Recruitment Group and asked how the Group was expected to contribute to breaking the cultural barriers that the overseas recruits would need to overcome. TD stated that a lot of actions had been undertaken from a pastoral perspective to provide the members of the Group with the opportunity to help the Trust identify the barriers which needed to be removed. TD noted that one of the first engagements with the Group was for them to agree on how they would like to be called, and this was still being progressed. PZL advised that those who could best provide information on the settling in process were the overseas recruited nurses who had now settled into their roles. HH advised that other sets of data suggested that white candidates had a 41% chance of being shortlisted for roles, whereas BAME candidates had a 20% chance of being shortlisted. HH noted that though the chances of a BAME candidate being recruited improved significantly after being shortlisted, the data suggested that from an original stack of applicants for recruitment, BAME candidates had a 3% probability of being hired, whereas a white candidate had an 8% probability of being hired. HH advised that though good improvement actions were being undertaken in this area, it needed to be recognised that more work needed to be undertaken. DA advised that though there were efforts to make the recruitment process completely anonymous, some details such as the schools attended could identify candidate as being BME. DP stated that the Trust had asked NHS Jobs to investigate ways of anonymising all candidate details which could be used to identify their ethnic heritage.

21.6 In response to JH's query around the position of an effort to understand why a higher percentage of the night workforce was BAME, DP stated that a survey was undertaken around August 2022 and the relatively low response rate indicated that they had chosen night shifts because of reasons including the higher pay rates, better working environment and childcare commitments. DP added that because the feedback also suggested that night workers did not have a lot of interactions with their managers, YC was taking steps to improve that. DP advised that the feedback assured her that the night workers had chosen to be on the night shift. DP stated that she and YC had an action to conduct another survey in the short term to assess whether there had been any improvements for the night workers, and the hope that there would be more responses. JH stated that considering the negative impact that long term night working could have on lifespans the Trust, as a good employer, needed to keep this issue under constant review. KH stated that though reviewing data was important, future presentations on the ED&I agenda should include the voices of BAME people so the Board could hear their lived experience. DP advised that the BAME Network had been asked to attend this presentation but had been unable to accept the invitation due to the short notice. DP stated that she had asked TD to attend the Board meeting in public to present on 3 key areas on a six-monthly basis and based on that schedule members of the BAME Network could also attend to speak to their lived experiences. In response to JS's query around the support provided to staff who suffer racist abuse, TD stated that such members of staff were debriefed and provided support by the Occupational Health team. AD thanked TD for the presentation.

Action: KMB and TD to schedule the planned presentations on the ED&I agenda.

21.7 The Board **noted** the presentation on the ED&I agenda.

22 Recent Board Appointments and the Management of Potential Conflicts of Interest

22.1 AD noted that the Board was aware that DA, JS and PZL were members of Milton Keynes Community Foundation's Trustee Board and would take steps to mitigate any potential conflicts of interest that may arise during their terms of office.

23 Corporate Risk Register

23.1 KJ presented the revised risk register to the Board.

23.2 The Board **noted** the significant risk register.

24 Declaration of Interests Report

24.1 KJ presented the Declarations of Interest Report.

24.2 The Board **reviewed** and **noted** the Declarations of Interest Report.

25 Use of Trust Seal

25.1 The Board **noted** the use of the Trust Seal.

26.1 Summary Report for the Audit Committee – 26 November 2022

26.1.1 The Board **noted** the report.

26.2 Summary Report for the Finance and Investment Committee Meeting – 04 October 2022

26.2.1 The Board **noted** the report.

26.3 Summary Report for the Finance and Investment Committee – 01 November 2022

26.3.1 The Board **noted** the report.

26.4 Summary Report for the Trust Executive Committee – 12 October 2022

26.4.1 The Board **noted** the report.

26.5 Summary Report Trust Executive Committee Meeting – 09 November 2022

26.5.1 The Board **noted** the report.

26.6 Summary Report for the Workforce & Development Assurance Committee – 20 October 2022

26.6.1 The Board **noted** the report.

27 Terms of Reference for Board Sub-Committees

27.1 The Board **approved** the Board Sub-Committee Terms of Reference for:

a. Charitable Funds Committee
b. Trust Executive Committee

28 Forward Agenda Planner

28.1 Board **noted** the Forward Agenda Planner.

29 Questions from Members of the Public

29.1 AD advised that there were two questions from members of the public and provided answers to them.

The first question from Mr Alan Hastings read: “With delays in elective treatment, what is the process for moving patients forward in the queue, if their condition has worsened and for ensuring that patients are not ‘inadvertently dropped off’ the queue?”.

Answer: “We do have an internal harm review process which our clinical teams undertake on those long waiting patients and that's the nationally advised process to be undertaken. There are other elements and ways of accessing healthcare, and certainly a GP is able to contact a consultant and escalate any need for urgent treatment. And similarly, a patient seen in clinic presenting in a different way can also be escalated. To address the point about dropping off the queue, we have some administration validation processes and checks that we undertake to make sure that no patient falls of the waiting list”.

AD invited Mr Hastings to get in touch with her or EL if he required further clarification.

29.2 The second question from Ms Victoria Bell read: “Will the Chair or CEO or other person of the Hospital Trust Board meet with me, a concerned member of the public, to discuss how to further the offering of healthy and plant-based foods in the Hospital’s shop, automatic machines, café, restaurant and patient’s meals? The aim would be to reduce the offering of unhealthy and unsustainable foods and to increase the offering of healthy, sustainable foods within hospital premises. The result of such a policy would be a reduction of greenhouse gases, pollution and pesticides, and a reduction in ill health in the community. The planet, people and animals would benefit, and the NHS would save countless pounds due to the improvement in people’s health”.

Answer: “Virginia had raised these issues last year with the Trust and actually they went up to the Parliamentary Ombudsman. But the matter wasn't taken any further there and it's fine that you raised it again. But just to note that our meals are developed with our dieticians and include vegan options; this month is Veganuary so there are more options available. And as hospital food is set within a national framework, there is a more extensive range as well. As you may know we cannot take a unilateral decision to enforce one type of diet for our patients or staff. as this would need a national policy but perhaps it might be helpful if you contact your MP. This could perhaps encourage national debate, because a major change like this to a statutory service would certainly need a national debate. I would strongly recommend that you contact your MP. But as I say, we do develop all our meals with our dieticians, and we do include vegan options. As you're probably aware we do have a sustainability agenda as well in this organization and what we eat is part of that. So, thank you for your question.

30 Any Other Business

30.1 There was no other business.

31 The meeting closed at 12:55

Updated : 28/02/23

NHS
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
24	03-Nov-22	18	Significant Risk Register	KJ, KMB and Paul Ewers to review the front sheet of the report to include an overview of the Trust's risk position and appetite	KJ/KMB/PE	12-Jan-23	Verbal Update. To be progressed after the Trust's Risk Appetite Statement has been reviewed.	Open
25	12-Jan-23	12.2	Patient and Family Experience Report	KJ to share data on the effectiveness on patients of the meaningful activities facilitator role	KJ	04-May-23		Open
26	12-Jan-23	20.3	Workforce Report	To include, from the March 2023 Workforce Report, data on the cost of hiring, and data on the number of staff leaving within a year of joining and why they were leaving	DP	09-Mar-23		Open
27	12-Jan-23	20.4	Workforce Report	The May 2023 Workforce Report to include data on the profile of leavers	DP	04-May-23		Open
28	12-Jan-23	21.6	Equality, Diversity and Inclusion (EDI) Update	KMB to schedule the planned six-monthly presentations on the ED&I agenda	KMB	04-May-23	Completed	Completed

Milton Keynes University Hospital
NHS Foundation Trust

Meeting Title	**Trust Board**	**Date: 09.03.2023**
Report Title	**Chair's Report**	**Agenda Item Number: 6**
Lead Director	Alison Davis, Chair of the Trust Board	
Report Author	Alison Davis, Chair of the Trust Board	

Introduction	To provide details of activities, other than routine committee attendance, and matters to note to the Trust Board:		
Key Messages to Note	An update for the Board on activity and points of interest including: • Visits by Clare Panniker from NHS England and Rima Makarem from BLMK Integrated Care Board • Research by the Open University on the impact of deprivation on young people • MKUH participation in the NHS Employers Conference on the Armed Forces Covenant in March		
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)*	N/A

Report History	N/A
Next Steps	Council of Governors, April 2023
Appendices/Attachments	Chair's Report

Chair's report: March 2023

To provide details of activities, other than routine committee attendance, and matters to note to the Trust Board:

1. I was involved in a stakeholder group as part of the interview process for a new Chair for Central & North west London Foundation Trust, who provide mental health services in Milton Keynes. The new chair is Tom Kibasi.

2. Bedfordshire Hospitals FT have a new Chair designate, Richard Sumray who will be in post from the 1st April 2023. We have met and will be having regular meetings once he is substantive.

3. Clare Panniker, Director for the East of England at NHS England visited the Trust in January to see some of our services, including the maple Centre and spoke with Joe Harrison and myself.

4. I met with Dr Wendy Turner from the Open University who is involved in a national study called CHiLL focusing on children's experiences growing up in under resourced areas. Woughton in Milton Keynes is one of the areas taking part in the study.
   She has summarised the project as follows:-

   ''Children's Lives in Changing Places (CHiLL)
   Recent rapid social, economic and cultural change, rising child poverty, digital inequality and the effects of Covid-19 have transformed contemporary childhood. Yet, the way in which these changes impact the quality of children's everyday lives and life chances and the role of 'place' in mediating these impacts are not fully understood.
   This new research project will involve participatory action research with young people (aged 10-15) to understand the changing significance of local neighbourhoods in their lives from their own perspectives, identifying priorities for change. The study will be conducted in the Ashbrow Ward of Huddersfield with parallel studies in Woughton Parish Milton Keynes and rural Lincolnshire. The project will engage with local and national stakeholders to build rich knowledge of the issues.
   The project will contribute to local and national policy priorities to promote place-based working in order to 'build back fairer', but also will provide insights into the lives of children growing up in the 2020s. This will provide a lens into changing cultures of childhood, the challenges of growing up in less advantaged neighbourhoods, the attributes and potential of place from children's perspectives and the extent to which these place attributes affect the quality of their childhoods.
   The focus will be on young people's experiences of their local neighbourhood, where and how children spend their free time and factors influencing that, how they value and use local spaces, their sense of place belonging and the significance of local places (families, communities, local environment) in affecting children's wellbeing, life chances and their sense of active citizenship.

The project is being conducted as part of the international Growing up in Cities project involving similar studies in over 14 countries https://www.nuffieldfoundation.org/project/childrens-lives-in-changing-places.
Working in partnership with local authority, voluntary sector and community stakeholders, this landmark study will create impact for multiple stakeholders at a local, national and international level through new knowledge and approaches concerning the changing significance of place on young people's lives and their role as researchers and change makers.
The project starts on September 1st and will continue until May 2024."

As this research is relevant to the objectives of the Integrated Care System, I have referred her on to colleagues at BLMK for further discussions.
Several young people have been identified to work on the project and I am hoping Wendy might be able to help us engage with potential Governors for MKUH.

5. NHS Employers are holding an Armed Forces Conference in March and MKUH has been asked to take part, highlighting the Silver Award systems in place to support armed forces staff and patients. It is a virtual event and if Governors would be interested in 'attending' I can provide a booking link.

6. On the 10th March I will be accompanying the Governor Clare Hill on her Friends of MKUH trolley round to the wards, to meet patients and staff.

7. On the 22nd February Rima Makarem, Chair of the Integrated Care Board visited the hospital and had a tour of the Maple Centre. The team were able to update Rima on the impact the service has had since opening and the ambitions for developing the centre.
The monthly meetings of NHS Chairs and Local Authority leaders continue, sharing details of areas of work that could be beneficial to the whole system

8. Work is progressing on the radiotherapy unit and planning is under way to launch the charitable fundraising to support the facility, especially enhancements for patients and staff.

9. I was able to attend part of the Governor Awayday on the 28th February. The discussions led to a number of suggestions for further development of Governor involvement and raising their profile within the hospital and externally.

10. As the NED lead for maternity services I continue to attend local and regional meetings and have regular updates from Melissa Davis.

11. For anyone who would like to attend the Board meeting of the Integrated Care Board, details can be found at Board Meetings - BLMK Integrated Care Board (icb.nhs.uk)

Milton Keynes Hospital NHS
NHS Foundation Trust

Meeting title	Trust Board	March 2023
Report title:	Serious Incident and Learning Report	Agenda item: 8
Lead director Report author Sponsor(s)	Dr Ian Reckless Kate Jarman Tina Worth	Medical Director DoCA Head of Risk & Clinical Governance
FoI status:	Published	

Report summary	This report provides a monthly overview serious incidents in the Trust.			
Purpose *(tick one box only)*	Information	Approval	To note	Decision
Recommendation	The Board is asked to note the content of the report.			

Strategic objectives links	Patient safety, patient experience, clinical effectiveness
Board Assurance Framework links	Lack of learning from incidents is a key corporate risk.
CQC outcome/ regulation links	This report relates to: This report relates to CQC: Regulation 12 – Safe care and treatment Regulation 17 – Good governance Regulation 20 – Duty of candour
Identified risks and risk management actions	Lack of learning from incidents is a key corporate risk.
Resource implications	Breaches in respect of SI submission can incur a £1000 penalty fine. Breaches in respect of the Duty of Candour have potential for penalty fine of £2,500..
Legal implications including equality and diversity assessment	Contractual and regulatory reporting requirements.

Report history	Serious Incident Review Group
Next steps	Routine reporting
Appendices	Paper follows

Serious Incident Report March 2023

Summary

This report provides an overview of serious incidents reported in January and February; key trends or concerns and other regulatory matters, including Coronial inquests. This report also provides an overview of quality improvement activity, which supports patient safety, harm prevention and learning.

Serious Incidents

There were four new SIs reported in January and February 2023. These are summarised as follows:

STEIS number	Category	Location	Details
2023/323	Delayed diagnosis (cancer)	Oral Maxillo Facial Surgery (OMFS)	Delayed diagnosis/ treatment following urgent referral from optician to ophthalmology and on to OMFS.
2023/1020	Suboptimal care	Medicine (Ward 16)	Delayed venous blood case.
2023/2009	Venous thromboembolism (VTE)	Medicine VTE Clinic	Patient admitted with intercranial haemorrhage.
2023/4173	Hospital acquired venous thromboembolism (VTE)	Maternity	Postnatal pulmonary embolism (PE).

Issues for further focus

- Patient falls with no/minor harm
- Medication incidents relating to discharge - medications missed or sent in error
- Sepsis and the importance of early recognition and compliance with the Sepsis 6 Protocols
- The importance of clear and accurate documentation
- Violence and abuse referencing staff incivility to each other when under pressure
- On admission/new pressure ulcers
- Medication incidents relating to insulins and management of diabetic ketoacidosis (DKA) and staff familiarity on protocols and insulin type variances and effects on blood sugars

Safety Action

A **Diabetes Safety Group** has been set up to focus on the following key themes:

- Incorrect insulin
- Incorrect dose
- Incorrect timing
- Omitted doses
- Incorrect formulation/type

The Trust Diabetes Specialist Nurse has launched a mandatory training module to support prescribing and administration and dispensing error risk management.

A quality improvement project has been established for **discharge summaries** linked to a recent SI and pending inquest focusing on:

- eCare discharge letter formatting
- Failure to record problems by the medical team
- Pharmacy issues - failure to follow the correct pharmacy workflow of admitting home medications, admission process and then discharge medications create problems with the discharge summary. As a minimum for a short stay admission knew medications should be prescribed electronically and recorded on the discharge summary
- Poor quality clinical narrative - to implement an educational programme with the junior doctors, to include a baseline audit.

Coronial Inquests/ Regulation 28 Reports

Preventing Future Death (PFD) report received from HM Coroner:

The patient was an otherwise healthy man who developed gallstone pancreatitis and was admitted to Milton Keynes University Hospital on the 3rd April 2021. He died on the11th April 2021 from 1a Acute pancreatitis and liver necrosis resulting from 1b Gallstones disease (ERCP 8th April 2021).

Coronial concern was that had the patient been effectively monitored and subject to senior surgical supervision during the 9th April 2021 it is more likely than not that he would have
survived.

The response has been sent to HM Coroner. Actions following the inquest focus on:

- Increased senior staff support for junior doctors on the wards, specifically in the surgical division. The Division of Surgery is creating a supernumerary doctor of registrar grade to support junior ward staff. This will be part of the plan to increase support for the new ‘Same Day Emergency Centre’.
- Revising the policies relating to sepsis and the deteriorating patient to align the NEWS scores that trigger an escalation

- Revising the sepsis policy algorithm to include ongoing investigation, escalation and care.
- Enacting training and education interventions to prevent further incidents of missed patients.

Trust QI project updates

Medicines Management QIP (Trust wide – Pharmacy led) actions February:

- Focus group met 21/02/23 discussed findings of observational work carried out and actions for taking forward.
- Observation and feedback undertaken with ED/Medicine/General Emergency Surgery teams to explore work as done vs work as imagined, barriers and opportunities work scan completed and identified actions sent to consultants and area leads for comment.
- Fish bone analysis completed using staff feedback.
- Aims:
    - To get buy in and ownership of actions identified by area leads for trial implementation as part of a PDSA movement.
    - Discover ICS/community link to help liaise patient through integrating care pathways
    - Patient education about the importance of bringing in medications – using communications

- The QI team are working with Patient Safety Partners using an Appreciative Inquiry approach to capture patient stories related to discharge summaries to explore the patient experience. A story has been captured from an elderly lady who explained she is dependent on family/friends for her household care and a dosette box for her medicines. She had fed back she was very happy with her care whilst an inpatient at MKUH and felt that she was attended to and safe and informed. At that discharge point in Patient Discharge Unit, it was discovered that her medicines were not given to her in the correct form and she had changes to her medicines which meant she would need to wait whilst these were made, delaying her transport and rescheduling family/friends waiting for her. This made her feel slightly frustrated.

Improving Discharge Summaries in Medicine QIP

- Discharge summary layout has been revised in E-care using the Situation, Background, Assessment, Recommendation (SBAR) communication tool (appendix 2)
- Run chart for process measure developed following analysis of the quality of discharge summaries completed.
- Individual feedback shared with staff via Educational Supervisor
- Education session to commence with a session organised at a grand round
- Do and Don't poster and learning videos to be developed to guide staff with completion of discharge information using E-care
- Appreciative Inquiry with patients to obtain patient feedback incorporated with Medicines Management QIP

Pre-op Anaemia QIP

- SOP and flowchart to go to next surgery CSU meeting in March 23 for agreement.
- New lead nurse for pre-op clinic to work with Matron lead to establish other areas they need to work with for similar workflow and feedback
- Matron to update on progress of E-care in PCU for prescribing iron remotely (still currently done on paper – delays with finding a prescriber)

Pressure Ulcer (PU) Management QIP

The QI team continue to support the Corporate Nursing team with the QIP for PU.

There are challenges with Radar data and accurate reporting for Statistical Process Control (SPC) charts which is reliant on a manual evaluation process. The Trust Risk Manager has been asked for timelines from Radar for when action requests may be completed.

The QI team have been working with the Patient Experience Lead on how we can improve information provided to staff, carers, relatives and other providers in various formats.

Trust QI Audit Activity

The Trust audit database is now available via the **Improvement Hub** intranet page. This provides audit leads with oversight of all audits registered in the Trust since 2019. Oversight is helpful for steering junior staff to QI topics and QI work which may be required for local or national audits where improvement may be required or cycles are incomplete.

Overdue audits are being followed up by the Clinical Governance Leads and Clinical Governance Administrators to establish if these require rolling over onto 2023/24 QI plan.

Clinical Audit Trust Activity

The new on line QI/audit registration process is working well. Projects registered February can be found in appendix 2.

Learning from QI

Improvements identified from QI projects presented at QI half day sessions

An automated QI outcomes form has been launched which captures successes, improvements, compliance and risks from QI projects presented at divisional audit half day sessions.

Meeting Title	Trust Board	Date: March 2023
Report Title	CQC Maternity Experience Survey 2022 Improvement Plan	Agenda Item: 10
Lead Director	Name: Kate Jarman	Title: Director of Corporate Affairs
Report Author	Name: Melissa Davis	Title: Divisional Chief Midwife

Key Highlights/ Summary	The 2022 CQC Maternity Patient Experience Survey results were released in January 2023. Following receipt of the results, the Trust has identified and implemented actions to improve service users' experiences of maternity care. A core part of the Trust approach is collaborating with the Maternity Voices Partnership to support progress with identified areas for improvement and also hear about and improve the experience of service users whose voices have yet to be adequately represented in the survey.			
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Noting** √	**For Review** √

Strategic Objectives Links	Improving Patient Experience
Board Assurance Framework (BAF)/ Risk Register Links	

Report History	
Next Steps	
Appendices/Attachments	Appendix 1 – CQC Maternity Experience Report 2022

CQC Maternity Experience Survey 2022 Improvement Plan

Background

The Care Quality Commission (CQC) Maternity Survey takes place annually and presents the Trusts with insights into service users' antenatal, labour and birth and postnatal care experiences. The CQC surveyed Milton Keynes University Hospital (MKUH) service users in February 2022 and embargoed the findings until January 2023. The survey was the first mixed-mode maternity survey where online responses were encouraged, and postal completion remained an option.

Of the 300 maternity service users invited to participate in the survey in February 2022, 169 responded, giving MKUH a response rate of 57% compared to an average Trust response rate of 47%. in terms of ethnicity, 62% described themselves as White, 15% as Asian or Asian British, 15% as Black or Black British, 4% as Multiple Ethnic groups and 4% as Not Known.

Headline Findings

The CQC report summarises and benchmarks maternity survey performance across all NHS Trusts in England. The MKUH results across all three components of the maternity pathway (antenatal, labour and birth and postnatal care) are summarised below:

- MKUH was better than expected compared to most Trusts in 2 of the 50 benchmarked questions (Postnatal Care).
- MKUH was somewhat better than expected compared to most Trusts in 3 of the 50 benchmarked questions (Postnatal Care).
- MKUH was about the same compared to most Trusts for 38 of the 50 benchmarked questions (Antenatal Care, Postanal Care and Labour and Birth).
- MKUH was somewhat worse than expected compared to most Trusts for 5 of the 50 benchmarked questions (Labour and Birth)
- MKUH was worse than expected compared to most Trusts for 3 of the 50 benchmarked questions (Labour and Birth).

The full CQC maternity experience report is included in Appendix 1. Compared to the 2021 CQC maternity survey, the results demonstrated a statistically significant improvement in the scores for five questions, no statistically significant change for 41 questions and no statistically significant decrease in score for any questions.

The survey's findings have been reviewed in detail, alongside data from complaints and FFT, to direct improvement efforts towards actions that will significantly impact service users' experience of maternity service at MKUH.

Impovement Actions

- **Induction of Labour Decision Making**

  To improve the involvement of service users in induction decision-making, a phone call service has been introduced. This service is a pilot and will be thoroughly evaluated based on the feedback and experience of service users. The service will provide opportunities to discuss the reasons for induction and provide information and a discussion of the process and timelines for induction following admission to the hospital.

  A quality improvement programme focusing on the breadth of the induction of labour experience has commenced and links all areas of service user experience and the Maternity Voices Partnership plan to ensure this work programme is prioritised.

- **Partner and Family Involvement**

  To improve birth partner involvement, the Trust have re-implemented a partner being able to stay overnight. This work has been supported by developing targeted information for birth partners that details what to expect and how to prepare to stay overnight in a ward environment.

  Visiting arrangements for siblings have also been reviewed and relaxed to facilitate children's visits. These arrangements will be reviewed regularly to identify and mitigate any impact from an infection prevention and control perspective.

- **Support During Labour and Birth**

  Meetings have been held with the Maternity Voices Partnership Co-Chairs to co-produce actions that reduce service users feeling alone when they are worried during labour and birth.

  An area of focus relates to times when health professional’s complete computer documentation. A quality improvement project on the documentation process during labour and birth has commenced and examines the efficiency and timeliness of electronic recording.

  Maternity experience feedback has also been introduced into mandatory training to provide examples of direct, relatable feedback and raise awareness of the impact on service users.

  Significant focus has also been placed on the implementation of mechanisms to support shared decision-making, informed choice, and consent, including:

1. Birth Rights Training
2. Birth Preferences appointment and individualised plan

- **Service User Feedback, Engagement, and Involvement**

  Maternity leadership wellbeing walk-rounds have commenced and involve speaking with staff and service users to understand their experiences. The feedback is collated, thematically reviewed, and included in the Maternity Improvement Plan.

  Maternity Voices Partnership collaboration, including co-authoring, maternity guidelines, and information leaflets. Themes from the birth reflections service, which is available to all service users following birth, and collected to identify areas for improvement.

Conclusion

The Board is asked to note the headline findings from the 2022 CQC Maternity Services Survey and the approach to acting upon the survey's findings. Targeted dissemination and analysis of the findings have been completed. The overall improvement plan and progress will be monitored through the Patient Experience Board and delivered in collaboration with the Maternity Voices Partnership.

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	Trust Board	**Date:** 09/03/23
Report Title	2022-23 Executive Summary M10	**Agenda Item Number:** 11
Lead Director	John Blakesley, Deputy CEO	
Report Author	Information Team	

Introduction	Purpose of the report: Standing Agenda Item

Key Messages to Note	In January 2023:
	
	Emergency Department:
	- There were 7,747 ED attendances, below the monthly year-to-date average.
	- ED 4-hour performance increased to 80.1%, exceeding both the national performance and the performance of the majority of other trusts within our Peer Group.
	- 81.0% of ambulance handovers took less than 30 minutes, above the year-to-date monthly average (80.1%).
	
	Outpatient Transformation:
	- There were 34,315 outpatient attendances, an increase in comparison to January 2020.
	- 14.0% were attended virtually, the lowest percentage to date this financial year.
	- 5.8% of patients did not attend their appointment, the best performance this financial year to date and below the threshold of 6.0%.
	
	Elective Recovery:
	- There were 1,724 elective spells, a decrease in comparison to January 2020.
	- At the end of the month 37,947 patients were on an open RTT pathway. Of these:
	  o 2,342 patients were waiting over 52 weeks, declining from 2,445 in December 2022.
	  o 150 patients were waiting over 78 weeks.
	  o 1 patient was waiting over 104 weeks.
	- At the end of the month 7,016 patients were waiting for a diagnostic test. Of these patients:
	  o 81.5% were waiting less than 6 weeks.
	
	Inpatients:
	- Overnight bed occupancy was 97.4%, exceeding the threshold of 93%.
	- A significant number of beds were unavailable due to:
	  o 141 super stranded patients (length of stay 21 days or more).
	  o 34 DTOC patients.
	  o 82 patients not meeting the criteria to reside.
	
	Human Resources:
	- Substantive staff turnover increased slightly to 17.2%, the highest rate to date this financial year.
	- Agency expenditure also exceeded its threshold.

	- Appraisals (excluding doctors) and mandatory training completion rates were better than their targets. However, December appraisal completion rate for doctors was only 35.7%. **Patient Safety:** - Two infections were reported and MRSA, MSSA, E-Coli and C.Difficile have all breached their 2022-23 thresholds.		
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)*	*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	
Next Steps	
Appendices/ Attachments	ED Performance – Peer Group Comparison

OBJECTIVE 1 - PATIENT SAFETY										
ID	Indicator	DQ Assurance	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
1.1	Mortality - (HSMR) ★		101.3	101.3		108.2	✗	▲		
1.2	Mortality - (SHMI)		100.0	100.0		103.8	✗	▼		
1.3	Never Events		0	0	1	0	✓	▬	✗	
1.4	Clostridium Difficile		10	<9	14	0	✓	▬	✗	
1.5	MRSA bacteraemia (avoidable)		0	0	2	0	✓	▬	✗	
1.6	Falls with harm (per 1,000 bed days)		0.12	0.12	0.15	0.06	✓	▲	✗	
1.7b	Midwife to birth ratio (Actual for Month)					33		▼		
1.8	Incident Rate (per 1,000 bed days)		50	50	47.16	48.49	✗	▼	✗	
1.9	Duty of Candour Breaches (Quarterly)		0	0	0	0	✓	▬	✓	
1.10	E-Coli		15	<13	18	1	✓	▲	✗	
1.11	MSSA		8	<7	18	1	✗	▲	✗	
1.12	VTE Assessment		95%	95%	96.3%	97.2%	✓	▼	✓	
1.14	Klebsiella Spp bacteraemia		15	<13	11	0	✓	▲	✓	
1.15	P.aeruginosa bacteraemia		10	<9	4	0	✓	▬	✓	

OBJECTIVE 2 - PATIENT EXPERIENCE										
ID	Indicator	DQ Assurance	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.2	RED Complaints Received		0	0	0	0	✓	▬	✓	
2.3	Complaints response in agreed time		90%	90%	92.7%	92.1%	✓	▲	✓	
2.4	Cancelled Ops - On Day		1%	1%	1.25%	0.65%	✓	▲	✗	
2.5	Over 75s Ward Moves at Night		1,500	1,250	1,423	155	✗	▲	✗	
2.6	Mixed Sex Breaches		0	0	4	0	✓	▲	✗	

OBJECTIVE 3 - CLINICAL EFFECTIVENESS										
ID	Indicator	DQ Assurance	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
3.1	Overnight bed occupancy rate		93%	93%	91.2%	97.4%	✗	▼	✓	
3.2	Ward Discharges by Midday		25%	25%	14.4%	14.1%	✗	▲	✗	
3.3	Weekend Discharges		63%	63%	60.5%	57.4%	✗	▼	✗	
3.4	30 day readmissions		7%	7%	6.7%	6.0%	✓	▼	✓	
3.5	Patients not meeting Criteria to Reside		TBC			82	Not Available	▼		
3.6a	Number of Stranded Patients (LOS>=7 Days)		184			291	✗	▼		
3.6b	Number of Super Stranded Patients (LOS>=21 Days)		50			141	✗	▼		
3.7	Delayed Transfers of Care		25			34	✗	▼		
3.8	Discharges from PDU (%)		12.5%	12.5%	9.4%	10.3%	✗	▲	✗	
3.9a	Ambulance Handovers <30 mins (%)		95%	95%	79.8%	81.0%	✗	▲	✗	
3.9b	Ambulance Handovers <60 mins (%)		100%	100%	96.7%	98.3%	✗	▲	✗	

OBJECTIVE 4 - KEY TARGETS										
ID	Indicator	DQ Assurance	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1a	ED 4 hour target (includes UCS)		90%	90%	79.4%	80.1%	✗	▲	✗	
4.1b	Total time in ED no more than 8 hours (Admitted)		100%	100%	30.1%	44.7%	✗	▲	✗	
4.2	RTT Incomplete Pathways <18 weeks		70%	70%		46.3%	✗	▲		
4.4	RTT Total Open Pathways		33,998	33,444		37,947	✗	▲		
4.5a	RTT Patients waiting over 52 weeks (Total)		0	140		2342	✗	▲		
4.5b	RTT Patients waiting over 52 weeks (Non-admitted)		0	TBC		1621	Not Available	▲		
4.6	Diagnostic Waits <6 weeks		90%	90%		81.5%	✗	▲		
4.7	All 2 week wait all cancers (Quarterly) 🖉		93%	93%		79.7%	✗	▲		
4.8	31 days Diagnosis to Treatment (Quarterly) 🖉		96%	96%		94.6%	✗	▼		
4.9	62 day standard (Quarterly) 🖉		85%	85%		63.7%	✗	▼		

OBJECTIVE 5 - SUSTAINABILITY										
ID	Indicator	DQ Assurance	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
5.1	GP Referrals Received		Not Available		70,403	5,489	Not Available	▲	Not Available	
5.2	A&E Attendances		104,759	88,022	85,489	7,747	✓	▲	✓	
5.3	Elective Spells		25,821	21,643	20,718	1,724	✗	▼	✗	
5.4	Non-Elective Spells		34,421	28,794	24,138	2,564	✓	▲	✓	
5.5	OP Attendances / Procs (Total)		407,339	343,093	339,517	34,315	✓	▲	✗	
5.6	Outpatient DNA Rate		6%	6%	7.2%	5.8%	✓	▲	✗	
5.7	Virtual Outpatient Activity		25%	25%	16.8%	14.0%	✗	▼	✗	
5.8	Elective Spells (% of 2019/20 performance)		110%	110%	98.9%	98.2%	✗	▼	✗	
5.9	OP Attendances (% of 2019/20 performance)		104%	104%	105.2%	102.2%	✗	▼	✓	

OBJECTIVE 7 - FINANCIAL PERFORMANCE										
ID	Indicator	DQ Assurance	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
7.1	Income £'000		332,163	276,654	285,177	24,851	✗	▼	✓	
7.2	Pay £'000		(208,343)	(174,894)	(187,359)	(19,276)	✗	▲	✗	
7.3	Non-pay £'000		(98,408)	(82,708)	(84,764)	(8,533)	✗	▲	✗	
7.4	Non-operating costs £'000		(25,412)	(21,704)	(15,849)	3,539	✓	▲	✓	
7.5	I&E Total £'000		(0)	(2,652)	(2,795)	581	✗	▼	✗	
7.6	Cash Balance £'000			41,602		29,476	✗	▼		
7.7	Savings Delivered £'000		12,049	8,247	8,248	1,484	✓	▲	✓	
7.8	Capital Expenditure £'000		(18,288)	(10,576)	(16,123)	(2,180)	✗	▼	✗	

OBJECTIVE 8 - WORKFORCE PERFORMANCE										
ID	Indicator	DQ Assurance	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
8.1	Staff Vacancies % of establishment		10.0%	10.0%		8.6%	✓	▲		
8.2	Agency Expenditure %		5.0%	5.0%	6.2%	7.1%	✗	▲	✗	
8.3	Staff Sickness % - Days Lost (Rolling 12 months) 🖉		5.5%	5.5%		5.2%	✓	▲		
8.4a	Appraisals (excluding doctors)		90%	90%		91.0%	✓	▼		
8.4b	Doctors due appraisal in the given month who have completed that appraisal by month end	TBC				35.7%		▼		
8.4c	Doctors who have completed appraisal since 01 April 2022	TBC				69.0%		▲		
8.5	Statutory Mandatory training		90%	90%		94.0%	✓	▬		
8.6	Substantive Staff Turnover		9.0%	9.0%		17.2%	✗	▼		
8.7	Percentage of employed consultants with (at least one) fully signed off (3-stage) job plan since 01 April 2021					89.2%		▲		

OBJECTIVES - OTHER										
ID	Indicator	DQ Assurance	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
O.1	Total Number of NICE Breaches		8	8		35	✗	▼		
O.2	Rebooked cancelled OPs - 28 day rule		90%	90%	77.8%	75.0%	✗	▲	✗	
O.4	Overdue Incidents >1 month		TBC	TBC		262	Not Available	▼		
O.5	Serious Incidents		75	<63	85	3	✓	▼	✗	

Key: Monthly/Quarterly Change

▲	Improvement in monthly / quarterly performance
▬	Monthly performance remains constant
▼	Deterioration in monthly / quarterly performance
	NHS Improvement target (as represented in the ID columns)
🖉	Reported one month/quarter in arrears
★	There was a notable increase in the value of Mortality (HSMR) in January 2022 due to the baseline being rebased. Further, from February 2022, the HSMR threshold may change on a monthly basis as we will be using the monthly peer value to compare MKUH performance against.

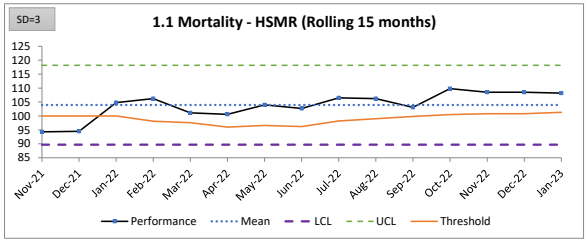
YTD Position

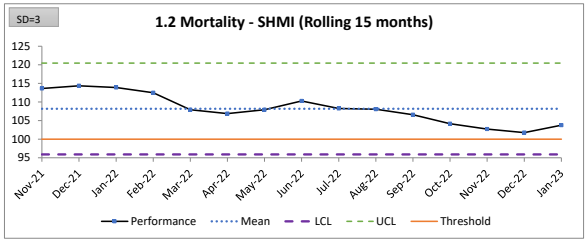
✓	Achieving YTD Target
	Within Agreed Tolerance*
✗	Not achieving YTD Target
✗	Annual Target breached

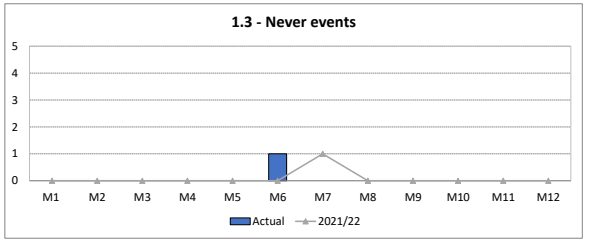
Data Quality Assurance Definitions

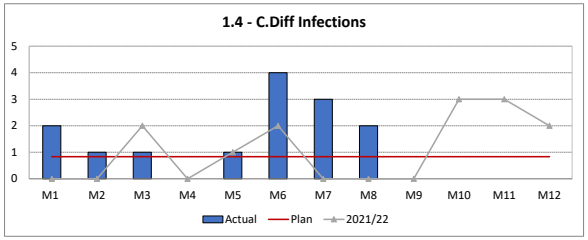
Rating	Data Quality Assurance
Green	Satisfactory and independently audited (indicator represents an accurate reflection of performance)
Amber	Acceptable levels of assurance but minor areas for improvement identified and potentially independently audited * /No Independent Assurance
Red	Unsatisfactory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

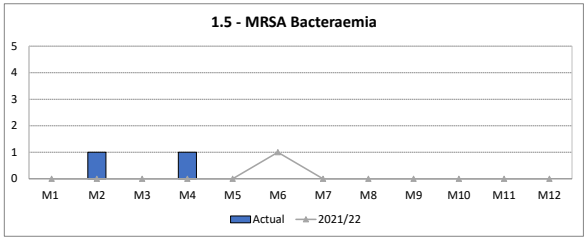
* Independently Audited – refers to an independent audit undertaken by either the Internal Auditor, External Auditors or the Data Quality Audit team.

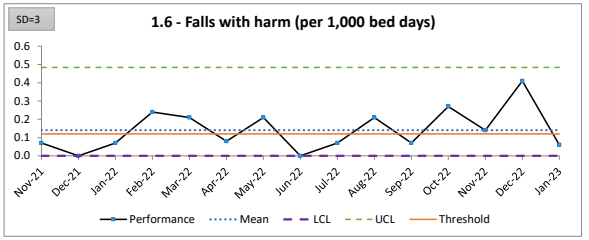


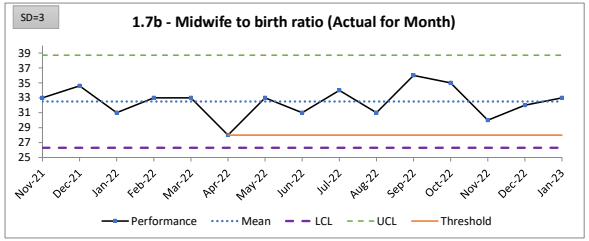


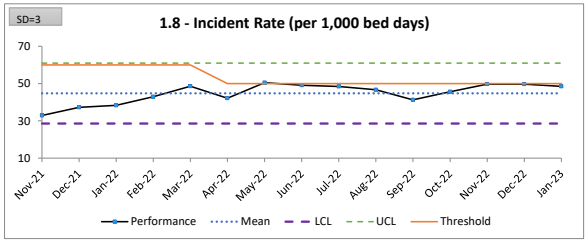


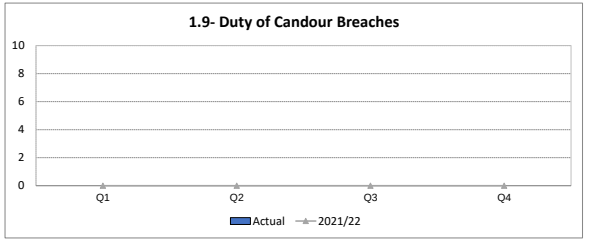


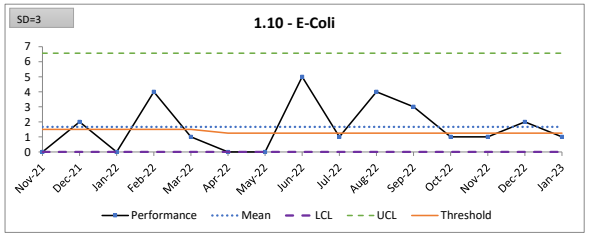


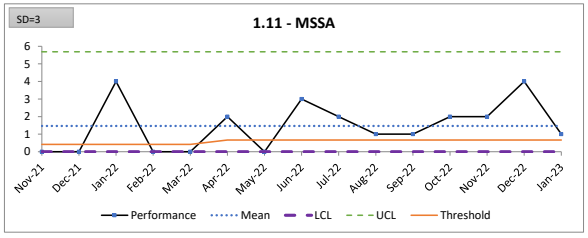


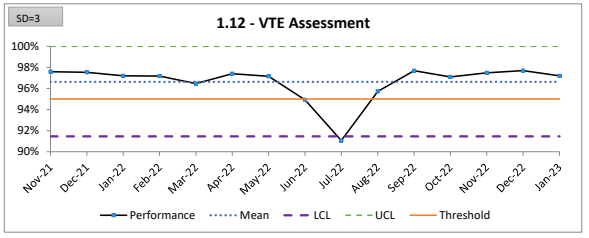


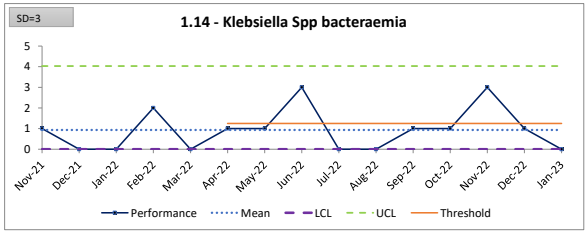


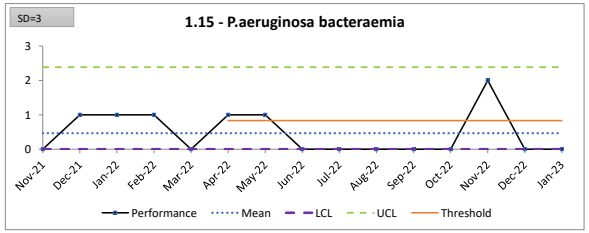












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- Average on a rolling 15 months/quarterly
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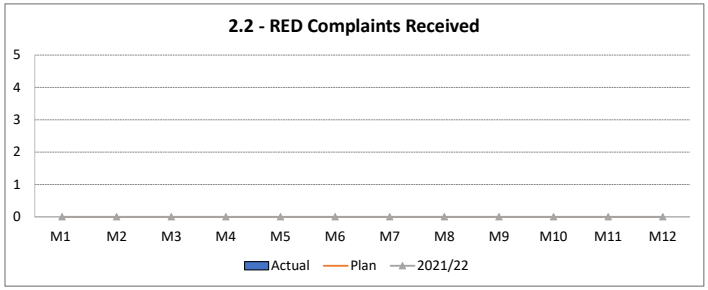
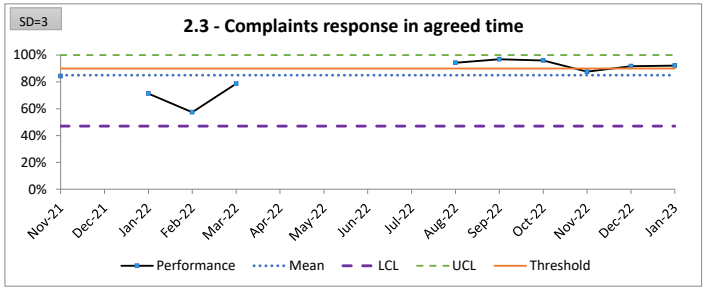
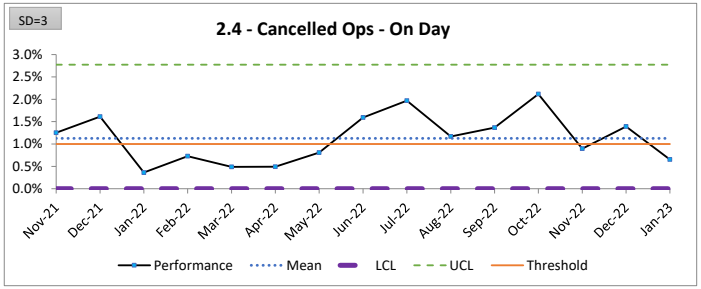
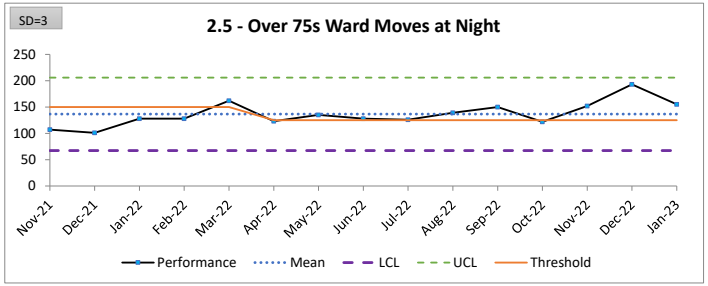
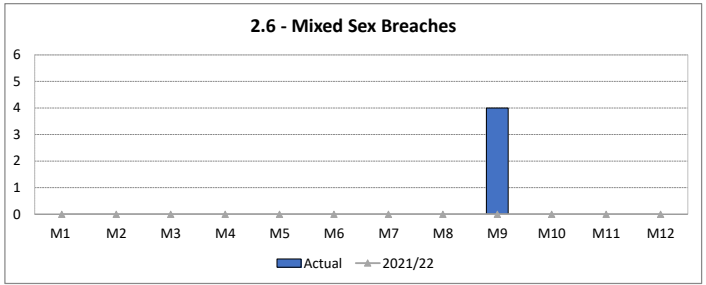
OBJECTIVE 2 - PATIENT EXPERIENCE











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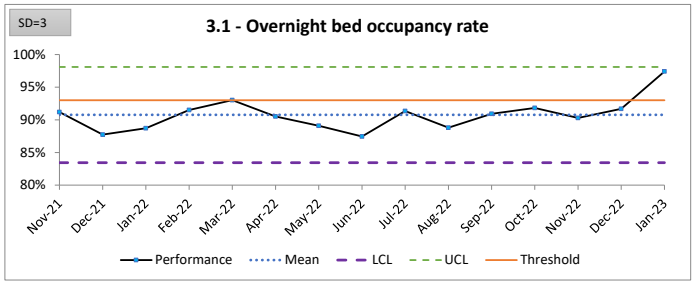
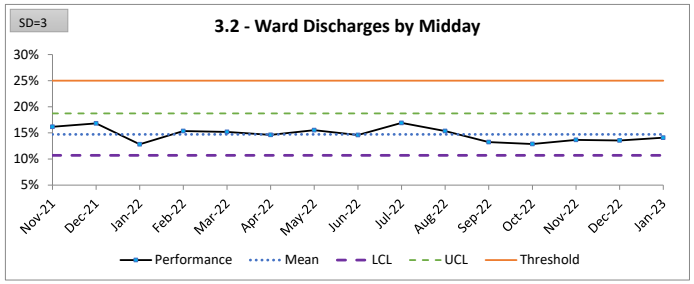
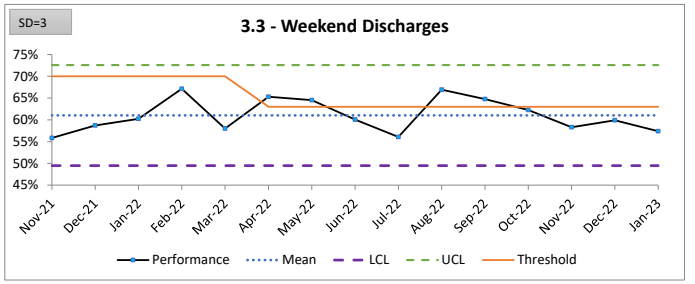
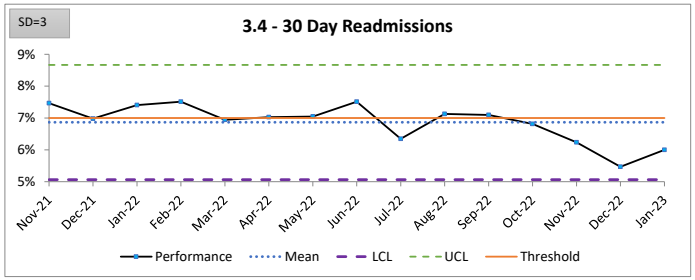
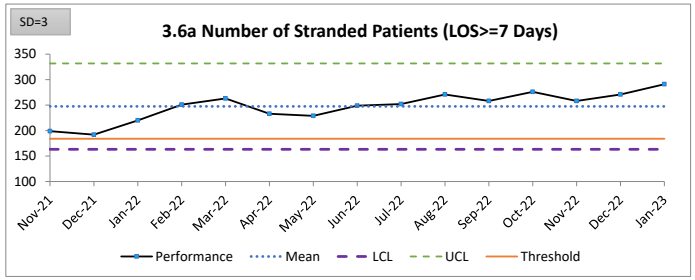
OBJECTIVE 3 - CLINICAL EFFECTIVENESS

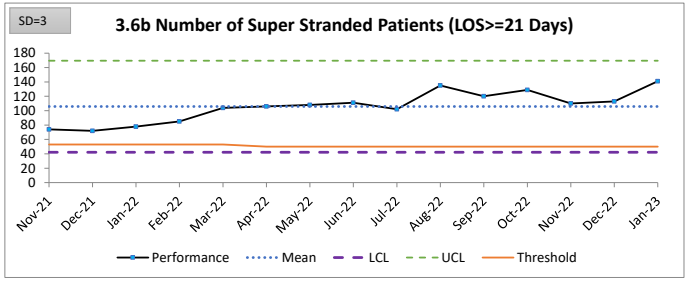


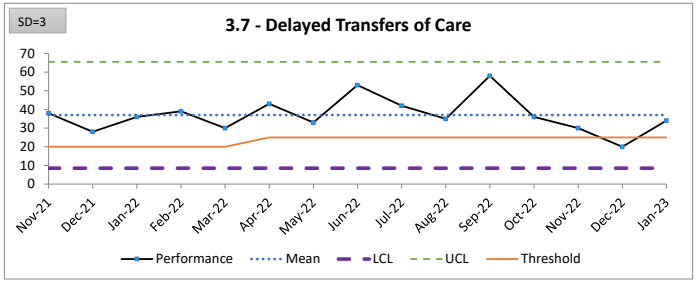


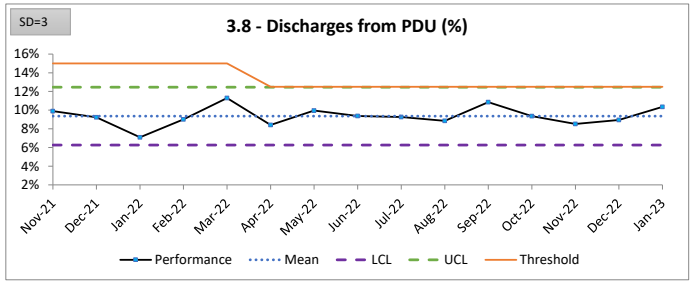


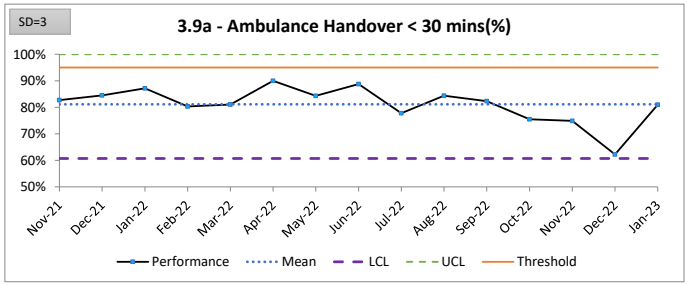


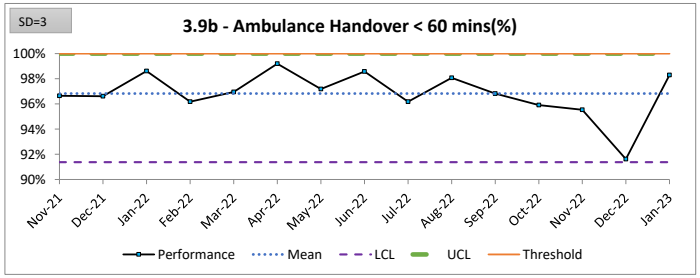












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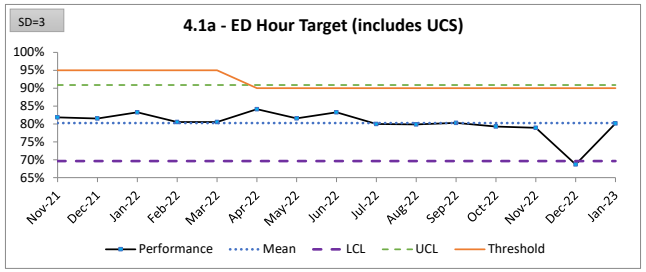
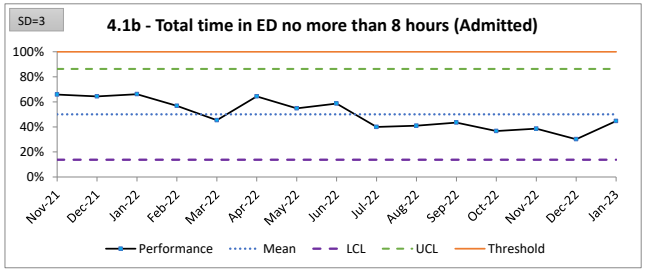
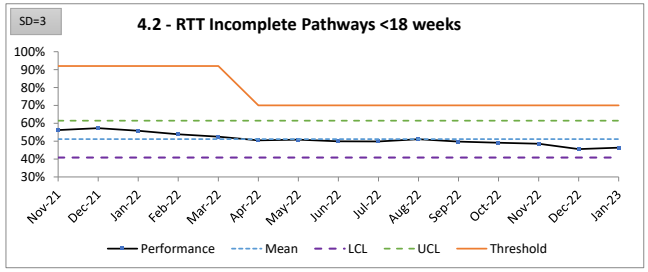
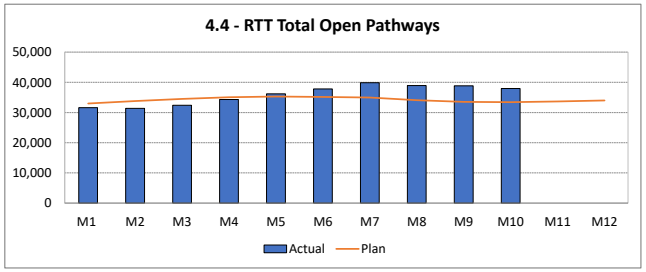
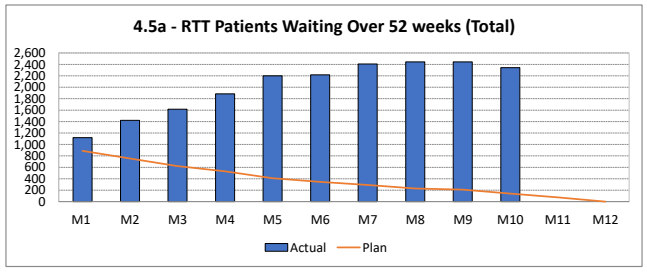
OBJECTIVE 4 - KEY TARGETS

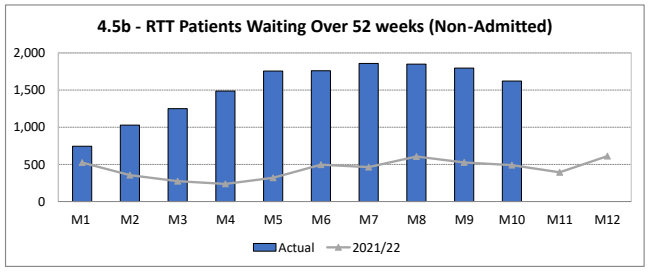


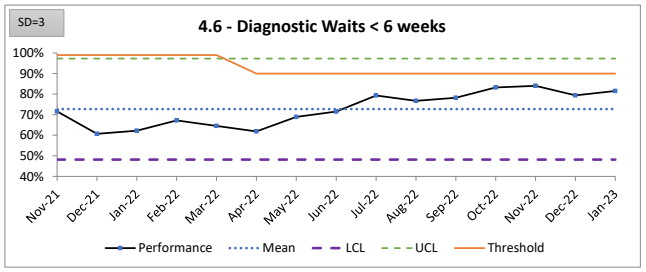


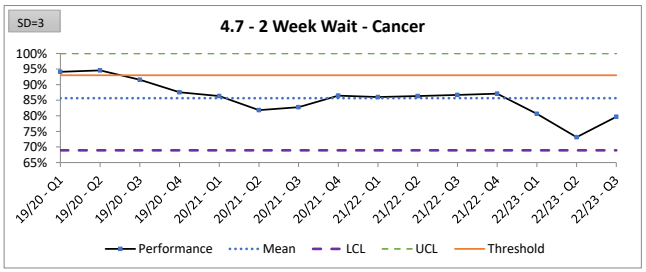


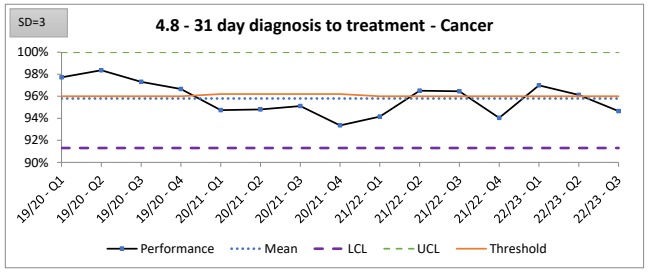


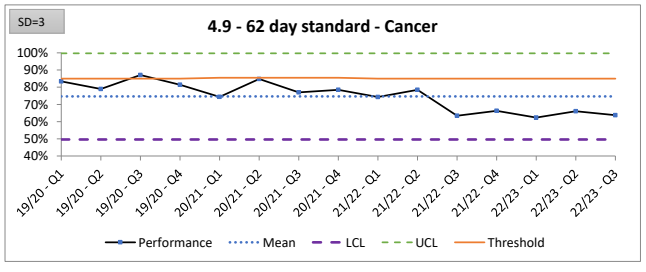












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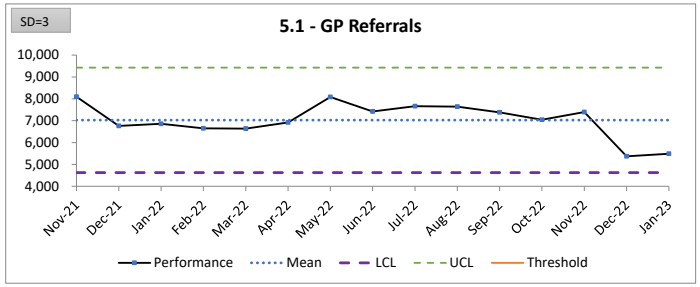
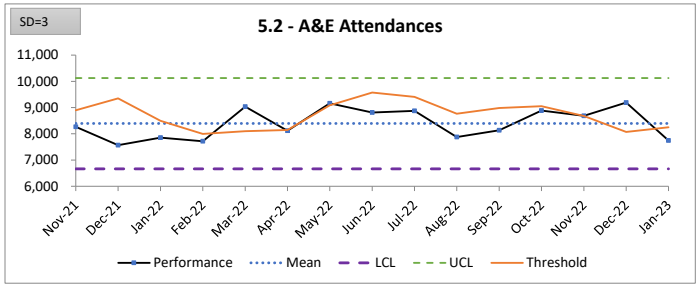
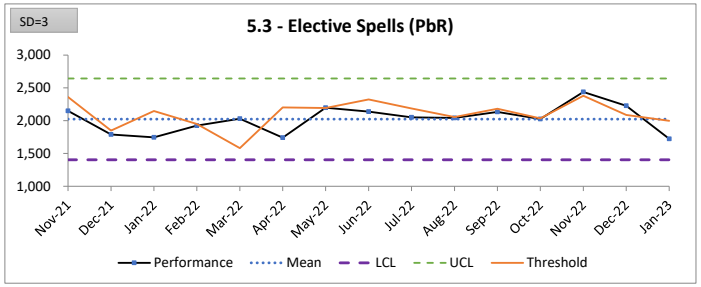
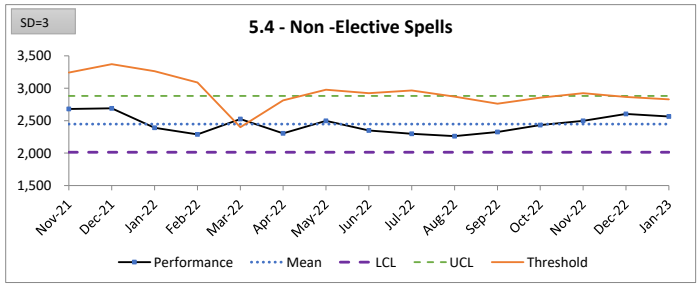
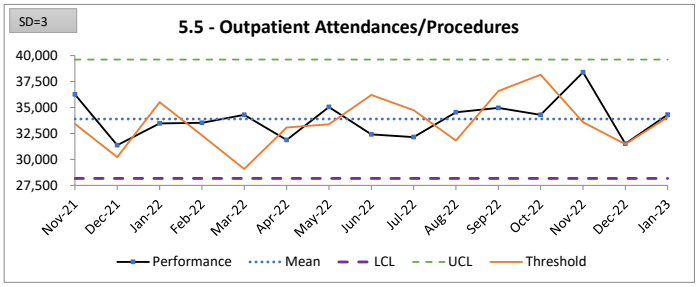
OBJECTIVE 5 - SUSTAINABILITY

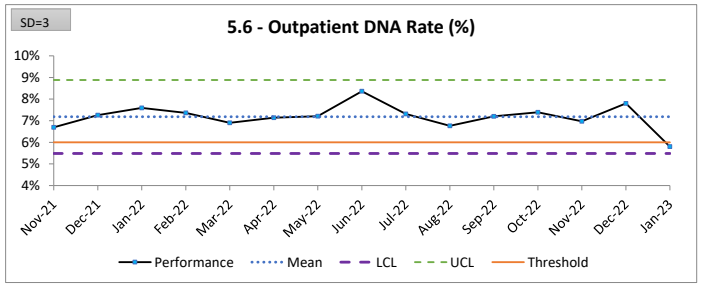












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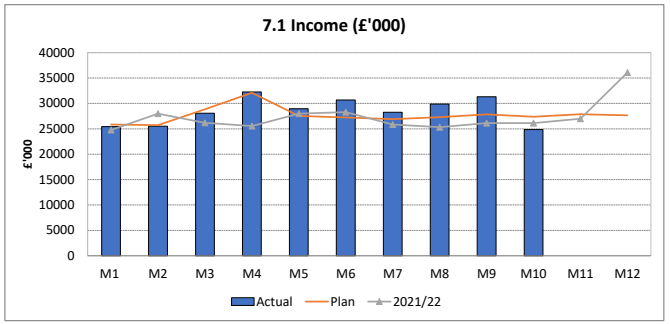
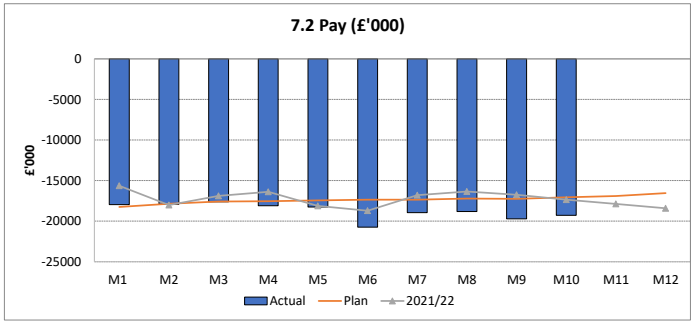
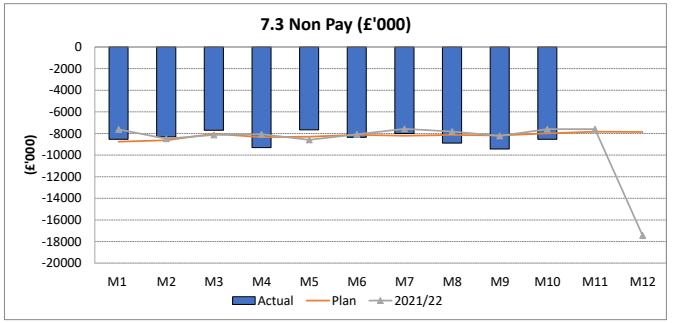
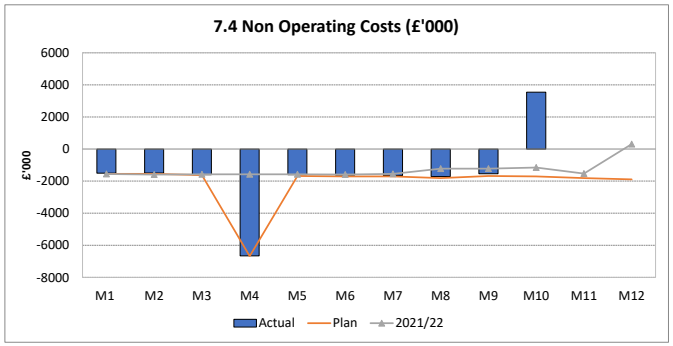
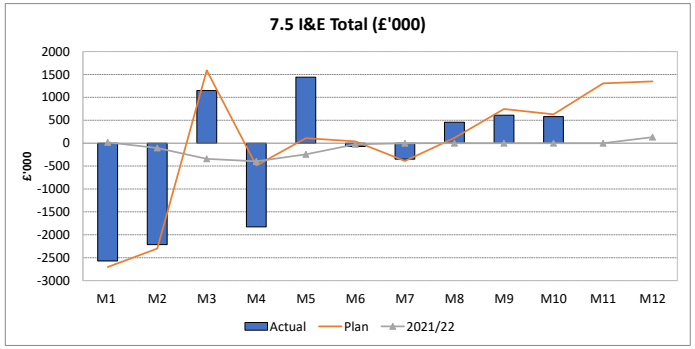
OBJECTIVE 7 - FINANCIAL PERFORMANCE

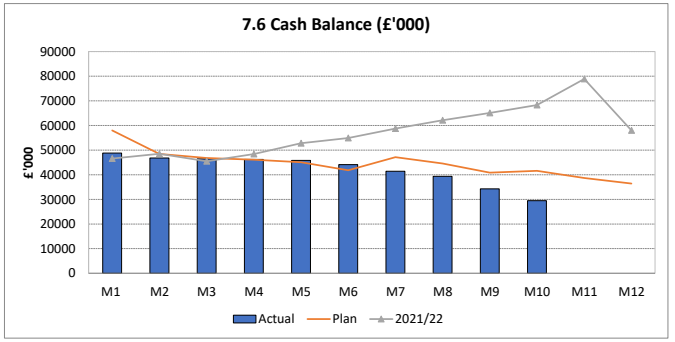


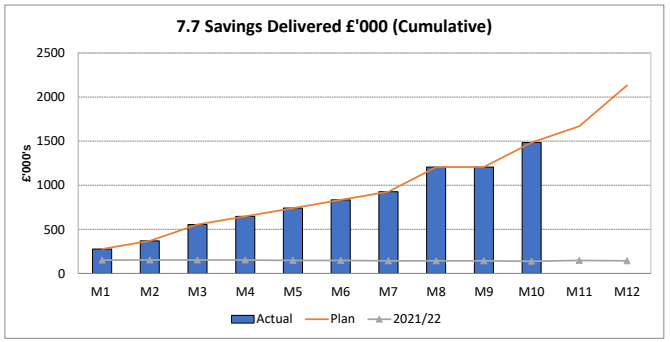


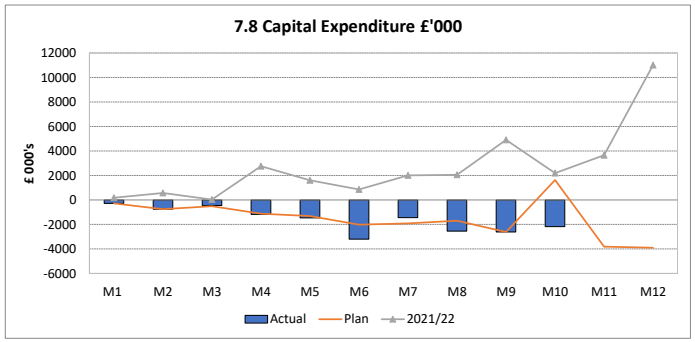




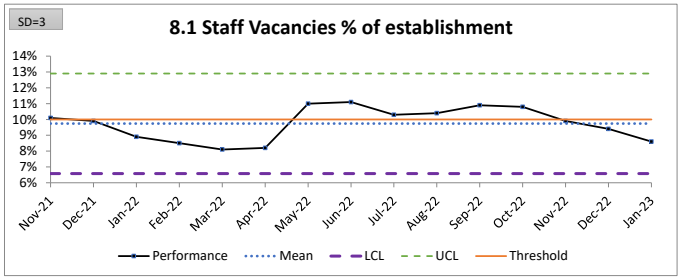


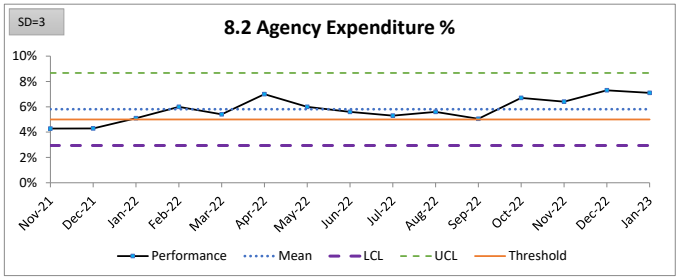


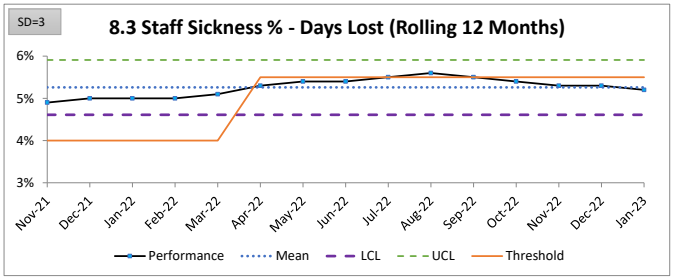


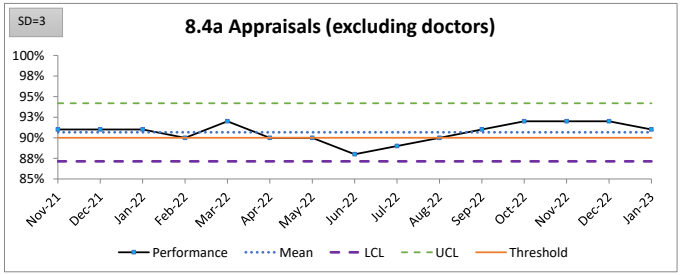


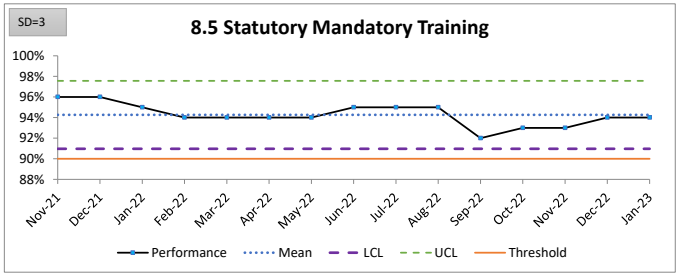
OBJECTIVE 8 - WORKFORCE PERFORMANCE

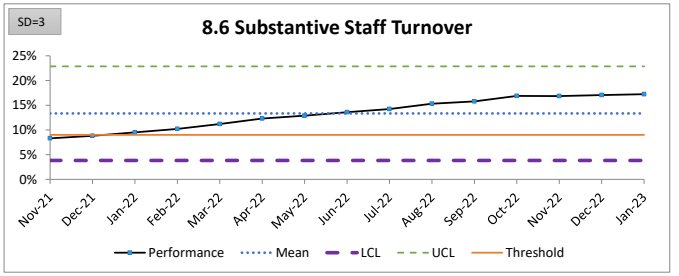












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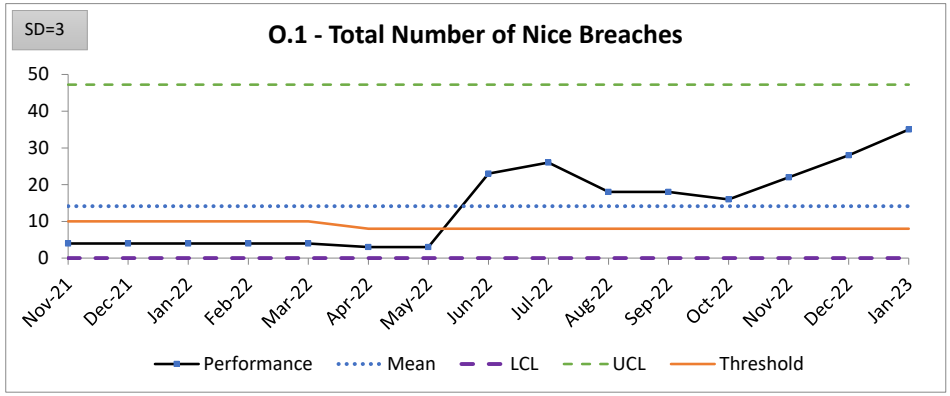

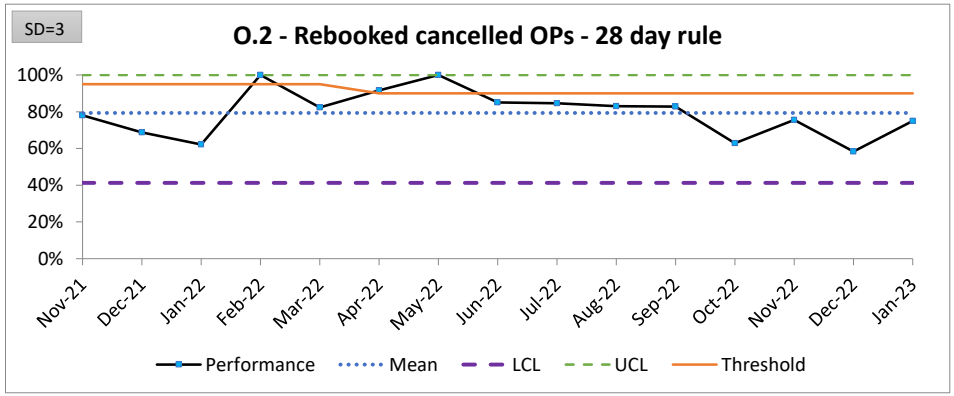

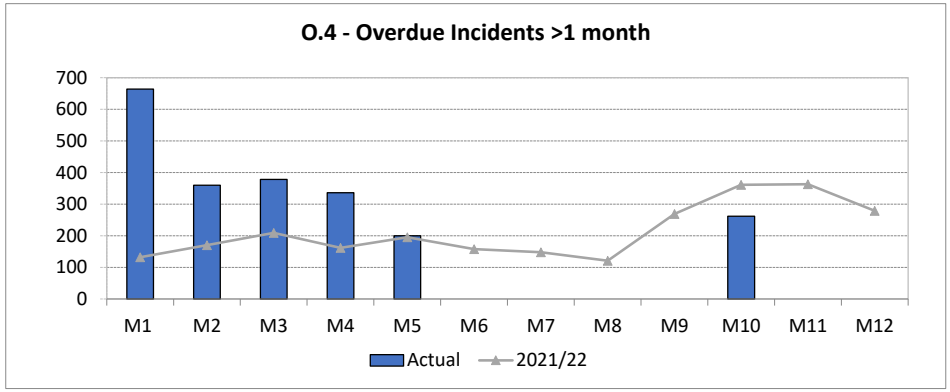

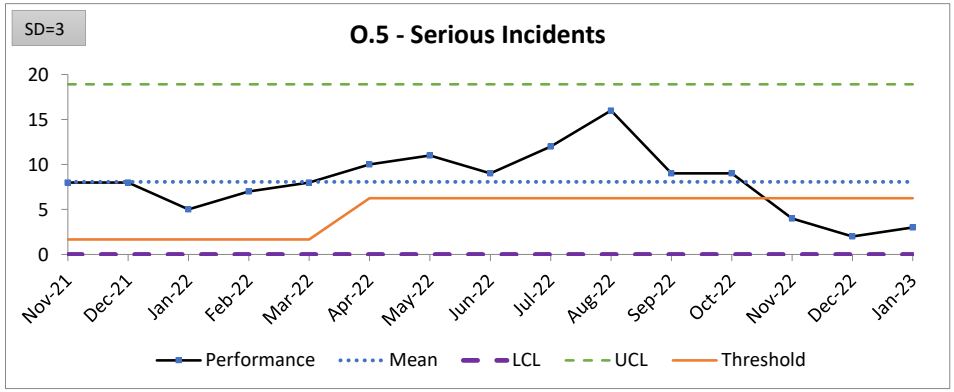

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Board Performance Report: M10 (January 2023)

Milton Keynes University Hospital NHS Foundation Trust

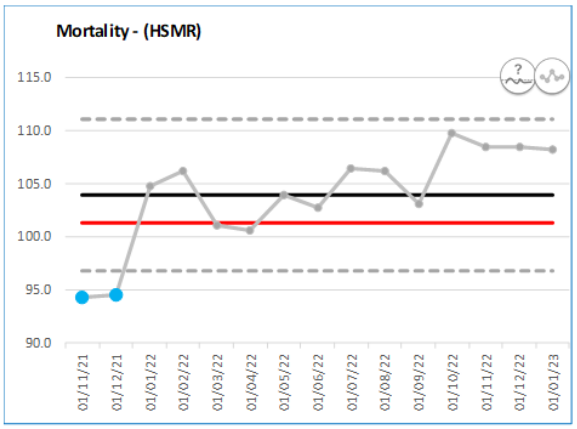
OBJECTIVE 1 – PATIENT SAFETY

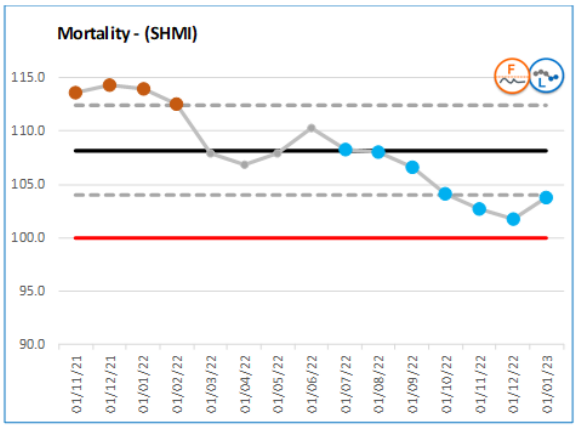
January 2023 and YTD performance against targets and thresholds:

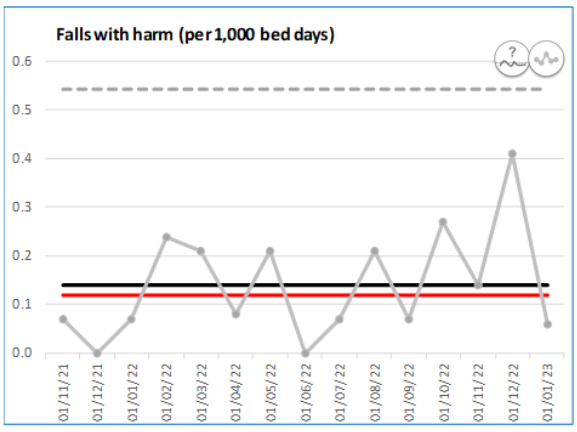
OBJECTIVE 1 - PATIENT SAFETY									
ID	Indicator	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
1.1	Mortality - (HSMR) ★	101.3	101.3		108.2	×	▲		
1.2	Mortality - (SHMI)	100.0	100.0		103.8	×	▼		
1.6	Falls with harm (per 1,000 bed days)	0.12	0.12	0.15	0.06	✓	▲	×	
1.13	Pressure Ulcers Classification - Cat 2,3,4 in total	120	100	236	20	×	▼	×	

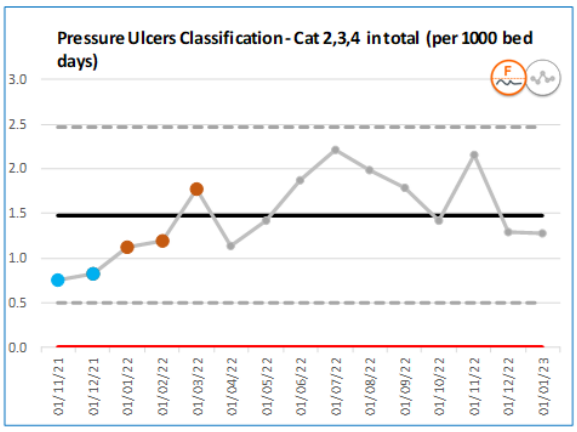
Key Points

- **HSMR:** HSMR remained relatively stable. Whilst higher than the national average, it is important to note that this is statistically 'as expected', and that assurance can be gained from qualitative review processes (e.g., medical examiners review 100% of hospital deaths).
- **SHMI:** SHMI deteriorated slightly in January 2023 to 103.8 from 101.8 in December 2022. This is statistically 'as expected', and that assurance can be gained from qualitative review processes (e.g., medical examiners who review 100% of hospital deaths).
- **Falls**: One fall with moderate harm occurred in January 2023, within the division of Medicine.
- **Pressure Ulcers**: There were 20 category 2, 3 and 4 pressure ulcers recorded in January 2023, below the year-to-date monthly average of 24. Please note, the table above shows the absolute numbers while the SPC chart shows this data as a rate per 1,000 bed days.









Board Performance Report: M10 (January 2023)

Milton Keynes University Hospital NHS Foundation Trust

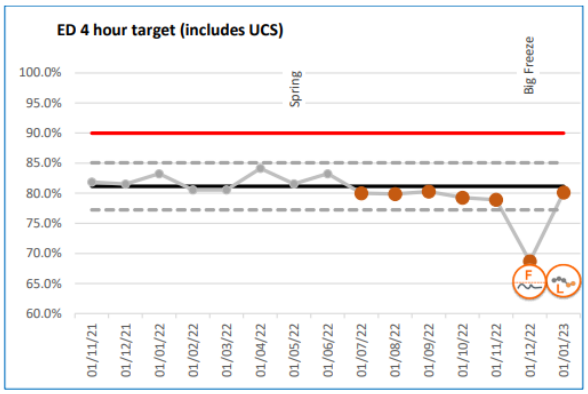
OBJECTIVE 4 - KEY TARGETS

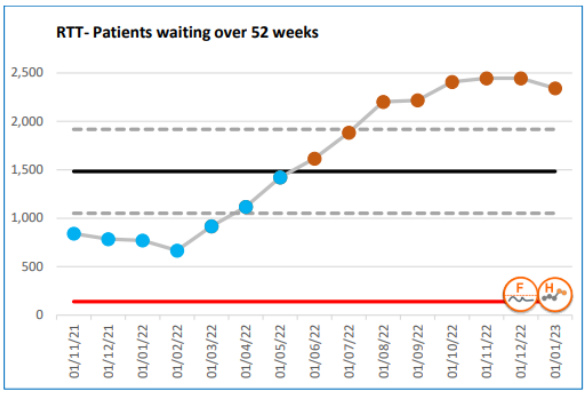
January 2023 and YTD performance against transitional targets and recovery trajectories:

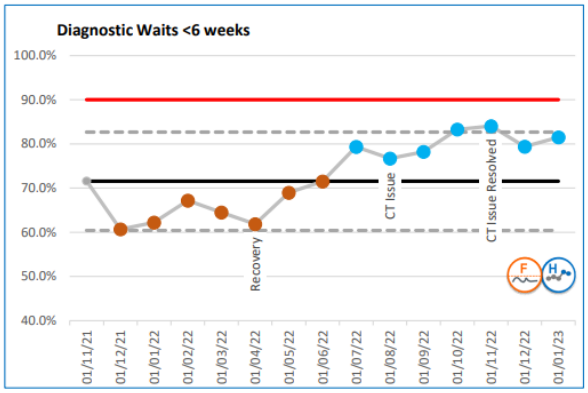
OBJECTIVE 4 - KEY TARGETS									
ID	Indicator	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1a	ED 4 hour target (includes UCS)	90%	90%	79.4%	80.1%	✗	▲	✗	
4.5a	RTT Patients waiting over 52 weeks (Total)	0	140		2342	✗	▲		
4.6	Diagnostic Waits <6 weeks	90%	90%		81.5%	✗	▲		
4.7	All 2 week wait all cancers (Quarterly)	93%	93%		79.7%	✗	▲		
4.9	62 day standard (Quarterly)	85%	85%		63.7%	✗	▼		

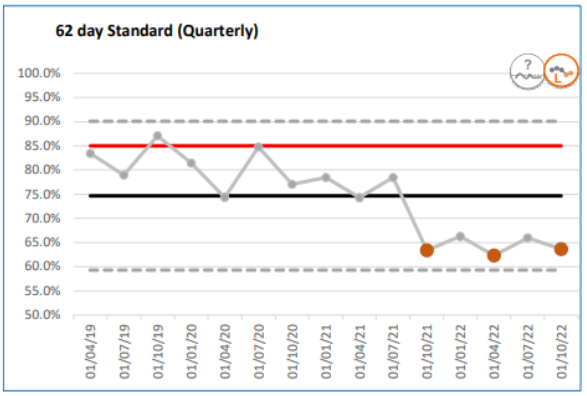
Key Points

- **ED:** 4-hour performance increased to 80.1% and exceeded the national performance and that of all but one of other trusts in our Peer Group.
- **RTT:** 37,947 patients waiting for treatment on an open RTT pathway, of which:
  - 2,342 patients were waiting over 52 weeks, declining from 2,445 in December 2022.
  - 150 patients were waiting over 78 weeks.
  - 1 patient was waiting over 104 weeks.
- **Diagnostics**: 7,016 patients waiting for a diagnostic test, of which:
  - 81.5% were waiting less than 6 weeks.
- **Cancer:**
  - 62-day standard performance in Q3 was 63.7% against a national target of 85%, a deterioration when compared to Q2's performance of 66.0%.
  - 79.7% of patients attended an outpatient appointment within two weeks of an urgent GP referral for suspected cancer, an improvement when compared to Q2's performance of 73.1%.









Board Performance Report: M10 (January 2023)

Milton Keynes University Hospital NHS Foundation Trust

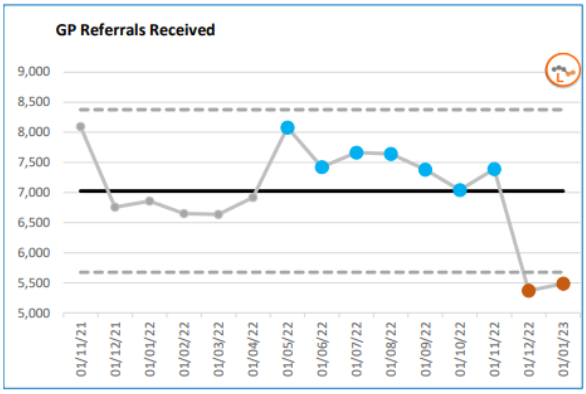
OBJECTIVE 5 - SUSTAINABILITY

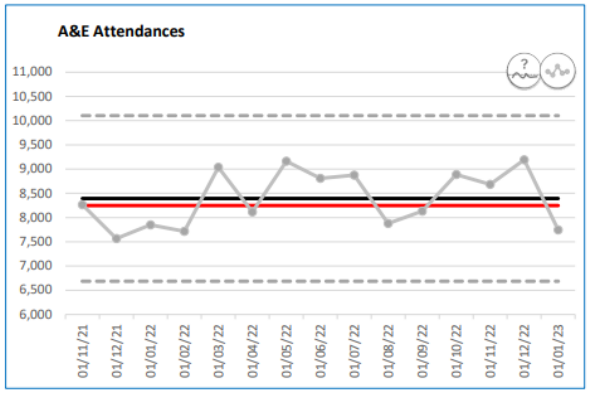
January 2023 and YTD performance against transitional targets and recovery trajectories:

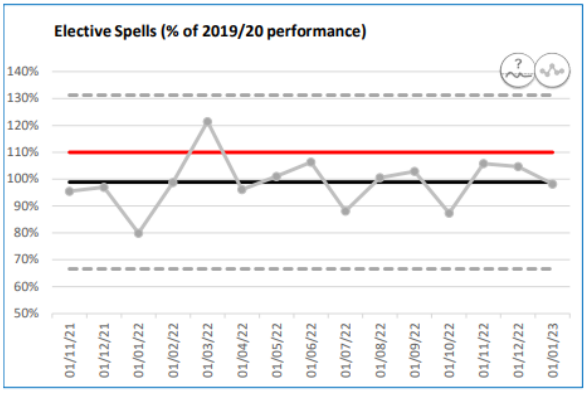
OBJECTIVE 5 - SUSTAINABILITY									
ID	Indicator	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
5.1	GP Referrals Received	Not Available		70,403	5,489	Not Available	▲	Not Available	
5.2	A&E Attendances	104,759	88,022	85,489	7,747	✓	▲	✓	
5.6	Outpatient DNA Rate	6%	6%	7.2%	5.8%	✓	▲	×	
5.8	Elective Spells (% of 2019/20 performance)	110%	110%	98.9%	98.2%	×	▼	×	
5.9	OP Attendances (% of 2019/20 performance)	104%	104%	105.2%	102.2%	×	▼	✓	

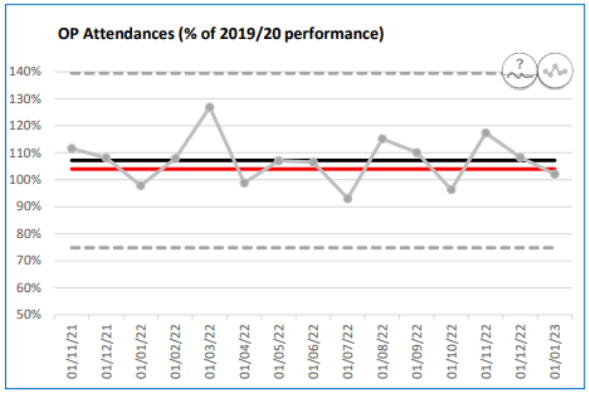
Key Points

- **GP Referrals:** 5,489 GP referrals were received in January 2023, well below the monthly year to date average of 7,040.
- **A&E Attendances:** There were 7,747 A&E attendances in January 2023, the lowest value year to date. An unusual downturn given the continuous increase in attendances seen in the previous winter months.
- **Outpatients:**
  - There were 34,315 outpatient attendances, an increase in comparison to January 2020.
  - 5.8% of patients did not attend their appointment, the best performance this financial year to date and below the threshold of 6.0%.
- **Elective Spells:** There were 1,724 elective spells, a decrease in comparison to January 2020.









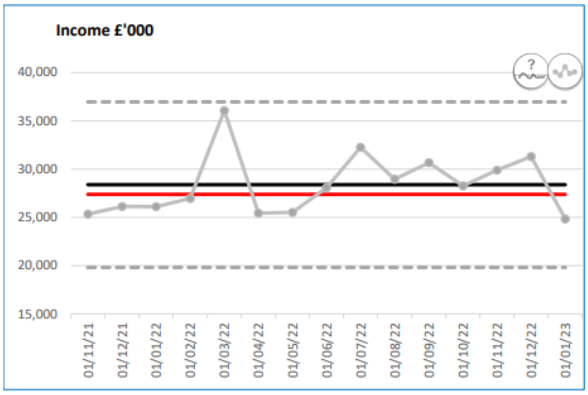
OBJECTIVE 7 - FINANCIAL PEFORMANCE

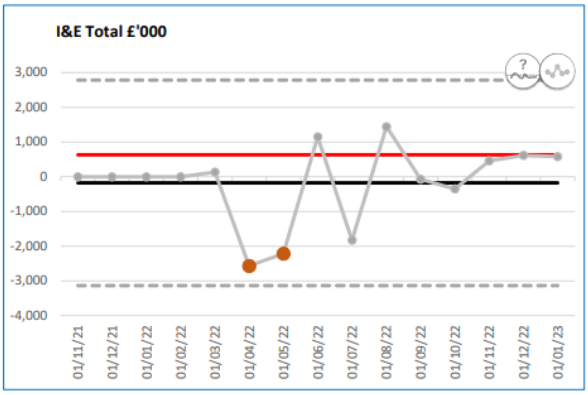
Financial performance up to January 2023 (month 10)

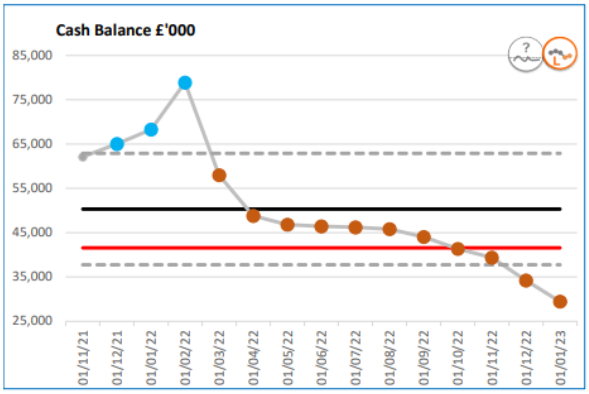
OBJECTIVE 7 - FINANCIAL PERFORMANCE									
ID	Indicator	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
7.1	Income £'000	332,163	276,654	285,177	24,851	×	▼	✓	
7.5	I&E Total £'000	(0)	(2,652)	(2,795)	581	×	▼	×	
7.6	Cash Balance £'000		41,602		29,476	×	▼		
7.7	Savings Delivered £'000	12,049	8,247	8,248	1,484	✓	▲	✓	
7.8	Capital Expenditure £'000	(18,288)	(10,576)	(16,123)	(2,180)	×	▼	×	

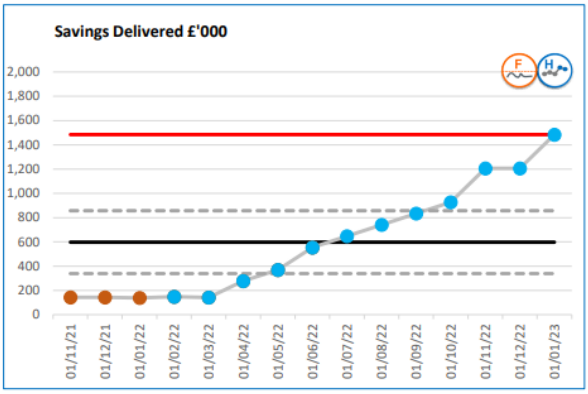
Key Points

- **Income:** The Trust has received income in-excess of plan due to:
  - Delayed payment (September) of additional funding for national pay award
  - Income received for out of area (BOB ICB) patient care above contracted level
  - Recognition of deferred income to support costs of additional activity above plan (e.g., winter escalation).
- **I&E Total:** Broadly on plan up to January and is forecast achievement of the annual breakeven position. This is reliant on non-recurrent mitigation of additional costs incurred to support elective care recovery and under delivery against planned levels of efficiency savings.
- **Cash Balance:** A robust cash position to meet operating obligations and planned capital investments.
- **Savings Delivered:** Forecast delivery of 70% of the annual savings target. The shortfall is non-recurrently mitigated in-year but will create a pressure on the underlying financial position.
- **Capital Expenditure:** On plan year to date and forecast. Variance due to grant income deferral following additional NHS capital budget available for national schemes.









Board Performance Report: M10 (January 2023)

Milton Keynes University Hospital NHS Foundation Trust

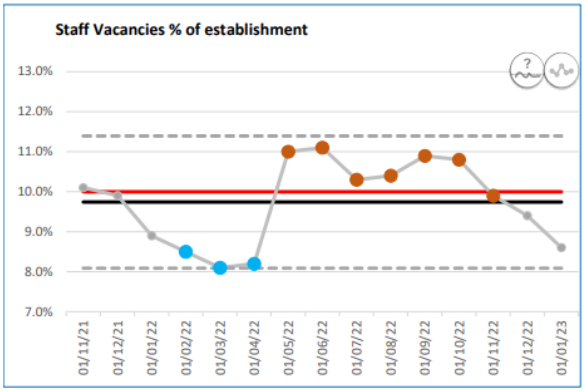
OBJECTIVE 8 - WORKFORCE PEFORMANCE

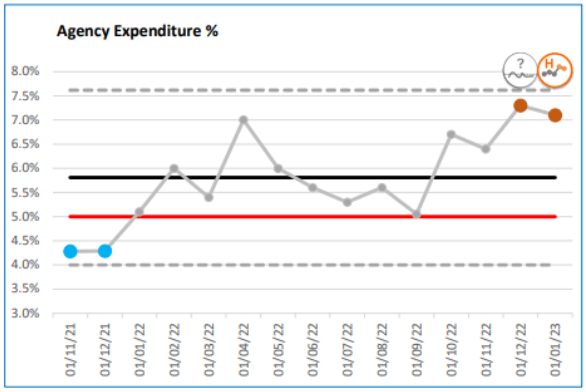
January 2023 and YTD performance against transitional targets and recovery trajectories:

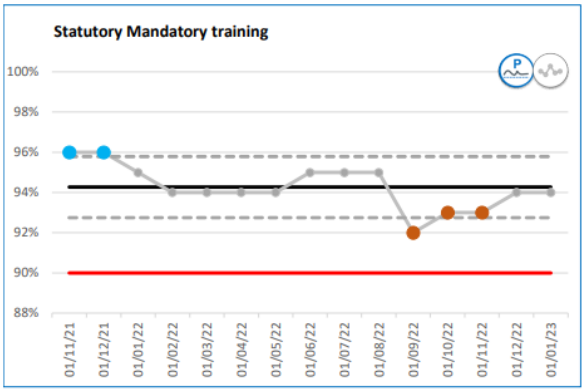
OBJECTIVE 8 - WORKFORCE PERFORMANCE									
ID	Indicator	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
8.1	Staff Vacancies % of establishment	10.0%	10.0%		8.6%	✓	▲		
8.2	Agency Expenditure %	5.0%	5.0%	6.2%	7.1%	×	▲	×	
8.3	Staff Sickness % - Days Lost (Rolling 12 months)	5.5%	5.5%		5.2%	✓	▲		
8.5	Statutory Mandatory training	90%	90%		94.0%	✓	▬		
8.6	Substantive Staff Turnover	9.0%	9.0%		17.2%	×	▼		

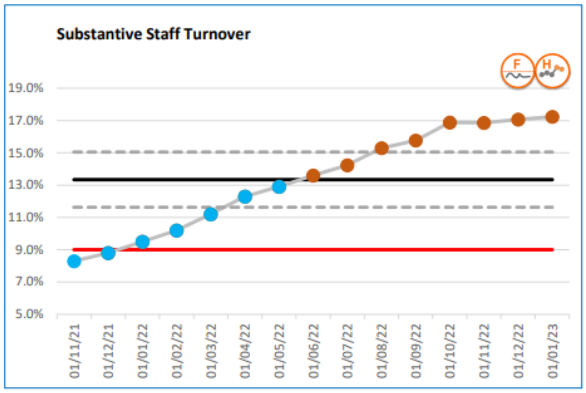
Key Points

- **Staff Vacancies:** Staff vacancies in January 2023 was 8.6% of the establishment, the best performance since April 2022 (8.2%). There are now 4075 employees in post in the Trust, which is the highest it has been, with an additional 197 staff in post compared to the same period in the previous year.
- **Agency Expenditure:** Agency expenditure remains above the threshold of 5.0%, a trend seen all financial year.
- **Staff Sickness:** Staff sickness in January 2023 was the lowest year to date, at 5.2%.
- **Statutory Mandatory Training:** In January 2023, statutory mandatory training remained at 94% and above the threshold of 90%.
- **Substantive Staff Turnover:** This increased slightly to 17.2% in January 2023, but is now starting to slow. The Turnover and Retention Group meet regularly to ensure a continued and consistent approach to addressing areas with high turnover and vacancies. This work is being monitored by the Workforce Development and Assurance Committee.









NHS
Milton Keynes
University Hospital
NHS Foundation Trust

Meeting Title	**Public Board**	**Date:** 9th March 2023
Report Title	**Finance Report - Month 10 2022/23**	**Agenda Item Number: 12**
Lead Director	Terry Whittle	Director of Finance
Report Authors	Sue Fox Cheryl Williams	Head of Financial Management Head of Financial Control and Capital

Introduction	The Purpose of the report is to provide an update on the financial position of the Trust at Month 10 (January 23)		
Key Messages to Note	The Trust is reporting a £2.8m deficit (on a Control Total basis) up to January, this is consistent with the plan. The Trust is forecasting achievement of the annual plan, but this position is reliant on non-recurrent mitigation to offset additional costs and a shortfall in delivery in the financial efficiency programme. There is a continued pay cost burden from bank rate enhancements and premium agency costs to cover sickness and vacancies. The Trust has also committed significant investment towards additional clinical capacity to accelerate recovery of the elective treatment backlog. The Trust has not received any additional payment for this activity (above the plan baseline) due to a change in the Elective Recovery Funding policy mid-year. The capital investment programme is on-track and the year-end forecast is expected to be consistent with the plan. Additional capital expenditure budget will be allocated for centrally funded NHS England programmes.		
Recommendation *Tick the relevant box(es)*	**For Information** ☐	**For Approval** ☐	**For Review** ☒

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	

Appendices	Pages 12-14

FINANCE REPORT FOR THE MONTH TO 31st JANUARY 2023

TRUST BOARD

CONTENTS

1	Executive summary	Page 3
2	Financial performance - month 10 (Jan)	Page 4
3	Financial performance - cumulative (Apr-Jan)	Page 5
4	Activity & Elective Recovery Fund	Page 6
5	Efficiency savings	Page 7
6	Capital	Page 8
7	Cash	Page 9
8	Statement of Financial Position (Balance Sheet)	Page 10
9	Recommendations to the Board	Page 11
10	Appendices	
11	Glossary of terms	

EXECUTIVE SUMMARY

(1 & 2.) Revenue – Clinical revenue (BLMK Integrated Care Board block contract and variable non-ICB income) is above plan. Income has been received for the payment of the backdated wage award. Other revenue is above plan due to income received for education and training. The forecast includes release of non-recurrent income to support costs.

(3. & 4.) Operating expenses – Pay costs are higher than plan for several reasons. These include payment of the national wage award (largely offset by in-year funding received), increased costs for temporary agency staff and bank pay enhancements (sickness, vacancies, and supernumerary cover), plus additional pay spend on elective waiting list recovery. Non-pay is above plan due to inflationary cost pressures and additional spend on clinical consumables and outsourcing.

(5.) Non-operating expenditure – Underspent due to interest received.

(8.) Elective Recovery Fund – Reported at planned levels to month 10 following informal guidance that baseline plans would be underwritten by NHSE.

(9.) Covid expenditure – Reduced direct Covid costs mainly relating to lower backfill for staff sickness absence.

(11.) Financial Efficiency– There is a shortfall against the in-year and annual savings target (c.70% delivered). The shortfall is mitigated by non-recurrent measures this year but will be a brought forward pressure into FY24.

(12.) Cash – Cash balance is £29.4m, equivalent to 31 days cash to cover operating expenses. Balances include £11.6m for capital schemes.

(13.) Capital – Capital expenditure programmes are on track in-year and are forecast to be in-line with the annual budget available. The reported variance is due to a deferral of a planned capital grant due to the availability of additional NHS capital budget following the successful approval of central schemes. This change explains the reported variance to plan.

(14.) ICS Financial Position – BLMK ICS is broadly on plan up to month 10 and forecast to achieve a break-even position at the year end.

Ref	All Figures in £'000	Month 10 YTD Plan	Month 10 YTD Actual	Month 10 YTD Var	Full Year Plan	Full Year Forecast	Full Year Var	RAG
1	Clinical Revenue	255,539	265,976	10,437	307,824	325,109	17,285	
2	Other Revenue	21,119	19,201	(1,918)	24,340	23,825	(515)	
3	Pay	(175,176)	(187,359)	(12,183)	(208,343)	(226,217)	(17,874)	
4	Non Pay	(82,417)	(84,764)	(2,347)	(98,408)	(102,475)	(4,067)	
5	Financing & Non-Ops	(17,099)	(16,326)	773	(20,804)	(20,804)	-	
6	Surplus/(Deficit)	1,966	(3,271)	(5,237)	4,609	(562)	(5,171)	
7	Control Total Surplus/(Deficit)	(2,645)	(2,794)	(149)	-	-	-	
	Memos							
8	ERF Delivery	6,580	6,580	-	7,381	7,381	-	
9	COVID expenditure	(5,217)	(4,286)	931	(5,776)	(5,683)	93	
10	High Cost Drugs	(17,840)	(18,435)	(595)	(21,299)	(21,299)	-	
11	Financial Efficiency	8,248	5,954	(2,294)	12,049	8,272	(3,777)	
12	Cash	41,602	29,476	(12,126)	36,417	24,943	(11,474)	
13	Capital Plan	(10,576)	(16,123)	(5,547)	(18,288)	(26,637)	(8,349)	
14	ICS Financial Position	(2,672)	(2,018)	654	-	-	-	

Key message

The Trust is reporting a £2.8m deficit (on a Control Total basis) up to January, this is consistent with the plan. The Trust is forecasting achievement of the annual plan, but this includes non-recurrent mitigation to offset additional costs and slippage in the financial efficiency programme. The shortfall in efficiency savings will create a pressure to the underlying financial position.

There is a continued pay cost burden from bank rate enhancements and premium agency costs to cover sickness, vacancies and supernumerary nursing arrangements.

The Trust has made significant investment in additional capacity to support elective service backlog recovery. No additional income has been received due to a change mid-year in the ERF payment policy.

The capital expenditure programme is on-track up to January and is forecast to meet the annual capital budget (CDEL). Receipt of planned grant funding has been deferred due to additional (in-year) NHS capital budget allocation.

FINANCIAL PERFORMANCE - OVERVIEW MONTH 10

2. **Summary Month 10**

For the month of January 2023, financial performance (on a Control Total basis) is a £0.6m surplus, this is £0.05m adverse to plan.

All Figures in £'000	Month 10 Plan	Month 10 Actual	Month 10 Var	Month 10 YTD Plan	Month 10 YTD Actual	Month 10 YTD Var	Plan Plan	Plan Forecast	Plan Var
Clinical Revenue	25,801	27,547	1,746	255,539	265,976	10,437	307,824	325,109	17,285
Other Revenue	1,566	2,314	749	16,039	19,201	3,162	19,169	23,825	4,656
Total Income	27,366	29,861	2,495	271,578	285,177	13,600	326,993	348,934	21,941
Pay	(17,192)	(19,276)	(2,084)	(175,176)	(187,359)	(12,183)	(208,343)	(226,217)	(17,874)
Non Pay	(7,845)	(8,533)	(688)	(82,417)	(84,764)	(2,347)	(98,408)	(102,475)	(4,067)
Total Operational Expenditure	(25,038)	(27,809)	(2,772)	(257,593)	(272,123)	(14,530)	(306,751)	(328,692)	(21,941)
EBITDA	2,329	2,052	(277)	13,985	13,055	(930)	20,242	20,242	0
Financing & Non-Op. Costs	(1,701)	(1,472)	230	(16,630)	(15,849)	781	(20,242)	(20,242)	0
Control Total Deficit (excl. top ups)	**628**	**580**	**(47)**	**(2,645)**	**(2,794)**	**(149)**	**0**	**0**	**0**
Control Total Deficit (incl. top ups)	**628**	**580**	**(47)**	**(2,645)**	**(2,794)**	**(149)**	**0**	**0**	**0**
Donated income	10	(5,010)	(5,020)	5,080	0	(5,080)	5,171	0	(5,171)
Depreciation	(48)	(48)	0	(468)	(477)	(9)	(563)	(563)	0
Impairments & Rounding	0	0	0	(1)	0	1	1	1	0
Reported deficit/surplus	**590**	**(4,478)**	**(5,067)**	**1,966**	**(3,271)**	**(5,237)**	**4,609**	**(562)**	**(5,171)**

3. Clinical Income
Clinical income shows a favourable variance of £1.7m. This is due to the release of deferred income from the prior year to offset non recurrent costs (winter and recovery related capacity).

4. Other Income
Other income shows a favourable variance of £0.7m due to higher than planned income for staff recharges and overseas recruitment received in-month.

5. Pay
Pay spend is above plan with the payment of enhanced bank rates as well as the unbudgeted element of the pay award. This is mostly offset by additional clinical income. An increased number of escalation areas were also open throughout January incurring premium agency staffing costs. Further pay detail is included in Appendices 1 and 4.

6. Non-Pay
Non-pay is above plan due to increased spend on drugs, clinical consumables, and clinical outsourcing. There was also a one-off credit relating to a historic water bill in month. Further detail is included in Appendices 1 and 5.

7. Non-Operating Expenditure
Non-operating expenditure is lower than plan in-month due to interest received.

Key message
For the month of January 2023, the position on a Control Total basis is a £0.6m surplus, which is slightly adverse to plan. The surplus is due to an increase in the release of deferred income to offset an increase in spend on temporary staffing and clinical consumables.

FINANCIAL PERFORMANCE - OVERVIEW YTD

8. **Summary Year to Date**

Cumulative financial performance (April-January) on a Control Total basis is a deficit of £2.8m. This is worse than plan by £0.1m. Overspends on pay costs are offset by increased clinical income.

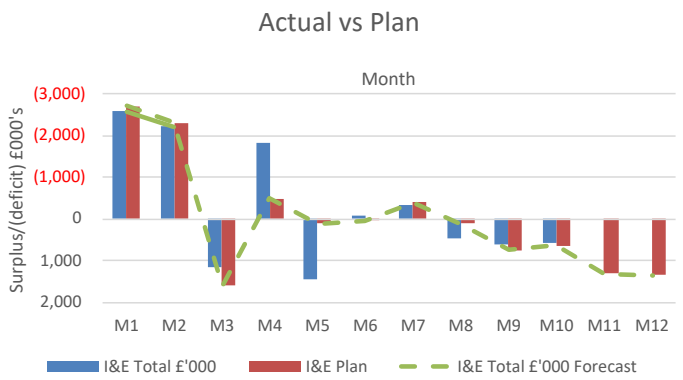
9. Clinical Income YTD
Clinical income shows a favourable variance of £10m which is due to overperformance on the remaining PbR contracts, revenue received for the wage award (paid in September) and deferred income from prior years to offset rising costs. Further detail is included in Appendix 1.

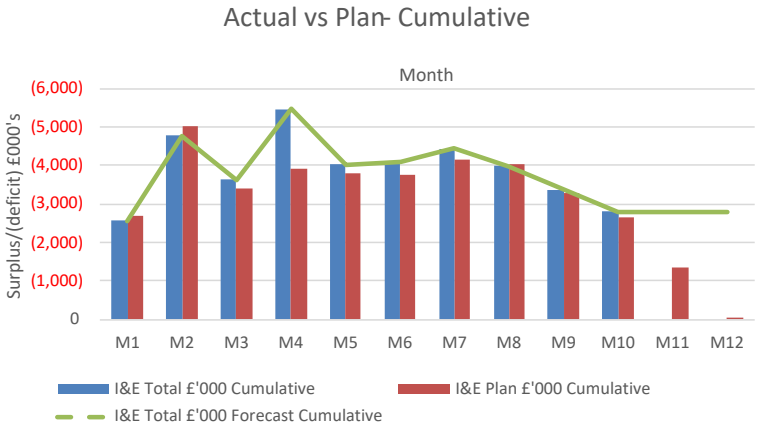
10. Other Income YTD
Other income shows a favourable variance of £3.1m. This is due to favourable variances against the R&D, education and training, and covid testing income.

11. Pay YTD
Pay spend is above plan by £12.2m YTD due partly to the payment of the wage award which is offset by increased clinical income, and partly due to unidentified cost improvements. Spend on temporary staffing costs is also going up with to enhanced rates increasing uptake in clinical areas. Further detail is included in Appendices 1 & 4.

12. Non-Pay YTD
Non pay is above plan due to expenditure on clinical supplies and establishment expenses relating to activity and inflationary pressures. Further detail is included in Appendices 1 & 5.

13. Non-Operating Expenditure YTD
Non-operating expenditure is lower than plan YTD due to interest received.





Key message
Up to January 2023, the position on a Control Total basis is a deficit of £2.8m. This is slightly worse than plan. Overspends on pay are partially offset by increased clinical income.

It should be noted that the plan in the final quarter of the year moves from a deficit to a breakeven position indicating an expected reduction in run-rate.

ACTIVITY PERFORMANCE & ERF

14. The Trust has recognised 100% of the expected ERF income available for the month on the basis that this will not be subject to clawback from NHS England. This is expected to continue in the final quarter of the financial year. The revised budget includes full achievement of the £7.6m of ERF allocated to MKUH (from the BLMK ICS) which requires achievement of 104% of activity versus 2019-20 baselines.

15. Activity vs Plan (as per CIVICA)

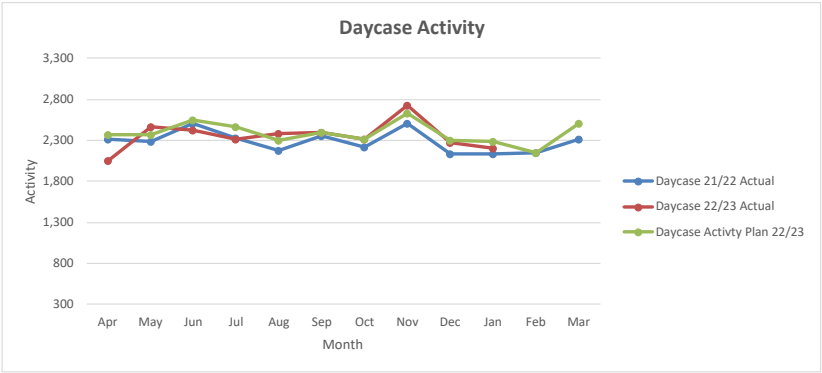
Day case activity-
Day cases have decreased since Month 9, slightly below the 22/23 plan and above 21/22 actuals. Day cases are running at 99.4% of 19/20 actuals against a target of 104%.

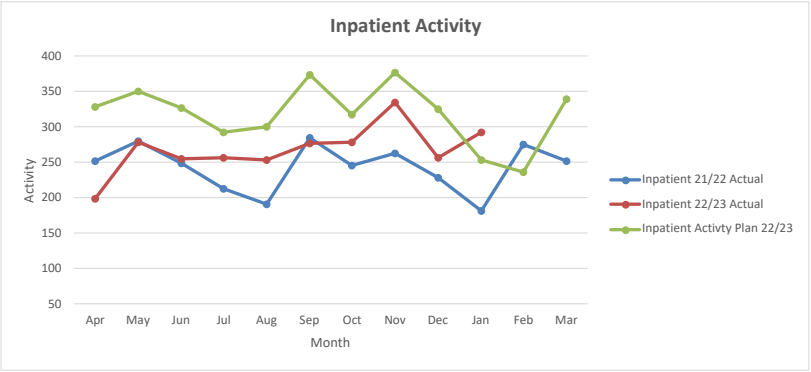
Elective Inpatient Activity-
Inpatient activity has increased since month 9 and is above the 22/23 plan and 21/22 actuals. Electives are running at 91.7% of 19/20 actuals against a target of 104%.

Outpatient Activity-
Outpatient activity has increased since month 9 and remains up against the 21/22 actuals and in line with the 22/23 plan. New appointments are 113% of 19/20 actuals against a target of 104%.

Non-Elective Spells-
Non elective activity has decreased since month 9 and is in line with 21/22 actuals but below the 22/23 plan.

A&E activity-
A&E activity has also decreased since month 9 and is in line with both 21/22 actuals and the 22/23 plan.





Key message
Non elective and A&E activity decreased in January and elective activity increased. ERF income has been recorded at 100% to month 10 following guidance from NHS England that any underperformance will not be subject to clawback. New outpatient appointments are ahead of the 104% target, but electives and day cases are behind the 104% target.

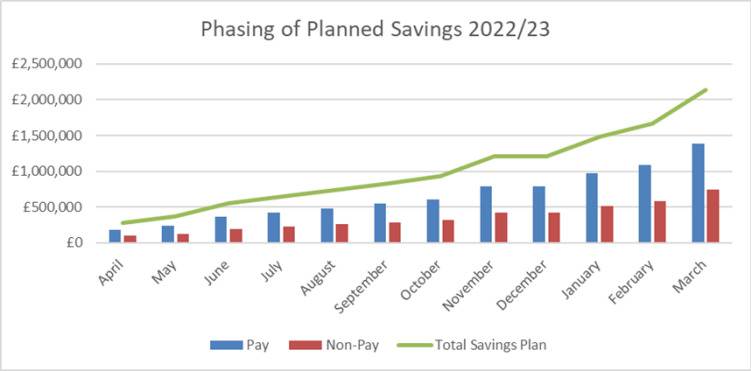
EFFICIENCY SAVINGS

16. The efficiency target is £8.2m to January 2023 and the schemes that have been signed off are delivering £6m. The remainder of the efficiency target is being achieved through non-recurrent mitigation.

17. Trust 'Better Value' Programme has identified circa £8.3m (up to Month 10) from schemes against the total plan level of £12m.

Division	Target	Risk Adjusted Plan PYE	Recurrent	Non-recurrent	% of target
	£000's	£000's	£000's	£000's	%
Medicine	3,399	2,612	1,087	1,525	77%
Surgery	2,709	1,013	903	110	37%
W&C	1,451	1,451	230	1,221	100%
Core Clinical	2,716	1,680	307	1,373	62%
Corporate	1,629	1,515	513	1,001	93%
Central Ops	103	0			0%
Latest position	**12,007**	**8,272**	**3,041**	**5,231**	**69%**

18. It should be noted that the phasing of the required savings increases during the second half of the financial year. This is shown in the graph below:



Key message

YTD the Trust has delivered its £8.2m efficiency requirement. This has been achieved through transactional savings schemes, managing the cost of operations within available resources and non-recurrent funding. Work is progressing through the Trust 'Better Values' programme to identify opportunities for the new financial year.

CAPITAL - OVERVIEW YTD

19. The YTD spend on capital after accounting for donated assets and derecognised assets is £14.4m, which is in line with Trust's revised capital plan (excluding national funding). There is £1.7m relating to derecognition of various assets following an internal review.

20. The Trust's ICS CDEL allocation is £15.9m and there has been further approved national funding in month for IT digitalisation £1.09 and CDC for £5m, a total of £8.0m national funding (detailed below). The Trust has an annual capital budget (CDEL) of £24m and is expected to contain spending within this limit at the year-end.

21. The full breakdown of all funding and sources of application is shown in the table below.

	ICS Approved CDEL Allocation 2022/23	National CDEL Allocation 2022/23		
Scheme Subcategory	**Internally Funded**	**Planned**	**Approved**	**Awaiting National Approval**
	£m	£m	£m	£m
Depreciation	15.04			
Self Funded	0.86			
PDC Funded				
New Hospital Programme		1.94	1.23	
Endoscopy		0.14	0.00	
Digital Diagnostic Funding - Pathology			0.32	
Digital Diagnostic Funding - Imaging			0.40	
New Lease impact (IFRS16)		0.31		2.69
IT - frontline Digilisation			1.09	
CDC - Lloyds Court & Whitehouse Park			5.00	
Cancer bids				1.32
Sub Total CDEL	**15.90**	**2.39**	**8.04**	**4.01**
CDEL Allocation Approved	**23.95**			
Total Planned CDEL	**18.28**			

Capital Item	**YTD Plan up to end of Jan 22** £m	**Value of approved BC** £m	**Actual up to end of Jan 22** £m	**PO & Pre-commitments up to end of Jan 22**	**YTD Variance to YTD Plan** £m	**Status**
Pre-commitments						
CBIG	2.89	2.66	2.64	1.26	-0.25	
Strategic	4.00	5.16	4.34	4.77	0.34	
Slippage from Pre-commitments						
Total Pre-commitments	**6.89**	**7.81**	**6.98**	**6.03**	**0.10**	
Scheme Allocations For 22/23 schemes						
CBIG including IT and Contingency	1.98	2.91	3.89	2.24	1.91	
Strategic Radiotherapy	0.50	4.50	2.43	2.43	1.93	
Strategic Contingency		0.00			0.00	
Funded from Strategic Contingency					0.00	
Asbestos Removal for flat roofs	0.00	0.16	0.16	0.16	0.16	
Additional costs for Whitehouse	0.00	0.04	0.00	0.04	0.00	
EV Chargers	0.00	0.05	0.00	0.04	0.00	
Escalation Beds & Mattresses	0.00	0.08	0.08	0.08	0.08	
Boiler Adaptation	0.00	0.05	-	0.05	0.00	
Total Proposed Scheme Allocations	**2.48**	**7.61**	**6.56**	**4.87**	**4.08**	
Total Pre-commitments and Scheme Allocations (ICS CDEL Allocation)	**9.37**	**15.43**	**13.54**	**10.90**	**4.17**	
Nationally approved schemes						
NHP	0.83	1.23	0.87	1.23	0.05	
Endoscopy	0.14	0.00	0.00	0.00	-0.14	
Digital Diagnostic Funding - Imaging	0.00	0.28	0.00	0.07	0.00	
Digital Diagnostic Funding -Pathology	0.00	0.31	0.00	0.00	0.00	
IT - frontline Digilisation	0.00	0.00	0.00	0.00	0.00	
CDC - Lloyds Court & Whitehouse Park	0.00	0.00	0.00	0.00	0.00	
Total Nationally approved schemes	0.97	1.82	0.87	1.30	- 0.09	
CDEL Approved capital plan	**10.33**	**17.25**	**14.41**	**12.20**	**4.08**	
New Leases Impact under IFRS 16 - held centrally	0.01	0.01	0.00	0.00	-0.01	
NHP - external fees	0.23	0.00	0.00	0.00	-0.23	
Submitted CDEL capital plan	**10.58**	**17.26**	**14.41**	**12.20**	**3.84**	
Donated Assets (excluded from CDEL)						
Maple Centre	5.10	5.00	4.14	5.04	-0.96	
Pathlake	0.00	0.14	0.00	0.00	0.00	
Staff Rooms	0.03	0.03	0.00	0.30	-0.03	
Other donated schemes	0.00	0.12	0.04	0.11		
Total Donated Assets	**5.14**	**5.29**	**4.18**	**5.45**	- **1.00**	
Awaiting Approval						
Cancer bids	0.00	0.00	0.00	0.00	0.00	
Total awaiting approval	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	

Key message
Capital expenditure is above the plan but within the revised CDEL allocation up to January. The Trust is forecasting full year spend in-line with its revised CDEL allocation.

CASH

Summary of Cash Flow

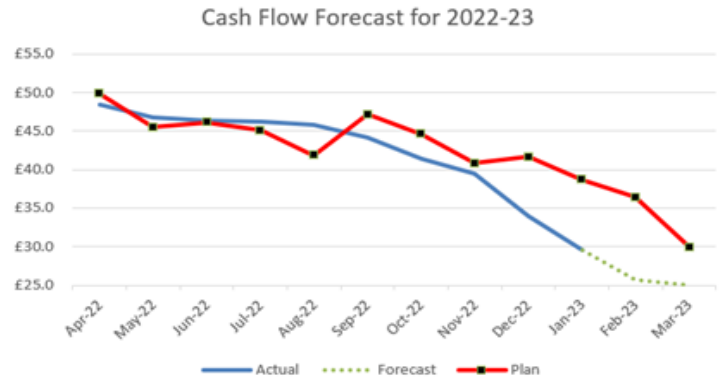
The cash balance at the end of January was £29.4m, this was £9.3m lower than the planned figure of £38.7m and a decrease on last month's figure of £34m. (see opposite).
See appendices 6-8 for the cashflow detail.

22. Cash arrangements 2022/23

The Trust will receive block funding for FY23 which will include an uplift for growth plus any additional incentive funding linked to activity delivery and funding for high-cost drugs on a pass-through basis.

23. 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 mainly due to the repatriation of SBS AP services, and the ongoing issues with agency invoicing. Both issues are being addressed and action plans are in progress to resolve them. This metric will continue to be monitored in accordance with national guidance and best practice.



Better payment practice code	Actual M10 YTD Number	Actual M10 YTD £'000	Actual M9 YTD Number	Actual M9 YTD £'000
Non NHS				
Total bills paid in the year	58,404	153,791	51,138	134,634
Total bills paid within target	49,143	137,454	44,042	122,361
Percentage of bills paid within target	**84.1%**	**89.4%**	**86.1%**	**90.9%**
NHS				
Total bills paid in the year	1,548	5,982	1,415	5,498
Total bills paid within target	1,190	3,631	1,081	3,471
Percentage of bills paid within target	**76.9%**	**60.7%**	**76.4%**	**63.1%**
Total				
Total bills paid in the year	**59,952**	**159,773**	**52,553**	**140,131**
Total bills paid within target	**50,333**	**141,085**	**45,123**	**125,832**
Percentage of bills paid within target	**84.0%**	**88.3%**	**85.9%**	**89.8%**

Key message

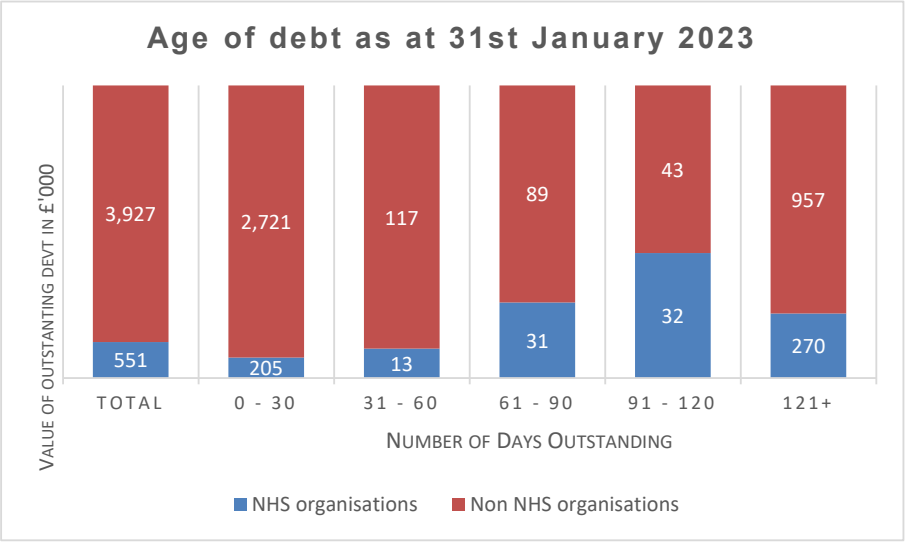
Cash is below plan by £9.3m, and the Trust has fallen below the 95% target for BPPC, mainly due to issues experience by SBS during their repatriation of AP services, and ongoing agency invoicing issues. Management is working to rectify payment performance to levels required.

BALANCE SHEET

24. Statement of Financial Position

The statement of financial position is set out in Appendix 9. The key movements include:

- Non-Current Assets have increased from March 22 by £16.3m; this is mainly driven by the inclusion of Right of Use assets related to the adoption of IFRS 16 1 April 2022 and capital purchases in year offset by in year depreciation.
- Current assets have decreased by £24.1m, this is mainly due to the decrease in cash £28.5m offset by an increase in receivables (£4.4m).
- Current liabilities have decreased by £17m, this is mainly due to the decrease in Trade Payables £15.3m offset by the inclusion of Right of Use assets related to the adoption of IFRS 16 1 April 2022 (£0.3m) and deferred income (£1.8m)
- Non-Current Liabilities have increased from March 22 by £12m, this is due to the inclusion of Right of Use assets (£12m) related to the adoption of IFRS 16 1 April 2022.

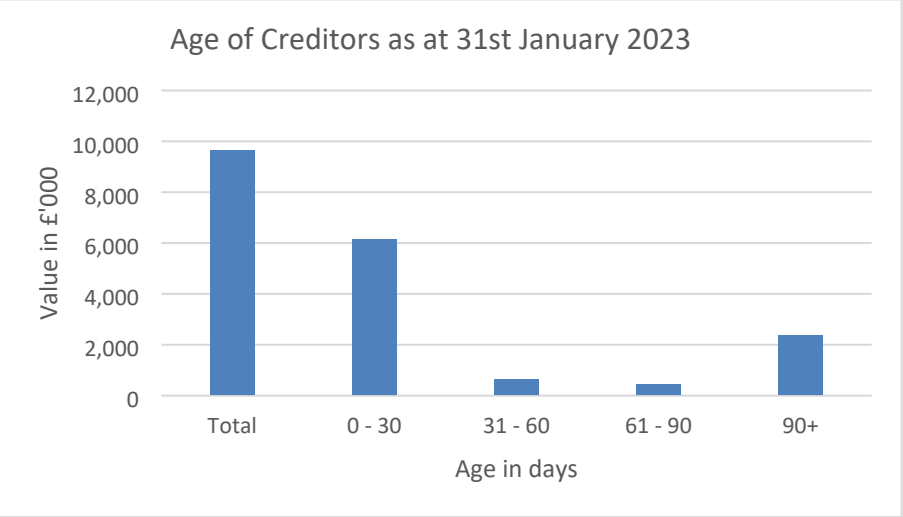


25. Aged debt

- The debtors position as of 31st January is £4.5m, which remains the same as the December '22 position. Of this total £1.2m is over 121 days old, the detail is shown in Appendix 10.
- The three largest NHS debtors are Bedford Hospitals NHS Foundation Trust £0.03m for salary recharges, NHS Buckinghamshire, Oxfordshire, and Berkshire West ICB £1.2m for Caristo RACP Pilot and NHS England £0.3m relating to midwifery and non-contract recharges. The largest non-NHS debtors include £0.1m for overseas patients, £0.8m with Northamptonshire council for sexual health, £2.16m with University of Buckinghamshire Ltd for utilities recharges and training recharges raised in Dec'22. Further details of the aged debtors are shown in Appendix 11.

26. Creditors

- The creditor's position is £9.6m, which is a decrease of £2.4m from the December'22 position. Of this £3.5m is over 30 days, with £2.5m approved for payment. The breakdown of creditors is shown in Appendix 12.



Key message

Main movements on the statement of financial position related to the inclusion of Right of Use Assets related to the adoption of IFRS 16 1 April 22 and decrease in cash; debtors are like the prior month but there is an aged debtor of over 121 days of £1.2m that is being closely monitored.

RECOMMENDATIONS TO BOARD

27. Trust Board is asked to note the financial position of the Trust as of 31st January and the proposed actions and risks therein.

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Board Report**	**Date: March 2023**
Report Title	**Workforce Report – Month 10**	**Agenda Item Number: 13**
Lead Director	Danielle Petch, Director of Workforce	
Report Author	Louise Clayton, Deputy Director of Workforce	

Introduction	Standing Agenda Item		
Key Messages to Note	This report provides a summary of workforce Key Performance Indicators for the previous 12 months up to 31 January 2023 (Month 10) and relevant Workforce and Organisational Development updates to Trust Board.		
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)*	Employ the best people to care for you

Report History	
Next Steps	JCNC & TEC
Appendices/Attachments	None

1. Purpose of the report

1.1. This report provides a summary of workforce Key Performance Indicators as at 31 January (Month 10), covering the preceding 13 months.

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

Indicator	Measure	Target	01/2022	02/2022	03/2022	04/2022	05/2022	06/2022	07/2022	08/2022	09/2022	10/2022	11/2022	12/2022	01/2023
Staff in post *(as at report date)*	Actual WTE		3390.5	3410.0	3414.4	3418.4	3418.8	3417.5	3445.6	3437.0	3458.0	3467.9	3507.1	3524.8	**3572.5**
	Headcount		3878	3904	3900	3902	3904	3901	3930	3917	3946	3956	4001	4018	**4075**
Establishment *(as per ESR)*	WTE		3722.9	3727.6	3716.9	3723.9	3839.8	3842.5	3840.8	3837.0	3881.4	3887.9	3892.8	3892.4	**3908.4**
	%, Vacancy Rate - Trust Total	**10.0%**	8.9%	8.5%	8.1%	8.2%	11.0%	11.1%	10.3%	10.4%	10.9%	10.8%	9.9%	9.4%	**8.6%**
	%, Vacancy Rate - Add Prof Scientific and Technical					23.0%	33.9%	33.2%	35.2%	32.4%	31.3%	33.7%	32.2%	32.5%	**32.7%**
	%, Vacancy Rate - Additional Clinical Services *(Includes **HCA**s)*					12.6%	2.9%	4.0%	4.3%	3.3%	10.1%	10.7%	11.2%	9.0%	**12.2%**
	%, Vacancy Rate - Administrative and Clerical					4.6%	8.8%	8.6%	8.5%	8.4%	8.1%	8.8%	7.6%	7.5%	**5.5%**
	%, Vacancy Rate - Allied Health Professionals					11.0%	18.7%	19.5%	20.2%	18.8%	18.9%	17.8%	16.7%	16.4%	**13.6%**
	%, Vacancy Rate - Estates and Ancillary					16.9%	13.9%	14.4%	14.3%	12.9%	11.5%	10.4%	9.0%	9.5%	**8.3%**
	%, Vacancy Rate - Healthcare Scientists					2.6%	3.5%	0.6%	0.8%	0.0%	0.0%	0.7%	0.0%	1.8%	**4.0%**
	%, Vacancy Rate - Medical and Dental					3.3%	4.9%	3.3%	0.0%	2.8%	0.0%	0.0%	0.0%	0.0%	**0.7%**
	%, Vacancy Rate - Nursing and Midwifery Registered					6.2%	15.3%	16.0%	15.5%	15.3%	15.3%	14.6%	12.8%	12.2%	**9.3%**
Staff Costs (12 months) *(as per finance data)*	%, Temp Staff Cost (%, £)		12.7%	12.9%	13.1%	13.4%	13.7%	14.0%	14.3%	14.5%	14.8%	15.1%	15.3%	15.6%	**15.7%**
	%, Temp Staff Usage (%, WTE)		13.0%	13.1%	13.2%	13.5%	13.7%	13.8%	14.0%	14.1%	14.2%	14.4%	14.4%	14.5%	**14.5%**
Absence (12 months)	%, 12 month Absence Rate	5.5%	5.0%	5.1%	5.3%	5.4%	5.4%	5.5%	5.6%	5.5%	5.4%	5.3%	5.3%	5.2%	***5.0%***
	- %, 12 month Absence Rate - Long Term		*3.0%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*	*2.9%*	*2.9%*	*2.8%*	*2.6%*	*2.6%*	*2.5%*	***2.6%***
	- %, 12 month Absence Rate - Short Term		*2.0%*	*2.1%*	*2.3%*	*2.4%*	*2.4%*	*2.5%*	*2.7%*	*2.6%*	*2.6%*	*2.7%*	*2.7%*	*2.7%*	***2.5%***
	%,In month Absence Rate - Total	4.0%	6.3%	5.4%	5.6%	5.0%	4.3%	4.4%	5.6%	4.1%	4.2%	5.0%	4.7%	5.0%	***4.2%***
	- %, In month Absence Rate - Long Term	*2.0%*	*3.0%*	*2.8%*	*2.5%*	*2.3%*	*2.6%*	*2.6%*	*2.6%*	*2.5%*	*2.3%*	*2.3%*	*2.6%*	*2.7%*	***2.5%***
	- %, In month Absence Rate - Short Term	*2.0%*	*3.3%*	*2.6%*	*3.1%*	*2.7%*	*1.7%*	*1.8%*	*3.0%*	*1.6%*	*1.9%*	*2.7%*	*2.1%*	*2.3%*	***1.7%***
	- %, In month Absence Rate - COVID-19 Sickness Absence		2.3%	1.6%	2.2%	1.5%	0.5%	0.7%	1.7%	0.6%	0.4%	0.9%	0.5%	0.2%	***0.2%***
Starters, Leavers and T/O rate (12 months)	WTE, Starters		390.3	376.5	382.0	409.1	427.3	433.9	447.8	492.1	505.8	517.4	543.0	578.1	**581.2**
	Headcount, Starters		441	428	431	459	481	490	507	550	570	587	613	651	**654**
	WTE, Leavers		277.9	296.9	329.4	364.6	380.6	400.1	417.1	449.4	469.0	504.7	506.0	513.8	**525.2**
	Headcount, Leavers		332	357	395	435	456	480	500	542	562	604	605	614	**627**
	%, Leaver Turnover Rate	9%	9.5%	10.2%	11.2%	12.3%	12.9%	13.6%	14.2%	15.3%	15.8%	16.9%	16.9%	17.1%	**17.2%**
	%, Stability Index		85.5%	85.3%	84.8%	83.7%	82.9%	82.7%	82.8%	82.5%	82.6%	82.7%	82.2%	81.9%	**81.8%**
Statutory/Mandatory Training	%, Compliance	90%	95%	94%	94%	94%	94%	95%	95%	95%	92%	93%	93%	94%	**94%**
Appraisals	%, Compliance	90%	91%	90%	92%	90%	90%	88%	89%	90%	91%	92%	92%	92%	**91%**
Time to Hire (days)	General Recruitment	35	72	65	72	58	52	65	59	64	56	54	53	48	**50**
	Medical Recruitment (excl Deanery)	35	52	49	68	47	79	63	89	72	73	63	80	33	**67**
Employee relations	Number of open disciplinary cases		10	7	9	4	4	9	13	14	15	22	26	22	**24**

2.1. **Temporary staffing usage** increased slightly in M10 alongside operational pressures on clinical areas and an increase in vacancy rate for HCAs. Fill rate for shifts continue to show higher success of fill rate for nights than days.

2.2. The Trust's **vacancy rate continues to fall** and is at **8.6%** with improvements across several staff groups. There are now 4075 employees in post in the Trust, which is the highest it has been, with an additional 197 staff in post compared to the same period in the previous year.

2.3. **Staff absence** has started to decline with an in-month absence rate of **4.2%** and 0.2% of which is due to Covid.

2.4. The **stability index figure** (defined as *proportion of staff in post at end of period who were in post at beginning of period)* has started to stabilise and has had an incremental decrease since M9, currently at 81.8%. **Staff turnover** has had an incremental increase up to 17.2% but is now starting to slow. The **Turnover and Retention Group** meet regularly to ensure a continued and consistent approach to addressing areas with high turnover and vacancies. This work is being monitored by the Workforce Development and Assurance Committee.

2.5. **Time to hire** has risen to 50 days due to absence within the team. The estimated cost to recruit to the 1159 new vacancies since 1st April is £241 per post. This includes the cost of the internal recruitment team, advertising and recruitment disbursements, such as visas, DBS checks, etc. The International Nurses programme costs are not included in this as they are funded via a separate business case.

2.6. The number of **open disciplinary cases** has increased in month, with several hearings being carried out in January. A detailed Employee Relations case report is produced monthly to JCNC and on a quarterly basis for Workforce Board.

2.7. **Statutory and mandatory training** compliance is at 94% and **appraisals** compliance remains at 91%. Divisions are addressing any underperformance against these KPIs locally and are asked to create recovery plans against target.

2.8. There are **68 nursing vacancies** across the Trust, a reduction of 27.5 from the previous month. The first 2023 cohort of 11 international nurses arrived in M11.

2.9. There are **115 HCSW vacancies** (B2 and B3 and including Maternity Support Workers) across the Trust which is a decrease of 10 on the previous month.

2.10. The team held a recruitment open day in M11 which attracted 90 potential recruits into nursing or HCA roles with 20 offers of employment (8 x Nursing and 11 x HCA) made on the day. The team piloted a new HCA interview process which involved activities and scenarios as part of the selection process. A 'one stop shop' process was also held to allow for ID checks and Occupational Health clearance to be undertaken at the point of interview, to reduce the time to hire. The team also facilitated a seminar about 'How to apply and complete your application' which was very well received.

3. Continuous Improvement, Transformation and Innovation

3.1. The HR Services Team are focussing on some **automation initiatives,** starting with a review of the vacancy control process with a view to launch an online version in M12.

3.2. The Trust ran a session on **financial advice** from Payplan to help staff be more confident with money management and understand how to budget, manage debt, and create financial resilience. More sessions are planned across the year.

4. Culture and Staff Engagement

4.1. The NHS Staff Survey will be released nationally on 9th March and early indicators show that the Trust has improved on several of its metrics against the People Plan Themes. HRBPs will be working with Triumvirates on their results and supporting them with their actions plans and listening events as early as possible. The Trust also invested in WRES and WDES heatmap reports to give additional insight into behaviours and lived experiences across the Trust.

5. Current Affairs & Hot Topics

5.1. The Trust consultation on the **change of pay date** closed in M10 with feedback being provided to the Executive Team in M11. If the proposed change of pay date goes ahead then a supplementary pay run will commence in April. This will ensure any underpayments are accurately amended in this additional run without the need to raise a manual payment.

5.2. The **Industrial Action Working Group** continues to meet to look at potential action that may impact the Trust. The BMA strikes are planned for 72 hours in M12 and the group are looking at contingency planning to ensure clinical safety is maintained.

6. Recommendations

Members are asked to note the report.

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	Trust Board	Date: 8th March 2023
Report Title	Maternity Clinical Workforce Paper	Agenda Item: 14
Lead Director	Name: Yvonne Christley	Title: Chief Nurse
Report Author	Name: Melissa Davis	Title: Divisional Chief Midwife

Key Highlights/ Summary	Maternity Staffing Overview Report submitted for Board Oversight to comply with Safety Action 4 & 5 of the NHS Resolutions Maternity Incentive Scheme requirement to submit a maternity staffing paper every 6 months during the relevant reporting period. The staffing paper contains the minimum required information including: <u>Midwifery</u> • A clear breakdown of Birth Rate Plus to demonstrate how the required establishment has been calculated • Details of planned vs actual midwifery staffing, including evidence of mitigation/escalation for managing staffing shortfall • An action plan to address the findings from the tabletop exercise or Birth Rate Plus report, where deficits in staffing levels have been identified • The midwife to birth ratio • The % specialist midwives employed and those in management positions and mitigation to cover any inconsistencies from the recommended 8-10% • Evidence demonstrating 100% compliance with supernumerary labour ward co-ordinator status and 1:1 care in establishment with action plans for board sign off where these are not achieved • Attached for sign off – Action plan to support compliance with: 1. Continued compliance with supernumerary status of the labour ward co-ordinator 2. Compliance with 1:1 care in established labour <u>Obstetrics</u> • Acknowledgement & commitment to the RCOG (Royal College of Obstetricians and Gynaecologists) Roles & Responsibilities of the Consultant workforce document • Compliance of consultant attendance for listed clinical situations <u>Anaesthetics</u> • Compliance with ACSA (Anaesthesia Clinical Services Accreditation) standard 1.7.2.1 <u>Neonatal</u> • Compliance with the BPAM (British Association of Perinatal Medicine) national standards for medical staffing • Compliance with the service specification for neonatal nursing standards			
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** √	**For Noting** ☐	**For Review** √

Strategic Objectives Links	Patient Safety, Compliance with National Safety Requirements
Board Assurance Framework (BAF)/ Risk Register Links	Midwifery staffing is currently on the risk register at a score of 15 No separate Obstetric & Gynaecology rota is currently on the risk register at a score of 12

	Obstetric middle grade rota gaps are currently on the risk register at a score of 6

Report History	6 monthly maternity clinical workforce staffing paper
Next Steps	To be reviewed at Trust Board and attached action plans to receive trust board sign off
Appendices/Attachments	Appendix 1 – Action plan to support continued compliance with supernumerary status of the labour ward co-ordinator Appendix 2 – Action plan to support compliance with 1:1 care in labour Appendix 3 – Neonatal medical & nursing workforce action plan Appendix 4 – Neonatal workforce staffing calculation tool

Maternity Staffing Overview Report

Introduction

A requirement of the NHS Resolution Maternity Incentive Scheme is the production of a paper detailing maternity clinical workforce staffing to provide the board with an overview of key staffing and safety issues, every 6 months.

Obstetric Workforce

The principles of the Royal college of Obstetrics & Gynaecology (RCOG) consultant roles & responsibilities document have been incorporated into the local clinical guidance and monitoring compliance of consultant attendance as per this document is in place and reported monthly on the governance report.

The reported compliance is as follows:

June 2022	100%
July 2022	100%
August 2022	100%
September 2022	100%
October 2022	100%
November 2022	100%
December 2022	100%
January 2023	1 case under review

It was highlighted at a regional CQC preparation visit that the lack of separate obstetric and gynaecology rotas should be included within the divisional risk register. Following this, a risk assessment was completed, and this was added to the risk register at a score 12.

The final Ockenden report included an immediate and essential safety action that if a trust does not have a separate obstetric and gynaecology rota, a risk assessment and escalation protocol must be in place and agreed at board.

The risk assessment has been completed as part of the process for inclusion of the risk on the risk register, the escalation protocol is currently in development and the initial draft, detailing management in hours, has been reviewed with the board level safety champions through the Maternity Assurance Group (MAG). To complete the protocol the management out of hours requires inclusion in the protocol, this will then be approved through the divisional governance processes before being escalated to board.

Since March 2022, 4 new SAS middle grade doctors have been recruited and commenced in post. There is unavailability within the trainee team due to sickness absence and maternity leave, and the deanery has agreed to 2 inter-deanery transfers so there will be no gaps from March 2023.

A 16th middle grade post has been offered pending a start date and this will facilitate moving to a 1 in 8 middle grade rota from August 2023.

Obstetric medical staffing is currently on the risk register at a score of 6, which has been reduced due to successful recruitment and only one remaining middle grade rota gap.

A new electronic recording of multidisciplinary attendance at ward rounds has commenced to support capture of this for audit and monitoring purposes. Multidisciplinary attendance at the twice daily safety huddles is not consistently achieved due to clinical prioritisation, the timings of the huddles are continually reviewed to identify any opportunities to maximise attendance; whilst enabling effective cascade of information to the site team.

There is currently significant work around positive safety culture taking place within the department and, it has been recognised that there is not as much opportunity for the obstetric consultants to be as involved in the operational, service and strategic planning within maternity services as would be preferable. On review of the availability to support the governance functions within maternity services, the majority of SPA time is organised for a Wednesday, and, whilst most of the forums take place on a Wednesday, this also poses a challenge to attending forums on alternative days. A review is currently taking place to prioritise forums for attendance and review the current organisation of these forums to support consistent multidisciplinary attendance.

BLMK Local Maternity and Neonatal System (LMNS) have agreed funding for 1 PA to support obstetric involvement in LMNS functions, to enable consistent multidisciplinary input into key aspects of the maternity system. In addition, there is obstetric engagement and attendance to the maternal and neonatal safety collaborative across the Thames Valley network.

A culture survey is currently taking place across the department to review and understand areas for focus to support the continued development of a positive safety culture in addition to continually assessing the baseline for service readiness for quality improvement. Alongside neonatal and operational colleagues, the quadrumvirate are enrolled on Co-Hort 2 of the Perinatal Culture and Leadership programme beginning in May 2023.

Anaesthetic Workforce

The anaesthetic rota is compliant with ACSA standard 1.7.2.1, there is a duty anaesthetist available specifically for obstetrics 24 hours a day, with a written a guideline for escalation to a consultant. The rota is available to view to provide evidence of the compliance of this standard.

The RCOA GPAS (Guidelines for the Provision of Anaesthesia Services) 2022 states that there should be a duty anaesthetist and a consultant, or an autonomously practicing anaesthetist, during normal working hours, plus consultant cover for separate elective caesarean lists and clinics. Currently there is one anaesthetist on labour ward during normal working hours, this would previously have been a consultant or associate specialist, recently the anaesthetist may be a ST5 trainee or a specialty doctor.

The RCOA definition of an autonomously practicing anaesthetist includes specialty doctors 'who can function autonomously to a level of defined competencies, as agreed within local clinical governance frameworks.'

In response to the final Ockenden immediate and essential safety action to ensure the role of consultants, SAS doctors and doctors in training to ensure appropriate service provision including periods of staff leave, a business case for another anaesthetist during the day, was submitted and approved to support continued compliance and service resilience.

Neonatal Nursing Workforce

The staffing calculation tool to demonstrate the current compliance of the neonatal nursing workforce is included as Appendix 4 of the staffing paper.

The neonatal nursing team has increased clinical leadership with the appointment of 2 WTE Band 7 neonatal unit managers, who provide both operational and clinical leadership within the neonatal unit. The neonatal practice facilitator establishment has been increased to 1 WTE which supports an increased provision of education and development across the neonatal service.

Recruitment and retention is positive within the neonatal unit with 2.3 WTE B6 & 5.2 WTE B5 vacancy currently, the service is fully recruited to nursery nurses. The team on the Neonatal unit have provided nursing support to the paediatric service during winter pressures, which has had a negative impact on the temporary staffing fill rate in the neonatal service due to a reluctance to be re-deployed to the paediatric environment. This has also impacted retention within the Band 5 workforce due to the impact of re-deployment to the paediatric service while consolidating knowledge and experience within the neonatal service. A review of the induction for new starters within the neonatal unit is planned to taking place to identify opportunities to reduce the impact of re-deployment within the initial 6 months.

There is also currently, a dedicated workstream reviewing paediatric staffing and the service demand, with an opportunity to increase options for planned rotation to support staff experience within both the paediatric and neonatal setting.

For the neonatal unit at MKUH, it is a requirement that 70.7% of nurses are qualified in specialty, currently 64% of the neonatal nurses are QIS trained. Covid has negatively impacted the trajectory of increasing this across the workforce and from the 2021 co-hort, and 4 students who commenced QIS training during Covid, did not complete their training.

There is an action plan in place to support an increase in QIS trained nurses, 1 nurse has just finished the training and 3 nurses commenced the training in December 2022, which, when complete, will meet the requirement for QIS trained within the unit. A plan for continued training to support workforce resilience is in place.

A workforce review within the neonatal service is planned to identify opportunities for development and growth of nurse led pathways of care, there is currently a vacant Advanced Neonatal Nurse Practitioner (ANNP) role which has been advertised and an appointment has not been made due to a lack of suitable applicants. A training post is being reviewed but would rely on a commitment to support a pipeline of ongoing development to ANNP posts.

There are opportunities to expand the current role of the ANNP both supporting career development opportunities in addition to service implementations including reducing length of stay, expanding community pathways, and increasing medical capacity.

Ockenden funding has been received to support allied health professional input into the neonatal service, enabling the development of enhanced pathways and opportunities to further embed these roles within the neonatal environment.

Neonatal Medical Workforce

The neonatal medical workforce meets the BPAM requirements for Tier One and Tier Two doctors and was compliant with the requirement for NHSR in year 3.

The workforce currently does not meet the requirement for NHSR year 4 as the BPAM criteria for Tier 3 doctors is not met. This requirement stipulates that any consultant covering neonates must work a minimum of 4 attending weeks (COTW) per year. The frequency of general paediatric consultants undertaking neonatal duties is below this expectation and currently, 10 consultants do not meet this requirement.

An action plan is currently in place to achieve compliance with Tier 3 medical staffing, this includes a business case to increase from 13 to 14 consultants which will enable an increase in the number of attending weeks on the neonatal unit by the paediatricians from 2 to 4 weeks, meeting the Tier 3 requirements. A review of the future opportunity to implement a split paediatric and neonatal rota is taking place.

BLMK Local Maternity and Neonatal System (LMNS) have allocated 0.5 PA to support neonatal medical input into the neonatal workstreams across the system, however, MKUH is unique in its organisation within the region as it sits within two separate systems for neonatal transformation and optimisation, including BLMK and Thames Valley. This results in a requirement for double reporting and maintenance of workstreams for improvement within different systems which at times, have alternative priorities. The requirement for engagement in the neonatal system is increased due to reporting mechanisms between alternative systems, negatively impacting on neonatal medical availability to support the progress of improvement.

The neonatal medical rotas currently have 2 WTE gaps on the tier 2 rota and one post operating without unsocial hours. In May 2023, a further 2 WTE trainee gaps are anticipated due to receiving notice and there is 1 WTE gap on the tier 1 rota. Posts are out to advert to support continued recruitment, but the current position creates challenges with ensuring effective medical cover across the paediatric and neonatal service.

Midwifery Workforce

Birth Rate Plus is currently the only approved demand and capacity modelling tool for use in the assessment and organisation of midwifery staffing, this is under review following the final Ockenden report which included an immediate and essential safety action to assess the suitability of the model.

A Birth Rate Plus assessment was completed for Milton Keynes maternity service in 2018 and has since been the basis of the agreed organisation of maternity staffing.

A new Birth Rate Plus Workforce assessment was completed in 2021 and the report was released in 2022, the corresponding executive briefing, and workforce report are included in the submission of the workforce paper.

Midwife to Birth ratio

The expected midwife to birth ratio at Milton Keynes is currently 1:28, which is based on the calculations following the Birth Rate Plus workforce report in 2018, for which a total funded clinical establishment of 142.57 WTE is required to support.

The recommended midwife to birth ratio in the Birth Rate Plus workforce report in 2021 is 1:24 resulting from the of the increased complexity in care of those accessing maternity care at MKUH. Birth Rate Plus 2021 recommends a clinical funded establishment of 160 WTE including Band 3 MSW's.

	Current funded establishment (post-Final Ockenden)	Proposed establishment (post-BR+ 2022)
RM (clinical), Band 6 WTE	138	144

The midwife to birth ration is published on the monthly obstetric dashboard for the previous year has fluctuated between 1:30 – 1:36

Month	Ratio
January	1:31
February	1:33
March	1:33
April	1:28
May	1:33
June	1:31
July	1:34
August	1:31
September	1:36
October	1:35
November	1:30
December	1:31
January	1:33

The fluctuation has been impacted by staff unavailability, and birth rate.

Planned Vs Actual Midwifery Staffing

Midwifery staffing is reviewed daily to identify the required staffing within all areas to manage the planned and acute activity.

Staffing is reported to the site team via organised virtual trust meetings at 08.30 and 18.30, Maternity Safety Huddles take place twice a day at 10.00 and 15.30 where a SIT REP form is completed to detail the daily staffing and activity and these reports are sent to the site team following the completion of the huddles.

A maternity escalation procedure is in place detailing planned actions to take in the event of staffing, activity or capacity concerns and challenges.
A midwifery business contingency plan is in place to support the management of midwifery staffing shortfalls which are unable to be mitigated by actions within the escalation procedure.

There is a maternity manager on call 24 hours a day, 365 days a year to support the continued provision of safe maternity services. A maternity bleep holder role was implemented to support the weekday operational management of the maternity service, specifically to enable effective organisation of planned activity against the acute service provision.

A maternity staffing update is reported monthly through the governance report, and this now contains the planned vs actual midwifery fill rate. This is based on the fill rate across the service and is calculated based on exact shift requirements month on month – which are changeable depending on the community midwifery requirements. The midwifery staffing across all in and outpatient areas dynamically adapts to meet the service needs, supported by the maternity escalation plan and midwifery business contingency plan. It is therefore necessary to review midwifery staffing fill rate across the service as opposed to area specific.

Month	Fill Rate
June	83%
July	79%
August	77%
September	81.7%
October	77.8%
November	81.1%
December	85.3%
January	93.1

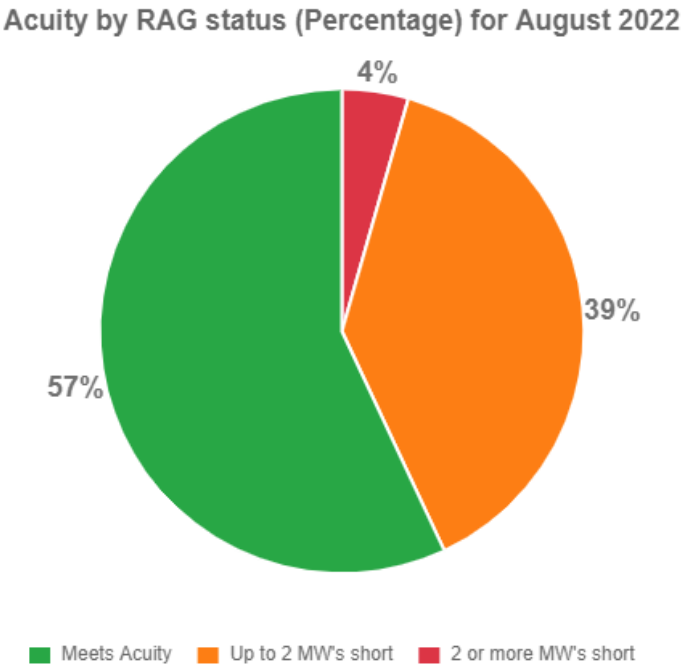
The fill rate includes substantive and temporary staff fill, approximately 10% of the fill rate each month is temporary staff, this comprises of substantive staff on bank shifts and one long line agency midwife.

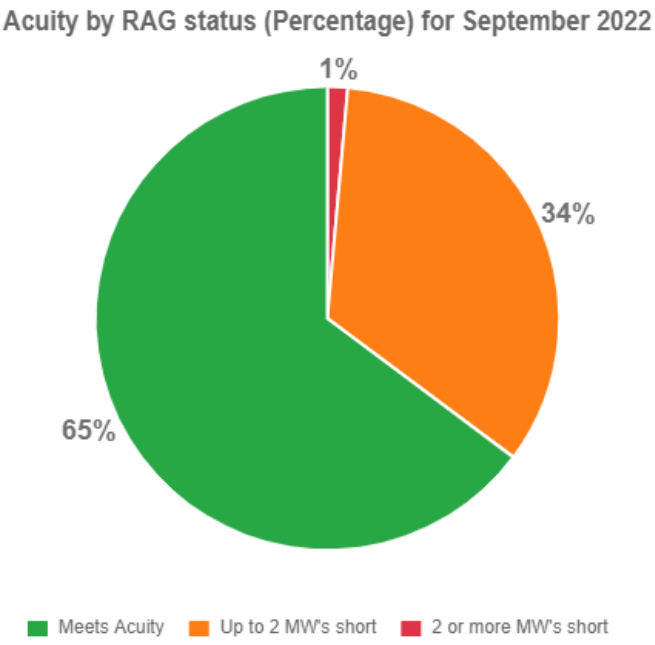
The regional maternity OPEL rating is used to support the identification of operational challenges with maternity services and is reported at all site team contacts and as part of the internal reporting mechanisms.

The Birth Rate Plus acuity app was implemented on labour ward in April 2022 to support midwifery staffing data collection and decision-making regarding allocation of staff. The escalation procedure was updated to reflect the new categorisation of complexity in care provision, demonstrating the WTE demand required to deliver the elements of care based on acuity.

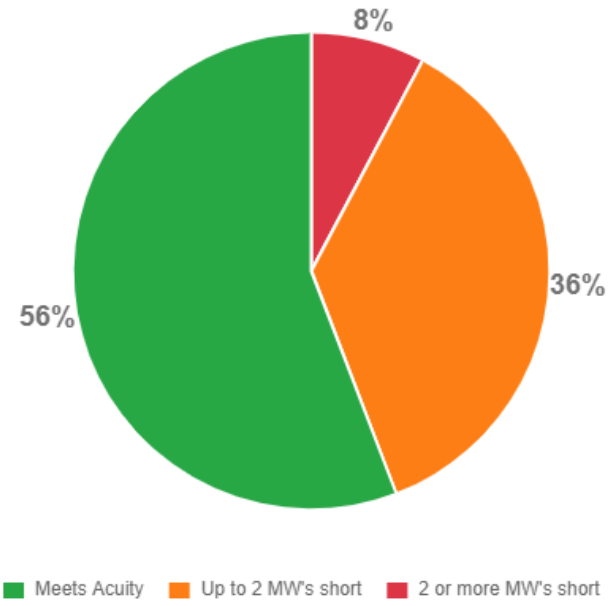
Birth rate plus produces reports detailing the staffing factors impacting on the provision of care, which is reported monthly through the governance report.

Monthly Staffing Rag Status (From August 2022):

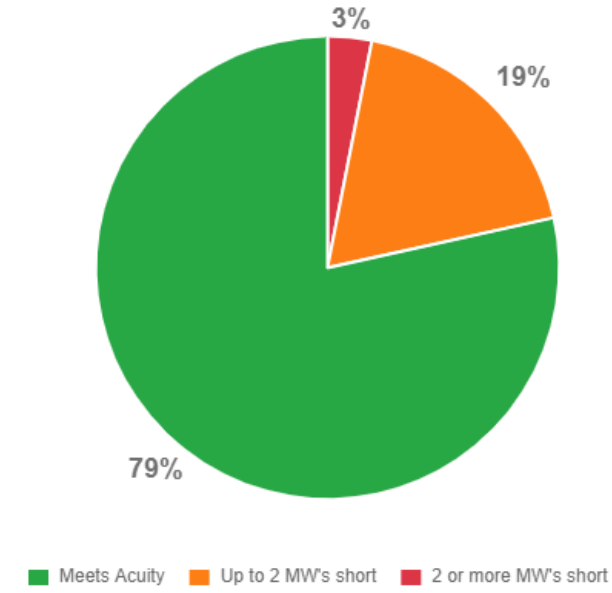

Acuity by RAG status (Percentage) for August 2022
4%
39%
57%
Meets Acuity
Up to 2 MW's short
2 or more MW's short

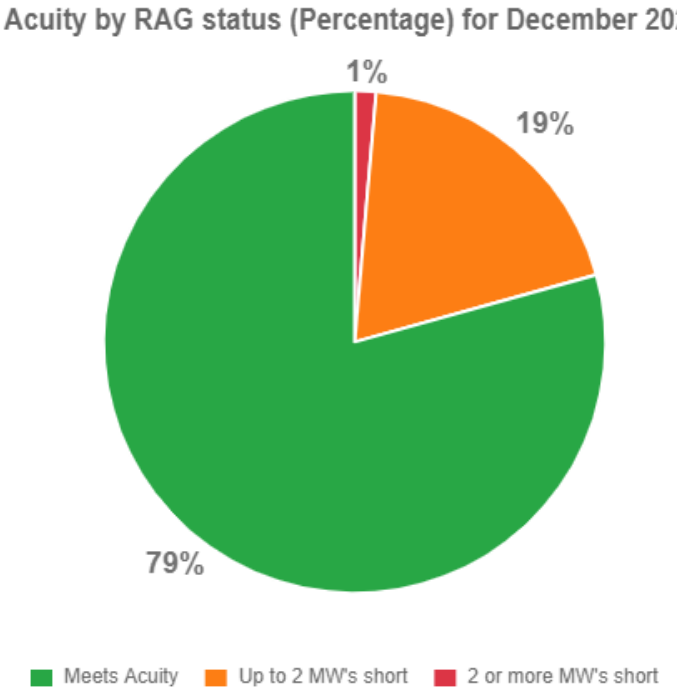

Acuity by RAG status (Percentage) for September 2022
1%
34%
65%
Meets Acuity
Up to 2 MW's short
2 or more MW's short

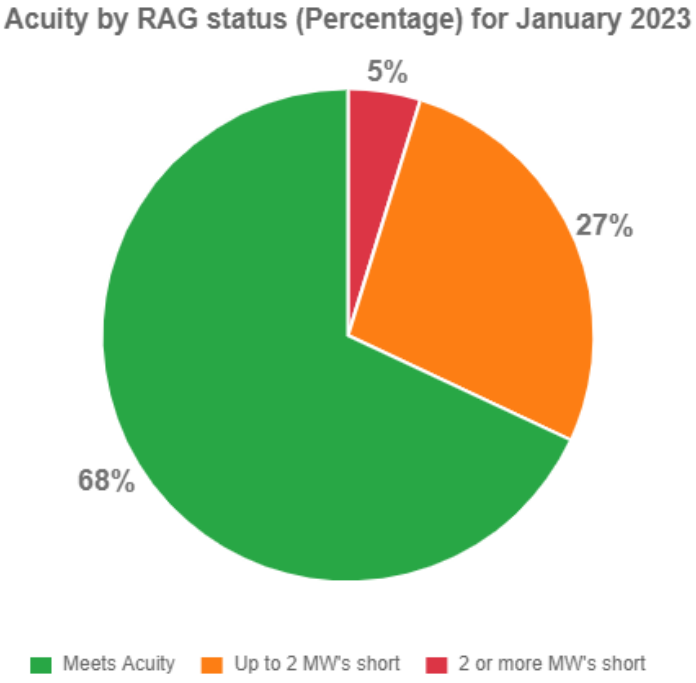
Acuity by RAG status (Percentage) for October 2022



Acuity by RAG status (Percentage) for November 2022







Since its implementation, training has been provided by the Birth Rate Plus team, to nominated staff within the department to ensure the organisation of consistent submissions. A confidence factor of over 85% is aimed for, since the implementation the app, this not been achieved and following review of the barriers to full data submission, an increased focus on the trigger points to support compliance of data completion have been implemented.

Month	Confidence Factor

April	68.33%
May	55.91%
June	70.56%
July	73.66%
August	84.95%
September	69.35%
October	69.35%
November	72.22%
December	77.96%
January	79.03%

The Birth Rate Plus app has recently been implemented within the maternity inpatient ward, however, this has been associated with increased complexity to the implementation on labour ward. The data submission is at a reduced frequency than the requirement on labour ward and the interpretation of the data submission based on the categories available has resulted in inconsistencies, which has led to unreliable baseline data. A further training session with Birth Rate Plus, has taken place to support increased understanding of the categories for data submission and review the elements of care which require an increased WTE input. Following this, it is anticipated that the data quality will improve and support inclusion in future staffing data reviews.

BLMK LMNS are currently organising a system wise Birth Rate Plus data sharing function to support management of maternity capacity within the system. The Birth Rate Plus team are providing further system training to support the implementation of this and it is anticipated to go live in June 2023.

Recognising the midwifery vacancy, a review of the workforce to identify other professionals with the opportunity to positively input into the provision of maternity care, enabling resilience of care delivery included the identification of an opportunity to implement registered nurses into the inpatient ward shift plan.

A business case was developed and submitted to gain funding for the implementation of registered nurses into the shift plan on the maternity inpatient ward, which received an A rating following review at the business case review panel. The business case was subsequently not supported at Trust Executive Group due to a requirement for further data of the uptake of registered nurse regular temporary staffing shifts implemented on the maternity inpatient ward, including the impact of this on care provision.
The business case is currently under review, to be updated and re-submitted with further data to support obtaining the funded establishment for substantive registered nurse posts.

Specific training has been identified to support the registered nurses with the development of skills pertinent to maternity and a pipeline for development is in place with the availability of the Midwifery master's course for registered nurses. This year there is one candidate enrolled on the midwifery master’s course with further expressions of interest to be released for next year.

MKUH is actively involved in the Maternity Support Worker (MSW) mapping exercise, the skills and competencies of all maternity support workers have been mapped, and a development pathway organised to detail the opportunities for career progression. A training provider with a maternity specific support worker apprenticeship has been selected and the initial co-hort of staff are being enrolled. The regionally agreed job descriptions have been progressed through the

trust processes for approval and implementation for all newly appointed staff. The consultation to transition all current staff to the new job descriptions has been developed and is due to commence in February 2023.

This will re-organise the workforce due to the adjustments in the roles and responsibilities of the Band 2 to 3 posts, with the increase in Band 3 roles and decrease in band 2 roles, supporting increased efficiency in midwifery allocation to midwifery specific tasks.

Unavailability

The current headroom applied to clinical midwifery posts is 22%, this includes 4% non-recruitable sickness absence. The sickness rate has fluctuated over the previous 12 months, with the lowest rates in for both staff groups in June/July.

Following July 22, the sickness rate in midwifery support workers has consistently increased and is currently at its highest level, on review themes have been identified in relation to the sickness absence.

August to October 22 was associated with significant sickness levels on labour ward, however, this is proportionate based on the small staff group on labour ward of 5.46WTE, equating to one maternity support worker per shift, which artificially inflates the sickness percentage. It was identified through the staff survey listening sessions that there is a reluctance to work on labour ward due to an inability to utilise all the skills and knowledge associated with the role and a perception of aspects of incivility. In response to this, it has been identified that there is a requirement for increased support worker support on labour ward to efficiently allocate tasks and a business case is in progress to implement 5.46 WTE Band 2 establishment.

October 22 to January 23 has demonstrated significant sickness levels in Triage, however, this is proportionate based on the small staff group on labour ward of 5.46WTE, equating to one maternity support worker per shift, which artificially inflates the sickness percentage. Triage appears to be an area associated with increased temporary staff fill and is an area where support staff have an opportunity to utilise an increased skill set.

From August 22, Ward 9 has experienced consistent MSW sickness levels above 8%, which is recognised to be impacted by the persistently high workload associated with the maternity inpatient ward. The business case to support the implementation of registered nurses on the inpatient ward to support the overall provision of care will effectively support the allocation of workload and, MSW recruitment is currently positive with an overall vacancy of 2.8 WTE.

The MSW mapping project will support the opportunity for staff to engage in tasks which enable them to utilise and demonstrate a range of skills and competencies aligned with their role and the review of required skills for each area has taken place to re-organise the shift plans.

There is currently a cultural survey out with staff to identify areas of focus to support a positive safety culture in addition to identifying the platform for further quality improvement. The survey is anonymous to support staff to provide direct feedback on their experience at work.
A lead for the maternity support workers has been identified within the practice development team and all training is completed collaboratively.

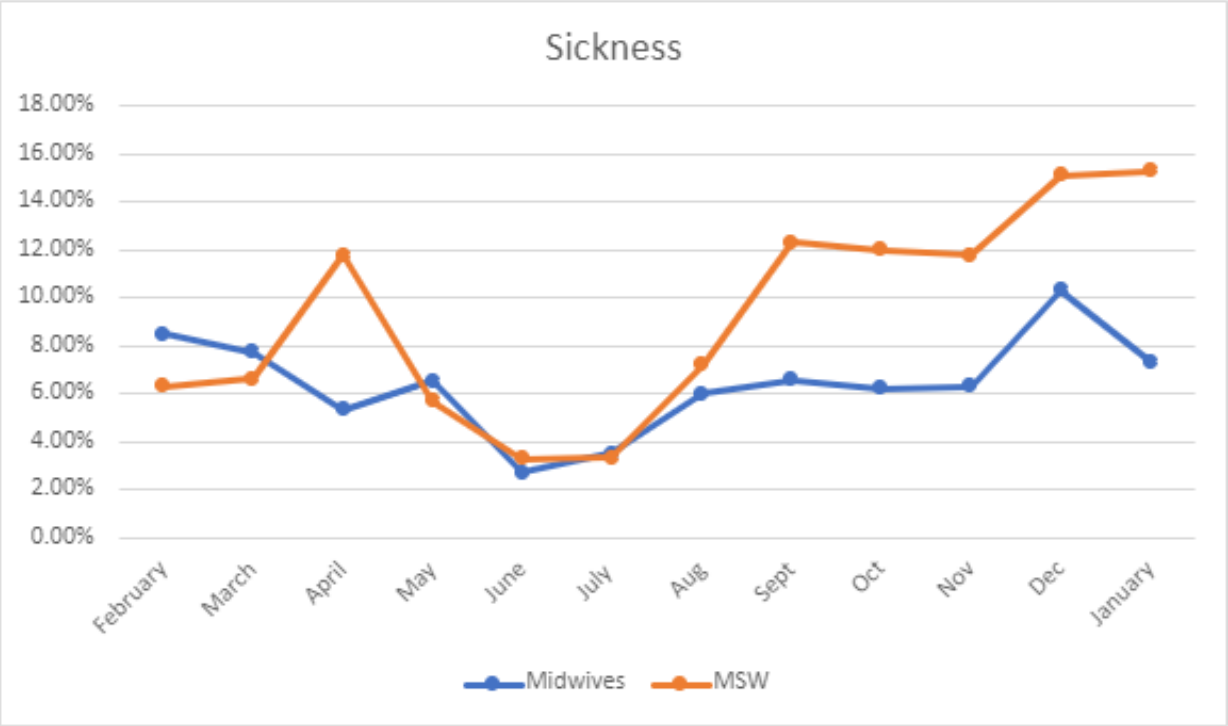
The overall midwifery sickness absence has remained consistently above 4% and, a

requirement of the Ockenden final report is to review the sickness absence rate over the previous 3 years to

support a local re-set of the headroom to reflect the average.

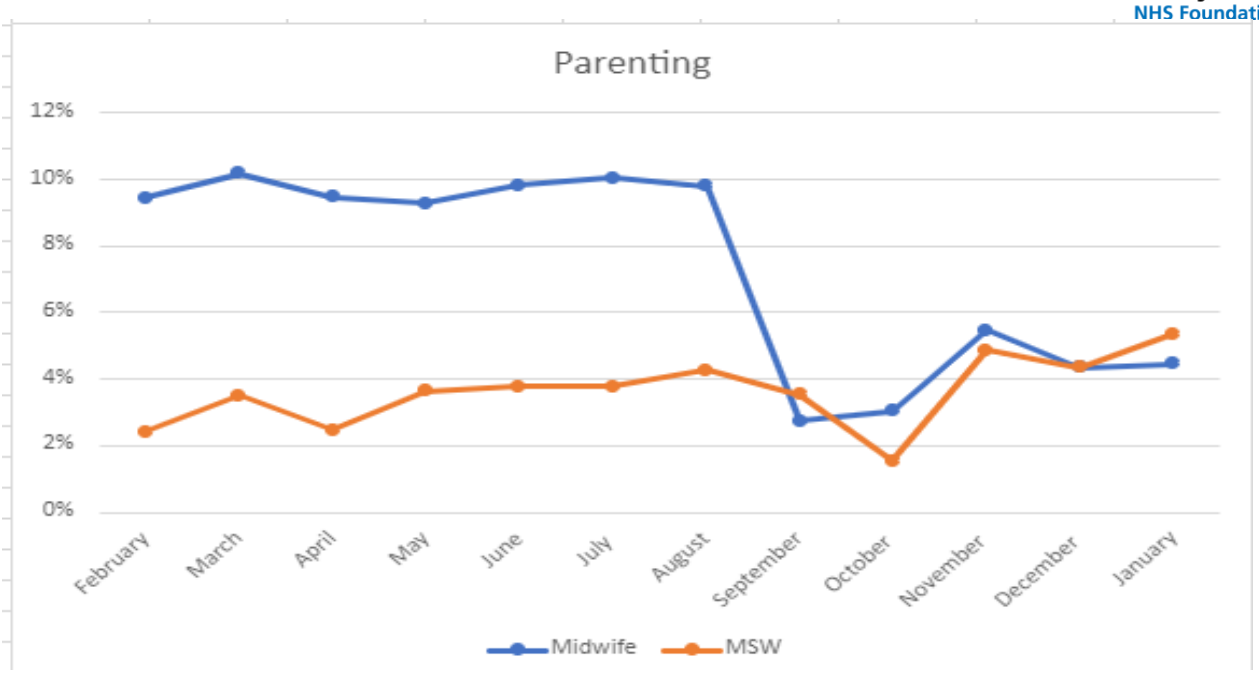
Sickness peaked in December which was associated with a significant increase in cold and flu, this was following a targeted opportunity for staff to access the flu and covid boosters in site with both an appointment booking and drop in option. Midwifery sickness is reviewed across the service as opposed to individual areas due to the fluidity of movement of staff on a daily basis to support the overall maternity service provision.

The highest reported reasons for sickness absence episodes include; cough/cold; stress/anxiety; gastrointestinal; headache/migraine.



Parenting leave remained static in both staff groups until September 22 when it significantly decreased, following which the rate has been consistently between 4-6% since November 22. The Ockenden final report requires a review of the average parenting leave over the previous 3 years to review inclusion in the uplift or funded establishment.

Parental leave cover is organised on a secondment basis, fixed term position or bank, depending on the role.



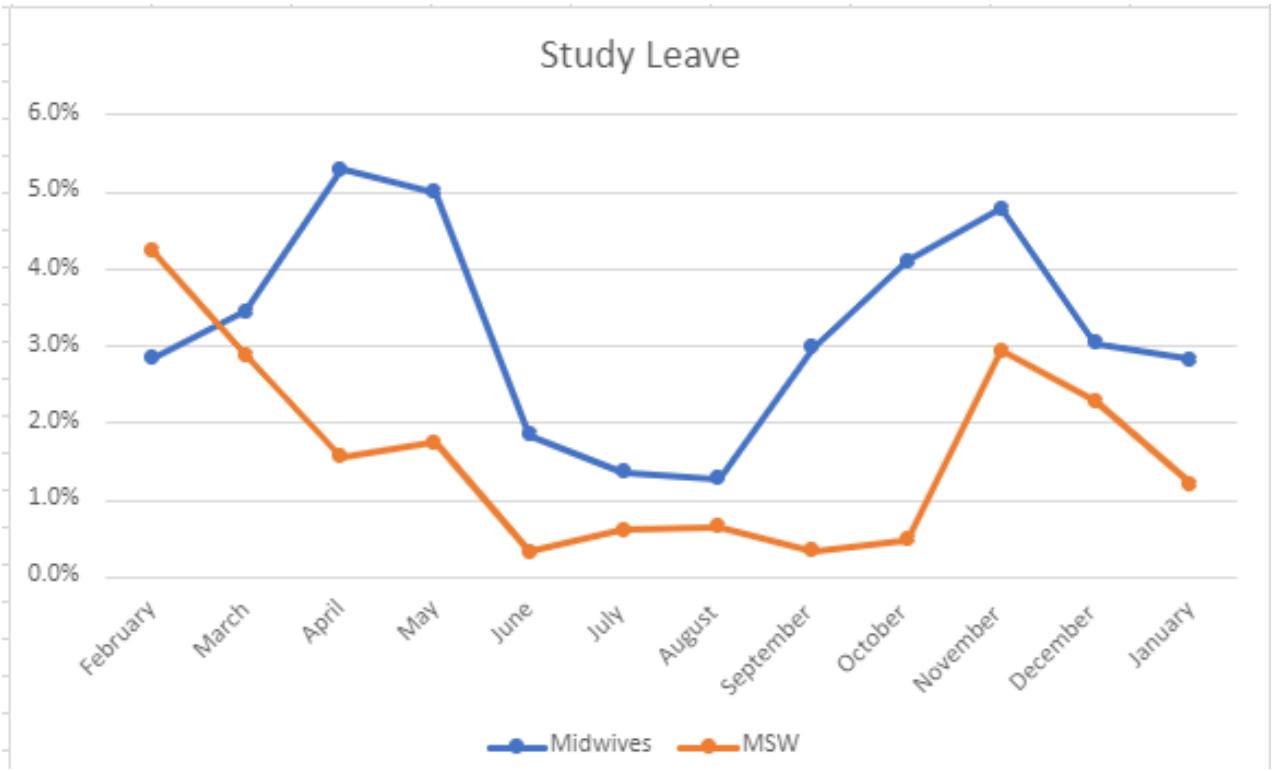
Study leave has demonstrated significant fluctuations since January in both registered and unregistered staff with registered staff often above the 3% training allowance in the current 22%. Due to the requirements for mandatory midwifery training, a 5% uplift for is required to support the delivery of training as mapped against the core competency document. In January this was increased due to compliance with the training requirements for the implementation of physiological CTG, this will increase again in October with the implementation of the Human Factors specific training.

The Ockenden final report requires a calculation of the average training rate over the previous 3 years to support an uplift in headroom reflective of the requirements. However, this does not take into consideration the local and national changes in training requirements or the current core competence document in place, which is also a CNST requirement.

These fluctuations are impacted by the organisation of external training, recently this has included; baby lifeline emergencies in the community; birth rights informed consent; maternity specific cultural competency; baby lifeline physiological CTG; human factors train the trainer; APEC pre-eclampsia management; specialist bereavement; CPAL – coaching and peer assisted learning; domestic abuse, stalking and honour based; perinatal and infant mental health; causal analysis; cognitive interview technique; PSIRF modules; PEARLS – perineal repair; NLS (Newborn Life Support); NIPE (Newborn and Infant Physical Examination); PMA (Professional Midwifery Advocate); PGCERT – teaching qualification.

The mandatory training is organised across the year in a way which reduces the impact on staffing within more challenging periods, including training being mapped across 10 months, avoiding organised training in July and August.

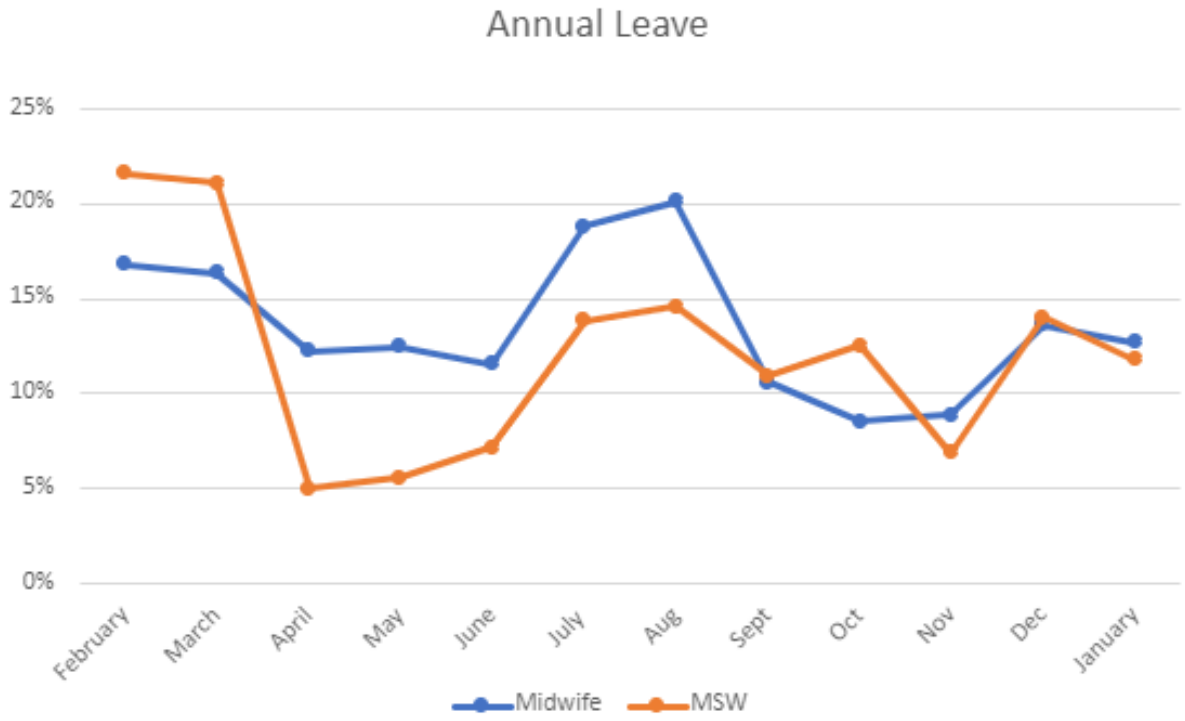
Core competency training for registered midwives is maintained at above 90%, which is enabled by the option of completing specific training as bank to reduce the impact on the substantive rota**.**



The annual leave allocation for registered midwives has remained consistently below the expected maximum parameter of 17%, other than a spike in July/ August, relating to the summer holiday period. Unregistered staff annual leave allocation has demonstrated increased fluctuations, partially related to the lower allocation of support staff to each clinical area. This results in increased percentages of annual leave across areas even in the event of only one team member being on annual leave.

Peaks of annual leave are associated with the year-end annual leave allowance and school holidays. In a predominantly female workforce, many of which with main carer responsibilities, this trajectory is expected and mitigated, to some extent, by bank utilisation during holiday periods, when flexibility is an increased factor in availability.

Roster check and challenge takes place to review the impact of pre-determined unavailability and roster requirements are in place to ensure appropriate spacing of annual leave across the year. Based on the data collected over the previous year, a focus on the allocation of annual leave within the department is planned for the next financial year.



Specialist Midwives & Management Roles

As part of the midwifery staffing model, Birth Rate Plus sets the expected percentage of specialist midwives and non-clinical midwifery managers to enable delivery of core functions within maternity services. The expectation is for this parameter to be between 8% and 10%, with a mitigation plan if the specialist and managerial input falls below 8%.

Based on the previous Birth Rate Plus report, our specialist midwife roles equal to 10% which is within the expected parameters. We also have several externally funded specialist roles to comply with national and regional workstream deliverables.

The revised Birth Rate Plus report recommends a non-clinical specialist and role allocation of 10% which equates to 16 WTE. Following the report, specialist roles have been implemented and we have now achieved compliance with this requirement.

Each of the specialist midwives also has a percentage of their role which is clinically based, and the specialist midwives support the daily on call escalation in line with the maternity escalation procedure.

The midwifery senior leadership team all take part in the 24-hour on call maternity manager rota, which is in place to supports the continual management of capacity and activity across the maternity service.

Labour Ward Co-Ordinator Supernumerary Status

To maintain situational awareness of the maternity unit it is a requirement that the labour ward co-ordinator has 100% supernumerary status, NHS Resolutions define that supernumerary status will be lost if “the labour ward co-ordinator it required to be solely responsible for any 1:1 care for a labouring woman or relieve for break – a midwife who is providing 1:1 care…….this includes supervising a student midwife providing 1:1 care”

NHR Resolution also states that the trust can report compliance with this standard, when relieving for a break if “the coordinator is not required to provide 1:1 care [and, this does not] occur on a regular basis and more than once a week”

Supernumerary compliance is reported on the regional monthly highlight reports to the Local Maternity and Neonatal System and monthly on the governance report via the trust reporting structure.

In April 2022, the Birth Rate Plus acuity app was implemented to enable the electronic collection of staffing and acuity including the supernumerary status of the labour ward co-ordinator.

Since the implementation of the acuity app, a reduction in compliance with 100% supernumerary status has been reported and NHSR have been contacted to ascertain clarification around the definition of “no caseload” and its relative impact on maintaining situational awareness. Inconsistencies have been identified in the data collection based on the interpretation of supernumerary status and a review with the labour ward co-ordinators took place to support consistency in reporting.

Following communication with NHS Resolutions in relation to the supernumerary status, an updated narrative was released in the October 22 version of the CNST requirements, providing further articulation of the requirement for supernumerary status.

If 100% supernumerary status (taking into consideration the requirements to achieve compliance) is not met, until the October 2022 update, an action plan was required to demonstrate the actions in place to support 100% supernumerary status of the labour ward co-ordinator. This was developed and submitted with the previous maternity staffing papers submitted in March 22 and September 22, the updated plan to support continued compliance is included in appendix 1. Following the October 22 update, an action plan was confirmed as being required but not confirmatory of sign off.

Month	Supernumerary Status
August	76% (Action Plan in Place)
September	85% (Action Plan in Place)
October	89% (Action Plan in Place)
November *	CNST Definition - 100% Self-Reported – 97% (Remains CNST compliant as not regular or frequency over once a week)
December **	CNST Definition - 100% Self-Reported: 98% (Further revised CNST definition - compliant as not regular or frequency over once a week)
January	CNST Definition - 100% Self-Reported: 96.8% (Revised CNST definition - compliant as not regular or frequency over once a week)

*The CNST definition of supernumerary status changed in October 22 – due to feedback from the labour ward co-ordinators in relation to the appropriateness of the definition the reporting has continued to incorporate CNST compliance and self-reporting.

**CNST released a further update detailing that self-reported supernumerary status would be valued

Labour ward coordinator supernumerary status is reviewed and reported monthly, through the governance report, and it is identified from the submission of red flags on the Birth Rate Plus acuity app.

1:1 Care in Established Labour

1:1 care in established labour is reported on the obstetric dashboard with an expected parameter of 100%, excluding BBA's where this would not be possible to achieve. This has been consistently reported as 99.2% to 100%:

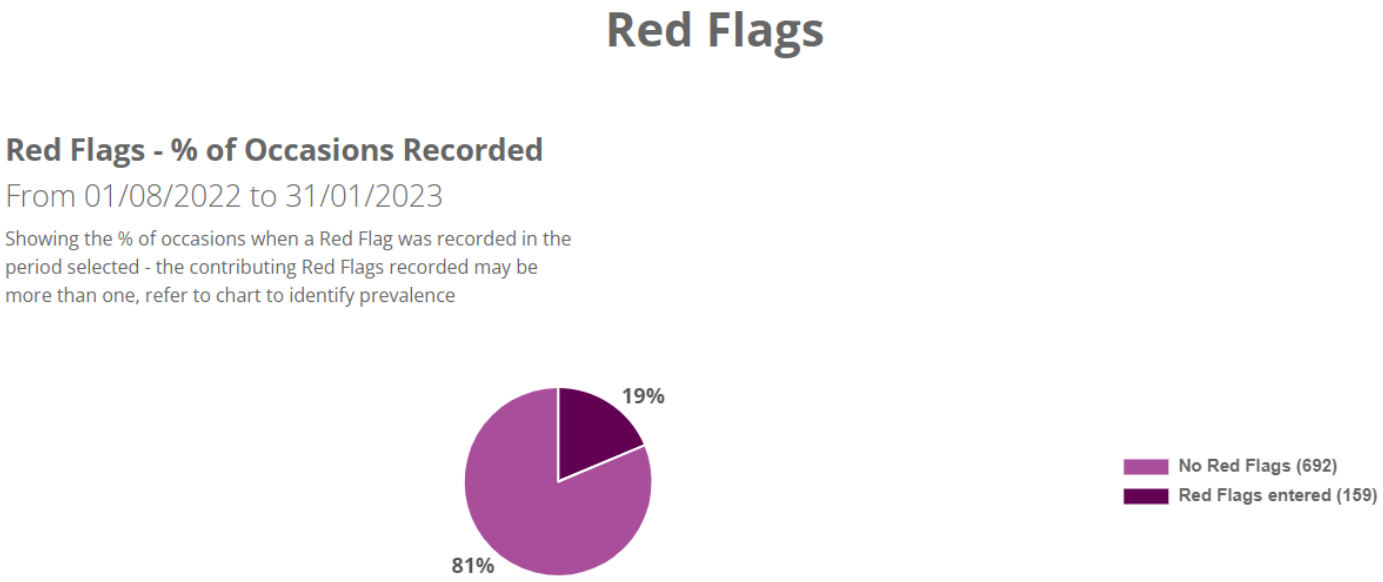
Month	% 1:1 Care
August	99.3%
September	100%
October	99.7%
November	100%
December	99.65%
January	99.67%

An action plan to support the consistent achievement of 1:1 care in established labour was submitted to Trust Board in March 22 and September 22, the updated action plan is included in appendix 2.

Reported Red Flags

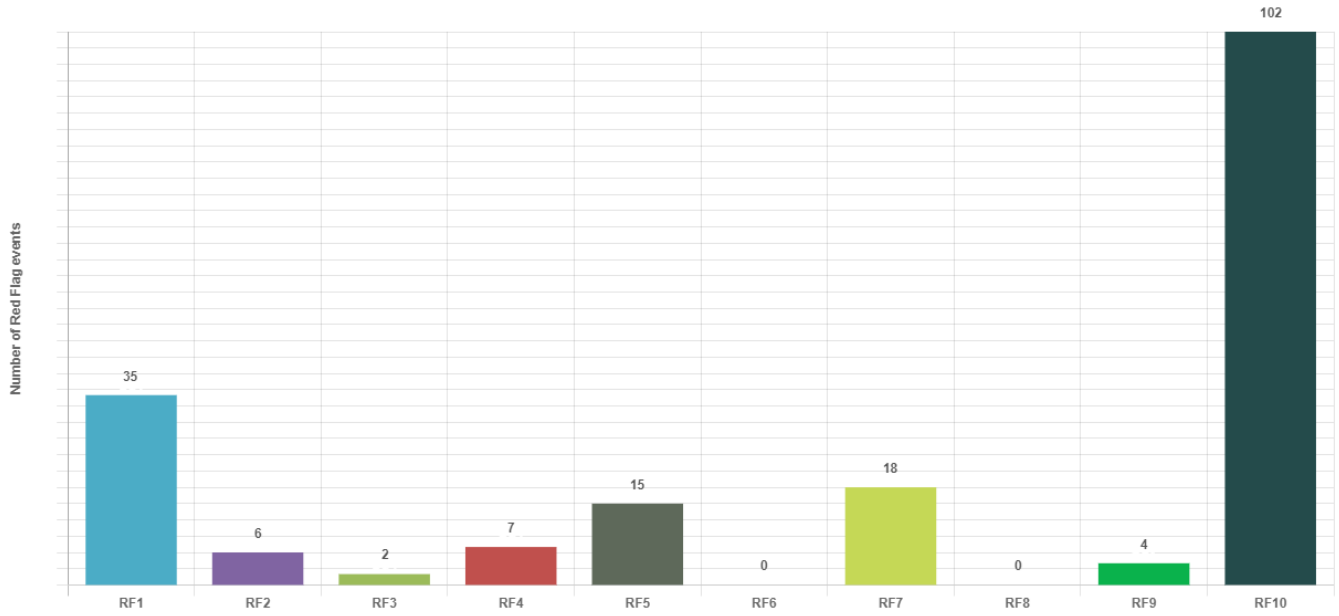
The Birth Rate Plus acuity app was implemented in April 2022 and is used as the electronic mechanism for recording red flags 4 hourly; this is reported monthly through the divisional governance structure.

Red flags raised for the period August 2022 – February 2023



Number of Red Flags Recorded

From 01/08/2022 to 31/01/2023



Number & % of Red Flags Recorded

From 01/08/2022 to 31/01/2023

RF1	Delayed or cancelled time critical activity	35	19%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	6	3%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	2	1%
RF4	Delay in providing pain relief	7	4%
RF5	Delay between presentation and triage	15	8%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	18	10%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	4	2%
RF10	Delivery Suite Co-ordinator not supernumerary	102	54%
	Total	189	

The highest reported red flag is for non-supernumerary status of the labour ward coordinator (not CNST definition), but this has demonstrated a significant reduction each month since August 2022.

The second highest reported red flag is for delayed or cancelled time critical activity which is predominantly related to delays in the progress of those who have commenced on an induction of labour (IOL) pathway. This leads on to the third highest reported red flag for delay between admission and commencement of the IOL process.

IOL is an area of current focus to support improvements in the pathway of care and experience of service users. The Maternity Voices Partnership have specified time for focus on a particular project which they have allocated to IOL to work alongside the MDT to support improvements in the delivery of the pathway.

CoC – Continuity of Carer

MKUH were operating 6 CoC teams until indicators identified a requirement for a further review of the community and CoC services, following which the impact of unavailability within the service overall, coupled with staff feedback led to a recommendation to pause and disband the continuity of carer (CoC) teams.

An options appraisal paper was submitted to the executive team and following a staff engagement process led by the chief executive and medical director – maternity and neonatal board level safety champion, a consultation was launched with the midwifery staff in community and CoC teams to review the continuation of service provision.

The outcome of the consultation was to disband all remaining CoC teams, which took place in August 2022, to support the overall service provision, while recognising that CoC still forms part of the maternity transformation programme.
A separate paper is currently in development to identify the proposed trigger point for proposed re-implementation of CoC.

Recruitment & Retention

A recruitment and retention plan is in place and details the approach to increasing and maintaining the maternity workforce, this is supported by the retention midwife who is currently developing a midwifery recruitment strategy.

The approach to supporting recruitment is reflective of extended routes into midwifery, this includes international recruitment for which we are engaged in the regional international recruitment programme; return to practice where we are supporting placement settings with guaranteed roles for those completing the programme; and legacy roles which we are exploring with those who are considering retirement.

There is a regional approach to advertising midwifery roles, including alternative platforms to NHS jobs, units are then individually contacted for candidates who request roles within their

organisation, we have appointed midwives via this route with direct requests to work at MKUH.

The approach to retention is centred around staff experience with a direct focus on staff wellbeing, flexibility in working practices and development. Actions following completion of the national recruitment and retention gap analysis and the 2021 staff survey have been progressed. There is a quality improvement plan in place for both workforce and culture, as the continued development and maintenance positive workplace culture is a consistent focus.

A maternity workforce plan has been developed to demonstrate the approach to supporting a resilient midwifery workforce, this includes a staffing projection based on predicted incoming and outgoing staff, taking into consideration the retention activities and workforce metrics.

Based on the current projections of incoming and outgoing staff and retention activity we are predicted to be fully recruited to current funded establishment by September 2023 and the monthly PWR data also demonstrates a trajectory of reducing vacancy.

A practice retention midwife has recently been appointed to support continued development within the band 6 workforce to specifically support resilience as Band 6 midwives have been identified as a hard to recruit staff group. To support midwifery skill mix, support newly qualified and student midwives and enable a midwifery career progression pipeline, a focus on Band 6 midwifery recruitment and retention is imperative.

The maternity service has completed the direct workforce support offer and following this, in addition to the flexible working opportunities already available to staff, a survey has been released for staff to indicate further areas of focus for flexible working within the workforce.

Varied recruitment opportunities have been explored and implemented including return to practice midwives, international midwives, bank only midwives and legacy midwives. A candidate is commencing the midwifery masters programme this year and successful candidates have been allocated places on the midwifery apprenticeship programme.

Links have been created with a new provider university and an increase in student numbers will support an ongoing midwifery pipeline, in addition to exploring the apprentice route for some of our current support staff to access midwifery training.

The organisation of student midwives within clinical placement and available capacity has been externally reviewed and determines with recommendations for opportunities to increase student capacity. Following this, training has been implemented in a new model of student supervision which will support a change in the organisation of students in placement from April 23. The Learning Education Lead (LEL) post has been made substantive to enable continual support to the students and the post has been associated with significant positive feedback from students.

Registered nurses continue to work on a temporary staffing basis on the inpatient ward to support provision of care and a revised business case is being re-submitted to enable implementation into the substantive shift plans.

A lead PMA (Professional Midwifery Advocate) has been appointed to support restorative clinical supervision and implement the A-EQUIP model. A further 5 midwives have commenced the PMA training which will increase the provision of support for the midwifery workforce. The recommended ratio of midwife to PMA is 1:20, the service is currently at a ratio of 1:26.5.

The PMA team do a weekly wellbeing walk around in all clinical areas to meet with staff across shift patterns and review the current experiences of the workplace environment.

The midwifery leadership team implemented daily (weekday) wellbeing walk rounds specifically on the maternity inpatient ward to speak with staff and service users on a daily basis to understand the experiences within the inpatient setting in order to organise improvements.

The board level safety champions offer monthly meetings to hear directly from staff of their experiences within clinical environments and the safety concerns dashboard is shared monthly and visible in clinical areas to demonstrate progress being made on identified areas for improvement.

“Chat with Melissa” (HoM) initially operated weekly and has moved to fortnightly to provide updates to staff in addition to a specific opportunity to raise aspects for review or development, which is strengthened with the organisation of various communication platforms to share information with staff and receive feedback.

A new exit interview process has been implemented in the department offering an opportunity to attend a review meeting with a selected member of the team, qualitative information relating to the rationale for leaving is collected to support continued development within the department. The initial stage prior to an exit interview is a discussion with the line manager to ascertain if there are any implementations which can support the employee to remain employed.

In addition to several members of staff have deciding to remain employed following the initial line manager discussion as part of the exit interview process, we have also experienced midwives returning following resignation earlier in the year. This was as a direct result of the improvements made following feedback through the exit interview process.

Personalised scrubs and lanyards have been ordered for staff to support both recognition of roles and increased comfort during work following a review with staff regarding uniform.

The TRiM (Trauma Risk Management) team have organised support for both midwifery and paediatric staff involved in traumatic events in the workplace. The guideline is progressing through the divisional governance process in February 23 and following this, the full implementation of TRiM will be embedded within the department.

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Trust Board**	**Date: 09/03/23**
Report Title	**Inclusion Leadership Council**	**Agenda Item Number: 15**
Lead Director	Danielle Petch, Director of Workforce	
Report Author	Thomas Dunckley, Head of Employee Relations	

Introduction	A summary of the Trust's Inclusion Leadership Council, it's purpose, agenda and key areas of progress.		
Key Messages to Note	The ILC has been in place since November 2021 and has actively run since. In January 2023 it was agreed with the ILC that a refreshed agenda would be implemented to ensure closer links with the Trust Board. Key areas of progress have been outlined within the paper.		
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)*	8. Employ the best people to care for you

1. Terms of Reference

The Inclusion Leadership Council (ILC) was formed in November 2021 as a governance meeting for staff networks at MKUH. It was created to bring all of the networks together as a "network of networks" alongside senior leadership within Workforce, providing a collaborative voice to better inform and guide Trust decisions, ensuring that equality, diversity and inclusion are considered.

The ILC is in place to ensure that effective and co-ordinated action is taken across the Trust to reduce disadvantage, discrimination and improve equality of opportunity, and promote diversity and inclusion in terms of the people it serves, its workforce, its partners and the services it delivers.

The meeting is chaired by Alison Davis, the Trust Chair and has the following attendance:

- Director of Workforce
- Deputy Director of Workforce
- ADO HR Services
- Head of Employee Relations
- Equality, Diversity and Inclusion Business Partner
- Equality, Diversity and Inclusion Advisor
- Staff Network Chairs

Colleagues from a number of other divisional areas are also invited but their attendance is optional.

2. Agenda

The ILC takes place once every other month, with the option to hold extraordinary meetings as necessary or required. In January 2023 a refreshed agenda was agreed to ensure closer links with the Trust Board and to provide ILC members with the opportunity to comment on Board papers of note, estates developments and HR policies. The refreshed agenda is as follows:

- Chair Update – an update provided by the Chair and/or Director of Workforce covering key news items from the organisation.
- Policy Update – recently published HR policies are brought to the ILC for awareness. Staff Network Chairs have the opportunity to comment on policies prior to this, as part of the Trust's Policy Review Group.
- Board Focus – the Trust Chair will bring a relevant board paper to the group for discussion, prior to being submitted to Board. Input from the ILC will be taken to Board to strengthen the links between both groups.
- Estates & Technology Development – representatives from Estates/IT will provide an update on developments to the site and infrastructure for the group to comment on. This will help raise areas where the group may feel these developments may impact particular groups so that these can be considered as part of plans.

- Network Strategic Programmes – this is an update from the ED&I on projects that require direct involvement from the staff networks.
- Ideas, Hot Topics, Issues & Niggles – this is where all network members in attendance will have the opportunity to put forward points of note, whether these be issues in need of fixing, ideas or hot topics amongst their networks.
- General Network Updates – each network is given a 5-minute slot to provide updates on network activity.
- Feedback/Comment for Board – attendees are given the opportunity to provide feedback and or comments to be shared at the next Board meeting.

3. Key Issues Raised and Progress

A number of issues have been discussed at the ILC. Below is a list of issues that have been raised since the last report and the key progress that has been made:

- Network Budgets – the networks have requested budgets to assist with communications spend throughout the year. We have been pleased to confirm that from April 2023, each network will receive an annual budget of £1,000 to spend on network events, marketing and activities.
- Protected Working Time – ongoing discussions about supporting network members with protected working time for network activities.
- Framework for Staff Networks – engagement has taken place with the staff networks to develop a framework for each network, outlining the composition of leadership, process for elections and engagement with the ED&I team.
- Freedom to Speak Up – through the ILC it has been agreed that Deputy Network Chairs will be trained as FTSU Champions, ensuring there is a champion in each network.

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Meeting Title	**Public Board**	**Date: 9th March 2023**
Report Title	**Risk Register Report**	**Agenda Item Number: 16**
Lead Director	***Kate Jarman, Director of Corporate Affairs***	
Report Author	***Paul Ewers, Risk Manager***	

Introduction	***The report provides an analysis of all risks on the Risk Register, as of 21st February 2023.*** ***The report was shared at the Risk & Compliance Board (01/03/2023) and the Trust Executive Committee (08/03/2023)***		
Key Messages to Note	***Please take note of the trends and information provided in the report.***		
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***

1. INTRODUCTION

This report shows the risk profile of the Trust, the aim of providing the Board with assurance that the Risk Management process is being effectively managed and highlighting key areas of concern.

2. RISK PROFILE

2.1 Overdue Risks

At the time of reporting, there are 9 risks out of 261 risks (3%), that are overdue their review date. This is a decrease of 22 risks since the last report.

2.1.2 Risks Overdue Review > 1 month = 2. There were 5 risk >1 month overdue in the last report.

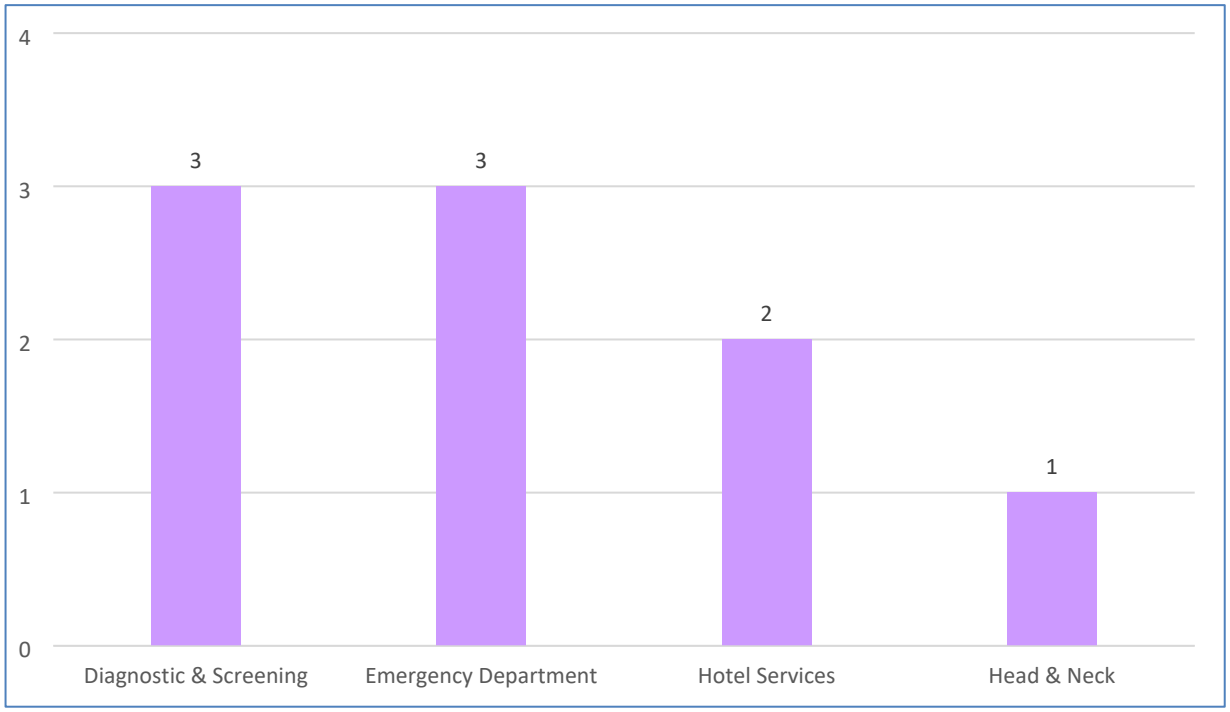
RSK-182 IF requests for radiology examinations have been placed by staff who are not trained or certified to do so THEN Imaging Department members of staff could be in breach of IR(ME) R National Regulations and CQC Guidelines for Practise. LEADING TO patients potentially receiving much higher than necessary doses of ionising radiation, which could negatively impact upon the patient's health (or that of their unborn child if they are pregnant at time of exposure). Patients could undergo highly invasive procedures unnecessarily. Patient could undergo intrinsically risky interventional procedures without need, potentially resulting in avoidable patient death. Patient care could be delayed through undergoing the wrong investigations first before attending for the required one at a later date. Staff placing the requests without required training could be liable to litigation. Due to breaching IR(ME)R regulations and CQC guidelines, the Trust reputation could be damaged. The Trust could also be fined should this be picked up in an IR(ME)R inspection

Risk Register: Diagnostic & Screening / Imaging
Risk Owner: Paula Robinson
Current Risk Score: 12 (Consequence 3, Likelihood 4)
Days Overdue: 61 days

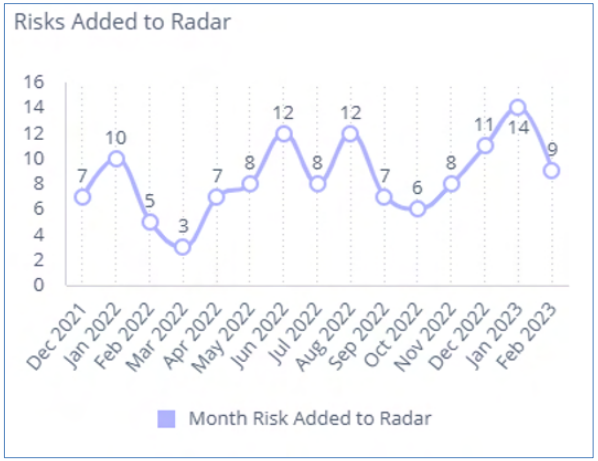
RSK-016 IF there is a lack of flow in the organisation THEN there may be an unsafe environment for patients. LEADING TO a potentially impact on bed space capacity, ambulance queues, missed Emergency Access Targets and overcrowding into ED/radiology corridors creating Health & Safety hazard and continued pressure, leading to poor patient care/treatment and delays in discharge/transfer and the potential for an increase of incidents being reported regarding assessment/care/treatment, and or significant number of patients with a high acuity/ dependency being cared for in areas that are not suitable for safe care

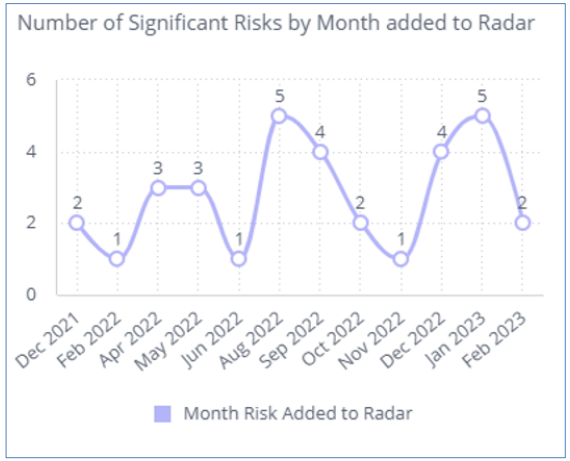
Risk Register: Medicine / Emergency Medicine
Risk Owner: Mahamayagodage Dias
Current Risk Score: 12 (Consequence 4, Likelihood 3)
Days Overdue: 52 days

2.1.2 Overdue Risks by CSU = 9



2.2 New Risks





There were a total 19 new risks added to Radar during February 2023, of these there were two where the Current Risk Scoring was 15 or more.

2.2.1 Significant (15+) risks added to Radar during November = 3

RSK-435 IF access and egress to the MRI Unit is not appropriate, including narrow corridors/doors/changing ramp inclines etc. THEN there may be limited access for manoeuvring beds and wheelchairs; there may be an inability for bariatric patients to access the facilities. LEADING TO potentially delayed diagnosis and treatment; deterioration of condition and poor outcomes for patients; increase in slips, trips, falls; potential inability to evacuate patients quickly in case of fire; staff, patients and visitors could sustain strains, sprains, musculoskeletal, back, fracture, entrapment, collision injuries; increase in complaints and claims; potential investigation/formal notices from Health & Safety Executive; impact on reputation of Trust through potential media coverage re safety concerns
Risk Register: Diagnostic & Screening / Imaging **Risk Owner:** Victoria Smith
Current Risk Score: 20 (Consequence 5, Likelihood 4)

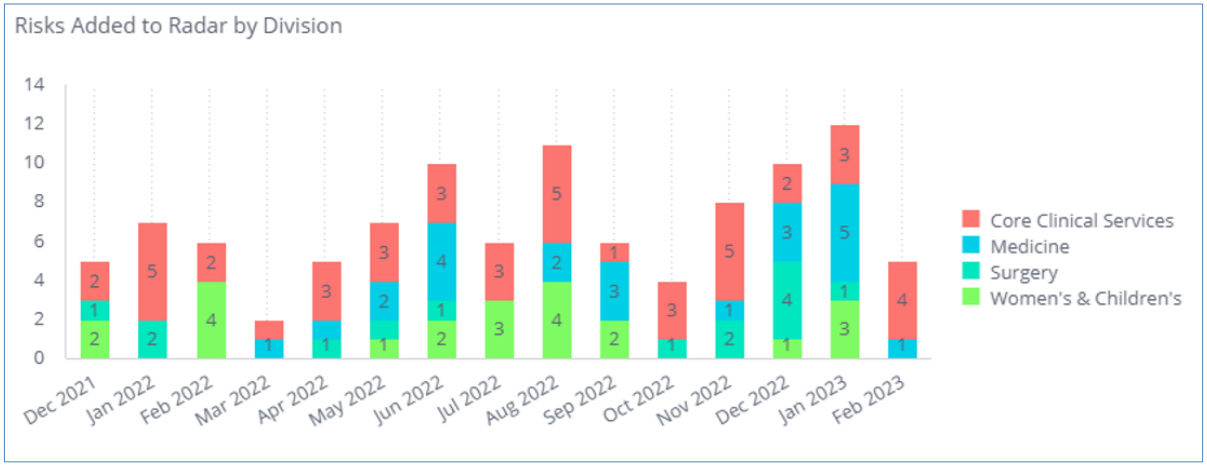
RSK-427 IF there is an increase in demand for inpatient and ED CT scans THEN some scans will be routinely waiting a number of days to be performed. LEADING TO potential delays to patient treatment; delays to discharge.
Risk Register: Diagnostic & Screening / Imaging **Risk Owner:** Michael Pashler
Current Risk Score: 16 (Consequence 4, Likelihood 4)

RSK-426 IF cancer 2ww booking service is not managed within SOP processes there is a RISK that the patients won't be booked within 2 weeks, communication will not be processed highlighting capacity requirements and clinical triage and referrals will not be tracked effectively THEN there is the risk treatment has been delayed, LEADING to potential delays, risk of missed referrals and non-tracking

Risk Register: Medicine / Haematology & Oncology **Risk Owner:** Sally Burnie

Current Risk Score: 15 (Consequence 3, Likelihood 5)

2.2.2 New Risks by Division



2.3 Closed Risks

There was 1 risk closed during February 2023.

RSK-220 IF there are insufficient side rooms THEN it may not always be possible to isolate patients and there is a risk that patients with a highly transmissible infection are not able to be isolated in a single room. LEADING TO Potential risk of an outbreak that can affect large numbers of patients and staff, ward closures, reduced numbers of staff, loss of revenue and increased waiting times. Implementation of new software to support patient movement/infection risk, will further mitigate.

Risk Register: Directorate of Patient Care / Infection Control **Risk Owner:** Angie Legate

Current Risk Score: 6 (Consequence 3, Likelihood 2) **Reason for Closure:** Further mitigate in place. Risk closed.

2.2.2 New Risks by Division

Risks for escalation onto the Corporate Risk Register

RSK-434 IF there is insufficient capacity of outpatient appointments THEN Patient Access will be unable to provide patients within designated timescales. LEADING TO a delay in diagnosing and treating patients; cancellation of appointments to ensure patients are appropriately prioritised; increasing waiting lists; breach in national appointment timescales

Risk Register: Corporate / Patient Access **Risk Owner:** Felicity Medina

Current Risk Score: 9 (Consequence 3, Likelihood 3)

Reason for Escalation: This is an overarching risk in relation to the waiting lists and outpatient appointments – Therefore it has Trustwide impact.

RCB Update: Risk Approved onto the Corporate Risk Register. Patient Access to have oversight of the risk, with Divisions managing their own waiting list risks, which will feed into the overarching risk. Risk Owner: Emma Hunt-Smith

Key Risk Indicators

The aim of the Key Risk Indicators is to give the Board a proactive view of activity that could affect the achievement of the Trusts Strategic Objectives, through aggregation of intelligence from incidents, complaints, claims/litigation, compliments, and safety alerts.

The below is an example of Key Risk Indicators that could be used to provide the Board with aggregated data to monitor Trust Objectives.

Objective: Improve Workforce Effectiveness

The first graph (top-left) shows the number of staffing level incidents reported per month since December 2021. The currently rolling average number of these types of incidents per month is 28, however the graph does show an overall increase and has been above 25 most months since January 2022. It should be noted that the figure for February only accounts for ¾ of the month. Therefore the project number of incidents for the month based on current reporting rate is around 17 incidents.

The second graph (top-right) shows the number of violence and abuse incidents towards staff per month for the same time period. Between December 2021 and January 2023 the number has been largely consisent, with peaks in February, August, October and December 2022. The rolling average number of these incidents is 28 per month, however September to November 2021 were significantly lower reporting months and will have reduced the overall average. The projected number of incidents for February 2023 (based on current reporting) is 24 incidents.

The third graph (bottom-left) shows the number of staff accidents per month since December 2021. There is a rolling average of 19 incidents per month. However, it should be noted that since September 2022 the number of staff accident incidents per month has been between 10-18 incidents per month showing a small decline in incidents over recently months. The projected number of staff accidents for February 2023 is around 15.

The fourth graph (bottom-right) shows the number of Personal Injury Claims per month since December 2021. It should be noted that there are not always personal injury claims raised each month. The graph shows that since October 2022 there has been 2 or 3 claims most months. There have already been 3 reported in February 2023. The graph suggests that there may be a small increase in personal injury claims since October 2022.

In light of the above data, it may be appropriate for there to be a deep-dive in relation to violence and abuse incidents, due to the number and increasing trend (albiet relatively small) and potentially the same to look at trends of Personal Injury Claims since October 2022, to see whether there is any learning that could be put in place to reduce these.

3. RECOMMENDATION

The Board is asked to review and discuss this paper.

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Meeting Title	Trust Board	**Date:** 09 March 2023
Report Title	Board Assurance Framework	**Agenda Item Number:** 17
Lead Director	Kate Jarman, Director of Corporate Affairs and Communication	
Report Author	Kwame Mensa-Bonsu, Trust Secretary	

Introduction	Assurance Report		
Key Messages to Note	The document remain under development and the Committee is asked to review and make recommendations as appropriate. **A. Risk Score** 1. The risk score for **Risk Entry 5** (page 17 have been revised downwards **–** from **20 to 15 –** because the specialist commissioners met on 10 January 2023 to progress the implementation of the head and neck cancer pathway.		
Recommendation *(Tick the relevant box(es))*	**For Information** [x]	**For Approval** [ ]	**For Review** [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. Employing 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	Trust Executive Committee, March 2023
Next Steps	Board Committees, March 2023
Appendices/Attachments	Board Assurance Framework

The Board Assurance Framework

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

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

Strategic Objectives

1. 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. Employing the best people to care for you
9. Expanding and improving your environment
10. Innovating and investing in the future of your hospital

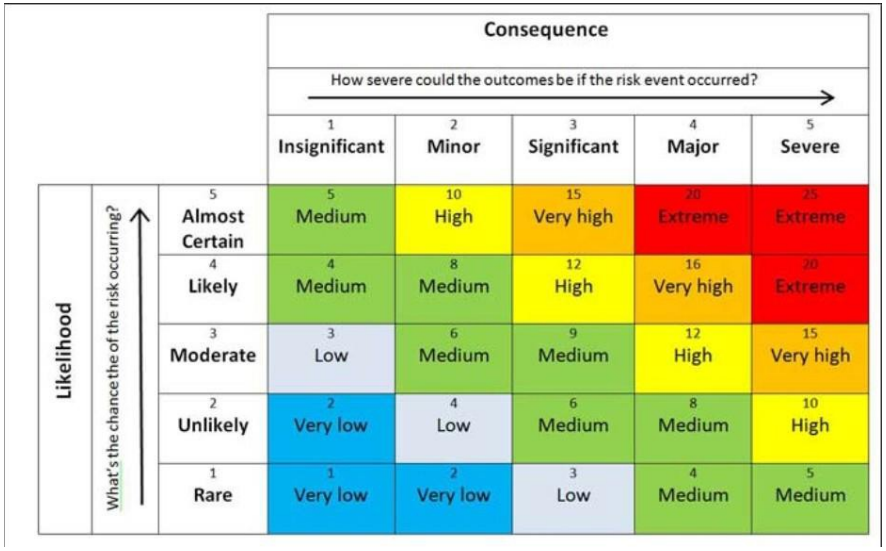
Risk treatment strategy: Terminate, treat, tolerate, transfer

Risk appetite: Avoid, minimal, cautious, open, seek, mature

Assurance ratings:

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

5X5 Risk Matrix:



Board Assurance Framework 2022-2023

The Board held a dedicated seminar on risk and the BAF in October 2022. This was to embed understanding among new members of the Board on the Trust's risk management processes, and to review the risks on the BAF, as part of a regular review.

In reviewing other Trust BAFs, particularly those recently evaluated through the Care Quality Commission Well Led process, recommendations to split BAF risk into immediate and medium/ long term was made and accepted by the Board to enable more robust management of immediate risk, and support risk horizon scanning.

The product of that seminar was a new set of recommended risks. These are described below. The next step for development is to work through the Committees and Executive to present a full new BAF at the January 2023 Trust Executive Group and public Board.

Next Six to 12 Month Risk Profile (2023)

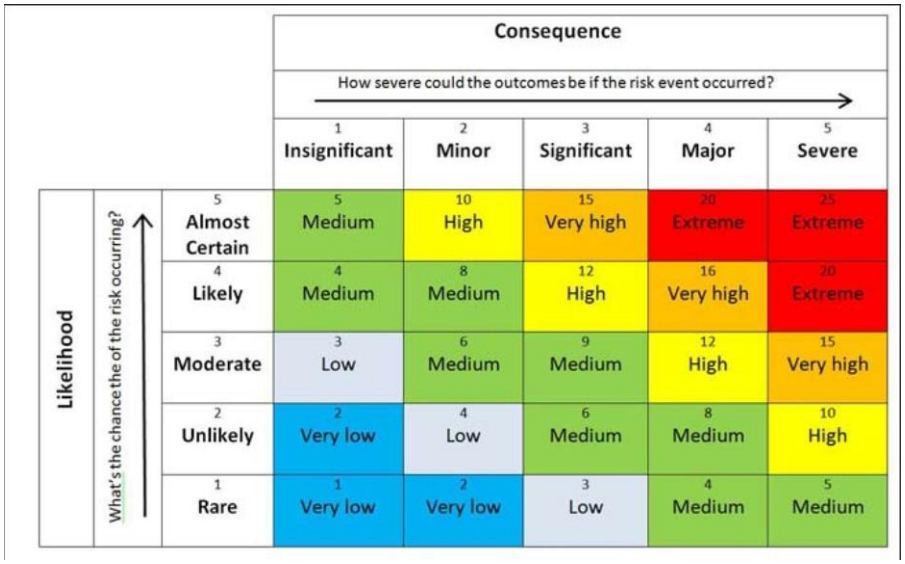
The feedback from the three Board risk seminar groups (shown below) has been distilled into five key risks against the achievement of the Trust's strategic objectives in the immediate term. These are as follows:

1. **Insufficient staffing to maintain safety**
2. **Patients experience poor care or avoidable harm due to delays in planned care**
3. **Patients experience poor care or avoidable harm due to inability to manage emergency demand**
4. **Insufficient funding to meet the needs of the population we serve**
5. **Suboptimal head and neck cancer pathway**

Group feedback (six-month to 12-month risk profile):

Group 1	Group 2	Group 3
• Staffing and capacity to meet demand • Care assurance consistency under pressure • Managing demand • Environmental conditions • Potential strike action	• Strike action • Covid • Emergency experience linked to waiting times and actual experience • General staffing • Winter capacity	• Shortage of clinical staff • Strikes • Cost of living crisis • Avoidable harm due to delays • Maternity - external perspective of services • Service provision failings due to capacity and staffing

Six-Month to 12-Month Risk Profile



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

	1 Insignificant	2 Minor	3 Significant	4 Major	5 Severe
5 Almost Certain					
4 Likely					
3 Moderate					
2 Unlikely					
1 Rare					

RISK 1: Insufficient staffing levels to maintain safety

Strategic Objectives

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. **Employing the best people to care for you**
9. Expanding and improving your environment
10. Innovating and investing in the future of your hospital

Strategic Risk	If staffing levels are insufficient in one or more ward or department, then patient care may be compromised, leading to an increased risk of harm						
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm	**Trend: STABLE**
Executive Lead	Director of Workforce	**Consequence**	5	5	**Risk Appetite**	Avoid	
Date of Assessment	December 2022	**Likelihood**	3	1	**Risk Treatment Strategy**	Treat	
Date of Review	Monthly	**Risk Rating**	15	5	**Assurance Rating**		

Cause	**Controls**	**Gaps in Controls**	**Action Required**	**Sources of Assurance**	**Gaps in Assurance**	**Action Required**
1. Increasing turnover 2. Sickness absence (short and long term) 3. Industrial action	Staffing/Roster Optimisation • Exploration and use of new roles. • Check and Confirm process	• Processes in development and review, yet to embed fully	• Complete embedding of processes • Divisional ownership	**First line of defence:** Active monitoring of workforce key performance indicators.	**First line of defence:**	

Cause	Controls	Gaps in Controls	Action Required	Sources of Assurance	Gaps in Assurance	Action Required
4. Inability to recruit	• Safe staffing, policy, processes and tools Recruitment • Recruitment premia • International recruitment • Apprenticeships and work experience opportunities. • Use of the Trac recruitment tool to reduce time to hire and candidate experience. • Rolling programme to recruit pre-qualification students. • Use of enhanced adverts, social media and recruitment days • Rollout of a dedicated workforce website • Creation of recruitment "advertising" films • Targeted recruitment to reduce hard to fill vacancies.	• Lack of Divisional ownership and understanding of safe staffing and efficient roster practices • Monitoring Divisional processes to ensure timely recruitment • Focussed Executive intervention in areas where vacancies are in excess of 20% Increased talent management processes	of vacancies, staffing and rostering practices • Workforce team monitor vacancies to ensure recruitment taking place • Executive oversight of areas with vacancies in excess of 20% Talent management strategy refreshed and revised	**Second line of defence:** Annual Staff Survey **Third line of defence:** Internal audit	**Second line of defence:** **Third line of defence:**	

Cause	Controls	Gaps in Controls	Action Required	Sources of Assurance	Gaps in Assurance	Action Required
	Retention • Retention premia • Leadership development and talent management • Succession planning • Enhancement and increased visibility of benefits package • Schwartz Rounds and coaching collaboratives. Onboarding and turnover strategies/reporting • Learning and development programmes • Health and wellbeing initiatives, including P2P and Care First • Staff recognition - staff awards, long service awards • Review of benefits offering and assessment against peers					

RISK 2: Patients experience poor care or avoidable harm due to delays in planned care

Strategic Objectives

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. Employing the best people to care for you
9. Expanding and improving your environment
10. Innovating and investing in the future of your hospital

Strategic Risk	If emergency or elective care pathways are delayed, then patients will wait longer to access treatment, leading to potential risk of harm						
Lead Committee	Quality & Clinical Risk, TEC	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm	**Trend: INCREASING**
Executive Lead	Chief Operating Officer	**Consequence**	5	5	**Risk Appetite**	Avoid	
Date of Assessment	December 2022	**Likelihood**	4	2	**Risk Treatment Strategy**	Treat	
Date of Review	Monthly	**Risk Rating**	20	10	**Assurance Rating**		

Cause	**Controls**	**Gaps in Controls**	**Action Required**	**Sources of Assurance**	**Gaps in Assurance**	**Action Required**
1. Overwhelming demand for emergency care	Clinically and operationally agreed escalation plan	Vacancies in nurse staffing		**First line of defence:**	**First line of defence:**	

Cause	Controls	Gaps in Controls	Action Required	Sources of Assurance	Gaps in Assurance	Action Required
2. Inability to treat elective (planned) patients due to emergency demand 3. Inability to treat elective (planned) patients due to staffing shortages 4. Patients delayed in elective backlogs 5. Inability to discharge patients to onward care settings 6. Elective activity is suspended (locally or by national directive) to enable the Trust to cope with emergency demand or further Covid-19 surges, resulting in increasing waits for patients needing elective treatment –	Clinically risk assessed escalation areas available. Surge plans Emergency admission avoidance pathways, SDEC and ambulatory care services. Maximising Use of Independent Sector. Divisional and CSU management of Waiting Lists. Agreement of local standards and criteria for alternative pathway management – clinical prioritisation and validation Long-wait harm reviews Extension of working hours and additional Waiting List Initiatives to compensate for capacity deficits through distancing and Infection Prevention and Control requirements.	Higher than normal turnover Increased volume of ambulance conveyances and handover delays. Admission areas and flow management issues. Limitations to what Independent Sector Providers can take. Historic issue with Appointment Slot Issues & capacity Resilience and wellbeing of staff and need for A/L and rest. Set up time for services off site.		**Second line of defence:** **Third line of defence:**	**Second line of defence:** **Third line of defence:**	

Cause	Controls	Gaps in Controls	Action Required	Sources of Assurance	Gaps in Assurance	Action Required
including cancer care	Additional capacity being sourced and services reconfigured. Winter escalation plans to flex demand and capacity Plans to maintain urgent elective work and cancer services through periods of peak demand Agreed plans with local system National lead if level 4 incident, with established and tested plans Significant national focus on planning to maintain elective care					

RISK 3: Patients experience poor care or avoidable harm due to inability to manage emergency demand Strategic

Objectives

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. Employing the best people to care for you
9. Expanding and improving your environment
10. Innovating and investing in the future of your hospital

Strategic Risk	If there is overwhelming demand for emergency care on successive days, then patients will not receive timely care, leading to the potential for harm					**Strategic Objective**	Keeping you safe in our hospital
Lead Committee	Quality & Clinical Risk Committee	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm	**Trend: INCREASING**
Executive Lead	Chief Operating Officer	**Consequence**	5	5	**Risk Appetite**	Avoid	
Date of Assessment	December 2022	**Likelihood**	4	2	**Risk Treatment Strategy**	Treat	
Date of Review	Monthly	**Risk Rating**	20	10	**Assurance Rating**		

Cause	**Controls**	**Gaps in Controls**	**Action Required**	**Sources of Assurance**	**Gaps in Assurance**	**Action Required**
1. Very high numbers of patients accessing emergency care	Clinically and operationally agreed escalation plan	Staffing levels - vacancies in professional staff groups,	Ongoing recruitment drive and review of staffing models and skill mix.	**First line of defence:** • Daily huddle / silver command and hospital	**First line of defence:**	Reduce occupancy Increase front door capacity

Cause	Controls	Gaps in Controls	Action Required	Sources of Assurance	Gaps in Assurance	Action Required
on successive days 2. Overwhelm or service failure (for any reason) in primary care 3. Overwhelm or service failure (for any reason) in mental health (adult of child) services)	Adherence to national OPEL escalation management system Clinically risk assessed escalation areas available. Surge plans, COVID-specific SOPs and protocols have been developed. Emergency admission avoidance pathways, SDEC and ambulatory care services.	higher than normal staff absences and sickness Increased volume of ambulance conveyances and handover delays. Over-crowding in waiting areas at peak times. Admission areas and flow management issues. Reduction in bed capacity / configuration issues through estates work.	Redeployment of staff from other areas to the ED at critical times of need. Enhanced clinical staff numbers on current rotas Services and escalation plans under continuous review in response to shrinking pandemic numbers and related non covid pressures	site meetings in hours. • Out of hours on call management structure. • Major incident plan .		Increase staffing Increase discharge profile with system partners Increase vaccine uptake in the community
				Second line of defence: • System-wide (MK/BLMK/ICS) Partnership Board, Alliance & Weekly Health Cell. • Daily system resilience calls (MK Place & BLMK) .	**Second line of defence:**	
				Third line of defence:	**Third line of defence:**	

RISK 4: Insufficient funding to meet the needs of population we serve Strategic

Objectives

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. **Employing the best people to care for you**
9. Expanding and improving your environment
10. Innovating and investing in the future of your hospital

Strategic Risk	If there is insufficient, then the Trust may be unable to meet financial plans and targets or deliver its strategic aims, leading to service failure and regulatory intervention						**Strategic Objective**	Keeping you safe in our hospital
Lead Committee	Finance & Investment Committee	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm	**Trend: INCREASING**	
Executive Lead	Director of Finance	**Consequence**	5	5	**Risk Appetite**	Avoid		
Date of Assessment	December 2022	**Likelihood**	4	2	**Risk Treatment Strategy**	Treat		
Date of Review	Monthly	**Risk Rating**	20	10	**Assurance Rating**			

Cause	**Controls**	**Gaps in Controls**	**Action Required**	**Sources of Assurance**	**Gaps in Assurance**	**Action Required**
1. Change in the NHS financial regime 1. The current NHS capital regime	The Trust has a process to target the investment of available capital finance to	The Trust does not directly control the allocation of strategic NHS capital finance	Continued review Close relationship	**First line of defence:** • Regular reporting of financial	**First line of defence:**	

Cause	Controls	Gaps in Controls	Action Required	Sources of Assurance	Gaps in Assurance	Action Required
does not provide adequate certainty over the availability of strategic capital finance. Consequently, it is difficult to progress development plans in line with the strategic needs of the local population 2. Increase in operational expenditure in order to manage COVID-19 3. Reductions in non-NHS income streams as a direct result of COVID-19. 4. Impaired operating productivity leading to additional costs for extended working days and/or outsourcing.	manage risk and safety across the hospital. The Trust is tactically responsive in pursuing central NHSE/I capital programme funding to supplement the business-as-usual depreciation funded capital programme. Cost and volume contracts replaced with block contracts (set nationally) for clinical income Top-up payments available where COVID- 19 leads to additional costs over and above block sum amounts Budgets updated to support known cost pressures and backlog recovery programmes Financial efficiency programme established to identify efficiencies in cost base.	No details known for 2023/24 funding and beyond. Ability to influence (negotiate) and mitigate inflationary price rises is modest at local level.	management of key external partners (NHSE) Await publication of multi-year revenue settlement from NHS England and work with ICS partners to forward plan. Closely monitor inflationary price rises and liaise with ICS and NHS England.	performance to operational leadership teams • Dedicated financial efficiency programme • Counter Fraud oversight and awareness • BLMK ICS finance performance reports.		
				Second line of defence: • Regular reporting of financial performance to senior Trust leadership Board Assurance Framework oversight to monitor effectiveness of 1st line defences	**Second line of defence:**	

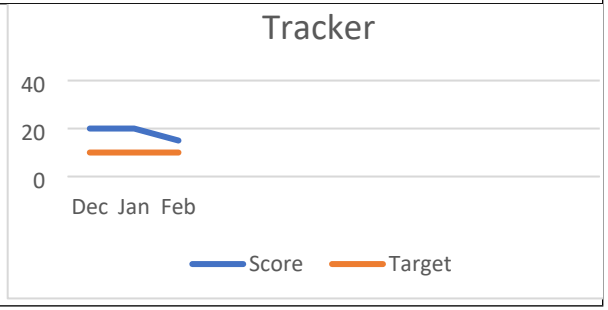
Cause	Controls	Gaps in Controls	Action Required	Sources of Assurance	Gaps in Assurance	Action Required
5. Increase in efficiency required from NHS funding regime to support DHSC budget affordability and delivery of breakeven financial performance. 6. Risk of unaffordable inflationary price increases on costs incurred for service delivery	Close monitoring of inflationary price rises.			**Third line of defence:** • Internal Audit reporting to senior Trust leadership Reporting from external bodies on relevant financial risks across sector	**Third line of defence:**	

RISK 5: Suboptimal head and neck cancer pathway

Strategic Objectives

11. **Keeping you safe in our hospital**
12. **Improving your experience of care**
13. **Ensuring you get the most effective treatment**
14. **Giving you access to timely care**
15. Working with partners in MK to improve everyone's health and care
16. Increasing access to clinical research and trials
17. Spending money well on the care you receive
18. Employing the best people to care for you
19. Expanding and improving your environment
20. Innovating and investing in the future of your hospital

Strategic Risk	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					
Lead Committee	Quality & Clinical Risk	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Medical Director	**Consequence**	5	5	**Risk Appetite**	Avoid
Date of Assessment	December 2022	**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	Monthly	**Risk Rating**	15	10	**Assurance Rating**	



Cause	Controls	Gaps in Controls	Action Required	Sources of Assurance	Gaps in Assurance	Action Required
MKUH does not provide head and neck cancer services but acts as a spoke unit to the hub at Northampton. Northampton faces:	MKUH clinicians have escalated concerns (both generic and patient specific) to the management team at Northampton. MKUH clinicians are advocating	No reliable medium to long term solution is yet in place (no definitive position has yet been made by commissioners)	Ongoing safety-netting for patients in current pathway	**First line of defence:** Number and nature of clinical incidents	**Third line of defence:** Regional quality team or independent review of pathway	

Cause	Controls	Gaps in Controls	Action Required	Sources of Assurance	Gaps in Assurance	Action Required
• Increased demand related to the pandemic; • Staffing challenges in the service • Reduced capacity as a consequence of having reduced the scope of work permissible at MKUH as the spoke site.	'mutual aid' from other cancer centers (Oxford, Luton) where appropriate. The issue has been raised formally at Executive level, and with East of England specialist cancer commissioners Safety-netting for patients in current pathway CEO to regional director escalation Report into cluster of serious incidents produced by Northampton and shared with commissioners			**Second line of defence:** Coronial inquest		

NHS
Milton Keynes University Hospital
NHS Foundation Trust

Meeting Title	**Audit Committee**	**Date: 12 December 2022**
Report Title	**Audit Committee Meeting Summary Report**	**Agenda Item Number: 18**
Chair	Gary Marven, Non-Executive Director	
Report Author	Kwame Mensa-Bonsu, Trust Secretary	

Key Messages to Note

1. Matters approved by the Committee/Recommended for Trust Board approval

The Committee reviewed the Declarations of Interest report and were satisfied with the progress made in 2022. The Committee supported the improvement actions around the management and monitoring of gifts and hospitality to be implemented in 2023 and approved the report for submission to the Board of Directors.

2. Items identified for escalation to Trust Board

a. The Committee was encouraged by the steps being taken to revise and upgrade the Board Assurance Framework so it became a more dynamic document.

b. The Committee was assured that a management action plan to return waiver utilisation to levels comparable to pre-pandemic was being developed.

3. Summary of matters considered at the meeting

a. The Committee reviewed and noted the 2021/22 Annual Accounts for ADMK Ltd, a subsidiary of Milton Keynes University Hospital, and the external audit arrangements for both businesses.

b. The Committee reviewed and noted the 2021/22 Annual Report for the Milton Keynes Hospital Charity.

c. The Committee reviewed the External Auditor's 2022/23 Audit Plan

d. The Committee reviewed the progress made against the Internal Audit 2022/23 Work Plan

4. Highlights of Board Assurance Framework Review

The Committee reviewed the draft Board Assurance Framework that was under development.

5. Risks/concerns (Current or Emerging) identified

N/A

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*

Milton Keynes University Hospital
NHS Foundation Trust

Meeting Title	**Finance and Investment Committee**	**Date: 6/12/2022**
Report Title	**Finance and investment update**	**Agenda Item Number:**
Chair	*Heidi Travis, (Non executive director)*	
Report Author	*Heidi Travis (Non executive director)*	

Key Messages to Note
1. Matters approved by the Committee/Recommended for Trust Board approval - Breast care unit capital business case reviewed and recommended.
2. Items identified for escalation to Trust Board - Year end management accounts FY 2023 reviewed and agreed ongoing work to be discussed in future meetings - BLMK draft medium term financial plan (MTFP) presented and discussed.
3. Summary of matters considered at the meeting - The Trusts operational and financial performance for Oct 2022 - An update on capital to Oct 2022 acknowledging progress and spend to happen in next 5 months. - Karl Storz contract extension for provision of theatre supplies, to be discussed at Trust Executive committee - Patient level information and costing system was presented for understanding of the work and process
4. Highlights of Board Assurance Framework Review - The BAF – Board assurance framework was reviewed for changes which were limited and accuracy with amends agreed.
5. Risks/concerns (Current or Emerging) identified - The 22/23 pay bill and what it entails for 23/24 - Medium term financial plan – and the scale and movement of likely outcome

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*

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	Trust Board Meeting In Public	**Date:** 9 March 2023
Report Title	Summary Report from the Trust Executive Committee Meeting held on 14 December 2023	**Agenda Item Number:** 18
Chair	Joe Harrison, Chief Executive	
Report Author	Julia Price, Senior Corporate Governance Officer	

Key Messages to Note

1. Matters approved by the Committee

Business cases

a. Breast Unit Works Business Case
b. Infrastructure work for Phase One chiller circuit
c. Conversion of admin room in Dermatology to a clinical space
d. Replacement of roller shutters doors in Stores
e. Replacement of breast screening equipment for mobile van
f. Consultant office moves and Pathology storage solution
g. Transport ventilator replacement for a transport ventilator
h. Intensive care relatives room refurbishment to be funded by Charitable funds
i. Downdraft dissection table, subject to funding becoming available

Policies/Guidelines/Strategies

j. Information Governance Strategy
k. Medicines Management Policy
l. Fundraising on Trust Premises Policy
m. Naming and Acknowledgment of Charitable Donations Policy
n. Authorised Signatory Policy
o. Safer Handling of the Plus Size Person Policy
p. Standard Operating Procedure for Fit Testing
q. Self-Harm Reduction Policy (including ligature risk)

2. Matters Recommended for Trust Board approval

a. Linen hire and laundry service contract extension
b. Waste collection service contract extension

3. Summary of matters considered at the meeting

- The reintroduction of mandatory facemask use in all areas where clinical care was being provided
- The reduction in overdue incident investigations and the working group established to improve the Trust's incident reporting rate
- Ongoing work to improve triage performance and patient flow through the emergency department
- The results of the maternity patient experience survey
- The quality improvement training strategy programme
- Compliance with clinical audits
- Increased paediatric demand following the closure of the Urgent Care Centre on several occasions
- Increasing demand for cancer services
- Ongoing work with trades union partners by the industrial action working group and measures being put in place to manage A&E handovers ahead of planned strike action by the ambulance service
- The re-establishment of the retention group in response to an increased turnover rate.

- Recruitment events and campaigns to address the growing vacancies in healthcare support workers
- Planning for the second phase of the international recruitment programme for an additional 100 nurses
- The outcome of the 'Dragon's Den' initiative, allocating available space on site

4. Highlights of Board Assurance Framework Review

The Board Assurance Framework was being revised and was not available for review.

5. Risks/concerns (Current or Emerging) identified

All appropriate risks considered.

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

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	Trust Board Meeting In Public	**Date:** 9 March 2023
Report Title	Summary Report from the Trust Executive Committee Meeting held on 11 January 2023	**Agenda Item Number:** 18
Chair	Joe Harrison, Chief Executive	
Report Author	Julia Price, Senior Corporate Governance Officer	

Key Messages to Note

1. Matters approved by the Committee

Business cases

a. The variation to the Endoscopy White House business case

Policies/Guidelines/Strategies

b. Pastoral, Spiritual, and Religious Care Policy
c. Freedom to Speak Up Policy and Procedure
d. Medical Job Planning Policy
e. Acting Down Policy and Procedure

2. Matters Recommended for Trust Board approval

None

3. Summary of matters considered at the meeting

- The operational impact of potential industrial action
- The management of oxygen usage in the event of reduced oxygen cylinder supplies
- Progress with the construction of the radiotherapy unit
- Ongoing CQC preparedness improvements and actions
- Each division's top three risks
- Progress in addressing ongoing issues with the Trust's incident reporting system
- The number of overdue incidents requiring investigation
- Reduction to the Trust's vacancy rate and the ongoing work to address the increased staff turnover
- Positive progress on the 'Work Any Hours' pilot campaign to create a pool of substantive staff to work their preferred hours on an 'allocate on arrival' basis
- The high level of influenza admissions
- The impact of increasing numbers of child protection medicals being carried out by hospital staff instead of in the community
- The number of corporate policies and guidelines requiring review
- The Trust's informal response to Module 3 of the Covid Inquiry
- The Complaints and PALS, Patient and Family Experience Quarter 2 Reports
- Increasing activity in the Emergency Department where in December 2022, 398 patients were seen in one day and the continuing pressures on emergency pathways
- Cancer performance challenges notably from a 42% increase in two week wait referrals, despite which, the Trust had performed better than peers across the East of England in delivering first treatments for patients for elective surgery, oncology and haematology.

4. Highlights of Board Assurance Framework Review

The revised BAF was reviewed. There were no comments of note.

5. Risks/concerns (Current or Emerging) identified

All appropriate risks considered.

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

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	Trust Board	Date: March 2023
Report Title	Quality and Clinical Risk Committee Meeting Summary Report	Agenda Item Number:
Chair	Bev Messinger, Non-Executive Director	
Report Author	Kwame Mensa-Bonsu, Trust Secretary	

Key Messages to Note

1. Matters approved by the Committee/Recommended for Trust Board approval

N/A

2. Items identified for escalation to Trust Board

a. improvement work ongoing in relation to pressure ulcer care and tissue viability.

3. Summary of matters considered at the meeting

a. The Committee noted that in Paediatrics - staff shortages, dissatisfaction with postgraduate medical education, and significant changes in clinical leadership and ways of working (e.g., eCare and e-prescribing) remained concerns.

b. The Committee noted that Emergency Department (ED) was busier than it had been pre-pandemic, with a 10 to 15% increase in daily volumes. Furthermore, there were substantial vacancies, particularly amongst Band 5 staff nurses but improvement steps were being undertaken.

c. The Committee noted that given the pandemic, the wave of demand that has followed the pandemic, the cost-of-living crisis, and a marked deterioration in public and political views on the health of the NHS, morale across the NHS (locally and nationally) was low at the time. A significant number of behavioural issues are being brought to the attention of senior leaders in the hospital, and there actions being implemented to resolve these issues.

d. The Committee received the Quarterly Complaints Report, the reviewed the overview of complaints and feedback received by the Complaints and Patient Advice and Liaison Service (PALS) teams, as well as details on some of the actions taken in response to the feedback. Actions were being undertaken to enhance the support for the PALS teams.

e. The Committee received the Patient and Family Experience Report, which provided a quarterly summary of the Trust's patient experience data, engagement, feedback, and actions taken to improve the patient and family experience. The report covered work across the organisation in various wards and departments, including the work of the Meaningful Activities Coordinator, the involvement with stakeholders such as Health Watch, projects centred on bedside information using QR codes, and work going on around deep tissue injuries.

f. The Committee also reviewed the following:

- Annual Infection Prevention and Control Report
- Infection Prevention and Control BAF
- Antimicrobial Stewardship - Annual Report

4. Highlights of Board Assurance Framework Review The Committee reviewed the draft Board Assurance Framework that was under development.
5. Risks/concerns (Current or Emerging) identified N/A

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*

Milton Keynes University Hospital
NHS Foundation Trust

Meeting Title	**Trust Board**	**Date: 09/03/23**
Report Title	**CFC Board Report from 05/12/22**	**Agenda Item Number: 18.4**
Chair	Haider Husain – Non-Exec Director	
Report Author	Haider Husain – Non-Exec Director	

Key Messages to Note
1. Matters approved by the Committee/Recommended for Trust Board approval • Charity's annual account approved • Charity Investment Policy, Fundraising on Trust Premises Policy, and the Naming and acknowledgment of charitable donations policy all approved
2. Items identified for escalation to Trust Board
3. Summary of matters considered at the meeting • Income from donations and grants slightly less than expected due to cost of living crisis and increased competition from other charities • Fundraising from major donors and corp bodies progressing as planned, continuing positive meeting with major donor who pledged £5M for radiotherapy building • Golf day planned for 4th Oct 2023 @ Woburn Golf Club • Changes to Charity team – 2 leavers and 1 new joiner • Charity partners – Friends of MKH and Als Pals invited to the meeting to build relationships and collaboration
4. Highlights of Board Assurance Framework Review
5. Risks/concerns (Current or Emerging) identified • Anticipated income target will not be achieved

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* *7. Employ the best people to care for you* *8. Expanding and improving your environment* *9. Innovating and investing in the future of your hospital*

Trust Board Meeting in Public

Forward Agenda Planner

Standing Items

Standing Business Items	Standing Trust Board Meeting In Public Items
Apologies	Patient Story
Meeting Quorate	Nursing Workforce Update
Declaration of Interests	Mortality Update
Minutes of the previous meeting	Performance Report
Action Tracker	Finance Report
Escalation items for Board attention	Workforce Report
AOB	Board Assurance Framework
Forward Agenda Planner	Trust Seal
	Summary Reports from Board Committees
	Significant Risk Register Report
	Serious Incident Report
	Patient Experience Report
	Maternity Assurance Group Update

Additional Agenda Items

Month	Assurance Reports/Items
January	Objectives Update
	Antimicrobial Stewardship - Annual Report
	Declaration of Interests Report
	Green Plan Update
	Maternity Patient Survey 2022 interim report
	Infection Prevention and Control Annual Report
	Equality, Diversity & inclusion (ED&I) Update
March	
May	Freedom to Speak Up Guardian Annual Report
	Quality Priorities
	Mortality Update
July	Annual Claims Report
	Equality, Diversity & inclusion (ED&I) Update
	Falls Annual Report

	Pressure Ulcers Annual Report
	Safeguarding Annual Report
	Green Plan Update
September	Research & Development Annual Report
	Emergency Preparedness, Resilience and Response Annual Report
	Annual Complaints Report
	Annual Patient Experience Report
November	CNST Maternity Incentive Scheme and Board Assurance Framework Sign Off
	Update on quality priorities (electives, diagnostics, emergency care and outpatients)
	Freedom to Speak Up Guardian Report
	Accountability and support for theatre productivity
	Mortality Update

TheMKWay

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

Board Meeting in Public
9 March 2023

Appendices

Item 10

1. NHS Maternity Services Survey 2022 Benchmark Report

Item 12 Finance Report:

1. Statement of Comprehensive Income
2. Statement of Cashflow
3. Statement of Financial Position
4. Glossary of Terms

Item 14 Maternity Staffing Report:

1. Labour Ward Co-ordinator Supernumerary Status
2. One to One Care in Labour Action Plan
3. Neonatal Nursing and Medical Workforce Action Plan
4. Neonatal Nursing Workforce Tool

Item 16 Risk Register Report:

1. Corporate Risk Register
2. Significant Risk Register

NHS Maternity Services Survey 2022 Benchmark Report

Milton Keynes University Hospital NHS Foundation Trust

NHS

CareQuality Commission

Ipsos

Contents

1. Background & methodology
2. Headline results
3. Benchmarking
   - Section 1. Antenatal care
   - Section 2. Labour and birth
   - Section 3. Postnatal care
4. Trends over time
   - Section 4. Antenatal care
   - Section 5. Labour and birth
   - Section 6. Postnatal care
5. Appendix

Background and methodology

This section includes:

- explanation of the NHS Patient Survey Programme
- information on the Maternity 2022 survey
- a description of key terms used in this report
- navigating the report

Background and methodology

The NHS Patient Survey Programme

The NHS Patient Survey Programme (NPSP) collects feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services.

The NPSP is commissioned by the Care Quality Commission (CQC); the independent regulator of health and adult social care in England.

As part of the NPSP, the Maternity Survey started in 2007 and the 2022 Maternity Survey will be the ninth carried out to date. The CQC use the results from the survey in the regulation, monitoring and inspection of NHS trusts in England.

To find out more about the survey programme and to see the results from previous surveys, please refer to the section on further information on this page.

The Maternity Survey 2022

The survey was administered by the Coordination Centre for Mixed Methods (CCMM) at Ipsos. A total of 45,621 mothers were invited to participate in the survey across 121 NHS trusts. Completed responses were received from 20,927 respondents, an adjusted response rate of 46.5%.

Individuals were invited to participate in the survey if they were aged 16 years or over at the time of delivery and had a live birth at an NHS Trust between 1 February and 28 February 2022. A full list of eligibility criteria can be found in the survey sampling instructions. If there were fewer than 300 people within an NHS trust who gave birth in February 2022, then births from January were included.

Fieldwork took place between April and August 2022.

Trend data

In 2021 the Maternity survey transitioned from a solely paper based methodology to both paper and online. This dual approach was continued in 2022.

Analysis conducted prior to the 2021 survey, concluded that this change in methodology did not have a detrimental impact on trend data. Therefore, data from the 2021 survey and subsequent years are comparable with previous years, unless a question has changed or there are other reasons for lack of comparability such as changes in organisation structure of a trust.

Where results are comparable with previous years, a section on historical trends has been included. Where there are insufficient data points for historical trends, significance testing has been carried out against 2021 data.

Further information about the survey

- For published results for other surveys in the NPSP, and for information to help trusts implement the surveys across the NPSP, please visit the NHS Surveys website.
- To learn more about CQC's survey programme, please visit the CQC website.

Background and methodology continued

Antenatal and Postnatal data

The maternity survey is split into three sections that ask questions about:

- antenatal care
- labour and birth
- postnatal care

It is possible that some respondents may have experienced these stages of care in different trusts. This may be for many reasons such as moving home, or having to travel for more specialist care, or due to variation in service provision across the country. For the purpose of benchmarking, it is important that we understand which trust the respondent is referring to when they are completing each section of the survey.

When answering survey questions about labour and birth we can be confident that in all cases respondents are referring to the trust from which they were sampled. It is therefore possible to compare results for labour and birth across all 121 NHS trusts that took part in the survey.

Trusts were asked to carry out an “attribution exercise”, where each trust identifies the individuals in their sample that are likely to have also received their antenatal and postnatal care from the trust. This is done using either electronic records or residential postcode information. This attribution exercise was first carried out in the 2013 survey. In 2022, 114 of the 121 trusts that took part in the survey completed this exercise.

The survey results contained in this report include only those respondents who were identified as receiving care at this trust.

Those trusts that did not provide the results of the attribution exercise to the CCMM at Ipsos do not receive results on the postnatal and antenatal sections of the survey.

Limitations of this approach

Data is provided voluntarily, and not all trusts provided this data. The antenatal and postnatal care sections of this report are therefore benchmarked against those other trusts that also provided the required information.

Some trusts do not keep electronic records of antenatal and postnatal care. Where this is the case, location of antenatal and postnatal care is based on residential location of respondents. This is not a perfect measure of whether antenatal and postnatal care was received at the trust. For example, respondents requiring specialist antenatal or postnatal care may have received this from another trust. This may mean that some respondents are included in the data despite having received care from another trust.

Key terms used in this report

The ‘expected range’ technique

This report shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part. It uses an analysis technique called the ‘expected range’ to determine if your trust is performing ‘about the same’, ‘better’ or ‘worse’ compared with most other trusts. This is designed to help understand the performance of individual trusts and identify areas for improvement. More information can be found in the Appendix.

Standardisation

Demographic characteristics, such as age can influence care experiences and how they are reported. Since trusts have differing profiles of maternity service users, this could make fair trust comparisons difficult. To account for this, we ‘standardise’ the results, which means we apply a weight to individual patient responses to account for differences in profiles between trusts. For each trust, results have been standardised by parity (whether or not a mother has given birth previously) and age of respondents to reflect the ‘national’ age distribution (based on all respondents to the survey).

This helps ensure that no trust will appear better or worse than another because of its profile of maternity service users, and enables a fairer and more useful comparison of results across trusts. In most cases this standardisation will not have a large impact on trust results.

Scoring

For selected questions in the survey, the individual (standardised) responses are converted into scores, typically 0, 5, or 10 (except for questions B3 and D8). A score of 10 represents the best possible result and a score of 0 the worst. The higher the score for each question, the better the trust is performing. Only evaluative questions in the questionnaire are scored. Some questions are descriptive and others are ‘routing questions’, which are designed to filter out respondents to whom subsequent questions do not apply (for example C3). These questions are not scored. Section scoring is computed as the arithmetic mean of question scores for the section after weighting is applied.

Trust average

The ‘trust average’ mentioned in this report is the arithmetic mean of all trusts’ scores after weighting is applied.

Suppressed data

If fewer than 30 respondents have answered a question, no score will be displayed for that question (or the corresponding section the question contributes to). This is to prevent individual responses being identifiable.

Further information about the methods

For further information about the statistical methods used in this report, please refer to the survey technical document.

Using the survey results

Navigating this report

This report is split into **five** sections:

1. Background and methodology – provides information about the survey programme, how the survey is run and how to interpret the data.

2. Headline results – includes key trust-level findings relating to the mothers who took part in the survey, benchmarking, and top and bottom scores. This section provides an overview of results for your trust, identifying areas where your organisation performs better than the average and where you may wish to focus improvement activities.

3. Benchmarking – shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part; using the 'expected range' analysis technique. This allows you to see the range of scores achieved and compare yourself with the other organisations that took part in the survey. Benchmarking can provide you with an indication of where you perform better than the average, and what you should aim for in areas where you may wish to improve. Only trusts that provide data on antenatal and/ or postnatal care and have sufficient respondent numbers are also provided with survey results for antenatal and postnatal care within this report.

4. Trends over time – includes your trust's mean score for each evaluative question in the survey. This is either shown as a historical trend chart or a significance test table, depending on the availability of longitudinal data.

Where possible, significance testing compares the mean score for your trust in 2021 to your 2022 mean score. This allows you to see if your trust has made statistically significant improvements between survey years.

Historical trends are presented where data is available, and questions remain comparable for your trust. Trends are presented only where there are at least five data points available to plot on the chart. Historical trend charts show the mean score for your trust by year, so that you can see if your trust has made improvements over time. They also include the national mean score by year, to allow you to see whether your performance is in line with the national average or not.

Significance test tables are presented where there are less than 5 data points available and questions remain comparable between 2021 and 2022.

5. Appendix – includes additional data for your trust; further information on the survey methodology; interpretation of graphs in this report.

Using the survey results continued

How to interpret the graphs in this report

There are several types of graphs in this report which show how the score for your trust compares to the scores achieved by all trusts that took part in the survey.

The two chart types used in the section 'benchmarking' use the 'expected range' technique to show results. For information on how to interpret these graphs, please refer to the Appendix.

Other data sources

More information is available about the following topics at their respective websites, listed below:

- Full national results; A-Z list to view the results for each trust; technical document: www.cqc.org.uk/maternitysurvey
- National and trust-level data for all trusts who took part in the Maternity 2022 survey: www.cqc.org.uk/maternitysurvey. Full details of the methodology for the survey, instructions for trusts and contractors to carry out the survey, and the survey development report can also be found on the NHS Surveys website.
- Information on the NHS Patient Survey Programme, including results from other surveys: www.cqc.org.uk/content/surveys
- Information about how the CQC monitors services: https://www.cqc.org.uk/what-we-do/how-we-use-information/using-data-monitor-services

Headline results

This section includes:

- information about your trust population
- an overview of benchmarking for your trust
- the top and bottom scores for your trust

Who took part in the survey?

This slide is included to help you interpret responses and to provide information about the population of mothers who took part in the survey.

300 invited to take part

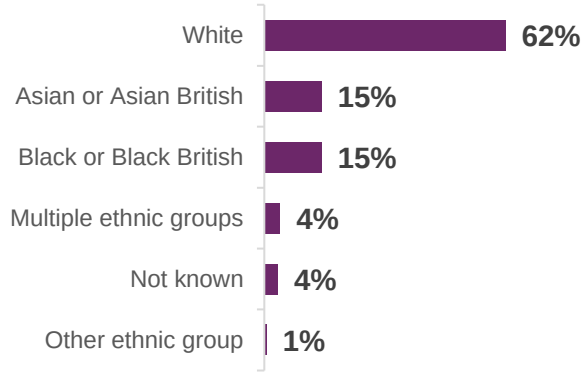
169 completed

57% response rate

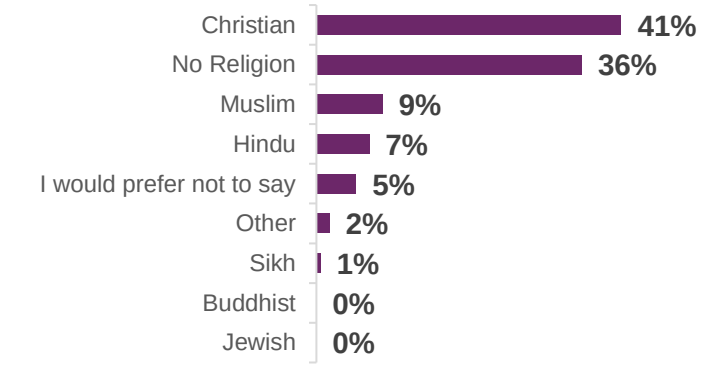
47% average trust response rate

56% response rate for your trust for 2021

ETHNICITY

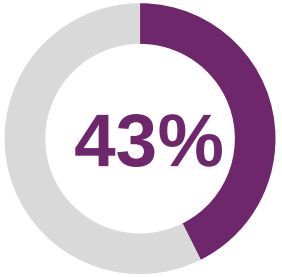


RELIGION



PARITY

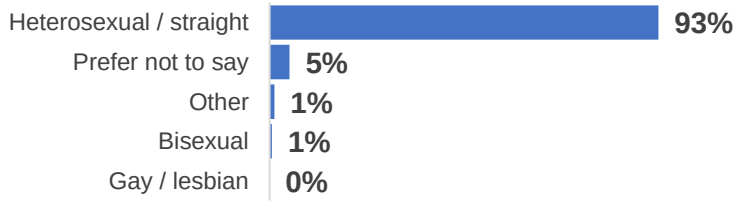
How many babies have you given birth to before this pregnancy?



of respondents gave birth to **their first baby.**

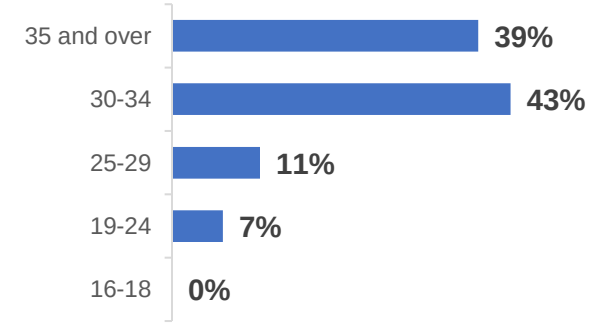
SEXUALITY

Which of the following best describes how you think of yourself?



93% of participants described themselves as heterosexual or straight.

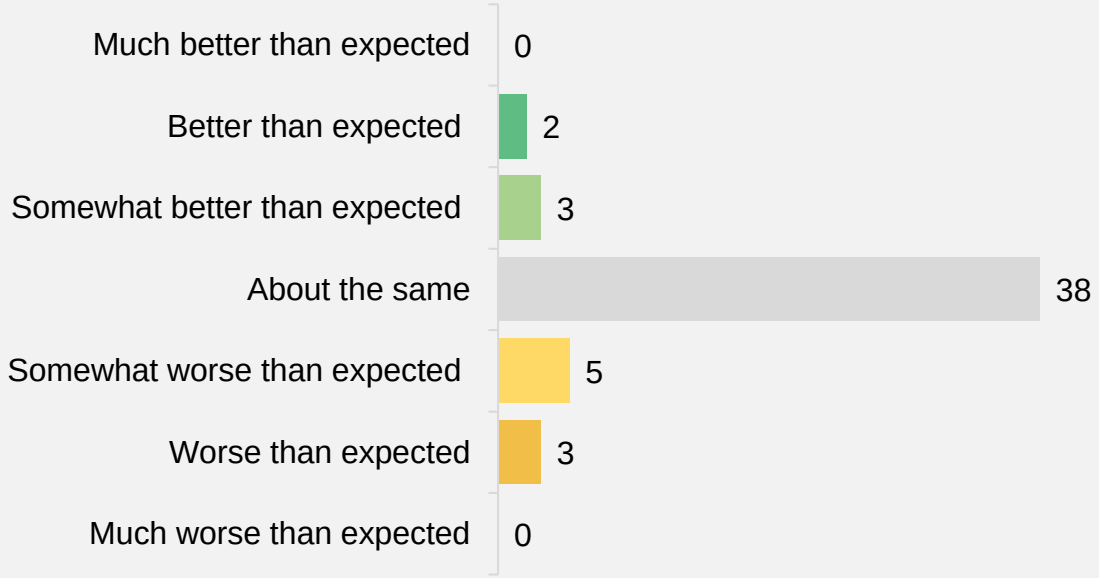
AGE



Summary of findings for your trust

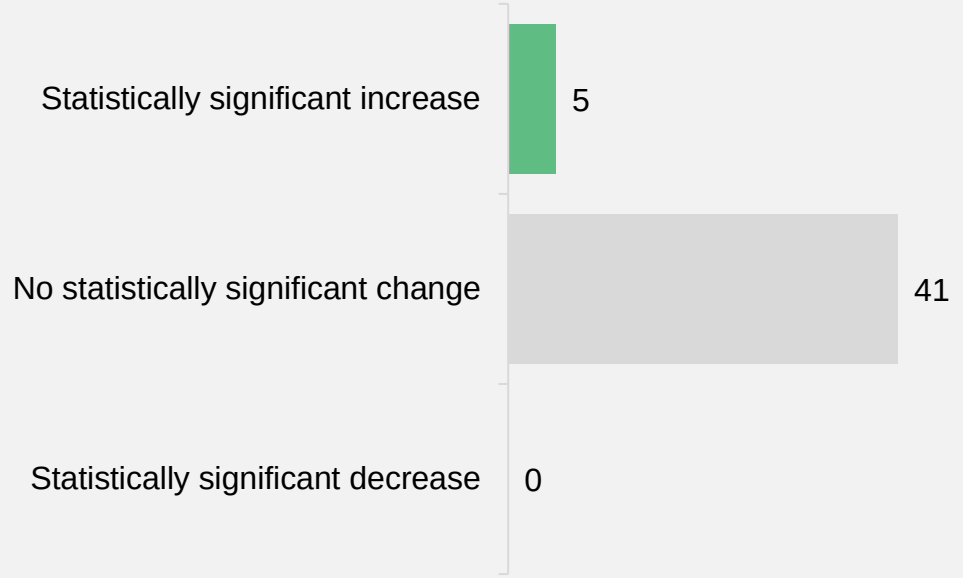
Comparison with other trusts

The **number of questions** in this report at which your trust has performed better, worse, or about the same compared with most other trusts.



Comparison with results from 2021

The **number of questions** in this report where your trust showed a statistically significant increase, decrease, or no change in scores compared to 2021 results.



For a breakdown of the questions where your trust has performed better or worse compared with all other trusts, please refer to the appendix section "comparison to other trusts".

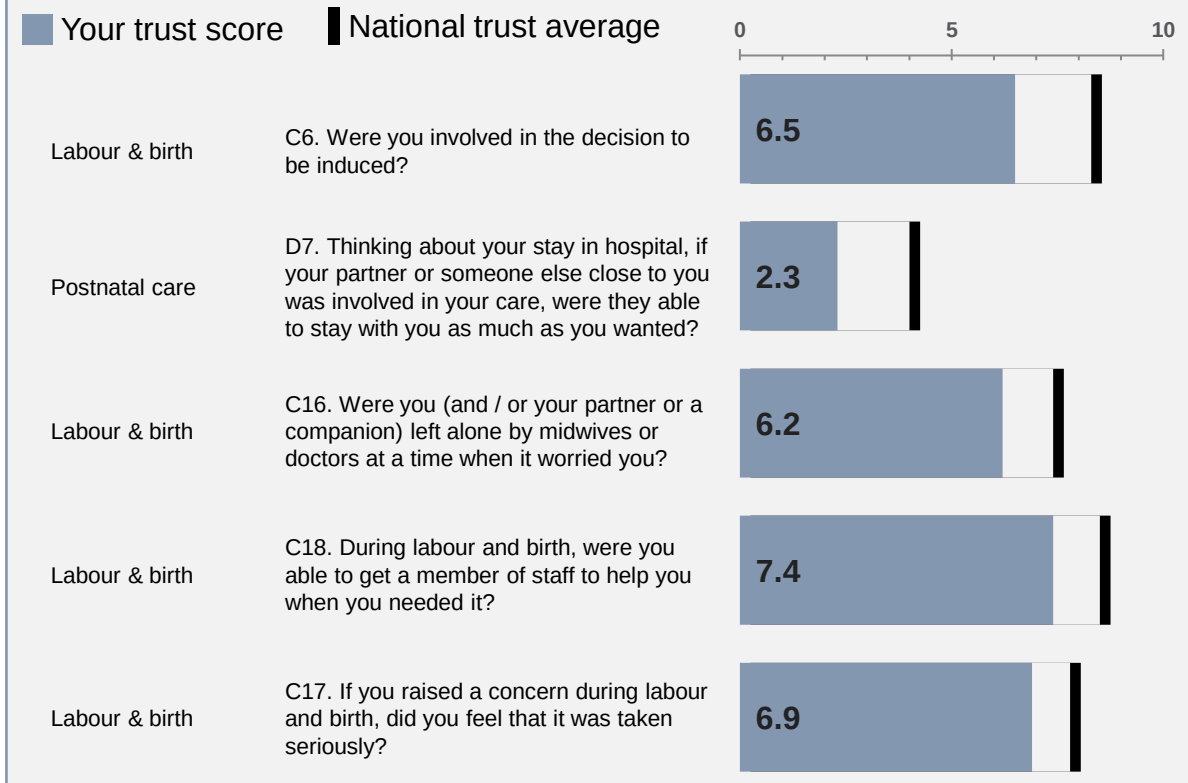
Best and worst performance relative to the trust average

These five questions are calculated by comparing your trust's results to the trust average (the average trust score across England).

- **Top five scores**: These are the five results for your trust that are highest compared with the trust average. If none of the results for your trust are above the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's best performance may be worse than the trust average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the trust average. If none of the results for your trust are below the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's worst performance may be better than the trust average.

Top five scores (compared with average trust score across England)

Bottom five scores (compared with average trust score across England)



Benchmarking

This section includes:

- how your trust scored for each evaluative question in the survey, compared with other trusts that took part
- an analysis technique called the ‘expected range’ to determine if your trust is performing about the same, better or worse compared with most other trusts.
- for more guidance on interpreting these graphs, please refer to the appendix

Benchmarking

Antenatal care

NHS

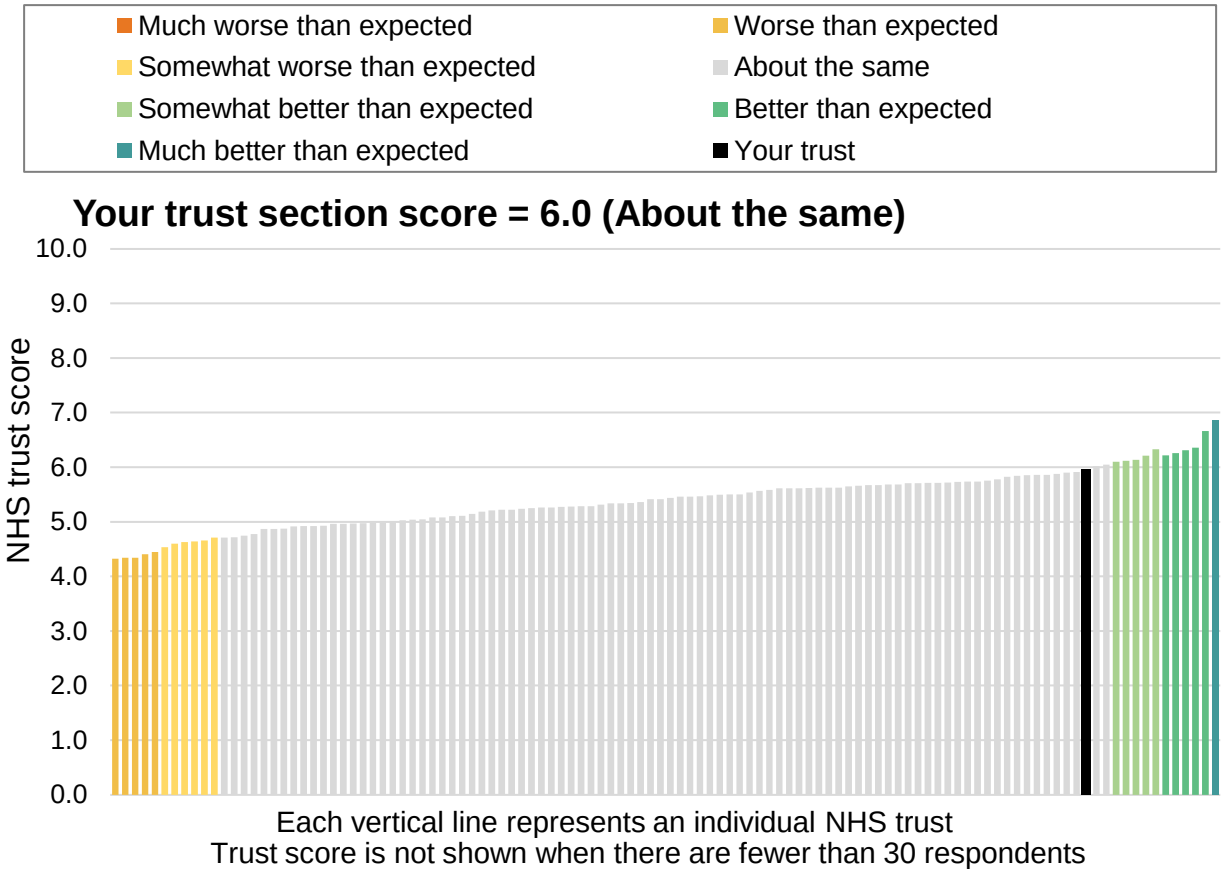
Care Quality Commission

Ipsos

The start of your care during pregnancy

Section score

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'the start of your care during pregnancy' is calculated from questions B3 to B5. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



Comparison with other trusts within your region

Trusts with the highest scores

Milton Keynes University Hospital NHS Foundation Trust	6.0
The Princess Alexandra Hospital NHS Trust	5.8
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	5.7
Cambridge University Hospitals NHS Foundation Trust	5.7
West Hertfordshire Hospitals NHS Trust	5.0

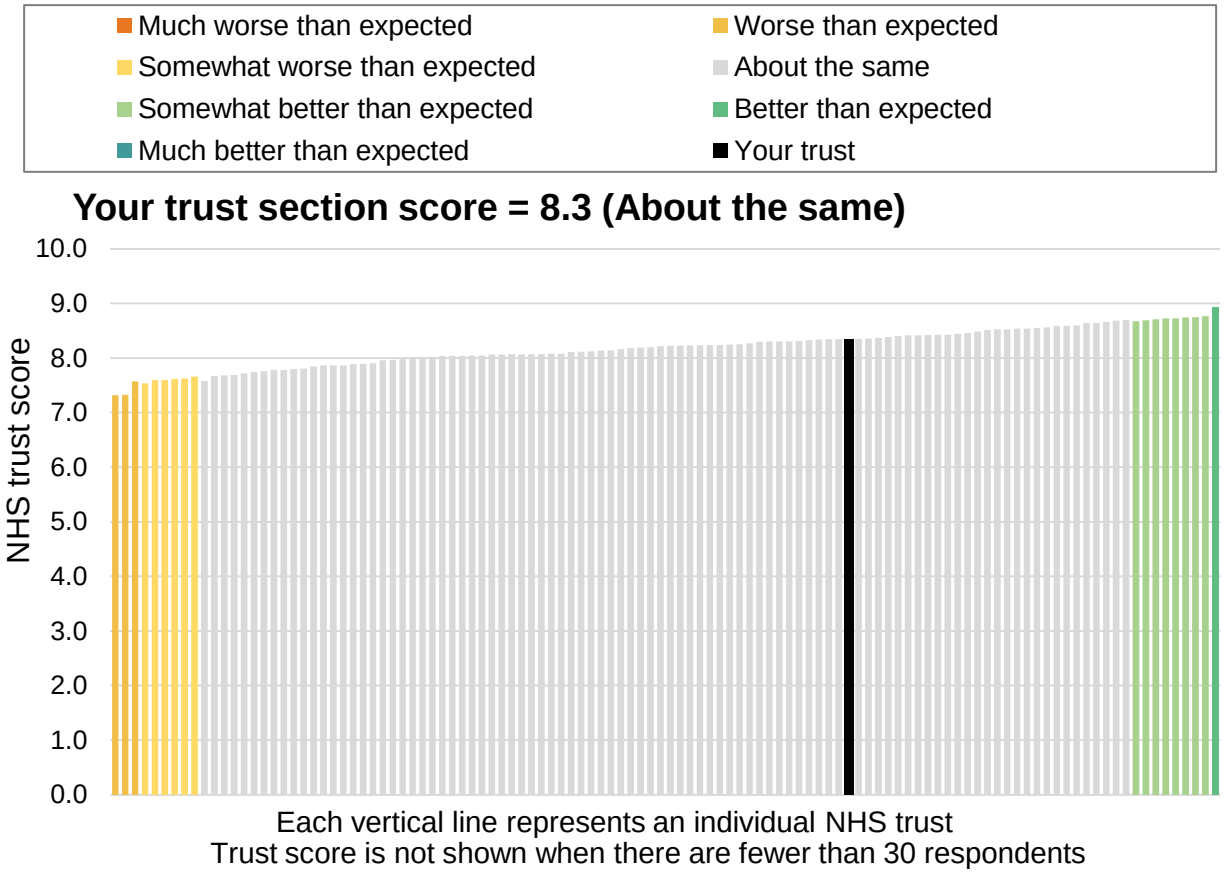
Trusts with the lowest scores

East and North Hertfordshire NHS Trust	4.3
East Suffolk and North Essex NHS Foundation Trust	4.7
North West Anglia NHS Foundation Trust	4.8
Norfolk and Norwich University Hospitals NHS Foundation Trust	5.0
Bedfordshire Hospitals NHS Foundation Trust	5.0

Antenatal check-ups

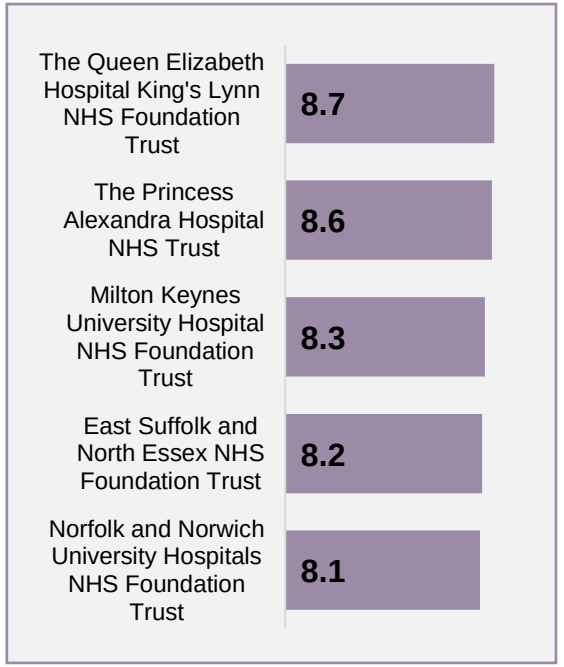
Section score

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'antenatal check-ups' is calculated from questions B8 to B11. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

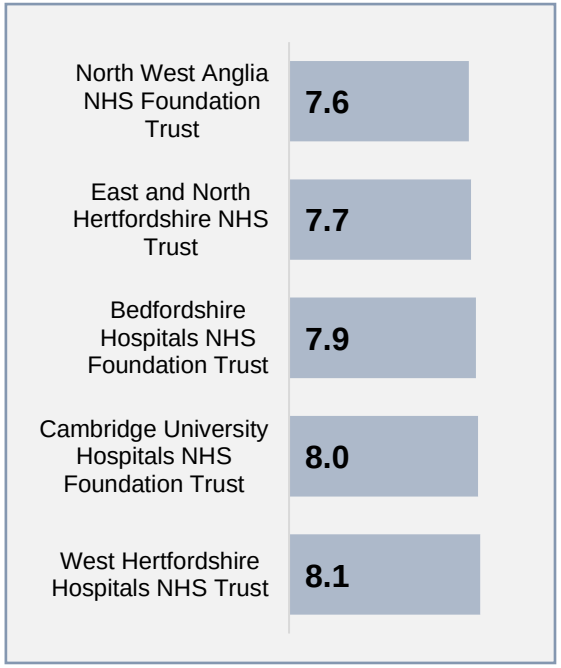


Comparison with other trusts within your region

Trusts with the highest scores



Trusts with the lowest scores



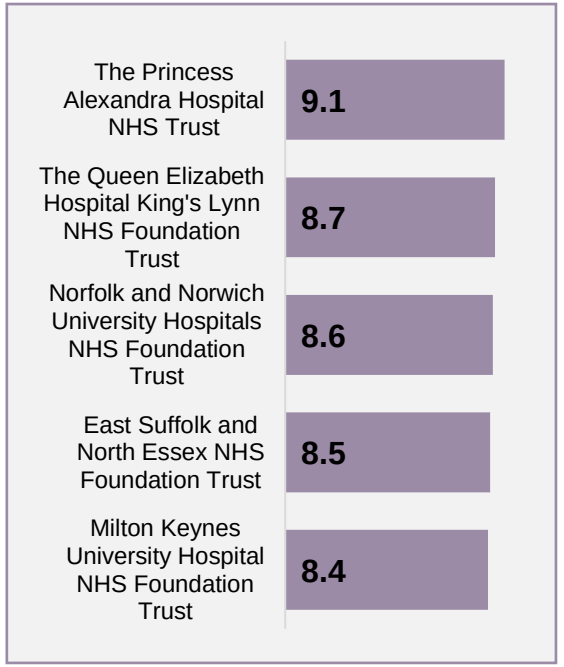
During your pregnancy

Section score

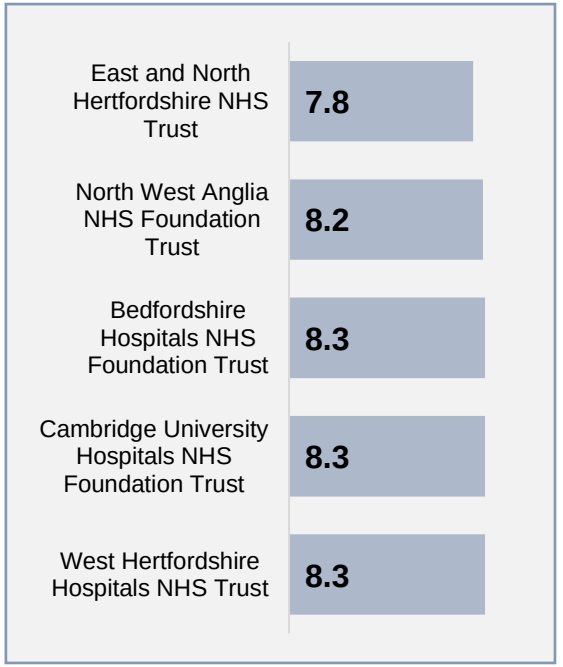
This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'during your pregnancy' is calculated from questions B12 to B18. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Comparison with other trusts within your region

Trusts with the highest scores

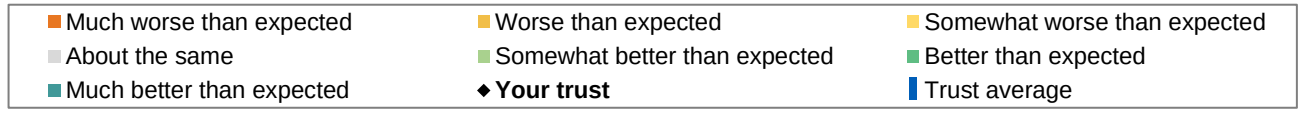


Trusts with the lowest scores



Benchmarking - Antenatal care

Question scores: Start of your pregnancy



		All trusts in England			
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
B3. Were you offered a choice about where to have your baby?	130	4.4	3.6	2.0	5.1
B4. Did you get enough information from either a midwife or doctor to help you decide where to have your baby?	155	7.3	6.6	5.0	8.6
B5. At the start of your care in pregnancy, did you feel that you were given enough information about coronavirus restrictions and any implications for your maternity care?	154	6.2	6.0	4.7	7.5

Somewhat better

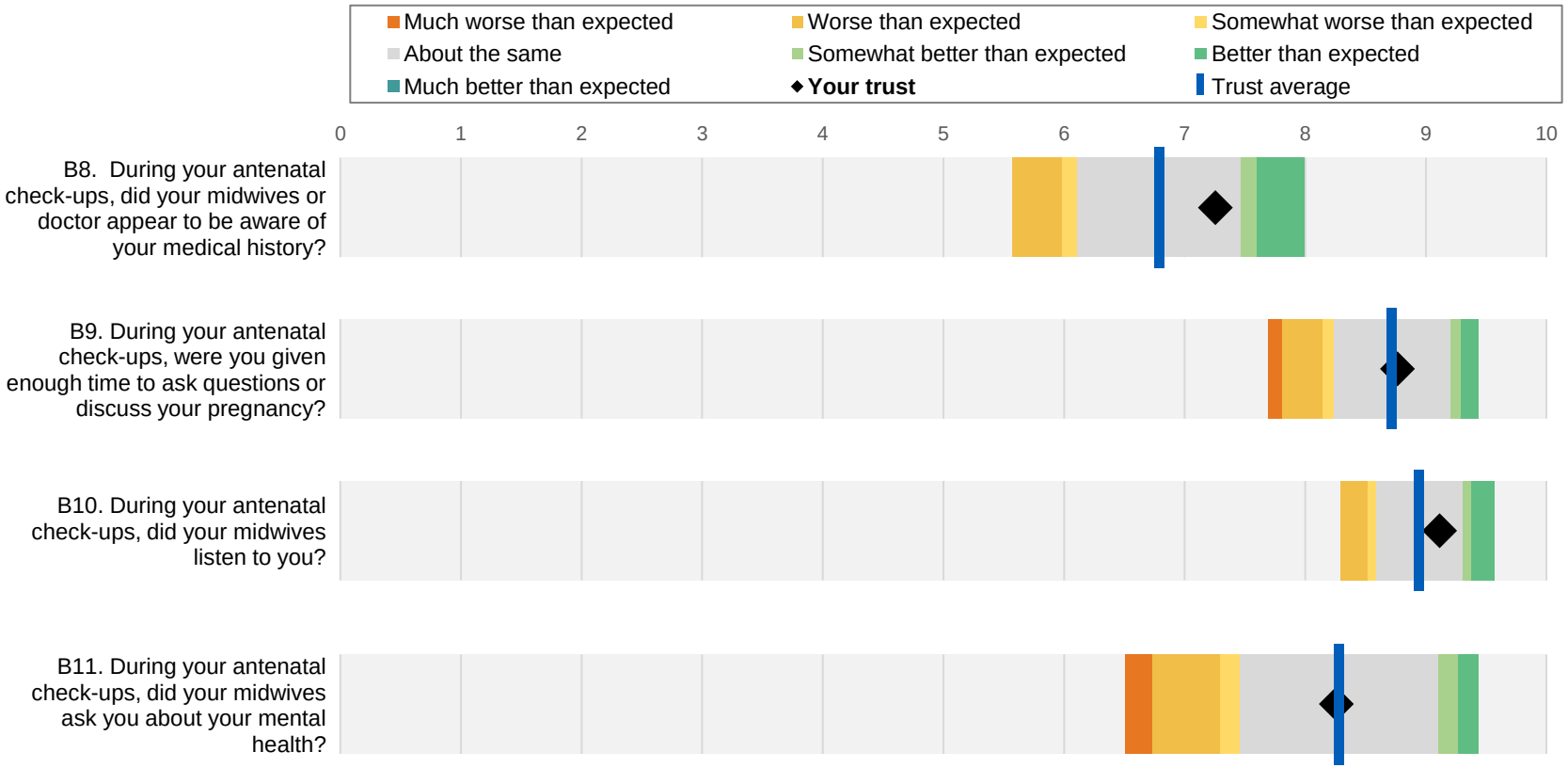
About the same

About the same

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Antenatal care (continued)

Question scores: Antenatal check-ups

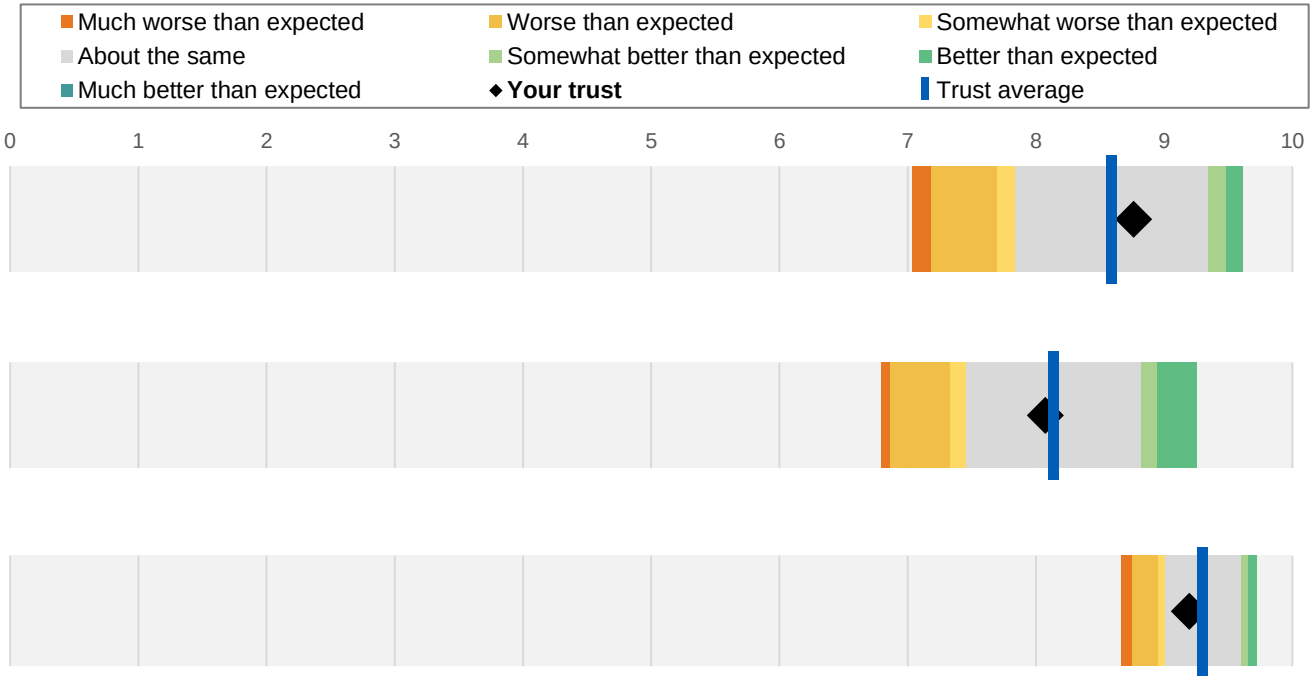


			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
About the same	156	7.3	6.8	5.6	8.0
About the same	159	8.8	8.7	7.7	9.4
About the same	159	9.1	8.9	8.3	9.6
About the same	157	8.3	8.3	6.5	9.4

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Antenatal care (continued)

Question scores: During your pregnancy



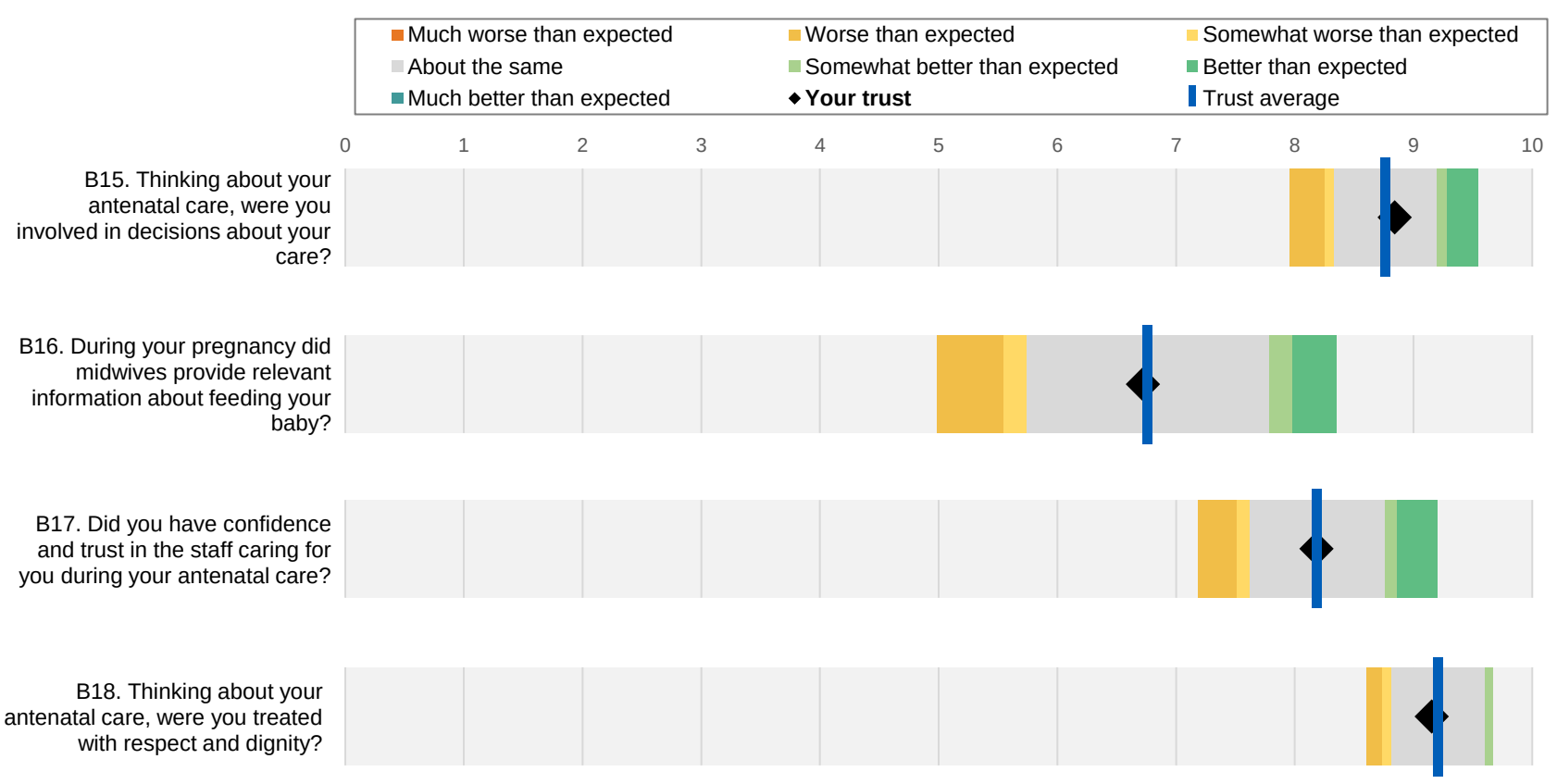
		All trusts in England			
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
B12. Were you given enough support for your mental health during your pregnancy?	101	8.8	8.6	7.0	9.6
B13. During your pregnancy, if you contacted a midwifery team, were you given the help you needed?	146	8.1	8.1	6.8	9.3
B14. Thinking about your antenatal care, were you spoken to in a way you could understand?	159	9.2	9.3	8.7	9.7

About the same

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Antenatal care (continued)

Question scores: During your pregnancy



			All trusts in England			
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score	
B15. Thinking about your antenatal care, were you involved in decisions about your care?	157	8.8	8.8	8.0	9.5	About the same
B16. During your pregnancy did midwives provide relevant information about feeding your baby?	159	6.7	6.8	5.0	8.4	About the same
B17. Did you have confidence and trust in the staff caring for you during your antenatal care?	159	8.2	8.2	7.2	9.2	About the same
B18. Thinking about your antenatal care, were you treated with respect and dignity?	158	9.2	9.2	8.6	9.7	About the same

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking

Labour and birth

NHS

CareQuality Commission

Ipsos

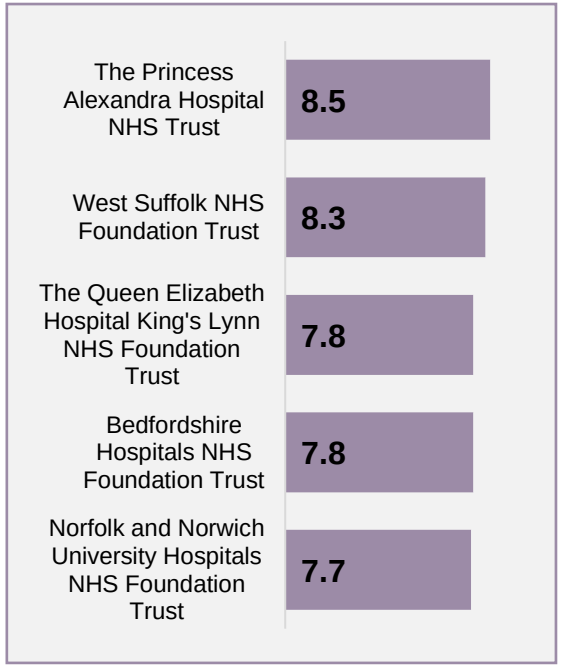
Your labour and birth

Section score

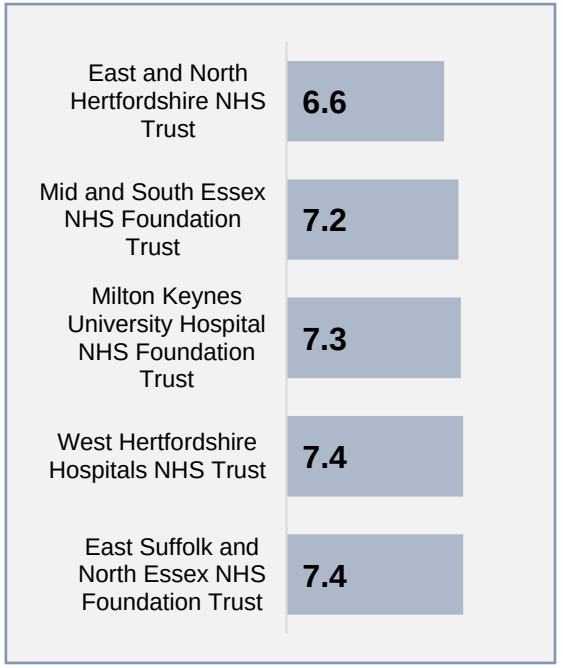
This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'your labour and birth' is calculated from questions C4 to C7 and C12. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Comparison with other trusts within your region

Trusts with the highest scores



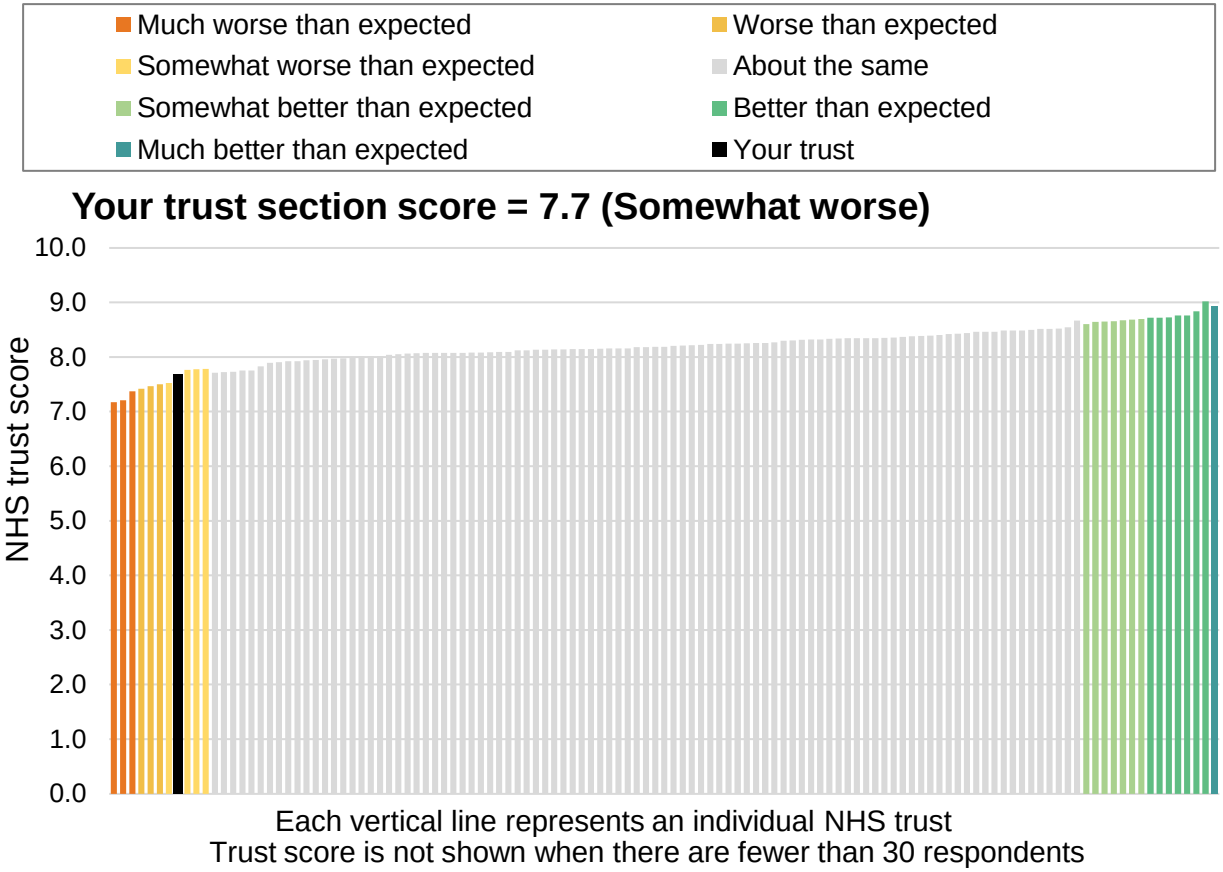
Trusts with the lowest scores



Staff caring for you

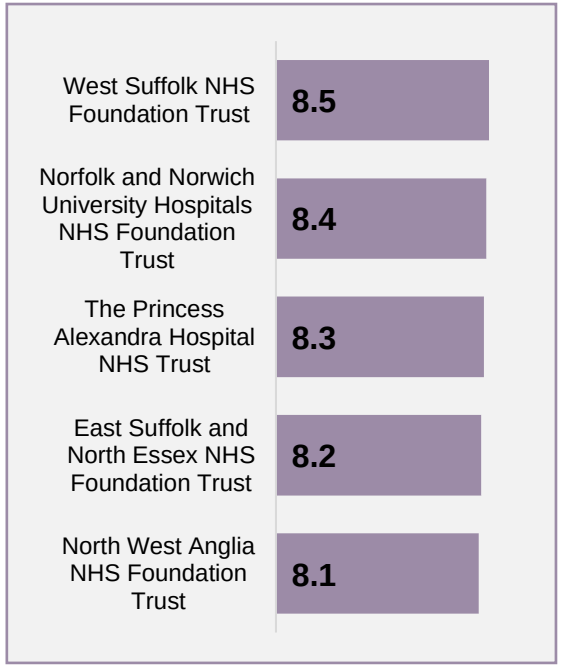
Section score

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'staff caring for you' is calculated from questions C14 and C16 to C24. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

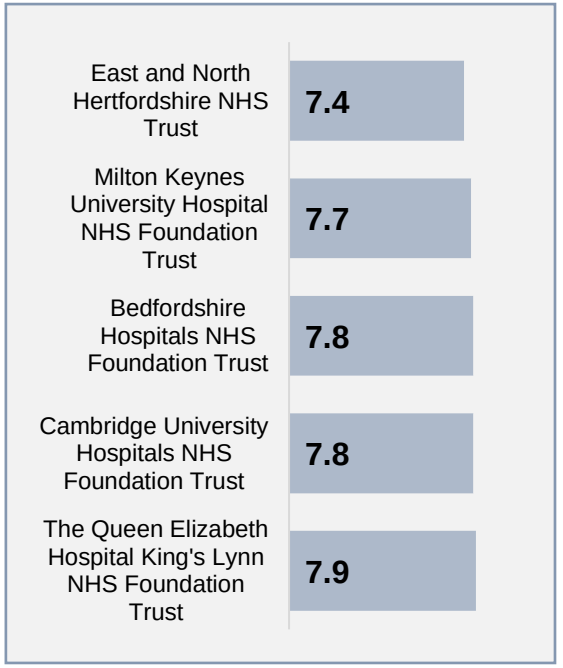


Comparison with other trusts within your region

Trusts with the highest scores



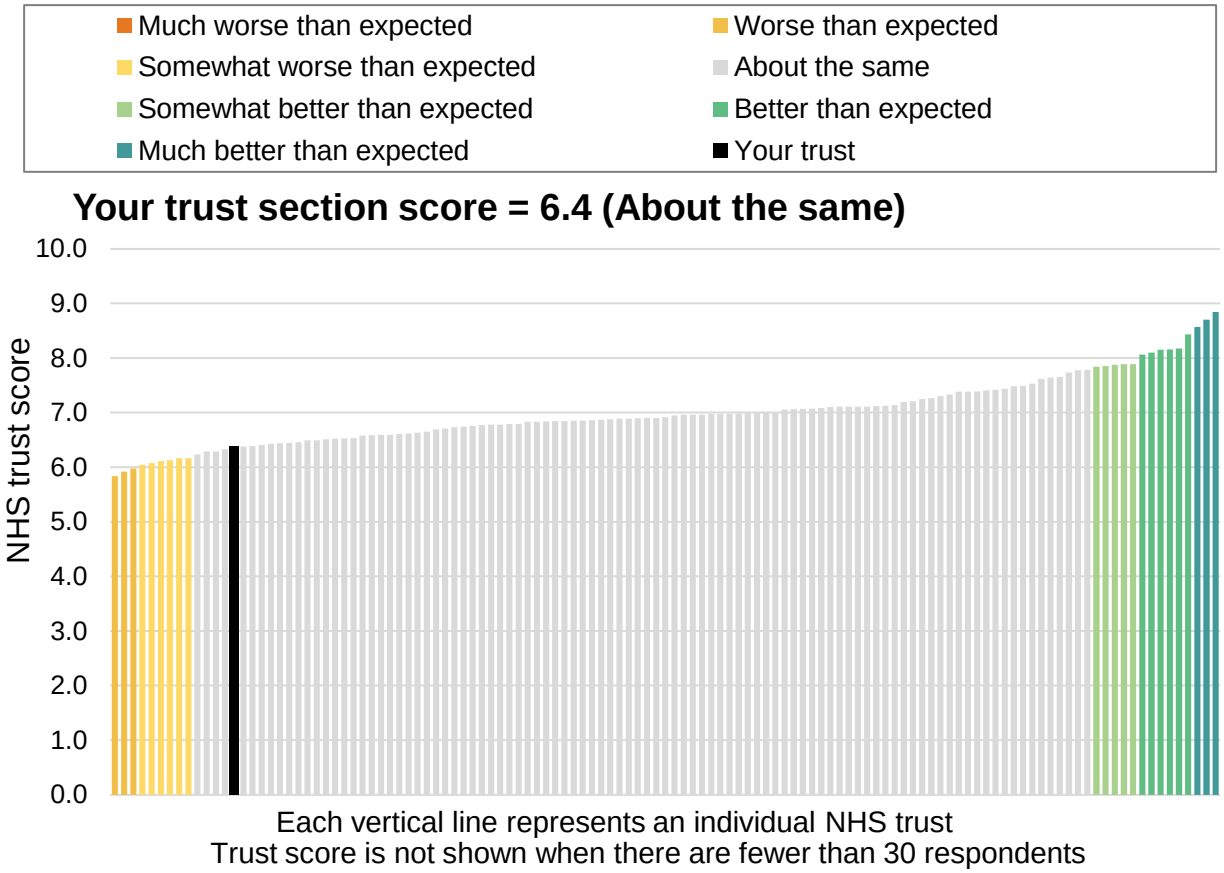
Trusts with the lowest scores



Care in hospital after birth

Section score

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, ‘care in hospital after birth’ is calculated from questions D2 and D4 to D8. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The ‘expected range’ analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as ‘about the same’ whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



Comparison with other trusts within your region

Trusts with the highest scores

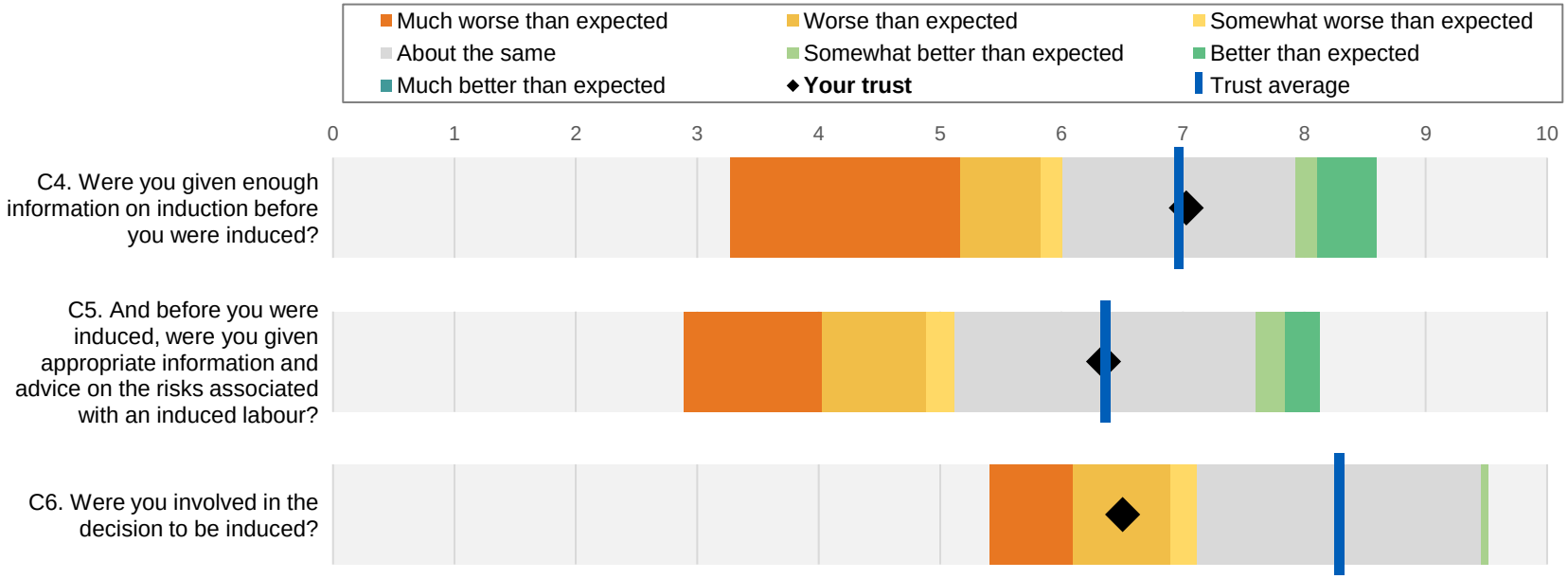
Cambridge University Hospitals NHS Foundation Trust	7.6
West Suffolk NHS Foundation Trust	7.4
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	7.1
North West Anglia NHS Foundation Trust	7.1
East Suffolk and North Essex NHS Foundation Trust	7.0

Trusts with the lowest scores

East and North Hertfordshire NHS Trust	5.8
Bedfordshire Hospitals NHS Foundation Trust	6.3
Milton Keynes University Hospital NHS Foundation Trust	6.4
West Hertfordshire Hospitals NHS Trust	6.6
Mid and South Essex NHS Foundation Trust	6.7

Benchmarking - Labour and birth

Question scores: Your labour and birth

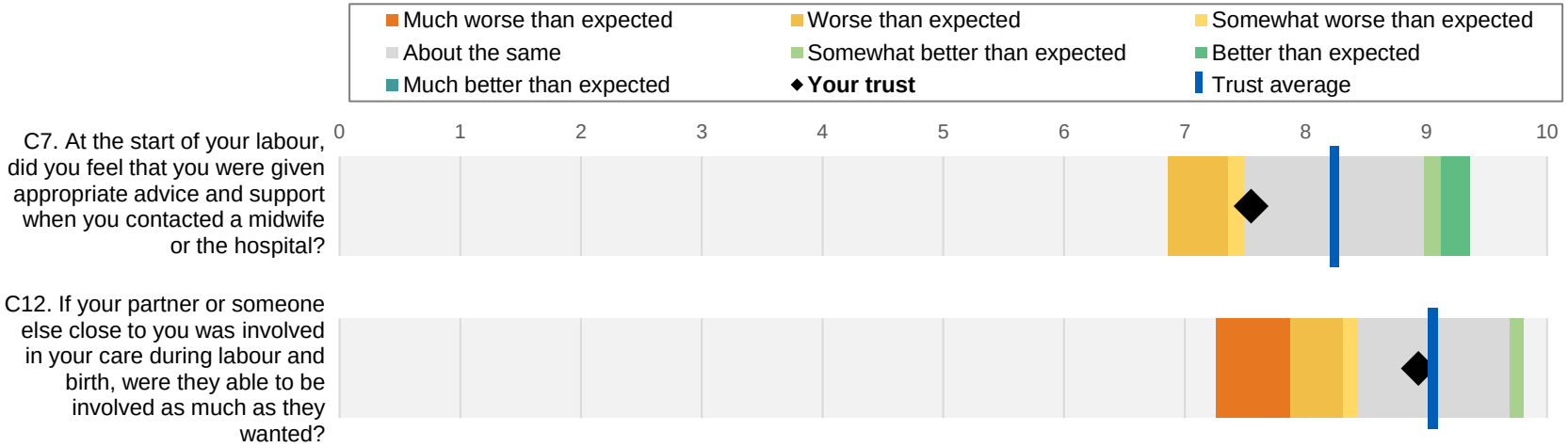


			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
About the same	55	7.0	7.0	3.3	8.6
About the same	50	6.3	6.4	2.9	8.1
Worse	52	6.5	8.3	5.4	9.5

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Labour and birth (continued)

Question scores: Your labour and birth



			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
C7. At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?	129	7.5	8.2	6.9	9.4
C12. If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?	155	8.9	9.1	7.3	9.8

About the same

About the same

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Labour and birth (continued)

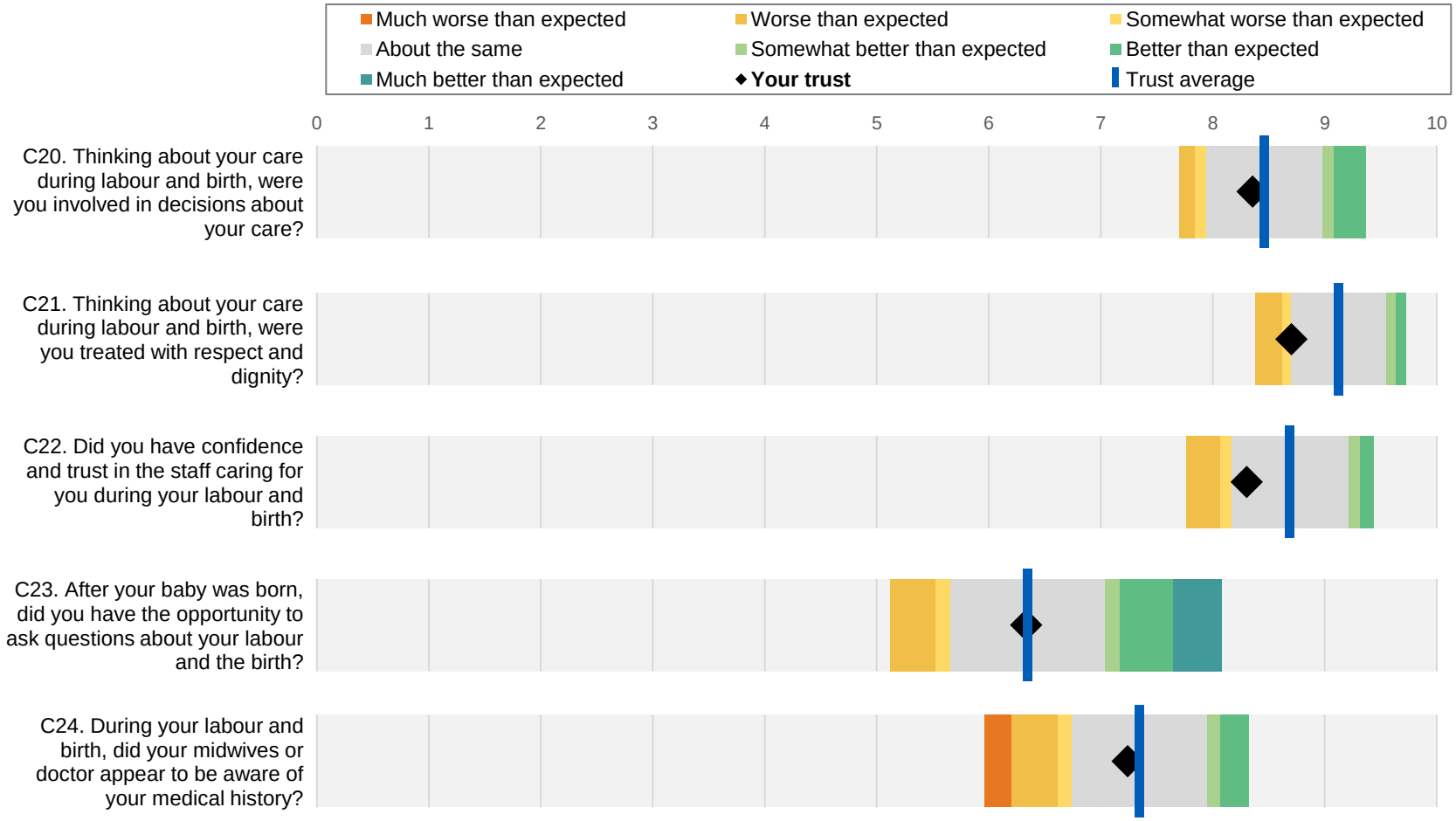
Question scores: Staff caring for you

		All trusts in England			
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
C14. Did the staff treating and examining you introduce themselves? — Somewhat worse	162	8.6	9.0	8.1	9.6
C16. Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you? — Worse	168	6.2	7.4	5.4	9.0
C17. If you raised a concern during labour and birth, did you feel that it was taken seriously? — Somewhat worse	113	6.9	7.8	6.4	9.0
C18. During labour and birth, were you able to get a member of staff to help you when you needed it? — Worse	167	7.4	8.5	7.2	9.4
C19. Thinking about your care during labour and birth, were you spoken to in a way you could understand? — About the same	169	8.9	9.2	8.5	9.7

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Labour and birth (continued)

Question scores: Staff caring for you

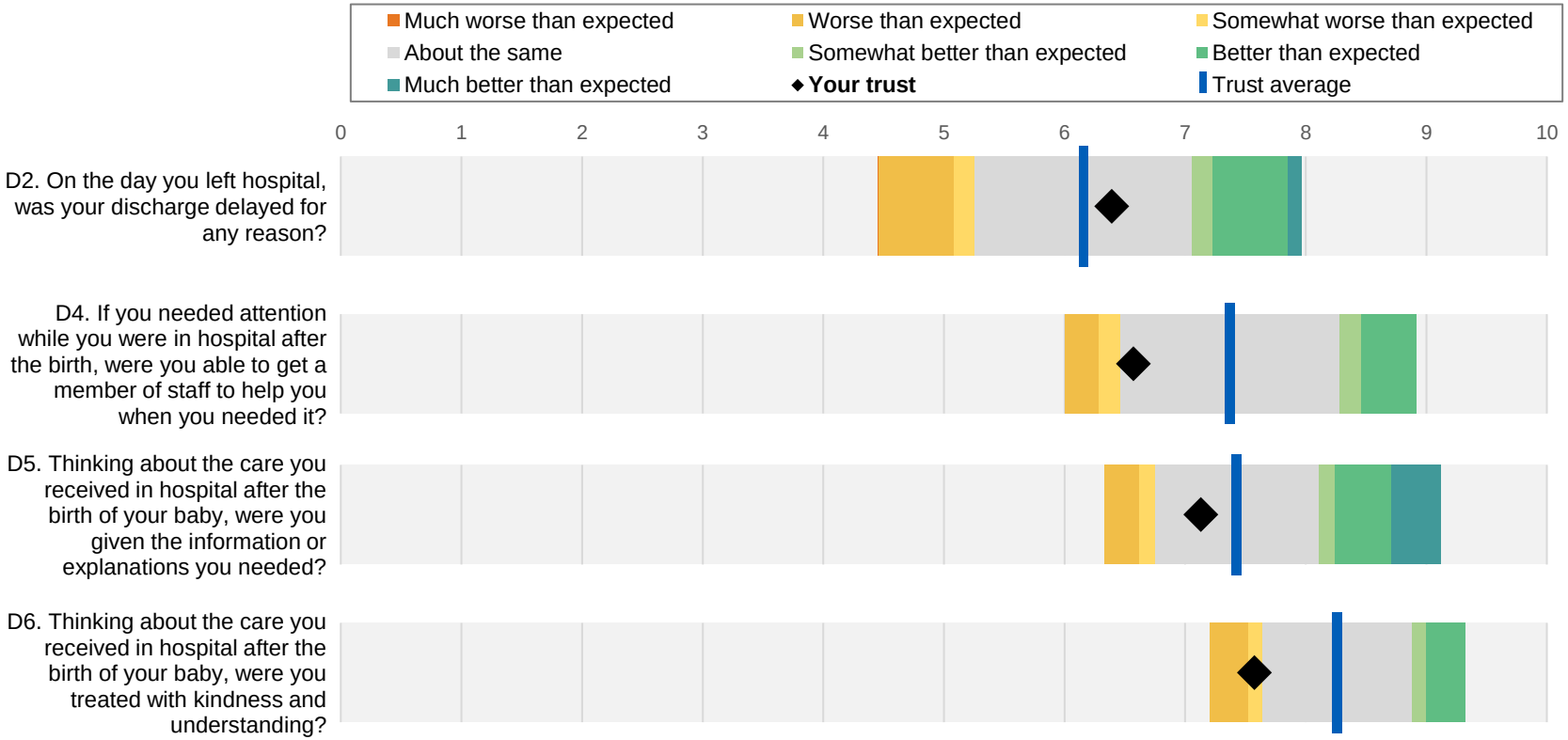


			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
C20. Thinking about your care during labour and birth, were you involved in decisions about your care?	167	8.4	8.5	7.7	9.4
C21. Thinking about your care during labour and birth, were you treated with respect and dignity?	168	8.7	9.1	8.4	9.7
C22. Did you have confidence and trust in the staff caring for you during your labour and birth?	169	8.3	8.7	7.8	9.4
C23. After your baby was born, did you have the opportunity to ask questions about your labour and the birth?	148	6.3	6.3	5.1	8.1
C24. During your labour and birth, did your midwives or doctor appear to be aware of your medical history?	158	7.2	7.3	6.0	8.3

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Labour and birth (continued)

Question scores: Care in hospital after birth

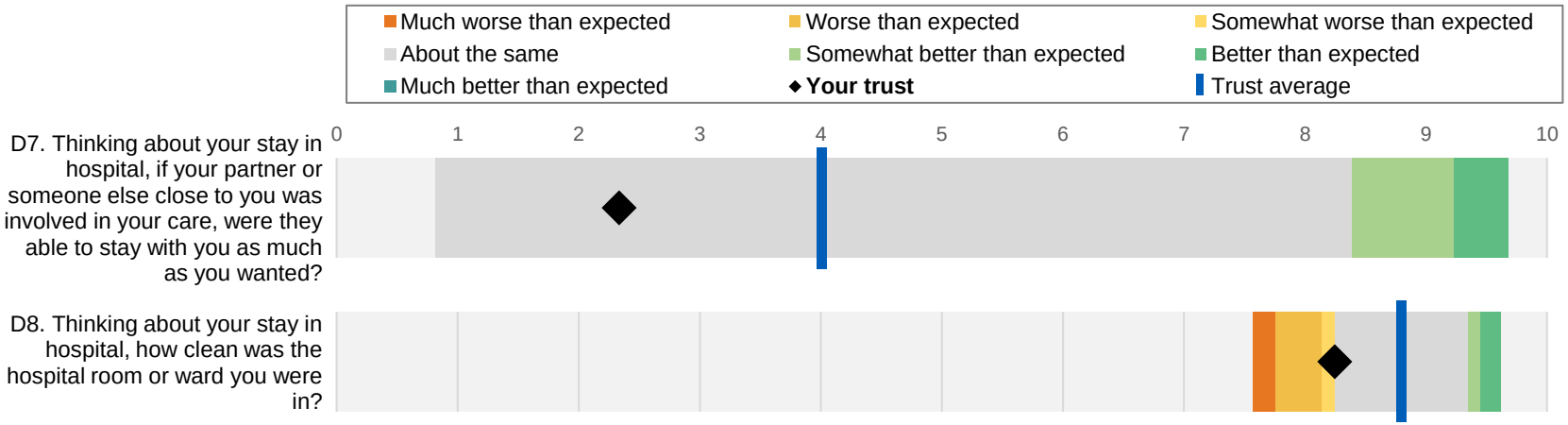


			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
About the same	169	6.4	6.2	4.5	8.0
About the same	153	6.6	7.4	6.0	8.9
About the same	165	7.1	7.4	6.3	9.1
Somewhat worse	168	7.6	8.3	7.2	9.3

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Labour and birth (continued)

Question scores: Care in hospital after birth



		All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
About the same	155	2.3	4.0	0.8	9.7
Somewhat worse	167	8.2	8.8	7.6	9.6

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking

Postnatal care

NHS

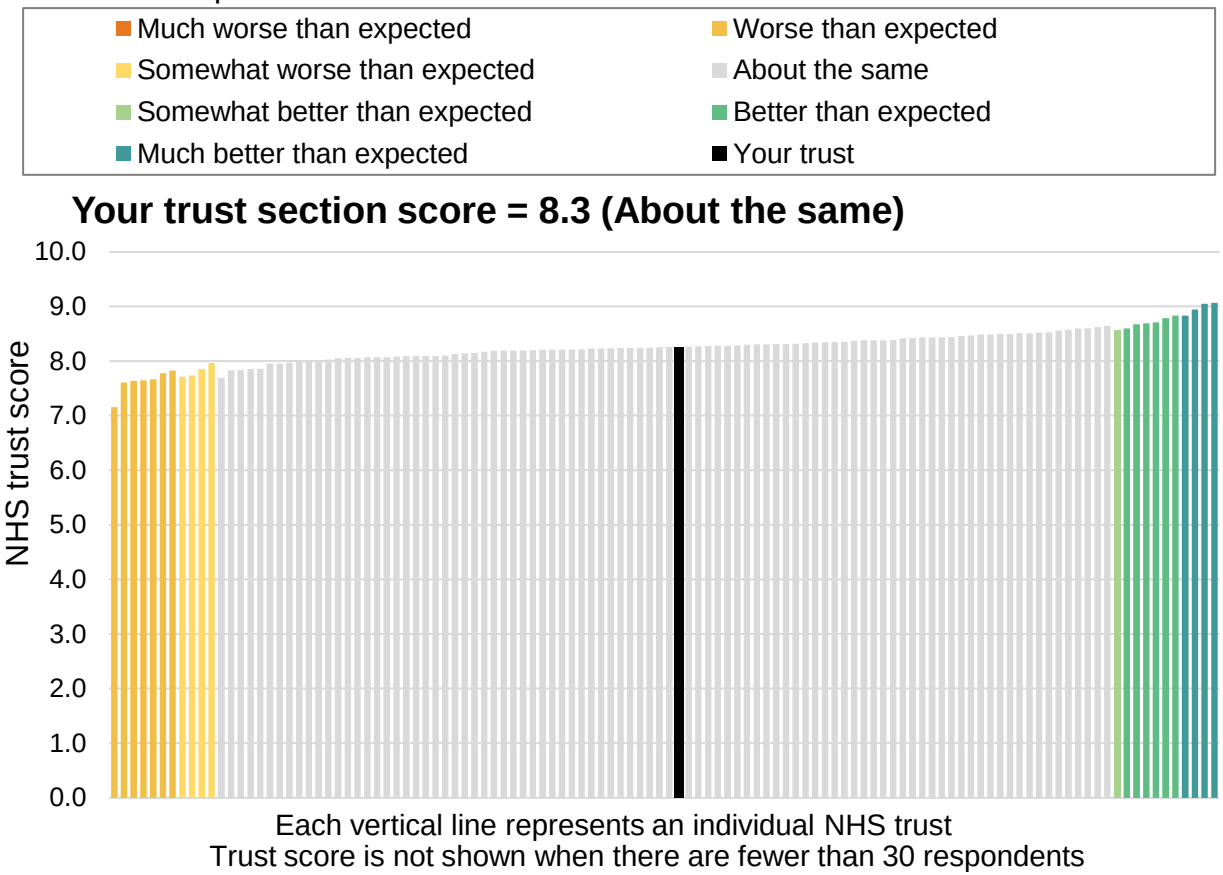
Care Quality Commission

Ipsos

Feeding your baby

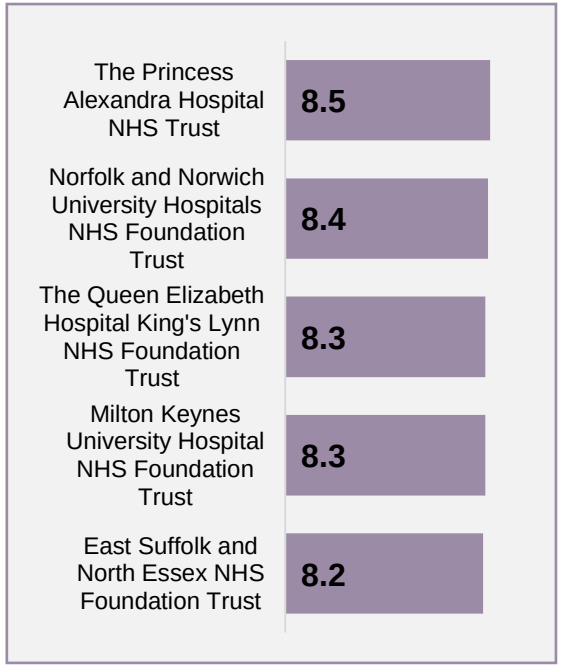
Section score

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for postnatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'feeding your baby' is calculated from questions E2 and E3 The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

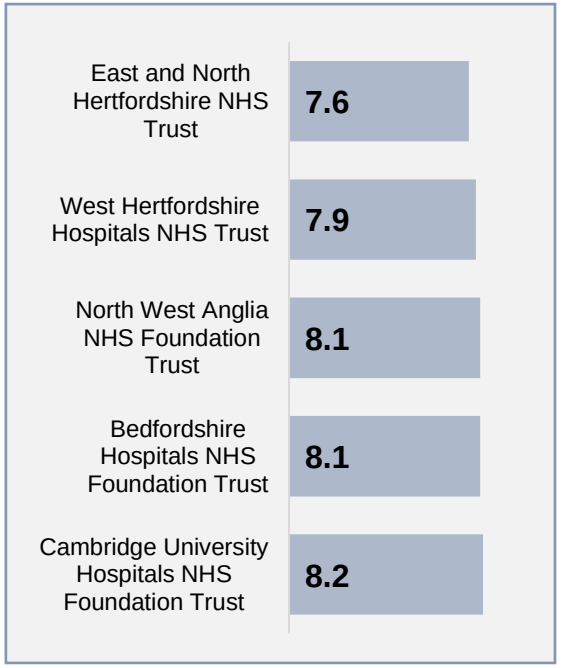


Comparison with other trusts within your region

Trusts with the highest scores



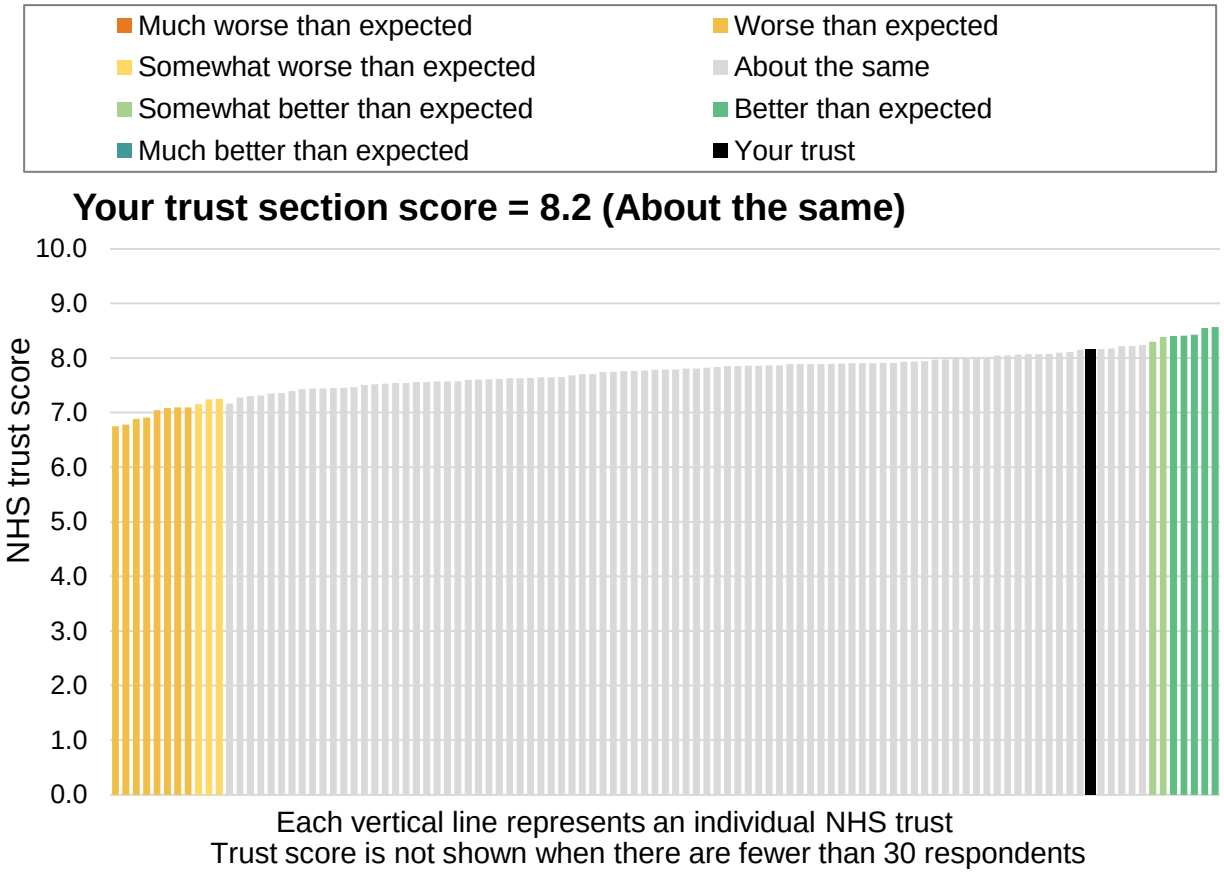
Trusts with the lowest scores



Care at home after birth

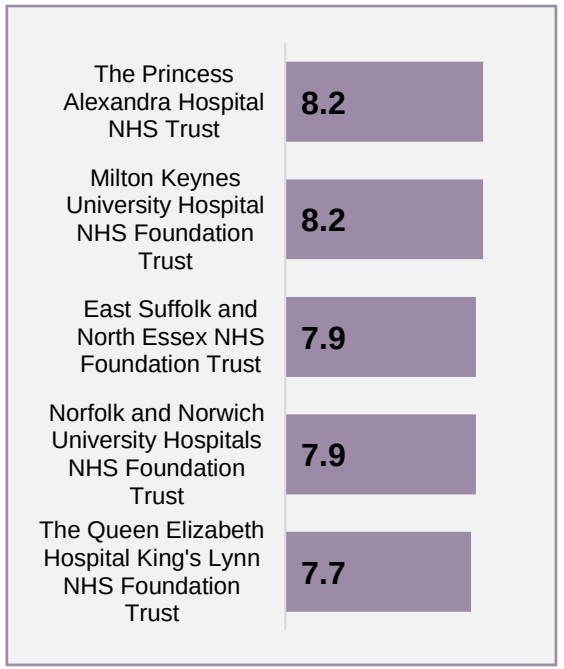
Section score

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for postnatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'care at home after birth' is calculated from questions F1 to F2, F5 to F9 and F11 to F17. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

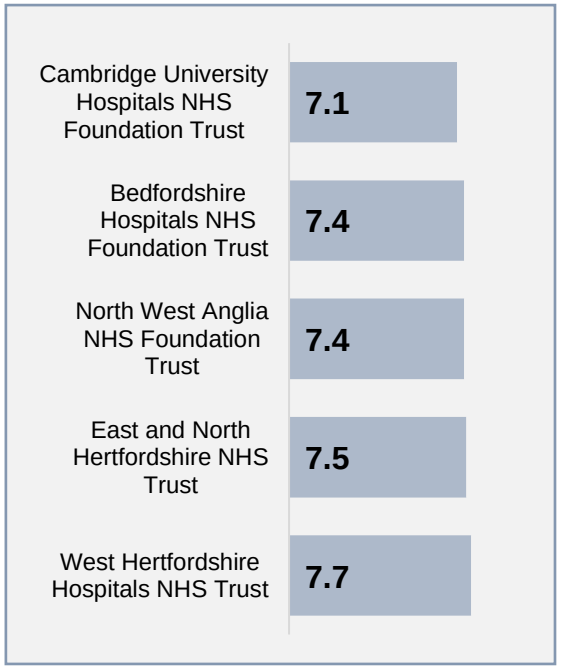


Comparison with other trusts within your region

Trusts with the highest scores

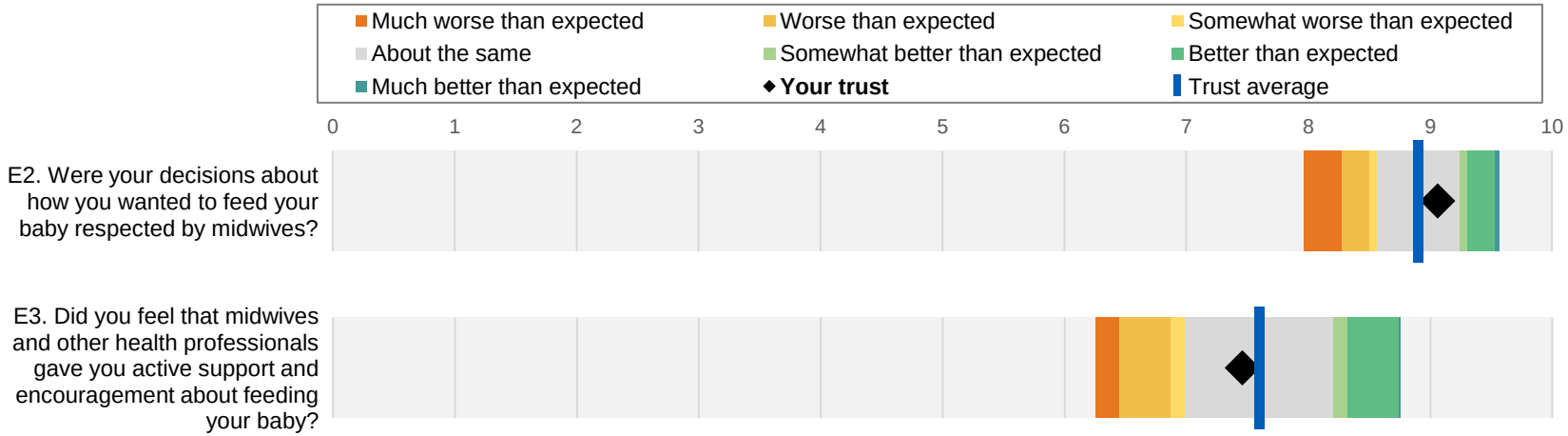


Trusts with the lowest scores



Benchmarking - Postnatal care

Question scores: Feeding your baby



		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
140	9.1	8.9	8.0	9.6
135	7.5	7.6	6.3	8.7

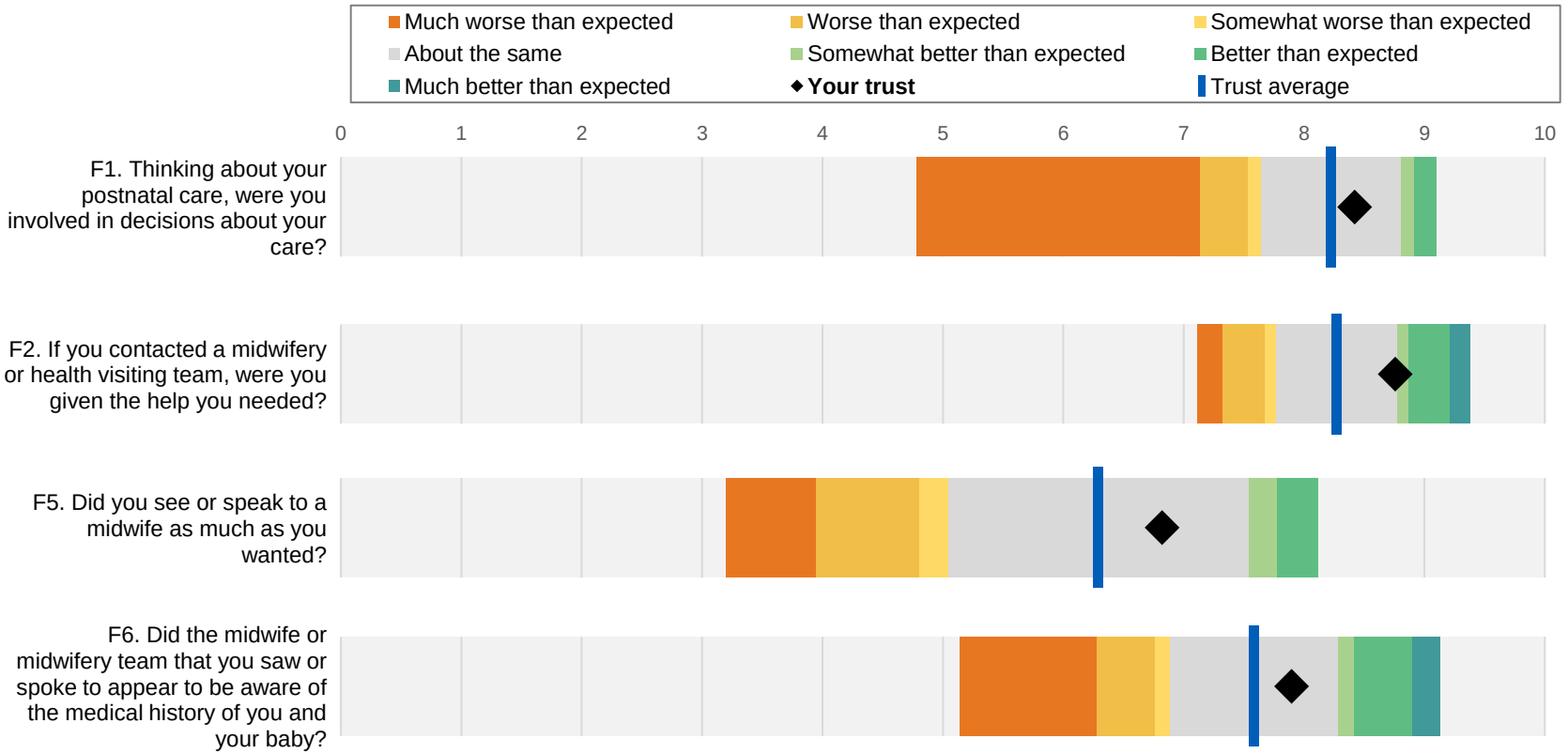
About the same

About the same

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Postnatal care (continued)

Question scores: Care at home after birth



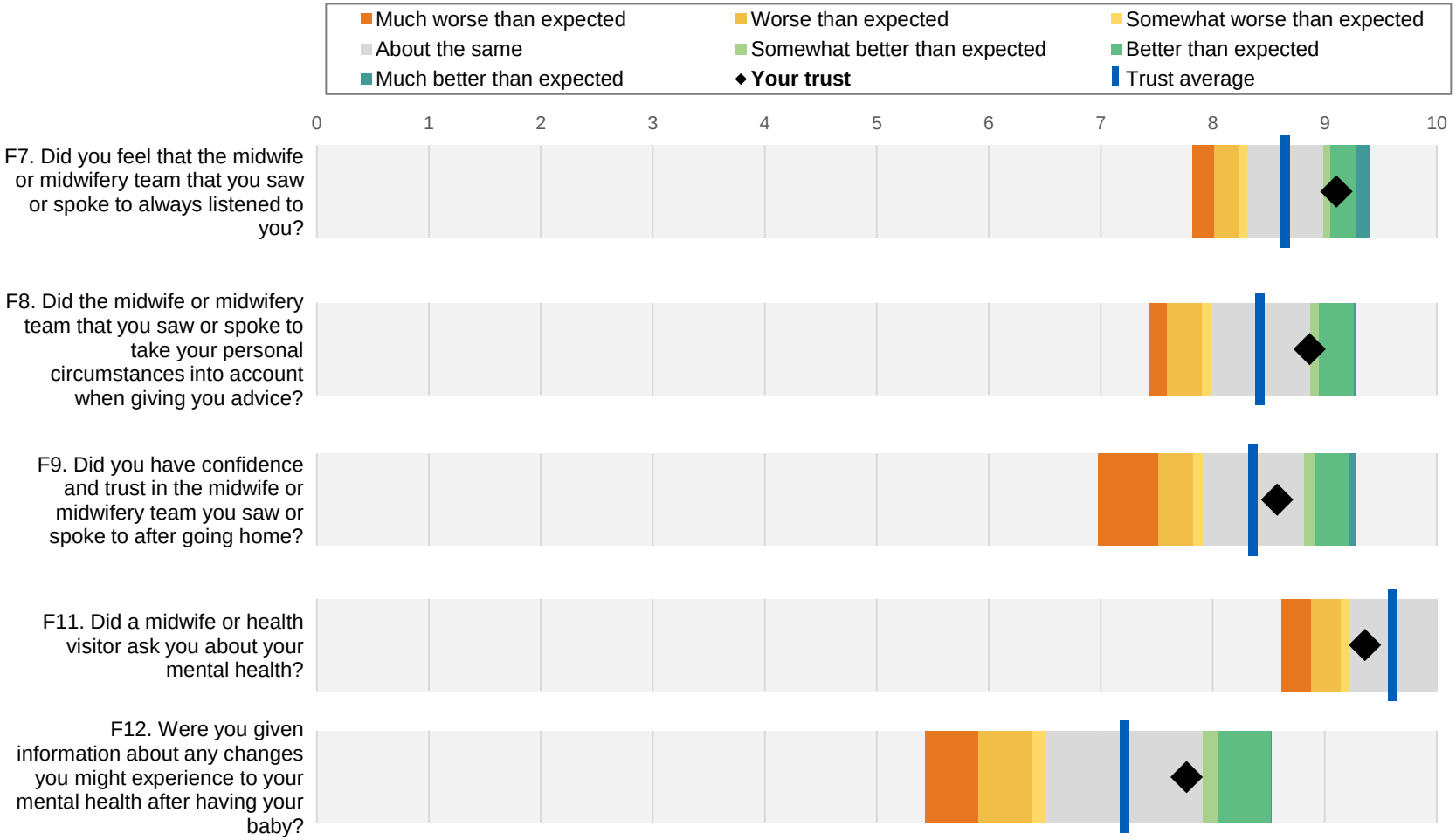
			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
F1. Thinking about your postnatal care, were you involved in decisions about your care?	140	8.4	8.2	4.8	9.1
F2. If you contacted a midwifery or health visiting team, were you given the help you needed?	117	8.8	8.3	7.1	9.4
F5. Did you see or speak to a midwife as much as you wanted?	141	6.8	6.3	3.2	8.1
F6. Did the midwife or midwifery team that you saw or spoke to appear to be aware of the medical history of you and your baby?	125	7.9	7.6	5.1	9.1

About the same

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Postnatal care (continued)

Question scores: Care at home after birth

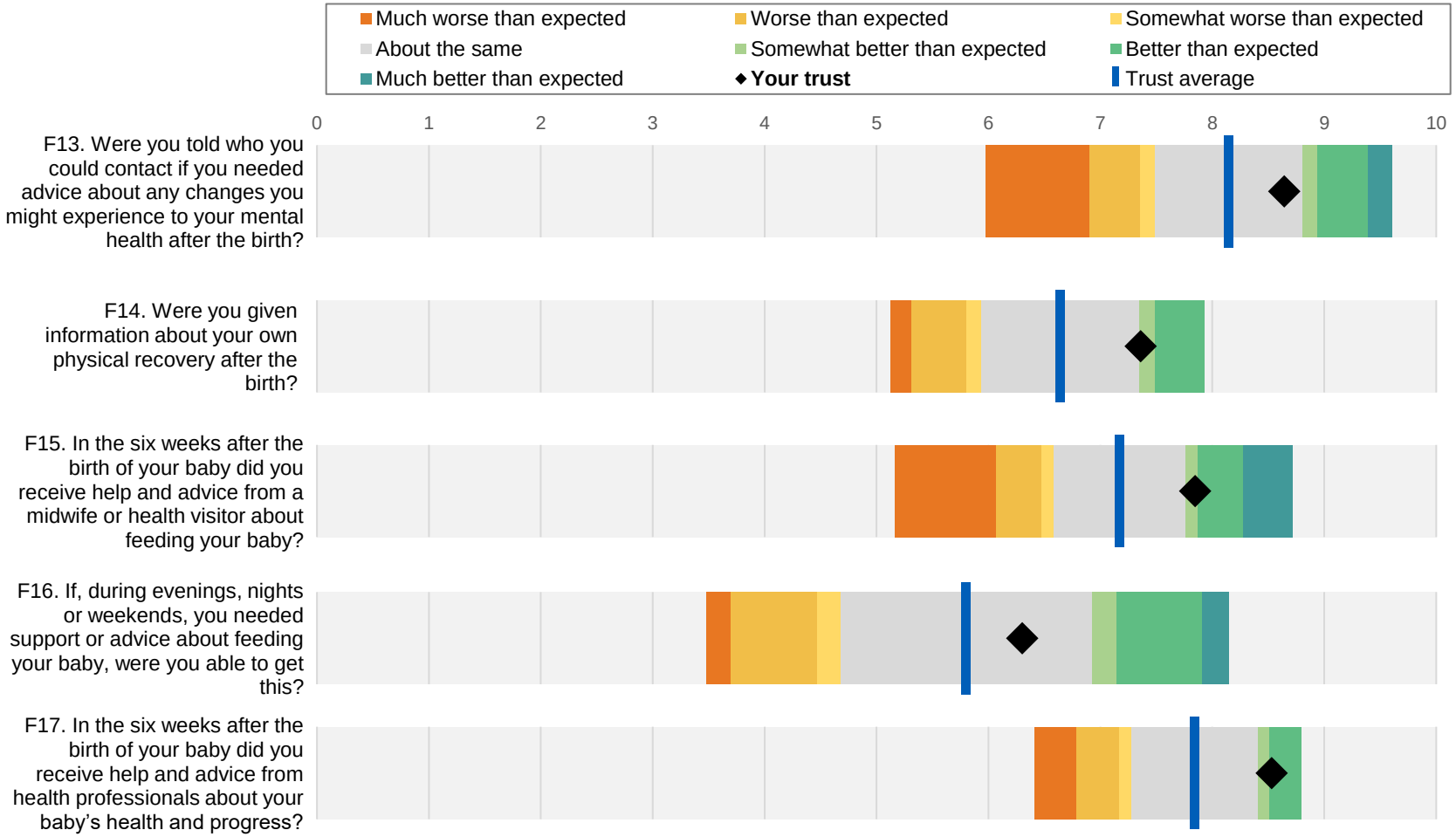


	All trusts in England				
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
F7. Did you feel that the midwife or midwifery team that you saw or spoke to always listened to you? (Better)	140	9.1	8.6	7.8	9.4
F8. Did the midwife or midwifery team that you saw or spoke to take your personal circumstances into account when giving you advice? (About the same)	130	8.9	8.4	7.4	9.3
F9. Did you have confidence and trust in the midwife or midwifery team you saw or spoke to after going home? (About the same)	138	8.6	8.4	7.0	9.3
F11. Did a midwife or health visitor ask you about your mental health? (About the same)	138	9.4	9.6	8.6	10.0
F12. Were you given information about any changes you might experience to your mental health after having your baby? (About the same)	132	7.8	7.2	5.4	8.5

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Postnatal care (continued)

Question scores: Care at home after birth



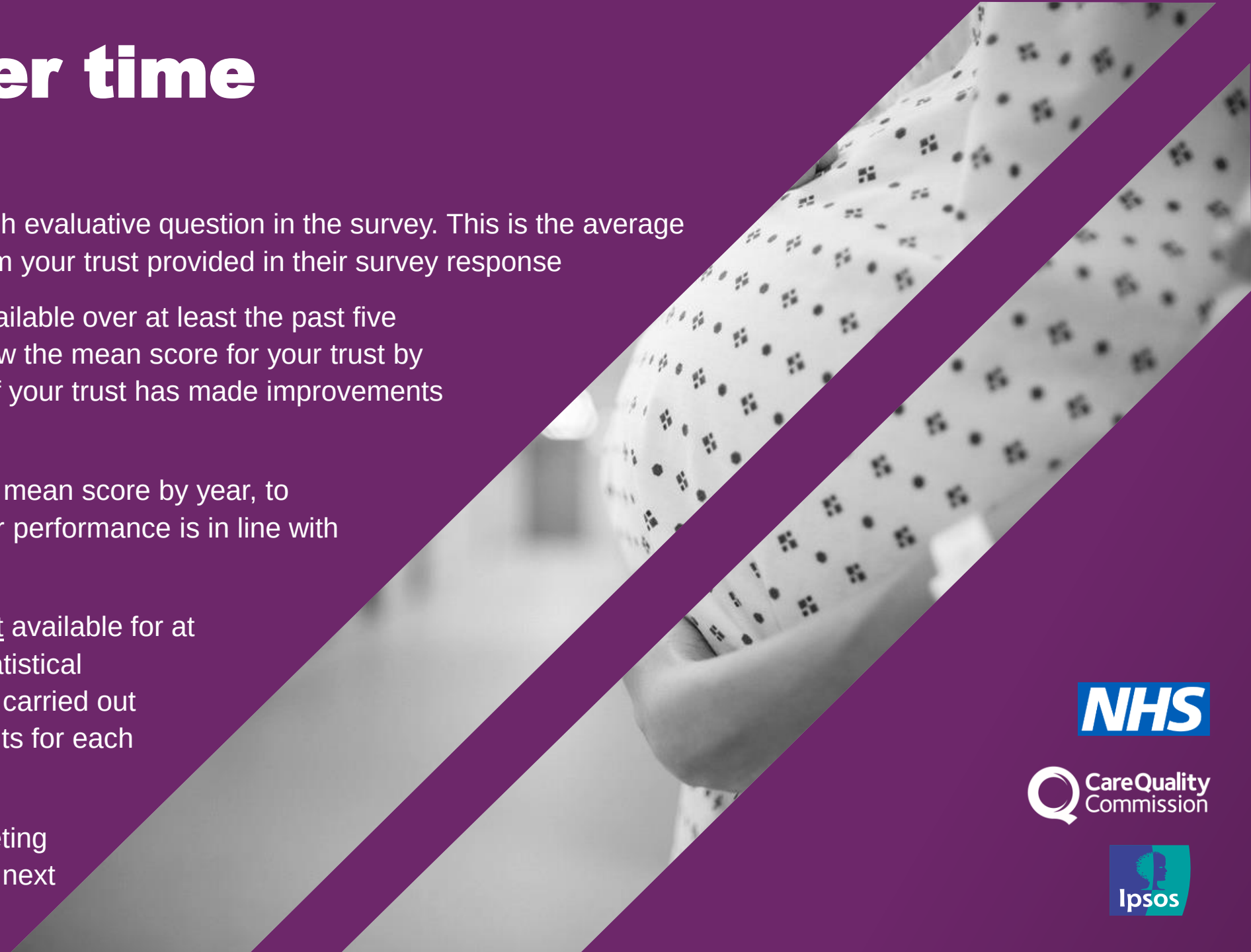
			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
About the same	118	8.6	8.1	6.0	9.6
Somewhat better	133	7.4	6.6	5.1	7.9
Somewhat better	121	7.8	7.2	5.2	8.7
About the same	53	6.3	5.8	3.5	8.2
Better	124	8.5	7.8	6.4	8.8

Trust score is not shown when there are fewer than 30 respondents.

Trends over time

This section includes:

- your mean trust score for each evaluative question in the survey. This is the average of all scores that mothers from your trust provided in their survey response
- where comparable data is available over at least the past five surveys, the trend charts show the mean score for your trust by year. This allows you to see if your trust has made improvements over time
- they also include the national mean score by year, to allow you to see whether your performance is in line with the national average or not
- where consistent data are not available for at least the past five surveys statistical significance testing has been carried out against the 2021 survey results for each relevant question
- for more guidance on interpreting these graphs, please see the next slide



NHS

CareQuality Commission

Ipsos

Trends over time

The following section presents comparisons with previous survey results. Statistically significant differences in the trust mean score between 2021 and 2022 are highlighted to show where there is meaningful change between years.

Historical trend charts are presented when there are at least five data points available to plot on the chart. Five data points may not be available due to:

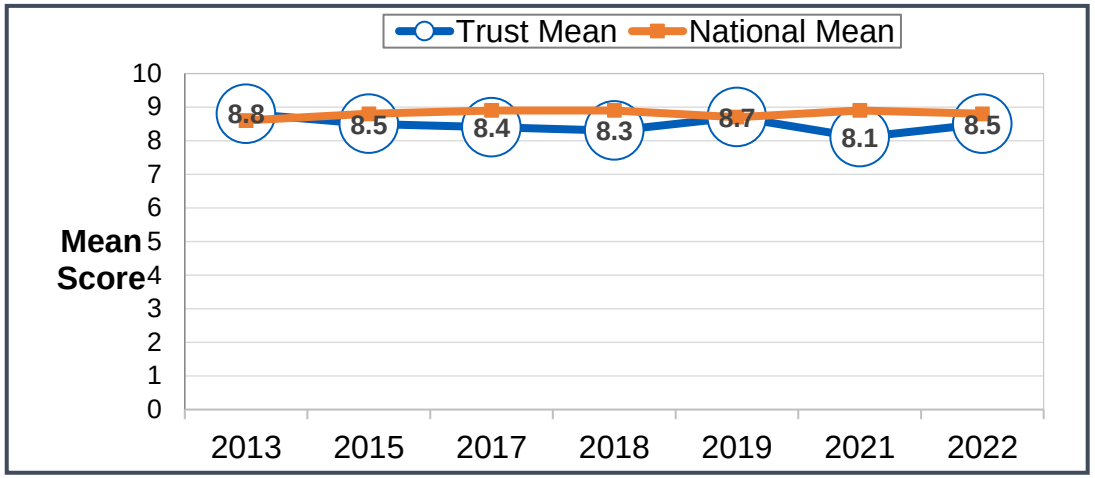
- changes to the questionnaire mean that a question is no longer comparable over time;
- organisational changes which impact comparability of results over time; or,
- historical errors with sampling or issues with fieldwork which impact comparability.

Statistically significant differences in the trust mean score between 2021 and 2022 are highlighted. These are carried out using a two sample t-test. Where a change in results is shown as 'significant', this indicates that this change is not due to random chance, but is likely due to some particular factor at your trust. Significant increases are indicated with a filled green circle, and significant decreases are in red.

Where comparable data is not available, statistical significance test tables are provided. Statistically significant changes in your trust score between 2021 and 2022 are shown in the far right column 'Change from 2021 survey', significant increases are indicated with a green arrow and significant decreases are indicated with a red arrow.

The following questions were new or changed for 2022 and therefore are not included in this section: B17, B18, C5, C24 and F1.

Historical trend chart example



Significance test table example

		2022 Trust Score	2021 Trust Score	No. of respondents	Change from 2021 survey
The start of your care in pregnancy					
B4.	Did you get enough information from either a midwife or doctor to help you decide where to have your baby?	4.3	7.1	178	▼

Trends over time

Antenatal care

Trends over time - Antenatal care

There are some questions in this section where data is not comparable prior to 2021. The following table displays changes since 2021, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected		2022 Trust Score	2021 Trust Score	No. of respondents in 2022	Change from 2021 survey
The start of your care in pregnancy											
B3.	Were you offered a choice about where to have your baby?							4.4	4.0	130	
B4.	Did you get enough information from either a midwife or doctor to help you decide where to have your baby?							7.3	6.5	155	
B5.	At the start of your care in pregnancy, did you feel that you were given enough information about coronavirus restrictions and any implications for your maternity care?							6.2	5.4	154	

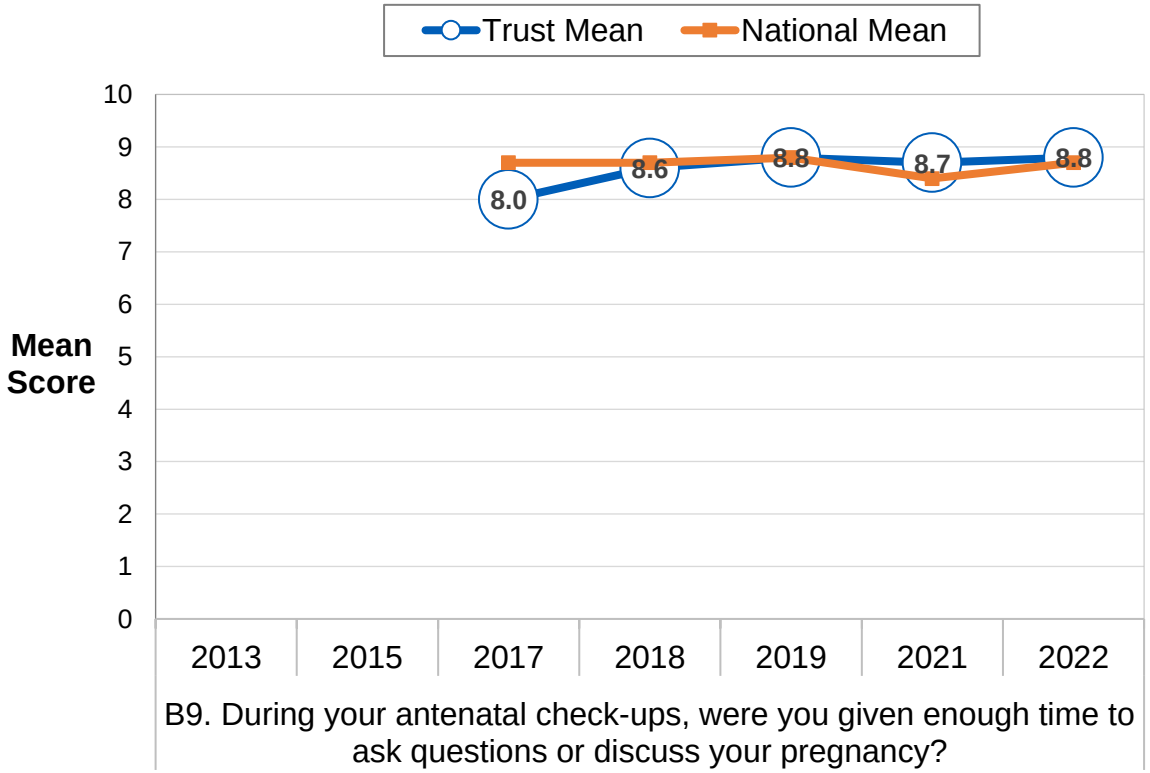
▼▲ Significant difference between 2022 and 2021

Blank No significant difference between 2022 and 2021

Trends over time - Antenatal care

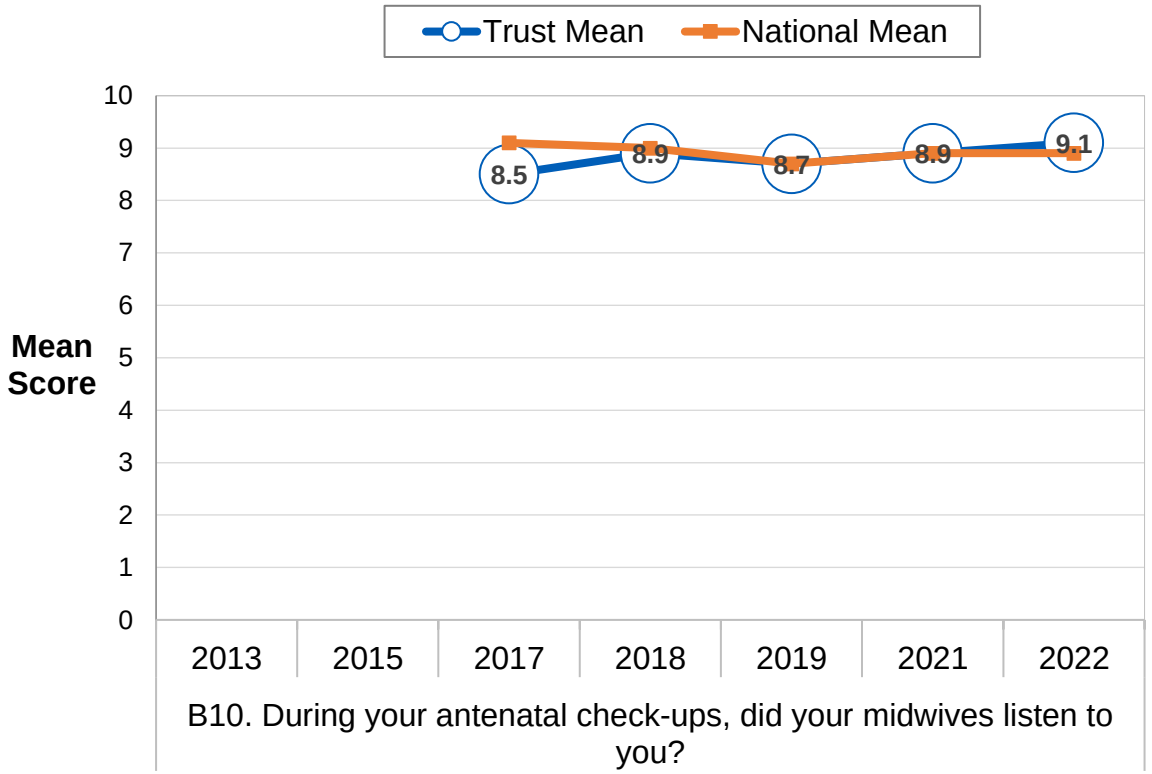
The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Antenatal check-ups



B9. During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?

Please note: *no data available for some years*



B10. During your antenatal check-ups, did your midwives listen to you?

Please note: *no data available for some years*

This shows a significant increase in the trust mean for this question for 2022 compared to 2021

This shows a significant decrease in the trust mean for this question for 2022 compared to 2021

Trends over time - Antenatal care (continued)

There are some questions in this section where data is not comparable prior to 2021. The following table displays changes since 2021, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

		2022 Trust Score	2021 Trust Score	No. of respondents in 2022	Change from 2021 survey
Antenatal check-ups					
B8.	During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?	7.3	7.2	156	
B11.	During your antenatal check-ups, did your midwives ask you about your mental health?	8.3	8.0	157	

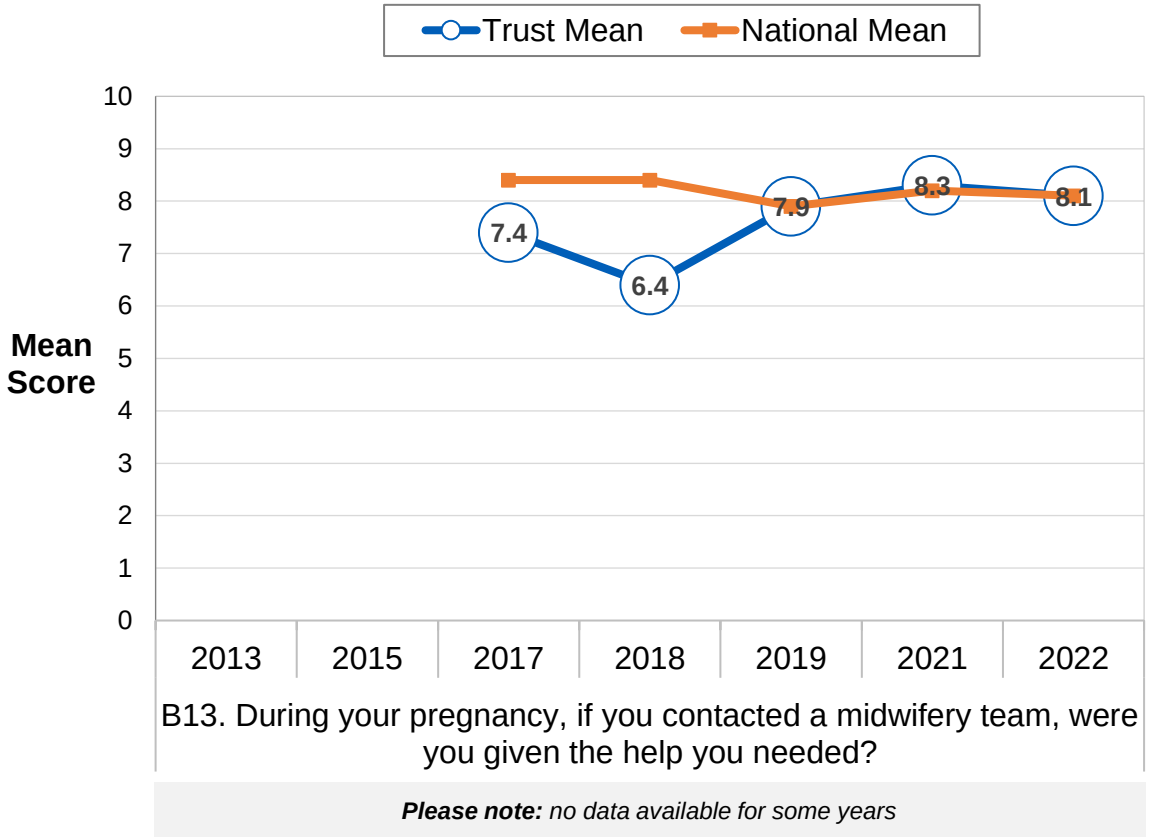
▼▲ Significant difference between 2022 and 2021

Blank No significant difference between 2022 and 2021

Trends over time - Antenatal care

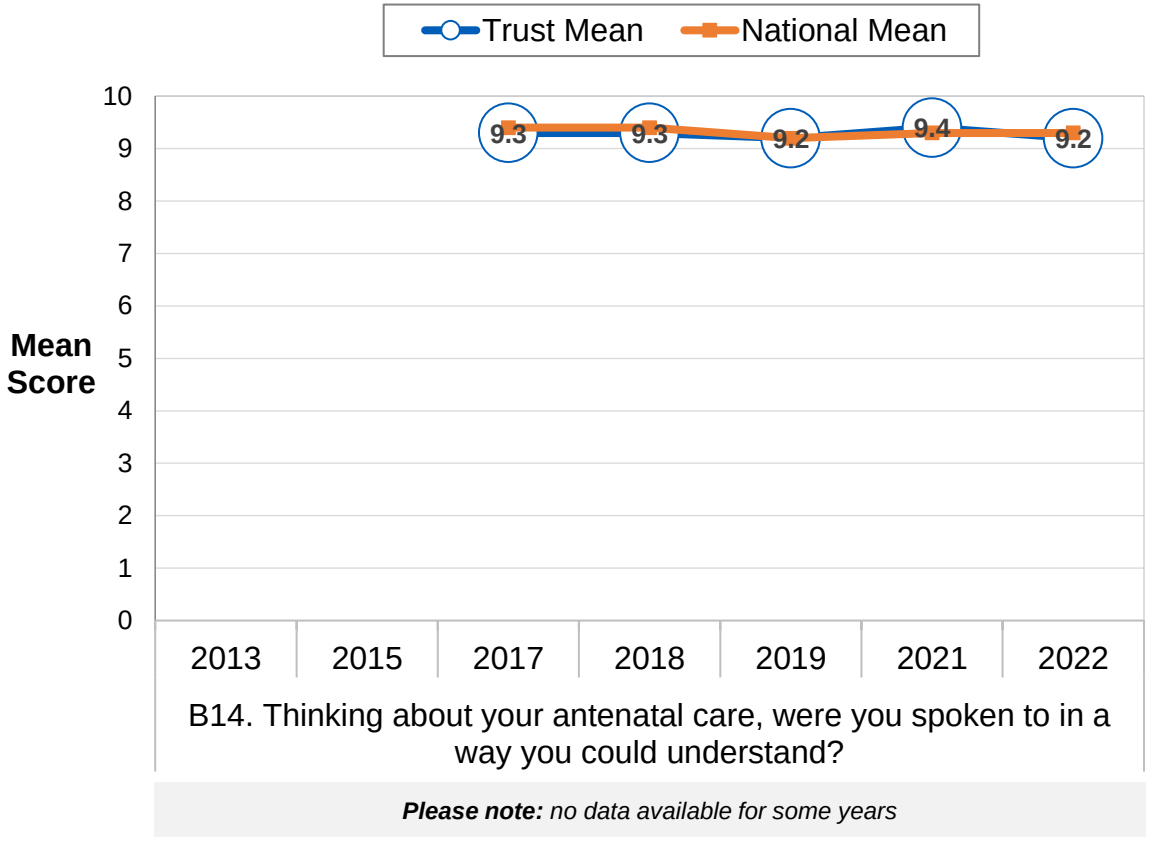
The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

During your pregnancy



B13. During your pregnancy, if you contacted a midwifery team, were you given the help you needed?

Please note: *no data available for some years*



B14. Thinking about your antenatal care, were you spoken to in a way you could understand?

Please note: *no data available for some years*

This shows a significant increase in the trust mean for this question for 2022 compared to 2021

This shows a significant decrease in the trust mean for this question for 2022 compared to 2021

Trends over time - Antenatal care (continued)

There are some questions in this section where data is not comparable prior to 2021. The following table displays changes since 2021, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected		2022 Trust Score	2021 Trust Score	No. of respondents in 2022	Change from 2021 survey
During your pregnancy											
B12.	Were you given enough support for your mental health during your pregnancy?							8.8	8.5	101	
B15.	Thinking about your antenatal care, were you involved in decisions about your care?							8.8	8.8	157	
B16.	During your pregnancy did midwives provide relevant information about feeding your baby?							6.7	6.4	159	

▼▲ Significant difference between 2022 and 2021

Blank No significant difference between 2022 and 2021

Trends over time

Labour and birth

Trends over time - Labour and birth (continued)

There are some questions in this section where data is not comparable prior to 2021. The following table displays changes since 2021, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected		2022 Trust Score	2021 Trust Score	No. of respondents in 2022	Change from 2021 survey
Your labour and birth											
C4.	Were you given enough information on induction before you were induced?							7.0	6.4	55	
C6.	Were you involved in the decision to be induced?							6.5	8.2	52	

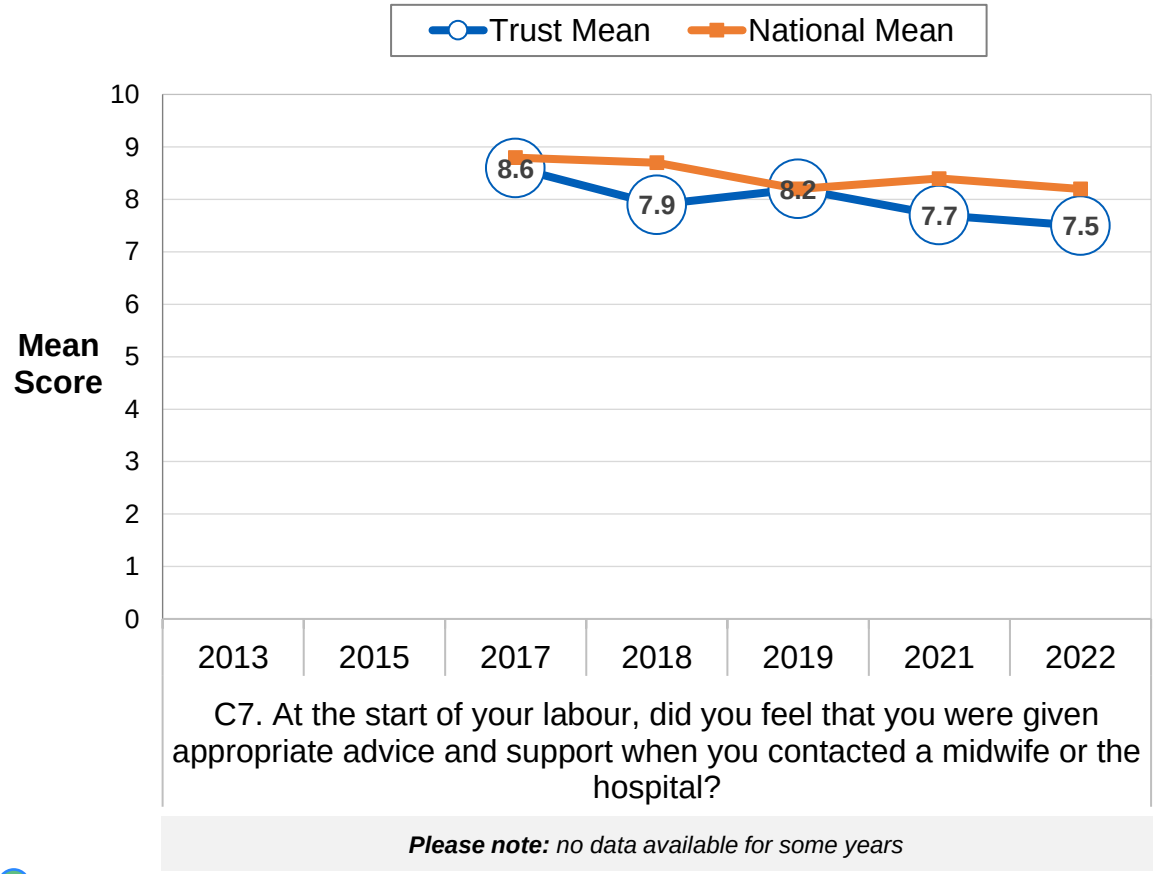
▼▲ Significant difference between 2022 and 2021

Blank No significant difference between 2022 and 2021

Trends over time - Labour and birth

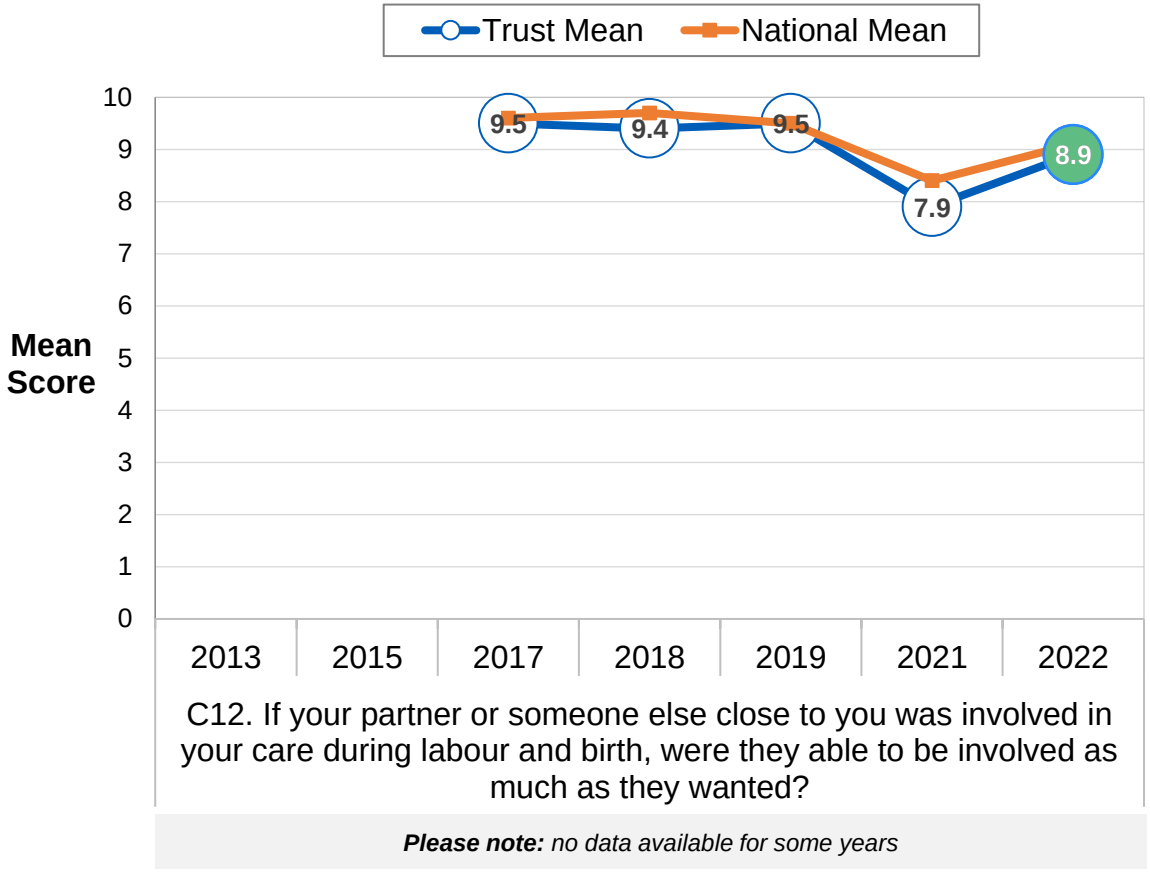
The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Your labour and birth



C7. At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?

Please note: *no data available for some years*



C12. If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?

Please note: *no data available for some years*

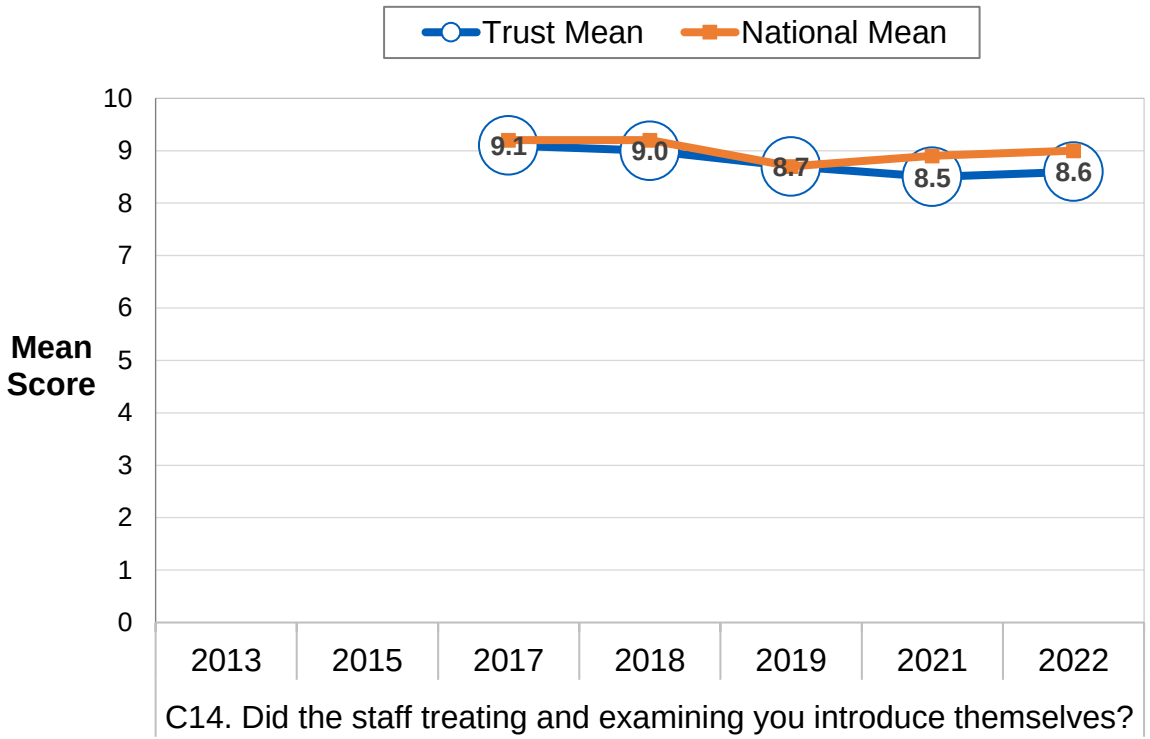
This shows a significant increase in the trust mean for this question for 2022 compared to 2021

This shows a significant decrease in the trust mean for this question for 2022 compared to 2021

Trends over time - Labour and birth

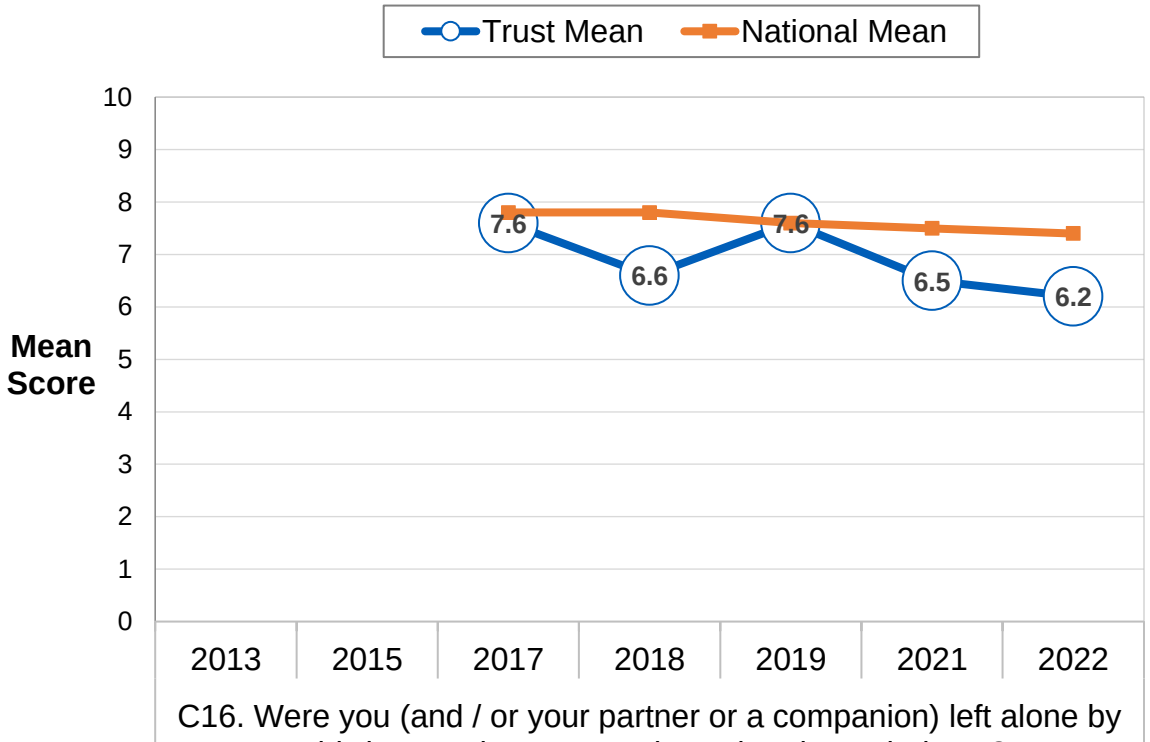
The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Staff caring for you



C14. Did the staff treating and examining you introduce themselves?

Please note: *no data available for some years*



C16. Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you?

Please note: *no data available for some years*

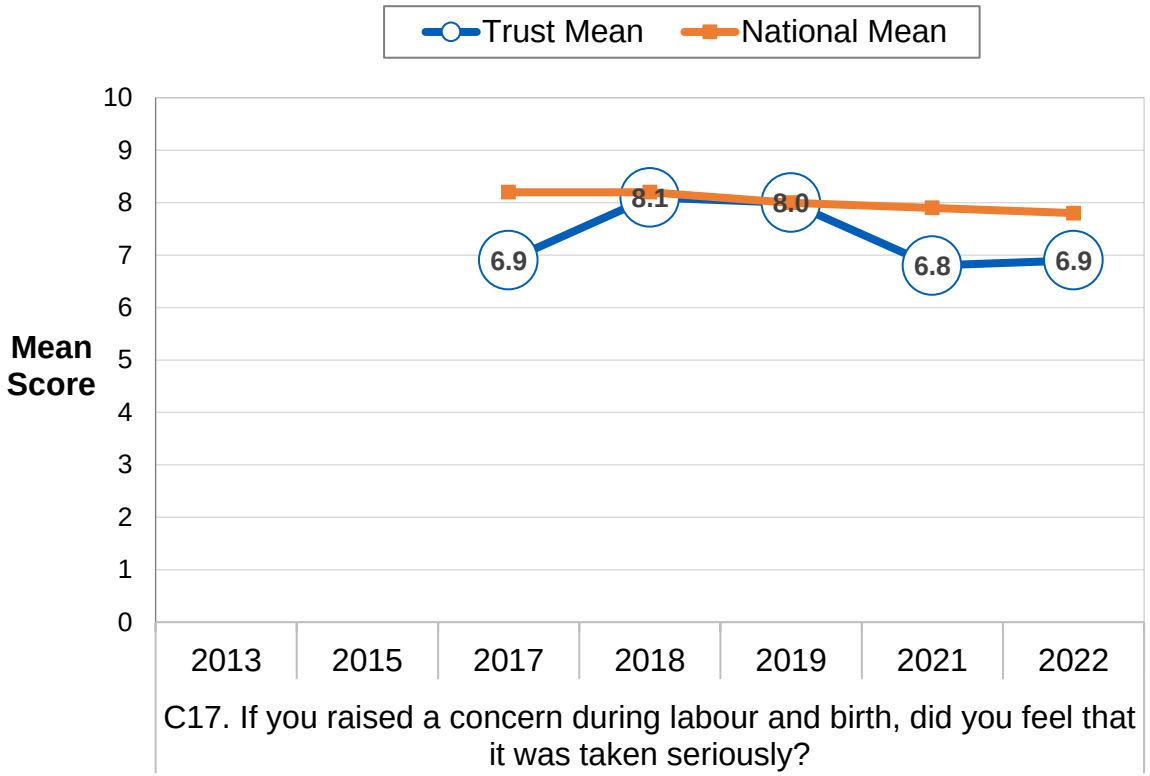
This shows a significant increase in the trust mean for this question for 2022 compared to 2021

This shows a significant decrease in the trust mean for this question for 2022 compared to 2021

Trends over time - Labour and birth

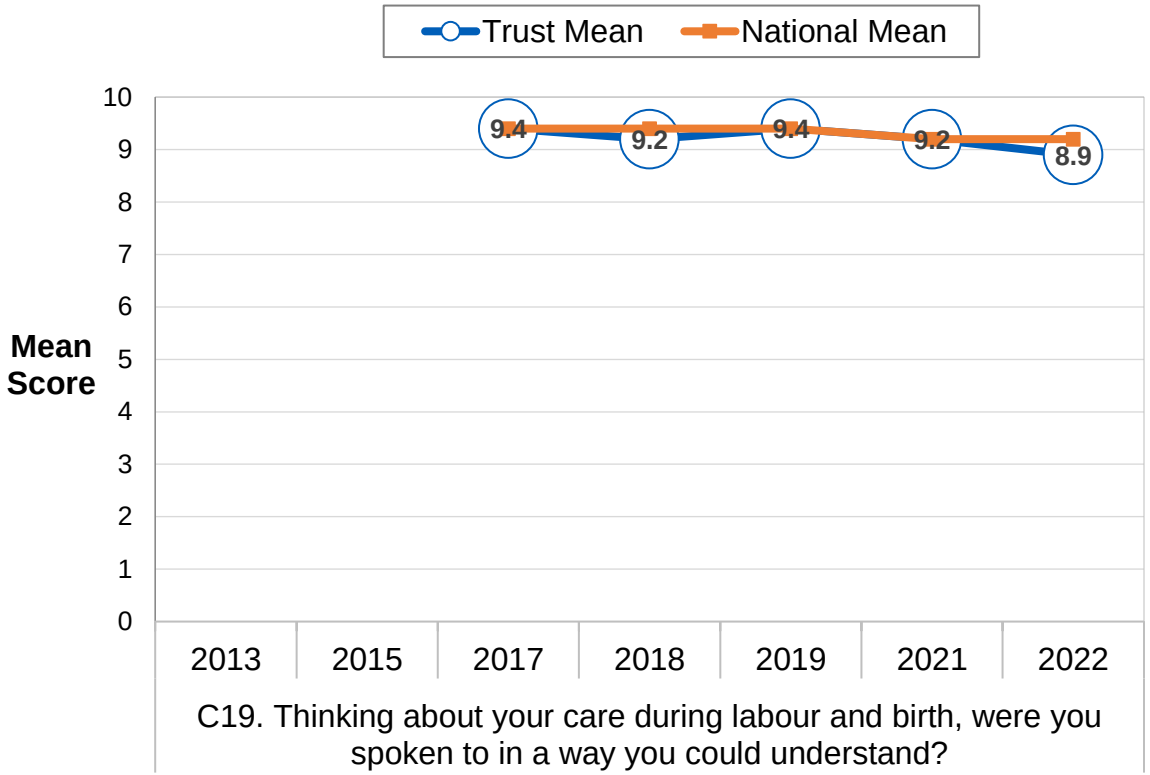
The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

The birth of your baby



C17. If you raised a concern during labour and birth, did you feel that it was taken seriously?

Please note: *no data available for some years*



C19. Thinking about your care during labour and birth, were you spoken to in a way you could understand?

Please note: *no data available for some years*

This shows a significant increase in the trust mean for this question for 2022 compared to 2021

This shows a significant decrease in the trust mean for this question for 2022 compared to 2021

Trends over time - Labour and birth (continued)

There are some questions in this section where data is not comparable prior to 2021. The following table displays changes since 2021, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected		2022 Trust Score	2021 Trust Score	No. of respondents in 2022	Change from 2021 survey
The birth of your baby											
C18.	During labour and birth, were you able to get a member of staff to help you when you needed it?							7.4	8.0	167	

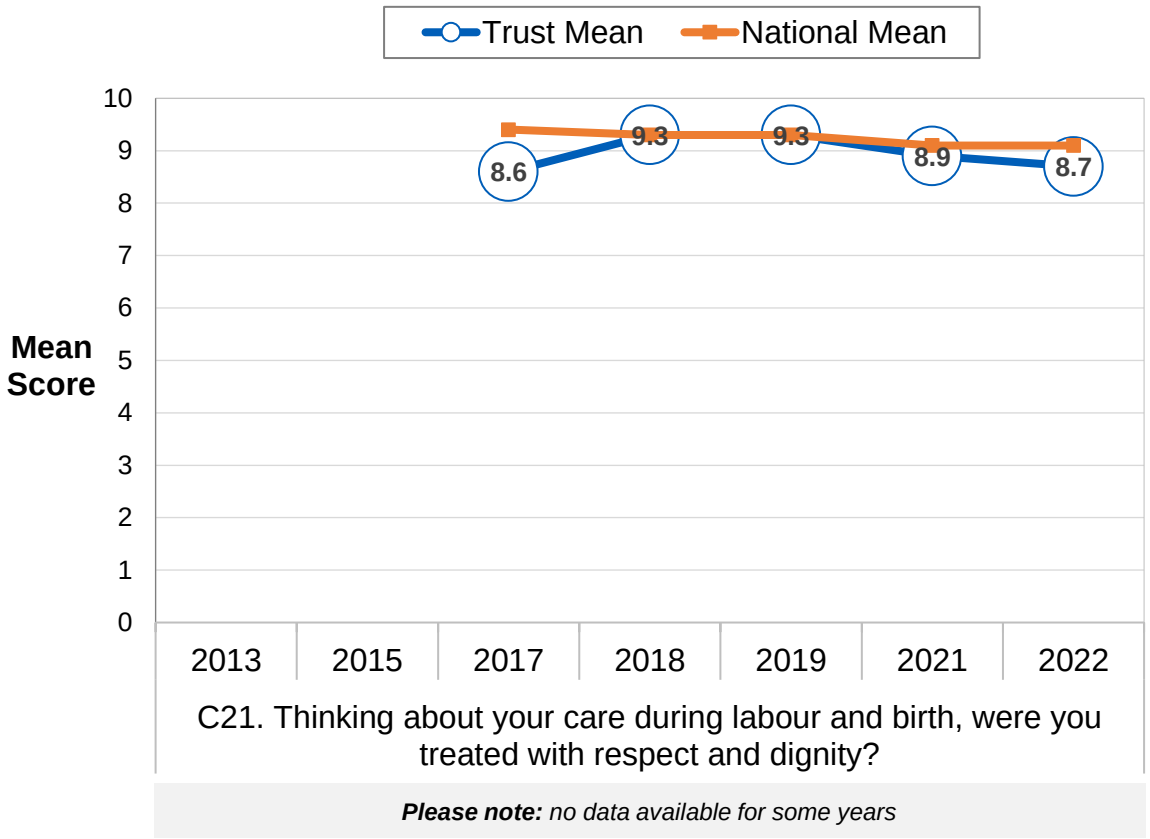
▼▲ Significant difference between 2022 and 2021

Blank No significant difference between 2022 and 2021

Trends over time - Labour and birth

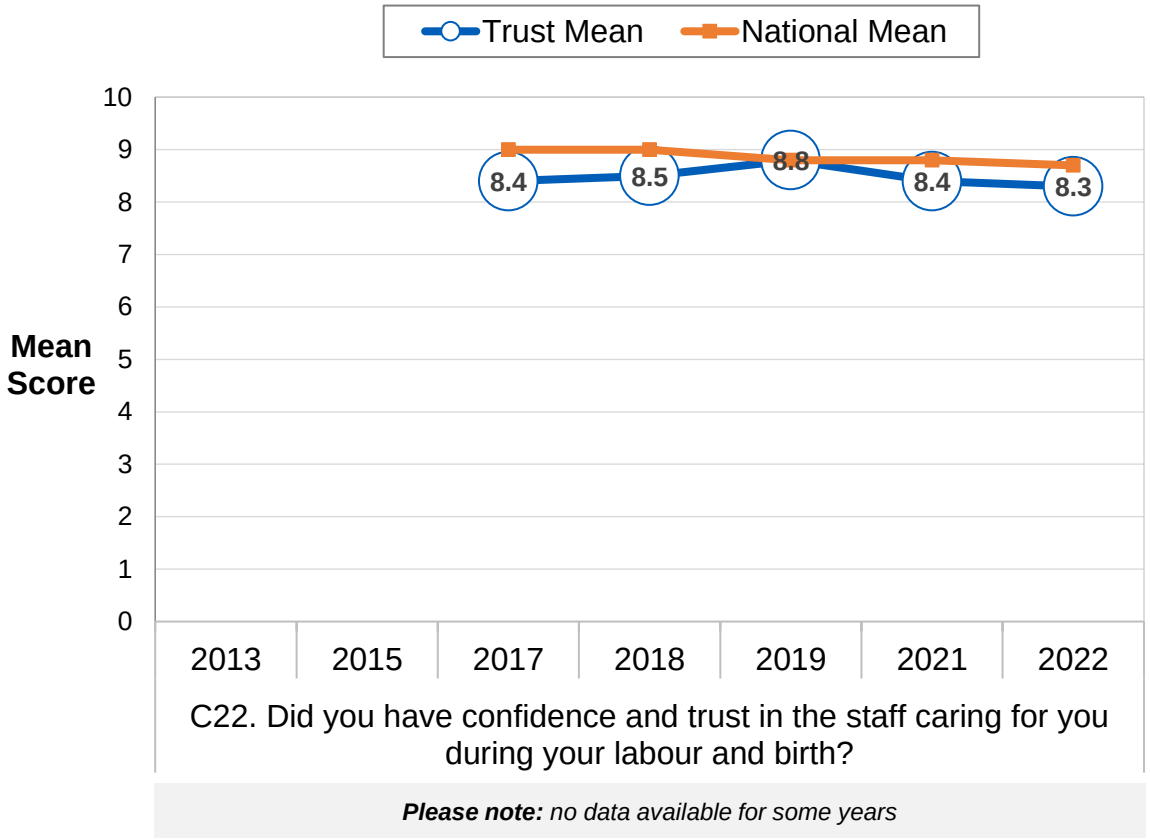
The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Staff caring for you



C21. Thinking about your care during labour and birth, were you treated with respect and dignity?

Please note: *no data available for some years*



C22. Did you have confidence and trust in the staff caring for you during your labour and birth?

Please note: *no data available for some years*

This shows a significant increase in the trust mean for this question for 2022 compared to 2021

This shows a significant decrease in the trust mean for this question for 2022 compared to 2021

Trends over time - Labour and birth (continued)

There are some questions in this section where data is not comparable prior to 2021. The following table displays changes since 2021, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected	2022 Trust Score	2021 Trust Score	No. of respondents in 2022	Change from 2021 survey
Staff caring for you										
C20.	Thinking about your care during labour and birth, were you involved in decisions about your care?						8.4	8.3	167	
C23.	After your baby was born, did you have the opportunity to ask questions about your labour and the birth?						6.3	5.4	148	

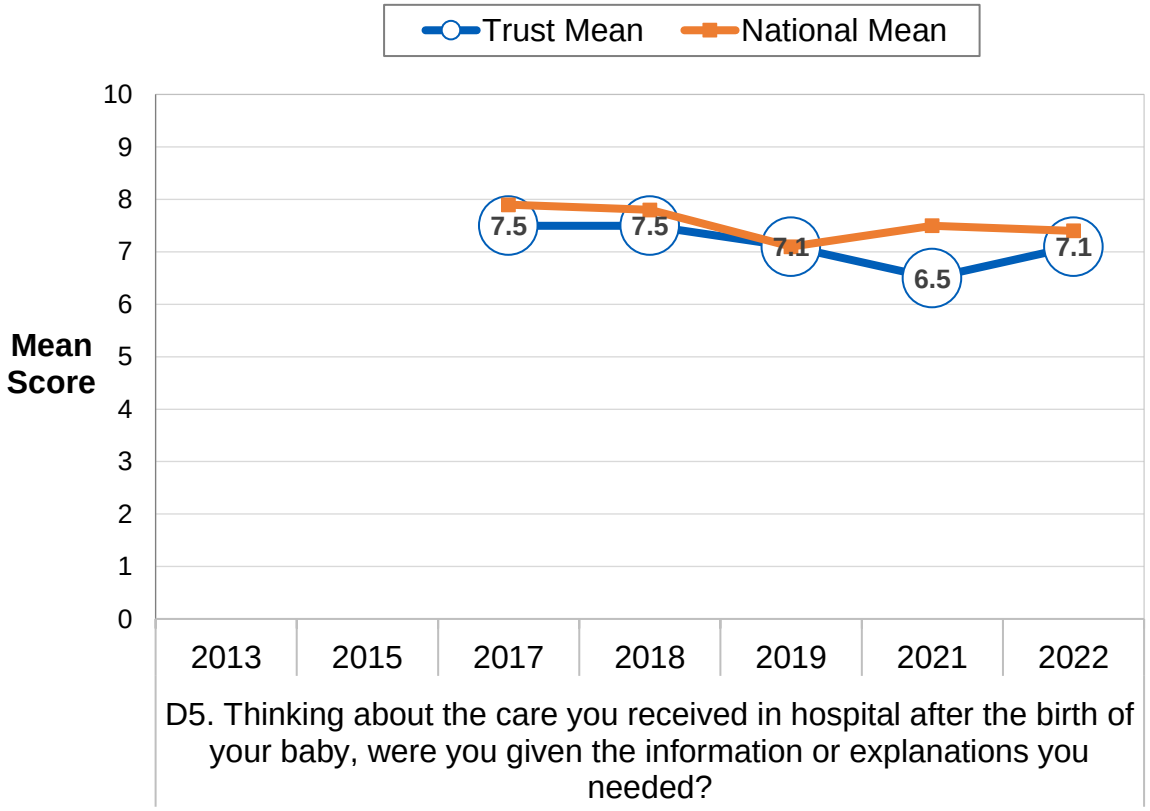
▼▲ Significant difference between 2022 and 2021

Blank No significant difference between 2022 and 2021

Trends over time - Labour and birth

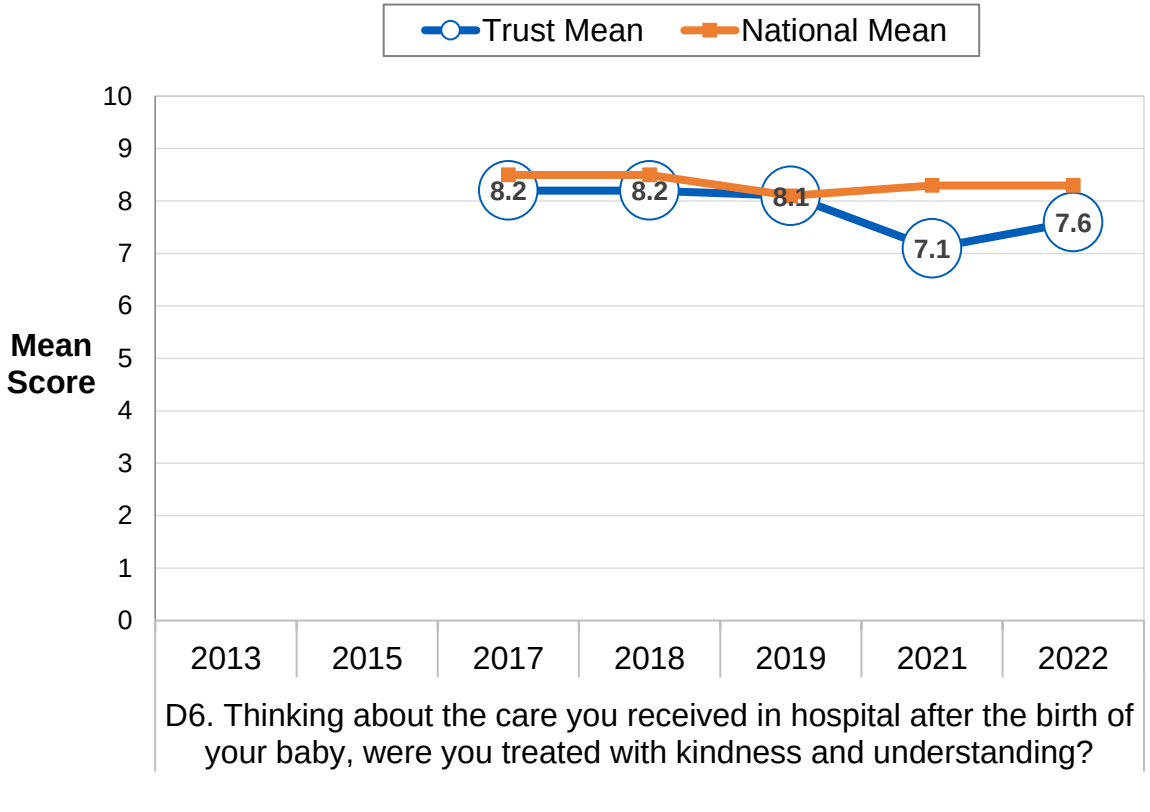
The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Care in hospital after birth



D5. Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?

Please note: *no data available for some years*



D6. Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?

Please note: *no data available for some years*

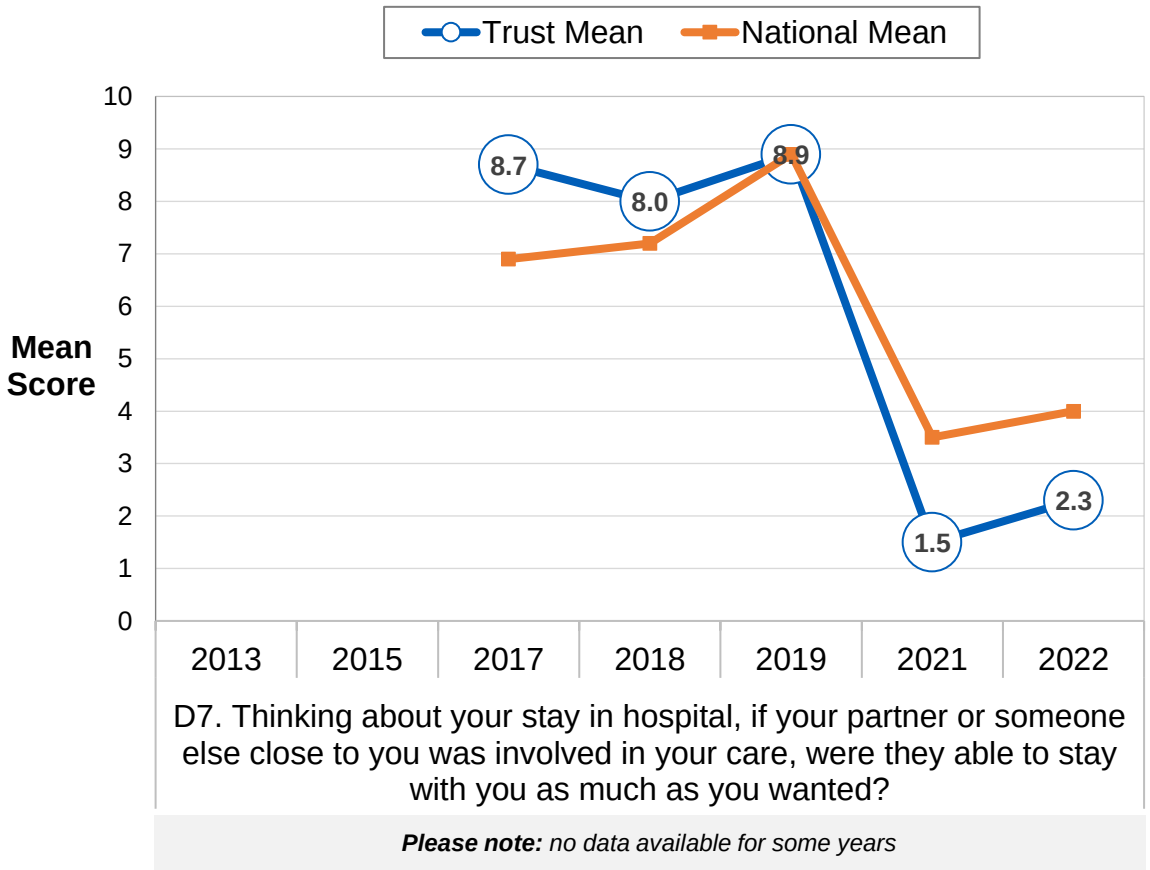
This shows a significant increase in the trust mean for this question for 2022 compared to 2021

This shows a significant decrease in the trust mean for this question for 2022 compared to 2021

Trends over time - Labour and birth

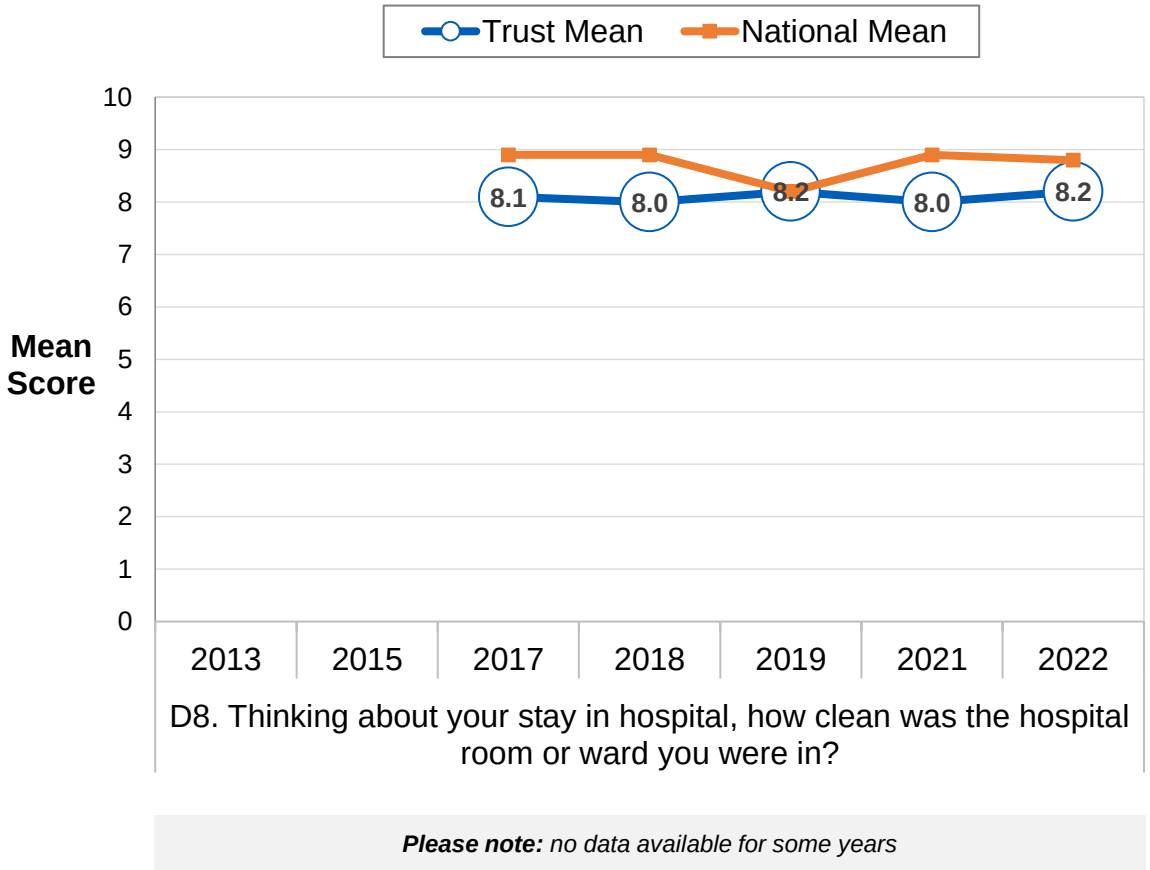
The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Care in hospital after birth



D7. Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?

Please note: *no data available for some years*



D8. Thinking about your stay in hospital, how clean was the hospital room or ward you were in?

Please note: *no data available for some years*

This shows a significant increase in the trust mean for this question for 2022 compared to 2021

This shows a significant decrease in the trust mean for this question for 2022 compared to 2021

Trends over time - Labour and birth (continued)

There are some questions in this section where data is not comparable prior to 2021. The following table displays changes since 2021, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected		2022 Trust Score	2021 Trust Score	No. of respondents in 2022	Change from 2021 survey
Care in hospital after birth											
D2.	On the day you left hospital, was your discharge delayed for any reason?							6.4	5.1	169	▲
D4.	If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you when you needed it?							6.6	5.5	153	▲

▼▲ Significant difference between 2022 and 2021

Blank No significant difference between 2022 and 2021

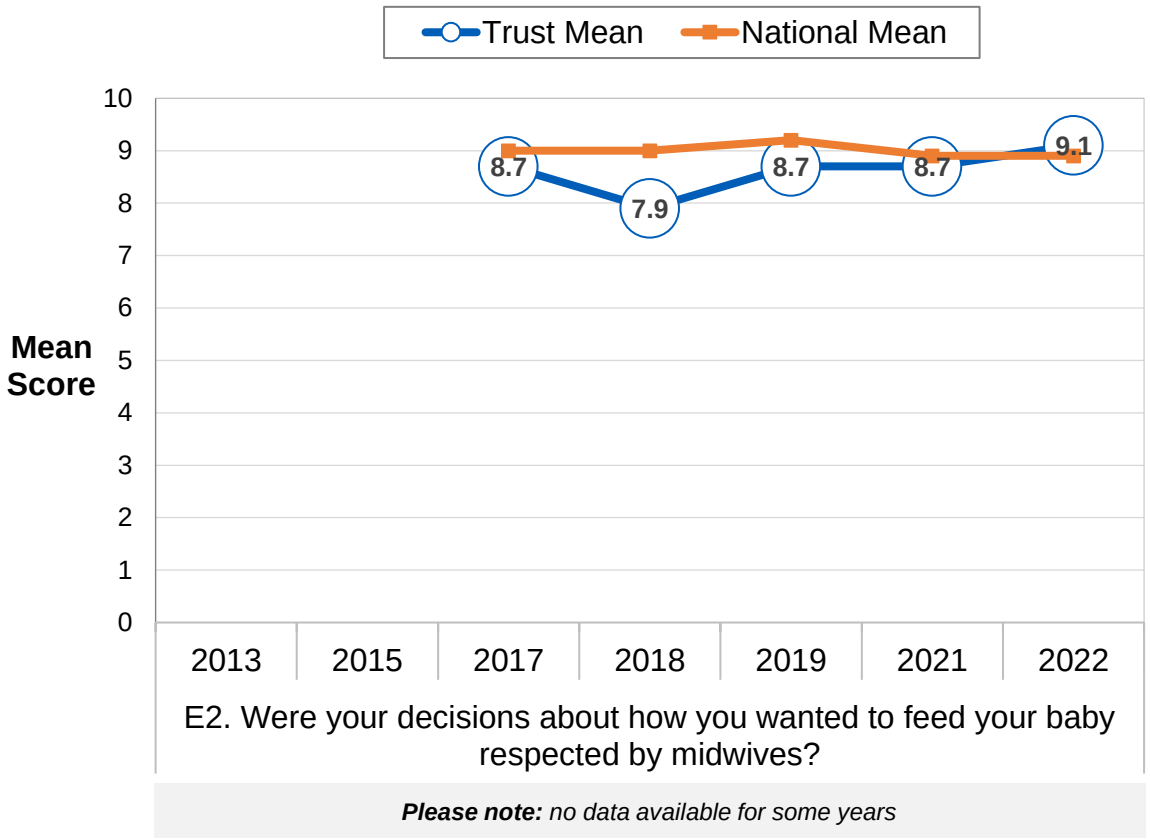
Trends over time

Postnatal care

Trends over time - Postnatal care

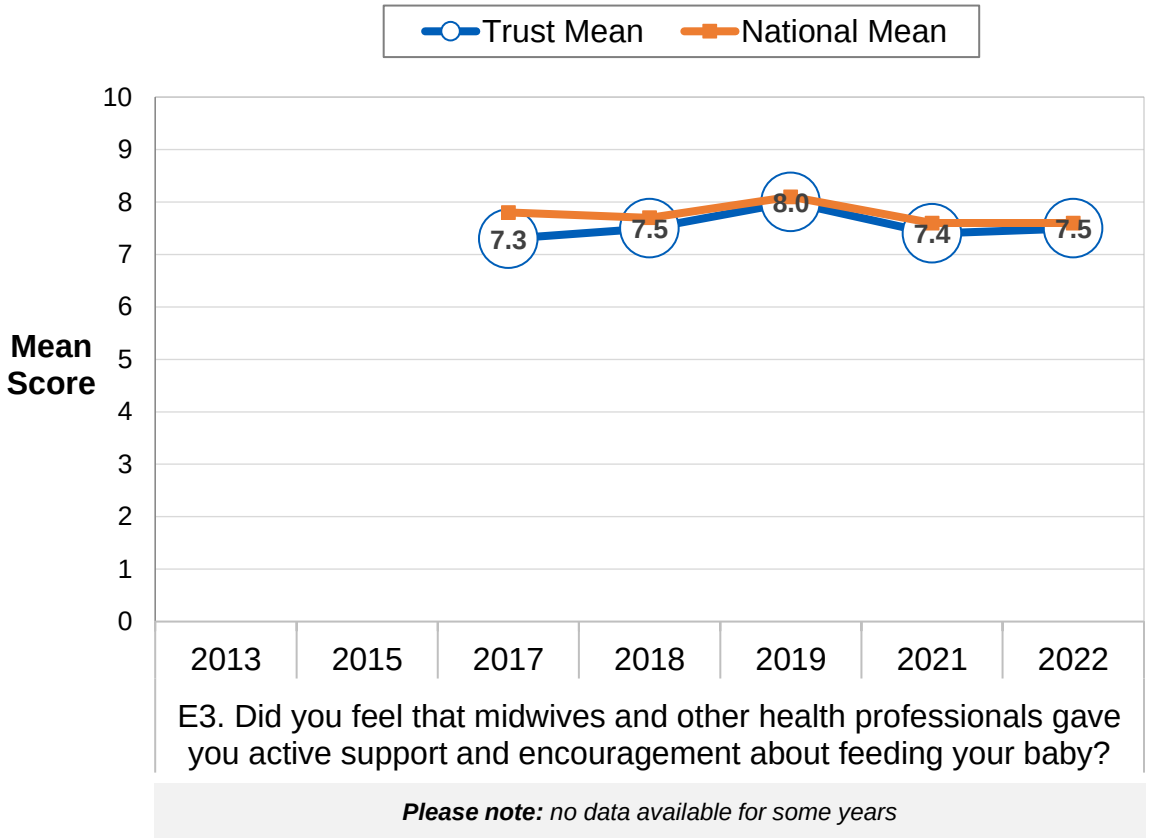
The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Feeding your baby



E2. Were your decisions about how you wanted to feed your baby respected by midwives?

Please note: *no data available for some years*



E3. Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby?

Please note: *no data available for some years*

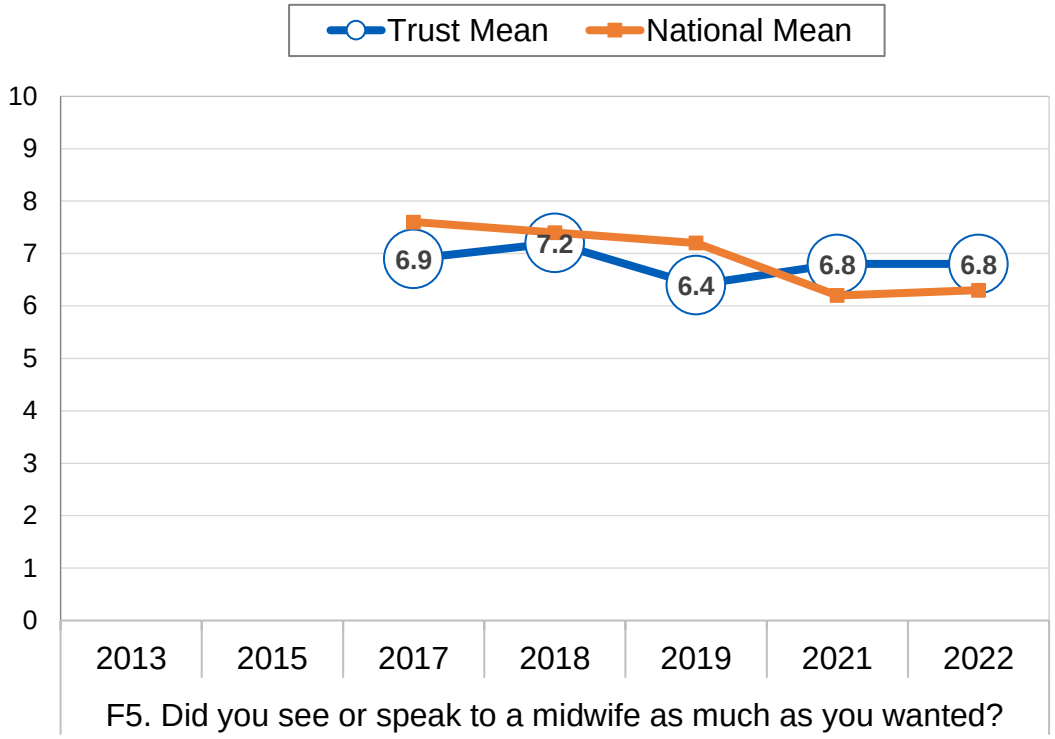
This shows a significant increase in the trust mean for this question for 2022 compared to 2021

This shows a significant decrease in the trust mean for this question for 2022 compared to 2021

Trends over time – Postnatal care

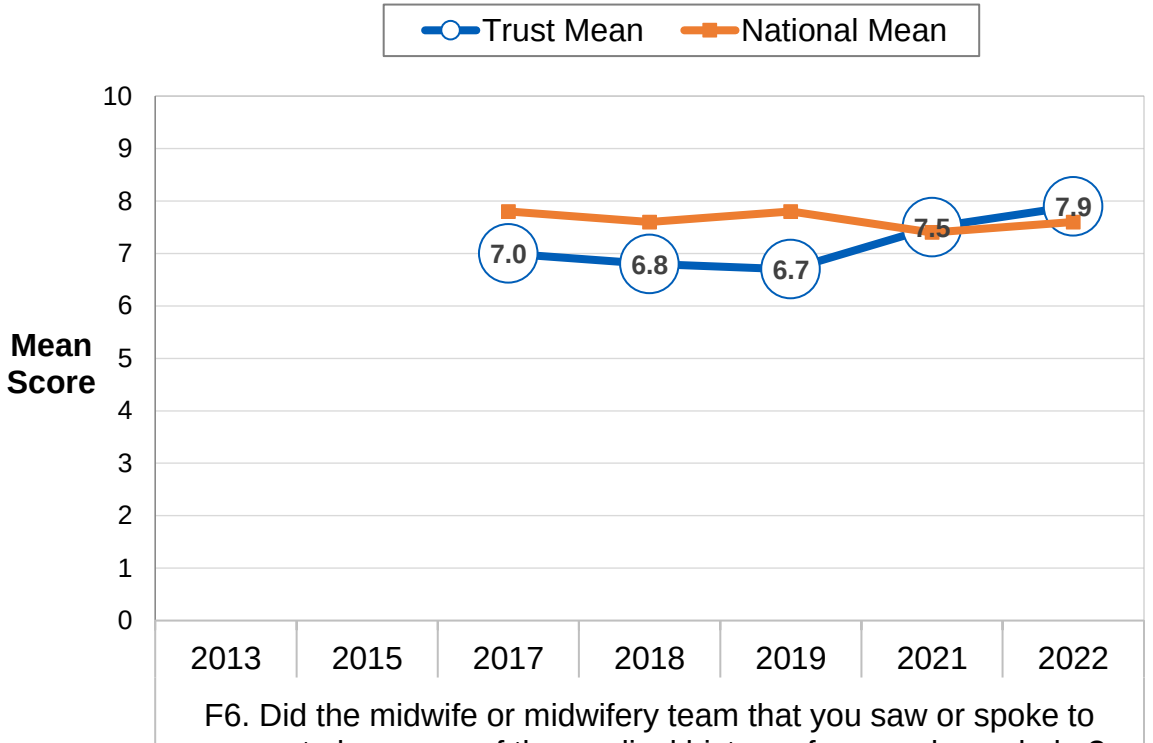
The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Care at home after the birth



F5. Did you see or speak to a midwife as much as you wanted?

Please note: *no data available for some years*



F6. Did the midwife or midwifery team that you saw or spoke to appear to be aware of the medical history of you and your baby?

Please note: *no data available for some years*

This shows a significant increase in the trust mean for this question for 2022 compared to 2021

This shows a significant decrease in the trust mean for this question for 2022 compared to 2021

Trends over time - Postnatal care (continued)

There are some questions in this section where data is not comparable prior to 2021. The following table displays changes since 2021, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected		2022 Trust Score	2021 Trust Score	No. of respondents in 2022	Change from 2021 survey
Care at home after the birth											
F2.	If you contacted a midwifery or health visiting team, were you given the help you needed?							8.8	8.5	117	

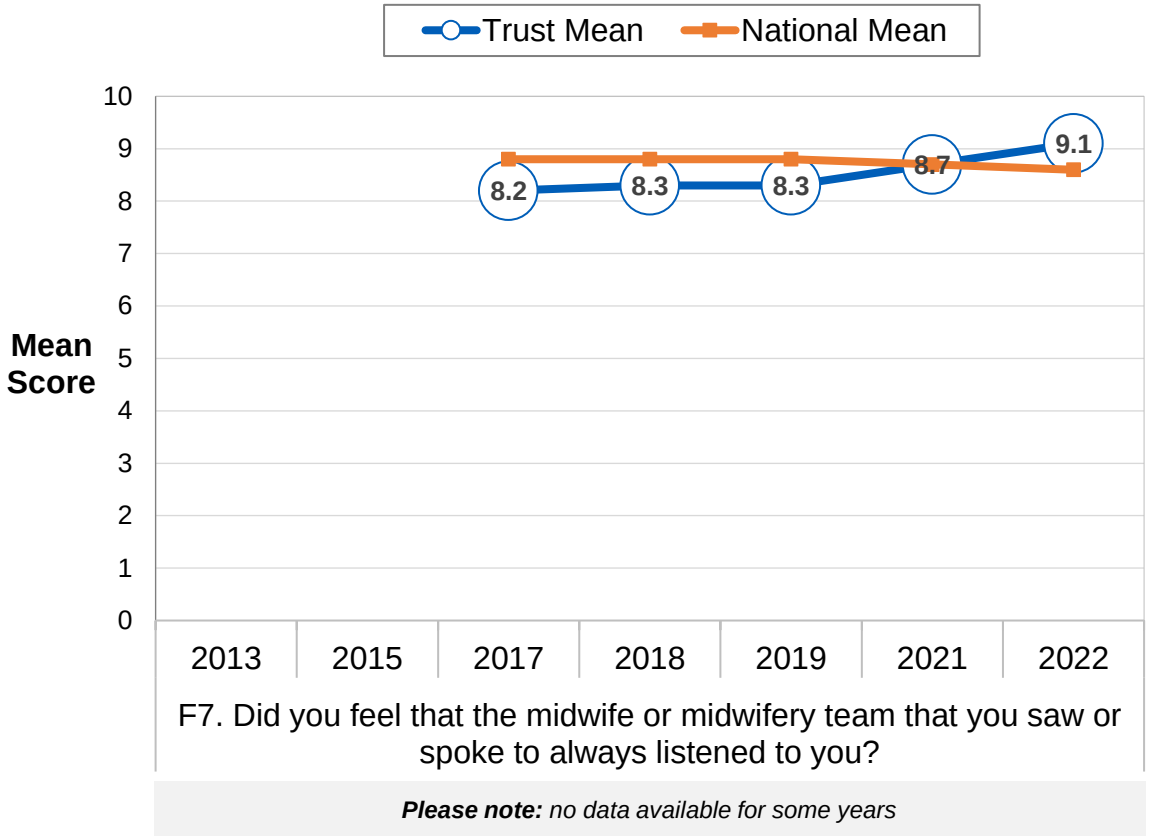
▼▲ Significant difference between 2022 and 2021

Blank No significant difference between 2022 and 2021

Trends over time - Postnatal care

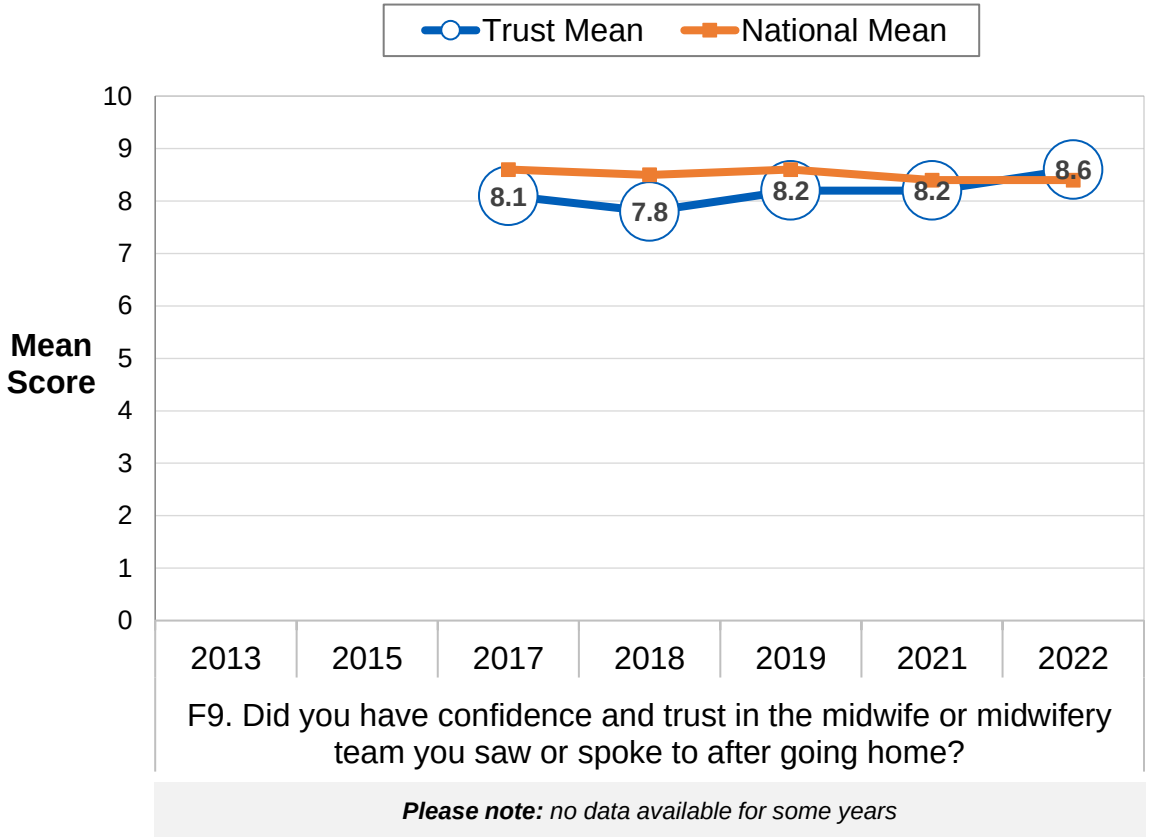
The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Care at home after the birth



F7. Did you feel that the midwife or midwifery team that you saw or spoke to always listened to you?

Please note: *no data available for some years*



F9. Did you have confidence and trust in the midwife or midwifery team you saw or spoke to after going home?

Please note: *no data available for some years*

This shows a significant increase in the trust mean for this question for 2022 compared to 2021

This shows a significant decrease in the trust mean for this question for 2022 compared to 2021

Trends over time - Postnatal care (continued)

There are some questions in this section where data is not comparable prior to 2021. The following table displays changes since 2021, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected		2022 Trust Score	2021 Trust Score	No. of respondents in 2022	Change from 2021 survey
Care at home after the birth											
F8.	Did the midwife or midwifery team that you saw or spoke to take your personal circumstances into account when giving you advice?							8.9	8.6	130	
F11.	Did a midwife or health visitor ask you about your mental health?							9.4	9.5	138	
F12.	Were you given information about any changes you might experience to your mental health after having your baby?							7.8	7.1	132	

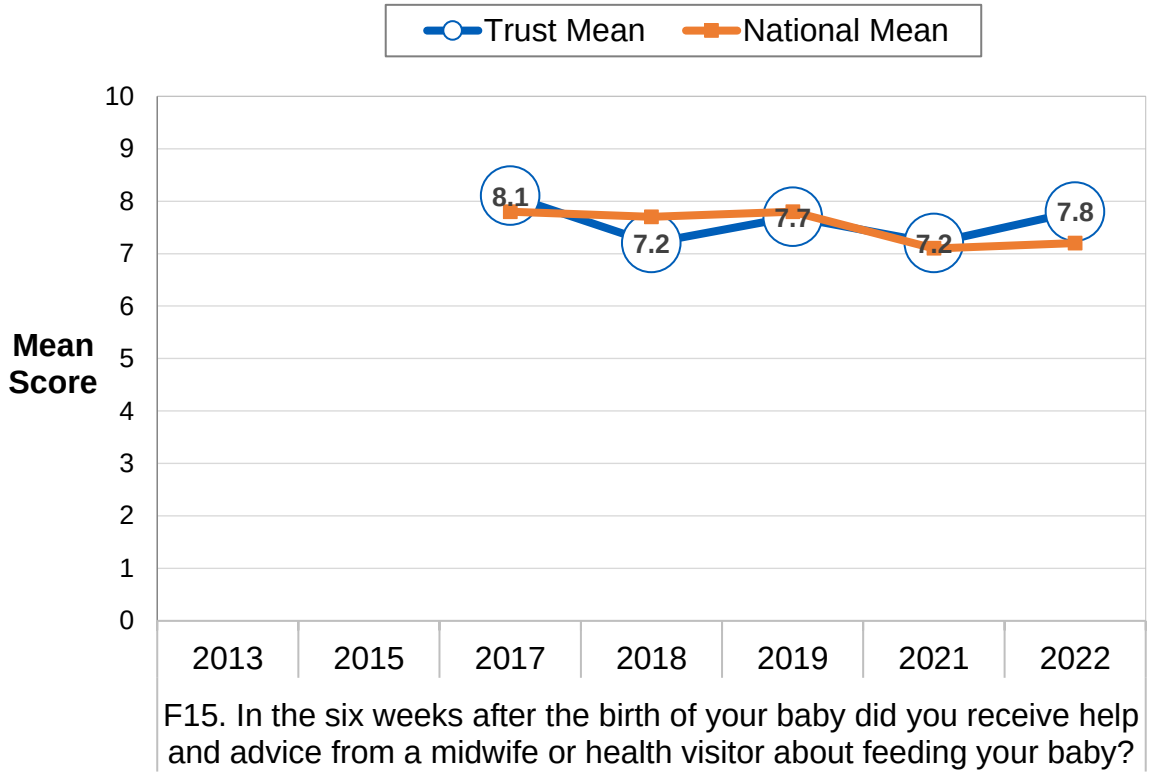
▼▲ Significant difference between 2022 and 2021

Blank No significant difference between 2022 and 2021

Trends over time - Postnatal care

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Care at home after the birth



F15. In the six weeks after the birth of your baby did you receive help and advice from a midwife or health visitor about feeding your baby?

Please note: *no data available for some years*

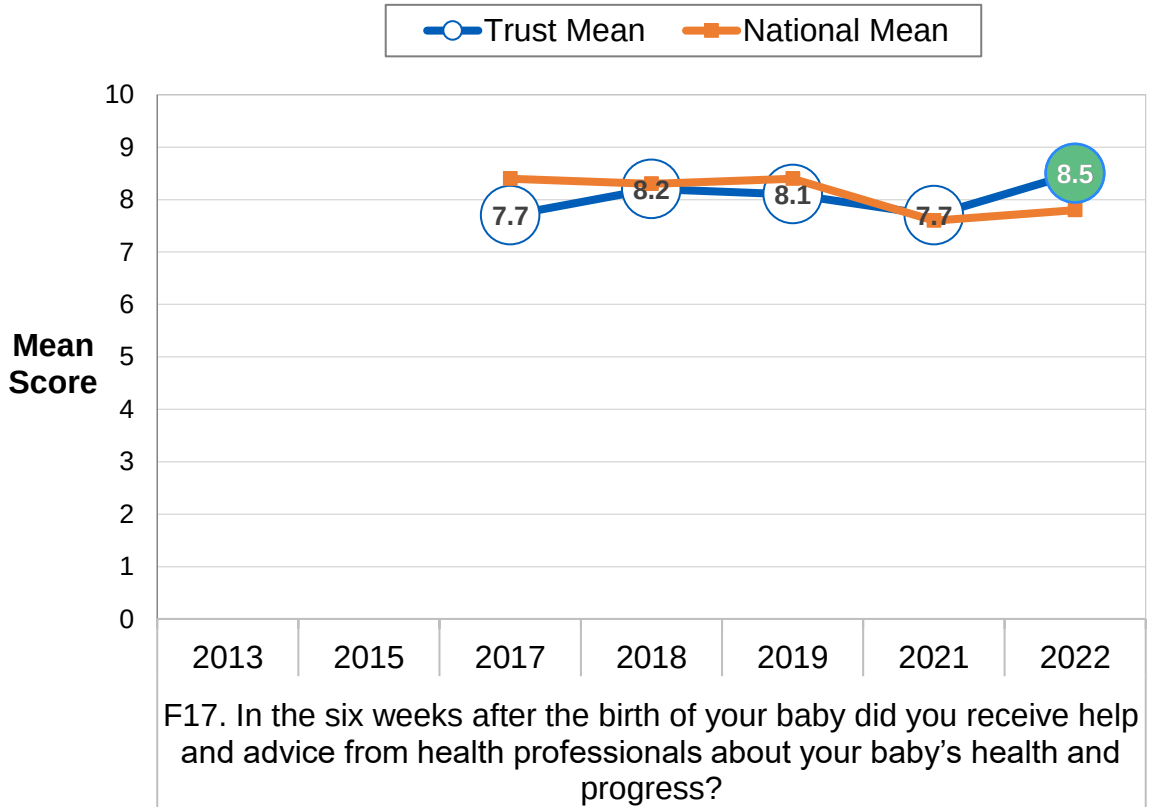
This shows a significant increase in the trust mean for this question for 2022 compared to 2021

This shows a significant decrease in the trust mean for this question for 2022 compared to 2021

Trends over time - Postnatal care

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Care at home after the birth



F17. In the six weeks after the birth of your baby did you receive help and advice from health professionals about your baby's health and progress?

Please note: *no data available for some years*

This shows a significant increase in the trust mean for this question for 2022 compared to 2021

This shows a significant decrease in the trust mean for this question for 2022 compared to 2021

Trends over time - Postnatal care (continued)

There are some questions in this section where data is not comparable prior to 2021. The following table displays changes since 2021, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected		2022 Trust Score	2021 Trust Score	No. of respondents in 2022	Change from 2021 survey
Care at home after the birth											
F13.	Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?							8.6	7.6	118	▲
F14.	Were you given information about your own physical recovery after the birth?							7.4	6.8	133	
F16.	If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this?							6.3	5.9	53	

▼▲ Significant difference between 2022 and 2021

Blank No significant difference between 2022 and 2021

Appendix

Comparison to other trusts

The questions at which your trust has performed worse compared with most other trusts are listed below. The questions where your trust has performed about the same compared with most other trusts have not been listed.

Much worse than expected	Worse than expected
• Your trust has not performed “much worse than expected” for any questions.	• C6. Were you involved in the decision to be induced? • C16. Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you? • C18. During labour and birth, were you able to get a member of staff to help you when you needed it?

Comparison to other trusts

The questions at which your trust has performed somewhat better or worse compared with most other trusts are listed below. The questions where your trust has performed about the same compared with most other trusts have not been listed.

Somewhat worse than expected	Somewhat better than expected
• C14. Did the staff treating and examining you introduce themselves? • C17. If you raised a concern during labour and birth, did you feel that it was taken seriously? • C21. Thinking about your care during labour and birth, were you treated with respect and dignity? • D6. Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding? • D8. Thinking about your stay in hospital, how clean was the hospital room or ward you were in?	• B3. Were you offered a choice about where to have your baby? • F14. Were you given information about your own physical recovery after the birth? • F15. In the six weeks after the birth of your baby did you receive help and advice from a midwife or health visitor about feeding your baby?

Comparison to other trusts

The questions at which your trust has performed better compared with most other trusts are listed below. The questions where your trust has performed about the same compared with most other trusts have not been listed.

Better than expected	Much better than expected
• F7. Did you feel that the midwife or midwifery team that you saw or spoke to always listened to you? • F17. In the six weeks after the birth of your baby did you receive help and advice from health professionals about your baby's health and progress?	• Your trust has not performed "much better than expected" for any questions.

NHS Maternity Survey 2022

Results for Milton Keynes University Hospital NHS Foundation Trust

Where mothers' experience is best

- ✓ Mothers being offered a choice about where to have their baby during their antenatal care.
- ✓ Mothers being given information about their own physical recovery after the birth.
- ✓ Mothers receiving help and advice from health professionals about their baby's health and progress in the six weeks after the birth.
- ✓ Mothers receiving help and advice from a midwife or health visitor about feeding their baby in the six weeks after giving birth.
- ✓ During antenatal check-ups, mothers being given enough information from either a midwife or doctor to help decide where to have their baby.

Where mothers' experience could improve

- ○ Mothers being involved in the decision to be induced.
- ○ Partners or someone else involved in the mother's care being able to stay with them as much as the mother wanted during their stay in the hospital.
- ○ Mothers (and / or their partner or a companion) being left alone by midwives or doctors at times when it worried them during labour and birth.
- ○ Mothers being able to get a member of staff to help when they needed it during labour and birth.
- ○ Mothers feeling that if they raised a concern during labour and birth it was taken seriously.

These questions are calculated by comparing your trust's results to the average of all trusts who took part in the survey. "Where mothers' experience is best": These are the five results for your trust that are highest compared with the average of all trusts who took part in the survey. "Where mothers' experience could improve": These are the five results for your trust that are lowest compared with the average of all trusts who took part in the survey.

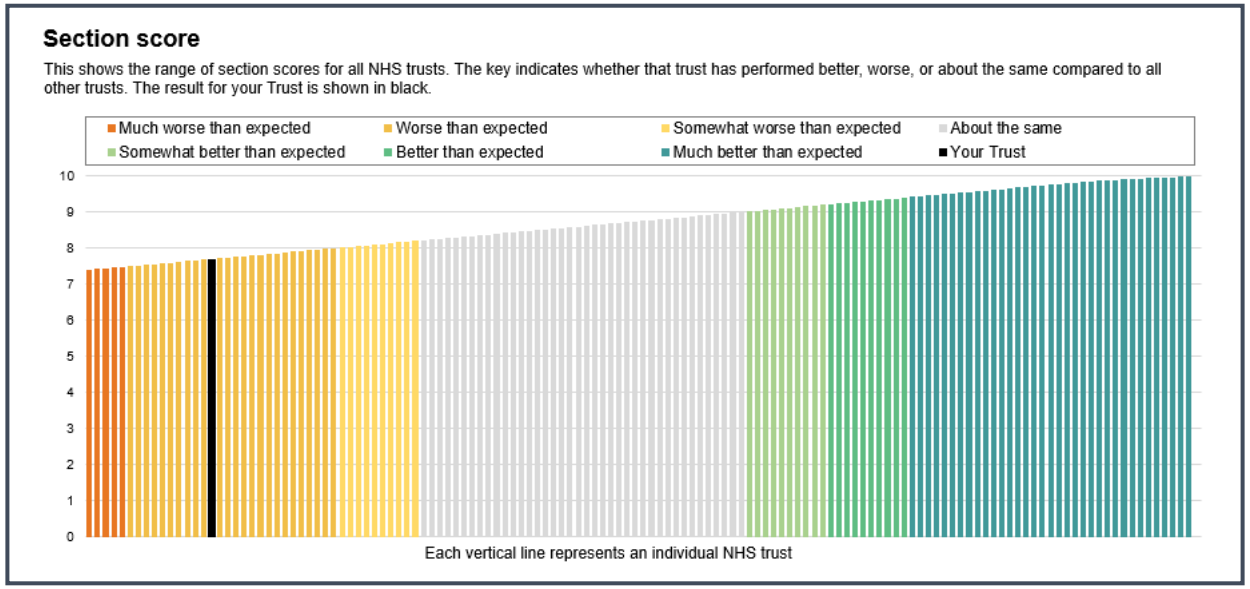
This survey looked at the experiences of individuals in maternity care who gave birth in February 2022 at Milton Keynes University Hospital NHS Foundation Trust. Between April 2022 and August 2022 a questionnaire was sent to 300 individuals. Responses were received from 169 individuals at this trust. If you have any questions about the survey and our results, please contact [NHS TRUST TO INSERT CONTACT DETAILS].

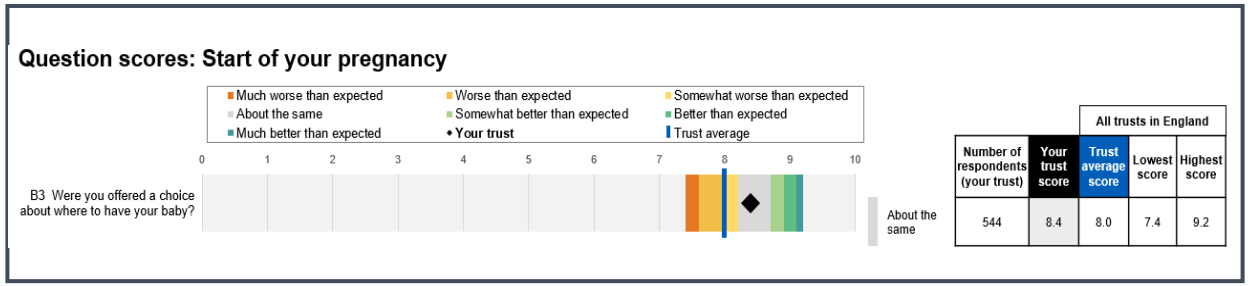
How to interpret benchmarking in this report

The charts in the 'benchmarking' section show how the score for your trust compares to the range of scores achieved by all trusts taking part in the survey. The black line shows the score for your trust. The graphs are divided into seven sections, comparing the score for your trust to most other trusts in the survey:

- If your trust's score lies in the **dark green section** of the graph, its result is 'Much better than expected'.
- If your trust's score lies in the **mid-green section** of the graph, its result is 'Better than expected'.
- If your trust's score lies in the **light green section** of the graph, its result is 'Somewhat better than expected'.
- If your trust's score lies in the **grey section** of the graph, its result is 'About the same'.
- If your trust's score lies in the **yellow section** of the graph, its result is 'Somewhat worse than expected'.
- If your trust's score lies in the **light orange** section of the graph, its result is 'Worse than expected'.
- If your trust's score lies in the **dark orange** section of the graph, its result is 'Much worse than expected'.

These groupings are based on a rigorous statistical analysis of the data termed the 'expected range' technique.





How to interpret benchmarking in this report (continued)

The ‘much better than expected,’ ‘better than expected’, ‘somewhat better than expected’, ‘about the same’, ‘somewhat worse than expected’, ‘worse than expected’ and ‘much worse than expected’ categories are based on an analysis technique called the ‘expected range’. Expected range determines the range within which a trust’s score could fall without differing significantly from the average, taking into account the number of respondents for each trust, to indicate whether the trust has performed significantly above or below what would be expected.

If it is within this expected range, we say that the trust’s performance is ‘about the same’ as other trusts. Where a trust is identified as performing ‘better’ or ‘worse’ than the majority of other trusts, the result is unlikely to have occurred by chance.

The question score charts show the trust scores compared to the minimum and maximum scores achieved by any trust. In some cases this minimum or maximum limit will mean that one or more of the bands are not visible – because the range of other bands is broad enough to include the highest or lowest score achieved by a trust this year. This could be because there were few respondents, meaning the confidence intervals around your data are slightly larger, or because there was limited variation between trusts for this question this year.

In some cases, a trust could be categorised as ‘about the same’ whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust. This occurs as the bandings are calculated through standard error rather than standard deviation. Standard error takes into account the number of responses achieved by a trust, and therefore the banding may differ for a trust with a low numbers of responses.

Please note, the benchmark bandings were updated for the 2021 survey to provide a greater level of granularity in the expected range score. The 2022 survey uses the same approach.

Additional information on the ‘expected range’ analysis technique can be found in the survey technical report on the NHS Surveys website.

An example of scoring

Each evaluative question is scored on a scale from 0 to 10. The scores represent the extent to which the mother's experience could be improved. A score of 0 is assigned to all responses that reflect considerable scope for improvement, whereas a score of 10 refers to the most positive patient experience possible. Where a number of options lay between the negative and positive responses, they are placed at equal intervals along the scale. Where options were provided that did not have any bearing on the trust's performance in terms of patient experience, the responses are classified as "not applicable" and a score is not given. Similarly, where respondents stated they could not remember or did not know the answer to a question, a score is not given.

Calculating an individual respondent's score

The following provides an example for the scoring system applied for each respondent. For question B8 "During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?":

- The answer code "Yes, always" would be given a score of 10, as this refers to the most positive patient experience possible.
- The answer code "Yes, Sometimes" would be given a score of 5, as it is placed at an equal interval along the scale.
- The answer code "No" would be given a score of 0, as this response reflects considerable scope for improvement.
- The answer codes "Don't know / can't remember" would not be scored, as they do not have a clear bearing on the trust's performance in terms of the mother's experience.

Calculating the trust score for each question

The weighting mean score for each trust, for each question, is calculated by dividing the sum of the weighting scores for a question by the weighted sum of all eligible respondents to the question for each trust. Weighting is explained further in the quality and methodology report.

Calculating the section score

An arithmetic mean of each trust's question scores is taken to provide a score for each section.

For further information

Please contact the Coordination Centre for Mixed Methods at Ipsos.

MaternityCoordination@ipsos.com

Appendix 1

Statement of Comprehensive Income
For the period ending 31st January 2023

	FY23	M10 CUMULATIVE			M10			PRIOR MONTH	
	Annual Budget	Budget	Actual	Variance	Budget	Actual	Variance	M9 Actual	Change
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME									
Outpatients	49,690	41,798	40,924	(874)	4,103	4,213	110	4,304	(91)
Elective admissions	33,324	28,087	24,170	(3,917)	2,344	2,397	53	2,466	(69)
Emergency admissions	81,933	68,708	69,463	755	6,704	7,181	477	3,169	4,013
Emergency adm's marginal rate (MRET)	0	0	0	0	0	0	0	0	0
Readmissions Penalty	0	0	0	0	0	0	0	0	0
A&E	19,076	16,114	16,241	127	1,485	1,501	16	1,676	(175)
Other Admissions	2,926	20,810	1,594	(19,217)	1,876	153	(1,722)	(11,051)	11,205
Maternity	24,851	2,258	15,294	13,036	339	1,590	1,251	12,606	(11,016)
Critical Care & Neonatal	7,141	6,070	5,657	(412)	609	1,033	424	403	630
Imaging	6,309	5,316	5,749	433	476	718	242	450	268
Direct access Pathology	4,724	3,921	4,363	442	394	480	86	412	68
Non Tariff Drugs and Devices (high cost/individual drugs)	21,299	17,840	18,435	595	1,799	2,019	220	1,870	150
Other (inc. home visits and best practice tariffs)	6,148	5,126	26,136	21,009	509	5,090	4,581	5,393	(303)
CQUINS	0	0	0	0	0	0	0	0	0
Contract Risk Provision - General challenge & CIP offset	0	0	0	0	0	0	0	0	0
National Block/Top up	50,403	39,492	37,952	(1,540)	5,163	1,171	(3,992)	7,372	(6,202)
MKCCG Block adj	0	0	0	0	0	0	0	0	0
Clinical Income	**307,824**	**255,539**	**265,976**	**10,437**	**25,801**	**27,547**	**1,746**	**29,070**	**(1,523)**
Non-Patient Income	19,169	16,039	19,201	3,163	1,566	2,314	749	2,232	83
PSF Income	0	0	(0)	(0)	0	0	0	0	0
Donations	5,171	5,080	0	(5,080)	10	(5,010)	(5,020)	0	(5,010)
Non-Patient Income	**24,340**	**21,119**	**19,201**	**(1,918)**	**1,576**	**(2,696)**	**(4,271)**	**2,232**	**(4,927)**
TOTAL INCOME	**332,164**	**276,658**	**285,177**	**8,520**	**27,376**	**24,851**	**(2,525)**	**31,302**	**(6,451)**
EXPENDITURE									
Pay - Substantive	(189,757)	(159,360)	(153,529)	5,830	(15,794)	(15,546)	248	(15,675)	129
Pay - Bank	(9,194)	(7,889)	(17,610)	(9,721)	(673)	(1,847)	(1,174)	(2,154)	308
Pay - Locum	(3,188)	(2,661)	(3,931)	(1,270)	(267)	(439)	(172)	(368)	(71)
Pay - Agency	(5,555)	(4,722)	(11,564)	(6,842)	(405)	(1,371)	(966)	(1,445)	74
Pay - Other	(758)	(636)	(724)	(88)	(62)	(73)	(11)	(72)	(1)
Pay CIP	41	34	0	(34)	3	0	(3)	0	0
Vacancy Factor	69	57	0	(57)	6	0	(6)	0	0
Pay	**(208,343)**	**(175,176)**	**(187,359)**	**(12,183)**	**(17,192)**	**(19,276)**	**(2,084)**	**(19,714)**	**438**
Non Pay	(77,110)	(64,577)	(66,329)	(1,752)	(6,046)	(6,514)	(467)	(7,569)	1,056
Non Tariff Drugs (high cost/individual drugs)	(21,299)	(17,840)	(18,435)	(595)	(1,799)	(2,019)	(220)	(1,870)	(150)
Non Pay	**(98,408)**	**(82,417)**	**(84,764)**	**(2,347)**	**(7,845)**	**(8,533)**	**(688)**	**(9,439)**	**906**
TOTAL EXPENDITURE	**(306,752)**	**(257,593)**	**(272,123)**	**(14,530)**	**(25,038)**	**(27,809)**	**(2,772)**	**(29,153)**	**1,344**
EARNINGS BEFORE INTEREST, TAXATION, DEPRECIATION AND AMORTISATION (EBITDA)	**25,412**	**19,065**	**13,055**	**(6,010)**	**2,339**	**(2,958)**	**(5,297)**	**2,149**	**(5,107)**
Interest Receivable	0	0	660	660	0	114	114	108	6
Interest Payable	(338)	(282)	(313)	(31)	(28)	(31)	(3)	(31)	0
Depreciation, Impairments & Profit/Loss on Asset Disposal	(14,474)	(11,823)	(11,784)	38	(1,221)	(1,216)	4	(1,165)	(51)
Donated Asset Depreciation	(563)	(468)	(477)	(9)	(48)	(49)	(1)	(48)	(1)
Profit/Loss on Asset Disposal & Impairments	0	0	0	0	0	0	0	0	0
DEL Impairments	0	0	0	0	0	0	0	0	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	**10,037**	**6,493**	**1,140**	**(5,352)**	**1,042**	**(4,140)**	**(5,182)**	**1,013**	**(5,153)**
Dividends Payable	(5,429)	(4,527)	(4,411)	115	(453)	(338)	115	(453)	115
OPERATING SURPLUS/(DEFICIT) AFTER DIVIDENDS	**4,608**	**1,966**	**(3,271)**	**(5,237)**	**590**	**(4,478)**	**(5,067)**	**560**	**(5,038)**

Appendix 2

Statement of Cash Flow
As of 31st January 2023

	Audited Mth12 2021-22 £000	Mth 10 £000	Mth 9 £000	In Month Movement £000
Cash flows from operating activities				
Operating (deficit) from continuing operations	2,699	792	5,017	(4,225)
Operating (deficit)	**2,699**	**792**	**5,017**	**(4,225)**
Non-cash income and expense:				
Depreciation and amortisation	11,278	12,261	10,996	1,265
Impairments	715	0	0	0
(Gain)/Loss on disposal	(48)	0	0	0
(Increase)/Decrease in Trade and Other Receivables	9,003	(4,419)	(11,826)	7,407
(Increase)/Decrease in Inventories	(375)	(13)	(13)	0
Increase/(Decrease) in Trade and Other Payables	14,788	(17,414)	(16,532)	(882)
Increase/(Decrease) in Other Liabilities	5,945	(1,787)	319	(2,106)
Increase/(Decrease) in Provisions	(338)	(47)	(42)	(5)
NHS Charitable Funds	(561)	0	(5,010)	5,010
Other movements in operating cash flows	(1)	(11)	(2)	(9)
NET CASH GENERATED FROM OPERATIONS	**43,105**	**(10,638)**	**(17,093)**	**6,455**
Cash flows from investing activities				
Interest received	36	660	545	115
Purchase of intangible assets	(4,160)	(1,690)	(1,289)	(401)
Purchase of Property, Plant and Equipment, Intangibles	(37,974)	(14,743)	(8,890)	(5,853)
Net cash generated (used in) investing activities	**(44,598)**	**(15,773)**	**(9,634)**	**(6,139)**
Cash flows from financing activities				
Public dividend capital received	15,273	500	500	0
Capital element of finance lease rental payments	(201)	(231)	(185)	(46)
Interest element of finance lease	(267)	(312)	(281)	(31)
PDC Dividend paid	(4,663)	(2,045)	(2,045)	0
Receipt of cash donations to purchase capital assets	561	0	5,010	(5,010)
Cash flows from (used in) other financing activities	0	0		0
Net cash generated from/(used in) financing activities	**10,703**	**(2,088)**	**2,999**	**(5,087)**
Increase/(decrease) in cash and cash equivalents	**9,210**	**(28,499)**	**(23,728)**	**(4,771)**
Opening Cash and Cash equivalents	**48,765**	**57,975**	**57,975**	
Closing Cash and Cash equivalents	**57,975**	**29,476**	**34,247**	**(4,771)**

Statement of Financial Position as of 31st January 2023

	Audited Mar-22	Jan-23 YTD Actual	YTD Mvmt	% Variance
Assets Non-Current				
Tangible Assets	189.6	196.5	6.9	3.8%
Intangible Assets	22.3	19.4	(2.9)	(13.4%)
ROU Assets	0.0	12.3	12.3	100.0%
Other Assets	1.0	1.0	0.0	1.3%
Total Non Current Assets	**212.9**	**229.2**	**16.3**	**7.4%**
Assets Current				
Inventory	4.1	4.1	0.0	0.0%
NHS Receivables	3.5	6.0	2.5	59.5%
Other Receivables	7.2	9.1	1.9	29.2%
Cash	58.0	29.5	(28.5)	(62.0%)
Total Current Assets	**72.8**	**48.7**	**(24.1)**	**(39.7%)**
Liabilities Current				
Interest -bearing borrowings	(0.2)	(0.3)	(0.1)	6.4%
Deferred Income	(19.4)	(17.6)	1.8	(9.2%)
Provisions	(2.4)	(2.4)	0.0	0.0%
Trade & other Creditors (incl NHS)	(60.4)	(45.1)	15.3	(29.7%)
Total Current Liabilities	**(82.4)**	**(65.4)**	**17.0**	**(22.6%)**
Net current assets	**(9.6)**	**(16.7)**	**(7.1)**	**49.1%**
Liabilities Non-Current				
Long-term Interest bearing borrowings	(5.4)	(17.4)	(12.0)	90.8%
Deferred Income	(1.5)	(1.5)	0.0	100.0%
Provisions for liabilities and charges	(1.8)	(1.8)	0.0	0.0%
Total non-current liabilities	**(8.7)**	**(20.7)**	**(12.0)**	**79.9%**
Total Assets Employed	**194.6**	**191.8**	**(5.8)**	**(3.0%)**
Taxpayers Equity				
Public Dividend Capital (PDC)	275.1	275.6	0.5	0.2%
Revaluation Reserve	52.6	52.6	(0.0)	(0.1%)
Financial assets at FV through OCI reserve	(2.3)	(2.3)	(0.0)	2.0%
I&E Reserve	(130.8)	(134.0)	(3.2)	2.4%
Total Taxpayers Equity	**194.6**	**191.8**	**(5.1)**	**(2.7%)**

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%
CBIG	Clinical Board Investment Group	Capital approval meeting overseeing small scale capital schemes including equipment replacement and building work.
CDEL	Capital Departmental Expenditure Limit	Equivalent to a capital budget. CDEL represents the 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
Maple Centre	Maple Centre	The initial project name for the Maple Centre was the Pathway Unit - a 23hr ambulatory care facility currently under construction

Labour Ward Co-Ordinator Supernumerary Status - Maintaining compliance action plan - Feb 2023

Recommendation	Action	Owner	Due date	Date complete	Comments	RAG
Ensure the escalation procedure documents expected actions to enable provision of labour ward co-ordinator supernumerary status	Review the escalation procedure to identify required additions to enable clarity of expected management	Inpatient Maternity Matron	Feb-23		Guideline to go through guidelines group in Feb-23	
MSW mapping project to increase skills & competencies of support staff, releasing midwifery time for focus on midwifery specific tasks	Consultation document outlining the change to the new JD's & competencies to launch	Maternity Matrons	Jan-23		JD's agreed. Consultation document written. Pathway of development & training in place. Training provider organised. Risk assessment completed.	
Business case to increase the level of support staff within the labour ward setting	Complete & submit business case	Inpatient Maternity Matron	Feb-23		Business case in progress	
Improved reporting rate of B7 co-ordinator status	Confidence factor of BR+ recommended 85% and above	HoM	Apr-23		Current confidence factor 77%	
Organise the shift plan to support two labour ward band 7's per shift, one identified as the co-ordinator	Ensure Band 7 establishment within the labour ward to support the provision of 2 per shift	HoM	Jan-22			
Identify themes within incident reports for non-supernumerary status labour ward co-ordinator	Update this action plan with identified themes and mitigations to reduce the risk of re-occurrence	Clinical Governance & QI Lead	Ongoing			
Implement a mechanism to review actions taken in cases where a red flag is raised for non-supernumerary status of the labour ward co-ordinator	Implement area within the data collection tool to document actions taken in response to raising a red flag for non-supernumerary status of the labour ward co-ordinator	Deputy HoM	Feb-22	Apr-22		

KEY

Risk of non-complience/ unable to implement	Further action needed to reach complience	On track to be complient	Complete/ closed

24-hour manager on call availability to enable robust escalation and oversight procedures	Maternity senior leadership team availability and contingency plan to support provision of the 24-hour manager on call	HoM	Jan-22	Jan-22		
Staffing escalation procedures in place to mitigate against unavailability of midwifery staff	Availability of maternity escalation procedure and maternity staffing business contingency plan detailing actions for the management of staffing shortfalls	HoM	Jan-22			
Clear divisional reporting structure for the escalation and mitigations of red flags	Reporting monthly red flags on the maternity governance report through divisional and directorate meetings	Clinical Governance & QI Lead	Feb-22			
Clarify the definition of supernumerary to support consistency in interpretation and reporting	Organise a session at the labour ward co-ordinators meeting to discuss the interpretation of supernumerary status	Inpatient Maternity Matron	Sep-22	Sep-23		
Review of staff unavailability themes and actions required to support increased midwifery staffing provision in the service	Complete a staffing unavailability action plan to identify and measure success of actions taken to increase midwifery staffing provision	HoM	Sep-22	Dec-22		
Improved consistency in reporting compliance with supernumerary status of labour ward co-ordinators	Implementation of Birth Rate Plus acuity tool for electronic submission of supernumerary status of the labour ward co-ordinator	HoM	May-22	May-22		
Update the risk register to include labour ward co-ordinator supernumerary status of less than 100%	Complete the risk assessment format for addition of risk onto the risk register and send to triumvirate for review	HoM	Feb-23	Feb-23	Review of current compliance and 100% compliant as per CNST definition. To continue to monitor complience and review requirement for risk register is compliance falls	

1:1 Care in labour - Action Plan Feb 2023

Recommendation	Action	Owner	Due date	Date complete	Comments	RAG
Review current admission criteria to the antenatal inpatient area to assess suitability of admission in cases of precipitate labour precluding 1:1 care in established labour	Identify changes to admission criteria or requirement for specific admission criteria to reduce potential for precipitate progress in the ward environment	Inpatient Maternity Matron	Apr-23			
MSW mapping project to increase skills & competencies of support staff, releasing midwifery time for focus on midwifery specific tasks	Consultation document outlining the change to the new JD's & competencies to launch	Maternity Matrons	Jan-23		JD's agreed. Consultation document written. Pathway of deve;opment & training in place. Training provider organised. Risk assessment completed.	
Business case to increase the level of support staff within the labour ward setting	Complete & submit business case	Inpatient Maternity Matron	Feb-23		Business case in progress	
Clarify the definition of established labour to enable consistency in reporting	Define established labour on the red flag reporting tool	Inpatient Maternity Matron	Feb-22			
Ensure the escalation procedure documents expected actions to enable provision of 1:1 care in labour	Review the escalation procedure to identify required additions to enable clarity of expected management	Inpatient Maternity Matron	Mar-22			

KEY				
	Risk of non-complience/ unable to implement	Further action needed to reach complience	On track to be complient	Complete/ closed

Identify themes within incident reports for cases where 1:1 care in established labour was not provided	Update this action plan with identified themes and mitigations to reduce the risk of re-occurrence	Clinical Governance & QI Lead	Ongoing			
Implement a mechanism to review actions taken in cases where a red flag is raised for 1:1 care not being provided in established labour	Implement area within the data collection tool to document actions taken in response to raising a red flag for 1:1 care not being provided in established labour	Deputy HoM	Feb-22			
24-hour manager on call availability to enable robust escalation and oversight procedures	Maternity senior leadership team availability and contingency plan to support provision of the 24-hour manager on call	HoM	Jan-22			
Staffing escalation procedures in place to mitigate against unavailability of midwifery staff	Availability of maternity escalation procedure and maternity staffing business contingency plan detailing actions for the management of staffing shortfalls	HoM	Jan-22			
Clear divisional reporting structure for the escalation and mitigations of red flags	Reporting monthly red flags on the maternity governance report through divisional and directorate meetings	Clinical Governance & QI Lead	Mar-22	Apr-22		
Review current staffing model in place against the recommendation from the updated Birth Rate Plus report	Identify alterations in the staffing requirements and complete an action plan for submission to Board detailing the requirements to achieve compliance with Birth Rate Plus recommendations	HoM	Oct-22	Jan-23	Position paper completed & submitted	
Review of staff unavailability themes and actions required to support increased midwifery staffing provision in the service	Complete a staffing unavailability action plan to identify and measure success of actions taken to increase midwifery staffing provision	HoM	Sep-22	Oct-22	Midwifery workforce plan complete. R&R plan complete.	

Triangulate against patient experience data themes related to care delays in maternity inpatient areas	Review specific patient experience themes from multiple sources to identify specific care delay concerns and include within the patient experience action plan	Outpatient maternity Matron	Oct-22	Oct-22	Experience action plan updated following complaint themes review & maternity survey	
Implementation of BSOTS triage to support consistency in the care pathways of service users contacting maternity	Organisation of the BSO	Deputy Head of Midwifery		Nov-22	BSOTS commenced	
Review accessibility to pain relief within the ward environment to identify opportunities to reduce transfer times to labour ward	Development of the Entonox SoP to detail the use of Entonox in a non-intrapartum area & timeframe associated with expected transfer	Outpatient maternity Matron	Jan-23	Jan-23		

Neonatal Nursing & Medical Workforce Action plan 2023

Staff Group	Date added as an action	Workstream	Area of focus	Action required	Action owner	Divisional lead	RAG	Comments/Updates
Neonatal Nursing Workforce	Jul-22	CNST Safety action 4 Part D	The neonatal unit meets the service specification for neonatal nursing standards. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies and share this with the Royal College of Nursing, LMNS and Neonatal Operational Delivery Network (ODN) Lead	1. QIS requirements not met - Neonatal workforce Tool (2020) calculates that 70.7% on unit staff should be QIS - currently only 58% in post.	LV/MD	Victoria Alner		July 2022 - shared with RCN, LMNS and ODN, Ockendon funding received in March 2022 from NCCR to improve staffing ratios. October 2022 - Staffing reviewed by ODN - with 2x Band 7s joining establishment, QIS improved to 64%. December 2022 - 3 RN undertaking QIS training theough UOB, 1 RN has completed QIS cource through TVWODN, awaiting final results.
Neonatal Medical Workforce	Jan-23	CNST Safety Action 4 Part C	The neonatal medical workforce meets the criteria for Tier 1 & 2 medical staff, the workforce currently does not meet the requirement for Tier 3 doctors. This requirement stipulates that any consultant covering neonates must work a minimum of 4 attending weeks (COTW) per year. The frequency of general paediatric consultants undertaking neonatal duties is below this expectation and currently, 10 consultants do not meet this requirement	1. A business case to increase from 13 to 14 consultants which will enable an increase in the number of attending weeks on the neonatal unit by the paediatricians from 2 to 4 weeks, meeting the Tier 3 requirements 2. A review of the opportunity to split the paediatric & neonatal rota is taking place	ZG	Victoria Alner		

KEY

Risk of non-complience/ unable to implement	Further action needed to reach complience	On track to be compliant	Complete/ closed

Neonatal Nursing Workforce Tool (2020): Milton Keynes

Input unit details			
Trust			
Unit	Milton Keynes		
Designation	LNU		
Completed by	Lisa Viola		
Date completed	20/08/22		
Activity period	2021/22	Days in period	365

Input activity (HRG 2016)		
	Activity	Declared cots
HRG 1 (IC)	340	1
HRG 2 (HD)	1,406	4
HRG 3 (SC)	2,468	12
Total	**4,214**	**17**

Input staffing numbers (WTE) DIRECT PATIENT CARE ONLY		
	Budget	In post
Total QIS	19.15	16.89
Total Non QIS	14.40	P
Total Non Reg	6.17	6.79
Total	**39.72**	**23.68**

Activity (HRG 2016)							
	Activity	*For calculations*		Declared cots	Occupancy for period	Cots required to meet activity at average 80% occupancy	Variance: declared cots against required
		80% of daily activity	*WTE (6.07 / BAPM)*				
HRG 1	340	*1.2*	*6.07*	1	93.15%	2	-1
HRG 2	1,406	*4.8*	*3.04*	4	96.30%	4	0
HRG 3	2,468	*8.5*	*1.52*	12	56.35%	9	3
Total	**4,214**			**17**	**67.91%**	**15**	**2**

Nursing workforce (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 42.49, of which 29.74 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	39.72	23.68	40.58	-0.86	-16.90
Total reg nurses	33.55	16.89	36.73	-3.18	-19.84
Total QIS	19.15	16.89	27.75	-8.60	-10.86
Total non-QIS	14.40	P	8.98	5.42	
Total non-reg	6.17	6.79	3.85	2.32	2.94
Reg nurses as % nursing staff	84.5%	71.3%	90.5%		
QIS as % reg nurses	57.1%	100.0%	75.6%		

Assumptions For further detail please refer to the narrative sheet.

- Calculations are valid for neonatal unit only - transitional care staffing and activity should be excluded.
- 6.07 WTE is required for 1 nurse per shift. The detail of how this multiplier was calculated is on a separate sheet.
- Staffing requirements are based on activity, and BAPM nurse to baby ratios are used, ie IC 1:1; HD 1:2; SC 1:4.
- Numbers are for nurses **providing direct patient care only**. Exclude additional roles e.g. management, outreach, education.
- A supernumerary nurse in charge is included for all units on all shifts.
- At least 70% of registered nurses should be Qualified In Specialty (QIS).
- All intensive and high dependancy care should be undertaken by registered nurses with QIS training.
- For special care, registered to non-registered staff ratios are calculated at 70:30.
- Cot calculations assume that cots can be flexed up but not down, so round up to the higher level cots. See narrative for more detail.

Corporate Risk Register

Reference	Created on	Description		Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-035	28-Sep-2021	IF there is a high turnover of staff due to: work pressure, not having the opportunity to work at the top of their licence, lack of capacity for development, lack of capacity for supervision / support. Also difficulty in recruiting. Loss of staff to primary care which offers more attractive working hours. THEN there will be insufficient staff in pharmacy to meet demands of the organisation and ensure patient safety in the use of medicines.	LEADING TO: 1. increased length of stay due to TTO delay 2. increase in prescribing errors not corrected 3. increase in dispensing errors 4. increase in missed doses 5. failure to meet legal requirements for safe and secure use of medicines 6. harm to the patients 7. adverse impact on mental health of Pharmacy staff All resulting in adverse patient outcomes. Lack of financial control on medicines expenditure Breach of CQC regulations	Helen Chadwick	26-Jan-2023	31-Mar-2023	Planned	20	20	6	Actively recruiting staff (07-Feb-2023)	Business Case for additional staff(05-Apr-2022), Temporary role realignment towards patient facing roles(05-Apr-2022), Use of Agency Staff(05-Apr-2022), Prioritisation of wards(28-Jun-2022)	Low	Treat	Risk reviewed at Pharmacy CIG 06/01/23: Staffing issue, progressing slowly, to review end of March, add in comments information on the latest recruitment, scoring unchanged.	07-Aug-2019
RSK-134	04-Nov-2021	If there is insufficient funding, then the Trust may be unable to meet financial plans and targets or deliver its strategic aims,	Leading to service failure and regulatory intervention THEN the Trust will be unable to meet its financial performance obligations or achieve financial sustainability	Karan Hotchkin	20-Feb-2023	16-Mar-2023	Planned	20	20	10	The current funding has now been clarified .The trust will work with BLMK system partners during the year to review overall BLMK performance, The risk for the current year can be managed but the underlying position going forward is uncertain due to lack of clarity on the medium term funding post March 2023	Cost and volume contracts replaced with block contracts (set nationally) for clinical income(04-Nov-2021), Top-up payments available where COVID-19 leads to additional costs over and above block sum amounts (until end of March 2022)(04-Nov-2021), Budgets to be reset for FY22 based on financial regime; financial controls and oversight to be reintroduced to manage financial performance(04-Nov-2021), Cost efficiency programme to be reset to target focus on areas of greatest opportunity to deliver(04-Nov-2021)	High	Treat	Risk transferred from Datix	01-Apr-2022
RSK-158	12-Nov-2021	If the escalation beds are open across the medical and surgical divisions Then the additional patients that will need to be seen will put additional demand on the Inpatient Therapy Services that are already stretched due to long term vacancies	LEADING TO: Patients deconditioning and increased Length Of Stay (LOS), high volume of patients will not be seen daily, priority will be given to new assessments, discharges and acute chests. Majority of patients may only be seen once a week for rehabilitation which is insufficient to maintain a patient's level of function. Staff morale will reduce as they will not be providing the appropriate level of assessment and treatment to their patients.	Adam Baddeley	03-Feb-2023	28-Feb-2023	Pending	16	20	6	Closure or Reduction in Escalation Beds (09-Jan-2023)	Therapy staff attend board rounds and work with the MDT to determine priority patients. The skills mix and workforce is reviewed twice weekly between Occupational Therapy and Physiotherapy to determine cover for the base wards. To work closely with community services to raise awareness and to increase discharge opportunities i.e. in reaching Therapies working with Long stay Tuesday initiative Therapies supporting new discharge pathway/process in the Trust Over recruitment of PT and OT band 5's Locum cover for vacant posts. Daily attendance at 10.30 system wide discharge call. Inpatient Therapy Service participation in MADE events. Review of staffing model across inpatient medical and frailty wards.(12-Nov-2021)	Low	Treat	Additional escalation areas such as ward 2b have been opened, further adding to the workload requiring to be seen daily. Therapy team morale very low.	27-Nov-2018
RSK-159	12-Nov-2021	Patients referred to the Occupational Therapy and Physiotherapy inpatient services covering medical and surgical wards are not being seen in a timely manner due to the number of long term vacancies and national challenges to recruit to vacant posts. THEN there will be a delay in these patients being assessed, treated and discharged.	LEADING TO deconditioning of vulnerable/complex patients requiring a short period of therapy; increased length of stay; potential readmission, increased demand for packages of care requiring double handed provision. patient experience and long term quality of life will also be impacted as patients are being discharged as more dependent on care.	Adam Baddeley	03-Feb-2023	28-Feb-2023	Pending	20	20	6	Review of Governance Structure (18-Oct-2022), Review Equity Tool - Safe Staffing (07-Feb-2023), Review Workforce Model and Structure (07-Feb-2023), Recruitment and Retention of staff (09-Jan-2023)	Daily prioritisation of patients cross covering and review of skill mix locum cover x1 OT and x1 PT in place Ward book for escalation wards setup and band 7 reviews the caseload on the ward daily Monday- Friday and requests the most urgent are reviewed. Recruitment process ongoing but vacancies have reduced slightly. Over recruitment of band 5 OT and PT roles. Non-recurrent funding application for increase in therapy assistants over winter months.(12-Nov-2021), Review Model of Care(19-Apr-2022), Education and Training of staff(19-Apr-2022)	Low	Treat	Inpatient therapy services across the Trust remain significantly stretched with the focus being on assessments and discharge. There is little ability to provide rehabilitation.	04-Mar-2019
RSK-341	17-May-2022	IF there is a delay with imaging reporting for CT and MRI for patients on cancer pathways THEN there could be a delay with diagnosis and the commencement of treatment	LEADING TO potential increase in the required treatment, potential poorer prognosis for patient, poor patient experience, increase in complaints and litigation cases.	Paula Robinson	09-Feb-2023	21-Feb-2023	Overdue	20	20	8	2x Specialist Doctors appointed on a fixed-term basis to uplift internal reporting capacity (14-Jun-2022), Specialist Radiology to be recruited to uplift reporting capacity, Explore alternative outsourcing for some specialist areas (e.g. lung), Imaging Business Case for substantive Radiologists and Radiographers	PTL tracking to escalate to imaging leads(18-May-2022), Agency Locum Consultant appointed 2 days a week to uplift internal reporting capacity(14-Jun-2022), Temporary reduction in double reporting for Quality Assurance to increase real-time scan reporting(14-Jun-2022), Current Radiologists doing 30% over standard reporting levels(14-Jun-2022)	Low	Treat	Risk reviewed by Claire McGillycuddy. No change to risk - review again February 2023	01-Jun-2022

Reference	Created on	Description		Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-001	06-Sep-2021	IF all known incidents, accidents and near misses are not reported on the Trust's incident reporting system (Radar); THEN the Trust will be unable to robustly investigate all incidents and near-misses within the required timescales;	LEADING TO an inability to learn from incidents, accidents and near-misses, an inability to stop potentially preventable incidents occurring, potential failure to comply with Duty of Candour legislation requiring the Trust to report all known incidents where the severity was moderate or higher, potential under reporting to the Learning from Patient Safety Events (LfPSE) system, and potential failure to meet Trust Key Performance	Tina Worth	29-Dec-2022	31-Mar-2023	Planned	20	16	12	Staff competence and confidence with Radar reporting, with improved reporting rate, reduction in inaccurate reports on system and/or failure of incidents being reported (24-Oct-2022)	Incident Reporting Policy(06-Sep-2021), Incident Reporting Mandatory/Induction Training(06-Sep-2021), Incident Reporting Training Guide and adhoc training as required. Radar to provide on site & bespoke training IT drop in hub to be set up 2 days a week for staff drop ins(06-Sep-2021), Datix Incident Investigation Training sessions(06-Sep-2021), Daily review of incidents by Risk Management Team to identify potential Serious Incidents and appropriate escalation(06-Sep-2021), Serious Incident Review Group (SIRG) ensure quality of Serious Incident Investigations(06-Sep-2021), SIRG ensure appropriate reporting of Serious Incidents to Commissioners(06-Sep-2021), Standard Operating Procedure re Risk & Governance Team supporting the closure of incident investigations during unprecedented demand on service(06-Sep-2021), Implementation of new Risk Management Software to make incidents easier to report and improve engagement with staff(06-Sep-2021)	Low	Treat	Risk unchanged. Remains concerns re system & incidents captured/not captured Ongoing work with Radar & NHSI to make system more efficient & user friendly	06-Sep-2021
RSK-036	28-Sep-2021	If there is no capacity in the Pharmacy Team THEN there is a risk that Pharmacy and Medicines Policies and Procedures may not be reviewed and updated in a timely manner, nor new policies developed	Leading to: Potential for Policies & Procedures to be out of date Potential for staff to follow out of date Policies & Procedures Failure to meet CQC requirements Lack of guidance for staff Potential harm to patients	Helen Chadwick	19-Dec-2022	31-Mar-2023	Planned	16	16	6	Recruitment of staff (07-Feb-2023)	Use of remote bank staff to update policies(28-Sep-2021), Business Case for additional Pharmacy staff(19-Apr-2022)	Low	Treat	Risk reviewed by Jill McDonald: The control of the pharmacy related risk remains dependent on staff recruitment. We are out to advert across all grades of pharmacist at present with some success however a number of posts will need readvertised. I do not expect the current recruitment to have a major impact for at least 3 months. Claire McGillycuddy requested review date is in 4 months	01-Oct-2021
RSK-115	29-Oct-2021	IF annual and quarterly test reports for Autoclaves and Washer Disinfectors used for critical processes are not being received in a timely manner from the Estates department and there is no Authorised Person (D) to maintain the day to day operational aspects of the role THEN the Trust will be unable to prove control, monitoring and validation of the sterilisation process as a control measure. Both units are reviewed only 1 day per month - a bulk of this time is spent checking records and the other aspects of the role do not get the sufficient time required to review and follow up.	LEADING TO possible loss of ISO 13485 accreditation due to non-compliance to national standards. Inconsistent checks or lack of scheduled tests for the steam plant also increase the risk.	Mark Brown	17-Feb-2023	31-Mar-2023	Planned	20	16	9	A meeting took place in January with estates managers, where HSDU were seeking assurance that the service would be covered. Estates have agreed to look for a plan to mitigate the risk and to keep HSDU fully informed. HSDU have informed the AE(D), so he is now aware that the site will not have any day to day operational AP(D) cover. (17-Feb-2023)	Estates management informed and plans in place to receive reports on time and to standard. Independent monitoring system in place monitoring machine performance. Weekly PPM carried out on machinery. An action plan has been created by estates, to include training the specialist estates officer so he can gain the recognised qualification he needs to carry out the role of the Authorised person for decontamination(AP(D)) and for additional training of the estates competent persons(CP(D) who test the decontamination equipment.(29-Oct-2021)	Low	Not Applicable	The AE is working with the departments in a timely order, they are supporting HSDU every month and our AP(D) is reviewing all weekly and quarterly reports with any recommendations forwarded to the AE (D) to action.	25-Aug-2021
RSK-126	04-Nov-2021	IF cot spacing in the Neonatal Unit does not comply with BAPM guidance or the latest PHE guidance for COVID-19 (the Unit is seeking to increase both total cot spacing and cot numbers by 4 HDU/ITU cots in line with Network 5 year projections of acuity and demand, and spacing in line with National Recommendations) THEN there will be overcrowding and insufficient space in the Neonatal Unit, exacerbated by need for social distancing due to COVID-19. The milk kitchen was condemned due to this	LEADING TO an inability to meet patient needs or network requirements. We will now also be unable to meet PHE recommendations for social distancing This may result in a removal of Level 2 status if we continue to have insufficient space to adequately fulfil our Network responsibilities and deliver care in line with national requirements. This may also impact on our ability to protect babies and their families during COVID	Zuzanna Gawlowski	20-Dec-2022	20-Mar-2023	Planned	25	16	9	Business Case for Refurnishing Milk Kitchen and Sluice	Reconfiguration of cots to create more space and extra cots and capacity, though this still does not meet PHE or national standards(04-Nov-2021), Parents asked to leave NNU during interventional procedures, ward rounds etc. Restricted visiting during COVID(04-Nov-2021), Added to capital plan(04-Nov-2021), Feasibility study completed(04-Nov-2021)	Low	Treat	Risk reviewed by triumvirate ,No change to risk or risk scoring	19-Dec-2022
RSK-142	04-Nov-2021	IF there is insufficient capacity and ongoing unsustainable demand for dietetic input for Paediatric patients (both inpatient and outpatient) . IF Home Enterally Fed Paediatrics patients continue to be seen our outpatient structure which is not adequate to meet their demands and needs (rather than the community contract). This means that these high risk groups of Children and Young People are not accessing the necessary specialist nutritional support at the appropriate time in their development THEN staff may be unable to cover a service that has not been serviced correctly, and the paediatric team cannot provide a full dietetic service to children and young people in the Milton Keynes area	LEADING TO patient care and patient safety may be at risk, vulnerable children may become nutritionally compromised, the service may be unable to assess and advise new patients and review existing patients in a timely manner, and there may be an impact on patients nutritional status and longer term dietary management on what is a very vulnerable group of patients. The majority of our caseload is infants or tube fed infants and children where there nutrition and growth is a priority.	Elizabeth Pryke	05-Feb-2023	31-Mar-2023	Planned	15	16	3	In contact with commissioners to discuss service provision Collecting additional data (feedback from stakeholders, benchmarking etc) to support business case	Existing staff are working some additional hours but this remains insufficient to meet the needs of the service(04-Nov-2021)	Low	Treat	Continuing to try and engage with commissioners regarding properly commissioned service Collecting data from stakeholders, benchmarking etc to support business case	01-Nov-2021
RSK-202	23-Nov-2021	IF Transformation delivery is not adequately resourced and prioritised and/or schemes are unrealistic and not well planned THEN There is a risk that the Trust is unable to achieve the required efficiency improvements through the transformation programme	LEADING TO the Trust potentially not delivering its financial targets leading to TO potential cash shortfall and non-delivery of its key targets	Karan Hotchkin	20-Feb-2023	16-Mar-2023	Planned	20	16	9	Divisional CIP review meetings in place attended by the DoF, divisional managers and finance business partner. There are no cross-cutting transformation schemes yet identified and savings of around £8m have been identified against the £12m target. Whilst this shortfall can be mitigated this year, the risk is around the underlying financial position.	Divisional CIP review meetings in place attended by the DoF, divisional managers and finance business partners(23-Nov-2021), Cross-cutting transformation schemes are being worked up(23-Nov-2021), Savings plan for 21/22 financial year not yet fully identified(23-Nov-2021)	Medium	Treat	Risk transferred from Datix	01-Apr-2022

Reference	Created on	Description		Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-305	06-Dec-2021	If there is insufficient strategic capital funding available THEN the Trust will be unable to invest in the site to maintain pace with the growth of the Milton Keynes population's demand for hospital services	LEADING To financial loss and reputational damage	Karan Hotchkin	20-Feb-2023	16-Mar-2023	Planned	16	16	9	Trust is discussing this with the regional Capital Team and with the ICB capital allocations for 23/24. 22/23 allocations are manageable	The trust has a process to target investment of available capital finance to manage risk and safety across the hospital(06-Dec-2021)	Medium	Treat	Risk was approved by Finance and Investment committee on 30/12/2021	01-Apr-2022
RSK-203	23-Nov-2021	IF the are negative impacts on the supply chain following the rising fuel costs and the conflict in Ukraine THEN there is a risk that the supply of key clinical products may be disrupted	LEADING TO some unavailabilty of clinical products, delays to deliveries and services may be disrupted or reduce resulting in impact on patient care	Lisa Johnston	20-Feb-2023	16-Mar-2023	Planned	16	15	6		Trust's top suppliers have been reviewed and issues with supply under constant review(23-Nov-2021), Procurement business partners use the NHS Spend Comparison Site and local knowledge supported by the clinical procurement nurse to source alternative products(23-Nov-2021), Clinical Procurement nurse to join the NHSI/E Supply Resilience Forum(15-Aug-2022), Clinical Procurement nurse is part of the NHSI/E Supply Resilience Forum created in August 2022.Trust's top suppliers have been reviewed and issues with supply under constant review, Procurement business partners use the NHS Spend Comparison Site and local knowledge supported by the clinical procurement nurse to source alternative products(16-Nov-2022)	Medium	Treat	Still ongoing risk	01-Jun-2022
RSK-250	26-Nov-2021	IF staff across MKUH continue to use eCARE in the same way, that the volumes of requests made to the IT Department remain at their current rate, and the volume of change and project work continues at the current volume THEN the IT Department will become less responsive and a range of functions within eCARE will continue to be left without action	LEADING TO increased clinical risk, increased risk to performance of eCARE, potential disruption to staff, and delays in the deliver or projects and realising their benefits	Craig York	25-Jan-2023	28-Apr-2023	Planned	15	15	3		Prioritisation of workload is in place to cover the most impacting of issues or projects, however this only reduces the potential impact slightly(26-Nov-2021)	Low	Treat	Volume of work is increasing month on month without additional staff to support.	25-Jan-2023
RSK-402	01-Dec-2022	IF there is a lack of Orthopaedic Therapy staff to provide rehabilitation, discharge planning and equipment to patients in the trauma and elective orthopaedic pathways. THEN fractured NOF patients may not be able to be offered mobilisation daily and have regular physiotherapy reviews; elective Orthopaedic patients may not be seen twice a day.	LEADING TO potential for length of stay for both trauma and elective patients to increase and reduce patient experience.	Adam Baddeley	19-Jan-2023	28-Feb-2023	Pending	15	15	6	Provision of agency staff (09-Jan-2023), Recruitment (09-Jan-2023)		Low	Treat	Have secured x1 band 4 locum to support the service and staff member on LTS is now on a phased return. Recruitment to x2 vacant OT posts still very challenging - agreed to try for a locum at 8a pay rates.	01-Dec-2022
RSK-406	09-Dec-2022	IF there is a global shortage of electronic components THEN this can impact the lead times for delivery of medical equipment	LEADING TO to inability to replace/repair aged equipment used to monitor and support patients during their hospital care.	Ayca Ahmed	08-Feb-2023	31-Mar-2023	Planned	25	15	10	Each Division to carry out a risk assessment and build it in their contingency plan	Medical Devices Manager (MDM) is in liaising with suppliers for delivery per each approved BC for medical equipment procurement and providing support/advice to each division lead(09-Dec-2022), Clinical Contingency arrangement(09-Dec-2022), Finance lead for Business Cases is reminding all attendees at each meeting to get the Business Cases ready(09-Dec-2022), Wards/depts are borrowing from another ward/dept within the Trust as a normal practice or lease, rent, arrange a loan via any other supplier(09-Dec-2022), The advice on alternative suppliers are available via the MDM(09-Dec-2022), Procurement has a list from the NHSSC route advising on delivery lead times(09-Dec-2022), Regular inspection and maintenance of current equipment(09-Dec-2022), Rolling programme of equipment replacement regularly reviewed and issues escalated at early stage(09-Dec-2022)	Low	Treat	Risk approved onto the Corporate Risk Register at RCB	11-Nov-2022
RSK-002	06-Sep-2021	IF recommendations and actions from audit are not evidenced, monitored and completed in the Trust; THEN required changes to practice may not implemented and we may not be meeting best practice criteria;	LEADING TO potential impact on the top 3 Trust objectives (patient Safety, Clinical Effectiveness, Patient Experience), potential poor quality of service and associated impact on resources and potential CQC concerns re audit activity and learning from national audits	Tina Worth	29-Dec-2022	31-Mar-2023	Planned	15	12	3	Scheduled implementation of Radar audit module (07-Dec-2022)	Audit report templates available to identify audit action plans(06-Sep-2021), Monitoring via Clinical Audit & Effectiveness Committee (CAEB)(06-Sep-2021), Terms of Reference (ToR) for Clinical Audit & Effectiveness Board revised to include quality improvement, GIRFT etc(06-Sep-2021), Escalation/exception reporting to Management Board(06-Sep-2021), Refresh of SharePoint data base to assist with data capture, with Level 1 audit a priority(06-Sep-2021), Structure review - Staff realignment to support audit agenda(06-Sep-2021), Pilot of new governance approach to reports/CIG meetings(06-Sep-2021)	Low	Treat	Risk score unchanged. Focus on national/NCEPOD audit evidence collation with clinical owners. Process review within governance team for updating data base Progression to audit module on Radar in due course	06-Sep-2021
RSK-003	06-Sep-2021	IF existing Radar governance system does not support meeting Trust/legal/stakeholder requirements and are unsupported by the Trust IT department or an external IT provider; THEN the Trust is unable to meet statutory and mandatory Good Governance requirements and accreditations;	LEADING TO potential delays in care, inappropriate/incorrect/sub-optimal treatment; potential increase in incidents, complaints and claims; reduced CQC rating and potential enforcement actions	Tina Worth	29-Dec-2022	31-Mar-2023	Planned	25	12	4	Implementation of Radar Documentation Module (20-Oct-2022), Implementation of Radar Audit Module (07-Dec-2022)	SharePoint and Q-Pulse in place(06-Sep-2021), Scheduled implementation of new system Radar(06-Sep-2021)	Low	Treat	Risk score unchanged. Trial of Radar document module for Urology with progression to Women's Health. For full review of audit module before implementation	06-Sep-2021

Reference	Created on	Description		Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-016	22-Sep-2021	IF there is a lack of flow in the organisation THEN there may be an unsafe environment for patients	LEADING TO a potentially impact on bed space capacity, ambulance queues, missed Emergency Access Targets and overcrowding into ED/radiology corridors creating Health & Safety hazard and continued pressure, leading to poor patient care/treatment and delays in discharge/transfer and the potential for an increase of incidents being reported regarding assessment/care/treatment, and or significant number of patients with a high acuity/ dependency being cared for in areas that are not suitable for safe care	Mahamayagodage Dias	09-Feb-2023	31-Dec-2022	Overdue	25	12	9	Recruitment drive for more nurses/HCA's ongoing. Active management of Nursing/Consultant and Registrar gaps in rota daily to ensure filled. (06-Jun-2022), Walking majors and resus reconfigured. Expanded Cubicle space in Majors - extra 10 spaces, increased capacity using Acorn Suite., Internal escalation policy in place. CSU lead developing trust escalation criteria to alert trust leads to problems sooner - diverting patients to; Ambulatory care, Since Covid pandemic, phasing plan in place with red and green zones within ED., Escalation plan for ED to mitigate patient pressures	EPIC consultant in place to aid flow within department and speed up decision making(22-Sep-2021), RAT-ing process and specialty referrals having a RAG system developed to prioritise sickest patients to be assessed.(22-Sep-2021)	Low	Treat	Risk reviewed at ED CSU. Risk Assessment being updated.	07-Mar-2016
RSK-093	22-Oct-2021	IF there is insufficient staffing within the dietetics department in paediatrics THEN they will be unable to assess and advise new patients and review existing patients in a timely manner.	LEADING TO an impact on patients nutritional status and longer term dietary management on what is a very vulnerable group of patients. The majority of our caseload is infants or tube fed infants and children where there nutrition and growth is a priority	Elizabeth Pryke	05-Feb-2023	31-Mar-2023	Planned	16	12	8	additional paediatric dietitian employed on bank contract for 2 sessions / week to help with long waiting lists - monitor waiting lists on a monthly basis (05-Feb-2023)	1. Dietetic manager has been given approval to source a band 6 experienced locum paediatric dietitian to provide cover.(22-Oct-2021), 2. As a back up plan, a band 5 basic grade dietitian is also being sourced from the locum agency, with the expectation that senior dietetic staff can cover the complex paediatric cases.(22-Oct-2021), 2 new starters to join the team in the next few weeks will start to increase paediatric dietetic provision - to review waiting list once new starters in post(19-Apr-2022), Paediatric Dietetic Assistant Practitioner appointed - to start on 9.5.22, after induction will help to reduce risk(29-Apr-2022)	Low	Treat	bank paediatric dietitian started 30.1.23 to help with additional OP clinics. Further member of the team returned from mat leave on 1.1.23, which will start to help with ward and NNU cover.	01-Oct-2021
RSK-211	23-Nov-2021	IF infection / colonisation with pseudomonas aeruginosa from contaminated water occurs within the Cancer Centre THEN there is a risk of infection and complications this could cause to immuno-suppressed cancer patients. Mitigations in place to avoid risk to patients and staff in Cancer Centre	LEADING TO susceptible patients within augmented care units such as Ward 25 and chemotherapy Suite potentially coming to harm	Angela Legate	03-Jan-2023	03-Mar-2023	Planned	16	12	8		For direct contact with patients water where testing has shown absence of P.aeruginosa(23-Nov-2021), For direct contact with patients water supplied through a point of use (POU) filter(23-Nov-2021), For direct contact with patients sterile water (for wound washing if required)(23-Nov-2021), Signs at all taps alerting people to refrain from drinking or brushing teeth with water(23-Nov-2021), Bottled water available(23-Nov-2021), Correct installation and commissioning of water systems in line with HTM 04-01 is adhered to. Schematic drawings are available for water systems(23-Nov-2021), Flushing of water outlets is carried out daily and documented (07:00 – 09:00 HCA)(23-Nov-2021), Plans for sampling and microbiological testing of water is in place(23-Nov-2021)	Low	Treat	Risk reviewed by Angie Legate. No change to risk, review again in 2 months	16-Mar-2021
RSK-219	25-Nov-2021	IF metal butterfly needles are used for administering subcutaneous infusions via syringe drivers, and bolus subcutaneous injections, particularly in palliative and end-of-life care THEN there is a risk that the member of staff (hospital or community) may sustain a needle stick injury as they are withdrawing the needle when the infusion is stopped	LEADING TO the staff being at risk of coming into contact with contaminated blood	Philip Ball	08-Feb-2023	30-Mar-2023	Planned	4	12	12		MKUH Sharps Management Policy ICM/GL/34 – advises use of safer needle alternatives wherever practical. Alerting ward staffs to be careful when inserting and removing the butterfly needles.(25-Nov-2021)	Low	Tolerate	Risk escalated onto the Corporate Risk Register at RCB. Risk Assessment to be updated.	25-Nov-2021
RSK-230	25-Nov-2021	IF a major incident was to occur requiring the trust to respond above service levels THEN there could be an impact to normal service. Eg/elective and inpatient care.	LEADING TO changes in routine working processes and procedures across the Trust for the duration of the major incident response and recovery phases.	Adam Biggs	09-Feb-2023	07-May-2023	Planned	16	12	8		Major incident response plan (IRP)(25-Nov-2021), Action Cards have been removed from the Major Incident Response Plan and are held as a separate annex(25-Nov-2021), CBRN arrangements outlined within the IRP(25-Nov-2021), Mass casualty response outlined within the IRP(25-Nov-2021), Regional casualty dispersal process in place(25-Nov-2021), Local resilience Forum working group meetings attended, with tactical and strategic levels represented by CCG and NHSE&I(25-Nov-2021), Training and Exercise programme in place to ensure the Trust meets national best practice and statutory obligations(25-Nov-2021), EPRR annual work plan in place and agreed with Accountable Emergency Officer (AEO) that is scrutinised and reviewed through the Emergency Planning Steering Committee on a quarterly basis attended by senior and key staff(25-Nov-2021), Annual NHSE&I EPRR Core Standards review conducted by BLMK CCG to ensure MKUH is meeting its statutory obligations, with internal report sent to Managing Board and Trust Public Board for sign-off(25-Nov-2021)	Low	Treat	No change to current risk as this will remain an open risk	25-Nov-2021

Reference	Created on	Description		Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-232	25-Nov-2021	IF there is an extreme prolonged weather conditions (heat/cold) THEN there is potential for wards/departments to be unable to maintain/provide effective service provision at required standards during prolonged extreme weather conditions	LEADING TO Service disruption/delays, Staff health & wellbeing, Patient safety, Adverse media publicity Breaches of Health & Safety at Work Act, Management of Health & Safety at Work Regulations, Workplace Health, Safety & Welfare Regulations	Adam Biggs	09-Feb-2023	16-Apr-2023	Planned	12	12	12		Business continuity plans in some areas(25-Nov-2021), Heat wave plan(25-Nov-2021), Extreme weather policy(25-Nov-2021), Cold Weather Plan(25-Nov-2021)	Low	Tolerate	No change to risk rating	25-Nov-2021
RSK-254	26-Nov-2021	If Nursing staff accidently select the incorrect prescription chart within eCARE THEN patients could receive medication which is prescribed for another patient.	LEADING TO potential harm to patients	Craig York	25-Jan-2023	28-Apr-2023	Planned	12	12	9		eCARE alert if mismatch between wrist band & electronic drug chart. Correct workflow taught in eCARE training. Monthly scanning compliance report(26-Nov-2021)	Low	Treat	Use of the CareAware Connect app, once live, will make it easier/more accessible to scan the patient wristband to highlight this potential risk and avoid impact.	25-Jan-2023
RSK-256	26-Nov-2021	IF the current server version for the Pathology ICE system is outdated. THEN the server is vulnerable, and a potential Cyber attack target.	LEADING TO negative impact on patient care. Should the system fail completely, with no further support offered from CliniSys.	Craig York	25-Jan-2023	28-Apr-2023	Planned	15	12	2		Hardware migrated(26-Nov-2021), Testing under way with Pathology(26-Nov-2021), Test issues raised and resolution activity taking place(26-Nov-2021)	Medium	Treat	The vulnerabilities identified in the risk have been mitigated but unfortunately replaced with others. Work identified in actions still required (repeated work).	25-Jan-2023
RSK-259	29-Nov-2021	If the Clinical Engineering and Medical Equipment Library Teams are unable to access the Medical Equipment Asset Management Database THEN they will not be able record PPMs, repairs, loans, report on assets for training logs and associated tasks and provide KPI reports in compliance with MHRA standards and as per the CQC guidelines – Regulation 15 Premises and Equipment. and be compliant	LEADING TO potential impact to clinical safety	Ayca Ahmed	14-Dec-2022	31-Mar-2023	Planned	16	12	4	Full implementation of the new database (11-Jan-2023)	IT provided access to remote desktop to connect to the server directly(29-Nov-2021), Business Case approved, out to mini competition to market for alternative asset database(29-Nov-2021), Draeger (CE) has access to the FMFirst database(29-Nov-2021)	Low	Treat	Reviewed by Medical Devices Manager, no change to risk rating.	12-Apr-2021
RSK-262	29-Nov-2021	IF the Trust Fire Dampers are not surveyed and remedial works funded THEN remedial work not being completed	LEADING TO the travel of fire between compartments causing risk to life, greater damage to the estate, poor public image and subsequent interventions from the Fire Brigade with potential enforcement notices.	Michael Stark	21-Dec-2022	30-Jun-2023	Planned	20	12	8	Changed Theatre 5 Damper, remaining 6 faults to be replaced 2022/2023 (13-Feb-2023)	A combination of fire door maintenance, fire alarm system, compartmentation inspections and remedials, fire damper inspections and remedials, automatically closing fire doors, emergency lighting, fire extinguishers and other elements of the fire strategy mitigates the reliance on any one component of fire safety(29-Nov-2021), Mandatory fire training(29-Nov-2021), Fire wardens(29-Nov-2021), Authorised Engineer (AE)appointed March 2020(29-Nov-2021), Annual inspections(29-Nov-2021), Funded annual remedial programme(29-Nov-2021), Site wide Damper annual audit, risk based approach to any remedials(29-Nov-2021), £10K of repair work ordered and new inspection(29-Nov-2021)	Low	Treat	Reviewed no change to rating	25-Aug-2021
RSK-263	29-Nov-2021	IF the Trust Fire Compartmentation are not surveyed and remedial works funded THEN remedial work not being completed	LEADING TO the travel of fire between compartments causing risk to life, greater damage to the estate, poor public image and subsequent interventions from the Fire Brigade with potential enforcement notices	Michael Stark	21-Dec-2022	30-Jun-2023	Planned	20	12	8	Outstanding items for last survey to be prioritised on risk basis (13-Feb-2023)	fire door maintenance, fire alarm system, compartmentation inspections and remedials, fire damper inspections and remedials, automatically closing fire doors, emergency lighting, fire extinguishers and other elements of the fire strategy mitigates the reliance on any one component of fire safety(29-Nov-2021), Mandatory fire training(29-Nov-2021), Fire wardens(29-Nov-2021), Annual Capital bids rolling program(29-Nov-2021), Annual audit regime in place(29-Nov-2021), Authorised Engineer (AE)appointment made March 2020(29-Nov-2021), Annual audit in place(29-Nov-2021), Annual Remedial programme in place, risk based priority(29-Nov-2021), Identified remedials were completed Jan 2021(29-Nov-2021), 21/22 programme approved at May 2021 Trust Exec Group(29-Nov-2021), Audit completed June 2021, included all plant room spaces(29-Nov-2021), 20% of Hospital streets audited annually on a rolling program(29-Nov-2021), Works identified including 140 fire doors to be fitted on electrical cupboards. Prioritisation on risk basis,	Low	Treat	Reviewed, no change to risk rating	25-Aug-2021

Reference	Created on	Description		Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-264	29-Nov-2021	IF the Trust Fire Doors are not regularly surveyed and remedial works funded THEN remedial work not being completed	LEADING TO the travel of fire between compartments causing risk to life, greater damage to the estate, poor public image and subsequent interventions from the Fire Brigade with potential enforcement notices.	Michael Stark	09-Feb-2023	29-Mar-2023	Planned	20	12	8		A combination of fire door maintenance, fire alarm system, compartmentation inspections and remedials, fire damper inspections and remedials, automatically closing fire doors, emergency lighting, fire extinguishers and other elements of the fire strategy mitigates the reliance on any one component of fire safety(29-Nov-2021), Mandatory fire training(29-Nov-2021), Fire wardens(29-Nov-2021), A new audit and prioritization has been established for 2019 onwards, with prioritised areas as discussed at Management Board July 2019(29-Nov-2021), Plant Room Doors surveyed(29-Nov-2021), Guaranteed Capital agreed brought service in house January 2020(29-Nov-2021), Authorised Engineer (AE)appointed March 2020(29-Nov-2021), Many Fire Doors have been replaced since Jan 2020 as part of the prioritisation programme(29-Nov-2021), Rolling programme with backlog to overcome issues(29-Nov-2021), 21/22 programme approved at May 2021 Trust Exec Group(29-Nov-2021), Reviews options for new AE, out to tender(29-Nov-2021)	Low	Treat	Reviewed risk owner and updated.	29-Nov-2021
RSK-266	30-Nov-2021	IF the Trust are unable to take up the New Hospital Plan THEN The Trust would have to fund all future developments from either internally generated funding defined for backlog investment or borrow the money	LEADING TO the Trust being unable to meet the needs of the future MK population with regard to the size and quality of the estate	Rebecca Grindley	09-Feb-2023	29-Mar-2023	Planned	16	12	8	Funding for Outline Business Case (OBC) agreed in Jan '22. Due for completion by March 2023.	Seed funding approved by DHSC to support the development of a Strategic Outline Case (SOC)(30-Nov-2021), SOC has been formally completed(30-Nov-2021), Regular monthly meetings on a formal basis with NHSE/I and DHSC(30-Nov-2021), Regular dialogue taking place with NHSE/I Strategic Estates Advisor(30-Nov-2021), Regular dialogue taking place at Board level(30-Nov-2021), Monthly reporting structure in place with NHSE/I(30-Nov-2021), Programme Board chaired by CEO set-up with agreed ToR(30-Nov-2021), Wider engagement with MK Council(30-Nov-2021), Wider engagement with senior colleagues in the Trust commenced(30-Nov-2021), Engagement with CCG undertaken(30-Nov-2021), SOC Submitted to NHSEI, OBC to be progressed in quarter 4(30-Nov-2021)	Medium	Treat	Reviewed risk owner and updated.	30-Nov-2021
RSK-269	30-Nov-2021	IF the Trust fails to comply fully with current DoH HTM 04-01 Parts A&B, Addendum relating to Water Systems and HTM 00 as identified in the Water Risk assessment THEN The Trust will be unable to provide assurance of a fully compliant water safety system	LEADING TO Increased risk to patients and staff, loss of reputation, financial loss to the Trust.	Ben Hazell	21-Dec-2022	31-Mar-2023	Planned	16	12	8		A Water Services Management Group operates quarterly, with agreed membership and agenda items(30-Nov-2021), Audit document and action plan has been circulated to the Group for discussion and progression at the next meeting(30-Nov-2021), Independent contractor commissioned to regularly test water outlets. Controls and testing regimes in place(30-Nov-2021), Review and Water Services Management Group membership includes independent contractor and Authorising Engineer(30-Nov-2021), Whole site risk assessments are current and risk reviewed at each meeting(30-Nov-2021), Risk assessment undertaken of augmented care areas(30-Nov-2021), House keepers are flushing water out lets in clinical areas and return flushing sheets to estates, Hotel Services Audit manager to track progress and compliance(30-Nov-2021), Tender awarded to Evolution, 2 year contract commenced 1st July 2019. extended for 6 months. New tender to be drafted(30-Nov-2021), Phase 1 and Cancer Centre risk assessments completed(30-Nov-2021), Phase 2 Risk Assessment completed June 2021, actions underway(30-Nov-2021), Audit and Risk assessments for outlying buildings planned 2022(30-Nov-2021)	Low	Treat	reviewed, changed risk owner to Ben Hazel from Mike Stark. no change to risk rating.	21-Dec-2022

Reference	Created on	Description		Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-274	30-Nov-2021	IF the Trust worn flooring is not replaced THEN there is a risk of failure of flooring	LEADING TO trip hazard & infection control issues	Paul Sherratt	21-Dec-2022	30-Jun-2023	Planned	15	12	6	3 year + 1 +1 . contract awarded. Annual audit of Common areas, corridors and circulation, includes repairs (13-Feb-2023)	Capital bid to be placed annually(30-Nov-2021), Ward 6 and Ward 1 full floor replacement completed(30-Nov-2021), Business Case written, funded 21/22(30-Nov-2021), Adhoc floor repairs made with temporary taping of any failures occurring(30-Nov-2021), Going to the market for new contractor, out to tender(30-Nov-2021), Crown Industrial flooring making small repairs(30-Nov-2021)	Low	Treat	reviewed risk no change to rating.	25-Aug-2021
RSK-281	30-Nov-2021	If the lift located in Outpatients (servicing levels 3, 4 of yellow zone, and Staff Health & Wellbeing) fails THEN disabled & mobility reduced/sight impaired individuals unable to access workplace or services – unable to fulfil contractual obligations. Persons entrapped in lift unable to exit. Delayed access/treatment of an individual taken ill whilst trapped. Claustrophobia, panic attacks, psychological harm, deterioration of condition	LEADING TO Reduced availability of staff, unable to carry out duties, reduced clinical input/unable to see clients (internal/external) in a timely manner – increased workload for other staff leading to increased work pressure/stress Loss of income of external clients who cannot be seen due to absence of clinician Service user dissatisfaction – complaints/reputation of service and organisation affected Adverse publicity if unavailability of service reported to local press/reputation of organisation and service affected The organisation would be in breach of statutory duties under Health & Safety At Work etc Act 1974, Equality Act 2010 – failure to provide safe access/egress/safe place of work – potentially leading to enforcement action/further interest of Health & Safety Executive Inspectorate	Mark Brown	21-Dec-2022	31-Mar-2023	Planned	12	12	9	M&E study completed, Business Case written to install a second lifting platform in outpatients (13-Feb-2023)	There is an SLA is place that states that the lift will be repaired within 4 hours, normally 1-2hours(30-Nov-2021), ResQmat are on the landings on floors 3 & 4 and should be used in the event disabled persons and those with limited mobility, are unable to leave their respective floors, although staff are not trained in their use(30-Nov-2021), Call bell/telephone in lift to call for assistance(30-Nov-2021), Monthly lift inspections in place(30-Nov-2021), 6 Monthly PPM in place(30-Nov-2021), Annual insurance inspections in place(30-Nov-2021), ResQmat training video in place created by Manual Handling adviser(30-Nov-2021), Refurbishment of ward 14 lift carried out(30-Nov-2021), Ward 16 undergone H&S improvements(30-Nov-2021), On the Capital Programme(30-Nov-2021), Outpatients Business Case approved for M&E study, with any identified anticipated to be completed end of FY 2022(30-Nov-2021)	Low	Treat	Reviewed, no change to risk rating	25-Aug-2021
RSK-423	24-Jan-2023	IF specific enteral feeds are not available due to national supply issues THEN patients will not receive the correct feed to meet their nutritional needs	LEADING TO impact on patients' nutritional status and dietary management, also increased workload for dietetic and stores staff arranging for different feeds to be ordered and prescribed.	Elizabeth Pryke	05-Feb-2023	31-Mar-2023	Planned	12	12	6	Weekly updates provided by feed suppliers, which dietitians are acting on Patients gradually changed to feeds that are less likely to be affected		Medium	Treat		24-Jan-2023
RSK-424	25-Jan-2023	IF the new information standard regarding SDEC is released without significant operational and technical changes to the way the relevant information is collected THEN MKUH may not be able to submit the dataset in the required format with the required content LEADING TO a potential financial and reputational impact to MKUH	Potential financial, reputational, contractual, or operational impacts.	Craig York	03-Feb-2023	28-Apr-2023	Planned	12	12	4			Medium	Treat		25-Jan-2023
RSK-007	06-Sep-2021	IF the team Fire Warden is not adequately trained or they are not present during a related emergency; THEN there would be no focal point for fire safety matters for local staff and supporting line managers on fire safety issues, and the team may not be represented in Fire Safety Committee meetings, and they will not be able to organise and assist in the fire safety regime within their local area	LEADING TO staff and other individuals visiting level 1 in Oak House potentially not being evacuate in a timely manner due to the lack of oversight. The lack of single focused oversight could cause confusion, delays in evacuation and people being left behind. This could lead to smoke inhalation, burns, death. Fire checking and prevention procedures may not be robust enough to identify potential hazards and prevent a fire from happening. Breach of statutory regulations	Tina Worth	29-Dec-2022	31-Mar-2023	Planned	15	10	5	There was a recommendation that in light of the working from home arrangements, it might be appropriate for everyone to have the training so that there is adequate cover. (24-Oct-2022)	Fire Warden advised to work within current knowledge and skill gained through mandatory fire training(06-Sep-2021), No team member to attempt to fight fires with equipment untrained to use(06-Sep-2021), Risk assessment shared with team / Staff awareness(06-Sep-2021), Quarterly fire safety audits completed(06-Sep-2021), Good housekeeping practicalities - reiterated at team huddle(06-Sep-2021), Fire safety signage displayed -action cards and assembly points identified, clearly visible to team members and others visiting corridor(06-Sep-2021), Fire alarm system checked regularly in line with Trust policy and is audible in corridor(06-Sep-2021), Team members have undertaken and are up to date with mandatory training (compliance checked monthly)(06-Sep-2021), Team risk assessment for lone working on back of Covid changes which covers fire(06-Sep-2021), Risk & Clinical Governance Team Fire Warden to attend Fire Warden Training(06-Sep-2021), There was a suggestion that posters were put up for staff to follow when Kevin is not in.(21-Dec-2021)	Low	Treat	Risk unchanged Staff all up to date with mandatory fire training	06-Sep-2021
RSK-125	04-Nov-2021	IF there is a surge of COVID-19 patients impacting on Trust ability to maintain patient care and clinical services, or loss of staff to support clinical and non-clinical services due to high levels of absence, or a loss of national stockpile in PPE or medical devices (ventilators) resulting in the Trust not receiving deliveries to preserve the safety of patients and staff THEN there is a risk of reduced capabilities in responding to a Novel Coronavirus (COVID-19) impacting on patient care within clinical and non-clinical services, with the inability to maintain safety for staff and patients due to national pressures on supplies and infrastructure	LEADING TO Loss of clinical and non-clinical services, risk to patient care, risk to staff wellbeing and financial impacts	Adam Biggs	09-Feb-2023	13-Mar-2023	Planned	25	10	10		COVID-19 operational and contingency plans in place(04-Nov-2021), PPE logged daily covering delivery and current stock(04-Nov-2021)	Low	Tolerate	No current change to risk scoring with watching brief concerning current COVID surge against national guidance and comms.	29-Apr-2020

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RSK-242	26-Nov-2021	IF a chemical, biological, radiological, nuclear (CBRN/HAZMAT) incident was to occur through either intentional or unintentional means THEN the Trust would require specialised response through national guidelines and expert advice	LEADING TO potential impact on Trust services and site safety to patients and staff; Possible impact on closing or disrupting ED operations, with further risk to all operations on how the Trust operate depending on the nature of the incident (e.g., Novichok incident at Salisbury)	Adam Biggs	09-Feb-2023	22-May-2023	Planned	10	10	10			Low	Treat	Not changes to risk scoring as an open risk. Ongoing CBRN training programme being delivered as part of national guidance with plans in place.	26-Nov-2021
RSK-260	29-Nov-2021	IF people working at height are not correctly trained THEN there is a risk from fall from height	LEADING TO staff/contractor injuries, potential claims, non compliance with statutory regulations and loss of reputation	Paul Sherratt	21-Dec-2022	31-Mar-2023	Planned	15	10	5		Staff training. Ladder/equipment inspections(29-Nov-2021), Written processes(29-Nov-2021), New lifting equipment purchased(29-Nov-2021), General H&S training conducted(29-Nov-2021), Cherry Picker obtained- staff trained(29-Nov-2021), RAMS from contractors reviewed by Compliance Manager(29-Nov-2021), Edge protection in place in all locations where plant or PV panels exist(29-Nov-2021), Treatment Centre now has edge protection replacing latchway system(29-Nov-2021), Trained RP in August 2021(29-Nov-2021), RP to be appointed by Alan Hambridge(29-Nov-2021)	Low	Treat	Reviewed, no change to risk rating	25-Aug-2021
RSK-010	06-Sep-2021	IF the Radar Risk Management System does not meet the needs to the Trust and of legal reporting requirements THEN the Trust will not have an appropriate system to manage incidents, complaints, claims, compliments, safety alerts and risks	LEADING TO an inability for the Trust to defend itself against future claims/litigation leading to potential financial penalties, improvement notices, PFD notices from HM Coroner, adverse publicity etc., an inability to evidence compliance with CQC regulations and freedom of information requests, and potential for an increase in incidents, complaints and claims due to lack of learning from incidents.	Paul Ewers	24-Jan-2023	31-Mar-2023	Planned	20	9	6	Enhancements / Developments to Radar System required to support staff in reporting incidents., Radar moving server from Windows to Linux to provide more stable analytics system, with improved speed and functionality	Project Manager identified along with 3 members of staff to provide cover and support to the project where necessary(06-Sep-2021), Radar Project Plan in place(06-Sep-2021), Radar Risk Assessment in place(06-Sep-2021), Working Groups identified to support design/build of system in line with Trust's requirements(06-Sep-2021), Radar Healthcare have a dedicated Project Manager and team in place to support MKUH with implementation(06-Sep-2021), Clearly defined roles added to the Project Plan(06-Sep-2021), Escalation process in place to Exec Sponsor(06-Sep-2021), Communication Strategy Developed(06-Sep-2021)	Low	Treat	Ongoing work with Radar to improve incident reporting and staff engagement. Action Plan to be developed with Radar.	28-Apr-2021
RSK-206	23-Nov-2021	IF the Trust is unable to recruit staff of the appropriate skills and experience; there continues to be unplanned escalation facilities; There are higher than expected levels of enhanced observation nursing; and there is poor planning for peak periods / inadequate rostering for annual/other leave. THEN the Trust may be unable to keep to affordable levels of agency and locum staffing	LEADING TO Adverse financial effect of using more expensive agency staff and potential quality impact of using temporary staff	Karan Hotchkin	20-Feb-2023	16-Mar-2023	Planned	16	9	9		Weekly vacancy control panel review agency requests(23-Nov-2021), Control of staffing costs identified as a key transformation work stream(23-Nov-2021), Capacity planning(23-Nov-2021), Robust rostering and leave planning(23-Nov-2021), Escalation policy in place to sign-off breach of agency rates(23-Nov-2021), Fort-nightly executive led agency reduction group meeting with aim of delivering reduction in both quantity and cost of agency used(23-Nov-2021), Agency cap breaches are reported to Divisions and the FIC(23-Nov-2021), Divisional understanding of how to reduce spend on temporary staffing to be developed(23-Nov-2021)	Medium	Tolerate	Risk transferred from Datix	01-Apr-2022
RSK-214	24-Nov-2021	IF there is insufficient nursing staffing THEN there is a risk that the number of patients requiring nutritional assistance at meal times exceeds staff availability	LEADING TO patients nutritional needs potentially not being met, impacting on poor outcomes, patient experience and length of stay	Elizabeth Winter	19-Jan-2023	01-Mar-2023	Planned	15	9	9		Protected meal times(24-Nov-2021), Red trays/jugs(24-Nov-2021), Meal time assistants(24-Nov-2021), Dining Companions Launched May 2018(24-Nov-2021), Senior Sister highlighting patients who require assistance at daily safety huddle(24-Nov-2021)	Low	Tolerate	No change risk.	24-Nov-2021
RSK-233	25-Nov-2021	IF we are unable to recruit sufficient qualified nurses THEN we may not have safe staffing levels in wards and departments	LEADING TO potential reduction in patient experience and patient care, giving rise to clinical/safety risk.	Louise Clayton	06-Jan-2023	31-Mar-2023	Planned	16	9	3	International Recruitment of 100 Nurses (31-Oct-2022)	Apprenticeship routes for nursing(25-Nov-2021), System in place to recruit student nurses from placements at MKUH(25-Nov-2021), Enhanced adverts, social media and recruitment open day tool kit for Divisions to use(25-Nov-2021), NHS People Plan strengthens action on education and new roles(25-Nov-2021), National NHS England recruitment publicity(25-Nov-2021)	Low	Tolerate	Risk reviewed - No change to risk	01-Nov-2021
RSK-235	25-Nov-2021	IF the Trust is unable to fill rotas THEN there may be insufficient medical cover	LEADING to increased clinical risk. We may not be able to easily provide sufficient clinical cover, leading to reduced service delivery, deteriorating patient experience	Louise Clayton	30-Jan-2023	01-May-2023	Planned	16	9	9		Recruitment and retention premia for certain specialties(25-Nov-2021), Advanced Nurse Practitioners development and integration in progress(25-Nov-2021), New SAS grade established(25-Nov-2021), New publication for International Medical Graduates developed(25-Nov-2021), Acting Down Policy in place(25-Nov-2021), Routine/regular evidence based trends inform early recruitment activity for shortage deanery specialties (e.g. medicine, paediatrics)(25-Nov-2021), Add a 'Recruitment and Retention Premia' initiative to key posts(31-Oct-2022)	Low	Tolerate	Risk Reviewed - No change to risk	03-Jan-2022

Reference	Created on	Description		Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-236	25-Nov-2021	IF there is inability to retain staff employed in critical posts THEN we may not be able to provide safe workforce cover	LEADING TO clinical risk. Increasing temporary staffing usage and expenditure Increased turnover Decreased stability rates Increased stress levels within trust Reduced morale	Louise Clayton	30-Jan-2023	01-May-2023	Planned	16	9	9	Attraction Campaign to launch Autumn 2022 with programme of events and mixed media advertising through to March 2023	Variety of Organisational Development and Reward initiatives, including Event in the Tent, P2P, Schwartz Rounds, Living our Values, Annual Staff Awards and feedback from staff being acted upon(25-Nov-2021), Monitoring via staff survey feedback and local action plan based outcomes(25-Nov-2021), Health and Wellbeing promotion, education and prevention via Staff Health and Wellbeing(25-Nov-2021), Online onboarding and exit interview process in place(25-Nov-2021), Flexible working and Agile Working policies in place(25-Nov-2021), MK Managers Way in place(25-Nov-2021), Recruitment and retention premia in place, including Golden Hello for Midwives(25-Nov-2021), Enhanced social media engagement in place and ongoing(25-Nov-2021), Annual funding initiatives to upskill staff and retain them through ongoing education e.g. Chief Nurse Fellowships, PGCE and Rotary Club Bursary fund(25-Nov-2021), Refer a Friend Scheme introduced in 2022 to improve retention and recruitment.(10-May-2022), International Recruitment ongoing to recruit 125 nurses in	Low	Tolerate	Risk Reviewed - Controls updated. No change to Risk Score	02-Jan-2023
RSK-258	29-Nov-2021	IF the Switchboard resources cannot manage the service activity THEN this may result in poor performance	LEADING TO failure To meet KPI's and Emergency Response Units will put Patients, Staff and Visitors at risk and Communication with Users will give poor perception of the We Care action initiative	Anthony Marsh	21-Dec-2022	30-Jun-2023	Planned	20	9	4		Re-profiled staff rotas(29-Nov-2021), Bank staff employed where possible(29-Nov-2021), IT Department implemented IVR to assist in reducing the volume of calls through the switchboard(29-Nov-2021), Contingency trained staff available to assist(29-Nov-2021), Two additional workstations/consoles created in Estates Information office and Security office to allow for remote working(29-Nov-2021), Review of staff rota profile(04-Mar-2022)	Low	Tolerate	reviewed and reduced risk rating to 9 from 16. The staffing rota is fully staffed.	25-Aug-2021
RSK-272	30-Nov-2021	IF the Passenger Lifts are not maintained THEN there is a risk of failure of components	LEADING to malfunction. Patients or visitors could get stuck in the lift, this could potentially cause panic or delay treatment. The public image of the trust could be affected.	Mark Brown	21-Dec-2022	31-Mar-2023	Planned	15	9	3	Luing Cowley Lift awaiting upgrades, difficult as no alternative when lift not in service, business case drafted for submission July 2022 (14-Nov-2022)	Maintenance Contracts are in place(30-Nov-2021), Insurance inspections are place(30-Nov-2021), Lift modernisation inspection has been completed and 5 year plan underway since FY17/18(30-Nov-2021), Eaglestone lift upgraded and some remedial and safety upgrades during FY19-20(30-Nov-2021), W14 upgraded 2020(30-Nov-2021), Maintenance contract awarded.(30-Nov-2021), AE (Authorising Engineer) to be identified.(01-Jul-2022)	Low	Treat	Reviewed, no change to risk rating	25-Aug-2021
RSK-276	30-Nov-2021	If the flat roofs identified in the Langley Roof report and 6 facet survey as requiring replacement or upgrading, are not replaced THEN there is a risk of roof failure in relation to flat roofs across the Trust	LEADING TO Water ingress - Potential damage to equipment, disruption to service, damage to reputation	Anthony Marsh	21-Dec-2022	30-Jun-2023	Planned	15	9	3	Replacement/upgrade of flat roofs identified in the 6 facet survey (24-Jun-2022)	Inspections and repairs as needed(30-Nov-2021), Updated annual 6 facet survey by Oakleaf(30-Nov-2021), Large patch repairs undertaken as emergency business cases(30-Nov-2021), 1 x Post Grad roof fully replaced 19/20(30-Nov-2021), Ward 10 - 50% of roof patch repairs completed 19/20(30-Nov-2021), Phase 1, Phase 2 and Community Hospital survey completed.(52 roof leaks noted in 12 months Jan 19 -Aug 20) 16 leaks in 1st week of October 2020(30-Nov-2021), Pharmacy small roof replaced September 20(30-Nov-2021), Business Case approved for 4 to 5 year rolling programme(30-Nov-2021), Community Hospital work completed July 2021(30-Nov-2021), Phase 1 and Phase 2 of the hospital works outstanding. Funding to be approved(30-Nov-2021), Funding for phase 2 included in carbon zero funds to be announced Jan 2022(30-Nov-2021)	Low	Treat	No changes to current risk rating	21-Dec-2022
RSK-279	30-Nov-2021	IF pedestrians in the hospital grounds walk over the verges, grassed areas, mounds, slopes, sloped/high curbs and do not stick to the designated pathways THEN Patients, visitors and staff could slip, trip or fall causing injury including fractures, sprains, strains	LEADING TO legal and enforcement action against individuals/and or the Trust leading to fines/compensation/exposure in local press leading to adverse publicity	Michael Stark	21-Dec-2022	31-Mar-2023	Planned	12	9	6	Areas suitable to install knee high fencing identified. To be prioritised and installed in future years.	Sloping curbs painted yellow where they may be crossed(30-Nov-2021), Fencing or railings in some areas to stop access(30-Nov-2021), Rolling Paths annual program to repair paths and roads(30-Nov-2021), Grass kept cut by grounds team(30-Nov-2021), Grass kept cut by grounds team(30-Nov-2021), Keep off the Grass signage in place(30-Nov-2021)	Low	Treat	Reviewed, no change to risk rating	25-Aug-2021

Reference	Created on	Description		Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-282	30-Nov-2021	IF there is a lack of on-site appointed person for decontamination - AP (D) THEN the Trust will not be able to implement and operate the Management's safety policy and procedures relating to the engineering aspects of decontamination equipment	LEADING TO non-compliant machines – working but not correctly; machine Failures – suddenly unusable, loss of production, out-sourcing; equipment released that is not disinfected or sterile – risk to staff; equipment released that contains endotoxins – risk to patients / SSI's	Michael Stark	21-Dec-2022	31-Mar-2023	Planned	12	9	6	An Estates Officer is to be appointed as AP(D) following training and approval. (04-Mar-2022), An external AP(D) will be needed for Endoscopy, however the AE(D) is currently covering this responsibility. Mark Brown will continue to provide estates operational management to service. All testing now undertaken by external expert contractor. (21-Nov-2022)	We are unable to employ or sub-contract and independent AP (D), the AE(D) is covering this role currently working with our internal, trained but yet to be appointed Estates Officer(30-Nov-2021), The AE(D) is coming to site once a month and spends his time validating servicing reports and giving feedback(30-Nov-2021)	Low	Treat	Reviewed, no change to risk rating	25-Aug-2021
RSK-283	30-Nov-2021	IF medical equipment is damaged due to misuse, inappropriate use, storage, transportation, and/or inappropriate cleaning THEN the medical equipment may be unavailable due to damage	LEADING TO delay in patient care and treatment; cost of parts; cost of repairs; purchasing replacement	Ayca Ahmed	13-Dec-2022	31-Mar-2023	Planned	12	9	6	Training in the use of medical equipment (11-Jan-2023), Auditing PPMs (11-Jan-2023), Medical Devices Management policy- following processes		Low	Treat	Reviewed by Medical Devices Manager, no change to risk rating.	16-Oct-2018
RSK-284	30-Nov-2021	IF staff members do not adhere to the Medical Devices Management Policy THEN they may not follow the correct procurement procedures for Capital and Revenue medical equipment purchases	LEADING TO them being not fit for purpose equipment being purchase; more costly; non-standardised; lack maintenance contract; lack of training for staff; incompatible/lack of consumables and accessory; additional IT integration costs	Ayca Ahmed	13-Dec-2022	31-Mar-2023	Planned	12	9	6	Medical Devices Group meetings are held monthly to discuss procurement (11-Jan-2023)		Low	Treat	Reviewed by Medical Devices Manager, no change to risk rating.	16-Oct-2018
RSK-300	30-Nov-2021	IF the call bell system is not replaced/upgraded THEN the call bell system could fail as parts obsolete for some systems to obtain	LEADING TO increased risk to patients and possible service disruption and poor patient experience	Mark Brown	21-Dec-2022	30-Jun-2023	Planned	9	9	3	Ward 1 and ED call bell systems ordered from FY22/23 capital for installation this FY. Upgrade programme to be included in rolling Capital bid (14-Nov-2022)	An emergency back up system of 30 units has been purchased in the event of current system failing. There is also an additional spare unit(30-Nov-2021), Ward 4, 5 and Milton Mouse & A&E Majors were replaced in FY18/19(30-Nov-2021), ADAU replaced as emergency business case October 2019(30-Nov-2021), Endo replaced in Jan 2020(30-Nov-2021), Vizcall no longer in business, plan to replace all Vizcall systems in 20/21 - Vizcall test equipment and spares purchased for in house support(30-Nov-2021), Above the line funding for 2 x wards and ED agreed for 2021 with Ascom(30-Nov-2021)	Low	Treat	Reviewed and corrected current risk rating. The replacement call bells were fitted to ward 15 and about to be installed in ED. The risk rating remains the same as original as there are wards were old calls bells are still in situ.	25-Aug-2021
RSK-364	15-Jul-2022	If SBS are not able to respond to supplier and finance queries in a timely way THEN there is risk that there will be a delay in paying suppliers leading to suppliers putting the Trust on stop and not delivering key supplies	LEADING TO impact on patient care through non supply of goods	Karan Hotchkin	20-Feb-2023	16-Mar-2023	Planned	16	9	6		On going monthly meetings with Senior SBS Client Relationship team to discuss issues and outline their plan on resolving this issue(15-Jul-2022), Additional Bank resource for Finance and Procurement staff(15-Jul-2022), Finance team reviewing supplier on stop notifications(15-Jul-2022), The Trust is meeting on a monthly basis with senior SBS client relationship team to discuss the issues and get a plan from SBS of how the situation can improve, In addition extra temporary resources are being employed to support the finance and procurement team to deal with the additional supplier queries. The Finance team are reviewing any suppliers who are providing stop notifications and arranging urgent payment if required(16-Nov-2022)	Low	Treat		15-Jul-2022
RSK-425	25-Jan-2023	IF the current mechanisms used for reporting on RTT status continue, along with the current use of the tools to populate PTL reporting THEN the data available for submission will continue to require significant overhead to review and improve (i.e. veracity etc.) LEADING TO an inability to submit with short turnarounds, continued challenges in seeing patient pathways, prioritizing care etc.	Potential impact to patient care due to an inability to see patient pathways at a system level.	Craig York	03-Feb-2023	28-Apr-2023	Planned	9	9	6			Medium	Treat		25-Jan-2023
RSK-008	06-Sep-2021	IF the Trust does not have an appropriate system to record mortality and morbidity data; THEN the Trust will not be able to record and/or provide accurate reports for governance or the Trust Board	LEADING TO non-compliance with the National Mortality & Morbidity 'Learning from Death' Framework	Nikolaos Makris	06-Feb-2023	10-May-2023	Planned	15	8	6		Governance Team putting forward deaths for Structured Judgement Reviews (SJRs) based on previously agreed clinical criteria e.g. sepsis related(06-Sep-2021), Learning from Deaths policy as a tool to indicate required processes and cases that require review(06-Sep-2021), Implementation of the new system - CORs(06-Sep-2021), M&M review meetings on a regular basis with all required SJRs completed(01-Apr-2022)	Medium	Treat	Risk reassigned to Associate Medical Director responsible for M&M	06-Sep-2021
RSK-163	12-Nov-2021	If there are inadequate computer facilities and working environment are not adequate to support the office needs for clinical staff located on the Stroke Unit. Then there is potential for staff to suffer musculoskeletal injuries and reduced efficiency of working when writing clinical notes and reports. Reduced patient experience from receiving rehabilitation in an unsuitable environment.	Leading to staff potentially being off sick due to injury; potential financial impact; potentially reduced service for patients. Potential for patient/family complaints due to poor condition of the environment.	Adam Baddeley	09-Jan-2023	28-Feb-2023	Pending	6	8	2	Current environment on the ward to be adapted/developed. Capital funding required. Business case has been written and submitted for review at CBIG in July 2022 (23-Nov-2022)	Assessed gym area Staff educated about correct postures Creating risk(12-Nov-2021)	Medium	Treat	Business case is out to tender.	01-Apr-2021

Reference	Created on	Description		Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-257	26-Nov-2021	IF the server MKH-CRIS-01 continues to run Red Hat Linux Enterprise Version 6, Version 6 currently has 337 vulnerabilities THEN the server will be extremely vulnerable to being exploited by a third-party threat actor	LEADING TO negative impact on patient care due to lack of the service	Craig York	25-Jan-2023	28-Apr-2023	Planned	15	8	6		The server is currently on the clinical VLAN, leading to security benefits.(26-Nov-2021), Additional support procured to mitigate the security risk(26-Nov-2021)	Low	Treat	The supplier have not made an upgrade available yet - they are still validating their system on the new version of the operating system.	25-Jan-2023
RSK-265	30-Nov-2021	IF there is local power failure and failure of emergency lights, due to age of existing fittings and lack of previous investment THEN there may be a failure to protect persons allowing a safe evacuation of the area	LEADING TO poor patient experience and safety, non-compliance with regulation, loss of reputation	Mark Brown	21-Dec-2022	30-Jun-2023	Planned	20	8	8		Future investment requirements identified by PPM , reactive maintenance and Estates Specialist Officer(30-Nov-2021), PPM checks in place with regular testing by direct labour(30-Nov-2021), Rolling program of capital investment(30-Nov-2021), Rolling PPM program PPM 3 hour E-light testing program in place(30-Nov-2021), List of known remedials to be completed and prioritised(30-Nov-2021)	Low	Treat	reviewed and reduced risk rating from 12 to 8, as all remedial works had been funded and completed for 2022.	25-Aug-2021
RSK-285	30-Nov-2021	IF footpaths and roadways are not maintained and inspected sufficiently and regularly THEN this could lead to trips and falls if not correctly maintained	LEADING TO harm to patients, staff and the general public, and damage to vehicles and other road users	Paul Sherratt	21-Dec-2022	31-Mar-2023	Planned	12	8	4	Annual Capital bid placed on the capital program FY23 (01-Jul-2022)	Inspections and ad-hoc repairs(30-Nov-2021), Annual Audit to be completed(30-Nov-2021), Some remedial captured by capital works at Cancer Centre(30-Nov-2021), Remedial works completed. Further improvements identified and action plan developed to address on a rolling program.(04-Mar-2022)	Low	Treat	Reviewed, no change to risk rating	25-Aug-2021
RSK-291	30-Nov-2021	IF the existing surface water drainage system is not suitably maintained or repaired THEN the surface water drainage system could fail	LEADING TO flooding and contamination and loss of service	Michael Stark	21-Dec-2022	31-Mar-2023	Planned	12	8	4		Reactive maintenance repairs(30-Nov-2021), A drain survey scheduled annually(30-Nov-2021), CCTV works has indicated areas of root re-growth with pipe damage to storm water pipes, works being undertaken during summer/autumn 2021(30-Nov-2021), BDP created scope for full site survey under the HIP program to identify shortfall in current data and future plan requirements. A new link is likely to be required as part of South Site development(30-Nov-2021), Road Gulley on PPM(30-Nov-2021)	Low	Treat	Reviewed, no change to risk rating	25-Aug-2021
RSK-293	30-Nov-2021	IF the current fuse boards are not updated to miniature circuit breakers THEN existing fuse-boards could fail	LEADING to delays in repairs/replacement resulting in possible service disruption and poor patient experience	Mark Brown	21-Dec-2022	31-Mar-2023	Planned	12	8	4		PPM testing and repairs(30-Nov-2021), Fixed electrical testing program in place to identify any potential risks and actions required(30-Nov-2021), Replaced Circuit breakers/fuses FY 20/21(30-Nov-2021), Ongoing funded, rolling program of refurbishment(30-Nov-2021), Ward 1 completed 2021(30-Nov-2021), Wards 15 & 16 have replacement circuit boards fitted as part of ward refurbishment in 2022(21-Dec-2022)	Low	Treat	Reviewed, no change to risk rating	25-Aug-2021
RSK-301	30-Nov-2021	IF the existing foul water drainage system is not suitably maintained or repaired THEN the system could fail	LEADING TO cause flooding, contamination and loss of service	Michael Stark	21-Dec-2022	31-Mar-2023	Planned	8	8	4		Reactive maintenance repairs(30-Nov-2021), Wards 1-5 identified as risk areas(30-Nov-2021), Some CCTV inspection has been completed(30-Nov-2021), Scope of works being reviewed for proactive maintenance(30-Nov-2021), Multiple areas descaled ongoing programme(30-Nov-2021)	Low	Treat	Reviewed, no change to risk rating	25-Aug-2021
RSK-005	06-Sep-2021	IF policies, guidelines and patient information are not reviewed and amended in a timely manner; THEN staff will be working with out of date information	LEADING TO potential error in patient care, non-compliance with legislative, national requirements, potential litigation and potential loss of reputation to Trust	Tina Worth	29-Dec-2022	31-Mar-2023	Planned	12	6	3	Implementation of Radar Document Management System to improve engagement and access to the documentation process (20-Oct-2022)	Trust Documentation Policy(06-Sep-2021), Library resource to source current references(06-Sep-2021), Governance Leads provide support to staff reviewing guidelines and policies(06-Sep-2021), Monthly trust documentation report shared with Governance Leads(06-Sep-2021), New process via Trust Documentation Committee for 'removal' of significantly breached documents(06-Sep-2021), Work plan in place to check approval of documents/links to national leaflets(06-Sep-2021)	Low	Treat	Divisional breaches lower Corporate documents & those linked to recent inquests and or likely CQC pending review being prioritised	06-Sep-2021

Reference	Created on	Description		Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-020	22-Sep-2021	IF there are ligature point areas in ED for Adult and C&YP in all areas of department THEN ED patients may use ligature points to self harm. There has been an incident where a mental health patient used a door closer as a ligature point.	LEADING TO increased safety risk to patients, safe and adverse publicity	Patricia Flynn	09-Feb-2023	22-Jun-2023	Planned	9	6	2	Mental Health pathway to be reviewed by the Corporate Team (23-Nov-2022), E-Care Risk Assessment Tool to be reviewed/adapted (26-Jan-2023)	Patients assessed and those at risk of self harming are placed in an area they can easily be observed.(22-Sep-2021), New mental health room has been ligature and risk assessed by CNWL team(22-Sep-2021), Remind all staff about keeping swipe doors closed so they don't access rooms where they are not observeble Last ligature audit was April 2019 and actioned.(22-Sep-2021), Risk Assessment of adult and C&YP areas reviewed April 2019(22-Sep-2021), Check list in place to risk asses each Adults and C&YP attending with MH/DSH issues to identify personalised action plan(22-Sep-2021), Follow up ligature RA completed as advised by H&S lead for trust Risk Assesment completed - identified need for collapsible clothes hangers in public toilets - request to estates to install and completed; x1 non-compliant cord pull also in toilet - changed(22-Sep-2021), Repeat Ligature Risk Assessment for 2020 required(22-Sep-2021), ensure all staff are aware of the new Policy - "Ligature Risk Awareness"(22-Sep-2021)	Low	Treat	discussed with safeguarding BJ.. noting a small number of identified pt with known MH issues who are high risk who are frequent attenders to ED.	05-Aug-2014
RSK-038	28-Sep-2021	If Covid-19 impacts NHS Trusts through reduction in availability of Pharmacy staff as a result of infections, self-isolation and redirection to assisting with vaccination programs. & therefore Trusts are purchasing more ready-to-administer injections rather than make the doses themselves. With commercial companies have also been affected by staff having to self-isolate, reducing their capacity and ability to meet the increased demand for ready-to-administer products Then a number of commercial companies that provide ready-to-administer injections of chemotherapy, will have capacity issues that might prevent doses of urgently required chemotherapy from being obtained by the Pharmacy department for issue to cancer patients	Leading to: Non-availability of ready-to-administer products may prevent patients being treated as planned. Where ready-to-administer products can be obtained from commercial companies, an extended lead time has been implemented that does not permit timely purchase of required products.	Stephen Thomas	09-Feb-2023	31-Mar-2023	Planned	15	6	6	A number of commercial companies that provide ready-to-administer injections of chemotherapy, have capacity issues that might prevent doses of urgently required chemotherapy from being obtained by the Pharmacy department for issue to cancer patients (03-Feb-2023)		Low	Tolerate		28-Sep-2021
RSK-204	23-Nov-2021	IF data sent to external agencies (such as NHS Digital, Advise Inc and tenders) from the Procurement ordering system contain patient details THEN there is a risk that a data breach may occur with reference to GDPR and Data Protection Act as the procurement department deals with large volumes of data.	LEADING TO a data breach and potential significant fine	Lisa Johnston	20-Feb-2023	16-Mar-2023	Planned	16	6	6		All staff attend an annual mandatory training course on Information Governance(23-Nov-2021), Staff are encouraged to use catalogues which reduces the requirements for free text(23-Nov-2021), Data sent out to external agencies is checked for any patient details before submitting(23-Nov-2021)	Medium	Tolerate	Ongoing risk	01-Apr-2022
RSK-205	23-Nov-2021	IF there is Incorrect processing through human error or system errors on the Procurement systems THEN there is risk that there may be issues with data quality within the procurement systems	LEADING TO Incorrect ordering resulting in a lack of stock and impacting on patient safety	Lisa Johnston	20-Feb-2023	16-Mar-2023	Planned	12	6	6		Monthly reviews on data quality and corrections(23-Nov-2021), Mechanisms are in place to learn and change processes(23-Nov-2021), Data validation activities occur on monthly basis(23-Nov-2021), A desire to put qualifying suppliers in catalogue(23-Nov-2021)	Medium	Tolerate	Risk transferred from Datix	01-Apr-2022
RSK-207	23-Nov-2021	IF there is major IT failure internally or from external providers THEN there is a risk that key Finance and Procurement systems are unavailable	LEADING TO 1. No Purchase to pay functions available ie no electronic requisitions, ordering, receipting or payment of invoices creating delays for delivery of goods. 2. No electronic tenders being issued. 3. No electronic raising of orders or receipting of income	Karan Hotchkin	20-Feb-2023	16-Mar-2023	Planned	12	6	6		If its an external issue, SBS the service provider of the purchase to pay and order and invoicing has a business continuity plan in place(23-Nov-2021), If its an internal issue. The Trust has arrangements with the CCG who also use SBS to use their SBS platform(23-Nov-2021)	Medium	Tolerate	Risk transferred from Datix	01-Apr-2022
RSK-209	23-Nov-2021	IF staff members falsely represent themselves, abuse their position, or fail to disclosure information for personal gain THEN the Trust/Service Users/Stakeholders may be defrauded	LEADING TO financial loss and reputational damage	Karan Hotchkin	20-Feb-2023	16-Mar-2023	Planned	12	6	6		Anti-Fraud and Anti-Bribery Policy(23-Nov-2021), Standards of Business Conduct Policy including Q&A section(23-Nov-2021), Standing Orders(23-Nov-2021), Local Counter Fraud Specialist in place and delivery of an annual plan(23-Nov-2021), Proactive reviews also undertaken by Internal Audit(23-Nov-2021), Register of Gifts and Hospitality(23-Nov-2021), Register of Declarations(23-Nov-2021)	Medium	Tolerate	Risk transferred from Datix	01-Apr-2022

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RSK-216	24-Nov-2021	If agreed processes for multi agency working are not appropriately managed THEN the information and shared working agreements may fail.	LEADING TO potential failures in care provision which may have a detrimental effect on patients and their families, members of staff and the Trust. The complexities of multi agency working especially within safeguarding requires sharing of information between multiple agencies and within agencies. Currently there are multiple pathways for sharing of information within and externally from the Trust. This carries a potential legal and financial cost to the Trust if not appropriately managed within agreed legal frameworks.	Lesley-Anne Johnson	28-Nov-2022	31-Mar-2023	Planned	9	6	6		Memorandum of understanding for the MK Safeguarding adult and children's board and for the subgroups that feed into this multi agency board, of which the Trust is a signatory(24-Nov-2021), There are electronic safeguarding forms available to staff to raise safeguarding concerns to the relevant external safeguarding adult or children's teams, SABR1, MARF. MARF now go to what is known as the Multi-Agency Hub and that has POLICE, EDUCATION, HEALTH AND SOCIAL SERVICES(24-Nov-2021), The Safeguarding Leads attend MARAC AND MARM COMMITEES which are Multi-Agency(24-Nov-2021), Safeguarding has an electric promoting welfare tab on EDM to identify individuals at risk(24-Nov-2021), Safeguarding children have a sharing information electronic form to help identify to school nurses and health visitors children who have attended or may be at risk due to the child behind the adult(24-Nov-2021), Maternity services use confidential communique on the Amalga system This has been widened to include children's and also the safe storage and collection of the MARF forms(24-Nov-2021), Trust Safeguarding Committee is multi agency(24-Nov-2021), MKHFT sits on the Milton Keynes Safeguarding Adults and Children's Boards(24-Nov-2021), MKHFT has named leads for Safeguarding Adults and	Low	Tolerate	Risk under control. Annual Review	24-Nov-2021
RSK-229	25-Nov-2021	IF there is poor quality of data input into the eCare system THEN there could be consequential impact on the data flow into the Trust data warehouse and reporting for both performance management and contracting (commissioners) data	LEADING TO Impacts all performance reporting. Impacts “Contracts” reporting leading to a loss of income for the Trust	Ian Fabbro	25-Jan-2023	28-Apr-2023	Planned	12	6	6		Extensive list of data quality reports to identify poor data quality(25-Nov-2021), Data Quality team is in place, who undertake a compliance function to review sample records to ensure early capture of data quality issues(25-Nov-2021), Control scripts to identify data quality issues when the data is loaded into the Data Warehouse(25-Nov-2021)	Medium	Tolerate	No significant improvement on staffing	25-Jan-2023
RSK-252	26-Nov-2021	IF eCARE does not prevent non-prescribers from prescribing medication which could then be administered to a patient THEN there could be limitations in restricting access to individual Smart Card holders permissions or individuals do not adhere to the correct workflow	LEADING TO Medications could be prescribed and administered to a patient that are not clinically required & could be contraindicated	Craig York	25-Jan-2023	28-Apr-2023	Planned	9	6	6		eCARE training of correct process -eCARE training includes advice on only performing tasks related to professional registration and job role(26-Nov-2021), Code of conduct - NMC -eCARE pop up requires staff to state who advised them to prescribe medication & how (verbally/written)(26-Nov-2021), Monthly audit of in place a mechanism where medications prescribed by non-physicians are audited monthly against the known list of Non-Medical Prescribers/pharmacists/Midwives. Inconsistencies will be escalated to CNIO for investigation(15-Dec-2021), SOP to be produced to support monthly audit.(16-Feb-2022)	Low	Tolerate	No progress made since prior review	25-Jan-2023
RSK-273	30-Nov-2021	If the Trust Wards and Departments fail to demonstrate their medical equipment is maintained to correct standards THEN there is a risk of the Trust not complying with CQC Regulation 15 Premises and Equipment and risk to patient care	LEADING TO non-compliance and negative impact on the reputation of the Trust	Ayca Ahmed	14-Dec-2022	31-Mar-2023	Planned	15	6	3	Contract KPI's agreed as part of new contract (11-Jan-2023)	Robust PPM maintenance schedule in place, audits of the rolling programme(30-Nov-2021), Audits monitored at Medical Devices Committee(30-Nov-2021), Escalation process in place to respond to 'unfound items'(30-Nov-2021), September 2018 , 6 Years contract approved(30-Nov-2021), Annual review of asset base and contract base reset linked to Capital Programme(30-Nov-2021)	Medium	Treat	Reviewed by Medical Devices Manager, no change to risk rating.	16-Oct-2018
RSK-299	30-Nov-2021	IF the Summary Record of Estates 5 year and Prioritised Backlog Maintenance risk based priority programme is not fully implemented THEN plant and equipment may fail in various areas of the hospital	LEADING TO infection control, financial implications, loss of services and reputation damage	Anthony Marsh	21-Dec-2022	31-Mar-2023	Planned	9	6	4	Ongoing reviews, identified backlog issues driving Capital Plan. Outstanding funding of Capital works required. Operational impact of significant works to be considered. (13-Feb-2023), New Hospital Programme guidance indicates funding to clear CIR backlog programme to be included as part of the project.	All areas are reviewed on a monthly basis by Estates Service Manager, or sooner if equipment/plant breakdown demands(30-Nov-2021), Business cases for plant replacement to be put forward FY21/22(30-Nov-2021), Compliance Officer reviewing to identify significant costs(30-Nov-2021), Review of recent 6 Facet Survey to identify future funding requirements e.g. Roof, Ventilation, Plant, HV, drainage(30-Nov-2021), March 2021 20% physical and remaining 80% desktop survey completed(30-Nov-2021), Annual Physical 20% of site 6 facet survey undertaken(03-Mar-2022)	Low	Treat	updated current rating to correct value, previous current score was incorrect.	25-Aug-2021

Reference	Created on	Description		Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-217	24-Nov-2021	IF patients are unable to feed orally and need an alternative feeding method to meet their nutritional needs and staff do not feel confident to pass Nasogastric Tubes (NG Tubes) due to the low patient numbers requiring them THEN there is a risk that Nasogastric (NG) Feeding Tubes are not inserted and/or positioned safety, or there is a delay in confirming that the NG Tube is not positioned correctly	LEADING TO 1) Potential for aspiration which could lead to subsequent death. 2) Poor and unreliable identification of correct placement of NGT can lead serious harm or death of a patient. This type of event is a NPSA "Never Event". 3) Patients would experience a delay in feeding. 4) If bedside documentation is not fully completed or is inaccurately completed as per NPSA recommendations.Patients may be fed inappropriately in an unsafe environment. 5) Incomplete documentation may also lead to a delay in a patient's nutritional needs being met and their discharge delayed. 6) Potential for staff to be unaware of what documentation requires completing.	Jane Radice	09-Feb-2023	31-May-2023	Planned	15	5	5		All NPSA recommendations were acted upon in 2011 in the Trust as per NPSA requirements by the ANP for Nutrition(24-Nov-2021), Nutrition Committee overseeing this alert and is standard item on agenda from Dec 16. Clinical Medical and Nutritional ANP leading on the action plan(24-Nov-2021), Policies, protocols and bedside documentation reviewed to ensure compliance(24-Nov-2021), Ongoing programme of audit. Previous audit data presented to NMB Spring 2016(24-Nov-2021), Dietetic Amalga database identifies patients who require Nasogastric feeding(24-Nov-2021), Trust declared compliance with 2016 Nasogastric Tube Misplacement: Continuing Risk of Death or Severe Harm Patient Safety Alert (NHS/PSA/RE/2016006)(24-Nov-2021), The NG tube used by the trust was changed in 2020 to a tube that is more radiopaque and is therefore easier to interpret on X-ray(24-Nov-2021), pH strips are purchased from one supplier to avoid confusion with colour interpretation(24-Nov-2021), Two nutrition nurses available to place NG tubes if there are no trained clinical staff available(24-Nov-2021), Radiographers trained to interpret x-rays for confirmation of NG tube tip position. This speeds up reporting and avoids junior medical staff having to assess X-rays(24-Nov-2021)	Low	Tolerate	Risk reviewed at Therapies CIG - No change to risk	23-Apr-2014
RSK-120	29-Oct-2021	IF medical devices are not correctly cleaned/disinfected/decontaminated/sterilised THEN the devices will not be sufficiently cleaned	LEADING TO possible patient and staff safety issues and cross contamination	Marea Lawford	05-Jan-2023	03-Jan-2024	Planned	9	4	4	monitor and increase score should it be required to do so. this is not seen as a likely risk (05-Jan-2023)	The trust has a decontamination policy which states how equipment can be risk assessed to ensure that the correct methods of cleaning are used.This is on the hospital intranet and can be accessed by all staff. The hospital has two departments HSDU and Endoscopy Decontamination both of which are accredited to ISO 13485 and these units process a vast majority of the medical devices used on a patient. Low risk items are usually dealt with on the wards and the Decontamination policy covers this. Any specialist equipment used in wards and departments is identified at the point of purchase using the PPQ to determine what methods of decontamination are required. If this equipment is unsuitable for reprocessing through HSDU or Endo Decon then a individual risk assessment will need to be completed. Guidance on this can be gained from IPCT, the Decontamination Lead, EBME and the Medical equipment manager. A decontamination group meets quarterly and ward managers/HOD's are requested that any items decontaminated on the wards are bought to the attention of the group in order to ensure that the correct methods are being used.(29-Oct-2021)	Low	Tolerate	annual review set, score is low, as contingency plan is robust and has been used successfully in the past.	05-Jan-2023
RSK-160	12-Nov-2021	IF the existing Bag Valve Masks (BVM) look similar to the Lung Volume Recruitment (LVR) bags that the department want to introduce as a Physiotherapy treatment modality for airway clearance THEN they could be used in error during resuscitation procedures	LEADING TO patient requiring resuscitation with a BVG could have resuscitation attempted with a LVR bag and could suffer consequences of incorrect treatment initially and delay to correct treatment procedures	Adam Baddeley	09-Feb-2023	07-Apr-2023	Planned	15	4	4		•The bag has “not for resuscitation purposes” printed on the bag by the manufacturers and also comes with a yellow “not for resuscitation purposes” tag attached to it. •There are clear differences in the two bags appearances - All staff that work in the ward environments will have completed BLS training at least so will be familiar with the BVM equipment. They will have seen and used the BVM in practice during resus training and therefore would know that it has an oxygen reservoir bag and tubing that connects to an oxygen flow meter which an LVR bag does not have. •BVM is kept in its packaging hung on the resus trolley. When an LVR bag is provided to a patient it would be kept in their bedside locker in the navy blue drawstring bag it comes from the manufacturer in. •The resus trolley is checked daily by ward staff so if the LVR bag mistakenly was put in the resus trolley by nursing staff that would be recognised. •All physio staff that would be issuing this equipment out would have specific training before being able to use with patients. •The patient would be seen daily by Physio who would recognise if the LVR bag was missing from that patients locker. •If an LVR bag was issued to a patient then the nurse involved in that patients care would be informed of the equipment being kept in the patients locker (but not expected to use the equipment with the patient) •Once the LVR is not longer being used with the patient we	Medium	Tolerate	Risk reviewed at Therapies CIG - No change to risk	17-Jan-2020

Reference	Created on	Description		Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-215	24-Nov-2021	IF Child Protection (CP) Medicals are not completed THEN there is potential for delay in proceedings for Child Protection and could mean the children remain in care longer than they should	LEADING TO the police and Social Services having to return to get the medicals completed, an increased risk to the child's safety and potential litigation against the Trust	Lesley-Anne Johnson	28-Nov-2022	03-Apr-2023	Planned	9	4	4	Ongoing discussions are being held with CCG and Designated Doctor to progress an agreeable pathway	Named Doctor to review the process of booking the patients in(24-Nov-2021), Social Service made aware that the earlier we know about CP Medicals the easier it is to get them in and out(24-Nov-2021), A interim process has been agreed that SW requesting CP Medical contacts the SGC Lead who will coordinate booking through ward 4 and discuss with on call consultant(24-Nov-2021)	Low	Tolerate	No change to risk. Outside control of the Trust. Annual Review.	24-Nov-2021
RSK-237	25-Nov-2021	IF the Trust is unable to spend the full amount of the Apprenticeship Levy each month THEN money which could have been used to develop our staff will be forfeit	LEADING failure to maximise taxpayers money. The Trust may not be able to use the apprenticeship levy to fund staff education, training and development. Inability to maximise the new apprenticeship standards may impact on recruitment, retention and career development	Louise Clayton	28-Nov-2022	28-Feb-2023	Pending	15	4	2	Review of the Nurse Apprenticeship pathway is underway with newly appointed Head of Practice Education (06-Jan-2023)	Apprenticeship Manager attends the Nursing, Midwifery and Therapies Education Forum to promote apprenticeship benefits(25-Nov-2021), NHS People Plan commitment to support apprenticeships and other key national entry routes(25-Nov-2021), There is a national tender for the radiography apprenticeships underway led by HEE(25-Nov-2021), Apprenticeship strategy approved, maximising Levy use going forwards(25-Nov-2021), Medical apprenticeship consultation ongoing(25-Nov-2021), New apprenticeships have been created for IT, Data Analyst roles and HR.(10-May-2022), Increase in advertising of apprenticeships across the Trust and through the network through widening participation.(10-May-2022)	Low	Treat	Risk reviewed - Additional controls identified. No change to risk scoring.	25-Nov-2021
RSK-261	29-Nov-2021	IF adequate PAT testing is not carried out in a systematic and timely manner THEN untested faulty equipment could be used	LEADING TO poor patient and staff safety and increased claims against the Trust	Mark Brown	09-Feb-2023	29-Mar-2023	Planned	8	4	4		Visual checks carried out by user(29-Nov-2021), 100% PAT testing completed annually by contractor(29-Nov-2021)	Low	Tolerate	Reviewed by Associate Director of Estates and Estates Services Manager. Agreed no change to risk rating.	29-Nov-2021
RSK-287	30-Nov-2021	IF the medical vacuum pumps fails to function or becomes non-compliant with HTM requirements THEN the vacuum plant may not be available	LEADING TO Potential loss of service, reduced patient safety and substandard care.	Michael Stark	09-Feb-2023	29-Mar-2023	Planned	12	4	4		PPM, schedule and reactive repairs in place as required(30-Nov-2021), Steve Goddard has been appointed Authorised Engineer and has conducted a site wide inspection. No specific issues were identified(30-Nov-2021), Phase 1 plant was replaced 2017(30-Nov-2021), Phase 2 Plant to be considered for replacement in future due to age, although no issues currently(30-Nov-2021)	Low	Tolerate	Reviewed risk owner and updated.	30-Nov-2021
RSK-288	30-Nov-2021	IF the medical oxygen supply fails to function or becomes non-compliant with HTM requirements THEN the oxygen plant may not be available	LEADING TO potential loss of service, reduced patient safety and substandard care	Michael Stark	21-Dec-2022	30-Jun-2023	Planned	12	4	4		PPM Schedule, and reactive repairs as required(30-Nov-2021), Robust contingency plan is in place with liquid O2(30-Nov-2021), Steve Goddard has been appointed as Authorised Engineer(30-Nov-2021), Estates Officer has been appointed as AP(30-Nov-2021), SHJ appointed as maintenance contractor(30-Nov-2021), AP training booked for and additional estates officer and estates service manager(30-Nov-2021), VIE capacity upgrade 2021(30-Nov-2021), Draft feasibility to achieve second VIE, and conversion of site to ring main, linked to HIP programme(30-Nov-2021)	Low	Tolerate	Reviewed, no change to risk rating	25-Aug-2021
RSK-294	30-Nov-2021	IF staff do not carry out either informal (i.e. experience-based) or formal risk assessments before attempting a work task THEN there is a risk of personal injury to staff carrying out routine work	LEADING TO poor staff safety, injury and financial loss	Michael Stark	09-Feb-2023	29-Mar-2023	Planned	12	4	4		All staff receive formal risk assessment training, and are competency assessed for their roles. Independent External Advisor contractor commissioned to review estates risk assessments and arrangements regularly.(30-Nov-2021), Risk awareness training is performed annually along with asbestos awareness training for all workshop staff as part of the H&S training package(30-Nov-2021), Training plan updated and implemented(30-Nov-2021), Facility to add Risk Assessments by task type to MICAD PPM tasks(30-Nov-2021), Weekly huddle meeting with maintenance staff to include H&S(30-Nov-2021)	Low	Tolerate	Reviewed risk owner and updated.	30-Nov-2021
RSK-295	30-Nov-2021	IF there is a lack of knowledge on use or poor condition of ladder THEN there is a risk of fall from height from ladders	LEADING TO risk of harm to staff, poor public image, a potential investigation by HSE	Paul Sherratt	09-Feb-2023	29-Mar-2023	Planned	12	4	4		Staff issued with safe use of ladder guidance(30-Nov-2021), Ladder inspections PPM schedule in place to check(30-Nov-2021), New replacement ladders have been installed, tagged and registered(30-Nov-2021), A competent training person needs to be identified to provide continual training(30-Nov-2021), RP Appointed(30-Nov-2021)	Low	Tolerate	Reviewed risk owner and updated.	30-Nov-2021

Reference	Created on	Description		Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-390	28-Oct-2022	IF the current Amber alert for Blood stock escalated to a Red Alert, THEN the Trust may be unable to provide required red cell components to patients in need	LEADING TO patients that do not fulfil the criteria of transfusion in a red alert situation may be denied red cell transfusions and potential shortening of the patient's life	Jasmine Marshall Beharry	06-Feb-2023	28-Feb-2023	Pending	12	3	2		Emergency Blood Management Arrangements (EBMA): Review of elective surgery. Defer all patients who have a greater than 20% chance of requiring transfusion of 2 units or more. Communicated to stakeholder hospitals. Top up transfusion threshold moved from 80g/L to 70g/L with and request over threshold being challenged by BMS staff and possibly referred to Haem clinicians for review.(28-Oct-2022), Top up transfusion requests with an Hb higher than 70 g/L will be challenged and referred to a consultant if required(28-Oct-2022), EBMA: Consider limiting transfusion to 2 units where Hb falls below trigger levels.(28-Oct-2022), Red cells for transport currently limited to 2 units(28-Oct-2022), Clinical area required to check Hb after single unit transfusions to determine whether more units are required(28-Oct-2022), Communication has been shared with Trust directors, Silver Command, HTC members, Stakeholder hospitals and managers in medicine, surgery, W&C and Oncology.(28-Oct-2022), As part of the Massive Haemorrhage Protocol (MHP) process, the designated communicator should inform the lab to stand down.(28-Oct-2022),	Low	Tolerate	Although NHSBT has not issued instructions to stand down from the pre-Amber alert, today's stock levels of red cells show national stock below the target (6 days) in group B- (5.65 days) and O+ (5.35) days. National stock of platelets show more that the minimum levels across all blood groups.	11-Oct-2022

Significant Risk Register

Reference	Created on	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-019	22-Sep-2021	IF there is an increased number of incidents of violence and aggression in Emergency Department THEN there will be an impact on patient safety, staff mental and physical health	LEADING TO an increased risk of physical or verbal damage to staff or other patients, risk of delay in care whilst incidents resolved; potential for litigation or claims dependent on harm; Increased staff sickness rate, poor retention and recruitment of staff; negative impact on Trust reputation; poor patient experience	Region	Emergency Department	Sushant Tiwari	08-Feb-2023	28-Mar-2023	Planned	12	20	6	Police panic button in reception and majors, unacceptable behaviour posters + national abuse posters, Security forum for Trust (22-Sep-2021), Review of Reception	CCTV cameras in place (dead spot remains in "Streaming")(22-Sep-2021), Conflict Resolution training(22-Sep-2021), Incidents reviewed on Datix incident reporting system(22-Sep-2021)	Low	Treat	Risk reviewed by Risk Owner. This is an ongoing risk within the department. No change to risk	09-Mar-2009
RSK-022	22-Sep-2021	IF there are insufficient Haematology Consultants in the department THEN there will be an increased workload for the substantive team who are undertaking WLI clinic to provide extra capacity and working additional on call to cover the rota.	LEADING TO patient's outpatient appointments potentially being re-scheduled and non-urgent patients are being delayed; patients potentially waiting 12-14 weeks for a non-urgent new appointment; poor patient experience; increased complaints; delay in seeing new patients in clinic and non-urgent follow up patients. New patients being booked at 5 months	Region	Haematology & Oncology	Margaret Pickard	02-Feb-2023	30-Mar-2023	Planned	6	20	4	Haematology Speciality doctor in recruitment. Advert out for substantive 10PA consultant post. Full time consultant post out to locum- no applicants (02-Feb-2023), 1 x 10 PA substantive consultant in recruitment (02-Feb-2023)	1 part time locum is in post There is an advert out for further locum consultant support. The full time post is out to advert.(22-Sep-2021), Haematology SpR in recruitment, out to agency for agency consultant, consultant team are running additional WLI clinics to accomodate patients from dr Hildyard who is on maternity leave. Nurse Haematology clinica are being set up.(21-Dec-2021)	Low	Treat	Risk reviewed at Haematology & Oncology CSU meeting. No change to risk. Review in 3 months	06-Jan-2020
RSK-035	28-Sep-2021	IF there is a high turnover of staff due to: work pressure, not having the opportunity to work at the top of their licence, lack of capacity for development, lack of capacity for supervision / support. Also difficulty in recruiting. Loss of staff to primary care which offers more attractive working hours. THEN there will be insufficient staff in pharmacy to meet demands of the organisation and ensure patient safety in the use of medicines.	LEADING TO: 1. increased length of stay due to TTO delay 2. increase in prescribing errors not corrected 3. increase in dispensing errors 4. increase in missed doses 5. failure to meet legal requirements for safe and secure use of medicines 6. harm to the patients 7. adverse impact on mental health of Pharmacy staff All resulting in adverse patient outcomes. Lack of financial control on medicines expenditure Breach of CQC regulations	Organisation		Helen Chadwick	26-Jan-2023	31-Mar-2023	Planned	20	20	6	Actively recruiting staff (07-Feb-2023)	Business Case for additional staff(05-Apr-2022), Temporary role realignment towards patient facing roles(05-Apr-2022), Use of Agency Staff(05-Apr-2022), Prioritisation of wards(28-Jun-2022)	Low	Treat	Risk reviewed at Pharmacy CIG 06/01/23: Staffing issue, progressing slowly, to review end of March, add in comments information on the latest recruitment, scoring unchanged.	07-Aug-2019
RSK-131	04-Nov-2021	IF the demand for CT and MRI increases and there is continued requirement to reduce scan turnaround times THEN there will be a delay in patient management, an inability to manage patients privacy and dignity, an increased risk of infection due to overcrowding of facilities, and there will be a lack of capacity for appropriate management of CT and MRI within KPI and DM01 timescales	LEADING TO financial targets being missed, negative impact on reputation due to long waiting times Reputation, and financial due to increased infection rates, and staff leaving due to poor working conditions.	Region	Diagnostic & Screening	Paula Robinson	06-Feb-2023	21-Jun-2023	Planned	20	20	16	Business Case to be developed for Radiographers, Review of Radiologists - demand and capacity, New CT Machine to be implemented, Recruitment of staff	Extended working hours and days(04-Nov-2021), Some scans sent off site to manage demand(04-Nov-2021), Reduced appointment times to optimise service(04-Nov-2021)	Medium	Treat	Risk reviewed at Imaging CIG, no change	01-Jun-2021
RSK-134	04-Nov-2021	If there is insufficient funding, then the Trust may be unable to meet financial plans and targets or deliver its strategic aims,	Leading to service failure and regulatory intervention THEN the Trust will be unable to meet its financial performance obligations or achieve financial sustainability	Organisation		Karan Hotchkin	20-Feb-2023	16-Mar-2023	Planned	20	20	10	The current funding has now been clarified .The trust will work with BLMK system partners during the year to review overall BLMK performance, The risk for the current year can be managed but the underlying position going forward is uncertain due to lack of clarity on the medium term funding post March 2023	Cost and volume contracts replaced with block contracts (set nationally) for clinical income(04-Nov-2021), Top-up payments available where COVID-19 leads to additional costs over and above block sum amounts (until end of March 2022)(04-Nov-2021), Budgets to be reset for FY22 based on financial regime; financial controls and oversight to be reintroduced to manage financial performance(04-Nov-2021), Cost efficiency programme to be reset to target focus on areas of greatest opportunity to deliver(04-Nov-2021)	High	Treat	Risk transferred from Datix	01-Apr-2022
RSK-158	12-Nov-2021	If the escalation beds are open across the medical and surgical divisions Then the additional patients that will need to be seen will put additional demand on the Inpatient Therapy Services that are already stretched due to long term vacancies	LEADING TO: Patients deconditioning and increased Length Of Stay (LOS), high volume of patients will not be seen daily, priority will be given to new assessments, discharges and acute chests. Majority of patients may only be seen once a week for rehabilitation which is insufficient to maintain a patient's level of function. Staff morale will reduce as they will not be providing the appropriate level of assessment and treatment to their patients.	Organisation		Adam Baddeley	03-Feb-2023	28-Feb-2023	Pending	16	20	6	Closure or Reduction in Escalation Beds (09-Jan-2023)	Therapy staff attend board rounds and work with the MDT to determine priority patients. The skills mix and workforce is reviewed twice weekly between Occupational Therapy and Physiotherapy to determine cover for the base wards. To work closely with community services to raise awareness and to increase discharge opportunities i.e. in reaching Therapies working with Long stay Tuesday initiative Therapies supporting new discharge pathway/process in the Trust Over recruitment of PT and OT band 5's Locum cover for vacant posts. Daily attendance at 10.30 system wide discharge call. Inpatient Therapy Service participation in MADE events. Review of staffing model across inpatient medical and frailty wards.(12-Nov-2021)	Low	Treat	Additional escalation areas such as ward 2b have been opened, further adding to the workload requiring to be seen daily. Therapy team morale very low.	27-Nov-2018
RSK-159	12-Nov-2021	Patients referred to the Occupational Therapy and Physiotherapy inpatient services covering medical and surgical wards are not being seen in a timely manner due to the number of long term vacancies and national challenges to recruit to vacant posts. THEN there will be a delay in these patients being assessed, treated and discharged.	LEADING TO deconditioning of vulnerable/complex patients requiring a short period of therapy; increased length of stay; potential readmission, increased demand for packages of care requiring double handed provision. patient experience and long term quality of life will also be impacted as patients are being discharged as more dependent on care.	Organisation		Adam Baddeley	03-Feb-2023	28-Feb-2023	Pending	20	20	6	Review of Governance Structure (18-Oct-2022), Review Equity Tool - Safe Staffing (07-Feb-2023), Review Workforce Model and Structure (07-Feb-2023), Recruitment and Retention of staff (09-Jan-2023)	Daily prioritisation of patients cross covering and review of skill mix locum cover x1 OT and x1 PT in place Ward book for escalation wards setup and band 7 reviews the caseload on the ward daily Monday- Friday and requests the most urgent are reviewed. Recruitment process ongoing but vacancies have reduced slightly. Over recruitment of band 5 OT and PT roles. Non-recurrent funding application for increase in therapy assistants over winter months.(12-Nov-2021), Review Model of Care(19-Apr-2022), Education and Training of staff(19-Apr-2022)	Low	Treat	Inpatient therapy services across the Trust remain significantly stretched with the focus being on assessments and discharge. There is little ability to provide rehabilitation.	04-Mar-2019

Reference	Created on	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-341	17-May-2022	IF there is a delay with imaging reporting for CT and MRI for patients on cancer pathways THEN there could be a delay with diagnosis and the commencement of treatment	LEADING TO potential increase in the required treatment, potential poorer prognosis for patient, poor patient experience, increase in complaints and litigation cases.	Organisation		Paula Robinson	09-Feb-2023	21-Feb-2023	Overdue	20	20	8	2x Specialist Doctors appointed on a fixed-term basis to uplift internal reporting capacity (14-Jun-2022), Specialist Radiology to be recruited to uplift reporting capacity, Explore alternative outsourcing for some specialist areas (e.g. lung), Imaging Business Case for substantive Radiologists and Radiographers	PTL tracking to escalate to imaging leads(18-May-2022), Agency Locum Consultant appointed 2 days a week to uplift internal reporting capacity(14-Jun-2022), Temporary reduction in double reporting for Quality Assurance to increase real-time scan reporting(14-Jun-2022), Current Radiologists doing 30% over standard reporting levels(14-Jun-2022)	Low	Treat	Risk reviewed by Claire McGillycuddy. No change to risk - review again February 2023	01-Jun-2022
RSK-369	10-Aug-2022	IF there is insufficient medical and nursing staffing for outpatient colposcopies clinics THEN; There will not be enough clinics to facilitate the 2 week wait pathway, which will increase the non-urgent referral wait list, including an increase in referrals. AND The service may not meet the Cervical screening: programme and colposcopy management of clinic staffing and facilities (1 level one registered nurse trained in colposcopy and A second support nurse trained in colposcopy).	Leading to; The service not meeting the Cervical screening: programme and colposcopy management practices	Region	Women's Health	Mary Plummer	07-Feb-2023	30-Apr-2023	Planned	15	20	3	Recruit lead nurse for colposcopy (13-Dec-2022)	Use of Locum and bank medical and nursing staff(10-Aug-2022), Advert and employ additional nursing staff(10-Aug-2022), Consultants using SPA time to support clinic session(10-Aug-2022), Business case for additional staffing(10-Aug-2022), Additional clinics on evenings and weekends(10-Aug-2022)	Low	Treat	Risk remains the same	10-Aug-2022
RSK-411	20-Dec-2022	IF child protection medical assessments continue to be undertaken with current workforce arrangements within the Paediatric Assessment unit (PAU) as part of the current consultant and junior doctor and nursing workload . THEN there will be issues regarding the current workflow and clinical risk within a busy acute/emergency area.	LEADING TO delays and avoidable risk in being able to complete the medical assessments as per RCPCH guidelines and completion of medicolegal child protection reports for multiagency partners and court with the subsequent impact of children suffering further abuse/neglect or death.	Region	Paediatric Services	Keya Ali	08-Feb-2023	08-Mar-2023	Planned	20	20	10	Junior doctor rota to include allocated slots in the week for child protection medical assessments and report writing, Time for child protection medical assessments to be factored into consultant's job plans with additional consultant on the rota for child protection medical assessments and supervision as per RCPCH standards., Protected SPA time for Medical Report writing and formal peer review processes. Time for paediatric consultants to meet with junior team and deliver education on interpretation of injuries, multiagency working and child protection processes., In other areas the service is provided by community paediatricians. Trust to offer service for children under the age of two years only. Further discussions with BLMK ICB to progress this issue, To include child protection activity within the winter escalation policy with a clear process as to how this activity will be managed safely given bed pressures (PAU closed to admissions and children to be seen in PED)., To move location to an outpatient or day care setting ensuring appropriate IT support/ equipment and support staff/ chaperone available., Allocated area,	Clinicians currently try and complete this work within regular workload or work additional hours without remuneration.(20-Dec-2022), Wherever possible the examinations are undertaken during the quieter times to enable an appropriate chaperone is present.(20-Dec-2022), Wherever possible cubicles are used for examinations(20-Dec-2022), The safeguarding nurses try and make themselves available. This has an impact on safeguarding team's capacity.(20-Dec-2022), HIE access on eCare SystmOne on certain computers only.(20-Dec-2022), Social worker requested to attend medical assessment(20-Dec-2022)	Low	Treat	Risk reviewed by Risk Owner who advised "Chief Nurse and Risk Owner met with Simon Hardcastle at BLMK ICS and the risk was discussed. Currently, there is no change."	28-Sep-2022
RSK-417	13-Jan-2023	IF the Gastroenterology Department has an overwhelming number of new and follow up patients on their waiting list, and there is a significant demand on follow up capacity THEN there may be insufficient capacity to meet the demand on the service and recover the backlog of patients	LEADING TO Patients not being seen in a timely manner, Urgent referrals not being seen as quickly as they should, poor patient experience, competing priorities between new and follow up demand.	Region	Specialty Medicine	Katherine Denning	13-Jan-2023	28-Feb-2023	Pending	20	20	10	Recruitment into 12-month consultant and 12 month middle grade post (30-Jan-2023), Recruitment of 1WTE middle grade. (06-Feb-2023), Service review to allow clinical triage of new and follow ups (13-Jan-2023), PTL validation of all patients over 18 weeks, Admin validation of Non-RTT (06-Feb-2023), Recruitment of nursing staff to enable more OPA capacity and implementation of IBD PIFU (06-Feb-2023), Training CBO to check for duplicate appointments before booking, when creating a referral in RPAS to book outside of eReferral, to make sure eReferral is closed and discharged., Monthly duplicate report to be done by patient access and duplicates removed and closed	Patients Expedited through WLI sessions(13-Jan-2023), Triaging of referrals where possible(13-Jan-2023), Slot utilisation report has been created and used by Patient Access and Medicine Division to ensure all slots are fully utilised and not wasted.(13-Jan-2023), Patient Pathway Coordinators ensure results are reviewed and follow up appointments booked when needed- linked to PTL validation.(13-Jan-2023), Clinical Validation of the non-RTT starting with the most overdue patients. This relies on free sessions and is slow progress at 25 patients per session.(13-Jan-2023), PIFU is implemented in Gastro, only small numbers of around 10-15 per month. Clinical triage is increasing numbers being put on PIFU.(13-Jan-2023), Patient Pathway Coordinators are now starting to review some clinics ahead of time to identify any duplicate appointments.(13-Jan-2023), One off report was run identifying over 200 duplicates, all duplicates were removed by Medicine Division.(13-Jan-2023)	Low	Treat	Risk approved at Specialty CSU Meeting	21-Oct-2022

Reference	Created on	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-435	16-Feb-2023	IF access and egress to the MRI Unit is not appropriate, including narrow corridors/doors/changing ramp inclines etc. THEN there may be limited access for manoeuvring beds and wheelchairs ; there may be an inability for bariatric patients to access the facilities.	LEADING TO potentially delayed diagnosis and treatment; deterioration of condition and poor outcomes for patients; increase in slips, trips, falls; potential inability to evacuate patients quickly in case of fire; staff, patients and visitors could sustain strains, sprains, musculoskeletal, back, fracture, entrapment, collision injuries; increase in complaints and claims; potential investigation/formal notices from Health & Safety Executive; impact on reputation of Trust through potential media coverage re safety concerns	Region	Diagnostic & Screening	Victoria Smith	16-Feb-2023	30-Mar-2023	Planned	20	20	10	Hazard warning tape on changes of level, Review area and remove/relocate vending machines/chairs/wall to provide a wider and more direct route onto ramp, Fire risk assessment and evacuation plan to be documented and provided by Fire Safety Advisor	Staff vigilance and awareness of changes in incline(16-Feb-2023), All trolleys and beds to have a minimum of 2 staff pushing/ pulling- regardless if a patient is on the bed/ trolley(16-Feb-2023), Wheelchair patients to be assessed on individual basis but 2 people to push up and down ramp if patient deemed to heavy for individual- approx. guide proposed would be patient more than 75 kg to require 2 staff(16-Feb-2023), Ask all patients prior to entering ramp area to keep all arms and hands inside the bed/ trolley/ wheelchair(16-Feb-2023), Staff vigilance. Ensure limbs are out of way when negotiating ramp(16-Feb-2023), Patients to be brought from wards in wheelchairs where possible(16-Feb-2023), One bed patient at a time only(16-Feb-2023), Bed patient to be transferred to an MRI safe folding trolley in emergency(16-Feb-2023), Some bariatric patients are managed medically and not bought to the unit(16-Feb-2023), Communication with staff and patients. Ability to raise concerns with local managers, exec team and safety advisors(16-Feb-2023), Specific manual handling risk assessment and safe system of work documented with support of Manual Handling and Ergonomics Advisor(16-Feb-2023)	Low	Treat	Risk approved onto the Risk Register by Claire McGillycuddy	06-Jun-2022
RSK-001	06-Sep-2021	IF all known incidents, accidents and near misses are not reported on the Trust's incident reporting system (Radar); THEN the Trust will be unable to robustly investigate all incidents and near-misses within the required timescales;	LEADING TO an inability to learn from incidents, accidents and near-misses, an inability to stop potentially preventable incidents occurring, potential failure to comply with Duty of Candour legislation requiring the Trust to report all known incidents where the severity was moderate or higher, potential under reporting to the Learning from Patient Safety Events (LfPSE) system, and potential failure to meet Trust Key Performance	Organisation		Tina Worth	29-Dec-2022	31-Mar-2023	Planned	20	16	12	Staff competence and confidence with Radar reporting, with improved reporting rate, reduction in inaccurate reports on system and/or failure of incidents being reported (24-Oct-2022)	Incident Reporting Policy(06-Sep-2021), Incident Reporting Mandatory/Induction Training(06-Sep-2021), Incident Reporting Training Guide and adhoc training as required. Radar to provide on site & bespoke training IT drop in hub to be set up 2 days a week for staff drop ins(06-Sep 2021), Datix Incident Investigation Training sessions(06-Sep-2021), Daily review of incidents by Risk Management Team to identify potential Serious Incidents and appropriate escalation(06-Sep-2021), Serious Incident Review Group (SIRG) ensure quality of Serious Incident Investigations(06-Sep-2021), SIRG ensure appropriate reporting of Serious Incidents to Commissioners(06-Sep-2021), Standard Operating Procedure re Risk & Governance Team supporting the closure of incident investigations during unprecedented demand on service(06-Sep-2021), Implementation of new Risk Management Software to make incidents easier to report and improve engagement with staff(06-Sep-2021)	Low	Treat	Risk unchanged. Remains concerns re system & incidents captured/not captured Ongoing work with Radar & NHSI to make system more efficient & user friendly	06-Sep-2021
RSK-036	28-Sep-2021	If there is no capacity in the Pharmacy Team THEN there is a risk that Pharmacy and Medicines Policies and Procedures may not be reviewed and updated in a timely manner, nor new policies developed	Leading to: Potential for Policies & Procedures to be out of date Potential for staff to follow out of date Policies & Procedures Failure to meet CQC requirements Lack of guidance for staff Potential harm to patients	Organisation		Helen Chadwick	19-Dec-2022	31-Mar-2023	Planned	16	16	6	Recruitment of staff (07-Feb-2023)	Use of remote bank staff to update policies(28-Sep-2021), Business Case for additional Pharmacy staff(19-Apr-2022)	Low	Treat	Risk reviewed by Jill McDonald: The control of the pharmacy related risk remains dependent on staff recruitment. We are out to advert across all grades of pharmacist at present with some success however a number of posts will need readvertised. I do not expect the current recruitment to have a major impact for at least 3 months. Claire McGillycuddy requested review date is in 4 months	01-Oct-2021
RSK-064	07-Oct-2021	IF the Eye Injection Clinic Capacity continues to grow and the Ophthalmology team are not be able to meet capacity demands THEN there will be an an increasing number of patients outstanding for eye injections (this is people plotted and increases every week as people are plotted from past injections).	LEADING TO a delay to sight saving treatment – time critical treatment.	Region	Head & Neck	Jodie Bonsell	09-Feb-2023	01-Dec-2023	Planned	20	16	4	Increase Use of non medical, allied health professional injectors (21-Apr-2022), Weekend WLI clinics planned to catch up as temporary measure, Training up of Optometrists to do injections, Recruitment to SAS and fellowship roles, Team to consider an increase in nursing staff to run eye injection clinics (24-Aug-2022), Nurse in training due to start in September & 2 nurses on ophthalmology course, CDC verbally approved waiting more details this will provide more capacity	Planning for second injection room - lack of space and need to need funding to convert room(07-Oct-2021), Introduction of further Injection Clinics all day Friday (staff permitting)(21-Apr-2022), One stop clinics were introduced - increase 2 sessions to 4 - consultant led(21-Apr-2022)	Low	Treat	Updated controls	11-Nov-2019

Reference	Created on	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-079	14-Oct-2021	IF there are increased referral rates, a lack of space to deliver treatment, an inability to deliver timely treatment (rehab/maternity), and a lack of administrative resources THEN Physiotherapy waiting lists will remain at an unacceptable level post pandemic	LEADING TO patient's not receiving timely treatment/intervention, patient's becoming unconditioned, continual pressure to provide appointments, a reduced patient outcomes and unnecessary waiting time for appointments. Increased staff stress and sickness, staff being unable to treat as many patients as pre Covid-19, staff having to use clinical time to support admin duties	Region	Therapies	Celia Hyem-Smith	30-Jan-2023	23-Apr-2023	Planned	20	16	12	Approval given for locum support until the end of November 2021 (23-Jan-2023), All referrals triaged on receipt and rated as urgent, routine and non-urgent. Maintain contact with long waiters to determine if they still need our service. Packs and leaflets sent out, as appropriate (03-May-2022), Set slots kept for very urgent cases but does not meet needs. (08-Aug-2022), 12-month fixed term contract approved for 1.00 WTE, Band 6 member of staff (14-Nov-2022), Seeking alternative options for gym space to increase capacity to deliver groups offsite as insufficient space in the Therapy outpatient gym area. (23-Jan-2023), Plans to re-instate small group sessions allowing approx. 40 patients to be seen per week (08-Aug-2022)	Virtual clinic appointments have been introduced as part of the treatment pathway(14-Oct-2021), Additional areas suitable for telephone and video clinics have been identified and additional resources supplied(14-Oct-2021), Reconfiguration of department to support virtual working, enable social distancing and allowing appropriate staff to work from home(14-Oct-2021), An additional room has been refurbished for MSK. Refurbishment of two orthotics rooms has provided workspace for the WMH team.(14-Oct-2021), Separate risk assessment completed relating to under resourcing within the admin team(14-Oct-2021)	Medium	Treat	Following partial booking letters being sent out MSK waiting lists have reduced from 40 weeks to 6 weeks. Plans are in place to start weekend working and off site clinics for respiratory physio - funding has been identified for pulmonary rehab clashes at Woughton Health Centre	14-Oct-2021
RSK-080	15-Oct-2021	IF the pathway unit is not in place THEN moderate to severe head injury patients will not be appropriately cared for and will not be treated in accordance with NICE guidance (CG176: Head injury: assessment and early management, updated September 2019) These patients may frequently fall under the remit of the T&O Team or be nursed on a surgical ward when they should be under a neurological team.	LEADING TO Potential reduction in patient safety - T&O surgeons and nursing teams may be unaware of how to care for patients with moderate to severe head injuries especially patient who are anticoagulated. Clinicians may have to wait for an opinion from the Tertiary Centre staff training, competency and experience Serious incidents Reduced patient experience	Region	Musculoskeletal	Emma Budd	08-Feb-2023	28-Feb-2023	Pending	12	16	8	Implementation of Pathway Unit	- On going discussions with Senior Medical Team - CSU Lead to escalate via trauma network - Alert process is in place for escalation within T&O & externally. - Resources available at tertiary site for advice/support(15-Oct-2021), 1, 2 c& 3. mitigating controls - Policy for management of head injuries has been developed - Awaiting appointment of head injury liaison Nurse - Long term plan for observation block to be built.(15-Oct-2021), GAPS: - Trust is not in line with other trauma units - Regional trauma centre advises head injury should not be managed by trauma and orthopaedics and after 24 hours the patient should be referred to neurosurgery. - Potential delay in opinion from Tertiary Centre(15-Oct-2021)	Low	Treat	Risk reviewed at T&O CIG Meeting. "The current score should be red as there are 4 spinal injury patients on the ward". Current Risk Score is 16, so is already flagging as a significant risk. No further change required.	14-Jul-2011
RSK-088	15-Oct-2021	IF there is overcrowding and insufficient space in the Neonatal Unit. THEN we will be unable to meet patient needs or network requirements (without the increase in cot numbers and corresponding cot spacing).	LEADING TO potential removal of Level 2 status if we continue to have insufficient space to adequately fulfil our Network responsibilities and deliver care in line with national requirements.	Region	Paediatric Services	Zuzanna Gawlowski	20-Dec-2022	20-Mar-2023	Planned	25	16	9	New Women's & Children's hospital build	1. Reconfiguration of cots to create more space and extra cots and capacity, though this still does not meet PHE or national standards(15-Oct-2021), Business Case for Refurnishing Milk Kitchen and Sluice(15-Oct-2021), 2. Parents asked to leave NNU during interventional procedures, ward rounds etc. Restricted visiting during COVID(15-Oct-2021), 3. Added to capital plan(15-Oct-2021)	Low	Treat	Risk reviewed by triumvirate , no changes to risk and scoring	19-Dec-2022
RSK-115	29-Oct-2021	IF annual and quarterly test reports for Autoclaves and Washer Disinfectors used for critical processes are not being received in a timely manner from the Estates department and there is no Authorised Person (D) to maintain the day to day operational aspects of the role THEN the Trust will be unable to prove control, monitoring and validation of the sterilisation process as a control measure. Both units are reviewed only 1 day per month - a bulk of this time is spent checking records and the other aspects of the role do not get the sufficient time required to review and follow up.	LEADING TO possible loss of ISO 13485 accreditation due to non-compliance to national standards. Inconsistent checks or lack of scheduled tests for the steam plant also increase the risk.	Organisation		Mark Brown	17-Feb-2023	31-Mar-2023	Planned	20	16	9	A meeting took place in January with estates managers, where HSDU were seeking assurance that the service would be covered. Estates have agreed to look for a plan to mitigate the risk and to keep HSDU fully informed. HSDU have informed the AE(D), so he is now aware that the site will not have any day to day operational AP(D) cover. (17-Feb-2023)	Estates management informed and plans in place to receive reports on time and to standard. Independent monitoring system in place monitoring machine performance. Weekly PPM carried out on machinery. An action plan has been created by estates, to include training the specialist estates officer so he can gain the recognised qualification he needs to carry out the role of the Authorised person for decontamination(AP(D)) and for additional training of the estates competent persons(CP(D) who test the decontamination equipment.(29-Oct-2021)	Low	Not Applicable	The AE is working with the departments in a timely order, they are supporting HSDU every month and our AP(D) is reviewing all weekly and quarterly reports with any recommendations forwarded to the AE (D) to action.	25-Aug-2021
RSK-126	04-Nov-2021	IF cot spacing in the Neonatal Unit does not comply with BAPM guidance or the latest PHE guidance for COVID-19 (the Unit is seeking to increase both total cot spacing and cot numbers by 4 HDU/ITU cots in line with Network 5 year projections of acuity and demand, and spacing in line with National Recommendations) THEN there will be overcrowding and insufficient space in the Neonatal Unit, exacerbated by need for social distancing due to COVID-19. The milk kitchen was condemned due to this	LEADING TO an inability to meet patient needs or network requirements. We will now also be unable to meet PHE recommendations for social distancing This may result in a removal of Level 2 status if we continue to have insufficient space to adequately fulfil our Network responsibilities and deliver care in line with national requirements. This may also impact on our ability to protect babies and their families during COVID	Organisation		Zuzanna Gawlowski	20-Dec-2022	20-Mar-2023	Planned	25	16	9	Business Case for Refurnishing Milk Kitchen and Sluice	Reconfiguration of cots to create more space and extra cots and capacity, though this still does not meet PHE or national standards(04-Nov-2021), Parents asked to leave NNU during interventional procedures, ward rounds etc. Restricted visiting during COVID(04-Nov-2021), Added to capital plan(04-Nov-2021), Feasibility study completed(04-Nov-2021)	Low	Treat	Risk reviewed by triumvirate ,No change to risk or risk scoring	19-Dec-2022
RSK-135	04-Nov-2021	IF the Pathology LIMS system is no longer sufficient for the needs of the department, due to being outdated with a limited time remaining on its contract THEN the system is at risk of failure, virus infiltration and being unsupported by the supplier	LEADING TO the Pathology service being halted and contingency plans would have to be implemented. Sensitive information could lost or security of the information could be breached.	Region	Diagnostic & Screening	Jessica Dixon	02-Feb-2023	30-Apr-2023	Planned	16	16	4	Low Level Design to be completed (02-Feb-2023)	Systems manager regularly liaises with Clinysis to rectify IT failures(04-Nov-2021), Meetings with S4 to establish joint procurement take place periodically(04-Nov-2021), Project Manager role identified to lead project for MKUH(04-Nov-2021), High Level Design Completed(01-Dec-2021)	Low	Treat	No change to risk. Continued discussion with S4 about timeline slippage due to complex LLD build in Microbiology. dedicated time allocated to ensure sufficient resource from MKUH and IT support. to Review in 2 months following confirmation with suppliers plan going forward and new defined timeline.	01-Sep-2019

Reference	Created on	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-142	04-Nov-2021	IF there is insufficient capacity and ongoing unsustainable demand for dietetic input for Paediatric patients (both inpatient and outpatient) . IF Home Enterally Fed Paediatrics patients continue to be seen our outpatient structure which is not adequate to meet their demands and needs (rather than the community contract). This means that these high risk groups of Children and Young People are not accessing the necessary specialist nutritional support at the appropriate time in their development THEN staff may be unable to cover a service that has not been serviced correctly, and the paediatric team cannot provide a full dietetic service to children and young people in the Milton Keynes area	LEADING TO patient care and patient safety may be at risk, vulnerable children may become nutritionally compromised, the service may be unable to assess and advise new patients and review existing patients in a timely manner, and there may be an impact on patients nutritional status and longer term dietary management on what is a very vulnerable group of patients. The majority of our caseload is infants or tube fed infants and children where there nutrition and growth is a priority.	Organisation		Elizabeth Pryke	05-Feb-2023	31-Mar-2023	Planned	15	16	3	In contact with commissioners to discuss service provision Collecting additional data (feedback from stakeholders, benchmarking etc) to support business case	Existing staff are working some additional hours but this remains insufficient to meet the needs of the service(04-Nov-2021)	Low	Treat	Continuing to try and engage with commissioners regarding properly commissioned service Collecting data from stakeholders, benchmarking etc to support business case	01-Nov-2021
RSK-157	12-Nov-2021	IF There is insufficient Speech and Language Therapy capacity to meet referrals demands	LEADING TO patients not receiving input in line with Sentinel Stroke Audit National Programme (SSNAP) (communication and and timely input to support patient discharges Delayed discharges, poor patient experience and increased length of staff	Region	Therapies	Jamie Stamp	20-Feb-2023	21-Mar-2023	Planned	16	16	4	To create Quality Scheduled to capture data relating to Speech and language Therapy activity for discussing at quarterly meetings with the provider. Head of Therapy has met with the Operational lead for medicine to start initial discussion about what data they want captured from a stroke point of view. (04-Jan-2023), To meet with medicine division to understand areas of improvement needed to achieve the SSNAP data for Speech and language Therapy (30-Jan-2023), Arrange meeting with CNWL to discuss current staffing levels and mitigation (30-Jan-2023)	Daily updates are provided by the SLT to confirm outstanding referrals and priority patients for that day.(12-Nov-2021), To review opportunities to skill mix current workforce in light of recruitment challenges. For example, meetings to take place with community services to consider increasing therapy assistant time to improve input on the Stroke Unit.(11-Apr-2022), Team Leader is now in post - to ensure that regular meetings are taking place to look at recruitment and training. Band 3 Therapy Assistant (FTC) interviews are scheduled. SSNAP actions plan has been updated to reflect this.(24-Jun-2022)	Medium	Treat	The risk score remains the same as workforce gaps continue to be evident due to skill mix being predominantly Band 5 and Band 3. The SSNAP data should look better for next month due to introduction of Speech and Language Therapy Assistants as they are able to focus on providing communication sessions to patients on the stroke ward. A team leader Band 7 has also been successfully appointed and is awaiting a start date. A meeting is scheduled with ICS to discuss stroke data for therapy as it has not been meeting KPI targets for a number of months.	12-Nov-2021
RSK-202	23-Nov-2021	IF Transformation delivery is not adequately resourced and prioritised and/or schemes are unrealistic and not well planned THEN There is a risk that the Trust is unable to achieve the required efficiency improvements through the transformation programme	LEADING TO the Trust potentially not delivering its financial targets leading to TO potential cash shortfall and non-delivery of its key targets	Organisation		Karan Hotchkin	20-Feb-2023	16-Mar-2023	Planned	20	16	9	Divisional CIP review meetings in place attended by the DoF, divisional managers and finance business partner. There are no cross-cutting transformation schemes yet identified and savings of around £8m have been identified against the £12m target. Whilst this shortfall can be mitigated this year, the risk is around the underlying financial position.	Divisional CIP review meetings in place attended by the DoF, divisional managers and finance business partners(23-Nov-2021), Cross-cutting transformation schemes are being worked up(23-Nov-2021), Savings plan for 21/22 financial year not yet fully identified(23-Nov-2021)	Medium	Treat	Risk transferred from Datix	01-Apr-2022
RSK-305	06-Dec-2021	If there is insufficient strategic capital funding available THEN the Trust will be unable to invest in the site to maintain pace with the growth of the Milton Keynes population's demand for hospital services	LEADING To financial loss and reputational damage	Organisation		Karan Hotchkin	20-Feb-2023	16-Mar-2023	Planned	16	16	9	Trust is discussing this with the regional Capital Team and with the ICB capital allocations for 23/24. 22/23 allocations are manageable	The trust has a process to target investment of available capital finance to manage risk and safety across the hospital(06-Dec-2021)	Medium	Treat	Risk was approved by Finance and Investment committee on 30/12/2021	01-Apr-2022
RSK-337	28-Apr-2022	IF the Children's Physiotherapy Department at MKUH has a waiting time for routine MSK and Core appointments of approximately 9 months. THEN the Trust is not meeting the target 18 week waiting time from receipt of referral, for routine musculoskeletal (MSK) appointments	LEADING TO a delay in the Physiotherapist's initial assessment, a delay in treatment, and an impact on patient safety and experience	Region	Therapies	Sarah Knight	14-Feb-2023	31-May-2023	Planned	12	16	16	Complete demand and capacity work to better forecast what staffing is needed to cover this service (06-Feb-2023), To use Children's Physiotherapy Pay underspend to fund a locum for January - March 2023, specifically to help reduced the Children's MSK waiting list. (30-Jan-2023)	All referrals are triaged and coded on receipt by a Band 7 Physiotherapist(28-Apr-2022), Referrals with insufficient information to enable triage are sent back to the referrer with a request for more information(28-Apr-2022), The department runs three 'sprint clinics' a month, where only new patients are seen, to reduce the delay in initial assessment(28-Apr-2022), The department runs two gait clinics a month. Gait problems tend to require short episodes of treatment, and therefore this facilitates the quick discharge of patients, reducing the waiting list(28-Apr-2022), Recruitment of vacant posts(28-Apr-2022), Send receipt of referral letters, asking parents/guardians to contact the department if they notice any significant deterioration in their child's ability or function(28-Apr-2022), Produce patient leaflets to send to patients upon referral, to provide information and advice on various conditions. Where suitable, these can also recommend basic exercises for patients to manage or improve their condition(28-Apr-2022)	Medium	Treat	Risk reviewed at Therapies CIG - Current risk should be 16, not 12. Risk updated	28-Apr-2022
RSK-373	22-Aug-2022	IF the aging Vacuum biopsy machine is not replaced and consumables are not available, THEN we will be unable to offer vacuum biopsy (VAB) to assist the pre-operative diagnosis of non-invasive/ invasive breast cancer.	LEADING TO impact on the quality of care as more women as VAB reduces the upgrade risk (DCIS diagnosed at biopsy) and more women will have unpredicted invasive disease at surgery meaning that they will require further axillary surgery	Region	Diagnostic & Screening	Deborah Noble	19-Dec-2022	31-Mar-2023	Planned	16	16	4	Purchase of replacement of current vac biopsy machine, Purchase an additional vac biopsy machine	Annual Maintenance of vac biopsy machine(01-Nov-2022), Maintaining communication with supply chains and national office(01-Nov-2022)	Low	Treat	Risk added to Risk Register	10-Nov-2022

Reference	Created on	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-377	30-Aug-2022	IF Microbiology does not have a Quality Management System and is unable to provide quality assurance THEN the department may not able to achieve accreditation for the range of tests performed in the department	LEADING TO potential for patients to receive incorrect results or delays in receiving results, diagnosis and treatment, impact on Trust's reputation, financial penalties, loss of Service User Contracts, loss of ICB commissioning, loss of staff, difficulties recruiting staff, inability to manage incidents, audit, Trust policies and equipment records in a timely manner	Region	Diagnostic & Screening	Jessica Dixon	02-Feb-2023	31-Mar-2023	Planned	16	16	8	Implement stock management system, Review rota Management (16-Jan-2023), Improve training and competency programme (16-Jan-2023), Lean process review of all bench areas - led by OUH staff	Quality Manager and Quality Associate Practitioner in post(30-Aug-2022), Monthly KPI's to monitor progression(30-Aug-2022), Additional support utilising bank staff as required(30-Aug-2022), Quality Management System in place that is robust in 5 other disciplines within Pathology(30-Aug-2022), Additional training for staff in utilising the QMS and understanding(30-Aug-2022), Monthly departmental and clinical meetings to review, communicate and action decisions(30-Aug-2022), EQA and IQC participation(30-Aug-2022), Audit Programme(30-Aug-2022), Training and Competency programme(30-Aug-2022), Mock UKAS inspection(30-Aug-2022), 1-1's with Senior staff to establish training gaps(30-Aug-2022), Increase formal training within departments for all staff to use Q-Pulse as required(30-Aug-2022), Improved clarity of roles and responsibilities(30-Aug-2022), 2x Band 7 acting as Chief from OUH to support for 3 months, .(16-Jan-2023)	Low	Treat	Action plan has been established, and additional staffing has been sourced from within the S4 to support the transformation. Review risk monthly as progress through the plan.	01-Jul-2022
RSK-399	09-Nov-2022	IF the staffing establishment within the Pharmacy Aseptic Team is not resilient and there is insufficient senior aseptic staff to complete the higher technical tasks THEN there is potential for the department to be regularly working over capacity	LEADING TO a breach in regulatory guidance, an ability to maintain the QMS work required.	Region	Pharmacy	Christopher Woodard	06-Feb-2023	31-Mar-2023	Planned	16	16	12	Review of staffing to establish what additional staffing is needed and who to improve retention and development of staff we currently have (06-Jan-2023), Review of senior staffing, including succession planning. Develop posts/time for staff to focus purely on quality tasks, not just operational. (06-Jan-2023)	Outsource some patient specific chemotherapy(09-Nov-2022), Discussed at monthly QMS meeting, more critical QMS tasks being prioritised for available time at present(09-Nov-2022)	Medium	Treat	Risk reviewed at Pharmacy CIG. No change to risk	01-Nov-2022
RSK-414	13-Jan-2023	IF The Dermatology Department does not have appropriately trained nursing staff to be able to provide a Phototherapy Service THEN the service will not be able to provide a phototherapy, which is an integral part of the Dermatology Service	LEADING to patients that are unable to access Phototherapiy being placed potentially on medication unnecessarily to try to manage their conditions in the interim	Region	Specialty Medicine	Michelle Hicks	09-Feb-2023	28-Feb-2023	Pending	16	16	12	Recruitment of adequately trained phototherapy nurse.	List is closed to new referrals(13-Jan-2023), Patients have been reviewed and where appropriate placed on medication(13-Jan-2023)	Low	Treat	Risk discussed at Specialty Medicine CSU: A Band 5 Nurse has been recruited. They are going to be trained in Phototherapy. They should be fully trained by Summer.	02-Nov-2022
RSK-419	13-Jan-2023	IF stock of FFN tests can not be obtained to support the prediction of the likelihood of preterm birth, THEN an alternative test, that does not predict timings of preterm birth, but instead a positive or negative result will be used	LEADING TO to an increase of inpatient antenatal service users at risk of preterm birth, which could lead to a delay in IOL and ELLSCS and an increased risk of service users birthing preterm babies outside the appropriate setting	Region	Women's Health	Faryal Nizami	07-Feb-2023	30-Apr-2023	Planned	16	16	2	Obtain FFN tests when available, Add alternative options to the preterm SOP in cases of FFN not being available in the future	Use alternative positive or Negative result (Partosure)(08-Feb-2023)	Low	Treat	Risk remains the same	13-Jan-2023
RSK-427	08-Feb-2023	IF there is an increase in demand for inpatient and ED CT scans THEN some scans will be routinely waiting a number of days to be performed.	LEADING TO potential delays to patient treatment; delays to discharge.	Region	Diagnostic & Screening	Michael Pashler	08-Feb-2023	31-Mar-2023	Planned	16	16	8	Purchase and installation of 4th CT scanner, Recruitment of Radiographers, Recruitment of Imaging Assistants	Patients are prioritised based on clinical urgency to minimise risks as best as possible(09-Feb-2023), Adopting a fluid approach to managing the workload. Adapting to changes in priority at short notice.(09-Feb-2023)	Low	Treat	Risk approved at the Imaging CIG on 17.01.23	20-Oct-2022
RSK-061	07-Oct-2021	IF Audiology staff have to manually input patient data into Auditbase (the Patient Management System for Audiology Services) as there is no link with e- care THEN there is risk of incomplete and inaccurate patient details on the Auditbase system.	LEADING TO the potential for deceased patients being contacted for appointments. Appointment letters may be sent to incorrect addresses and therefore missed appointments Increased temporary and duplicate patient numbers on Auditbase Possible breaching as clinical time is being used for entering patient demographics Clinical governance breaches due to incorrect patient information Loss of income Adverse publicity Adverse effect on morale of all Audiology staff	Region	Head & Neck	Jane Grant	16-Jan-2023	28-Feb-2023	Pending	12	15	4	Review outcome of CBIG meeting	A working group is being set up with H&N to address issues within the service.(07-Oct-2021), The Auditbase upgrade had now taken place and is functioning well. - It is expected that Audiology will start diaglogue with IT to undertake work relating to the link could commence. - Ensuring datix incidents related to this risk are logged and acted upon. - Manual data input is a consequence of the failure of the PAS interface. - Not accepting medical students in Audiology - CEO advised of this in email 15.7.19 from Head of Audiology Services.(07-Oct-2021), IT Request form submitted (24.4.2022) for the development with Auditdata of an interface between Auditbase and e-care: 1. To enable demographics to be downloaded from e- care onto Auditbase when a new patient is registered on Auditbase 2. To automatically update demographics on Auditbase when there are changes to demographics on e-care 3. To download results of hearing tests from Auditbase into a results section within e-care(07-Oct-2021), Audiology staff have to manually input patient data into Auditbase(27-Apr-2022), Auditbase eCare integration(24-Nov-2022)	Low	Treat	Review outcome of CBIG meeting at which business plan was considered end of January 2023	20-Nov-2017
RSK-101	25-Oct-2021	IF the maternity service at MKUK do not have their own dedicated set of theatres. THEN maternity are left vulnerable to not having a guaranteed emergency theatre available 24hrs a day.	LEADING TO increased risk of poor outcome for mothers and babies if theatre delay; Psychological trauma for staff dealing with potentially avoidable poor outcome; Financial implication to the trust	Region	Women's Health	Melissa Davis	15-Dec-2022	31-Jul-2023	Planned	15	15	6	Hospital new build to include Maternity theatres, Escalation policy available for staff to use in situations where a 2nd theatre is needed by can not be opened	Elective Caesarean work is completed the Theatre 1 during a booked morning session, Theatre 3 is set for obstetric emergencies.(01-Sep-2022)	Low	Treat	No change to the risk score - terminology to be updated once agreed.	06-Sep-2021

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RSK-111	26-Oct-2021	IF there is a national shortage of midwives THEN there may be insufficient midwives to provide for the needs of MKUH patients	LEADING TO a local negative impact on delivering excellent patient care, patient experience and staff experience.	Region	Women's Health	Melissa Davis	07-Feb-2023	31-Mar-2023	Planned	16	15	6	Implement Ockenden 2 (Recalculated headroom/gap), Business case for suture funding of birth rate+ to be developed., Business case to be taken to board for agreement., MSW project	There are significant efforts to recruit new midwives.(26-Oct-2021), The early recognition by GOLD and the Chief Executive to advertise for new midwives following the Ockenden report.(26-Oct-2021), Also working with NMC to achieve PIN numbers early for newly qualified staff.(26-Oct-2021), Enhanced bank rates.(26-Oct-2021), Rolling job advert for band 5/6 clinical midwives(27-Apr-2022), Review establishment birth rate+ report(27-Apr-2022), Workforce retention and recruitment plan(13-Jan-2023), Midwifery workforce plan(13-Jan-2023), Interview and offer shortened MW course places(13-Jan-2023)	Low	Treat	No change to score	13-Dec-2022
RSK-170	12-Nov-2021	IF the Autoclave machines are not replaced THEN there is a risk that the Pathology department will be unable to sterilise bio-hazardous laboratory waste prior to discarding. Accumulation of waste potentially infective, bad odour, and consuming much needed space. External contractors can remove category 1 and 2 waste only, category 3 waste cannot be removed from the site without being processed through the autoclave.	LEADING TO Health & safety risk to the laboratory staff; Failure to meet COSHH regulations in relation to waste management and autoclave of all HG3 known and suspected biological agents/clinical materials waste; potential disruption to the service; potential to affect Trust's reputation; accumulation of waste products; limiting user of autoclave to preserve lifespan	Region	Diagnostic & Screening	Imran Sheikh	02-Feb-2023	08-Mar-2023	Planned	12	15	5	Ensure robust Autoclave contingency plan to deploy contractors to collect and manage hazardous waste is tried and tested (06-Jan-2023)	PPE; Gloves, safety goggles, ear defenders and Lab coat worn at all times, with good hand hygiene practice. Heavy duty gloves, full face visor and apron must be worn when unloading.(12-Nov-2021), Health & Safety training and competency procedures for all staff working with HG3 waste and the autoclaves.(12-Nov-2021), The autoclave maintenance is performed once per week to regularly check working order and functionality.(12-Nov-2021), Business Case Development for replacement/repair of autoclaves(11-May-2022), Autoclave thermometric tests and calibrations to ensure correct processing of load. Checking printout of every run to ensure process passed. Only authorised staff to work on autoclaves.(12-Sep-2022), 2nd autoclave being used to supply spares – these will run out(12-Sep-2022), Report deficiencies to Estates. Report incidents onto RADAR and escalate to senior management team(12-Sep-2022), Waste is being segregated in to two waste streams to ensure only HG3 waste is autoclaved to reduce over use of the autoclaves – All routine microbiology waste is being sent for incineration, whereas all waste produced from the CL3 room that is potentially HG3 waste is being disposed of in autoclave bags, inside autoclave metal tins and being autoclaved once weekly. In case of failure of autoclaves, offsite contingency is in place with Tradebe.(12-Sep-2022),	Low	Treat	Business case is completed and sent to finance for review. This is going to be pushed through before end of March. To liaise with finance about pre-commitment permissions. Review in March	10-Jul-2022
RSK-203	23-Nov-2021	IF the are negative impacts on the supply chain following the rising fuel costs and the conflict in Ukraine THEN there is a risk that the supply of key clinical products may be disrupted	LEADING TO some unavailabilty of clinical products, delays to deliveries and services may be disrupted or reduce resulting in impact on patient care	Organisation		Lisa Johnston	20-Feb-2023	16-Mar-2023	Planned	16	15	6		Trust's top suppliers have been reviewed and issues with supply under constant review(23-Nov-2021), Procurement business partners use the NHS Spend Comparison Site and local knowledge supported by the clinical procurement nurse to source alternative products(23-Nov-2021), Clinical Procurement nurse to join the NHSI/E Supply Resilience Forum(15-Aug-2022), Clinical Procurement nurse is part of the NHSI/E Supply Resilience Forum created in August 2022.Trust's top suppliers have been reviewed and issues with supply under constant review, Procurement business partners use the NHS Spend Comparison Site and local knowledge supported by the clinical procurement nurse to source alternative products(16-Nov-2022)	Medium	Treat	Still ongoing risk	01-Jun-2022
RSK-250	26-Nov-2021	IF staff across MKUH continue to use eCARE in the same way, that the volumes of requests made to the IT Department remain at their current rate, and the volume of change and project work continues at the current volume THEN the IT Department will become less responsive and a range of functions within eCARE will continue to be left without action	LEADING TO increased clinical risk, increased risk to performance of eCARE, potential disruption to staff, and delays in the deliver or projects and realising their benefits	Organisation		Craig York	25-Jan-2023	28-Apr-2023	Planned	15	15	3		Prioritisation of workload is in place to cover the most impacting of issues or projects, however this only reduces the potential impact slightly(26-Nov-2021)	Low	Treat	Volume of work is increasing month on month without additional staff to support.	25-Jan-2023
RSK-271	30-Nov-2021	IF there is insufficient space within the Medical Equipment Library (MEL) THEN MEL staff will be unable to carry out the required cleaning process to comply with the appropriate guidelines set by CQC and MHRA	LEADING TO Lack of cleaning and processing space due to the growth of the MEL over the years means not keeping unprocessed and processed equipment separately, not complying with CQC Regulation 15: Premises and equipment and MHRA Documentation: Managing Medical Devices January 2021	Region	Estates	Ayca Ahmed	14-Dec-2022	31-Mar-2023	Planned	15	15	3	The MEL dept relocation is on the draft capital plan under estates (28-Nov-2022)	Staff members are taking processed equipment straight to the shelving areas as soon as it is cleaned to avoid cross contamination. This ensure equipment is kept separate, but this is not a productive method of working(30-Nov-2021), Issue has been raised at Space Committee (June 2021)(30-Nov-2021), 2019-2020 Additional office has been provided, outside of the main department for the Service Manager and the Equipment training Auditor. This has created some additional space for the Library(30-Nov-2021), 2019-2020 Additional storage provided outside of main department in the location of a storage facility within a staircase approved and provided for a number of services under an approved Business Case on the Capital Programme(30-Nov-2021)	Medium	Treat	Reviewed by Medical Devices Manager, no change to risk rating.	23-Aug-2020

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RSK-310	22-Dec-2021	IF all maternity related incidents are not reported on the Trust incident reporting system THEN maternity's ability to demonstrate effective governance processes and procedures, both within internal trust mechanisms and to the external stakeholders will be negatively affected	LEADING TO a potential reduction in the ability to learn from incidents and improve patient care/safety, an increase in incidents occurring, and complaints and claims being received	Region	Women's Health	Melissa Davis	07-Feb-2023	31-Mar-2023	Planned	15	15	6	Review trust level training for radar (09-Jan-2023)	Reminders are send to staff of incidents that are identified as part of review(12-Apr-2022), Feedback to NHS England(08-Nov-2022)	High	Treat	No change to score	22-Dec-2021
RSK-324	09-Feb-2022	IF there are significant nursing vacancies within the Paediatric Unit, including Maternity Leave and Long-Term Sickness - we are currently 38% of permanent staff roles unfilled- this is being partially mitigated with use of regular Agency and Bank staff THEN there will not be sufficient/safe numbers of nursing staff to cover shifts.	LEADING TO an increased risk for children's safety due to the absence of permanent skilled staff; an increased use of agency; an increasing number of shifts that do not comply with national recommended safe staffing levels	Region	Paediatric Services	Helder Prata	20-Dec-2022	20-Mar-2023	Planned	15	15	9	Establishment Review to be completed	We are using regular Paediatric Agency and Bank staff to fill gaps wherever possible, we are planning a minimum of 50% of permanent staff on each shift. We are constantly advertising and interviewing for replacement staff- we are steadily recruiting. We are effectively managing Long term sickness in accordance with Trust guidance and with the input of HR(09-Feb-2022)	Low	Treat	Reviewed by triumvirate , no change to risk or risk scoring	19-Dec-2022
RSK-331	06-Apr-2022	If current demands on the therapies admin service continues without the capacity to meet the volume of work Then clinicians diary slots will be left unfilled and patients won't be contacted in a timely manner.	Leading to increased waiting lists and poor patient outcomes. Lack of capacity to book appointments leaving diary slots unfilled; patients not achieving expected outcomes especially if treatment is not provided within post surgical timescales; negative impact and possible litigation against the Trust	Region	Therapies	Celia Hyem-Smith	30-Jan-2023	30-Apr-2023	Planned	15	15	9	Approval for two bank staff until 1.7.22 (08-Aug-2022)		Medium	Treat	Admin staffing remains a challenges due to short term absence, 2-3 staff consistently off per week. Interviews have taken place for remaining vacancies and to fund 2.5 wte administrators until the end of March 23.	06-Apr-2022
RSK-343	23-May-2022	If there is insufficient dietetic staff in post THEN the service may be unable to meet referrals demand	Leading to patients not receiving dietetic input as needed, which could result in: - Insufficient dietetic education for adults with complex nutritional issues, including adults with diabetes, gastrointestinal disease, those either malnourished or at risk of malnutrition needing nutritional support etc. - Reduction in patient experience and poorer outcomes - MDT will not work effectively as insufficient dietetic input, increasing workload of other members of MDT - Patients with long term conditions such as Diabetes, CHD etc will not have the support to develop the skills for independence and self-management to achieve good health outcomes	Region	Therapies	Elizabeth Pryke	05-Feb-2023	10-Mar-2023	Planned	15	15	9	Locum Dietitian working remotely To go back out to advert for B6 Dietitian	Triaging patient referrals based on clinical need Daily team huddle to try and manage this and ensure communication is good across the team Advised ward staff so they can start first line nutritional support(23-May-2022), Setting up weekend telephone clinic(23-May-2022), Patients triaged as more urgent will be seen - reduced service communicated to senior nurses, consultants etc(14-Jun-2022), Patients triaged as more urgent will be seen - reduced service communicated to senior nurses, consultants etc(14-Jun-2022), Locum started to provide x 2 clinics / week(29-Jun-2022)	Low	Treat	Locum Dietitian working remotely Substantive members of staff working additional bank hours to help Will go back out to advert for B6 dietitian	02-May-2022
RSK-374	23-Aug-2022	IF patients on the cancer pathway wait longer than 62 days THEN there is the risk treatment has been delayed,	LEADING TO potential harm a risk of potential harm physical or psychological or both	Region	Haematology & Oncology	Sally Burnie	13-Dec-2022	31-Mar-2023	Planned	12	15	9	weekly restore and recovery clinical meetings and weekly operational meetings (13-Dec-2022)		Medium	Treat		05-Aug-2022
RSK-388	17-Oct-2022	IF Audiology Services do not get a second testing room equipped for the testing of younger and complex children THEN there will be a delay in offering appointments to these children	LEADING TO delayed diagnosis, delayed treatment, delayed management and diagnostic breaches.	Region	Head & Neck	Jane Grant	24-Nov-2022	26-Jan-2023	Overdue	15	15	4	Second testing room equipped for the testing of younger and complex children	Current room being used to full capacity.(17-Oct-2022), Contact Estates and external company to explore options for conversion of workshop on Level 4 to testing facility(17-Oct-2022)	Low	Treat	Risk approved at Audiology Clinical Governance Meeting	22-Sep-2022
RSK-402	01-Dec-2022	IF there is a lack of Orthopaedic Therapy staff to provide rehabilitation, discharge planning and equipment to patients in the trauma and elective orthopaedic pathways. THEN fractured NOF patients may not be able to be offered mobilisation daily and have regular physiotherapy reviews; elective Orthopaedic patients may not be seen twice a day.	LEADING TO potential for length of stay for both trauma and elective patients to increase and reduce patient experience.	Organisation		Adam Baddeley	19-Jan-2023	28-Feb-2023	Pending	15	15	6	Provision of agency staff (09-Jan-2023), Recruitment (09-Jan-2023)		Low	Treat	Have secured x1 band 4 locum to support the service and staff member on LTS is now on a phased return. Recruitment to x2 vacant OT posts still very challenging - agreed to try for a locum at 8a pay rates.	01-Dec-2022
RSK-406	09-Dec-2022	IF there is a global shortage of electronic components THEN this can impact the lead times for delivery of medical equipment	LEADING TO to inability to replace/repair aged equipment used to monitor and support patients during their hospital care.	Organisation		Ayca Ahmed	08-Feb-2023	31-Mar-2023	Planned	25	15	10	Each Division to carry out a risk assessment and build it in their contingency plan	Medical Devices Manager (MDM) is in liaising with suppliers for delivery per each approved BC for medical equipment procurement and providing support/advice to each division lead(09-Dec-2022), Clinical Contingency arrangement(09-Dec-2022), Finance lead for Business Cases is reminding all attendees at each meeting to get the Business Cases ready(09-Dec-2022), Wards/depts are borrowing from another ward/dept within the Trust as a normal practice or lease, rent, arrange a loan via any other supplier(09-Dec-2022), The advice on alternative suppliers are available via the MDM(09-Dec-2022), Procurement has a list from the NHSSC route advising on delivery lead times(09-Dec-2022), Regular inspection and maintenance of current equipment(09-Dec-2022), Rolling programme of equipment replacement regularly reviewed and issues escalated at early stage(09-Dec-2022)	Low	Treat	Risk approved onto the Corporate Risk Register at RCB	11-Nov-2022

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RSK-420	17-Jan-2023	IF the ward environment of Ward 23 is not fit for purpose THEN the will be reduced visibility and observation of patients, increased risk of patient falls, reduced ability to work as a team, delays in patient care, lack of room to manoeuvre/use equipment, staff may have to escalate emergencies via telephone, delay in identifying which space call bell has been activated in, increased risk of self-harm, increased risk of confidential information being inappropriately shared, lack of sluice, increased risk of infection/cross contamination, inability to control temperature levels	LEADING TO increased risk of harm to patient, increased length of stay, compromise in medical condition / slow rehabilitation, increased risk of falls, lack of privacy/dignity, increased infection rate, negative impact on staff morale, anxiety/stress, health-related concerns, increased staff absence/turnover, increased risk of moving/handling injuries,	Region	Musculoskeletal	Alexandra Stock	17-Jan-2023	28-Feb-2023	Pending	15	15	10	Recruitment of staff, Redevelopment / Redesign of bays and bathrooms to accommodate required equipment and suitability for patient group, Additional sluice and storeroom, Installation of air conditioning in the side rooms	Establishment of staff to allow for a nurse or HCA to be in a bay at any one time so far as can(17-Jan-2023), Call bells for patients to use when needing help from staff, emergency buzzers in case of emergency situation.(17-Jan-2023), Establishment of staff to ensure that two members of staff are always in bay 7(17-Jan-2023), Barriers around open area(17-Jan-2023), Staff using yellow bags to cover any bodily fluids that need to be taken to the sluice(17-Jan-2023), Small supply of continence products kept near side rooms(17-Jan-2023), Doors of side rooms kept close to reduce risk of infection(17-Jan-2023), Appointments booked to minimise amount of people waiting in corridors(17-Jan-2023), Fans in rooms however only circulating warm air(17-Jan-2023), Additional tea trolley for side room areas(17-Jan-2023)	Low	Treat	Risk approved at November MSK CIG Meeting.	07-Jul-2022
RSK-426	31-Jan-2023	IF cancer 2ww booking service is not managed within SOP processes there is a RISK that the patients wont be booked within 2 weeks, communication will not be processed highlighting capacity requirements and clinical triage and referrals will not be tracked effectively THEN there is the risk treatment has been delayed,	LEADING to potential delays, risk of missed referrals and non tracking	Region	Haematology & Oncology	Sally Burnie	31-Jan-2023	28-Feb-2023	Pending	9	15	3	Centralisation of 2WW service to Central booking team		Medium	Treat		31-Jan-2023