Board of Directors

Public Meeting Agenda

Meeting to be held at 1.00 pm on Friday 9 November 2018 in Room 6, Postgraduate Education Centre, Milton Keynes University Hospital.

Item No.	Title	Purpose	Type and Ref.	Lead
1. Introduction and Administration				
1.1	Apologies	Receive	Verbal	Chairman
1.2	Declarations of Interest • Any new interests to declare • Any interests to declare in relation to open items on the agenda	Noting	Verbal	Chairman
1.3	Minutes of the meeting held in Public on 7 September 2018	Approve	Pages 3-14	Chairman
1.4	Matters Arising/ Action Log	Receive	Pages 15-16	Chairman
2. Chair and Chief Executive Strategic Updates				
2.1	Chairman's Report	Receive and Discuss	Verbal	Chairman
2.2	Chief Executive's Report	Receive and discuss	Verbal	Chief Executive
2.3	Sustainability and Transformation Partnership	Note	Verbal	Chief Executive
3. Quality				
3.1	Patient Story	Receive and Discuss	Verbal	Director of Patient Care and Chief Nurse
3.2	Nursing staffing update	Receive and Discuss	Pages 17-24	Director of Patient Care and Chief Nurse
3.3	Mortality update report	Receive and Discuss	Pages 25-32	Medical Director
4. Strategy				
4.1	Patient Experience Strategy update	Approve	Pages 33-44	Director of Corporate Affairs
5. Performance and Finance				
5.1	Performance report Month 6	Note	Pages 45-58	Deputy Chief Executive
5.2	Finance update report Month 6	Receive and Discuss	Pages 59-66	Director of Finance
5.3	Workforce update report Month 6	Receive and Discuss	Pages 67-70	Director of Workforce
6. Governance				
6.1	UK Corporate Governance Code 2018	Note	Pages 71-74	Director of Corporate Affairs
7. Assurance and Statutory Items				
7.1	Board Assurance	Receive and	Pages 75-84	Director of

Item No.	Title	Purpose	Type and Ref.	Lead
	Framework	Discuss		Corporate Affairs
7.2	Updates to Terms of Reference of the Board and its Committees	Approve	Pages 85-124	Director of Corporate Affairs
7.3	Board Register of Interests	Note	Pages 125-130	Director of Corporate Affairs
7.4	Use of Trust Seal	Note	Pages 131-132	Director of Corporate Affairs/Deputy Chief Executive
7.5	Management Board upwards report	Note	Pages 133-136	Chief Executive
7.6	(Summary Report) Audit Committee – 29 October 2018	Note	Pages 137-140	Chair of Committee
7.7	(Summary Report) Finance and Investment Committee – 3 September and 1 October 2018	Note	Pages 141-142	Chair of Committee
7.8	(Summary Report) Quality and Clinical Risk Committee – 29 October 2018	Note	Page 143-144	Chair of Committee
8. Administration and closing				
8.1	Questions from Members of the Public	Receive and Respond	Verbal	Chairman
8.2	Motion to Close the Meeting	Receive	Verbal	Chairman
8.3	Resolution to Exclude the Press and Public	Approve	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."*	Chairman

BOARD OF DIRECTORS MEETING

Minutes of the Board of Directors meeting held in PUBLIC on Friday 7 September 2018 in Room 6, Postgraduate Centre, Milton Keynes University Hospital

Present:

Simon Lloyd	Chairman
John Blakesley	Deputy Chief Executive
Andrew Blakeman	Non-executive Director (Chair of Quality and Clinical Risk Committee)
John Clapham	Non-executive Director (University of Buckingham representative)
Parmjit Dhanda	Non-executive Director
Robert Green	Non-executive Director (Chair of Audit Committee)
Caroline Hutton	Director of Clinical Services
Mike Keech	Director of Finance
Lisa Knight	Director of Patient Care and Chief Nurse
Tony Nolan	Non-executive Director (Chair of Workforce and Development Assurance Committee)
Danielle Petch	Director of Workforce
Ian Reckless	Medical Director
Heidi Travis	Non-executive Director (Chair of Finance and Investment Committee)

In Attendance:

Kate Jarman	Director of Corporate Affairs
Jamie Stamp	Therapy Services Manager (items 1.1 to 3.1)
Ade Kadiri	Company Secretary

2018/09/01	**Welcome**
1.1	The Chairman welcomed all present to the meeting.
2018/09/02	**Apologies**
2.1	Apologies for this meeting were received from Helen Smart and Joe Harrison.
2018/09/03	**Declarations of interest**
3.1	No new interests had been declared and no interests were declared in relation to the open items on the agenda.
2018/09/04	**Minutes of the meeting held on 6 July 2018**

4.1	The minutes of the public Board meeting held on 6 July 2018 were accepted as an accurate record of that meeting, with the exception that the account of the Trust's position with regard to Provider Sustainability Funding is to be clarified.
2018/07/05	**Matters Arising/ Action Log**
5.1	There were no matters arising in addition to those included on the agenda.
5.2	The action log was reviewed in turn: <u>356 Performance Report Month 12</u> Action already presented at the July meeting. Closed. <u>357 Approach to safety checklists within the Trust</u> The Medical Director reported that Dr Aidan Fowler, the National Director of Patient Safety at NHS Improvement had visited the Trust the previous day. He had spent 2 hours in the hospital and had had a positive conversation on patient safety with the Chief Executive, Medical Director, Chief Nurse and Director of Corporate Affairs. He had also made the point that NHS Improvement will take control of issues around mortality and the clinical examiner role. Closed. <u>358 Outpatient Transformation Programme Board</u> On agenda. Closed.
2018/09/06	**Draft Minutes of the Council of Governors' Meeting held on 17 July 2018**
6.1	The draft minutes of the Council of Governors' meeting held on 17 July 2018 were received and noted. The point was made that the cyber security update had been well received and it was recommended that it be shared more widely.
2017/07/07	**Chairman's Report**
7.1	The Chairman was pleased to note that construction work had begun on the Cancer Centre.
7.2	He made mention of a dinner that he had attended at which Baroness Dido Harding, Chair of NHS Improvement had also been present. Baroness Harding had highlighted the challenges facing the entire health system, and there had been a useful debate about the impact of the closer working relationship between NHSI and NHSE on this. She referred to the ongoing focus across the service on talent management, workforce and culture, and stressed the need to develop executives in order to build a cohort of senior managers who are able to speak authoritatively within and to organisations.
7.3	The Chairman had also presented at the NHSI regional chairs meeting on the digital work that is being done at this Trust. He stated that there had been much interest in Zesty. He had also spoken to colleagues about the implementation of eCare, and was assured that MKUH is in a good place in comparison to others.
7.4	The Chairman also made mention of his attendance at a conference on corporate

	governance, one of the key messages emerging from which was that there is as yet no discernible governance model for STPs.
7.5	The Annual Members' Meeting will take place on 12 September in the new Education Centre. 60 members have already signed up to attend.
7.6	Finally, the Chairman thanked staff for their hard work over what was a challenging summer period. The hospital's performance had been fantastic. **Resolved**: The Board **noted** the Chairman's report.
2018/09/08	**Chief Executive's Report**
8.1	The Deputy Chief Executive announced that next week is Organ Donation week.
8.2	The Trust has been shortlisted for an HSJ award in relation to the Event in the Tent. Two members of staff, Karen Rice and Vanessa Holmes, have been nominated in the Women Leaders Awards. The Deputy Chief Executive also reminded the Board that the Trust's staff awards ceremony is coming up – there have been 530 nominations, and these will be shortlisted. This is good news. The Chairman indicated that he would unfortunately not be able to attend the event, which is to be held at Stadium MK, but he confirmed that all non-executive directors are welcome to attend.
8.3	Bob Green enquired about an announcement in the media regarding an additional £200m of funding that is to be made available for "top digital trusts". The Deputy Chief Executive was unclear about what this announcement meant, but he confirmed that £400m is being distributed via STPs for IT developments. BLMK STP has been awarded £6m of this and it is possible that this will be used for the development of shared records. The Trust is already a fast follower on the Global Digital Exemplar initiative, in relation to which it is in receipt of £5m of funding. **Resolved**: The Board **noted** the Chief Executive's Report.
2018/09/09	**Sustainability and Transformation Partnership**
9.1	The Deputy Chief Executive informed the Board that Mark England, the managing director of the BLMK STP, will be leaving to take up a role in NHS England. Emma Goddard will take on the managing director role on a temporary basis as the STP decided on its next step.
9.2	The Chairman reminded the Board that Patricia Davies has been appointed as accountable officer for the three CCGs within BLMK, and she will take up post in November. She will be meeting with Joe Harrison in the next few weeks. A joint Finance Director appointment has also been made, and a consultation process is underway with regard to the posts within the team below this. It is expected that one executive will be responsible for the MK patch.
9.3	The question was raised, in the context of these developments, as to how the CCG would be able to maintain its focus on the MK Place agenda. There is ongoing

	discussion, both within BLMK and elsewhere about what is deliverable. It is likely that some significant changes will take place as STPs are not seen as living up to their early promise. **Resolved**: The Board **noted** the Sustainability and Transformation Partnership update.
2018/09/10	**Patient's Story**
10.1	The Therapy Services Manager attended to introduce the patient's story in the form of a video clip in which the daughter of a patient with dementia described her interactions with the hospital.
10.2	The patient's daughter had lodged a complaint about the care that her mother had received on her first admission to hospital. She was not satisfied with the Trust's response to those concerns, and had agreed to share her experiences as part of a learning exercise for the team.
10.3	In the clip, the daughter explained that five years previously, her mother had become unable to recognise members of the family, and she subsequently lost the ability to communicate verbally. She can now only feed herself with the assistance of visual prompts. The daughter was therefore surprise when she was informed by the hospital that her mother was fine and ready to be discharged home. Concerns raised by the daughter in relation to the first admission included the use of jargon by staff (the word "mobilising" has a different meaning to ordinary people from clinical staff), the fact that she never spoke to the same member of staff about her mother's condition, the failure by members of the team to call her mother by her name, and a lack of communication between the physio department and her mother's care home.
10.4	By contrast, the daughter remarked that the subsequent visit to A&E had been brilliant – the family had had someone with them at all times, and they were kept constantly updated on what was happening. She had had a positive conversation with the occupational therapist who had then communicated in a timely manner with mother's care home. The daughter also remarked that her mother was always in her own clothes. She confirmed that major improvements had been made since the previous interactions.
10.5	The Therapy Services Manager indicated that a longer video providing more detail on the two interactions and exploring further outcomes is to be shared with the wider team. He noted that the first interaction had taken place in November when the hospital was under pressure, but acknowledged that this should not excuse the provision of a poor patient experience. It was also accepted that there had not been sufficient communication about the patient's fluctuating abilities.
10.6	In terms of next steps, it was confirmed that the patient's daughter is content for the clip to be used for training purposes. There is a need for the Trust to continue to reinforce good practice. A documentation audit is underway – this is with a view to understanding whether clinical records are being suitably personalised. The Trust is also taking a multidisciplinary approach to dementia training. All staff currently receive level 1 of this training and there is a question whether more staff need level 2. The Therapy Services Manager confirmed that this had been a positive

	experience for him, and he noted that the staff connected well with the patients' daughter ads part of the process, even though she was quite challenging to them.
10.7	Heidi Travis noted that a lot of the daughter's concerns related to communications, and she questioned whether this had been exacerbated by the fact that the patient has dementia. The Therapy Services Manager accepted that communication can be challenging in this context, and stated that this emphasises the need for such a patient to have a single point of contact. The Director of Clinical Services enquired about the impact that the pathway had on the discharge process, and the therapy Services Manager conformed that the Dementia Steering Group will be examine the pathway from start to finish, and that any recommendations will be presented to the Nursing and Midwifery Board.
10.8	Parmjit Dhanda enquired whether there will be lasting lessons on the use of jargon. The Therapy Services Manager agreed that embedding a plain language culture is a challenge, but this footage brings the importance of this issue home to staff. There is a need to hold workshops to do with documentation. In response to a question from Kate Jarman as to whether the daughter felt that she had not been heard in the response to her initial complaint, it was noted that she had not been offered the opportunity to meet with staff, even though she was unhappy about the letter. Heidi Travis commended the Therapy Services Manager and the team for what was a brave and significant undertaking. Andrew Blakeman noted that lessons from this event would form part of the Quality and Clinical Risk Committee's consideration of the Patient Experience Strategy at their next meeting. **Resolved**: The Board resolved to **note** the Patient's Story.
2018/09/11	**Nursing staffing report**
11.1	The Director of Patient Care and Chief Nurse presented this report. she made reference to the new guidance from NHSI on the calculation of care hours per patients day (CHPPD), which has had the effect of changing the Trust's overall CHPPD meaning that ward coordinators and allied health professionals (AHPs) are now included. Wards 7 and 14 would have AHPs reported, and ward 7 in particular would be complicated as the therapists are not currently on the rota. The Chief Nurse is a member of the CHPPD regional advisory group, and consideration will be given to warranted and unwarranted variations across different specialities. The Chief Nurse also made the point that the Trust's orthopaedic wards benchmark unfavourably against regional multi-trauma centres.
11.2	With regard to vacancies, it was noted that the Trust's headline figure of 10.3% for qualified nurses looks positive compared to neighbouring trusts, but there is no room for complacency, as this is the time of the year when staffing levels are at their best. Parmjit Dhanda enquired if it would have been better for AHPs to have been measured separately. In response, the Chief Nurse stated that it is likely that there will be measurements for AHPs in the future, but in the meantime, CHPPD is a new measurement that needs time to bed in. However, the data is already being clouded. The Medical Director made reference to the 76% fill rate for registered nurses on ward 5 and asked if this is a cause for concern. The Chief Nurse indicated that there are a number of empty beds on this ward.

11.3	In relation to the Neonatal Unit (NNU), the Chief Nurse stated that each year, the Trust runs a safe patient care tool which considers the level of dependency. This has been used for the first time in paediatrics – a lot of high dependency care is provided in paediatrics, but it is not always counted as such. Heidi Travis asked whether the establishment is tracking the increase in the number of patients, the Chief Nurse explained that the Trust is already considering the potential impact of winter as well as the cancer centre and pathway unit when they come online.
11.4	In response to a question from the Chairman about student numbers, the Chief Nurse stated that the Northampton intake is filling up. The March intake has been problematic, but the expectation is that the nursing associate initiative will make up for any shortfall. **Resolved**: The Board resolved to **note** the nursing staffing report.
2018/09/12	**Mortality update report**
12.1	The Medical Director presented this routine report setting out the Trust's current position on mortality. He made reference to the latest HSMR figure, which is within the "lower than expected" range. Two significant negative outliers, 'other perinatal conditions' and 'other fractures', had been identified, and both are being investigated. With regard to perinatal mortality, MBRACE-UK data, which is more granular in its assessment, has found the Trust to have a lower than average perinatal rate. The point was made that at this Trust, a higher number of babies are coded as being well, thereby reducing the expected number of deaths for the number of deliveries. 13 deaths in the 'other fractures' diagnostic group are being looked at but it is not expected that this will raise any issues.
12.2	The outcome of the qualitative reviews of deaths will be published in November. In response to a question from John Clapham, the Medical Director indicated that coding is now to be more prospective. **Resolved**: The Board resolved to **note** the mortality update report.
2018/09/13	**Outpatients Transformation Programme**
13.1	The Director of Corporate Affairs provided this overview of the Outpatients Transformation Programme, with a view to highlighting the breadth of the work that is being carried out. One of the key aims of the programme is to significantly reduce the organisation's reliance on paper based processes, particularly in relation to patient interactions. Bob Green raised a question as to what would happen if a patient does not respond to electronic communications. In response, the Director of Corporate Affairs stated that this would depend on the speciality, and how the original appointment was booked. Efforts are being made to standardise practices, but it was stressed that in any event, all patients would be picked up.
13.2	Tony Nolan noted that a lack of consistency and poor queuing systems are issues at other trusts, and asked if they are being addressed here. The Director of Corporate Affairs stated that in some cases, the existing booking rules are to blame. Many of the current processes are quite labour intensive, but the expectation is that MyCare

	will address some of these issues. It was noted that partial booking has also contributed to the current state of affairs. There is much to explore, but the new system has the potential to bring about significant improvements. Andrew Blakeman acknowledged the complexity of the process, and questioned whether there is to be a set of key performance indicators to help measure success. The Director of Corporate Affairs stated that these are being developed, with some (such as outcome forms) being relatively easy to audit, while others like booking models are just being finalised. The Director of Clinical Services added that managing the various interdependencies can be problematic. The Chief Nurse made the point that the PALS team are in possession of a large quantity of data which could provide a good temperature check.
13.3	The Chairman enquired whether implementation of the system is going as quickly as it could. The Director of Corporate Affairs stated that changes are now just being noticed, and the administrative teams are excited about the possibilities, although some concerns remain. There is a rapid roll out plan, and there will be an evaluation afterwards with staff and patients. The vast majority of patients who have used the system have reacted positively to it. In response to a question from Tony Nolan as to when it will all be up and running, the Director of Corporate Affairs indicated that staff moves are currently taking place. There is some ongoing estates work, and it is expected that all changes will be completed by the end of November. The step change in the way that the staff work will be in place by the end of this calendar year. **Resolved**: The Board resolved to **note** the approach to safety checklists
2018/09/14	**Performance Report Month 4**
14.1	The Deputy Chief Executive introduced this routine report, noting that some of the most up to date data is not available. He informed the Board that the figure for falls with harm (per 1000 bed days) is 0.06, and that the FFT Recommend Rate (patients) is 95%. Maternity remains an area of concern with reporting issues affected by the quality of the initial data received.
14.2	An issue had been raised about the measurement of “minors” in A&E. These are now counted differently than in the past and relate to patients whose acuity is regarded as low, and they are mostly treated in the urgent care centre. If the relevant dataset is not completed, the case in question is automatically regarded as a minor. The data needs to be recorded in real time as minors tend to be fast moving. There is still a problem with keeping up to date in this area. As far as the hospital is concerned most of such patients were previously treated in the Acorn Centre, but now they could be anywhere. With regard to the care of these patients, the point was made that the number of quoted breaches among minors is not regarded as correct. It was noted that part of the reason for the reduction in A&E income is that the teams are behind on coding. It was confirmed that patients treated at the urgent care centre count as part of the Trust’s A&E figures but as a type 3 department, they do not complete the dataset. Andrew Blakeman questioned whether, in light of the fact that there is currently no metric for minors, one ought to be devised. It was agreed that this would be sensible and that it should be referred to the Finance and Investment Committee.

14.3	Parmjit Dhanda questioned whether there is a financial consequence to this issue. The point was made that the case-mix changes each month, and there has been a large increase in the number of patients with no investigations, probably as a result of coding issues. It is unclear exactly what difference this would have made in income terms, but it is thought that the impact on the Trust is around £20k.
14.4	Births are a different issue. Although coding is done at birth, the Trust does not have full confidence in the reports emerging from Cerner. The Deputy Chief Executive made the point that significant progress has been made this week to ensure effective data flows through the eCare system. There are some other issues around the maternity datasets and work is ongoing with Cerner in this regard.
14.5	In relation to the upper and lower control limits, Andrew Blakeman questioned why they are not all set at SD3. The Deputy Chief Executive agreed to bring back an answer to this. **Action: Deputy Chief Executive**
14.6	Bob Green noted that the number of delayed transfers is down, but yet ambulance handovers have been a problem. The Deputy Chief Executive pointed out that the ambulance service records handover times differently to the Trust. This has been recognised and is being addressed. The Director of Clinical Services added that at the time of eCare implementation, validation of handovers was carried out, but it has been difficult to maintain this process more recently as a result of the high numbers involved. On delayed transfers, there has been a lot of changes, with board rounds, for example. Having social workers on the ground has meant that there has been effective early planning. The number of delays has been held at a reasonable level for some time, and more initiatives are now being worked on. At least a third of the current delays are from outside the Milton Keynes area (12 of the 30 are from Northamptonshire), and therefore less under the control of local agencies. The teams are now better integrated which is a big step forward, but the Council has expressed some concern about the cost to them of this way of working.
14.7	Tony Nolan raised a question about the cancer data and the apparent inconsistency in performance recorded against the 2 week and 62 day targets. In response, the point was made that measurements for both targets start on the same day, and that the Trust devotes much effort to dealing with all of the 2 week referrals within that time. The 62 day target has been missed for this quarter, but there has been a significant improvement in performance recently, although there are specific issues in urology.
14.8	In response to concerns about A&E performance, the Director of Clinical Services stated that the introduction of real time reporting has been challenging. Work is being done with the teams on shift leadership, and there is an action plan for improvement. The time that it takes to treat patients has lengthened and the experience of A&E patients has genuinely deteriorated. Staff are accustomed to writing on paper, but the system now depends on everyone recording everything in real time. Staff are therefore treating patients first and going back to completing the documentation afterwards, thereby increasing the total amount of time that they are on the system. Once there are up to 45 patients in the system, there is a domino effect which then leads to breaches occurring. The point was also made that regular A&E staff are now getting better, but more work needs to be done with some of the

	speciality doctors who do not work regularly in the department. Weekly meetings are being held with the department addressing issues within the system and workflow. Cerner provided daily support in A&E over a 4 week period which included tips on how to do things better. Support was also provided internally. The point was made that other organisations have taken up to 5 years to properly get accustomed to the system.
14.9	Heidi Travis enquired about the potential impact of winter pressures. The Director of Clinical Services stated that she was confident about the plans that are being put in place to support services, although she acknowledged that the winter period will once again be tough. A plan for the dealing with the anticipated pressures is to be brought to the October meeting. **Resolved**: The Board resolved to note the Month 4 Performance Report.
2018/09/15	**Finance Report Month 4**
15.1	The Director of Finance presented this regular report, noting the complexity of the position. The Trust is on track, both in month and YTD, with its control total, excluding Provider Sustainability Funding (PSF). There are 3 elements to PSF – the Trust is on track with regard to the financial and performance elements, but there is an adverse variance of £225k on the ICS financial element because the BLMK STP did not meet its overall control total in Q1 – the adverse variance for the STP as a whole is £4.5m. The Director of Finance advised that is would be prudent for the Trust to look again at its forecast position. He made the point that there is also a risk to the achievement of the performance element of PSF as a result of the pressures in A&E – this amounts to a £616k cash risk.
15.2	With regard to donated assets, which are not part of the control total, the Director of Finance expects that this will catch up once the grant agreement with Milton Keynes Council has been signed.
15.3	Income is performing well overall, with a £909k positive variance in month, but the picture underneath this headline position is mixed. Maternity income is a risk, with bookings below planned levels. Non-elective income is also below plan, but this is offset by good elective performance which is significantly above planned levels.
15.4	On the costs side, pay is overspent, this is potentially a cause for concern, although some of this will contribute to clinical income, for example the added investment in ward 23. CIP delivery is underperforming - £8.9m worth of schemes have been identified against a target of £10.1m, and £6.5m of these schemes have been validated. There is a continued push for the full target to be met.
15.5	In response to a question from Bob Green, the Director of Finance confirmed that the Trust's current cash position does not give cause for concern. In terms of the identified risks that require the most focus, he stated that the focus should be on the transformation programme – although the Trust is in a better place than at the same time last year, the full amount of savings have not been identified. It would be important that by February, the |trust would be in a position to hit the ground running with respect to the 2019/20 programme.
15.6	With regard to agency staffing, it is expected that the Trust will stay within the

	ceiling. There are some pressures from medical staffing as not all vacancies have been filled, but there is an expectation that the use of agency doctors would be avoided. The Medical Director explained that junior doctor vacancy rates are sensitive to the number of doctors that the deanery is able to provide. The point was made that notwithstanding that the Trust will not exceed its ceiling, agency spend remains high.
15.7	In response to a question from Parmjit Dhanda, the Director of Finance confirmed that although operational costs are almost £1m above plan, income is expected to grow commensurately. The point was also made in relation to high cost drugs that this is a pass through cost which has no impact on the Trust's control total.
15.8	The Director of Finance confirmed that month 4 is unusual in terms of the extent of the overspend against budget. **Resolved**: The Board **noted** the month 4 Finance Report.
2018/09/16	**Workforce Report month4**
16.1	The Director of Workforce presented this report and highlighted the following: • There has been a positive increase in headcount • Agency spend has reduced slightly • The sickness absence policy has been relaunched and training sessions to introduce the changes have been put on. It is hoped that this will help to reduce absences. Long term sickness is defined as two weeks and over • Steps are being taken to help further reduce turnover, including sessions with new joiners • Statutory and mandatory training stands at 90% • Appraisal rates have increased again this month – it is expected that this trend will continue but slowly. It was noted that Agenda for Change increments will now be linked to appraisals. The documentation will be updated to reflect this.
16.2	Parmjit Dhanda noted that industrial relations data is not routinely presented to the Board, but it was confirmed that this information is received at the Workforce and Development Assurance Committee and this has given no cause for concern. **Resolved:** The Board **noted** the Month 4 Workforce Report.
2018/09/17	**Board Assurance Framework**
17.1	The Director of Corporate Affairs presented the latest iteration of the BAF. She noted that there are a number of static scores, and informed the Board that they will be asked to review their risk appetite at their meeting in October. The Director of Corporate Affairs made mention of the following BAF risks: • 5-4 (failure to maximise the benefits of eCare) the description this risk is to be updated to reflect an emerging awareness around ongoing clinical risks. It is also likely that risk 5-3 will be closed down and the benefits realisation

	piece will be brought out. • 5-5 (failure to maximise the benefits of the Trust's digital strategy) this is a new addition to the BAF and will help the Trust determine what sort of proactive risk it is willing to take in this area • 9-1 (insufficient capacity in the Neonatal Unit to accommodate babies requiring special care) – capacity in the NNU has been a longstanding issue for the organisation. It was acknowledged that this risk should have been on the BAF earlier.
17.2	Andrew Blakeman questioned why 7-5 which is a financial risk is the highest rated on the BAF. He was not convinced that this should be rated higher than a patient related risk. The Director of Finance made the point that over £1m is at risk if the Trust is unable to access Provider Sustainability Funding. **Resolved**: The Board **noted** the contents of the Board Assurance Framework.
2018/09/18	**Use of the Trust Seal**
22.1	The Director of Corporate Affairs confirmed that the Trust Seal had been used in relation to the settlement of the P22 major works stage 3 contract between the Trust and Galliford Try in respect of the construction of the Cancer Centre. It was clarified that a stage 4 contract is still to be executed. **Resolved**: The Board **noted** the use of the Trust Seal.
2018/09/19	**Management Board upwards report**
	The Board **noted** the Chief Executive's upwards report from the Management Board meeting of 1 August 2018.
2018/09/20	**Board Committee summary reports**
20.1	The Board noted the contents of the summary reports of recent Board Committee meetings as follows: • Finance and Investment Committee meetings held on 25 June and 6 August 2018 • Workforce and Development Assurance Committee meeting held on 6 August 2018 • Quality and Clinical Risk Committee meeting held on 21 June 2018. It was confirmed that there is in fact no management issue on ward 23
2018/09/21	**Questions from members of the public**
21.1	There were no questions from members of the public
2018/09/22	**Any other business**
22.1	There was no other business.

	All					**Action log – All items**				
	Public/ Private	**Action item**	**Mtg date**	**Agenda item**		**Action**	**Owner**	**Due date**	**Status**	**Comments/Update**
Board of Directors	Public	356	4 May 2018	14.7	Performance Report Month 12	The Infection Control team would be asked to attend the next meeting of the Quality and Clinical Risk Committee and then report back to the Board	Lisa Knight	7 Sept 2018	Closed	Action already covered at the July meeting
Board of Directors	Public	357	6 July 2018	13.3	Approach to safety checklists within the Trust	The outcomes from the meeting on Never Events to be held in August with the national safety lead are to be reported to the Quality and Clinical Risk Committee and to the Board	Ian Reckless	5 Nov 2018	Closed	The National Director of Patient Safety at NHS Improvement has visited the Trust, during which time he held positive conversations with members of the executive team. NHSI is to take control of issues around mortality and the clinical examiner role
Board of Directors	Public	358	6 July 2018	15.3	Outpatient Transformation Programme Board	A further report on this programme is to be presented at the next Board meeting	Kate Jarman	7 Sept 2018	Closed	On agenda
Board of Directors	Public	359	7 Sept 2018	14.5	Performance Report Month 4	Clarification to be provided as to why the upper and lower control limits within the report have not all been set at SD3	John Blakesley	2 Nov 2018	Open	

Meeting title	Board oOf Directors	**Date:** 9 November 2018
Report title:	Nursing Staffing Report	**Agenda item: 3.2**
Lead director **Report author Sponsor(s)**	**Name:** Lisa Knight **Name:** Matthew Sandham	**Title:** Director Of Patient Care/Chief Nurse **Title:** Associate Chief Nurse
FoI status:		

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

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

Report history	To every Public Board
Next steps	
Appendices	Appendices A & B

Board of Directors Report on Nursing and Midwifery staffing levels
Amalgamated report for August and September 2018

1. Purpose

To provide Board with:-

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

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

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

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

$$\text{CHPPD} = \frac{\text{hours of care delivered by Nurses and HCSW}}{\text{Numbers of patients on the Ward at midnight}}$$

CHPPD	Total Patient Numbers	Registered Midwives/Nurses	Care Staff	Overall
August	13932	5.0	3.5	8.5
September	14180	4.9	3.5	8.5

Hospital Monthly Average Fill Rates for February 2017 and March 2017

Month	RN/RM Day % Fill Rate	HCA/MCA Day % Fill Rate	RN/RM Night % Fill Rate	HCA/MCA Night % Fill Rate
August	82.3%	110.1%	97.3%	138.3%
September	84.9%	115.6%	98.7%	146.1%

A Ward by Ward breakdown of fill rates for the two months has been included in the Appendices A and B.

The CHPPD hours have increased due to new guidance in regards the collection of hours CHPPD now includes the addition of Ward Sister/Charge nurses hours in the care time delivered, where they were previously excluded.

3. Areas with notable fill rates

Bed occupancy was down on previous reports, with a number of wards having empty beds at the midnight bed count. This raises the CHPPD. Ward 2 has had a bay of 6 beds closed for refurbishment.

4. Safer Care Nursing Tool

The Safer Nursing Care Tool is an evidence based tool that enables nurses to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that nursing establishments reflect patient needs in acuity/dependency terms.

The Safer Care Nursing Tool (SCNT) is one method that can be used to assist Chief Nurses to determine optimal nurse staffing levels .The SCNT was used in all wards including ward 24 and ward 5 for the first time in September 2018. The SCNT has developed a new tool for paediatrics and has been utilised on ward 5 and we are planning to re-run the tool in February to give us an understanding of the acuity in winter. The Audit was carried out over a 20 day period. The Trust has carried out this audit 4 times and this forms part of the annual staffing review and the findings are laid out in the chart below.

Ward	Establishment	2015 SCNT	2016 SCNT	2017 SCNT	2018 SCNT	Difference	Comments
Ward 1	40.40wte	38.7wte	n/a	35.657wte	30.7wte	+9.7wte	SCNT tool is not designed for assessment units, and does not reflect the assessment and turnover on the unit.
Ward 2	33.70wte	38.18wte	41.255	38.172wte	29.6wte	+4.1wte	1 Bay Closed for refurbishment
Ward 3	37.84wte	40.12wte	41.59	38.9985wte	36wte	+1.84wte	
Ward 5	39wte				44.3wte	-5.3wte	Requires rerun to achieve better data
Ward 7	44.2wte	40.99wte	40.536	35.6875wte	37.6wte	+6.6wte	Includes supernumerary hyper – acute stroke bleep holder
Ward 8	33.70wte	31.92wte	39.035	25.269wte	26wte	+7.7wte	Professional judgement and acuity tool are not aligned – planning to have peer review
Ward 14	32.00wte	27.16wte	29.03	33.9435wte	33wte	-1wte	
Ward 15	39.21wte	36.12wte	38.7435	31.6275wte	39wte	+0.21wte	
Ward 16	37.08wte	36.7wte	40.629	33.8955wte	33.8wte	+3.28wte	
Ward 17	36.53wte	n/a	27.964	29.479wte	30.5wte	+6.03wte	Probable opening of additional beds within establishment
Ward 18	43.36wte	n/a	n/a	35.421wte	45wte	-1.74wte	
Ward 19	36.70wte	26.79wte	n/a	S/R	33,5wte	+3.2wte	
Ward 20	37.93wte	32.74wte	31.578	31.374wte	33.1wte	+4,83wte	
Ward 21	32wte	32.34wte	39.2325	S/R	30.3wte	+1.7wte	
Ward 22	33.8wte	28.92wte	25.0325	27.9705wte	25wte	+5.29	Meeting national cancer nursing standards
Ward 23	58.17wte	30.8wte	40.379	S/R	50.4wte	+7.77wte	Complex ward due to size/ geography and complexity
Ward 24	22.29wte	n/a	n/a	n/a	22.4wte	-0.11	

S/R- Surgical Reconfiguration
n/a Not Available
wte – Whole Time equivalent.

5. Recruitment and Vacancies

Qualified Staff Vacancies

Division	wte vacancies now	% vacancy now	Post recruited to	Residual wte vacancy	Residual % vacancy
Women's & Children	32wte	12%	12wte	20wte	8%
Medicine	72.8wte	16%	25wte	47.8wte	10%
Surgery	44wte	16%	17.5wte	26.5wte	9.5%

Total vacancy rate for the trust for qualified nurses' once new staff in post approx. **9.7%**

HealthCare Assistant Vacancies

Division	wte vacancies now	% vacancy now	Post recruited to	Residual wte vacancy	Residual % vacancy
Women's & Children	4.5wte	3.75%	4wte	0.5wte	2%
Medicine	23wte	11%	16wte	7wte	3%
Surgery	18wte	15%	8wte	10wte	8%

Total Trust vacancy rate for HCA once new staff in post approx.**5%**

Please note that these figures are dynamic and so are changing on a daily basis – and recruited to posts will still be subject to drop outs. Within these figures the areas of most concern remain – operating theatres, ward 3, 15 and 16.

6. Student Recruitment

Our main providers of students have stated that they have made target numbers for adult nursing, and paediatric students for September intake. Midwifery is of concern as the cohort has been split into two intakes. The September in take has achieved its numbers by taking two students who had taken a gap in training, returning this year. March intake is of concern as we currently are 4 students short, the Head of Midwifery has a planned meeting with the University to address this short fall and we will be carefully monitoring the situation.

7. Controlling Premium Cost

Agency nursing expenditure continues stabilise. The focus over the next 3 months is to reduce the number of agency Health Care Assistant's, and to continue work on maximising the productivity of our e roster system.

Fill rates for Nursing, Midwifery and Care Staff August 2018

Ward Name	Day		Night		Care Hours Per Patient Day (CHPPD)			
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
AMU	82.4%	119.2%	102.0%	128.9%	612	6.0	3.2	9.2
MAU 2	76.6%	103.6%	97.3%	165.9%	551	4.6	4.6	9.3
Phoenix Unit	79.9%	114.2%	98.9%	154.8%	620	3.6	4.6	8.3
Ward 15	89.1%	151.6%	98.5%	221.0%	813	3.8	4.5	8.3
Ward 16	78.4%	110.6%	100.8%	128.5%	833	3.5	2.9	6.4
Ward 17	81.2%	101.6%	99.2%	129.0%	724	4.4	2.5	6.9
Ward 18	81.7%	112.4%	100.0%	159.4%	804	3.3	4.6	7.9
Ward 19	75.4%	102.5%	96.8%	137.6%	821	3.0	4.0	7.0
Ward 20	76.6%	109.7%	101.5%	106.4%	745	3.9	2.8	6.7
Ward 21	80.7%	95.5%	100.1%	126.0%	615	4.3	2.8	7.1
Ward 22	85.3%	126.8%	98.9%	154.8%	599	4.2	3.7	7.9
Ward 23	83.7%	136.6%	102.4%	138.0%	969	4.0	4.6	8.6
Ward 24	161.5%	92.8%	94.6%	-	408	8.5	1.1	9.6
Ward 3	80.8%	107.2%	99.6%	142.7%	827	3.2	4.2	7.3
Ward 5	70.5%	107.4%	98.2%	93.5%	349	9.8	2.4	12.1
Ward 7	80.0%	93.5%	102.2%	134.4%	648	4.0	4.8	8.8
Ward 8	75.1%	109.2%	100.0%	146.6%	726	3.5	3.5	6.9
DOCC	48.1%	63.2%	87.6%	-	176	21.7	1.4	23.1
Labour Ward								
Ward 9	83.2%	93.6%	85.4%	96.8%	1059	2.7	0.7	3.4
Ward 10	99.2%	95.2%	88.2%	1500.0%	621	2.4	1.2	3.6
NNU	100.0%	102.1%	101.2%	116.5%	412	9.5	2.0	11.5

Fill rates for Nursing, Midwifery and Care Staff September 2018

Ward Name	Day		Night		Care Hours Per Patient Day (CHPPD)			
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
AMU	78.6%	112.1%	103.3%	126.5%	736	5.7	2.5	8.2
MAU 2	85.7%	108.8%	102.6%	140.7%	614	4.3	3.9	8.2
Phoenix Unit	84.2%	115.8%	97.8%	156.7%	715	3.1	4.0	7.1
Ward 15	80.0%	163.4%	98.4%	233.2%	833	3.3	4.5	7.8
Ward 16	78.1%	109.5%	96.5%	116.0%	858	3.3	2.6	5.9
Ward 17	85.1%	148.6%	100.0%	183.3%	713	4.8	3.5	8.3
Ward 18	85.3%	112.2%	100.1%	152.1%	811	3.2	4.3	7.6
Ward 19	77.7%	120.4%	109.2%	185.7%	849	3.1	4.7	7.9
Ward 20	78.4%	128.3%	102.2%	126.5%	761	3.8	3.2	6.9
Ward 21	80.4%	89.5%	98.9%	101.7%	683	3.7	2.2	5.8
Ward 22	89.2%	131.3%	99.1%	166.6%	623	4.2	3.6	7.9
Ward 23	85.9%	146.1%	101.7%	156.9%	1072	3.6	4.6	8.1
Ward 24	88.8%	99.0%	97.8%	-	470	4.9	1.2	6.1
Ward 3	90.5%	98.8%	101.0%	135.5%	831	3.3	3.7	7.1
Ward 5	78.3%	77.6%	109.7%	88.7%	524	7.0	1.6	8.5
Ward 7	86.9%	111.4%	102.2%	142.2%	682	4.0	5.0	9.0
Ward 8	81.3%	115.4%	103.3%	149.8%	730	3.6	3.5	7.1
DOCC	86.1%	97.5%	86.2%	-	187	26.5	2.2	28.7
Labour Ward								
Ward 9	81.1%	95.0%	88.9%	93.3%	734	3.8	1.0	4.7
Ward 10	90.0%	86.7%	91.7%	-	323	4.3	2.2	6.5
NNU	102.7%	97.9%	105.6%	100.4%	431	8.5	1.6	10.1

Meeting title	**Board of Directors**	**Date: 9 November 2018**
Report title:	**Mortality update report**	**Agenda item: 3.3**
Lead director **Report author** **Sponsor(s)**	**Dr Ian Reckless** **Dr James Bursell**	**Medical Director** **Associate Medical Director**
FoI status:	**Publicly disclosable**	

Report summary				
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** X	**Decision** ☐
Recommendation	To note			

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

Report history	This is a regular paper at Trust Board
Next steps	To note
Appendices	N/A

Executive Summary

This paper summarises the Trust's current position in relation to mortality based on the latest Dr Foster data available and as discussed through the Trust's mortality review group (MRG). In addition, it reports upon the qualitative review work undertaken within services to examine the care provided by the Trust to patients who have died (through the mortality and morbidity (M&M) meeting framework), including the assessment of 'avoidability'.

Definitions

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

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

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

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

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

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

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

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

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

HSMR

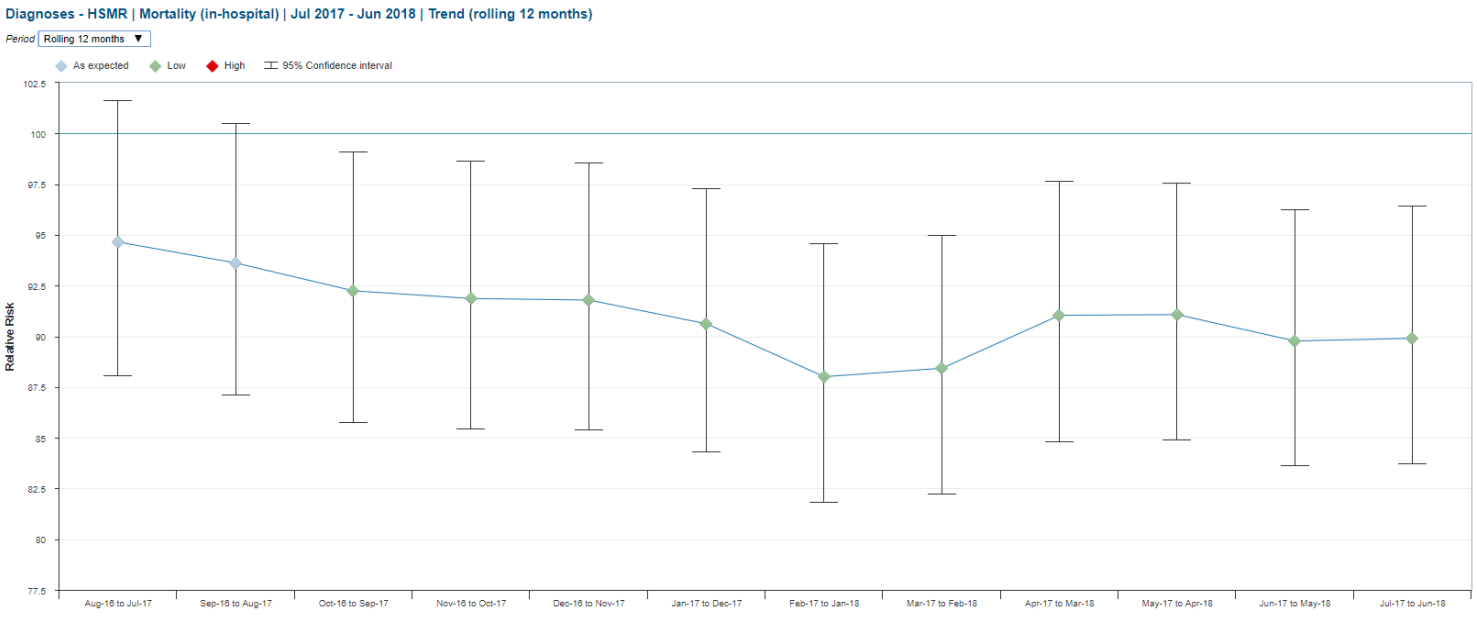
Data period: July 2017 – June 2018

Key Highlights:

- HSMR relative risk for 12 month period = **89.9** 'lower than expected' range
- Crude mortality rate within HSMR basket = **3.3%** (MKUH local acute peer group rate = 3.9%, national crude rate 3.9%)
- **1 significant outlier** was identified within the HSMR basket for this period – 'other perinatal conditions'.

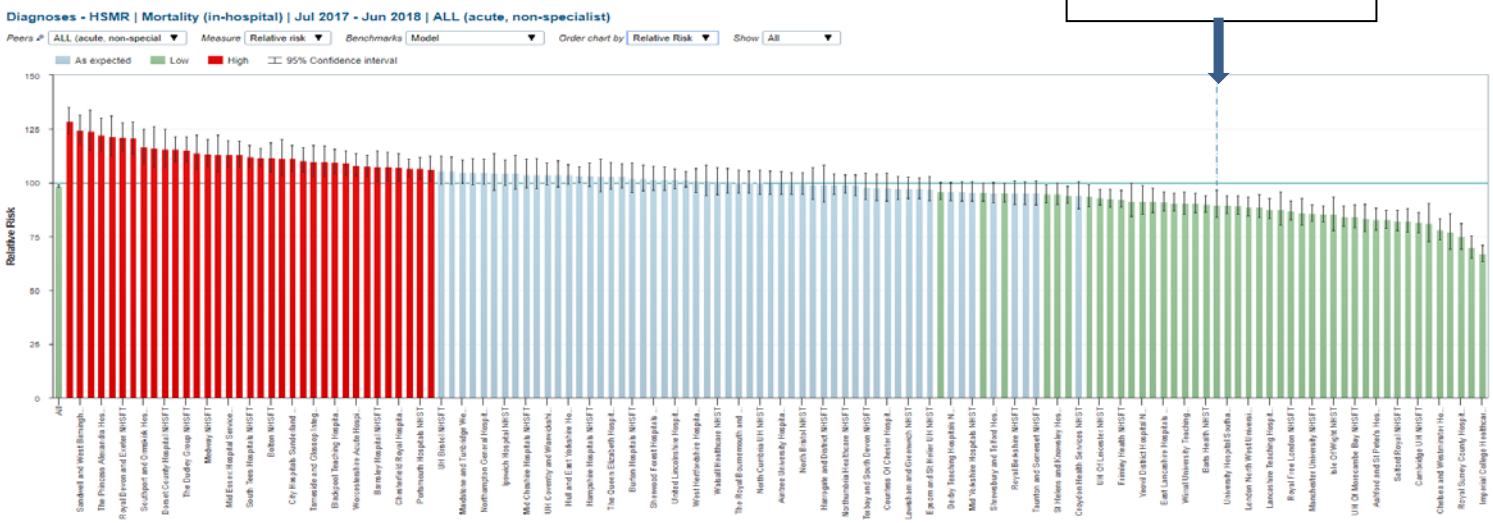
The Trust currently continues to rank 2nd (2nd lowest HSMR relative risk value) against its MKUH peer group and 19th lowest (best) against 136 national peers. The Trust is one of only 2 Trusts from 21 within the peer group with an HSMR which is statistically 'lower than expected'.

Trust level HSMR monthly performance Trend rolling 12 months (July 2017 – June 2018)



HSMR position vs. national acute peers: July 2017 – June 2018

HSMR = 89.9 'lower than expected'
(27th lowest out of 136 non specialist acute Trusts)



HSMR relative risk = 89.9 'lower than expected' (27th lowest out of 136 non-specialist acute). 1st lowest ranking indicates the trust with the lowest (best) HSMR relative risk.

SHMI

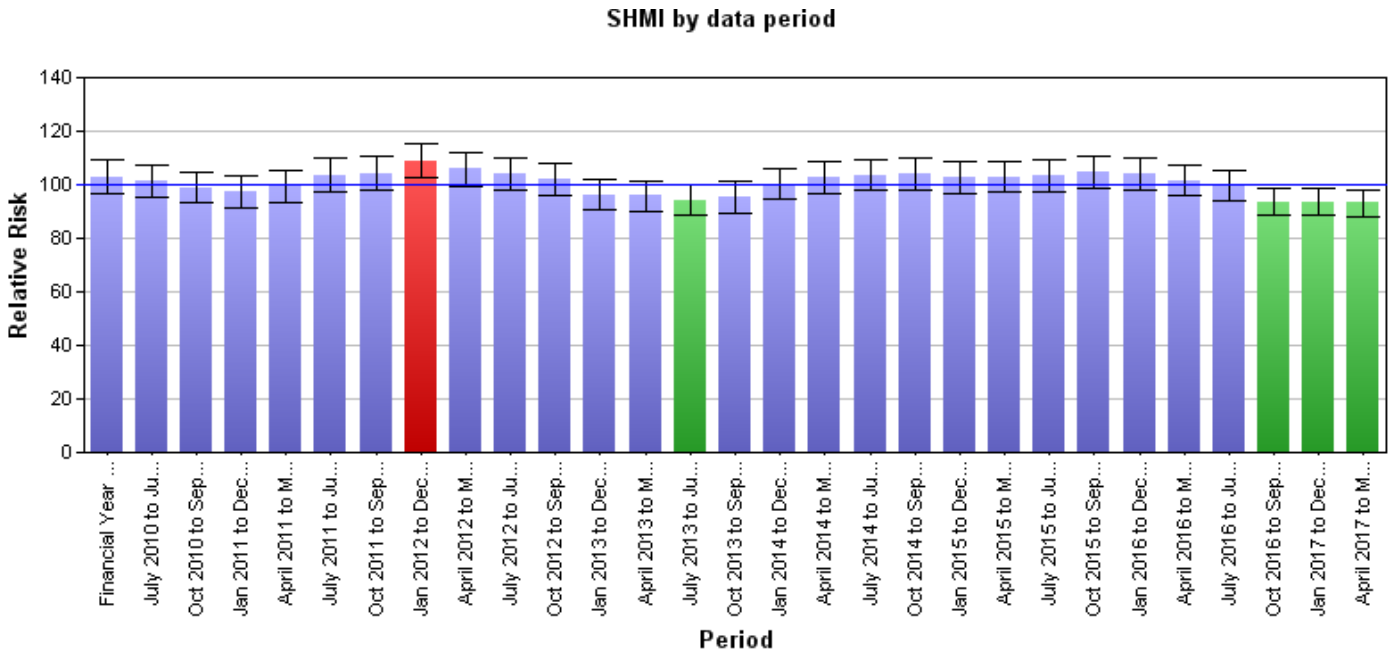
Data period: April 2017 – March 2017 (most up to date data available)

The Summary Hospital-level Mortality Indicator (SHMI), which includes out of hospital deaths occurring within 30 days of discharge, is measured by the Health and Social Care Information Centre (HSCIC). The SHMI relative risk is the ratio between the actual number of patients who die following treatment at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated. A SHMI score below 1.00 is better than average.

Key Highlights:

The latest SHMI published in March 2017 by HSCIC for the rolling 12 months to March 2018 = **0.93** '**as expected'** range. Previous rolling 12 months to September 2017 SHMI was also 0.935 (as expected).

The Trust is currently ranked 27th in SHMI performers among the 136 non-specialist acute trusts in England (ranking 1 = lowest or 'best' SHMI) on 12 month data to September 2017. The Trust previously ranked 90th in SHMI on 12 month data to September 2016, 66th on 12 month data to March 2017 and 53rd on 12 month data to June 2017.

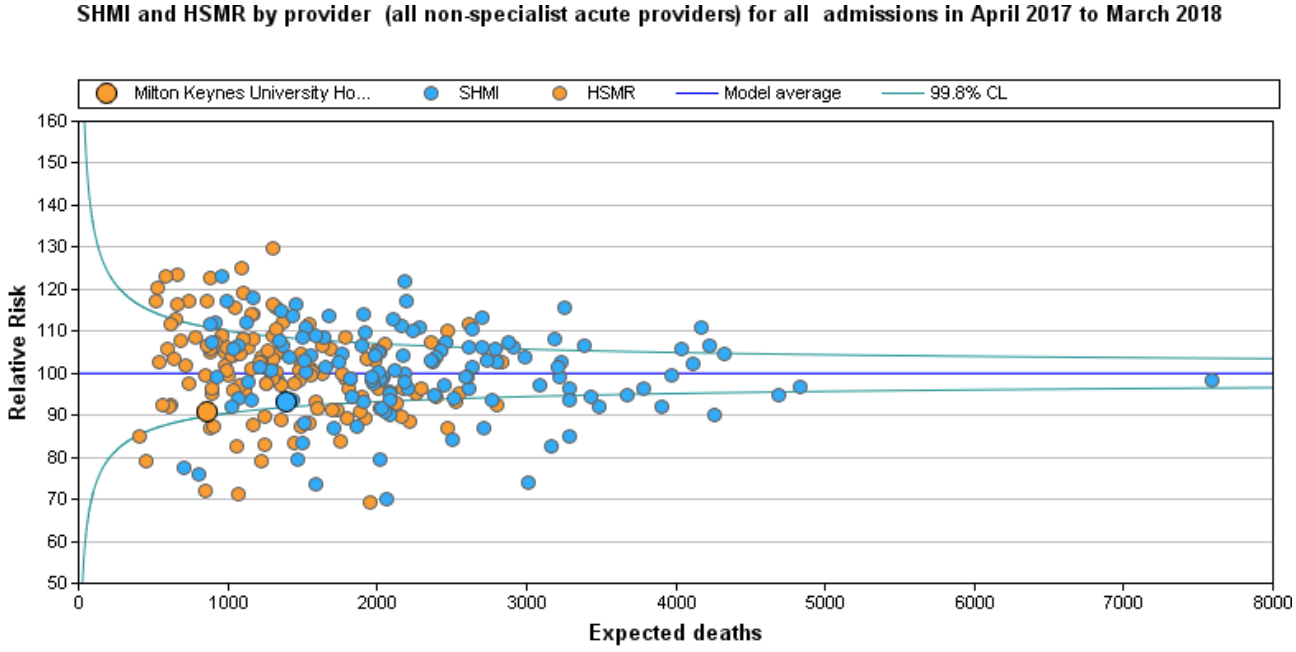


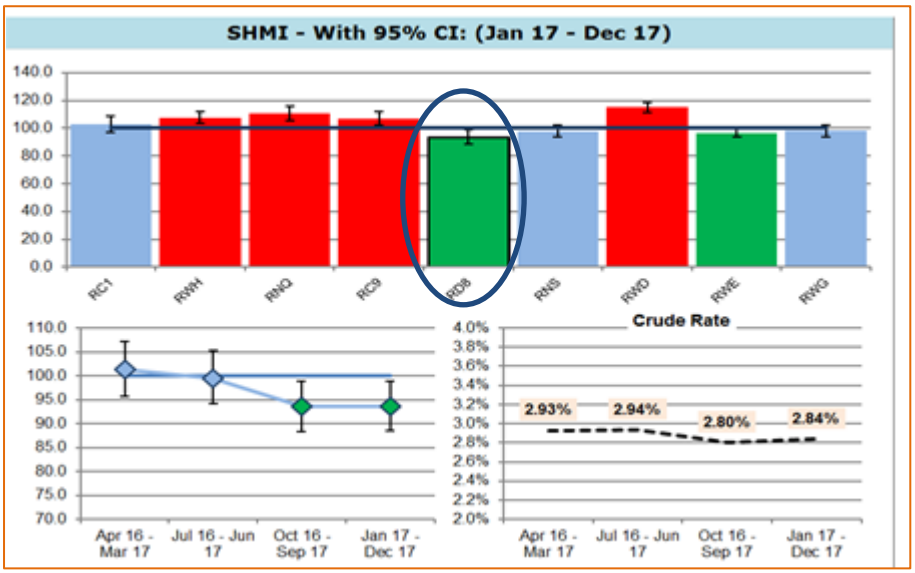
Summary Hospital-level Mortality Indicator (SHMI) • April 2017 - March 2018

I00699: Summary Hospital-level Mortality Indicator (SHMI)
Rolling one year period, six months in arrears

Standardised ratio	0.2	0.4	0.6	0.8	1.0	1.2	1.4	1.6	1.8	2.0
SHMI with 95% over-dispersion control limits (2)					Lower: 0.89, Upper: 1.13					
					0.93					

SHMI position vs. national acute peers: April 2016 – March 2017





This relates to MKUH SHMI data

Most recent SHMI peer review data from Dr Foster – RD8 is MKUH

Investigations of Deaths

The data for Q1, Q2, Q3 and provisional Q4 are illustrated in the graph below outlining the number of deaths within the Trust that have:

1. Been reviewed and assessed by the consultant responsible for the patient's care with the potential for the case to be 'screened out' of further formal review. This active case record review process recognises that in many cases death in hospital will have been inevitable and appropriate. The process assists in directing collective review efforts to those cases where multi-professional review is likely to lead to learning. A subset of those cases 'screened out' is subjected to formal review at random.

2. Undergone formal review – the Trust aims for ~ 25% of all deaths to undergo a formal review process however it is recognised that this figure may not been achieved for Q3 as winter pressures can lead to cancellation of some departmental M&M meetings. It should be recognised that deaths that occur within Q4 are still undergoing the process of formal review as per the Trust Mortality policy and more complete data will be available for Q4 at the next Trust Board meeting.

3. Judged as potentially 'avoidable' – using the current system of classification within the Trust this includes 'suboptimal care where different management MIGHT have changed outcome and 'suboptimal care where different management WOULD have changed outcome'

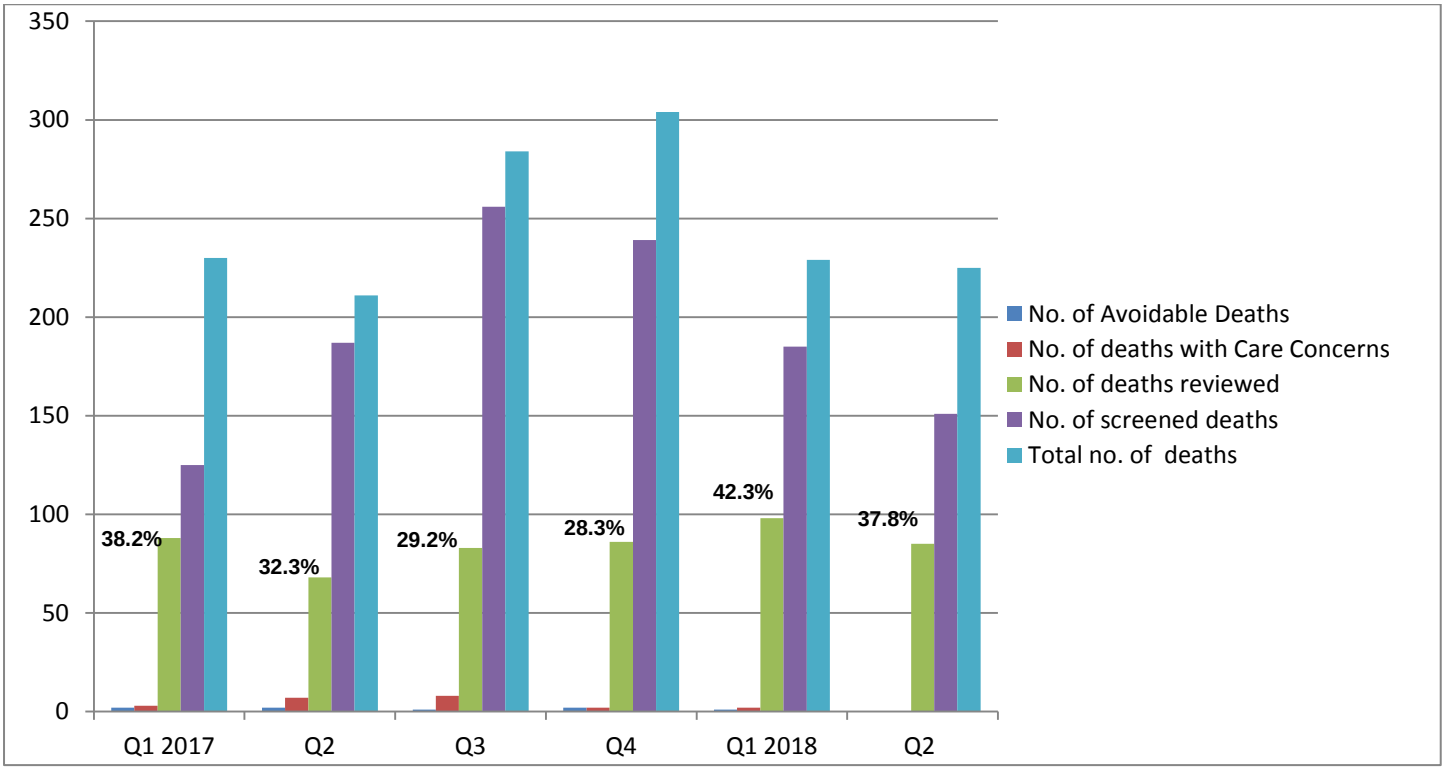
4. Judged as 'non-avoidable' but where there have been Care Quality concerns identified. This includes 'suboptimal care where different management WOULD NOT have changed outcome'.

As the Trust adopts the RCP methodology of SJRs, the classification of deaths and 'avoidability' will change.

	Q1 2017	Q2	Q3	Q4	Q1 2018	Q2
No. of deaths	**230**	**211**	**284**	**304**	**229**	**225**
No. of deaths reviewed by responsible consultant (% of total)	**125 (54%)**	**187 (89%)**	**256 (90%)**	**239 (79%)**	**185 (80.8%)**	**151(67%)***
No. of investigations (% of total)†	**88 (38.2%)**	**68 (32.3%)**	**83 (29.2%)**	**86 (28.3%)**	**98 (42.3%)**	**85 (37.8)***
No. of deaths with Care Quality concerns (%)	**3 (1.3%)**	**7 (3.3%)**	**8 (2.8%)**	**2 (0.6%)**	**2**	**0***
No. of potentially avoidable deaths (%)	**2 (0.8%)**	**2 (0.5%)**	**1 (0.5%)**	**2 (0.6%)**	**1**	**0***

† All deaths that have been investigated have been through the initial case record review process

* Q2 data are provisional and are still subject to further modification (as formal review processes occur within the Trust's clinical divisions).



Qualitative information on deaths (whilst maintaining patient anonymity)

Cases not previously published at Public Board meetings

2018 Q1 Avoidable deaths or deaths where suboptimal care where different management MIGHT have changed outcome care

1. A woman in her 6th decade was referred with abdominal pain and discharged home following surgical evaluation with advice and plans for repeat bloods with GP the next day. Patient represented 6 days later with worsening symptoms and collapse and treated for sepsis by medical team. Imaging suggested intraabdominal pathology but following surgical review was not considered to be suitable for surgery. Patient deteriorated overnight and was transferred to the Department of Critical Care with evidence of multi-organ failure requiring intubation, renal support and inotropic support. Patient was subsequently taken to theatre and underwent a laparotomy and subsequent bowel resection of necrotic sections of bowel. This case was subsequently discussed at medical and surgical M&M meetings. Earlier imaging and consideration of earlier surgical exploration for the cause of deterioration were discussed as areas that might have changed outcome however delayed representation noted as a possible contributory factor.

Q1 - Care Quality concerns that would not have changed outcome

1. Suboptimal care due to a delay in insertion of chest drain under ultrasound guidance. Chest drain subsequently inserted without radiological support by Level 2 trained senior doctor without incident. Plans to review possibility of increasing number of Level 2 trained doctors able to undertake chest drain insertion with ultrasound guidance.

2. Patient given anticoagulant in Emergency Department for possible pulmonary embolus despite evidence of gastric bleeding. This complicated subsequent treatment of bleeding gastric ulcers that required an emergency laparotomy following an unsuccessful endoscopic attempt to stop bleeding. Patient death 8 days later was not associated with anticoagulation. Plans to feedback to Emergency Department M&M governance meeting.

Meeting title	Board of Directors	Date: 9 November 2018
Report title:	Patient Experience Strategy Development Update	Agenda item: 4.1
Lead director Report author Sponsor(s)	Kate Jarman Joe Harrison	Director of Corporate Affairs Chief Executive
FoI status:		

Report summary	This paper summarises the Trust's development of a new patient experience strategy, as part of a suite of policy and strategy development supporting good quality governance. This document sets out a framework to structure improvements to patient experience – particularly as measured in the national surveys as these have been relatively static for some time.			
Purpose *(tick one box only)*	Information ☐	Approval ☒	To note ☐	Decision ☐
Recommendation	The Board is asked to approve the contents of this summary paper			

Strategic objectives links	All strategic objectives
Board Assurance Framework links	
CQC regulations	Responsive, Well Led
Identified risks and risk management actions	There is a risk that staff are not familiar with the trust's vision, values, strategic aims and objectives.
Resource implications	None
Legal implications including equality and diversity assessment	None

Report history	Previous Board review and discussion.
Next steps	Development of formal strategy and implementation of governance and involvement to progress work plan.
Appendices	Papers follow

Patient Experience Strategy Development Update

A revised approach to developing a patient experience strategy and to refreshing the governance and involvement networks and infrastructure to support improving patient experience has been presented to a number of forums over the last eight weeks.

The Quality and Clinical Risk Committee reviewed and discussed the proposal at its October meeting.

The executive and committee membership agree to the patient experience strategy being developed along the lines proposed.

Next steps are to do as follows:

1. Formalise the work programme, including a comprehensive programme plan for each of the ten workstreams
2. Formalise the governance structure and any associated resources
3. Engage and involve patient/ hospital user and representative groups throughout the above, and establish collaborative and multi-agency forums to progress work as proposed
4. Return a formal strategy document and work programmes through the reporting and assurance committees and to Board in the December/ January cycle

Recommendations to the Board

That management proceed with developing the strategy and return the formal document and programme plan to Quality and Clinical Risk Committee and then Board in the December/ January reporting cycle for approval and on-going monitoring.

Improving Patient Experience

Kate Jarman

Director of Corporate Affairs

Improving Patient Experience at MKUH: Context

- Generally low/ poor scores in the national inpatient survey and main specialist surveys (maternity, cancer, children's services, ED) – although some exceptions
- Trend of stasis in thematic areas (communication, discharge, information, food choices, cleanliness, noise, involvement in care)
- Lack of progress at odds with improvement in other care quality (notably patient safety) indicators
- Annual interventions made, with some improvements noted (e.g. noise) but no significant score uplift and other survey participants improving at a greater rate
- Appears to be a level of disconnect between sources of intelligence and reporting on patient experience – e.g. significantly more positive Friends and Family Test
- Appears to be a level of disconnect between patient and staff surveys – the latter at a higher 'baseline' and improving at a faster rate

Improving Patient Experience at MKUH: Context

- No current overall quality strategy for the organisation (as currently being updated and re-developed)

- Patient experience strategy in draft for some time but not currently viewed as meeting executive/ Board requirements

Improving Patient Experience at MKUH: Context

- Areas for focus (scoring worse than peers) from the 2017 inpatient survey (overall 41 areas declined in 2017):
    - Cleanliness of wards
    - Choice of food
    - Help with eating
    - Doctors answering questions in a way patients can understand
    - Trust and confidence in doctors
    - Planned admission: admission date changed by hospital
    - Discharge communication, information and timeliness
    - Privacy

Improving Patient Experience at MKUH: Current Survey Programme

Lead sector	Survey	Fieldwork timing	Expected month of publication	Notes
2017/18 surveys				
Acute Trusts	2017 Adult Inpatients	September 2017 to January 2018	13 June 2018	NHS providers will need to fund implementation on the same basis as in previous years.
Mental Health Trusts	2018 Community Mental Health	Feb- June 2018	November 2018 (TBC)	NHS providers will need to fund implementation on the same basis as in previous years.
2018/19 surveys				
Acute Trusts	2018 Maternity	April – August 2018	January 2019 (TBC)	NHS providers will need to fund implementation on the same basis as in previous years.
Acute Trusts	2018 Adult Inpatients	September 2018 to January 2019	May/ June 2019 (TBC)	NHS providers will need to fund implementation on the same basis as in previous years.
Acute Trusts	2018 Emergency Department	October – March 2019	August 2019 (TBC)	NHS providers will need to fund implementation on the same basis as in previous years.
Acute Trusts	2018 Children and Young People	January – May 2019	September 2019 (TBC)	NHS providers will need to fund implementation on the same basis as in previous years.
Mental Health Trusts	2019 Community Mental Health	Feb- June 2019	November 2019 (TBC)	NHS providers will need to fund implementation on the same basis as in previous years.
2019/20 surveys				
Acute Trusts	2019 Maternity	April – August 2019	January 2020 (TBC)	NHS providers will need to fund implementation on the same basis as in previous years.
Acute Trusts	2019 Adult Inpatients	September 2019 to January 2020	May/ June 2020 (TBC)	NHS providers will need to fund implementation on the same basis as in previous years.
Mental Health Trusts	2020 Community Mental Health	Feb- June 2020	November 2020 (TBC)	NHS providers will need to fund implementation on the same basis as in previous years.
If you would like to subscribe to updates about the survey programme, please sign up here.				

Improving Patient Experience at MKUH: Proposition & Principles

- Improving patient experience positioned as an integral part of 'the MK Way' vision, values and strategy re-launch and a key strategic improvement programme

- Three-year programme is proposed, tackling thematic issues, using a marketing approach to segment and target patient groups.

- A combination of work programmes will comprise the overall improvement programme:
    - Campaign/ quality improvement programme-based interventions (e.g. cleanliness, food quality, noise)

    - A new approach to patient involvement and engagement, including dedicated work programmes on:
        - Service co-design;
        - Patient information and stakeholder engagement (particularly focussed on groups like Health Watch and patient representative groups); and
        - A systemic approach to customer training

Improving Patient Experience at MKUH: Segmentation Matrix

Survey Segment	Patient Group
Inpatient 1	Inpatient: Elective
Inpatient 2	Inpatient: Emergency
Inpatient 3 Cancer 1	Inpatient: Condition-Specific Groups
Inpatient 4	Inpatient: Age Profile (18 to 25; 25 to 45; 45 to 65; 65 to 80; 80+)
Paediatric 1	Inpatient: Children & Families
Maternity 1	Maternity
*No Survey	Outpatient: Condition-Specific Groups
*No Survey	Outpatient: Age Profile (18 to 25; 25 to 45; 45 to 65; 65 to 80; 80+)

Improving Patient Experience at MKUH: A Values-Led Work Programme

We Care	We Communicate	We Collaborate	We Contribute
1. Cleaning work programme 2. Food work programme 3. Mealtime support work programme	1. Patient information work programme 2. Customer care training programme (link to Admin transformation) 3. Planned care work programme (link to MyCare) 4. We Communicate Hub (patient/ user-led)	1. Discharge work programme (co-design with patients; link to Red2Green) 2. Ward environment (privacy and noise) work programme (co-design with patients) 3. We Collaborate Multi-Agency Patient Experience Forum	1. Responsive care work programme (link to staff engagement)
CQC safe, caring	CQC responsive, effective	CQC responsive, effective, caring	CQC responsive, caring

Ten work programmes tackling key problem areas identified in the inpatient, children and maternity surveys. Two co-design programmes with patients.

Programmes will adopt the segmentation model to create targeted interventions by patient group.

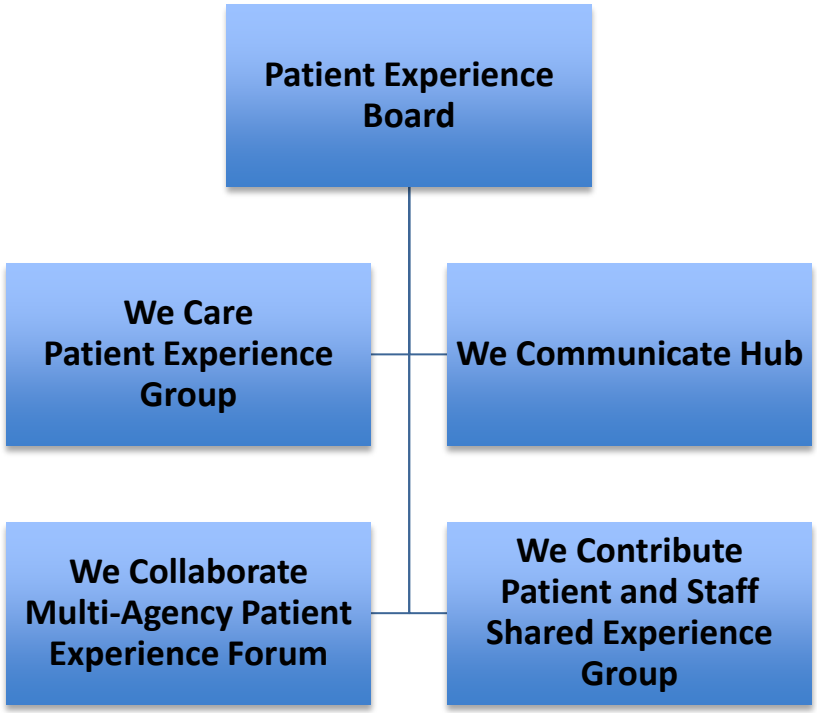
Incorporates work identified in the draft patient experience strategy (described under the four priorities/ commitments).

Improving Patient Experience at MKUH: A Values-Led Work Programme

Measurement (Indicative)

- Patient survey statistically significant change (in key defined questions)
- Reduction in complaints (specifically relating to communication)
- Increase in FTT (or equivalent NPS/ other measure) response rate and positive scores
- Increase in group engagement levels
- Increase in positive contacts with the hospital in defined areas

Improving Patient Experience at MKUH: Governance and Involvement Model



- All PEGs are multi-professional
- All PEGs include or are led by patient representatives/ hospital users

Meeting title	Board of Directors	Date: 9 November 2018
Report title:	Performance Report indicators for 2018/19 (Month 6)	Agenda item: 5.1
Lead director Report author Sponsor(s)	Name: John Blakesley Name: Hitesh Patel	Title: Deputy Chief Executive Title: Associate Director of Performance and Information
FoI status:	Disclosable	

Report summary	Lists the proposed key performance metrics for the Trust for the financial year 2018/19			
Purpose *(tick one box only)*	Information [x]	Approval [ ]	To note [ ]	Decision [ ]
Recommendation				

Strategic objectives links	All Trust objectives
Board Assurance Framework links	None
CQC outcome/ regulation links	
Resource implications	None
Legal implications including equality and diversity assessment	None

Report history	None
Next steps	None
Appendices	None

Trust Performance Summary: M6 (September 2018)

1.0 Summary

This report summarises performance in September 2018 across key performance indicators and provides an update on actions to sustain or improve upon Trust and system-wide performance.

The Trust was clearly operating under more pressure with increasing readmissions, poor discharges from the Discharge Unit and occupancy increasing partly due to increases in the super stranded patients. DTOCs are a bright spot and remain low. The Trust achieving 91.0%, down from 94.8% last month against the 4 hour emergency access standard albeit with higher numbers of attendances. Nationally England achieving 88.9% placing the Trust at 41th out of 134.

On the elective side the RTT performance has improved in month to 86.9% up from (86.7% last month). In August (the most recent month that National data has been published) the England performance was 86.8% with MKUH being 107th out of 160 Trusts. Of continued concern is the numbers of breaches over 52 weeks. We had 24 out of the 3,306 countrywide 52 week breaches. August's data show the Trust at 134th out of 160 in the country. The pressure to reduce this number from regulators continues to grow.

2.0 Sustainability and Transformation Fund (STF)

Performance Improvement Trajectories

September 2018 performance against the Service Development and Improvement Plans (SDIP):

ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change
4.1	ED 4 hour target (includes UCS)		92.5%	91.3%	92.7%	91.0%	✗	▼
4.2	RTT Incomplete Pathways <18 weeks		90.1%	89.8%		86.9%	✗	▲
4.9	62 day standard (Quarterly)		82.4%	82.4%		82.8%	✓	▼

In September 2018, 91% of patients were seen within 4 hours in ED compared to 94.8% in August 2018. This was lower than both the 95% national target and the Trust's NHS Improvement trajectory (91.3%). However, despite not achieving these milestones in September, the performance compared favourably to the national A&E performance, which was 88.9% in September 2018. This reinforces the challenge across the health system to achieve this target.

At the end of September 2018, the Trust did not achieve the referral to treatment (RTT) 92% national standard for incomplete pathways. An aggregate performance of 86.9% was reported, which was an increase of 0.6% on August 2018 performance. The performance was also below the NHS Improvement trajectory of 89.8% for the month, and lower than the combined NHS England performance for RTT in August 2018, which was 87.2%.

Cancer waiting times are reported quarterly, around six weeks after the end of a calendar quarter. The most recent confirmed position therefore was Q1 2018/19, when the Trust did not achieve the 85% Cancer 62 day standard, closing at 82.8%. The 85% standard currently looks set to have been achieved in Quarter 2 of 2018/19, but the final validated figures will not be reported until early November 2018.

3.0 Urgent and Emergency Care

Performance across urgent and emergency care services continued to operate under pressure in September 2018, as represented across the following range of KPIs:

ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change
2.4	Cancelled Ops - On Day		1.0%	1.0%	0.8%	0.7%	✓	▲
3.2	Ward Discharges by Midday		30%	30%	19.2%	21.0%	✗	▲
3.4	30 day readmissions		6.4%	6.4%	8.3%	8.9%	✗	▼
4.1	ED 4 hour target (includes UCS)		92.5%	91.3%	92.7%	91.0%	✗	▼

Cancelled Operations on the Day

In September 2018, the volume of operations that were cancelled on the day for non-clinical reasons decreased to 18 from 22 in August 2018. This represented 0.7% of all planned operations during the month, which was within the 1% tolerance.

Of those cancelled on the day, eight were due to staff availability. Insufficient time was the next most frequently cited reason for last minute cancellations, accounting for seven of the total. Emergency priority (1), equipment failure (1) and scheduling error (1) accounted for the rest.

Readmissions

The readmission rate was again higher than the 6.4% threshold, with a rate of 8.9% in September 2018. Surgery and Women & Children accounted for the increase compared to August 2018, with rates of 6.2% and 5.5% respectively in September 2018. Medicine preserved a relatively consistent rate compared to the previous month.

Delayed Transfers of Care (DTOC)

The number of DTOC patients as at midnight on the last Thursday of September 2018 was 19. This was a decrease of three compared to the number reported for August 2018. However, the cumulative number of days delayed for all patients throughout the month increased to 555 days in September 2018 from 458 in August 2018.

Ambulance Handovers

The percentage of ambulance handovers that took longer than 30 minutes increased to 6.3%, indicating that the target was missed by 1.3%. The number of handovers reported to have taken longer than 60 minutes during September 2018 also increased to thirteen compared to four in August 2018.

4.0 Elective Pathways

ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change
3.1	Overnight bed occupancy rate		93%	93%	92.5%	96.5%	✗	▼
3.5	Follow Up Ratio		1.50	1.50	1.53	1.59	✗	▬
4.2	RTT Incomplete Pathways <18 weeks		90.1%	89.8%		86.9%	✗	▲
4.6	Diagnostic Waits <6 weeks		99%	99%		99.2%	✓	▼
5.6	Outpatient DNA Rate		5%	5%	7.2%	7.5%	✗	▲

Overnight Bed Occupancy

The Trust bed occupancy was above the 93% internal threshold at 96.5% in September 2018. This was a significant increase in occupancy compared to August 2018 (91.5%). The NHS England bed occupancy statistics for Q2 2018/19 will be published on 22/11/2018. In Q1 2018/19, the average occupancy rate for all beds open overnight was 87.9%.

Overnight bed occupancy at such high levels can increase the risk of infections and affect the timely admission of emergency and urgent care patients as well as those booked for surgery. Constant demand for beds represents a huge challenge for the Trust.

Follow up Ratio

Planning outpatient capacity to cope with new referrals is impacted by the demand for follow ups. In September 2018, the follow up ratio continued above the threshold with a ratio of 1.59 follow up attendances for every new attendance seen.

RTT Incomplete Pathways

As mentioned previously, the Trust 18 week RTT performance continued below the 92% RTT national standard and the NHS Improvement target (89.8%). At the end of September 2018, the overall waiting list size increased and the number of patients waiting more than 18 weeks decreased, resulting in an improved RTT performance. The RTT National standard (92%) was last achieved by the Trust in October 2017.

When compared to last month, the number of patients waiting more than 52 weeks without being treated increased to 24 at the end of September 2018. 22 were in Surgery and two were in Medicine.

Diagnostic Waits <6 weeks

In September 2018, the Trust continued to meet the operational standard of less than 1% of patients waiting six weeks or longer for a Diagnostic test, with a performance of 99.2%. Nationally, the operational standard was not achieved in August 2018 and performance was also the worst since March 2008. The national performance for September 2018 will be published by NHS England in November 2018.

Outpatient DNA Rate

The outpatient DNA rate decreased from 7.6% in August to 7.5% in September 2018. This small decrease was evident across Surgery and Medicine divisions, but overall it remains higher than the 5% target.

DNAs represent clinic capacity that cannot be otherwise utilised. All services should ensure that they adhere to the Trust Access Policy to minimise DNA rates.

5.0 Patient Safety

NICE Breaches

In September 2018, the number of NICE breaches (110) almost doubled compared with the position in August 2018. Medicine accounted for 84% of the breaches.

ENDS

Performance Report 2018/19
September 2018 (M06)

NHS
Milton Keynes University Hospital
NHS Foundation Trust

OBJECTIVE 1 - PATIENT SAFETY										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
1.1	Mortality - (HSMR)		100	100		89.9	✓	▲		
1.2	Mortality - (SHMI) - Quarterly		1	1	0.94	0.94	✓	▲	✓	
1.3	Never Events		0	0	2	0	✓	▬	✗	
1.4	Clostridium Difficile		20	<10	10	3	✗	▬	✗	
1.5	MRSA bacteraemia (avoidable)		0	0	0	0	✓	▬	✓	
1.6	Pressure Ulcers Grade 2, 3 or 4 (per 1,000 bed days)		0.6	0.6	0.52	0.32	✓	▲	✓	
1.7	Falls with harm (per 1,000 bed days)		0.15	0.15	0.12	0.08	✓	▲	✓	
1.8	WHO Surgical Safety Checklist		100%	100%	100%	100%	✓	▬	✓	
1.9	Midwife : Birth Ratio		28	28	28	28	✓	▲	✓	
1.10	Incident Rate (per 1,000 bed days)		40	40	33.79	33.09	✗	▲	✗	
1.11	Duty of Candour Breaches (Quarterly)		0	0	0	0	✓	▬	✓	
1.12	E-Coli				14	1		▲		
1.13	MSSA				8	2		▲		

OBJECTIVE 2 - PATIENT EXPERIENCE										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
2.1	FFT Recommend Rate (Patients)		94%	94%	95.0%	95%	✓	▼	✓	
2.2	RED Complaints Received		8	4	0	0	✓	▬	✓	
2.3	Complaints response in agreed time		90%	90%	81.4%	69.5%	✗	▼	✗	
2.4	Cancelled Ops - On Day		1.0%	1.0%	0.8%	0.7%	✓	▲	✓	
2.5	Over 75s Ward Moves at Night		2,554	1277	1,143	168	✓	▲	✓	
2.6	Mixed Sex Breaches		0	0	0	0	✓	▬	✓	

OBJECTIVE 3 - CLINICAL EFFECTIVENESS										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
3.1	Overnight bed occupancy rate		93%	93%	92.5%	96.5%	✗	▼	✓	
3.2	Ward Discharges by Midday		30%	30%	19.2%	21.0%	✗	▲	✗	
3.3	Weekend Discharges		70%	70%	70.2%	62.6%	✗	▼	✓	
3.4	30 day readmissions		6.4%	6.4%	8.3%	8.9%	✗	▼	✗	
3.5	Follow Up Ratio		1.50	1.50	1.53	1.59	✗	▬	✗	
3.6.1	Number of Stranded Patients (LOS>=7 Days)		227	227		233	✗	▼		
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)		91	91		107	✗	▼		
3.7	Delayed Transfers of Care		25	25		19	✓	▲		
3.8	Discharges from PDU (%)		16%	16%	10.8%	10.7%	✗	▲	✗	
3.9	Ambulance Handovers >30 mins (%)		5%	5%	6.5%	6.3%	✗	▼	✗	

OBJECTIVE 4 - KEY TARGETS										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
4.1	ED 4 hour target (includes UCS)		92.5%	91.3%	92.7%	91.0%	✗	▼	✓	
4.2	RTT Incomplete Pathways <18 weeks		90.1%	89.8%		86.9%	✗	▲		
4.3	RTT Patients Waiting Over 18 Weeks		1,287	1,235		1,820	✗	▲		
4.4	RTT Total Open Pathways		12,999	12,111		13,870	✗	▼		
4.5	RTT Patients waiting over 52 weeks			10		24	✗	▼		
4.6	Diagnostic Waits <6 weeks		99%	99%		99.2%	✓	▼		
4.7	All 2 week wait all cancers (Quarterly) ✎		93%	93%		97.8%	✓	▲		
4.8	31 days Diagnosis to Treatment (Quarterly) ✎		96%	96%		100.0%	✓	▲		
4.9	62 day standard (Quarterly) ✎		82.4%	82.4%		82.8%	✓	▼		

OBJECTIVE 5 - SUSTAINABILITY										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
5.1	GP Referrals Received		60,189	30,095	30,732	4,600	✗	▼	✓	
5.2	A&E Attendances		91,286	45,768	44,679	7,480	✗	▲	✗	
5.3	Elective Spells (PBR)		25,530	12,666	13,291	2,389	✓	▲	✓	
5.4	Non-Elective Spells (PBR)		35,286	17,691	17,047	2,877	✗	▲	✗	
5.5	OP Attendances / Procs (Total)		367,859	182,217	185,961	29,703	✓	▼	✓	
5.6	Outpatient DNA Rate		5%	5%	7.2%	7.5%	✗	▲	✗	
5.7	Number of babies delivered				1817	304		▼		
5.8	Number of antenatal bookings				1851	293		▼		

OBJECTIVE 7 - FINANCIAL PERFORMANCE										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
7.1	Income £'000		238,802	115,180	117,303	19,223	✗	▼	✓	
7.2	Pay £'000		(161,048)	(81,322)	(82,374)	(13,588)	✗	▲	✗	
7.3	Non-pay £'000		(72,791)	(36,517)	(39,121)	(6,290)	✗	▲	✗	
7.4	Non-operating costs £'000		(12,893)	(6,447)	(6,424)	(1,069)	✓	▲	✓	
7.5	I&E Total £'000		(7,930)	(9,106)	(10,616)	(1,723)	✗	▼	✗	
7.6	Cash Balance £'000		2,500	2,610		3,118	✓	▼		
7.7	Savings Delivered £'000		10,130	3,639	4,005	1,217	✓	▲	✓	
7.8	Capital Expenditure £'000		29,673	10,424	3,511	503	✓	▲	✓	

OBJECTIVE 8 - WORKFORCE PERFORMANCE										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
8.1	Staff Vacancies % of establishment		12%	12%		13.4%	✗	▲		
8.2	Agency Expenditure %		8%	8%	5.9%	5.5%	✓	▲	✓	
8.3	Staff sickness - % of days lost		4%	4%		4.0%	✓	▬		
8.4	Appraisals		90%	90%		85.0%	✗	▬		
8.5	Statutory Mandatory training		90%	90%		89.0%	✗	▼		
8.6	Substantive Staff Turnover		12%	12%		12%	✓	▲		
8.7	FFT Response Rate Staff (Quarterly)		15%	15%	14.0%	14.0%	✗	▼	✗	

OBJECTIVES - OTHER										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
O.1	Total Number of NICE Breaches		8	8		110	✗	▼		
O.2	Rebooked cancelled OPs - 28 day rule		95%	95%	72.3%	54.5%	✗	▼	✗	
O.4	Overdue Datix Incidents >1 month		0	0		106	✗	▼		
O.5	Serious Incidents		45	<23	32	3	✓	▲	✗	
O.7	Energy Consumption (GJ)		239,937	111,014	46,582	6,380	✓	▲	✓	
O.8	Completed Job Plans (Consultants)		90%	90%		90%	✓	▼		

Key: Monthly/Quarterly Change

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

YTD Position

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

Data Quality Assurance Definitions

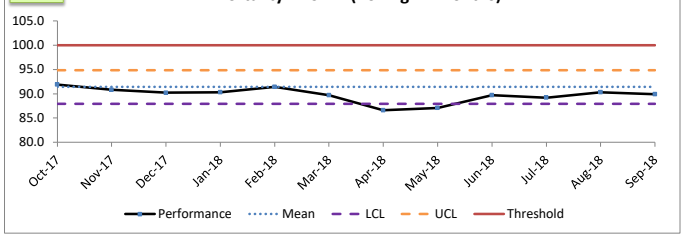
Rating	Data Quality Assurance
Green	Satisfactory and independently audited (indicator represents an accurate reflection of performance)
Amber	Acceptable levels of assurance but minor areas for improvement identified and potentially independently audited * /No Independent Assurance
Red	Unsatisfactory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

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

Milton Keynes University Hospital NHS Foundation Trust

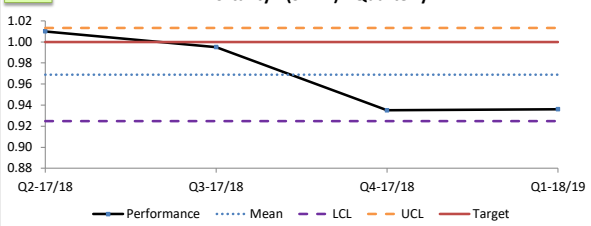
SD=3

1.1 Mortality - HSMR (Rolling 12 months)

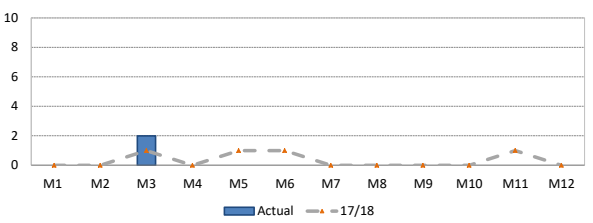


SD=3

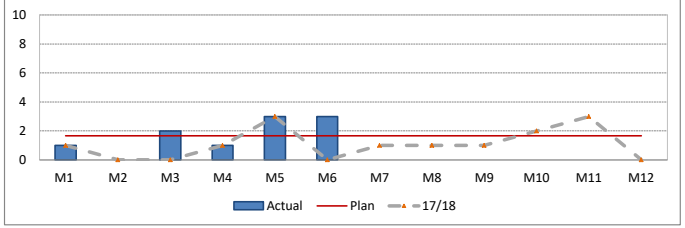
1.2 Mortality - (SHMI) - Quarterly



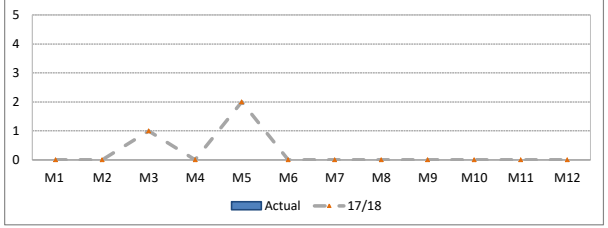
1.3 - Never events



1.4 - C.Diff Infections

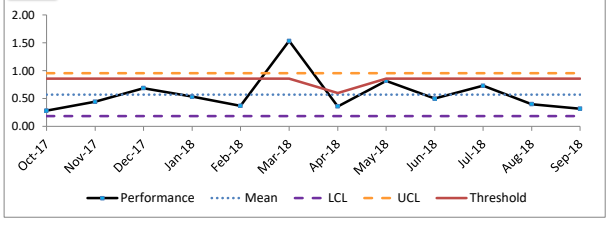


1.5 - MRSA Bacteraemia



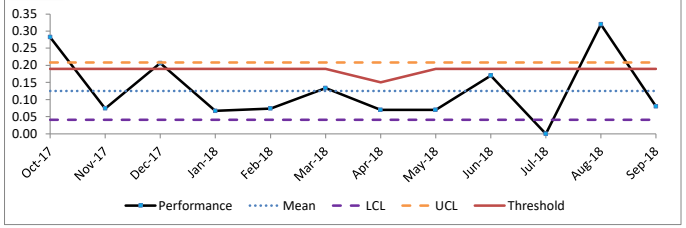
SD=1

1.6 - Pressure Ulcers Grade 2, 3 or 4 (per 1,000 bed days)

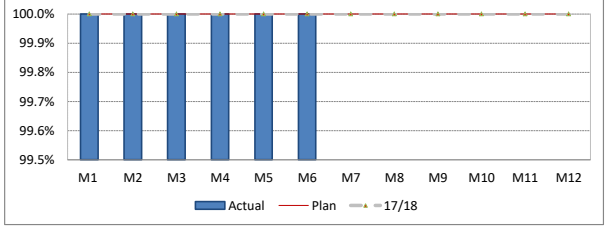


SD=1

1.7 - Inpatient falls causing harm

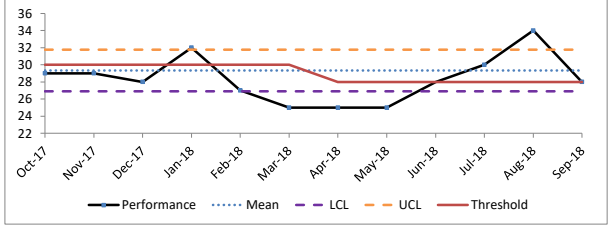


1.8 - WHO Surgical Safety Checklist



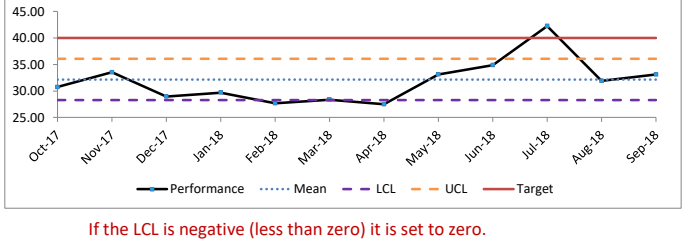
SD=1

1.9 - Midwife to Birth Ratio

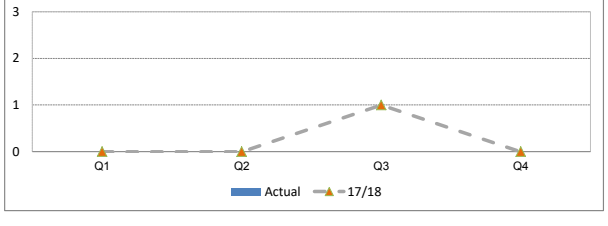


SD=1

1.10 - Incident Rate (per 1,000 bed days)

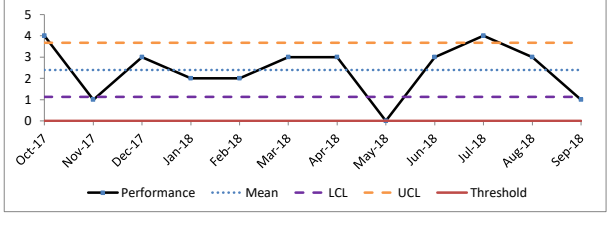


1.11- Duty of Candour Breaches



SD=1

1.12 - E-Coli



If the LCL is negative (less than zero) it is set to zero.
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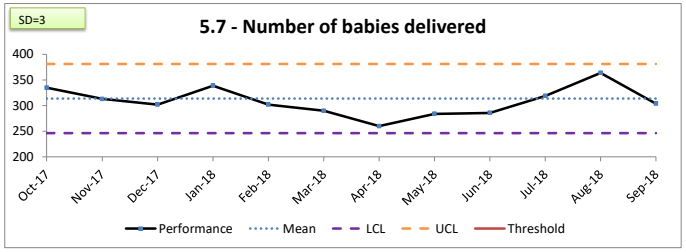
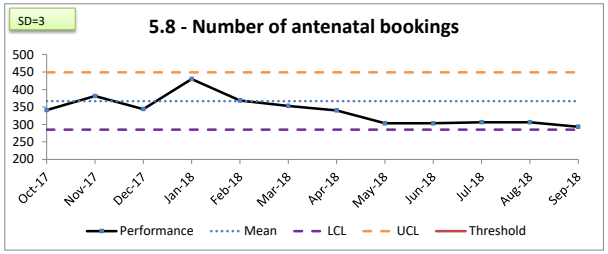
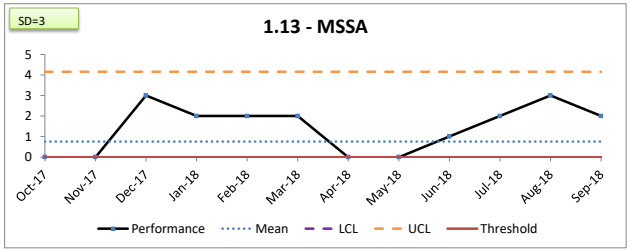
- Performance activity on a rolling 12 months/quarterly
- Average on a rolling 12 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories







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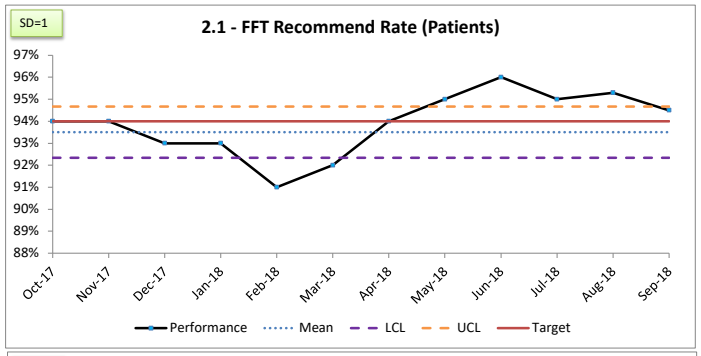
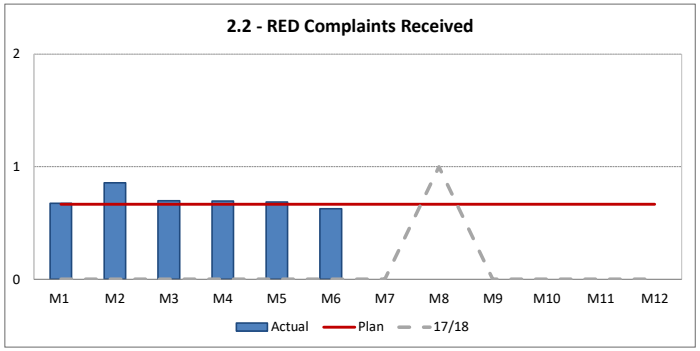
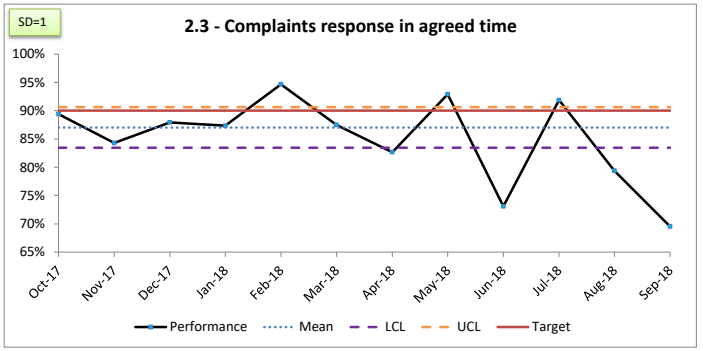
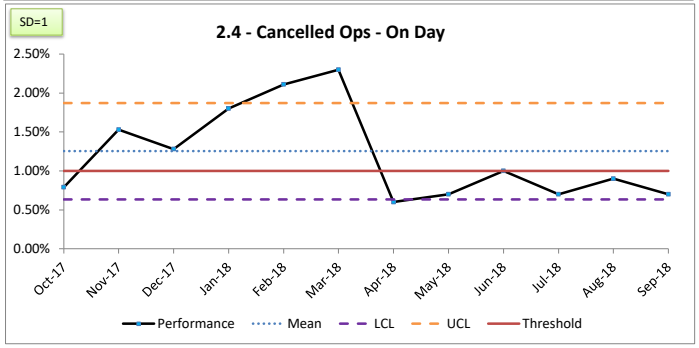
- Average on a rolling 12 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

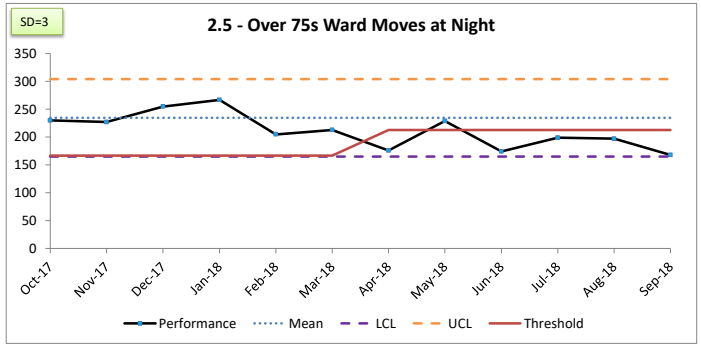
OBJECTIVE 2 - PATIENT EXPERIENCE

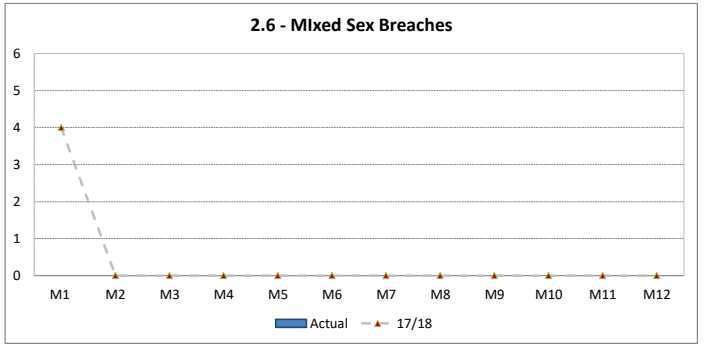












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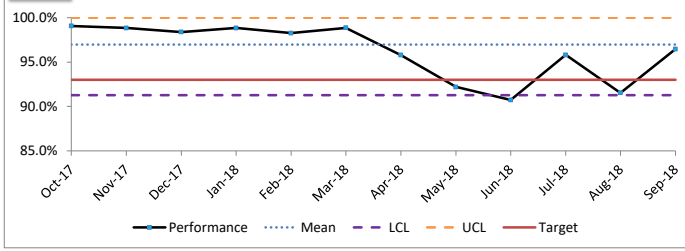
- Average on a rolling 12 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

OBJECTIVE 3 - CLINICAL EFFECTIVENESS

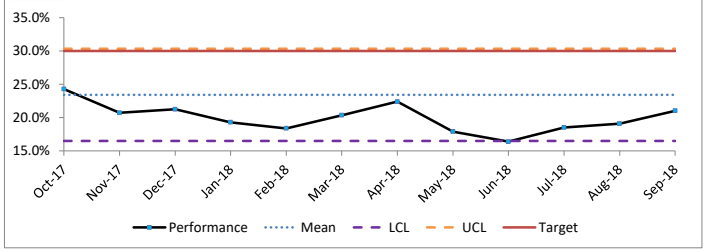
SD=3

3.1 - Overnight bed occupancy rate



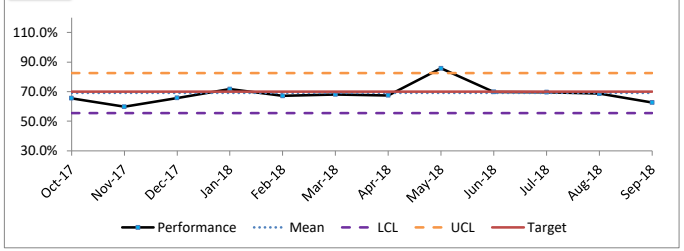
SD=3

3.2 - Ward Discharges by Midday



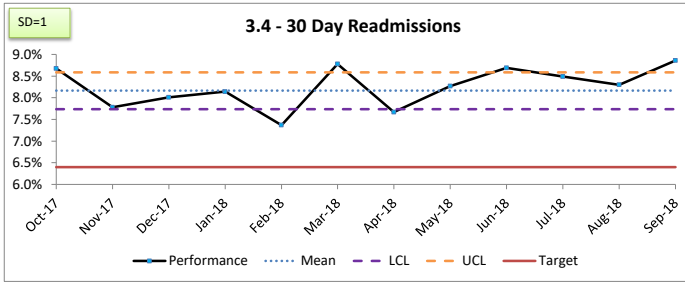
SD=3

3.3 - Weekend Discharges



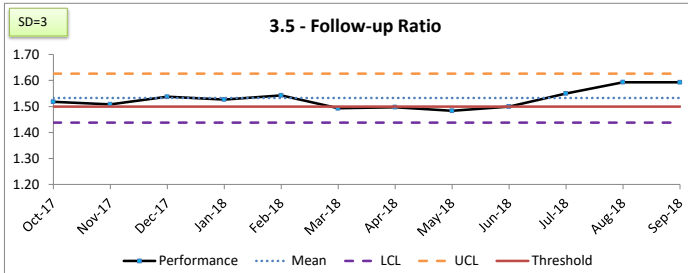
SD=1

3.4 - 30 Day Readmissions



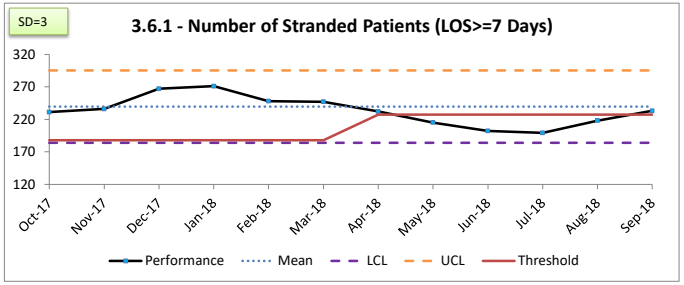
SD=3

3.5 - Follow-up Ratio



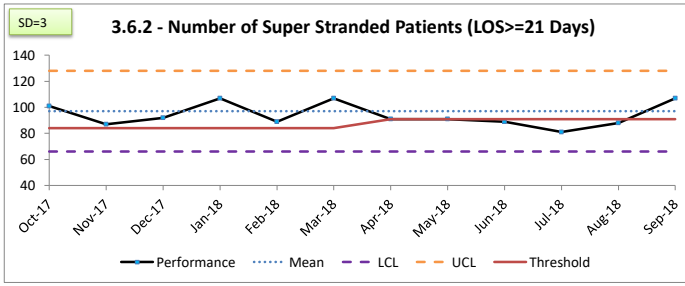
SD=3

3.6.1 - Number of Stranded Patients (LOS>=7 Days)



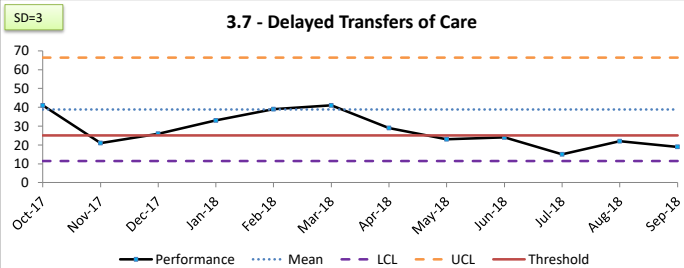
SD=3

3.6.2 - Number of Super Stranded Patients (LOS>=21 Days)



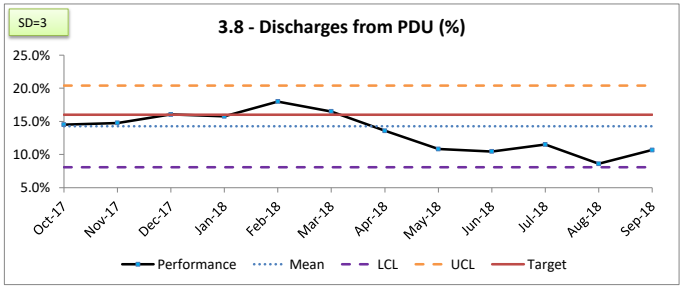
SD=3

3.7 - Delayed Transfers of Care



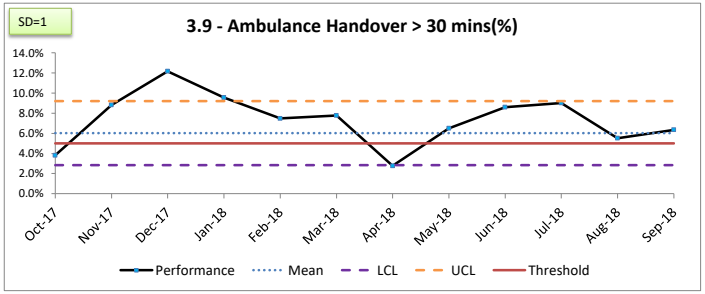
SD=3

3.8 - Discharges from PDU (%)



SD=1

3.9 - Ambulance Handover > 30 mins(%)



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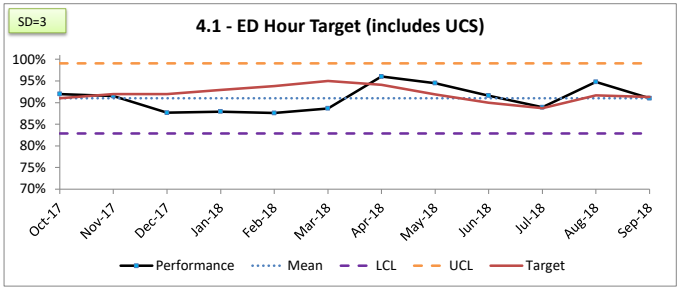
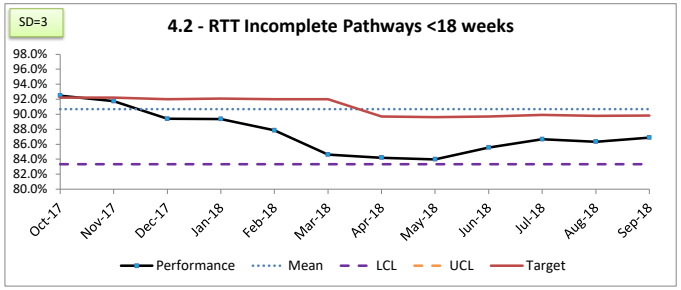
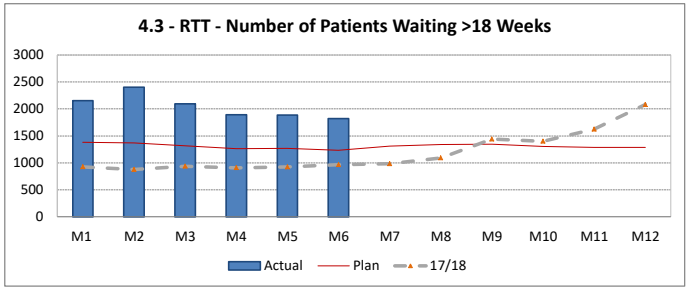
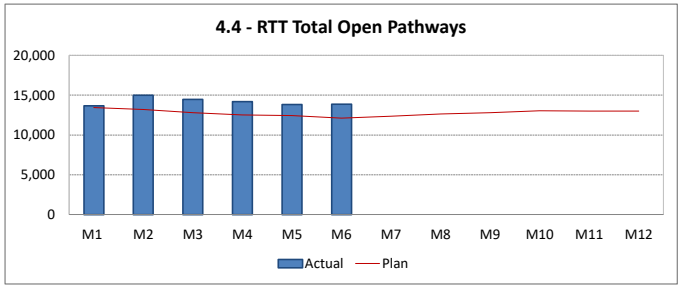
- Average on a rolling 12 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

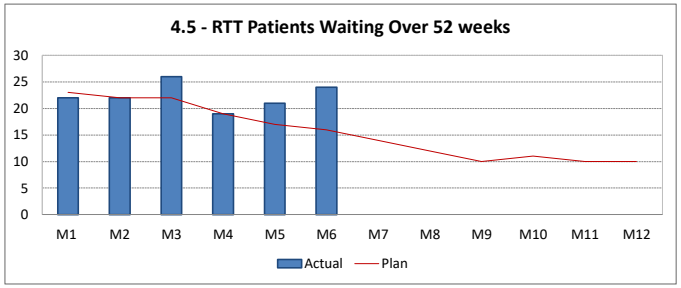
OBJECTIVE 4 - KEY TARGETS

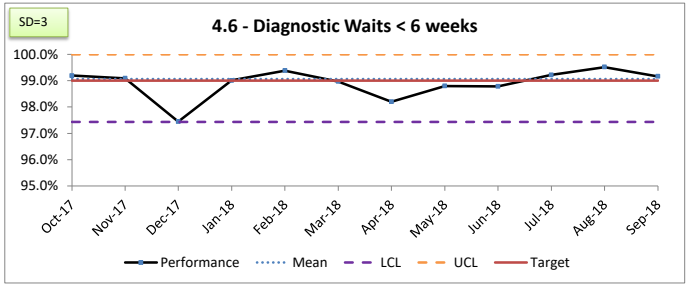


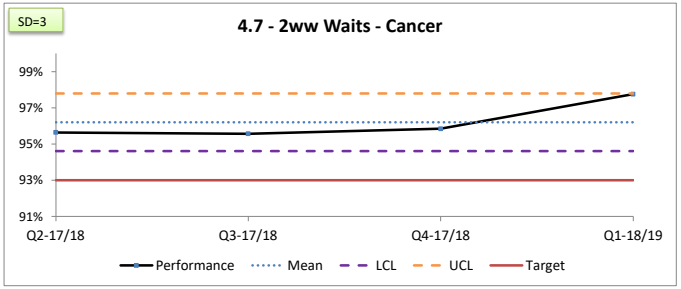


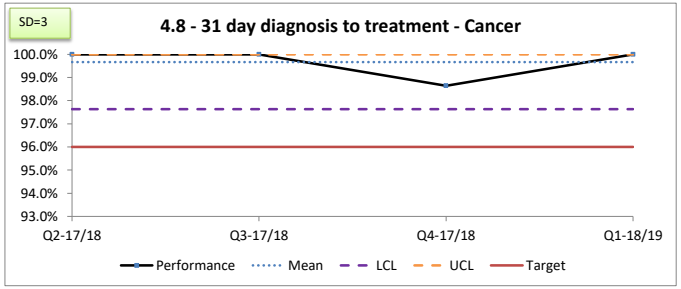


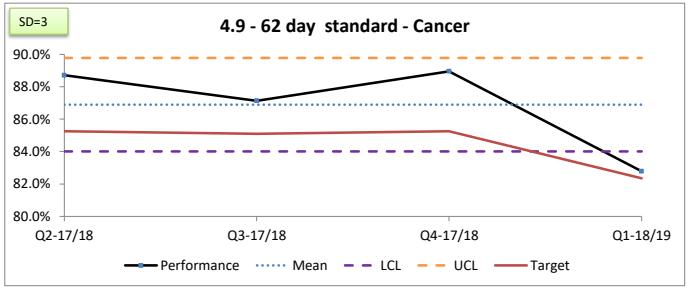












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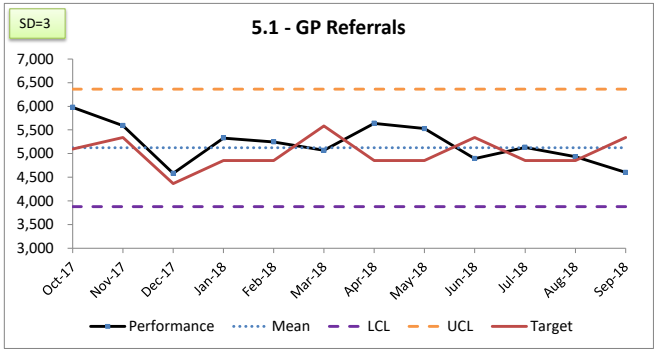
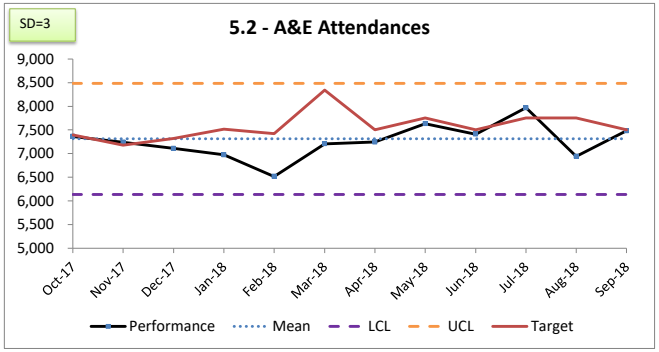
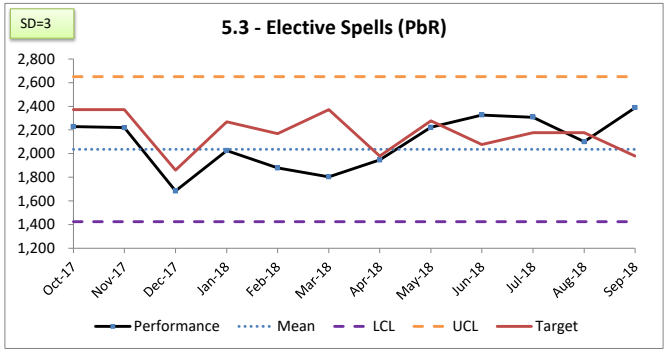
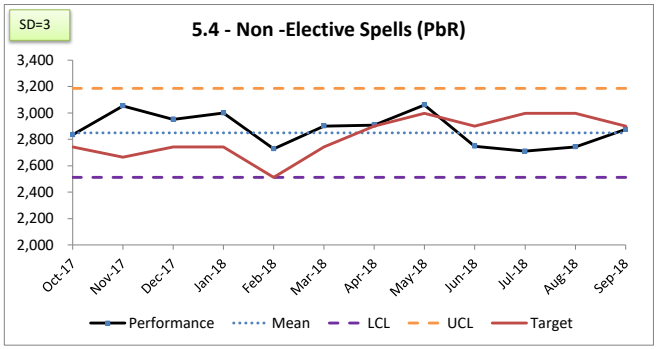
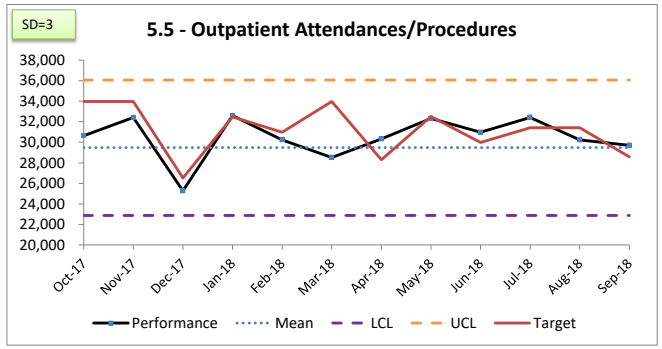
Milton Keynes University Hospital NHS Foundation Trust

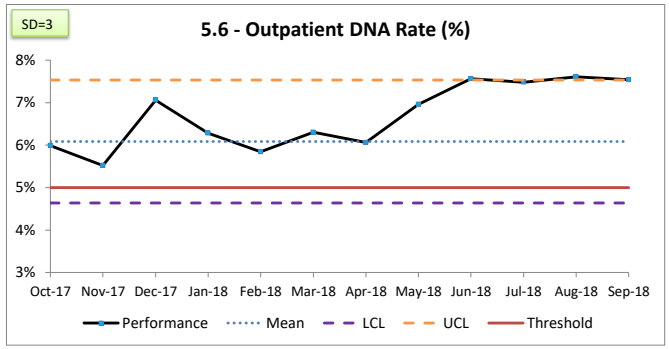












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- Performance activity on a rolling 12 months/quarterly
- Average on a rolling 12 months/quarterly
- Lower Control Limit (LCL)
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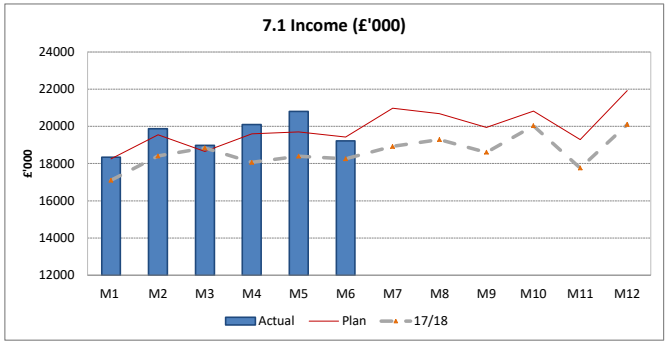
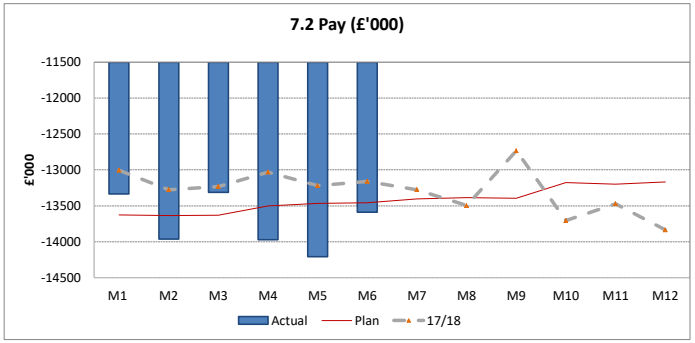
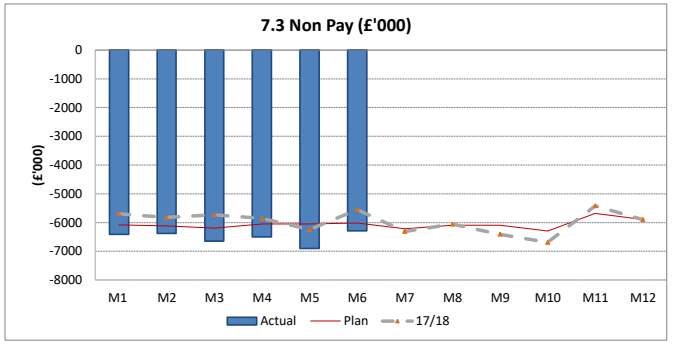
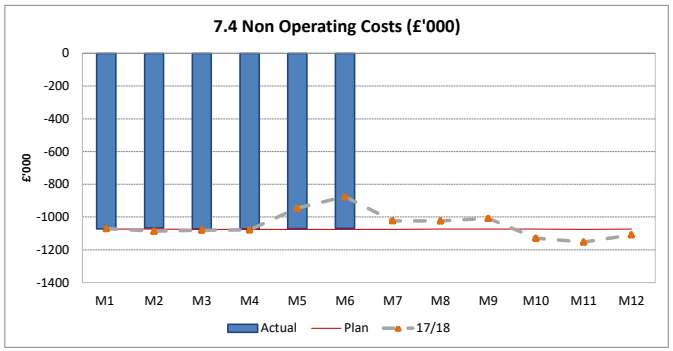
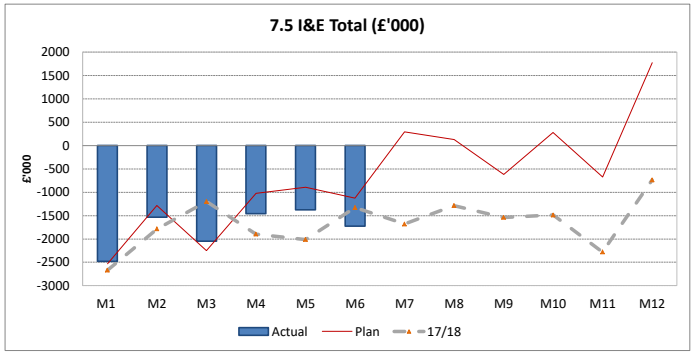
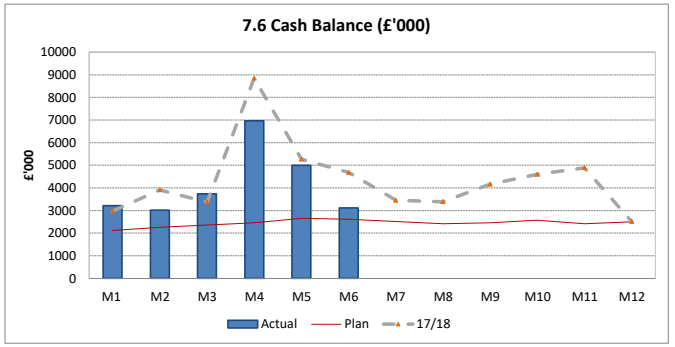

7.1 Income (£'000)
£'000
24000
22000
20000
18000
16000
14000
12000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

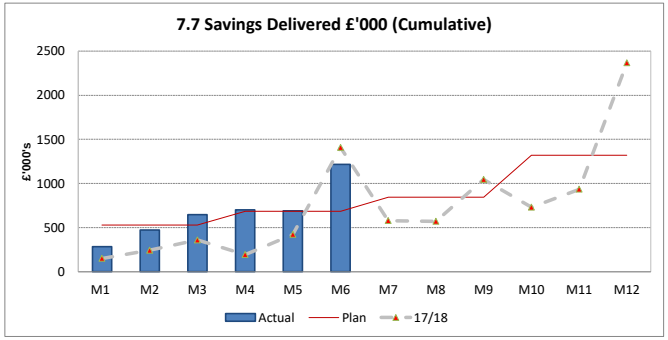

7.2 Pay (£'000)
£'000
-11500
-12000
-12500
-13000
-13500
-14000
-14500
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

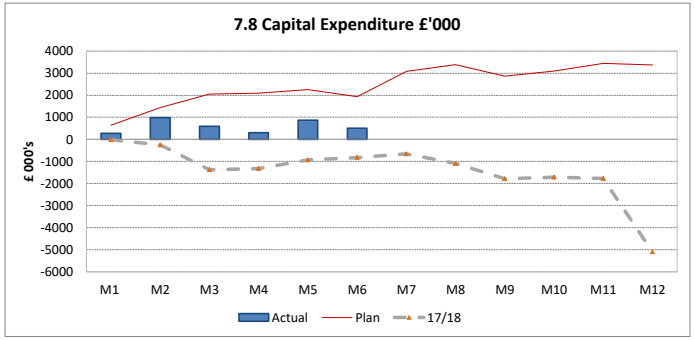

7.3 Non Pay (£'000)
(£'000)
0
-1000
-2000
-3000
-4000
-5000
-6000
-7000
-8000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18


7.4 Non Operating Costs (£'000)
£'000
0
-200
-400
-600
-800
-1000
-1200
-1400
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

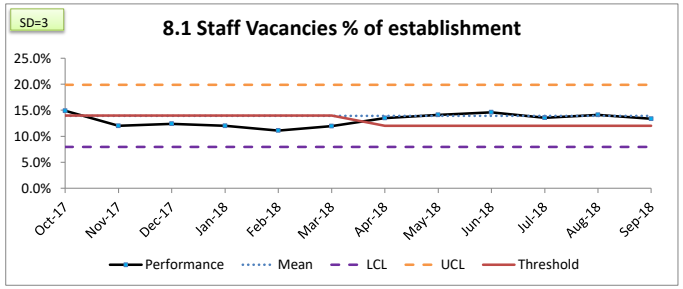

7.5 I&E Total (£'000)
£'000
2000
1500
1000
500
0
-500
-1000
-1500
-2000
-2500
-3000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

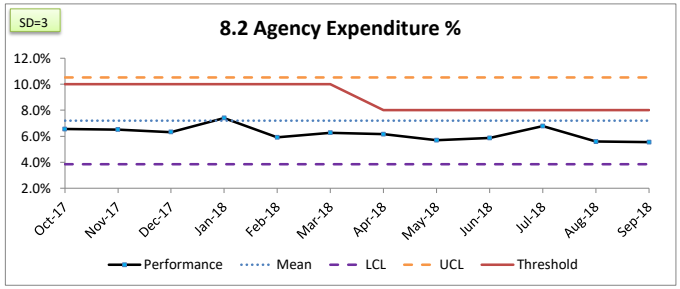

7.6 Cash Balance (£'000)
£'000
10000
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

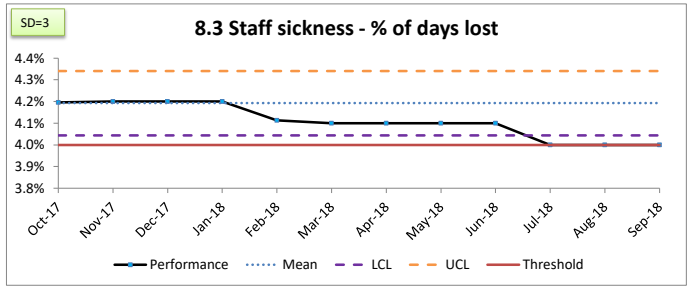

7.7 Savings Delivered £'000 (Cumulative)
£'000's
2500
2000
1500
1000
500
0
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

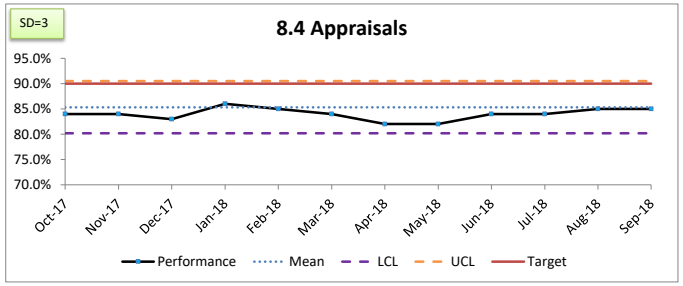

7.8 Capital Expenditure £'000
£ 000's
4000
3000
2000
1000
0
-1000
-2000
-3000
-4000
-5000
-6000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

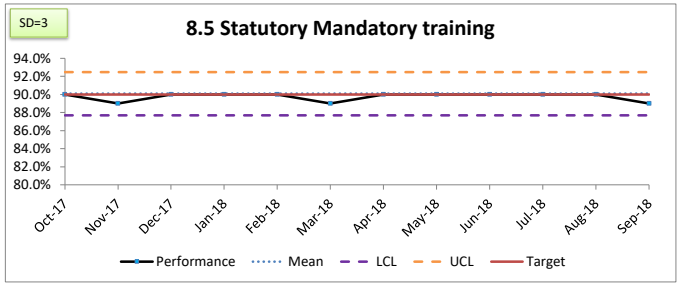
OBJECTIVE 8 - WORKFORCE PERFORMANCE

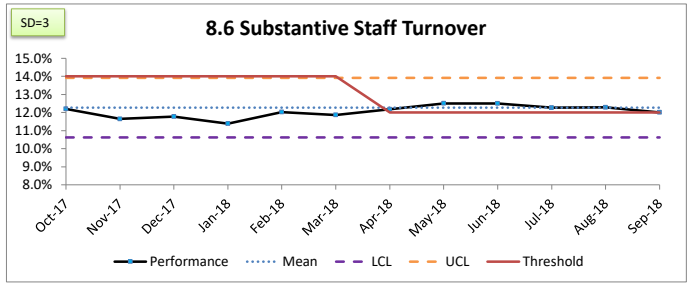


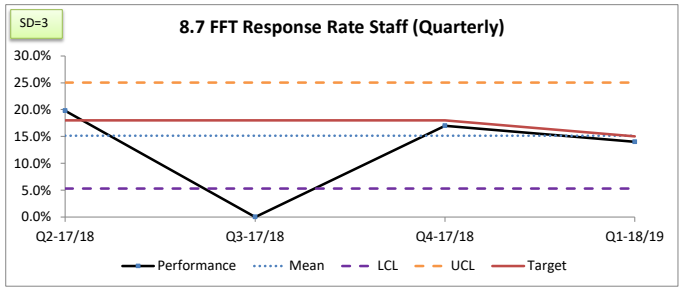






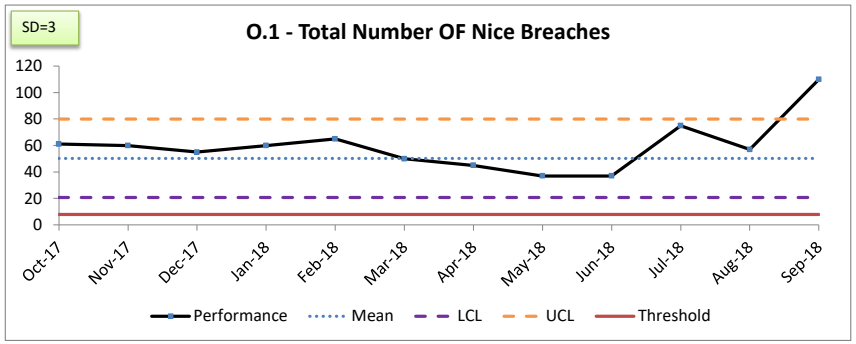


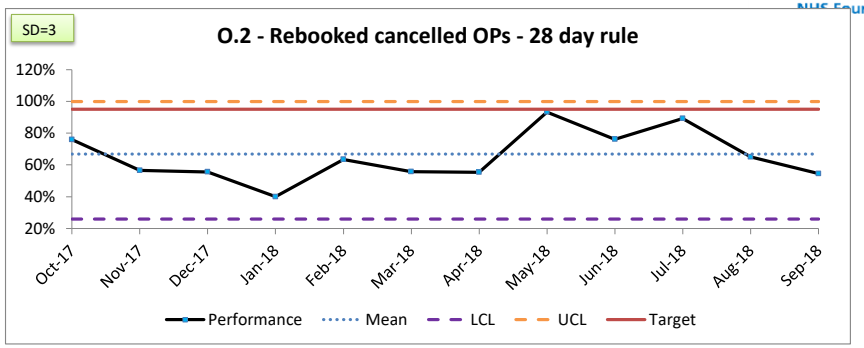


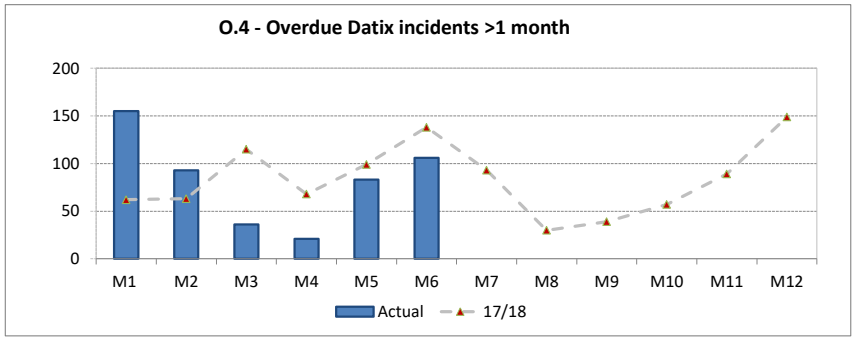


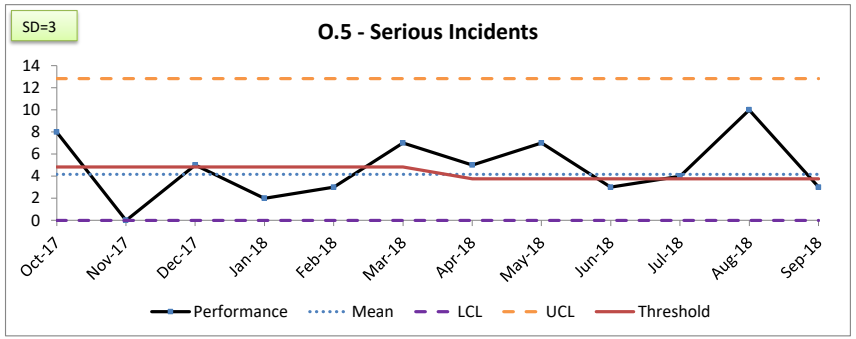
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

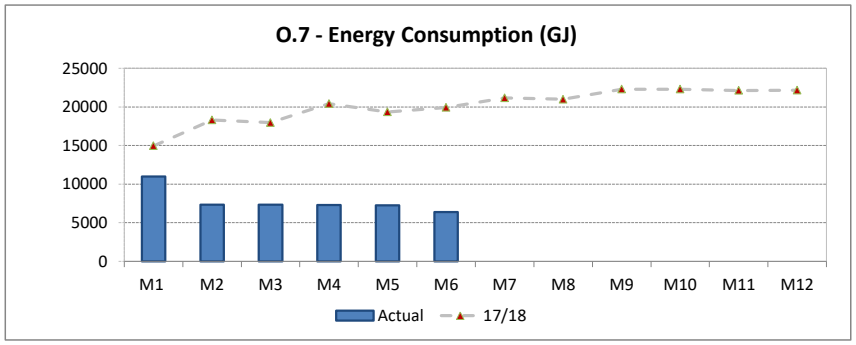
- Performance activity on a rolling 12 months/quarterly
- Average on a rolling 12 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

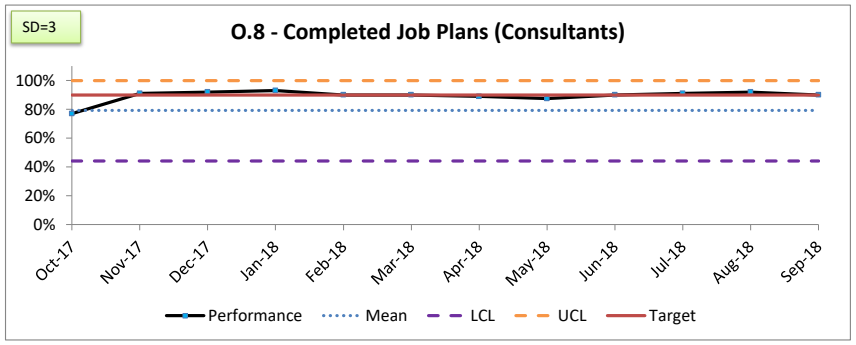












If the LCL is negative (less than zero) it is set to zero.
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- Performance activity on a rolling 12 months/quarterly
- Average on a rolling 12 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Board of Directors	Date: 9 November 2018
Report title:	**Finance Paper Month 6 2018-19**	**Agenda item: 5.2**
Lead director **Report authors**	Mike Keech Daphne Thomas Christopher Panes	Director of Finance Deputy Director of Finance Head of Management Accounts
FoI status:	Private document	

Report summary	**An update on the financial position of the Trust at Month 6 (September 2018)**			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** X	**Decision** ☐
Recommendation	Public Board to note the contents of the paper.			

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

Report history	None
Next steps	None
Appendices	1 to 3

FINANCE REPORT FOR THE MONTH TO 30th SEPTEMBER 2018

PUBLIC BOARD MEETING

PURPOSE

1. The purpose of the paper is to:

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

EXECUTIVE SUMMARY

2. *Income and expenditure* –The Trust's deficit for September 2018 was £1.7m which is £0.6m negative to budget in the month and £1.8m year to date although marginally better than the Trust's control total (excluding PSF).

3. *Cash and capital position* – the cash balance as at the end of September 2018 was £3.1m, which was £0.5m above plan due to the timing of capital spend. The Trust has spent £3.5m on capital up to month 6 of which £1.25m relates to eCARE, Cancer Centre £0.7m, Multi-Storey Car Park £0.3m, North site infrastructure £0.15m, UEC and GDE £0.1m and £1m on patient safety and clinically urgent capital expenditure.

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

5. *Cost savings* – overall savings of £1.2m were delivered in month against an identified plan of £1.2m and the target of £0.7m. Overall for the year £9.3m of schemes have been identified, of which £7.9m have been validated and approved against the £10.1m target.

INCOME AND EXPENDITURE

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

All Figures in £'000	Month Plan	Month Actual	Month Var	YTD Plan	YTD Actual	YTD Var	Full Year Plan	Full Year Forecast	Full Year Var
Clinical Revenue	16,155	16,344	189	100,443	102,116	1,673	200,842	200,842	0
Other Revenue	1,587	1,853	266	9,643	11,663	2,020	19,107	19,107	0
Total Income	17,742	18,197	455	110,086	113,779	3,693	219,949	219,949	0
Pay	(13,472)	(13,588)	(116)	(81,385)	(82,373)	(988)	(161,178)	(161,178)	0
Non Pay	(6,009)	(6,290)	(281)	(36,454)	(39,122)	(2,668)	(72,662)	(72,662)	0
Total Operational Expend	(19,481)	(19,878)	(397)	(117,839)	(121,495)	(3,656)	(233,841)	(233,841)	0
EBITDA	(1,739)	(1,681)	58	(7,753)	(7,716)	37	(13,892)	(13,892)	0
Financing & Non-Op. Costs	(1,016)	(1,011)	5	(6,093)	(6,076)	17	(12,191)	(12,191)	0
Control Total Deficit (excl. PSF)	**(2,755)**	**(2,692)**	**63**	**(13,846)**	**(13,792)**	**54**	**(26,082)**	**(26,082)**	**0**
Adjustments excl. from control total:									
PSF- Performance	206	616	411	1,078	1,078	0	3,079	3,079	0
PSF- Financial	410	410	0	2,152	2,152	0	6,147	6,147	0
PSF- ICS Financial	69	0	(69)	363	0	(363)	1,037	1,037	0
Control Total Deficit (incl. PSF)	**(2,070)**	**(1,666)**	**404**	**(10,253)**	**(10,562)**	**(309)**	**(15,818)**	**(15,818)**	**0**
Donated income	1,000	0	(1,000)	1,500	0	(1,500)	8,592	8,592	0
Donated asset depreciation	(58)	(58)	0	(348)	(348)	0	(697)	(697)	0
Reported deficit	**(1,128)**	**(1,724)**	**(596)**	**(9,101)**	**(10,910)**	**(1,809)**	**(7,923)**	**(7,923)**	**0**

Monthly and year to date review

7. The **deficit excluding Provider Sustainability Funding (PSF)** in month 6 is £2,692k which is £63k better than plan in month. Year to date, the deficit excluding PSF is £13,792k which is £54k better than plan year to date and therefore the Trust has secured the financial element of PSF in Q2. The Trust also met the A&E performance requirements on a year to date basis in order to secure the Q2 performance element of PSF (this followed a change in the rules which allowed for performance to be assessed on a year to date basis, not only on quarterly performance). The STP continues to be behind plan at M6 with an adverse variance of £6.4m to the control total (before PSF) and as a result the Trust has reported a negative variance of £69k (£363k YTD) in respect of the STP element of PSF.

8. The Trust reported deficit in month 6 is £1,723k which is £596k adverse against a planned deficit of £1,128k (£1,809k adverse against a year to date deficit of £10,910k). The adverse variance includes £1,000k (£1,500k YTD) due to timing differences in the receipt of donated income, £69k (£363k YTD) of lost PSF linked to the STP's performance; this is only partly offset by positive variance against the control total before PSF.

9. **Income (excluding PSF and donations)** is £455k favourable to plan in September and £3,693k favourable YTD. High levels of outpatient, day case and high cost drug pass through

income was partially offset by low non elective activity and maternity bookings. The income position includes additional income for the AFC pay award offset in pay.

10. **Operational costs** in September are adverse to plan by £397k and £3,657k YTD.

11. **Pay costs** are £116k adverse to budget in Month 6. The variance is a result of high substantive and bank expenditure in month mainly due to the back pay relating to the pay award which is offset by central funding as noted above (total of £187k in month).

12. Non pay costs were £281k adverse to plan in month and £2,668k YTD. The majority of the variance can be attributed to high levels of high cost pass through drugs, unidentified CIP targets and a planned increase in outsourcing, this has been offset in month by a £296k rebate against CNST costs.

13. Non-operational costs are on plan in month.

COST SAVINGS

14. In Month 6, £1,217k was delivered against an identified plan of £1,204k and a target of £686k.

15. Overall for the year £9.3m of schemes have been identified, of which £7.9m have been validated and approved against the £10.1m target.

16. The Trust is working to develop robust schemes to cover the current £2.1m gap of schemes included on the tracker.

CASH AND CAPITAL

17. The cash balance at the end of September 2018 was £3.1m, which was £0.5m above plan due to the timing of capital spend.

18. The Trust required a draw down in in September of £0.5m

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

    - Non-Current Assets are below plan by £6.8m; this is mainly driven by the timing of capital projects.

    - Current assets are on plan due to cash £0.5m and inventories £0.1m above plan offset by receivables £0.6m below plan.

    - Current liabilities are above plan by £4.2m. This is being driven by Trade and Other Creditors £4.1m and deferred income £0.1m above plan.

    - Non-Current Liabilities are below plan by £8.1m. This is being driven by the timing of revenue loan funding from NHSI being different to planned.

20. The Trust has spent £3.5m on capital up to month 6 of which £1.25m relates to ECare, Cancer Centre £0.7m, Multi-Storey Car Park £0.3m, North site infrastructure £0.15m, UEC and GDE £0.1m and £1.0m on patient safety and clinically urgent capital expenditure.

RISK REGISTER

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

a) Continued Department of Health and Social Care (DHSC) cash funding is insufficient to meet the planned requirements of the organisation.

Funding to cover the planned financial deficit in 2018/19 is subject to approval by DHSC on a monthly basis and remains a risk in the new financial year. The Trust also requires additional capital funding in order to progress essential schemes.

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

The Trust has a challenging target of £10.1m to deliver for the 2018-19 financial year. The full target in 2017-18 was not met and the Trust position was secured by non-recurrent items. The Trust is working to close the gap to the full target value.

c) The Trust is unable to keep to affordable levels of agency (and locum) staffing.

The Trust has an annual agency ceiling of £11.4m in 2018-19 which is in line with the level included in the financial plan. There will be significant pressure on the Trust to maintain its current trajectory over the winter period.

d) The Trust is unable to access £10.3m of Provider Sustainability Funding.

In order to receive the full amount of Provider Sustainability Funding (PSF, previously sustainability and transformation funding) in 2018-19, the Trust needed to achieve its financial control total (linked to 70% of funding), and meet performance standards in respect of urgent and emergency care (linked to 30% of funding). The targets are measured on a quarterly basis. The Trust failed to meet the performance standard requirements for quarter Q4 in 2017/18. A part of a first wave integrated care system £1.1m of the Trust's PSF is contingent on the STP as whole meeting its system control total – this represents a significant risk to the Trust given the current STP financial position.

e) Main commissioner is unable to pay for the volume of activity undertaken by the Trust.

If the Trust over performs against the contract this places financial pressure on the Trust's commissioners who are more likely to challenge other areas in the contract such as the application of penalties. For 2017/18 a significant level of contract challenges has been raised by commissioners in particular with the new (more stringent) process for authorisation of Procedures of Limited Clinical Value (PoLCV) and this represents a risk to recoverability.

RECOMMENDATIONS TO FINANCE & INVESTMENT COMMITTEE

21. The Trust Board is asked to note the financial position of the Trust as at 30th September 2018 and the proposed actions and risks therein.

Appendix 1

Milton Keynes Hospital NHS Foundation Trust
Statement of Comprehensive Income
For the period ending 30th September 2018

	September 2018			6 months to September 2018			Full year
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME							
Outpatients	3,281	3,429	148	20,765	21,247	482	42,079
Elective admissions	2,268	2,320	52	14,117	14,326	209	28,189
Emergency admissions	5,288	4,869	(419)	32,255	31,265	(990)	64,335
Emergency adm's marginal rate (MRET)	(270)	(148)	122	(1,648)	(1,503)	145	(3,287)
Readmissions Penalty	(213)	(213)	(0)	(1,301)	(1,303)	(2)	(2,594)
A&E	1,093	1,041	(52)	6,669	6,257	(412)	13,302
Maternity	1,839	1,615	(225)	11,416	10,227	(1,189)	22,856
Critical Care & Neonatal	508	511	3	3,099	3,221	122	6,181
Excess bed days	0	0	0	0	0	0	0
Imaging	368	384	16	2,358	2,500	142	4,752
Direct access Pathology	354	365	11	2,267	2,302	35	4,569
Non Tariff Drugs (high cost/individual drugs)	1,367	1,404	37	8,324	9,455	1,131	16,607
Other	270	766	497	2,124	4,124	2,000	3,854
Clinical Income	**16,155**	**16,344**	**189**	**100,443**	**102,116**	**1,674**	**200,842**
Non-Patient Income	**3,272**	**2,879**	**(392)**	**14,736**	**14,893**	**157**	**37,963**
TOTAL INCOME	**19,427**	**19,223**	**(203)**	**115,179**	**117,009**	**1,830**	**238,805**
EXPENDITURE							
Total Pay	**(13,472)**	**(13,588)**	**(116)**	**(81,385)**	**(82,373)**	**(989)**	**(161,179)**
Non Pay	(4,642)	(4,885)	(244)	(28,130)	(29,667)	(1,537)	(56,054)
Non Tariff Drugs (high cost/individual drugs)	(1,367)	(1,404)	(37)	(8,324)	(9,455)	(1,131)	(16,607)
Non Pay	**(6,009)**	**(6,290)**	**(281)**	**(36,454)**	**(39,122)**	**(2,668)**	**(72,661)**
TOTAL EXPENDITURE	**(19,480)**	**(19,878)**	**(397)**	**(117,838)**	**(121,495)**	**(3,657)**	**(233,841)**
EBITDA*	**(54)**	**(654)**	**(601)**	**(2,660)**	**(4,486)**	**(1,827)**	**4,965**
Depreciation and non-operating costs	(942)	(938)	5	(5,651)	(5,635)	16	(11,309)
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**(996)**	**(1,592)**	**(596)**	**(8,311)**	**(10,123)**	**(1,811)**	**(6,343)**
Public Dividends Payable	(132)	(131)	1	(790)	(789)	1	(1,579)
OPERATING DEFICIT AFTER DIVIDENDS	**(1,128)**	**(1,723)**	**(595)**	**(9,101)**	**(10,912)**	**(1,810)**	**(7,923)**
Adjustments to reach control total							
Donated Income	(1,000)	0	1,000	(1,500)	0	1,500	(8,592)
Donated Assets Depreciation	58	58	0	348	348	0	697
Control Total Rounding	0	0	0	0	0	0	0
PSF	(684)	(1,027)	(343)	(3,593)	(3,230)	363	(10,263)
CONTROL TOTAL DEFECIT	**(2,754)**	**(2,692)**	**62**	**(13,846)**	**(13,794)**	**53**	**(26,081)**

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

Appendix 2

Milton Keynes Hospital NHS Foundation Trust
Statement of Cash Flow
As at 30th September 2018

	Mth 6 £000	Mth 5 £000	In Month Movement £000
Cash flows from operating activities			
Operating (deficit) from continuing operations	(9,046)	(7,629)	(1,417)
Operating surplus/(deficit) of discontinued operations			
Operating (deficit)	**(9,046)**	**(7,629)**	**(1,417)**
Non-cash income and expense:			
Depreciation and amortisation	4,557	3,797	760
(Increase)/Decrease in Trade and Other Receivables	6,241	5,545	696
(Increase)/Decrease in Inventories	(3)	0	(3)
Increase/(Decrease) in Trade and Other Payables	1,499	1,851	(352)
Increase/(Decrease) in Other Liabilities	61	136	(75)
Increase/(Decrease) in Provisions	(22)	(7)	(15)
Other movements in operating cash flows	(2)	(2)	0
NET CASH GENERATED FROM OPERATIONS	**3,285**	**3,691**	**(406)**
Cash flows from investing activities			
Interest received	22	16	6
Purchase of Property, Plant and Equipment, Intangibles	(4,358)	(3,464)	(894)
Net cash generated (used in) investing activities	**(4,336)**	**(3,448)**	**(888)**
Cash flows from financing activities			
Loans received from Department of Health	4,100	3,600	500
Loans repaid to Department of Health	(476)	(381)	(95)
Capital element of finance lease rental payments	(72)	(60)	(12)
Interest paid	(948)	(789)	(159)
Interest element of finance lease	(153)	(128)	(25)
PDC Dividend paid	(789)	0	0
Net cash generated from/(used in) financing activities	**1,662**	**2,242**	**209**
Increase/(decrease) in cash and cash equivalents	**611**	**2,485**	(1,874)
Opening Cash and Cash equivalents	**2,507**	**2,507**	0
Closing Cash and Cash equivalents	**3,118**	**4,992**	**(1,874)**

Appendix 3

Milton Keynes Hospital NHS Foundation Trust
Statement of Financial Position as at 30th September 2018

	Audited Mar-18	Sep-18 YTD Plan	Sep-18 YTD Actual	In Mth Mvmt	YTD Mvmt	% Variance
Assets Non-Current						
Tangible Assets	171.9	175.7	170.4	(5.3)	(1.5)	(0.9%)
Intangible Assets	10.0	12.1	10.5	(1.6)	0.5	5.0%
Other Assets	0.4	0.4	0.5	0.1	0.1	23.2%
Total Non Current Assets	**182.3**	**188.2**	**181.4**	**(6.8)**	**(0.9)**	**(0.5%)**
Assets Current						
Inventory	3.3	3.2	3.3	0.1	(0.0)	(1.2%)
NHS Receivables	19.1	13.1	10.2	(2.9)	(8.9)	(46.6%)
Other Receivables	4.1	4.4	6.7	2.3	2.6	63.4%
Cash	2.5	2.6	3.1	0.5	0.6	23.7%
Total Current Assets	**29.0**	**23.3**	**23.3**	**(0.0)**	**(5.7)**	**-19.8%**
Liabilities Current						
Interest -bearing borrowings	(32.3)	(31.8)	(31.8)	0.0	0.5	-1.5%
Deferred Income	(1.6)	(1.6)	(1.7)	(0.1)	(0.1)	6.2%
Provisions	(1.4)	(1.4)	(1.4)	0.0	0.0	0.0%
Trade & other Creditors (incl NHS)	(28.4)	(24.7)	(28.8)	(4.1)	(0.4)	1.3%
Total Current Liabilities	**(63.7)**	**(59.5)**	**(63.7)**	**(4.2)**	**0.0**	(0.0%)
Net current assets	**(34.7)**	**(36.2)**	**(40.4)**	**(4.2)**	**(5.7)**	**16.5%**
Liabilities Non-Current						
Long-term Interest bearing borrowings	(83.6)	(95.8)	(87.7)	8.1	(4.1)	4.9%
Provisions for liabilities and charges	(1.1)	(1.1)	(1.1)	(0.0)	(0.0)	3.8%
Total non-current liabilities	**(84.7)**	**(96.9)**	**(88.8)**	**8.1**	**(4.1)**	4.9%
Total Assets Employed	**62.9**	**55.1**	**52.1**	**(3.0)**	**(10.8)**	**(17.1%)**
Taxpayers Equity						
Public Dividend Capital (PDC)	99.2	100.4	99.2	(1.2)	(0.0)	0.0%
Revaluation Reserve	78.7	78.7	78.7	0.0	0.0	0.0%
I&E Reserve	(115.0)	(124.0)	(125.8)	(1.8)	(10.8)	9.4%
Total Taxpayers Equity	**62.9**	**55.1**	**52.0**	**(3.0)**	**(10.8)**	**(17.3%)**

Meeting title	Board of Directors	Date: 9 November 2018
Report title:	Workforce report	Agenda item: 5.3
Lead director Report author	Name: Danielle Petch Name: Paul Sukhu	Title: Director of Workforce Title: Deputy Director of Workforce
FoI status:		

Report summary	This report provides a summary of workforce Key Performance Indicators for the full year ending 30 September 2018 (Month 6). This report now presents vacancy factor data split by staff group with effect from Month 6.			
Purpose *(tick one box only)*	Information [x]	Approval [ ]	To note [x]	Decision [ ]
Recommendation	Trust Board is asked to note the Workforce report, in particular the inclusion of vacancy data with effect from Month 6			

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

Report history	Full monthly corporate workforce information report - Executive Management Board, Divisional Accountability 17 October 2018
Next steps	
Appendices	

Workforce report – Month 6, 2018/19

1. Purpose of the Report

1.1. This report provides a summary of key workforce Key Performance Indicators for the full year ending 30 September 2018 (Month 6).

2. Staff in post

2.1. The Trust's staff in post by whole time equivalent (WTE) was 3012.8 as at 30 September 2018; an increase of 49.0 WTE since September 2017.

2.2. The Trust's headcount is 3499, an increase of 70 since September 2017.

2.3. The largest increases of staff in post since September 2017 have been in Professional, Scientific and Technical, Estates and Ancillary and Healthcare Scientist staff groups.

3. Vacancy rate

3.1. Medical and Dental and Nursing and Midwifery vacancy rates are the highest month 6 Trust-level vacancy rates at 18% and 17.6% respectively.

3.2. A more detailed Quarterly Workforce Information Report is produced for Workforce Board, Workforce and Development Assurance Committee and JCNC, including vacancy rate by staff group. Further detail is presented at Divisional level to the Executive Management Board in the Divisional Workforce reports.

3.3. Month 6 is the first inclusion of these data to the monthly Corporate Workforce Information Report; it should be noted, however, that these data are derived from ESR and may therefore be subject to some variation from data presented from the financial ledger due to the timing and input of the post virement/changes process.

4. Temporary staffing

4.1. The temporary staff usage (bank and agency) for the rolling year-to-date was 5818.4 WTE, which was 14.1% of total WTE staff employed (14.5% in M2, 14.3% in M3, 14.2% in M4, 14.1% in M5).

4.2. Agency staff usage was 3.9% of the total WTE staff employed for the rolling year to date but was 6.3% of the total annual staff expenditure, predominantly driven by medical and dental agency locums.

4.3. The Trust target for Agency Staff Expenditure for 2018/2019 is 8.0%. (10% in 2017/18)

5. Sickness absence

5.1. The sickness absence rate (N.B. 12 months to M5, 31 August 2018) for the Trust remains slightly above the trust target of 4.0% at 4.03% (1.83% short term and 2.20% long term).

5.2. Overall, the Trust's sickness absence levels have been lower than the same period for the last two financial years since October 2017.

5.3. Steps are being taken to address under-reporting of sickness absence across the Trust, in particular in the medical and dental profession. Over 30% of Trust-wide sickness absence is for 'unknown/undeclared' reasons.

5.4. Sickness absence improvement will continue through the Workforce Transformation agenda, reporting to the quarterly Workforce Board.

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

6. Turnover

6.1. Overall, the Trust's leaver turnover rate has been lower in 2017/18 than it was in 2016/17 and in line with its trend for Q2, has reduced from 12.6% to 12% since May 2018.

6.2. As part its work in Cohort 3 of the Retention Direct Support Programme with NHS Improvement the Trust is reviewing its Onboarding and Exit Questionnaire processes in addition to the outputs from exiting staff to feedback to the Clinical Divisions in particular.

6.3. This programme supports further retention focused work; including; Health and Wellbeing, HealthRoster utilisation improvement and implementation plan, Matron's Accountability Framework and Internal Transfer Market.

6.4. Working through task and finish subgroups, the work in support of retention reports to the quarterly Workforce Board and the Nursing and Midwifery Board and features heavily in the Trust's Workforce Strategy delivery plan 2018-21.

7. Statutory and mandatory training

7.1. Statutory and mandatory training compliance as at the end of September 2018 was 89% against the Trust target of 90%.

7.2. Reassurance of the Divisional and Corporate statutory and mandatory training trajectories has been sought and received at Executive Management Board (Divisional Accountability) to the end of March 2019.

7.3. It is anticipated that the 2018 Agenda for Change pay structure reform will support the Trust's improvement plans in this area. Policy development is ongoing to support implementation.

Training Compliance by Division	
Core Clinical	91%
Corporate Services	90%
Medicines Unplanned Care	86%
Surgical Planned Care	87%
Women's and Children's	90%
Trust Total Compliance	**89%**

8. Appraisal compliance

8.1. Appraisal compliance as at the end of September 2018 remained at 85% against the Trust target of 90%.

8.2. Compliance has deteriorated from 86% since January 2018 but has improved steadily since M1 (82%).

8.3. It is anticipated that the 2018 Agenda for Change pay structure reform will support the Trust's improvement plans in this area. Policy development is ongoing to support implementation.

Appraisal Completion by Division	
Core Clinical	91%
Corporate Services	82%
Medicines Unplanned Care	82%
Surgical Planned Care	81%
Women's and Children's	90%
Total Trust	**85%**

9. Recommendations

9.1. Trust Board is asked to note the Workforce report, in particular the inclusion of vacancy data with effect from Month 6.

Meeting title	Board of Directors	Date: 9 November 2018
Report title:	Introduction to the UK Corporate Governance Code 2018	Agenda item: 6.1
Lead director Report author	Name: Kate Jarman Name: Adewale Kadiri	Title: Director of Corporate Affairs Title: Trust Secretary
FoI status:	Private	

Report summary	To draw the Board's attention to the publication in July 2018 of a new UK Code of Corporate Governance, and the impact that this may ultimately have on governance within the NHS			
Purpose *(tick one box only)*	Information ☐	Approval ☐	To note x	Decision ☐
Recommendation	That the Committee notes the publication of the new Code.			

Strategic objectives links	Objective 7 Become well governed and financially viable.
Board Assurance Framework links	
CQC regulations	
Identified risks and risk management actions	
Resource implications	
Legal implications including equality and diversity assessment	

Report history	
Next steps	A further update will be provided to this Committee and the Board in relation to any changes that will be made to the FT Code of Governance or its successor.
Appendices	Appendix 1: UK Code of Corporate Governance 2018 - highlights

Introduction to the UK Code of Corporate Governance

1. The UK Code of Corporate Governance has been in place since 1992. It has been subject to a number of updates since then to take account of developments and significant events, negative and positive within the corporate sphere. While the Code has focused largely on what happens in public limited companies, its principles have significantly influenced the development of governance across other sectors, and in particular, it has formed the basis for the NHS Foundation Trust Code of Governance which was published by Monitor in July 2014. It is expected that NHS Improvement will in due course take the opportunity to update this document (and possibly rename it) in light of the introduction of the new UK Code.

2. A document setting out the highlights of the new Code is attached. While most of these are specific to publicly listed companies, some of the changes, including around the need for engagement with a wider range of stakeholders and the requirement for higher quality external board evaluations, have relevance to NHS organisations, and may in due course make their way into a revised NHS Code.

3. This Board and the Audit Committee will be kept updated on developments in this area.

Revised UK Corporate Governance Code 2018 highlights

Code content

Broadens the definition of governance and emphasises the importance of:

- Positive relationships between companies, shareholders and stakeholders.
- A clear purpose and strategy aligned with healthy corporate culture.
- High quality board composition and a focus on diversity.
- Remuneration which is proportionate and supports long-term success.

Designed to:

- Set higher standards of corporate governance to promote transparency and integrity in business.
- Attract investment in the UK for the long term, benefitting the economy and wider society.

Detailed changes

Stakeholders

- Emphasis on improving the quality of the board and company's relationships with a wider range of stakeholders.
- Taking effective action when receiving significant shareholder votes against resolutions and reporting back more promptly.
- Board responsibility for workforce policies and practices which reinforce a healthy culture.
- Engaging with the workforce through one, or a combination, of a director appointed from the workforce, a formal workforce advisory panel and a designated non-executive director, or other arrangements which meet the circumstances of the company and the workforce.
- The ability for directors and the workforce to be able to raise concerns and for effective enquiry of these concerns.

The boardroom

- Emphasis on importance of independence and constructive challenge of the boardroom.
- Strengthening consideration of 'overboarding'.
- A focus on diversity, the length of service of the board as a whole, and effective board refreshment.
- 'Comply or explain' provision for a maximum nine-year length of service, allowing flexibility to extend "to facilitate effective succession planning and the development of a diverse board… particularly in those cases where the chair was an existing non-executive director on appointment".
- Nomination committee responsibility for more effective succession planning that develops a more diverse pipeline. Reporting on the gender balance of senior management and their direct reports.
- Higher quality external board evaluations, emphasising the importance of the evaluator's direct contact with the board and individual directors.

Remuneration

- More demanding criteria for remuneration policies and practices.
- Clearer reporting on remuneration, how it delivers company strategy, long-term success and its alignment with workforce remuneration.
- Directors exercising independent judgement and discretion on remuneration outcomes, taking account of wider circumstances.
- Remuneration committee chair should have served on a remuneration committee for at least 12 months.

Code structure and reporting

The Code does not set out a rigid set of rules; instead it offers flexibility through the application of Principles and through 'comply or explain' Provisions and supporting guidance. It is the responsibility of boards to use this flexibility wisely and of investors and their advisors to assess differing company approaches thoughtfully. The 2018 Code:

- is shorter and sharper;
- "Supporting Principles" have been removed; and
- has fewer Provisions.

Renewed focus on the Principles

- By reporting on the application of the Principles in a manner that can be evaluated, companies should demonstrate how the governance of the company contributes to its long-term sustainable success and achieves wider objectives
- The statement should cover the application of the Principles in the context of the particular circumstances of the company, how the board has set the company's purpose and strategy, met objectives and achieved outcomes through its decisions
- High-quality reporting will include signposting and cross-referencing to other relevant parts of the annual report.

The effective application of the Principles should be supported by high-quality reporting on the Provisions

- The Provisions establish good practice on a 'comply or explain' basis.
- Companies should avoid a 'tick-box approach'. An alternative to complying with a Provision may be justified in particular circumstances based on a range of factors, including the size, complexity, history and ownership structure of a company.
- Explanations should set out the background, provide a clear rationale for the action the company is taking, and explain the impact that the action has had.
- Where a departure from a Provision is intended to be limited in time, the explanation should indicate when the company expects to conform to the Provision.
- Explanations are a positive opportunity to communicate, not an onerous obligation.

The role of investors and their advisors is very important

- Investors should engage constructively and discuss with the company any departures from recommended practice.
- When considering explanations, investors and proxy advisors should pay due regard to a company's individual circumstances.
- Proxy advisors have every right to challenge explanations if they are unconvincing, but explanations must not be evaluated in a mechanistic way.
- Investors and proxy advisors should also give companies sufficient time to respond to enquiries about corporate governance reporting.

Exec Lead	Risk Ref	Objective	Committee	Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance				Residual risk rating	Progress since last report	Further mitigation/assurances	Action completion date	Target risk score
						Consequence v Likelihood		Level 1 Operational (management)	Level 2 Oversight functions (Committees)	L3 Independent	Overall					
CH	1-1	SO1	Quality & Clinical Risk	Strategic failure to manage demand for emergency care	Lack of demand management by the local health economy Inadequate primary care provision/ capacity Inadequate community care provision/ capacity Inadequate social care provision/ capacity	4x4=16	Working with partners to manage peak demand periods (e.g expediting discharge; using full community/ social care capacity)	Strategic planning at trust-wide and service level Strategic planning within local health economy (CCG, CNWL, GP Federation)	Regular strategic planning withing the system - include Emergency Care Delivery Board Regular reporting to Management Board; Committees and Trust Board on strategic planning	System-wide Emergency Care Delivery Board Regular NHSI oversight (PRMs) External scruitny through Transformation Board, Health and Wellbeing Board and Health Overview and Scrutiny Committee Part of ICS (STP) priority programme on acute care	Good	3x4=12	Executive strategy session 23/03/17	System-wide strategic plan		(4x2) = 8
CH	1-2	SO1	Quality & Clinical Risk	Tactical failure to manage demand for emergency care	Annual emergency and elective capacity planning inadequate or inaccurate Daily flow/ site managmement plans inadequate or ineffectual Poor clinical/ operational relationships impacting on patient flow through the organisation Poor operational/ managerial relationships impacting on escalation Ineffective engagement with stakeholders to support patient flow day-to-day	4x4=16	Introduction of ED streaming Working with UCC to manage demand Implementation of national flow improvement programmes - Red2Green; 100% Challenge; EndPJParalysis; SAFER Strong clinical and operational leadership and ownership; good team working Clear escalation and well-known and understood flow management and escalation plans Positive relationships with stakeholders through daily working and medium-term planning	Daily operational oversight Medium-term planning at service-level Daily and short/ medium-term planning with local health economy partners to support flow and right care/ right place	Regular strategic planning withing the system - include Emergency Care Delivery Board Regular reporting to Management Board; Committees and Trust Board on strategic planning	System-wide Emergency Care Delivery Board Regular NHSI oversight (PRMs) External scruitny through Transformation Board, Health and Wellbeing Board and Health Overview and Scrutiny Committee Part of ICS (STP) priority programme on acute care	Good	3x4=12	Daily management	Continue the implementation of ED streaming Continue the roll out of Red2Green and SAFER across the hospital in order to improve flow through the hospital. Continue to work with external partners to help to reduce ED attendances and reduce delayed discharges		(4x2) = 8
CH	1-3	SO1	Quality & Clinical Risk	Ability to maintain patient safety during periods of overwhelming demand	Significantly higher than usual numbers of patients through the ED Significantly higher acuity of patients through the ED Major incident/ pandemic	5x4=20	Clinically and operationally agreed escalation plan Adherence to national OPEL escalation management system Clinically risk assessed escalation areas available	Daily operational management command structure in place to manage emergency and elective activity safely Clinical site team 24/7 SMOC and EOC 24/7 Daily patient safety huddle	Daily reporting to clinical, oepratonal and executive management Daily sit-rep reporting to regulatory and commissioning bodies Twice-monthly oversight at Management Board (formal reporting)	Daily sit-rep reporting and review by external bodies (CCG, NHSI, NHSE)	Good	4x4=16	Daily management	Continue to clinically review escalation plans in line with demand to ensure patient safety is no compromised		(4x2) = 8
IR	1-4	SO1	Quality & Clinical Risk	Failure to appropriately embed learning and preventative measures following Serious Incidents	Failure to appropriately report, invesitgate and learn from incidents and complaints	5x3=15	All SIs and action plans processed through the Serious Incident Review Group Actions including learning distribution tracked through SIRG Core component of all Clinical Improvement Group Meetings Lessons communicated via Trust-wide channels Debriefing embedded in specialties and corporately Training and skills programme annually Cultural work (inc Greatix and FTSU Guardians	Incident reports and action plans Performance information on incident numbers Emerging or existing trends analysed and reported Repeat incidents analysed and reported - particularly for failure to learn	Serious Incident Review Group Oversight at Clinical Quality Board Oversight at Quality and Clinical Risk Committee	CCG satisfaction with RCA reporting Stakeholder involvement with RCA/SI investigation Internal Audit review of SI process	Satisfactory	5x2=10	QI project on incident reporting in its early stages. Plan to be in place by the end of the year			(5x1) = 5

Exec Lead	Risk Ref	Objective	Committee	Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance				Residual risk rating	Progress since last report	Further mitigation/assurances	Action completion date	Target risk score
						Consequence v Likelihood		Level 1 Operational (management)	Level 2 Oversight functions (Committees)	L3 Independent	Overall					
IR	1-5	SO1	Quality & Clinical Risk	Failure to recognise and respond to the deteriorating patient	Non compliance with the NEWS protocols; failure to appropriately escalate NEWS scores or failure to clinically assess patients outside protocols (i.e. 'hands on, eyes on' patients who are ill but not triggering on NEWS)	5x3=15	National NEWS protocol in place Level 1 pathway in place	Performance is reported to the Clinical Quality Board and is regularly audited Serious Incident Review Group process where issues around deteriorating patient identified eCare implementation supports early earning systems Standardised mortality review process to identify issues and learning	Serious Incident Review Group Oversight at Clinical Quality Board Oversight at Quality and Clinical Risk Committee	Coronial review of deaths	Satisfactory	5x2=10				(5x1) = 5
IR/LK	1-6	SO1	Quality & Clinical Risk	Clinical error or omissions of care due to poor or incorrect use of eCARE (recording and retrieving information)	Inadequate training; poor compliance with the system; local system work-rounds; lack of resolution when issues raised	5x4=20	Training programme in place which is reviewed and audited Clinical Advisory Group in place to reivew all decisions with a clinical impact All nursing and midwifery registered staff written to in September Nursing super-user training established Regular escalation and discussion at medical management forums Review at SIRG for single issues and themes/ trends	Clinical Advisory Group in place - key decision-making body for clinical/ operational risks and issues Clinical safety lead in place - decision making alongside Medical Director and Director of Nursing SIRG for incident review	Oversight at Health Informatics Programme Board Oversight at Management Board Oversight at Trust Board		Satisfactory	5x3=15	New risk (October)			(4x2) = 8
LK	2-1	SO2	Quality & Clinical Risk	Failure to provide an appropriate patient experience	Despite largely positve feedback that is received via social media and through the Friends and Family Test, the Trust has scored relatively poorly in most of the annual patient surveys. There are also a number of recurring themes from complaints, including poor communication, unsatisfactory food, and patients being unable to have a proper say in their care	4x4=16	Risk and incident reporting awareness campaign ongoing Risk and incident training programme in place Integrated Datix system Embedded governance and assurance teams to provide more resource, internal challenge and audit. Lesson of the week shared through the weekly CEO message, supported by divisional publications, briefings and plenary. Appointment of Picker to manage FFT responses and capture more qualitative feedback from patients Appointment of patient experience manager; clinical leads Launch of hellomynameis across the Trust Implementation of new complaints system, and raising the profile of complaint handling across the divisions Receipt of patient stories at the Trust Board Production and monitoring of action plans followjng annual patient surveys Real time feedback provided as appropriate to issues and comment on social media	Oversight at Risk and Compliance Board and Serious Incident Review Group	Oversight at Quality and Clinical Risk Committee and at the Quality and Clinical Risk Committee – reports include details of themes from complaints and evidence that learning is taking place		Poor	4x4=16	Increased executive support to co-ordinate strategy and plans to improve patient experience (July 2018) Strategy and plans to be presented to September 2018 Management Board and Board	Feedback from various patient surveys – inpatient, maternity, ED and children's.		(4x2) = 8 (4x2) = 8

Exec Lead	Risk Ref	Objective	Committee	Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance				Residual risk rating	Progress since last report	Further mitigation/assurances	Action completion date	Target risk score
						Consequence v Likelihood		Level 1 Operational (management)	Level 2 Oversight functions (Committees)	L3 Independent	Overall					
KB/IR	3-1	SO3	Quality & Clinical Risk	Lack of assessment against and compliance with best evidence based clinical practice through clinical audit	Insufficient resource to introduce or embed process and lack of engagement by clinicians	3x4=12	Forward audit plan agreed and published annually Clinical audit leads in place with new (2018) job descriptions and agreed time within job plans Clinical governance leads and audit support in place to support audit leads in CSUs/ divisions Audit assessment process in place - supported and monitored by clinical governance leads and central audit support team New clinical governance structure (2018) in place to improve oversight and escalation of audit	Oversight and scrutiny at Clinical Effectiveness Board; Risk and Compliance Board and Clinical Quality Board Internal compliance monitoring and reporting monthly Reporting to CIGs and divisional management meetings	Oversight at the Quality and Clinical Risk Committee and the Audit Committee	External audi (KPMG) reivew in 2017/18 which identified areas for improvement. On forward audit plan for external audit review in 2018/19.	Satisfactory	3x4=12	Clinical Audit and Effectiveness Board established and first meeting held in July 2018 to improve clinical oversight and identify clinical leadership actions or support required. Improvements in compliance noted.			(4x2) = 8
KB/IR	3-2	SO3	Quality & Clinical Risk	Lack of assessment against and compliance with NICE guidance	The Trust has a significant backlog of NICE guidelines	3x4=12	Monthly assessments of compliance against published NICE baseline assessments Process in place to manage baseline assessments with relevant clinical lead - supported by clinical governance leads Independent review by compliance and audit lead Requires clinical engagement and ownership	Oversight and scrutiny at Clinical Effectiveness Board; Risk and Compliance Board and Clinical Quality Board Internal compliance monitoring and reporting monthly Reporting to CIGs and divisional management meetings	Oversight at the Quality and Clinical Risk Committee		Satisfactory	3x4=12	Clinical Audit and Effectiveness Board established and first meeting held in July 2018 to improve clinical oversight and identify clinical leadership actions or support required. Improvements in compliance noted.			(4x2) = 8
CH	4-1	SO4	Executive Management	Failure to meet the 4 hour emergency access standard	The Trust is unable to meet the target to see 95% of patients attending A&E within 4 hours	4x5=20	Operational plans in place to cope with prolonged surges in demand Cancelling of non urgent elective operations New elective surgical ward open to reduce liklihood of above control Opening of escalation beds Working with partners for social, community and primary care	Divisional and Trust performance reports Rates of discharge; DTOC	A&E Delivery Board	Ongoing NHSI review of key indicators Internal audit work on data quality Quality Report testing of key indicators by external auditors	Satisfactory	4x4=16	Current performance remains variable day-to-day. July has proved challenging with the heatwave and high demand.			(4x2) = 8
CH	4-2	SO4	Executive Management	Failure to meet the key elective access standards - RTT 18 weeks, non-RTT and cancer 62 days	The Trust is unable to meet the 18 week RTT and 62 day cancewr targets, and unable to reduce its non-RTT backlog as required	4x3=12	Regular PTL meetings Work on improving administrative pathways Work with tertiary providers on breach allocations RTT and non-RTT action plans	Divisional and Trust performance reports Management Board scrutiny and oversight of RTT and non-RTT action plans	Finance and Investment Committee scrutiny of financial and operational performance Quality and Clinical Risk Committee oversight	NHSI regional information on performance against key access targets	Satisfactory	4x4=16	Recovery plans established. Additional resource in surgery and T&O. Alternative models to increase capacity and reduce waiting lists approved. Long waiters actively managed. Increased oversight by executive. Weekly reporting to executive directors.			(4x2) = 8

Exec Lead	Risk Ref	Objective	Committee	Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance				Residual risk rating	Progress since last report	Further mitigation/assurances	Action completion date	Target risk score
						Consequence v Likelihood		Level 1 Operational (management)	Level 2 Oversight functions (Committees)	L3 Independent	Overall					
JB	4-3	SO4	Audit	Failure to ensure adequate data quality leading to patient harm, reputational risk and regulatory failure	Data quality governance and processes are not robust	4x4=16	Robust governance around data quality processes including executive ownership Audit work by data quality team	Oversight of progress against action plans by Data Quality Compliance Board	Standing agenda item at the Audit Committee	Outcome of Internal audit assessment of data quality Outcome of External Audit Quality Report testing Outcome of NHSI review	Satisfactory	4x3=12	Testing to commence in specialties where new outcome forms have been in active use for three months or more (September 2018).			(5x1) = 5
JB	5-1	SO5	Audit	Failure to adequately safeguard against major IT system failure (deliberate attack)	Weakneses in cyber security leave the trust vulnerable to cyber attack	3x3=9	Investment in better quality systems GDE investment NHS Digital audits and penetration tests	Results of penetration and phishing tests	Audit Committee review of cyber security	Performance against NHS Digital standards	Good	5x2=10				(4x2) = 8
JB	5-2	SO5	Finance & Investment	Failure to adequately safeguard against major IT system failure (inability to invest in appropriate support systems/infrastructure)	Lack of suitable and timely investment leaves the Trust vulnerable to cyber attack	3x3=9	2 dedicated cyber security posts funded through GDE All Trust PCs less than 4 years old Robust public wifi network EPR investment	Robust capital prioritisation process overseen by Managment Board	Oversight of IT investment strategy and decision making by the Finance and Investment Committee	External oversight of uses of the GDE funding	Good	4x2=8				(4x2) = 8
CH	5-3	SO5	Executive management	Poor escalation of issues relating to eCARE due to lack of understanding or support available	Issues that present a clinical or serious operational risk are not identified or understood and escalation as staff have not been adequately trained; and/ or technical or expert resource to identify and resolve issues is unavailable	5x3=15	Robust programme management, including executive oversight Involvement and engagement of all operational and clinical staff Comprehensive training programme IT investment and system ownership	Oversight by the Health Informatics Programme Board chaired by the Chief Executive and attended by all Executives. This Board reports to Management Board, and in turn, Trust Board	Regular updates to the Finance and Investment Committee Updates to the Trust Board		Satisfactory	5x2=10	Risk recommended for closure now post implementation			(5x1) = 5
CH	5-4	SO5	Executive Management	Failure to maximise the benefits of EPR	That the Trust does not derive all of the benefits in terms of efficiency and productivity from the EPR system as had been anticipated in the business cases	4x3=12	eCare operational delivery board being put into place in order to cover the spectrum of optimisation opportunities both financial and non-financial as a result of the implementation (and upcoming upgrades and changes). An initial schedule of opportunities that forecasts a lvel of savings in line with those in the original business case is being monitored against although there is likely to be some slippage against this when taking into account time for the new system to bed-in across the organisation.	Delivery of financial savings against those specified in the original business case. Delivery of non-financial savings, particualrly releasing time-to-case				3x2=6				(4x2) = 8
	5-5	SO5	Executive Management	Failure to maximise the benefits of the Trust's digital strategy (patient access)	That the Trust does not adequately define its digital strategy to increase and improve patient access to online services and information supporting the management of their own healthcare	4x3=12	Integrated programme plan under development for review at Management Board/ Board in September 2018 Programme resourcing increased to support planning and delivery	Current programme managed through the Outpatients Transformation Board			Limited	4x3=12				(4x3) = 12

Exec Lead	Risk Ref	Objective	Committee	Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance				Residual risk rating	Progress since last report	Further mitigation/assurances	Action completion date	Target risk score
						Consequence v Likelihood		Level 1 Operational (management)	Level 2 Oversight functions (Committees)	L3 Independent	Overall					
MK	7-1	SO7	Finance & Investment	Inability to keep to affordable levels of agency and locum staffing	Inability to recruit to difficult to recruit to posts (across disciplines but particularly in medicine) Short notice sickness absence Poor planning around activity peaks Poor rostering of annual leave/ other leave requirements Increased requirement for enhanced observation levels of care National price caps mean that in a range of areas the Trust has little prospect of full compliance in short term future.	5x4=20	Weekly vacancy control panel review agency requests. Control of staffing costs identified as a key transformation work stream Bank rates and enhancements Capacity planning Robust rostering and leave planning Escalation policy in place to sign-off breach of agency rates Fort-nightly executive led agency reduction group meeting with aim of delivering reduction in both quantity and cost of agency used. Agency cap breaches are reported to Divisions and the FIC .	Transformation plans with tracked delivery. Oversight at the Vacancy Control Panel. Action plan reviews at fortnightly Executive Director Meetings Divisional deep dive sessions Monthly reports to Workfoirce Board and then to Management Board	Performance reported to the F&I Committee Oversight by the Workforce and Development Assurance Committee	Internal audit assessment on the use of medical locums NHSI performance review meetings NHSI agency weekly returns Review of processes and controls by Internal Audit	Good	(3x4)=12	The Agency spend up to mth 6 is £5m which is below plan. The risk to achieving the agency ceiling has reduced as the agency costs have been constantly below the planned level for 2018/19, however the situation will continue to be monitored due to the potential for rising demand to lead to increase in use of agency (particualrly over the winter period).	More robust and comprehensive capacity planning. Consistent approach to rostering and leave planning across the trust.	Current and ongoing	(3x4) = 12
	7-2	SO7	Finance & Investment	Timing and release of capital and revenue funding for 2017/18		5x5=25	Ongoing dialogue with NHSI regarding status of cash commitment from the DH. Revenue funding has been approved by the DoH in the form of an uncommitted term loan. Revenue plan submitted in line with 2018/19 control total of £15.8m deficit. The Trust is in on-going dialogue regarding other strategic capital funding apporval in line with its annual plan.	Capital Expenditure is reviewed at the monthly capital control group and management board	Updates reported to the F&I Committee and Trust Board on a monthly basis	The Trust discusses the position at its monthly PRM calls with NHSI	Good	4x4=16	The Trust has received a pre-commitment for part of the funding required for the eCARE programme; however, the Trust will continue to seek apporval for funding of other capital schemes in 2018/19 in line with its annual plan. The Trust is seeking clarity over what will happen when its revenue support loan due now for repayment in March 2019 (as the Trust has no reasonable prospect of repaying the loan)	Clarification has not yet been received on repayment of the revenue support loan after March 2019, but it is expected that the loan will be rolled over to March 2020 unless a longer term is agreed.	Current and ongoing	(3x4) = 12
MK	7-3	SO7	Finance & Investment	Inability to achieve the required levels of financial efficiency within the Transformation Programme	Increased unplanned activity Inability to identify sufficient savings schemes, or to achieve the expected levels of savings Inability to deliver identified schemes	5x4=20	Tracker in place to identify and track savings and ensure they are delivering against plan Savings measured against trust finance ledger to ensure they are robust and consistent with overall financial reporting All savings RAG rated to ensure objectivity	Fortnightly CIP review meetings between with the Director of Service Development, DoF, divisional managers and project managers Recovery plans requested for off-track schemes Savings plan for 18/19 financial year not yet fully identified.	Monthly CEO chaired Transformation Board oversight, providing leadership and scrutiny of programme delivery		Satisfactory	(4x4)=16	The Trust is forecasting to achieve its control total for 2018/19 and has identified more schemes in 2018/19 than at the same time in 2017/18. Therefore the residual risk scoring has been assessed and has been reduced to 16, but the overall programme is still behind what is planned	Further saving schemes to be identified to deliver maximum savings in 2018/19 and full year effect benefits in to 2019/20.	Current and ongoing	(4x3) = 12

Exec Lead	Risk Ref	Objective	Committee	Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance				Residual risk rating	Progress since last report	Further mitigation/assurances	Action completion date	Target risk score
						Consequence v Likelihood		Level 1 Operational (management)	Level 2 Oversight functions (Committees)	L3 Independent	Overall					
	7-4	SO7	Finance & Investment	Disagreement with main commissioner over the level of performance that they are prepared to fund	Over performance is not payable until up to four months after the activity undertaken, putting pressure on cash flows CCG financial position is such that ability to hold their financial plan will be challenging if over-performance continues at a similar level to 2016-17.	5x4=20	Clearly defined quarterly reconciliation process of contract payments made with close monitoring of the payment for over performance invoices. Escalation of issues to NHSI for intervention where required.	Twice monthly meetings with MKCCG, attended by the DoF and the Deputy CEO to discuss contractual and actual levels of activity	Updates reported to the F&I Committee and Trust Board on a monthly basis		Satisfactory	4x4=16	Over performance for the prior year is still to be discussed with the commissioners and recovery of income remains a significant risk.	The Trust to continue to work closely with the CCG on demand management solutions.	Current and ongoing	(4x3) = 12
MK	7-5	SO7	Finance & Investment	The Trust is unable to access £10.3m of Provider Sustainability Funding (PSF), split into £7.3m General Fund and £3m of additional PSF	That Trust does not meet the performance targets in relation to the A&E 4 hour standards and cancer treatment and therefore does not qualify for PSF	5x5=25	In order to receive £7.3m of PSF General Funding in FY 2018-19, the Trust needs to achieve its financial control total (ie 70% of the funding) and its A&E performance trajectory (30% of the funding). To receive the £3m of additional PSF, the Integrated Care System needs to achieve its control total. The Trust has agreed a control total of £15.8m deficit and its performance trajectory with NHSI and is forecasting to achieve its control total	Financial performance and A&E performance is reviewed at the Executive Director meetings.	F&I committee reviews the monthly financial performance against the control total and receives updates in respect of the A&E performance a monthly basis. The Trust Board reviews A&E performance as well as financial performance on a monthly basis		Satisfactory	5x4=20	The Trust achieved its Q1 and Q2 finance control total and its A&E target Q1 and Q2 YTD, however there is significant risk that the Trust will not meet the Q4 A&E target of 95% in March, soething the Trust did not achieve in 2017/18. As part of an ICS, part of the Trust's PSF is also contingent on achievement of the STP control; given underlying financial pressures in other organisations in the STP, this represents a risk to the Trust as other organisations are not meeting their control totals.	The Trust will continue to closely monitor its performance against the financial and activity targets	Current and ongoing	(3x4)=12
LK	7-6	SO7	Board of Directors	Failures in compliance leading to regulatory intervention (CQC)	That the Trust fails to meet the CQC's fundamental standards and receives a critical report foollowing an inspection	4x4=16	Compliance assessments embedded in divisions and CSUs (through CIGs and compliance reporting) Divisions undertaken Well Led Assessment in quarter three 2017/18 Trust commissioned GGI to prepare for corporate Well Led Assessment review process Corporate governance structure updated to further strengthen quality and compliance oversight and reporting - effective quarter one 2018/19	Oversight through CIGs Oversight at Risk and Compliance Board Oversight at Nursing and Midwifery Board Oversight at Clinical Quality Board Oversight at Management Board	Regular engagement with the local CQC relationship manager Oversight at Quality and Clinical Risk Committee Trust Board engagement in GGI review	Well Led peer review exercise to be held with kingston Hospital Commissioned GGI to undertake Well Led Assessment preparatory review	Satisfactory	4x3=12	Chief Nurse leading a review of compliance and performance against CQC KLOEs. Gap analysis and plan to be brought to Management Board/ Board in September (date tbc).			(4x2) = 8

Exec Lead	Risk Ref	Objective	Committee	Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance				Residual risk rating	Progress since last report	Further mitigation/assurances	Action completion date	Target risk score
						Consequence v Likelihood		Level 1 Operational (management)	Level 2 Oversight functions (Committees)	L3 Independent	Overall					
OE	8-1	SO8	Workforce	Inability to recruit to critical vacancies	National shortages of appropriately qualified staff in some clinical roles, particularly at consultant level Competition from surrounding hospitals Buoyant locum market National drive to increase nursing numbers leaving market shortfall (demand outstrips supply)	4x4=16	Participation in local and regional job fairs Targeted overseas recruitment activity Apprenticeships and work experience opportunities Exploration and use of new roles to help bridge particular gaps Use of recruitment and retention premia as necessary Use of the Trac recruitment tool Use of a system to recruit pre-qualification students Use of enhanced adverts, wsocial media and recruitment days Rollout of a dedicated workforce website	Vacancy control panel Divisional deep dive sessions Monthly reports to Mangement Board Workfoce Board oversight Use of workfoce planning templates Outcomes from the recruitment and retention task and finish group Workforce transformation reports	Quarterly reports to the Workforce and Development Assurance Committee	NHSI Model Hospital benchmarking Staff survey results	Satisfactory	4x3=12	The Trust's vacancy rate is at its lowest for a year. The Trust is working with NHSI on nurse retention, but it has been affected by the difficulties in obtaining visas for overseas doctors.	More attempts are to be made to optimise the Trust's workforce website. Further reduction in time to hire Enhanced on-boarding programme creation of recruitment "advertising" films Creation of Benefits Package literature and marketing materials Creation of bespoke role based recruitment strategy		(4x2) = 8
OE	8-2	SO8	Workforce	Inability to retain staff employed in critical posts	Poor working and management envinroment, lack of progression or development opportunities make it difficult to retain key staff	4x4=16	Variety of organisational change/staff engagement acitivities, e.g. Event in the Tent Schwartz Rounds and coaching collaboratives Recruitment and retention premia We Care programme Onboarding and exit strategies/reporting Staff survey Learning and development programmes Health and wellbeing initiatives, including P2P and Care First Staff friends and family results/action plans Links to the University of Buckingham Staff recognition - staff awards, long service awards, GEM Leadership development and talent	Monthly reports to Workforce Board and Managment Board Workforce transformation reports Line managers' work on staff retention	Reports to Workforce and Development Assurance Committees and the Finance and Investment Committee	NHSI Model Hopsital benchmarking, Staff survey results NHS Improvement staff retention exercise	Satisfactory	4x3=12	Following receipt of the Staff Survey, the Workforce Strategy is to be worked up to address staff engagement, led by the trustwide strategy	Staff survey focus groups Creation of Benefits Pckage literature and marketing materials Creation of workforce strategy and plan to deliver improvement to working experience/environment		(4x2) = 8

Exec Lead	Risk Ref	Objective	Committee	Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance				Residual risk rating	Progress since last report	Further mitigation/assurances	Action completion date	Target risk score
						Consequence v Likelihood		Level 1 Operational (management)	Level 2 Oversight functions (Committees)	L3 Independent	Overall					
	9-1	SO9	Finance & Investment	Insufficient capacity in the Neonatal Unit to accommodate babies requiring special care	The current size of the Neonatal Unit does not meet the demands of the service. This risks high numbers of transfers of unwell babies and potential delayed repatriation of babies back to the hospital. There is a risk that if the Trust continues to have insufficient space in its NNU, the unit's current Level 2 status could be removed on the basis that the Trust is unable to fulfill its Network responsibilities and deliver care in line with national requirements.	4x4=16	Reconfiguration of cots to create more space Additional cots to increase capacity Parents asked to leave NNU during interventional procedures, ward rounds, etc to increase available space	Daily clinical management and operational oversight NNU feasibility study in progress and awaiting decision (DATE REQUIRED) as to whether to proceed with reconfiguration			Limited	4x4=16		Outline business case for NNU re-build still to be developed by the Estates Department and submitted to the STP for consideration		(4x2) = 8
KJ	10-1	SO9	Finance & Investment	Failure to achieve the required level of investment (including appeal funds) to fund the Cancer Centre	Lack of suitable and timely engagement with key players within the city and wider area during the private phase of the appeal, and an inability to enthuse and gain the support of potential donors more broadly, means that the Charity is unable to achieve the required level of charitable contribution to the project	4x3=12	Fundraising strategy and plan in place Financial forecasts under very regular scrutiny Experienced consultancy engaged to support existing senior and experienced fundraising staff Tactical plan for private and public appeal phase developed and implemented	Regular reporting to Committee Operational oversight	Oversight at Charitable Funds Committee	Appeal Leadership Committee	Satisfactory	4x3=12	Income forecasts in place and reiewed weekly.			(4x2) = 8
JH	10-2	SO10	Board of Directors	Inability to progress the Milton Keynes Accountable Care System and wider ACS/STP programme	Lack of effective collaboration among all the key local partners means that the goal of a comprehensive and integrated place based health and social care solution within MK is not realised	4x3=12	Chief Executive and Executive team engagement both at ICS and MK Place levels. MK Place leaders chairing 3 of the 5 ICS priority workstreams	Direct MKUH senior invokvement in decision making. Regular CEO progress updates to Management Board	Standing agenda item at the Trust Board		Satisfactory	4x3=12				(4x2) = 8

Strategic Objective	Risk Ref	Committee	Risk Description	Proximity	Risk Score (consequence v likelihood)							Target	Movement towards target (since Mar 2018)	Risk Appetite
					Jan-18	Apr-18	Jun-18	Aug-18	Oct-18	Dec-18	Mar-19			
SO1: Patient Safety	1-1	Quality and Clinical Risk	Strategic failure to manage demand for emergency care	Next 3 to 6 months	Not on BAF	(4x3) = 12	(4x3) = 12	(4x3) = 12	(3x4)=12			(4x2) = 8	Remains static	Avoid
SO1: Patient Safety	1-2	Quality and Clinical Risk	Tactical failure to manage demand for emergency care	Next 3 to 6 months	Not on BAF	(4x3) = 12	(4x3) = 12	(4x3) = 12	(3x4)=12			(4x2) = 8	Remains static	Avoid
SO1: Patient Safety	1-3	Quality and Clinical Risk	Ability to maintain patient safety during periods of overwhelming demand	Next 3 to 6 months	(4x5) = 20	(4x4) = 16	(4x4)= 16	(4x4)= 16	(4x4)=16			(4x2) = 8	Remains static	Avoid
SO1: Patient Safety	1-4	Quality and Clinical Risk	Failure to appropriately embed learning and preventative measures following Serious Incidents	Next 3 to 6 months	(5x2) = 10	(5x2) = 10	(5x2) = 10	(5x2) = 10	(5x2)=10			(5x1) = 5	Closer to target	Avoid
SO1: Patient Safety	1-5	Quality and Clinical Risk	Failure to recognise and respond to the deteriorating patient	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(3x3) = 9	(5x2) = 10	(5x2)=10			(5x1) = 5	Remains static	Avoid
SO1: Patient Safety	1-6	Quality and Clinical Risk	Clinical error or omissions of care due to poor or incorrect use of eCARE (recording and retrieving information)	Next 3 to 6 months	Not on BAF	Not on BAF	Not on BAF	Not on BAF	(5x3)=15			(5x2) = 10	Closer to target	Avoid
SO2: Patient Experience	2-1	Quality and Clinical Risk	Failure to provide an appropriate patient experience	Next 3 to 6 months	(4x4) = 16	(4x4) = 16	(4x4)= 16	(4x4)= 16	(4x4)=16			(4x2) = 8	Remains static	Cautious
SO3: Clinical Effectiveness	3-1	Quality and Clinical Risk	Lack of assessment against and compliance with best evidence based clinical practice through clinical audit	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3) = 12	(3x4)=12			(4x2) = 8	Remains static	Cautious
SO3: Clinical Effectiveness	3-2	Quality and Clinical Risk	Lack of assessment against and compliance with NICE guidance	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3) = 12	(3x4)=12			(4x2) = 8	Remains static	Cautious
SO4: Key Targets	4-1	Management Board	Failure to meet the 4 hour emergency access standard	Next 3 to 6 months	(4x5) =20	(4x4) =16	(4x4)= 16	(4x4)= 16	(4x4)=16			(4x2) = 8	Remains static	Cautious
SO4: Key Targets	4-2	Management Board	Failure to meet the key elective access standards - RTT 18 weeks, non-RTT and cancer 62 days	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x4) = 16	(4x4)=16			(4x2) = 8	Remains static	Cautious
SO5: Sustainability	4-3	Audit	Failure to ensure adequate data quality leading to patient harm, reputational risk and regulatory failure	Next 3 to 6 months	(4x5) = 20	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3)=12			(4x2) = 8	Closer to target	Cautious
SO5: Sustainability	5-1	Audit	Failure to adequately safeguard against major IT system failure (deliberate attack)	Next 3 to 6 months	(3x3) = 9	(5x2) = 10	(5x2) = 10	(5x2) = 10	(5x2)=10			(5x1) = 5	Remains static	Cautious
SO5: Sustainability	5-2	Finance	Failure to adequately safeguard against major IT system failure (inability to invest in appropriate support systems/infrastructure)	Next 3 to 6 months	(3x3) = 9	(4x2) = 8	(4x2) = 8	(4x2) = 8	(4x2)=8			(4x2) = 8	Remains static	Cautious
SO5: Sustainability	5-3	Management Board	Poor escalation of issues relating to eCARE due to lack of understanding or support available	Next 3 to 6 months	Not on BAF	Not on BAF	Not on BAF	Not on BAF	(5x2)=10			(4x2) = 8	Closer to target	Cautious
SO5: Sustainability	5-4	Management Board	Failure to maximise the benefits of EPR	Next 3 to 6 months	(4x3) = 12	Reassessment required	Reassment required	Reassment required	(3x2)=6			(3x2)=6	Closer to target	Open
SO5: Sustainability	5-5	Management Board	Failure to maximise the benefits of the Trust's digital strategy (patient access)	Next 3 to 6 months	Not on BAF	Not on BAF	Not on BAF	(4x3) = 12	(4x3)=12			(4x2) = 8	Remains static	Seek
SO7: Finance and Governance	7-1	Finance	Inability to keep to affordable levels of agency and locum staffing	Next 3 to 6 months	(5x4)=20	(4x3) = 12	(5x4)=20	(4x4) = 16	(4x4)=16			(4x3) = 12	Remains static	Open
SO7: Finance and Governance	7-2	Finance	Timing and release of capital and revenue funding	Next 12 months	(5x5) = 25	(4x4) = 16	(4x4)= 16	(4x4)= 16	(4x4)=16			(4x3) = 12	Remains static	Open
SO7: Finance and Governance	7-3	Finance	Inability to achieve the required levels of financial efficiency within the Transformation Programme	Next 12 months	(5x4) = 20	(4x4) = 16	(5x4) = 20	(5x4) = 20	(5x4)=20			(4x3) = 12	Remains static	Seek

SO7: Finance and Governance	7-4	Finance	Disagreement with main commissioner over the level of performance that they are prepared to fund	Next 12 months	(5x4) =20	(4x4) = 16	(4x4)= 16	(4x4)= 16	(4x4)=16			(4x3) = 12	Remains static	Seek
SO7: Finance and Governance	7-5	Finance	The Trust is unable to access £7.3m of Sustainability & Transformation Funding	Next 3 to 6 months	(5x5) = 25	(4x4) = 16	(5x4) = 20	(5x4) = 20	(5x4)=20			(4x3) = 12	Remains static	Seek
SO7: Finance and Governance	7-6	Finance	Failures in compliance leading to regulatory intervention (CQC)	Next 12 months	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3)=12			(4x2) = 8	Remains static	Cautious
SO8: Workforce	8-1	Workforce	Inability to recruit to critical vacancies	Next 3 to 6 months	(4x4) = 16	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3)=12			(4x2) = 8	Remains static	Seek
SO8: Workforce	8-2	Workforce	Inability to retain staff employed in critical positions	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3)=12			(4x2) = 8	Remains static	Seek
SO9: Estate	9-1	Finance	Insufficient capacity in the Neonatal Unit to accommodate babies requiring special care	Next 3 to 6 months	Not on BAF	Not on BAF	Not on BAF	(4x4) = 16	(4x4)=16			(4x2) = 8	Remains static	Minimal
SO10: Corporate Citizen	10-1	Charitable Funds	Failure to achieve the required level of investment (including appeal funds) to fund the Cancer Centre	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3)=12			(4x2) = 8	Remains static	Open
SO10: Corporate Citizen	10-2	Board	Inability to progress the Milton Keynes Accountable Care System and wider ACS/STP programme	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3) = 12	(4x3)=12			(4x2) = 8	Remains static	Seek

Meeting title	Board of Directors	Date: 9 November 2018
Report title:	Terms of Reference Review	Agenda item: 7.2
Lead director	Name: Kate Jarman	Title: Director of Corporate Affairs
Report author	Name: Adewale Kadiri	Title: Trust Secretary
FoI status:	Disclosable	

Report summary				
Purpose *(tick one box only)*	Information ☐	Approval ☒	To note ☐	Decision ☐
Recommendation	That the updated Terms of Reference for the Board and its Committees (excluding the Remuneration Committee) be approved			

Strategic objectives links	Objective 7 Become well governed and financially viable
Board Assurance Framework links	None
CQC regulations	None
Identified risks and risk management actions	None
Resource implications	None
Legal implications including equality and diversity assessment	None

Report history	The draft Terms of Reference for the Board Committees, with the exception of the Remuneration Committee, have been considered at the respective committees.
Next steps	Once the changes have been approved, clean copies of the respective terms of reference will be produced and sent to Committee members.
Appendices	Terms of Reference: • Board of Directors • Audit Committee • Charitable Funds Committee • Finance and Investment Committee • Quality and Clinical Risk Committee • Workforce and Development Assurance Committee

1. Purpose of the Report

To present the updated draft Terms of Reference for the Board of Directors and each of its Committees (with the exception of the Remuneration Committee) to the Board for approval.

2. Body of the Report

Paragraph 5.4 of Annex 7 (Standing Orders for the Practice and Procedure of the Board of Directors) to the Trust Constitution stipulates that each committee or sub-committee shall have such terms of reference and powers as the Board shall decide. The Terms of Reference of each of the Committees specify that these should be updated on an annual basis, taking into account, for example, any changes to their remit or membership.

Each Committee has reviewed its Terms of Reference, and the suggested changes are highlighted in track changes:

i. With regard to the Audit Committee, the Director of Clinical Services has been added to the attendance list. Some minor housekeeping has also been done to ensure full compliance with the NHS Audit Committee Handbook, and the Committee's responsibility for oversight of the Trust's cyber-security arrangements confirmed.
ii. For the Charitable Funds Committee, in exceptional circumstances, funding from charitable funds for staffing on a temporary basis may be considered.
iii. Finance and Investment Committee – minor changes to attendance (and further administrative changes will be made to the appendices to ensure that they accurately match the current Standing Financial Instructions).
iv. Some minor changes have been made to the attendance for the Quality and Clinical Risk Committee.
v. Confirmation that a 'staff story' will be received at each meeting of the Workforce and Development Assurance Committee. The Committee will no longer oversee the work of the Medical School, although it will continue to receive medical education updates.

In addition, for each of the Committees, with the exception of the Audit Committee and the Charitable Funds Committee, a publicly elected member of the Council of Governors will be invited to attend one meeting a year, in line with their responsibility to hold the non-executive directors to account for the performance of the Board. A member of the Council will continue to serve as a member of the Charitable Funds Committee.

With regard to the Board's Terms of Reference, the only changes are to reflect the increase in the size of the Board and the fact that the Director of Clinical Services is now a voting member.

3. Recommendations/ Actions

That the updated Terms of Reference for the Board and its Committees be approved.

Board of Directors
TERMS OF REFERENCE

1. Constitution

1.1 The Board of Directors is mandated under paragraph 23 of the Constitution.

2. Authority

2.1 The powers of the Board of Directors are set out in the Trust Constitution and relevant legislation.

3. Accountability

3.1 The Board of Directors is accountable to the various bodies set out in statute, including NHS Improvement and other third party bodies and is also accountable to the Trust Membership via the Council of Governors.

4. Duties

4.1 The Board of Directors will exercise the powers of the Foundation Trust, as set out in the 2006 NHS Act, Health and Social Care Act 2012 and as stated in the Trust Constitution (paragraph 43.2):

"The powers of the Foundation Trust shall be exercised by the Board of Directors on behalf of the Foundation Trust".

4.2 The Board will set the strategic direction, aims and values of the Trust, taking into consideration the views of the Council of Governors, ensuring that the necessary financial and human resources are in place to enable the Trust to meet its objectives and review management performance.

4.3 The Board will ensure that the Trust is compliant with its Provider Licence, its constitution, mandatory guidance issued by NHS Improvement, relevant statutory requirements and contractual obligations. In particular the Board will:

- review the Annual Plan submission to NHS Improvement
- receive sufficient high level reports to assure itself that the Trust is compliant with its terms of authorisation

4.4 The Board as a whole is responsible for ensuring the quality and safety of healthcare services, education, training and research delivered by the Trust and applying the principles and standards of clinical governance set out by the Department of Health, the Care Quality Commission, and other relevant NHS bodies and as documented within the Trust's Risk Management Strategy. In particular the Board will:

- review the Trust's Registration and compliance monitoring arrangements

4.5 The Board should also ensure that the NHS foundation trust exercises its functions effectively, efficiently and economically.

4.6 The Board will recognise that all directors have joint responsibility for every decision of the Board regardless of their individual skills or status and recognise that all directors have joint liability.

5. Risk Management

The Board Assurance Framework will be scrutinised by the Board at each of its meetings. Risks which are rated 15 or over are escalated from service risk registers, via the Divisions, Risk and Compliance Board, Management Board and to the Trust Board for inclusion in the Significant Risk Register. The Board will assess risks to the delivery of the Trust Objectives and include these on the Board Assurance Framework.

6. Membership

6.1 The Chairman of the Board shall be appointed by the Council of Governors;

6.2 The Membership of the Board of Directors shall be as mandated in paragraph 18 of the constitution and shall consist of:

- a Non-Executive Chair
- 7~~6~~ other Non-Executive Directors.
- the Chief Executive
- 6~~5~~ voting Executive Directors including the positions of Medical Director and Director of Patient Care and Chief Nurse, Deputy Chief Executive, Director of Clinical Services, Director of Finance and Director of Workforce

The above comprise the voting membership of the Board of Directors

6.3 Additionally the following will fully participate in Board of Directors meetings but not be entitled to vote:

- any associate Non-Executive Directors
- any other Executive Directors

6.4 The meeting is deemed **quorate** when at least six directors must be present including not less than three voting Executive Directors (one of whom must be the Chief Executive or acting Chief Executive) and three voting Non-Executive Directors (one of whom must be the Chair or Deputy Chair).

6.6 The Board may invite non-members to attend its meetings as it considers necessary and appropriate. The Trust Secretary, or whoever covers those duties, shall be Secretary to the Board and shall attend to take minutes of the meeting and provide appropriate advice and support to the Chair and Board members.

7. Responsibilities of Members

7.1 Members of the Board of Directors have a responsibility to attend at least 75% of meetings, having read all papers beforehand;

7.2 Identify agenda items for consideration by the Chair at least 14 days before the meeting;

7.3 Submit papers to the Trust Secretary by the published deadline (at least 10 days before the meeting). Papers received after this deadline will normally be carried over to the following meeting except by prior approval from the Chair;

7.4 Members must bring to the attention of the Board any relevant matters that ought to be considered by the Board within the scope of these terms of reference that have not been able to be formalised on the agenda under Matters Arising, or Any other Business

7.5 Executive members must send apologies to the Trust Secretary and seek the approval of the Chair to send a deputy if unable to attend in person;

7.6 Members must maintain confidentiality in relation to matters discussed in the Private session of the Board;

7.7 Members must declare any conflicts of interest or potential conflicts of interest at the start of each meeting in accordance with Milton Keynes University NHS Foundation Trust policy (even if such a declaration has previously been made);

8. Frequency of Meetings

8.1 Meetings will normally take place every two months. Meetings may take place more frequently at the Chair's discretion;

8.2 The business of each meeting will be transacted within a maximum of two-and-a-half hours.

9. Committee Administration

9.1 Committee administration will be provided by the Trust Board Secretariat;

9.2 Papers should be distributed to the Board members no less than five clear days before the meeting;

9.3 Draft minutes of meetings should be made available to the Chair for review within 14 days of the meeting;

10. Review

10.1 Terms of Reference will normally be reviewed annually, with recommendations for changes submitted to the Trust Board for approval.

Version Control

Draft or Approved Version:	DRAFT
Date:	~~October 2017~~November 2018
Date of Approval:	
Author:	Trust Secretary
To be Reviewed by:	Trust Board
To be Approved by:	Trust Board
Executive Responsibility:	Director of Corporate Affairs

Milton Keynes University Hospital NHS Foundation Trust

AUDIT COMMITTEE
TERMS OF REFERENCE

CONSTITUTION

1.1 The Trust Board hereby resolves to establish a Committee of the Trust Board to be known as the Audit Committee (known as 'the Committee'). The Committee is a non-executive chaired committee and as such has no delegated authority other than that specified in the Terms of Reference;

1.2 The Committee has been established by the Trust Board to:

- Ensure the effectiveness of the organisation's governance, risk management and internal control systems
- Ensure the integrity of the Trust's financial statements, the Trust's Annual Report and in particular the Annual Governance Statement
- Monitor the work of internal and external audit and ensure that any actions arising from their work are completed satisfactorily.

2. ~~2~~. Delegated Authority

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2.1 The Committee has the following delegated authority:

2.1.1 The authority to require any officer to attend and provide information and/or explanation as required by the Committee;

2.1.2 The authority to take decisions on matters relevant to the Committee;

2.2 The Committee does not have the authority to commit resources. The Chair may recommend to the Board that resources be allocated to enable assurance in relation to particular risks or issues.

3. Accountability

3.1 The Committee is accountable to the Trust Board. Any changes to the Terms of Reference must be approved by the Trust Board, and notified to the Council of Governors;

3.2 The Chair of the Committee is accountable to the Board and to the Council of Governors.

4. Reporting Lines

4.1 Following each meeting, the Committee will provide a written report to the next available meeting of the Trust Board, drawing the Board's attention to any issues requiring disclosure or Board approval;

4.2 The Committee will report back to the Council of Governors through a regular written report;

4.3 The Committee will receive regular reports from the other assurance Committees and formal reports from directors to cover the breadth of its delegated responsibilities.

4.4 **The Committee will report to the Board at least annually on its work in support of the annual governance statement, specifically commenting on:**

- The fitness for purpose of the assurance framework
- The completeness and embeddedness of risk management bin the organisation
- The integration of governance arrangements
- The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a Trust.
- The robustness of the processes behind the quality accounts.

4.5 The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

5. PURPOSE:

5.1 The Audit Committee will provide assurance to the Board on:

- the effectiveness of the organisation's governance, risk management and internal control systems
- the integrity of the Trust's financial statements, the Trust's Annual Report and in particular the Annual Governance Statement
- the work of internal and external audit and any actions arising from their work

5.2 The Audit Committee will have oversight of the internal and external audit functions and make recommendations to the Board and to the Nominations Committee of the Council of Governors on the reappointment of the external auditors.

5.3 The Audit Committee will review the findings of other assurance functions such as external regulators and scrutiny bodies and other committees of the Board.

6. DUTIES OF THE AUDIT COMMITTEE

To promote the trust's mission, values, strategy and strategic objectives;

6.1 Integrated Governance, Risk Management and Internal Control

6.1.1 The Audit Committee shall review the establishment and maintenance of an effective system of governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives.

6.1.2. In particular, the Committee will review the adequacy of:

- The Board Assurance Framework;
- Annual Governance Statement, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to discussion by the Board where possible.
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the disclosure statements in the above.
- the policies for ensuring compliance with NHS Improvement ~~Monitor~~ and other regulatory, legal and code of conduct requirements

- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority ~~and Security Management Service and NHS protect~~.
- the Trust's insurance arrangements.

6.1.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these. It will also seek reports and assurances from officers as appropriate, concentrating on the overarching systems of governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key Committees so that it understands processes and linkages. However, these other Committees must not usurp the Audit Committee's role.

6.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management, which meets the requirements of the Public Sector Internal Audit Standard 2017 ~~mandatory NHS Internal Audit Standards~~ and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.
- reviewing and approving the Internal Audit programme and operational plan, ensuring that this is consistent with the audit needs of the organisation
- reviewing the major findings of internal audit work, management's response, and ensuring co-ordination between the Internal and External Auditors to optimise audit resources
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- reviewing the responses by management to the internal audit recommendations
- annually reviewing the effectiveness of internal audit

6.3. External Audit

The Committee shall review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work. This will be achieved by:

- considering the appointment and performance of the External Auditor
- discussing and agreeing with the External Auditor, before the audit commences, on the nature and scope of the audit as set out in the annual plan.
- discussing with the External Auditors their local evaluation of audit risks and assessment of the Trust and the impact on the audit fee,
- reviewing all External Audit reports, including discussion of the annual audit letter and any work carried outside the annual audit plan, together with the appropriateness of management responses
- Ensure that there is in place a clear policy for the engagement of external auditors to supply non audit services.

6.4 Whistleblowing

The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical and safety matters and ensure that any such concerns are investigated proportionately and independently. In this regard, the Committee will receive a quarterly update from the Trust's Freedom to Speak Up Guardians.

6. 5 Other Assurance Functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications on the governance of the organisation.

These will include, but will not be limited to, any reviews by NHS Improvement , Department of Health, Arms' Length Bodies or others (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

In addition, the Committee will receive the minutes and review the work of other committees within the organisation, whose work could be of assistance to the Committee in gaining assurance around risk management and internal control across the organisation .

The committee will periodically review its own effectiveness and report the results of that review to the Board.

6.6 Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS protect standards and shall review the outcomes of the work in these areas.

7. Membership

7.1 The Membership of the Audit Committee shall be as follows:

- A Non-Executive Director who is not the Chairman or Chair of another Board Committee will be appointed by the Chair of the Trust to chair the Audit Committee. .
- Two other Non-Executive Directors, neither of whom should be the Chair of the Finance and Investment Committee, or the Chair of the Trust.

7.2 Other Non-Executive Directors of the Trust, but not including the Chair, may substitute for members of the Audit Committee in their absence, in order to achieve a quorum.

7.3 The meeting is deemed quorate when at least two members are present. The attendance of other Non-Executive Directors of the Trust who are substituting for members, will count towards achieving a quorum.

7.4 At least one member of the Audit Committee must have recent relevant financial experience. Other members of the Committee must receive suitable training and induction on taking on their role.

8. Attendance

8.1 The following should attend Audit Committee meetings (Attendees)

- The Director of Finance
- Deputy Chief Executive
- Deputy of the Finance Director
- Director of Clinical Services
- Director of Corporate Affairs
- The Internal auditor
- The External auditor
- A Counter Fraud Specialist
- The Trust Secretary
- Medical Director, Associate Medical Director or the Director of Patient Care and Chief Nurse ,

8.2 The Chair and Chief Executive should be invited to attend to discuss with the Committee the process for assurance that supports the Annual Governance Statement.

8.3 The Committee may ask any other officials of the organisation to attend to assist it with its discussions on any particular matter.

8.4 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

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9. Responsibilities of Members, Contributors and Attendees

9.1 Members of the Committee must attend at least 75% of meetings, having read all papers beforehand (Attendees (or their substitutes as agreed with the Chair in advance of the meeting) should attend all meetings);

9.2

9.3 Officers presenting reports for consideration by the Committee should submit such papers to the Trust Secretary by the published deadline (at least 7 days before the meeting). Papers received after this deadline will normally be carried over to the following meeting except by prior approval from the Chair;

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9.4 Members and Attendees must bring to the attention of the Committee any relevant matters that ought to be considered by the Committee within the scope of these Terms of Reference that have not been able to be formalised on the agenda under Matters Arising or Any Other Business. All efforts should be made to notify the Trust Secretary of such matters in advance of the meeting;

9.5 Members and Attendees must send apologies to the Trust Board Secretary and also seek the approval of the Chair to send a deputy if unable to attend in person at least 3 days before the meeting;

9.6 Members and Attendees must maintain confidentiality in relation to matters discussed by the Committee;

9.7 Members and Attendees must declare any conflicts of interest or potential conflicts of interest at the start of each meeting in accordance with Milton Keynes University NHS Foundation Trust policy (even if such a declaration has previously been made);

10 Information Requirements

10.1 For each meeting the Audit and Risk Assurance Committee will be provided (ahead of the meeting) with:

- a report summarising any significant changes to the organisation's strategic risks and a copy of the strategic/corporate Risk Register;
- a progress report from the Head of Internal Audit summarising: • work performed (and a comparison with work planned);
- key issues emerging from the work of internal audit;
- management response to audit recommendations;
- any changes to the agreed internal audit plan; and
- any resourcing issues affecting the delivery of the objectives of internal audit;
- a progress report (written/verbal) from the External Audit representative summarising work done and emerging findings (this may include, where relevant to the organisation, aspects of the wider work carried out by the NAO, for example, Value for Money reports and good practice findings);
- management assurance reports; and
- reports on the management of major incidents, "near misses" and lessons learned.

10.2 As appropriate the Committee will also be provided with:

- proposals for the terms of reference of internal audit / the internal audit charter;
- the internal audit strategy;
- the Head of Internal Audit's Annual Opinion and Report;
- quality assurance reports on the internal audit function;
- the draft accounts of the organisation;
- the draft Governance Statement;
- a report on any changes to accounting policies;
- external Audit's management letter;
- a report on any proposals to tender for audit functions;
- a report on the Trust's approach to cyber-security, including updates on how cyber threats- have been dealt with

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- a report on co-operation between internal and external audit; and
- the organisation's Risk Management strategy.

11 Frequency

11.1 The Committee will meet at least five times a year, in May, June, September, December and March. The May meeting shall specifically focus on reviewing the Trust's Annual Report and Accounts and will be timed to fit in with the statutory timetable set down by Monitor. The Chair of the Audit Committee may convene additional meetings, as necessary.

11.2 The Board or the Accounting Officer may ask the Committee to convene further meetings to consider particular issues on which the Committee's advice is required.

12 Management

The Committee shall request and review reports and seek positive assurances from directors and managers on the arrangements for governance, risk management and internal control

The Committee may also request specific reports from individual functions within the organisation (e.g. clinical audit) as relevant to the arrangements.

13 Financial Reporting

The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

The Audit Committee shall review the Annual Report and Financial Statements, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- changes in, and compliance with, accounting policies and practices
- unadjusted mis-statements in the financial statements
- decisions on the interpretation of policy
- significant judgements in preparation of the financial statements
- significant adjustments resulting from internal and external audits.
- Letters of representation
- Explanations for significant variances.

The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

14 Committee Administration

14.1 The Trust Secretary shall provide secretarial support to the Committee;
14.2 Papers should be distributed to Committee members no less than five clear days before the meeting;
14.3 Draft minutes of meetings should be made available to the Chair for review within 14 days of the meeting and distributed to all members and attendees within 1 month;

15. Review

Terms of Reference will normally be reviewed annually, with recommendations for changes submitted to the Trust Board for approval.

Version	Date	Author	Comments	Status
0.1	December 2008	James Bufford	Approved for Board by Audit Committee December 2008	Draft

1.0	January 2009	James Bufford	Approved by Board	Approved
1.1	Dec 09	Maria Wogan	Reviewed by Audit Committee – proposed amendments to the Board March 2010	For approval
1.2	March 10	Maria Wogan	Annual Review by the Board	Approved
2.0	Sept 2011	Geoff Stokes	Annual review by the Board	Approved
2.1	Jan 2012	Geoff Stokes	Add clinician to attendees list	
2.2	June 2012	Michelle Evans-Riches	Change to membership as Clinician cannot be a member	Approved
3.0	March 2013	Michelle Evans-Riches	Review by Audit Committee and Trust board	Approved
4.0	Sep 2013	Michelle Evans-Riches	Annual Review	Approved
5.0	Sep 2014	Michelle Evans-Riches	Annual Review	Approved
6.0	Nov 2017	Adewale Kadiri	Annual Review	Approved
7.0	Oct 2018	Adewale Kadiri	Annual Review	

Milton Keynes University Hospital
NHS Foundation Trust

CHARITABLE FUNDS TERMS OF REFERENCE

1. Constitution

1.1 The Trust Board hereby resolves to establish a Committee of the Trust Board to be known as the Quality and Clinical Risk Committee (known as 'the Committee'). The Committee is a non-executive chaired committee and as such has no delegated authority other than that specified in the Terms of Reference.

1.2 The Committee has been established to assure the Trust Board that there is in place an effective system of quality and clinical governance, clinical risk management and internal controls across the clinical activities undertaken by or within Milton Keynes Hospital NHS Foundation Trust, to support the organisation's objectives.

1.3 The Committee is established under Standing Order 5 of Annex 7 of the Trust's Constitution.

2. Delegated Authority

2.1 The Committee has the following delegated authority:

2.1.1 The authority to require any officer to attend a meeting and provide information and/ or explanation as required by the Committee

2.1.2 The authority to take decisions on matters relevant to the Committee

2.1.3 The authority to establish sub-committees and the terms of reference of those sub-committees

~~**2.2** The Committee does not have the authority to commit resources.~~

3. Accountability

3.1 The Committee is accountable to the Trust Board. Any changes to the Terms of Reference must be approved by the Trust Board

3.2 The Committee will provide a written report to the next available meeting of the Trust Board following its meetings

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4. DUTIES OF THE CHARITABLE FUNDS COMMITTEE

The Charitable Funds Committee is charged by the Board to:

i) support, guide and encourage the fundraising activities of the Trust;
ii) monitor charitable and fundraising income;
iii) oversee the administration, investment and financial systems relating to all charitable funds held by the Trust;
iv) develop policies for fundraising and for the use of funds

v) ensure compliance with all relevant Charityable Commission regulations, and other relevant items of guidance and best practice.
vi) review the work of other committees within the organisation, whose work can provide relevant assurance to the Charitable Funds Committee's own scope of work.
vii) consider any funding request above the Directorate Fund level, or outside the scope of these funds, which is made to the Charitable Funds Committee. These must have been through the relevant standard Trust approvals processes for either Capital or Revenue (See Appendix One).
viii) consider and approve any urgent requests in advance of any formal meeting, on an exceptional basis through the approval of the named executive director and the committee chair.
ix) oversee and advise on the running of major fundraising campaigns.

5. MEMBERSHIP, ATTENDANCE AND QUORUM

Membership

The Membership of the Charitable Funds Committee shall be as follows:

- A Non-Executive Director will be appointed by the Chair of the Board of Directors to chair the Charitable Funds Committee
- A Non-Executive Director who may be an associate Non-Executive Director or the Chair of the Trust.
- A Named Executive Director (other than Chief executive or Director of Finance)
- A named Governor from the Council of Governors.

The Chief Executive and Director of Finance will be ex-officio members of the Committee but their attendance will not count for quorum

Other Non-Executive Directors of the Trust, including associate Non-Executive Directors may substitute for members of the Charitable Funds Committee in their absence. Such directors will count towards the achievement of a quorum

The Secretary of the Committee will be the Trust Secretary.

The meeting is deemed **quorate** when at least one Non-Executive Director, one Executive Director and one other member is present. Deputies cannot be considered as contributing to the quorum.

6 Responsibilities of Members and Attendees

6.1 Members or attendees of the Committee have a responsibility to:

6**.1.1** Attend at least 75% of meetings
6.1.2 Identify agenda items for consideration by the Chair at least 14 days before the meeting
6.1.3 To submit papers, as required, by the published deadline (7 days before the meeting) on the approved template
6.1.4 If unable to attend, send apologies to the Trust Board Secretary and where appropriate seek the approval of the Chair to send a deputy
6.1.5 To maintain confidentiality, when confidential matters are discussed within the Committee
6.1.6 Declare any conflicts of interest or potential conflicts of interest at the start of each meeting in accordance with Milton Keynes University Hospital NHS Foundation Trust policy, even if such a declaration has already been made

7. MEETINGS AND CONDUCT OF BUSINESS

Frequency

7.1 The Committee will meet four times a year on a quarterly basis and at least 14 days prior to the Trust Board to allow a Committee report to be submitted.

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Version control

Version	Date	Author	Comments	Status
0.1	December 2008	Wayne Preston	Considered by Charitable Funds Committee and approved for Board	Draft
1.0	January 2009	James Bufford	Approved by Board	Approved
1.1	March 2010	Maria Wogan	Minor amendments recommended to Board 24.03.10	For approval
1.2	March 10	Maria Wogan	Annual Review by the Board	Approved
1.3	April 2012	Michelle Evans-Riches	Review of Committee Structure By Finance and Investment Committee	For approval
1.4	September 2012	Michelle Evans-Riches	Implement changes from Charitable Funds Sub-Committee 27 September 2012	For approval
2	August 2013	Michelle Evans-Riches	Annual Review and changes to Committee Structure	For approval
2.1	November 2013	Jonathan Dunk	Updated to reflect new charitable funds approval guidance	For approval
3	June 2014	Michelle Evans-Riches	Review following changes to Terms of Reference template	For approval
4	October 2017	Ade Kadiri	Annual Review	For approval

Appendix One

PROCEDURE FOR BID APPLICATIONS FROM DIVISIONAL GENERAL FUNDS

Wards and departments are able to apply to their Divisional General Fund to "fund new equipment, improve the hospital environment or fund staff training that will improve the experiences of patients and families at Milton Keynes University Hospital".

Funding for staffing may, in exceptional circumstances, be considered where there would be a clear benefit to patients and it is additional to what has already been funded by the NHS. Such funding must be for a specified and limited purpose and period, and any proposed extension would require a further application to this Committee

In order for bids to be considered the following process must be followed.

1) A bid application which includes the charitable fund order form (Appendix 1) should be requested from the Charitable Fund Administrator, this application form must be completed by Divisional Fund Holders, (nominated signatories for the division).

2) Once the application is completed it should be sent to the Divisional General Manager who will be responsible for checking the following:

CAPITAL IMPLICATION

- If the bid is for a single piece of equipment or works over £5k. The bid application will need to be presented to the relevant Capital Group.

Please note:
For all potential capital items you should provide:
Details of the quotation received including any VAT implication

REVENUE IMPLICATION

If it is likely that there will be ongoing revenue costs, the bid application will need to be presented to the relevant forum for approval.

3) Bid Applications up to £1,000 – can be approved by senior Trust fund holder with proviso that no one fund, can spend more than £10k on a range of schemes in a period, without Charitable Fund Committee approval

4) Bid Applications over £1,000 and up to £14,999 must be agreed by senior Trust fund holder and Director of Finance, with explicit immediate notification to the charitable funds committee

5) Bid Applications £15,000 upwards – must go through a formal charitable funds committee approval process at their quarterly meeting, with capital and/or revenue consequences for the Trust made clear.

6) All agreed bid applications should be forwarded to the Charitable Fund Administrator for processing.

7) Rejected bid applications will be returned to the relevant department/ ward

CHECKLIST

It is important that you send the following information with your bid application form. Failure to include relevant documentation/information will delay your application. Please use the tick boxes to confirm included documents.

- ☐ **Fully completed Bid Application form signed by the relevant Fund Holders**
- ☐ **A completed, signed Charitable Fund order form**
- ☐ **Quotes approved by the relevant internal departments (including Capital Group for equipment, building work and Management Board for revenue impact)**
- ☐ **All backing documents relevant to the bid application (quotes etc)**

APPLICATION FOR BID FROM DIVISIONAL GENERAL FUND

Please state the name of the Divisional Charitable Fund you wish the money to come from.

CHARITABLE FUND DIVISION _____

1. DETAILS OF BID APPLICANT (This is the person to whom all correspondence will be addressed) Name Job title Department
Tel: Email:
2. TOTAL BID REQUESTED
3. WHAT IS THE BID FOR? (please provide a brief description of your funding request and the reasons for it, together with details of the expected benefits)
4. WHAT IS THE BENEFIT TO PATIENTS? (It is a requirement of charitable funding that any application has a direct or indirect benefit to patients.)
5. WHY CAN'T THE NHS FUND THIS REQUEST? (It is a requirement of charitable funding that NHS funds are not otherwise available. It is not acceptable to simply state "The NHS has no funds". We want to understand why the NHS is not able to fund it, yet still wants the charity to consider funding)
6. WHAT HAVE YOU DONE / WHAT CAN YOU DO IN ORDER TO HELP FUNDRAISE FOR THE CHARITY IN SUPPORT OF THIS REQUEST? (Some charitable requests can be granted straightaway, some require additional fundraising. Your support will help us increase the number of Bids we can approve)

Applicant:
I declare that, to the best of my knowledge, the information provided in this application is true, accurate and complete.

Name:

Signed: Date:

DIVISIONAL GENERAL MANAGER: ☐ Approved ☐ Rejected

I confirm that I have checked the financial details of this application.

Name: .....

Signed: ..... Date: .....

CHARITABLE FUND ORDER FORM

Date	
Department Name	
Division Req Point	
Requisitioner Name	
Supplier Name	
Product Details	
Product Code	
Unit of Issue	
Quantity Required	
Product Price	
Division Fund Number	
Charitable Signatory 1 (name and signature required)	Date.....
Charitable Signatory 2 (name and signature required)	Date.....
Charitable Signatory Finance (name and signature required)	Date.....
VAT Exemption Y/N	

PLEASE NOTE THAT THIS FORM AND YOUR ORDER CAN NOT BE PROCESSED UNLESS ALL BOXES HAVE BEEN COMPLETED
AND SIGNATURES ARE VALID FOR THE TRUST FUND IDENTIFIED

Finance and Investment Committee
TERMS OF REFERENCE

CONSTITUTION

The Board of Directors hereby resolves to establish a sub - committee of the Board to be known as the Finance and Investment Committee. The Finance and Investment Committee is a committee of the Board and has no executive powers other than those specifically delegated in these terms of reference.

The Finance and Investment Committee is constituted under paragraph 41 of the Constitution and under Standing Order 5 of the Annex 7 of the constitution.

ACCOUNTABILITY

The Finance and Investment Committee is a committee of the Board of Directors of the Trust and accountable to them.

A minute of each meeting will be taken and approved by the subsequent meeting. Once the draft minutes have been approved by the Chair of the Committee, these unapproved minutes will be submitted to the next meeting of the Board of Directors.

The Chair of the Committee shall make a written report to the public meeting of the Board of Directors immediately following each Committee meeting, drawing Board's attention to any issues that require disclosure to the full Board or Board approval.

The Committee will also make an annual report to the Board.

The Committee will make a written report to the Council of Governors.

PURPOSE:

The Finance and Investment Committee will provide assurance to the Board on:

- the effectiveness of the organisation's financial management systems
- the integrity of the Trust's financial reporting mechanisms
- the effectiveness and robustness of financial planning
- the effectiveness and robustness of capital investment management
- the robustness of the Trust's cash investment strategy
- business case assessment and scrutiny (including ensuring that quality and safety considerations have been taken into account)
- the management of financial and business risk
- the capability and capacity of the finance function
- the administration, investments and financial systems relating to all charitable funds held by the Trust

- the effectiveness of the Trust's health informatics and information technology strategies and their implementation
- decisions for future investment in information technology
- the effective implementation and management of the Trust's estates strategy, ensuring that this is in line with the Trust's overall strategy.

The Finance and Investment Committee will review the findings of other assurance functions where there are financial and business implications.

MEMBERSHIP, ATTENDANCE AND QUORUM

Membership

The Membership of the Finance and Investment Committee shall be as follows:

- A Non-Executive Director who is not the Chairman, or Chair of another Board committee will be appointed by the Chair of the Trust to chair the Finance and Investment Committee
- One other Non-Executive Director, who should not be the Chair of the Audit or Quality and Clinical Risk Committees
- The Chief Executive or the Deputy Chief Executive
- The Director of Finance or appointed Deputy
- The Chair of the Trust ex-officio
- Medical Director/ Associate Medical Director/Director of Patient Care and Chief Nurse
- The Director of Clinical Services.

Other Non-Executive Directors of the Trust may substitute for members of the Finance and Investment Committee in their absence and will count towards achieving a quorum.

Attendance

Members of the Finance and Investment Committee are expected to attend all meetings of the Committee.

The following should attend Finance and Investment Committee meetings:

- The Deputy Director of Finance
- ~~Divisional/Business Unit Management Teams (as appropriate)~~
- Trust Secretary or nominated representative

The Chief Executive and Director of Finance will have formally nominated Deputies.

One publicly elected member of the Council of Governors will be invited to attend one meeting a year as observer in line with the Council's role of holding the non-executive directors to account.

Quorum

A quorum of the Committee shall be three members at least two of whom shall be a Non-Executive Director. Other Non-Executive Directors of the Trust, including associate Non-Executive Directors who are substituting for members can be counted in the quorum.

MEETINGS AND CONDUCT OF BUSINESS

Frequency

The Committee will meet regularly as agreed by the Chair of the Committee and the ~~in the~~ Board ~~and Committee timetable~~.

Calling of additional meetings

An additional meeting may be called by the Chair of the Committee or any two of the other Members of the Committee.

Committee Administration

The Committee will at least annually review these terms of reference.

Committee administration will be provided by the Trust Secretariat. The Agenda for meetings will be circulated to all Board members who have requested to receive particular papers. In line with Standing Order 3.4, full papers will be sent to members of the Board so that they are available to them at their normal electronic or physical address 5 clear days before the meeting. Draft minutes of meetings should be available to the Chair for review within fourteen days of the meeting.

Responsibilities of Members

Members of the Committee are expected to attend at least 75% of meetings. In the event that they identify any items for consideration by the Committee, these should be brought to the attention of the Chair at least 14 days before the meeting. Members must declare any conflicts of interest or potential conflicts of interest at the start of each meeting in accordance with the Trust's Conflicts of Interests Policy (even if such a declaration has previously been made).

DUTIES OF THE FINANCE AND INVESTMENT COMMITTEE

Financial Management

- To ensure a comprehensive budgetary control framework that accords with guidance and legislation.
- To review financial plans and strategies and ensure they are consistent with the overall Trust Strategic Planning process.
- To approve budget setting timeframes and processes, and recommend budgets to the Board of Directors.
- To monitor business performance against planned levels and hold to account for corrective action planning, including finance, activity, workforce, and capacity.
- To scrutinise and assess business cases.

Financial Reporting

- To review the content and format of financial information as reported to ensure clarity, appropriateness, timeliness, accuracy and sufficient detail.

Performance Management

- To r~~R~~eviews~~s~~ the potential or actual financial impact of operational performance against a defined set of indicators, such indicators to be subject to on-going review.

Business and Financial Risk

- To consider business risk management processes in the Trust.
- To review arrangements for risk pooling and insurance.
- To consider the implications of any pending litigation against the trust.

Value for Money and Efficiency

- To ensure at all times the Trust receives value for money and operates as efficiently as possible.

Capital Investment

- To ensure robust capital investment plans are in place, kept updated, and progress monitored. (reporting arrangements as per Appendix 1)

Cash

- To act as the Investment Committee in line with approved Investment Policy.
- Ensure cash investments are monitored and give best returns.
- Ensure cash balances are robust, and continue to be so, on a 12 month rolling basis.

Technology

- To ensure that the Health Informatics strategy is implemented effectively and to review decisions for future investment in technology
- To oversee the implementation of the Trust's information technology strategy, and ensure that this is developed in line with best practice within the sector and in accordance with the Trust's overall strategy.

Estates

- To oversee the implementation and development of the Trust's estate strategy in line with the Trust's overall strategy.

RELATIONSHIP WITH AUDITORS AND AUDIT COMMITTEE

The auditors interact with the Trust through the Audit Committee, neither internal nor external audit are therefore included as members of the Finance and Investment Committee. However, both parties can if required request an invitation to attend.

The Audit Committee is distinct and separate from the Finance and Investment Committee, and as such areas of overlap should be minimised. The Finance and Investment Committee should specifically exclude itself from:

Audit

- Review of audit plans and strategies.
- Review of reports from auditors.
- Review of the effectiveness of the internal control framework and controls assurance plans.
- Any recommendations or plans on auditor appointments.

Annual Accounts

- Consideration of the content of any report involving the Trust issued by the Public Accounts Committee or the Controller and Auditor General and the review of managements proposed response.

SFI's and SO's

- Examinations of circumstances when waivers occur.
- Review of schedules of losses and compensations.
- Monitoring of the implementation on standards of business conduct for members and staff.

Fraud

- The review of the adequacy of the policies and procedures for al***l*** work related to fraud and corruption as set out in the Secretary of State Directions and as required by the Directorate of Counter Fraud Services.

Version control

Version	Date	Author	Comments	Status
0.1	5 January 2009	Wayne Preston	Approved for Board	Draft
1.0	January 2009	James Bufford	Approved by Board	Approved
1.1	11 Sept 2009	James Bufford	Added requirement for annual review of these terms of reference	Draft for Finance Cttee
1.2	March 2010	Maria Wogan	Additional amendments from Finance Director re: meeting frequency	Draft for approval by Board
1.3	March 10	Maria Wogan	Annual Review by the Board	Approved
2.0	Nov 2011	Geoff Stokes	Annual review by the Board	Approved
2.1	Aug 2012	Michelle Evans-Riches	Financial Reporting triggers included as appendix	Approved

3.0	Mar 2013	Michelle Evans-Riches	Review by Committee and Trust Board	Approved
4.0	Sep 2013	Michelle Evans-Riches	Annual Review	Draft for approval by Board
5.0	Oct 2013	Michelle Evans-Riches	Annual review by the Board	
6.0	March 2015			
7.0	October 2017	Ade Kadiri	Annual Review	Draft for approval by Board
8.0	October 2018	Ade Kadiri	Annual Review	Draft fpr approval by the Board

Appendix 1

Approval Matrix - Business Case			
Value		**In Annual Plan**	**Not in Annual Plan**
Greater than £1.0m	Document	Full business case	
	Approval	Trust Board	
	Review final stage - Recommendation to invest	Finance Committee	
	Review stage 2	Management Board	
	Review stage 1	Capital Investment Programme Board	
£500k and less than £1.0m	Document	Full business case	
	Approval	Finance Committee	Trust Board
	Review final stage - Recommendation to invest	Management Board	
	Review stage 1	Capital Investment Programme Board	
£250k and less than £500k	Document	Full business case	
	Approval	Management Board	Finance Committee
	Review stage 2	Capital Investment Programme Board	
	Review stage 1	Capital Control Group	
£100k and less than £250k	Document	Dependent on type of expenditure – Discretion of Capital Programme Manager	
	Approval	Capital Investment Programme Board	Capital Investment Programme Board
	Review stage final with recommendation to invest	Capital Control Group	
Less than £100k	Document	Investment Justification Document	
	Approval	Capital Control Group	Capital Investment Programme Board

In exceptional circumstances where an urgent capital investment decision is required which cannot wait until the next meeting of the relevant authorising group e.g.

essential medical equipment which has failed, the approval of the Chairman and one other member of the Group may be sought. Where approval is sanctioned, the decision will must be recorded and formally reported at the next meeting of the relevant authorising group where the decision would have been made

Area	Metric	Measure	Plan
Achievement of plan	EBITDA achieved	85.0% (FRR 4) of plan.	85.0%
	Capital spend against plan	+/- 25% of plan for the year to date. Actual % determined by annual plan target.	0.0%
	Prudential Borrowing Limit not exceeded	£29.2m external borrowing limit for FY12 (FY13 not yet set by Monitor), includes leases.	£29.2m
	Workforce	YTD WTE against planned trajectories.	2607
Underlying performance	EBITDA margin	FY13 5.0% (FRR 3) or greater. Actual % determined by annual plan target.	3.0%
	Patient income variance to plan	YTD performance against plan.	£0.0m
	Delivery against Tx Programme target	YTD performance against planned trajectories.	100%
Financial efficiency	Return on assets after financing	FY13 -0.5% (FRR 3) or greater.	-0.9%
	I&E surplus margin	FY13 -2.0% (FRR 2) or greater. Actual % determined by annual plan target.	-10.1%
	National reference cost index		100.0
Working capital	Liquidity ratio	15 days (FRR 3) cover or greater - Cash plus trade debtors plus unused WCF less trade creditors expressed as the number of days operating expenses that could be covered.	> 15 days
	Cash variance to plan		0.0
	Debtors	90 days past due account for more than 5% of total debtor balances	< 5.0%
	Creditors	90 days past due account for more than 5% of total creditor balances	< 5.0%
Financial sustainability	Minimum dividend cover	Greater than 1, YTD or forecast next 12 months.	> 1.0
	Minimum interest cover	Greater than 3, YTD or forecast next 12 months.	> 3.0
	Minimum debt service cover	Greater than 2, YTD or forecast next 12 months.	> 2.0
	Maximum debt service to revenue	Less than 2.5%, YTD or forecast next 12 months.	< 2.5%

Milton Keynes University Hospital NHS Foundation Trust

Quality and Clinical Risk Committee
TERMS OF REFERENCE

CONSTITUTION:

The Quality and Clinical Risk Committee (QCRC) is a sub-committee of the Board of Directors and has no powers other than those specifically delegated in these terms of reference.

The QCRC is constituted under Paragraph 5.8 of Annex 7 to the constitution. The Terms of Reference will be reviewed annually.

Authority

The QCRC is authorised by the Board to investigate any activity within its terms of reference. It is authorised to request the attendance of individuals from inside or external to the Trust with relevant experience and expertise if it considers this necessary. All employees are directed to co-operate with any request made by the Committee.

PURPOSE:

The QCRC is charged by the Board with the responsibility for providing assurance to the Board that the Trust is providing safe, effective and high quality services to patients, supported and informed by effective arrangements for monitoring and continually improving the safety and quality of care, and the patient experience. It will receive information from the CSUs and Divisions via the Management Board and will, where necessary, escalate issues to the Board.

MEMBERSHIP, ATTENDANCE AND QUORUM:

Membership

The Membership of the QCRC shall be as follows:

- A Non-Executive Director who is not the Chairman, Deputy Chairman or Chair of another Board committee will be appointed by the Chair of the Trust to chair the QCRC
- One other Non-Executive Director
- The Chair of the Trust ex-officio
- The Chief Executive ex-officio
- The Director of Patient Care (or deputy)
- The Medical Director (or deputy)

- The Director of Clinical Services (or deputy)
- The Director of Corporate Affairs
- Ex-officio members of the Committee count for quorum but are not required to attend every meeting ~~and their attendance will not be reported in the Annual Report~~
- Attendance
- Trust Secretary or their representative
- ~~Associate Medical Directors (to attend on rotation)Deputy Chief Nurse~~
- Head of Clinical Governance and Risk
- ~~One of the publicly elected members of the Council of Governors shall attend meetings as an observer~~
- Senior members of Divisional Management will be invited to attend meetings as required.
- One publicly elected member of the Council of Governors will be invited to attend one meeting a year as observer in line with the Council's role of holding the non-executive directors to account.

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Quorum

A quorum of the Committee shall be two NEDs and one Executive Director. Other Directors of the Trust, including Directors who are substituting for members can be counted in the quorum.

ACCOUNTABILITY:

The QCRC is a committee of and accountable to the Board of Directors.

A minute of each meeting will be taken and approved by the subsequent meeting. Once the draft minutes have been approved by the Chair of the Committee, these approved minutes will be submitted to the next private meeting of the Board of Directors. They will also be submitted to the Audit Committee. An action log will be maintained by the meeting secretary.

The Chair of the Committee shall present ~~make~~ a written ~~verbal~~ report to the Public Board meeting immediately following each Committee meeting.~~, drawing Board's attention to any issues that require disclosure to the full Board or Board approval~~.

The Committee will also make an annual report to the Board.

MEETINGS AND CONDUCT OF BUSINESS:

Frequency of Meetings:

The Committee will meet at least on a quarterly basis, with the possibility that additional meetings may be scheduled as necessary at the request of the Committee Chair.

Agenda

The Agenda for meetings will be circulated to all Board members who have requested to receive particular papers.

In line with Standing Order 3.4, full papers will be sent to members of the Committee so that they are available to them at their normal address **5 clear days before the meeting**.

There will be an expectation for information from the Committee to be cascaded to front line staff by managers.

DUTIES OF THE QUALITY AND CLINICAL RISK COMMITTEE:

- To define the Trust's approach to ensuring the quality of its services as part of its overall strategic direction and organisation objectives.
- To promote clinical leadership so that the culture of the Trust reflects a strong focus on quality, clinical effectiveness, safety and patient experience.
- To ensure appropriate structures and systems are in place to support and deliver quality governance including clinical effectiveness, patient safety and patient experience.
- To assure the Board that systems operate effectively within each Division and to report any specific problems as they emerge.
- To receive reports on serious incidents, incidents and near misses, complaints, inquests, claims and other forms of feedback from patients, ensuring learning from all clinical risk management activity, identifying trends, comparing performance with external benchmarks and making recommendations to the Board as appropriate.
- To identify serious unresolved clinical and non-clinical risks to the Audit Committee and the Board.
- To oversee the effective management of risks, as set out within the Board Assurance Framework (BAF) ~~and Significant Risk Register (SRR)~~ as appropriate to the purpose of the Committee.
- To ensure that the views and experience of patients and staff are heard and acknowledged in the work of the committee and by the Board, and that this drives the delivery of the Trust's services.
- To monitor strategies and annual plans for quality governance, clinical audit and effectiveness, research and development, public and patient engagement and equality and diversity. To oversee the production of the Trust's annual Quality Accounts, ensuring compliance with national guidance.
- To ensure that effective consultation with stakeholders takes place, and to monitor the delivery of the quality targets.
- To agree and submit annual quality governance assurance report to the Board.
- To receive relevant reports from internal reviews and external bodies and assurance regarding the implementation of associated action plans.
- To commission, as appropriate, internal and external audits and reviews of services to assure the Board that the Trust is compliant with statutory and regulatory requirements.

- To approve and monitor the Trust's clinical audit programme ensuring it is aligned with Trust priorities, responds to trends in complaints and incidents and is led by and involves staff from all disciplines, liaising with the Audit Committee as appropriate.
- To monitor compliance with the terms of the Trust's CQC registration and NHS Resolution Risk Management Standards.

Version control

Version	Date	Author	Comments	Status
1.0	26.05.10	Maria Wogan Trust Secretary	Final draft approved by the Board of Directors	Approved
2.0	Aug 2011	Geoff Stokes	Annual review by the Board	Approved
3.0	May 2012	Michelle Evans-Riches	Review by Quality Committee following Committee Review by Board	Approved
4.0	March 2013	Michelle Evans-Riches	Review by Quality Committee recommended to Board	Approved
5.0	April 2017	Adewale Kadiri	Review by Quality and Clinical Risk Committee recommended to Board	Approved
6.0	November 2018	Adewale Kadiri	Review by Quality and Clinical Risk Committee recommended to Board	

WORKFORCE AND DEVELOPMENT ASSURANCE COMMITTEE
TERMS OF REFERENCE

1. Constitution

1.1 The Trust Board hereby resolves to establish a Committee of the Trust Board to be known as the Workforce and Development Assurance Committee (known as 'the Committee'). The Committee is a non-executive chaired committee and as such has no delegated authority other than that specified in the Terms of Reference;

1.2 The Committee has been established by the Trust Board to:

1.3 Ensure that the workforce has the capacity and capability to provide high quality, effective, safe patient care in line with the Trust's strategic objectives and We Care values ;

1.4 Monitor the governance of the Trust's workforce strategy, ensuring accountability for the continuous improvement of quality and performance.

1.5 The Committee is established under Standing Order 5 of Annex 7 of the Trust's Constitution;

2. Delegated Authority

2.1 The Committee has the following delegated authority:

2.1.1 The authority to require any officer to attend and provide information and/ or explanation as required by the Committee;

2.1.2 The authority to take decisions on matters relevant to the Committee;

2.2 The Committee does not have the authority to commit resources. The Chair may recommend to the Board that resources be allocated to enable assurance in relation to particular risks or issues.

3. Accountability

3.1 The Committee is accountable to the Trust Board. Any changes to the Terms of Reference must be approved by the Trust Board;

3.2 The Chair of the Committee is accountable to the Board and to the Council of Governors;

4. Reporting Lines

4.1 The Committee will report to the Trust Board through a regular written escalation and assurance report following each Committee meeting;

4.2 The Committee will report back to the Council of Governors through a regular written report;

4.3 The Committee will receive regular reports from the Workforce Board on specific initiatives, business cases and activities that support the delivery of the Trust's Workforce Strategy.

4.4 The Committee will receive formal reports from directors and other Trust staff, covering the breadth of the workforce agenda, including statutory requirements

4.5 The Committee will receive at each meeting, either via the attendance of a member or members of staff, or a representation made on their behalf, an account of their experience of working in the Trust, taking account of relevant workforce strategies, initiatives and activities.

5. Duties

5.1 To promote the trust's mission, values, strategy and strategic objectives;

5.2 To keep under review the development and delivery of the Trust's workforce strategy to ensure performance management is aligned to strategy implementation and promote this across the organisation;

5.3 To hold the executives to account for the delivery of the trust's strategic objectives to improve workforce effectiveness;

5.4 To review progress on clinical and non-clinical training, development and education for Trust employees.

5.5 ~~To maintain oversight over the work of the University of Buckingham Medical School~~

5.6 To ensure that the Trust meets its statutory obligations on equality and diversity.

5.7 To monitor the progress of the Trust's plans to improve staff engagement.

5.8 To ensure that processes are in place to understand and improve staff health and wellbeing.

5.10 Provide assurance to the Board that there are mechanisms in place to allow staff to raise concerns and that these are dealt with in line with policy and national guidance

5.11 The Committee will provide **assurance** to the Trust Board in relation to the following:

5.11.1 Ensure all workforce indicators are measured and monitored;

5.11.2 Ensure that all key performance indicators of a well-managed workforce are regularly reviewed and remedial action is put in place as necessary

5.11.3 Ensure that legal and regulatory requirements relating to workforce are met.

5.11.4 Review and provide assurance on those elements of the strategic risk register/board assurance framework are identified seeking where necessary further action/assurance

6. Membership

6.1 The Chair of the Committee shall be appointed by the Trust Board Chair;

6.2 The Committee will comprise the following members:

- At least two non executive directors (one of whom shall chair this committee)
- Director of Workforce
- Deputy director of workforce
- Director of patient services & chief nurse (or deputy)
- Director of clinical services (or deputy)
- Medical Director
- Director of Medical Education
- Assistant director of education and organisational development

Other directors and Trust staff may be invited to attend at the discretion of the Chair.

One publicly elected member of the Council of Governors will be invited to attend one meeting a year as observer in line with the Council's role of holding the non-executive directors to account.

6.3 The meeting is deemed **quorate** when at least one non-executive director, one executive director and one other member is present. Deputies will not be considered as contributing to the quorum.

7. Responsibilities of Members

7.1 Members of the Committee are required to attend at least 75% of meetings, ;

7.2 Identify any agenda items in addition to those included on the Committee's workplan, for consideration by the Chair at least 14 days before the meeting;

7.3 Submit papers to the Trust Secretary by the published deadline (at least 7 days before the meeting). ;

7.4 Members should bring to the attention of the Committee any relevant matters that ought to be considered by the Committee and are within the scope of these terms of reference, but have not been included on the agenda

7.5 In the event that Committee members are unable to attend a meeting they must send apologies to the Trust Board Secretary and where appropriate seek the approval of the Chair to send a deputy if unable to attend in person;

7.6 Members must maintain confidentiality in relation to matters discussed by the Committee;

7.7 Members must declare any actual or potential conflicts of interest at the start of each meeting in accordance with Milton Keynes University Hospital NHS Foundation Trust policy (even if such a declaration has previously been made);

8. Frequency of Meetings

8.1 Meetings will normally take place quarterly and at least 14 days prior to the Trust Board to allow a Committee report to be submitted. Meetings may take place more frequently at the Chair's discretion;

8.2 The business of each meeting will be transacted within a maximum of two hours.

9. Committee Administration

9.1 Committee administration will be provided by the Trust Secretariat;

9.2 Papers should be distributed to Committee members no less than five clear days before the meeting;

9.3 Draft minutes of meetings should be made available to the Chair for review within 14 days of the meeting;

10. Review

10.1 Terms of Reference will normally be reviewed annually, with recommendations for changes submitted to the Trust Board for approval.

Version Control

Draft or Approved Version:	DRAFT
Date of draft	August 2018
Date of Approval:	November 2018
Author:	Trust Secretary
To be Reviewed by:	Workforce Assurance Committee, Trust Board
To be Approved by:	Trust Board
Executive Responsibility:	Director of Corporate Affairs; Director of Workforce

Meeting title	Board of Directors	Date: 9 November 2018
Report title:	Report of the Board of Directors' Register of Interests	Agenda item: 7.3
Lead Director Report author	Name: Kate Jarman Adewale Kadiri	Title: Director of Corporate Affairs Title: Trust Secretary
FoI status:	Public document	

Report summary	The updated Trust Board Register of Interests is attached for consideration in advance of publication on the Trust website			
Purpose *(tick one box only)*	Information [x]	Approval [ ]	To note [x]	Decision [ ]
Recommendation	The Board is asked to review, note and advise on any amendment required to the Register of Interests declared by members of the Board, for publication on the Trust website.			

Strategic objectives links	None
Board Assurance Framework links	None
CQC regulations	Regulation 5: fit and proper persons: directors Regulation 17: Good governance
Identified risks and risk management actions	None
Resource implications	None
Legal implications including equality and diversity assessment	Failure to fully and properly declare potential conflicts of interests could expose the Trust to the risk of litigation, for example under procurement law, and/or regulatory action

Report history	
Next steps	Publication of the agreed register on the Trust website
Appendices	Register of Interests

Declarations and Register of Interests

1. Paragraph 32 of the Trust Constitution imposes on members of the Board a duty to avoid a situation in which they have or can have a direct or indirect interest that conflicts or may conflict with the interests of the Trust. Paragraph 34 further directs that the Trust shall have a register of interests of directors.

2. From 1 June 2017, NHS England's *Guidance on Managing Conflicts of Interest in the NHS* came into effect, and the Trust's Conflicts of Interest, Hospitality, Gifts, Donations and Sponsorship Policy is based on this guidance. This policy specifies that the register of interest for executive and non-executive directors of the Trust will be published, and will be refreshed annually. The policy also details the different types of interest as set out in the NHS England guidance.

3. The Trust Board's Register of Interests is attached as Appendix A. Board members are asked to confirm that this represents the extent of their relevant interests in advance of publication on the Trust website.

Other Matters

4. The Trust policy on conflicts also relates to senior clinical and non-clinical staff as well as staff deemed to be in 'decision making' roles, including in relation to finance and procurement. Declarations from these staff have been collected onto a separate register, and in line with the policy, this is available from the Trust Secretary on request.

BOARD OF DIRECTORS - DECLARATIONS OF INTERESTS

The table below sets out the declarations of interests made by all members of the Board of Directors.

Director	Title	Do you, your spouse, partner or family member hold or have any of the following: - A directorship of a company? - Any interest or position in any firm, company, business or organisation (including charitable or voluntary organisation) which has or is likely to have a trading or commercial relationship with the Foundation Trust? - Any interest in an organisation providing health and social care to the National Health Service?	Do you, your spouse, partner or family member have a position of authority in a charity or voluntary organisation in the field of health and social care?	Do you, your spouse, partner or family member have any connection with any organisation, entity or company considering entering into a financial arrangement with the Foundation Trust including but not limited to lenders of banks?
Blakeman, Andrew	Non-executive director	Yes. 1. BP P.I.C and subsidiaries (possible provision of road transport fuels, fuels payment and cards) 2. Independent external member of the Quality and Clinical Government Committee of Public Health England (Commissioning of population health screening services, other public health services)	Yes – Trustee of Milton Keynes Hospital Charity	No
Blakesley, John	Deputy Chief Executive	1. Yes – Director of ADMK Ltd (wholly owned subsidiary of MKUH) 2. Spouse has taken up post as Managing Director of the Buckinghamshire Accountable Care System	Yes – 1. Trustee of Milton Keynes Hospital Charity 2. Partner is Trustee of Facial Palsy Charity	

Jarman, Kate	Director of Corporate Affairs	Yes – 1. Spouse is director of Elevation Public Relations Ltd 2. Family Member working in South Lincolnshire CCG. 3. Member of the Labour Party 4. member of the Women's Equality Party	Yes – 1. Trustee of Milton Keynes Hospital Charity	No
Goddard, Emma	Director of Service Development	No	Yes – Trustee of Milton Keynes Hospital Charity	No
Green, Robert	Non-executive director	Yes. 1. 2. Chasely Associates Ltd 3. Chairman – MK Development Partnership (Part of MK Council)	Yes – Trustee of Milton Keynes Hospital Charity	No
Harrison, Joe	Chief Executive	Yes. 1.Spouse working with Harvey Nash (firm involved in Trust Chair recruitment 2017) 2. Two Family members Durrow Health Management consultancy 3. Board member of NHS Provider Board 4. Board member of University of Buckingham Council 5. 3M Consultant 6. Guidepoint Consultant 7. Keele University – Visiting speaker 8. Chair Oxford AHSN Board 9. Spouse a Director of "Collaborate" 10. Spouse works for Centene, which owns Ribera Salud and The Practice Group with whom the Trust will be working	Yes – Trustee of Milton Keynes Hospital Charity	No
Hutton, Caroline	Director of Clinical	No	Yes – Trustee of Milton	No

	Services		Keynes Hospital Charity	
Knight, Lisa	Director of Patient Care & Chief Nurse	Yes. 1.Spouse is Finance Director, Irisguard Ltd	Yes – Trustee of Milton Keynes Hospital Charity	No
Lloyd, Simon	Chairman	Yes. 1. Chairman of Abbey National Treasury Services PLC	Yes – Milton Keynes Hospital Charity	No
Nolan, Tony	Non-executive Director	Yes. 1. Cathedral Homecare Ltd 2. UK Business Transformation Ltd.	Yes – Milton Keynes Hospital Charity	No
Dhanda, Parmjit	Non-executive director	Yes, 1. Director of PRZM Ltd 2. Chair of Allied Health Professions Federation 3. NED of Longhurst Housing Group 4. Executive Director of Back Heathrow	Yes – Trustee of Milton Keynes Hospital Charity	No
Keech, Michael	Director of Finance	1. Yes - Director of ADMK Ltd (wholly owned subsidiary of MKUH) 2. Spouse is a Partner at a GP Practice in Hertfordshire	Yes – Trust of Milton Keynes Hospital Charity	No
Reckless, Ian	Medical Director	1. Yes – Director of ADMK Ltd (wholly owned subsidiary of MKUH) 2. Spouse is currently an employee of MKUH (doctor, postgraduate trainees on regional rotation).	Yes – Trustee of Milton Keynes Hospital Charity	No
Smart, Helen	Non-executive director	Yes – Transformation consultant, Barnet Enfield, Haringey Integrated Care Trust	Yes – Trustee of Milton Keynes Hospital Charity	No
Petch, Danielle	Director of Workforce	Yes – 1. Spouse is Director of S4 Software Solutions, S4 Media Ltd and S4 Resourcing Ltd.	Yes – Trustee of Milton Keynes Hospital Charity	No

		2. Spouse works for Opus Trust Marketing Ltd who print NHS payslips and associated services to MKUH 3. Spouse is IT Director of AMOC Ltd.		
Travis, Heidi	Non-executive director	No.	Yes – Chief Executive Officer of Sue Ryder Hospice and Neurological Care Trustee of Milton Keynes Hospital Charity	No
Clapham, John	Non-executive director	Yes – 1. Pro vice chancellor of the University of Buckingham 2. Director of MDM Ltd. (owners of the Academic Centre)	Yes – Trustee of Milton Keynes Hospital Charity	No

Meeting title	**Board of Directors**	**Date: 9 November 2018**
Report title:	**Use of Trust Seal**	**Agenda item: 7.4**
Lead director **Report author** **Sponsor(s)**	**Name: Kate Jarman** **Name: Adewale Kadiri**	**Title: Director of Corporate Affairs** **Title: Company Secretary**
FoI status:	**Public**	

Report summary	To inform the Board of the use of the Trust seal.						
Purpose *(tick one box only)*	**Information**	x	**Approval**		**To note**	x	**Decision**	
Recommendation	That the Board of Directors notes the use of the trust seal for the settlement of the grant agreement between the Trust and Milton Keynes Council.						

Strategic objectives links	Objective 7 become well led and financially sustainable.
Board Assurance Framework links	**None**
CQC outcome/ regulation links	**None**
Identified risks and risk management actions	**None**
Resource implications	
Legal implications including equality and diversity assessment	None

Report history	None
Next steps	None
Appendices	

Use of Trust Seal

1. Purpose of the Report

In accordance with the Trust Constitution, this report informs the Board of one entry in the Trust seal register which has occurred since the last meeting of the Board.

2. Context

The Trust Seal was executed on 19 September 2018 for the settlement of the tariff funding agreement between Milton Keynes University Hospital NHS Foundation Trust and Milton Keynes Council.

Meeting title	Board of Directors	Date: 9 November 2018
Report title:	Report of the Management Board meeting held on 3 October 2018	Agenda item: 7.5
Report author	Name: Joe Harrison	Title: Chief Executive
FoI status:	Public document	

Report summary				
Purpose *(tick one box only)*	Information [x]	Approval [ ]	To note [ ]	Decision [ ]
Recommendation	The Board is asked to note the update from the Chief Executive summarising the outcome of discussions at the October Management Board meeting.			

Strategic objectives links	All
Board Assurance Framework links	None
CQC regulations	None
Identified risks and risk management actions	None
Resource implications	None
Legal implications including equality and diversity assessment	None

Report history	
Next steps	
Appendices	None

Chief Executive's Report - key points arising from the Management Board meeting on 3 October 2018

1. Chief Executive update

The flu vaccination campaign was launched during the month the Trust has (at the time of drafting this report) achieved 58.8% - a 7.5% improvement compared to the same point last year.

2. Staff engagement – Staff Survey

Management Board received a report on activities continuing to take place to address issues raised in the previous National Staff Opinion Survey.

- Violence against staff (in all forms) is a national theme and one recognised as an area for continued focus at MKUH. Focus groups are being held in areas where results have raised the most concerns to help understand the issue in greater depth in order to put in the most effective interventions.
- Greatix has been recognised as an effective and useful tool in recognising good practice and positive learning. The level of engagement from clinical staff has been higher than for any other scheme.

3. Freedom to Speak Up

- The focus of this national initiative is changing, with more of an emphasis on encouraging staff to speak up about all concerns and issues, including those that may be seen as 'minor' or of less seriousness.
- At MKUH, staff have been asked to volunteer as Freedom to Speak Up Ambassadors to increase the number of trained staff to whom colleagues might refer concerns quickly. This also aims to help to embed a speaking-up culture across the Trust. More potentially serious concerns will continue to be referred to the existing Guardians.
- It is likely that some of these Ambassadors might come from existing networks such as P2P – an already positively seen, used and well-embedded scheme - but all volunteers are welcome.

4. Q1 Complaints, PALS and Patient Experience Report

- There has been an increase in the number of complaints received over the previous quarter, particularly in the Emergency Department. Specific actions will be required to address the key themes arising from these concerns.

5. Health and safety update

- Safety of staff, including effective interventions to prevent violence and aggression were discussed at the Committee
- The new manual handling advisor is investigating how the workstations on wheels (WoWs) might be made more ergonomically friendly
- The Safety Alert System is being reviewed to ensure on-going robust compliance and assurance for national safety alerts

6. Estates quarterly fire report

Fire alarms are being tested weekly and evacuation of buildings will be tested with support from fire wardens. Visitors and staff will be advised of the fire alarm testing.

7. Risk Management upwards report

- The Trust continues to be a relatively low reporter of incidents compared to other hospitals of a similar size.
- The investigation of serious incidents is of a high standard.
- A Quality Improvement programme to examine the drivers for reporting and how reporting can be improved will be undertaken during November and December. This will include analysing comparative data from other organisations.

8. Board Assurance Framework

- Management Board acknowledged the reduction in ratings for two of the finance related risks – agency and locum spending; and the transformation programme.
- Clinically, the highest risk areas were confirmed as eCare, elective pathways and emergency care.

9. Information governance

- The Trust continues to work hard to ensure on-going compliance with the General Data Protection Regulation (GDPR).

Audit Committee Summary Report

1. Introduction

The Audit Committee met on 29 October 2018. A summary of the key matters discussed is provided for the Board:

2. Matters Arising

There was a discussion about data quality, with particular reference to the recording of A&E and RTT performance. The systems in A&E, part of the eCare package, are now very different to what they were, and staff are still getting used to them. An Optimisation and Operational Improvement Group has been set up to address ongoing issues with the day to day use of eCare, and there has been a particular focus on A&E.

Although there has not yet been a change in systems with regard to RTT, a major organisational change process has taken place, with the move to centralised administrative teams.

Overall, it is expected that some improvement will be recognised in testing, assuming that these two indicators are once again selected.

Operationally, particular attention is being paid to reducing the number of elective patients approaching a 52-week wait time. A new manual handling advisor has been appointed and is doing some good work across the Trust.

3. External Audit

The external auditor, Deloitte, introduced their planning report for the audit year ending 31 March 2019, highlighting in particular the risks that their team would be focusing on in their work; which include as before revenue recognition, management override of controls, and the Trust's going-concern status.

4. Internal Audit

RSM, the Trust's new internal audit providers were in attendance for the first time. They introduced their plan, indicating that they had held conversations with KPMG, Deloitte and the executive team. They have already commenced work on the financial control and CIP reviews. The RSM team also presented their indicative three-year strategy. It was confirmed that feedback has already been received from the executive team, and it has been agreed that the clinical audit review will be done next year to give the executive team a chance to address the issues raised in the KPMG report. The internal audit plan was agreed. Outstanding actions from the KPMG reviews will be presented at the December meeting.

5. Counter Fraud

The Committee was notified of the outcome of the NHS Counter Fraud Authority assessment which was carried out over the summer. The Trust had self-assessed itself as green (compliant/ good) against strategic governance and amber (compliant/

satisfactory) for inform and involve, and these were replicated in the assessment. The amber assessment was due to a lack of evidence demonstrating the evaluation of inform and involve activities. Activities to be carried out as part of fraud awareness week in December should start to address this. Overall, this was a positive outcome.

In addition to the fraud awareness week, a procurement review is to be undertaken in November, and HR training is to be carried out.

6. Financial Controller Report

Write-offs for the quarter amounted to £23k and they were covered under the Trust's bad-debt allowance. The Committee agreed to approve these write-offs.

Losses during the period amounted to £8k, and were mostly made up of pharmacy stock write-offs. The Committee was assured that the stock is well managed.

In terms of credit notes over £20k, the Committee was informed that an error in an automated payment function had led to VAT being added erroneously to a number of monthly contract invoices raised to various commissioners. All of the errors have now been corrected, and a process has been put in place to prevent this from happening in the future. The Committee were content about this, but raised the wider question as to whether there is a process for learning from mistakes.

There were 19 tender waivers in the period, which is high compared to what has been reported in the past. It was reported that there is confidence that the procurement process is now working better.

6. Risk Management Framework

This updated framework was presented to the Committee for noting. The Committee raised concerns about the use of the word 'catastrophic' in the risk management matrix, but it was noted that this is part of the standard CQC wording. It was agreed that more work needs to be done on getting staff to rate their risks appropriately. It was agreed that the Framework should be referred to the Board for approval.

With regard to the Board Assurance Framework (BAF), the point was made that the actions set out to mitigate the risks should either be time-bound, or their effectiveness should be reviewed. There was also the question whether there is sufficient focus on the inherent scores and their mitigation. It was suggested that discussion of the BAF be given more time at the next Board meeting to ensure it is driving the Board agenda.

7. UK Code of Corporate Governance update

It was noted that a new version of the Code was published earlier this year, and it is likely that NHS Improvement will seek to update the Foundation Trust Code of Governance, which is based on the UK Code. The Committee will be kept informed of any developments in this area.

8. Audit Committee Terms of Reference update

The Committee noted the proposed changes in line with the NHS Audit Committee Handbook. In terms of attendance, it was agreed that the Medical and Nursing Directors are not required except for specific agenda items, but that the Director of Clinical Services and Deputy Chief Executive should remain on the membership.

9. Minutes from Board Committees

Minutes of the following Board Committee meetings were presented to the Committee for information:

- Finance and Investment Committee meetings on 25 June (approved) 6 August, 3 September and 1 October 2018 (draft)
- Quality and Clinical Risk Committee meeting on 21 June 2018 (draft)
- Charitable Funds Committee on 31 August 2018 (draft)
- Workforce and Development Assurance Committee meeting on 6 August 2018 (draft)

There was a discussion as to whether these minutes should continue to be presented to this Committee, and it was agreed that they should. In addition, it was agreed that the Chair's Board reports be updated to highlight:

- Cross-committee items
- Adjustments to the BAF
- Risk register items
- Wider learning for the organisation

10. Recommendation

The Board is asked to:

i) Note the report; and
ii) Consider the escalation items and any necessary actions.

MEETINGS OF THE FINANCE AND INVESTMENT COMMITTEE HELD ON 3 September and 1 October 2018

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

At the 1 October meeting, the Committee approved:

- The subsidiary Cancer Centre business case, and
- relatively minor changes to the Committee's Terms of Reference.

Matters referred to the Board for final approval:

The subsidiary Cancer Cemtre business case and the Committee's updated Terms of Reference were referred to the Board for ratification.

Matters considered at the meeting:

1. Performance Dashboard:

The Committee noted that:

I. The Trust is working with the South Central Ambulance Service to ensure that the number of ambulance handover delays is accurately recorded.
II. The Trust's A&E performance is above its agreed trajectory, but it did not reach the threshold for Provider Sustainability Fund (PSF) performance based payments. Consideration was being given as to whether to lodge an appeal on the grounds of the impact that eCare had on the Trust's performance.
III. Although there is a great deal of management focus on dealing with the 52 week waits, the number of such patients increased in August as a result of a number of patients refusing treatment on the dates offered.
IV. The overall number of GP referrals is once again in the increase. There is now a sharper focus on making better use of technology in Outpatients.
V. The Trust is in discussion with the CCG in relation to the calculation of the readmissions credits.

2. Board Assurance Framework:

At the September meeting, the Committee noted that there had been little change in relation to the finance related risks on the BAF. Following further discussion in October, the following changes in risk ratings were made:

I. 7-1 (agency and locum staffing) to reduce from 20 to 12 (4x3) on the basis that it is unlikely that the Trust would not stay within its ceiling.
II. 7-3 (transformation) to reduce from 20 to 16 given the better position of the programme this year compared to last year.

3. Finance Report M4

I. The Integrated Care System element of the Provider Sustainability Fund was not achieved as a result of financial issues elsewhere within the STP.
II. Maternity and non-elective care were both reported to be below plan in month in September, but in October, it was reported that maternity had had a very busy August with 364 births.
III. In September, it was noted that the current deficit was greater than it was at the same time last year, and the need to improve the underlying position was emphasised. It was expected that the impact that the introduction of eCare has had on the year to date position would fade over the rest of the year. By October, the control total was at the expected level both in month and YTD.
IV. The Committee noted the proactive approach being taken by procurement to derive savings from across the whole supply chain. It also noted the steps being taken to address the risks to meeting the Trust's control total

4. Agency update

I. The increase in agency spend in July had been discussed with divisions and is being monitored.
II. The impact that the pay award could have an agency use was unknown.
III. Efforts to recruit substantively to recruit posts are continuing.
IV. There is an expectation that the agency cap will reduce further in 2019/20.

5. CQUIN report for 2018/19

I. The total CQUIN value for ythe year is £4.4m, and at M4, the delivery forecast was £3.7m.

6. Transformation Programme

I. £9m worth of schemes have been identified, but £1m of this is still work in progress, leaving a £2m gap to the £10m target.
II. The Trust is beginning to adopt a rolling approach to identifying CIPs, moving away from having to start the process afresh each year. Discussions are already being held in relation to 2019/20 schemes.
III. Opprtunities are being explored to derive the best value from the investment in eCare

7. Subsidiary Cancer Centre business case

The Committee considered this business case and approved it for ratification by the Board.

Quality and Clinical Risk Committee Summary Report

1. Introduction

The Quality and Clinical Risk Committee met on 29 October 2018.

2. Key matters

The following items were presented to the Committee:

Action log (highlights)

Seven day services – The Trust's performance in a recent national audit of progress against the core standards was not as we would have hoped. Part of this was due to a data input issue which is being investigated. A new national reporting mechanism is to be introduced in April 2019, and this is expected to provide more clarity. This is being piloted at a number of sites but the nature of this process (local Board assurance on 7DS) is not yet clear. In the meantime, steps are being taken internally to monitor progress against delivery and these will continue. It is proposed that Trust Board is updated in February 2019 when local data will be available, and the national plan may have been articulated.

Quarterly highlight report

The top issues, positive and challenging, occupying the Medical Director and the Chief Nurse's minds included:

- Some concerns remain about the quality of documentation generated through eCare. Concerted action is being taken to address these issues and improvements are being made.
- The inquest into the death of the lady from the multi-storey care park is to be held in November, and there is likely to be a focus on how mental health patients are managed in the hospital. Discussions on this subject are already taking place across the STP.

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

- Much winter planning work is taking place within and outside the hospital in relation to the management of emergency care. It was agreed that a discussion is to be held at the Board on whether to change the risk rating.
- The risk around the failure to respond to the deteriorating patient is to be rewritten to include reference to NEWS 2 and sepsis.

Mortality update

- The 'other perinatal conditions' category continues to flag, as a result of coding issues. Although there are no concerns about the standard of coding, the issue of staffing challenges within the team is to be raised at the Board.
- Changes to the lead time for SHMI data mean that the data produced will now be slightly more current.

Quarterly Serious Incident Report

- A non-executive member of this Committee had attended a Serious Incident Review Group meeting and was impressed both by the culture and atmosphere at the meeting. This gave the Committee further assurance as to the robustness of that process.

Improving Patient Experience

- The Director of Corporate Affairs delivered a presentation setting out the priorities to be addressed in the Patient Experience Strategy, having recently taken over responsibility for this area of work from the Chief Nurse.

- It was noted that the divisions would be required to take ownership for the delivery of most of the priorities.
- The Committee stressed the need to seize opportunities for close working with patients' and other groups, building on the success of this approach with regard to food.
- An updated version of the presentation is to be delivered to the Board.

Draft Quality Improvement Framework
Although agreement has not yet been reached as to how quality improvement should be modelled and what approach is to be used, a Quality Improvement Faculty has been set up with a view to progressing this agenda. The Committee commended the strategic direction as articulated, but stressed that there is more to be done, suggesting that good practice at other trusts should be taken note of. Further discussions should be held by the executive team around the development of both a 'bottom up' approach and a 'top down' leadership strategy in this area ahead of a future Board discussion.

Pressure Ulcers: revised definition and measurement
There are to be changes from 2019 on how pressure ulcers are recorded and measured, with a view to developing a consistent national approach. The terms 'avoidable' and 'unavoidable' will no longer be used, and a number of new categories will be introduced. This may lead to an increase in the pressure ulcers recorded at this Trust.

National Clinical Audits update
- The Trust is not as compliant as it should be, as was reported by Internal Audit last year.
- Much work has been done to understand what the problems are, and the establishment of the Clinical Audit Effectiveness Board is one of the key changes that have been put in place. That Board has already identified gaps around clinical leadership in this area.
- It was also acknowledged that there are gaps in personnel, particularly, in the Medicine Division, which has made it more difficult for some of the audit obligations to be met.
- The Committee were not assured that the audit plan would be delivered by April 2019, and an updated plan, with milestones is to be presented at the next meeting.
- Failing to deliver the plan would have financial consequences for the Trust and professional implications for individual clinicians.

MKUH stroke services
The Committee considered the background to the issues around the provision of stoke care, and agreed that the approach proposed by the Medical Director is in the best interests of patients in this area. The Committee therefore recommend the Medical Director's draft letter to the CCG regarding stroke services to Trust Board.

Other Items
The Medical Director's Newsletter had been received by the Committee for information. Members expressed particular interest in the potential development of 'robotic surgery' and would welcome further information at Trust Board.

3. Conclusions
The committee was assured that the hospital remains safe, and commended the engaged and professional executive team.

The Board is asked to note this report and the specific items escalated for the Board's attention.